

**University of Southern Queensland**

**Yatdjuligin: The Stories of Queensland Aboriginal  
Registered Nurses 1950–2005**

A Dissertation submitted by  
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# Abstract

This research and its presentation as a dissertation was undertaken utilising an Aboriginal methodology. This methodology, known as Djarpligin, is used by South/Western Gurreng Gurreng people for the transference of our knowledges. Djaparligin translates to singing corroboree. This means it is bound to Gurreng Gurreng language, inclusive of our songlines and ceremonies. This methodology is utilised to tell the stories of the participants of this research. The findings of this research are the stories of the participants as they describe their journeys as Aboriginal women who are registered nurses. The presenting of this thesis is Yatdjuligin.

An in-depth literature review was required for this research and it is more than a literature review but it is a component of my Djaparligin methodology. A thorough investigation was undertaken to look at the stories of Aboriginal nurses in Queensland and Australia. In constructing the stories of the research participants it was essential to contextualise them. First and foremost is their Aboriginality. This is entwined with the nursing history of each era and finally the government policies of the day. This was further contextualised by undertaking a substantial review of the literature to explore the voices of Indigenous nurses in the United States, Canada and New Zealand.

The findings of this research are ‘Yatdjuligin: The Stories of Queensland Aboriginal Registered Nurses 1950–2005’.

# Certificate of Authorship / Originality

I certify that the work in this thesis has not been previously submitted for a degree nor has it been submitted as parts of requirements for any degree except as fully acknowledged within the text.

I also verify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

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## ENDORSEMENT

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Signature of Supervisor

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Date

# Acknowledgements

I acknowledge the owners of the land this work is being examined on. I thank their elders both past and present for their continued care of country. I also acknowledge my Elders for the gifting of my bloodlines and the strength to undertake this research.

During this journey I have had unusual amounts of love and support from beginning to end, which has guided me on this five and a half year journey. First and foremost I thank Tom Kirk, Wakgun Clan ‘knowledge keeper’ for teaching me culture, language, lore and land, thank you cuz.

Don, for your supervisory support and guidance and your unwavering belief in me to be able to do this. To my sista Kath, your cultural guidance and support was always unwavering as was the constant meals and love, thank you.

To Daz and Kelly and Mabel, thank you muchly for the technology support and fixing up my messes and the moments of pure clarity.

In closing, I have to say, Gadge “I think I’m the good slayer now”, and to my Grandma Joy, “I think I have finished my lessons”. Your belief in me set me on this path of which I can never thank (or maybe curse) the both of you enough.

This work is dedicated to the amazing, awe-inspiring, smart Aboriginal nurses that I walk with every day.

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# List of Abbreviations

ABS	Australian Bureau of Statistics
ACDON	Australian Council of Deans of Nursing
AE	Accident and Emergency
AES	Aboriginal Employment Strategy
AHS	Area Health Services
AICHS	Aboriginal and Islander Community Health Service
AIH	Australian Institute of Health
AIHW	Australian Institute of Health and Welfare
AIN	Assistant in Nursing
AMS	Aboriginal Medical Service
ANAC	Aboriginal Nurses Association of Canada
ATSI	Aboriginal and Torres Strait Islander
ATSIC	Aboriginal and Torres Strait Islander Commission
AWL	Absent Without Leave
CATSIN	Congress of Aboriginal and Torres Strait Islander Nurses
CCHS	Community Controlled Health Service
CPHA	Canadian Public Health Association
CNC	Clinical Nurse Consultant
CRRAH	Centre for Rural and Remote Area Health
DOGIT	Deed of Grant in Trust
DOHA	Department of Health and Ageing
DON	Director of Nursing

EN	Enrolled Nurse
FCAATSI	Federal Council for the Advancement of Aborigines and Torres Strait Islanders
FN	First Nations
GP	General Practitioner (medical doctor)
GT	General Trained Nurse
HECS	Higher Education Contribution Scheme
HIV	Human Immunodeficiency Virus
HRSCAA	House of Representatives Standing Committee on Aboriginal Affairs
ICU	Intensive Care Unit
INE WG	Indigenous Nurse Education Working Group
JCU	James Cook University
LPN	Licensed Practical Nurse (Canada)
NACCHO	National Aboriginal Community Controlled Health Organisation
NAHS	National Aboriginal Health Strategy
NAIHO	National Aboriginal and Islander Health Organisation
OATSIH	Office for Aboriginal and Torres Strait Islander Health
OATSIHS	Office of Aboriginal and Torres Strait Islander Health Services
OCNO	Office of Chief Nurse Officer (Queensland Health)
PA	Princess Alexandra Hospital
PNC	Preliminary Nursing Course



PNS	Preliminary Nursing School
QAIHC	Queensland Aboriginal and Islander Health Council
QAIHF	Queensland Aboriginal and Islander Health Forum
QNC	Queensland Nursing Council
QNU	Queensland Nurses Union
QUT	Queensland University of Technology
RCAP	Royal Commission into Aboriginal People (Canada)
RCNA	Royal College of Nursing Australia
RFDS	Royal Flying Doctor Service
RN	Registered Nurse
RPN	Registered Practical Nurse (Canada)
SAAP	Supported Assistance Accommodation Program
TAFE	Technical and Further Education
TPP	Tertiary Preparation Program
TSRA	Torres Strait Regional Authority
UCSQ	University College of Southern Queensland
UQ	University of Queensland
USQ	University of Southern Queensland
WHO	World Health Organisation

# Chapter 1: Introduction

---

**First and foremost I acknowledge the traditional owners of the land that this work is being examined on. I pay my respect to their Elders both past and present and acknowledge them for their continued care of country.**

## **1.1 Djaparl Nganya – ‘song of me’**

The protocol for introducing one’s self to other Indigenous people is to provide information about one’s cultural location, so that connection can be made on political, cultural and social grounds and relations established. (Moreton-Robinson 2000)

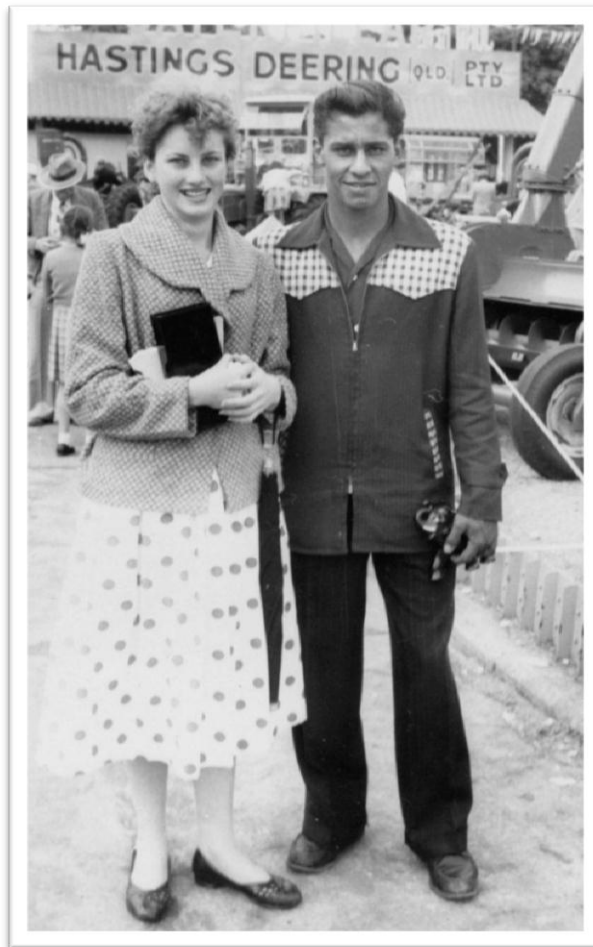
In accordance with custom and to acknowledge the statement above I will introduce myself. In my grandmother’s *Wakgun* dialect of the *Gurreng Gurreng* Nation, *Djaparl Nganya* translates to ‘*song of me*’.

Within this entire work I have utilised my maternal grandmother’s language and knowledges. The English translation will always be offered alongside.

I have been gifted with multiple Aboriginal identities. As is the experience of many Aboriginal people across Australia, I have been affected by the issue of ‘removal’. I was born in March of 1968 in Brisbane, Queensland. At this time the ‘powers’ of removing half-caste children were rampant and I was one of them. My birth mother Laurel Booth was administered under the Queensland Aboriginal and Opium Protection Act in Queensland. Essentially this meant that my birth mother was a domestic and was moved around the state of Queensland to work for a pittance at different households and rural stations. It was whilst at a rural station in Central Queensland that I was conceived. My mother was ordered to go and work at the

University of Queensland (UQ) as a domestic. I was born on the floor of International House at UQ after my mother had worked a long day whilst in labour. I was then taken by ambulance to the Royal Brisbane Hospital. My mother was not allowed to travel with me but was also taken to the Royal Brisbane. My birth mother was allowed to see me briefly on the third day and named me Nancy Faye Booth. Little did my birth mother know that she would not see me again or look into my face for another 32 years.

I was taken to *Wirilda* orphanage and adopted by Lorraine and John Best at six weeks of age.



**Figure 1.1 Lorraine and John Best**

My adopted mother is a third generation white Australian of Welsh and Scottish descent. My adopted father is a *Koomumberrri* man having been born on his country at Southport, Gold Coast. As with a number of the Aboriginal nations outlined by Tindale, my adopted father's nation is not identified. On the Horton Map it is identified as *Yuggerra* (see Figure 1.2).

My father John is a saltwater man and comes from a long lineage of exceptional fishermen. On the map below there are two Islands off the coast of Brisbane which are now known as North and South Stradbroke Island. South Stradbroke is where my father largely grew up after being born at Southport Hospital (on his country).



**Figure 1.2 Horton Map of Aboriginal Australia**

In late 1897, his grandfather, Albert Levinge, bought with his brother the Moreton Bay Oyster Company. The company at this time was owned by an Englishman, Beau Palmer. The oyster beds ran from the Tweed right up to the mouth of the Mary River opposite Fraser Island. They were known as the ‘Oy Oy’ brothers. As part of the sale of the company my family acquired a 99 year lease on a portion of South Stradbroke Island that went from *Curagee* up to *Jumpinpin Bar*. My great grandfather, Albert Levinge, is buried at the Dunwich cemetery, North Stradbroke Island. My grandmother (see Figure 1.3, next page) was schooled at Dunwich State School on North Stradbroke and lived for decades on South Stradbroke Island. This granted, in many respects, avoidance of experiencing the harsh policies of Aboriginal administration. I had an idyllic childhood spending months of the year whilst not schooling in Brisbane on what we called, ‘Nanna’s Island’. Dad had cousins on North Stradbroke and as children we occasionally visited North Stradbroke.

My childhood was filled with the continuation of the ancient traditions of my grandmother’s people. Myself and my siblings (mum and dad adopted four children) were taught to fish in open waters and go crabbing in the mangroves, filling sugar bags with plump oysters and digging for *eugaries* (pippies) on the beach in front of our grandmother’s shack.

My father and grandmother on South Stradbroke Island taught me the beginnings of some of the knowledges of the *Koomumberri* people. It was as an adult that I re-connected with my birth family and found my link to land and my bloodlines.



**Figure 1.3 Nanna and Grandad Best**

### **1.1.1 Bloodlines**

I have been gifted with two Aboriginal bloodlines. I am *Gurreng Gurreng*, dialect of the *Wakgun* (scrub turkey), clan of the *Gurreng Gurreng* Nation, South Western Area (see Figure 1.4, next page). Our country extends north along the Burnett River, west as far as Munduberra, north to Eidsvold along the Dawes Range to Cania Gorge then east across to Miriamvale and Baffle Creek. The land then extends south, down to Mt Perry and to the Burnett River. These boundaries have always been in our stories. It is this bloodline that I most identify with.

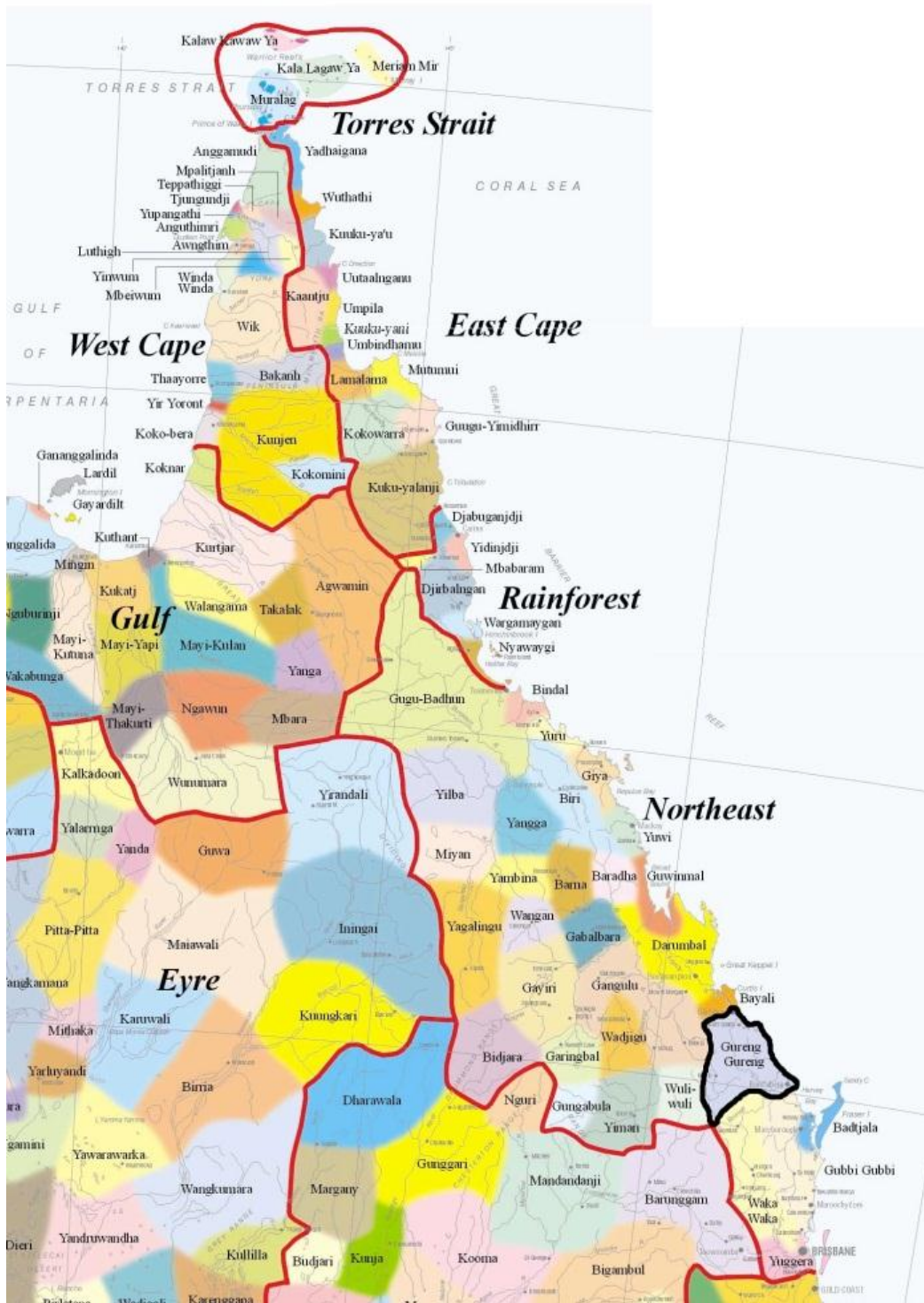


Figure 1.4 Horton Map of Aboriginal Australia

(The author has outlined the *Gurreng Gurreng* Nation in black)

My great grandmother Pearl was the last in our direct line born on country at Mount Perry. Granny Pearly (as she was affectionately called), lived to be a very old woman. We are not sure of her age; however, she lived to be a great-great grandmother before passing away in 1979. As a very young woman Granny Pearly had two children to an Irish kangaroo shooter. She was removed from her country and taken to *Woorabinda* Mission as a result of government policy in the day of the Protectionism and Segregation Era. Granny Pearly and her two girls were rounded up and started the long trek from Taroom (where my grandmother had been born) to *Woorabinda*. *Woorabinda* became gazetted as a mission in 1927. It was here that my grandmother was housed in the dormitory as a ‘half-caste’ child because her father was white. Granny Pearly was placed in the ‘full-bloods’ camp.



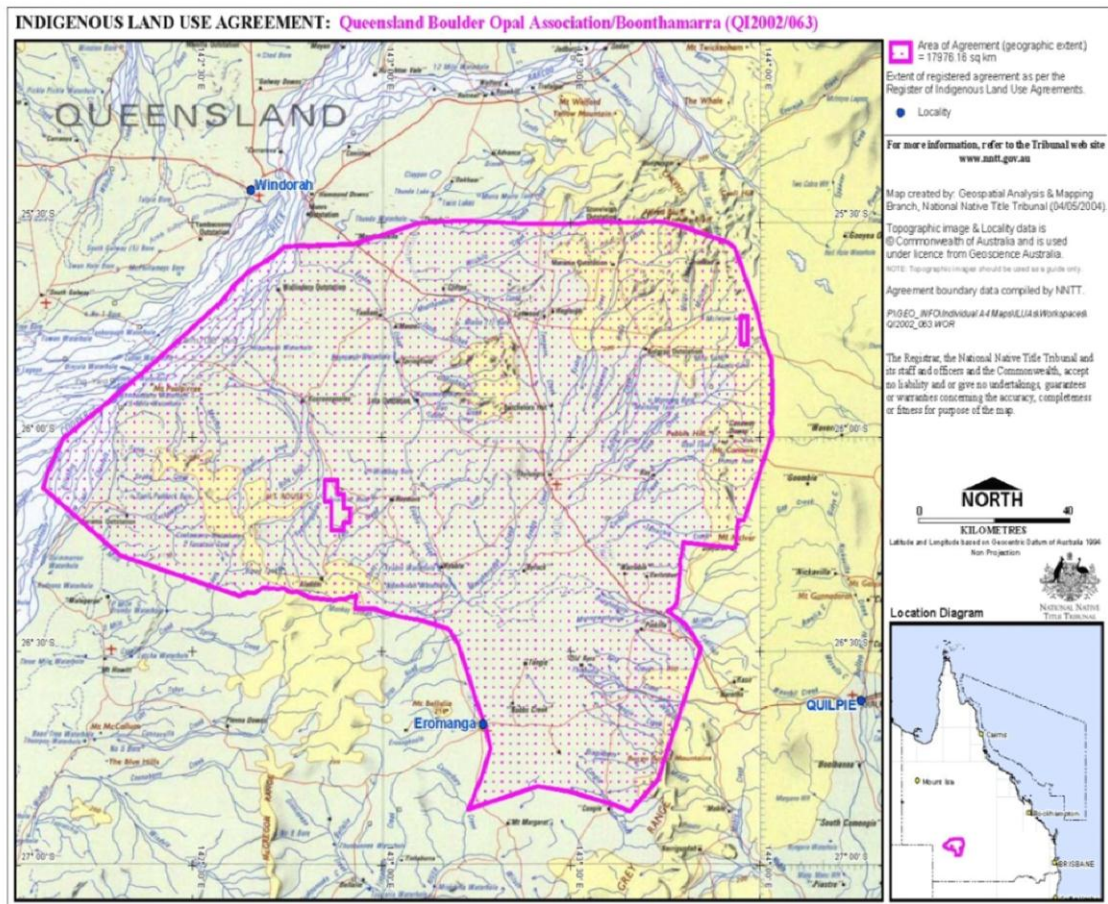
**Figure 1.5 Great Grandmother Granny Pearl**

My grandfather was also removed to *Woorabinda*. He was a *Boonthamurra* man whose Nation also does not appear on the Tindale Map of Aboriginal Australia. Figure 1.6 (next page) is a map of the country belonging to the *Boonthamurra* People. I did not meet my grandfather as he passed away before I re-united with my birth family. He too had been removed off country and had a long trek to *Woorabinda*. Once removed, he and his siblings were transported into Brisbane and were placed in Boggo Road prison for a short amount of time. My grandfather would



have been about 10 years of age. They were transported up to Cherbourg Mission where his mother passed away.

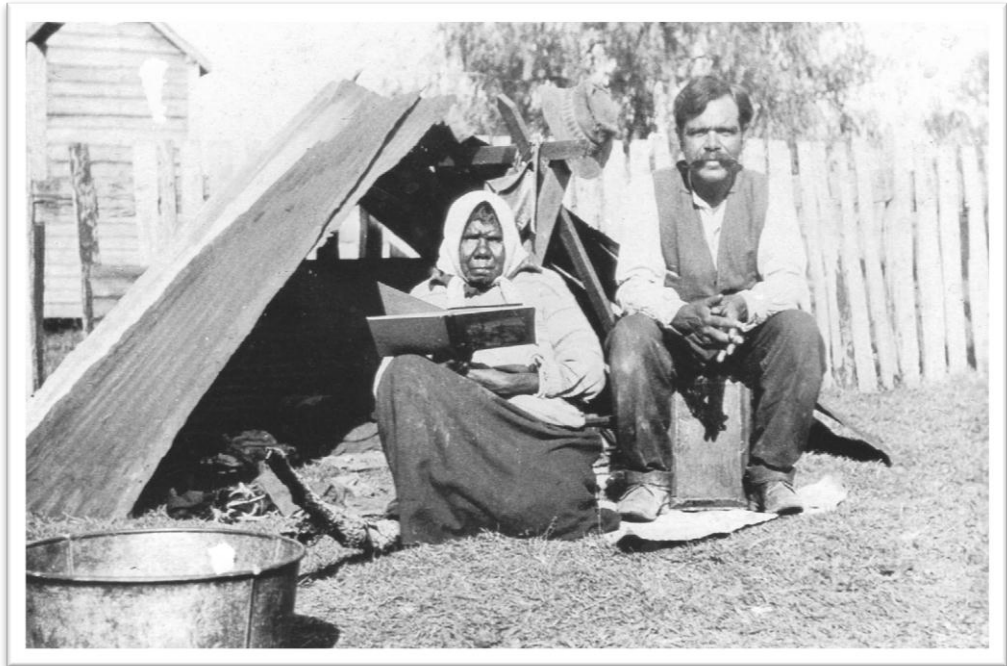
My grandfather and his siblings were split up and my grandfather was taken to *Woorabinda* Mission where he was placed in the ‘full-bloods’ camp. It was at *Woorabinda* that my grandparents met as children. Then, as young adults they were granted permission to marry and raised seven children of which my birth mother was the fourth eldest.



**Figure 1.6 Boonthamurra Country**

Indigenous Land Use Agreement: Queensland Boulder Opal Association /Boonthamurra (QI2002/063), viewed 28 June 2011

[http://www.atns.net.au/objects/QI2002\\_063.jpg](http://www.atns.net.au/objects/QI2002_063.jpg)



**Figure 1.7 Great Grandparents at Cherbourg**



**Figure 1.8 Pa and Nanna Booth**

My grandmother is still alive today living in Rockhampton, Central Queensland and is a respected Elder of the community. She is a great-great grandmother just as her mother had been. There are several lines of five generations in our family. She is the only remaining survivor of the infamous Taroom to *Woorabinda* trek of 1927 and the only surviving ‘dorm girl’ of *Woorabinda*. In the journey of discovery with my birth family I have since learned that Granny Pearly was a holder and practitioner of *Wakgun* traditional medicines. Nanna Booth was under the ‘Act’ and was sent out to work as a ‘nurse’ girl at the age of twelve. Aunty Pearl also worked as a ‘nurse’ at the hospital in *Woorabinda* under the Act. Aunty Pearl desperately wanted to go into Rockhampton and undertake her hospital training. However, she was repeatedly knocked back as The Rockhampton Base Hospital did not accept ‘coloured’ girls from the Mission. In my journey this gave me a sense of knowing that I am from a long line of women healers who live long.

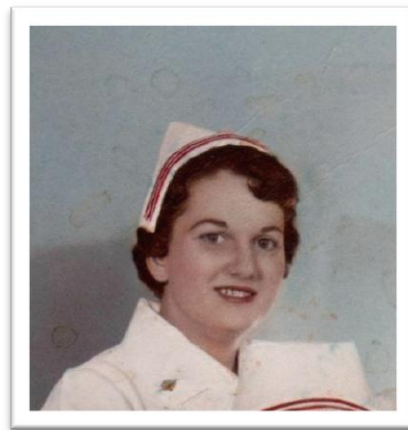


**Figure 1.9 Mum (L) with Uncle Marlin and Aunty Laura**

The above *Djaparl Nganya* has allowed me to provide information about my cultural location and establish connection to country, ultimately guiding and enabling me to undertake this research.

### 1.1.2 Student Nurse Days

For many Aboriginal nurses, at times our experiences are influenced or impacted on by our Aboriginality. Within my own nursing story this impact was felt from the start. On my first day as a young PNC (pre-nursing course) student nurse commencing at the Princess Alexandra Hospital in 1989 I had an educator ask me in front of the class, within the first ten minutes, whether I was Aboriginal. This may not seem such an offensive comment and it's not, but the impact of being singled out on my first day made me very uncomfortable. I was immediately identified as different and had forty pairs of eyes looking at me. My aunty at the time (non-Indigenous) was a Nursing Supervisor of the hospital. She had encouraged me to go to the Princess Alexandra Hospital as it was the hospital that she had trained at in the 1960s. There was a sense of pride that I was following in her footsteps.



**Figure 1.10 Aunt Kay – a student nurse at P.A.**

My aunt spoke to me after my first day wanting to know how it was. I told Aunty Kay that it was good but I was embarrassed at being singled out as being Aboriginal. My aunt was outraged and whilst this is not the response I was looking for it somehow validated my level of discomfort at being singled out. Little did I

know that in the capacity of a Nursing Supervisor my aunty spoke to this educator the very next morning. During morning tea break the educator apologised to me for causing any discomfort.



**Figure 1.11 Odette Best – 2nd year student nurse**

Throughout my training, at differing times I was pulled out of my ward and sent down to Accident and Emergency to ‘look after’ the Aboriginal patients that were coming through. Again I do not believe these were necessarily racist episodes but it did make me think, ‘What happens to mob accessing hospitals without Aboriginal nurses being there to look after them?’ These episodes have all been a part of my story as an Aboriginal nurse. Over the last twenty years I have thought of these episodes often and how they are entwined and enmeshed within my nursing story. I did however progress through my training at The Princess Alexandra Hospital and graduated in the last graduation ceremony at Brisbane City Hall in 1992.



**Figure 1.12 Graduation Day from Princess Alexandra Hospital**

I knew that I didn't want to work in hospitals and that I desperately wanted to work in Aboriginal health. For me it was a fairly quick transition into Aboriginal health as by the closing of 1993 I had commenced working in the Brisbane Aboriginal and Islander Community Health Service (AICHS). It was whilst at AICHS that for the first time I worked with other Aboriginal nurses: Beryl Heppie and Mary Martin. For the first time as a nurse I felt safe. I worked at AICHS for seven years in the youth team where I was the sexual health coordinator for young at risk Indigenous women. It was here that I started to have conversations with Beryl and Mary about their history and work as nurses. Since those days, my clinical work has always been within Aboriginal health and this has been in wide and varied positions. It included working in Boggo Road Women's prison and youth detention centres. I enjoyed being a sexual health nurse, however, I also continued to undertake tertiary studies.

### **1.1.3 'I'm a Nurse' Documentary**

The genesis for this dissertation occurred through the making of a documentary via

an initiative called micro docs. The micro docs initiative was facilitated through Bush TV in Rockhampton, Queensland. Bush TV is a community based organisation that produces Indigenous multi-media. In 2004, whilst I was a Nurse Academic in the Department of Nursing and Midwifery, University of Southern Queensland (USQ), I produced a documentary for Bush TV entitled *I'm a Nurse*. The premise behind making the documentary was the friendships I had with a number of Aboriginal nurses, some of them for many years.

Over the years that I had been a nurse, I had worked with all except one of the participants in the documentary in a number of capacities and varying settings. At differing times and places I would talk to the participants about this research and about their training experiences. Obviously comparisons were made between the decades. I too was also making comparisons due to teaching in the tertiary sector and mentoring and teaching Aboriginal nursing students at the University of Southern Queensland (USQ). At this time I would think, 'Wow, haven't things changed since I undertook my hospital based nursing qualification.' This brought hours of discussion and laughter amongst all of us across many years and settings. It also brought sadness for me when hearing stories told by mostly the older women who had undertaken their training in the 50s-70s and were so clearly impacted on by their Aboriginality and also the impact of government policy that they and their communities were being administered under.

It became an easy process to gather six decades of Aboriginal nurses, pitch the idea to Bush TV and also to the participants, to tell their stories in a documentary. Overwhelmingly all of them said, "Our stories need to be told." The documentary after completion was picked up by ABC Television and viewed on Message Stick.

On completion of this, I thought out loud, ‘There’s a PhD in this,’ and hence the journey began for me.

The *I’m a Nurse* Documentary (attached as Appendix A) was approximately seven minutes long and presented short vignettes of six Aboriginal Queensland nurses from 1950–2005 who undertook their nursing qualification/s at a number of hospitals and universities across Queensland. It commenced with Mawn Young in the 1950s and progressed its way to Anne-Maree Neilsen in 2000. It was filmed in Toowoomba and the University of Southern Queensland was supportive in utilising the Department of Nursing laboratory space for filming. The 1980s vignette was the impetus for this research. In developing this research from a documentary for television to a robust and academically sound research topic, it became essential to find another participant who was a *Murri* nurse who trained in Queensland in the 1980s. I approached Janet Blair who was willing to participate in the research. Being a *Butchelar* woman and having trained at Rockhampton Base Hospital in the 1980s made Janet the ideal choice.

In 2005 I enrolled in a PhD at the USQ and this thesis unfolded. Early on in undertaking the literature review I discovered there was a dearth of literature on Aboriginal nurses in Queensland from 1950–2005. There were two publications. Torres registered nurse Ellie Gaffney’s book, entitled *Somebody Now* (1989), and *In our Own Voices* (2003), a collection of short stories that was edited by Sally Goold, President of the Congress of Aboriginal and Torres Strait Islander Nurses. I believed at this point that this thesis would add to the literature on the voices of Aboriginal nurses that had not been documented nor heard.

On the pages that follow, I provide the outline of this thesis.



## **1.2 Chapter summaries**

### **1.2.1 Chapter 2: Literature Review**

This Chapter has been divided into three sections and describes the literature that is fundamental to the research setting. Many national and international Indigenous nurses' voices will be utilised in presenting the literature. The Indigeneity of the authors will be identified clearly throughout this entire work with italics (*I*). This is not to suggest that non-Indigenous literature will not be utilised. The international literature comparison and review includes New Zealand, the United States of America and Canada.

The first section provides an overview defining the research setting. This includes a suite of facts and figures outlining both the Australian and Queensland Aboriginal and Torres Strait Islander statistics. This is followed by briefly outlining an international Indigenous health comparison. Section 1 then provides the Australian and Queensland Aboriginal and Torres Strait Islander nursing and midwifery workforce data. There is a need to provide both Australian Indigenous cultures as there isn't any data available on just one. Lastly, Section 1 provides an international comparison of the Indigenous registered nurses' workforce participation rates and is followed by a brief outline of the first Indigenous registered nurses of New Zealand, Canada and the United States of America. These countries clearly identified their first Indigenous registered nurses in the literature. Very little work has been done on this in Australia.

Section 2 of the literature review chapter provides the stories of Aboriginal nurses in Queensland. Whilst there is a considerable and ever growing body of research on a number of issues such as recruitment and retention authored by

Aboriginal registered nurses, there is little work done on their stories of being Aboriginal registered nurses. This is clearly demonstrated, when drilling down to the timeframe of this research (1950–2005), that presently there is only a handful of published works on the stories of Queensland Aboriginal registered nurses.

Section 3 of the literature review will then outline the voices of Maori, Native American, Canadian Aboriginal and Australian Aboriginal registered nurses. There is a notable body of literature from Indigenous nurses globally on a range of issues impacting on them and their communities. The body of work covers recruitment and retention of Aboriginal nurses, experiences of undergraduate Indigenous nurses, racism experienced by Indigenous nurses and Indigenous derived models of care and theoretical frameworks.

### **1.2.2 Chapter 3: Methodology**

I will present an Indigenous methodology of how *Wakgun* people of the *Gurreng Gurreng* Nation transfer knowledge. The *Wakgun* methodology has not to date been documented prior to this thesis. In the beginning of my PhD journey, I initially thought I would be undertaking qualitative research. The methods would be in-depth interviews and questionnaires with my participants in order to gain and construct their stories. Whilst I felt satisfied that this would academically be acceptable, culturally I was challenged. I then had to take a step back and think, ‘What am I actually trying to achieve?’ I believed that by listening to the stories of six decades of Aboriginal nurses, I and many other Indigenous nurses could learn of the struggles these women had gone through. This thesis became about transferring knowledge to me. The challenge then became constructing it as readable and useful narratives for others.

Tom (my first cousin) ‘gifted’ me with two words that were to become integral to gathering the stories, ‘*Djaparlogin*’ and ‘*Yatdjuligin*’.

‘*Djaparlogin*’ translates to ‘making corroboree’ or ‘songlines’. This is the methodology of obtaining the six stories of the research participants. ‘*Yatdjuligin*’ translates to ‘talking in a good way or happy way’. This is the presentation of the thesis. It needs to be noted that this knowledge has not been presented prior to this thesis.

### **1.2.3 Chapter 4: Mawn Young**

This Chapter presents the story of my first participant, Mawn Young. Mawn is of *Kooma* and *Yuwaalaray* descent. Mawn’s *Yuwaalaray* bloodline is from her Grandmother Eckford. Mawn’s *Kooma* bloodline is through her Grandfather Dancey’s line. Mawn was born on her mother’s country in Dirrinbandi and her totem is the long necked turtle.

Mawn commenced her training at the Royal Brisbane Hospital in 1952 and finished her training after transferring to the Cairns General in 1956. Mawn worked as a registered nurse for 50 years. I respectfully call her Aunty Mawn and we have a friendship that is greatly treasured. I have learnt a lot listening to her stories.

### **1.2.4 Chapter 5: Beryl Meiklejohn**

Chapter 5 presents the story of Beryl Meiklejohn, a *Noonuccal* descendent of the *Quandamooka* Nation (Moreton Bay) from Minjerriba (North Stradbroke Island). Her totem is the carpet snake. Beryl undertook her training at the Royal Brisbane Hospital from 1969–1972 and was the last to participate in the four year training program. Beryl further went on to become a Registered Psychiatric Nurse in 1977. I

have worked with Beryl in a number of capacities over a number of years and her ‘nursing stories’ are by far the funniest I have ever heard.

### **1.2.5 Chapter 6: Mary Martin**

Mary is also a *Noonuccal* descendent of the *Quandamooka* Nation (Moreton Bay) from Minjerriba (North Stradbroke Island). Her totem is the carpet snake and she is a first cousin of Beryl. This chapter holds a very special place for me as Mary was and still remains a mentor. Mary undertook her General Nurses Training at the Mater Hospital in Brisbane from 1971–1974. She was the first to participate in the three-year program.

### **1.2.6 Chapter 7: Janet Blair**

Chapter 7 outlines the story of Janet Blair. To include Janet in this research has been a gift. Janet is a *Badtjala* woman who has family and grew up in Rockhampton. Janet knew a lot about my birth family. Furthermore, she had worked with some of my birth family. Janet undertook her training at The Rockhampton Base Hospital from 1984–1987 and went on to become a midwife in 1997.

### **1.2.7 Chapter 8: Raelene Ward**

Chapter 8 presents the story of Raelene Ward. Raelene is a *Kunja* descendent through her mother’s bloodline and is a *Kamilaroi* descendent through her father’s bloodline. Raelene was born in Brisbane and grew up in Cunnamulla on her mother’s country. Raelene began her nursing journey at Goondiwindi Hospital undertaking her enrolled nurses training. This qualification supported Raelene as she journeyed on to become a registered nurse, graduating from the University of Southern Queensland in 1996.

### **1.2.8 Chapter 9: Anne-Maree Neilsen**

Chapter 9 presents the story of Anne-Maree. She is a *Wakka Wakka* descendant through her mother's bloodline. Anne-Maree was not born on country but in Sydney. Her mother has close affiliations and ties with her nation and is currently residing back on country in Cherbourg. I first met Anne-Maree in 2000 as a shy young woman who was undertaking her Tertiary Preparatory Program (TPP) at the University of Southern Queensland. I asked Anne-Maree what she wanted to do after completing TPP. Anne-Maree said she wanted to be a nurse. It has been my immense pleasure to watch Anne-Maree grow from an undergraduate student nurse to now a PhD candidate.

### **1.2.9 Chapter 10: Discussion and Conclusion**

After presenting the stories of the six decades of the participants I will discuss the narratives. There are remarkable similarities that lay at the heart of all the participants' stories, obviously the first being their Aboriginality. Other such similarities are that racism was an issue that impacted on all participants and all at some stage worked or continue to work in Aboriginal Health. This discussion also analyses nursing history, identifying the changes in 50 years from when many hospitals did not accept Aboriginal nursing students to now, a time when there is a desperate cry for more.

In conclusion, I will present some thoughts on the journey that has been this research. I will also discuss recommendations of undertaking much broader research into the history of Aboriginal and Torres Strait Islander nurses and midwives. This

journey reaffirms the need to re-new and '*Djaparl*' or 'sing' history as we have much to learn from these stories.

## Chapter 2: Literature Review

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### ***Section 1: Indigenous Australian facts and figures***

#### **2.1 Overview**

This chapter has been divided into three sections and describes the literature that is fundamental to the research setting. Many national and international Indigenous nurses' voices will be utilised in presenting the literature. The Indigeneity of the authors will be identified clearly throughout this entire work with italics (*I*). This is not to suggest that non-Indigenous literature will not be utilised.

The international literature comparison and review includes New Zealand, the United States of America and Canada. 'England explored and colonised the United States of America, Australia, New Zealand and Canada under the authority of an international law called the Doctrine of Discovery' (Miller 2010). Obviously the other binding factor in the development of 'nursing' is that Florence Nightingale has had influence over the development of nursing in these countries.

The first section provides an overview defining the research setting. This includes a suite of facts and figures outlining both Australian and Queensland Aboriginal and Torres Strait Islander statistics. This is followed by a brief outline of an international Indigenous health comparison. Section 1 then provides the Australian and Queensland Aboriginal and Torres Strait Islander nursing and midwifery workforce data. It is noted that there is the need to provide both Australian Indigenous cultures due to no data being available on just one. Lastly, Section 1

provides an international comparison of the Indigenous Registered Nurses workforce participation rates and is followed by a brief outline of the first Indigenous registered nurses of New Zealand, Canada and the United States of America. These countries identify clearly their first Indigenous Registered Nurses in their literature. Very little work has been done on this in Australia.

Section 2 of this chapter will provide the stories of Aboriginal nurses in Queensland. There is a considerable and ever growing body of research on a number of issues, such as recruitment and retention, authored by Aboriginal registered nurses. However, there is little work focused on the individual stories of Aboriginal registered nurses. This is clearly demonstrated when drilling down to the timeframe of this research (1950–2005). Presently there is only a handful of published works on the stories of Queensland Aboriginal registered nurses.

Section 3 then outlines the voices of Maori, Native American, Canadian Aboriginal and Australian Aboriginal Registered Nurses. There is a notable body of literature from Indigenous nurses globally on a range of issues impacting on them and their communities. This body of work covers recruitment and retention of Aboriginal nurses, experiences of undergraduate Indigenous nurses, racism experienced by Indigenous nurses, and Indigenous derived models of care and theoretical frameworks.

## **2.2 The Research Setting: Indigenous Australia**

Aboriginal and Torres Strait Islander people are the original inhabitants of Australia. It is estimated that they have lived in this country for 40–60,000 years (O'Connor 1995). European invasion and colonisation in Australia commenced in 1788 (Broome



2002). The estimated Indigenous population at the time was at least 300,000 divided across 500 tribes (Broome 2002).

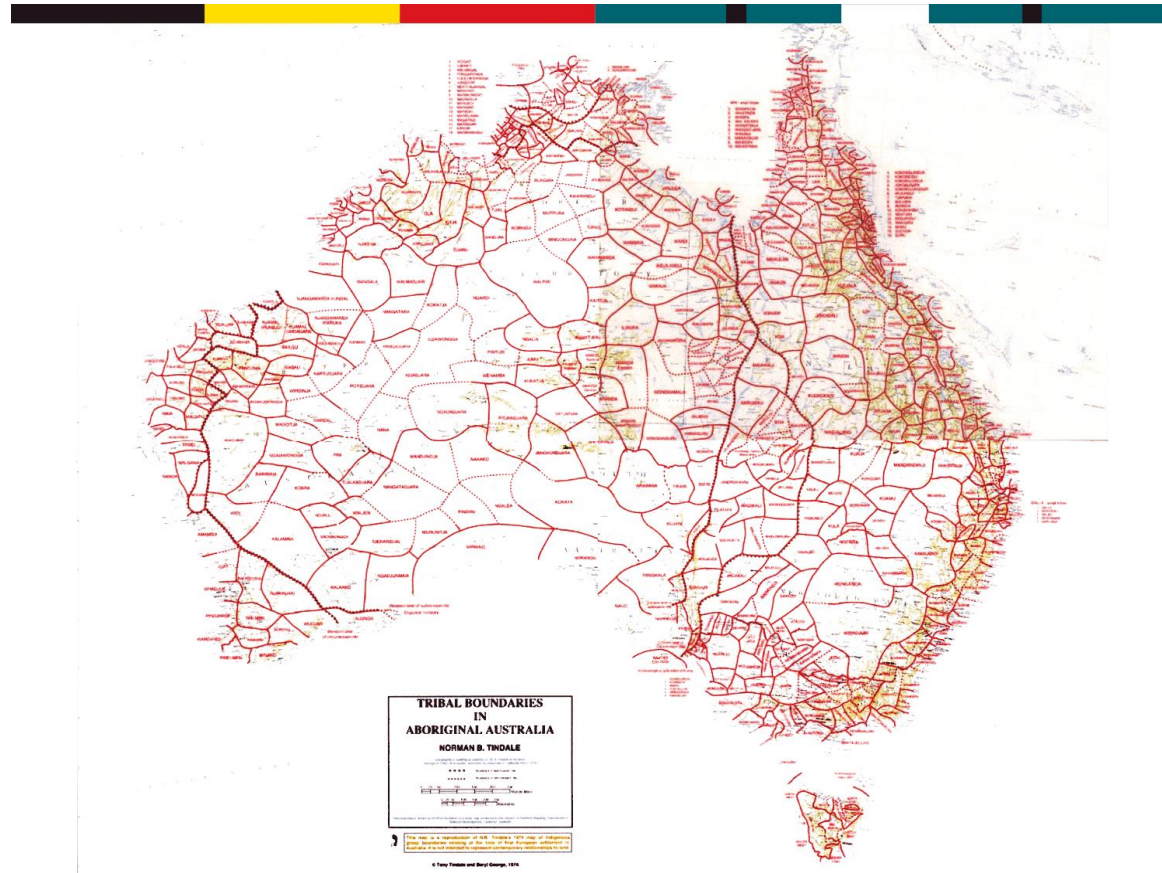
The Tribal Boundaries in Aboriginal Australia, shown in Figure 2.1 (next page), is the work of Australian anthropologist Norman Tindale. Whilst it is a good overall representation, it is known amongst many Aboriginal nations to not be explicitly correct. Tindale's tribal map was first published in 1940 and revised in 1974.

### **2.2.1 Pre-invasion health status**

Although there is little quantitative data on diseases in Aboriginal or Torres Strait Islander populations with little or no European contact, numerous early reports describe them as having been lean and apparently physically fit (Guest 1992; O'Dea 2005). The ethnographic evidence from early contact suggests that Aboriginal people who survived infancy were relatively fit and disease free (Flood 2006, p. 121).

It is a commonly held Aboriginal perspective that Aboriginal Australians were, at the time of invasion/colonisation, a fit and healthy race of people. The Aboriginal tradition of passing on history verbally tells us uniformly that we were a functional community, one that was full of physical exercise that took many forms such as hunting and gathering, preparation of food, and also ceremonial activities. The colonisers also noted this level of physical fitness. Bartlett (1995, p. 10) states:

The health status of Aboriginal people before colonisation is difficult to assess in ways comparable to current data. However, there is strong evidence that a number of infectious diseases (such as measles, flu, and smallpox) were not present before the invasion. It also appears that 'lifestyle' diseases (such as diabetes, high blood pressure, and ischaemic heart disease) were unknown. Early descriptions of Aborigines painted a picture of a lean, athletic, robust and dignified people...



**Figure 2.1 Tindale Map of Aboriginal Australia**

Tindale Map of Aboriginal Australia, viewed 25 June 2010 <http://archives.samuseum.sa.gov.au/tribalmmap/>,

Another early description offered by the Dutch explorer Jan Cartensz was made at the time of his voyage to Australia in 1623 in which he explored the northern coast. In his writings Cartensz outlines an incident where one of his men 'seized one of the blacks by a string which he wore around his neck and carried him off to the pinnace' (Cummins 2009, p. 187). Cartensz went on to describe the Aboriginals, most probably having had a close look at the one his men brought to the ship, 'These natives are coal black, with lean bodies and stark naked'.

'The English explorers who wrote about Aboriginal people in Southern Queensland noted that they were fit and stronger in stature than most Europeans, an indication of a good diet and a healthy lifestyle' (Steele 1972, cited in Gregory 2009).

Whilst Aboriginal health presumably was not perfect, the style of living was more in tune with the environment in which the people lived. Diets were good and bush tucker was plentiful. Australia's native foods supported a nutritious, balanced diet of protein and vegetables, with adequate vitamins and minerals with little salt, sugar and fat. Life on the move kept people physically fit (Flood 2006, p. 122). Hunting and gathering was full of physical activity. Both men and women at times would engage in many hours of exercise in order to feed themselves. People lived on what their country offered and accepted the responsibility of caring for their country, protecting water holes and sacred sites. People lived in harmony with their environment, accessing the land's resources in a way which protected that resource. Waste disposal was not a major issue due to the non-existence of non-biodegradable products.

After 222 years of colonisation, the reality is that the Aboriginal health status

has been radically altered. Aboriginal Australians are no longer a fit and healthy race. The Aboriginal perspective is that the health differentials between Aboriginal and non-Aboriginal Australia are a direct result of the invasion/colonisation process.

### **2.2.2 Traditional Medicines**

The havoc wrought on Aboriginal society through the destruction of traditional medical practices proved profoundly damaging and destructive to Aboriginal health. Florence Nightingale (1865, p. 1) in her notes on the Aboriginal races of Australia, after correspondence with Bishop Salvado, articulated in her public address in 1865:

The consideration that he (Bishop Salvado) adduces all lead to one conclusion, that as soon as native habits and customs begin to undergo change under European influences, the work of destruction has at the same time begun. 'Few sick aborigines'", he says, 'are restored to health,' whereas, under similar circumstances, 'few Europeans would die'.

It is also evident that, throughout the era of conquest and occupation, Indigenous Australians were inflicted with many new diseases. As Bartlett (1995, p. 11) notes:

The conquest began in different areas of the continent at different times, from 1788 when the First Fleet landed near Sydney, to the 1950s when the Desert people were 'brought in' by government officials. During these times, Church missions were set up and many people took refuge in these to escape the murderous gangs, or for food. Once on the missions, however, they were subjected to a process of cultural genocide.

Many Aboriginals themselves saw the introduction of disease and the decline of their health as 'white' man's poisons or diseases, and were ill equipped to combat them. The establishment of missions and the incarceration of entire communities saw to a large extent the demise of traditional medical practices. These practices were forbidden on the missions, being seen as 'witchcraft'.

Aboriginal communities had their own traditional medicinal practices that had been effectively administered and valued for generations. As part of the colonisation

process, these treatments and practices were often quashed by traditional, western medical practices. However, when traditional Indigenous practices were tested within western means, they were often deemed effective. Hunter (1993, p. 55) notes that:

Lawson Holman found confirmation of the effectiveness of a particular traditional treatment. Patients with lacerations and compound fractures occasionally arrived at the hospital with 'antbed' plasters on their wounds, made from material obtained from specific types of anthills. These were usually promptly replaced with a conventional dressing. Having noticed that there seemed to be more problems with infection following removal, Holman opted in certain cases to leave the antbed plaster on, with good results. Subsequent testing demonstrated antimicrobial properties within the antbed plasters.

Within a nursing context Gregory states that 'Nursing history in Queensland encompasses traditional Aboriginal practices and Torres Strait Islander custom' (Gregory 2009, p. 1). The author would also argue that this includes traditional midwifery and birthing practices. Gregory in her work on the nursing history of Queensland states:

Dame Mary Gilmour reported that women in many parts of Queensland preferred Aboriginal accouchement assistance to that of unhygienic white doctors and nurses. (Alford, cited Gregory 2009, p. 3)

Gregory continues:

Puerperal fever resulting from unhygienic obstetric and midwifery practices, whether conducted in hospitals or in patients' own homes, were the scourge of childbirth in European societies. In contrast, Aboriginal people in north-east Queensland for example, knew nothing of this problem. In that area, women in labour were attended by experienced senior women who ensured that placentas were burnt or deeply buried rather than left to rot in buckets under beds as was often the case in English hospitals. (Roth, cited Gregory 2009, p. 3)

The reality is that many Aboriginal traditional healing and birthing practices have been lost, however there are many practices that are still utilised in various parts of Australia. Within my own family, the usage of Quinine Water is an unbroken

traditional practice that has been passed on and made for thousands of years. The Aboriginal knowledge outlining the production of quinine and its usages will be discussed in-depth in the Methodology Chapter.

### 2.2.3 Definitions of health

Within this work it is essential to outline the differing definitions of health from an Indigenous and non-Indigenous perspective. The Aboriginal definition is contrasted against arguably the most accepted definition of health as outlined by the World Health Organisation (WHO). This allows the reader to understand that with differing definitions of health differing health care may be/is needed. *The National Aboriginal Health Strategy 1989* states that health is:

not just the physical well-being of the individual but the social, emotional and cultural well-being of the whole community. This is a whole of life view and it also includes the cyclical concept of life-death-life. (NAHS 1989, p. x)

Further to this definition Swan (*I*) and Raphael (*I*) (1995, p. 19) comment:

The Aboriginal concept of health is holistic, encompassing mental health, physical, cultural and spiritual health. The holistic concept does not refer to the whole body but is in fact stepped in harmonised inter relations which constitute cultural well-being. These inter relating factors can be categorised largely into spiritual, environmental, ideological, political, social, economic, mental and physical. Crucially, it must be understood that when the harmony of these inter relations is disrupted, Aboriginal ill health will persist.

The World Health Organisation (WHO) states that health is:

not only the absence of infirmity and disease but also a state of physical, mental and social well-being.

<https://apps.who.int/aboutwho/en/definition.html>

The WHO definition has not been amended since 1948. The above outlined definitions of health whilst similar are also markedly different. From an Aboriginal perspective what is most obviously inclusive in its definition is the community and the distinct inter-connectedness of all elements. The Aboriginal definition also outlines the continuation of health by including Indigenous spirituality as the continued cycle of 'life-death-life'. Prior to

invasion, Aboriginal people had control over every aspect of their life. In today's terminology this has been called an holistic approach to health, but in Aboriginal society prior to 1788 this was perceived as the norm. Every aspect of the person was equally regarded, this being the biological, psychological, sociological, spiritual, and communal.

It can be argued that the WHO definition looks at health from an individual perspective. It does not reflect community in its definition nor does it include spirituality.

Comparing and contrasting the above two definitions is not about trying to identify which is right or wrong. What this endeavours to do is firstly, offer an Aboriginal definition of health and secondly, highlight that differences in defining health are valid and need to be acknowledged.

#### **2.2.4 Social determinants**

Data on the health status of Indigenous Australians cannot be presented without including the social determinants of health. From both an Aboriginal perspective and from the WHO, the social determinants are identified as being integral to health.

Within an Australian Aboriginal context:

Health inequalities can be shown to relate directly to social determinants of health. Their causes derive from the history of colonialism, dispossession and dominance, and current racism, social marginalisation, cultural exclusion, poverty and resultant trauma. These lead to destructive cycles of hopelessness, despair, criminality, self-harm, addiction and violence, emerging from and then contributing to community disease. (Centre for Rural & Remote Mental Health Queensland 2009, p. 6)

This connection was aptly stated by the Australian Governor General, The Hon. Sir William Patrick Deane, AC, KBE, in 1996:

The present plight, in terms of health, employment, education, living conditions and self-esteem, of so many Aborigines must be acknowledged as largely flowing from what happened in the past. The dispossession, the destruction of hunting fields and the devastation of lives were all related. The

new diseases, the alcohol and the new pressures of living were all introduced. True acknowledgement cannot stop short of recognition of the extent to which present disadvantage flows from past injustice and oppression. (Deane, cited in Couzos & Murray 1999, p. 1)

The World Health Organisation states that:

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries. (WHO 2008, p. 26)

The above WHO statement obviously connects the amendment of poor health status with addressing the defined social determinants but lacks components that reflect the social health determinants specific to Aboriginal health.

Providing the above outlines of the impact of social determinants on Aboriginal health from an Aboriginal and non-Aboriginal perspective allows me to provide the framework to present the below data on Indigenous Australians and Indigenous Queenslanders. For the purpose of this research I will begin by providing national population data for Aboriginal and Torres Strait Islanders. I will then outline brief snapshots of the three social determinants that define the living reality of many Aboriginal Australians, which are education, housing and employment. Finally I will present the health status of Indigenous Australians. In order to provide an Aboriginal perspective I then outline a brief historical explanation of factors that have caused the social determinants of health, such as mass removal of Indigenous peoples from their lands and lack of access to employment, education and housing.

#### **2.2.4.1 – National Population**

At 30 June 2008, the Australian Bureau of Statistics (2008) outlined:

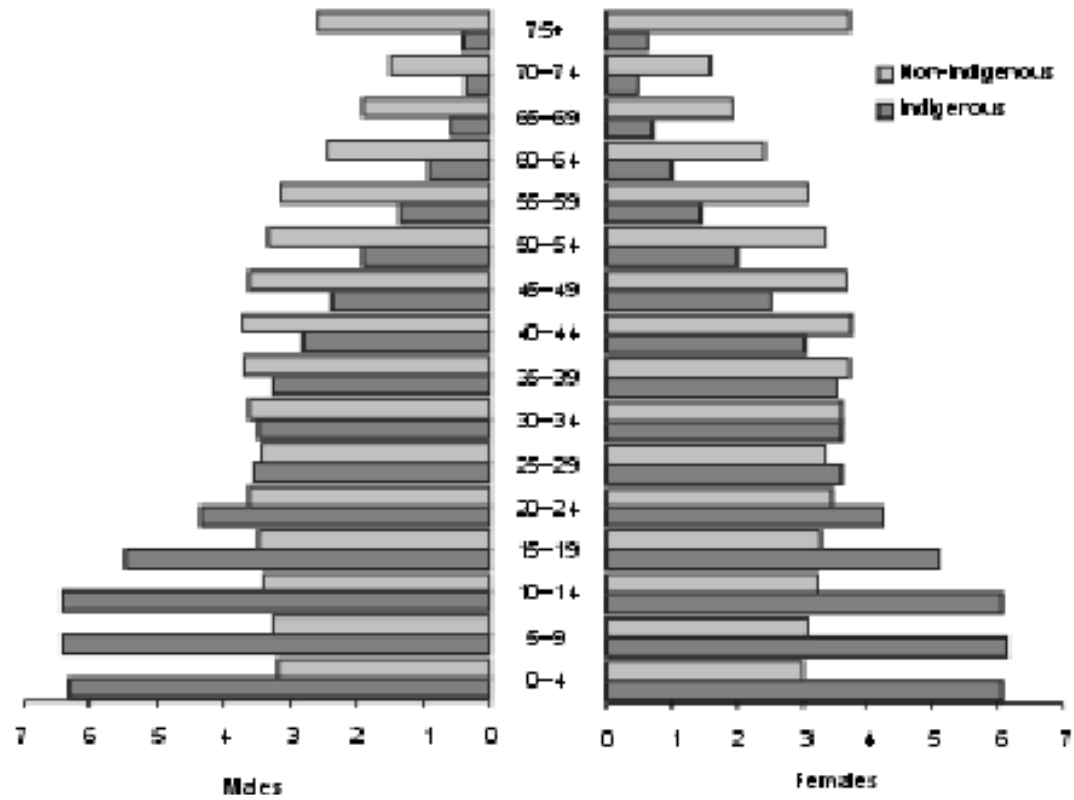


- the estimated resident Aboriginal and Torres Strait Islander population of Australia was 517,200, or 2.5% of the total population
- the Indigenous population estimate was 14% higher than the 2006 unadjusted Census count (455,028)
- the majority of Indigenous people in Australia lived in major cities (31%). The remaining Indigenous population was evenly distributed across inner regional (22%), outer regional (23%) and remote/very remote Australia combined (24%)
- in terms of absolute numbers, New South Wales (148,200) and Queensland (146,400) had the largest estimated resident Indigenous populations
- the Indigenous population is relatively young, with a median age of 21 years compared with 37 years for the non-Indigenous population. This is the product of higher rates of fertility, and deaths occurring at younger ages among the Indigenous population.

Table 2.1 (next page) clearly shows that the Indigenous population diminishes substantially in the 40s age group and then is followed by a stark drop off. Australia's health industry often publicises having to face the aged care crisis, while this is not the case for the Indigenous population.

It also clearly demonstrates the number of Indigenous Australians is substantially higher in the 0–14 age groups.

**Table 2.1 Estimated Resident Population by Indigenous status and age – 2006 (preliminary)**



(ABS 2008, p. 4)

#### **2.2.4.2 – Education**

*The Health and Welfare of Aboriginal and Torres Strait Islander Peoples* (ABS 2008) outlined that:

- Between 2001 and 2006, there was a slight increase in the proportion of Indigenous people aged 15 years and over (excluding those still at school) that had completed Year 12, with the largest increases being in major cities and very remote areas. In comparison, almost half (49%) of non-Indigenous Australians had completed Year 12 in 2006.
- While Indigenous retention rates remain considerably lower than those for non-Indigenous school students, the disparity between the two groups is slowly lessening. In Year 11, the difference between Indigenous and non-Indigenous students decreased by 13 percentage points between 1998 and 2007. While the Year 12 differences decreased by eight percentage points over this time period, Indigenous students were still much less likely than non-Indigenous students to progress to the final year of schooling in 2007.

When looking at the above statistics it is important to have an historical understanding of access to education by Indigenous peoples in this country. From approximately 1850–1950 the first official, legally sanctioned policy used to administer Aboriginal people was the Protection Policy. Under the Policy of Protection, reserves and missions were established. These established reserves and missions offered very little suitable or sustainable living for the many Aboriginal people forced to live within their confines. The education that was offered was minimal and basic. It was thought that Aboriginal people needed little if any education due to the expectation of them not to engage in meaningful work, suited

only to embark on work as domestics and cattlemen. Also under this policy Aboriginal children were excluded from state schools (Eckerman et al. 1992).

#### **2.2.4.3 – Housing**

The Australian Bureau of Statistics (2008) outlines:

- one in every two Indigenous households were receiving some form of government housing assistance, such as living in public or community housing, or receiving rent assistance
- one in seven Indigenous households (14%) were overcrowded in 2006, and around one-quarter of the Indigenous population (27%) or 102,300 people, were living in overcrowded conditions
- indigenous peoples were overrepresented in the national Supported Accommodation Assistance Program (SAAP) for the homeless and those at risk of homelessness, comprising 17% of all SAAP clients
- the proportion of Indigenous households who owned or were purchasing their homes in 2006 was half the rate of other Australian households (34% compared with 69%).

The WHO (2008, p. 1) states:

Many cities in rich and poor countries alike are facing a crisis in the availability of, and access to, affordable quality housing. The crisis will worsen social inequalities in general and health in particular.

The issue facing many *Deed of Grant in Trust* (DOGIT) communities (ex-missions/reserves) across Queensland is the lack of available housing. It is important to remember that overcrowding is a very real issue for many of these communities. It is also important to remember that the Indigenous population is a young and growing

community, which is the exact opposite of the non-Indigenous community. Thirty-eight per cent of Indigenous peoples are under 15 years of age and this figure is only 19% for non-Indigenous. This statistic does impact upon housing.

In summary, it is important to reflect on the historical issues facing Indigenous communities across Australia. Clearly past policies and practices have undoubtedly impacted on many Indigenous peoples and the struggle to attain adequate housing.

#### **2.2.4.4 – Employment**

Within Australia the inequity between Indigenous and non-Indigenous peoples in employment is stark. As outlined in the 2008 Health and Welfare of Aboriginal and Torres Strait Islander Peoples (ABS):

Between 2001 and 2006, the unemployment rate for Indigenous people aged 15–64 years decreased from 20% to 16%, while the labour force participation rate increased from 52% to 54%. However, the unemployment rate for Indigenous people in 2006 was three times the rate of non-Indigenous people (16% compared to 5%).

Again there is an important historical context needed to understand the obvious legacy of lower employment rates of Indigenous peoples. Australia has a complex and very confronting history of Indigenous rights abuses. This has impacted on the history of employment for many Indigenous people. Overwhelmingly until the 1960-1970s, reserves and missions were still operational. This meant that many Aboriginal peoples were administered under racist and ill-informed policy, dictated by the Protector of Aborigines, Rowley (1971, cited in Eckermann 1992):

Wages for Queensland Aboriginal people were well below those of non-Aboriginal people and were supplemented by rations. Should an Aboriginal person have gained permission to have his family with him on the farm/station, they would receive rations; in return, the employer could

demand 12 hours of work from the employee's wife. Further, even though wages were low, Aboriginal people were only paid out that portion which the Protector decided was adequate. The rest was 'kept' for the Aboriginal employee by the employer, who was required to keep a record of these 'savings' and pass it on to the Protector. So until 1966, most of an Aboriginal employee's wages went into a trust fund over which the Director of Aboriginal and Island Affairs had complete control. This practice was still occurring as late as 1973. (Booth, L, pers. comm. 12 March 2010)

The WHO (2008, p. 60) outlines that:

Employment and working conditions have powerful effects on health equity. When these are good, they can provide financial security, social status, personal development, social relations and self-esteem, and protection from physical and psychosocial hazards. Action to improve employment and work must be global, national and local.

Without doubt the above outline of social determinants is the reality of Aboriginal people's health today and is at best, appalling.

#### **2.2.4.5 – Health status**

The deplorable state of Aboriginal ill health is well-documented (Bartlett 1995; Eckermann et al. 1992; Franklin 1976; Hunter 1993; Saggars & Gray 1991). There is now a plethora of epidemiological information on our health status and the outstanding differentials that remain between Indigenous and non-Indigenous Australians.

The significant disadvantage of Aboriginal health and social determinants is well recognised. The ABS outlines:

- in 2004–05, Indigenous adults were twice as likely as non-Indigenous adults to report their health as fair/poor (29% compared with 15%)
- indigenous adults were twice as likely as non-Indigenous adults to report high/very high levels of psychological distress
- in 2005–06, Indigenous peoples were hospitalised at 14 times the rate of non-

Indigenous people for care involving dialysis and three times the rate for endocrine, nutritional and metabolic diseases (which includes diabetes)

- indigenous Australians were hospitalised for potentially preventable conditions at five times the rate of non-Indigenous Australians
- Life expectancy for Indigenous Australians was 59 years for males and 65 years for females (ABS 2008, p. xxii).

The life expectancy of Indigenous Australians for the period 2005–2007 was 67.2 for Indigenous males as opposed to 78.7 for non-Indigenous males. For Indigenous females life expectancy was 72.9 and for non-Indigenous females it is 82.6. This is an 11.5 year gap between Indigenous and non-Indigenous males and an 8.9 year gap between Indigenous and non-Indigenous females (ABS 2009)

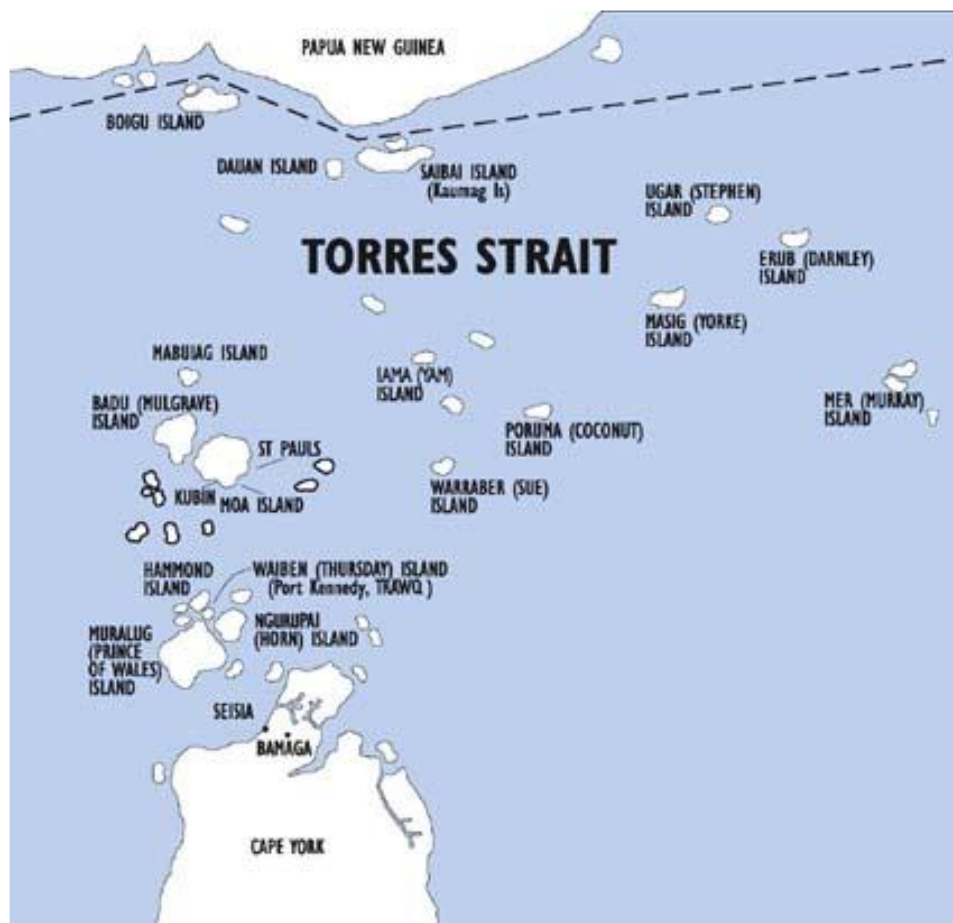
These statistics are largely how Aboriginal Australian health is viewed within a Western framework of measuring health and certainly played out in the non-Aboriginal research agenda. However from a distinctly Aboriginal perspective, and perhaps most succinctly in the words of the late Puggy Hunter:

A certain kind of industrial deafness has developed. The meaning of these figures is not heard or felt. The statistics of infant and perinatal mortality are our babies and children who die in our arms... The statistics of shortened life expectancy are our mothers and fathers, uncles, aunts and elders who live diminished lives and die before their gifts of knowledge and experiences are passed on. We die silently under these statistics. (ATSIC 1995, p. 99)

### **2.3 Indigenous Queensland**

In Queensland the demography is quite different to the rest of Australia. Queensland holds not only many differing Aboriginal nations but also encompasses the Torres Strait Islands. The Torres Straits are a collection of Islands that sit between the top of Queensland and Papua New Guinea. The Torres Strait Islands, through invasion and

subsequent colonisation, were put under Queensland jurisdiction. Whilst there may be some similarities between Aboriginal and Torres Strait Islander peoples (such as a hunter/gatherer lifestyle) there are vast differences (such as languages, totems and ceremonies) between the cultures and it is not acceptable to liken Aboriginal people to Torres Strait Islanders. Below is a map of the Torres Strait Islands from the Torres Strait Regional Authority. Unlike the Aboriginal Map of Australia there is little disagreement with its accuracy. It is widely accepted that this map is reliable and clearly outlines the varying peoples and Islands of the Torres Strait.



**Figure 2.2 Map of Torres Strait Islands**

Torres Strait Islander Regional Authority, viewed 10 June 2010  
<http://www.tsra.gov.au/the-torres-strait/regional-map.aspx>



The below map is an overall representation of Aboriginal Queensland. Whilst not seen as uniformly correct by all Indigenous peoples it is still powerful and informative.



**Figure 2.3 Map of Indigenous Languages in Queensland**

Map of Indigenous Languages in Queensland, n.d. viewed 4 May 2010

<http://www.slq.qld.gov.au/info/ind/languages/qld>

### **2.3.1 Social determinants**

For the purpose of this research, I will provide Queensland population data of Aboriginal and Torres Strait Islanders. I will then outline the three social determinants that define the living reality of many Indigenous Queenslanders. In order to do this I will present brief snapshots of education, housing and employment. Finally, I will present the health status of Indigenous Queenslanders. This section will not include an Aboriginal perspective as outlined in the national presentation of data. This is due to many of the issues identified on a state by state and/or territory basis being the same as those experienced nationally.

#### **2.3.1.1 – Population**

The Queensland Government Aboriginal and Torres Strait Islander Queenslanders Census 2006 Bulletin 4 (p. 1) outlines:

- 127,600 Aboriginal and Torres Strait Islander people
- 18,400 people as Torres Strait Islander
- 10,500 were of Aboriginal and Torres Strait Islander origin
- 98,700 people as Aboriginal.

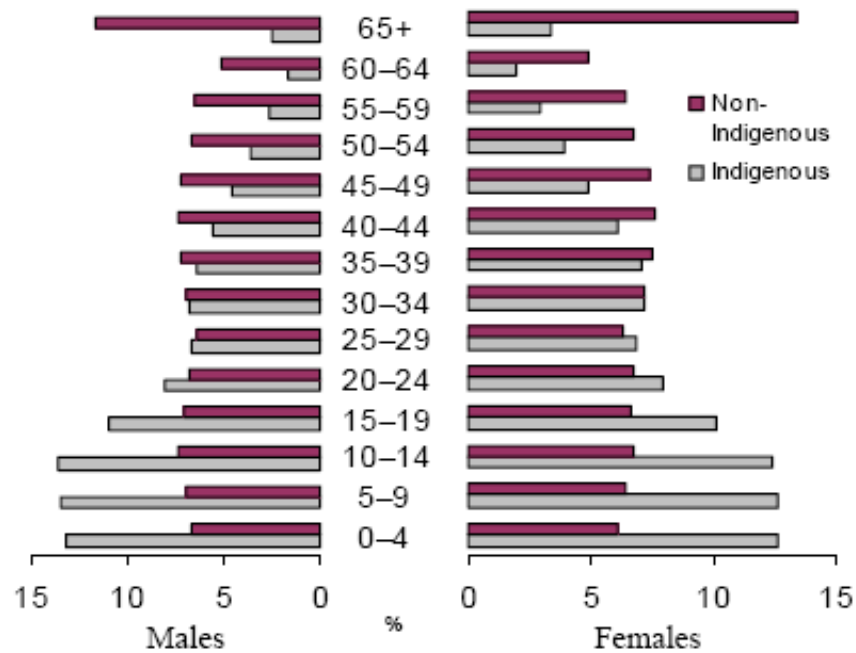
Many of Queensland's Indigenous people live in the more highly populated areas of the state. Further, in the 2006 Census (p. 2):

- 32.4% of the Indigenous population lived in the Brisbane region
- 41.1% lived in the three Indigenous regions of Rockhampton, Townsville and Cairns
- 22.2% lived in remote or very remote communities.

Table 2.2 outlines Queensland compared to Indigenous Australia as a whole. It shows that the Indigenous population diminishes substantially in the 40s age group then is followed by a stark drop off.

**Table 2.2 Age structure by Indigenous status**

**Figure 3: Age structure by Indigenous status(a) by sex, Queensland, 2006**



(a) Excludes Indigenous status not stated.  
Source: ABS, 2006 Census of Population and Housing

**2.3.1.2 – Education**

The ABS (2008) outlines the following:

- the apparent retention rate from year eight to year 12 for Indigenous school students in Queensland was 54.3% in 2006, substantially lower than the rate for non-Indigenous students (80.2%)
- compared with non-Indigenous persons, Indigenous persons were more likely to attend TAFE and less likely to attend university.

These figures again demonstrate a marked difference in educational attainment for Indigenous Queenslanders.

#### **2.3.1.3 – Housing**

The ABS (2008) outlines the following:

- indigenous Queensland family households (4.0 people) contained more people than other family households (3.1 people)
- 3.3% of Indigenous Queenslanders lived in dwellings such as caravans, cabins, improvised homes and tents compared with the non-Indigenous population (1.6%).

#### **2.3.1.4 – Employment**

The ABS (2008) outlines the following:

- the Indigenous unemployment rate for persons aged 15-64 years was 13.2% in 2006, almost three times the rate for the non-Indigenous population (4.6%)
- non-Indigenous persons were more likely to work in the retail trade and professional, scientific and technical service industries than Indigenous persons for both males and females.

#### **2.3.1.5 – Health**

Nationally, Indigenous peoples have poorer-than-average health compared to their non-Indigenous counterparts. The difference in health status is also evident at the Queensland state level. When comparing the health status of Indigenous Queenslanders to their non-Indigenous counterparts the health statistics stay relatively the same as national comparisons and, where they do not, the Queensland Indigenous health statistics are worse.

Queensland Health Burden of Disease and Injury series (2006) outlines that:

within Queensland the current gap in life expectancy between Aboriginal and Torres Strait Islander and non-Indigenous Queenslanders is 10.4 years for males and 9.0 years for females.

The article by Begg S et al. (2009, p. 3) *Burden of disease and health adjusted life expectancy in Health Service Districts of Queensland Health* outlines that the rate of burden of disease from all causes among Aboriginal and Torres Strait Islander Queenslanders was 2.3 times that of the non-Indigenous population.

The six leading drivers of the health gap between Aboriginal and Torres Strait Islander and non-Indigenous Queenslanders in 2006 were:

- cardiovascular disease – approximately 28% of the health gap
- diabetes – approximately 16% of the health gap
- chronic respiratory disease – approximately 11% of the health gap
- cancers – approximately 9% of the health gap
- injuries – approximately 9% of the health gap
- mental disorders – approximately 8% of the health gap.

Aboriginal and Torres Strait Islander Queenslanders are hospitalised at much higher rates than non-Indigenous Queenslanders for most conditions, particularly in the far northern and north-western areas of Queensland.

## **2.4 International Indigenous Health Comparison**

International comparisons of the health of Indigenous peoples are difficult as there are differences in data collection methods. However, some broad points can be made. The life expectancy of the Indigenous peoples of New Zealand, the United States and Canada is greater than that seen in Australia (AIHW 2009a).

Significant health disparities exist between Indigenous and non-Indigenous populations in Australia, Canada, New Zealand and the United States. In all four countries Indigenous people have lower life expectancies, higher rates of chronic and preventable illnesses, poorer self-reported health and higher likelihood of hospitalisation (Bramley et al. 2004; Freemantle et al. 2007; cited in AIHW 2009b). The information below is a snapshot of the four countries showing the comparison between Indigenous and non-Indigenous peoples in each country.

#### **2.4.1 Australia**

The life expectancy of Indigenous Australians for the period 2005–2007 was 67.2 for Indigenous males as opposed to 78.7 for non-Indigenous males. For Indigenous females life expectancy was 72.9 and for non-Indigenous females it was 82.6. This is an 11.5-year gap between Indigenous and non-Indigenous males and an 8.9 year gap between Indigenous and non-Indigenous females (ABS, 2009)

#### **2.4.2 Canada**

In 2001, First Nations (FN) men 70.4 years, all Canadian men 77.1 years; FN women 75.5 years, all Canadian women 82.2 years (Treasury Board of Canada Secretariat 2005, (cited in AIHW 2009c).

#### **2.4.3 New Zealand**

For the period 2000–2002, females of Maori ethnicity 73.2 years, non-Maori females 81.9 years; males of Maori ethnicity 69.0 years, non-Maori males 77.2 years (Statistics New Zealand 2008b, cited in AIHW 2009).

#### **2.4.4 United States**

Life expectancy tables by race published by the US government through the national Centre for Health Statistics relate only to white and black populations. The Indian Health Service has published estimates of life expectancy for the period 1999-2001, which state that life expectancy was 2.4 years less than for the all-race population of the United States (US Census Bureau 2008, cited in AIHW 2009).

### **2.5 International Indigenous Nursing Workforce Comparison**

It must be noted that reliable data on the number of Aboriginal and Torres Strait Islander registered or enrolled nurses is not available.

The below data presents the current approximate Indigenous registered nurse workforce in Australia, with Queensland figures included separately, New Zealand, Canada and the United States. It is important to note that these figures are estimates only. The data available on Australian Aboriginal and Torres Strait Islander nurses has historically been problematic to attain. Available data from the 2008 AIHW Nursing and Midwifery Labour Force Survey is reliant on self-identification. Within Queensland the Labour Force Survey is not mandatory when gaining registration. ‘The overall response rate to the 2008 survey was estimated to be 46.6%’ (AIHW 2010, p. 2). However, data that has been collected will be presented with obvious caution due to low responses in some jurisdictions.

I will briefly identify the first Indigenous registered nurses of New Zealand, Canada and the United States of America. These countries identify clearly their first Indigenous Registered Nurses in the literature. Very little work has been done on this in Australia.

### **2.5.1 Australian Indigenous Nursing Workforce participation rates**

The 2008 AIHW *Nursing and Midwifery Labour Force Survey* (p. 10) identified that in 2007:

- there were 2,164 employed nurses who identified themselves as Aboriginal and/or Torres Strait Islander, representing about 0.8% of nurses. The Northern Territory had the highest proportion of Indigenous nurses at 1.6%
- Indigenous nurses were, on average, 1.6 years younger than non-Indigenous nurses (42.1 years and 43.7 years)
- the percentage of male Indigenous nurses (11.5) was slightly higher than the non-Indigenous proportion (9.6).

#### ***2.5.1.1 – Australian Aboriginal entry into nursing***

In Australia, the first Aboriginal nurse or midwife is yet to be fully researched and identified.

#### ***2.5.1.2 – Queensland Indigenous Nursing Workforce participation rates***

The 2008 AIHW *Nursing and Midwifery Labour Force Survey* identified that within Queensland there were approximately:

- 401 Aboriginal registered and enrolled nurses
- 24 Torres Strait Islander registered and enrolled nurses
- 30 Both Aboriginal and Torres Strait Islander registered and enrolled nurses

A problem with this data is the lack of a breakdown of Aboriginal and/or Torres Strait Islander registered nurses and enrolled nurses (AIHW 2008).



### ***2.5.1.3 – Queensland Aboriginal entry into nursing***

In Queensland, as across Australia, the identity of the first Aboriginal nurse or midwife is yet to be fully researched and identified.

## **2.5.2 New Zealand Indigenous Nursing and Midwifery Workforce participation rates**

As in Australia data collected for Indigenous nurses and midwives is often murky and at best an approximation to be treated with caution.

Ramsden (2002, p. 4) in her PhD outlined that:

Ethnicity figures have not been kept as to the numbers of people (Maori) who enter nursing programmes and who choose to change their identity during the course of their education. It is therefore very difficult to assess the rates, by ethnicity, of final passes of people leaving programmes. It was and remains unrealistic to expect Maori to provide a nursing workforce when Maori make up 14% of the New Zealand population in the 1996 census (Statistics New Zealand, 1997) and Maori entry to and exit from nursing is extremely difficult to assess.

The Ministry of Health, Maori Health Workforce Profile (2007, p. 13) identified that:

- there were 2,729 Maori active (i.e., working) registered nurses, representing seven percent of all active registered nurses (39,016)
- there were 110 Maori active registered midwives of an overall (2828). There was an increase in 2006, with 157 Maori active midwives representing 6.7 percent of all active registered midwives (2358).

### ***2.5.2.1 – Maori entry into nursing***

Within New Zealand there has been a concerted effort to identify the first western trained Maori registered nurse. Akenihi was the first nurse and midwife to register under her Maori name. There had been Mereana Tangata before her – also known as Mary Ann Leonard – but when the register was opened she was simply entered as No

252. Supported by Sir Apirana Ngata, Akenehi Hei was in every way a pioneer – working doggedly against the odds, often getting little support from officials concerned with minimising costs - and a government not fully committed to Maori health (Turia 2010, p. 1).

‘The object of training Maori nurses was not, however, to have them work in Pakeha [non-Indigenous New Zealanders] hospitals. In November 1907 the government had agreed that, once trained, Maori women would be employed as district nurses by the Department of Public Health. Hei was anxious to qualify, and undertook a midwifery course at St Helens Hospital in Christchurch, passing her final examination in December 1908. Because the department still did not have funds to pay Maori nurses, Hei then returned to Gisborne and began private nursing (Sargison 2010).

#### ***2.5.2.2 – Canadian Aboriginal nursing and midwifery workforce participation rates***

As in Australia data is not routinely collected on Indigeneity. This of course makes it impossible to get a true picture of the nursing and midwifery workforce. The available documented data is widely differing in its estimations of true numbers and percentages.

Whilst Canada does not routinely collect national statistics on race or culture of health professionals in this country, it is widely accepted that our health professional population is not representative of the general public. (Canadian Nurses Association 2004, p. 6)

Lemuchuk-Feval and Jock (2004, p. 35) outlined:

The Aboriginal Nurses Association of Canada currently has a membership of about 300 registered nurses, licensed practical nurses and registered nursing assistants. Not all Aboriginal nurses are members of this organization. The Canadian Public Health Association (CPHA) in a brief to RCAP in 1993

estimated that there might be as much as 3,000 Aboriginal registered nurse graduates in Canada.

### **2.5.2.3 – Canadian Aboriginal entry into nursing**

Charlotte Edith Monture, from Six Nations, is the most well-known Aboriginal nurse who served in the First World War and was recognised by the Indian and Inuit Nurses of Canada as the first Canadian Indian to become a registered nurse. Edith graduated with honors as an RN in 1914 at New Rochelle Hospital in New York. She joined the US Army Corps in 1917 (Dubash 2006).

### **2.5.2.4 – United States Indigenous nursing and workforce participation rates**

It would appear that the United States had the most reliable source of data pertaining to its Indigenous nurse population. Table 2.3 (next page) presents the Indigenous registered nurse data against the Indigenous United States population data.

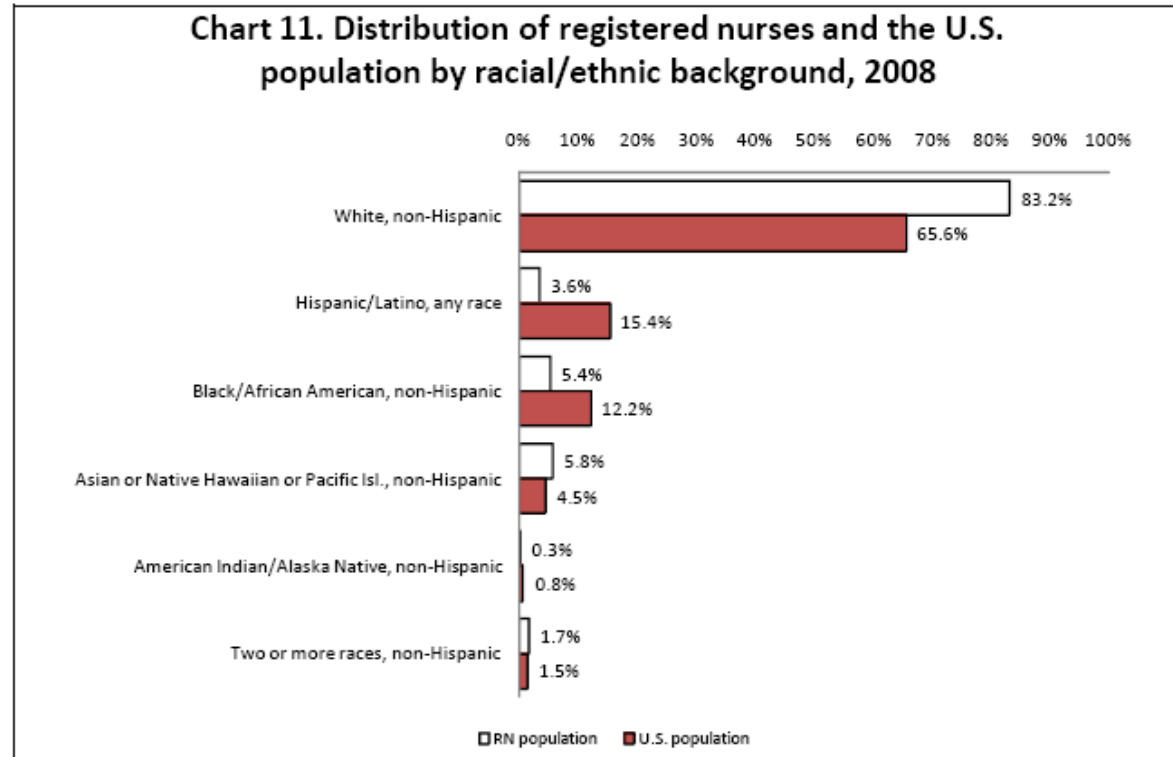
### **2.5.2.5 – United States Indigenous entry into nursing**

Within the United States there has been some discrepancy identifying the first Native American nurse to enter western formalised nursing education.

In 2002 Susie Walking Bear Yellowtail was the first American Indian Nurse named to the Nursing Hall of Fame. Susie graduated from Boston City Hospital School of Nursing in 1923 (*Minority Nurse* n.d.).

However, by the winter of 2008, the publication *Minority Nurse* had received a letter to the editor refuting that Susie Walking Bear Yellowtail was indeed the first Native American western trained nurse.

**Table 2.3 United States: Distribution of RN's by racial/ethnic background**



U. S. Department of Health Human Services/Health Resource Service Administration 2008, *The Registered Nurse Population: Findings from the 2008 National Sample Survey of Registered Nurses*. Viewed 16 October 2009, <http://bhpr.hrsa.gov/healthworkforce/rnsurvey2008.html>

The author of the letter to the editor identified that in fact her grandmother was the first and had this to say:

My grandmother Elizabeth Sadoques Mason and her sister Maude Sadoques were both full-blooded Abenki Indians and both became registered nurses. Elizabeth studied in New York and became an RN in 1919, I have a copy of her nursing certificate.

The author further states:

I am not sure if my great Aunt and grandmother were really the first Native American RN's. I think this question should be investigated and a real search done to ascertain who the first Native American nurse really was. (*Minority Nurse* 2008)

In conclusion, the first section has provided an overview of the research setting. This included a suite of facts and figures outlining both the Australian and Queensland Aboriginal and Torres Strait Islander statistics. This was followed by briefly outlining an international Indigenous health comparison. Section 1 then provided the Australian and Queensland Aboriginal and Torres Strait Islander nursing and midwifery workforce data. Lastly, Section 1 provided an international comparison of the Indigenous Registered Nurses workforce participation rates and was followed by a brief outline of the first Indigenous registered nurses of New Zealand, Canada and the United States of America.

## ***Section 2: Queensland Aboriginal Nursing and Midwives Stories 1950–2005***

### **2.6 Overview**

Section 2 of this chapter provides the literature available on the stories of Aboriginal nurses in Queensland. When drilling down to the timeframe of this research (1950–2005), it is essential to note that presently there is only a handful of published works. This literature includes one published book titled *In our own right: Black Australian nurses' stories* (Goold & Liddle 2005), and a documentary for television entitled *I'm a Nurse* (Best 2003) (Appendix A).

*In our own right: Black Australian nurses' stories*, is a collection of 20 stories from Aboriginal and Torres Strait Islander Nurses from across Australia published in 2005. The stories vary in length from a few hundred to approximately 5000 words. Of the 20 stories, there are two authors who identify as Queensland Aboriginal nurses who undertook their training in Queensland and therefore fit the scope of this research. Brief snapshots of their stories will follow.

Further to this, there were three Aboriginal nurses who identified as undertaking their training in Queensland but did not identify if they were Murriss or they identified as Murriss but had not undertaken their training in Queensland. These three stories were deemed not to fit in the scope of this research which is the stories of Queensland Aboriginal nurses who undertook their training in Queensland 1950–2005.

## 2.7 The Queensland Aboriginal and trained Nursing Voice

### 2.7.1 Noela Bagrie

In *In our own right* (Goold & Liddle 2005), Noela Baigrie (nee Fogarty) is a proud *Wadja Wadja/Wakka Wakka* woman. In her story Noela talks about the influences of harsh Queensland government policies during the time she was growing up in the 1950s and 60s, and the defiance of her father in having the family removed to Woorabinda Mission. The policy of the time had a strong impact on Noela and she stated 'I remember having to hide up trees when the authorities came, I was never told why' (p. 108). Noela was also well supported by her mother and grandmother in her desire to enter nursing and talks about being taught 'forward dreaming'. 'They said, "You dream of being a nurse and don't let anybody take it away from you"' (p. 108). Noela did continue to dream of being a nurse and 'due to my sister's persuasion and influence with the hospital matron of the time, I was allowed to commence my training at Barcaldine Hospital. Because of the hospital being short of nurses, I was able to start when I was only sixteen years old'.

Noela's nursing work history was marred by racism, commencing her training at Barcaldine Hospital and completing it at the Royal Brisbane Hospital in the late 1960s. Noela states that enduring racism 'has been so much a part of my journey and every time I encountered racism, it made me more determined to teach people about cultural respect and our ways' (p.108). Noela outlines experiences of racism from patients refusing to be nursed by a black nurse to being told a white uniform was deemed unflattering as it just made her look blacker. Interestingly Noela also states of the time of being a student nurse that 'As Aboriginal nurses, we always had to do things 110 per cent' (p. 108).

What Noela's story outlines and brings to the literature is the battle for recognition by family. Noela described that 'working with my own people at times was difficult and traumatic. So many times, they did not recognise my skills and qualifications and saw them as a threat. On many occasions, my extended family struggled with the fact that I was a nurse. They thought and said I was trying to be white; but I knew that what I was doing was getting an education so that I could come back and help them. That was something I had to come to terms with and that they and I have had to deal with during the passage of time' (p. 110).

Noela has had a long and diverse work history but says 'my special interest has always been in aged care' (p. 109).

### **2.7.2 Diana Ross**

In *In our own right* (Goold & Liddle 2005) Diana is depicted as a proud descendant of both the *Kaanju* and *Juru* people. Diana's early history, like Noela's, is one marred with being administered under the racist Aborigines Protection Act of Queensland. Due to this, generational removal happened resulting in Diana's mother and grandmother being taken to Yarrabah Mission. Her mother was eventually moved onto the Palm Island Mission where her father was. Diana says of this time 'Mum and Dad met on Palm Island where their courtship began, but because of the racist policies they could talk to each other only through high wire fencing'. It was on Palm Island that Diana was born (p. 116).

Diana outlines growing up as one littered with racist experiences and says 'at Ingham in far north Queensland, where we lived, there were few Aboriginal families and we were used to being taunted with words like "Nigger, nigger, pull the trigger, bang, bang, bang"' (p. 116).



It was in the 1960s that Diana entered nursing although she doesn't state where she commenced it. However, Diana does outline her transferring to the Townsville General and it was at this time she began courting her future husband and says 'when Ralph and I married, I was forced to leave my job as a nurse, because it was hospital policy in those days' (p. 118).

Diana married and raised a family and it was when her daughter was in high school that 'she came out and asked me if I would like to go back to nursing full time. My career had begun again' (p. 119). Diana's family were supporters of her choice but she does say that 'the family thought I was nuts to want to put myself through all the stress of university studies at my age; but without hesitation, they supported and encouraged me through the years' (p. 119). Diana also gained a lot of support from a group of mates at University who were similar in age. Diana didn't give up and was awarded with a Degree in Nursing Science in 1996 from James Cook University. However Diana does say 'despite their enthusiasm in helping me to fulfil my dream, the staff of JCU could not protect me from the racism and xenophobia I would encounter during those years of study, from fellow students, from some staff on placement, and later in the workforce. Racism is alive and well today. Very little has changed over the last 200 years and, unfortunately, in Indigenous and non-Indigenous organisations there are still many minds that think the colour of your skin still dictates your level of education and ability' (In our own right, Goold & Liddle, 2005, pp. 119–20).

However, despite this, Diana says 'my life experiences also helped me make really clear my commitment to continuing to work in the health area, to do whatever is necessary to help our people gain some dignity, self-esteem, equality and hope for

the future' (p. 120). This has shown in Diana's work history as a nurse which has included being a St John's Ambulance Officer, a student support officer at James Cook University and working at the Townsville Aboriginal and Islander Health Service. For this unwavering commitment Diana received the award of Sister of St John Australia.

Obviously the stories of the above two Murri registered nurses are heavily impacted upon by the government policies of the day in relation to the administration of Aboriginal Queenslanders. Both stories demonstrate clearly the tenacity of both women to pursue their dreams of becoming nurses working with and for their people. Their stories add to the dearth of literature that is available on the Stories of Queensland Aboriginal nurses from 1950–2005.

### **2.7.3 'I'm a Nurse' documentary**

The genesis for this dissertation occurred through the making of a Documentary via an initiative called micro docs. The micro docs initiative was facilitated through Bush TV in Rockhampton, Queensland. Bush TV is a community-based organisation that produces Indigenous multi-media. In 2004 I produced a documentary for Bush TV called *I'm a Nurse*. The premise behind making the documentary was the friendships I had with a number of Aboriginal nurses, some of them for many years. Over the years that I had been a nurse I had worked with all of the participants in the documentary in a number of capacities and varying settings. At differing times and places I would talk to the participants about this research and about their training experiences. Obviously comparisons were made between the decades. I too was also making comparisons due to teaching in the tertiary sector and mentoring and teaching Aboriginal nursing students at USQ. At this time I would think 'wow

haven't things changed' since I had undertaken my own hospital based nursing qualification. This bought hours of discussion and laughter amongst all of us across many years and settings. It also bought sadness for me when the stories being told by mostly the older women who had undertaken their training from the 1950s to the 1970s were so clearly impacted on by their Aboriginality and also the impact of government policy that they and their communities were being administered under. It became an easy process to gather six decades of Aboriginal nurses, pitch the idea to Bush TV and also to the participants, to tell their stories in a documentary. Overwhelmingly all of them said 'our stories need to be told'. After completion the documentary was picked up by ABC Television and was viewed on *Message Stick*. On completion of this I thought out loud 'there's a PhD in this', and so the journey began for me.

The *I'm a Nurse* documentary was approximately seven minutes long and presented short vignettes of six Aboriginal Queensland nurses from 1950–2005 who undertook their nursing qualification/s at a number of hospitals and universities across Queensland. It commenced with Mawn Young in the 1950s and progressed its way to Anne-Maree Neilsen in 2000. It was filmed in Toowoomba and the University of Southern Queensland was supportive in utilising the Department of Nursing lab space for filming. The 1980s vignette was the impetus for this research. In developing this research from a documentary for television to a robust and academically sound research topic, it became essential to find another participant who was a Murri nurse who trained in Queensland in the 1980s. I approached Janet Blair who was willing to participate in the research. Being a *Butchelar* woman and

having trained at Rockhampton Base Hospital in the 1980s made Janet the ideal choice.

#### **2.7.4 Discussion on the Queensland voices in the literature**

The above two published works of Queensland Aboriginal nurses' stories gives a much-needed voice to Murri nurses and their stories. As previously mentioned there is a minuscule amount of research or publications on the stories of Queensland Aboriginal nurses and even less when drilled down to the timeframe of this PhD. Interestingly what Noela and Diana bring to the literature is the scrutiny by other Indigenous people including family, and the impact upon gaining nursing qualifications and their subsequent work history. Another element that the above two stories bring to the literature is the enduring hardships of being administered under the *Aboriginal Protection Act* that is unique to their era of growing up in Queensland. *I'm a Nurse* brings to the body of work, the stories of Queensland only Aboriginal registered nurses which to date is the only documentary of its kind. Section 2 of this chapter has provided the stories of Aboriginal nurses in Queensland 1950–2005.

## ***Section 3: The voices of Australian and International Indigenous nurses and midwives***

### **2.8 Overview**

Section 3 will provide the Indigenous nurses and midwives' voices. The inclusion of non-Indigenous nurses/midwives is due to a number of Indigenous registered nurses working within teams and therefore co-written publications are included. This is evident by presenting work from the Indigenous Nursing Education Working Group (2002) and also the National Forum for Development of Strategies to increase the numbers of Aboriginal and Torres Strait Islander Peoples in Nursing (1997). The Australian literature will be both an Aboriginal and Torres Strait Islander voice. As previously outlined in this chapter, the international Indigenous nurses' voice will come from New Zealand, the United States of America and Canada.

There is a dearth of literature on the stories of Queensland Aboriginal nurses/midwives who undertook their nursing qualification in Queensland, and there is now a growing body of literature authored by Australian Indigenous nurses on a range of nursing and midwifery issues.

In commencing the literature search and review of the stories and voices of Australian Indigenous nurses and or midwives, it became obvious that I would be accessing grey literature, and including an interview of myself undertaken by the Australian Nursing Journal. This was necessary to piece together an historical timeline of the involvement of Australian Indigenous nurses and midwives in the respective professions.

Therefore, the parameters for inclusion into this Section were:

1. authored by an identified Australian Aboriginal and or Torres Strait Islander nurse/midwife
2. authored by an international Indigenous nurse/midwife in the utilised literature
3. content of literature is about nursing and or midwifery
4. sources include academic journals, books, research, DVD, Documentary for TV, Government Reports, unpublished theses, magazines, newspapers and nursing textbooks
5. recommendations or reports of Indigenous nursing and midwifery Working Groups/Forums.

Whilst the above may seem to be wide parameters, the reality translates to a small amount of literature. This literature review outlines 24 voices of Australian Indigenous nurses and or midwives.

Interestingly, the Indigenous nurses and midwives' voices extend beyond writings on nursing and midwifery and include many areas of research that have Indigenous nurses and midwives as team members. These writings do not fit the criteria for inclusion into this literature review.

The scarcity of Indigenous nurse and or midwifery authored literature and writing is not unique to Australia and was evidenced by Ramsden, who in undertaking her PhD noted:

Nursing and midwifery input is from the white New Zealand context. Most of the Indigenous work has only been available since the end of the Second World War and is still difficult to obtain since indigenous writers often do not have access to traditional academic pathways to publication. (Ramsden 2002)

Section 3 is written chronologically and presents to the reader both the

academic and cultural requirements of a robust literature review. The cultural requirement for me as an Aboriginal nurse is to provide the voices of Australian Indigenous nurses/ midwives in an appropriate way, which means not manipulating their voices.

Presenting diverse grey literature chronologically has allowed me to piece together a timeline of Aboriginal and Torres Strait Islander women who are/were nurses. This allows many Indigenous nurses, and indeed the broader Indigenous community, to pay respect to our elders who are nurses and midwives. This includes both past and present whose voices are unique, as is their journey into and their stories of practising as nurses and or midwives. This also provides the reader with very time specific snapshots into the broader lives of Indigenous peoples. Proceeding this way is another reflection of my Aboriginality and how our stories are transmitted. In presenting their voices chronologically I am not disturbing or disrupting the voices of these Indigenous nurses/midwives. I am not interrupting the rhyme nor rhythm in which these voices have been put forward and in doing so I do not manipulate the flow or history of the voices.

I believe this also meets the academic requirement. Due to accessing diverse materials and voices, I have created and presented an historical timeline that until now has not been presented in Australian research. I contend that this chronological review of the literature gives Queensland a work in progress timeline of Aboriginal and Torres Strait Islander involvement in nursing/midwifery. Academically I would put forward that this PhD becomes integral in piecing together the broader Australian nursing and midwifery history that has not previously been undertaken.

The Indigenous nurse/midwife authored literature from New Zealand, the

United States and Canada is also presented chronologically. The literature provided is not as comprehensive as the Australian voice. The international Indigenous nurses and or midwives that are presented are considered leaders within the ranks of nursing and midwifery by Indigenous and non-Indigenous peers and colleagues alike. Each country is unique in its Indigenous nurses' offerings and has defined areas of strength within the literature.

In the New Zealand context this is the development of cultural safety authored by the late Maori nurse Irihapeti Ramsden. An in-depth discussion will occur on Ramsden's work as it is the most frequently used example of an Indigenous nursing framework in academic settings. Many Indigenous nurses globally are familiar with this work.

The Native American content is based on the Essence of Native American Nursing framework which has been developed by Struthers, Littlejohn and Lowe. This is the unique body of work developed from the Native American nurses' voices. The work around the essence of Native American nursing is a defined and a well-crafted voice which informs practice.

Canada has a long history of an Aboriginal Nurses' Association. This has created unique research occurring amongst Indigenous nurses across Canada. Canada also has attained critical mass in nursing programs with the University of Saskatchewan having over 200 Aboriginal students in its nursing program (Arnault, V, pers. comm.).

## **2.9 The Australian Aboriginal and Torres Strait Islander Nurses/Midwives Voices**

Presenting the Australian voice required usage of grey literature. This allowed the



emergence of the first voice in 1955 in *Dawn Magazine*. Within the nursing literature the first Aboriginal voice emerged in 1989. This is interesting as the 1980s are considered a decade of arguably the biggest change to nursing education, being transferred from the hospital to the tertiary sector. It took a while for nursing to embrace publishing research and yet amongst this turbulent transition sits an Aboriginal nurse's voice.

Interestingly, in the introduction to this publication, editor Rosalie Pratt states that 'despite these two chapters (there was another chapter written by a non-Indigenous nurse working in an Aboriginal community), which made compelling reading, it is probable that for the majority of non-ATSI Australian nurses the issue of the health of Australia's Indigenous people remains of secondary importance, and that ATSI nurses and their wealth of qualifications, expertise and experience remain largely invisible' (Gray & Pratt 1995, p. 210).

### **2.9.1 1950s**

It needs to be noted that I could not find or access any traditional or grey literature of the voices of Aboriginal registered nurses prior to this date. This is not to say that there is no literature available. What did change in the 1950s was the publication of *Dawn Magazine*. The *Dawn* and *New Dawn* magazine was published by the New South Wales Aborigines Welfare Board between the years of 1952–1975. It was thought that the magazine would provide information and exchange news and views. The *Dawn* and *New Dawn* shared information on conditions and the lives of Aboriginal people on reserves and missions, stations, homes and schools across New South Wales. It is without doubt a rich and diverse publication that documents hundreds of births, deaths and marriages and presented hundreds of photographs

throughout this era. The emergence of the Aboriginal nurse's voice in the 1950s was through being interviewed and then articles being written up and published in *Dawn* Magazine. <<http://www1.aiatsis.gov.au/dawn/docs/v11/s12/12.pdf>> viewed 10 October /2009)

### **2.9.1.1 – 1955 Stanley (I)**

It is within *New Dawn* that snapshots of Sister Muriel Stanley's story appeared twice in 1955 and again in several articles in 1962. In 1955 an article appeared entitled 'Aboriginal Nurse Honoured'. It outlined Muriel's move from her Yarrabah mission home and her acceptance into obstetric nursing undertaken at South Sydney Women's Hospital at Camperdown. It went on further to outline Muriel's move back to Yarrabah the following year to take up the Matron's position. Muriel's voice does come through in a small burst at the end where she said 'You are always reading and hearing that we are a backward race, I felt it was time some of us pushed forward and let the world see what could be done. I do think it's time the White Australians realised what they owe the Australian aborigine' (Rowe 1955).

### **2.9.2 1960s**

Again as in the 1950s there is a dearth of literature from Aboriginal or Torres Strait Islander registered nurses/midwives. The *Dawn* publication was still in circulation and continued printing articles through interviewing Aboriginal midwife Muriel Stanley and the Bush nursing twin sisters. Although not definitively known there were very few Aboriginal registered nurses and even fewer Torres Strait Islander nurses/midwives.

### **2.9.2.1 – 1962 Stanley (I)**

*New Dawn* featured another article about Muriel entitled ‘Brief Story of my calling to the Service of God’ (Bacon 1962). Within this article Muriel outlines her missionary work and her eventual move into obstetric training at South Sydney Women’s Hospital. Muriel said of this transition ‘during these last months (of missionary work) I felt I wanted to train as a midwife realising the great need for this training and how I could do much more for my people in a more practical way than by just being an Evangelist’ <<http://www1.aiatsis.gov.au/dawn/docs/v11/s12/13.pdf>> viewed 26 March /2010). Muriel did undertake her obstetric training and had this to say on her completion:

Early in 1945, my Midwifery Training completed, I was invited to take over the hospital at Yarrabah Mission. My home, just imagine the joy, the thrill, the excitement of returning to work amongst my own people, so on the 21st April, 1945, I took over the Mission Hospital, giving my services there for nearly 14 years helping my people both bodily and spiritually. (<http://www1.aiatsis.gov.au/dawn/docs/v11/s12/13.pdf>, p. 11)

The snapshots of Muriel’s story were brief but the importance of their inclusion cannot be underestimated. An Aboriginal Matron, which was unheard of at this time, was making a very strong political stance about non-Indigenous Australians taking responsibility for the legacy of mistreatment towards Aboriginal people. What it also clearly identifies is a desire, common to many Indigenous nurses and midwives, to work with her people.

### **2.9.2.2 – 1962 Bush Sisters (I)**

*Dawn Magazine* in 1962 presented a brief article, ‘The patients see double, when they’re treated by the nursing twins’ (Munday 1962, p. 12). Aboriginal twin sisters Alison and Jennifer Bush were born in Sydney due to the threat of bombing in

Darwin during the war. The article outlined the nursing history of the twins and how highly unusual it was to see one 'Aboriginal nurse in a city hospital let alone two' (p. 12).

The girls, when interviewed, said 'they have not decided whether they will return to Darwin when they finish their Sydney general training which ends in two years' time as they might stay on to study obstetrics and take a special mothercraft course' (p. 12).

Interestingly, the issue of racial prejudice was addressed when 'the sisters say that neither at school nor at the hospital have they come up against any racial prejudice.' The girls proved immensely popular amongst their peers and in '1961 Jennifer was chosen by her fellow nurses to attend the 12<sup>th</sup> International Nurses' Congress in Melbourne' (p. 12).

At the time of writing this article little did they know that both sisters would work for decades in nursing and midwifery and that Alison would receive an Order of Australia Medal for her work as an Aboriginal midwife, be inducted into the Hall of Fame at NSW Health's Award and deliver over 1000 babies.

### **2.9.3 1970s**

I could find no voice from Aboriginal and/or Torres Strait Islander nurses or midwives in the 1970s. *Dawn*, which for many Indigenous Australians was a vital publication for many and varied reasons, ceased in the early 1970s. However it was in the 1970s that community-controlled Aboriginal Medical Services were established which saw a number of Aboriginal nurses and midwives working in them. Indeed, as has been uncovered in this research, all participants have worked at Aboriginal Medical Services at some stage of their career.

#### **2.9.4 1980s**

As far as could be researched, there was one Aboriginal and one Torres Strait Islander registered nurse in the 1980s that was published. At this time there were not a large number of Aboriginal or Torres Strait Islander people entering the nursing profession. Indeed myself, and the 1980 participant of this research were the only Aboriginal nursing students in our intakes.

The largest transition to nursing and midwifery was occurring and the profession as a whole was still finding its feet in publishing academic literature. However, it was in nursing literature that the only Aboriginal nurse's voice of the 1980s was found. In Queensland at this time there were no identified Indigenous nurse academics in Departments/Schools of nursing. The first Torres Strait Islander voice was clearly heard with Ellie Gaffney publishing her life story.

##### **2.9.4.1 – 1989 Gaffney (I)**

*Somebody Now* (Gaffney 1989) is the story of the first qualified Torres Strait Islander registered nurse and midwife, Ellie Gaffney. Gaffney wrote 'at the time of writing this book, there are all together five Torres Strait Islanders trained as sisters' (p. 45). It is the only comprehensive life story of an Indigenous nurse available in the Australian literature. Ellie was born in the Torres Strait and at a young age wanted to be a nurse. It was at the age of 14, whilst working at the local hospital as an assistant nurse that she was encouraged by one of the non-Indigenous nursing sisters to go down south and do her nurse training. Ellie started to write to various hospitals to enquire about nursing. For many of the Indigenous women who were wanting to become nurses at this time it was not without difficulty including discrimination and at times blatant racism.

Ellie approached the local priest who at this time said to Ellie, ‘Surely you didn’t think for one minute that you would be able to do the nursing training and become a nursing sister did you, it’s only for certain types of girls’. ‘I interpreted that to mean only educated white girls were able to do nursing’ (p. 27). Ellie’s dream began to be realised when in 1954 she became a trainee nurse at the Royal Brisbane Hospital and graduated in 1958. On graduating she then undertook her midwifery training also at the Royal Brisbane Hospital. Ellie did go back home to Thursday Island as a qualified nurse and midwife, the first of her people to do so.

Ellie’s story is full of the trials and tribulations she endured to become a nurse and which she experienced throughout her working life as a nurse/midwife. This at times included facing horrendous racism from non-Indigenous people, including other nurses, but also at times the lack of acceptance from her own people. Ellie talks throughout, telling that even though she was the first identified Torres Strait Islander to become a qualified nursing sister, it took her own people some time to acknowledge that she really was a registered nurse and not the nurse’s aide. This level of unacceptance was even felt from immediate family including her father who:

As a patient in Thursday Island Hospital, he was ashamed to see her giving orders to nurse’s aides. He felt that the nurse’s aides should not be doing menial tasks, and said angrily to Ellie “Who do you think you are...? Jus cos you bin go south, you think you somebody now.” (back page)

Despite the level of qualifications Ellie held she was never allowed to progress into senior management at Thursday Island Hospital, which brought much personal disappointment. In the hope of moving into Senior Management Gaffney had also obtained a Diploma in Applied Science in Nursing Administration from the

Queensland Institute of Technology and was in the graduating class of 1979. ‘My nursing life lasted 26 years, which could have been longer if the Thursday Island Hospital Board had made a different decision in 1980. I must admit I was bitterly disappointed in not securing the nursing superintendent position at the local hospital, because I knew I was an efficient nursing sister with the experience and qualifications’ (p. 31).

Further to this, Gaffney outlines that at the time of applying for the Nursing Superintendent position her application was never acknowledged until she made enquiries and it was stated that Gaffney was not for the job. In Gaffney’s words ‘at this time when government was crying for self-management, how could there be a decision not to employ one of their own (Torres Strait Islander) who had the experience and qualifications’ (pp. 47–8). It was this poor and ill-informed decision that saw Gaffney leave nursing. Reading her story at times is anguishing because of the blatant denial of career progression and the impact of this denial of progression driving her out of her nursing career.

Interestingly, throughout some of her diverse working history was Ellie’s time at Yarrabah from 1963–1965. Ellie fondly remembered her time at Yarrabah, ‘the people had never seen a black sister in a government hospital, except for dear Sister Stanley who was their own Yarrabah girl at their mission hospital’ (p. 53).

#### **2.9.4.2 – 1989 Winch (I)**

The nursing publication, *Issues in Australian Nursing 2, 1989* included an article by Joan Winch, entitled ‘Why is health care for Aborigines so ineffective?’ I believe that this was the first time an Aboriginal nurse’s voice appeared in the nursing literature. At the time of writing this article Winch had established an Aboriginal

health worker education program which in 1990 was named the *Marr Moditj* (meaning 'good hands') Foundation.

Winch commences by referring to some of the associated problems of colonisation experienced by Indigenous peoples and clearly articulates that 'the medical model has manifested itself insidiously over the last twenty years' (p. 53). Further to this, Winch states that it is 'white nurses in white uniforms that have proven to be a barrier to the improvement of health' (p. 58).

Winch states 'It is clear that radical change is required, and that the twin pillars supporting such a change are education and participation' (p. 69). This is contextualised by discussing the need for participation by Aboriginal people in Aboriginal health decisions and also education, primarily needing to be aimed at the non-Indigenous nurse about the health of Indigenous Australians.

Winch talks of her experience as an Aboriginal registered nurse working at a large urban Aboriginal Medical Service and says 'it became apparent that knowledge and understanding about sickness was scanty and coping methods non-existent'. Importantly Winch contextualises this for the profession and states that 'this is a serious danger to the nurse who has taken on the responsibility of improving Aboriginal health' (p. 57).

In concluding her work, Winch advocates strongly for the implementation of preventative programs with the ultimate aim being the betterment of Aboriginal health, and clearly outlines the structure to be able to undertake the process of engaging community. Also and equally as important is the challenge that was thrown to education providers about the lack of current Indigenous content in most of the curriculum, including nursing and midwifery. Winch's work set the agenda for the



voices that followed in the next two decades. Sadly it would seem that the two fundamental issues remain the same 22 years later.

### **2.9.5 1990s**

Without doubt the 1990s saw a dramatic increase in the voices of Aboriginal nurses and midwives. For the first time we experienced the delivery of the Patricia Chomley Oration sponsored by the Royal College of Nursing, being delivered by a Murri registered nurse. This decade saw the development of both traditional academic literature and the generation of grey literature offering multiple voices of both Aboriginal and Torres Strait Islander registered nurses and midwives.

It needs to be noted that 1995 saw the publication of *Issues in Australian Nursing 4, Part III, Nursing and Australia's indigenous peoples*. This nursing publication was the first publication to present multiple Aboriginal nurses' voices in the nursing literature.

The 1990s also saw Aboriginal registered nurses enter universities to teach, albeit in very small numbers. Aboriginal nurses also started to participate in tertiary offered post-graduate courses. The 1990s also saw the development of an organisation for Aboriginal and Torres Strait Islander nurses called the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN).

#### **2.9.5.1 – 1990/1995 Smallwood (I)**

In 1990 Gracelyn Smallwood was the inaugural Aboriginal nurse to present The Twenty-Fourth Patricia Chomley Oration. This prestigious oration hosted by the Royal College of Nursing, Australia, commenced in 1966 and was named after the College's first Director Patricia Chomley. Smallwood's presentation, entitled

*Aboriginal Health by the Year 2000*, outlined a plethora of devastating facts and figures on the state of Indigenous health. Smallwood started by stating:

During my career as a nurse and activist for my people, I believe that I have had to be twice as good as a white professional in order to achieve anything at all. Sometimes, I have wondered if it is just professional jealousy within nursing circles, or if the resistance is due to the old fashioned restricted and narrow perspective so common in nurses trained solely in the medical model. (p. 1)

Smallwood did not write a chapter for the *Issues in Australian Nursing 4, Part III, Nursing and Australia's indigenous peoples* however, she offered some comments that Rosalie Pratt included in her introduction to the chapter. Smallwood states:

I have nursed people who openly tell me that they have been brought up to be racist, and have changed their attitude of stereotyping, when they find that not only myself, but other ATSI nurses have treated them with utmost respect and care. To us Aboriginals in the nursing profession we are just practising the philosophy of nursing. (Gray & Pratt 1995, p. 211)

Smallwood identified clearly that the nursing profession is struggling with providing care to Indigenous Australians due to the 'cultural barriers' that exist and states that 'this profession is extremely conservative and in the western model' and that necessary content about Aboriginal health does not exist. Smallwood believes this can be redressed by 'nursing curriculum having a compulsory component of Aboriginal health and culture taught by preferably Aboriginal people' (p. 211).

The above first wave of Indigenous nurses' voices clearly articulate that the nursing curriculum needs to include Indigenous health. This collective voice believes it is through educating the masses or through mainstream education that positive change can occur for Indigenous health.

#### **2.9.5.2 – 1993 Sykes (I) *Murrawina Australian Women of High Achievement***

The book, *Murrawina Australian Women of High Achievement*, was authored by

Indigenous writer, author and activist Dr. Roberta Sykes and is a collection of 31 stories from a wide and varied number of Aboriginal and Torres Strait Islander women from across Australia. Of the 31 stories offered six of these women undertook nursing education through both hospital and tertiary sectors. These remarkable women are:

1. Mary Ann Bin-Salak
2. Joan Winch
3. Marjorie Baldwin-Jones
4. Rhoda Roberts
5. Barbara Shaw
6. Jianna Richardson.

I will not be outlining all of the above stories of these participants as their voices were not necessarily about their history of nursing but of their broader lives, which for a number of them nursing was a small component. In stating this however, it needs to be noted that three of these Aboriginal registered nurses clearly faced racism by their non-Indigenous nursing peers. Their experiences of racism included not being accepted into nursing training and having to re-apply, in some cases a dozen times until eventually being accepted, and also not being accepted for promotion. It was *Murrawina Australian Women of High Achievement* that brought to the literature a collection of Indigenous nurses' voices for the first time.

#### **2.9.5.3 – 1995 Bush (I) & van Holst Pellekaan**

It had been 35 years since Alison and Jennifer Bush had appeared in *Dawn* magazine as the 'Aboriginal nursing twins'. By 1995, at the time of the chapter being written, Sister Alison (as she was affectionately known) had a 35-year work history primarily

as a midwife, which included being an Aboriginal Liaison Midwife and Clinical Nurse Consultant CNC at Royal Prince Alfred Hospital. Sadly, this chapter was also dedicated to Alison's twin sister Jennifer who was deceased. Jennifer had a very long and distinguished nursing career and was a fierce advocate for Aboriginal people and in the words of Aboriginal nurse Juanita Sherwood, 'Jennifer's commitment to nursing was paramount over all other aspects of her life, she gave of herself fully to ensure that Aboriginal people received first class health care' (Gray & Pratt 1995, p 219).

This chapter provides a substantial historical background of Indigenous Australians. Importantly it also provides some accounts of the issues that have impacted upon Indigenous people gaining nursing and or midwifery qualifications. Bush with her wealth of experience believed that the low representation of Indigenous peoples in nursing/midwifery was due to a harsh and at times unrelenting colonisation process which actively denied adequate education for Indigenous people, and as Bush states 'the path to formal qualifications being far more difficult than for any other segment of the population' (p. 221). As with most Indigenous nurses Bush names racism as an experience of most and having to be 'highly motivated' in spite of it.

Bush also uniquely brings to the literature the skills the Indigenous nurse has in caring for Indigenous patients but also importantly their family and states:

There is recognition of common 'Aboriginality' which allows for better communication avenues for that person and their relatives; there is someone who understands a little about why they are uncomfortable and reluctant to be away from country. (p. 227)

As already stated, Sister Alison had a distinguished career at the time this

article was written. She had helped countless Aboriginal mums and their babies. In fact it was Sister Alison who delivered pre-natal care and delivered Anne-Marie Neilsen's (the last participant of this research) eldest child. Indeed Anne-Marie as a young and very shy teenager, talks fondly of having an experienced Aboriginal midwife as her care provider.

Bush and van Holst Pellekaan (1995, p.231) conclude by outlining some of the difficulties that Indigenous registered nurses have experienced and say of these struggles:

The Aboriginal or Torres Strait Islander who has gained qualifications as a registered nurse has done so by overcoming the difficulties encountered by many of their people, and has demonstrated determination and motivation to attain their goals. Many have faced dislocation from their communities and thus have traded some part of their heritage to the dominant society.

Bush succinctly outlines the identity of the Aboriginal nurse/midwife and concludes with:

The ATSI contribution can be thought of as a trail of footprints, for in traditional culture footprints are a revealing and identifying sign of a person within the group. If nurses recognise the footprints they may finally see the person, the group and the culture that has survived. (p. 231)

Bush's work is very clear in articulating the experience of the Aboriginal nurse both good and bad.

#### **2.9.5.4 – 1995 Townsend & de Vries (I)**

In Gray and Pratt (1995) Townsend and de Vries offer the reader a conversation that occurred between the two of them which became the basis of this article. De Vries offers a very personal journey from working in nursing homes for 27 years, through her journey of undertaking her nursing studies and graduating and working as a registered nurse.

This journey was not without, at times, many issues which included the amount of writing that had to be undertaken in nursing assignments. De Vries cultural perspective of this is clear when she says ‘early on there was frustration from never having written anything down. It’s not something that’s handed down to Kooris, (generic word for Aboriginals from New South Wales and Victoria) we did everything orally and suddenly we had to do five pages on something’. This unique Indigenous perspective has been found nowhere else in the nursing and midwifery literature and is vitally important as educating the large non-Indigenous readership of this work.

De Vries clearly talks about the level of support offered from the Indigenous education unit at the university. Most Indigenous nursing students have stated in the research and through anecdotal evidence that Indigenous education units are the pillar of support in the endeavour to get through studies.

Having worked within health settings for a long time made the experience of clinical placement for de Vries usually a positive one which was eagerly anticipated. Whilst on placement if de Vries ‘found a patient whom I knew instinctively felt uncomfortable with me I would go out of my way to let them see that I was as capable as anyone else’ (p. 276). De Vries did complete her nursing program and was the first Aboriginal nurse to graduate from the Macarthur Campus, University of Western Sydney. She was 56 years of age and went on to work in the area of mental health for nearly 20 years.

Concluding her writings de Vries says ‘in the end we just want the good old Aussie go. We need to break down the barriers of physical and intellectual isolation, institutional and interpersonal racism, black tokenism, and the imposition of white

expectations'. It was with great sadness that Nancy de Vries passed away in 2006.

#### **2.9.5.5 – 1995 McCarthy (I)**

At the time of the publication authored by McCarthy she was the director of Nursing at Yarrabah Hospital. The article is called 'Laurel's story' and her voice is strong and vibrant as she tells of cultural conflict that has impacted on many aspects of her life including her nursing career where Laurel believes that 'Aboriginal and Torres Strait Islander registered nurses are often caught between the black and white cultures during their nursing practice' (Gray & Pratt 1995, p. 340).

McCarthy's nursing journey began at Innisfail Hospital in North Queensland where she also undertook her midwifery training. It was during this time that McCarthy's experience of racism was experienced from both non-Indigenous community members and fellow nursing staff. In particular an incident was recounted 'where a young student nurse, daughter of a prominent local citizen, refused to accept McCarthy's authority as an RN. The student nurse's father brought influence to bear, insisting that McCarthy appear before the Hospital Board for her 'attitude'. However, justice prevailed when the Matron intervened on McCarthy's behalf.'

Laurel also briefly outlines an incident where she was supporting an Aboriginal mother of thirteen children who had just lost two in a tragic house fire. 'The woman's grief was seen as the woman being unco-operative and her situation was dismissed in the following words: "she's got thirteen kids – she's not going to miss two now"' (p. 342). Further to this McCarthy's writings outline in depth a very personal experience of being a nurse and daughter and the delineation of the two worlds that Indigenous nurses and midwives often negotiate.

Again the belief is clear that ‘the inclusion of modules such as “health beliefs of Indigenous Australians” in nurse education programs is a logical first step but it is essential that these modules are developed in full consultation with local Indigenous peoples especially with local black RNs’ (p. 344).

This writing also strongly reaffirms the experiences and stories of other Indigenous nurses.

#### **2.9.5.6 – 1995 Goold (I)**

Goold’s Master of Nursing research asked the question as to why there are so few Aboriginal nurses. Goold’s research sought two sources of data. Firstly, all schools/departments of nursing throughout Australia were surveyed, to determine the numbers of Aboriginal students entering them, the retention and attrition rates of those students, how many graduated and what support systems were in place.

Secondly, Goold accessed a number of Aboriginal registered nurses for informal interview. In answer to her research question ‘why are there so few Aboriginal nurses?’, Goold summarises her findings as follows:

The reasons that Aborigines are underrepresented or seemingly invisible in nursing are many, including racial attitudes, discriminatory practices, restrictive admission policies, educational, economic and social deprivation and the high expectations placed on Aboriginal nurses which frequently place them on the front line. Nursing has a political and moral responsibility to accept the social and cultural challenge to attract and retain Aboriginal students, if the principles of social justice and equal opportunity that are espoused are to be more than just rhetoric and if the benefits that Aboriginal people would bring to nursing are to be recognised. (Gray & Pratt 1995, p. 250)

Goold’s early work is considered ground breaking in asking the questions and raising the agenda of the invisibility of Aboriginal nurses. It also put into the public arena the experiences of Aboriginal nurses which until this time had not been placed or



rarely discussed in the realm of mainstream nursing.

### **2.9.5.7 – 1996 Smallwood (I)**

The publication of *Mental Health and Nursing Practice* (Clinton & Nelson 1996) saw for the first time in any Australian mental health nursing textbook the voice of an Aboriginal mental health nurse. Smallwood commences her chapter with the words ‘The land has spiritual significance for Indigenous peoples. To break this bond is an assault on mental health’ (p. 102).

Smallwood seeks to assist the student in understanding the multiple layers that can impact upon the mental health care of Aboriginal and Torres Strait Islander peoples which includes:

- considering the cultural values implicit in western concepts of mental health and illness
- appreciating how colonisation had impacted on the mental health of Aboriginal and Torres Strait Islander peoples
- understanding that Aboriginality in itself is not a risk factor for mental illness
- appreciating cultural identity as a primary factor in mental well-being
- recognising the importance of culturally safe care
- understanding the crucial importance of integrating nursing skills within traditional networks when working with Aboriginal communities
- appreciating the need to reinforce the cultural identity of Aboriginal clients and their families. (p. 104)

Importantly, and for the first time within the literature, Smallwood clearly identifies the needs of urban Indigenous peoples accessing mental health facilities and states

‘mental health services in urban areas must become more attuned to reinforcing the cultural identity of Indigenous clients’ (p. 116).

***2.9.5.8 – 1997 The National Forum for Development of Strategies to increase the numbers of Aboriginal and Torres Strait Islander Peoples in Nursing***

In 1997 at an initial gathering of Indigenous Nurses in Adelaide, funded by the Office of Aboriginal and Torres Strait Islander Health Services, (OATSIHS) the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) was formed. This group of Indigenous nurses had come from various states and territories across Australia. This gathering was the genesis of Indigenous nurse voices around a range of issues that impacted not only on them but their communities (Young, L, pers. comm.). This process began the push for Indigenous nursing to be on the agenda at both federal and state levels. From this humble initial gathering, recommendations were formed which were and remain pivotal to ensuring that tertiary trained nurses were prepared to work safely with Aboriginal and Torres Strait Islander people (Young, L, pers. comm.).

Strategies were formed and included:

- mandatory inclusion of Indigenous content in all undergraduate nursing curricula (including history, culture and health issues)
- the provision of funding to assist non-Indigenous students to attend clinical placements in Indigenous communities
- employment and professional development of Indigenous academics in schools of nursing
- the delivery of cultural awareness programs to all nurse academics so that

they might be better prepared to assist Indigenous students who do enrol in undergraduate nursing courses.

Further to this, CATSIN was founded to formally represent Indigenous nurses, with a commitment to the implementation of the recommendations (CATSIN 2010).

### **2.9.6 2000s**

The 2000s saw an explosion in the voices of Aboriginal nurses/midwives. The numbers of Aboriginal registered nurses attached to Schools/Departments of Nursing/Midwifery had grown as had the numbers of Aboriginal nurses entering and now graduating from post-graduate nursing and midwifery programs. There was also a very noticeable push into Government Departments and the introduction of Indigenous specific nurse and midwifery policy and strategy documents. It also saw the introduction of Indigenous nurse authored chapters in nursing textbooks and Indigenous nurses being part of research teams and therefore subsequent publications. Multiple voices are being heard with no one prolific writer to date. At this stage Queensland's Indigenous nurse academics have grown steadily with currently four of the eight universities having Aboriginal nurse academics within Department/Schools of Nursing/Midwifery.

#### **2.9.6.1 – 2001 O'Donoghue (I)**

Lowitja O'Donoghue is a proud *Yankunytjatjara* woman who has worked as a registered nurse, mental health nurse and welfare officer for over thirty years and was the inaugural Chairperson of the Aboriginal and Torres Strait Islander Commission (ATSIC). Lowitja's story as a registered nurse will be discussed in more

depth in this Section as she published a short history of her life. Lowitja is almost undoubtedly our most highly awarded Aboriginal Australian Nurse.

In May 2001, Dr O'Donoghue presented the thirty-fifth Patricia Chomley Oration in Sydney entitled *Healing the Wounds: Nurses and Reconciliation*, the second Aboriginal nurse to do so. Dr O'Donoghue questioned and challenged the nursing profession on their potential role in reconciliation and offered some practical strategies to progress reconciliation such as:

- being actively interested – not only in physiological health profiles – but also in the social realities that underlie them
- finding out what is already happening to advance Aboriginal health
- taking these issues into the professional arena and using your influence as a significant group to advocate and support them
- being prepared to collaborate, and to share your expertise in partnership with Aboriginal people
- auditing services in your own context from the point of view of their appropriateness for Indigenous people
- mentoring inexperienced staff about the importance of respect for difference
- eliminating behaviour that blames the victim
- eliminating any racist behaviours in the health context
- auditing the experience of Aboriginal employees in your workplace or professional association
- in-servicing staff about cultural diversity
- demonstrating your organisation's support of Aboriginal people by displaying appropriate resource materials

- raising with your professional group the initiatives your organisation could take in support of nurses for reconciliation
- politically advocating for Aboriginal health initiatives and services
- advocating for more Indigenous nurses to be trained
- supporting existing Indigenous employees
- letting the training organisations know that you expect graduates to have had some education about these issues. ( O'Donoghue, 2001 pp 13-15)

The above strategies are practical nursing interventions that if implemented could impact upon service delivery. Obviously the two-fold impact is a nursing and or midwifery workforce providing appropriate care for the Indigenous communities.

#### **2.9.6.2 – 2001 Goold (I)**

Goold's Keynote address at the 26<sup>th</sup> annual conference of the Transcultural Nursing Society conference in Australia (2001), clearly asked the question '*Transcultural Nursing - Can we meet the challenge of caring for the Australian Indigenous Person?*'

In doing so Goold states that 'unfortunately, the principles of transcultural nursing are not inherent traits of nurses – they really do need to be taught – just as other principles need to be taught; they also need to be taught by people who are committed to the philosophy underpinning it and who have knowledge and understanding of the particular group being focused upon'.

Goold further stated that 'Many nurses have had contact with Aboriginal and/or Torres Strait Islander people, yet overall the care remains culturally inappropriate and culturally unsafe due to their lack of knowledge about the group as

well as their lack of knowledge of transcultural nursing.’ Further to this Goold offers an overall general guide to interacting with Indigenous peoples. Herein lays the problem with the presentation of Goold’s information. It doesn’t address the issue of diversity of Indigenous Australians and the types of communication that are needed. For example, Goold states that ‘European based society places great significance on eye contact, whereas Indigenous cultures look upon this as aggressive, rude, or disrespectful. It is considered impolite to talk to people and look them straight in the eye and most will avoid eye contact.’ Statements like this are simply not the case for many Indigenous peoples.

#### **2.9.6.3 – 2001/2002/2005 Lovett (I)**

The Office of the Chief Nursing Officer, New South Wales Health in 2001 conducted research via surveys to the 19 Area Health Services (AHS) and produced the NSW Area Health Service Aboriginal Nurse Workforce Survey Final Report. The project co-ordinator was the then Aboriginal Nurse Project Officer, Ray Lovett. At the time, as now, there was little information on the numbers of Aboriginal nurses within New South Wales (NSW). Interestingly NSW did have in place a cross health *Aboriginal Employment Strategy (AES)* which outlined the aim of a 2% Aboriginal workforce across all occupations (Balding, S 2008, pers. comm.).

A questionnaire was sent to all AHS and 100% of surveys were returned. The report findings identified that of the 239 Aboriginal nurses in NSW, 63 were registered nurses with the remainder obviously having enrolled nurse qualifications.

The findings stated:

The survey confirmed that Aboriginal nurses working in the NSW public health system remains small (0.7%). While second and third level nurses (assistants in nursing, and enrolled nurses) are meeting the AES 2% target;

the registered nurse classification is underrepresented. In order to increase the Aboriginal nurse numbers, particularly the registered nurse category, strategies need to be developed and implemented. (Goold, 2001 p. 3)

In response to this research, 2002 saw the publication of the *New South Wales Rural and Remote Aboriginal Nursing Strategy*, also authored by Ray Lovett. The Strategy was the result of a State Government commitment to increase the numbers of Aboriginal registered nurses working throughout rural and remote New South Wales. The Strategy outlined that in order to develop effective nursing career and nursing education opportunities for Aboriginal people, the health system needs to:

- provide clear leadership and direction
- provide appropriate infrastructure
- ensure on-going coordination of specifically focused nursing recruitment, retention and career development initiatives
- ensure effective implementation, monitoring and evaluation of Aboriginal nursing initiatives. (p. 5)

The Strategy was designed to increase the number of Aboriginal nurses in two ways:

- increasing the number of Aboriginal people undertaking nurse education
- increasing Aboriginal nurse employment and career development opportunities within the public health system. (p. 6)

The New South Wales Government recommitted itself to increasing the number of Aboriginal nurses as a result of the NSW Alcohol Summit held in 2003. In early 2005, the name of the Rural and Remote Aboriginal Nursing Strategy was changed to the New South Wales Aboriginal Nursing and Midwifery Strategy (Balding, S, pers. comm.). In 2006 the Strategy was reviewed and expanded and was re-launched as the New South Wales Aboriginal Nursing and Midwifery Strategy

2007–2010. Its Vision Statement was clear, ‘Improved health for Aboriginal people by providing culturally respectful and competent nursing and midwifery services in NSW’ (New South Wales Aboriginal Nursing and Midwifery Strategy [www.health.nsw.gov.au/nursing/](http://www.health.nsw.gov.au/nursing/) viewed 10 January 2009).

It also outlined very clear domains which are the enablers to increase the numbers of Aboriginal people in nursing. These domains are:

1. Strategic Planning – To ensure Aboriginal participation and partnership in the development, implementation and evaluation of the NSW Aboriginal Nursing and Midwifery Strategy
2. Cultural Respect and Competence – To provide an educated nursing and midwifery workforce that is culturally respectful and competent, to care for Aboriginal people
3. Workforce Development – To identify and promote nursing and midwifery career pathways that are supportive and responsive to the needs of the Aboriginal community

Information Systems – To develop effective information systems that will guide and assist in the design, monitoring and evaluation of the Aboriginal nursing and midwifery workforce. (New South Wales Aboriginal Nursing and Midwifery Strategy [www.health.nsw.gov.au/nursing/](http://www.health.nsw.gov.au/nursing/) viewed 10 January 2009).

This represented a very clear and concise change in the voice of the Aboriginal nurse. The above was the first state government response in Australia through research, policy and strategies to increase the number of Indigenous nurses and midwives.



**2.9.6.4 – 2002 Report of the Indigenous Nursing Education Working Group**

Nationally, in 2000 the Office for Aboriginal and Torres Strait Islander Health (OATSIH) established the Indigenous Nursing Education Working Group (INE WG). The INE WG was to work on a project to ‘increase the number of registered Indigenous nurses and improve the competency of the Australian nursing workforce to deliver appropriate care to Indigenous people’ (p. xi). The INE WG consisted of representatives that included the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) and also membership from the Australian Council of Deans of Nursing (ACDON).

This type of collaborative work had not been undertaken in Australia prior to this. The INE WG rapidly surveyed Australian universities to gather information about a raft of issues such as Indigenous content in nursing curricula, how many Departments/Schools had Indigenous nursing academic staff and what, if any, recruitment and retention strategies for Indigenous students were in place. The Report ‘*gettin em n keepin em*’ was the outcome of this work (INE WG 2002).

The Report provided a raft of recommendations in order to address Government commitment to increasing the number of Australian Indigenous nurses. What is missing is the of the need for Indigenous midwives and indeed, in the Reports strategic framework there is no mention of midwifery in its aims for the period 2002–2007 which were to:

1. increase the recruitment, retention and graduation of Indigenous students of nursing
2. promote the integration of Indigenous health issues into core nursing curricula

3. improve nurses' health service delivery to Indigenous Australians
4. monitor outcomes and revise strategies accordingly.

The INE WG also outlined the following principles to underpin the framework:

- knowledge, understanding and respect for historical events, cultural beliefs, values and practices that impact upon the health and wellbeing of Australian Indigenous people is essential so that nurses can provide culturally safe care
- an increase in cultural capacity will assist in addressing social justice issues, which in turn will increase a capacity to learn and improve self-esteem
- understanding and applying the concepts of an holistic approach to primary health care provides a vehicle to explore Indigenous health issues and care
- in order to appreciate Indigenous perceptions of health, health and nursing education should be congruent with the health model as outlined in the National Aboriginal Health Strategy (1989)
- recognition of the cultural needs of Indigenous people will improve the effectiveness of recruitment, retention and education of Indigenous peoples
- accountability and responsibility for the improvement of Indigenous health should be shared by governments, individuals, Indigenous communities, the health care sectors and the wider community at large. (p. xi)

This work cannot be underestimated in its significance to the Australian nursing landscape. Prior to this publication there had been no nationally coordinated endeavour from nursing schools to address the need to increase Indigenous nurses and midwives. '*gettin em n keepin em*' is considered one of the benchmark documents of recruitment and retention of Indigenous nurses.

**2.9.6.5 – 2003 Mickeljohn (I), Wollin, Cadet-James (I)**

Mickeljohn (I) et al. in 2003 outlined the experiences at Queensland University of Technology (QUT) and documented the *Successful completion of the Bachelor of Nursing by Indigenous people*. In 1991 QUT had two Indigenous students enrolled in the Bachelor of Nursing Program. Neither student successfully completed units at that time. This limited performance resulted in a range of strategies being implemented over a nine year timeframe which has resulted in 24 Indigenous students graduating from QUT with a Bachelor of Nursing from 1994 until 2003. This work focuses on the issues of recruitment and retention.

Mickeljohn et al. identified appropriate recruitment being undertaken such as advertising on the local Brisbane Aboriginal radio station, advertising in the Koori Mail (a National, fortnightly Aboriginal newspaper), and participating in local career displays and expos for the Indigenous community. All of the recruitment strategies are done via a very strong collaborative approach between the School of Nursing and the Oodgeroo Unit which is the Indigenous Education Support Unit at QUT.

Most importantly, and what this work brought to the literature penned by Indigenous nurses, was the need to focus strongly on the retention of Indigenous students. Prior to this little work had been undertaken on specific retention strategies for Indigenous nursing students. Mickeljohn et al. clearly identified their success in retention and successful completion via the following strategies:

1. a close collaborative relationship must exist between university schools and Aboriginal and Torres Strait Islander support units in order to achieve the range of strategies needed to meet the needs of Indigenous students
2. admission processes need to be flexible, including allowing for late

- admissions without penalty, in order to encourage more applicants
3. applicants need to be informed after interview of an offer of a university place in order to promote a sense of acceptance at QUT
  4. individualised study programs need to be developed in order to overcome educational disadvantage
  5. Abstudy funding needs to be maintained for as long as it takes for a student to complete a university-approved program of study in order to avoid undue financial difficulties that prohibit study
  6. key personnel, both at School level and in the Aboriginal and Torres Strait Islander support unit, need to be identified to support and act as advocates for Indigenous students. This is particularly important early in a student's course
  7. there needs to be a critical mass of students, in order to optimise support, reduce the social isolation, provide opportunities for friendship development and promote academic success. (pp. 8–9)

This research and subsequent publication is a benchmark across Queensland universities as the forerunner of implementing identified strategies for graduating Indigenous nursing students.

#### **2.9.6.6 – 2003 Best (I)**

In 2002 I was successful in gaining a Churchill Fellowship. My outlined program was to investigate Indigenous health taught in nursing curricula and to further investigate support programs for Indigenous nursing students in New Zealand and Canada. The Department of Nursing at the University of Southern Queensland (USQ) committed to incorporating Indigenous health as undergraduate core nursing curriculum to commence in second semester 2003. At this time I could find no

Department/School of nursing in Australia who had made the same commitment. This ten week program enabled me to engage and gain an incredibly valuable insight into the differing and similar experiences of Indigenous nursing students. On my return I implemented some very practical and appropriate strategies that I gained from undertaking this fellowship. This in essence was the humble beginnings of dedicated strategies aimed at retaining Indigenous nursing students at the USQ. As part of the Churchill Fellowship requirements a Report was written and submitted and is publically available to all. As part of my report I outlined the below recommendations:

1. all Nursing Departments in the tertiary sector must incorporate Indigenous health being taught to all undergraduate student nurses as a compulsory core unit
2. all Universities gainfully employ Indigenous nurse academics within their Departments of Nursing to teach and develop Indigenous health curricula across Australia
3. each school of nursing create one to two Higher Education Contribution Scheme (HECS) free scholarships for Indigenous nursing students across Australia
4. broader and further dissemination to Indigenous communities across South-East Queensland to access nursing as a career option at the University of Southern Queensland
5. better communication and support mechanisms are set in place between Indigenous Education Units and the Departments of Nursing at Universities within Queensland and

6. all appropriate state and federal nursing bodies endorse the inclusion of Indigenous health curricula in nursing programs across Australia.

This Churchill fellowship profoundly influenced who I am as an educator today. I cannot emphasise enough the fundamental impact of spending time with Irihapiti Ramsden and spending time at the University of Saskatoon, Saskatchewan, Canada (Best 2003).

#### **2.9.6.7 – 2003/2005 O'Donoghue (I)**

In 2003 O'Donoghue wrote and published some of her nursing experiences within the publication *Lowitja by Lowitja*. Lowitja's story briefly includes her journey into nursing at a small rural hospital in South Australia but is also much broader in telling her life story, including being the first Aboriginal and Torres Strait Islander Commission (ATSIC) Chairperson, and meeting her birth mum.

But it is within *In our own right: Black Australian nurses' stories* that Lowitja has the opportunity to give an in-depth account of her nursing journey. Whilst commencing at South Coast District Hospital in the 1950s in South Australia, Lowitja's real dream was to train at the Royal Adelaide Hospital. This aspiration was one that was fraught with difficulty and rejection. Lowitja recalls:

I had also made enquiries to the Royal Adelaide Hospital, but I already knew they did not take Aboriginal nurses and that getting in would be difficult. I was knocked back several times; I think at least half a dozen times. I knew the reason I was being knocked back, but I kept trying, anyway. On my many visits to matron's office, not once did she ask me to sit down. I remember Matron Schrymgour telling me, "This is not the place for you Aboriginal girls. You should go and nurse your own people in Alice Springs." I thought that was ridiculous, my people didn't come from Alice Springs. (2003 p. 49)

O'Donoghue did win her battle and was eventually allowed to transfer to the Royal Adelaide Hospital and graduated in 1957. Although being transferred from

South Coast District Hospital and despite training there for three years, the Royal Adelaide gave O'Donoghue no credit for her previous training. O'Donoghue talks in depth about her journey and the episodes of racism that also came from patients. Repeated episodes of racism also came from the nursing hierarchy, especially the matron. On the occasion when Queen Elizabeth II was touring the Royal Adelaide Hospital, O'Donoghue as a charge nurse was ordered back inside by the matron after wheeling all her patients out. O'Donoghue's response to being told this was 'No, these are my patients; I brought them here, and I will take them back' (p. 51).

Most interestingly is O'Donoghue's voice of still being under *The Aboriginal Protection Act*. O'Donoghue as a registered nurse stated that, 'I remember every week the Protector of Aborigines would contact me to become exempt. That meant that I would become white just like that. I said, "No, I am an Aboriginal person and would not have a dog medal of any kind"' (p. 53).

O'Donoghue tells of her diverse nursing history which included undertaking her midwifery and mental health certifications. Interestingly, O'Donoghue talks of her work in India in the 1960s and her motivation behind this was 'because they were also a group of people who suffered under a colonial regime'. What is invaluable to the Aboriginal health literature is O'Donoghue's experience of her work undertaking the nursing patrols into the Pitjanjatjara Lands in the 1960s. Interestingly

O'Donoghue remembers of these times:

In those days I mostly treated sores. There was no malnutrition; kids were generally healthy. It was a beautiful experience because most of the people were well. All the confinements went well. It was unusual for things to go wrong, because grandmothers delivered babies. (p. 54)

O'Donoghue's nursing story is beautifully woven and she is a gifted story

teller. The three aspects of O'Donoghue's story reflect how the participants' stories of this research have been woven and told. O'Donoghue's story begins with her Aboriginality, her link to land, and how this is fundamental to who she is. Secondly, she has woven the fundamental impact of her Aboriginality on her journey into nursing and becoming a registered nurse. Lastly and running parallel, but also at times intersecting the above two components, is the nursing history that impacted fundamentally upon O'Donoghue's decision to leave the profession due to the 'introduction of nurse aides' (p. 54). All three components intersect each other and I argue for Aboriginal nurses, one component cannot be told without the other two. O'Donoghue's story is both unique and powerful and certainly fills a gap of Aboriginal nursing voices in Australia.

#### **2.9.6.8 – 2005 *Goold (I) and Liddle***

*In our own right: Black Australian nurses' stories*, is a collection of 20 stories from Aboriginal and Torres Strait Islander Nurses from across Australia published in 2005. The stories vary in length from a few hundred to approximately 5000 words. Of the 20 stories, there are two authors who identify as Queensland Aboriginal nurses who undertook their training in Queensland, and their stories were outlined within Section 2 of this Literature Review. It needs to be noted clearly that the experiences of the older nurses and midwives who undertook their training in the 1950–1970s experienced the greatest impact of Australian government policy.

As outlined in a number of stories there were blatant attempts to prevent Aboriginal women from undertaking their nurses training. This is obviously not the case for Indigenous peoples today. However one issue that has remained is the racism that nearly every participant of *In our own right: Black Australian nurses'*



*stories* states has been a part of their nursing journey. This book is an important part of the growing literature on the stories or voices of the Australian Indigenous nurse and/or midwife.

I will not outline each individual story as I have presented several within the previous Section of the Literature Review and the story of Lowitja O'Donoghue has been presented within this Section. Needless to say this publication does provide depth to the stories/voices that are available about Australian Indigenous nurses and midwives.

#### **2.9.6.9 – 2005 Neilsen (I) Best (I)**

The below research was undertaken in 2005, whilst I was an Academic at the Department of Nursing and Midwifery, University of Southern Queensland (USQ). Ms. Neilsen was a graduate Aboriginal registered nurse of the USQ and is also the last participant of this thesis. At this stage Ms. Neilsen and I had been successful in receiving funding from the Queensland Nursing Council (QNC) Novice Research Funding Grants. Ms. Neilsen asked me to mentor her through the novice round to which I agreed. The research and subsequent report to the QNC identified the challenges that were faced by Aboriginal registered nurses throughout their tertiary studies and the strategies that facilitated their journey through to graduation.

The strongest and most consistent theme was that racism was experienced by all of the participants whilst they were studying nursing. The incidents of racism came from a number of sources which included students, patients whilst on clinical placements, and in some cases staff of the university.

A fresh perspective that occurred from this research was that of racism experienced by fairer skinned Aboriginal nursing students. Several participants were

persecuted for not only being Aboriginal, but for not being Aboriginal enough because of the colour of their skin.

The second theme that emerged from the study related to the participants' responses as to why they chose nursing as a career. For many of the participants, their motivation in becoming nurses seemed influenced by their cultural background, as highlighted by the desire to work for 'their' people.

The third major theme was that all of the interviewed graduates identified two key areas of support at university that were paramount to their success: the Indigenous on-campus support unit and an Indigenous nurse academic within the Nursing Department. The Indigenous support centre offered the students a place to socialise with other Indigenous students, and support staff who helped to maintain motivation and thus progression throughout the duration of the course. Having an Indigenous nurse academic on-campus provided these former students with course specific support and a genuine understanding of their culturally specific needs.

The findings of this research are consistent with the voices of Indigenous women in their endeavours to become registered nurses. What is very unique in this research is articulating the issues of double loaded racism experienced by 'fair skinned' Indigenous people.

#### **2.9.6.10 – (2006) Dadirri: Report of the Indigenous Nurse Education Working Group**

*Dadirri: A report on the status of Indigenous nurse education in Australia* was submitted to the Department of Health and Ageing (DOHA), Office of Aboriginal and Torres Strait Islander Health (OATSIH) in 2005. This report was authored by the Indigenous Nurse Education Working Group (INE WG) which had been

established in 2000 through the OATSIH. In 2002, the INE WG presented their initial Report '*gettin em n keepin em*' of which 32 recommendations were outlined in order to increase the recruitment and retention of Indigenous nursing students.

OATSIH provided further funding to the INE WG, which in turn formed a project team and engaged a Project Officer. The project team became an oversight committee, which focused upon the implementation of the 32 recommendations outlined in '*gettin em n keepin em*'. *Dadirri* provided the strategies to achieve the recommendations that had been outlined in '*gettin em n keepin em*'. *Dadirri* was never released by the Department to the public as its predecessor report '*getting em n keeping em*' had been (Usher, K, pers. comm.).

*Dadirri* clearly stated that 'significant work is needed to continue the progress made by the INE WG, universities, nurse registering authorities and nursing organisations'. To achieve this *Dadirri* outlined the following recommendations that provided a framework for the future to enable:

- fuller inclusion of Indigenous culture, history and health in both nursing and midwifery
- greater and more successful attempts at recruiting and retaining Indigenous students in nursing and midwifery
- the development of pathways to enable all nurses and midwives to be culturally competent to care for Indigenous peoples. (p. 30)

The Report also contained strategies to achieve these recommendations:

1. Student recruitment
2. Residential Programs
3. Student funding and scholarships

4. Places for Indigenous students
5. Learning support for Indigenous students
6. Analysis of recruitment, retention and attrition data
7. Accreditation guidelines for undergraduate Indigenous content
8. Accreditation guidelines for midwifery courses and other postgraduate courses
9. Cultural Safety training for university staff
10. Indigenous clinical placements for students
11. Enhancing Indigenous employment in universities
12. Professional development of Indigenous nurses and midwives
13. Data on Indigenous students and registered nurses and midwives
14. Data on enrolled and graduating Indigenous students. (pp. xiv–xv)

As part of its function the INE WG had conducted surveys in schools of nursing in 2000, and with further funding repeated surveys in 2003 and 2004. In 2000 they stated that ‘Indigenous content in undergraduate curricula was low.... However, Indigenous content rose markedly so that by 2004, 66.7% of schools offered Indigenous content in either stand-alone subjects or integrated across subjects’ (Dadirri p. 291).

In 2003 and 2004 I was interviewed by the Project Officer about the USQ experience. As an Aboriginal nurse academic I was also at this time on a research team that involved a number of Aboriginal nurses and an Aboriginal community controlled health service. Attached as an Appendix of the *Dadirri* report were reflections of myself and Associate Professor Don Gorman which were presented as an example of excellence in a collaborative partnership between an Aboriginal

community and the tertiary sector. The Indigenous Nurse Education Working Group stated:

Their data provided valuable information upon which to base a health promotion program for the prevention and/or management of diabetes. Academics and Indigenous communities, when working in partnership through research, can make an outstanding contribution to the body of knowledge of various disciplines and facilitated tangible positive health outcomes. (Appendix A)

This report also offered an in-depth literature review and research findings on recruitment and retention of Indigenous nursing and midwifery students. To date work on this level or depth has not been repeated and perhaps it would be timely if it were to occur.

It is without doubt that the work undertaken by INE WG was the first of its kind in Australia and certainly secured the Indigenous nursing agenda on a national scale that had never been seen before in Australia. This report also differed from ‘*gettin em n keepin em*’, as it clearly included midwifery. It would be interesting to know why the government chose not to release this report.

#### **2.9.6.11 – 2006 Edwards (I) Sherwood (I)**

Edwards and Sherwood (2006) articulate that ‘it is important to acknowledge the isolation and marginalisation we have endured as Aboriginal nurses, academics and researchers within the western academic and health care settings. We have witnessed the continuation of poor policy and service provision in Aboriginal communities. Our stories, perspectives and insights of what will help to improve health outcomes for our communities are regularly silenced’ (p. 180).

In their writing, entitled *Decolonisation: A critical step for improving Aboriginal health*, Edwards and Sherwood argue that their work is ‘written to

inform the nursing workforce within urban, rural and remote regions of Australia about the critical importance of de-colonising all aspects of the health service delivery related to Aboriginal health' (p. 178).

The harsh and unrelenting legacy of invasion/colonisation is as Edwards and Sherwood argue 'the critical issues that underlie the lack of improvement in Aboriginal health' (p. 178). Edwards and Sherwood believe that it is by undertaking a process of decolonisation that a shift in the paradigm will occur. It is clear throughout this work that the onus of change is held by the non-Indigenous nurse and or midwife. Sherwood and Edwards present that 'de-colonising processes require all individuals to explore their own assumptions and beliefs so that they can be open to other ways of knowing, being and doing' (p. 178).

We believe that Australian nurses must undergo a process of decolonisation in order that Aboriginal people's pain, worry, anguish and torments are heard, recognised, accepted, so that there may be an improvement in the health and wellbeing of Aboriginal people. To do this, non-Indigenous Australian nurses need to be receptive to and respectful of the voices of Aboriginal society, without expecting that as a people we must constantly justify and argue our basic rights. It is only when this happens that we can all come together as a healthy nation free of guilt, blame, and separation.

Edwards and Sherwood provide a framework for the nursing and midwifery workforce that has not been presented, utilising the concept of 'decolonising'. Whilst earlier work has identified the need for change this work gives a framework for that change to occur. It is very unique work within the collective Indigenous nurse/midwife voice.

#### **2.9.6.12 – 2006 Nash, Meiklejohn (I) Sacre**

The *Yapunyah* project was made possible by a Queensland University of Technology (QUT) grant awarded under the teaching and Learning Development

Large Grant Scheme. The scheme funded a two-year (2004–05) initiative called *Incorporating Aboriginal and Torres Strait Islander Perspectives within Curricula: An Innovative Strategy by the Faculty of Health*. The essence of the *Yapunyah* Project was reflected in the QUT's Reconciliation Statement which committed to incorporating Indigenous content and perspectives appropriately into the University's curriculum and teaching practices (Meikeljohn, B 2010, pers. comm., 10 October).

This research and its subsequent publication, entitled 'Embedding Aboriginal and Torres Strait Islander perspectives in the nursing curriculum' (2006), involved a unique process of incorporating core Indigenous health curricula in nursing at QUT. Nash et al. outlined that there 'are several imperatives for embedding Indigenous perspectives in nursing curricula, including ethical, clinical, accreditation, and regulatory imperatives' (2006, p. 298). The student population of the School of Nursing was accessed through a survey of which 89 were completed and analysed. The students 'voiced the concern that knowledge about various other cultures, also relevant to their future careers, should not be overlooked. In addition, students believed that learning about the perspectives of people from diverse cultural and linguistic backgrounds were also necessary' (p. 305). Appropriate curriculum was then developed and embedded. Nash et al. believe 'it will be important to continue to assess learning and skills in relation to Indigenous perspectives and cultural competence in an on-going way' (p. 311).

This project, its team and the research process and outcomes is very unique and to date it has not been replicated. What set this project apart was that 'the *Yapunyah* project team worked on the premise that cultural competence could be

redefined to incorporate the ideals of cultural safety so that expectations of graduates could be clearly identified and assessed. In this way, excellence in nursing care in relation to cultural competence could be defined and measured by the university, accreditation and regulatory bodies, and recipients alike' (p. 301).

This research and publication is benchmark research in the Queensland University School/Department of Nursing.

### **2.9.6.13 – 2006 Goold (I) & Usher**

Goold and Usher in their work query *how nursing education is meeting the health needs of Indigenous people*. They argue that there are three factors that are fundamental to being able to do this:

1. non-Indigenous health professionals who are better prepared to work with Indigenous people
2. strategies to prepare non-Indigenous student nurses to work with Indigenous people
3. indigenous content in undergraduate nursing curricula and relevant clinical experiences. (pp. 290–91)

This literature is part of the body of work that states that Aboriginal health should be mandatorily taught at all Australian Schools/Departments of nursing/midwifery.

Obviously the outcome is the potential to have a better informed nursing and midwifery workforce working with Indigenous people and Indigenous Australians receiving appropriate care.



**2.9.6.14 – 2008 Best (I)**

*Nurses Helping Our Mob* is an on-line and hard copy DVD (attached as Appendix B) resource that was created in 2008. At this time I was the Indigenous Nurse Advisor for Office of the Chief Nursing Officer, Queensland Health and was responsible for its production. This resource was produced as a recruitment tool in Queensland Health's endeavour to increase the number of Indigenous people into nursing and midwifery with the outcome of being able to employ more Indigenous nurses and midwives throughout Queensland Health facilities.

The resource was seven short vignettes of three to five minutes in length. Each vignette is the story of an Aboriginal or Torres Strait Islander nurse or midwife from across Queensland and their journey, not only into nursing and midwifery, but what they are doing now within their profession. The diversity amongst the vignettes was enormous and purposefully done, including both male and female Indigenous nurses in diverse settings. Their stories were told, from a highly urban hospital to remote Aboriginal and Torres Primary Health Care services, to a rural Aboriginal Medical Service. It further included the stories of two Aboriginal nurses within the tertiary sector in both academic and nursing student support officer positions. Lastly, it included my story of working in Government.

The resource was created and aimed at distribution amongst the Indigenous community. It was widely distributed to Aboriginal Medical Services across Queensland with many having DVD Players in their waiting rooms and being asked just to play the DVD a couple of times a day. This obviously is to a captive audience but is an excellent way of showcasing some amazing Indigenous nurses and midwives and their stories.

The DVD also became a part of the Office of the Chief Nurses website and to date receives approximately 600 hits a month (Creavy, L, pers. comm.). This was purposefully done so Indigenous people had access even in remote communities across Queensland. In 2009 the *Nurses Helping Our Mob* also became part of the *My Nursing Kit* for Kozier and Erbs, *Fundamentals of Nursing* textbook (2010). This distribution is invaluable as it allows a very large non-Indigenous student nurse population to hear the stories of Indigenous nurses and midwives. Importantly and worth noting is that all of the seven Indigenous nurses and midwives work within Indigenous health in very diverse settings. To access these stories on-line go to: [www.thinknursing.com](http://www.thinknursing.com) and click on Indigenous nurses.

#### **2.9.6.15 – 2009 West (I) Park & Hakiha**

West et al. (2009), states that ‘it is important to recognise that Aboriginal and Torres Strait Islander health services are not solely responsible for Aboriginal and Torres Strait Islander Health’ (p. 108).

Importantly the work outlines an Indigenous definition of health which demonstrates the difference between this and the World Health Organisation definition of health. West discusses that there is a potential myriad of issues when dealing with Indigenous Australians who are consumers in the mental health context and that a greater understanding is needed in the nursing workforce about Aboriginal and Torres Strait Islander issues:

A number of issues need to be considered, including trust and rapport and the historical context of these concepts. It is important to recognise that the history of colonisation in Australia continues to affect communication between nurses and Aboriginal and Torres Strait Islander people. (p. 109)

Communication is obviously identified and discussed as an underlying issue of poor

nursing and care received by Indigenous people who need immediate attention. West states that ‘Nurses need to understand what the effects of cross-cultural communication are on the therapeutic relationship, which is the foundation of mental health nursing’ (p. 108).

#### **2.9.6.16 – 2009 Blackman (I)**

Blackman’s writings offer an exemplar of an Aboriginal male patient and an ‘example of perceived racism through the eyes of an Aboriginal nurse’ (p. 211). Blackman outlines an episode of care of a 45-year-old Aboriginal man from a remote community with suspected tuberculosis who believes he is being treated poorly and ‘threatens to discharge himself’. An Aboriginal registered nurse is contacted and presents to the client who ‘is angry and the (Aboriginal) nurse is met with hostility’ (p. 211).

Blackman argues that Aboriginal nurses bring unique skills to Aboriginal health and that the value of the Aboriginal nurse is obvious in providing the appropriate care to Aboriginal patients and there is a vital learning opportunity for non-Indigenous nurses that is yet to be fully realised and incorporated into care of the Indigenous patient. Indeed Blackman goes as far to say that ‘as nurses it is important we can reflect and recognise aspects in the practice of nursing that are unfamiliar. Nursing practice is a lifelong learning experience and failing to recognise a learning opportunity that could enhance knowledge and skill does nursing a great disservice’ (p. 213).

Blackman further to this challenges the non-Indigenous nursing workforce and states:

Nurses must also recognise the value of familiarising themselves with local Aboriginal health networks or community members, who can assist in culturally confronting situations, and help nursing contribute to better outcomes for Aboriginal patients. (p. 213)

Blackman identifies that there is a lack of knowledge amongst non-Indigenous nurses and this is a common and consistent theme amongst nearly all of our voices to date. Blackman's discussion brings to the literature the uniqueness of Aboriginal nurses and their skills in caring for Indigenous clients, but also challenges the non-Indigenous nurse to embrace their nursing knowledge deficits when caring for Indigenous people as a potential learning experience.

Reading Blackman's work there is clear echoes of Bush's work in discussing the 'unique skill set' that Aboriginal nurses bring to the practice of nursing.

#### **2.9.6.17 – 2009 Bush (I)**

The New South Wales Nurses Association *The Lamp* in 2009 paid homage to Sister Alison who was inducted into the Hall of Fame at NSW Health's Aboriginal Health Awards. For her achievement Sister Alison was interviewed by *The Lamp*. Of her accomplishments Sister Alison said 'my work involves endeavouring to help people understand Aboriginal history, people often say oh that was in the past, but it's not you know. The difference in the living standards is now it's in the present' (p. 21). Further to this and as articulated overwhelmingly by most of the reviewed voices of this research, Sister Alison believes it is the need for appropriate communication between nurses and Indigenous peoples that is most needed. Sister Alison states, 'communication is the most important thing in health care, and to communicate well you have to have an understanding, I think that all health professionals should do a

course in Aboriginal history and in cultural awareness as part of their formal training' (p. 21).

Tragically, Sister Alison passed away in Sydney in October 2010. Her accolades were many and varied and were received from both the Indigenous and non-Indigenous community in which she lived and worked and included: Officer of the Order of Australia, recipient of the Centenary of Federation Medal, and she was named an honorary fellow of the Royal Australian and New Zealand College of Obstetrics and Gynaecologists. For the Aboriginal community her loss was enormous. Sister Alison in her words stated 'pregnancy and childbirth are sacred to my people' and it is with this mandate that Sister Alison delivered our babies for decades.

Sadly in 2010 Sister Alison Bush lost her fight with pancreatic cancer which was a devastating loss to the Aboriginal community. Sister Alison was taken back to her lands in Darwin and was buried with her twin sister Jennifer. Her absence is still felt.

### **2.9.7 2010s**

In this new decade to date the voices of Aboriginal and Torres Strait nurses and midwives gets stronger. It is also evident that the Indigenous nurse voice is now consistently part of the academically sound nurse/midwifery literature. This is not to suggest that there are large numbers of Indigenous nurses but our voices are certainly being heard across many and varied settings.

Further, this decade to date offers new and innovative ground in which the Indigenous nurse/midwife voice resonates. We now see an in-depth recruitment and

retention tool and a larger presence in nursing texts. I predict this decade will see the emergence of a substantial cohort of PhD prepared nurses /midwives.

### **2.9.7.1 – 2010 Stewart (I)/Nielsen(I)/Horner (I)**

Stuart, Nielsen and Horner identify that essentially there are five major issues that impact significantly on retention and therefore graduation of Indigenous registered nurses. They are:

1. students need financial, academic and program support to progress
2. students need to know that there is a way back without being judged when they go off track
3. students need time management guidance
4. students need to make a commitment to themselves and a mentor to stay motivated
5. students need to know that someone cares whether they succeed or not.

Stuart et al. outline that the ‘Indigenous nursing student support (INS) model “Helping Hands” is currently used by the USQ Indigenous nursing academics.’ This is an extensive model containing a series of support tools. The following five strategies underpin the retention tool and are as follows:

1. The Deadly Dilly Bag

Indigenous students need substantial financial and academic support and need to know how to navigate studies. The Deadly Dilly Bag is comprised of a survival kit which addresses the identified support needed and is an intensive process of trying to adequately secure financial support. This is done in conjunction with one of the Aboriginal academics.

The USQ has now had substantial success in attracting a number of national

Indigenous nursing scholarships such as the Puggy Hunter and Sally Goold Book Bursary, and also have secured a substantial number of Queensland Health Indigenous nursing cadetships.

2. The Boomerang Tracker

The second identified issue is addressing when students sometimes go off track and do not understand the implications to their study to the point at times of it impacting on their course progression. This is an intensive process of contacting the student without judging using multiple forms of access which includes emails, texts, phone call to home and mobile.

3. The Academic Footprint Tracker

One of the identified impacts for Indigenous students is the rigor of tertiary time management which includes attendance being compulsory. This is clarified through time tabling which includes regular consults with one of the three Aboriginal nurse academics and accessing the federally funded Indigenous Tutorials Assistance Scheme (ITAS) tutoring arranged for each semester. This familiarises the student with the extent of the commitment and is paramount as an individually devised plan.

4. The Heartprint Handwritten Contract

The contract is a strategy to enlist a commitment from the Indigenous nursing student. Stuart et al. state that 'it is the single most effective strategy within the retention tool of the "Helping Hands" model that ensures that students keep their university studies as number one priority' (p. 7). There is a contract written up at the beginning of each semester. The students sign it committing to reaching their true potential of getting through the semester whilst

accessing all the support mechanisms that have been put in place.

5. The Cockatoo Alert

The last issue is identifying when students are at risk of slipping through the cracks. The cockatoo alert is the strategy which instigates a fully unified call for support from the three Indigenous nursing academics and fellow nursing students and the Indigenous education centre.

The above framework is unique to the USQ and is obviously a huge help in graduating Indigenous nurses. Within the literature it is the first offering of a framework of support since the mid-1990s. What this model brings to the literature is an in-depth retention tool and the strategies that are used in conjunction. This retention tool has been measured and tested and deemed very effective in graduating Indigenous nurses from the USQ.

**2.9.7.2 – 2010 Nielsen (I)**

Nielsen seeks the experience or journey of the Aboriginal registered nurse. Nielsen states ‘much has been written on the recruitment and retention strategies dedicated to improving the numbers of Aboriginal registered nurses, but what of the experiences of these nurses once they graduate and commence work within dominant white healthcare facilities?’ (Nielsen 2010).

This research is both exciting and innovative in its endeavour and gives a much needed voice. Nielsen sought to answer the below:

Influential also in the development of this topic was the fact that the researcher (also an Aboriginal registered nurse) noted through personal and professional experience that very few of her Aboriginal nursing network actually worked full time in mainstream healthcare settings. This for me posed the question as to why the shift away from mainstream health care, where arguably this is where they are undeniably needed the most. Could it be then that the necessity to merge into the dominant ‘whiteness’ of hospital



culture significantly contributes to the decision of Aboriginal registered nurses to pursue their careers where they are not required to conform? (p. 8)

Nielsen undertook in-depth interviews with Aboriginal registered nurses with varying lengths of nursing work history, which varied from three to 20 years. There are four major categories that became the identified themes of this research:

1. Discrimination

As thought, this was experienced by all research participants. And one participant stated: 'I've come across nurses using inappropriate language to describe Aboriginal patients or to describe Indigenous nursing students' (p. 13).

2. Whiteness of nursing

Nielsen within her research clearly defines and states 'the whiteness of nursing describes the structural and systematic white dominance of this profession which pervades all areas from colleague interactions to the provision of patient care' (p. 23).

3. Provision of care

Nielsen's research uncovered that the participants have all had cultural clashes within their nursing experience when the dominant Westernised biomedical model conflicted with the culturally based holistic practices of Aboriginal clients and nurses.

4. Cultural vitality

Cultural vitality through resilience was identified by all participants as part of whom and what they are. This is unique in the literature that the voice of an Aboriginal registered nurse acknowledges 'that more than anything, bloody

resilience at times got me there because I just – you know your black, you know what it's like to have a fucked up family and trying to study and get through' (p. 34).

The whole notion of the 'whiteness' of nursing has not been explored by an Indigenous Australian nurse to date. Until Nielsen's work there was no research that suggested it is the 'whiteness' of nursing that is driving out Indigenous nurses from mainstream health care facilities which is arguably where they are needed the most. This is another example of the depth of unpublished post-graduate research that is occurring primarily amongst Queensland Indigenous nurses. Nielsen clearly identifies that using a small sample in this research was a hindrance and suggests this research needs to be undertaken on a much larger scale. Nielsen's research greatly adds to the current literature and stands apart from most of the research that has been undertaken.

### **2.9.7.3 – 2010 Best (I)**

The Queensland Aboriginal and Torres Strait Islander Nursing and Midwifery Strategy 2010–2012 was the inaugural strategy produced by the Office of the Chief Nursing Officer (OCNO) Queensland Health, which was launched in July 2010. I was the author of this Strategy. The development of this Strategy was informed by a two day workshop and was attended by 12 Aboriginal and Torres Strait Islander registered nurses and midwives from across Queensland. This cross section was broad and diverse and included as its participants, Indigenous male and female nurses and female midwives from urban, rural and remote settings. The participants were nurse academics/researchers, government nurse advisors and Aboriginal community controlled health sector nurses/midwives.

The Queensland Aboriginal and Torres Strait Islander Nursing and Midwifery Strategy 2010–2012 aims to improve Indigenous health by providing opportunities for Aboriginal and Torres Strait Islanders to gain education, training and employment opportunities in the field of nursing and midwifery. The Strategy identifies five domains that if implemented, are believed will significantly increase the Aboriginal and Torres Strait Islander nursing and midwifery workforce in Queensland.

1. Workforce

To identify and promote nursing and midwifery career pathways that are supportive, evidence based and responsive to the needs of the Queensland Aboriginal and Torres Strait Islander communities.

2. Education and Training

To provide an Aboriginal and Torres Strait Islander nursing and midwifery workforce that is competent in providing care to communities in Queensland.

3. Profession and Practice

Develop Indigenous nursing and midwifery practice through new models of care, innovation and best practice standards that are culturally safe for Aboriginal and Torres Strait Islander people.

4. Workplace

To evolve the nursing/midwifery workplace and as required, adapt roles, systems and procedures to ensure the professions are able to practice safely and effectively.

5. Cultural Respect and Competence

To ensure a nursing and midwifery workforce that is culturally safe and

competent in providing health care to Aboriginal and Torres Strait Islander people. (p. 5)

The Queensland Health Aboriginal and Torres Strait Islander Nursing and Midwifery Strategy 2010–2012 have clear Key Performance Indicators outlined that are reported against quarterly by the Indigenous Nurse Advisor, Office of the Chief Nursing Officer, to the Human Resources Executive Committee of Queensland Health. The mandate is clear. The current Indigenous nursing workforce is 437 or 1.5%, by 2014 this needs to be 701 and in 2018 this figure needs to be 1025 to reach the target of a 3.7% Indigenous nurses and midwifery workforce in ten years within Queensland Health. This will prove its success as a strategy and as a Queensland Health commitment.

#### **2.9.7.4 – 2010 Best (I) & Drummond (I)**

In 2010 I co-authored with Ali Drummond, a Torres Strait Islander male nurse, two chapters in separate nursing texts. Firstly, Long-term Caring 2<sup>nd</sup> edition (Scott et al. 2020), included for the first time work produced by Indigenous Australian registered nurses titled *Working with Aboriginal and Torres Strait Elders*. The text had an embedded Torres Strait Islander nurse perspective presenting the context of providing appropriate care for Torres Strait Elders. The voice is interwoven with an Aboriginal nurse perspective outlining appropriate care for Aboriginal Elders.

History is a pivotal part of setting up the chapter and allows largely a non-Indigenous student readership to understand the historical trauma that the older Indigenous population has lived through often under harsh and racist policies. This demands recognition and nursing intervention when care is provided for these patients. It is the belief of both authors that understanding history informs nursing

practice. This chapter adds depth to the literature in that to date there has been a miniscule amount of work authored by Torres nurses.

Secondly, I co-authored, again with Ali Drummond, *Indigenous Health Issues in Australia in Understanding Pathophysiology* (Craft et al. 2010). This work provided a pathophysiological snapshot of Indigenous Australians. However, interwoven into the suite of facts and figures were Indigenous perspectives such as the impact of past policy on Indigenous Australians, traditional medicines, a pre-invasion health status, and importantly the impact of social determinants on Indigenous health. This work does not provide for the reader specific nursing interventions but more the living reality of Indigenous Australians, and the link of how this history has impacted upon the present day presentation of the health of Indigenous Australians.

The inclusion of Aboriginal health content in nursing textbooks that are written by Indigenous nurses has only occurred within Australia in the last five years. This is certainly a new and vital medium for non-Indigenous nursing students to be informed of an Indigenous nursing context for meeting the unique needs of Indigenous Australians. This work cannot be underestimated in its impact on the Australian nursing education landscape.

#### **2.9.7.5 – 2010 West (I) Usher & Foster**

West, Usher and Foster begin their article with the title, ‘Increased numbers of Australian Indigenous Nurses would make a significant contribution to ‘closing the gap’ in Indigenous health: What is getting in the way?’. Their work commences with the understanding that ‘the provision of a well-trained and culturally safe health workforce is critical to reducing the current health gap and to achievement of optimal

health outcomes for Australian Indigenous peoples' (p. 121).

Undoubtedly this is one benefit to increasing the numbers of Australian Indigenous nurses but West et al. argue that they (Indigenous nurses) 'are also better positioned to assist non-Indigenous nurses to improve their understanding of Indigenous cultural issues and how these impact on the delivery of culturally appropriate health care' (p. 123).

The lack of Indigenous nurses they believe 'is still not enough to make a significant difference to the health outcomes of Indigenous peoples' (p. 127). In order to increase the numbers of Indigenous nurses that are needed to make significant contributions to the health of Indigenous Australians, West et al. provide a number of recommendations sourced from previous research and importantly their own experiences. These recommendations are:

- a critical Indigenous pedagogy, grounded in an oppositional consciousness, needs to be utilised in all undergraduate nursing education
- further research needs to be undertaken to explore the reasons for the success of programs that have demonstrated high numbers of successful completions of Indigenous registered nurses when compared to other schools with similar intakes
- educational workshops need to be developed for non-Indigenous nurse academics on factors affecting Indigenous student retention/completion and the issues faced specifically by Indigenous students, and effective learning and teaching approaches for Indigenous students
- Indigenous nurses must be employed as academics in nursing schools across Australia to teach specific programs of relevance to the health of Indigenous

people, to act as support persons for Indigenous students, to encourage the appropriate inclusion of Indigenous content in curricula, and to act as role models for Indigenous students (p. 128).

It is the authors' inherent belief that if these proposed recommendations are indeed implemented there will be greater Indigenous participation in the nursing workforce by Indigenous peoples.

#### **2.9.7.6 – 2011 West (I) & Usher**

West and Usher (2011) again bring to the mental health nursing literature the voice of an Aboriginal mental health nurse and how to work with Indigenous people. This provides a much needed Aboriginal voice given the Aboriginal conceptualisations of mental health. The importance of this content cannot be underestimated, as for the importance of it being presented in core curriculum for mental health nursing students. Providing an Indigenous conceptualisation of mental health is essential knowledge for the non-Indigenous mental health nurse workforce.

West presents the facts, statistics and figures and then offers the Indigenous perspective of how 'Indigenous people prefer to use the term social and emotional well-being rather than mental health, because it has a more positive and holistic connotation which is in keeping with Indigenous beliefs about health' (p. 399). This is then followed by the unique nursing interventions that are outlined.

Importantly there is also a listing of support available for resources and organisations. Offering the critical mass the skills and nursing interventions has very positive outcomes for the potential nursing and midwifery workforce in care for Indigenous people. The provision of policy and the impact on service delivery also allows the reader (student) to connect the importance of these processes and the

impact on the Indigenous community.

This chapter is by far more in-depth than West's previous offering and provides the reader an in-depth presentation of valuable knowledge and its implication on practice such as assessment from the Indigenous nurse. West's voice is strong in outlining nursing interventions such as:

- being aware of spiritual issues
- remembering to assess the consumer's level of English comprehension
- not assuming that the consumer has the same level of background knowledge as you have
- not mistaking shyness or reluctance to communicate with you as a problem
- remaining respectful of gender issues.

This is the first comprehensive Aboriginal mental health nurse's voice outlining the provision of specialist nursing care for Indigenous people. Again, this is a new voice that has emerged recently.

#### **2.9.7.7 – 2011 West's (I) & Usher**

In 2009 in the small remote community of Mt. Isa, Queensland, a locally designed nursing education model was delivered to 38 Aboriginal people. The program was designed for the students to exit with a *Certificate III in Health Service Assistant*, meaning they were eligible to work as Assistants in Nursing. The delivery model became known as *Tjirtamai* which means 'to care for'. This name was gifted to the program by the Traditional Owners of the land on which the course was conducted and was delivered by descendants of the same traditional owner group who were either Aboriginal registered nurses or primary health care workers.



‘Of the 38 Aboriginal students who enrolled in the course, 26 students completed. Of these students, 18 have since enrolled in a bachelor degree in nursing while another four enrolled in a diploma of nursing’ (p. 39).

West et al. argue that in part the reason for its success is that the ‘*Tjirtamai* model was built around the provision of direct social and emotional support to the students alongside intensive face-to-face delivery education sessions’ (p. 40). *Tjirtamai* was an intensively supported model with the understanding that the challenges that impact on Indigenous students accessing education are often a myriad. ‘As a result, it was funded to include assistance with child care, housing, transport, meals (including breakfast, morning tea, lunch and afternoon tea), and contextualised support around the development of numeracy and literacy skills’ (p. 43).

West et al. outline that there were a number of challenges in delivering the course and they were acutely aware of the potential challenges unique to many Indigenous students. ‘For example “sorry business” has had a significant impact on the attendance of the students and on average, we experienced approximately a funeral each week during the delivery of the program which required the model to be adapted accordingly’ (p. 46).

It is the belief of West et al. that the *Tjirtamia* is a successful model for increasing the numbers of Indigenous peoples entering into nursing and there is potential for its applicability and transferability amongst many Indigenous communities across Australia.

#### **2.9.7.8 – 2011 Stuart (I) & Nielsen (I)**

Stuart and Nielsen present to the reader that it ‘is a foregone conclusion that

Aboriginal nurses are the most suitable nurses to provide optimal cross cultural care for Aboriginal patients, due to having similar cultural backgrounds' (p. 96). Their article, 'Two Aboriginal registered nurses show us why black nurses caring for black patients is good medicine', outlines the optimistic belief that 'possibilities of expanding the ranks of Aboriginal registered nurses through role modelling, and channelling their research to achieve this with the aim of providing better health outcomes for their people' (p. 96).

In research undertaken (Masters Honours Programs) by both authors in which a qualitative methodology design was utilised, themes emerged that were similar and compatible in both research projects. The themes that emerged were:

1. cultural healing communication
2. barriers to healing for Aboriginal patients
3. caring is inherent in Aboriginal nurses.

Within the first identified theme the authors argue that 'with Aboriginal nurses, there exists an ease in communications and a vested interest in the outcomes for their Aboriginal patients' (p. 98). The second theme Stuart and Nielsen argue is 'this level of cultural understanding in the nurse/patient relationship is virtually impossible for the large majority of Aboriginal patients to experience, due to the limited number of Aboriginal nurses and that as a result non-Aboriginal patients continue to thrive in our Western dominated healthcare system, whereas Aboriginal patients are slowly being nursed to death' (p. 99). The last identified theme Stuart and Nielsen argue is the innate sense within Aboriginal people to nurse 'as this exists in their genetic blueprint' (p. 99).

Again the above literature adds to the growing body of evidence of the unique

contributions that Indigenous nurses can and do make to Indigenous health and ‘strongly indicates that Aboriginal nurses caring for Aboriginal patients is good medicine’ (p. 100).

#### **2.9.7.9 – 2011 Blackman (I)**

Blackman offers to the reader a reflection as an Aboriginal registered nurse who is in the pursuit of understanding culture in practice. Blackman states ‘that the aim of this paper is to contribute to current debate, from an Australian Indigenous nurse’s point of view, about the importance of reflective practice in the delivery of culturally competent nursing practice’ (p. 32).

Blackman, having worked in a remote Aboriginal community for approximately ten years states that this ‘has presented me with rare and valuable learning experiences in the delivery of health care to Aboriginal people’ (p. 33). This is a unique voice within the literature as Blackman identifies that, as an Aboriginal nurse, she too has learned about the delivery of health care to Aboriginal people. This breaks away from a commonly held belief that Aboriginal nurses know ‘everything’ about Aboriginal health. This belief also challenges the notion that Stuart and Nielsen provide in the previous literature that Aboriginal people inherently know how to look after Aboriginal patients. An example is demonstrated through Indigenous people being removed as part of past Government policy who have had their link to community severed. This severance from community and culture can impair their ability to give culturally relevant and safe care.

For Blackman, being able to impact positively within the community has meant undertaking constant reflective practices that have been ‘core to my learning experiences and used in conjunction with other sources of knowledge to build both

knowledge and nursing skills to enable competent nursing practice’ (p. 33).

Blackman argues that the capacity to build a culturally competent workforce can be achieved within Australia, ‘however, it is a long and complicated journey for health professionals who wish to work in cross cultural environments in a culturally competent way’ (p. 33). She further states that ‘the starting point for developing cultural competence must be critical self-exploration and awareness coupled with a willingness to learn’ (p. 33).

In conclusion, Blackman believes that “nurses and other health professionals must recognise the importance of reflective practice to culturally competent practice or risk delivering continued inadequate health care” (p. 34).

### **2.9.8 Discussion of the Australian Indigenous nursing/midwifery voice**

Undoubtedly, the above covers a wide and diverse range of Indigenous nurse and midwives’ voices. The first Aboriginal nursing voice emerged in 1955 in *Dawn Magazine*. This publication cannot be underestimated for the voice it gave to many Aboriginal people that was heard and shared across Australia. In 1995 there was the voice of only one Aboriginal midwife from Yarrabah Queensland. In the 1960s there were only two voices and both were again reported in the publication *Dawn*. Again Sister Muriel Stanley’s voice emerged and I propose this is the first activist voice for Aboriginal health from an Aboriginal health professional within Australia. Further to this pioneer voice was the introduction of the Bush Sisters who both had highly acknowledged careers in Aboriginal health like we had never had before. All these women were ‘under the Act’ still and their journeys are truly inspiring.

The 1970s was the decade of change for Aboriginal and Torres Strait Islander people. Community control emerged as the operational framework for administration

of services. The mantra was very much ‘by the people, for the people, with the people’ (Martin, M, pers. comm.). The Standing Committee on Aboriginal Affairs (1979) tabled the first ever report, entitled *Aboriginal health*, which stated that ‘there were no Aboriginal doctors and few Aboriginal nurses and nurse trainees, and a limited number of nurse aides’ (p. 125). Again this part of unique Aboriginal nursing history has not been documented. Along with creating these services came the few Aboriginal nurses that were local and qualified to work in them.

The overarching policies of administration (*The Aboriginal Protection Act* and *The Aboriginal Protection and Restriction of the Sale of Opium Act 1897* in Queensland) of Aboriginal people largely ceased within the 1970s. A new era of self-determination was seen as the ‘way forward’ for Indigenous peoples. *Dawn* ceased to be published and the voices of Aboriginal and Torres Strait Islander nurses and midwives were no longer heard.

I argue that Aboriginal and Torres Strait Islander nurses and midwives up until the 1980s struggled with an unequalled racism. I further argue that this is due to overtly racist policies of the era, which in many cases impacted on them being accepted into nursing and or midwifery programs. This is not an issue that is faced by today’s Indigenous people entering nursing via the tertiary sector. The 1980s saw for the first time an Aboriginal nurse within the nursing literature. This is unique for this era as the largest transition was occurring from the hospital to tertiary sector training. It took a long time for many non-Indigenous nurses/midwives to publish academically and yet in the midst is a single Aboriginal nursing voice. There were no self-identified Indigenous nurse academics in Departments or Schools of nursing/midwifery. This decade also provided the published story of the first trained

Torres Strait Islander nurse/midwife.

The 1990s saw multiple Aboriginal nurse voices emerge and be published. There was also a move into post-graduate research by Aboriginal nurses albeit small. It also saw a definite move into the nursing literature which included the first Aboriginal nurse authored chapter of a mental health nursing textbook. The decade following would see an explosion of Aboriginal nurses/midwives' voices in both grey and academic literature.

The 2000s would see the largest to date number of Aboriginal nurse/midwife voices being published. This decade also saw major reports published that specifically focused on the increased recruitment and retention of Aboriginal and Torres Strait Islander people into nursing. There is also a clear and concise voice from Aboriginal Academics in the tertiary sector which provided literature on successful completion of degrees for Indigenous nursing students.

In this current decade we have seen the re-emergence of a Torres Strait Islander nurse's voice through textbook publication. Already a unique framework around retaining Aboriginal nursing students has emerged from a team of Aboriginal nurse academics at one university. The landscape is remarkably different now with four of the eight tertiary providers in Queensland employing Aboriginal nurse academics in Departments/ Schools of Nursing. It promises to be an exciting decade and I predict the emergence of a number of PhD prepared Aboriginal registered nurses.

As a whole the voices from the first appearance in 1955 in *New Dawn* until 2011, 56 years later, look like this:

1. there are 21 Indigenous nurse/midwifery authors

2. there are three Torres Strait Islander nurses/midwifery authors
3. the strongest but not exclusive themes of the voices are identified as:
  - a) education of non-Indigenous nurses and midwives in the history and health of Aboriginal and Torres Strait Islander peoples must be mandatory
  - b) There must be greater participation of Aboriginal and Torres Strait Islander nurses and midwives
  - c) racism has been experienced by most Aboriginal and Torres Strait Islander people in their nursing careers.
4. Murri nurses and midwives were pioneers in the literature with initial voices being from both Aboriginal and Torres Strait Islander nurses and midwives
5. there is no one prolific writer to date
6. there has been a noticeable increase in the last ten years in the amount and types of publications from Aboriginal and Torres Strait Islander nurses/midwives
7. a Torres Strait Islander nursing voice has re-emerged.

Reviewing the above academic and grey literature I have created a time line which to date has not been done; this allowed me to identify the uniqueness of this research. As far as can be explored there has been no post-graduate research conducted on the stories of Queensland Aboriginal nurses. The stories that are available have been presented through grey literature such as documentaries for television, books/novels and DVD/on-line resources. This in-depth literature review from the voices of Aboriginal and Torres Strait Islander nurses/midwives undoubtedly fills a gap in the literature.

### **2.9.9 The Maori Voices**

The highlight of my nursing career occurred whilst undertaking my Churchill Fellowship. I had first met Irihapeti Ramsden in 2001 at the Congress of Aboriginal and Torres Strait Islander Nurses Conference (CATSIN) in Melbourne. Irihapeti gave the keynote address and spoke of her journey in developing the framework of *Cultural Safety*. I was inspired by her and we maintained contact. Whilst undertaking the Churchill Fellowship I spent the first two weeks in New Zealand and three days of this with Irihapeti who was very sick at this time with breast cancer. I would sit with her and we would talk for hours whilst she was receiving intravenous pain control. Irihapeti shared some of her story with me about her life and journey as a Maori woman, registered nurse, educator, activist and leader. Irihapeti passed away that year not long after I left New Zealand and I was greatly saddened by her passing.

In presenting the voices of the Maori nurses I have only provided two. The first will be that of Irihapeti Ramsden and the framework of cultural safety. The more recent voice that I bring is Maori nurse researcher Victoria Simon. I only provide these two voices as I believe that they have been the most prolifically utilised Maori nurse voices within research and developing frameworks that have impacted upon the profession of nursing as a whole.

#### **2.9.9.1 – Irihapiti Ramsden 2002**

Ramsden developed the model of *Cultural Safety*. The framework's development and history is comprehensively outlined in her PhD titled 'Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu' (2002).

Within her introduction Ramsden states 'that the dream of *Cultural Safety* was about helping people in nursing education, teachers and students, to become



aware of their social conditioning and how it has affected them and therefore their practice' (p. 2). This desire emerged from Irihapeti's own journey from being a Maori student nurse to being a new graduate and her response to the educational process which 'was so obviously designed for student nurses who did not, and could not share the experience of the colonisation of my land and people and history' (Ramsden, I 2002, pers. comm., 18 February).

Irihapeti noted that the experiences of the Maori nurse and the pakeha (white) nurse were in stark contrast. The lack of understanding of the brutal colonial and racist history of colonisation in New Zealand amongst her pakeha nursing peers was very evident and distressing. These in fact were the formative dealings for Irihapeti which led to the development of cultural safety (2002, pers. comm.).

For Irihapeti:

The omission of the colonial history of New Zealand in the basic state education system had led to a serious deficit in the knowledge of citizens as to the cause and effect outcomes of colonialism. Without a sound knowledge base it seemed to me that those citizens who became nurses and midwives had little information of substance on which to build their practice among this seriously at risk group. (Ramsden p. 3)

As a young graduate nurse Irihapeti was constantly faced with being expected to look after Maori patients and their families only. When this was not the case Irihapeti would watch inappropriate care being given to Maori patients, and saw the distress of these patients. She would no doubt at some time in her shift add to her own patient load by assisting or explaining things that the pakeha nurse had instructed them to do. This at times made it hard as Maori patients would ask to be looked after by Irihapeti. The pakeha nurse would just shrug their shoulders, look at Irihapeti and walk away (2002, pers. comm., 18 February). For Irihapeti 'this meant dealing with

such social mechanisms as personal and institutional racism in the context of a violent colonial history and coming to terms with the inherent power relations, both historical and contemporary' (Ramsden p. 3). As a consequence of this inappropriate nursing care Irihapeti argued whether 'consciously or unconsciously such power reinforced by unsafe, prejudicial demeaning attitudes and wielded inappropriately by health workers, could cause people to distrust and avoid the health services. Nurses need to understand this process and become very skilled at the interpretation of the level of distrust experienced by Indigenous people when interacting with the health service which has its roots in the colonial administration' (p. 3).

Irihapeti stated that the idea in developing the framework of *Cultural Safety* was that it advocated and then implemented the replacement and demystification of colonial history in terms of its development of attitudes and beliefs toward Indigenous peoples. The inevitably created stereotypes were often all that the pakeha nurses had to work from due to many of them not having contact with Maori (2003, pers. comm.)

For Ramsden, identifying the imbalance in power relations between the nurse and the patient became obvious. This greatly informed the development of cultural safety. As a result Ramsden states that 'cultural safety became concerned with social justice and quickly came to be about nurses, power, prejudice and attitude rather than the ethnicity or cultures of Maori or other patients' (Ramsden p. 5). Further to this Ramsden states that:

Cultural Safety has been expanded to include all people encountered by nurses who differ in any way from the nurse. It is concerned with the unique, individual and bicultural (i.e., one person to one person) relationship between the nurse and the patient. Whatever the difference, whether it is gender, sexuality, social class, occupational group, generation, ethnicity or a grand combination of variables, difference is acknowledged as legitimate and the

nurse is seen as having the primary responsibility to establish trust. Cultural Safety is therefore about the nurse rather than the patient. That is, the enactment of Cultural Safety is about the nurse while, for the consumer, Cultural Safety is the mechanism which allows the recipient of care to say whether or not the service is safe for them to approach and use. Safety is a subjective word deliberately chosen to give the power to the consumer. (pp. 5–6)

Ramsden identified that the process of cultural safety is a continual one and that the ‘the process towards achieving Cultural Safety in nursing and midwifery practice can be seen as a step-wise progression from Cultural Awareness through to Cultural Sensitivity and on to Cultural Safety. However, the terms cultural awareness and cultural sensitivity are not interchangeable with Cultural Safety. These are separate concepts’ (p. 117).

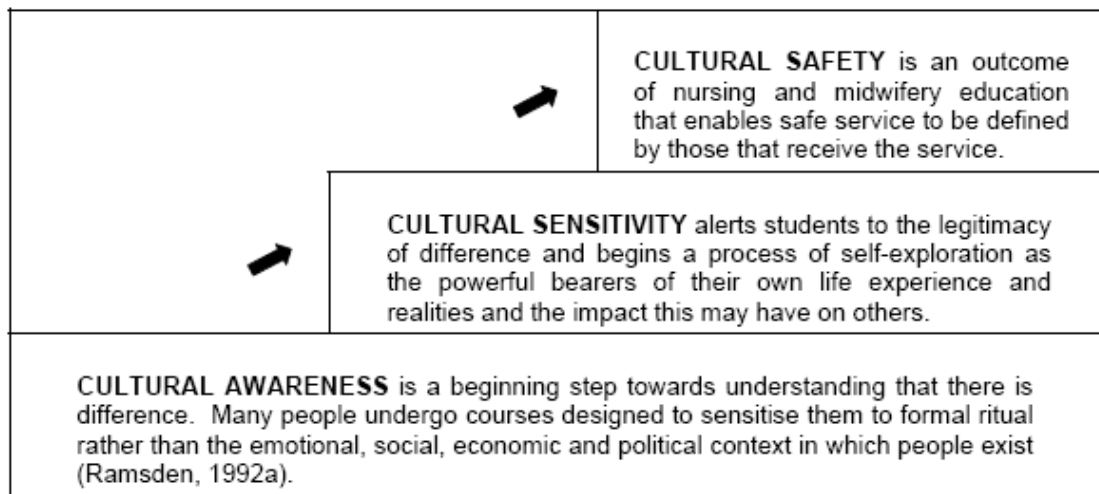


Figure 6  
The process toward achieving Cultural Safety in nursing and midwifery practice

**Figure 2.4 Ramsden’s process towards cultural safety**

(Ramsden 2002, p. 117)

The development of *Cultural Safety* has had wide and far reaching impacts on both the nursing and midwifery professions within New Zealand. It has also had far-

reaching implications for both professions globally. Cultural safety has been discussed, debated, analysed, critiqued but also importantly it has been embedded into nursing and midwifery curricula across the globe. For many Aboriginal and Torres Strait Islander nurses and midwives that have read Irihapeti's work, there are the silent nods of understanding the evolution of the framework. Undeniably Irihapeti is one of the unique and remarkable Indigenous nurse leaders of our time. Her framework of Cultural Safety will forever be on the nursing and midwifery landscape. She is profoundly missed.

#### **2.9.9.2 – Simon 2006**

In 2002 Irihapeti stated that 'there is still major debate about the definition of Maori let alone what might comprise Maori nursing practice' (p. 6). In 2006, four years after the death of Irihapeti, Maori nurse researcher Victoria Simon started exploring and indeed beginning to articulate what the characteristics of Maori nursing practice were.

In introducing this research Simon states that although Maori nurses have a long history of practice within the New Zealand health care system, it is still not easy to identify what might constitute Maori nursing practice (2006, p. 204). Simon further states that 'given the limited literature about Indigenous nursing practice, the research undertaken attempted to characterise Maori nursing practice by facilitating the explanation of Maori nurses' practice by Maori nurses themselves' (p. 205).

The lack of understanding in characterising Maori nursing practice as Simon outlines, was identified by the Ministerial Taskforce on Nursing which stated that 'Maori nurses undertake alternative ways of practicing which achieve positive health outcomes for Maori yet these are often not recognised as they are unable to be

validated' (p. 204). For Simon it became imperative for this research that the voices of Maori nurses were clearly articulated, heard and documented.

The participants of the research undertaken were all self-identified Maori nurses who worked both within mainstream and Maori health services. Simon identifies that in order to attain this information from Maori nurses it was 'the use of a Maori nurse peer as a researcher that not only helped in understanding the terms the nurses used to explain their experiences, but also in understanding the cultural values, beliefs and norms of the group' (p. 207).

For Simon 'understanding colonisation and its impact on Maori people's lives became an important part in the development of this research and its exploration of the experiences, knowledge, practices, and education of Maori registered nurses' (p. 205).

Informed by the research Simon identified that Maori nursing practice can be characterised as having five features:

1. the promotion of cultural affirmation including cultural awareness and identity
2. the support of, and access to Maori networks
3. the adoption of Maori models of health
4. the enabling of visibility and pro-activity as Maori nurses
5. the validation of Maori nurses as effective health professionals. (p. 210)

Further to this, three recommendations for promoting Maori nursing practice are made in relation to staff in the workplace and in nurse education programmes. All nursing staff need to be alerted to the:

1. impact of western scientific models on Maori healthcare

2. (often passive) non-acceptance of Maori within mainstream institutions
3. benefits of valuing Indigenous nursing programmes. (p. 203)

In listening and documenting the voices of Maori nurses and their practice Simon identifies that ‘the future practice of Maori is not about returning to traditional practice only, rather it is about a blend of contemporary and traditional practices’ (p. 212). The study is significant due to facilitating the voices of Maori nurses to self-identify their practices and what informs these practices. This has been done with very few Indigenous populations of nurses and midwives.

The voice of Maori nurses and midwives is both strong and clear and there is much that can be learnt from these voices. I argue that it is the Maori voice that has impacted upon the landscape of nursing and midwifery the most. Prior to the development of the framework of *Cultural Safety* there was a dearth of nursing frameworks that looked at the power relationship between the nurse and patient and even less penned by Indigenous nurses/midwives. This initial work now has a global impact on the professions and the voice of Maori nurses remain strong and clear and has included further development of the characteristics of the Maori nursing practice.

### **2.9.10 The Native American Voices**

In presenting the voices of Native American nurses I have commenced with work that was largely undertaken in the 1990s. This is not to say that there was not a Native American voice prior to this but this era saw the development of very specific Native American frameworks that were not documented prior to this. As with many other Indigenous nurses the voice that has emerged from Native American Nurses has been strong and clear. I present the work that is written by Native American nurses that are considered as leaders both nationally and internationally.

**2.9.10.1 – Struthers and Littlejohn 1999**

Significant work emerged at the ‘Gathering our Wisdom: American Indian Nursing Summit III’ which was held in October 1997. At this summit there was an attendance of 203 Native American participants of which 60 were students. To examine the essence of Native American Nursing, a process was used to elicit responses from all participants. The summit participants were randomly assigned to groups of approximately 11 participants. The groups were led by Native American Nurses to explore and define the essence of Native American Nurses (Struthers & Littlejohn 1999).

Seven major themes emerged and content of each were identified from the collected data. The seven major themes are outlined below in ascending order of significance:

1. Caring

- caring is paramount
- caring keeps nursing from becoming tedious and technical
- the nurturing qualities of Indian women bring them into nursing naturally
- nursing is the expression of your personal, caring nature
- nursing and caring is a calling
- unconditional caring and love
- love and caring
- caring means partnership in healing
- caring brings healing presence

2. Traditions

- Indian people have values and traditions to sustain themselves professionally
- sensitive to traditions
- caring of elders is in our tradition
- connection of heritage helps in the nursing process
- the cultural tradition approach is the art of nursing, not the science of nursing
- being culturally competent is important and one never stops learning
- nursing brings innate knowledge of community
- keeping old ways
- knowing the past to call upon that wisdom and strength
- honouring traditional medicine

3. Respect

- honour and respect
- respect their stories

4. Connection

- we acknowledge and connect with each other
- being a bridge
- put the puzzle back together
- putting the pieces of the quilt together



- family connection important
- commonalities for Indian people, they have similarities, so can establish a relationship

5. Holism/Holistic

- Native American nursing is more holistic. It is spiritual, emotional and physical
- ability to see the whole person

6. Trust

- building relationships
- open to me as a nurse and trust me with themselves
- patient shares piece of self with the nurse
- responsibility to build a relationship with the patient
- be there, stay, build trust

7. Spirituality

- we are all spiritual beings
- healing through spirituality
- teach spirituality
- need to teach the spiritual piece in professional services
- spirituality provides a firm base
- centre yourself with Mother Earth and care for self

- Indians emphasise spirituality in their nursing practice
- we use both Western and Indian medicine. They complement each other. Indian nursing doesn't have all of the answers. We need Western medicine. However, we don't discount magic and miracles of spirituality and Indian medicine.
- acknowledge and appreciate spiritual beliefs
- balance nature and spirit
- relationships with the great mystery. (pp. 133–4)

This framework is unique as it gives voice to the practices of Native American people's provision of care in their nursing practice. Prior to this research and subsequent publications there was no such comprehensive voice which outlined the unique attributes of Native American nurses. The importance of this work cannot be underestimated in defining the differences of Native American nurses/midwives and therefore their practice. The collective Indigenous voice of nurses and midwives also becomes more visible and defined with this valuable contribution in the literature.

#### ***2.9.10.2 – Lowe and Struthers 2001 A Conceptual Framework of Nursing in Native American culture***

The above work was further defined by Struthers and Lowe and is presented as 'A Conceptual Framework of Nursing in Native American Culture'. This framework was presented at the 10<sup>th</sup> annual Native American Indian Education Conference in March 2000.

Lowe and Struthers (2001, p. 282) state:

The dimensions, characteristics, and components of the phenomenon of nursing in Native American culture provide a culturally appropriate conceptual model. Many of the same dimensions exist in mainstream nursing. Nevertheless, Native American nurses often define their nursing practice differently from other nurses because they perceive life through a world view that is different and that guides them in making their own sense of the world and health matters.

Lowe and Struthers further discuss the framework not only as the Native American voice that it is but also the potential to facilitate understanding amongst non-native American nurses:

This model can be used by Native American nurses to provide a structure for engaging in the profession of nursing. Further, it can be used by nurses of other cultures to understand nursing in the Native American culture and to provide health care to Native American people. (p. 279)

This work obviously built on the work that had been earlier penned within the 'Essence of Native American Nursing' (Struthers & Littlejohn 1999) and it is evident the work developed significantly as a defined framework of nursing. This extends beyond defining what Native Americans 'do' in their nursing practice and importantly it offers a better understanding for non-Native American nurses. Further to this it can potentially inform practice for non-Native American nurses and midwives.

Importantly, the development of this model saw the evolution of a defined voice of Native American nurses. The work clearly defines that whilst there are dimensions of nursing that are the same between Native American and non-Native American there are many specific nursing practices that are unique to Native American nurses.

**2.9.10.3 – Lowe 2002 *Balance and Harmony through Connectedness: The Intentionality of Native American Nurses***

This work by Lowe builds again on the voices, concepts and frameworks of the Native American nurse as outlined in the previous work ‘A Conceptual Framework of Nursing in Native American Culture’ (Lowe & Struthers 2001). Lowe’s work further describes how Native American nurses facilitate and promote harmony and balance through connectedness.

Lowe states that ‘according to the Conceptual Framework of nursing in the Native American Culture, connectedness is at the core of intentionality of Native American nurses’. Further to this, Lowe states that ‘Connectedness occurs through the dynamics of an interdependent and interrelated relationship between the nurse and the client’ (p. 4).

In the work titled ‘Balance and Harmony through Connectedness: The Intentionality of Native American Nurses’ (2002), Lowe further expands on this framework and states that ‘Native American nurses sometimes connect at a deep indigenous “oneness” level when caring for another Native American, especially in regard to how the past, present and future has impacted their lives and existence in similar ways. Caring for another is regarded an honor [sic] and an expression of deep respect’ (p. 10).

Lowe offers to the reader a number of components that impact on the interpretation of the framework which I argue are fundamentally unique to the experience of Native American people and therefore Native American nurses. Lowe outlines an understanding of connectedness as the core of intentionality and is followed by the Native American world view. This voice is of course determined by

the experiences of Native American cultures being impacted upon by processes of colonisation. Undoubtedly this impacts upon the relationship of a Native American nurse in the care of a Native American client/patient. An understanding of a shared history amongst Indigenous peoples is indeed a very powerful motivator for many Indigenous nurses and impacts on the care provided for Indigenous peoples.

The three pieces of work above by Lowe, Struthers and Littlejohn have clearly and uniquely defined Native American nurses and their voices. Lowe, Struthers and Littlejohn provide a clear process for Native American nurses defining the *essence of their nursing practice*. These initial writings morphed into the development of 'A Conceptual Framework of nursing in Native American culture' of which Lowe then offers an insight into how Native American Nurses facilitate and promote the 'Balance and Harmony through Connectedness: the Intentionality of Native American Nurses'.

### **2.9.11 The Canadian Voices**

Canada has had strong Aboriginal nurse leadership through the forming and administration of the Aboriginal Nurses Association of Canada as early as 1975. Canada also has a history of supported programs for Aboriginal nursing students. Major research has occurred not only amongst Aboriginal undergraduate nursing students but also Aboriginal registered nurses.

#### **2.9.11.1 – 2002 Against the Odds**

In 2002, Health Canada asked the Canadian Association of University Schools of Nursing to facilitate a national task force that would examine Aboriginal nursing in Canada. The task force engaged in an extensive literature review, conducted a

national survey of nursing programs, and explored recruitment and retention strategies. The Task Force was co-chaired by Aboriginal Nurse Leader, Professor Fjola Hart Wasekeesikaw.

The major findings of the Report are presented along five themes and these are:

1. Preparation

Preparation for entry into a nursing program is enhanced by students' high school education experiences and the guidance they receive to consider nursing as a viable career option.

2. Recruitment

Successful recruitment of Aboriginal youth into nursing programs depends upon concerted and targeted recruitment efforts, visible role models, community development and ongoing partnerships between schools of nursing and aboriginal communities.

3. Admission, Nursing Access and Bridging Programs

An affirmative action process to admit Aboriginal students into schools of nursing is of critical importance. Other transitional supports that have demonstrated their effectiveness or have the potential to foster success include Nursing Access Programs and Bridging Programs.

4. Progression

Student's progression through nursing programs is enhanced when schools of nursing have flexible programs that are relevant to the world views and life experiences of Aboriginal students.

Innovative curricular programming and the establishment and support of student communities increase the likelihood of students' success.

5. Post-graduate Recruitment and Retention

The initiation of targeted mentoring programs, development of nurse managers, and enhancement of the capacity of community health representatives hold potential for supporting new graduates and/or new employees. (pp. 7–10)

The findings were released as a major report titled *Against the Odds: Aboriginal Nursing National Task Force on Recruitment and Retention Strategies*. In part the report identified that the determination and indomitable human spirit motivating Canadian Aboriginal people to strive to become registered nurses stems from a deeply rooted commitment to one's self, to one's family and to the Aboriginal people, a commitment which motivates many Canadian Aboriginal people upon completion of their nursing degree to give back to their Aboriginal communities.

The significance of this report cannot be underestimated. It outlined not only the literature surrounding the issues of involving more Aboriginal people into the profession of nursing but gave a voice to many of the Aboriginal nursing students who were interviewed. The implementation of its recommendations will be the true test as to the commitment of engaging more Aboriginal Canadian people into the profession of nursing.

**2.9.11.2 – *Twice as Good, A History of Aboriginal nurses 2007***

In 2007 The Aboriginal Nurses Association of Canada (ANAC) released the publication *Twice as Good, A History of Aboriginal Nurses*. The publication presented the timeline of Canadian Aboriginal peoples and their pursuit to receive nursing training.

‘Up until the 1930’s, only a minority of hospitals were open to receive

Aboriginal nursing students. In fact, many nurses in this period trained in the United States, where they did not face the same ethnic barriers as they did in Canada' (p. 5). 'Most Aboriginal graduate nurses in the period worked at hospitals. A number of Aboriginal women found private duty jobs caring for individual convalescents, but these positions were often associated with domestic service, not nursing'" (p. 18).

Below is a snapshot of the defined eras:

1. 1945–1969

Indian Affairs became increasingly committed to monitoring vocational training for Aboriginal people and developed a number of opportunities for Native people to attain LPN and RPN employment. A large number of native women took advantage of these developments in an effort to get nurse qualifications and skills. However, many still had to overcome the barriers of racism in the education system, workplace and in Canadian law and society more generally.

2. 1969–1989

This period is considered one of organised political struggle towards self-determination for Aboriginal people in Canada and Aboriginal nurses partook in this struggle in significant ways. The Registered Nurses Association of Canadian Indian Ancestry (later the Aboriginal Nurses Association of Canada) formed with the distinct goals of improved health for Aboriginal people, Indian control of health services and the recruitment of people of Aboriginal ancestry to health professions. A correlation between health status and representation within the profession was entrenched, and a number of university and college programs aimed specifically at recruiting Aboriginal



students. A theory of trans-cultural nursing was developed in this period and had an enormous impact on the criticism and development of health services for Aboriginal people. Aboriginal nurses were increasingly looked to as experts in this field.

3. 1989–2006

This period is considered the fourth generation. ‘Cultural competency’ and ‘Cultural Safety’ became key concepts in the practice of nursing, as did the validation and respect for traditional knowledge. The latest innovation in nursing education is Aboriginal Health Nursing, which demonstrates the most notable shift in Aboriginal nursing in the 21st century. The goal of the Aboriginal nurse was no longer to augment participation, representation and a voice in the nursing profession, but to reform the profession itself to suit the cultural needs and intellectual goals of Aboriginal nurses and communities.

(pp. 2–3)

***2.9.11.3 – Cultural competence and Cultural Safety in First Nations, Inuit and Metis Nursing Education 2009***

*Cultural Competence and Cultural Safety in First Nations, Inuit and Metis Nursing Education* is a collaborative work undertaken by the Aboriginal Nurses Association of Canada (ANAC), the Canadian Association of Schools of Nursing and the Canadian Nurses Association. This work is the culmination of the belief that ‘ensuring safe passage through these programs (nursing) entails, in part, the inclusion of Indigenous worldviews, academic and personal support for students, and curricula which fosters competence among Aboriginal and non-Aboriginal graduates in the provision of care to Aboriginal people’. The belief is that ‘programs adopting these

best practices not only foster success among Aboriginal students, but create safe learning environments for all nursing students' (p. 1).

The purpose of this document is to address these nursing education challenges by integrating the literature and consequently developing a best practice framework. This framework will assist educators to foster cultural competence and safety among students and particularly in relation to First Nations, Inuit and Metis contexts.

Within the Canadian framework is the inclusion of cultural competence. 'Cultural competence is beyond cultural awareness and cultural sensitivity, and focuses on skills, knowledge, and attitudes of practitioners' (p. 22). It is identified as part of the concept in working towards nursing in a culturally safe way.

The importance of this framework cannot be underestimated. 'To advance Aboriginal Health nursing as a specialty, this document recommends that cultural competency, cultural safety, and traditional knowledge be incorporated into nursing curricula. Nursing graduates would then be prepared to provide culturally safe care to Aboriginal peoples and other ethno-cultural groups' (p. 5).

### **2.9.12 Discussion of the Indigenous nurses' voices**

Most noticeably in discussing the International and national literature there are well defined experiences of similarity. All international Indigenous authors come from a colonised voice and this is almost uniformly articulated in all writings.

Overwhelmingly there are the experiences of racism from both client/patient and other health service providers. Some of these experiences are written on a personal level and some of them are written within a research context.

Clearly the voice of the Indigenous nurse/midwife talks of the history of

colonisation historical exclusion. At times Indigenous nurses/midwives were able to undertake nursing training but also witnessed a blatant denial of access to progression and promotion. The Indigenous nurse's voice has clearly defined Indigenous frameworks that validate them as Indigenous nurses with clearly differing operational components that set them apart from non-Indigenous nurses.

This literature review disclosed work that covers recruitment and retention of Aboriginal nurses, experiences of undergraduate Indigenous nurses, racism experienced by Indigenous nurses and Indigenous derived models of care and theoretical frameworks. What has also clearly come from the Indigenous nurses/midwives voices are the frameworks for greater inclusion of Indigenous nurses/midwives.

Table 2.4 at the end of this chapter provides the national and international literature at a glance that was utilised for this literature review. Obviously an in-depth Australian Aboriginal and Torres Strait Islander nurse's voice has been provided. As previously stated it is not a comprehensive review of the International literature but is a snapshot of the most widely utilised and recognised Indigenous authors. Arguably, it is the authors discussed in this thesis that have brought to the nursing and midwifery arena the Indigenous nursing voice. At this time we have lost a number of these international Indigenous voices but yet their work continues.

## **2.10 Conclusion**

This chapter was divided into three sections and has described the literature that is fundamental to the research setting. Many national and international Indigenous nurses' voices were utilised in presenting the literature.

The first section provided an overview defining the research setting. This included a suite of facts and figures outlining both the Australian and Queensland Aboriginal and Torres Strait Islander statistics. This was followed by briefly outlining an international Indigenous health comparison. Section 1 then provided the Australian and Queensland Aboriginal and Torres Strait Islander nursing and midwifery workforce data. Lastly, Section 1 provided an international comparison of the Indigenous Registered Nurses workforce participation rates and was followed by a brief outline of the first Indigenous registered nurses of New Zealand, Canada and the United States of America.

Section 2 of this chapter then provided the stories of Queensland Aboriginal nurses from 1950–2005 who trained in Queensland. When drilling down to the timeframe of this research (1950–2005), the literature identified that presently there is only a handful of published works on the stories of Queensland Aboriginal registered nurses.

Section 3 then outlined the voices of Maori, Native American, Canadian Aboriginal, and Australian Aboriginal and Torres Strait Islander Registered nurses and midwives. There is a notable body of literature from Indigenous nurses globally on a range of issues impacting on them and their communities. The body of work covers recruitment and retention of Aboriginal nurses, experiences of undergraduate Indigenous nurses, racism experienced by Indigenous nurses and Indigenous derived models of care and theoretical frameworks.

**Table 2.4 Summary of literature used in this literature review**

<i>Key achievements / learnings of Indigenous nurses</i>	<i>AUSTRALIA</i>	<i>CANADA</i>	<i>UNITED STATES OF AMERICA</i>	<i>NEW ZEALAND</i>
Indigenous nurses Association	Congress of Aboriginal and Torres Strait islander Nurses (1997)	Aboriginal Nurses Association of Canada (1975)	National Alaskan Native American Indian Nurses Association (1984)	National Council of Maori Nurses (1983)
Government/Schools of Nursing Recruitment/retention Report	gettin em n keepin em Report (2002)	Against the Odds: Aboriginal Nursing National Task Force on Recruitment and Retention Strategies (2002)		
Identify the first Indigenous Nurse	Not identified	Charlotte Edith Monture (1914)	Susie Yellowtail Boston City Hospital School (1923)	Akenehi Hei Napier Hospital (1908)
Framework developed around u/graduate recruitment/retention	Stuart, Neilsen & Horner 'Helping Hands' (2010)	Cultural Competence and Cultural Safety in First Nations, Inuit and Metis Nursing Education (2009)		Cultural Safety: Irihapiti Ramsden (2002)
Nurse identified Frameworks for Practice	Not done	Cultural Competence and Cultural Safety in First Nations, Inuit and Metis Nursing Education (2009)	Essence of Native American Nursing (1999) Lowe (2002)	Cultural Safety: Irihapiti Ramsden (2002)

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Research/writing on racism in nursing	Gafney Somebody Now (1989) Goold (1995) Best & Neilsen (2005)	Against the Odds: Aboriginal Nursing national Task Force on Recruitment and Retention Strategies (2002)		Cultural Safety: Ramsden, Irihapeti (2002)
Published books on Indigenous nurses written by Indigenous nurses	Gafney Somebody Now (1989) In their own voices (2005)	Twice as Good: A History of Aboriginal nurses (2007)		
Defining Indigenous nursing characteristics and nursing practice	Passionate About Practice Conference Report (2010)	Not done	Essence of Native American Nursing (1999)	Simon (2006)
Research amongst Indigenous nurses	Goold (1995) Best & Neilsen (2005) Neilsen (2010)		Essence of Native American Nursing (1999)	Simon (2006)

## Chapter 3: Methodology

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### 3.1 Introduction

At the beginning of my PhD journey I thought I would be undertaking qualitative research. The methods would be in-depth interviews and questionnaires completed by participants in order to gain and construct their stories. Whilst I felt satisfied this would be academically acceptable, culturally I was challenged. I took a step back to consider what I hoped to achieve. I believed that by listening to the stories of six decades of Aboriginal nurses, I and many other Indigenous nurses could learn from the struggles these women had faced. This thesis became about transferring knowledge to me. The challenge then became constructing it as readable and useful narratives for others.

Central to participant's stories was their Aboriginality. This was validated by asking all participants 'how they identified'. Without hesitation all six stated their Aboriginality was who they were, and nurses were what they were. One participant went as far as to state 'Our Aboriginality is our being, everything we experience in post-colonial Australia is constructed around this and that's part of our being'. This comment stayed with me for a long time and resonated.

I then commenced many conversations with family, in particular my Grandmother Ivy Booth. My grandmother instructed me to speak to my first cousin Tom Kirk. In my early conversations with Tom I asked him how we as Wakgun people, Gurreng Gurreng nation, transfer knowledge and also the language to do so. I explained to Tom that for this thesis I wanted to tell the stories of six decades of

Queensland Aboriginal registered nurses and that each participant identified as Aboriginal first, and then as a nurse.

I further explained to Tom that I wanted to use the making of quinine water as an example of how Wakgun people, transfer knowledge so that non-Indigenous readers would have an understanding of this Indigenous methodology. This thesis became a journey of transferring knowledge and constructing it. Tom provided two words that were to become integral to gathering the stories *Djaparligin* and *Yatdjuligin*.

The identified Wakgun Model of transferring knowledge is a gift passed from one member to another. But the essence is far more than that, as it is embedded and untraceably woven with the threads of our birthright which dictates who we are, the beginning of our knowledge gaining and how our worldview is determined. Each of these threads cannot exist in isolation but underpin and determine who we are as Wakgun Clan of the Gurreng Gurreng Nation.

*Djaparligin* translates to ‘making corroboree’ or ‘songlines’. This is the methodology of obtaining the six stories of the research participants.

*Yatdjuligin* translates to ‘talking in a good way or happy way’. This is the presentation of the thesis.

At this time I also accessed literature prepared by Indigenous researchers from a range of disciplines. For me there was a sense of resonance in the writings from these Indigenous researchers and their experiences of undertaking appropriate research that utilised Indigenous methodologies and methods.

Aboriginal researcher and author Rigney (cited in Martin 2003) defines ‘Indigenous research as culturally safe and culturally respectful research that is



comprised of three principles: resistance as an emancipatory imperative; political integrity in Indigenous research and privileging Indigenous voices in the Indigenist research' (p. 4). Aboriginal academic and researcher, Karen Martin, states 'I research from the strength and position of being Aboriginal and viewing anything western as "another", alongside and amongst western worldviews and realities' (2003, p. 4).

Martin expands on Rigney's principles which are:

- recognition of our worldviews, our knowledge and our realities as distinctive and vital to our existence and survival
- honouring our social mores as essential processes through which we live, learn and situate ourselves as Aboriginal people in our own lands and when in the lands of other Aboriginal people
- emphasis of social, historical and political contexts which shape our experiences, lives, positions and futures
- privileging the voices, experiences and lives of Aboriginal people and Aboriginal lands (p. 5).

Further to this, Aboriginal academics and authors Moreton-Robinson and Walter outline that Indigenous methodologies reflect our ways of knowing, our ways of doing and our ways of being. Saami academic Porsanger (cited in Walter & Moreton-Robinson 2004), outlines that "this means that Indigenous methodologies make visible what is meaningful and logical in our understanding of ourselves and the world and apply it to the research process" (p. 2).

It is the words of these Indigenous researchers that enabled me to use alternative Wakgun methodology of Djaparligin and presentation, or Yatdjuligin in this research. These words validated my experiences as an Aboriginal woman who is

a registered nurse and researcher, and whose research is to inform the Indigenous liberation struggle. Their words allowed me to be brave.

### **3.2 Wakgun Standpoint**

This thesis is written from a Wakgun Standpoint. Firstly, I present how Wakgun Clan transfer knowledge. This is underpinned by both Djaparligin and Yatdjuligin. In passing on knowledge, the process of Djaparligin occurs first. Djaparligin literally translates to ‘singing corroboree’ which includes singing, dancing, mimicking, showing, instructing and talking. It is the ceremonies that are only linked to Wakgun Clan, Gurreng Gurreng Nation; this is our ‘being’. From our being, which is inextricably linked to our traditional lands and is passed by birth right, our ‘knowings’ and ‘doings’ as Wakgun Clan unfold accordingly.

Corroboree is utilised across many Aboriginal nations and is considered ceremony for Aboriginal people. Traditionally corroboree is transferring private and public knowledge. Corroboree is utilised to transfer knowledge from a vast array of differing knowledge. It is an expression of Wakgun Clan, Gurreng Gurreng Nation’s being, the intricate knowledge of clan lands and resources, the knowing, and utilising them, the doing.

For example, corroboree is used to pass on knowledge about hunting and gathering, creator spirits, responsibility for looking after country, men’s and women’s business, and traditional medicines. Corroboree is also used in times of festivities; as a way of showing respect and gratitude to our creator spirits for providing bountiful resources; and also in times of deep mourning such as *sorry*

*business*, meaning death. For Wakgun People, Djaparligin comprises of singing, dancing, talking components, with the intent of transferring knowledge.

After Djaparligin has occurred in its many forms, the process of Yatdjuligin begins. Yatdjuligin is pulling all the threads of the knowledge together. For some knowledges there are a multitude of layers that have to be progressed through. This is certainly the case with Wakgun Pharmacopeia or traditional medicines.

Djaparligin and Yatdjuligin combine in obtaining and presenting Wakgun transference of knowledge.

### **3.3 Wakgun Model – transferring knowledge**

Below I provide the Wakgun Model to transfer knowledge. This model is then contextualised for the reader and is the underpinning of this research.

The Wakgun Model demonstrates the traditional framework of our Clan transferring knowledge. Traditionally, this model was utilised for many and differing knowledges to be passed from generation to generation. This is Djaparligin; the singing of corroboree to transfer knowledge. The Wakgun Model has not been contextualised to a specific knowledge transfer but outlines how transfer of knowledge occurs.

I then present an example of the Wakgun Model which contextualises the model for the reader as I present the example of how this knowledge transfer is undertaken for making quinine water.

Thirdly, I present the model as it is utilised for the purposes of this research. This is contextualising the model to transfer non-traditional knowledges. I argue that ‘being’ relates to the participants’ link to their ancestral lands. This is innate and is not negotiable.

### 3.3.1 Model

#### Djaparlagin – ‘singing corroboree’

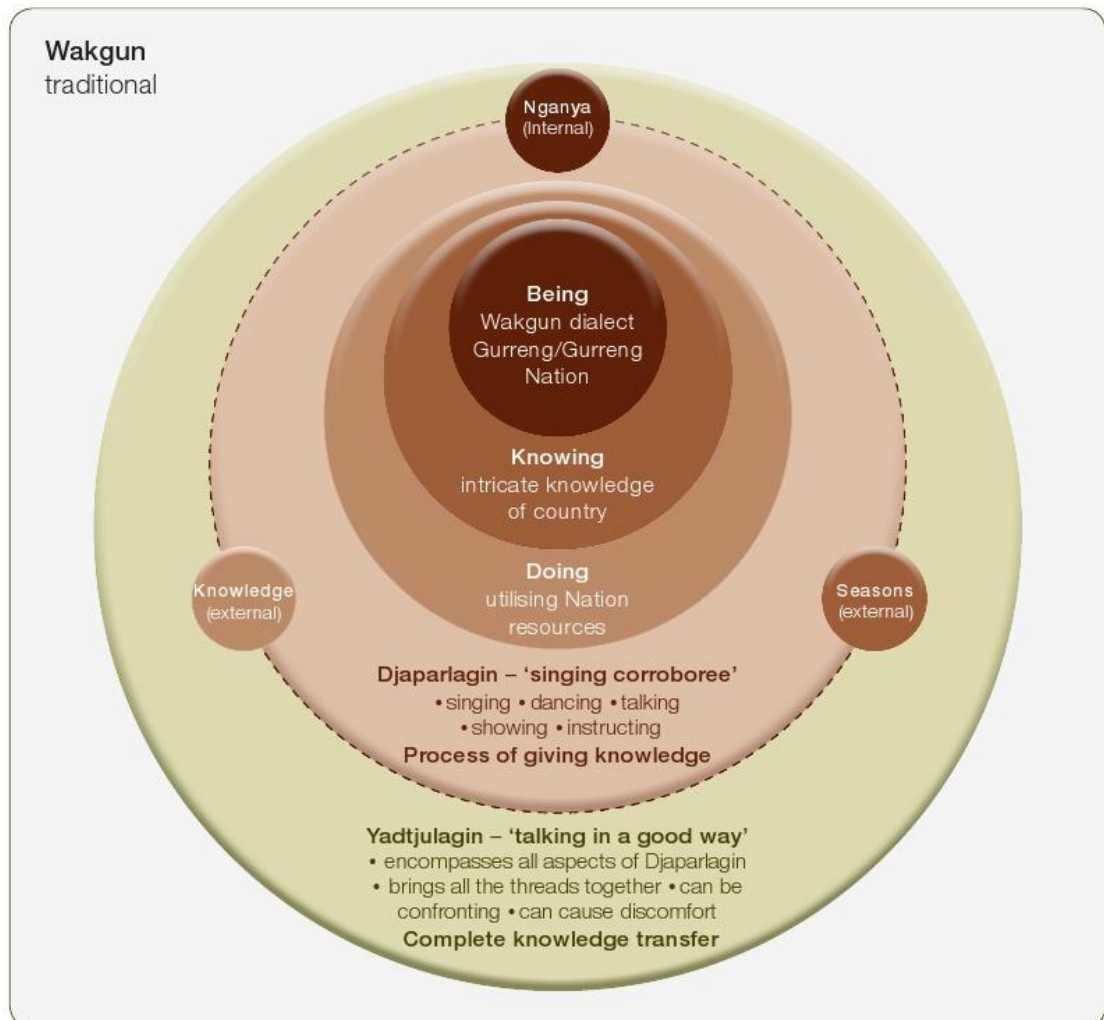
- songlines
- ceremony
- knowledge.

Also includes:

- instructing
- showing
- talking
- mimicking.

#### Yadtjuligin – ‘talking about it in a good way’

- encompasses all aspects of Djaparlagin
- brings all the threads together
- contextualises the knowledge
- can be confronting
- can cause discomfort.



**Figure 3.1 Wakgun Model – traditional**

### 3.3.2 Djaparligin

#### 3.3.2.1 – *Wakgun Clan - ways of being (internal)*

We are Gurreng Gurreng, dialect of the Wakgun (scrub turkey) clan of the Gurreng Gurreng Nation, South Western area. Our country extends north of the Burnett River, west as far as Munduberra, north to Eidsvold along the Dawes Range to Cania Gorge, then across east to Miriamvale and Baffle Creek, and south, down to Mt Perry and the Burnett River. These boundaries have always been in our stories. For resource sharing, reciprocity obligations extended as far as Springshore to the west, Bundaberg to the east, and even to Fraser Island and as far south as the Bunya Mountains. Below is the Horton Map of Aboriginal Australia that outlines the Gurreng Gurreng Nation. It needs to be noted that Wakgun People spell our Nation slightly differently from Horton. Wakgun spelling will be utilised for this thesis.



Figure 3.2 Horton Map of Aboriginal Australia

Members of our clan group were multi-lingual due to broader family networks across the nation. Trade and ceremony such as participation in the Bunya Nut ceremony was prolific amongst these clan groups requiring multilingualism for many.

### **3.3.2.2 – Wakgun Clan - ways of knowing (external)**

Wakgun clan, Gurreng Gurreng lands are full of resources, both traditional and what are now considered contemporary trade resources. To this day within our clan lands there is a proficiency in the open country of *buroo* (kangaroo), *djularn* (lizard), *dilarl* (possum), *milby* (turtle), *gatjul* (wallaby), *marun* (sand goanna), *ngwye* (bee), *gekgair* (echidna), and *gutdja* (bush honey). Our country also has many traditional medicines still growing including witchetty grub (a mild anaesthetic used on teething babies gums), quinine tree (used to make antiseptic) and eucalyptus (used for respiratory ailments). Clan lands are also rich in resources such as sandstone, white clay, spring fed creeks and gold.

Intricate knowledge of these lands was needed for seasonal movement, including food sources and gatherings of clan groups within nations and cross nations, such as ceremonies associated with the Bunya Nut Seasons. Gatherings were integral for trade of resources and responsibility to country. The Bunya Nut festival was held and is embedded within the stories of Gurreng Gurreng, Wakka Wakka, and Gubbi Gubbi people. This festival was attended by thousands, made up of dozens of clan groups and many nations, to hold a range of ceremonies including initiations, communicating with others and telling stories in many languages.

Within the stories of many nations within south-east Queensland there is the telling of Bunya Nut Season.

### **3.3.2.3 – Wakgun Clan - ways of doing (external)**

Knowledge was transferred constantly and continually amongst Wakgun people for thousands of years and was unbroken prior to invasion. Differing knowledge for functionality of family groups within clan and the broader Gurreng Gurreng Nation was broad and diverse. Knowledges regarding shelter, food, and the components of physical survival was part of Wakgun ‘doing’ and was a physical expression of Wakgun ‘being’. Whilst no doubt at times difficult and diverse the clan lands sustained survival.

### **3.3.3 Yatdjuligin**

Yatdjuligin is putting all the pieces together and discussing them in a context that translates to ‘learning in a good way’. It can be confronting and can cause discomfort.

If the information is confronting or challenging, Yatdjuligin sets the scene to enable you to receive it in a good way. For example if you were about to be told information that you may find challenging and cause anxiety, Yatdjuligin is the process which helps manage the anxiety. This is due to it being told in a ‘good way’ whilst intricately trusting the people who are teaching you.

## **3.4 Traditional example of model: Wakgun Model – making quinine water**

### **Djaparligin - ‘singing corroboree’**

- songlines – it is the essence of Wakgun peoples’ birth right to sing quinine water knowledge

- ceremony – it is our innate link to land and our right to utilise the quinine bush to make quinine water (pharmacopeia)
- knowledge – intricate knowledge of country and the usages of quinine water.

Also includes:

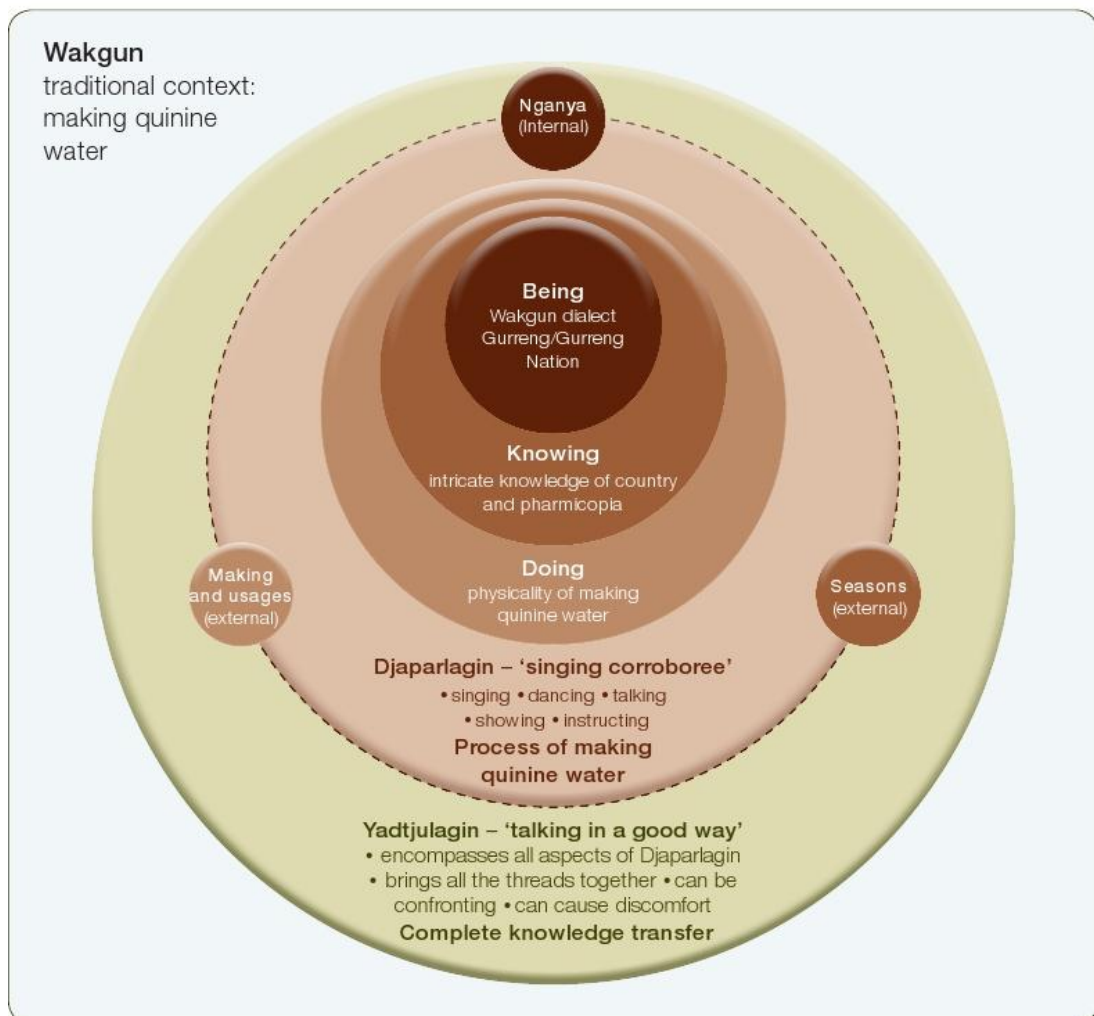
- instructing – what part of the quinine bush to utilise
- showing – demonstrating the physicality of making quinine
- talking – explaining the making of quinine water, including feedback
- mimicking – practicing the skills and knowledge imparted .

**Yatdjuligin – ‘talking about it in a good way’**

- Encompasses all aspects of Djaparligin which includes instructing, showing, talking and mimicking. The process of making quinine water is multi layered. This is talking the process through, informed by Djaparligin.
- This brings all the threads together. It is the process of using internal knowledge and showing the intricate links to the external factors for making quinine water. Traditional medicine for Wakgun is not just the physical quinine water. Rigorous discussion ties the threads together, informed by Djaparligin.
- Contextualises the knowledge. This starts with birth right, as it is Wakgun people, Gurreng Gurreng Nations knowledge, our being. This is enfolded by our intricate knowledge of country, our knowing, and is demonstrated through making quinine water, our doing.



- Can be confronting. Passing on knowledge can sometimes be difficult to undertake for a myriad of reasons. This can be due to the nature of the knowledge, or people not wanting to know, or are not ready to learn.
- Can cause discomfort. Again this relates to the knowledge that is being transferred. Whilst knowledge that is being undertaken may cause discomfort, there is the safeness within this process for it to occur. It is a part of the transfer of knowledge that whilst it may cause discomfort, it is essential.



**Figure 3.3 Wakgun Model – making quinine water**

### **3.4.1 Djaparligin**

#### **3.4.1.1 – *Wakgun being - Quinine Water - (internal)***

Traditional Aboriginal medicines are complex and intricate systems. They incorporate cultural and belief systems that can be explicitly linked to ‘their land’ and puts to use an extensive knowledge of fauna and flora.

The making of quinine water starts with the internal Gurreng Gurreng knowledge, followed by the external impacting season. The intricate knowledge of it and the making and usages of quinine make this the external Djaparligin methodology. These three elements make it Djaparligin.

The production of quinine water amongst the Gurreng Gurreng people is an ancient process. Production of this medicine has been done for many thousands of years. The quinine tree is a shrub that grows on the Gurreng Gurreng nation. It is considered *Nganya*, meaning I or me, internal knowledge. This is due to it being derived from the Gurreng Gurreng Nation, it is Gurreng Gurreng knowledge, it is our medicine and it belongs to us. This is done through singing corroboree. It is a layer of Djaparligin.

#### **3.4.1.2 – *Wakgun - knowing – Seasons (external)***

Making quinine is affected by many factors. External seasonal factors impact profoundly on its production. Intricate knowledge is needed of country in finding quinine bark shrubs, choosing the most appropriate foliage and understanding the appropriate time to pick the foliage. Extensive knowledge is known of the physical impact of seasons on country. Dry seasons or opposing wet seasons impact upon flora production profoundly at times.

### **3.4.1.3 – *Wakgun - doing - Making/Usages Quinine Water (external)***

Obviously there is a physical aspect to making quinine water. This physical production of quinine water is only part of the process. Essentially to make quinine water you strip the bark from the shrub, boil it in water, the water goes a purple colour, it's then left to draw for a time before straining it and utilising it as necessary. From this differing dilutions are used according to the ailment for which it is needed. This type of knowledge is often talked and shown. This is Djaparligin. This is not the complete story of making quinine but is a part of it.

There is also the knowledge that sits around the uses of quinine water, the external aspect. It is widely used as an antiseptic, as well as sterilising instruments for surgical procedures, considered private knowledge of women's and men's business, and also as a disinfectant for wounds, which is public knowledge. To date there has been no western scientific studies undertaken to prove or disprove its efficacy. Amongst the Gurreng Gurreng people there is little need for this to occur. It is a traditional medicine that has and will continue to be passed on and taken by descendants of the Gurreng Gurreng people.

### **3.4.2 Yatdjuligin**

Yatdjuligin is putting all the pieces together and discussing them in a context that translates as 'teaching you in a good way'. For making quinine this means discussing all the elements.

Yatdjuligin is the second component of transferring completed knowledge. Once Djaparligin has been done through its many forms there is the need to pull all the knowledge threads together. Yatdjuligin contextualises the knowledge that has been given through Djaparligin. It brings together the birth right that making quinine

water is for Wakgun people and then journeys through the multi layers of Djaparligin, which includes identifying medicine and the physical production of it. In some instances it can be confronting and it can cause discomfort. This is not shunned but is essential within Yatdjuligin. Whilst the knowledge that is being undertaken may cause discomfort, there is the safeness within this process for it to occur. Until Yatdjuligin is undertaken, knowledge transference is not considered complete.

The above has outlined how Djaparligin and Yatdjuligin are entwined in the passing on of traditional medicines. Whilst traditional medicine has been utilised as the example, both Djaparligin and Yatdjuligin are utilised in much broader contexts for passing on to Gurreng Gurreng people such as law, ceremony, culture and songlines. Yatdjuligin is the process that encompasses Djaparligin. Once all aspects of the Djaparligin are done, the making of quinine can be ‘talked about in a good way’.

### **3.5 Model as applied to this dissertation**

#### **3.5.1 Wakgun Model – participants’ stories**

##### ***3.5.1.1 – Djaparligin - participants singing their stories***

- songlines – the participants link to their birth rights
- ceremony – each participant ‘sang’ their story to me
- knowledge – the stories of Aboriginal registered nurses.

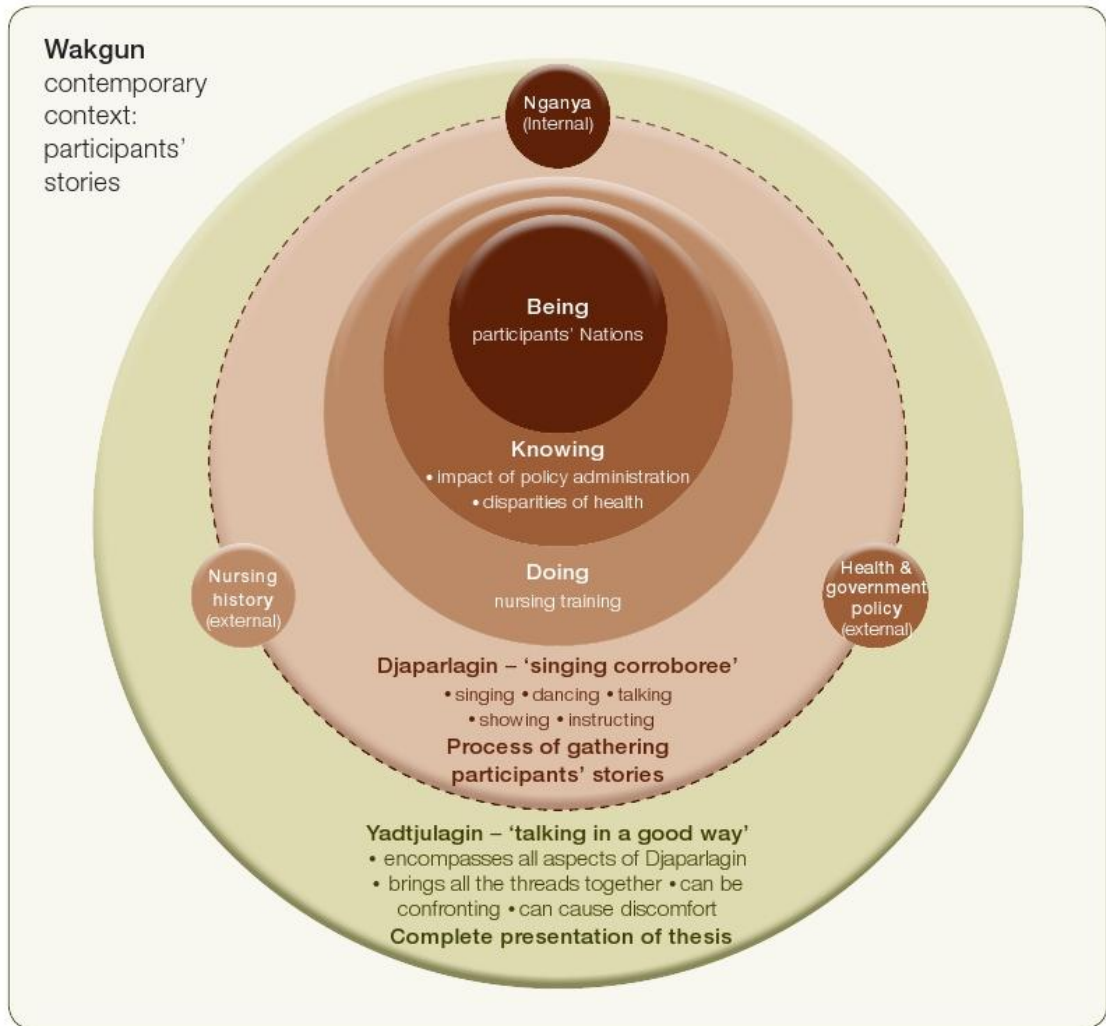
The participants’ stories were recorded via in-depth yarning, commencing with broad, open ended questions. Each participant sang their story to me. Each participant’s story began with identifying their Nation (link to land) and identifying their totems. In each of the participant’s stories was the blending of their Aboriginality (their being), the impact of political administration and its subsequent

outcomes (their knowing), and undertaking nursing (their doing). I then commenced weaving each story and turning it into the narratives that they are. The process of Djaparlgin became the stories of the research participants and informed how I obtained them.

### **3.5.1.2 – Yatdjuligin – Presentation of Thesis**

- Contextualising the stories of each participant had multiple layers. For the participants who undertook their training from the 1950s to the 1970s the Aboriginal Protection and Restriction of the Sale of Opium Act was a factor that particularly impacted upon them. Their stories were further contextualised by undertaking their nursing qualifications in its various forms at differing hospitals and the tertiary sector. Fundamental changes have occurred within nursing, especially with its introduction into the tertiary sector, and this is part of the participants' stories.
- Can be confronting. In each participant's story there were times when it was confronting for me to hear the harsh realities of their experiences. This was due to the much harsher history of the policies of administration that Aboriginal people have been forced to live under. Again this impacted more harshly and impacted more on the participants stories about the 1950s to the 1970s.
- Can cause discomfort. Some of the participants felt immeasurable discomfort in telling their stories. Painful memories emerged of racism, discrimination and the lack of understanding of Aboriginal people held by the non-Indigenous nurses they were training and working with.

Yatdjuligin enabled me to weave all these threads together and present this thesis.



**Figure 3.4 Wakgun Model – participants' stories**

### 3.5.2 Djaparlagin

#### 3.5.2.1 – *Being – The Participants' Nations (internal)*

The participants of this research are Aboriginal women from varying Aboriginal nations. All participants identified as Aboriginal first and nurse second. One participant went as far as to say 'my story can't be told without identifying as an Aboriginal nurse, not a nurse who is Aboriginal'. The participants' Aboriginality is the starting point from which the stories are created.

This then led me to accessing the stories from each participant. This was achieved by in-depth interviewing. Simply put this meant long hard 'yarning' with

each participant. These yarnings were recorded, transcribed and then became the basis for each story. This methodology is reliant on their Aboriginality and its impact on them as nurses. This is the internal.

### **3.5.2.2 – *Knowing – Aboriginal Health & Government Policy (external)***

Undoubtedly government policy has impacted on the current status of Aboriginal health today. For many Aboriginal people this is harshly entwined. Prior to commencing this research I engaged in some good long yarning (discussions) with each participant. At the time of the making of the *I'm a Nurse* documentary for ABC television (Appendix A) there were six decades of Aboriginal women nurses having many cups of tea and yarning. I found it interesting that the oldest participant, Ms 1950s, wanted to talk to the youngest participant, Ms 2000s. As the documentary was being filmed, there were often long breaks and much yarning amongst the participants. Ms 1950s was taken aback by the level of support the Indigenous nursing students had, with access to an Indigenous education centre, an Aboriginal nurse academic and more. This was further validated by Ms 1960s and Ms 1970s stating things have certainly changed since they were in training. Sitting around the lunch table, these stories highlighted just how different the experience was from one generation to the next. It struck me that government policy had a deep impact on the lives of these Aboriginal women including within their professional lives on their journeys from student nurse to registered nurse. This became essential to include in their stories. For example, the impact of the policy of segregation and protection was fierce for many Aboriginal people. This policy did not allow health care service provision to be delivered to them. Ms 1960s told of the experience of not being allowed to enter Cherbourg mission as late as 1977 due to government policy of the

day. Ms 2000s story is one of having access to an Aboriginal nursing academic, being taught Aboriginal health as core undergraduate curriculum content and having an Indigenous education unit to access whilst undertaking her studies.

It became clear that these stories could not be told without including the impact of government policy on the lives of Aboriginal Queenslanders. It was anticipated whilst documenting their stories that some of the government impact would come to light. It was also anticipated that to truly understand the impact of the government policy, that appropriate sources would need to be accessed.

### ***3.5.2.3 – Doing – Nursing Training (external)***

Each participant is a nurse. In order to tell their stories it became essential to include some of the nursing history of the decade in which they undertook their training.

Each participant had the same goal of wanting to become a nurse. Some identified this at a much earlier age than others, but the end qualification is the same. The history of the nursing profession has impacted on each participant differently, the earlier participants being trained under the apprenticeship system, the later the tertiary system. Also, it needs to be noted that nursing has not always been embracing of Aboriginal people within its ranks.

For the purpose of this work this meant accessing nursing history via a number of sources. Elements of nursing history were found during in-depth yarning with each participant. Ms 1960s identifies clearly as the last of the four year training program and Ms 1970s identifies as the first of the three year training program. Other sources were identified, such as interviewing academics who were part of the crossover from hospital-based to tertiary-trained nursing programmes. Gleaning and gathering information from the Queensland Nurses' Union and the Queensland



Nurses' Council also became essential to demonstrate effectively the nursing history.

### **3.5.3 Yatdjuligin**

By undertaking the above Djaparligin process, *stories of Aboriginal registered nurses in Queensland from 1950–2005* were woven. Integral to telling the participants stories was the inclusion of an in-depth literature review. This required a very thorough search of all available literature to tease out historically what Aboriginal nurses have said. I argue this is part of the methodology due to extensively providing the voices of Aboriginal and Torres Strait Islander nurses and midwives that are not the participants of this research. It was necessary to sing the stories of the wider Aboriginal and Torres Strait Islander nursing and midwifery voices. Pulling all these elements of Djaparligin together has enabled me to transfer this knowledge or 'talk about it in a good way' (Yatdjuligin).

### **3.6 Conclusion**

The utilisation of Djaparligin as methodology and Yatdjuligin to present this thesis has enabled me to fulfil both academic requirements and cultural obligations. The journey at times has been fraught with difficulties, often personal, as I struggled with my Wakgun Clan processes. However, through gaining an understanding, and utilising my people's knowledges, the process has been the most satisfying research experience to date for me.

## Chapter 4: Mawn Young

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*Kooma/Yuwaalaray Nations*

**Registered Nurse 1952–1956**



**Figure 4.1 Mawn as a third year student nurse at Cairns Hospital**

I met Mawn at the time the *I'm a Nurse* documentary was in pre-production. I initially had a long phone conversation with Mawn. Listening to her stories of her experiences throughout her nursing training was simply amazing. The longevity of Mawn's nursing career was also something to be acknowledged and shared. After this initial conversation I realised that it was essential to include her in the documentary and this suggestion was warmly welcomed by Mawn.

Mawn is of *Kooma* and *Yuwaalaray* descent. Figure 4.2 (next page) is the Horton Map of Aboriginal Australia. It is well known that this map is not explicitly correct. This is certainly true for Mawn's *Yuwaalaraay* nation which is not represented on this map. Mawn's *Yuwaalaaray* bloodline is from her Grandmother Eckford. However, the map does show the *Kooma* Nation. Mawn's *Kooma* bloodline is through her Grandfather Dancey's line. Mawn was born on country in *Dirrinbandi* which is her mother's people. Her totem is long necked turtle.



Figure 4.2 Horton Map of Aboriginal Australia

(The author has outlined the *Kooma* Nation in black)

*I realised very early in life. That's all I ever wanted to be [a nurse]. I would have been roughly, around ten. I was in the Red Cross out home and every year we used to march in the Anzac Parade and I had a uniform, a cape and a veil with a little red cross on it that was the beginning of, "I am going to do something where I'm going to have a veil". And so that was my first indication that I wanted to be a nurse and then Mum bought me a little Red Cross box where it had a pretend thermometer and pretend, all things that nurses have.*



**Figure 4.3 Mawn in her Red Cross Uniform**

*I also had a dear old grandma, named Grandma Eckford. She used to love to fish, so I was sent to the river, the Balonne River with Grandma, to watch her when she was fishing. Anyhow, my Grandma used to get lots of pains and so I used to rub her shoulders and her legs. She said to me one day, "What do you want to be Mawn when you grow up?" and I said, "Oh Grandma I want to be a nurse." And she said, "You will do very well because you have healing hands." She lived with us for many babies and deliver them and we always thought and knew in our hearts that she delivered a lot of station owners' babies but because she was Aboriginal well they wouldn't admit that she had delivered their babies and we never ever asked her. She was just a traditional midwife and also a healer. She could do up, different herbs and everything and go out in the bush and pick them. She had wonderful experiences of being a healer. She was definitely my mentor. I would have been about 13, 14, she was very old, when she died in our home, my Mum's home. My Mum laid her out and she never wanted to go into hospital, so she went from home to the cemetery.*

Many Aboriginal families across Queensland and indeed Australia talk of similar experiences within their families. Utilising the knowledge and skills of traditional midwifery, or women's business as it is commonly known amongst Aboriginal nations, amongst white women was a common practice in the early days. For Mawn's Grandmother Eckford her 'women's business' knowledge and skills were still being utilised as late as the 1940s across her country.

Many white people in the Australian bush relied heavily on the Aboriginal women on whose land they settled, particularly in childbirth and for assistance in infant care. Dame Mary Gilmour reported that women in many parts of Queensland preferred Aboriginal accouchement assistance to that of unhygienic white doctors and nurses. Puerperal fever resulting from unhygienic obstetric and midwifery

practices, whether conducted in hospitals or in patients' own homes, was the scourge of childbirth in European societies. In contrast, Aboriginal people in north-west Queensland, for example, knew nothing of this problem. In that area, women in labour were attended by experienced senior Aboriginal women who ensured that umbilical cords were cut with sharp shells sterilised in the fire, and that placentas were burnt or deeply buried, rather than left to rot in buckets under beds as was often the case in English hospitals (Gregory 2009).

The 1950s for most Aboriginal Australians was a harsh living reality. 'The official, legally sanctioned policies from the 1890s to the 1950s were those of protection and segregation. Government reserves and Christian missions were established across Australia, generally on land that Europeans did not want, supposedly to protect Aboriginal people until they died out' (Forsyth 2007, p. 35). Officially, Aboriginal Queenslanders were being administered under *The Aboriginal and Opium Protection Act*. Missions and reserves had been established. *The Aboriginal Protection and Restriction of the Sale of Opium Act* (Qld) allowed the 'Chief Protector' to remove local Aboriginal people onto and between reserves and hold children in dormitories. From 1939 until 1971 this power was held by the Director of Native Welfare. The Director was the legal guardian of all Aboriginal children, whether or not their parents were living, until 1965. Under the legislation, Aboriginal people were effectively confined to reserves and banned from towns. Reserves were administered by government agencies or missionaries and every aspect of life was controlled, including the right to marry, guardianship of children, the right to work outside reserves, and management of assets (Creative Spirits n.d., *Aboriginal History timeline*, Viewed 20 May 2010).

By the 1950s and 60s there was mounting evidence of the continued poor

state of Aboriginal health. Doctors for instance, wrote letters to the editor of the *Medical Journal of Australia* on Aboriginal health (Thomas, cited in Forsyth 2007). 'Nurses reported on the intractability of the health of Aboriginal people and their unhealthy living conditions, but there is no evidence they questioned why this state of affairs occurred or why it was allowed to continue' (Forsyth 2007, p. 39).

Technically in 1951 the *Assimilation Policy* became very clearly defined. It was obvious that Aboriginal people were not dying out as first expected. 'It stated that all Aborigines shall attain the same manner of living as other Australians, enjoying the same rights and privileges, accepting the same responsibilities, observing the same customs and being influenced by the same beliefs, hopes and loyalties' (Lippmann 1992, p. 27).

However this was not the reality for many Aboriginal people who were still living on missions, not being paid for work, experiencing the removal of their 'half-caste children', complete lack of appropriate health care and no acknowledgement of ancient tradition and customs. The havoc wrought on many Aboriginal societies through the destruction of traditional medical practices was also felt at this time. Many Aboriginal people themselves saw the introduction of disease and the decline of their health as 'white man's' poison or diseases, and were ill equipped to combat them. The establishment of missions and the incarceration of entire communities saw to a large extent the demise of traditional medical practices. These practices were forbidden on the missions, being seen as witchcraft (Booth, I, pers. comm.). The obscenely racist and inhumane health service provision practices went largely unnoticed and unmentioned.

Not all Aboriginal families were placed on missions; Mawn's family is one example. Mawn was unique in being able to access education and to receive her

scholarship. For Mawn to attain her goal of becoming a nurse she essentially had to bide her time until she was old enough to be considered. It also meant that she had to leave country (*Dirrinbandi*) and move to Brisbane. Mawn's dream was starting to finally be realised. To achieve acceptance into nursing Mawn had focused on finishing her schooling and then undertaking her Mothercraft Nurse course. *I was only 16 when this all happened and I finished my Scholarship, to get into nursing, but before that I went and worked at a cotton mill and that was, back in '51. I lived with my sister until I could get in to do my Mothercraft at the Lady Solento Mothercraft Hostel.*



**Figure 4.4 Mawn undertaking her Mothercraft Course**

Mawn successfully navigated her way through the Mothercraft course (see Figure 4.4 next page) and she became one step closer to achieving her true aim of becoming a nurse. *I did 12 months there and then I was old enough to start my training at the Brisbane General, as it was called then and I applied there. I had to go up to the hospital and meet the Matron. I had to give her my certificate that I had*



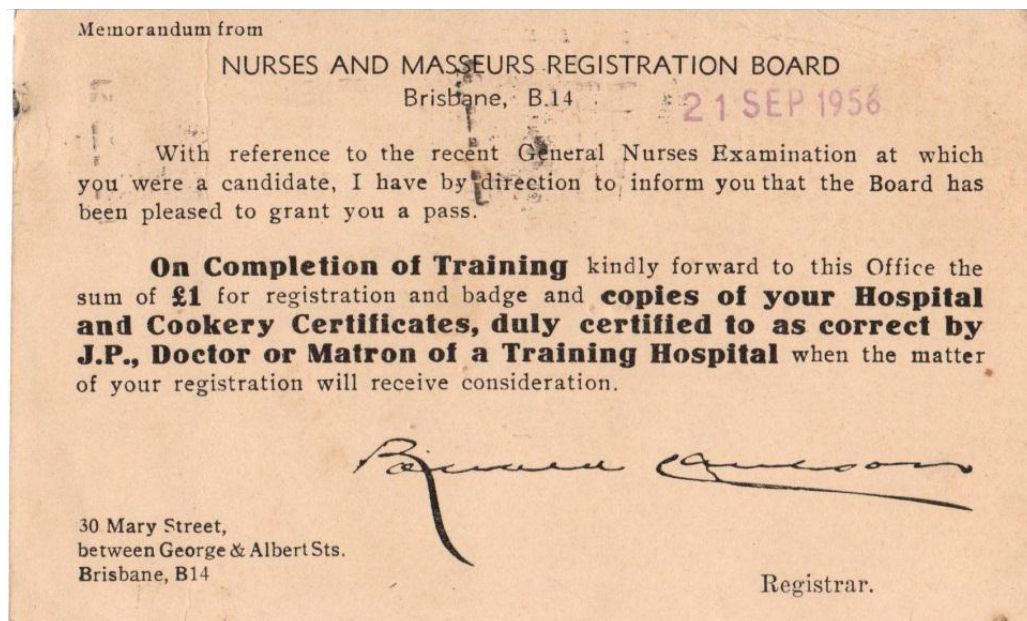
*been at the Lady Solento Hostel and then I was told that I could start. I had to go and be measured for my uniform and that was the big start at the Brisbane General. I started in 1952. We had a six month preliminary course in the school to teach us what we had to do when we went into the wards and that was all very good to do and to learn but when you got into the wards it was a different matter altogether.*

*Mawn finally entered her training at the Brisbane General. I was as proud as punch that I had at last made it. You would have thought I was finished my training, I was a nurse but I wasn't real happy there, with the study and if you were a bit behind in your Anatomy and Physiology and Medical you had no one to turn to to help you. I never saw any Murri nurses and there were hundreds of nurses there. You would change a shift and there were hundreds coming down and hundreds going up and I never saw any. Mind you I only did a couple of wards there. You only had your tutor sister through those hours of the day when you were training and there was sort of no one and it was pretty tough and I just thought, "Well if I'm going to be a Registered Nurse, I'm going to have to go to a smaller hospital." I was only there 12 months and I transferred to the Cairns Base Hospital because I knew it was a smaller hospital and I would get more help with my study and everything. I didn't know where Cairns was, I didn't even look up a map. I was told by people it was the most beautiful place and that the hospital was right on the Esplanade. They didn't say it was mud flats. They said, "It's beautiful", but when I got off that train in 1952 and saw Cairns with the beautiful mountains and the tropics I said to myself, "I will never leave or be far away from Cairns" and I have never been far away. When I started in Cairns I was put back, you always lost a lot of months if you transferred. They didn't encourage it.*

Mawn's transition to Cairns was a smooth one. In reminiscing about those

times Mawn talks about how very hard the work was. *You were more or less an underpaid domestic if you like. You did everything. You cleaned the lockers and they were all silvery, metal ones, so you had to do them down every morning, had to serve the meals out, you had to make the egg flips and do the junkets for the patients, boil the eggs, and so it went on. Now you don't do any of that, you do nursing, that's what it's all about. There wasn't a real lot of nursing probably until you got to year three and then there was year three and then you were butterfly in year four and then you were finished on your merry way.*

Mawn's reminiscence of having to prepare food for the patients was very much a part of the day to day duties of nurses at this time. This was considered an essential skill of a 'good' nurse. In fact it was considered essential in order to gain registration. As shown below in Mawn's General Nurse Exam results, in order for her to gain registration she needed to supply a copy of her 'Cookery Certificates' that needed to be certified by a Justice of the Peace, a Doctor or the Matron.



**Figure 4.5 Mawn's letter of passing her final nursing exam**

*Life was completely different when I commenced at Cairns Base Hospital. It was a smaller hospital and we had the loveliest old tutor sister. That was back in the 50's and she was so supportive and if I wanted to know something or get help with study and that she helped me. That's how I found it and I just loved it. So it was this old tutor sister who was the encouragement for me when I got up to Cairns she was a white woman. It was also here that I encountered other Murri nurses doing their training. That was in 1954. One was Dulcie Reading who is now Dulcie Flowers. Dulcie worked at the Redfern AMS for many years. Then there was Louise Jacobs who is now Louise Priest. I knew they were there but I didn't really socialise with them. I was a senior nurse and I didn't have much to do with them. I had to wait two years into my training to come across these two other Murri student nurses. It was also here that I saw for the first time an Aboriginal Matron, Sister Muriel Stanley. Now Muriel Stanley (I found out later) was the Matron at Yarrabah Mission Hospital. I remember seeing her at the refectory whilst having my lunch. Now you have to remember this was in the "old days" of nursing training. At this time we student nurses had to stand up and back to let the sisters come through. We only had such short tea breaks then and it was often rushing to the refectory and quickly shoveling something down your throat and then straight back up to the ward. Well on this day I was quickly eating my lunch and the Matron of Cairns Base and Sister Stanley came into the refectory. Like good little soldiers we all had to stand up and I remember being annoyed because I only had a few minutes left of my break and my lunch was being interrupted. When I did look up Sister Stanley was the first one I saw. I was immediately struck by the fact that she was Aboriginal and was a sister, not only a sister but a Matron.*



**Figure 4.6 Muriel Stanley as Matron of Yarrabah**

I believe Mawn's lack of socialising with the other Aboriginal nursing students demonstrates the regimentation of nursing within that day. It was very much a hierarchical approach to how nursing was conducted. As a senior nurse you stayed essentially within your group and didn't socialise with the junior nurses. For Mawn this changed upon receiving her registration. *Now that we're both in our 70's Lou and I have become very friendly because Lou lives here, my husband has died, her husband has died and we've become very friendly. We go everywhere together now and we also have an older nurses get together every six weeks or so. Lou and I were together last week at our dinner and we were talking about the old days of our*

*training. We were talking how hard our old Matron was at the time. I found that old matron was a real old tart. She used to give us hell, but then she was responsible for a lot of teenagers and they were all away from home, therefore she was responsible. Of course she would be down on us. How dare we go AWL (absent without leave) if we were out until after 10pm when we weren't supposed to be. I am sure she felt responsible for all us girls because she probably had cranky parents ringing them up or sending them letters if something had of happened. And if anything happened to them I imagine she would cop hell because we were young, but I never understood that until I was older because I used to detest her. But as you get older and you mature you understand the place that she was in?*

Mawn flourished whilst at the Cairns Base Hospital and felt there was better support but also being a 'country girl' from western Queensland it suited her better. The hospital was noticeably smaller than the Brisbane General and was more conducive to Mawn's happiness. Mawn's childhood obsession with wearing a veil was about to become a reality.

*The last day of my training was very sad. I had lots of friends. They used to always say, "when you finish your schooling you will be sad." Let me tell you I was as happy as anything, I'd finished school, but when I finished training, everyone would say, "You will be happy when you finish your training" and I was very sad. I didn't come from Cairns, I'm from Dirranbandi and I was going to miss all those girls and everyone went everywhere. A lot of them I've never seen since 1956. I received my Certificate of Registration on the 11<sup>th</sup> October, 1956 (see Figure 4.7, next page).*

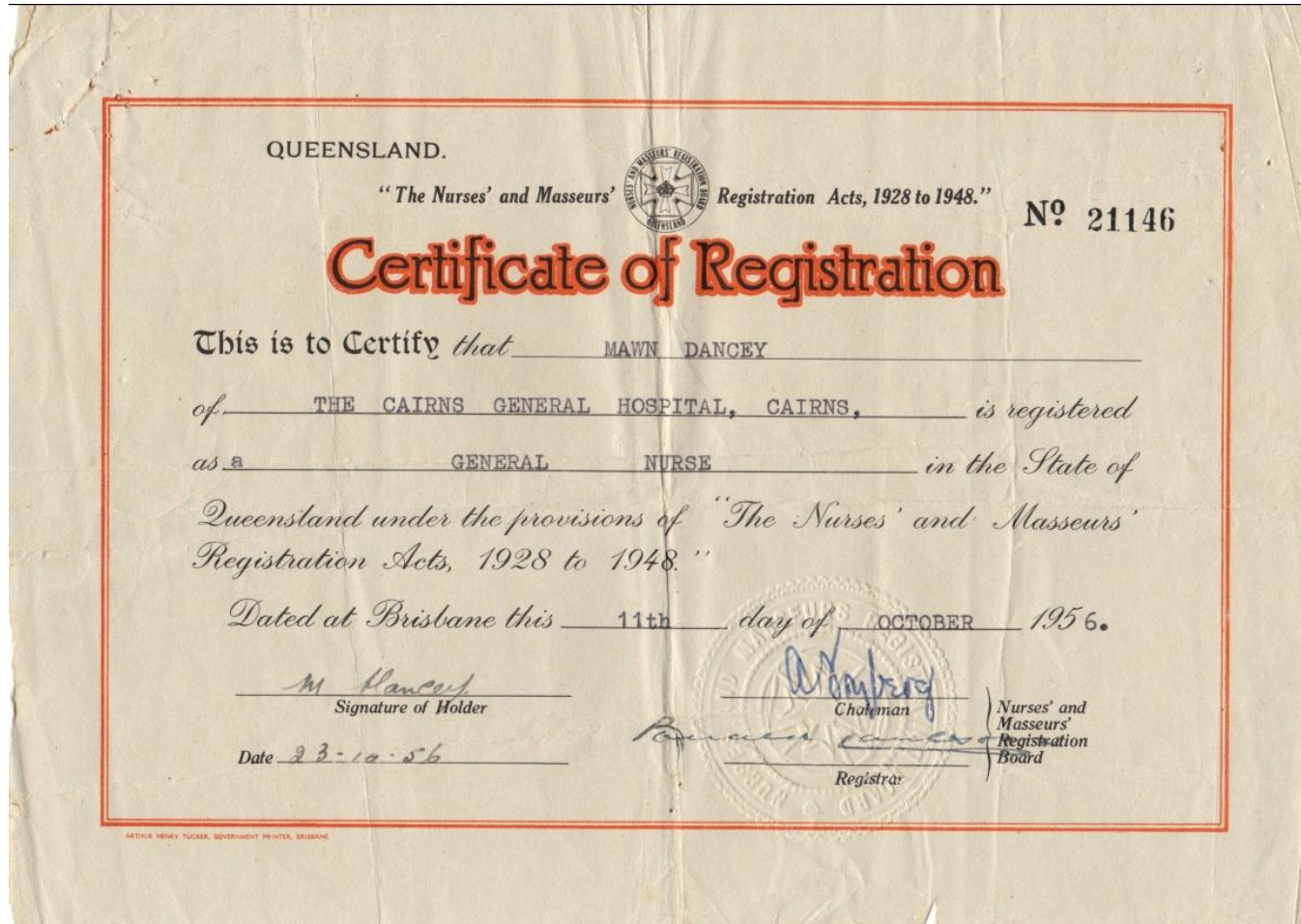


Figure 4.7 Mawn's Certificate of Registration

By looking closely at Mawn's Certificate of Registration it can be noted that it was administered by *The Nurses and Masseurs Registration Act*. Within this research Mawn is the only participant to be registered under this Act. "Between 1 Mar 1912 – 1 Jan 1929, the *Nurses Registration Board of Queensland (I)* was established to oversee the registration of nurses. With the need to standardise the education and training of nurses as well as their registration, the *Nurses and Masseurs Registration Board* was then established (1 Jan 1929 – 27 Jul 1965). This Board was disbanded when the *Physiotherapists Board of Queensland* and the *Nurses Board of Queensland* were set up on 27 Jul 1965. On 23 Dec 1976 the decision was made to separate the function of registration from education and training and this was done by establishing the Board of Nursing Studies, and re-establishing the *Nurses Registration Board of Queensland (II)*. On 23 December 1976, the *Nurses Registration Board of Queensland* was reestablished to oversee the registration of nurses". Nurses Registration Board of Queensland II, viewed 1 June 2010,

<<http://www.archivesearch.qld.gov.au/Search/AgencyDetails.aspx?AgencyId=1459>

*I also felt happy about finishing though. So I travelled down to Dirranbandi and worked there as a Registered Nurse for six months. I was engaged and I knew when I got married that we would come back eventually to Cairns. Going back home was absolutely unreal and Mum and Dad and my brothers and sisters were just so proud I was back there. My brothers used to say a week before I got out there that I was the pan carrier. When I got out there it was "my sister's a Registered Nurse. She's a Sister." I was so proud. It was just the wonderfulest thing and I'm so pleased I went back out there and did that.*



**Figure 4.8 Mawn's Nursing Ball**

At this time Aunty Mawn loved functioning as a registered nurse in her home town but it was not without its moments of exclusion and racism. Aunty Mawn says of this time, *I had a mate and we travelled around together, we worked in Dalby and we worked in Sydney and that all together, and she would get invited out to stations and that but I was never invited. Because I was Aboriginal and all my family is there and they're all Aboriginals and I wasn't invited, but she was. Ruby was invited and I was never invited to the stations and at first I thought, "Why?" And then I thought, "Wake up to yourself Mawn you're back in Dirranbandi." I knew it was because I was Aboriginal.*





**Figure 4.9 Mawn Nursing in Dirrinbandi as a registered nurse**

After working in Dirrinbandi for approximately six months Mawn married and moved to the Eastern Suburbs Hospital of Sydney. It was here that Mawn flourished and worked in theatre and also accident and emergency. Mawn says of this time *that I would say that was my favourite job as an operating theatre sister. I absolutely loved it. I loved comforting patients, helping the elderly people and most importantly helping the Indigenous patients because they needed it. It was here that I thought for the first time, 'we really need Indigenous nurses here'. I also really liked A&E [Accident and Emergency], you never know what's going to come through that door and it's very interesting. I felt so important there in the operating theatres, knowing all the instruments and the doctors and everything. It was just unreal, plus I didn't have to hand out the food in those days. I used to hate all that food business you had to go to the trolley and hand out, it wasn't my scene.*

On the national Indigenous agenda change was starting to occur. The political

activity and agitation occurring in the Brisbane Indigenous community in the late 1960s formed the breeding ground for the establishment, not only of the health service, but also of many Indigenous community controlled services in Brisbane. In the Brisbane community a number of black activists became involved in the Federal Council for the Advancement of Aborigines and Torres Strait Islanders (FCAATSI):

FCAATSI was formed in 1958 in Adelaide at a meeting of Aboriginal leaders, politicians, church and trade union representatives. FCAATSI became the first truly national lobby group that led the battle for equality and better living conditions for Aboriginals. The Council became an effective pressure group (Watson, n.d.).

The Queensland members of FCAATSI included *Oodgeroo Noonuccal* (then Kath Walker), Denis Walker (Kath Walker's son), Pastor Don Brady, and Don Davidson, all of whom were active members of the Brisbane community. FCAATSI was the driving force behind the 1967 Referendum and was involved in national Indigenous politics. Once FCAATSI members passed on national information to its Queensland members, tension began stirring in the Indigenous community of Brisbane. But in 1956 as Mawn finished her training, such things as culturally appropriate care for Aboriginal people was still a long way off. It was the small number of Aboriginal nurses that did what they could for Aboriginal patients within the largely hostile hospital environments and the often racist care givers.

Mawn and her husband Tom did make the move back up to Cairns and Mawn went back to her training hospital in 1959. *We went to Mareeba in late 1959 to live and I nursed all the time. I nursed there 40 years on and off.* Mawn worked at Mareeba District Hospital from 1959 until approximately 1974. This was not done consecutively as Mawn left nursing in approximately 1963 to have her three beautiful children when an opportunity presented itself that Mawn could not refuse.

*Well when I went back to work after the children were born I couldn't go into theatre. The only thing I could do and still be with the children and my husband was night duty. So I did permanent night duty for just over 18 months and it was very hard.*

*We had a very nice doctor there, and I got on very well with him even though he used to scare stiff a lot of the other staff. Anyhow, I worked there and I used to protect this doctor a bit because I didn't get him up at nights, I used to suture people, which we weren't supposed to do in those days. RNs weren't supposed to suture and I knew I could do it because I worked in theatres for years, used to help stitch people up. Anyhow, I used to diagnose and treat if they were a patient I knew, it was all the old ones that used to come in anyhow. I used to admit them and then in the morning before I went off duty I would ring the doctor, he was the Superintendent, and tell him what I had done.*

*Then this position came up in Chillagoe, a nurse told me that night that the Matron was going to leave up there, so I went and saw the Medical Sup and I said, "look I'm going to put in for a job in Chillagoe as the Matron but I've only got a single certificate, I'm not a double certificated sister" and I wondered how I would go and he said to me, "Well, sister I will help you as much as I can." The next minute I know I put in my application and I got the job. He said when there's a maternity case on, you go across to Maternity Ward and watch them deliver. If any emergency comes up and I thought, "Oh God forbid, but I think I can do it." But I went over there and learned as much as I could and saw them delivering babies and felt that I sort of knew as much because the two that were delivering, the enrolled nurse and the RN hadn't had any children and I had three so I knew what it was like and I felt very confident about this. So would you believe it I got the job and I was*

*the Matron at the Chillagoe Hospital, for about 12 months that was in 1974.*

*I was fully in charge. I used to diagnose, I used to suture, I did it all on night duty at the Cairns Base and at Mareeba Hospital. It was just unreal, Northern Queensland in the old days. I felt confident and I felt in control. I had lots of different cases. There was only one that got me a bit mixed up and that. This was a lady that came in with an infection in her finger. Now I did everything and I would clear it up and it would break out. I would clear it up. After the second time I rang up the Superintendent who was my boss in Mareeba and he said, "Well send her down and we will have a look." This was an Aboriginal lady and in the 1970's nobody was ever tested when they first came in for diabetes and he rang up and said, "You couldn't get it because she's a diabetic." Now the first thing you do is a Blood Sugar Level (BSL). Because every second Aboriginal person has diabetes, my firm belief is we should never, never ever have refined food. We should never ever have all that. The white people can have them, we can't. We should never ever have anything that's refined. We shouldn't have sugar, we shouldn't have white flour, we shouldn't have all those things and it can happen in this day and age where you don't have to have it. You can go and buy things that aren't really refined.*

Like all of the participants in this research, Mawn loved nursing and caring for Aboriginal people throughout her career but at times this was not without incident both good and bad.

*Because most Aboriginal people are quiet people and they don't say too much and I used to hate the way that the white nurses say, "Jimmy Smith is in there, he's Aboriginal, but he's a nice man." And then when they used to get to Brian Steel or somebody, and they would say, "He's in room six." And I would say, "Is he white and a nice man too?" And they would look at me you know. I used to challenge them*

*and don't go talking about my people like that. Just because we are Aboriginal we are nice people. The Aboriginal patients loved having an Aboriginal nurse. Because I was Aboriginal and I understood them and said words that were comforting. One night I put a big heavy blanket on an old Aboriginal man and I said, "This is just like a wagga." Well, I don't think anyone had ever said that to him before and he laughed and laughed and laughed. He thought that was funny, it was just things I used to say to them you know. A wagga is two big bags, usually sugar bags that are sewn together, those bags, mum used to have them. They were like doonas, but you can move under doonas. You couldn't move under a wagga but they sure were warm. It was also just different little things that you could say to them and they would say, the old Aboriginal men would say, "what tribe you from?" Things like that and it was lovely and that was good and it was always the older ones. Towards the end the younger ones got a little bit cheeky. So obviously I knew no matter where you were working, you were the black nurse.*

At this time Mawn's husband wanted to take on the lease of a hotel in Mareeba and Mawn and Tom partnered up to run the Hotel for the next fifteen years. At this time though Mawn maintained her registration and went back to the Mareeba Hospital in 1979, 1984 and 1989 for several months at a time. It was essential for Mawn to maintain her nursing skills and was part of registration requirements. There was to be no lapse in nursing greater than five years or registration would be lost. Mawn says *I had to keep up my skills because things had changed so much. I always say the biggest changes were probably in the 70's. When I went back once and 'holy jeepers' everything had changed so much. But I was determined like a dog with a bone to stay skilled and competent as a registered nurse and so I did.*

In 2000 Mawn made the move back to Cairns and it was at this time that

Mawn made her move into Aboriginal Health. In 2001 Mawn commenced work at Wuchopperen Health Service (AMS) in Cairns. *I think we would do anything to help our people who haven't been fortunate enough to look after themselves, to stick up for themselves and yeah we go there to help. I then went from there to the Aboriginal and Islander Alcohol Relief Services and that was totally different, and I just loved it there but it was only for a matter of time. I did go back to Wuchopperen briefly to help with the immunisation for Pneumonia and Flu. My registration was due again and then I thought, "If you don't register you can't work, you've got to stop." So I didn't re-register so I stopped and I've never been back. Two days after I finished I got two jobs offered to me and I thought, "Now see, if you hadn't of given it away you could have worked and you are too old." It was time to hang up my shoes. I held my registration for fifty years. I was registered in 1956 and I always registered. That was my lifeline determination to not going back and be scrubbing floors if anything went wrong in your marriage or if something happened to your husband and you've got children, so what do you do? But if you've got your Certificate, you come back and you do what you love doing and that's what I did and I never stopped.*

*I think everyone that's Indigenous can get through anything, you can do whatever you like. The Aboriginal nursing students today have a lot more support in getting through. You get all the support in the world I keep telling these young ones. You ask Lou and Dulcie, we had no support, no nothing. You had to have a family that paid off your bills sometimes and things like that when you were training because you had no money to mention. The good thing was you never starved, you lived in the hospital, and the nurses in the quarters became your family.*

Mawn's last words to me after spending much time together was *if there's such a thing as reincarnation I'm coming back as a nurse.*

# Mawn now can rest up

By north Queensland correspondent  
GERTRUDE YGOSSE



The Wuchopperen Medical Service paid tribute at a recent ceremony in Cairns to one of its retiring staff members, Mawn Young, for her 40-year career.

Mawn Young's (nee Dancey) dream was to be a nurse, but in 1950, when she left school in Dirranbandi, she was only 16 and too young to begin her nursing training.

Not one to be idle, Ms Young worked in a cotton mill in Toowoomba until she was 17, then enrolled in a 12-month mothercraft course at the Lady Cilento Mothercraft Hostel in Brisbane.

After the completion of that course, she was 18 and old enough to begin her registered-nurse training. Ms Young started her training at the Brisbane General Hospital (now known as the Royal Brisbane Hospital).

After 12 months of study, she transferred to the Cairns Base Hospital where she continued training for the next three years.

Ms Young recalls two other Indigenous nurses who were beginning their training at the Cairns Base, Lou Preece (nee Jacobs) and Dulcie Flowers (nee Reading).

Ms Young has worked in hospitals in Queensland and NSW in a range of areas.

Ms Young now feels the time is right for her to retire and relax. She is looking forward to spending some quality time with her family and friends and travelling to places she has always wanted to see.

Ms Young says she has always loved nursing, and if she had her life over again, she would still want to be a nurse.



Recently retired nurse Mawn Young and her daughter Dallas Young after the ceremony at Wuchopperen Medical Service in Cairns.

Figure 4.10 Mawn's farewell reported in the *Koori-Mail*

## Chapter 5: Beryl Meiklejohn

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*Noonuccal Nation*

**Registered Nurse 1969–1972**

**Registered Psychiatric Nurse 1977**



**Figure 5.1 Beryl as a student nurse**

I first met Beryl in 2002 in Adelaide, South Australia. At this time I was invited to attend a gathering of a number of Indigenous academics that worked in the tertiary sector from across the country, in schools/departments of nursing, medical faculties and allied health departments. At this stage Beryl was, and still is, working as a Lecturer within the Faculty of Health at the Queensland University of Technology. Beryl was passionate about embedding Indigenous health content across all health courses at QUT. University of Southern Queensland at this time had not commenced



this journey of embedding core Indigenous curriculum into its nursing program and I was keen to discuss this at length with Beryl. I spent many hours with Beryl listening to her experiences of being a registered nurse but also working in the tertiary sector. Shortly after this in 2003 I contacted Beryl and asked her to participate in the *I'm a Nurse* documentary, Beryl agreed and our friendship was cemented. Beryl has taught me so much about the early struggles of being an Aboriginal nurse. For me Beryl is an activist and advocator for her people and community. She also has a wicked sense of humor.

Within presenting Beryl's story it should be noted that there is a noticeable lack of early photos of Beryl throughout her training days. This is due to Beryl and her family experiencing a house fire which destroyed many of their precious belongings.

Beryl is a *Noonuccal* descendent of the *Quandamooka* Nation (Moreton Bay) from *Minjerriba* (North Stradbroke Island). Her totem is carpet snake. As previously acknowledged, the Horton Map of Aboriginal Australia (Figure 5.2, next page) is not explicitly correct. This certainly is the case of the people of North Stradbroke Island. North and South Stradbroke Islands are the two Islands off Brisbane. North Stradbroke has two clans groups which are *Noonuccal* and also *Goenpul*.

Beryl entered her nursing career at an exciting time where much change was occurring for Indigenous Australians. Beryl was the first of three cousins that went into nursing within close proximity of each other. Beryl entered the Royal Brisbane Hospital in 1969. She was closely followed by her cousins Mary Martin (who is the next participant of this research) who entered nursing in 1971 at the Mater Hospital, and her cousin Rosemary Bell (nee Graham) at the Ipswich General.



**Figure 5.2 Horton Map of Aboriginal Australia**

(The author has outlined North Stradbroke Island in black)

This time is a murky time in defining the policy of administration for Indigenous peoples across Queensland and indeed Australia. This time was the cusp of the tsunami that was to be the birth of community-controlled services across the country. At this time Aboriginal people were technically administered under the *Assimilation Policy* which was defined in 1951 and stated:

All Aborigines shall attain the same manner of living as other Australians, enjoying the same rights and privileges, accepting the same responsibilities, observing the same customs and being influenced by the same beliefs, hopes and loyalties. (Lippmann 1981, p. 38)

However, at the Native Welfare Conference of 1961, the Assimilation Policy was redefined to be:

The policy of assimilation seeks that all persons of Aboriginal descent will choose to attain a similar manner of living to that of other Australians and live as members of a single community – enjoying the same rights and privileges, accepting the same responsibilities and influenced by the same hopes and loyalties as other Australians. (Policy of Assimilation 1961 p. 2)

This time amongst the Indigenous community across Australia and indeed Queensland was one of action and agitation. ‘In the late 1950s and 1960s, interest in Aboriginal Affairs grew rapidly and that which was described as “such a small problem” became the enormous social and political issue which it still is today’ (Hasluck 1988, p. 10). Moreover, Gardiner-Garden (1996–97, p. 7) noted ‘in this period more and more voices drew attention to the meagre achievements of the assimilation policy, the denial of civil rights, which it entailed, and the poor international image it gave Australia. These voices were both Aboriginal and non-Aboriginal’.

Continuing into the 1970s virtually all organisations working for the ‘welfare’ of Aboriginals were run and administered by white people. No government

assistance was received by any organisation that provided services for Indigenous Australians. The 1960s saw the emergence of a demand for self-determination. This was evident in the 1963 'Freedom Rides', which drew media and public attention to discriminatory practices in rural New South Wales, and the 1966 walk-off by the *Gurindji* people, led by Vincent Lingiari of Wave Hill Station, over a land claim in the Northern Territory (Watson, S, pers. comm.). During this time there was an ongoing campaign for a Referendum on Aboriginal issues:

This task was largely initiated and facilitated through the Federal Council for the Advancement of Aborigines and Torres Strait Islanders. Their task was to obtain 100,000 signatures on petitions to present to Parliament therefore demonstrating public support for a referendum (1967 Referendum, Citizens at Last 1997).

On the 27 May 1967, an event unprecedented in Australian political history occurred: with a referendum to transfer power from the States to the Commonwealth – with reference to Aboriginal people (Attwood et al. 1997, p. ix).

For the community-based organisation, the Federal Council for the Advancement of Aborigines and Torres Strait Islanders, and other organisations, a decade-long public campaign ended in success. It was a long and arduous task that Indigenous people faced in the push for the 1967 referendum. However, it is also important to note that agitation and action germinated within Indigenous communities.

The Indigenous community believed that the Referendum would result in Indigenous health being addressed on a national level. However, it resulted in bitter disappointment. The support of the Australian public to 'win' the referendum did not translate into practical support. The working reality was that there was no further improvement in Indigenous health. Governments did not take responsibility for

addressing the widening differentials in the health status of Indigenous and non-Indigenous Australians. Aboriginal people were still turned away at hospital casualty departments and general practitioners still refused to see or treat Aboriginal people. Indigenous Australians were still dying in droves. Gardiner-Garden (1996–97, p. 8) notes:

Many popular notions associated with the 1967 Referendum belong in the category of myths. The referendum was not whole-heartedly supported by both sides of politics, did not end legal discrimination, did not confer the vote, equal wages and citizenship for Indigenous Australians and did not permit for the first time Commonwealth government involvement in Aboriginal Affairs. The repeal of the State legislation, which discriminated against Aboriginal people, was a process which was independent of the 1967 referendum and which had begun before the referendum. The Commonwealth government some years before the referendum had clarified Aboriginal voting rights and employment rights. The referendum result moreover, did not automatically make the Commonwealth more involved and indeed little changed for five years.

Throughout the decade-long push for the referendum and through intensive lobbying by Indigenous persons and their sympathetic white counterparts, the decline of Aboriginal health was tabled repeatedly as a national disgrace and an embarrassment to Australia. It was believed that action in reducing these differentials could no longer be ignored (Collins, L, pers. comm.).

For many Indigenous peoples the referendum was hailed as a breakthrough for the rights and self-determination of Indigenous Australians. However, as the months passed, it became increasingly evident that the referendum would not lead to parity between Indigenous and non-Indigenous Australians in social, economic, or health status. Indigenous people expected the Commonwealth Government to seize power in determining better service provision for Aboriginals. This was not to be and was made apparent by the then Prime Minister, Harold Holt, who in 1967 stated that:

...while the Commonwealth is now in a position to make laws and to prevail should a conflict arise with a State, the Commonwealth does not seek to intrude unnecessarily in this field or into areas of activity currently being dealt with by the States. There is a big variation in the circumstances and needs of Aborigines in the States. For this reason, administration has to be on a regional or State basis if it is to be effective. (Holt, cited in Franklin 1976, p. 189)

This was a blow to the Indigenous community. While it was anticipated that the referendum would move responsibility from state to federal level, this was not to be. For Queensland this was an exceptionally hard blow. At the time of the 1967 Referendum, Queensland was arguably entering its darkest political administration of Indigenous people, headed by Premier Joh Bjelke-Petersen. Bjelke-Petersen was known among the Aboriginal community as being exceptionally racist, having welcomed the speech by Holt. Responsibility for Indigenous Australians was, in theory, the responsibility of the Commonwealth government. However, Holt had explicitly stated his reticence to step into state matters. For Queensland Indigenous people this meant that our health would continue to decline, as Bjelke-Petersen had no interest in the affairs of his State's Indigenous people. This racist behaviour continued throughout the Bjelke-Petersen administration, which lasted until 1988 (Watson, S, pers. comm.).

However, the political activity and agitation occurring in the Brisbane Indigenous community in the late 1960s formed the breeding ground for the establishment, not only of community-controlled Indigenous health services, but also many Indigenous community controlled services in Brisbane such as legal and housing. One of the young members of the Brisbane Indigenous community at this time was Sam Watson. Watson was very active in the establishment of Indigenous services in Brisbane and was also involved in the establishment of the Queensland

Chapter of the Black Panthers. Whilst I was undertaking my Master of Philosophy titled, *Community Control Theory and Practice: A case study of the Brisbane Aboriginal and Islander Community Health Service*, I interviewed Watson in-depth about his involvement in the establishment of Indigenous services, in particular the Brisbane Aboriginal and Islander Community Health Service (AMS). According to Watson:

...the radicalisation of Indigenous people in Brisbane led to a small group of Aboriginal and Torres Strait Islander leaders holding a meeting in the upstairs room at a bank building in Stanley Street, Mater Hill in 1968. The purpose of that meeting was to talk about the situation of the black community in Brisbane and to formulate strategies to address the seemingly insurmountable problems of our health that were being faced by every Indigenous family and individual in the greater Brisbane area (Watson, n.d.).

Beryl says of this time that *I was one of the oldest in a big family and at high school I went to a school where we had rebel teachers. The high school was called the 'rebel school' or the 'red school' by Joh Bjelke-Petersen. So I grew up in a time of change, I always considered myself a unionist.*

This was the era that Beryl entered her nursing training. *I didn't realise I wanted to become a nurse at all. It came down to waiting for our results to come out and my father looking at my friend and I and saying you've been unemployed too long, here's the Saturday paper. Whatever happens, you get a job, no matter what. The paper fell open and here was an ad to the Royal Brisbane Hospital and we said, "Ah we'll go and see if we can become nurses". That is how we did it, that was 1968. We basically, wrote a letter to the Royal Brisbane answering the ad and then we were invited in for an interview and we took our senior certificates with us and we got accepted in to do our training at the Royal Brisbane Hospital. We were asked if wanted to go in on December the 24<sup>th</sup> and we said no, so we started the following*

*year, it was the 13<sup>th</sup> March 1969. I can remember my commencing, we all had to live-in, so on the Sunday, at two o'clock in the afternoon, we had to meet in the quad at the Royal Brisbane nurses' quarters, on the dot, with our ports and no parents. That was my first time away from home.*

*My first day of training I remember it in many ways mostly because of our stupid uniform. The night before it took us so long to put the buttons on and pull our hat together because it was a string thing. A lot of us were worried about our uniforms being right, we had to wear our hats into class and it was so stiff, made of so much starch it stood up by itself. I was probably lucky because of my friend who I went nursing with; we were at school together, so I had someone that I knew.*

*I smile when I think about it today because you're teaching the nursing classes of 400, and we had 40, and we were seen to be a large class and I can remember walking into it. It was like going back to school because of the way the desks were set up and we had to sit in alphabetical order, we just couldn't plonk down. It was actually the old nurses' quarters for Preliminary Nursing School (PNS). We went into the big towers, but we were all together on one floor, so in ways, they kept us cocooned and all the new PNS students stayed in the one corridor, just off the home matron's office. I think back now it was more to stop us from running away. The end of our first day we all went back to our room and thought what in the world are we doing here? We'd always go back to someone's room, we were always together and you'd sit down and in that way you were able to debrief and get all that crap and everything that was happening in your day out. And in ways that was a good thing.*

Support for Beryl was paramount in getting through and came in differing



forms and from different people both within and out of family. Beryl discusses support coming from the 'nursing family' that they formed throughout their training. The uniqueness of this support is eloquently stated by Beryl. *I was having a conversation yesterday with two first year nursing students and one of them said to me "you know when I was at UQ last year doing an Arts degree, I made only one friend but since I've been doing my nursing this year, we're in smaller groups there's a friendship thing". I said to them that was one of the things that was good about living in doing hospital training. Now I am not advocating for hospital trained nurses these days, but the friendship that you got and developed certainly is different than today I believe. I have still got friends that I went through with, and I've still got friends from the ones that started with PNS.*

Beryl also identified that support came from Aboriginal people unexpectedly throughout her journey. *One of the people who got me through besides having my friends in nursing and other students was a Murri woman. She was the pink lady in one of the wards. She used to spoil me. She'd say Beryl come here (I'm talking softly) I'd go into the kitchen and she'd have coffee made for me and toast, I was about 46 kilo. She was one person who really got me through, even when I didn't work in her ward, she'd see me and she'd ask me how I was going.*

*I also worked in a ward where the charge nurse was a Murri woman. She was tough with me and I had a go at her but the thing was she said to me "this is a tough place and if you are going to survive girl, I'm going to treat you tough" and in a way, that kind of toughness got me through. When she finished at the Royal Brisbane, she was a supervisor. We used to call them blockies in my day but she ended senior. She was in charge of the ward. I'm talking someone in their seventies,*

*an Aboriginal woman. She was in charge of the ward and was very well respected. Even though she was tough with me, she was also good with me and in a way during my training I probably didn't help myself a lot.*

With the support of her friends and a Murri nurse and pink lady, Beryl made it through her first year of training. *I can remember vividly the end of my first year, because we were paid such poor pay. I could have earned more working in a factory. A week's wages in the factory was equal to two weeks wages and at the hospital you were doing much longer hours. It used to annoy me to think of my sisters, one was working in Woolworths and the other was working in a factory and they were earning more money than I was earning, and I was working much longer hours and it was hard work as far as the physicality of it. But I remember when we sat our exams, which was quite stressful, it was actually the question of what and where we were going to work during our five weeks off, because we needed money. I said I was not going to the pineapple factory, I was not pulling beer so I actually went off and picked grapes up at Stanthorpe. You had to survive and nursing pay was so poor in those days that many of the student nurses picked up work in their holidays. You know you had a bit of a holiday. So basically you had to have money to survive.*

Like all the participants of this research racism was part of the journey. Beryl states that her first real episodes of racism were at school. *Put it this way, I actually experienced my first lot of really institutional racism at high school. It probably prepared me to go into nursing. I'll tell you why it was. When we were in high school in grade 11, we had to vote for the school captains the following year. I got it from the election and the school would not allow an Aboriginal person as the school captain. So when I went nursing I had it a couple of times given to me, but the staff*

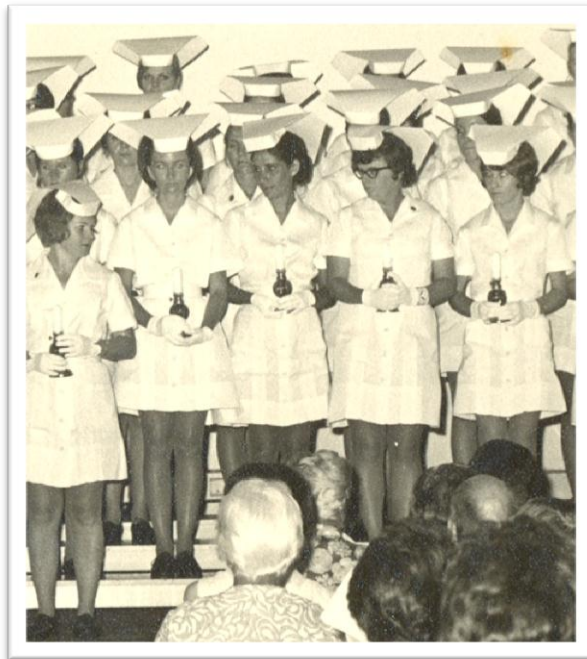
*members who did it to me, I thought you are insignificant. If that's the way you're going to think and that, you're not going to affect my nursing. You're not going to stop me from nursing. Some of it was more passive. A couple of the patients would say "oh you black thing" or something like that. That didn't worry me. I didn't let it get to me because being a black nurse helped a lot of our black patients. You could talk to them and you could be there. So, racism when it happens to me I don't think I'm doing anything wrong. If anyone's got a problem it's them.*

*The other thing I found hard to deal with was the regimentation. When we left the nurses' quarters we had to sign out and had to sign in. We were signing on, signing off at our shifts and we had to dress in our uniforms to go in to the cafeteria where we sat. Miss Abell was up the top and we were down the bottom because we were the first year nurses. For the first six weeks you were the lowest of the low. So when the next lot came through you made sure that they stood back for you but the hierarchical system was so strong. We were sort of half way between being nuns and in the military. I refer to the nuns because I think it's the caring kind of thing. Not that nurses were merciful or anything like that, but it was that sort of thing they wanted you to be. The only thing that we didn't have to do was kneel down and pray as if we were in the nunnery. So, that sort of thing was there, but it was how it was and the shift work was incredibly hard to get used to.*

*When we finished our training, we were the last of the 4<sup>th</sup> years, so we had the time where we were not student nurses, but not registered, you had to be 21 to register. At seventeen you started, and finished at 21. So I had turned 21 so that was not an issue for me, but we had what they used to call the butterfly era, I didn't have to wear a butterfly cap. The Royal Brisbane at the time got rid of the butterflies and*

*we had the three stripes and the stamp on the front of our uniforms.*

The changing of nurse education had been a long battle that the Royal Australian Nursing Federation (Queensland Branch) had spearheaded. The call was for improvement in nurse education. This overt agitation and action was achieved in 1969, when the Minister for Health announced that the general nursing course would be reduced from four years to a three year course. The other significant change of this time was that the lectures that student nurses were required to undertake were now within the employers' time and not the nurses' own time. This was closely followed by a new Schedule of Study to provide an increase in the minimum hours of lectures that student nurses were undertaking with a massive increase from 148 hours throughout the training to 840 hours (Queensland Nurses Union viewed 10 June 2010, <<http://www.qnu.org.au/your-union/about-us/history>>).



**Figure 5.3 Beryl's Graduation Ceremony  
(Beryl is front row, 3rd from the left)**

*I was sad about finishing but I was also happy because I had survived. I had done it and I finished in what we used to call in those days the Casualty in Royal Brisbane. Every time it rained the roof leaked so you had to put the umbrella up and things like that and I know I finished on an afternoon shift on a Sunday. I had to get my penalty rates, which were good and I didn't have a split shift. It was also here that Beryl demonstrated again her belief in the rights of the student nurse. At this time split shifts were still imposed on student nursing staff. Beryl believed that this was incredibly difficult to maintain whilst working in Accident and Emergency. Beryl says of this time *it was again in casualty that I caused a stink and got the Casualty staff out of having to do split shifts. I finished in April 1972 and I was pregnant. I got treated like shit as you also weren't supposed to be married. So there were a couple things I did that upset the apple cart with being pregnant and being married. It was bizarre how we finished up, being the last of the four year trainees. We had sat our final exams six months before we were supposed to. We were a bit in limbo land having passed our exams but still having another six months' worth of shifts.**

*My first job as a registered nurse was at Montrose. Montrose at the time was a charitable organisation and a home for handicapped children. They used to call it the Montrose Crippled Children's Home. It was children that had some kind of physical handicap such as spina bifida or bad asthma. I put in to do my Mental Health and I got accepted but I promised Montrose I would do 12 months and I would start my Mental Health a year later. It was here that I was looking after a young Aboriginal boy when his mum passed away. It was really quite sad because I couldn't go to her funeral because I was with him and I took him out to the movies and took him out for lunch. When I think about it, it was the most bizarre thing that*

*this boy's mother had died and the rest of the family were grieving, and here I am doing this, and to me it was very hard, because, I knew his mother very well because we went to school together and she was married to my mum's brother.*

Beryl within her first job as a Registered Nurse again demonstrated initiative and the desire to challenge what was considered the 'norm' of nursing. This came to the forefront whilst working at Montrose. *I enjoyed working with the kids. Montrose was a really funny and very strange place. The regimentation was still there and was so strong and I really struggled. You know in ways, I think I was like a bull in a china shop. You always had afternoon tea with silver service and the fine china and all of that and Matron used to say "don't cross your legs, cross your ankles" and to me of all people! Matron was very old school and I struggled. I must have been doing something right though as I was asked to step in and act as the Matron for three months whilst she took leave. One of the first things I dealt with was changing the uniform. I just didn't understand having to wear white uniforms; it was so impractical especially nursing kids. So the Matron went on leave and the manager and I got together and we changed the uniforms. We decided we needed colour and practicality which meant we actually went into lilac tops and purple slacks. Now remember, this is in the 70's and plus I thought I looked good in purple. When the Matron got back she nearly had a heart attack because a couple of things happened. In her absence I also was gunning for penalty rates to be brought in and we were successful in doing that. We did this all in three months. When I think about it, I probably wasn't the best Matron.*

Beryl as she promised the Matron, spent 12 months at Montrose and then went on to undertake her psychiatric nursing certificate. *I commenced at the Park,*

*Wolston Park, and I was a Woogaroo screw, in those days they used to call them that. Again I can remember my first day. It was in July and it was a cold winter. My husband dropped me off and the first person I saw was this man who reminded me of the Hunchback of Notre Dame. He was hanging around making funny sounds and I really thought what am I doing here and being July and being at Wolston Park there was a heavy fog because of being close to the river.*

*I went in and was greeted by this grumpy old male nurse, and being a registered nurse went down like a lead balloon. You didn't go into class first, you were thrown into the ward and I was sent to a male admission ward. Well, that was really bad because the only females that usually worked there were the assistants in nursing, and I got thrown up there and they said "you can join up with this student nurse they will look after you". It was a male and being a General Trained Nurse or GT as they used to call us, well they didn't call it, they spat it at us, it was certainly a day to remember. I think in a way they thought they could see what you were really made of so I was this skinny little thing sent to a male admission ward. I think they thought she'll be out before she knows it and I didn't, and I actually worked for a very long time in mental health over the years. I graduated from my psychiatric nursing in 1977.*

Of this time in the 1970s Gregory outlines in her *Nursing Queensland Always Q150* essay: 'Nursing, apart from mental nursing, was still primarily a profession dominated by women'. This would explain Beryl's story of not having many women at Wolston Park undertaking their mental health training and instead were assistants in nursing.

*After I graduated at the end of 1977 I then went to work at the Brisbane*

*Aboriginal and Islander Community Control Health Service (AICHS) over at Woolloongabba. Working at the Aboriginal Health Service was a different experience and it was an enjoyable experience. I enjoyed working with the community. We used to actually do the old outside clinics and I tell you we were outside. We didn't sit at a desk, we were, a mobile team. This was done in a caravan so we used to have to tow the caravan. In the five days we would do Inala twice, the Aboriginal hostel that was at Wacol, where now there's a prison. Kambu wasn't an independent Aboriginal Medical Service (AMS), so we used to do Kambu at Ipswich and we used to do Acacia Ridge and we also used to do one day a week at Murgon. We couldn't go into Cherbourg because it was a mission and we did not have permission to run the clinic in Cherbourg. That was a government policy that stopped us from doing that. We used to leave very early in the morning and drive up there and we had a lot of clients on our books. We were allowed to provide transport for the mob on Cherbourg into Murgon. It gave the people at Cherbourg an opportunity to go out to a different health service rather than going to the hospital. Some of the things they used to say to us were really quite stressful. A lot of it came down to the way people were treated by the white staff basically. I can remember some of the women saying about having their babies and then the babies just being taken away. I found this incredibly distressing and you must remember this was decades before the phrase stolen generations was coined. It was a constant reminder of the dreadful state of how many Aboriginal people were "administered". That was in the late 1970's. You knew where your boundary was, because of government policy you weren't allowed to step into the mission to offer health care. So we were at the boundary of the mission.*



Aboriginal Elder and activist Sam Watson says of this time:

You have to remember we were about five years behind all other states. Of course at this time Queensland was under a Bjelke-Petersen regime. I still remember when, in 1978, Mr. Bjelke-Petersen kicked Fred Hollows and his trachoma team out of Queensland for fighting against the inequalities in our health. It was seen as threatening and undermining the National Party line on Aboriginal health and he was therefore dealt with effectively. (Watson, S 1998, pers. comm., 12 March)

This blatant and racist mindset was obviously demonstrated in Beryl's nursing experience and it was very hard to deal with as an Aboriginal nurse. *Even though it was a long exhausting day it was always good, and the people we looked after, some of them were very sick. I think it was what you could offer, even though it was only once a week and it was very long hours. There was a health worker, myself, a doctor of course, and a driver. So there was a team that went up to provide that service.*

Whilst Beryl thoroughly enjoyed working at AICHS, running the outside mobile clinics was very hard and incredibly long hours, and with a young family Beryl found this hard to keep up. Beryl decided to utilise her psychiatric endorsement and commenced a long journey of working within mental health nursing. *I went back to The Park and then the Princess Alexandra was opening up the new psych unit and so I started there. The Princess Alexandra Psych Unit was a big black building; some architects need shooting! A black building with purple carpet! They told us the purple carpet was because schizophrenics don't react to that colour. That was crap; we all knew it was just carpet that Parliament House didn't want.*

*In ways we were the envy of everybody else at PA Hospital because we were the only building that had air conditioning, and we used to walk out in summer with our capes on because we were freezing. I was there for about three years. One of the*

*things when I was there that was interesting; I can remember putting in for a charge nurse's position at the time. I actually didn't get the position and I wasn't very happy about it, but at the time I was asked if I was interested in going to the School of Nursing at PA and I said I'm not going to be an Educator, I'm not going to be a teacher. Unbeknown to me, when I think of where I am now and what happened after that maybe that person had better foresight than I did. I stayed there and then I went back to The Park to work.*

*I went back first as a registered nurse and then I went up to deputy not long after that. Then when I was there the changes were happening in Queensland Health with a push out to the regions. We were under a Region at the time and there was an Aboriginal group that was involved and I was part of that, I think because of my involvement in the Union. I was involved in the QNU all the way through from back in the days as a student nurse and I think that's where I had the contact with the Regional Office Manager. They had an Indigenous group and then they decided they were going to develop an Aboriginal and Torres Strait Islander Health Advancement Unit and set it up in Ipswich, and being the most senior Aboriginal person at the time at The Park, (there were a couple of other registered nurses), they asked me if I was interested in it so I did it. We had Mums and Bubs groups happening and actually held probably one of the first male health groups. I had a male health worker who was with me at the time but I was the one that sent out the invitations and we promoted it, we got it together. When I think back on those things that we were doing, these days they seem to be so 'innovative'. I did that job from 1992-1994 and officially was the Acting Coordinator of the Aboriginal and Torres Strait Islander Health Advancement Unit in the West Moreton Regional Health Authority which was*

*based in Ipswich.*

At the end of 1994 Beryl entered the tertiary sector, initially being offered a Research Assistant position which was funded through Queensland Health but based at the Queensland University of Technology. Beryl relished this position and was responsible for workshops on 'submission writing and project management' for Indigenous health workers. These workshops were attended by 120 community health workers. The health workers submitted successful proposals for small grants for health promotion activities. It was this position that provided the transition for Beryl to enter the tertiary sector as an academic. Beryl entered the School of Public Health at the Queensland University of Technology in 1998. *In the meantime I upgraded my nursing training of course to a university degree and graduated with a Bachelor of Nursing (post-registration) in 1999 from the Australian Catholic University. I was also doing my Graduate Diploma in Health Promotion through QUT and finished that in 1999 as well.*

*I sit in the Faculty Office and I work across the whole of the faculty teaching across Psychology, Optometry, Nursing and Public Health. I have a lot of contact with our Murri students and I have a lot to do with the recruitment of our Murri students. Seeing the Murri kids that have gone through and graduate gives me great pride, they're like one of your hatchlings. I think my thing now is the pleasure of seeing our people graduate and I say "go on you better get through because I want you to graduate before I retire and so you kids had better move quick". Knowing that not only have they got the Oodgeroo Unit as support, but there's some of these students that feel more comfortable coming to talk to me and I think it's because I'm a nurse.*



**Figure 5.4 Beryl (far right) with graduating nurse Ida Bligh (middle)**

Since Beryl began her academic journey she has engaged in ground breaking research. In 2000 Beryl was part of a research team that was successful in receiving funding to undertake a pilot project on traditional Indigenous games. This was an innovative pilot project called 'Our Games: Our Health'. This project had success in re-introducing traditional Indigenous games as a cultural thread to build pride, enhance social cohesion and increase physical activity in primary and secondary schools, men's groups, elders' groups in Cherbourg and Stradbroke Island. In 2003 this research was built on through 'Sustaining Health through Indigenous Traditional

Games' in the Western Queensland Cape College. This program was further consolidated in 2004 to develop 'Dreamtime Games: Pathways for our youths' future', which looked at expanding this program into the South-West Queensland region. This program still continues and Beryl is monumental in teaching people traditional Indigenous games. In 2008 Beryl received the (Faculty of Health) Neville Bonner Award for Indigenous Education.



**Figure 5.5 Beryl (far left) teaching traditional Indigenous Games**

Beryl has been passionate her whole nursing journey about Aboriginal health and people. Beryl is the first wave of Aboriginal Registered Nurses that graduated who could work within community-controlled health services. *We black nurses that went through in this time could work in our health services. For me it has always been about giving back to our community, I think that's one of the most important things. I actually think about my involvement, because of Mary being my cousin and*

*our other cousin Rosie, we're three registered nurses who followed each other into nursing. If you want to think about it, we were hunters and gatherers. We gathered, we shared with the whole family and the whole group. Now in this context it's giving back. I've got this training, I can help improve the health of our mob. I see myself now more as a teacher to our Murri students. It is essential to pass our knowledge on so that knowledge can get passed on to bring about change for our people.*

## Chapter 6: Mary Martin

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*Noonucal Nation*

**Registered Nurse 1971–1974**



**Figure 6.1 Mary as an RN 1974**

I first met Mary in 1994 at the Brisbane Aboriginal and Islander Community Health Service (AICHS). At this time Mary was working at the Stradbroke Island Aboriginal Medical Service as a registered nurse. Mary was the first Aboriginal registered nurse that I worked with. Without any formalised arrangement or discussion Mary was my first mentor. This mentorship role has continued for me as I have progressed through the last 16 years of my journey as an Aboriginal registered nurse. Mary's mentorship involved not only the work journey, but also my post-graduate study as well. In 1997 I enrolled in a Masters of Philosophy and as part of this process I established an Aboriginal working group to guide and help navigate the

process of undertaking culturally appropriate research with the Brisbane AICHS. Her cultural insight has been significant in my personal journey. I approached Mary in 2003 to also be a part of the *I'm a Nurse* documentary to which she agreed. Mary's influence and impact on me has been fundamental to who I am today. I am indebted to Mary for both my cultural and professional development and feel privileged to say so.



**Figure 6.2 Mary and I at a conference 2001**

Mary is a *Noonuccal* descendent of the *Quandamooka* Nation (Moreton Bay) from *Minjerriba* (North Stradbroke Island) (see Figure 6.3, next page). Her totem is carpet snake. As previously acknowledged the Horton Map of Aboriginal Australia is not explicitly correct. This certainly is the case of the people of North Stradbroke Island.





Mary entered her time in nursing at arguably one of the most significant times for the Aboriginal community, post-invasion, across Australia. It was the birth of Aboriginal community-controlled services. Within Brisbane after the establishment of a small group of Aboriginal and Torres Strait Islanders meeting in 1968, action to form services was wide spread. For the Brisbane Indigenous community this ignited the urge to take to the streets and protest. One of the first public street marches for the Brisbane Indigenous community was led by Pastor Don Brady from the Normanby Fiveways to his church in Spring Hill, on Invasion Day 1970. Invasion Day is a commonly used term amongst many Indigenous communities and peoples across Australia instead of 'Australia Day'. Some non-Indigenous people may find this terminology offensive, but this term is how many Indigenous Australians articulate the process. In that same year, 1970, the Aboriginal and Torres Strait Islander Council was established:

In 1970, Don Brady, Dennis Walker and their group set up the Aboriginal and Torres Strait Islander Council. They decided to have a governing committee of twenty people, all of whom had to be Aboriginal or Torres Strait Islander adults. The governing committee drew up the main areas of need and appointed a Tribal Councillor to be responsible for each portfolio. Jane Arnold was in charge of health (Watson, n.d.).

The establishment of the Tribal Council added momentum to the drive in establishing the health service. Much debate and discussion was focused on what could be done about the obvious lack in health service provision for the Brisbane Indigenous population. Further discussion centred on how services could be delivered to this community. The response to this being that:

The late Jane Arnold and her small band of helpers enlisted sympathetic white doctors from the public hospital system and visited Aboriginal and Torres Strait Islander homes in the inner city suburbs and administered free

medications and advice to the families they visited. This was the very first actual health program that was conceived, established and run by Brisbane Aboriginal and Torres Strait Islander people to serve their own community (Watson, n.d.).

Also at this time protesting and rallying of support was of paramount importance in the Brisbane Indigenous community. Les Collins, another young Aboriginal member of the Brisbane community, was also very active in the establishment of Indigenous services within Brisbane. Collins has worked within Indigenous health for many years, across both government and community sectors. Collins recalls of this time:

We started on the streets with a lot of protesting activities where Aboriginal people in Brisbane and throughout Queensland and Interstate would come together. What we were trying to do was redress some of the more obvious discriminatory practices, for example the blatant denial of access to existing health care systems. This included talking to the Indigenous community, lobbying politicians and gaining political support from non-Aboriginal sympathisers, especially students and academics, and essentially we took it to the streets. (Collins, L 1998, pers. comm., 14 March)

As a result, the first major civil rights march occurred on the streets of Brisbane in September 1971. In what became known as the George Street Clash, Indigenous men and women from the Tribal Council attempted to storm the Native Affairs building in George Street. Several of the Tribal Council were arrested. While in the Indigenous community this action was seen as essential in our struggle for the right to Indigenous services, government bodies of the day saw it as too political and militant in its execution and subsequently the small amount of federal funding secured by the Tribal Council was withdrawn.

It was during this time of action that in January 1971 Mary entered her general nurse certificate training at the Brisbane Mater Hospital. Mary says of this time that *I didn't grow up wanting to be a nurse; I didn't know what I wanted to be.*

*I'd received a scholarship to go to Brisbane Girls Grammar and in the last year of school they had a vocational careers day and part of the exercise was that you had to go to the stalls and consider what it was you wanted to do. I looked around the room and I thought I could do nursing; it was something that I felt confident that I could do, so it wasn't a love of people that got me into the field. I had to speak to Mum and Dad and they supported me. There were certain things you had to do, including a written application and then a physical examination. When you'd completed that you went into the recruiting office at the hospital. I got accepted and started in January 1971.*

Indeed the 1970s was a decade of much change not only within the Indigenous Australian communities but also within the nursing profession. Gregory (2009) outlines:

Nursing in Queensland changed in the 1970's. In the general hospitals, the rigid insistence that all nurse trainees live in nurses' homes was fading. As well as far greater numbers of married nurses in hospitals who refused to live in nurses' homes, more men were admitted to general nurse training schools and to midwifery courses. (p. 9)

The overt regimentation of the training era presented within Mawn's and Beryl's stories was starting to slowly loosen. Indeed Mary's was the first intake of student nurses who were not required to live in the nurses' quarters. Throughout her story Mary also comments on men entering nursing and said, *and then when men went into nursing I thought "wow!". Mum went with me the first day of nursing; otherwise I would never have gone Dad said. We lived at Inala, so I had to get from Inala to South Brisbane and you had to catch a bus and then a train and then another bus but my Mum came with me. She and Dad must have talked because they knew if it was up to me, I probably would never have gone. So Mum actually walked with me virtually*

*hand in hand to the building to drop me off like a little kid going to kindergarten. That was the first day. I don't know whether I was excited at that time but I remember everything was new. I was the only Aboriginal person in the room and there was probably a group of 25 of us. I can remember that clearly though, Mum going with me from Inala.*

As Mawn identified in her story Mary also loved the veil and uniform. *I kind of loved the uniform, loved the veil, I loved the whole part about the uniform. That's what you worked towards wasn't it. In our training we had caps and the goal was to become a sister and wear a veil. Also at this time at the Mater Mary was the first of the three year programs. We were the first lot of three's and that was in 1971. I can remember on the ward there, there were these butterfly nurses. So they were the last lot of the fours who were completing their term.*



**Figure 6.4 Mary as a student nurse**

Mary progressed through her first year and says of this time *there must have been some satisfaction because I was still there. I think it was the supportive environment from my family, both Mum and Dad, and also my peers there. I think the atmosphere at the Mater must have lent to a conducive learning environment, so I must have felt good, because I don't think I would have stayed if I wasn't feeling valued and supported.*

As Mary entered her second year of her training significant changes were occurring both on a state and national level for Indigenous Australians. The overarching policies of self-determination and self-management were articulated as the way to progress Aboriginal Affairs in the country by many. 'The election of the Whitlam Government heralded a marked politicisation of Aboriginal affairs in the wider community, and a new era of policies aimed at self-determination' (Forsyth 2007, p. 40).

Although funding had been withdrawn from the Brisbane Tribal Council, their push for the establishment of Indigenous services remained. The Council was still meeting on a regular basis to continue discussing the establishment of Indigenous services in Brisbane. The Tribal Council at this time deemed that:

The Indigenous population base of the greater Brisbane area and the scope of the various areas of need, really required specialist organisations to deal with areas of need in specific ways. Therefore it was decided to set up separate purpose built organisations to deal with the big three problems – law, health and housing. In August of 1972, a public meeting was held at the University of Queensland – Law Faculty, to talk about setting up a legal aid service. That meeting elected a steering committee made up of Aboriginal leaders, lawyers and supporters. In a matter of months, the federal government had granted a small operational budget and the governing committee had leased an office space and hired staff. (Watson, S 1998, pers. comm., 12 March)

In Queensland this was the birth of community controlled Indigenous

services. It is important to note that the term 'community control' had not been articulated at this time. However, a common Indigenous catch cry throughout Australia at this time was 'black affairs in black hands'; this concept is an essential element of community control. It was the above framework that was integral in the development of other Indigenous community controlled services within Brisbane and across Queensland. For the first time the local Brisbane Indigenous community had not only mobilised, but also established a governing committee that was made up of western professionals such as lawyers, doctors, and nurses as well as the Indigenous leaders. Never before in neo-colonial history within Queensland had a service of any kind been established for Indigenous people where Indigenous peoples were responsible for its establishment and held key roles in its structure. This service was established by Indigenous peoples for Indigenous peoples.

It was also the first time that Indigenous peoples were being utilised for their expertise in knowing and being able to truly identify the needs within their community as well as identifying some solutions to these needs. Part of the solution was that community controlled services should be about services for the people, by the people, and with the people.

It was during this time that the community again came together to discuss and elect a steering committee to establish an Aboriginal and Torres Strait Islander Medical Service in Brisbane. At this time Mary entered her second year of nursing training and this was not without incident. *Nursing was a whole new thing. It was a disciplined system I learned under, in terms of being nurtured and being paid to actually do the work and the training. To me, that was ideal. I can remember when I first started; a lot of my friends were working nine to five with weekends off. I was*

*everything but a weekend off. Anyway I didn't turn up for work then didn't ring in. Admittedly I was having too much of a good social life when I should have been at work and the Deputy Matron came round to my flat. I didn't open the door of course so I started running round the corner and I think that was out of guilt. There was also another time my Dad came hunting me. I had no idea how he knew where I was but I think that was the blackfella in him, how the hell he managed because I didn't know where I was going to be. Anyway, he's standing out the front of the unit there yelling at me. Because I should have been at work! But I can remember these two episodes that happened never happened again, I think I was so embarrassed. I've no idea if the Matron did that to anybody else or whether it was only me, but I don't think so.*

Mary also remembers of this time that her class was seen as quite radical. *I think in our class, we were the first ones at the Mater where someone in our group was pregnant. Yeah, some of them adopted their kids out, some of them still had them but I don't know what the Mater thought of us, dead set! We were the first ones to have single unmarried mums in our class.*

As Mary continued with her training in 1973, the Brisbane Aboriginal Medical Service commenced. As Watson remembers:

There was only a very small group of us and we managed to get the legal service and we started to initiate funds through fundraising such as barbecues and the like. Basically what we were able to with these funds was hire an ex bookshop up on Musgrave Road, Red Hill, Brisbane. We then had a few weekends transforming the shop into suitable space for the health service. Pastor Don Brady was a qualified cottages carpenter so he knew how to handle a saw and hammer. Then we constructed a list of voluntary doctors who could give 2 to 3 hours a week and in that way we were able to launch the clinic on 13th February back in '73 as a voluntary run health service for the community. (1998, pers. comm., 12 March)



For the first three months of operation (February – May 1973), volunteers staffed the Red Hill Clinic on a part-time basis. During this period, 119 different patients were seen, and there were 145 appointments (Department of Aboriginal Affairs 1973). Watson notes:

In those first three months of 1973, whilst the Board waited for the funds to come through, they were able to set up a roster of voluntary doctors who came in for two to three hour sessions and provided general clinics. The word had to be passed around the community (by word of mouth) that doctors were available on certain days to see patients. People flocked to see the doctors and were content to wait for hours. The service was also provided with boxes of free drug samples, so they were able to operate a limited pharmacy. (1998, pers. comm., 12 March)

Politically the conservative Bjelke-Petersen administration remained harsh on Aboriginal Affairs (Watson, S, pers. comm.). In 1973 The Commonwealth Government made a formal offer to the State Ministers to assume from them full responsibility for Indigenous Affairs policy and planning. With the exception of Queensland, all the States accepted the offer ( HealthInfoNet 2008).

Watson says of this time:

The Board secured funds from Canberra, which in itself created a situation fraught with political dangers. The state government of Joh Bjelke-Petersen was violently opposed to the Whitlam administration and they resisted every attempt by Canberra to move into a state area. It was at this time that Gough Whitlam called Bjelke-Petersen a “Bible bashing bastard”, during question time in the House of Representatives. This was in reference to Bjelke-Petersen’s habit of returning to his electoral heartland on weekends to deliver sermons from the pulpit, that invariably attacked the “socialist menace from Canberra”. (1998, pers. comm., 12 March)

However, it was this ‘socialist menace from Canberra’ that was providing direct funding to a state Indigenous, community-controlled health service, which in turn provided funds for health service provision to the Brisbane Indigenous community

and Indigenous communities further afield who were in desperate need of direction from Brisbane.

Mary entered her final year of nursing as the birth of community controlled services occurred not five kilometres down the road from where she was undertaking her training. Mary progressed through her final year without incident although she had to follow through until March 1974 due to the time off needed to have her gall bladder removed. Figure 6.5 is a photo that was taken in November 1973 with her graduating class.



**Figure 6.5 Mary's Graduating class**

**(Mary is on the top row, first on the right)**

Mary completed her training the following year and says of this time *I honestly can't remember how I felt on my last day but I would have thought it must have been fun. I finished in March 1974. As you were going through your final term what would happen was the charge nurses or the ward nurses would actually kind of*

*earmark people, or approach them. So I ended back in children's nursery and I stayed there for a couple of years and I loved it. The fact that I would have been approached to go back to that, had meant somebody had seen competence or had confidence in my skills to be able to do what was needed. You're looking after the little babies and they can't talk, so you've got to be their eyes and ears and everything and I loved it. So that was my first job as a Registered Nurse.*

Whilst Mary was completing her nursing studies a number of Aboriginal Medical Services had been established across Australia. In 1974, during a national meeting for Aboriginal Medical Services, held in Albury, a proposal to establish the National Aboriginal and Islander Health Organisation (NAIHO) occurred. NAIHO was formalised in 1976 where it was officially named. NAIHO was established and continues to be the peak national body for Aboriginal medical Services across Australia. It was renamed in 1992 to the National Aboriginal Community Controlled Health Organisation (NACCHO) and is a living embodiment of Aboriginal communities and their struggle for self-determination. viewed 29 June/2010 <[www.naccho.org.au/aboutus/history.html](http://www.naccho.org.au/aboutus/history.html)>

Throughout the 1970s, nurses too increasingly politicised about, and were interested in, Aboriginal matters. A special Indigenous edition of the Australasian Nurses Journal became an annual event from the mid 70's (Forsyth 2007). Edna Davis was the editor of the journal at this time and considered the time for burying our collective heads in the sand 'like the proverbial ostrich' was over, in relation to the past injustices to Australia's Indigenous people (Davis, cited in Forsyth 2007). 'In tune with the politicisation of Aboriginal issues and the change in government policy, many nurses experienced in working in Aboriginal communities now

considered self-determination as the most effective way to improve Aboriginal health” (p. 41).

The establishment of the Brisbane Aboriginal and Islander community health Service also meant that Aboriginal nurses now had the opportunity to work within ‘their’ communities. Throughout this research a number of the participants clearly articulated that they wanted to work for their mob within Aboriginal health. Mary does not identify this as a career path that she clearly wanted to move towards and almost fell into working in Aboriginal health through being there at the right time and place.

*I worked in nursery for a couple of years and then my cousin Rosemary Graham worked at the Aboriginal Community Health Service, Brisbane, over at Red Hill, it was around Christmas time. She asked me to go and work there but I do admit I was quite happy where I was at the time. So I met up with Rosemary and we talked about things and then I decided that I would resign from the Mater and go and work there. That was January 76 that I went to work there. It was such a different environment because you're actually working in the community. You know, working in an Aboriginal Community Control Health Service as opposed to one person working in a hospital system. Big difference there, but I had the support of my cousin Rosemary. It was also the first time that I had worked with a number of other Aboriginal nurses such as Rosemary, Pam Mann and my other cousin Beryl. For me it was about being an Aboriginal person working with other Aboriginal people to make terms better for the Aboriginal community.*

*Dennis Walker was the manager there at the AICHS at Red Hill and I acknowledge him now for being a good role model/mentor. If you have never*

*brushed shoulders with Dennis Walker then you are missing a big piece of the contemporary Aboriginal Health Movement. Yes I can look back now and say things about him that at the time I couldn't see because I was in it, without realising. I had my ears shut, and until you open your eyes and ears and feel and touch and see things it doesn't really make a connection as to what it means to be an Aboriginal nurse working in an Aboriginal health service for the Aboriginal community. Like I said, at times it was overwhelming. I learnt so much from working in community control. The Primary Health Care Team taught me not about the nursing side of things, but about the Aboriginal Health side of things. I didn't realise at the time what I was experiencing. I always said "I don't want to get involved in politics. I just want to do the nursing" and yes 20 years later I can realise how naive I was.*

As the Brisbane Aboriginal and Islander Community Health Service was going from strength to strength in the mid-1970s the nursing profession was also at this time slowly and publically questioning nursing care in regards to nursing Aboriginal and Torres Strait Islander peoples. Never before in the history of the nursing profession were these questions asked, let alone researched. However, within Brisbane in the mid-1970s Nurse Mary Samisoni surveyed Aboriginal and Torres Strait Islander peoples about their experiences of being hospitalised. Samisoni referred to the 'rudeness and abrupt manner of nursing staff' as most troubling. Further to this the failure of the nursing staff to provide 'adequate comfort and personal cleanliness' at a time when patients were most vulnerable and dependent was equally noted. She also noted that, in many cases, 'there was a feeling of prejudice and bias' experienced by the Indigenous patients (Samisoni, cited in Forsyth 2007, p. 46).

From 1976–1978 Mary worked at Brisbane AICHS and then had her two children in 1978 and 1979. 1979 saw the release of the *House of Representatives Standing Committee on Aboriginal Affairs (HRSCAA)* report on Aboriginal Health. This Inquiry into Aboriginal health came at the request of the commonwealth to the HRSCAA to conduct a review on Aboriginal health. Interestingly within the report it states that:

There are no Aboriginal doctors, few nurses and nurse trainees and a limited number of nurse's 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 these professions in the shortest time possible. (Inquiry into Aboriginal health 1979, p. 125)

The report went on further to discuss the comparison between minority groups within western countries and showed that Aboriginal Australians are grossly underrepresented in the ranks of health professionals (Inquiry into Aboriginal health 1979, p. 125).

Mary then started working back at the medical centre the odd day or two in 1980. In 1984 Mary was offered the opportunity to help establish the Aboriginal Medical Service on North Stradbroke Island. Mary was still based at Brisbane AICHS and as part of her position was required to go over to the Island one day a week and run a clinic. Mary was in a team with a health worker and doctor and initially the clinic was run out of the community hall at Dunwich. Mary says of this time, *we were there a few years and Oodgeroo, (Cath Walker) and the Aboriginal Housing Co-op on North Stradbroke Island, wanted their own health service. So that's what we did, we eventually moved the service into the Housing co-op. The service gradually expanded and grew into what it basically is today and I was there until 1988. I left briefly to do a short stint at a Neighbourhood Centre but I soon*

*returned to the Island in 1989 and was there until 1996.*

It was at this time that Mary stepped back from direct clinical service provision and moved into program and project administration. *I was involved in doing a six month national consultancy about the feasibility of establishing an Aboriginal Health Worker forum. This was done under the tutorage of Naomi Mayer who was the Chief Executive Officer at Redfern Aboriginal Medical Service and was also the Deputy Chairperson of the National Aboriginal Community Controlled Health Organisation (NACCHO). Not long after doing the consultancy work a position came up dealing with the Indigenous Workforce. I applied and was successful and began as the Workforce Recruitment and Promotion Officer in 1996. The position was based in Brisbane at the Queensland Aboriginal and Islander Health Corporation (QAIHC).*

The Queensland Aboriginal and Islander Health Forum (QAIHF) was established in 1990 and was reconstituted to the Queensland Aboriginal and Islander Health Council (QAIHC) in 2004. QAIHC is the state peak body representing over 20 of the community controlled health sectors in Queensland. Nationally QAIHC represents the community controlled health sector through its affiliation and membership on the board of the National Aboriginal Community Controlled Health Organisation (NACCHO). viewed 30 June 2010 <[www.qaihc.com.au](http://www.qaihc.com.au)>

*I was in that position for about six years. Then I was Deputy CEO of QAIHC, for probably just under twelve months and then moved into this position that I'm in now which is the Practice Education and Training Coordinator. So now I work with general practice registrars. From south of Mackay down to the border, every GP in Queensland will meet me. Every person going into general practice training will*

*meet me. I conduct workshops which I facilitate. I love doing this. Obviously I teach these GPs about Aboriginal health. They're usually always interesting and sometimes a little problematic when talking about "Aboriginal health". There is so much wrong and inappropriate information out there amongst non-Indigenous health professionals about us. What I'll do within the workshops if there are issues, I put it back onto the group at large. I don't respond first, I put it back onto the group to see has anybody else experienced that. So you want that peer experience or that peer reflection. Sometimes they learn better from their peers.*

*Many of the General Practitioners are fairly ignorant but they want to know about Aboriginal people, Aboriginal health, and Aboriginal issues. You get the odd one or two that will say "I'm never going to see an Aboriginal patient". I wouldn't call it racism; I probably would call it ignorance. Although it's probably racism to some degree, but I think everybody has got an opinion and I can't change that. My job is to inform them it's not to change them, they've got to do that.*

Mary along with the first two research participants, has relished working in Aboriginal health. Though Mary admits to not particularly *thinking about working in Aboriginal health*, once there she remained there and has done so for more than 30 years. *As I mentioned before, it was the timing in my particular life that gave me the opportunity to enter Aboriginal Health. Apart from that, who knows? If my cousin hadn't have rang me, I might be still at the Mater now and not have my life's experiences that I have had. However, I think it was meant to be, for me, given my cousin, there being a vacancy, the supportive environment there. The most extraordinary and unique experiences such as the political nuances around Aboriginal nurses working in an Aboriginal Health environment. I always thought*



*that all I wanted to do was to be a nurse but there were things that were happening there within my community that I couldn't ignore. I suppose I was quite naive, because I had come out of school straight into nursing and all of a sudden I'm finding myself in an Aboriginal Health setting. This took some getting used to since I had come out of a big environment into a much smaller environment. I was also seeing more of the Indigenous community as opposed to in hospital. A lot of them you knew too and that was not what it was like at the Mater, in the Aboriginal health setting you knew them and their mob. I remember at AICHS that somebody would recognise your features and ask are you so-and-so and that was a connection. I think if I had to do it all over again I wouldn't want to change it. For me to do the work that I currently do now, I'm just grateful that I was where I was when I was, with the people that I was with at time and who put me on that path. I was heading down a path and I didn't even realise it, you know?*

Mary's story unlike Mawn and Beryl, is not one scattered with racism within her nursing career. Mary however does talk about the non-nursing experience of racism. *It's interesting I wake up to racism every day, whether I experience it or not. In saying that I didn't notice any racism at all within my nursing training. If it was there, I didn't see it for what it was and I think that lends back to the environment of the Mater Hospital, the other nursing students, the wards, I never noticed any out there. But what I'm saying is I didn't recognise it if there was any. I was just busy, you know, doing my training, studying for exams, doing assignments and having friendships with my other colleagues. So if there was racism, I didn't recognise it. In the AMS, I never experienced racism at all. I think that's because we were all the same mob there. I don't think it was the environment for it anyway, because we're all*

*affected whether I'm a nurse or a patient of the service there we were all subject to it, or the potential of it.*

*Racism hasn't been about me being a nurse but I deal with it every day in other ways. Maybe I'm thick skinned and that, but I can go into a shop now and they can obviously see that you're there and the cowardly person who goes to serve the person who has just come in and what happens is, nine times out of ten, the person who they go to serve says no, she was there before me, and I'll say thank you. Is this racism, probably, you just get a feel for it.*

*I love being in Aboriginal health. I just enjoy it. I've got the capacity to give a good grounding in Aboriginal Health. It's doing new things, meeting new challenges, being able to spread the Aboriginal Health word, or the actual word on both sides of the fence. Being the bridge I suppose, but I need to be grounded in both sides before I could do that. I've never made that connection to say that maybe our role in it for us aboriginal nurses is that bridging effect.*

Mary relishes working in her current role and is considered amongst the leaders of the Queensland community controlled health sector. Mary has won a plethora of awards for her focused and continued work within Aboriginal Health and the community controlled sector. In 2006 Mary was awarded Honorary Membership of the Royal Australian College of General Practitioners. This award had never been awarded to an Aboriginal non-General Practitioner. In 2007 Mary received the Inaugural Lifetime Achievement Award at the Aboriginal and Torres Strait Islander Health Awards viewed 30 June 2010 <[www.qaihc.com.au](http://www.qaihc.com.au)> In closing Mary's story it has been written about this remarkable woman that:

An astute and effective networker, her influence has been as profound as the pride she has in her heritage. Mary has modelled, championed and

strategically influenced the development of doctors, nurses, allied health care professionals, resources and policy. Her work has resulted in significant improvements in cultural understanding and practice by hundreds of health professionals across Australia. <[www.qaihc.com.au/halloffame2008](http://www.qaihc.com.au/halloffame2008)> viewed 30 June 2010.

## Chapter 7: Janet Blair

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*Badjala Nation*

**Registered Nurse 1984–1987**

**Registered Midwife 1997**



**Figure 7.1 Janet on her first day as an RN**

I initially knew of Janet without having met her. As there is not an overwhelmingly big Aboriginal registered nurse population I had been told about Janet by my family in Rockhampton as she had worked with my Aunty at the Aboriginal Medical Service there. At this stage of my PhD journey I was still intending to be the 1980s participant, but I felt uncomfortable with the idea of trying to tell my own story in a way that was robust and academically sound. I eventually had a phone conversation with Janet introducing myself and also outlining what I was doing with my PhD.

Janet is the only participant of this research that was not a part of the *I'm a Nurse* Documentary. I finally met Janet in 2008 when I went to interview her.

Talking to Janet was comfortable and relaxing. What made this process easier was the fact that Janet had lived in Rockhampton for many years and knew my birth family well. The rapport was immediate and Janet agreed to be included in this research. Janet's story has a remarkably different feel to it than the rest. Interviewing her I was struck by her natural storytelling ability. The difference is also possibly due to not having known her as I did the other participants.

Janet is a woman of *Badtjala* descent. Janet's nation is included on the Horton map (Figure 7.2, next page).

Arguably the 1980s was when the biggest single change to nursing education occurred; the transfer of hospital based nursing education to tertiary based education. Whilst there had been post-registration courses run at the Queensland Institute of Technology (now QUT) in 1978, it wasn't until 1982 that QUT offered an undergraduate nursing course (Gregory 2009). This is considered a unique time within nursing education as the hospital trained certificate qualification was still being offered as was the new tertiary degree qualification. This also meant that at times on the wards throughout Queensland there were both hospital based and tertiary student nurses working. 'In 1984, the Commonwealth government encouraged state public hospital systems to transfer all basic nursing courses to colleges of Advanced Education and to standardise curricula across the nation' (Gregory 2009, p. 9). In 1984 the Commonwealth Task Force on Aboriginal Health Statistics was also established (HealthInfoNet 2008). Prior to this, very random statistics were collected on Australian Indigenous peoples.



Figure 7.2 Horton Map of Aboriginal Australia

(The author has outlined the *Badtjala* Nation in black)

The 1980s also saw major developments in the number of community-controlled Indigenous services being established across the country including within Queensland. The Indigenous derived framework established in the 1970s was growing stronger every year since its inception and Aboriginal and Islander Medical Services were established across the state of Queensland. At this time the Brisbane health service was well established and had thoroughly entered the Federal Government funding rounds to enable continuation of the service. The conservative Bjelke-Petersen government was in power, so the service did not receive much state government support. Nonetheless, the health service grew in size and expanded the programs delivered to the community such as sexual health programs.

It was at this time that Janet entered her nursing training. *I was in my last year of high school at Rockhampton State High in 1982. I knew I wanted to get into some sort of field where I would be around people, whether they be young or old, or caring for people, so I actually applied for both nursing and teaching and got accepted for both, but decided to take a year off and I chose to commence my nurses training in January at Rockhampton Base Hospital in 1984. So it wasn't a strong realisation to become a nurse. I wanted to stay in Rockhampton with my family, so that's the reason why I chose nursing. Back in those days it was just a simple form to fill out and you posted it in. I handed it in to the nursing administration office at the hospital and I had an interview with Miss Norma West. I was this timid little shy thing when I rocked into her office and I actually thought I probably wasn't going to get in. I thought I wasn't outgoing enough but I obviously did alright because I got a letter a few weeks later saying I'd been accepted.*

Whilst living in was no longer mandatory, for many nurses this was still a

viable option. Janet chose to live in and some still strong friendships began. Janet looks back on this time fondly. *I remember moving into the nurses' quarters on the Sunday and we unpacked and I remember being up on the 8<sup>th</sup> floor and we were all going crazy, but I was still quite shy. I did feel a little bit out of it as I was the only Murri one. We'd already got our uniforms prior to that so you had the uniform ready to go and we had to wear caps, what a nightmare. So we had to have the right amount of bobby pins and I remember everyone looking at each other's head going have you got your cap on the right way.*

*We were called PNCs (preliminary nursing course) and we ended up walking down the hill together to our first day of lectures. I remember feeling excited and overwhelmed, there were about 31 of us and one bloke. The end of the first day I felt really good. It was a funny sort of feeling, I actually felt, that I'd really made the right decision. Funnily enough, all groups were colour coded in those days, and our group was the black group. We were known as the black group and I think everyone was thinking "shit I hope they don't think that was directed at her" because there was the purple group, the gold group, the silver group. But yep, the 1984 January intake was the black group.*

Janet went through her first year without academic incident and was relieved to have made it through. *I look back over that first year and it was full of highs and lows. We had our six weeks PNC course and that was great. I don't think you really grasped the enormity of nursing until you were put into the roster system and you hit the floor running. What I really remember about those early days was that in that six weeks we did get a pay packet. It was a little white envelope with actual cash in it*



*with a little white pay slip and it was a hundred and something dollars, but it was so exciting to open it up and see your cash in there.*



**Figure 7.3 PNC class photo**

**(Janet is in the 2nd row, 3rd from right)**

As with all the participants of this research, support for Janet was instrumental in being able to succeed. *I did feel supported in my training and especially by one nurse educator and it was Sister Makin. She was really tough and expected very high standards and you were always afraid if you were going to pass, because she just wouldn't pass you, you had to have really high standards. She'd tell you "no Janet do it this way". So I enjoyed having her because I wanted to do well*

*and I actually always felt from the outset, being the only Murri nurse that I did have to prove myself a little bit more. I think it's a feeling of acceptance. You don't want to be known as the one who is the dodo of the group or the dummy and you know everyone is looking at you anyway because you're black and I was this little black skinny thing. I started in January and I looked in stark contrast to everyone else with my little white cap on. They were all blonde and brown haired and white skinned so I did really stick out.*

*My first rotation after PNC was in the geriatric ward. Now you can imagine Rocky at the end of January and February. There was no air-conditioning in those days and it was tough. You worked hard and when you're a first year you got the shit jobs. I was ready to quit actually in that first few weeks in the geriatric ward and the only thing that kept me going was I knew I was going to go to the orthopaedic ward. That first year was full of highs where you just think you're Super Nurse and you can take on the world and then the other end of the spectrum you were sobbing in your bed at night thinking I just can't get up that early in the morning. Don't make me go. Don't make me go.*

It was also at this time that, as Gregory outlines:

Patient care in the wards changed in the 70's and 80's. The old Nightingale wards with beds ranged around the walls of large rectangle spaces were being replaced by smaller, more private six or eight bed rooms. Sophisticated nursing stations increasingly became a feature of ward and unit design; and team nursing and patient care plans replaced functional nursing. (Gregory 2009, p. 10)

Although self-determination had become the new overarching 'policy' for the administration of Indigenous peoples in the 1970s, change in Queensland occurred slowly. In the continued push for self-determination for Indigenous communities

significant and fundamental changes occurred in 1982 for the many Indigenous communities across Queensland still living on reserves and missions. At this time Queensland established a system of community level land trusts, called Deeds of Grants in Trust (DOGIT), to own and administer former reserves. These trust areas became local government areas managed by Aboriginal Coordinating Councils and Island Coordinating Councils (See Aborigines and Torres Strait Islanders (Land Holding) Act 1985 (Qld) at <<http://foundingdocs.gov.au/item-sdid-55.html>> (accessed 22/9/2009).

Whilst the demise of administering Indigenous peoples on missions across Queensland was seen as moving forward, there was still the legacy of mission life with Indigenous peoples having generations of their children born on missions and not on their own country. Insurmountable levels of damage had been imposed on Indigenous peoples in these places. Decades of racist policy and neglect left its mark. On many of the reserves and missions, health was appalling, unemployment rife and education limited. Whilst creating DOGIT communities was seen as a positive step in self-determination there was a lot of damage that occurred that still to this day has not been fully acknowledged.

As Janet entered her second year of nursing in 1985, the Canberra based Australian Institute of Health (AIH) was established within the commonwealth Department of Health. It was given the commonwealth responsibility for the development of Indigenous health statistics (HealthInfoNet 2008. *Major developments in national Indigenous health policy since 1967*). Also at this time in 1985, NAIHO (the national peak body of the Aboriginal Medical Services) established its own secretariat with an office in Melbourne, and accepted government

funds for the first time, having previously relied entirely on donated monies (viewed 30 June 2010) <[www.naccho.org.au](http://www.naccho.org.au)>.

Janet had found her groove and whilst it was tough going and hard work she flourished in the remainder of her training; but it was not without both academic incident and facing racism as a nurse. *I can picture this as clear as day during my nursing training every ward you go to you got a report at the end of the ward, on how you went. You had an interview with the Nurse Manager of the unit and I worked in the private unit and at the end of my rotation there she went through my report. She said "Janet, there were a couple of complaints about your nursing style here but you know what, I ignored them because I felt they were actually racist. I didn't like the manner in which they were presented and I'm not putting it into your report because I felt these patients were extremely racist towards you. I have seen your work in action and I have spoken to your senior nurses." I distinctly remember the patient who she was talking about. I knew that feeling from the moment I walked in the room to look after him that he was not going to like me no matter what, but you know what, I never said don't put me with that patient. I think sometimes you get more with honey than you do with lemon and I did know who she was talking about and I said to her "Yes I think he was racist but it didn't worry me". I never complained about it. I never said anything because I thought I don't have a problem he's got the problem. I thought I'm a nurse and I deserve to be here and I'll give the best care no matter if you're racist or not. I do remember that. The racism really stuck out in that first two years of my training.*

For Janet this was not to be her only experience of racism. Janet clearly articulates several experiences, not only from patients but also other nurses. *I had*

*racism that was directed at an Aboriginal patient and it was from my colleagues and they would say things like "Oh he's just a drunk black". These comments weren't only said in front of me. Other girls in my groups would say "Janet, they're really racist those older nurses". I also think at times some staff, mostly RNs, were very careful when I walked into a room. But you know, when you're a young Murri woman and you're listening to a report and you can hear the undercurrents of it all, if you can look them dead in the eye when they start to falter and splurt and not quite finish what they've got to say, you know you're making them realise what they're saying.*

What got Janet through these times was the incredible support from some of the staff. *In my training that first three years I always had support. There was a couple in particular who just got me through even when I stuffed up. Ashley Reid was one of the Nurse Educators and she really supported me in those three years as did Meg Wilson who was the head of the nursing program. I would not have made it through without Meg and Ashley and Jane Makim. All these wonderful non Indigenous nurses seeing my potential and wanting and supporting me to succeed. I'm going to start crying if I talk about it. God, I didn't think I was going to do this. I failed my eighteen month exam. I remember this because I wanted to quit. It was my own fault. I had been partying and Jane just kicked me up the butt and said "You will study. You will re-sit and you are going to pass" and she believed in me.*

On the last day of her training Janet was full of differing emotions. The three years of her training had been monumental in shaping who she was and was full of one-of-a-kind experiences that Janet considered her rites of passage. *By the end of my training I'd turned 21, I'd lost the first love of my life, I'd experienced death, I'd*

*experienced heartache, joy and grief. I was really sad to leave that group of girls and Pete because we were an extremely close group. I was looking forward though because I had applied for jobs in Brisbane and I just wanted to leave Rockhampton and get on with my career, good things had to come to an end and I was so proud of myself. Really proud for achieving something and my family was so proud. I felt this sense of pride from my family but also a sense of (gasp) “I’ve got to get out and find my first job”.*



**Figure 7.4 Janet on her graduation day**

As Janet had finished her training in the 1980s she saw a very noticeable shift in nursing care. As Gregory outlines ‘there was no room in expensive acute care wards for the aged and chronically ill. A new era of care in the home and in nursing homes re-emphasised the role of domiciliary nursing services and geriatric care’

(Gregory 2009, p. 10). It was in this new era of nursing that Janet secured her first job as a registered nurse. *I moved to Brisbane in 1987 and worked for a nursing agency and I was doing palliative care in the home, which I'd never done before and I was also working at the Greek Nursing Home in West End. I had applied to the Princess Alexandra Hospital for the RN Graduate Program. I got accepted and I went to work in M8, which is the infectious diseases unit. I was there for 12 months doing my graduate year and that finished in January 1988. I was actually admittedly very nervous starting there but I always felt so supported. I've always managed to find someone who has been like a mentor or really good support so I felt nurtured.*

It was at this time that Janet made a move into Indigenous health. Janet did not go into working at an Aboriginal Medical Service initially but chose to go to a community which was overwhelmingly Indigenous. *After I finished my Graduate Program I wanted to go up to the top end of Australia and so I rang Thursday Island Hospital. I started there in April 1988. I had never been to Cairns and had never seen a lot of Torres Strait Island people. So that was new and they are completely different to us. I landed on Horn Island and then went across to Thursday Island and found my new room at the nurses' quarters. So I worked on Thursday Island for a few short months then went to Bamaga for six months and then back again to Thursday Island. My favourite place I have to say was working at Bamaga hospital, without a doubt it is one of my most favourite places I've ever worked. It holds a really special memory.*

*Bamaga is a mixture of Aboriginal and Islander people and they were taken from Mapoon which is on the western side of the peninsula [in Queensland] and brought up to live on that area. There are five communities and I was sort of adopted*

*by one of the local Aboriginal families. When I first walked in there I used to say yeah I'm a blackfella, I'm a Murri, I'm a Butchela girl. But then I walked in there and they said oh you're a half caste girl....(laughter). But you know, they still really loved me and you think shit I've never been called that and it's my own people calling me that. I tell you what though, it was just really funny and you think I'm black, I'm black, I AM black!*

*I look back at Bamaga because I think that's where I really grew up as a nurse. I'd been in hospital systems and I'd been to Thursday Island but when I went to Bamaga, you're in charge with one enrolled nurse or one AIN and I tell you what you really had to know your stuff. I remember this as clear as day. I had the orientation that week and then come Saturday the doctor was being farewelled from the community. So here I am Saturday doing the late shift, because obviously they were all at the party and it was football season wasn't it and then the paddy wagon rocked up. Six of the biggest football blokes hop out and I must have been all of 58kg. The biggest blokes rock out of the back of the paddy wagon, slashes, arms in slings and I just thought I'd never done any of this before. I mean I had basically but I was there coordinating it and I actually had to do first aid and I had to learn to suture and everything and I really grew up. I became more confident although I was shit scared learning to suture, learning to talk to RFDS, learning to communicate with doctors. My skills really accelerated there.*

*During my training, the head of ICU at Rockhampton Base said to me "Janet you've got a real thing with ICU" and I thought I might do it eventually. So I thought OK I'm going to go and work in ICU for twelve months at Royal Brisbane. Just one of the busiest in Queensland! It was such a good unit and good male nurses that just*



*took you under their wing. So I was really lucky in that respect. I just flourished and enjoyed it and I was there for twelve months. I then went to Ayr District Hospital. I was only going for six weeks but ended up staying for eight months and I lived in the nurses' quarters. It was a bit of a wild time in my life I must admit. Country towns are so much fun. You had a core group of friends, cane fields, harvesting, drinking in the local pubs, playing pool, tequila shots, it all comes back to me now.*

*I then decided I was going to work in LA [Los Angeles] and I left Ayr and worked in LA for six months and I didn't like it. I was very, very unhappy there and I quickly left and came back to Australia. I came back and applied for a job at St. Andrew's in Rockhampton. It was whilst I was at St. Andrew's that I decided I was going to go and work in Saudi Arabia, didn't I? So I started the process for Saudi Arabia while I was working on night duty.*

*It was at St Andrew's that I looked after predominately white middle class private health insured patients. Working in that hospital was interesting, because they didn't expect a Murri nurse to be working there and they'd often say "it's amazing to see one of your people here" and I'd go "what a really gorgeous, young, sexy woman working in here" and they'd start laughing. I knew exactly what they meant. I got a lot of comments working there for that two years, but I also knew I was a really good nurse. I gave good nursing care and enjoyed working there. My Mum was a cleaner there funnily enough. So she was really proud to have me working there. She's still working there to this day. I used to do night duty. Can you imagine me coming on to night duty and going "hello I'm Janet, I'm your nurse for the night". I'd often get mistaken for the cleaner too. Some people would go "can you clean my..." and I'd say "excuse me but I'm not the cleaner I'm actually the*

*registered nurse and yes, I'm in charge tonight". I don't know though, I'd never get offended, it's because I don't get offended by people's judgements, because if that's all they've known, then you're re-educating them, you're saying "hey I can be a nurse". I always thought to myself don't you want to change people's views of Aboriginal people by being the best you can be, not being angry and uptight. The more you present yourself as being professional, articulate, smart and funny the more people are drawn towards a person like that rather than a person who says "oh well I'm not looking after you today because I don't like your attitude". So I've always tried to live that in both my personal and my work life.*

*The impact of racism was also there at St. Andrew's. I guess too I was only young in those days and I just had a sense of it. Probably these days I would say something differently. The supervisor in charge one night said whilst giving a report that there's a bunch of Abo's outside making a racket and I looked at her and said "excuse me Louise what did you just say?" She said "ah there's a bunch of Abo's...". I said "No no no why are you referring to them in that way Louise?" She said "I don't mean you Janet". I said "Yes, you do mean me, that's my mob. I find that highly offensive", but I was very calm. I didn't lose my temper and then later on she actually came and apologised to me and I said "You know Louise, you've got to be careful about what you say and where you say it in a group of people". Also several of the nurses went up to her later and said "I found that offensive what you said to Janet and I don't like the way you spoke". She was my supervisor and I highly respected her and thought she was a good clinician but I was just amazed because she had never spoken like that before. I was really hurt by her and I lost respect for her that night*

*It wasn't long after that incident that I remember working with different people at Royal Brisbane saying "yeah go to Saudi" and "I had a friend go to Saudi". So I did that long application and the process, was quite a long process because all the blood tests. There were lots of formalities and interviews and processes and health checks. You had to be tested for HIV and show you were free of HIV to enter that country and yeah I then took off to Tabuk. I'm a pretty strong person in myself but I tell you that's very testing as a young woman, going into a Muslim country, never having been around Muslim people and you stick out because you're told to dress to cover all your body but most people are wearing the black abaya. They dropped me at the airport the next morning and I just had to find my way onto the plane and very, very strong men in that country but I eventually got onto the plane and went west to Tabuk. It's like going from Brisbane to Perth and its three hours west of the red sea. So I rocked into Saudi Arabia didn't I, into Tabuk into 40 degree heat and it's a really dry heat.*

*I could write a book about my experiences in Saudi. I spent two years in Saudi working in the ICU. First though I ended up in a medical ward and Allah I hated it and I kept thinking I don't like this ward. They then had a shortage in ICU and they asked me if I'd like to go and work in the ICU and I said yes. So I worked in the ICU for two years and what an incredible experience that was. I hate to say this but I broke every rule in the first week, as you do in a Muslim country but you shouldn't be. I would describe it as a den of iniquity. There were just all sorts of things going on. It was really interesting. I worked with people from all over the world. Quite a few Aussie boys worked in the ICU and they were fantastic ICU nurses.*



**Figure 7.5 Janet in Saudi Arabia with a group of nursing friends**

**(Janet is 2<sup>nd</sup> on left)**

*After two years there I came back to Australia and had a break in 1996 to have my son. I had him at the hospital where I was born and my Mum was born, at the Royal Brisbane. It was the first extended break I had from nursing. But when he was a little fellow I ended up doing tutoring for health workers in Rocky, and I did that for a short while and I really loved that. So then I decided to apply for midwifery. So I went through the interview process again and it was quite a tough interview. This was the second last group of hospital trained midwives, and they had like a thousand applicants for 12 positions.*

*It was extremely competitive so I was teetering and believe it or not I was really hoping I could play the “black card” and I probably did, I probably played it. I said “look there’s not enough Aboriginal midwives. I think you really need to have me” but I did it in a nice gentle way that said I’d really love to go back to my community or work in areas and have this behind me. All my friends kept saying you’re going to get in, you’re going to get in and I did, April 1997 at Redcliffe Hospital.*

*I had magnificent family support around me. So off I trudge again to do the shift work thing and the study. Once again I so enjoyed my training. I loved it. It was a passion and all I had to do was get 65% and above which I did. Can you imagine once again me being the only Murri nurse on the labour wards?*



**Figure 7.6 Janet on her first day of midwifery training**

*But you know when I went to my midwifery training I actually felt so completely peaceful with women in labour, it didn't frighten me. I think because I had been through my own birth and seen it but it was a hard year. Passing and doing assignments and studying and shift work and I had a little baby. My parents were instrumental because when I had big exams coming up and they were quite tough exams, he would go to them for a couple of weeks and then come back to me. On completing my midwifery I went straight from there back home for a few months and I then worked in Mackay Base Hospital for two years. I must admit when I walked in as a graduated midwife I kept thinking shit Janet your first delivery better go off really well. It was on a birth stool on the floor and I kept thinking don't drop the*

*baby whatever you do because then your reputation will be 'don't go to Mackay Base because there's this black nurse up there and she doesn't know what she's doing, she drops babies!' (laughter).*

*I came back to Rocky to be near my parents and ended up staying for a couple of months deciding what to do. I knew at Rockhampton Base you got a predominately high turnover of Aboriginal patients from Woorabinda and the township itself. It services the community and they didn't have much going but I did some casual shifts and once again I worked with some really lovely people. I thought this seems a really good environment and then they offered me permanent part time work and I was just drawn to the fact that yes a high number of your clients are Aboriginal and South Sea and Torres Strait.*

*I'd been there for a while and the manager of Aboriginal and Islander Health Services who was a friend of Dad's had heard I was back in town and came hunting me and said I want you to come and work for us. I ended up being casual then getting some contracts and then I got permanent work there and I actually ended up being the Midwifery Coordinator for the Ngua Gundi Program, which is the Mother and Child Program. I worked there for four years and then I found love and ended up moving to Murwillumbah. For the last couple of years I've just been doing casual work.*

*When I was in Rocky for that six years, I had a tough time but I also really enjoyed my years working at Aboriginal and Islander Health Service. I never thought about going to work with Aboriginal and Islander Health Services. I didn't realise it was under the umbrella of Community Health. I probably thought about it in the back of my mind but I was sort of entrenched in the hospital system. However, I think*

*about it differently now. I know I was being drawn to it. I don't know, I think there's a joy in looking after your own people and also the expectation too I think initially. Are you as good as the white nurses? Do you know as much as the white nurses? You feel a little bit of trepidation there. I've always been conscious of the fact that I've really got to prove myself from day one and you do carry a sense of something on your shoulders to prove. But when you know you've got the skills and ability it just flows. I do feel like with hospital training I was well prepared. To go into Community Health was amazing to bring cultural skill to my work. I think you bring the skill too that you do understand your own people.*

*You nurse from a different perspective because you've got that history. It's entrenched in your DNA. It's in your cell memory. My Dad grew up in a mission for a short time as did my grandparents. When you read back through the paperwork you realise it's in your DNA. So you understand when you see someone who's drunk in a park. They're not just drunk in a park. There's hurt lying there and I take it with a sense of gee whiz the paths my ancestors have trodden for me to be where I am. I think we're part of a collective family, especially in Central Queensland, you do feel a sense of understanding without even words being spoken.*

*When you see an old Murri lady with a black face and white hair and she's diabetic, when you touch and connect with her it's different to touching a Greek person. When you touch your own people you're transferring something that's history, that's tangible, that's living, and that's through the ages. That's how I would describe it. When you touch them you're going back into your own history. You don't go back into Greek history. I'm not Greek. You know my history is this woman sitting here, it's innate. It's so innate that you actually don't have to unpack it to actually*

*work out how you do it. And automatically you're transferring history between the two. You don't have to say anything, it's the look in the eye, it's the touch.*

*There's something about your old grandmother, your old auntie or uncle. The living breathing history and you wouldn't be here if it wasn't for the path that they've gone down. All our history and the nurses that are going to come after us they can hopefully look back and see the path we've trodden and the linkage is still going. I'm hoping that we can get more Murriss into nursing. I hope we can encourage more Murriss into nursing. Look if I can come through the 80's and do this and we can think about all our aunties who have come through the decades. Gee when I think about my training and when you meet them old girls and think oh shit, I didn't have it half as bad as them did I? I was lucky I had a lot of beautiful white women supporting me. I think it's time now that more of us get through.*



## Chapter 8: Raelene Ward

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*Kunja/Kamilaroi Nations*

**Enrolled Nurse 1990–1991**

**Registered Nurse 1992–1996**

**Masters of Health 2007–2010**



**Figure 8.1 Raelene on graduation day**

I met Raelene in 2002 in Toowoomba. At the time Raelene was working for Goodnir Aboriginal Medical Service as a Registered Nurse. I was struck by Raelene's passion for working within the Aboriginal community and her commitment to facilitating the process of articulating Aboriginal health workers into registered or enrolled nurses. At this time Goondir had several clinics. The Head Office was based in Dalby and Raelene was the Practice Manager based at the Toowoomba satellite clinic of Goondir.

When the *I'm a Nurse* documentary was being conceived it was obvious that the 1990s vignette was to be Raelene. I had discussions with Raelene about the documentary and Raelene accepted my proposal as to her involvement representing the 1990s as the decade that she undertook both nursing qualifications. Raelene is the only participant of this research that has transcended from hospital based to tertiary based in gaining firstly, an enrolled nurse qualification then a registered nurse qualification. Here is Raelene's story.

Raelene is a *Kunja* descendent through her mother's bloodline and is a *Kamilaroi* descendent through her father's bloodline. Raelene was born in Brisbane and grew up in Cunnamulla on her mother's country. Until recently Raelene's parents lived on her mother's country in Cunnamulla. Figure 8.2 (next page) is a section of the Horton Map of Aboriginal Australia which identifies the boundaries of both the *Kunja* and *Kamilaroi* nations.

Raelene realised *when I was in grade 10, living in Cunnamulla that I wanted to become a nurse. When I was 15, we had to do work experience, I did some time at the hospital in Cunnamulla, as part of that, I think that sort of opened it up and started the ball rolling. After that we had those work experience people at schools that talk to you about what you want to do, and I initially wanted to be a nurse with the Navy. I wasn't going to go on and do grade 11 and 12. I was going to leave at the end of grade 10 and go into the Navy and be a nurse that way. I think I liked the fact that you could go away and travel to different places and it was an experience in your training while you were there. Mum and I had a talk about doing grade 11 and 12 and that's when Mum had sourced a boarding school for my sisters and I to go to.*



*Well, I did 11 and 12, at St. Hilda's Boarding School at Southport. A lot of us were trying to find a career, and I still had wanted to be a nurse but when I was at boarding school I never achieved the score high enough to get into uni, but I was determined to take that path, and get there however I could.*

*After I finished school, I went home to Cunnamulla. I worked at home in a public bar, just to get some money together. Then I moved from Cunnamulla to Goondiwindi, because I didn't have a career or a full time job. I moved there knowing no one and I did cotton chipping and stick picking for a good twelve months to earn a living and then I'd met this fellow. He and I became partners and his mother was the Director of Nursing (DON) at the local hospital. I still showed my interest in nursing and part of the recruitment there locally was to put in an application and be considered to do your enrolled nursing through Goondiwindi hospital. That was 1990. I copped some flack I suppose getting into the course it was who I knew. That entry was easy for me but I did find that there were a lot of people saying that you only got in because of your relationship with the DON, but that didn't bother me. I just kept going. I finished my enrolled nursing in 1991.*

*Raelene's gaining her enrolled nurses qualification was not without incident. Obviously when I first started my enrolled nursing, I don't recall [racism] but my friend did, and I assumed that was from other nurses. It wasn't ever directed straight at me, and I think, because of the person that I am, they wouldn't dare do it. It wasn't until a couple of years ago now, that this friend and I who had gone through together had said to me, because she'd watched the documentary of us on Message Stick, called I'm a Nurse. We were just talking about the experiences. Anyway, she had said to me, and I didn't recall anyone saying it, but she remembers people saying*

*“oh, she'll never get through. She'll only complete some part and then go”.*

*From her recollection it was because I was Aboriginal. Moving from Cunnamulla to Goondiwindi, family kept reinforcing to me, “oh don't go to Goondiwindi, it's a very racist town” and because Boggabilla wasn't far away, it was just over the bridge from Goondiwindi, there was a lot of racism and animosity between people over the border and those that lived in town. There was a lot of that but I just didn't let anything affect my career.*

*I worked as an enrolled nurse right up till I actually graduated from my Bachelor of Nursing (1996). I enrolled myself into the Australian Catholic University in Brisbane in 1992 and that process was quite good. They had an Indigenous unit there called Weemala and having that unit there and other Indigenous people, made the process comfortable. They [Weemala] did some kind of a get together before with all the Indigenous students. I didn't feel like I even experienced a lot of university with the mainstream nursing students because we're our own network you know [Indigenous students], but we still went to lectures and tutes with everyone else. I had family that lived at Mitchelton so I boarded with an auntie of mine, so that was only walking distance from her place to the uni so that helped me. At that time in my life, confidence wasn't a big thing. It grew though once I became more regular there and did what was required and my results were quite good, I was passing, that's all that mattered to me I completed two years there.*

Raelene wanted to move closer to family in 1993. At this time her partner and soon to be husband was still living in Goondiwindi and her family still living on country in Cunnamulla. Raelene lodged the appropriate paperwork to transfer her nursing degree to the University of Southern Queensland, Toowoomba.

*I transferred to USQ in 94. Because I had actually done two years I tried to get a lot of what I already had done in credits, so that I would only have to do a year. I ended up having to do two years at USQ which turned into three years due to failing a couple of subjects. Through my uni process I had to re-educate myself, particularly with calculations, how to divide, and where the decimal point went. I liked doing assignments and essays and when I did get results back, you do have that feeling of yeah, I can do this and when I did fail a subject or didn't get a pass mark, it was very disheartening and my self-esteem went right down, but I always said to myself if I don't do well in something, I'll give it another go and that's how it was for me at uni. So I started at USQ in 1994 and completed at the end of 1996.*

Raelene entered nursing at the University of Southern Queensland whilst it was in its infancy as a degree program. It was an exciting time for the nursing profession due to the transition from hospital based (the apprenticeship system) to a Tertiary based degree program. The University of Southern Queensland, as it is now known had gone through major changes from its humble beginnings in 1967 when it commenced as the Queensland Institute of Technology (Darling Downs). In 1971 it was known as the Darling Downs Institute of Advanced Education and remained with this name until 1990. In 1990 it morphed into The University College of Southern Queensland and it was under this name that tertiary based Nursing programs began (University of Southern Queensland 2009). At this time Kathleen Fahy was appointed Head of the Nursing Program and the Diploma of Applied Science (Nursing) commenced at UCSQ in February 1990 with 165 full-time students (Nursing Newsletter from the Nursing Programme of the University College of Southern Queensland Edition 1). However, before the Diploma commenced it

became a Bachelor of Nursing and the first graduands were in late 1992. USCQ was renamed one last time in 1992 to become the University of Southern Queensland. This transition was one of extremes and required dedicated and 'thick skinned' nursing academics. Associate Professor Roslyn Reilly remembers of this time that 'we were very passionate about nurse education being a tertiary education' (2010, pers. comm., 20 May). Arguably the transition from hospital to tertiary sector education is one of the largest and most fundamental changes to occur in nursing history.

According to Professor Reilly, not only did this have an impact on the students wanting to become nurses but also there was an impact on the Nurse Educators, many of whom had come out of hospital trained Nurse Educator backgrounds (Reilly, R 2010, pers. comm., 20 May). The other impact she identified was on the greater public who for many decades had an understanding that nurses were trained in hospitals. This was not an easy transition for all concerned and as part of the support required for these students the Nursing Program was running debriefing sessions for the students. Professor Reilly further outlined that the students needed the support to manage comments from the public aimed at them around nursing now being in the tertiary sector. Comments such as 'people don't have to be clever to be a nurse so why are you going to uni', or 'why do you have to go to Uni these days to learn to wipe bums?' (Reilly, R 2010, pers. comm., 20 May). Professor Reilly believes that this level of support and debriefing for the students was '*unique to this era*'.

Prior to nursing commencing at USQ the Institute of Aboriginal Studies had been established in 1986 at the Darling Downs Institute of Advanced Education.

According to Associate Professor John Williams-Mozley, it too went through a series of name changes and was briefly re-named the Office of Aboriginal and Torres Strait Islander Education in 1990 and was subsequently re-named Kumbari Ngurpai/Lag Indigenous Higher Education Centre in 1991 (Williams-Mozley, J 2010, pers. comm., 20 May). A dedicated space had been established for Indigenous students to access whilst pursuing academic goals.

This was the milieu that Raelene entered to undertake her Bachelor of Nursing Program in 1994. Raelene was in the fifth intake of nursing students at USQ and there had been two graduating classes before her (1992/1993).

Raelene progressed throughout her first year without academic incident but like many of the participants of this research experienced racism. *One incident I recall within my tertiary education was in this lecture room and there was a panel of people... they were indigenous people, coming in to talk about their experiences and I remember one person, clearly non-Indigenous asking the question around funding. Abstudy/Austudy that sort of questioning and why were Aboriginal people getting Abstudy. It's always been about what we get versus what they get and I think that's what I've come across quite a lot in my time. So when I hear stuff like that, I just want to go up there and tell them how it is. I want to educate them.*

In December 1994 as Raelene was enjoying the end of her first year at the USQ and working as an enrolled nurse there was the release of the *Evaluation of the National Aboriginal Health Strategy* (NAHS) in December. The Evaluation of the NAHS was brutal and was damning in articulating the lack of support in its implementation. The Executive Summary stated:

The Committee established to evaluate the National Aboriginal Health Strategy found little evidence of it. Instead, the Committee found only traces



where the strategy had been – small amounts of money (compared with the need) spent on housing and health services.

It found minimal gains in the appalling state of Aboriginal health. Following consultations with Aboriginal and Torres Strait Islander peoples, much discussion, and reviewing the available information, the Committee calls upon governments and people of Australia to make a renewed commitment to Aboriginal health and fund bold, well managed community owned programs. (The National Aboriginal Health Strategy and Evaluation, Executive Summary 1994)

Raelene returned to her degree in the following year as debate raged amongst the Aboriginal community-controlled sector and many Aboriginal communities about another lack lustre report that had failed in its lack of implementation. Raelene continued her studies and completed her nursing degree in 1996. On completion of her degree Raelene had a smooth transition into the workforce as a Registered Nurse.



**Figure 8.3 Raelene's BN Graduation 1997**

*I felt my previous nursing experience as an EN gave me enough knowledge and experience and confidence to be able to work in the workforce as a registered nurse. It wasn't that hard to deal with because I'd been working as an EN at the hospitals locally right up until I finished, so I already had a rapport with mainstream services. They knew that I was studying and once I became an RN the opportunity was there. So I took that.*

*My first official job as an RN was with the Baillie Henderson Health Service in 1997 and I stayed for two years. So I'd been working for them as an EN and when I became a registered nurse they were looking for nurses in mental health. I thoroughly enjoyed my time there. I didn't think I'd ever work in mental health but I found the base hospital environment was very routine-ish and same thing every day and I ended up working in mental health because there was a lot more variety. You did a lot more activities with people and outings like taking them to work, driving the bus and I liked that local community stuff. Having worked there sort of brought me into the Aboriginal Community Control Health Sector which is where I wanted to be long term, Aboriginal community-controlled health. For Raelene, from the very first time that I wanted to become a nurse, I always wanted to focus on Aboriginal Health and working with Aboriginal people, people that I know and can relate to on a lot of levels. That's what made me strive to be where I am today.*

At this time the national agenda around Indigenous Nurses was also gaining momentum.

The National Forum for Development of Strategies to Increase the Numbers of Aboriginal and Torres Strait Islander Peoples in Nursing, held in August 1997, funded by the Office of Aboriginal and Torres Strait Islander Health Services was an

historic event. The first meeting made a number of recommendations with implications for the public and private sectors, the higher education sector and primary, secondary and tertiary health delivery mechanisms. The Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) was founded to formally represent Indigenous nurses, with a commitment to the implementation of the recommendations. A second meeting in August 1998 augmented the original recommendations and sought to shape an organisation of relevance to the nursing profession and to Indigenous nurses (viewed 20 May 2010 <<http://www.indiginet.com.au/catsin/history.html>>

*At Baillie Henderson I'd worked with a nurse that was already based at Goondir Aboriginal Health Service in Toowoomba (AMS), and she was leaving the place and she'd rung me and said there's a job down here as a registered nurse with Goondir Health and would you like to put in an application. I jumped at the opportunity, went for the interview out at Dalby, because that's the Head Office. That was 2000 and I was at Goondir until 2005. When I went to Goondir initially, the position was as a registered nurse, so it was general nursing. A lot of basic nursing but then as time went on there was a need to have myself up-skilled as an Endorsed Nurse Immuniser, so I put myself through that training.*

*When I first went to Goondir there wasn't a lot of Murri people coming there. I felt very fortunate to be where I was and I was quite passionate about getting the service known out there and getting more people in because funding was based on how many people we got through the centre. I think myself and other team members, over the years, promoted it quite effectively and it became a good service and we got quite busy there. I then went into a Practice Management role in 2002. I came into*

*that role by undertaking an external course that I was interested in which was a Certificate 4 in Practice Management through Armidale University which I did externally over two years. When I first started at Goondir, there were only four staff plus we had a GP full time and a GP part time. As the place became better known and busier, we needed more staff to service the community. So by the time I went into the Practice Manager's role, we had seven or eight staff and there was a need to manage staff as well as coordinate the delivery of services.*

Within this role Raelene commenced working with the Queensland Aboriginal & Islander Health Forum (QAIHF) and began her immersion into working within Aboriginal health.

QAIHF was established in 1990 and reconstituted in 2004 as the Queensland Aboriginal & Islander Health Council (QAIHC). QAIHC is the state peak body representing the Community Controlled Health Sector in Queensland at both a state and national level. Its membership comprises 21 Community Controlled Health Services (CCHS) located throughout Queensland. Coordination at a state level is achieved through the Queensland Aboriginal & Islander Health Partnership established under the Queensland Agreement on Aboriginal and Torres Strait Islander Health. The Partnership is made up of senior representatives from QAIHC, Queensland Health and the Australian Department of Health and Ageing. Nationally, QAIHC represents the Community Controlled Health Sector through its affiliation and membership on the board of the National Aboriginal Community Controlled Health Organisation (NACCHO) (viewed 20 May 2010, <<http://www.qaihc.com.au>>).

Raelene had finally made the move into working within the Aboriginal health arena. As the Practice Manager of the Goondir clinic in Toowoomba Raelene's role was diverse and exciting. Raelene within this role was passionate. *She was sitting on the Workforce Committee which looked at up-skilling Aboriginal health workers and that was an area I wanted staff to excel in, up-skilling health workers to become nurses.* At this time Goondir was very proactive in its articulation pathway for its health workers. To date Goondir has supported and encouraged five of its former health workers to become registered nurses. All five are USQ graduands.

*I left Goondir in 2005. I then came to work for Queensland Health, setting up Regional Health Forums across four Districts. Again that was working with QHAIC. So I had knowledge and experience with QHAIC and their committees, and also was proactively involved in the Goondir service operationally and the delivery of services. I also had that practice management role behind me. I got into a project coordinator's role. Having those skills allowed me to coordinate Regional Health Forums across four Districts. They were the Toowoomba District Health Service, the South Burnett Health Service, the Dalby District Health Service as well as the Goondiwindi/Warwick District Health Service. So my role was to coordinate Regional Health Forums in the southwest. The people that sat on the Regional Health Forums were Chief Executive Officers (CEOs) from community controlled health organisations (the AMS), QHAIC representatives and myself as the Queensland Health representative. The process was to inform funding bodies and policy makers around what money should be allocated locally, in communities where community control sat. It also made the services accountable for monies that they were receiving, as in ensuring that service delivery was out there to local people. I*

*sat in that role for six months. It was around the National Strategic Aboriginal and Torres Strait Islander Health Framework.*

*The National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003* was endorsed by the Australian and State/Territory governments through their respective Cabinet processes and signed by all Health Ministers in July 2003. As outlined in its foreword:

Within the health system, the crucial mechanism for improving Aboriginal and Torres Strait Islander health is the availability of comprehensive primary health care services. Effective and appropriate primary health care services must be available to all Aboriginal and Torres Strait Islander peoples. These services should maximise community ownership and control, be adequately funded, have a skilled and appropriate workforce and be seen as a key element of the broader health system. (NATSIHC 2003, p. 1)

The *Agreements on Aboriginal and Torres Strait Islander Health* (Framework Agreements) provide a sustained commitment from governments to policy directions agreed between all partners at the state and territory level, and are an important component of this *National Strategic Framework*. Through the *Framework Agreements*, initiatives have commenced which address the four key areas listed below. This *National Strategic Framework* is consistent with and builds on these areas:

- increasing the level of resources to reflect the higher level of need of Aboriginal and Torres Strait Islander peoples
- improving access to both mainstream and Aboriginal and Torres Strait Islander specific health and health related programs which reflect the higher level of need

- joint planning processes which allow for full and formal Aboriginal and Torres Strait Islander participation in decision-making and determination of priorities
- improved data collection and evaluation.

This *National Strategic Framework* was touted a complementary document that built on the 1989 NAHS (National Aboriginal community controlled Health Organisation viewed 20 May 2010 <http://www.naccho.org.au/resources/nsfatsih.html>).

*At that time they were talking about allocating funding for that position for the next four years. There was an election and we had to stop working for some part of that six months because of that. Then at the end of September, all of this work had been done and we had to leave it because there was no more funding. So, I went back to Goondir at the Dalby Head Office. I commenced working for them in October 2006 as the Executive Officer and I was in that role for about eight months. Working with Goondir we had conversations with the Centre for Rural and Remote Area Health (CRRAH), at USQ. Goondir had already had a research partnership with the Centre [CRRAH] and the Better Living Diabetes Project. There was an opportunity for Goondir to enter a similar research partnership around a new project that was coming up.*

The research spun out of the National Suicide Prevention Strategy. USQ was one of the many partners for this research that was submitted via the Centre for Rural and Remote Mental Health - Queensland. This was a multi-site research project that encompassed Dalby and Yarrabah. The aim of the project was to establish effective, sustainable, community-based approaches to building individual, family and

community resilience, reducing suicide risk and self-harming behaviour and supporting community recovery processes among four Indigenous communities in Queensland. Raelene worked closely around transference of knowledge between Yarrabah and Dalby. Raelene identified that *specifically, the project draws on the positive experiences and knowledge of one community, Yarrabah, in developing community strengths in the face of the negative impacts of a number of past suicides. Yarrabah was used as a model for the development of similarly effective and sustainable community based approaches towards reducing suicide risk and self-harm in other Indigenous communities.* Raelene left Goondir and was successful in being appointed as the Project Coordinator for the National Suicide Prevention Strategy Project, and commenced in that position in May 2007.

Not long into this position with encouragement and support from CRRRAH Raelene enrolled in her Masters of Health by research. Raelene's thesis title is *What Services are available, accessed and why by the Aboriginal community of Dalby who have been affected by suicide or self-harm.* Raelene submitted her dissertation in January 2010 and at the time of this writing is still currently under examination.



**Figure 8.4 Higher Degree by Research Residential School 2009**

**(Raelene is 2<sup>nd</sup> from left)**



This was a pivotal turn for Raelene in her working career. After having a substantial history working within community-control Raelene saw the move into research that was appropriate between the tertiary sector and community-controlled sector as a natural progression for her. Within this research the two Aboriginal communities that were identified to work with were Yarrabah and Dalby. For Raelene it felt right as *I remember when I was undertaking my nursing, my boyfriend and I were talking about going throughout Australia and I said "well I want to go to Yarrabah (mission outside of Cairns) and work there as a nurse" and I remember saying that because we were going to buy a Kombi van and drive up there. I thought, back then that was where I wanted to be in the future and I then had the opportunity in that project to work with Yarrabah, it was very satisfying.*

Raelene had moved into research, *I think that over my time of employment I now know and realise that research is the only way that I can, or we as nurses can inform policy and make a change and if that's where we need to be, or where I need to be today to recruit more Indigenous people to do that, well I'm happy with that.*

Raelene's reward for this research went well beyond the personal satisfaction of working with the Yarrabah community which she had long wanted to do. In October 2009 Raelene received a national accolade and was awarded a prestigious Suicide Prevention Australia LIFE Award (see Figure 8.5, next page). LIFE Award organisers said Ms. Ward's tireless perseverance and ongoing commitment to the implementation of the Building Bridges project had undoubtedly been a major contributor to the project's success (*The Chronicle* 2009).



**Figure 8.5 Raelene receiving LIFE Award from Senator Moore**

There is no doubt that Raelene's passion lies within being part of appropriate Aboriginal nurse driven research. It has at times been a long journey for Raelene to get here. Raelene clearly talks about her support systems getting through her nursing career. As with all the participants of this dissertation, family has been paramount in their success. Raelene states that *it was my boyfriend and my extended family who were my main supports in the first couple of years.*

For Raelene being an Aboriginal registered nurse has proven at times an arduous road but one that has proven to be rewarding time and again. Raelene has found her niche and believes her future is within research. Raelene is passionate about supporting more Aboriginal people into nursing and states that *it is essential for so many reasons. I think because we're Aboriginal ourselves, we relate to our people. We know that there are not enough services out there. We know that our*

*health is like a third world country and it's not up to par, but for me, and I think I can say this for other people that we get into nursing because it's an opportunity to improve Aboriginal culture, Aboriginal Health, Aboriginal education and we can already see that happening now. We can see change just by more people being recruited into university, there's a lot more appropriate research. We're only going to see things improve or change by us being involved, and I think that's why I did my Masters.*

Raelene is grounded in the knowledge she carries from her mother and her country. *For us it's different now we can do what we want and be who we want to be. The generation that I've grown up in is different to my mother's. I've come to realise that. Her attitudes and her opinions are different to mine because her generation grew up when Blacks weren't allowed in town, white people were. You weren't able to go into town unless you had a letter or you were going to school. They lived over the Sandhill and that was within our own home town, on my mother's country. So being aware of my mother's generation and other people older than me that have gone through a lot more tragic times than us as a generation has undoubtedly informed who I am and what I do.*

Raelene commenced back at the Centre of Rural and Remote Area Health in May 2010, in as far as can be identified, as the only Aboriginal Nurse research position in the country. Raelene will be focusing on two research projects. Firstly, the Framework of 'what it is about an Indigenous Nurse that makes them unique and how they function in their roles as registered nurses'. Secondly, Raelene will be looking at developing Indigenous Nurse Practitioner Models of Care. Both these projects are entering 'new' territory for Queensland Indigenous nurses. Both projects

will add depth to the voices of the Queensland Aboriginal Registered Nurse as to date there are no Aboriginal derived models of care for the Aboriginal Nurse Practitioner and there is scant work on any operational framework that is identified/articulated by Queensland Aboriginal nurses.

The outcomes of Raelene's research are eagerly anticipated.

## Chapter 9: Anne-Maree Nielsen

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*Wakka Wakka Nation*

**Registered Nurse 2001–2003**

**Masters of Mental Health 2004–2005**

**Master Honours 2007–2008**

**PhD Candidate 2010**



**Figure 9.1 Anne-Maree graduating with her Masters of Mental Health**

I had the pleasure of meeting Anne-Maree in February 2000. At the time I was an academic in Kumbari Ngurpai Lag, University of Southern Queensland (USQ). Kumbari Ngurpai Lag is the Indigenous Education Support Unit at USQ. Anne-Maree had enrolled in the Tertiary Preparatory Program (TPP) through the Kumbari Unit. TPP was a bridging program offered to Indigenous people to undertake study over 12 months and who wanted to enrol in an undergraduate degree program. I was teaching the communication component of this program. The Program was essentially an enabler for Indigenous peoples to prepare them to undertake tertiary study.

Anne-Maree was an incredibly bright student and was very quiet and shy. I spoke to Anne-Maree towards the end of my teaching into the program as 'to what she thought she may want to do after TPP'. At this stage I was leaving Kumbari Ngurpai Lag and about to embark on a seven year teaching journey in the Department of Nursing at USQ. Anne-Maree quietly stated she wanted to become a nurse. I cannot express the pleasure that I had in hearing this. At this stage there were only approximately four nursing students who identified as Aboriginal, so the cohort was small and needed to be dramatically increased.

Anne-Maree throughout her story talks of 'walking into the auditorium on her first day and being overwhelmed at the lack of Indigenous students'. For me, I sat in the front row looking at Anne-Maree and I was filled with pride. I had the enormous pleasure of teaching Anne-Maree throughout her degree and was amazed at her persistence and secretly so proud of the fact that she was an incredibly bright student. I am even prouder of the fact that in 2010 Anne-Maree is an Academic within the USQ Department of Nursing and Midwifery and is also travelling the same journey as I am of undertaking our PhD Programs at the University of Southern Queensland. Here is Anne-Maree's story.

Anne-Maree is a *Wakka Wakka* descendant through her mother's bloodline. Anne-Maree was not born on country but in Sydney. Her mother has close affiliations and ties with her nation and is currently residing back on country in Cherbourg which is an ex-mission. Cherbourg is a Deed of Grant in Trust (DOGIT) community. Figure 9.2 (next page) is a section of the Horton Map of Aboriginal Australia which identifies the boundaries of the *Wakka Wakka* Nation.



Anne-Maree knew from a young age that she wanted to be a nurse. *I remember being at primary school and writing a piece on “wanting to become a nurse when I grow up”. I’m not sure where the idea of nursing came from; I just knew that it involved caring for people and looking after the sick and for some reason that appealed to me. I ended up losing my way for a while as a youth and during this time the desire to become a nurse left me. I ended up an expectant mother at fifteen and I can remember starting my antenatal care at the Redfern AMS (Aboriginal Medical Service) in Sydney. The more I became involved in the health of my baby and myself, the more I felt the reigniting of my childhood ambition to become involved in healthcare in some way. Episodes of racism that were directed at me by nurses during my pregnancy and post natal care further fuelled my desire to become a nurse, with the added motivation to become a nurse to care for my Aboriginal community.*

Anne-Maree with her family moved to Toowoomba to be closer to country. Anne-Maree’s mother wanted to go to University to undertake studies in counselling. For Anne-Maree this was a motivator to reignite her desire to become a nurse. With encouragement from her family Anne-Maree went to Kumbari and inquired about undertaking the TPP. Anne-Maree soon enrolled and her academic journey began in 2000.

At this time (2000) on the national Indigenous nursing agenda the Office for Aboriginal and Torres Strait Islander Health (OATSIH) established the Indigenous Nursing Education Working Group (INE Working Group). The INE Working Group was to work on a project to increase the number of registered Indigenous nurses and improve the competency of the Australian nursing workforce to deliver appropriate



care to Indigenous people. The INE Working Group consisted of representatives of the Australian Council of Deans of Nursing (ACDON) and the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN). The INE Working Group (2002) surveyed Australian universities to gather information to ascertain Indigenous content about health, the involvement of Indigenous registered nurses in teaching and curriculum development, and the current recruitment and support strategies in place for Indigenous students of nursing.

Further to this the Royal College of Nursing Australia (RCNA) in 2000 released its position statement on Nursing Education for Aboriginal and Torres Strait Islander Peoples. As part of the position statement the RCNA had recommendations that:

- all nursing curricula include Aboriginal and Torres Strait Islander history to facilitate a better understanding of the current lifestyle and health problems
- strategies be developed and implemented to enable Aboriginal and Torres Strait Islander students to meet the unique family and community commitments without disadvantage.

Importantly the RCNA apart from the above outlined recommendations resolved to:

- support the profession in its endeavours to improve the recruitment and retention of Aboriginal and Torres Strait Islander peoples into nursing
- monitor progress in relation to the numbers of Aboriginal and Torres Strait Islander nurses

- collaborate with organisations dedicated to the recruitment and retention of Aboriginal and Torres Strait Islander peoples in nursing.

(Royal College of Nursing Australia 2000, p. 2)

The national agenda had been set and was progressing. Anne-Maree without doubt had entered her nursing journey at an exciting time. The need to increase the numbers of Indigenous Australians was firmly on the agenda.

After Anne-Maree successfully navigated her way through the TPP offered at Kumbari Ngurpai Lag she was accepted to undertake her nursing degree in 2001. Anne-Maree remembers *feeling a mixture of excitement, nerves and apprehension upon starting at uni. The other TPP students that were interested in nursing either dropped out during the TPP year or they never followed through with mainstream studies, so I knew that I would be the only Aboriginal one in the tutorials and in the lectures. Sure enough, I walked into the massive lecture hall on my first day and looked around; I was the only Aboriginal student in the hall. I remember seeing clusters of students from different ethnic backgrounds, but I was disheartened to fully realise that I was it. I handled it the way I always had, which was to retreat inside myself.*

Anne-Maree progressed throughout her first year without academic incident but it was not without its other problems. *I felt a sense of relief at the end of my first year. I was also surprised at how well I was achieving and keeping up with the rest of the first year nursing students. But even though I was getting through okay academically, I had doubts about returning the next year. These doubts stemmed from the time I spent out on clinical. In the first year we had to spend time at a daycare, at Toowoomba Council and at a nursing home. Having come from a*

*somewhat sheltered background where my interactions with people were limited to having to speak to and deal with a wide range of people absolutely flawed me. I remember the question of my being Indigenous used to come up time and again. I can remember people's surprise at finding out I was Aboriginal and the condescending tone that used to surface in some people's voice when speaking to me. Comments like "it's good to see an Indigenous person trying to make something of themselves" or "maybe you should ask the other student (white) how to do that". I experienced blatant episodes of racism during that first year and I hadn't experienced anything like that since being in primary school in suburban Sydney years previous.*

But Anne-Maree did go back to commence second year and went on to complete her undergraduate degree in 2003. For Anne-Maree *the fact that I had actually finished my nursing degree did not fully hit me until graduation the year later. Again I suppose I felt relief at not having to step foot inside a lecture hall or tutorial class again. I suppose I felt proud of myself for completing a degree having given up on school so early. Everyone was praising me for what I had achieved, but I didn't believe I was someone special for just getting through uni. I felt a tinge of sadness at having to give up studying and of having to leave behind the small tight knit group of friends that I had made within the Indigenous study unit. I also felt apprehension at entering the nursing workforce because I knew that the protection and support I had at university was not going to help shield me once I hit mainstream nursing. I was aware that as a Murri nurse, I would be the minority within mainstream healthcare facilities. I had all this running through my mind, along with the fact that I didn't feel prepared for the responsibility of nursing*

*patients. Academically I did alright at uni, but clinically I struggled a bit so I guess I was scared of having to prove myself as a registered nurse in the hands on department.*

This highlights that support for Anne-Maree was paramount. Anne-Maree's educational experience is by far the most culturally inclusive and supported experience that the participants of this research have had to date. What does this mean and how is this achieved? At USQ the Department of Nursing engaged a full-time Indigenous nurse academic in June of 2000. Primarily this position was offered to teach within the Primary Health Care course delivered to third year undergraduate nursing students. Within 12 months this position morphed into supporting Aboriginal nursing students and Anne-Maree reflects on the importance of having an Indigenous nurse academic on her journey. *Having an Indigenous academic to speak to in regards to academic and clinical issues was invaluable, she was the go-between with the non-Indigenous academics and clinical facilitators when required and advocated on behalf of myself numerous times. Most importantly though, she understood the barriers we faced as Indigenous students, be they financial, familial, cultural and racial etc. There were a number of times when I was up in her office bawling my eyes out or just having a yarn, and each time she found the time to listen, to offer endless support and encouragement and to most importantly, validate my place at university as an Indigenous nursing student. I can honestly say that I would have struggled to persevere with my studies had I not had her support.*

In 2003 the Indigenous Health and Primary Health Care Course was delivered as core undergraduate curriculum for third year nursing students for the first time. USQ was the first University within Queensland to do this in. Anne-Maree was the

first Aboriginal nursing student to undertake this course. As I taught this course it was an interesting perspective to watch the non-Indigenous students interact with Anne-Maree. I believe within this classroom there was an element of inappropriate comments being contained purely due to having an Aboriginal lecturer teaching Aboriginal Health. However, in other courses Ann-Maree says she experienced *exclusion from group work and snide remarks made during discussion of Indigenous issues. I was made to feel as though they had preconceived notions of me as being dumb or ignorant, thinking that I required further explanation of issues.*

The other important support factor for Anne-Maree was Kumbari Ngurpai Lag (since re-named The Centre for Australian Indigenous Knowledges). Kumbari as previously stated, is the Indigenous Education Support Unit for USQ. This unit offers a 'safe' space for Indigenous students accessing tertiary education. Not only does Kumbari administer the TPP (since re-named the Indigenous Higher Pathway Program) but also provides computer labs, tutorial rooms, small lecture rooms and it also had a small nursing resource room. Kumbari also offers to the student the social space with which to support each other and has lunch space facilities and couches and space to relax in. Anne-Maree found this space invaluable throughout her journey and on the last day of her degree *felt a tinge of sadness at having to give up studying and of having to leave behind the small tight knit group of friends that I had made within the Indigenous study unit.*

The following year Anne-Maree, now a Registered Nurse, enrolled in her Masters of Mental Health Nursing, again choosing the University of Southern Queensland. This also meant that she was entering the workforce. *My first nursing job was a dual role as a casual out at Baillie Henderson Psychiatric Facility and at*

*the Acute Mental Health wing of the Toowoomba Base Hospital. My job as a casual RN lasted for about a year and I mostly worked night shifts due to my family commitments. I had mixed feelings about this job role. Even though I was enjoying my time working within the mental health field, I had trouble forming working relationships with the other nurses because I rarely worked in the same section for long periods of time. I can honestly say I struggled with my first clinical role. However, working within these facilities helped me to better understand the content of my Masters of Mental Health degree, which I commenced in 2004, my first year out as an RN. During this year I also worked as a tutor for Aboriginal and Torres Strait Islander nursing students within the Indigenous student support centre at USQ. I really enjoyed this job as I got a sense of satisfaction from helping Murri students attain quality results which helped build their confidence and strengthened their abilities to succeed.*

Anne-Maree's passion to work with her people had been ignited and she finally made the transition into Aboriginal Health. Within 2006 Anne-Maree gained employment at Carbal Aboriginal and Torres Strait Islander Medical Centre in Toowoomba. Carbal is one of the many community-controlled Aboriginal Medical Services across Australia. It was here that Anne-Maree gained endorsement for Sexual and Reproductive health through Queensland Family Planning. In 2007 Anne-Maree was employed as a Registered Nurse at Goondir Aboriginal and Torres Strait Islander Health Services in Dalby and graduated with a Masters in Mental Health.

During her employment at Goondir Health Services, Anne-Maree worked at the Stolen Generation Counselling Service (a section of Goondir) in which she was

responsible for counselling, and for mental health assessments for drug and alcohol misuse. Anne-Maree was there until 2008.



**Figure 9.3 Anne-Maree and Hilma Dillon at Goondir Health Services, Dalby**

In 2009 Anne-Maree joined the University of Southern Queensland as an academic in the Department of Nursing and Midwifery and in April 2010 was awarded her Master of Nursing Honours for a dissertation titled ‘What are Aboriginal registered nurses’ experiences of the cultural challenges, if any, involved in working in mainstream healthcare?’. The aim of Anne-Maree’s thesis was two-fold. Firstly she wanted to reveal, explore and therefore develop an understanding of the experiences of Aboriginal registered nurses who had worked in mainstream healthcare settings in relation to their experience of the concept of ‘whiteness’. Secondly there was the aim of identifying the cultural challenges experienced by

Aboriginal registered nurses who have worked within mainstream healthcare settings. Anne-Maree's Masters Honours work clearly demonstrated that there are identified 'cultural challenges' that do impact on Aboriginal nurses working in mainstream healthcare. Anne-Maree articulates that *it stands to reason that cultural clashes will occur within the field of nursing when confronted with the rigid structure of the dominant Westernised healthcare model. As a minority attempting to retain culturally specific healthcare knowledge and practices, Indigenous people generally experience scepticism and rejection when contemplating and embracing traditional treatment modalities* (Nielsen 2010 unpublished).



**Figure 9.4 Anne-Maree graduating with her Masters Honours.**

**(Anne-Maree is 2nd from left)**



Anne-Maree clearly is passionate about Aboriginal health and her ground-breaking research has and will continue to inform the landscape of the values of Aboriginal nursing and the construction of Aboriginal nurses and how we are viewed. Anne-Maree believes that *Aboriginal nurses can truly be themselves when they are working amongst their people. There is no need to try to fit in when you are working alongside your community. The times I worked on a mainstream ward, I was the only Aboriginal nurse, and I remember that it felt like I was walking on eggshells the whole time trying not to stuff up because I believed that it was expected of me anyway. Another reason is that the whole Westernised healthcare system does not respond to cultural deviances in presenting symptoms, healthcare beliefs and alternate treatment methods. As such I sometimes found it difficult to be present as an Aboriginal nurse due to workplace constraints as to my availability and limitations on promoting my culture's practices. For example, knowing that Murri families generally rock onto the wards in large groups, wanting to visit their loved ones out of the rigid visiting hours, I felt torn knowing my duties as a mainstream employee and feeling the need to accommodate these families' requests. Knowing that there is an Indigenous nurse on the ward, I know that Aboriginal clients and family members seek you out because they know that you understand the healing consequences of accommodating such requests.*

*Communication with many of the other white nurses seemed forced as it seemed like we lived a whole different lifestyle and had not much in common outside of work. I also felt very defensive towards certain non-Indigenous staff members when I heard them make negative comments about Aboriginal clients and their families. Once the comments have been made, you notice the hush come over the*

*room and everybody looking at you for some type of reaction. Back then I let things slide, but these days I feel more confident and empowered to respond accordingly. However, in saying that I also met a lot of non-Indigenous healthcare providers who were culturally respectful and appropriate in interactions towards both myself and their Aboriginal and Torres Strait Islander clients, so I don't like to give the impression that I am painting them all with the same brush (even though it happens to us all the time).*

*Working at Aboriginal Medical Services, I felt that my contributions as an Aboriginal registered nurse were validated. I gained personal satisfaction from knowing that I helped my Murri clients to better their health in some way. I know that many of the Aboriginal clients came to see me because they felt comfortable with me and they know that I can relate to their home life, their family circumstances and their cultural identities. Working alongside other Aboriginal health professionals is not only very comforting, but motivating as well, as we are all working towards the same goal – better health outcomes for our people. At our services (AMS's), the Indigenous workers have the last say – we decide the best course of action for our Aboriginal and Torres Strait Islander clients, it is not dictated to us by non-Indigenous healthcare providers under the guise of having “the best intentions”.*

Anne-Maree's journey like many Aboriginal nurses is one that has been impacted upon by racism. This was certainly evident in Anne-Maree sharing of her student experience and continued when she became a Registered Nurse. When I was a student *within the clinical setting this came from both preceptors and patients. I had some very negative experiences with one preceptor in particular. Once again it was the exclusion and being made to feel as though you are incapable, especially*

*when you are not given the opportunity to prove your worth as a clinician. Name calling from a resident at a nursing home, there was the patronising behaviour from a lot of the older clients, wanting to 'look after' the little black nurse. Comments made during handover in regards to Aboriginal clients. There were always small instances of racist and biased behaviour that seemed to be continual. I could go onto the ward feeling positive and optimistic about my shift, but then a racist comment would be made and I'd allow that to make me feel negative and downtrodden for the rest of the shift.*

*Initially, these experiences of racism made me feel inadequate as a person, like I didn't belong at university or in mainstream healthcare environments. After each episode of racist bullshit, I felt like giving up altogether. I found it exhausting trying to fit in, trying to gain approval from non-Indigenous nursing colleagues, lecturers, fellow students and clients. I felt like the odds were stacked against me, in that the majority of these people expected me to fail and as such I felt like a failure. After much deliberation however, I decided to keep going with my nursing career as I felt that my success might hopefully change people's perceptions of the next Murri nursing student to come along. So ultimately I believed these experiences of racism made me a stronger person in that it strengthened my resolve to follow through, making me feel more self-confident and proud of being an Indigenous registered nurse.*

*There is no doubt that Anne-Maree's support systems were vital to her success in getting through her degree and her journey into working as a registered nurse. Throughout my training I relied on the support of my family. My mum helped a lot in the way of taking care of my kids when I had to do shift work. Mum's belief in*

*my ability to succeed also played a major role in helping my confidence and in strengthening my resolve to finish what I had started. My kids were my motivation every day to go back into the lecture halls, to return to the wards and to get up in front of the classroom to deliver that oral presentation. I wanted to provide them with every opportunity I could and I knew that my completing a nursing degree would do just that. I also learnt to lean on the other Murri nursing students as we all were in the same boat and shared a lot of the same experiences throughout our training.*

It is without doubt that Anne-Maree's story is unique. Whilst obviously there is some overlap of issues faced by all the participants such as racism, Anne-Maree also had unique educational experiences that set her apart from the other participants.

In 2010 Anne-Maree enrolled in her PhD with a working title of *What do Indigenous Nurses say the Impact of the Whiteness of Nursing has been on/for them*. Anne-Maree's PhD work is looking at the construction (arguably whiteness) of nursing. As far as can be identified this is the only work of its type occurring in Australia by an Aboriginal nurse. Anne-Maree questions why the 'cultural struggle and recognition for Indigenous nurses happens. Anne-Maree is clearly expanding this work and carrying it on to undertake her PhD as she clearly notes 'through my personal and professional experience that very few of my Aboriginal nursing network actually work full-time in mainstream healthcare, when this is where they are undeniably needed'. The author believes that this work is needed to further understand the 'landscape of nursing'. To date Anne-Maree's work certainly validates the stories of the participants of this research that all have worked in Indigenous health.

The next chapter of Anne-Maree's nursing story is eagerly anticipated and I believe that its impact will be felt and bring depth to the literature on Australian Indigenous nurses and our experiences/stories.

## Chapter 10: Discussion and Conclusion

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The chapter of this thesis is underpinned by both Djaparligin and Yadtjuligin. In gathering the stories, weaving them together and undertaking an in-depth literature review, I too went through the multiple layers of Djaparligin. I learnt an enormous amount from the stories of the participants but also broadly about Aboriginal nurses. This for me is the tenets of Djaparligin. This enabled me to bring together the broader tenets of this research and enabled me present these stories through Yadtjuligin or being able ‘talk about in a good way’. The multiple layers of Djaparlagin and Yadtjulagin were essential in providing this research and also for me personally. It enabled me to discover some of the hidden realities of Aboriginal nurses and in doing so create a body of work that is unique to the nursing discipline.

To do this I needed to understand and learn many things. For me this was an evolving process that at times I struggled with greatly. Learning language and how Wakgun knowledge’s are transferred in my Grandmother’s language was at times difficult and did cause me discomfort. This process started with seeking Clan permission through my Grandmother and later cousin, learning language and then applying language to understand the transferring of Wakgun Clan knowledge. This is when I commenced to visualise and conceptualise this into a tangible and readable form. For Wakgun Clan, ways of our transference of knowledge has never been put into written words nor conceptualised utilising a model.

I argue I have articulated and demonstrated both cultural and academic obligation by providing Wakgun transference of knowledge, demonstrated its

application to the making of quinine water and finally its applicability in gathering the stories of Aboriginal nurses in Queensland from 1950–2005. Whilst I believe I have met criteria for this research I also believe that the evolution of writing the transference of Wakgun knowledge is not completed and will continue to evolve for me as will the model.

In weaving the stories together of the participants there were obvious similarities amongst all of them. There were also unique differences between each story as well. I believe that each story can sit as an individual narrative but when presented chronologically over six decades both similarities and differences are markedly obvious.

The starting point and central to the participant's stories is their Aboriginality. All the participants of this research are Aboriginal women from varying Aboriginal nations. All participants identified as Aboriginal first and nurse second. With the diversity in nations comes a unique voice that is not replicated and is unique to each story.

All participants have encountered racism in their personal lives. Five of the stories disclosed episodes of racism encountered within their nursing. This was not a surprising finding of this research as racism encountered is well documented by Indigenous nurses as presented within the literature review of this research. I believe for the reader that this may at times cause discomfort at reading the stories that disclose the levels of racism that have been encountered from non-Indigenous nurses. For me it certainly was at times confronting that racism was such a common theme in weaving the participant's stories together but also by undertaking the literature review of the broader Indigenous nurses voice. I also suggest that the issue of racism

amongst nurses demonstrated the immediate need to incorporate cultural safety in nursing education in the hope of eradicating racism with the profession of nursing and midwifery.

Another similarity was that all participants had or continue to work in Aboriginal health. All participants clearly articulated the desire to work with their people. It was not by design that the participants of this research were chosen for their work in Aboriginal health but it has been a unique finding of this research. Undeniably Government Policy 'of the day' has had a deep impact on the personal lives of these Aboriginal women but also within their professional lives as their transitions began of student nurse to registered nurse. This became essential to include in their stories as arguably these impacts cannot be unpacked such is the impact on many Aboriginal people. Obviously these policy impacts were unique to their era. In telling these stories at times did cause me discomfort and was very confronting at the level of discriminatory impact of government policies.

One of the most obvious differences is the accessibility of nursing education. As outlined in this research in a span of 50 years nursing history has gone from having harsh exclusionary policies in some hospitals to now having tertiary commitment to actively increasing the numbers of Indigenous nurses and midwives. The advent of hospital to tertiary education for nurses I argue had fundamental impacts on accessing nursing education for Indigenous people. The in-depth literature review clearly articulated that there has been a common thread of being denied access to nursing education in many hospitals due to their Aboriginality. These exclusionary practices of the nursing profession, whilst well known amongst Indigenous nurses are still not well acknowledged further than this. I argue the



discriminatory practices that were identified in the literature well into the 1980s changed significantly with the transition into the tertiary sector.

Another such fundamental difference with the educational transition is the greater support mechanisms for Aboriginal nurses in the pursuit of nursing qualifications. This had not been apparent in hospital training, where often the support came from family and also fellow nursing students. The transition saw a stark contrast across the decades of this research. From beginning with no cultural specific support from nursing in the 1950s to the 2000s being one of having access to an Aboriginal nursing academic, being taught Aboriginal health as core undergraduate curriculum content and having an Indigenous education unit to access whilst undertaking her studies. The differences are stark and the transition of the profession of nursing has certainly changed.

This research is new work and adds to the nursing literature. As far as could be researched to date there has been no historical offering of Aboriginal nurses voices in PhD research. From these voices there is a lot to be learnt for all of the nursing and midwifery professions. There needs to be much more research undertaken from the hands of and the voices from Indigenous nurses.

I believe that reading the stories may have been confronting or caused discomfort for the reader. I should imagine this could be a very confronting issue for many non-Indigenous nurses and midwives as I argue that navigating the multiple realities is not the experience of most non-Indigenous nurses and midwives. This is obviously a part of Yadtjuligin and is completing the knowledge transfer of '*The stories of Aboriginal nurses in Queensland from 1950–2005*'.

First and foremost I acknowledge my Grandmother Ivy Molly Booth, without

her this research would be markedly different.

I believe I have woven the stories of these hidden and private histories to meet both academic requirements and cultural obligations. The stories of these women need and deserve to be told. It also needs to be acknowledged that I have walked amongst Aboriginal nurse peers in this journey, as currently there are approximately 8 Aboriginal registered nurses across Queensland who are immersed in their PhD journeys. I believe this decade will see the works and voices of these remarkable women change the landscape of nursing.

At the beginning of this PhD journey I was excited at the prospect of hopefully identifying our early Aboriginal nurses. To date we have access to Aboriginal nurses that are still alive who undertook their training in the 1950s. Prior to this, there is a deathly silence of earlier Aboriginal nurse trainees. On this journey, I have uncovered May Yarrowick, who was an Aboriginal nurse who trained in New South Wales and was registered in both general and midwifery between the years of 1900–1910. Whilst obviously outside of the scope of this research, a desire began for me to unearth this remarkable woman's story. I look forward to engaging in my passion of telling the stories of Aboriginal nurses and saving those stories from historical oblivion.

I pay my respect and love to all the participants. Singing their stories to me was one of immense pleasure and I feel humbled to have been able to do this. It truly has been a journey for me of discovery, re-connection to culture, learning of language and traditional medicines.

As I close this research I am indebted to clan and country and thank Wakgun for language, lore and my being.

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# **Appendix A**

## ***– I'm a Nurse***

(A copy of this documentary is attached to the thesis)

# **Appendix B**

## ***– Nurses Helping Our Mob***

(A copy of this film is attached to the thesis)

# Appendix C

## – Glossary of Aboriginal English words

<b>Blackfella</b>	Aboriginal or Torres Strait Islander person, either male or female
<b>Boomerang</b>	A curve-shaped throwing tool or weapon for hunting made from wood or bone
<b>Cockatoo</b>	Bird often found in large, colourful and noisy flocks
<b>Corroboree</b>	Aboriginal ceremonies involving singing and dancing
<b>Country</b>	A traditional place of belonging or homeland and way of seeing the world through places, seasons, stories and spirits
<b>Deadly</b>	Really good
<b>Dilly Bag</b>	Traditional bag for carrying food woven from plant fibres
<b>Dreaming</b>	Sacred time, often involving creation, which informed beliefs about country and ways of living - can also refer to past, present and future
<b>Eugaries</b>	Pippies
<b>Invasion Day</b>	Term in common use amongst Aboriginal and Torres Strait Islander people in place of Australia Day marking the anniversary of the arrival of the First Fleet of 11 convict ships from Great Britain in 1788
<b>Koori</b>	Generic word for Aboriginals from New South Wales and Victoria
<b>Men's business</b>	Ceremonies and practices for men
<b>Mob</b>	Refers to family or community group, sometimes used more generally to refer to a gathering of Aboriginal or Torres Strait Islander people (eg you mob) or Aboriginal or Islander people in general (eg us mob)
<b>Murri</b>	Generic word for Aboriginals from Queensland

<b>Sacred sites</b>	Traditional places of significance requiring particular care through customs
<b>Songlines</b>	Paths across the land made by creation spirits, which are passed on through song, stories, dance and painting
<b>Wagga</b>	Sleeping blankets usually sewn together from sugar bags
<b>Women's business</b>	Ceremony and practices for women

# Appendix D

## – Glossary of Wakgun dialect, Gurreng Gurreng Nation words

<b>Buroo</b>	Kangaroo
<b>Dilarl</b>	Possum
<b>Djaparligin</b>	Making corroboree/ songlines
<b>Djaparl Nganya</b>	Song of me
<b>Djularn</b>	Lizard
<b>Gatjul</b>	Wallaby
<b>Gekgair</b>	Echidna
<b>Gutdja</b>	Bush honey
<b>Marun</b>	Sand Goanna
<b>Milby</b>	Turtle
<b>Ngwye</b>	Bee
<b>Wakgun</b>	Scrub turkey
<b>Yatdjuligin</b>	Talking in a good or happy way