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The deconstruction exercise: An assessment tool for enhancing critical thinking in cultural safety education

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Abstract

The ‘deconstruction exercise’ aims to give non-Indigenous health profession students the ability to recognise language that is imbued with power imbalance, so as to avoid the perpetuation of racialised ways of interacting with Indigenous peoples in the health system.

Informed by Ngarrindjeri and Malak Malak perspectives, this is a measured anti–racism strategy, one able to address unexamined, racist language in a manner that avoids the emotive or combative nature of unstructured discussions around the impacts of racism.

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We argue that once a health care professional is able to exhibit decolonised language, together with a re-orientation towards decolonised practice, a door opens; one vital for the development of a more-effective, culturally-safe practitioner.

In an academic setting, this 'Ngarrindjeri way' has shaped the deconstruction exercise, which ensures that students are 'having the hard conversations' in a pragmatic manner that challenges 'whiteness', whilst honouring each student's dignity, on a learning journey that is informed by Indigenous methodologies.

Keywords

Deconstruction, cultural safety, decolonisation, racism, critical pedagogies.

Introduction

In Aboriginal and Torres Strait Islander (Indigenous) health settings, clinical effectiveness is the end product of culturally-safe care. Such care has both individual practitioner and institutional dimensions (National Aboriginal Community Controlled Health Organisation (NACCHO) 2001). Whilst attention to both dimensions is vital to ensure a medically-optimal outcome for Indigenous patients or clients, this paper will focus on the training of non-Indigenous, tertiary level, health profession students to become culturally safe health care professionals who decolonise their practice (Thiongo 1986).

In this article, to 'decolonise' is to address the inequities brought about by colonisation by recognising First Nations people's rights, autonomy, diversity, language, culture and our (Indigenous/non-Indigenous) shared histories, particularly by diminishing current power imbalances and the continuing impacts of structured privilege.

Becoming a culturally safe health care practitioner requires the development of a critical stance[1] and a reflective practice. Such development is not straightforward; it is neither the gathering of discrete nuggets of knowledge, nor the acquisition of an acknowledged set of best practice modes of interaction. As Vesely and Sherlock (2005) note:

[1] A point of clarification for the reader regarding the italicised text inserts: These are anonymous questions, from students of various health professions, from which we source 'Deconstruction Questions' for assessment in order to develop such a critical stance through critical thinking and/or writing. Our rationale for the 'disruptive' nature of their inclusion is premised on our experience. This is the way facilitators, tutors and/or participants encounter them—abruptly and unexpectedly. Yet dealing with them in a prepared, structured manner, we argue, is crucial to maintaining a 'safe' and, therefore, effective educational space. Other text inserts also offer challenging questions, but juxtapose them with exemplar student responses. All text inserts are written exactly as received, that is, there are all *sic*.

> A continuing challenge for many educators is translating the philosophical desire and the empirical support for critical thinking into pragmatic, pedagogical practice.

Their response is to offer "Learning Journals, Book Critiques, and Persuasive Essays" (Vesely & Sherlock 2005, p.1) as specific developmental avenues. In isolation, these may be helpful, but insufficient, tools to facilitate a "disassembling of planks of belief" (McDermott 2012, p.197) that is sufficiently powerful, and fit-for-purpose, to enable students to successfully embrace the challenge of critical thinking and self-reflection.

If Aboriginals hate to be judged why do they still do the things people judge them for? e.g alcoholics/petrol sniffers

One method that we have developed, which has become central to our project to extend students' criticality and reflective capacity, is an assessment piece that we have termed the 'deconstruction exercise' (see Sallis 1987). Serving dual objectives, this is both an anti-racism strategy and a criticality-extending enterprise, facilitated by a structured, assessed paper wherein students articulate the sociological space from which the question is asked, rather than *answer the question* itself. In their analysis, students are required to identify assumptions, racialised language and/or approaches, and to identify omissions. A successful analysis will identify whiteness, institutional racism and an understanding of the social determinants of Indigenous health. 'Student Evaluation of Teaching' (Flinders University-wide evaluations of teachers and topics) data suggest a particular utility for transformative learning or, rather, transformative un-learning (Horn 2008; Quist-Adade 2007).

Anon. Student Question
Can we really allow the process of decolonisation? And what are the implications for white Australia?

Student Critique:
It is clear that colonial discourse reverberates throughout the question and that the questioner's worldview supports maintaining colonial power imbalances at the expense of Aboriginal and Torres Strait Islander people's health.

The target cohort for this assessment piece is predominantly non-Indigenous health professionals and health profession students, however, many Indigenous students and academics have recognised it as a pragmatic, anti-racism strategy that can be employed to decolonise (Smith 1999) their peers and the academy, and to diffuse sometimes emotive and/or difficult teaching and learning spaces.

In the three years since the public introduction of the deconstruction exercise, its potential has been recognised by public health, nursing and medical educators in several universities in Australia, New Zealand and Canada. We would like to acknowledge the support and collegiality of Associate Professor Papaarangi Reid, Dr Elana Taipapaki Curtis, Dr Rhys Jones and Dr Esther Willing from Te Kupenga Hauora Māori, Faculty of Medical and Health Sciences, University of Auckland, who have incorporated the deconstruction exercise into their curricula over the last few years. We also acknowledge our colleagues Cheryl Ward, Leslie Varley, Nancy Laliberte, Rain Daniels, Laurie Harding and other staff members of the San'yas Indigenous Cultural Safety

Programme of the Provincial Health Services Authority, British Columbia, Canada. This extensive training programme (27,000 Provincial Health Services Authority employees have undertaken the programme as at April 2016) is currently under consideration to incorporate the deconstruction exercise into the San'yas programme (Laurie Harding, personal communication with Provincial Health Services Authority, British Columbia, Canada, 2016). Its appeal appears consonant with searches for educational strategies that are both decolonising and anti-racist, yet eschew an unproductive 'blaming and shaming' methodology. For example, a number of Indigenous medical students, attending at the introduction of the deconstruction exercise at a 2013 conference, expressed their relief at the development of an anti-racism strategy that was practical, with specific implications for their medical course experience, as well as being far-reaching. (Dries & Good 2013).

I, David Sjoberg, write from a position of privilege as an Anglo-Celtic Australian. I was taught and nurtured into an understanding of my whiteness by Malak Malak, Ngangikurunggurr and Ngarrindjeri uncles, aunties and teachers, who introduced me to what has become a life-long critical appraisal of how I perceive myself in Australian society. Elders and community members encouraged me in the development of effective tools to decolonise my mind and my work. This paper is about sharing some of those tools to decolonise curricula in Indigenous health education.

I, Dennis McDermott, write as a Koori man, now living on Kaurna country. Part of my work in the academy is to open it up to Indigenous knowledges and pedagogies. My professional training is as a psychologist, but my encounters, over some decades, with elders and community peers in southern Queensland, New South Wales, Victoria, South Australia and the Northern Territory have profoundly reshaped the way I think and the way I think about what I do; my clinical and academic praxis.

Anon. Student Question
Why are Aboriginal people prone to drug and alcohol addiction?

Student Critique
In the question the notion of "Western" superiority is reaffirmed. Given that Aboriginal culture is portrayed negatively, whereby all Aboriginals are susceptible to addiction implicitly compares Aboriginal culture with its superior counterpart, namely "Western" culture, where no such issues presumably exist.

Our approach has been especially informed by the race relations teaching methods of the late, highly respected, Ngarrindjeri Elder, 'Uncle' Tom Trevorrow. A central notion within his pedagogical style was that whilst a 'blame and shame' approach may be emotionally satisfying for some, it risks being pedagogically ineffective. As 'Uncle' Tom succinctly noted, "there's no use slapping whitefellas around the ears with their own ignorance" (Tom Trevorrow, personal communication, July 2000).

It is imperative that students (encompassing practising health professionals undertaking professional development) have an opportunity to reflect on the everyday language in which they may be immersed, to see behind the dominant Australian lexicon to the colonial, discursive position from which it has been constituted. A major difficulty arises when an educator attempts to add complexity to overly-simplistic constructions of Australian 'tolerance'. A

lack of understanding about race and racism, one uncritically accepting of tolerance as being the national default position, is consonant with unexamined privilege. The deconstruction exercise promotes learning about structured privilege, learning that is gained through critical reflection (Mezirow 1981), rather than 'imposed' as topic content. This pragmatic approach assists educators and students to traverse teaching and learning experiences that, otherwise, have the potential to become emotive or combative if not delivered in a considered and culturally safe manner.

This exercise honours 'Uncle' Tom Trevorrow's legacy; his life-long race relations work is a valuable gift from an inspirational Elder to our youth. It is a powerful example of how Indigenous knowledge can reposition the work of the academy and how an Indigenous-led methodology can assist students of Indigenous health to come to a deeper, practice-informing, understanding of racism as a central, social determinant of Indigenous health (Australian Government 2013).

How Does Indigenous Knowledge and Pedagogy Underpin this Approach?

The Malak Malak and Ngangikurunggurr people of Naiyu Nambiyu community on the banks of the Daly River in the 'Top End' of the Northern Territory use the term 'proper way' (as do many First Nations Australians) to refer to a culturally appropriate and/or respectful way to be, speak or act (J Nambatu, Nauiyu Nambiyu community, Daly River, Northern Territory, personal communication, November1988). It is practiced and preserved by the community and prescribes Indigenous cultural protocols. If non-Indigenous health care professionals do not have an understanding of racism and privilege as being significant social determinants of Indigenous health, they will be working without respect and failing to adhere to the 'proper way' (Australian Government 2013). Health practitioners cannot deliver culturally safe care whilst blind to 'whiteness' and cannot diffuse power imbalances whilst unaware of privilege. A culturally safe health practitioner in the Australian context must address the reality that there are alternate ways of being and knowing, then accept the validity of their contemporaneous existence, in order to begin the process of bridging the divide between seemingly incommensurable discourses. To assist non-Indigenous, health profession students to appreciate this incommensurability, and its relevance to practice, we have incorporated Indigenous-led methodologies into curricula that disrupt the dominance of unexamined, colonisation-forged, conceptual frameworks. This has been achieved by making possible student apprehension of the colonisation-continuing processes of 'cognitive injustice' or 'epistemicide' (Bennett 2007; Grosfuegel 2013; Lebakeng, Phalane and Nase 2006; Santos 2014).

How successful has the physical and mental integration of the Aboriginal population into modern western civilisation been? Is the majority of the Aboriginal population willing to integrate or would they prefer to regress back to their Traditional lifestyle?

On the Kurangk (Coorong), in Ngarrindjeri Ruwe (country), between Goolwa and 42 Mile Crossing, South Australia, the Ngarrindjeri Land and Progress Association runs Camp Coorong Race Relations and Cultural Education Centre, which aims to guide non-Indigenous Australians to an understanding of shared histories from a Ngarrindjeri perspective. Hearing stories of 'fringe camp' days enables non-Indigenous peoples to begin to see non-Indigenous privilege from a Ngarrindjeri viewpoint. Many Australians, who do not consider themselves to be 'privileged', find this a difficult outlook to accept. Upon learning of the social and economic exclusion that the Ngarrindjeri suffered for many generations—and still endure—some people's thinking may undergo change. Nurtured through this change by Ngarrindjeri cultural and race relations educators, a person's perception of themselves and their country can undergo significant shifts in understanding: "…he's Grinkarie (Whitefella), but he's got some understanding" (Tom Trevorrow, personal communication, January 2000).

When visitors to Camp Coorong speak or behave in a way that displays their 'whiteness', they have the opportunity to listen to a Ngarrindjeri perspective, one that resonates with Malak Malak and Ngangikurunggurr standpoints that, similarly, inform thinking and develop criticality. The delivery method of those Indigenous views is crucial to their reception.

Are there still traditional 'indigenous mobs' living in Australia?

If delivered without due care, defence mechanisms are likely to halt any operation of the desired process; in Malak Malak vocabulary, the process is known as 'Dadirri'—deep listening (Miriam Rose Ungunmerr-Baumann, personal communication, 1988). This process cannot be done in isolation and is not instantaneous; it takes time and relationship to develop: "…we have to bring them on a journey with us…" (Tom Trevorrow, personal communication, April 2000). Such a journey, in itself, needs careful planning and support. An overarching contemporary imperative, however, is that avoiding the addressing of racism in the effective preparation of the health workforce is simply not optional (McDermott 2012). As the most recent National Aboriginal and Torres Strait Islander Health Plan (Australian Government 2013, p.14) notes, officially recognised for the first time in such a nationally comprehensive plan, "racism is a **key social determinant of health** for Aboriginal and Torres Strait Islander people" (emphasis added).

The mandates for interpersonal care and careful listening that arise from both Ngarrindjeri and Malak Malak perspectives underscore the necessity to acknowledge the potential for negative student responses to any attempt to name racism or 'settler' privilege. Bond (2015), after DiAngelo (2011), recognises the notion of "white fragility" and argues that it needs to be taken into account in this type of delivery. Bond's (2015) work elucidates the fraught situation in which many health educators exhibit 'uncomfortability' when considering racism and 'whiteness', and are reluctant to teach those particular aspects of the curricula that are seen as contentious and based (in these educators' perspectives) on a deficit model of settler Australia. Previously, we have noted that many non-Indigenous students mirror such 'uncomfortability'

with Indigenous health topics, thus engendering a corresponding need for tailored pedagogical approaches that set parameters to contain and provide emotional support structures for a mode of response we have previously termed 'manageable disquiet' (McDermott & Sjoberg 2012). Ngarrindjeri methodology in race relations assists here: It aims to ameliorate discomfort, including 'cognitive dissonance' (Chan 2013), by taking time and care in the delivery whilst pulling no punches (Tom Trevorrow, personal communication, February, 2004).

Why is a Strong Focus on Developing a Wider Criticality Deemed Essential?

Many students and health professionals, alike, struggle to engage fully with Indigenous health curricula. We, teachers of Indigenous health, are asking students to enter an emotionally charged zone, one that requires them to feel safe enough to open up to difficult questions and one premised, not only on *cognitive* learning, but also *affective* learning. Where that involves tapping into deeply held feelings, beliefs and prejudice, engagement may prove too confronting (Gabb & McDermott 2008; Rasmussen 2001).

North American medical education literature identifies class or privilege as a mediator of a documented student resistance to the role of the social determinants of health (SDoH) in shaping patient presentations. Such resistance might include, for example, a medical student from a privileged background encountering a patient, or even simply a case study where the presentation might involve obesity or tobacco use, with a judgemental response derived from a social and political lack of exposure and/or naivety that could be paraphrased as 'Why don't they just choose the healthier option?' One recommendation from that literature is to move from the individual depictions favoured by narrative medicine to socio-political analyses of the way the SDoH operate (Wear & Aultman 2005). Our approach responds to a deeper reading: In an Australian context of a widespread denial of troubling elements of our shared national history, analysis of colonisation-related determinants can be sufficiently disquieting to threaten student engagement with the subject under study (McDermott 2004). The praxis of cultural safety requires students to explore the cultural underpinnings that they, themselves, bring to the health encounter. Some students are able, however, to not only grasp the benefit, but also embrace the uncertainty engendered, in enhancing their criticality. "Critical thinking is a continuous process of open-minded analysis and communication of foundational principles and underlying assumptions and biases, in order to gain greater clarity and depth of understanding" (Dries & Good, 2013, p.2).

The Royal Australian College of General Practitioners (RACGP) (2011, p. 411) deems critical thinking to be "a core competency for evidenced based general practice", which parallels conclusions arrived at in an Australian literature review about critical thinking in relation to nursing education (Simpson & Courtney 2002). Where, though, students prefer 'concrete' modes of thinking, where 'certainty' of procedure is 'king', where such are educationally linked to clinical competence, and where Indigenous health and

cultural safety are seen as peripheral to core clinical business, the impetus for engagement withers (Rasmussen 2001). By contrast, becoming a thinking, culturally safe practitioner is also a prerequisite for emerging as a clinically safe one (McDermott 2012). Successful Indigenous health pedagogy, then, aims to develop a critical stance and a reflective practice. Systematically exploring such issues as power imbalances in health settings, the contemporary consequences of colonisation and the pervasiveness of racism—and the profundity of their effects—however, may fundamentally challenge those participating on personal, professional, organisational and political levels.

Our teaching experience of a strongly embedded, multiply reinforced privileging of 'certainty' resonates with Simpson and Courtney's (2002, p.15) noting that "Nurse educators face many challenges in teaching critical thinking". A major challenge to our teaching praxis is our experience of numbers of health professional students looking for 'shopping list' responses to patient care; a phenomenon potentially related to reports of student anxiety about their clinical performance, particularly making clinical mistakes (Kleehammer, Hart & Keck 1990), and to allied findings that "creative solutions [can] threaten students' security and assuredness of being correct" (Miller & Malcolm 1990, p.70). To overcome such challenges, Simpson and Courtney (2002, p.15) conclude that "success in critical thinking requires creative strategies".

If Burbach, Matkin and Fritz (2004, p.483) are correct that "the process of critical thinking encourages students to realise *everything is not as it may seem to be on the surface*…", then, rather than the joy of discovery, such realisation may provoke fear. Encountering the 'Terra Incognitus' (Lebakeng 2004) of one's own assumptions and biases may be a necessary step in broadening the limitations of our personal worldviews, but potential student discomfort in stepping beyond one's conceptual comfort zone requires a structured, nuanced response. The success of curricula and pedagogy may depend on the dismantling of particular barriers to the apprehension of well-established evidence or coherent argument. Yet, the process of resisting, disengaging from or failing to apprehend a persuasive explication of material central to better health outcomes is not necessarily a conscious one, nor does the 'problem' reside solely with the individual person. In the Australian context, the 'great Australian silence' (early twentieth century eliding of profound, colonisation-related impacts that were openly acknowledged in the nineteenth century) (Stanner 1969) and the 'History Wars' (late twentieth century revisionism of widespread commission of massacres and other atrocities (Windschuttle 2002)—allied with policy, institutional and public official (police/mission manager/pastoral station manager), 'virtual' or 'Clayton's' apartheid (McDermott 2004)—support the existence of potent constraints, within an energetically-policed national discourse, on thoroughly examining the consequences of colonisation, including with respect to health outcomes.

Do aboriginal people dislike us (white people) in regards to what we did to them in the past? Even though it wasn't our generation that were involved in for example the stolen generation?

Although we are all 'culture bearers' (Pourier 2012), where there is little support, opportunity, even language, for cultural self-examination, that culture may be presumed to be universal. A necessary embrace of pluralist notions, then, becomes difficult; personally and politically challenging. The learning journey can resemble a steeplechase, with hurdles and water jumps that threaten a fall from certainty.

Equally, participants may fear being judged as unsure, ignorant or racist. As threats to self-esteem and social status have been found to provoke higher levels of cortisol change than non-socially-evaluative threats (Dickerson & Kemeny quoted in Wilkinson & Pickett 2009, p.39), participants in Indigenous health and cultural safety education may find themselves experiencing classic 'flight, fight or freeze (paralysing-to-action)' responses to sudden threat. Attention to these fears and careful maintenance of our pedagogical imperative of not pushing students beyond a 'manageable disquiet' (McDermott & Sjoberg 2012) has led to student comments in our topic evaluations that, often, welcome as positive the change to their thinking and gratefully note the impacts on their praxis:

> "this Topic has fundamentally changed me as a human being"
>
> "I didn't know that I was racist, now I'm going to raise my kids differently."

Some non-Indigenous students experience vulnerability—at times even expressing a sense of violation—when they realise they are not living in the same country that they thought they were:

> "I feel like I'm being attacked when I read [the core text]."
>
> "I was made to feel guilt and shame…"

Successfully developing criticality in the service of Indigenous health and cultural safety education, then, may involve appropriate means to address participant resistance, disengagement (including non-attendance and/or intellectual or emotional withdrawal), fear and/or frozen communication—succinctly depicted as "paralysis" by a number of authors (Cowlishaw 1999; Sonn [no date]; Williams 2000 [all cited by Ranzijn & Severino 2006])—and micro- or overt aggression. It certainly calls for pragmatic pedagogies that assist intellectual shift, but requires contemporaneously parallel, but deep stratum, strategies that work with and through resistance and discomfort.

Anon. Student Question
If we come from Adam and Eve, then where do black people come from?

Student Critique
The question is linked to … racial essentialism, in the simultaneous privileging of whiteness, and devaluing of Aboriginality, to construct a symbolic boundary according to a binary of 'us-them' and 'superior-inferior' that is assumed to be natural, which was part of a state-sponsored ideology of Social Darwinism within the Assimilation era.

What is needed is an approach that is capable of successful deconstruction of persistent, discourse-limiting, colonial narratives and the centrality of historical Western mindsets upon which they rest—that yet incorporates 'care-full' facilitation; that minimises threat and the likelihood of student hypervigilance; and that builds cultural safety for participants, not only for future patients or clients but, also, a 'safe room' or safe educational space for *themselves*—and so maximises engagement in the service of real educational progress.

Why is it that so many Aboriginal people are uneducated / unemployed?

As noted, our pedagogy desires to foster both criticality and a continuing habit of professional self-reflection. Together with an acceptance of uncertainty and the role of the social determinants of Indigenous health, we also ask participants to monitor and modify the power imbalance that can render clinical encounters both inequitable and ineffective.

What Happens when We Employ 'Deconstruction' as a Strategy—and Why?

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

> The transcultural paradigm is the 'equation' formed when individuals of different cultures interact… Transcultural teaching for health professionals requires that the study of 'clients in the fishbowl' should be abandoned, as in that model there is no account taken of the culture and values of the clinician, who forms part of the clinical equation. (Gabb & McDermott 2008, pp.69 & 78)

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

critical reflection and addresses some of the ‘hard conversations’ (McDermott 2016) that Australia must have.

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

Deconstruction as a Dual Tool for Developing a Culturally Safe Practitioner and Promoting a ‘Safe’ Classroom

As much as the self-reflection mandated by models of cultural safety may threaten student engagement, many non-Indigenous people find studying Indigenous health a confronting experience. In our teaching at Flinders University, we avoid a preeminent focus on health and illness presentations, rather, that which is foregrounded are the social determinants of Indigenous health; these are the factors to which we give prime attention. The incorporation of history and racism as significant social determinants requires exposure to unsettling ways of looking at Australian society. Given the long-existent paucity of education about Indigenous Australia and the thin apprehension of the concept of a shared national history in our primary and secondary schools, many come to a tertiary institution with not only little knowledge, but also a mindset mired in myth and misinformation.

Once at university, some students are silenced in class by the fear of sounding ignorant or causing offence, perhaps inhabiting a space of hypervigilance (Rasmussen, Willingham & Trinh 1996) that is not conducive to learning. Many non-Indigenous students have reported in their evaluations of our topics (subjects within our courses) that they appreciated a space within which they could participate in discussions about sensitive issues and, yet, experience a measured response from fellow students and tutors or lecturers; one that ensured a safe learning environment free from judgement.

Over a seven year period, the authors have evaluated student responses to Indigenous health and cultural safety teaching. To these, we have added evaluation data of professional development workshops from about seven years prior (Gabb & McDermott 2008). Our findings have been paralleled by large scale evaluation data reported from a province-wide, online cultural safety training delivered in British Columbia (Daniels & Ward 2015). In both the Australian and Canadian jurisdictions, we note the emergence of

distinctive modes of responding to the challenging material that many students are meeting, in a comprehensive way, for the first time.

Why don't we just give them all guns so they can shoot themselves?

Both sets of responses ranged from very negative to very positive. Students and practising professionals alike showed evidence of at least four response styles, merging one into the next along a spectrum. The first, which we have dubbed 'Accepting/Keen for more' (in the Canadian context 'Truth-tellers/Champions' (Daniels & Ward 2015)), could be characterised by its openness and willingness to engage, together with a desire to know and learn, no matter the difficulty of some of the material (McDermott 2016). In the second mode, 'Moved/Uncertain', there was often a sense of sorrow around the events and consequences of colonisation; a perception of a national shame, but no indication of feeling personally blamed. The third discernible grouping, 'Disturbed/Flummoxed', responded to challenging material with evident distress, a number of participants believing that they were being judged, and found guilty. To many within this group, the material was a source of major dissonance. Comments displaying a sense of betrayal jostled with others indicating denial or resistance. A reluctance to stay engaged with curricular material was evident. The final group, dubbed 'Hostile/Rejecting', often evidenced anger and class disruptiveness, sometimes even overt racist commentary or behaviour (McDermott 2016). Perhaps the most graphic of this group's comments was, "Why don't we just give them all guns so they can shoot themselves?"

When teaching a group of health profession students, one may not expect to hear such a comment—one, perhaps, more likely to be aired in a front bar, rather than a tutorial setting. Yet, recently this comment was proffered in response to a discussion concerning the social determinants of Indigenous health. Such a comment is commensurate with colonial, discursive practice evidencing a genocidal flavour. (Said 1978; Spurr1993).

The tutor, in this instance, was shocked and unsure of how to progress with a student's contribution that was not only non-academic and unprofessional, but quite disturbing. Whilst debriefing and supporting the tutor, supervisors and/or mentors were compelled to consider ongoing discussions about alternate pedagogies and the development of curricula focussed on Indigenous health education.

What is the NT intervention? I've hardly heard anything about it.

We argue that tutors must be supported to cope with overt racism, as well as 'common sense' racism (Hollinsworth 1998), utilising teaching strategies that facilitate an unpacking of these types of comments, so as to understand a racialised framework and how it may present itself in the tutorial setting. Extreme comments, such as the one under discussion, are an indicator of a level of negative socialisation that persists regarding Indigenous

peoples and one which educators need to facilitate the critical analysis of, in order to genuinely assist health profession students to make the transition into culturally safe health practitioners.

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

One method employed is to start the semester with an 'anonymous question' session, so that students are able to ask questions about Indigenous Australia in a non-threatening environment. It is essential that facilitators or tutors foster a 'safe room' for a discussion that may be highly charged with emotion, misinformation, fear and confusion, and which can easily become counterproductive, if the tutor is not well versed in guiding students on a non-combative journey of learning. An approach that confronts students with difficult material, yet lacks a manageable pathway for learning, is more likely to cement entrenched misinformation than to develop or enhance criticality.

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

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

Teaching strategies that are informed by Indigenous knowledge systems, together with authors such as Fanon (1968), Foucault (1985), Freire (1972), Said (1988) and Moreton-Robinson (2004), give students an opportunity to consider power and its construction of knowledge and 'truths', whilst introducing concepts such as 'structured white privilege' and 'the other'. Comparative studies of patterns of power abuse and its effects on the

powerless also canvass the experience of many countries, informing the students of global issues, rather than supporting any perception of a simple focus on Australia as a 'rogue nation'. It is not enough to identify 'whiteness' and its impact on continuing Indigenous disadvantage if we do not handle the fallout of receiving such unsettling perspectives of Australian society:

> Paralysis is…an issue for educators introducing critical perspectives on racism and whiteness. Ross Williams (2000)and Gillian Cowlishaw (1999), reflecting on the responses of students and others to critical examinations of whiteness, have noted the prevalence of discomfort, paralysis and helplessness. Chris Sonn has also reported that a lot of students at some stage experience a temporary paralysis of some sort [in Ranzijn & Severino, 2006]. (Every, 2008)

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

How to Incorporate the Deconstruction Exercise into Teaching: Practical Steps

1. Begin by having students write down an anonymous question, anything they want to know about Indigenous Australia, but have been afraid to ask. The clarification gives students the opportunity to ask questions that may be contentious if asked in public. From these questions, choose those which are suitable for deconstruction. These questions must hold the potential for analysis that will give students the opportunity and scope to elucidate whiteness and the importance of understanding the social determinants of Indigenous health.

2. Explain to students that the object is *not* to answer the questions. Instead they are to examine the space from which they were asked. Whilst workshopping, and for assessment, we consider it important to utilise anonymous questions from previous classes (so as not to put the current student's questions under immediate examination). This approach fosters a continuance of student engagement and helps avoid the 'blame and shame' often felt when students examine their own 'whiteness'.

3. Give an example of a question that has plenty of scope for critical discussion; field suggestions from the class as to how you might critically analyse the question. Ensure that you model critical analysis in the discussion. Ask students to articulate the space from which the question was asked. Are particular sociological markers employed in the language used?

4. Does the example question evidence respectful inquiry? Or does it, instead, echo stereotypical representations or discriminatory positioning?

5. Students are asked to articulate hidden assumptions and show critical writing about the origins of those assumptions, as well as the impact they may have on the social determinants of Indigenous health.

6. Assist students to identify assumptions that are indicative of a racialised approach, for example, “Why are all Aboriginal people lazy bums?” This question gives you the opportunity to open up a discussion about stereotyping, racialised language and/or social and economic exclusion. Ensure that students can recognise, and explicate, homogenous depictions of Indigenous peoples that deny diversity; depictions that set up a racialised space where Australian First Nations groups are reduced to a one-dimensional, catch-all category deemed ‘inherently dysfunctional.’

7. It is vital to illuminate the unspoken, crucial omissions that shadow a colonial discursive position. If students can identify these silences (what is *not* said), then they are developing the critical tools needed to identify the ‘framing’ that is evident in the Council of Australian Governments (COAG) contested ‘Closing the Gap’ policies, for example (Potter & Wetherell 1987, cited in Dawson 2015).

Before any assessment is due, it is important to support students’ ability to successfully apply deconstructive strategies. The facilitator/tutor should workshop the questions again with the students, creating a dot point list for start-up discussions that articulate critical thinking. One way to initiate work on such a dot point list is to pose questions that critique the original question, such as in the following examples:

Question: Why are Aboriginal people prone to drug and alcohol addiction?

- All Aboriginal people?
- Is racism a factor in this question?
- What is “prone”?
- Is this a human condition or an ‘Aboriginal condition’
- What is being omitted from this question? (Social determinants of Indigenous health?)
- What is the pertinence of such issues as history, trans-generational trauma, systemic disadvantage and the existence of an Australian version of ‘apartheid’? What is the role of stereotyping or marginalisation?

It can often be useful to provide exemplar responses to the task, deconstructing different questions, if possible. The following examples have been excerpted from ‘deconstruction exercise’ papers wherein the student has clearly evidenced a critical approach:

Exemplar Responses:

> *Why are Indigenous people prone to drug and alcohol addiction?*
>
> This 'question' embodies the taken for granted "world view" of "Western eyes" whereby categorisation or stereotyping is used to construct an image of Indigenous life (Hall 1997). Whether the question actually reflects reality is of little concern according to colonial discourses, as "truth" lies with those with power (Hall 1992). Reflecting Spurr's (1993) discursive practices of surveillance and appropriation, the commanding view of the person asking the question, as a "Westerner" assumes the "right to know" how things "are" in regards to Indigenous drug culture and use. This question implicitly stereotypes an entire culture negatively through the use of colonizing discourse. (De-identified student paper)
>
> *Why are all Indigenous people lazy bums?*
>
> Analysis of the term 'lazy bum', what it is inferring in regards to Western understandings of work; and challenging perceived notions of choice under a neo-liberal framework that obscures historical and structural impacts of colonisation and white privilege. (De-identified student paper)
>
> *Why is it that Indigenous people of mixed blood have more success in life?*
>
> The phrase 'mixed blood' is one that is heavy with historical racist overtones and discredited biological notions of superiority. Selecting this phrase instead of the more benign 'mixed race', 'biracial' or 'multiracial' serves several purposes. Firstly, it is a dehumanising phrase such as one might apply to breeding stock or in denigrating an animal's pedigree. Secondly, in this context the term 'mixed' stands in opposition to pure. The phrase connotes a contaminated or adulterated substance. In this case the implication is that European blood is contaminated with Indigenous blood which is why, this question suggests, these individuals are between white and Indigenous on the spectrum of success. (De-identified student paper)

These examples are encouraging articulations of a burgeoning reflective and critical approach. Students have clearly identified and positioned the space from which the question was asked. Upon reflection, that hitherto unknown space becomes clearer and students realise that they are living in a country quite different to their understanding before engaging in this transformative (un)learning (Horn 2008, Quist-Adade 2007) environment. Entering into a teaching and learning environment where 'critical pedagogical' (Friere 1970) approaches are valued and supported enables students to take with them a capacity to think about equity and health in an informed manner. This is a promising outcome for future health professionals (whether their final

destination lies in clinical, preventative or academic fields) since, otherwise, to perpetuate dominant discourses is to perpetuate the power imbalances that create and sustain poor health outcomes for many Indigenous Australians.

Why do some Indigenous people take their own lives in gaol? - is it an instinctive spiritual thing?

The ways in which language has been deconstructed by Malak Malak and Ngarrindjeri Elders and community members now serves to inform our Indigenous health and cultural safety pedagogy. The 'deconstruction exercise' is an extension of the decolonising processes practiced by many Indigenous Australian nations, who continue to resist what has been pertinently described as 'ontological gerrymandering', where the 'framing' of the way we think and conceptualise Indigenous health has been limited and controlled in order to fit a government's health policy perspective (Potter & Wetherell 1987, cited in Dawson 2015). When both the legacy and continuing processes of colonisation are unrecognised and unaddressed, they continue to set the parameters for Australian society's thinking about and knowledge of Aboriginal and Torres Strait Islander peoples and their health. This exercise is founded on an offer from Indigenous Australia to non-Indigenous Australia; it operationalises a means to comprehend, and act upon, a richer perspective of Australia. Crucially, such a perspective does not dismiss Indigenous knowledge systems, rather, it reverses the 'killing of knowledge', taking a stand against 'epistemicide' (Bennett 2007; Grosfuegel 2013; Lebakeng, Phalane & Nase 2006; Santos 2014)

Conclusion

The 'deconstruction exercise' aims to give non-Indigenous health profession students the ability to recognise language that is imbued with power imbalance, so as to avoid the perpetuation of racialised ways of interacting with Indigenous peoples in the health system. This is an anti–racism strategy adopted by Indigenous academics and students as a tool to address unexamined, racist language in a measured manner that avoids the emotive or combative nature of unstructured discussions about the impacts of racism. Apart from the emotional toll on both student participants and their facilitators/tutors, what is also avoided is significant student disengagement from the very curricular material that is crucial to allowing the emergence of a culturally safe practitioner. As we have noted, our strategy of deconstructing stereotypical and racialised language is designed to disassemble earlier learning that will likely hinder future professional efficacy. We argue that, once a health care professional is able to exhibit decolonised language, together with a reorientation towards decolonised practice, a door opens, one vital for the development of a more-effective, culturally safe practitioner. Only then, we argue, will she/he gain an understanding of what practitioner fostered empowerment means with regard to Indigenous agency. Deconstructing racialised language reveals to non-Indigenous students, often for the first time, the extent to which the agency of Indigenous peoples is diminished by institutional and interpersonal racism (Ziersch et al. 2011). For educators, the

act of facilitating the unpacking of racialised socialisation processes in the tutorial setting is a rich and rewarding experience; educators witness students starting to use decolonised language and behaviours that incorporate respect, that recognise Indigenous strengths and our shared histories. Students and health care professionals are unlikely to reflect on their own privilege without assistance. This critical approach helps, productively, to reveal the structured workings of 'whiteness' and how 'whiteness', itself, often remains unspoken or misunderstood by those who inhabit spaces of privilege (Frankenberg 1993; Moreton-Robinson 2004).

When 'Uncles' Tom Trevorrow, George Trevorrow, Neville Gollan and Matt Rigney (all deceased) took the time to teach the perspectives of Ngarrindjeri peoples, they did so with patience and kindness. Their legacy lives on through this 'critical pedagogical' approach (Friere 1970) that serves to honour the Ngarrindjeri struggle for justice and equity by challenging positions of dominance. In an academic setting, this 'Ngarrindjeri way' has shaped the deconstruction exercise, which ensures that students are 'having the hard conversations' (McDermott 2016) in a pragmatic manner that challenges 'whiteness', whilst honouring each student's dignity, in a learning journey that is informed by Indigenous methodologies. Such critical pedagogy (Motta 2013) as this deconstruction exercise offers both a portal, and the means for change, in developing health professionals able to continue a life-long learning journey towards culturally safe practice.

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