

An argument on culture safety in health
service delivery:
Towards better health outcomes for
Aboriginal peoples

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Acknowledgment.

There is nothing I do that I cannot pay respect to, nor thank others.

Firstly, I acknowledge the peoples of the Land of my Grandmother's birth

I acknowledge this Land as theirs and that it always will be.

I acknowledge those children, who lost their connection to Land by death or authority, and those children whose families became unknown to them.

I acknowledge my sister, my brother and our mother, and the extended family we have come from and pray that one-day we will meet other family currently unknown to us.

I acknowledge Sally for the time, love and patience; who will go far as an important collector of facts and historical data. Her support and research skills has made chapter one possible.

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My friend and mentor Prof Jeanette Ward.

And most especially I acknowledge Jessie Waratah, my little Nana!

Ethical bias.

I am an Aboriginal women. I was born, as was my mother and sister, on the Land of the Gadigal people. The Gadigal speak the Iyora (Eora) dialect of the Dharug language. This area is now known as Newtown. It is also the same Land upon which the University of Sydney belongs.

As an advocate and an insider to my families culture, I experience difficulty in describing the effects and suffering of the continuing waves of colonisation that started in 1788. I am unreconciled to the fact that in this hugely wealthy country, the multiple beneficiaries of the colonisation and dispossession described here and elsewhere remain ignorant to the plight of the majority of Aboriginal people. The worst thing though, is the shameful blame and victimisation some people ascribe to the Aboriginal people and their kin.

For my part, like many of the people of Wiradjuri descent to whom I connect, have a blended heritage. I have two grandfathers, one Welsh, the other a Scot, finding belonging and family to two Aboriginal women of New South Wales.

I also find my words are limited by the experience of my own life. I was a 14 year old run-a-way from school and home. I was without decent numeracy and literacy. By some miracle I ended up living in a nurses home as a pupil nurse and meet extended family there. This led me eventually to medical school and onto the study of public health and beyond.

To be completely accurate, I can only speak from my own experience, and from the experience of those around me. In all other circumstances, I rely on the literature, observations made in the field and those of my family and mentors.

All of this experience and learning and family and friendships have shaped me and my approach to this work.

For my life partner, my lover and dear friend

And in honour of our late Uncle Eugene Bullganee Biles, a Ngmba and Murra Warri elder

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Research Philosophy

Finding the truth involves digging deeply into the historical record to find the Aboriginal voices. In this thesis I have, by necessity, referred to many secondary sources, including those who have ...

... carefully re-examined the records compiled, for their own purposes, by the English observers whose journals, diaries, official dispatches, private letters and printed histories still survive.(Smith 2001:pviii)

This historical information is interspersed with linking narrative and derives from a timeline of historical events I have developed over the last ten years or so. There are also two tables in this work developed by Sally Fitzpatrick as a part of her own research. They are identified as such.

There is so much I have had to leave out of this work, so many events that should be included in a work such as this. I have by necessity, been selective about inclusion of historical material and trust that I have not been biased in my selection. References will point the reader to my sources and the sources of others examined in this work.

Within Aboriginal pedagogy, the degree of understanding is directly related to the readiness to know a piece of information. Information theorist Dervin(Dervin 1999) holds that each information seeking task is affected by the personal situation of the information seeker, in this case, the readers of this thesis. This situationality is a synthesis of many factors and these can affect the information seeking behaviour.

There is another point to include here however. That is the point of shared history. The knowing of this history has been consistently put forward as an important step in the mending of relations between Aboriginal people and Torres Strait Islanders and the rest of the Australian population. I wish to push this actual *point of knowing* to the forefront, paramount to the pursuit of better relations and ahead of any acknowledgments or actions such as apologies by any party. It is my view that it is at this *point of knowing* that true change can take place. I believe this work helps the understanding of it all.

Study objectives

- Identify events and circumstances after 1788 that have influenced the way Aboriginal people react to the delivery of health care and the impact of this upon their current lives.
- Identify circumstances that stop people from getting the best out of the health care system.
- Examine the aspects of Aboriginal peoples involvement with the health care services and how people feel safe (or not) in the system.
- Apply findings from the above reviews to selected aspects of health service delivery to Aboriginal people.

Abstract

The bureaucratic measure of health service, health performance indicators, suggest that we are not effective in our legislated responsibility to deliver suitable health care to some of the populations we are meant to serve. Debate has raged over the years as to the reasons for this, with no credible explanation accepted by those considered stakeholders. One thing is clear though, we have gone from being a culture of believing that the needs of the many far outweigh those of the few, to one where we are barely serving the needs of the 'any'. This is most apparent in the care delivered to the Aboriginal and Torres Strait Islander people of Australia.

This is presents in many ways, and includes poor interactions between providers of health care and those wishing to attain a state of health and are evidenced by inter-cultural mis-communication and distrust, inadequate health services and so called 'non-compliance' of people with health and medical instructions.

Clashes in sensitivities and understandings, such as the imposition of western health care (as being the right way), the passive receiving of treatments by patients and the expectation of compliance by practitioners all exist as barriers to the safe delivery of health services to Aboriginal people. Some of the determinants of the health conundrum, and the wider recognition (or lack thereof) and identification of these determinants are examined in this work.

This examination begins with a presentation of historical events that have changed significantly the health of Aboriginal and Torres Strait Islander Australians since 1788 and examines our shared history in order to find reasons or rationale for the current circumstances of contemporary Aboriginal peoples' health.

This historical review is then placed in the context of current times, with a review of the national and state data expanded and explained within the context of performance indicators, policies, benchmarks and priority outcomes. Data-sets are reviewed in a research project on Indigenous identification which illustrate how little is known about people using the health services in NSW.

There is acknowledgement of the importance of the work done in Aotearoa to identify the health inequities in the health system there. Yet, for the New Zealanders, *Cultural Safety* has at its core the acknowledgement of having two large groups of people residing there, one group the Māori, the other being everyone else. Although the experience of the New Zealanders may well be a good starting point for Australia, given the current climate, it is clear that any such acknowledgment is not going to happen at a federal level.

There is also the conundrum that, at an intellectual level, many Aboriginal people believe themselves to be outside mainstream society. Control has never been relinquished to the coloniser and the certainty of Aboriginal sovereignty remains intact. On the other hand, for someone to receive service means that they must take part in the collective process of that service. While an affirmation of sovereignty by government and others remains an abstract notion, the continuing drug, alcohol and social dependencies will continue to numb the pain.

In order to understand Aboriginal peoples' health needs and some of the consequences of poor health delivery, this thesis demonstrates that the causes of ill-health are not only a result of the effects of "abuses and denigration" (Human Rights and Equal Opportunity Commission 1997:p193) of current physical disease, but germinate with the onset of invasion in 1788, the foundation time of the dispossession of Aboriginal people from the Land.

In-service, cross-cultural education and policy direction regarding Aboriginal people has long been a derivative of multicultural and ethnic policy, espousing such notions as cultural sensitivity, horizontal equity and trans-cultural awareness. Such a framework must find Aboriginal sovereignty at its core, despite the present legal and political resistance to do so. As the Mohawk woman Monture-Angus sets down clearly regarding the Lands of her people (Canada):

It was a colonial mistake of the past to exclude Indian nations from the legislative division of powers. (Monture-Angus 2000 p117)

Any framework must have the potential to seep beyond the provision of health services into service/client interactions of any discipline. Again, these should be applied to the benefit of all Australians. The first step is to place interactions between two cultures as just that: They should take place *in-between* the two cultures. Neither party can afford to limit the rights of the other.

Departments across the health sector are now acknowledging the inequities inherent in the system, and realise that for there to be appreciable health gains in the communities most needing them, we must rethink our current plans and strategies. This thesis goes part of the way.