

A plague of presumption

Lorraine Holland, Louise Lawler, Charles Sturt University, Dubbo NSW

ABSTRACT

A cross-sectoral evaluation of a specialised Bachelor degree for Indigenous Health Workers offered from Charles Sturt University's Dubbo campus indicates the course is enjoying retention (87%) and graduation rates (83%) which outstrip many mainstream tertiary health courses.

However, this study has also revealed disturbing dynamics in many workplaces that continue to undermine the role and effectiveness of Indigenous Health Workers. An exploration of the relationships, real and perceived, between many Indigenous Health Workers, and the multi-disciplinary health teams they work in, indicate polarised problems expressed by and indeed contributed to by all parties.

Exhaustive surveys and interviewing were carried out across the full spectrum of health agencies employing over one hundred Indigenous Health Worker students attached to the degree program from 1997 to 2003. These included the Health Workers themselves, community members, workplace supervisors and non-Indigenous colleagues from multi-disciplinary health teams.

Utilising grounded theory as an analysis strategy, the study revealed in-trenched presumptions by many non-Indigenous and Indigenous health workers that serve to create a 'Mexican stand-off' where the value of Indigenous health work and workers continues to be undervalued, under utilised and undermined.

This paper explores the socio-politico-cultural contexts which prevail in many public health services giving rise to the perceptions and realities dogging the roles and responsibilities of Indigenous health work in NSW. It provides some innovative insights into the underpinning environments which foster and maintain an impasse position in a 'lose-lose' situation and provides some valuable advice and direction for making the adjustments necessary to create a 'win-win' situation for all involved – not least Indigenous community health.

THE EVALUATION PROJECT

The evaluation of an undergraduate degree in Health Science (Community and Public Health) concluded in 2003 after seven years of data collection, provided ample evidence that the course has met successes far in excess of the nominal expectations of similar programs. Since its inception, the program has enrolled 129 students from eight offerings. Against an average national graduation rate of a 76% for undergraduate Health Science degrees, this program has consistently achieved an 83% graduation rate. Graduate employment rates are maintained at 93% with 40% gaining promotions as a direct result of their participation in the course.¹

Methodology and analysis

The nature of the education program and the availability of longitudinal data lent itself to qualitative research methods. A mixture of ethnographic and evaluative case study

methodologies which contain description, explanation and judgement, were used to enable the evaluation of multiple facets of this program.

Evaluative data were collected via surveys and added to data gathered across the six years of course offerings. Information relevant to the initial recommendations and ongoing expectations of the course and stakeholders including students, teachers (guest and permanent) and student's workplace supervisors was sought. From this data a comprehensive longitudinal evaluation of the educational program was constructed. Formal and informal evaluations were conducted on, teaching sessions, individual teachers, guest speaker's performance and acceptability, course materials and graduate attributes. Longitudinal data from reflective observations of principal learning facilitators and student forums were also utilised.

The data was analysed using grounded theory to explain the causal links in real life interventions that are too complex for experimental strategies. It describes the real life contexts in which an intervention occurs and explores interventions in which there no clear single set of outcomes.

Findings

The data yielded consistent complaints from students who reported they felt unsupported by their workplace and from graduates stating they were prevented from applying knowledge and skill learned from their studies in the clinical setting. However, the process of analysing the data using grounded theory produced some peripheral but significant results.

Simultaneously, data obtained from clinicians who delivered lecturers and workplace supervisors expressed concern that most Indigenous health workers, despite their studies, were incapable of functioning in higher order positions within the workplace. This was significant when measured against the fact that most of the students were senior health workers with many years of practical industry experience, many in excess of 10 years.

The survey data indicated that the majority of educators and workplace supervisors believed there to be deficits in the clinical and learning abilities of many Indigenous health workers. The data describe a situation in which Indigenous health workers are often portrayed as inexperienced, inefficient and incapable, by their colleagues in the workplace. Social psychologists identified this as the "fundamental attribution error" which is a general tendency to attribute the behaviour of others to internal dispositions rather than environmental circumstances.²

They also alluded to another issue, that of hierarchy and just where on the health food chain it is 'acceptable' for Indigenous health workers to be placed. The evidence arising from the study in support of this claim lay in the selection of skills deemed necessary for health workers to attain. Responses overwhelmingly concentrated on basic skill acquisition, such as active listening skills, time management and working collaboratively, again negating the seniority and experience of the Health Workers. Link² suggests that it is due to the existent professional health hierarchy that Indigenous Health workers struggle for acceptance as valid and credible practitioners as they are continually judged by those who consider themselves of much higher professional status.

A second idea emerging from the data was the antithesis of this first, yet enhanced the initial view. It indicated that high-level autonomy of health workers was viewed as less desirable than their capacity for carrying out set tasks and following orders. This is reported commonly in the literature when race based workplace inequities are described. Chen and Kleiner³ maintain that there are two competing concepts of inequality, that of opportunity and result. For Health Workers the equity of opportunity is guarded by government regulations, however the result

or outcomes of their work endeavours are judged by professional health colleagues, who, according to the findings of this study continually find them lacking.

Despite clinical skill acquisition being touted as essential by students, educators and workplaces, comparison with skill expectations of health workers from the northern Australian states, indicates that few Indigenous health workers from regional NSW departmental health services, appear to be encouraged or supported in taking leadership roles encompassing, high level clinical, managerial or research responsibility. Again this is a demonstration of Link's² ideas of the power differential at work where the interests of high status professionals are particularly salient in maintaining privileged access to health care delivery.

These findings confirm that many teachers and supervisors see Indigenous health workers as being in need of aggressive training and that this should commence at levels preliminary to Degree studies. They suggest students, working predominantly full-time, and often long-term employees, should be undertaking comprehensive studies with emphasis on the acquisition of basic clinical skill via theoretical education and practical placements. Interestingly the students confirm the need for education in this area. However, the vast majority of health workers undertaking studies in this course have been health employees for more than 5 years, charged with and taking responsibility for Indigenous health, which includes clinical procedures. Worrying questions that emerged were; "whose responsibility has it been to ensure these Indigenous health workers are adequately and appropriately prepared to undertake and be responsible for the work they are already doing?" And ... "If they are so in need of additional education and training, how have they been able to carry out their work competently and effectively during their terms of employment?"

The data suggests that a contributing factor to this situation is a lack of knowledge and understanding of the political and cultural contexts of Indigenous health and education. While teachers and educators believe professional clinical placements are essential, most view cultural excursions as "a perk".¹ Wyatt maintains that cultural capital, which comes from life experience and prior learning, is to frequently given no value. This in turn is frequently interpreted by the student health worker that they as individuals and their culture are of no value to the workplace.⁴ This is a common discrepancy between what is viewed as viable content (clinical knowledge and skill) and what is seen as irrelevant to the clinical workplace – 'cultural issues'. In combination with this is the information that while 60% of the educators indicated some cross-cultural experience, the workplace supervisors indicate a dearth of it. This suggests that the connections between experience and understanding of Indigenous health and the socio-politico-cultural contexts are not being made at workplace level resulting in ignorance being a contributing factor in the failure to improve Indigenous health.

Another critical finding noted that many students lament that they lack Indigenous cultural knowledge and understanding themselves. While one educator noted this "surprised by the lack of Indigenous knowledge of the students", it is, in the authors' opinion, vital learning for the workplace and essential for progressing debate to where meaningful reconciliation can occur. On this issue the literature is emphatic, that greater understanding of cultural issues is as valid to improving health outcomes as clinical competence.⁵

Although many students found the technical aspect of clinical health subjects challenging, it was seen as an essential yet often absent part of their working knowledge. The assumed level of viable health knowledge that contributes to the notion of health worker underachievement is reflected in the comment of a workplace supervisor that they (the students) "didn't know, they didn't know". This is confirmed by student's evaluations that welcome basic clinical health education as "refreshing, if unexpected".¹ In 1991 a study by Higgins⁶, surmised that Indigenous cultural heritage is such that the learning processes of what and when as opposed

to why and how dominate to such a degree that some Aboriginal people appear unable to monitor their thinking enough to realise “I’m not doing this correctly”.

Another study.⁷ found that many Indigenous people have relatively undeveloped ideas of the expectations of the contemporary workplace, relating it to doing what they are instructed to do. There was little reflection on content, process or strategy relevant to their own role in the work team. This correlates with the continuum of disadvantage, the more socially and educationally disadvantaged the worker, the more undeveloped their ability to conceptualise the requirements of the work. The study found Indigenous university students demonstrated marked discontinuities between the ‘what’ and the ‘how’ aspects of completing a learning task and that they did not see that understanding was necessary to learning. She concluded that the learners “fail to make the links to the life world”. This suggests that health workers are failing to learn how to work which acts to impede their functionality in a team and their impact on community health.

Professionals, governments and health service management have failed to identify the knowledge deficit of many Indigenous health workers by assuming the presence of a basic knowledge and skill level of both Indigenous and health issues. Indigenous health workers from across the nation plead again and again for education⁸, however the point is continuously missed by governments and institutions alike – it is basic knowledge they seek not in-depth technical wizardry – that they can learn from the workplace. The need is for foundational knowledge and understanding on which they can attach and build information and skill as it comes to them through practice and workplace training. The attestation is clear as students claim that due to their learning in clinical subjects that are couched in contemporary Indigenous contexts, they finally understand the tasks that many have been expected to undertake in their professional role for years.

Four assumptions that impede progress in NSW Indigenous health

Historically the NSW health industry has had primary responsibility for Indigenous health worker training. However, the inherent difficulties with Indigenous education and the fact that the industry’s expertise is in health and relies on clinical health professionals as educators ensures the link between content delivery and actual educational outcomes is rarely considered. Professional educators would be sceptical of any process that relies solely on subject or topic content to provide successful educational outcomes. Embedding content into a contextual framework where existing understandings are established, valued and built upon is required to link new knowledge, clinical or cultural.⁴ Failure to understand this has given rise to an unco-ordinated and sometimes amateurish approach to Indigenous health worker training.⁹

This often disjointed approach to workplace training is fostered from an assumption that Indigenous health workers, because of their Indigenousness, are able to relate clinical health and lifestyle behaviours and practices to concepts and contexts of Indigenous culture and history.^{10,11} However their inability to make these connections serves to dislocate already unrelated information and creates a void of understanding often perceived as a lack of ability or motivation. This illuminates a second assumption, that health workers are either learning information they choose not to implement in their practice or they are not learning due to lack of intelligence or academic laziness.

The mismatch comes from criticism, which compares high expectation of practice and performance in the workplace, with a perception that Indigenous students achieve below average academic norms.^{12,13,14} Measured in this context, the students cannot win!

A third assumption arises from the plethora of this uncontextualised clinical training, which is usually lacking in any broad based Indigenous expertise. It is frequently assumed that Indigenous health workers are 'experts' in Indigenous issues, including health and lifestyle factors leading to their being charged with much responsibility for Indigenous community health education. Given the superficial nature of the educational process they are exposed to in the workplace they are denied any potential to be able to reflect on and explore their own understandings rendering it impossible for them to relate theory to application in the contexts of Indigenous community life.¹⁵ This is a significant flaw in any educational process however it strategically serves to provide industry with receptacles for the responsibilities of Indigenous health and a scapegoat when efforts fail to achieve targets.

This predicament is aided and abetted by Indigenous politics and the 'cultural rights' mandate of race, which is demanded for transfer of Indigenous related information...with or without adequate expertise or competence. Neill¹⁰ reports 'black politics' claims "only Indigenous people can speak on Indigenous issues, including health". While 'white politics' encourages this it also ensures the blame for failure rests on the shoulders of those charged with responsibility – the Indigenous health workers. Exaggerating this is the climate of unquestioning 'political correctness' where any discussions that may arise and provide an opportunity for debate and progression are avoided under the pretext of offering cultural respect and a desire to avoid misunderstanding which could lead to dispute.¹⁶

This complex arrangement of processes and response has produced an impasse situation described by all health workers, workplaces and clinicians participating in the study. It gives rise to a predicament that ensures Indigenous health workers do not receive the education they require to make a difference to Indigenous health, while absolving health agencies from charges of failure to provide adequate services. It also supports non-Indigenous health professional's perceptions that Indigenous health workers are in the main only capable of functioning at lower clinical levels and cannot competently hold higher order positions in management, research or clinical practice.

The findings of the degree evaluation determined that disjointed understandings of health content and the socio, politico, cultural contexts of Indigenous community life, combined to prevent Indigenous health workers from meaningfully relating theory and practice, thus retarding efforts of translating ideation to application. Impacting on this is the fact that many Indigenous Health Workers in NSW lack even basic knowledge and understanding of Indigenous cultural concepts that are essential for success in their work and are assumed by industry. Thus Health Workers become trapped by the myth of a fourth and most detrimental assumption that "if you are Indigenous you hold Indigenous knowledge", which includes health. When this situation has been sustained for years it comes to replace the 'cultural understandings' that were initially assumed. Thus a void of non-information becomes protected and in some cases almost 'sacred cultural knowledge' that only Indigenous people can know – a pretence that leads to the continued undervaluing and underutilisation of Indigenous health workers as an integral component of the health team, the downward spiral of the Indigenous health status and the maintenance of institutional racism.

These findings may be unpalatable to some Indigenous people and health services, however they serve to raise key questions that need to be confronted. Failing to grapple with such issues and dilemmas serves to restrict any potential of moving either Indigenous health or education forward.¹⁷ The move to create educationally rigorous programs in the tertiary sector, incorporating research into the obstacles to improving education access and success must assist the health industry acknowledge and deal with these ingrained and complicated issues, regardless of the insensitivities associated with them. We must enter the debate in order to move forward – Indigenous health cannot wait any longer, too much is at stake.²

Further research should aim to exonerate those health services that are doing well and the Indigenous health workers as they have the both the pawns (dumped upon) and the victims (dumped) due to the interplay of politics.

ADJUSTMENTS FOR A 'WIN-WIN' OUTCOME

The literature highlights perceived differences with Indigenous people being considered different academically.¹⁸ However, this is presented in a way that highlights the fact that they are Indigenous rather than considering that everyone is different academically with different background, aptitude, understandings and ability. Indigenous ability to learn and take in meaning has therefore been linked to degrees of traditionality or assimilation. In this respect, culture is held accountable for academic ability.⁷

The problems associated with Indigenous education are well documented^{19,4} and are universally characterised by absenteeism, family mobility, literacy and numeracy, retention, ill health, and failure to achieve.^{20,4} These problems have large degrees of social, economic and cultural importance as well as political potency.²¹

For employers, the problem is a double-edged sword. The literature is littered with condemnation of the failure of the health system to accommodate Indigenous employees, of which Aboriginal Health Workers are an integral part and the public face. All too frequent is the portrayal of employers as having a lack of care and concern²² giving inadequate attention to the cultural matrix¹⁵ and being unable to ever understand Indigenous knowledge and ways of knowing.²³ Conversely, Indigenous health is an area that receives notoriety for its failure.

Failing to recognise and address these issues promulgates false hopes and rather than building capability and self-esteem, Health Workers are set up to commence the cyclical journey of failure reinforcing failure. However, this fosters the complication of providing evidence of a conspiracy to keep Indigenous Australians from gaining access to the benefits of mainstream society. This is attested to by many authors but is summarised nicely²⁴ by one who speaks of the necessity of including strategies in Health Worker programs as "...part of the process of uncovering the tricks of power". It is no surprise then that many Indigenous Health Workers believe the workplace and health professionals continue to negate the roles and effectiveness of Aboriginal Health Workers.

In enhancing the personal, professional and academic development of the Health Worker there is the challenge of balancing interchanges between Worker and supervisor, Worker and community and Worker and industry. Adoption of, and dedication to, the principles of contemporary employment can be facilitated through such interchanges that encourage critical thinking, reflection and engagement.²⁵ The aim is to develop capacities for life long learning. It must include knowledge of content, contexts and application. In this the workplace has a primary responsibility in developing these skills in all staff, however it needs to also understand that this need may be emphasised in Aboriginal Health Workers as they grapple with scientific clinical knowledge and apply it to a community setting that struggles with issues of cultural difference and identity.

However, huge barriers stem from the vagaries that non-Indigenous people have no right, no mandate and no authority to intrude in Indigenous issues. The ideologically sanctioned silence that results from this is enforced on two separate fronts, first from political activists and second from the governments and regulatory authorities who have adopted a 'hands-off' attitude justified as respect for self-determination.¹⁰ This has created a vacuum in public discussion and enabled racial criticism to exclude non-Indigenous voices from vital debates^{26,27} including health and education.

In health an obvious example of this is the rise of the Aboriginal Medical Service (AMS). Historically, mainstream service providers have not adequately serviced minority groups, causing the evolution of community organisations to serve these groups as a result. However it is believed that AMSs if working with communities in isolation can reinforce separation and add to division.²⁸

Workplaces need to do more than simply offer one-off minimalistic workshop type “cultural awareness” programs. They need to ensure that all staff are included in discussion, consultation, planning and development activities. Ideally a modified mentoring program designed to match team members who can contribute equally to learning, would be a preferred strategy. For example a community nurse and the Aboriginal Health Worker assigned to that specialty for example, child and family health or eye health would work as a clinical ‘pair’ or – the nurse sharing clinical knowledge and the Health Worker sharing community insight and cultural understandings.

Indigenous health worker training needs to be fully formalised in tertiary settings²⁹ as evidence confirms that piece-meal staff development at industry level has not been effective in improving Indigenous health status.

Pedagogy needs to be developed in-line with the specific socio-politico-cultural contexts and individual student need. This includes adherence to principles of adult education and instructional design, ensuring education is evidence based and assumptions find no place in the process. This will necessitate a revision of staff development approaches in many areas in NSW that focus on quality professional education and the relegation of culture to the learning content and context.

CONCLUSION

In order to overcome the assumptions plaguing Indigenous health work in the public health arena in NSW we need to ensure the debates on Aboriginal health and education are kept alive to examine options and practices that might help change the way in which Aboriginal health is developed and delivered. In this the workplace must reexamine its own staff development strategies and higher education must become the benchmark for the training of Indigenous health workers.

Simultaneously, Indigenous health workers need to evaluate their roles as community workers and leaders. Hard decisions need to be made regarding accepted community norms and whether they are detrimental to the people that constitute them. Indicators of internal social dysfunction must be faced up to and challenged in order to improve health, educational and life outcomes for Indigenous people. In order to achieve this Aboriginal Health Workers require access to and understanding of the clinical, social and political issues that are at work.

REFERENCES

- 1 Bachelor of Health Science (Community and Public Health) Stage Four Review Document. Charles Sturt University Australia. 2003.
- 2 Links BG, The Production of Understanding. Journal of Health and Social Behaviour. 2003; 44(4): 457-470.
- 3 Chen S and Kleiner BH. Race discrimination in the workplace. Equal Opportunities International. 1998; 17(3-5):85-89.

- 4 Wyatt K. A Fateful Expedition or a Journey for Life? The Australian Indigenous Education Conference, Fremantle, 2000.
- 5 National Aboriginal Health Strategy. Canberra: Department of Aboriginal Affairs, 1994.
- 6 Higgins, R. Effective Teaching Strategies in Isolated Aboriginal Communities: Some Issues to Consider. *Aboriginal Child at School*.1991; 19(4): 3-13.
- 7 Bunker A. Conceptions of learning held by Aboriginal entrants to a bridging programme. Australian Indigenous Education Conference. Fremantle, Kurongkurl Katitjin, Edith Cowan University, 2000.
- 8 Report from the National Indigenous Health Worker Conference. Fremantle, 2000.
- 9 National Aboriginal Health Strategy Committee and Gordon S. The National Aboriginal Health Strategy: an evaluation. Australian Government Publishing service. Canberra, 1994.
- 10 Neill R. *Whiteout: how politics is killing black Australia*. Allen and Unwin. Crows Nest, 2001.
- 11 Sandall R. *The Culture Cult*. Westview Press. Colorado, 2002.
- 12 Bonnett M. Teaching thinking and the sanctity of content. *Journal of Philosophy of Education*. 1995; 29 (3) 295-309.
- 13 Dunne, E. *The learning society: International Perspectives on Core Skills in Higher Education*. Kogan Page London Page, 1999
- 14 Harvey L, Moon S, and Geall V. Graduates' work: organisational change and students' attributes. Birmingham Centre for Research into Quality. University of Central England, 1997.
- 15 Byrnes J. Aboriginal Learning Styles and Adult Education: Is a Synthesis Possible? *Australian Journal of Adult and Community Education*, 1993; 33(3): 157-171.
- 16 Cope, B. and M. Kalantzis. *Cultural Difference and Self Esteem: Alternative Curriculum Approaches*. Centre for Multicultural Studies. University of Wollongong, 1997.
- 17 Pearson N. *Our right to take responsibility*, Noel Pearson and Associates Pty Ltd. Cairns.2000
- 18 Malin M. Moving on to... What? *Theorising Aboriginal Education*. 2000; www.edoz.com.au/adoz/archive/features/abed2.html. 2001.
- 19 Partington G. *Reconstructing Aboriginal Education*, 2000; www.edoz.com.au/adoz/archive/features/abed2.html. 2001.
- 20 McConaghy C. *Rethinking Indigenous Education – Culturalism, Colonialism and the Politics of Knowing*. Flaxton: Post Pressed, 2000.
- 21 Partington G, Godfrey J, Harslett M, Richer K. Can Non-Indigenous teachers succeed in teaching Indigenous students? Fremantle: The Australian Indigenous Education Conference, 2000.
- 22 Evans M. Acting across boundaries in Aboriginal curriculum development – Examples from Northern British Columbia. *Canadian Journal of Native Education* 1999; 23(2): pp.190.
- 23 Catchpole M. Evaluation Guidelines for Aboriginal Studies Courses. *Aboriginal Child at school*1994; 22(2): 56-66.
- 24 Dawson G and Gondarra B. Two Sisters Teaching and Writing: A Model for Education. *Best Practice in Aboriginal and Torres Strait Islander Education*. 1993; 61-65.
- 25 Knowles M. *The modern principles of adult education*. New York: The Adult Education Company, 1980.

- 26 Sutton P. The politics of suffering; Indigenous policy in Australia since the seventies. Anthropological forum, November, 2001.
- 27 Pearson N. in Neill R. Whiteout: how politics is killing black Australia. Crows Nest: Allen & Unwin, 2002.
- 28 Little M. Is the sector contributing to growth in segregation? Third Sector 2004; June 335:12-13.
- 29 Report of Indigenous nursing education working group. 2002, 'Getting em n keepin em'. Commonwealth Department of Health and Aging. OATSIH.

PRESENTERS

Lorraine Holland is a lecturer in and course co-ordinator of the Bachelor of Health Science (Community and Public Health) offered from the Dubbo campus of Charles Sturt University. Lorraine has considerable expertise in Indigenous education and research and was a co-engineer of this successful degree program. Lorraine has continued work in developing and refining this course across 7 years of offering and has based much of her Masters studies around this work.

Louise Lawler is a senior research officer working from the Dubbo campus of Charles Sturt University. Experience in Indigenous health and education spanning 25 years positioned Louise well to undertake two major community-based research projects concurrently in 2004. Both projects utilised action research and were heavily focused on collaborative work with the Indigenous community. It is working with the people and being able to contribute in the real world that Louise finds most satisfying and a welcome change.