Factors which inhibit successful Indigenous participation in health service delivery in northern Australia

Heather McDonald, Visiting Research Fellow – Indigenous Social Health, Australian Institute of Aboriginal and Torres Strait Islander Studies

Different cultural knowledges

Anne Lowell has written an excellent series of papers on communication and miscommunication between Western health professionals and Indigenous clients. She reports on a survey of a random sample of 10% Territory Health Services staff where 82% of Western staff reported difficulties interacting with Indigenous clients and 100% of Indigenous staff reported difficulties interacting with Western staff. Miscommunication can result in patients taking prescribed drugs without knowing their purpose or side effects; being admitted to hospital unaware of the type of medical treatment they are to receive; receiving medical treatment without consent; failing to receive adequate post-operative pain relief; and being returned home with a serious condition.

Suggested solutions to these problems are Cultural Awareness Programs, health interpreter services in regions where English is spoken as a second language, improved health services management, and increased support for health staff as a way to reduce the unacceptably high turnover of staff in rural and remote regions. Cultural education programs for Western health professionals need to go beyond cultural awareness and competency training to develop the capacity to engage in ongoing intercultural dialogue with Indigenous staff and patients. Impressive work is being done in some Fourth World contexts to develop intercultural health services. Instead of a one-way flow of information from Western health professional to Indigenous client, intercultural health services promote information-sharing and development of collaborative approaches to treatment and prevention of illness. Health programs are carried out within a framework of decolonisation, community development and self-determination.

In this paper I want to talk about differences in cultural knowledges about health and sickness. These differences tend not to be recognised or investigated by Western health professionals or by their Indigenous clients. In 2003–04 I conducted ethnographic research and analysis of doctor–patient consultations in a northern Australian Aboriginal Medical Service (AMS). This project was carried out in the Kimberley region and to protect the privacy of people involved, I have changed the names of all people involved in this project.

Plain English descriptions of medical conditions

Western health professionals believe that plain English explanations of disease processes, treatment programs and health education programs are sufficient for Aboriginal people in northern Australia. However, plain English descriptions are full of Western concepts. Descriptions of the heart, in medicalese, consist of archaic Roman and Greek city–state concepts. In plain
English versions atrium and ventricles become chambers. However, chambers meaning “rooms” is a Western term not used by Aboriginal people in the Kimberley. Medical explanations need to be in Aboriginal-friendly English—an English which includes Aboriginal idioms and Aboriginal ways of thinking about the world.

I am involved in a collaborative project with Kimberley Interpreting Services’ health interpreters on writing Aboriginal-friendly medical stories. The stories are about obesity, high blood pressure, heart disease and diabetes. We convert the plain English descriptions into Aboriginal-friendly English, then the health interpreters translate the stories into the local Kimberley languages. The result is a blending of Kimberley and Western views of the body and its processes. In writing the heart stories, however, we insist that the heart is a pump (or a kind of pump) and that the heart is a vulnerable organ dependent on the health of the blood vessels.

Interpretations of disease processes

Indigenous people may use Western disease labels such as high blood pressure, heart disease and diabetes but they interpret these disease processes in Indigenous cultural terms. Mabel is a 58 year old woman with diabetes and high blood pressure. At the consultation the doctor took Mabel’s blood pressure, finger prick test for blood sugar levels, and urine test for kidney function. Mabel told me that the blood pressure test was “For my blood. To see if it’s good or no-good. When he [ie blood pressure] is high, that means too much sugar”. For Mabel, the blood pressure recording reveals rubbish or sickness of any kind (sugar is just one kind) anywhere in the body. What the blood pressure recording reveals is the quality of the blood, not the pressure of the heart contractions on the artery wall. If the blood pressure is high, that means there is too much rubbish in the blood. The term “high blood pressure” has very little meaning for Kimberley people. In Australian Indigenous societies height did not become a metaphor for power, intensity or goodness. Although some Aboriginal people talk about the blood pressure machine and what it records, they don’t relate that recording to the physiology of the heart and arteries. Traditionally, the quality of the blood was important to people. Good blood comes from strong food. Meat which replenishes human blood is a strong food *par excellence*. Middle-aged to older Kimberley people interpret blood pressure according to their beliefs about the quality of the blood. They say when the blood pressure is high, the blood is no-good. They don’t see the heart as a vulnerable organ dependent on the health of the blood vessels.

Mabel said the finger prick test was “to find out if the blood is clean or dirty. Clean blood is right. Dirty blood is caused by sickness anywhere in the body. My blood looks clean, red blood mine. If he dirty one, you got something inside. When you have dirty blood, that’s the time you got cancer or gallstones or lump in your body”. Mabel said the urine test was “to see if the urine is good or no-good, clean or dirty”. For Mabel, all three tests (blood pressure, finger prick and urine test) are basically different versions of the same thing—to find out if the blood and body fluids are clean or dirty.

In Kimberley Indigenous traditions, sickness is caused by rubbish or debris which blocks the body’s organs and channels, obstructing the healthy flow of life energies through the body. Body organs are not understood as collections of specialised tissue which perform specific functions in the body. They are containers and channels for the flow of body fluids and life energies. Foreign objects can enter the body in various ways and for various reasons, in the past commonly through ancestral intervention or sorcery. Today, whitefella substances (for example, alcohol, whitefella tobacco and cane sugar) take on the characteristics of rubbish in the body. Alcohol, tobacco and cane sugar mix with the blood making it dirty and thick so that it is unable to flow properly. This thick mixture blocks the heart and respiratory organs, making the person short-
winded. When the blood is thick and congealed, the blood flows sluggishly and the person feels heavy, drowsy and lacking in vitality.

Aboriginal people also interpret Western medicine in Indigenous cultural terms. Good medicine should clear the rubbish out of a sick body, revive the spirit from its drowsy state, and make the person walk again. “Blocked heart” is a common disease description in the Kimberley. When someone has a “blocked heart”, Western medicine is taken to melt the congealed blood. Diabetes medicine is taken to render the sugar weak and clear it out of the blood. Asthma medicine clears the thick phlegm out of the respiratory organs and channels so that a good breeze can flow through the body. Some people complain that Western medicine doesn’t clear all the rubbish away from the body. They argue that Aboriginal traditional healers should be employed to clear the rubbish out of the body and this can be followed by Western medicine.

Good medicine is strong medicine but it should not be too strong for sick bodies. When the body is weak it may not be able to tolerate strong medicine. Aboriginal people frequently complain that Western medicine is too strong for them. It makes their body skinny, their blood dry and their spirit drowsy. When the body is weak and sick, weak or diluted medicine should be given until the body builds up its strength again. When Kimberley people feel that Western medicine is too strong for them they may stop taking it for a while to give their bodies a rest. Others only take Western medicine when they feel weak and sick. They don’t take it when they feel strong.

Mabel said to me at the end of her consultation that all her tests (BP, finger prick and urine test) were normal so she is all right. There is nothing wrong with her. She doesn’t know why the doctor has referred her to the dietician. Only her guts (belly) is too big. That’s all. Because her tests were normal, Mabel believes that nothing is wrong and she doesn’t need to make behavioural changes to keep her body healthy. She can eat as much sugary food as she likes because the diabetes medicine will clear the excess sugar out of her blood.

Knowledge of Western institutions

Indigenous people in the Kimberley lack knowledge of Western institutions and practices, for example, medical training, epidemiological studies, and professional ethics. For middle-aged to older people, what goes on in large, imposing buildings in southern cities is largely unfathomable. Traditional Aboriginal healers (and some churches) claim to be able to heal people instantly. The fact that Western doctors are not able to do this reduces their effectiveness in Aboriginal people’s eyes. Traditional healers gain their knowledge and credentials from experienced healers, dreaming experiences and from attending to the quality of their own body-life. The healer’s body is a conduit for healing life-forces. The healer keeps his body clean and its channels open so that its life-renewing powers can flow unimpeded. Healers prepare themselves for the task of healing by ritual practices and dietary restrictions, not by studying books for many years in large, imposing buildings. Western doctors need to give Indigenous patients some insight into the training processes they have undergone to prepare themselves for the task of healing.

Access to epidemiological information

Indigenous patients lack access to epidemiological information which may help them make an informed decision about their medical treatment. Sarah Bateman died of breast cancer with liver metastases in January this year. She was diagnosed with breast cancer four years ago in the Kimberley by a travelling breast cancer screening clinic. Sarah attended the Royal Perth Hospital Breast Clinic but refused to have a mastectomy which was the recommended treatment for her
type of breast cancer. When I rang Sarah from Canberra to try and find out why she wouldn’t have a mastectomy, she told me her breast cancer was “just lumps”. She had not assimilated the information that these lumps were invasive and would spread to other parts of her body and eventually kill her. Medical professionals at the Breast Clinic and at the local Aboriginal Medical Service were unable to present this information to Sarah in an Aboriginal-friendly format. The local Aboriginal Medical Service did not use the health interpreting services provided by the Kimberley Interpreting Services.

Sarah was unable to make an informed decision about her breast cancer treatment because she didn’t have access to epidemiological information on breast cancer treatments and survival rates. She could only rely on people she knew who had had mastectomies and died shortly afterwards. When Sarah was told these people were diagnosed with breast cancer too late; her breast cancer was diagnosed early and a mastectomy could save her life, she didn’t seem to hear this. Epidemiological analysis requires literacy, numeracy, highly developed recording procedures and other disciplinary techniques developed in military city–state societies. The medical specialists were unable to present epidemiological data on breast cancer to Sarah in an Aboriginal-friendly format.

**Oral transmission of knowledge**

In the Kimberley, a culture of oral transmission of knowledge exists within a wider Western culture of literacy. Although younger Aboriginal people are taught to read at school, they do not value literacy as a vehicle of knowledge. People who live in oral cultures have ways to establish the reliability of knowledge. If many people believe something, it is likely to be reliable. If an authoritative person espouses something, it is likely to be reliable. However, in egalitarian societies, people reserve the right not to “listen to” (pay attention to) authoritative people.

Hilda is a middle-aged woman with diabetes and high blood pressure. During her consultation, the doctor gave Hilda a copy of a diabetes pamphlet called “Diabetes: Too Much Sugar in Your Blood” produced by Kimberley Aboriginal Medical Services Council Health Promotions Unit. Hilda glanced through the pamphlet without much interest. She was taught to read and write at school, but she doesn’t read as an adult. She says she is out of practice at reading. Hilda relies on the spoken word for information and gets most of her information from card games, church sermons and television. Health professionals need to work with Indigenous oral cultures rather than ignoring them in favour of literacy. We can learn from the successful proselytising strategies of evangelical churches in northern Australia with their sermon and testimonial traditions. The television in the waiting room of many Aboriginal Medical Services could be used for Aboriginal-friendly health promotion rather than showing interminable American sitcom programs.

**Provider/client relationships**

Aboriginal clients in northern Australia frequently express dissatisfaction about their medical treatment and about the behaviour of health professionals. This relates to different views about appropriate health service delivery, diagnostic procedures and medical treatment. Aboriginal people complain that doctors ask too many questions during the medical interview. Doctors should know the patient’s condition. In Central Australia, Aboriginal women believe that hospital nurses should know when they are in post operative pain. In Western societies information can be elicited by asking one-sided questions. Questioners don’t need to provide any information about themselves or their motivations. In Aboriginal communities information exchange is a two-way process with both the knowledgeable person and the questioning person contributing.
information. White people in positions of power frequently ask direct questions in ways which are highly inappropriate to Indigenous ways of interacting.\textsuperscript{6,7} Direct questioning is interpreted as interrogation and accusation.

Aboriginal people do not accept a hierarchical, authoritarian relationship between doctor and patient. Doctors are considered to be authoritative but fallible, and sometimes not to have the interests of their patients at heart. People do not feel any compulsion to give the doctor an accurate account of their diet and lifestyle in relation to their disease profile. During her consultation with Hilda, a middle-aged woman with diabetes and high blood pressure, the doctor talked about her diet. Hilda said she eats meat and vegetables. She didn’t tell the doctor that she frequently eats fatty take-away food from the most unhealthy food outlet in town. Many Aboriginal adults say, “I don’t listen to the doctor”. There is a need to increase the image of the doctor as a person of authority (without increasing authoritarianism). Doctors can talk to Indigenous patients about their medical training, about the ways doctors acquire their knowledge and experience, and about how medical knowledge is produced.

**Different childrearing practices**

Aboriginal people adhere to permissive childrearing practices that worked well in hunter-gatherer times and that are humane in comparison with Western disciplinary practices. However, permissive practices but do not work well in a Western world with institutions that are highly regulated and disciplinary, which promote a Protestant work ethic, which adhere strictly to the notion of working days and working hours, and which run on clock time. Alice Sims took her son, Jake, to see the doctor. Jake, a 12 year old boy, was skinny, suffered from malaise and hyperactivity, and had right ear pain. After examination, the doctor prescribed worm tablets, iron, and antibiotics for Jake. Alice said to me when the doctor and Jake were out of the room, “Jake won’t take his medicine. He won’t listen to me. Can the doctor put him in hospital for three days [so that he’ll get his medicine properly]?"

Alice wanted to abdicate her responsibility as a mother to white people (who had the power to force Jake to take his medicine against his will—a power that Alice did not believe she had). Alice understood that Jake needed to take all his medicine to get well, and her way of ensuring that he got the medicine he needed was to put him in hospital. The doctor did not put Jake in hospital for three days. She told Alice to bribe Jake to take his medicine. The doctor said, “Give him a dollar every time he takes his medicine”. I doubt that Alice had dollars to give away in this fashion and I don’t know whether Jake took his medicine or not, because I was leaving town the next day.

**Influence of charismatic churches**

The Pentecostal church in the Kimberley claims to be able to heal people instantly. This is similar to traditional healing and it is not surprising that Aboriginal people are attracted to this kind of church healing. Middle-aged to older people nominate missionaries as the most knowledgeable people in the world because they have God’s knowledge, that is, knowledge of everything. Some younger people say that scientists are the most knowledgeable people but they don’t know how scientists acquire their knowledge.

Pentecostal churches inhibit successful Indigenous participation in health service delivery because pastors insist that God does not want people going to Perth to undergo major operations such as kidney transplants. God wants to heal them in their own environment and
without human intervention to demonstrate to East Kimberley people his supernatural power. The pastors make extravagant claims during healing sessions that the sick person will never again need their wheelchair, their dialysis tubes or their insulin. They claim that “God is at this very moment fashioning new kidneys for [the sick person] with his own hands”.

Conclusions

Western health professionals and their Indigenous clients lack insight into each other’s cultural knowledges. This leads to unrecognised miscommunication. In the provider-client relationship it is the service providers who are in positions of power. Health providers working in rural and remote Australia need increased intellectual and cultural support, and pathways to career development. Health professionals who are adequately trained and supported can develop new abilities to enhance their relationship with Indigenous clients. They need to develop the ability to engage in ongoing intercultural dialogue with Indigenous staff and patients, and the ability to switch between Western and Indigenous modes of knowledge and practice.

References


