

Dhungalla Kaella Oration, Shepparton, Victoria, May 2009

Dr Carmen Lawrence – The Prejudice of Good People

Thank you very much indeed and that's way too generous and I'll tell you in a moment why it is. But first, I want to say thank you very much to Aunty Frances Matheysson for such a wonderful welcome and I of course would like to pay my respects to the traditional owners and the community elders who are here with us today, this evening, thank you for inviting us to your country and for making us feel so welcome.

It's in many ways a difficult kind of thing to say. I've listened to the formulaic presentation of acknowledging the traditional owners, the people – the Yorta Yorta people – the community elders in many places around Australia and I think we're in grave danger and I sometimes feel as if I am not really feeling it, of not hesitating for a moment, pausing and recognising in a sense, what it is we're saying. It was writ large in the apology to the stolen generation – to the apology for whites having come to this country and overlooked the indigenous people for so many years and it is very important that we always pay our respects to the traditional owners and acknowledge the community elders who are with us but I sometimes feel as if I personally – I'm not criticising others – don't think carefully enough at that moment, about what it is precisely that I'm saying. In a way what I want to do tonight is to draw attention in a sense, to the things that we should remember every day, especially in tertiary institutions, in places of learning, where professionals are being trained, where young people are being educated and influenced.

The title of my talk is 'The Prejudice of Good people' and that comes from a quote by Vikram Seth, a very fine writer, whose 'A Suitable Boy' was popular in the 1990s and he said, and I think this is a very powerful quote, 'It's not only bad people who are prejudiced. That would not have such a strong effect; most people would not wish to imitate them and so such prejudices would not have much direct effect except in exceptional times. It is the prejudices of good people that are so dangerous' and by that he means, I think, the prejudices that we all carry around in our heads. They're on both sides of the racial divide; they're in all ethnic minorities and religious groups but they're particularly dangerous when people who have authority and power can exercise them to the detriment of those who have less power. I want to argue that prejudice, racism, is not just a question of human rights – although it is – but also a key factor in public policy and especially – and I want to talk about this evening given some of our partners – in health. It's true that in international terms if you look around at the various research papers here and there, Australians are not the worst in expressing blatant racism, although sometimes it seems as if we might be and we do have a suite of laws that have been expressly designed to reduce racism and prejudice in our communities. But we also know despite that, that racist attitudes persist and that even those – and this is my message in a way – who think themselves free of it, free of prejudice, may actually express it in their behaviour toward aboriginal people. Of course we know that racism in that more blatant form, the more overt form where people are sworn at and discriminated against, that continues to cause harm as well.

Many of you will know – because I know you're specialists in this field, or interested in it – that there are almost universal and persistent inequalities in health that are based on race and ethnic groups and in Australia we've heard already, we're all too familiar with the extreme health disadvantage of our aboriginal people. Now you get lots of explanations for why that will be so; some will have to do with the experience of dispossession and removal.

Poverty is frequently invoked as a causal factor and we know that there's a link between poor health and various social factors – the social determinates of health such as inadequate housing and education and poor income and unemployment. But there's a sneaking suspicion too – and now a lot of evidence – that the poorer health of racial minorities everywhere including in Australia with aboriginal people, it's partly due to the fact that they actually receive poorer quality health care. So it's not just the set circumstances in which they live; it's the care that's delivered to them and this is something I think that we need to examine if we're to properly address the problem of poor health. In a review of over one hundred studies on health care delivery the authors said when they looked at the studies across the world – because this is not just unique to Australia – that they were struck by the consistency of the finding that minorities are less likely than whites to receive needed services including clinically necessary procedures. Now that's an extraordinary conclusion. They just get fewer services and it didn't matter what the disease type was or the type of procedure; whether you were treating cancer or heart disease or mental illness, whether these were major interventions or just routine procedures and testing.

Generally speaking, the dominant white culture gives themselves more than they do the racial minorities and similar results have been obtained here in Australia. We know that there are excess levels of illness and shorter life expectancy amongst indigenous peoples but Aboriginal and Torres Strait Islander peoples in Australia receive less specialist health care, both as inpatients and outside hospitals. One study at least has shown that Indigenous patients were less likely than other patients to get a major procedure when it was needed like surgery, even when you take account of the type of patient or the location, it's not just a rural/urban divide, let me assure you. It holds whether you're talking about two people in Shepparton, two people in the Northern Territory or two people in Brisbane and it holds for most types of diseases and conditions. There are systematic differences in the treatment of patients who are identified as Indigenous. Other studies have shown differences in treatment including for cancers and, as I mentioned, unequal access to cardiovascular health care. In my own state of Western Australia there was a recent exploratory study that found that aboriginal people who had lung cancer or prostate cancer were less likely to get surgery for those cancers than the non-indigenous population and that couldn't be accounted for by anything else. It wasn't that the aboriginal people didn't turn up for their appointments and it's now generally agreed, I think, that the phenomenon of fewer and poorer health services for aboriginal people, for ethnic minorities in other countries is real and it can't be explained by the behaviour of the people who are getting the treatment.

As well as the things that we know exist in our health care systems, many of which cause problems in the delivery of health care like cultural and language barriers, we also know that the provider behaviour – the behaviour of nurses and doctors and decision-makers in the system, is also implicated. In some ways that's a hard message because the people who work in those systems are often very dedicated, especially when they're working in adverse circumstances. But what happens is that we all carry around with us – and I'm one of the people who do carry around with me too – instantaneous assumptions about people based on their race or their religion or their gender, but often on race. It's one of those things and we hardly even know that we're doing it and in that circumstance what a lot of people do is express uncertainty and those prejudices that they're unaware of are reflected in the way that they act, the way that they look, the way that they speak. It may not be very visible, certainly not to themselves even if they were looking in the mirror, but there's a lot of evidence that as well as those more subtle things, health care providers generally and service providers altogether – that includes educators, includes public servants, includes

probably everyone in this room in their roles – we do hold stereotypes based on the race particularly of – in the case of health providers, the patients, which do influence the interpretation of what the patient's saying, the symptoms that they provide and inevitably operate to the detriment of the person from that minority group, to the indigenous person.

There hasn't been a huge amount of work in Australia unfortunately and I think there should be more but one United States study found that doctors rated black patients as less intelligent, so they couldn't give them complicated information, as less educated, as more likely to abuse drugs and alcohol, as less likely to follow medical advice, as not having the sort of social support that would be necessary if they were to be treated at home and less likely to participate in their own rehabilitation. Now if you think those attitudes are only in the United States, I think you should think again. I think you'll find that they're alive and well in many of our systems. And even, we know from a lot of research in my now returned-to discipline of psychology, even people who express explicitly egalitarian views, you know 'I believe all people are equal' – important attitude to hold, but they can still carry around, as I've said I think we all do, these negative ethnic and racial stereotypes, sometimes called 'unconscious biases' or 'covert or aversive racism'. In some cases they can be just as destructive as the more obvious ones because the more obvious ones you can pin down; you can see it, it's operating – if someone's calling you a name, crossing the street to avoid you, behaving in an overtly racist way, it's easy to deal with that than someone who's eyes just slide off you as they're talking to you, who cut short the consultation rather than spending time explaining things to you, who doesn't prescribe the necessary medication and truncates the care - very hard to pin that down and therefore much harder to deal with.

Usually as these attitudes, as I say, don't result in expressions of hatred or open contempt, but rather in anxiety and discomfort which then leads to avoidance which is just, as I say, the prejudice of good people can be very dangerous. And of course, those of us who are doing that don't see it; we don't recognise it when our actions are racially biased in this way. We don't necessary read our own non-verbal cues which might signal that negativity and that distrust but, when you look closely at it, the research shows that whites often report feeling anxious when they're interacting with blacks. They often say 'No, I'm not prejudice but I just don't feel entirely comfortable'. That is a form of avoidance behaviour which, as I say, then permeates the way they make judgments, particularly when they're not certain of their circumstances. So in a crisis, in other words, when it really matters that you use your professional skills to the utmost and you're not certain about the other person that you're dealing with, then you're more likely to fall back on stereotypes of prejudice on those ideas that are based not on the patient or the person in front of you, but on the group that they belong to. So if it's a complex problem or you're in the middle of a very difficult situation, you're more likely to revert to those stereotypes. Then if the patient is alert to signs of prejudice and you'd forgive aboriginal people in this country if they were, then that avoidance is going to be interpreted too as reflecting a hostile attitude. So even if it may only just be anxiety and uncertainty and a desire not to stay too long in the situation, for the person who's been subjected to racism all their lives, and prejudice, they will read it and, I think, reasonably accurately as something that reflects, if not a hostile attitude, certainly one that suggests 'I don't want to be engaged'.

We know that when people in a doctor/patient relationship, indeed any relationship of that kind, experience that, then that relationship is compromised. It means that the person who is in that relationship is less likely to follow advice, surprise, surprise because they actually

don't trust the person that they're dealing with. They won't follow the regime as closely as they would if they trusted them. So this sort of racism in this more subtle and indirect form does produce poorer treatment and it can result in decisions being made that are really not suitable to the people who are being diagnosed. One study for instance found that doctors were less likely to refer black female patients – black women were less likely to get treatment for osteoporosis for example and in one case where they looked at video taped actors trained to display the symptoms of cardiac disease – some were black, some were white – then the white females got the catheterisation for the heart disease recommended; the black women didn't. Similarly when doctors presented with hypothetical descriptions of cardiac patients showed more implicit negative attitudes toward blacks and stronger stereotypes of blacks as unco-operative patients. So this sort of thing is going on all the time and although, as I say, there isn't nearly enough research in Australia, it is something that I think we should be very well aware of.

A major study of the consultations involving minority group members around the world concluded – and I think this is very important – that patients are less likely to engender sympathetic responses from doctors if they come from racial minorities. In other words they don't feel like the person that they're talking to and they're less likely to receive, as I say, adequate information and to be engaged as partners. And as I say, given such experience, it's not surprising that a lot of aboriginal people, people who come from minority backgrounds, don't fully participate in the health care system or for that matter; in any system that provides services for the community at large. We also know of course that there are direct effects of racism and I'll talk about those in a minute. But the important thing I want to say tonight is that we have to acknowledge these behaviours because if we don't we're unlikely to do anything about them. If we hide behind the formal presentation of anti-discrimination legislation, of 'I'm not a racist. I don't harbor these attitudes. I'm not capable of behaving in a discriminatory fashion', we're likely to continue to repeat the patterns that do damage. So even the best of people, with the best of intentions, can do these things and even however, when these prejudicial ideas are largely unconscious because as I say, we all carry them around on both sides of the racial divide, strategies and skills can be taught but first you have to face it. Hiding our collective heads in the sand certainly won't help at all.

I just want to talk too a little bit about the direct effects of racism and a couple of other psychological concepts that I think are very important for understanding the possibilities of reconciliation. We've often thought of racism as something that poisons people's social relationships, but it also poisons their health directly. When people are subjected to discrimination on a regular basis, when they experience racism on a daily basis, it affects their health; not just their mental health, although that's important, depression and anxiety are increased, but also smoking and alcohol consumption and in some cases there's clear evidence that it also affects physical health. Again, work in my own state of Western Australia shows that those people regularly subjected to racism and stereotyping about their behaviour are the ones most likely to be affected in the community and to show the body's physical signs of stress – heart disease for instance, and cancers. These are things we don't always think about. We tend to think of prejudice and stereotype as having social effects but they have physical effects as well.

One of the consequences of course of being subjected to pervasive negative stereotypes is that those views actually become internalised and in some ways, this is the most dangerous thing of all. If people are constantly being told that they have certain inferior

characteristics sadly, a lot of them come to believe it. You think of a child being raised constantly told that he or she is stupid or lazy or incapable or angry or whatever the label is, you'll find very often that that child starts to act according to the label that's been provided, whether or not it's justified. Aboriginal people have often had to live with those labels of inferiority and it's not surprising that in those circumstances they show distress and in fact, in some cases, actually live out the expectations of low achievement, of poor socialisation and although I focused on health today, I want to make it clear that's not to condemn health care providers as I said earlier; many of whom work very hard under extremely challenging circumstances to try and make sure that people get the best care but I do want to suggest that those prejudices and stereotypes operate all around the country, a lot of the time. If you look closely at public policy – and I know that you'll be doing that through your partnership with Melbourne University – you will often see underpinning it are assumptions about aboriginal people that would not be made if the people who are being provided with that service were white. For me the most vivid example of that recently was the intervention in the Northern Territory. Underpinning that was the idea that the aboriginal people in those communities were so completely debased that none of them were really capable of being partners in addressing the catalogue of problems that were real; only outsiders could possibly diagnose the problems and devise the solutions.

As anyone who's ever worked with people to try and reduce socially destructive behaviours, whether it's alcoholism or smoking or indeed abuse of children will tell you, reinforcing a sense of powerlessness is precisely the opposite of what you need to do. So taking away agency, taking away authority, beating people around the head with those stereotypes, taking away decision-making is the worst thing that can possibly be done because at the core of the policy is a prejudice that all aboriginal people in the Territory and in many cases in the past, around the country, should be treated the same, no matter what. The prejudice is that all black fellas are the same. Indigenous communities are portrayed as stereotypically violent, abusive drunks and that's the message that came over again and again and again. Apart from the sharp insult, what message does it send to the parents who are actually providing good care for their children and cherishing them when they're placed on the same regime as parents they know who are neglecting their children. That's the antithesis of making people responsible for their lives and I hear some commentators say 'Well aboriginal people should be responsible for their lives' but every decision is being taken away from them – the decision about their children's schooling, about where they live, now in the Northern Territory, about how they spend their money. Some people would say that the breakdown was so complete that you had to take over control completely. Well, I've been in enough of those communities and I know people have here, to know that that's rubbish. That corrosion of self-efficacy and the knowledge that you're not respected – I notice Paul used the word 'respect' several times – the knowledge that you're not respected, is at the root of a lot of that social collapse. My prediction, and I've made this before, is that the gains that are made that rely on coercion and taking away people's power and authority, will be short-lived because the psychology underpinning those measures is perverse. There may be compliance in the first instance, because people don't really have any choice, but when the restrictions are removed, there won't have been any fundamental change in behaviour.

So those things that reinforce powerlessness, that reinforce those so-called self-fulfilling prophecies that I talked about, that put control in other people's hands, there's a whole literature and psychology which we apply to ourselves; we know that when people are told over and over again that they can't control their fate and indeed, they're prevented from

controlling their fate, they don't. They give it up to other people, they under-perform, they under-estimate themselves and I think we've constantly reinforced this so-called 'learned helplessness' in aboriginal communities. We know that when people are repeatedly experiencing unpleasant events over which they have no control, not only will they experience trauma, but they'll come to act as if they believe that it's actually not possible to exercise control in any situation and that whatever they do is largely futile.

I'm going to conclude there because I think it's important to understand that when we look at aboriginal people in our community, we look at it through a set of assumptions, a set of beliefs that may or may not be helpful. They mightn't really I suppose attach the label 'racism' to that in the sense that we know about that blatant and aggressive form of it but I think unless we examine ourselves, we're likely to continue to do damage – the prejudice of good people. What can be done is to constantly observe ourselves, to look at the ideas and values that underpin our institutional and public policy, to test it constantly and to test ourselves for prejudicial and racist attitudes. We can't do that without leadership, without government and we have to dismantle obviously the institutionalised racism as well. But until we look into our own hearts and try to observe our own behaviour and work closely to provide the mechanisms to reduce that bias in everything that we do and think, we're unlikely, really, to be able to sustain reconciliation because we'll be walking around with a set of ideas in our heads that do damage to aboriginal people every day. Thank you.