THE NEED FOR UNDERSTANDING: A CASE STUDY OF ABORIGINAL AND NON-ABORIGINAL PERSPECTIVES ON HEALTH CARE

by

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THESIS

Submitted in partial satisfaction of the requirements for the degree of

MASTER OF SCIENCE

in

NURSING

in the

GRADUATE DIVISION

of the

UNIVERSITY OF CALIFORNIA

San Francisco

Date University Librarian

Degree Conferred: . . . SEP 8 1985 . . . . . .

Abstract

This thesis examines Aboriginal clients' experiences in the Australian health care system and explores Aboriginal and Non-Aboriginal health care providers' perceptions of interactions with Aboriginal clients in order to develop guidelines for future health staff training.

Chapter I outlines relevant background on Australian Aborigines and Aboriginal health and details the study problem(s) and sub-problems.

Chapter II reviews literature and proposes a conceptual framework to examine proximal and distal variables influencing Aboriginal health status in Country Town, New South Wales.

Chapter III details the strengths and weaknesses of the project's methodology and highlights some of the ethical, procedural and pragmatic dilemmas encountered. In particular the concept of 'co-researching' is discussed.

Chapter IV analyzes Aboriginal clients' experiences in the health system and health care providers perceptions of interactions with Aboriginal clients. Information gathered from three sample groups is discussed.

Chapter V compares data gathered in the three sample groups. Proximal variables, within the conceptual framework, related to attitudes/behaviours and service delivery, are expanded. Guidelines for future intercultural training for health personnel are presented.

Acknowledgements

This research would not have been possible without access to and co-operation from many health care providers in the North Coast Region of New South Wales. In particular I would like to thank Doctor Owen Spencer, Director of Clinical Services; Mrs. Brenda Smith, Aboriginal Liaison Officer; Mr. Leon Melville, Chief Executive Officer; Sister P. Grey, Deputy Director of Nursing; Mr. Peter Baker, Team Co-ordinator Community Health Services and all hospital/community health staff who participated in the project.

A special thank you is extended also to Mr. Hector Dungay and the Board of Directors and staff at Country Town Aboriginal Medical Service.

I am indebted to my friend and co-researcher Mrs. Pat Dixon, who contributed her time and ideas to the project as well as introduced me to many Aboriginal families in Country Town. I am particularly grateful to all the Aboriginal people who offered us advice, support and welcomed us to their homes.

I would like to thank my academic committee, Professor Anne Davis, Professor Joan Ablon and Doctor Gay Becker of the University of California, San Francisco for their advice and encouragement.

To my friends and colleagues in Australia Doctor

Anne-Katrin Eckermann and Professor Betty Watts I will always be indebted for their untiring support, patience and invaluable guidance.

Thanks to the Kellogg Foundation for supporting this project as well as my studies in the United States.

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CHAPTER I

INTRODUCTION AND BACKGROUND

Australian Aborigines

Aborigines have inhabited the Australian continent for at least 40,000 and possibily 120,000 years (Broome, 1982). They were divided into 500 different language groups, comprising at least 500,000 people (Butlin, in press). At the time of colonization, in the eighteenth century, the Aboriginal family was a self-sufficient economic unit, its members having clearly defined roles and responsibilities. Aborigines adhered to one of the most sophisticated kinship systems in the world, which provided a framework for their economic, social and psychological security within rich and complex cultural traditions.

In 1788 the British claimed Aboriginal land in the name of the Crown. The indigenous people were thought to lack any sense of ownership, government, religion, or culture (and therefore considered to have no claim to the land of which they, themselves, believed they were a part). Because there was no land cultivation, the British did not consider a treaty for possession necessary and dispossession was followed by rapid depopulation (in some areas to the point of virtual

extinction). Government policies, which forced Aborigines onto reserves as wards of the state then were implemented to "protect" the diminished population. In the process, traditional systems of law, religion, economics, and social organization were destroyed among many groups, most languages were lost, and a majority of Aborigines become totally dependent for survival on the conquering British.

Thus, Thiele (1982), identified three broad stages in the history of contact between Europeans and Aborigines: neglect, direct control and more recently, indirect control. These, however, should not be seen as clear, discrete stages of contact which began and ended at a given point in time. In fact, it can be argued, especially when the environmental/health situation of Aborigines in New South Wales (NSW) is examined, that elements of all three still exist today.

Historically, neglect, both deliberate, and conditional ('upon Aboriginal docility', Thiele, (1982) was the dominant feature of the government's approach to Aborigines. Problems resulting from massacres, guerilla warfare, dispossession of land, rapid depopulation and maltreatments of Aborigines were largely ignored.

Thus, Thiele (1982) emphazised that as a consequence of defeat:

> (Many Aborigines) became, in general, economically and politically unimportant to the capitalist development of Australia. They came or were made to depend upon government handouts or the largesse of various missionary bodies. In these circumstances the government could, by and large, afford to neglect the problems of Aborigines. (p. 3, my brackets)

To ensure complete domination of Aboriginal people in NSW, the Aboriginal Welfare Board was set up in 1889 and settlements/reserves were established under the Aboriginal Protection Act (1909). This legislation placed Aborigines under the direct control of white managers, some of whom had authoritarian ideas about codes of behaviour and how Aborigines should be "civilised". In addition white power positions were often reinforced by Aborigines' fear of white settlers and police.

Europeans of the time were of course a product of their own culture. Thiele (1982) implied that their ethnocentricism and xenophobia ensured that they acted:

> ...consciously or unknowingly, as agents of social control. They attempted to pacify and settle Aborigines, and to promote the legitimisation of the European governments,their instrumentalities, especially the police, and other institutions relating to such things as education, religion and the law. (p. 3)

Appalling conditions on the NSW reserves were not upgraded until the 1950s when outside pressures were exerted on the government to improve the situation. Further, restrictive laws were extended throughout the 1930s to control behaviour and the movement of Aboriginal people to and from the reserves. Such restrictive laws impinged on all aspects of Aboriginal life, including education. For example, Aborigines in NSW were excluded from mainstream schools for 66 years (Miller, 1985) and educated to third/fourth grade only in segregated All Black, reserve-based schools, often staffed by unqualified teachers, until the 1960s. Indeed, until 1972, it was possible to exclude Aboriginal children from government schools on "health" grounds if non-Aboriginal parents complained (Harris, 1978).

These restrictions and the patterns of under-education during the Protection Era left their mark on Aboriginal people and their communities in terms of self-sufficiency, self-confidence and decision-making.

Aboriginal organizational ability was further undermined by people's experiences when they left the reserves. Many continued to be under direct government control despite the fact that people could apply for exemption from provisions of the Protection Act (1909).

Even those who obtained Exemption Papers (frequently referred to as Dog Licences by Aborigines) continued to experience indirect government control through the activities of government agents such as the police and welfare officers. Programs implemented to "assimilate" them were designed and controlled by non-Aborigines who maintained the status quo by operating according to the dominant Australian legal system and administrative rules (Thiele, 1982). In order to "prepare" Aborigines for assimilation (and later integration) there was little consultation or delegation of authority and responsibility to them.

Such experiences form the living history of many Aborigines. Today, understandably some of their attitudes reflect a real suspicion/fear of government authority and intervention.

Thus Aboriginal groups throughout NSW have been subjected to a series of deliberate government policies ranging from extermination, during the uncontrolled frontier days (1788-1840s), to protection/segregation (the settlement/reserve days 1840-1950s), to assimilation (1951-1967) to integration (1967-1972), to self-determination (1972-1975), to self-management (1975 to the present). The explicit as well as the underlying theme of these policies until 1972 has always been assimilation/protection and its

resultant dependence on white decision-making.

The early history also appears to have had devastating effects on urban Aboriginal decision-making skills and acquisition of coping strategies to survive in the wider community. In the process of institutionalizing people on reserves and "resocialising" them through cultural domination and manipulation, traditional Aboriginal leaders and their kinship laws were ignored (Thiele, 1982). Many groups, for example, who would not normally have associated with each other, were forced together on reserves by governments who assumed all Aborigines were "the same" (Coombs, 1978; Eckermann, 1984).

Such early assumptions, still prevalent today, have had major ramifications on Aboriginal community organization. Coombs (1978) suggested that:

> It has only been since white occupation and the emergency need for groups, however separate and mutually suspicious, to work together to resist a common danger, that some sense of identity between Aborigines of different kinds has began to emerge. This sense of identity is still largely embryonic and lacks effective institutions through which it can be expressed. (p. 240)

Today in Australia there are many different groups of Aborigines, living a variety of lifestyles in diverse environments. They number 180,000 and represent slightly more than one per cent of the total population (Department

of Aboriginal Affairs, 1981). The majority of Aborigines are at the bottom of the socio-economic scale and poorly represented in trade, industry, commerce, and the professions. Unemployment is high (Commission of Inquiry into Poverty 1975, 1976).

Aborigines are affected by poverty and all its concommitant side-effects including not only economic but also socio-psychological dependency (Cawte, 1974). Eckermann (1982) has pointed out that:

> This dependency has been the product of 200 years of subjugation, of being told what to do. Today, it appears many Aboriginal organizations are crippled because they feel insecure, inefficient, incapable of making decisions, unable to reach consensus. Others are hamstrung by non-Aborigines who pay lip service to self-determination/management, but don't want to relinguish their decision-making role. They fear for their own positions which are built on the premise that Aborigines **need** guidance. This is a major dilemma. Far too often Aboriginal people are tempted to ask non-Aborigines to provide, to organize, to manage. (p. 23)

Nevertheless, over the last decade political awareness has grown among Aboriginal people, who are challenging the government at a national and international level to give reality to its policies of self-determination/self-management. Such challenges have also found reflection in their attitudes to research. As Watts (1982) has pointed out:

> There have been calls for action research, for relevant research and for Aboriginal involvement in research...As Aboriginal groups and individuals identify problematic aspects of their environment, they (should be able to) increase their sense of control over (it). The knowledge that they can initiate relevant research action is likely to assist them to view their situation more critically and to seek to change it. (p. 160, my brackets)

Following the work of Watts (1982) the research to be discussed represents an attempt to involve Aboriginal people in identifying, recounting and analyzing issues related to Aboriginal health.

Aboriginal Health

Many state and federal government reports, as well as a number of independent studies, have indicated that there are gross deficiencies in Aboriginal health care and that conventional health care services (both government and private) are often underutilized by Aborigines.

Only since the 1960s have some states, including NSW, begun to document and confirm the nature of disease among Aborigines, in order to provide some basis for determining health priorities and planning. Analysis of these records indicates that patterns of ill-health, which have arisen from the historic experiences of the Aboriginal people and their present social situations, resemble those in Third World countries. This is evident in the NSW Task Force Report (1983) which identifies several characteristics of Aboriginal morbidity and mortality:

1. Infant mortality rates for Aborigines are estimated at 30-52 per 1000 live births compared to 12.2 in the total population.

2. The age standardised death rate for male Aborigines is almost four times greater than for the total population while for females the rate is three and a half times greater.

3. Average life expectancy for a NSW Aborigine at birth is approximately 50 years, which is 20 years less than the life expectancy of a non-Aborigine.

4. By comparison to the total population, Aborigines experience a disproportionate number of deaths from pneumonia, gastro-enteritis, other diarrhoeal diseases, cirrhosis of the liver,

pancreatitis, cot death[a] and motor vehicle accidents.

5. The level of childhood mortality is of the same order as in countries in a transitional stage of development, but the level of adult mortality is much worse, and of the same order as is found in the poorest countries.

6. The hospital admission rate for Aborigines is almost 2.5 times the state average for all citizens.

Comparison of these 1983 figures with those collected a decade earlier (Moodie, 1973) indicates that improvement in Aboriginal health status in NSW over the last decade has been only minimal. Thus, however well current state health services cater for non-Aborigines, they do not appear to meet adequately the needs of Aboriginal people (NSW Task Force Report, 1983). The Health Commission (1981) itself recognises this fact and points out:

> The development of an effective approach to the health needs of Aboriginal communities is severely constrained by: failure to allow Aboriginal communities to make their own decisions concerning health services required, housing needs and land ownership. (p. 55)

In response to this situation several independent community-controlled Aboriginal Medical Services (AMSs) have

[a] Sudden Infant Death Syndrome

emerged in NSW since the early 1970s. Fagan (1984) points out that:

> Rather than being set up by the Government of the day, (AMS) was born of the Aboriginal community's consciousness of the need for the provision of more accessible and appropriate health care to the people...Its establishment and initial survival was achieved by local people and depended on the active support of the community. From the beginning it was a Medical Service operating along lines dictated by Aboriginal people. (p. 19)

At the time of AMS's inception, Aboriginal relationships with the white mainstream health system were extremely poor--in most cases, Sykes (1978) reports, non-existent. To some extent this is still true today. A lack of adequate support for these community-controlled medical services, inadequate level of resources caused by funding restrictions, and widespread negative social attitudes are still cited as contributing to present day Aboriginal health "problems" (NSW Task Force Report, 1983).

One solution recommended by the House of Representatives Standing Committee on Aboriginal Affairs: Aboriginal Health (1979) was that comprehensive courses and regular inservice training should be provided for non-Aboriginal staff recruited to work in Aboriginal communities. This has been endorsed

and broadened by a Health Commission of NSW (1982) Aboriginal Health Policy which has emphasized that all health care workers should be made aware of the several factors (cultural and other) affecting the health and well-being of the Aboriginal community.

In practical terms, however, a dilemma remains, which is the major justification for this study. There are no formal training courses today in NSW which ensure that non-Aboriginal health staff, especially those employed in mainstream medical services, fully understand and relate to the needs of Aboriginal communities. Without access to this knowledge, health professionals are not able to provide adequate, accessible, and appropriate care for Aboriginal people. The pilot project to be outlined below provides an opportunity for health care providers and their Aboriginal clients to collaborate in the identification of training needs in Aboriginal health.

Purpose(s) of the Study

To collect data that will provide a basis for:

1. Describing interactions between health care providers and Aboriginal clients.

2. Developing some understanding of the "pressure points" in communications which may lead to misunderstandings and potential conflicts between health care providers and

Aboriginal clients.

3. Drafting guidelines for discussion re: staff orientation/inservice training and community orientation to health services.

Problem Statement

The specific aim of the study was to explore and describe Aboriginal clients and health care providers' perceptions of interactions with each other in a hospital or community health setting.

Definition of Terms--refer to Appendix A.

Sub-Problems

1. What factors impede or facilitate interaction between health care providers and Aboriginal clients?

2. How do health care providers believe they can be better prepared to work with Aboriginal clients?

3. How do Aboriginal clients believe health care providers can be better prepared to work effectively with the Aboriginal community?

4. What approach is needed to increase professional awareness and effectiveness in Aboriginal health?

In order to fulfil the purpose of the study and examine the stated problems and sup-problems, the project confined itself to a country town of NSW.

Limiting the project to a specific geographic area had a number of advantages:

1. The area is serviced by an independent Aboriginal Medical Service (AMS) as well as conventional health services (private medical centre, state hospital and community health centre).

It was therefore possible to tap a wide range of health care providers associated with various spects of Aboriginal health.

2. The town and surrounding district have the highest concentration of Aborigines residing in this particular geographic region of NSW (Department of Health, 1983).

3. Most of the Aborigines living in Country Town share historical and experiential continuity in that they are "coastal people", have had the experience of similar reserves and missions and belong to interrelated family groups.

4. Through previous work with Aboriginal communities in a neighbouring geographic region I have had access to family networks in Country Town. Such access is necessary if non-Aborigines are to make meaningful contact in Aboriginal communities (Eckermann, 1980; Nathan,1980). Further, previous contact made it possible to engage an Aboriginal co-researcher, Mrs. Pat Dixon.

CHAPTER II

REVIEW OF THE LITERATURE AND DEVELOPMENT OF A CONCEPTUAL FRAMEWORK

This chapter will discuss some of the numerous and diverse factors influencing Aboriginal health in detail. Many of these influences, as outlined in Chapter I, are related to past black/white contact, the history of colonization and government policies. Such influences may be described as **distal**, that is, once removed from directly affecting Aboriginal health today. Other factors, foreshadowed in Chapter I, have a much more immediate, or **proximal**, influence on Aboriginal health. Jessor and Richardson (1968) clarify the difference between proximal and distal variables when they write:

> What many authors are referring to as °crude' or °gross' environmental variables, e.g., social class,are more properly considered as distal variables whose relationship to behavior must be considered to be mediated by proximal variables. Thus race and socio-economic status...are environmental descriptions relatively remote from psychological or experiential significance. That they have implications for the latter is quite true--that is why they have often been used as relatively effective codependent variables. But their implication can only be taken to be probablistic in nature: to be Negro in the United States involves a high probability of being exposed to a stigmatizing interpersonal

> environment. The crucial point is that behavior and development are invariant with the latter, the proximal environment of stigmatizing stimuli, rather than the former, the distal environment of being a Negro. (p. 4)

Thus, if this approach is applied to the health situation of Aboriginal people in Australia, proximal variables intervene as filters between the central issue i.e., Aboriginal Health, and distal/historical variables (see Figure 2, p. 35). Proximal variables to be discussed in this chapter include:

* General black/white interaction today.
* Elements of conflict and prejudice.
* Aboriginal reaction and non-Aboriginal response.
* Cultural barriers in health care
* Interaction between Aboriginal clients and non-Aboriginal health care providers.
* Cross-cultural training for health professionals.
* Environmental factors, particularly funding and proximity.

General Black/White Interaction Today, Elements of Conflict and Prejudice:

Chapter I clearly indicates that Aboriginal/non-Aboriginal interaction is historically based on conflict. Thus, Lippmann (1977) points out that although "dramatic discord and strife have not been

common in our history...social tension, prejudice and discrimination have been constantly with us" (p. 2). Similarly, Broome (1982), although optimistic about race relations in Australia, states that:

> There are grounds for believing that injustices may long continue. Racist attitudes are still present in the minds of too many ignorant white Australians. Government departments still seek to control the lives of Aborigines. Too many European Australians blame Aborigines for their present problems, rather than see them as victims of white exploitation. (p. 200 - 201)

Further, Aboriginal people themselves stress [for example, in their submission to the Commissioner for Community Relations (1979)] the reality and scope of prejudice in present day Australia. As one lady exclaims "Racial discrimination?--You live and breathe it from the day you're born". (p. 3)

In efforts to combat prejudice and to bring about change in patterns of interaction between Aborigines and non-Aborigines, government has largely encouraged Aboriginal people to assimilate (especially in education and health). Such an approach has assumed that conflict is a temporary phase and will be resolved when Aborigines internalise the attitudes and values of the dominant culture. The counter-balance i.e. encouraging white Australians to perceive Aboriginal culture as

positive, complementary to and compatible with their own, is not prevalent.

These policies and practices have placed Aboriginal people under considerable pressure while doing little to increase their real participation in Australian society. As pointed out in Chapter I, Aborigines have always held and continue to occupy the lowest socio-economic strata in Australian society (Young and Fisk 1982). Like many minority groups, they are literally caught in a vicious cycle of poverty and dependency (See Myrdal 1971). The interaction of prejudice and other factors contributing to and intensifying the situation are represented diagramatically by Eckermann (1985) in Figure I.

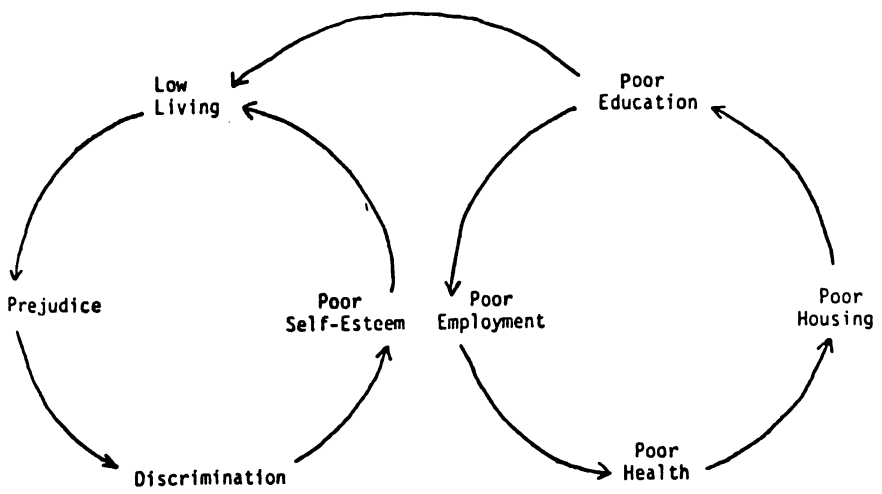


Figure 1. Myrdal's (1971) cycle of poverty adapted by Eckermann (1985).

Thus, Coombs (1969) realisticallly predicts that an Aboriginal person subjected to such a cycle:

> Is likely to be lethargic, irresponsible and poverty-stricken, unable to break out of the iron cycle of poverty, ignorance, malnutrition, ill-health, social isolation and antagonism. (p. 55)

Wild (1980) points out that the **vehicle** for maintaining this pattern is social inequality and powerlessness. Referring back to Myrdal's (1971) circle of cumulative causation, it becomes clear that inequality and powerlessness, while maintaining the cycle of poverty, are also a result of its perpetuation.

Aboriginal Reaction/non-Aboriginal Response

Dependence and powerlessness have had inevitable repercussions on Aboriginal psyche. The noted Aboriginal writer and poet Kevin Gilbert (1973) portrays their ramifications when he says:

> Probably the toughest thing that blacks are going to come to grips with is their own psychological condition. Sure, the white man put you there but even if he wants to he can't get you out. Materially yes, psychologically no. What then are we going to do about the self-hatred that he has imposed upon us? (p. 202).

Further, given past and present minority/majority interaction, social distance between Aborigines and non-Aborigines is likely to be maintained (Lippmann 1973; Bochner 1982). Social distance in itself, as indicated

by Tatz (1979) and Lippmann (1973), is not necessarily negative.

However, among Aboriginal people, social distance does reinforce isolation and this ensures that the minority will not gain the skills to break down the cycle of dependence on non-Aboriginal decision-making. Consequently, Aborigines will continue to experience marginality and personal discomfort. The degree of discomfort experienced by some Aborigines has been vividly depicted by one Aboriginal woman in her comments to the Commissioner for Community Relations (1979):

> Sometimes I get so depressed that I just wish I could unzip my black skin and take it off" (p. 4).

A more recent investigation by Eckermann, Watts and Dixon (1984) reports:

> A much higher level of discomfort among (Aboriginal) groups participating in (their) study than those reported by earlier researchers. (p. 48, my brackets)

Further, Aboriginal "problems", including health care, have been, and continue to be largely ignored (See Middleton, 1977) even though factors illustrated in Figure 1, and their relevance to health care have been documented time and time again in the literature (Moodie 1973; Hetzel (1983); Tatz (1974); Kalokerinos (1974); Sykes (1978); Reid (1979); Baume (1981);

Interaction Between Aboriginal Clients and non-Aboriginal Health Professionals

Numerous articles and government reports confirm that interaction between Aboriginal clients and health care providers is frequently marked by the same conflict which is evident in the general society. Thus Reid (1978), in traditional areas, identifies:

> Enforced isolation, lack of information about illness and its treatment, indifference or hostility of staff towards the patient's concerns, fear of medical procedures offered, and the dislike of the hospital environment. (p. 29)

Studies by Cawte (1974), Soong (1983) and Taylor (1977, 1978) draw similar parallels locating the source of conflict and misunderstanding in differing concepts, values and beliefs.

Similarly, from observations in southern rural-urban settings, Nathan (1980) reports that the comments and practices of Victorian nurses:

> Reflect(ed) not only cultural misunderstanding but also a limited grasp of the relationship between the personal and the socio-economic experiences of Aborigines. (p. 89)

Another source of conflict, identified by Stuart, Tonkison and Tonkinson (1978) centres on problems of communication. Such problems give rise to serious misunderstandings which disadvantages Aboriginal

clients. The authors suggest that:

> The establishment of good rapport rests heavily on a keen awareness **not** just of cultural differences but of the behavioural consequences of these differences and how they affect the treatment of Aboriginal clients. (p. 213, my emphasis)

Further, Kamien (1978) describing a NSW country town observes that "neither the medical and nursing staff nor the Aborigines had much insight into each others' conceptual world" (p. 198). Limited attention to this area in the literature on Aboriginal health indicates that unlike other countries e.g., the USA, we are only beginning to come to terms with issues related to cross-cultural understanding and their corollary, cross-cultural training in health.

However, communication blocks are perhaps inevitable because health professionals, more than any other group in society, are likely to encounter people from a variety of backgrounds whose values and social norms may well differ from their own.

Further, through their professional socialization doctors and nurses have a distinct culture of their own (Lippmann, 1977). A similar view is expressed by Kamien (1978) who supervised medical students during his research among Aboriginal people in North West New South Wales:

> Nearly all the medical students came from middle-class backgrounds, and nearly all found it diffucult to relate to Aboriginal people. When they first arrived in Bourke, most expressed the view that the condition of the Aboriginal people was simply a manifestation of their °laziness and drunkenness'. This °Protestant ethic' view of life was conditioned by the attitude of the dominant society in the town and also by the students' competitive middle-class backgrounds. (p. 244)

Consequently Ferguson (1983) points out that there is an equally urgent need for the nursing profession to understand its own culture, both general and profession specific, before attempting to understand that of another ethnic group.

The situation is further complicated by the fact that many aspects of health care are outside the control of nurses or other health professionals. The Department of Health (1984) manual on multi-cultural nursing, for example, highlights some of these factors:

> While the nursing ethic demands equal treatment of every patient regardless of colour (culture) or social status, the long standing health problems which confront us, usually associated with complex social problems, often make nurses feel inadequate as carers of Aboriginal patients.
> (p. 10.2, my brackets)

While nursing ethics may demand that health care

providers be prepared to recognize and even to tolerate differences, tolerance of difference does not indicate a willingness to accept difference. Thus Richardson (1976) emphasizes:

> The real problem...of course, is that tolerance is based upon value-judgements which may be very one-sided...(on either side)...most regrettably...the continuing incidence of prejudice stems from the fact that tolerance, rather than acceptance continues to be the basis in which racial co-existence rests. (p. 26, my brackets)

Consequently, it would seem that health professionals may be subject to two types of communication blocks. One arises from their own cultural background, the other from the culture of their professional training.

Cultural Barriers in Health Care

Clarke (1983) suggests that communication blocks resulting from conflict between personal and professional cultural backgrounds generally fall into five major categories:

a) Language use and communication patterns.
b) Medical roles and responsibilities.
c) Explanatory models of disease.
d) Contextual factors.
e) Emotional impact and stigma.

Each one of Clarke's (1983) categories has particular relevance in the Australian situation and will be discussed in turn.

a) Language use and communication patterns

Although the majority of Aboriginal people speak English, it is often a dialect rather than the standard form of English. Consequently, as Sykes (1978) has indicated, medical staff with little or no previous contact with Aboriginal clients are likely to have difficulty in communicating and even if "patient and sympathetic, may be unable to elicit the necessary information..." (p. 34). Conversely, Aboriginal patients will have real difficulty explaining/understanding medical staff.

b) Medical (nursing and paraprofessional) roles and responsibilities:

As outlined previously, a major barrier contributing to underutilization of existing and available health services by Aborigines relates to professional, paraprofessional and client perceptions and expectations of each other. Kamien (1978), for example, finds that a "lack of reciprocal understanding between the white providers of health care and...dark consumers" (p. 205) is an important obstacle to more efficient use of available services.

Moodie (1973) adds yet another dimension to the situation by pointing out that:

> Neither the patient nor his family is always fully aware of what happened to him or what the implications are for his future, and it is very difficult for him to find these things out later because the contact point is not in his immediate environment. Individuals who have a contact with a doctor, a nurse, a health professional--especially through connections or neighbours--are at an advantage over those who have no such contact. Generally speaking Aborigines...fall into the latter class. (p. 252)

Further, an increasing number of researchers depict the perceptions/expectations Aboriginal patients have of doctors and nurses (Kamien 1978; Nathan 1980; Reid 1983; Taylor 1977, 1978). Some of the issues raised in these writings demonstrate the kinds of conflicts which may arise from staff ignorance of Aboriginal kinship roles and responsibilities, especially in relation to the extended family and hospital visiting rules.

Further, a growing amount of literature highlights "role uncertainity" , confusion and conflict which health care providers may encounter when they are operating in two different cultures at the same time. Stacy (1974) describes some of the difficulties nurses encounter and Soong (1975, 1977, 1983), in examining the changing role of the nurse to teacher, consultant,

resource person, points out that most non-Aboriginal health workers have difficulty adjusting to this new role. Soong (1983), for example, stresses that:

> In a cross-cultural situation, the nurse who combines the role of teacher and supervisor is fraught with tremendous difficulties unless she is a very skilled person. (p. 56)

In addition, a significant body of literature highlights the vital but difficult role of the Aboriginal paraprofessional as a "cultural broker" or "mediator" (Soong 1982; Hargrave 1982; Dibley & Waddell 1983). Simon (1979), an Aboriginal health worker herself says "I see the health worker's job as a bridge for the Aboriginal people between other organizations which are white-oriented" (p. 42).

In communities where Aboriginal clients seek traditional healers as alternative and/or supplementary to the western health care provider the paraprofessional faces special role dilemmas (Tynan, 1979). However, even in southern rural-urban areas, where this practice is less likely to occur, Aboriginal Health Workers often encounter conflict in attempting to meet the dual and sometimes conflicting expectations of white health professionals and their own community (Hart, 1979).

c) Explanatory models of disease:

Many writers point out that health behaviours and practices are related to ideas/beliefs about different levels of causality (Cawte 1974; Soong 1983; Reid 1983; Taylor 1977, 1978). These authors offer comment on their observations about Aboriginal explanations/models of disease which need to be understood by health professionals. Although most of the research in this area has been undertaken in traditional Aboriginal communities there is some evidence that it is also relevant in rural-urban situations (Cottrell, 1977; Nathan, 1980).

d) Contextual factors:

Contextual factors, according to Clarke (1983) are:

> Culturally patterned behaviors that are not an integral part of the medical system, but that clearly play a large part in levels of health and the kinds of health problems most often found. (p. 808)

Examples of these in the Aboriginal context include patterns of black/white interaction and decision-making (Eckermann, 1973); cultural patterns in diet/nutrition (Stacy 1975, 1978; Thomson 1982), socialization of children (Eckermann 1980; Taylor 1977, 1978), traditional healing--remedies/folklores and in particular bush medicines (Devanesen & Henshall 1982; Umbidong, 1983).

e) Emotional impact and stigma:

Several authors relate the emotional impact and stigma expressed by many Aborigines towards certain types of illness. Similarly, considerable shame appears to be associated with seeking help from the white establishment when ill. Cawte, (personal communication, February 1985), for example, believes that Aboriginal people, like many other groups, stigimatise mental illness. Other writers (Mobbs, 1984) report the shame that many Aborigines feel when having to seek help for relatively personal matters from white health care providers. Similarly, the NSW Department of Health (1984) in its guidelines for health education point out that:

> Many Aboriginal patients express a concept they refer to as "shame" when having to bathe or carry out other intimate activities in front of white people. This concept seems to embody modesty, powerlessness, and fear or anxiety. (p. 10.9)

Cross-Cultural Training for Health Professionals:

From the above analysis it is quite clear that an important factor underlying efficient health service to Aboriginal clients is training of health care providers to increase their cultural awareness and understanding and their general sensitivity to differences.

Although over the past twenty years much has been documented on general intercultural communication and training (see Landis and Brislin, 1983), readings specific to health personnel are few. Notable exceptions include Berry, Kessler, Foder and Wato (1983); Kahn (1981); Pedersen (1983) and Sue (1981). In the health field the major emphasis over the last decade has been on intercultural training of mental health professionals and counsellors.

Some nurses and anthropologists (Leininger, 1975; Brink, 1976; Templeton Brownlee, 1978) have developed guidelines to help nurses cope more effectively in cross-cultural situations encountered in the U.S. However, formal intercultural training of health care providers who are working in a majority/minority situation has not been well reported. In Australia there has been some (though limited) recognition of the need for intercultural training of professionals who work in northern tribal Aboriginal communities where cultural differences are more obvious. O'Brien and Plooij (1976), for example, have produced a culture training manual for teachers and medical workers. This manual examines implications of cultural differences for the effective performance of non-Aborigines in Aboriginal communities.

In the southern rural-urban areas of Australia much work remains to be done. In 1976 Cawte pioneered the field of cross-cultural health needs by providing a medium (The Aboriginal Health Worker Journal) for sharing and exchanging professional experiences among people working in Aboriginal health. Many of the articles submitted by Aboriginal Health Workers demonstrate the importance of, and the need for greater intercultural understanding in Aboriginal health care. For example, Kennedy (1977) describes the cycle of poverty in which many of her people are caught and says:

> Many...people have known nothing different, and may not even realize that is can be better. However, even when help is available from the professional doctors, psychologists and social workers, the people in need may feel uncomfortable with professionals...Often professionals from different backgrounds simply cannot understand what it is like. (p. 41-42)

Government has also begun to recognize the importance of special training to sensitize health professionals to cultural difference. Thus, evidence presented to the House of Representatives Standing Committee on Aboriginal Affairs (1979) indicates that:

> There is a need to introduce into undergraduate and graduate medical and nursing courses a component which deals with all aspects of Aboriginal health including relevant socio-cultural

> factors...(it) ...must be an integral part of the training undergraduates. (p. 138)

Nurses, too, are not unaware of such a need. Munzo and Mann (1982) for example point out that nurses responsible for primary health care in Aboriginal communities in South Australia and the Northern Territory receive inadequate preparation in their general training to work effectively in a cross-cultural Aboriginal health situation in outback Australia.

To overcome such inadequacies a number of nurses have called for inclusion of cross-cultural training in basic training (Saunders, 1983; Flint, 1983).

Environmental Factors: Funding and Proximity

Environmental/situational factors play a significant role in Aboriginal health. Thus, Nathan (1980) highlights several proximal environmental variables including government funding priorities and policies, particularly resource allocation, as important influences in Aboriginal health. Foley, McGuinness and Roberts (1980) point out the massive discrepancy, for example, between funding allocations to State Aboriginal health services and independent Aboriginal controlled medical services.

Further although, consistently, most funds are allocated to state controlled services Aboriginal professional representation in such services has not markedly increased. By and large those employed have not been placed in key decision-making roles. Thus, their actual and potential contribution to increasing the effectiveness of government services for Aborigines has not been adequately explored or monitored.

However, there is ample evidence in the literature to show that when Aborigines are directly involved in health care delivery, influencing planning and policy decision-making (as occurs in the AMSs), at least the level of utilization of such services by Aborigines increases (Kennedy, 1977; Copeman, 1980; Nathan 1980). This of course provides only one dimension for evaluating the effectiveness of health care delivery, but it is a valuable starting point. Further, although numerous reports (e.g., NSW Task Force 1983; Goldstein, Hunt and Sharkey 1978; House of Representative Standing Committee on Aboriginal Affairas: Aboriginal Health 1979) highlight the invaluable contribution of Aboriginal Health Workers to health care delivery, in the past in NSW, few Aboriginal Health Workers have been given the opportunity to acquire the skills and training they need to gain status and power to influence

decision-making in the mainstream health service.

Therefore, it is not surprising that Hollows' (1981) questions "Why, in spite of the money and efforts is Aboriginal health still so illustrative of failures in delivery of health care?" (p. 138), has as yet not been satisfactorily addressed by government. Hollows offers part of the answer by suggesting that systemic biases, including institutional racism prevent Aboriginal involvement, participation and consultation in the health system.

Other well known barriers to utilization of health services including proximity, costs/convenience, transportation, are recorded by Larsen 1978; Nathan 1980; and Kamien 1978. Bullough (1972) suggests that such factors (which are often taken for granted) are reinforced by alienation, powerlessness, hopelessness and social isolation.

Having discussed factors which are distal as well as those which are proximal to Aboriginal health, it is possible to clarify the lines of interaction diagramatically (see Figure 2).

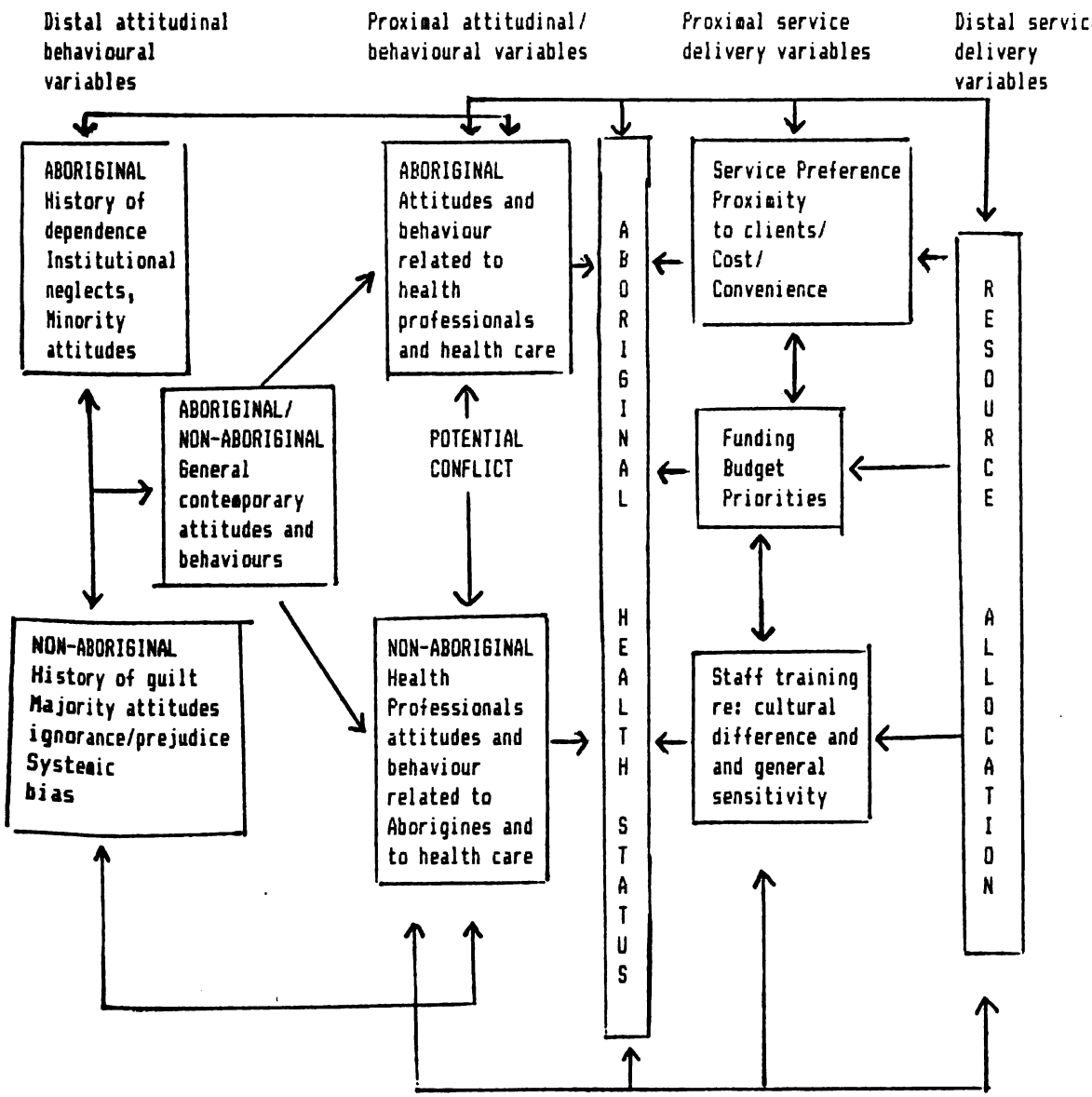


Figure 2 Lines of interaction of proximal and distal variables influencing Aboriginal health.

Figure 2 summarizes factors identified in the literature as influenzing Aboriginal Health. Utilizing Jessor and Richardson's (1968) concept of proximal and distal variables, Figure 2 clearly indicates that a series of variables (both proximal and distal) are related to Aboriginal/non-Aboriginal interaction and resultant attitudes and behaviours. Another group of variables are related to service delivery and associated issues of staff training, funding and resource allocation. Again factors can be identified as either proximal or distal. Primary field data, gathered for this project, will explore the relative importance and interrelationship of these factors. Diesing (1972) suggests that by "connecting themes in a network or pattern" (p. 155) it is possible to build a model of explanation which primarily describes links or themes emerging from the data.

Further, Reason (1981) emphasizes that a pattern model of explanation "is rarely if ever finished,...(and) is subject to change in the course of its development as new data become available" (p. 186). The themes, however, can be tested and retested with reference to the data. The methods by which data were collected for this project are outlined in Chapter III.

CHAPTER III

METHODOLOGY

Research Design

The sub-problems/problems/questions outlined in the introduction and supported by relevant literature review in Chapter II, include the following:

1. What factors impede or facilitate interaction between health care providers and Aboriginal clients?

2. How do health care providers believe they can be better prepared to work with Aboriginal clients?

3. How do Aboriginal clients believe health care providers can be better prepared to work effectively with the Aboriginal community?

4. What approach is needed to increase professional awareness and effectiveness in Aboriginal health?

In order to explore and describe Aboriginal community and health care providers' perceptions of interactions with Aboriginal clients in a hospital and/or community health setting, three groups of individuals in a NSW country town have been interviewed. These groups comprise Aboriginal community members, staff employed at the local Aboriginal Medical Service and registered nurses (RNs) at the local hospital. Consent procedures are detailed in Appendix G.

As such, this project has used a case study approach defined by Polit and Hungler (1983) as "a research method that involves a thorough, indepth analysis of an individual, group, institution or other social unit" (p.610). Such an approach, incorporating some of the principles of new paradigm research (Reason and Rowan, 1981), provides the best opportunity, in an informal setting, to establish sufficient rapport with participants to probe some fairly sensitive issues related to health and the provision of health care. This is an important consideration because Aborigines have been "investigated" probably more than any other group in Australia. Similarly, due to past and present Aboriginal/ non-Aboriginal relations, some non-Aboriginal health professionals are somewhat sceptical, if not "guarded" in their comments about Aborigines. Further, as Polit and Hungler have suggested, case studies have the advantage of conveying the "richness of the real-life subject matter" (p. 208).

Of necessity, the research to be outlined is also a pilot study. Given the available time a full scale indepth case study (which may provide some basis for generalization and hypothesis generation) was thought to be unrealistic.

Such a "pilot case study" does contain a number of methodological weaknesses. The major one is its lack of generalizability. However, such an approach does have a certain predictive value. As Polit and Hungler (1983) suggest:

> It may be perfectly reasonable to make predictions of future behaviour concerning the (institutions) who (are) the subject of the case study based on events or relationships experienced in the past. (p. 208)

Further, the case study method may help to identify/clarify important concepts and variables as well as ways of measuring them (Polit and Hungler). Another methodological risk inherent in a case study is that the researchers become too involved or biased. In fact, there can be no controls in terms of "traditional scientific research" to ensure that data analysis and interpretation will not be distorted by researcher subjectivity. This should however, not be judged as a major methodological weakness.

As Reason and Rowan (1981) point out:

> The only criterion for the °rightness' of an intepretation is **intersubjectivity**--that is to say that it is right for a group of people who share a similar world. (p. 243)

Further, they suggest that to meet the criteria of validity research should also be useful and illuminate

issues of concern.

> Validity in new paradigm research lies in the skills and sensitivities of the researcher, in how he or she uses herself as a knower, as an inquirer. Validity is more personal and interpersonal, rather than methodological. (p. 244)

There are therefore no **standard** criteria to strengthen the validity of such research. However, Reason and Rowan offer the following points as guidelines to increase the validity of an inquiry.

1. Research should not be done alone.
2. High quality awareness is necessary.
3. Awareness results from systematic personal and interpersonal co-researcher development.
4. Systematic feedback loops are essential.
5. Different forms of **knowing** should be explored.
6. Information must be cross-checked from different data sources, so that it is possible to see how one piece of datum fits into the whole picture.

In terms of this research project, issues related to points 1, 2, and 3, have been addressed by involving an Aboriginal co-researcher, holding extensive discussions and developing training strategies before entering the field as well as adapting/modifying materials and strategies during piloting. These issues will be explored in much greater detail later in this chapter.

Points 4, 5 and 6 have also been considered. Thus, in recognition of the need for **systematic feedback loops**, this case study should be seen as only the beginning of the feedback loop. Results will be fed back to the organizations/institutions, ensuring opportunity for a "process of correction of impression to take place" (Reason and Rowan, p. 248).

Similarly this case study explores **different forms of knowing** (e.g., institutional, political and media) in order to offer different perspectives on participants' experiential and practical understanding/knowledge of the systems in which they work or which they utilize.

Further information has been constantly **cross-checked** and cross-examined in order to enhance convergent and contextual validity. Maruyama (1981) states that convergent validity involves seeing:

> Whether a number of measures which purport to measure the same thing all point in the same direction, or whether a number of different viewpoints yield a similar picture. (p. 240)

In this study convergent validity is weak--as it has not been possible in the time available, to incorporate more than one primary method of data collection; nor has it been feasible to train co-researchers in more than one method of data collection. However, the interviewing process has revealed different perspectives which have

been compared with data emerging from reviews of internal documentation and administrative reports. Thus, it has been possible to increase contextual validity by seeing how data from these sources fit in with the whole picture emerging from the case study.

Whenever contradictions have arisen the co-researchers have met with interested participants and advisory resource people to check and cross-check the information. These advisory resource people have included past employers, past members of the governing boards of the institutions, community members involved in establishing local area health services, and informed members in the workforce and Aboriginal community not participating in the interviewing process.

Replicability is frequently cited as a desirable mechanism for ensuring validity (Reason & Rowan, 1981). Exact replication of this case study may not be possible (nor, in terms of the aims, desirable). However, the methodological framework is sufficiently developed to allow other research to build on it and to alert researchers to potential pitfalls in conducting a similar study.

Some of the weaknesses inherent in this research approach, then, are also its strengths. The project has invited interested people to participate in the

research process, and it has provided an opportunity for them to offer guidelines and recommendations on health care provision and training in a cross-cultural situation.

Thus, in a narrow sense, the project has been action/change oriented. Ideally, action research should, as Schensul (1974) has suggested, contribute to the quality of life of the people studied; it should meet some relatively short-term goals and also play a part in community development.

In this project advisory resource personnel at each institution and in the Aboriginal community have been consulted to ensure the relevance of the research goals to the issues identified. However, involvement of local participants (concerned health care providers and Aboriginal clients) in the research process (beyond interviewing), although desirable, has not been possible. Distance/geographic location, local politics as well as the time required for field preparation, training and interviewing have prevented their involvement in other stages of the research process.

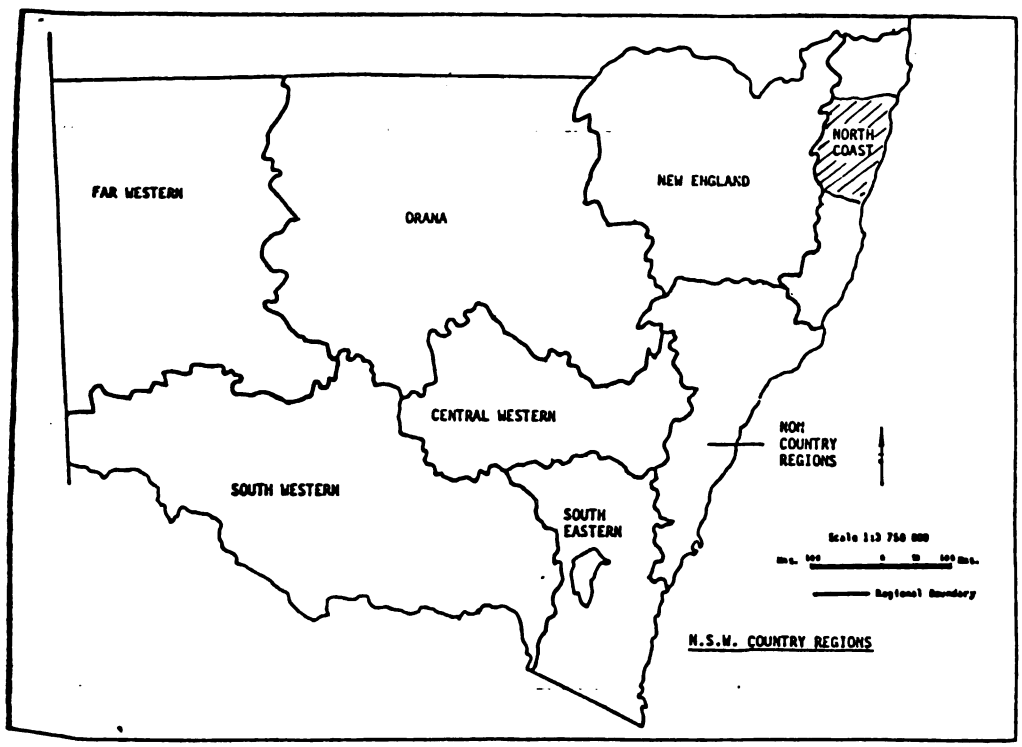
Nevertheless as will become evident in later discussion (Chapter 5), the project is likely to achieve "some relatively short-term goals" especially in relation to

the Aboriginal co-researcher and the institutions involved in the case study.

Research Setting

Geographic location and population of state, regional and local area

NSW, which is divided into six country and three major metropolitan health regions (See Map 1), has a total population of 5,137,4000 and an Aboriginal population of 45,000 (Department of Aboriginal Affairs, 1981).



Map 1 New South Wales Health Regions including North Coast Central District serviced by Country Town Local Area Health Service Organization and Country Town Aboriginal Medical Service.

The North Coast Region, the geographic location for the research, has a total population of 326,965 and an Aboriginal population of 6000. The region, which contains 13.4% of the NSW Aboriginal population, enjoys the highest annual population growth rate (28 per cent) in the state (Department of Health, 1983).

The case study has been limited to Country Town, located in the Central North Coast Region. Approximately 20,000 people live in this rural agricultural district, half of whom are resident in Country Town. Aborigines represent 10 per cent of the town population.

Local Aboriginal Community

Most (1200) of the Aborigines reside in the immediate township of Country Town; the remainder live in small clusters on three outlying reserves. First contact with whites occurred in the early 1800s. By the mid 1800s Aborigines were removed from their ancestral land and forcibly relocated to government reserves. In Country Town district, at least, relocation has not markedly separated kinship groups, and some continuity has been maintained although most of the Aboriginal languages have been lost, to be replaced by English. Today there are two main tribes, made up of largely interrelated family groups, living in the

district, and English is the only language spoken by the majority of the people.

These interrelated family groups form a number of clearly identifiable factions or interest groups which associate themselves largely with one or other of a number of Aboriginal organizations in the town. Examples of the latter include the Aboriginal Medical Service, the Housing Co-operative, and the Local Land Council.

As is true of comparable rural towns in NSW, race relations in country Town are not harmonious. They are steeped in a history of segregation/separate services and backlash:

> When I did go to _____(Country Town) I really felt **Black**... they wouldn't rent places to black fellas...so I had to live on the mission. I hatred it...the prejudice. They didn't have much in _____ (Country Town) in my opinion but...those low class white fellas...it was just like...they wouldn't bid yu' the time of day or even give yu a smile. I used to love goin' to the pictures...(but) they wouldn't let us go in up there before "God Save The Queen"...they let all the white fellas get all the seats. Yu'd go into a shop and yu'd have to stand up the back and it went on like that for years.

At least 50 per cent of the adult Aboriginal population is unemployed. This is in contrast to relatively low (7.5 - 9.0 per cent) unemployment in the

total Country Town population (Department of Employment and Industrial Relations, 1984).

Further, if mortality rates (standardized for age) are used as a measurement of health, then Aborigines have very high infant and child mortality and morbidity; a high general morbidity, especially from infectious and parasitic causes, alcohol related disease, and poor nutrition. These conditions are interwoven with other problems, including poor housing (Department of Health, 1983).

Country Town Area Health Service

Country Town district hospital and community health services have been integrated since December 1983 (See Figure 3). A corporate body (board of directors) now controls the government funded Area Health Services in the district.

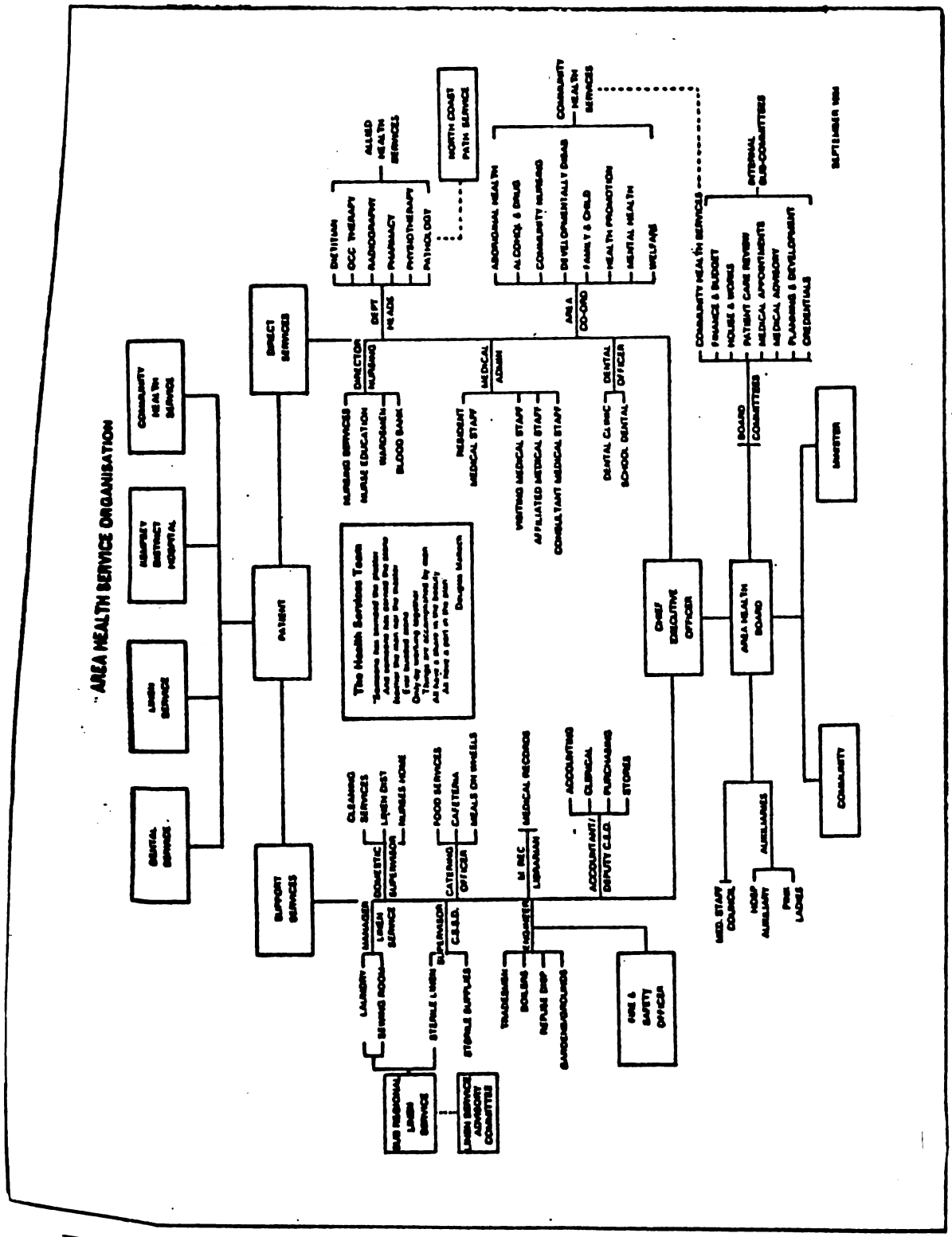


Figure 3 Country Town Area Health Service Organization (copied with permission of Local Area Health Service)

Figure 3 shows that the new Area Health Service is made up of the district hospital, community health service, dental service and linen service. The local district hospital and the community health service, which is based in the hospital grounds, are of particular relevance to this project.

Local Hospital

Country Town District Hospital, the fifth largest in the North Coast Region, provides a comprehensive range of medical, nursing, and support services to the community. Most general practitioners resident in the town have visiting rights at the hospital, and they are rostered to provide casualty/outpatient services. In addition local specialists provide regular specialist medical services. Most country residents who require hospitalization are admitted to the local hospital via their general practitioner or directly through the casualty/outpatient department. Cases beyond local competence or technology are referred to base or metropolitan hospitals. Country Town District Hospital has a bed capacity of 155 and a total staff of 259. Staff composition, as reported in the 1984 hospital annual report is outlined in Table 1.

Table 1

Country Town District Hospital Staff Employed at 30th June, 1984 (full time equivalent)

Nursing	141
Medical and medical support services	34
Other	84
TOTAL	259

The first Aboriginal people were employed at the hospital during the 1950s when they worked as cleaners and domestics in the section of the hospital designated for Aboriginal patients only. It was not until 1960 that an Aboriginal person was employed to work on the general staff. This time was recalled with some bitterness by an Aboriginal woman who remembered:

> To go into _____ hospital...the atmosphere amongst the white people were bad. They used 'ta just have all the black fellas in the Aboriginal ward...they had one big room, didn't even have a lino on it... (There were a) lot of Aboriginal people sick in the hospital there...when I used to mop the front of the verandah where the outpatients...black fellas come...and it was a terrible cold place where the black fellas had to sit...they had to all sit there like a mob of cattle...and all in one corner separate.

Although with the advent of government subsidy for Aboriginal employment, an increasing number of Aborigines have found employment at the local hospital, (which adheres to the policy of equal employment opportunity), the proportion of Aborigines on staff remains very low. Currently only six Aborigines are employed at the hospital--two as enrolled nurses, one as a trainee in the central sterilizing department and the remainder in permanent salaried positions in the laundry and linen services.

Community Health Service

The local community health service which has administrative and management links with the hospital (See Figure 3) employs approximately 20 people. A community health sevices committee is responsibile to the Local Area Health Services board of directors for the planning, co-ordination and monitoring of community health services in Country Town district. The community health service also has administrative links (essentially in terms of its funding operations) with the Department of Health regional office.

General community health services available to all the community include child health, nursing, alcohol/addiction, social/welfare, family planning, special support for the developmentally disabled and the

chronic psychiatric, as well as specialist psychological, occupational and speech therapy services.

Prior to the integration of the Country Town Area Health Services, a separate Aboriginal Health Unit, normally staffed by one white nurse and one Aboriginal health worker, existed within the general state health department to provide special services to Aborigines. The Aboriginal Health Unit is now obsolete. In efforts to improve existing services and their relevance to local Aborigines, two Aboriginal trainees, (a welfare officer and drug and alcohol counsellor) have recently been appointed to the community health staff. In addition an Aboriginal health worker is employed through the Department of Health to provide services to one of the outlying reserves. All community health staff are responsible to the area co-ordinator (See Figure 3). Regional advisory personnel such as the Aboriginal liaison officer and director of Aboriginal health education can, however, make recommendations to the Local Area Health Services board regarding services provided to the Aboriginal people in Country Town.

Co-operation and communication between the community health service and the local independent Aboriginal Medical Service are minimal. However, in 1984 the Area Health Service sponsored, under the

Hospitals Promotion Programme, a twelve month Aboriginal Nutrition project supervised by the Community Health Service and co-ordinated by one of the medical officers at the Aboriginal Medical Service. The project aimed to improve nutrition in two specific Aboriginal groups, namely diabetic and pregnant women.

Aboriginal Medical Service

The local Aboriginal Medical Service (AMS) is situated five kilometres from the town centre at one of the Aboriginal communities on the outskirts of Country Town. In July 1977, the AMS commenced operations from a small shed located near the local pre-school. The service now operates from a modern bright and spacious brick building which features a waiting/reception area, treatment and consulting rooms, a small dispensary and offices for the administrator and Aboriginal health workers (AHWs).

These new premises officially opened in August 1979. Extensions, completed in 1981, include a well equipped modern dental clinic with adequate treatment rooms and storage areas. The dental section is part of the main premises but it has its own entrance, reception and waiting area.

The AMS attempts to provide general medical, dental, and preventative/self-help services to all Aborigines

living within a 50 kilometre radius of Country Town. In particular, it tries to meet the special needs of mothers and babies, pre-schoolers, diabetics, pensioners and people with alcohol-related problems.

Doctors conduct clinics at the main centre and, along with other staff, make regular field trips to the reserves and outlying areas where a similar service is not available.

Staff composition, detailing ethnic origin and position of personnel at AMS, can be seen in Table 2. Most staff are on 24 hour call; referrals are made to specialists and the hospital when necessary. Normal week day clinic hours are from 8a.m. to 5p.m. and a doctor is usually also available at the centre on Saturday mornings.

AMS is dependent on the mainstream local area health organization for some essential services. The local hospital, for example, orders and labels drugs while the area linen service provides laundry and linen to the centre.

Table 2.

Ethnic Origin and Composition of AMS Staff

Position	Ethnicity	
	Aboriginal (n=13)	non-Aboriginal (n=6)
Administrator	1	
Dentist		1
Dental Nurse Assistants	3	
Medical Officers[a]		4
Health Workers	5	
Registered Nurse		1
Nurse Aide	1	
Trainee Nurse Aides	1	
Receptionist	1	

Note [a] Two male doctors work full-time while their wives provide a part-time medical service. In addition, two medical specialists, a physician and an obstetrician visit AMS weekly and use the premises to conduct their clinics.

Limited business/advisory and charitable relationships exist between AMS and other community agencies e.g. the Country Town private medical centre, pharmacists, alcohol rehabiliation centre, local farmers etc. in the district.

Research Sample

Three groups of respondents form the sample for this case study. They include:

1. English-speaking, adult, female Australian Aborigines who live in Country Town and are recipients of the local health care services.

2. Aboriginal and non-Aboriginal health care providers employed at the local Aboriginal Medical Service.

3. Registered nurses employed at Country Town District Hospital.

The sample population is presented in Table 3.

Table 3.

Distribution of Sample Population

Population	Aborigines	non-Aborigines	Total
Aboriginal Community Participants	19	-	19
AMS participants	12	6	18
Local Hospital Participants	-	20	20
TOTAL	31	26	57

In order to discuss the nature and size of each sample and the criteria for sample selection, each target group will be discussed in turn.

The Aboriginal Community

The Aboriginal community in Country Town can be meaningfully divided into North, South, East and West. Major family groups in each area were identified by the Aboriginal co-researcher and cross-checked with key resource people in Country Town. One in four families was chosen at random from each area for interview.

In each major family group a woman over the age of 30 years was randomly selected to represent the main decision-maker in relation to family health. This decision was reached on the following basis:

1. We felt that because the interviewers were both women they would be more acceptable to other females.

2. Discussions with Aboriginal people in a neighbouring town and Country Town indicated that women under the age of 30 years tend to consult or defer decision-making to older matriarchs.

This finding is borne out by Eckermann (1977) who indicates that decision-making in Aboriginal families is influenced by family organization and age of female household head.

Further, Sykes (1978), an Aboriginal woman herself, points out that " the responsibility for the health of the community generally lies in the hands of the women" (p. 34).

Relatives of the Aboriginal co-researcher were excluded as were immediate kin of Aboriginal health staff, the former for obvious reasons of bias, the latter to ensure that respondents would feel free to offer their opinions on services/interactions without implicating members of their family.

Details of the Aboriginal community sample are provided in Table 4.

Table 4

Composition of Aboriginal Community Sample, Country Town by Age and Location Indicating Proportion of Households Represented by Female Head in Sample

Age	Community Area				
	East	South	North	West	N
30-34	1	1	1	2	5
35-39			1	1	2
40-44	1	2	1	2	6
45-49			1		1
50-54		2		1	3
55-59		1			1
60+				1	1
N	2	6	4	7	19
Total No. of households in each area	8	24	16	29	
Proportion of households represented by female head interviewed	1:4	1:4	1:4	1:4	

The Aboriginal Medical Service

It was possibile to interview all members of staff (N=19) at the Aboriginal Medical Service (AMS). Their ages, sex and roles in the organization are outlined in Table 5. Six (6) of the 19 staff are of non-Aboriginal descent.

Table 5

Composition of Staff Interviewed at Aboriginal Medical Service by Age, Sex and Role.

Age X Sex	Role							
	Medical Officer*	Administrator	Health Field Worker	Dental Nurse	Nurse Aide	Receptionist	Registered Nurse*	Dentist*
20-24 M								1
20-24 F				2	3	1		
25-29 M	1		2	1				
25-29 F	1							
30-34 M								
30-34 F	1							
35-39 M			1					
35-39 F								
40-44 M		1	1					
40-44 F							1	
45-49 M								
45-49 F								
50+ M	1							
50+ F								
N	4	1	4	3	3	1	1	1

* All individuals are non-Aboriginal

Note. In addition to the medical officers employed two honorary medical specialists visit the service weekly.

Country Town Local Hospital

Staff from four hospital departments were chosen for inclusion in the sample because their departments were identified as most frequented by Aboriginal patients. These departments included the medical ward, outpatients' department, children's ward and the maternity ward.

Because of the number of nurses employed at Country Town Hospital (See Table 6), interviewing was limited to registered nurses (RNs). This decision was based on the supposition that RNs would ultimately be responsible for patient care and, because of their supervisory role, would also be influential in setting the tone for interactions and the attitudes exhibited towards patients and relatives. For the same reason all supervisors and charge nurses were included in the sample[a].

On this basis one in two of the RNs employed in the four departments have participated in this project. All the RNs were randomly selected from duty rosters

[a]Enrolled Aboriginal nurses (N=2) employed at the hospital have been excluded from the present analysis because they are not registered nurses and are easily identifiable.

provided by the hospital administration. One RN declined to be interviewed and a substitute from the same department was randomly selected to take part in the study.

Because of the small number of nursing supervisors associated with the four departments, it was possibile to interview almost all of them. Only one chose not to participate. Neither of the respondents who refused to participate in the project volunteered a reason for their decision.

Thesize of the sample of RNs involvedinthis case study is represented in Table 7.

Table 6

Age Distribution and Role of Nursing Staff at Country Town Hospital

Age	Role					
	Registered Nurse	Supervisor	Charge Nurse	Student Nurse	Enrolled Nurse	
17-19				3		
20-24	9			18	4	
25-29	8			10	4	
30-34	10			9	6	
35-39	14		2	8	7	
40-44	8	3	1	7	7	
45-49	6	1		5	4	
50-55	4	1		5	5	
55-59	2			3	3	
60+				1	1	
N	61	5	3	69	41	179

Table 7

Size and Location of Hospital Sample by Area of Individual's Responsibility

Area of responsibility	N in department	N in sample	Proportion of staff represented in sample
Medical ward	9	4	1:2
Outpatients' department	4	2	1:2
Children's ward	4	2	1:2
Maternity ward	6	3	1:2
Supervisors	6	5	1:1
Charge nurses	4	4	1:1
N	33	20	

Data Collection

This research project has made use of a team approach. An Aboriginal co-researcher and I collected data to be discussed in the subsequent chapters.

Because such an approach to research, though relatively unusual, is absolutely essential in terms of new paradigm research, this discussion of methodology will detail the processes involved in co-researcher/team research at some length.

Team preparation

The project commenced with a six week team preparation period (mid June-July, 1984). This time was used to explain, discuss, plan and modify our ideas about the project and data collection techniques. The first two weeks included inservice training with colleagues on such topics as: the principles of conducting research in a hospital and Aboriginal community, channels of communication, responsibilities and role of co-researchers and difficulties likely to be encountered. This initial orientation period encouraged honest and open discussion which facilitated development of appropriate data collection techniques during an additional four week of preparation and piloting.

Planned procedure

It was anticipated that an informal interview schedule would be the primary means of data collection, supplemented by limited systematic participant observation.

The general plan was that health care providers would be questioned, in a conversational style, about their contact with Aboriginal clients to establish on whose territory (hospital, health centre, reserve, client's home) contact usually occurred, the time span of the interaction, its purpose, the type of

involvement, and the frequency of contact as well as the perceived degree of rapport with the client. These dimensions were cited by Bochner (1982) as being important variables in understanding cross-cultural interaction. It was assumed that they would provide a useful and a non-threatening framework in which to ask staff to discuss their work and recall situations they had encountered with Aboriginal clients. To balance health care providers' perceptions of interactions with those of their clients', the plan was to also interview Aborigines.

The exact nature of interview probes and observational dimensions were to be determined during the preparation and piloting period.

Actual procedure

We discussed the planned method of data collection in detail and attempted to develop appropriate probes or "talking points" to elicit information on the major dimensions of cross-cultural contact identified by Bochner (1982). Although there was early team consensus about the approach, it quickly became obvious that our planned methodology, of employing informal discussion as a medium for extracting information, would not work. Nor would time permit the development of guidelines for limited systematic participant observation.

The Aboriginal co-researcher found it extremely difficult and upsetting to conduct interviews without a clear framework, set questions and detailed probes. In retrospect, this development was really not unexpected. Pat belongs to a minority which consistently has been undervalued in Australian society. Her own educational qualifications and training have not prepared her for an interview technique which relies largely on the interviewer's personal style and self-confidence to elicit relevant data.

Consequently we began to modify the procedure by developing major categories of information (See Appendix A) related to our research objectives. Each one of these categories was explored in detail and refined to include a series of appropriate open-ended questions. The wording, structure and sequencing of questions were reorganized and reorganized until we felt that each area was fully covered.

At this point we used tapes and conducted several practice interviews (15) independently and as a team. On review of the tapes we analyzed questioning techniques, sequencing of questions, probes and depth of data obtained at length. Each time we discussed methods of improvement. On the basis of our discussions, we developed three interview schedules--one suitable to

Aboriginal community members, one suitable to Aboriginal health staff and one to tap the views of non-Aboriginal health staff. The latter, the instrument for non-Aboriginal health staff, developed out of the questions and categories emerging from those schedules developed for Aboriginal people. These interview schedules proved to be a much more appropriate and reliable way of obtaining the information we were seeking.

We piloted these instruments among people in a neighbouring town as well as in Country Town as set out in Table 8.

Table 8

Individuals Involved in Instrument Piloting by Location, Age and Sex.

Age X Sex		Neighbouring Town			Country Town		
		Aboriginal		Non-Aboriginal	Aboriginal		Non-Aboriginal
		Community	Health staff	Health staff	Community	Health staff	Health staff
20-29	M		1				
	F	2	1	2	2	2	
30-39	M						1
	F	3	1	3	2	1	2

Simultaneously, we liaised and negotiated with the local institutions at the research site (Country Town Hospital and AMS) where the data collection techniques were to be used. Early consultation with advisory resource people in these institutions before and during the piloting process provided feedback which helped us to set some realistic parameters to judge, not only the appropriateness, but also the feasibility of our approach to data collection.

The above discussion of data collection clearly details the consultative process employed in this project. Such a process is cited by Reason and Rowan (1981) as an essential factor underlying validity.

All of the non-Aboriginal pilot interviews were conducted by me because advice from hospital staff indicated that people would not be willing to discuss aspects of Aboriginal/non-Aboriginal interaction openly in front of an Aboriginal interviewer. This advice proved sound. At the end of each pilot interview I asked "How would you have felt doing this interview with an Aboriginal person present?" All respondents indicated that they would have been more cautious, "a bit uptight", more anxious. On this basis we decided that I would interview all non-Aboriginal health staff in the hospital by myself.

We received a different reaction from Aboriginal respondents. The Aboriginal co-researcher interviewed ten (10) people by herself. These people were asked to indicate their reaction to a non-Aboriginal interviewer. Their responses showed that although they might occasionally be more "polite" in the presence of a non-Aboriginal, their answers would be no different, nor would they feel particularly uncomfortable. Pat Dixon did however encounter anxiety over the question: "How would you say you get along with most white people". Consequently this item was deleted from the community schedule. We conducted a further six (6) interviews as a team and I followed this up with three (3) solo interviews.

In all cases we were given feedback indicating that generally people were not hesitant to discuss their opinions in front of a non-Aborigine. Consequently, we decided that both of us would conduct interviews in the Aboriginal community as well as with the staff (Aboriginal and non-Aboriginal) at the AMS. We chose a team approach to non-Aboriginal interviews at the AMS on the basis that these staff would be constantly interacting with Aborigines and should therefore feel much less threatened by an Aboriginal interviewer than general hospital staff.

The piloting process proved frustrating, yet invaluable. We discovered incongruities between schedules, we found illogical sequencing of questions, as well as repetitive items, confusing wording, non-sensical probes.

On the basis of detailed discussions, extensive analysis of taped and written responses and advice from colleagues, the schedules were revised four times until we arrived at versions which tapped similar categories of information, in a logical, uncomplicated series of questions. These final versions are attached in Appendix C, D and E.

The schedules

Although the number of items that appear in the interview schedules (See Appendix C, D, and E) varies, (to accomodate different styles of co-researcher communication) items cluster around ten categories of information.

1. Demographic data
2. General and specific culture contact
3. Employment
4. Job satisfaction
5. Staff selection
6. Staff preparation and continuing education
7. Perception of health care provider role

8. Experience in the health care system

9. Situational dilemmas

10. Recommendations

Demographic information (Category 1) is of course necessary to get a picture of each sample group involved in the case study. Other categories (3,4 and 5) provide valuable background information about employment, job satisfaction and staff selection.

The remaining categories relate to three major assumptions about cross-cultural interactions which have influenced the parameters of this study.

1. Role perception (Category 7) has important influences on individuals' abilities to cope with difference and resultant tensions and anxieties. (See Kleinburg's (1982) emphasis on status and role perception in determining levels of cross-cultural co-operation).

2. The degree of culture contact and cross-cultural staff preparation/continuing education (Categories 6 and 2) are important determinants of cross-cultural relationships (See Landis and Brislin, 1983).

3. Experiences in and accounts of situational dilemmas in the health care system (Categories 8 and 9) are important determinants and expressions of the level

of cross-cultural understanding.

Limitations of schedules

Kidder (1981) clearly indicates that the face to face interview situation is more likely to facilitate rapport, will provide more opportunity for obtaining in depth information and will afford greater opportunity to probe and clarify answers than any form of questionnaire/survey.

Interview schedules, particularly those employed in this research, will, however only be as adequate as the care with which they have been designed. In methodological terms, our schedules have followed established guidelines of interview design, including re-examination,revision, piloting and further revision.

Question construction could, however, have been much more economical. Not until we began analyzing the data did we find that some items proved superfluous in that other items tapped similar issues. For example, Schedule 2, (Aboriginal staff), items 58 & 59, Appendix D. Further, some items proved meaningless and consistently they had to be explained e.g., Schedule 1 (Community), item 25, Appendix C difficulties were experienced with the term AHW; ibid Schedule 3 (non-Aboriginal staff), item 37, Appendix E.

During interview preparation/training emphasis was placed on creating an atmosphere conducive to natural conversation. However, the specific, ordered list of questions/topics imposed formality which to some extent destroyed the conversational style of the interview. Further, at times the interview structure created difficulty, especially for the Aboriginal co-researcher, if respondents in their comments to one question answered others that were to follow. Again conversation quality was lost and occasionally the interview situation became repetitive and disorganized.
In addition, Aboriginal Health is a highly emotive subject, not only because it is seen to relate to Aboriginal/non-Aboriginal relations, but also because appalling Aboriginal mortality rates engender feelings of guilt, compassion, anger and pain among both Aboriginal and non-Aboriginal respondents.

Entree to the field

Prior to the project commencing, correspondence and a research proposal were forwarded to Country Town Department of Health Regional Office, Country Town District Hospital and the AMS. Phone contact was made with each organization before our first visit to the field in mid-July.

The Aboriginal co-researcher already had well established links with the Aboriginal community and AMS in Country Town. These were followed up during our early visits to the field.

We met informally with the administrator of the AMS and with two members of the board of trustees who were all very co-operative and interested in the study. We also made contact with the Deputy Director of Nursing and Senior Nursing Supervisor at the local hospital. Although not familiar with the project they were very welcoming and curious about what we intended doing. The Director of Nursing and the Chief Executive Officer, who had received formal communication from Regional Office about the study, were absent on leave.

From Country Town we visited the Department of Health Regional Office. There we discussed the project in detail with the Regional Director of Clinical Services, the Regional Aboriginal Liaison Officer and the Director of Aboriginal Health Promotion.

A further two (2) visits were made to the field to develop good rapport and liaison with key contacts and to collect and cross-check data that would provide a reliable basis for sample selection. Background information was obtained from key resource people in the community: previous employees of AMS and the local

hospital, members of the AMS board of trustees (one of whom is also a member of the hospital board), the Aboriginal Seventh Day Adventist Church, and several members of the Aboriginal community.

Entree to the field, especially to the AMS, where previous requests to conduct research had been refused, was facilitated by Pat's family ties and her reputation in both the Neighbouring Town and Country Town communities.

At the local hospital introducing myself as a nurse and Pat as a health worker proved to be an advantage. Nursing administration took a particular interest in the study. They provided figures on staffing, including breakdown by age and position; they also ensured that we had adequate working space and accommodation.

Interviewing as a team in the field

As pointed out earlier in this chapter, all interviews in the Aboriginal community and at AMS were conducted as a team. These interviews highlighted a number of problems associated with field work generally e.g., method of recording, and team research in particular.

Method of recording

Originally, during practise and pilot interviewing we used tapes. These enabled us to cross-check

information, evaluate each other's questioning techniques and analyze depth of information obtained from each question. In addition, the use of tapes did not appear to be perceived as threatening by Aboriginal participants while it was supposed to provide an opportunity for the Aboriginal co-researcher to carry out interviewing by herself to develop further her confidence.

However, after three interviews it became apparent that the use of tapes was starting to arouse anxiety in the Aboriginal co-researcher. She had difficulty with the equipment during one interview in the community and thereafter became very concerned about it not recording. Although people indicated that they did not mind being taped, it became obvious that they felt some reservation and the interviews lacked spontaneity. Pat's pre-occupation with the equipment also detracted from her listening skills and I tended to record less detail in writing (knowing it would be on tape).

Further, we considered the cost and time involved in transcribing and the difficulty of giving each other meaningful cues to improve the interviewing process. Consequently we decided to abandon the tapes. This change proved to be a positive step. Pat's interviewing, especially her listening skills, improved greatly. She

used more meaningful links and relevant probes. I also found that I listened more carefully and certainly recorded data in greater detail.

However, recording responses in writing also proved problematic at first. For example I had been unaware that the speed of my writing served as a subtle guide to the pace of the interview, and that it often became the focus of attention and distracted from the interviewing process. Thus we had to develop deliberate cues for slowing down or increasing the pace of the questions. Indeed, we established a clear and precise repertoire of cues which could be used in all situations we encountered.

Interviews in the community and at the hospital averaged one hour. Those at the AMS lasted for one to one and a half hours (with occasional delays or interruptions). All interviews were recorded in writing at the time of interview and all answers were recorded verbatim.

In addition to the above routine recording I kept systematic field notes using Schatzman and Strauss's (1973) model of recording observations before, during and after interviews. The notes were completed in detail and discussed each evening for verification with the Aboriginal co-researcher.

Thus, **observational notes** (ONs), as Schatzman and Strauss suggest ,detailed the "who, what, when, where and how" (p. 100) of activities. **Theoretical notes** (TNs), in this case study, primarily consisted of inferential comments to be followed up and cross-checked with the Aboriginal co-researcher, colleagues and at times other resource people. **Methodological notes** (MNs), particularly in relation to co-researcher interaction/communication, as well as completed and planned research action, were also recorded.

Schatzman and Strauss's model provided not only a practical means of monitoring our research activites, but also an invaluable "ready reference" for recording and cross-checking data emerging from different sources--especially informal communications outside of the interview situation.

The influence of stress

Whenever people work together as a team, it is inevitable that there will be some adjustments, some stress and strain, particularly if people come from different cultural backgrounds. Our situation was in some ways unique because Pat and I had been working together previously over a two year period.

Nevertheless, throughout our fieldwork there was a constant need to come to terms with interpersonal

tensions, cultural differences and contrasting styles of communication. The process was facilitated by early recognition of differences and problems. Pat's perceptions of this process are detailed in Appendix F. For example, accepting the need for deliberate cues to indicate messages between co-researchers was an area of considerable concern. Pat initially interpreted my suggestions about developing a pattern of cues as a "put down" i.e. another way in which I was trying to make things "easy" for her. Only slowly did she come to realize that such cues were important to **both** of us and that they would only develop and prove effective if we both worked at them.

An important principle underlying the project, utilizing and valuing individual abilities and skills, proved to be another source of contention. This area of concern was related to previous role definition and anxiety resulting from the role changes of trainer-trainee to co-researchers (to be discussed in more detail in the next section). I did not always communicate to Pat my high evaluation of her abilities, perhaps because I had forgotton the persistent influence of past experiences which have caused her (as well as many Aboriginal people) to question her capabilities when in contact with non-Aborigines. Further, because I was confident

of Pat's skills, I sometimes pressured her into situations which she felt to be threatening e.g., conducting interviews utilizing different schedules on the same day. This pressure caused her some anxiety - on the other hand, success at difficult tasks enhanced her confidence.

Contrasting styles of communication proved a more lasting source of anxiety. It is quite common for long pauses to mark Aboriginal/Aboriginal communication in the interview situation. These pauses were acceptable to me; however, they caused Pat considerable anxiety, perhaps because of her previous work experience and knowledge of non-Aboriginal interaction patterns, perhaps because she was still trying to "measure up" to some criterion of excellence which she believed I expected of her. In an Aboriginal/Aboriginal situation, then, long pauses between questions and answers or between answers and the next question appeared to conform to Aboriginal norms.

This pattern was, however, **not** common in non-Aboriginal styles of communications. In these situations "delays" in the interview process caused all participants, both researchers as well as interviewees, considerable stress. The interviewees and I found the interaction at times demanding and tiring. Similarly

Pat found the constant verbalising exhausting and tended to "tune out". She often lost concentration which led to repetitive questioning, embarrassment or, for me, the need to "rescue" the situation without causing her loss of self-esteem.

It was interesting that Pat was anxious about Aboriginal/Aboriginal communication patterns because she expected me to misunderstand. However, she frequently employed these same patterns with non-Aborigines, or simply distanced herself from the interaction and expected me to "rescue" her.

It seems to me that such a reaction of distancing may well mark Aboriginal/non-Aboriginal communications generally.

Throughout the period of fieldwork we dealt with stress and strain by means of frank, open, honest discussion and feedback. It will be evident in the next section on "Insider-Outsider role", and in particular, in the discussion of "Co-reseacher role and relationship" that these strategies proved effective.

Insider-Outsider role

The Aboriginal co-researcher was an "outsider" in the mainstream white health institution, but in the local community, in terms of her Aboriginal descent and kin ties, she was an "insider". To some extent I was an

"institutional insider" in that I had worked in settings similar to Country Town hospital, but an "outsider", in terms of my culture, in the Aboriginal community.

The dual role of insider-outsider was an area afforded special attention during the team preparation period because of the likelihood of it inviting ambiguity, confusion and conflict.

Further, the advantages and disadvantages of being familiar with the culture of participants and research setting were closely examined.

Stephenson and Greer (1981) have suggested that in field work familiarity does not necessarily aid perception and understanding. People and situations are frequently overlooked because they are taken for granted. However, Jarvie (1982) has argued that to some extent the success of field work "derives from exploiting the situations created by the role clashes of insider/outsider, stranger/friend, pupil/teacher" (p. 68). All of these roles have relevance to this case study and they were adjusted to by the co-researchers with some difficulty.

As indicated earlier Pat and I had been working together previously in a "trainer-trainee" role. One of the first adjustments we consequently had to make was to change our interactions from previous "teacher-learner"

situation to the present co-researcher relationship.

Pat overcame her self perceptions as "helper", "assistant", by swinging to the role of "leader", "doing it all", perceiving the interview situation as a competitive one of beating the other co-researcher. She reverted to the role of "helper" when she became anxious, which caused both of us considerable frustration. I too found it difficult to adjust to our new roles. My own commitment to the project at times made me impatient, anxious that the work be done well and on time, critical of delays and interferences.

The ongoing period of adjustment throughout the field work highlighted a number of preconceptions we each had about the role of co-researcher.

Co-researcher role and relationship

Early team discussions pinpointed the main objectives of having an Aboriginal co-researcher involved in this case study. Primarily such a role was necessary to:

* Lessen white researcher bias.

* Attempt to counter the dependent-power relationship that commonly exists between white Australians and Aborigines.

* Ensure that the research was not conducted alone.

These objectives served to strengthen the validity of the case study (Reason and Rowan, 1981).

There is always a danger that a solo researcher can easily become "locked" into one perspective, especially when utilizing the affective/interpersonal principles inherent in new paradigm research. Further, in a situation where participants differ from the researcher in terms of class and culture there is a special need for **binocular vision** (Maruyama, 1981). Thus, the co-researcher role and relationship became a vital part of this project. Each co-researchers' perception of her own her partner's contribution to different stages of the research process is detailed in Table 9.

The Aboriginal and non-Aboriginal co-researcher independently assessed (without predetermined criteria) each others as well as her own contribution/influence on decision-making. Later discussion between co-researchers and local research advisors about the patterns evidence in Table 9 highlighted not only the importance of **binocular vision** but also some of the difficulties inherent in this approach.

Table 9

Co-Researchers' Level of Contribution to the Research Process

Stages of Research Process		Level of Contribution							
UCSF Thesis Guidelines	Sub-steps in Country Town Pilot Case Study (adapted from Reason & Rowan 1981)	Aboriginal Co-researcher				Non-Aboriginal Co-researcher			
		zero	low	medium	high	zero	low	medium	high
I STUDY PROBLEM	Deciding what to study (discovering the problem)	x			✓				x✓
II LITERATURE REVIEW CONCEPTURAL FRAMEWORK	Background reading	x							x✓
	Thinking/discussing/ refining study problem		x						x✓
III METHODOLOGY	Team preparation/piloting			x	✓				x✓
	Deciding how to do the research		x		✓				x✓
	Deciding where to do research				x✓			x	✓
	Contacting/liaison and negotiation with:								
	Hospital			x	✓			x	✓
	AMS				x✓			✓	x
	Aboriginal Community				x✓			✓	x
	Choosing who to interview:								
	Hospital			x✓					x✓
	AMS				x✓				x✓
	Aboriginal Community				x✓				x✓
	Deciding the best method for collecting information			x	✓				x✓
	Getting permission from people to interview them:								
	Hospital			x✓					x✓
	AMS				x✓			✓	x
	Aboriginal Community				x✓		✓	x	
	Deciding how to record peoples responses				x✓			✓	x
	Collecting information (interviewing)			✓	x				x✓
	Co-researcher evaluation				x✓				x✓
IV RESULTS/ DATA ANALYSIS	Making sense of the results: (peoples responses)								
	Hospital	x		✓					x✓
	AMS	x		✓					x✓
	Aboriginal Community	x			✓				x✓
	Deciding on best to use the findings			x✓					x✓
V DISCUSSION	Communicating the outcome to people:								
	Hospital	x		✓					x✓
	AMS			x	✓				x✓
	Aboriginal Community				x✓				x✓

Note. ✓ perception of own contribution
x partners' perception of contribution

Table 9 analyzes **only** co-researcher perceptions of own and others' contribution to the project and can therefore be seen as one example of differing perceptions which may have influenced many other aspects of the research.

There is consensus in 81 per cent of cases between Aboriginal and non-Aboriginal co-researchers when evaluating the non-Aboriginal's contribution to various sub-steps of the project (see Table 9).

This pattern does not hold when considering perceived contributions by the Aboriginal co-researcher. Here consensus has been achieved in only 50 per cent of cases. Obviously Aboriginal and non-Aboriginal co-researchers have employed different criteria for evaluation. As there are no "right" or "wrong" perceptions/interpretations, it is important to identify the premise from which each co-researcher made her analysis, particularly highlighting those areas in which they failed to reach consensus.

It is evident in Table 9 that Pat "overestimated" her contribution to the project, in my estimation, in 12 out of 26 of the sub-steps; in one case I "overestimated" Pat's contribution in terms of **her** evaluation.

There is no doubt that my perceptions of contributions to the research process have been shaped significantly by my educational background, research training and experience. Pat's evaluations have, however, been shaped by different criteria as apparent in the following examples of verbatim comments in relation to:

Deciding what to study

> My concentrating on how people work together...whites with blacks. I knew I needed to get a clearer picture of what happens...it never came to me so clear as it did during this project...all the frustrations, my experiences working and living in the community...listening to what others say about us (Aborigines)...and Aboriginal comments about whites too.

Background reading

> I did a lot there. I read my Uncle's story...and my Mother's story...that made me think a lot...also read about how women can work together.

Deciding how to do the research

> I really worked there...I knew **personal contact** with Aborigines makes them feel important. They see us they can trust us...(they) don't like reading, letters, notes and that. It's not threatening to them when you go and talk to them.

Collecting information (interviewing people)

> I put medium there...because I wasn't writing anything down...that was the only thing.

Contacting/liaison/negotiating with the hospital and making sense of the results (people's responses) at the hospital

I have collapsed these two sub-steps because the hospital context was the most threatening to the Aboriginal co-researcher. Although some of her retrospective comments appear unrelated to the sub-steps in question, they reflect important concerns which preoccupied her thoughts at the time.

> It was frigthening when I first got there (to the hospital), but I showed myself for them (the hierarchy) to get to know me. A lot of non-verbal I suppose...by showing myself, especially to the whites. With the Aboriginal staff it was different...just had to see them and my communication was pretty good.

> Because of the hospital situation...you know...lots of things happening there with Aboriginal people.[a] I mainly just played my part as a co-worker...I knew about a lot of the things happening around the hospital...it made me feel uneasy...

[a] During field work July-November 1984 several incidents occurred where Aborigines were suspected of assault and minor thefts.

> I sometimes used to wonder how people was going to respond to me, how I was going to respond. But that didn't stop me in what I wanted to do. Lots of things came through in different ways...like talking (informally) to the nurses in their lounge room. I pulled back a bit (in the hospital) because of too many things going on. You'd have to be there a long stay...an Aboriginal person would. I could have fitted in with them (hospital staff)... easier for an Aboriginal to fit in their way than for them to look in my direction.

Reason and Rowan (1981) advocate that a co-researcher should have an **equal part** to play in influencing **all** stages of the researh process. Belief in such a role and "equality" may, as in this project, be an important principle shared by co-researchers, but the reality is fraught with difficulties when people come from a different cultural and educational background.

The situation becomes more complex when the type of commitment of one co-researcher differs from that of the other. For example, in this case study, certain predetermined, well established but culturally biased academic criteria had to be met for the project to be considered valid. Thus, the Aboriginal co-researcher was faced with having to adapt to alien, and at times, to her, non-sensical rules and procedures.

For example Pat was initially somewhat bewildered by the need to **exclude** her relations from "this type of research". To her they were the most reliable source of knowledge in the community, she stressed "they will tell us how they really feel...". Further, not being able to discuss and share valuable information with close relatives, (which is normally one way of asserting "belongingness" in the Aboriginal community), was at times frustrating and contradictory to her belief that "you can trust them...".

Similarly gaining consent in the Aboriginal community proved an area of misunderstanding. Because at times in the past, consent has not been sought from Aboriginal respondents, or they have not been fully informed of the nature of projects, I tended to be over-anxious and concerned that "they clearly understood what was being asked of them". Pat, on the other hand did not share my concern.

On a one to one basis, she gained consent (See Appendix G) from all Aboriginal clients she approached to participate in the study. Although we discussed it, and she explained that her kin relationships and her body language were important, I was never quite certain of exactly what she said to them until the project had been completed. Pat was reluctant or, perhaps, just

found it difficult to detail the actual communication, but she reassured me several times that "they understood" and "it would be all right...they know you are with me". Client non-verbal behaviour and the general reception we received when we entered someone's home certainly confirmed that this was the case.

Further, although Pat clearly understood at a logical level that she had **as much** to contribute to the project as I she had strong reservations about her own abilities and skills.

I have discovered that the concept of "equal contribution" to the research process has not been adequately defined by Reason and Rowan (1981). In reality, especially in an Aboriginal/non-Aboriginal situation, there needs to be quite tangible, concrete evidence that allows the Aboriginal co-researcher to see that her contribution is comparable.

In this case study the co-researcher evaluation sheet (See Appendix H), which was completed independently each evening, provided some evidence and reassurance to each co-researcher. We discussed our evaluations of our own performances with each other and we pinpointed those aspects of each other's work which were positive, negative, supportive, problematic.

Sometimes these discussions would take as long as

the original interview , but they proved invaluable in highlighting differences in communication styles and in sorting out minor irritations which are part and parcel of team work. More importantly they heightened our cross-cultural awareness and general sensitivity to the impact we were each having on the other.

The evaluation process convinced Pat that she was not simply an "assistant"/"helper" engaged to gain access to the Aboriginal community and to provide and collect data. As can be seen in Table 9 she made an essential contribution which influenced many stages of the reseach process.

The central ingredient which helped to sustain and complement the co-researcher role and relationship, especially at times of stress, was the fact that we were pursuing, not only a common goal, but one that could not be obtained without co-operation and interest in each other's welfare.

Data Analysis

Demographic data and background data (categories 1, 3, 4 and 5) were tabulated to clearly identify the age, experiential and educational/professional qualities of participants in this project. Responses to each open ended question were recorded verbatim and categories were developed in later analysis from these responses.

This method of data analysis is well supported in research. Indeed, Glaser and Strauss (1980) argue categories arising from primary data are much more effective for utlimately generating theory than predetermined/preestablished categories into which data can be "fitted".

> Although categories can be borrowed from existing theory...generating theory does put a premium on emergent conceptualizations. ...emergent categories usually prove to be the most relevant and the best fitted to the data. As they are emerging, their fullest possible generality and meaning are continually being developed and checked for relevance...(p. 37)

CHAPTER IV

RESULTS

Data gathered for this project will be presented in four sections:

Section A: Country Town Community Participants

Section B: Aboriginal Medical Service Participants

Section C: Local Hospital Participants

Section D: Situational Dilemmas

Sections A B and C will, where appropriate, essentially cover the same areas including:

* Demography
* General and Specific Culture Contact
* Job Satisfaction
* Experience in the Health System
* Staff preparation and Training
* Perception of Health Care Provider Role
* Staff Selection

One major area of data collection, that related to situational dilemmas, will form a separate section in which issues raised by participants from all three sample groups will be outlined.

SECTION A

COUNTRY TOWN COMMUNITY PARTICIPANTS

Demographic Data

As indicated in Chapter III, 19 women over the age of 30 years have been randomly selected to participate in the project. Their ages and location are recorded in Table 4. All but one are long-term residents of Country Town who have lived there for at least ten years. Indeed, as shown in Figure 4, over half of the group have lived in Country Town for 30 years or longer. Not surprisingly, more than 65 per cent of their children were born at the local Country Town Hospital (see Table I-1, Appendix I).

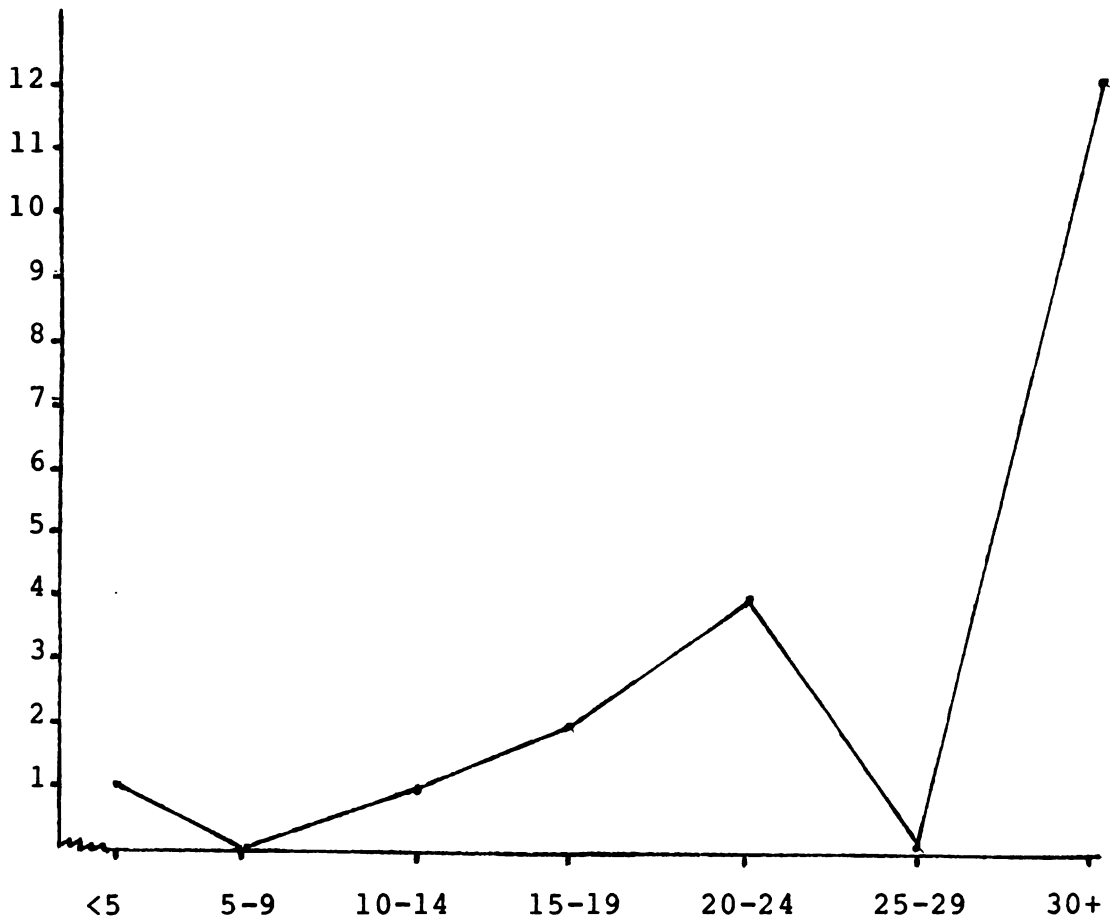


Figure 4: Length of residence in Country Town: Aboriginal community participants.

The nature and composition of the households represented by the women is detailed in Table I-2 (Appendix I). Using Eckermann, Watts and Dixons' (1984) definitions, the families have been classified into four types: nuclear, extended, single parent and compound.

> All households comprising husband, wife and their children have been classified as **nuclear.**
>
> All households comprising husband, wife, their children and one or more grandparents have been classified as **extended.**
>
> All households comprising a single parent and his/her children have been classified as **single parent.**
>
> The **compound family** (describes) households which may contain a diversity of "relatives"...a group of people where the household head, whether male or female, whether single or married, agrees to accept a boarder or to foster a child who may or may not be a close relative with or without payment. (p. 20)

Table I-2 indicates that the majority (N=16) of families represented are either nuclear or extended. The compound form of household organization represents only two of the families included in this project.

Table I-3 (Appendix I) details age of mothers by the number and age of children in each household. Country Town households included in the sample (N=19) care for 107 children; just over a third (N=38) are

under the age of 15 years.

Table 10 indicates the age and level and type of formal education of individuals interviewed.

Table 10

Aboriginal Community Participants: Age by Level and Type of Formal Education

Age	Education level attained				
	Lower Elementary	Upper Elementary	Junior High School	Senior High School	Don't Know
30-39			7	1	
40-49		3	3		
50-59	2	1	1		
60+					1
N	2	4	11	1	1

The majority (N=12) of the women interviewed have achieved a high school level of education. However, it should be noted that more than half (N=8) of this group are in the younger age bracket (30-39 years). Older women have generally attained no more than lower or upper elementary school education. This pattern reflects past

educational practices (noted in Chaper II) which considered Aboriginal people to be educable to fourth grade only and frequently excluded them from public schools (Miller, 1985, Harris, 1978).

All (N=19) of the community participants classify themselves as housewives. The longest time the majority have been unemployed coincides with the period they have spent either having or raising their children. Currently, just under half (N=9) of the group have full-time commitments as housewives and mothers.

However, only three participants have never been employed. Table I-4 (Appendix I) indicates that the group as a whole has primarily been employed in domestic or factory work. Only one participant has formal professional qualifications (as a nurse). Five people in the community sample report work experience as a domestic or voluntary aide in a local health care setting.

Today only four participants are employed--two full-time and two in part-time positions. Table I-5 (Appendix I) indicates that eight participants are relying on social security for support.

General and Specific Culture Contact

Table 11 investigates Aboriginal participants' contact with non-Aborigines and the type of interaction with non-Aborigines.

Table 11

Aboriginal Community Participants Contact and Interaction with non-Aborigines

Time of contact	Contact		Frequency and type of interaction			
			Occasional		Frequent	
	Yes	No	Casual contact	Mutual contact	Casual contact	Mutual contact
At school	12	7	8	4	—	—
Since leaving school	12	7	12	—	—	—

Nearly two thirds (N=12) of the group have had contact with non-Aborigines (predominantly white Australians) during their school years. However, the type of contact for most of this group (n=8) has been occasional and casual. Only four participants relate being "close friends" or "playmates" with white Australians whilst at school. None of the participants report frequent close interaction with non-Aborigines.

Seven respondents who have had interaction with non-Aborigines during their school days have continued to have occasional/casual contact with white Australians since leaving school. A further five participants have developed such interactions for the first time in employment situations. Most frequently this contact has been work-related. For example, "at week-ends I'd go and do housework...mostly for white people" or "I worked for a lawyer...did housework...(only) three dollars a week ...didn't do it for long".

Other participants relate that their main contact with non-Aborigines would be with a particular person, for example, "Mrs _____ at the corner shop" and some participants (N=6) recall that they were forced into interactions when they were on the missions or "taken from their families" by the Welfare Board.

Although six participants report contact with members of other non-Anglo-Saxon cultures, none of the participants currently has frequent close contact with Anglo-Australians.

The four participants employed obviously have frequent casual cross-cultural contact in their working situations. However, none of these participants relate mutually supportive "friendship" relationships with non-Aborigines.

Further, three participants report **no** contact with non-Aborigines whilst at or since leaving school. They explain "...all Black fellas down there...never used to go anywhere much off the mission...it's only these days you see 'em mixing". In contrast another respondent points out that although she " never lived on a mission...I was always out at the beach with my inlaws...only had Aboriginal friends...always on our own".

In the preceding discussion, community participants' reports of their contacts/interactions with non-Aborigines reveal quite marked social distance between the two ethnic groups.

Further support for this finding is found in Table 12, which indicates that just under half of participants (N = 9) are undecided or believe that most

health care providers have only a **partial understanding** of Aborigines. Respondents point out, for example, that they "should understand us better ...".

Table 12

Aboriginal Community Participants: Perceptions of Most Health Care Providers' Understanding of Aborigines

Perceived level of understanding			
Undecided	Full	Partial	None
4	3	5	7

In addition, just over a third of participants (N =7) believe most health care providers have **no understanding** of Aborigines.

> ...Probably not...probably don't think it's important to understand the Aboriginal culture...
>
> ...I don't think a lot (do) understand because they haven't got an understanding of Aboriginal culture or their ways ...how they do things.
>
> No...they don't understand ...I met people at the hospital that didn't grow up with Aboriginal people and I find this has been the problem....

A further two respondents distinguish between the understanding of non-Aboriginal health care providers at AMS and those at the hospital.

> Most at the hospital don't understand....some do at _____ (AMS) they do.
>
> The doctors and nurses.... they think they do now.... there's been a big breakthrough from when we used to go to the hospital... before they got the medical centre (AMS).

By and large the factors participants report as **most misunderstood** are related to attitude-communication patterns and Aboriginal culture as outlined in Table 13.

Table 13

Aboriginal Community Participants: Perceptions of Factors Most Misunderstood by Health Care Providers

Factors misunderstood	N[a]
Attitudes/communication patterns	6
Aboriginal culture	5
Cultural differences	2
Intra-cultural differences	1
Nothing	4

[a]Some participants suggest more than one factor and three participants are undecided.

Experience in the Health Care System

Table 14 reports which health services participants prefer to utilize and the reasons for their preference.

Table 14

Health Service Attended by Reason(s) for Preference: Aboriginal Community Participants

Health Service most frequented	N	Reason(s) for Preference						
		See own doctor	Privacy confidentiality	Free Service	Close Convenient	Efficient Service	Friendly Atmosphere	Staff attitude
AMS	6	3	-	1	2	4	3	-
Medical Centre	7	7	1	-	-	-	-	-
Own Doctor	6	6	-	-	-	-	-	-
N	19	16	1	1	2	4	3	-

Note. Several participants offer more than one reason for their preference.

Just over a third (N=7) of clients prefer to attend the Country Town private medical centre. However the proportion seeking attention at the local AMS (N=6) and/or their doctors surgery/residence (N=6) is not significantly different. Further nearly all (N=16) clients attend the health service of their choice primarily because they can visit their own doctor. As one client expresses "I just like stickin' to the one doctor".

Therefore it is perhaps not surprising that only two people mention attending after hour emergency services at the outpatients' department at Country Town hospital when their own doctor is not available.

All (N=19) clients are pleased with the care they receive from the particular service they choose to attend. Those attending the private medical centre or their doctor's surgery/residence believe that there is no way the service could be improved. Privacy and confidentiality are ensured and they report that all staff are polite, obliging and efficient.

In addition several clients indicate the importance they attach to "people having time for them" and "explaining things clearly".

Other clients report that they like the way their doctor involves them in decision-making related to

family health matters. For example:

> "...he'll sort explain to yu' ...yu' can sit down and ask him questions about yu'self and the kids...he'll tell me straight out...he asked me first...if they (children) want to be admitted (to hospital)...or take 'em home"

One doctor in particular is singled out by eight clients as caring, competent and occasionally giving preferential treatment to "dark people". "He's just a friendly doctor...he's got to know all the dark people...just like a good friend".

Two clients who prefer to see their own doctor at the private medical centre usually take their children to the AMS because they have found one of the doctors there "to be pretty good with children".

Other clients emphazise the fast efficient and friendly service AMS provides. One lady, reluctant to attend any health agency relates:

> I'm getting used to it now...they see you straight away...there are plenty of doctors...they make you welcome as soon as you walk in the door...(it's the) atmosphere...everybody talks to one another".

Other comments confirm similar feelings about waiting time/appointments, availablilty of doctors and the informal, secure atmosphere at AMS. In

addition clients cite proximity, costs, convenience and availability of transport as added incentives for attending AMS.

> It's handy...close...you know all the workers...friends and that...you feel comfortable with them.
>
> They're better and they are quicker...got more time for you than other doctors and that...I like it better at _____(AMS).
>
> You can go there anytime you like and ask for things (they've) got cars there to transport you (to) surgery...Xray...they're there to help you all the time.
>
> I get on real good with all the workers...(they) offer you a cup of tea...sit down and have a good old yarn.
>
> Well, it's free...with a private doctor down town...you have to make an appointment and wait and wait...

However, two thirds (N=4) of participants currently attending AMS and several (N=7), who used to attend, believe that the service offered could be improved. Table 15 outlines clients' suggestions for improvement. Most of the points (N=12) relate to the institution/system itself.

Table 15

Aboriginal Community Participants' Suggestions for Improvement to the Local AMS

Major Area	Suggestions	N[a]
Institution and System	Improve service efficiency	6
	Employ more skilled staff	4
	Provide training for AHWs	1
	Review service aims and objectives	1
	Reset annual election time	1
Staff/clients	Maintain privacy and confidentiality	3
	Change staff attitudes	3
	Improve communication with clients	2

[a]N represents total number of suggestions in each major area.

Competent staff, service efficiency (including transport on demand) and short waiting time appear to be important issues for most of the clients. Thus they suggest:

> It could be a better place if you had more skilful (Aboriginal) nursing staff...

> ...sometimes I don't like goin' up there... when you're in for a car... you've to wait for them to pick you up...
>
> ...(AMS) is closer instead of goin' to the hospital...trouble is in the night when you're sick...there's no car to take you there.
>
> I don't like goin' up there myself really...got to sit there...wait your turn. They seem to take their time there too...if you've got to wait for the doctor to see you...they could have the sister check them before they see the doctor.

Just under half the suggestions in Table 15 reflect participants' dissatisfaction with attitudes displayed by staff to each other or towards clients. The following comments provide some examples:

> I don't like the staff...or drivers...they're not very efficient...you have to wait...could be in pain or something.
>
> You don't know what they're goin' to tell you down there...they could probably get a better doctor for a start...(one there is) a real impatient sort of bloke.
>
> I always used to go to____(AMS) ...got nothin' against the doctors... just the staff and their attitudes. It's not like it used to be...it had to be used for Aboriginal people...I refuse to go there...I feel intimidated.
>
> The medical centre down town is more private than up here (AMS)...here they know everything about you.

Thus the level of discontent amongst those clients who are dissatisfied is quite high. However, two people with complaints point out that the service is relatively new and most of the Aboriginal staff are untrained.

> (Aboriginal staff) could treat patients and other staff with more respect (especially the doctors)...you can't blame the staff...they're just brought up that way and don't know any better...they do their best

> I can't really growl about them...they do their best. They've got a lot to learn...only been opened four years...(and they are) changing their staff.

Finally the timing of the annual election to choose the Board of Trustees at AMS, which will be discussed in Chapter V, is a bone of contention for some people in the community. Most spoke of their concerns informally following interview, however one lady highlights the issue by relating that:

> The community itself is split...people not turning up to vote...they (AMS) have the elections on the time of the Aboriginal knockout football (weekend)...people will complain that they don't like the Board of Directors but they don't stay and vote. A lot of other people in the community put a lot into it...we feel it's not being used now for the people...

Regardless of participants' preference for attending a particular health service, all respondents

interviewed (N=19) in Country Town have, at some stage of their lives, utilized the mainstream hospital system. Table 16 outlines participants' age and their attendance as an outpatient/inpatient at the local Country Town hospital.

Table 16

Aboriginal Community Participants: Age by Type of Hospital Service Utilized

Age	Hospital Attendance		
	Inpatient	Outpatient	
	Self	Self	Family Member
30-39 (n=8)	8	2	6
40-49 (n=6)	6	1	5
50-59 (n=4)	4	-	4
60+ (n=1)	1	-	-
N	19	3	15

Participants' perceptions of each of these facilities will be discussed in turn.

All participants (N=19) have been inpatients and just under half of the group (N=8) report hospitalization for reasons noted in Table 17 during the 12 months preceding this project. The length of hospitalization varies from an average of six days for adults to four days for children.

Table 17

Aboriginal Community Participants: Reasons for Hospitalization During Last 12 Months

Reasons for adult admission	N
Maternity	2
Renal condition	2
Diabetes	1
Heart	1
Abdominal pain	1
Infection	1

Further, it is evident in Table 16 that the family members of nearly all (N=15) of the participants have attended the local hospital outpatients department.

Three quarters (N=12) of this group sought attention for themselves or someone in their family during the last 12 months.

When the frequency and reasons for presentation to outpatients during this time are examined (see Table 18) it is significant that nearly all (N=10) of attendances at outpatients are for children. Only two adults report a pre-admission visit.

Table 18

Aboriginal Community Participants: Reasons for Outpatient Attendance

Group	Complaint	N
Children	Trauma/accident	5
(n=10)	Respiratory infection	3
	Epilepsy	1
	Cellulitis	1
Adults	Pre-admission	2
(n=2)	- renal condition	
	- elective surgery	

Thus, **all** participants have been patients in Country Town hospital at some time; 10 participants have been admitted in the last 18 months (eight of these during the preceding 12 months); the other nine respondents, however, have **not** been hospitalized for up to ten years. Whether or not individuals have had recent experiences at the hospital appears to influence their level of satisfaction with the services as outlined in Table 19.

Table 19

Aboriginal Community Participants' Satisfaction with Hospital Inpatient/ Outpatient Services by Time Since Last Admission/Attendance

Type of Service	Time interval since last admission/ attendance	Level of Satisfaction		
		Undecided	Satisfied	Dissatisfied
Inpatient service	< 18 months	-	10	-
	> 18 months	-	6	3
Outpatient service	< 18 months	-	8	2
	> 18 months	-	4	4

Note. One participant has never attended the outpatient department.

All clients (N=10) who have been hospitalized during the past 18 months felt "all right" or "good" about their experiences. "It was good. Treated me all right...had no hassles with them" and "Good...I like(d) it...I knew most of the nurses there...cos' I'm in and out all the time". A few people in this group express minor reservations "So...so...I suppose...they were all right" and "I sort of had good care...".

However, half of the clients (N=3) whose recollections are more distant, have stronger reservations related to their experiences in hospital:

> When I had my first baby the Aboriginal Mums were put out on the verandah...it was in August...very, very cold...at that time you thought you couldn't question things so you accepted (what they did). There's still that separation there... I suppose it's because Aboriginal people when they go in always like to be with somebody else...that's what they do...(But) I think they are still restricted to a certain section in the hospital.

> I was in a long time ago when they had (Aboriginal wards) on their own...those days you had to get the right person there...a nurse...never had doctors or sisters...we had a nurse...had good nurses...they looked after us.

In addition one lady speaking of more recent times points out that "down there...the doctor not told me nothin'...from then on I decided to go up to _____(AMS).

Nevertheless, it is clear from Table 19 that the majority of clients (N=16) were satisfied with the care they received whilst in hospital. Indeed when asked how the services might have been improved, just under half of the group (N=9) definitely state that **nothing** could have been improved (see Table 20). Thus, they point out "...it was lovely ...I can't complain about any of the care I got at all.

Table 20

Aboriginal Community Participants: Suggestions for Areas of Improvement in Hospital Inpatient/Outpatient Services

Type of Service	Suggestions for improvement									
	Nothing	Undecided	Unspecified	Staff attitudes	Quality of care	Waiting time	Choice of Doctor	Equal access to facilities	Patient activities	Communication
Inpatient service	9	2	1	4	1	-	-	1	2	2
Outpatient service	7	-	1	4	4	8	2	-	-	2
N	16	2	2	8	5	8	2	1	2	4

Note. Some participants offer several suggestions.

Those who could make recommendations for the improvement of inpatient services, including three clients who were generally satisfied, centre their comments on staff attitudes, communication and patient activities (see Table 20). For example: One time...I couldn't get off the bed...I wet the bed a couple of times and I just had to lay in that nightdress you know. And this went on one night...all night. I didn't bother saying anything...think they let me out before time...could have kept me in a couple of more days.

> I think they should have little work rooms for patients who want to get up and about...ones who get a bit impatient and want to go home...give them something to do with their hands...to occupy their minds. Sometimes they (do) get impatient and want to sign themselves out you know...they don't understand what has to be done for them.

Some clients express particular discontent when discussing their children's experiences in hospital. The following examples reflect concern, and at times anger, about inadequate care/supervision and negative staff attitudes.

> Only more staff...nurses are overworked...especially in the children's section...'round tea time...they (children) can't get the attention...unattended too...could have been better care

> My baby was cryin' and the nurse shouted at him "Yu'put me in mind of a little ape...". I told my doctor...he was goin' to take it to the Board...she hurt my feelings...
>
> If I find anything wrong...if they're not doin' things right...like when my grand kids were in there...they was feedin' 'em out of plastic mugs (like you get at the garage station)...I went into 'em over that...
>
> I didn't like it when (the baby) was in hospital...I boarded in with him...they had me down in the ward with all the other kids...I didn't like the idea of staying with all the kids...the room there...(for mothers)...was no-one in it...

A similar pattern is evident when participants are asked to comment about outpatients services. A significantly high proportion of respondents (N=7) believe that outpatient services are fine and could not be improved.

Table 19, however, shows that when satisfaction with inpatient services is compared with participants' reaction to outpatient services, more clients (N=6) are dissatisfied with the latter. Further, just over two thirds of Aboriginal clients, including the six people generally dissatisfied with the outpatients services, offer suggestions for areas of improvement (see Table 20).

Participants' comments highlight a number of concerns about outpatients services which range from perceived prolonged, unnecessary waiting hours, negative staff attitudes, inferior medical/nursing care, to lack of choice of doctor and at times poor communication from health care providers. For example:

> Don't matter when you go...you got to wait for hours...have to wait for a long time...'til they come...wait and wait. They must give white people that cup of tea and that...you see the tray there.
>
> With outpatients...you wait and wait...you have to be satisfied with the doctor on call...
>
> I didn't like it much...kept you waitin' a long time...sometimes they're a bit short tempered with you...if babies are there and playing up...
>
> Sometimes I feel like goin' and tellin' them off...they don't sit down and talk to you...they have 'em students doctors there...they send 'em (patients) home with aspirin...could have done that myself.
>
> Well, in the last five years yes (I've been pleased)...before that no...only one or two there that really cared...went there one day with my daughter...she had bronchitis...the ampicillin they gave her had to be stored in the fridge...she (the nurse) was so awful...she said this ampicillin had to go in the fridge..."You do have a fridge!". I said "No, I

> don't...I live over the river in a bark humpy". She was trying to put me down but I reversed it on her.

Some of the areas of client dissatisfaction with hospital inpatient services (e.g., language/communication difficuties, staff attitudes and quality of care) are reflected when they discuss concerns about hospitalization experienced by Aboriginal and non-Aboriginal patients. These concerns are outlined in Table 21. Nearly all the worries which participants note are perceived to be **shared** by both groups of patients.

Table 21

Aboriginal Community Participants: Perceived Concerns re: Hospitalization for Aboriginal and non-Aboriginal Clients

N	Perceived concerns re: hospitalization	N
	Aboriginal patients — Shared — non-Aboriginal patients	
7	Nothing	4
5	Family concerns	3
2	Language/communication	1
3	Serious illness/operations	1
3	Fear of dying	1
1	Fear of unpleasant procedures	1
1	Fear of unknown	1
1	Premature discharge of children	1
1	Fear of hospitalization	1
3	Negative staff attitudes	2
1	Fear of inadequate care	1
	Dislike of hospital food	
29		17

Note. Seven Aboriginal participants are uncertain about concerns of white patients.

Further, the number of participants indicating specific concerns about hospitalization is relatively low and a significant proportion (N=7) of Aboriginal participants report that there is nothing in particular that concerns them.

Although, just under half (N=7) of Aboriginal participants are uncertain about what might worry white patients, only one respondent believes that a particular concern (dislike of hospital food) is unique to Aboriginal people.

However, Table 21 also indicates that just over half of the perceived areas of concern (N=6) reported by participants are thought to worry Aboriginal people more frequently.

This picture is reflected to some extent in the patterns emerging in Table 22 which investigates Aboriginal participants perceptions of Aboriginal and non-Aboriginal peoples' general understanding of the hospital system.

Table 22

Aboriginal Community Participants: Age by Perception of Aboriginal and non-Aboriginal Peoples' Understanding of the Hospital System

Age	Perceived level of understanding							
	Aboriginal People				non-Aboriginal people			
	Don't Know	Full	Partial	None	Don't Know	Full	Partial	None
30-39 (n=8)	1	1	3	3	2	3	3	-
40-49 (n=6)	2	2	1	1	3	2	1	-
50-59 (n=4)	2	-	1	1	1	-	2	1
60+ (n=1)	1	-	-	-	1	-	-	-
N	6	3	5	5	7	5	6	1

Although a similar proportion (approximately a third) of Aboriginal participants are either uncertain or believe that both Aboriginal and non-Aboriginal groups share at least a **partial understanding** of the hospital system, clearly more participants (N=5) believe that white people have a **full understanding** of the system. Indeed only one Aboriginal participant believes whites have **no understanding** of how the hospital works.

In contrast, only three participants perceive that Aboriginal people have a **full understanding** and significantly more participants (N=5) believe Aboriginal people have **no understanding** at all of the hospital system (see Table 22).

However, although some of the perceived dissatisfaction with the hospital system appears to centre on interpersonal relationships, communications and cross cultural contact, these are not the major factors perceived to be most understood about the hospital by Aboriginal people. Thus, Table 23 indicates that the majority of participants (N=10) stress procedural and institutional/role factors as being most misunderstood.

Table 23

Aboriginal Community Participants: Perceptions of Factors Most Misunderstood about The Hospital

Factors most misunderstood	N
Nothing	5
Don't know	4
Lanugage and communication	3
Medical treatments/procedures	2
Discharge/follow-up	1
Medi-care/card	1
Routine and rules	1
Need for hospitalization	1
Doctor's role	1
Purpose of hospital	1

Nevertheless, the following quotes reflect and reinforce the underlying importance participants place on clear and acceptable communication.

> They don't understand about discharge...they think that's it! It's all over and they're well...when they get home they don't follow the advice from the doctors...
>
> Certain things being done in a certain way at a regular time...
>
> Communicating...long words...they don't understand...the nurses think they don't want to talk to 'em and that...

Although one participant points out: ...It's hard to understand a lot of things...they don't relate to it as an institution...it's a place where they go when they're ill and that's it... Table 23 also shows that just under half of the group (N=9) are either uncertain or believe that there is definitely **nothing** that Aboriginal people misunderstand about the hospital system.

Perception of Health Care Provider Role

All Aboriginal community participants (N=19) perceive the role of health care providers (doctors, nurses and Aboriginal health staff) to be important. Table 24 records their reasons for the importance they attribute to the work of doctors and nurses.

Table 24

Aboriginal community Participants: Importance Attributed to Doctors and Nurses

Reasons for importance	N
Essential life saving work	13
Encourage self-help	1
Understanding and friendly	1
Unspecified	4

The majority of participants (N=13) emphasize that these roles are essential because "only for doctors and nurses a lot of people wouldn't be alive today" and "what's goin' to happen if there's no nurses and doctors and everybody gets sick?".

Although four participants do not specify why they believe the work of doctors and nurses to be important, others emphasize that beyond "curing people" and "saving lives" some health professionals are accepting, caring and compassionate:

> Our nurse...we've got up here now should be getting two wages...she really works hard...been working over 20 years...she really knows Aboriginal people and she's really fitted in...that's made a lot of difference.
>
> They're there to help you get better...when you visit they make you feel welcome...the doctors are very understanding...
>
> I think their work is important. They try to make people better and encourage them to get well and things like that...

However, three participants although acknowledging the importance of the doctor/nurse role qualify their response:

> I think a doctor...a doctor they should listen and talk to you...some youcouldn't discuss thingswith them...happened more with Aboriginal patients.
>
> Only some doctors...and nurses...but thework they **should** be doing is important.

When Aboriginal participants are asked what they expect of doctors and nurses in their work with Aboriginal people **all** participants (N=19) emphasize the interpersonal qualities and communicative skillsthey expect health professionals to possess (see Table 25).

Table 25

Aboriginal Community Participants: Expectations from Doctors and Nurses

Expectations	N
Interpersonal communication skills	8
Cross-cultural communication skills	8
Desirable personal qualities	4
Community involvement	4
Non-discriminative medical treatment	3
Knowledge of Aboriginal environmental/living conditions	2

Thus participants explain that they expect doctors and nurses:

> To be nice...to be kind...everything should be confidential...that's the main thing I'd say....

I think they should explain things...anything that's wrong with you...should tell you straight out what to expect.

The doctors especially could be a little bit more patient and treat an Aboriginal person with more understanding...Aboriginal patients ...don't ask questions readily enough...too shy...always wait 'til the doctor ask first...doctors could be a bit more open with them ...talk to them 'round their illness...health habits.

They should have more understanding about Aboriginal culture...that Aboriginal kids are different to white kids...especially with discipline...need for 'em to know that...

I expect them to find out how Aborigines live and their background ...understand their way of living...their wants and different ways, especially in their emotional ways...a lot of dark people over emotional...will abuse and swear when they don't understand...they (doctors and nurses) should learn how to cope.

To be well informed of family situation, type of house...living conditions, the situation with alcohol, children too...if they cause you any worry...for example, women in the house all the time...involved with the kids ...women are open to diseases...like diabetes because of stresses and worries.

> Should understand them...a lot goes inthere and forget where they are...they start using the language (swearing)...we know...we understand...but doctorsusually don't understand.

Similarly, all Aboriginal participants (N=19) believe the work of Aboriginal health care providers is important as outlined in Table 26.

> They're good they are...'cos they're doin'a good job now.

> They(healthworkers)...have a field day - (sister) goes out with oneof the workers...they come here once a week askin' the women if they need anything for the little ones.

Further, nearly all participants (N=15) perceive thatother health professionals attribute importance to the work of Aboriginal health staff. However,byand large, most comments from Aboriginal participants (N=17) relate only to the work of the Aboriginal health workers or field officers employed at AMS.

When self-reports of the health workers /field officers' actual duties (see Section B) are compared with Aboriginal participants' knowledge of their work Table 26 indicates that **none** of the participants demonstrate **full understanding** of what health workers/field officers do.

Table 26

Aboriginal Community Participants: Level of Understanding and Importance Attributed to the Role of Aboriginal Health Care Providers and Perceptions Attributed to Doctors and Nurses

	Level of understanding				Importance attributed		
	Undecided	Full	Partial	None	Yes	No	Don't know
Self	-	-	11	8	19	-	-
Doctors and Nurses	11	4	2	2	15	-	4

Further, **partial understanding**, which characterizes the majority of participants (N=11) is limited to the knowledge of one or two duties with which the health workers are involved. For example:

> They transport patients to and from the clinic...check with doctors what medication is for...try to help people...drive the cars.

Table 26 also shows that a significant number of participants (N=8) claim to have **no understanding** of the duties of health workers / field officers employed at AMS. They state, for example, "I don't know what they do in their jobs..." and "I don't know...never had any contact with 'em...never see 'em.

However, several participants (N=6) in the past have been familiar with their work.

> Well, they used to come 'round and see if you needed anything...panadol, combs, bandages...don't think they do it anymore.

> Going around the houses...distributing whatever's needed...once every two weeks...they don't do it now.

In addition a few participants (N=6) have taken the opportunity to express their reservations and/or dissatisfaction with the work of health workers:

> I've never seen 'em go to the hospital and visit people...Black fellas...never seem 'em go up there.
>
> They don't do nothing much...don't know what they do there...seem so many of 'em...a terrible lot there for that one little clinic...sort of be in one another's way.
>
> (They) used to send cars out for people that's got no cars or ways of getting up to the clinic...they don't do it now...I think that's a bit slack...that's what the clinic's there for...
>
> They pick up patients and take 'em home...you've got a hard job of gettin' 'em at times...

The two participants who refer to the work of Aboriginal health staff at the hospital comment that they "...try to help people...they understand the system too...explain how the system works...they're there for people who go into hospital".

The majority of Aboriginal participants (N=13) believe that there could be changes in the role of Aboriginal health care providers employed at both AMS and the local hospital/community health centre.

Table 27 rank lists their suggestions for future role development.

Table 27

Aboriginal Community Participants: Suggested Extension of Aboriginal Health Staff Role

Suggestions	N
Home visits	9
Liaison/resource person	7
Health education	3
Hospital visits	1
Provide emergency transport service	1

> Home visits...to say hello..to see if there was any problems or if anyone needed help...that's very important...they'd get all that feedback...(and set up) asupport system to help people.
>
> If we could get some health workers to help the dark people...when they're sick and there's no way to get to the doctors..and to take medicine...
>
> We need a lot of Aboriginal people in the hospital...feel like there is someone there with them...makes them sortof contented...especially the kids..I tried to comfort a white kid...he could see I wasn't like he was used to...
>
> An older woman deteriorated in front of my eyes...she wouldn't ask for anything...didn't want to stay in hospital any longer than she had

to...she didn't want to cause them (staff) any hassles. That's where girls of our people could help around amongst their own.

Get into more of the homes in _____ (CountryTown)...go to the people...lot need help but just won't go and get it...if staff went they'd readily accept help...if they know staff are willing...health starts at home...

(They should)...make contact with single mums, pensioners...not just once...but every second week...depending on how needy that person is....like the pensioner living alone.

Participants' Recommendations

Staff preparation and training

The areas noted in Table 13 that participants perceive as frequently misunderstood by health care providers are reflected in the pattern that emerges when they are asked to suggest important factors that doctors and nurses should learn about Aborigines in their training (see Table 28).

Table 28

Aboriginal Community Participants: Suggested Areas of Input to Health Professionals' Training

Important Factors	N
Aboriginal culture/lifestyle	10
Communication	9
Cultural differences	6
Aboriginal coping skills	1
Environmental/living conditions	1
Crisis intervention	1

Table 28 clearly shows that Aboriginal participants again highlight the need for greater awareness, sensitivity and empathy among health professionals working in their communities.

> They should treat 'em all the same and understand the Black fellas more and understand the Black fellas have different ways to the white fellas.
>
> ...Communication...especially their language...not only from the mouth...got body language and all Aboriginal people.
>
> Aboriginal people are very shy to openup...when they go to the doctor ....he should try and get around 'em and talk to 'em ...like a friend...taking clothes off and that (to a stranger...) they don't like that...
>
> I wanted to ask questions of the doctors and I was frightened...you walk in and they say "What's wrong with you?" instead of talking to you...
>
> On the reserve they shy away from them...not to make people feel ashamed...not to discriminate...

Only one participant does not believe that health professionals need any special knowledge in order to work with Aboriginal people.

> Not really...we're the same as everybody else. They should treat everybody the same, no matter what colour your skin or anything.

Staff selection

Table 29 indicates that nearly all participants (N=18) believe that ethnicity should not be a major factor when choosing someone to work in Aboriginal health. Onlyone participant feels that it is preferable to have an Aboriginal person:

> Someone special...sort of person you could go up to and talk to ...(because) sometimes with the sisters...some of them you can go up and have a yarn with...only a few.

Table 29

Aboriginal Community Participants: Preferred Ethnicity of Health Professionals Working with Aborigines

Preferred ethnicity	N
Aboriginal	1
Non-Aboriginal	0
Either	18

The majority of participants clearly believe that **regardless** of ethnicity health care providers "still have to understand them" and be "accepted by them .... get along with them... so they (Aborigines) open up (to them)". Other participants suggest someone who has "a sense of humour", "...a happy-go-lucky person...not a

severe person".

> Got to be a person that they like or grow to like...someone they can trust...know their likes and dislikes...someone with a nice personality you'd say.

Table 30 indicates that just under half of the participants (N=9) place a high priority, **not** only on communication skills but also on knowledge of Aboriginal culture/lifestyle as well as formal professional qualifications.

Table 30

Aboriginal Community Participants: Preferred Qualities of Health Care Providers

Preferred qualities	N
Personal qualities	
Easy going/acceptable/flexible	14
Patient and understanding	9
Caring	4
Professional qualities	
Knowledge of Aborigines	9
Qualifications	9
Motivation/interest to learn	3
Communication styles/attitudes	7

> They should have an understanding of Aboriginal people...know their ways...

> Preferably somebody who's sensitive to their culture....
>
> Have to be experienced and qualifications (too)...at the hospital...someone who's not prejudiced...
>
> Anyone who goes through training.

Aboriginal health professionals

Even though the majority of respondents do not see ethnicity as a major factor in selecting health professionals to work with Aborigines all agree that there would be advantages if health professionals could be of Aboriginal descent. Table 31 indicates that increased rapport, self-esteem and confidence are seen to be the greatest benefits associated with Aboriginal health care professionals.

Table 31

Aboriginal Community Participants: Perceptions of Benefits of Having More Aboriginal Health Professionals

Perceived benefits	N
Better rapport	9
Increase self-esteem/confidence	8
Improve Black/White interaction	2
Improve health	2
Increase utilization of health services	1
Provide role model	1
Unspecified	1

When considering why there are so few Aboriginal health professionals respondents identify three main reasons - lack of suitable educational background, motivation and confidence (see Table 32).

Table 32

Aboriginal Community Participants' Perceptions of Reasons for Few Aboriginal Health Professionals

Perceived reasons	N
Education	8
Lack of motivation	6
Lack of confidence	5
Unsuitable temperament	2
Nature of training	1
Prejudice	1
Lifestyle	1
Expense	1
Don't know	1

Preferred ways for non-Aboriginal health professionals to learn about local Aboriginal communities

When considering how non-Aboriginal health professionals could best learn about Aboriginal people (see Table 33), the majority of respondents (N=11) indicate the importance of personal contact and communication. "Just getting to know 'em..."

Table 33

Aboriginal Community Participants: Preferred Ways for non-Aboriginal Health Professionals to Learn about Local Aboriginal Communities

Preferred ways	N[a]
Personal contact and communication	11
Use a cultural broker	6
Visit Aboriginal organizations	6
Work **with** them not **for** them	1

[a]Several participants offer more than one suggestion.

However, Table 33 also shows that an equally high proportion of participants suggest that non-Aborigines learn about the community through Aboriginal "go-betweens" and by visiting Aboriginal organizations.

> People could go to AMS or to pre-school...wherever Aboriginal people are...go to their meetings ...to where some organizations are ...they can't just go out to the community.

SECTION B

ABORIGINAL MEDICAL SERVICE PARTICIPANTS

Demographic data

Eighteen participants were interviewed at AMS. Table 34 outlines their ages, and positions in AMS. Of these 18 participants 12 are of Aboriginal and six are of non-Aboriginal descent.

Table 34

Age and Sex by Position: AMS Participants

Age and Sex		Position								
		Administrator	Dentist	Dental Nurse Assistants	Medical Officers	Health/ Field Workers	Registered Nurse	Nurse Aides.	Receptionist	N
20-29	M		1		1	4				
	F			3	1			3	1	14
30-=39	M	1								
	F				1					2
40-49	M									
	F						1			1
50-59	M									
	F									
60+	M				1					
	F									1
N		1	1	3	4	4	1	3	1	18

.Includes two trainee nurse assistants.

Five non-Aboriginal participants are Australian born of Anglo-Saxon origin while one is of Asian descent. All Aboriginal participants were born in Australia, the majority (11) in Country Town district. All Aboriginal participants have lived there for more than ten years (see Table J-2, Appendix J). In contrast most (N=5) of their non-Aboriginal counterparts have lived in Country Town for less than five years; only one has resided in the district for more than ten years.

Education standards in the non-Aboriginal group are high. One participant has completed the intermediate high school level to enter the nursing profession; the other five participants have all attained tertiary level education appropriate to their profession. In addition two of the medical officers have completed post-graduate studies. By contrast while all Aboriginal participants have attended highschool for some years, half (N=6) of the group has completed only lower highschool and half (N=6) has achieved the school certificate (intermediate) level (see Table J-2, Appendix J).

The majority (N=4) of non-Aboriginal participants have qualified more then five years ago (on average 12 years); only one participant graduated two years prior to employment at AMS (see Table J-3, Appendix J).

Most of the participants (N=15) have been in their current postion at AMS for more than one year (see Table J-3 and J-4, Appendix J).

However, participants' reports of past employment patterns and associated training reveal that Aboriginal staff at AMS are relatively inexperienced and "undertrained".

Thus Table J-5 (Appendix J) reveals that past employment has generally been confined to unskilled jobs; only five participants, all female, have experienced any form of training. Further, long periods of unemployment have been a fact of life for all the male participants (N=5) who are currently working as administrator and health workers.

Further Table J-6 (Appendix J) indicates that only two Aboriginal participants have had previous experience in, and some training for, the field in which they are currently working i.e. one nurse aide and the receptionist.

At this stage all but two Aboriginal participants have received, or are receiving, on-the-job training. However only four respondents record participating in an orientation to their current work while only two have attended any workshops related to health (see Table J-7, Appendix J).

This picture is quite different when non-Aboriginal participants' employment patterns are considered. All non-Aboriginal participants (N=6) are well qualified for their professions and half (N=3) of the group have had previous experience working in Aboriginal health (see Table J-8, Appendix J). A further two participants have had experience in cross-cultural medicine overseas.

However, none of the non-Aboriginal respondents have received an orientation to their present work with culturally different people, nor have they had an opportunity to attend any workshops/inservices on Aboriginal health or issues related to Aboriginal Affairs (see Table J-9).

General and Specific Culture Contact

Table 35 indicates the levels of culture contact and interaction experienced by AMS participants.

Table 35

Present Position by Contact and Interaction with Aborigines/ Non-Aborigines: AMS Participants

Time of contact	Present Position	Contact		Frequency and type of contact			
				Occasional		Frequent	
		Yes	No	Casual contact	Mutual support	Casual contact	Mutual support
At School	Nursing staff	-	1	-	-	-	-
	Medical staff	-	5	-	-	-	-
	Aboriginal staff	8	4	6	2	-	-
Since Leaving School	Nursing staff	1	-	-	1	-	-
	Medical staff	1	4	-	1	-	-
	Aboriginal staff	8	4	8	-	-	-
Current Outside of Work	Nursing staff	1	-	-	-	-	1
	Medical staff	1	4	1	-	-	-
	Aboriginal staff	3	9	3	-	-	-
N				18	4	-	1

No non-Aboriginal participants report any contact/interaction with Aborigines during their school years. Only one had contact with people from other non-Anglo Saxon cultures during schooling.

Although half (N=3) of the non-Aboriginal participants have lived or worked with people from a culture different from their own since leaving school, the majority (N=4) have not had contact with Aborigines before taking on a position at AMS. One participant who had spent a lifetime as a teacher points out "I had never met one before I went to be a doctor".

Since leaving school two people have established occasional mutual supportive relationships with Aborigines.

In contrast, Table 35 shows that half (N=6) of the Aboriginal participants have had occasional/casual contact with non-Aborigines while at school. A further two have maintained occasional but more in-depth mutual supportive relationships during their school days. Six of this group have continued to maintain occasional/casual contact with non-Aborigines since leaving school. Two other participants established such contact with non-Aborigines for the first time when they entered the workforce. Only two of the Aboriginal participants report **any** contact with cultures other than

white Australian.

It is evident in Table 35 that the majority (N=9) of Aboriginal participants currently have no contact with non-Aborigines outside their working situations. Only three people report occasional/casual contact with non-Aboriginal staff and other white community members (e.g., shop-keeper, teacher).

Table 36 indicates that just under half (N=5) of the Aboriginal participants perceive their relationship with non-Aborigines as **acceptable** by indicating that it "is pretty good" or "they are all right to me". A further five Aboriginal participants believe their interaction with non-Aborigines to be **reasonably good.** Four of this group simply state they "get along O.K." with whites, while the remaining participant considers that he is "one of the lucky ones".

Table 36

AMS Participants: Perceived Relationship Between Aborigines and Non-Aborigines

Type of perceived relationship	Ethnicity.	Reasons for perceived relationship						
		Get on well	Problem free interaction/ All right to me	Say hello	Treat the same, on own merit	Professional relationship	Unsure/ wary hesitant	N
Very good	AS	1						1
	NAS	1	1					2
Good	AS	4						4
	NAS				2			2
Acceptable	AS	2	3					5
	NAS					1		1
Fairly Distant	AS			1			1	2
	NAS						1	1
N		8	4	1	2	1	2	18

Aboriginal staff (AS) and non-Aboriginal staff (NAS).

Only two Aboriginal participants maintain a **fairly distant relationship** with non-Aborigines pointing out that "these people here...talk good to your face...some of them are school friends...they'll stop in the street and say hello...that's all".

Although the majority (N=4) of non-Aboriginal participants have no contact with Aborigines outside of work, it is quite clear from Table 36 that they believe that when they do interact with Aborigines they establish a **"good"** to **"very good"** relationship. Two of these participants emphazise that they "treat people as individuals...judging each on its own merits". One person in reporting problem-free interaction from his perspective however admits uncertainty about how Aborigines might perceive the relationship.

> I get on well with Aboriginal people I think...I have no difficulties in relating to them...there are no problems for me...whether there are problems for them I don't know.

In addition, one non-Aboriginal participant describes her interaction as **acceptable.** "I probably relate mostly on a doctor/patient basis...I think I'm fairly acceptable by the ones I know...it takes time". Only one participant perceives interaction as "fairly distant I guess...not very close...I think they hesitate to become over friendly with me.".

A very different picture emerges when AMS participants record their perceptions of understanding between Aboriginal people and health staff **not** associated with AMS, as outlined in Table 37.

Table 37

Perceived Understanding of Aborigines by Other Health Staff: AMS Participants

Type of position	Ethnicity		Level of Understanding			
	AS[a]	NAS[b]	Undecided	Full	Partial	None
Administrator	1					1
Dentist		1			1	
Dental Nurse Assistants	3			1	1	1
Medical Officers		4		1		3
Health/Field Workers	4				2	2
Registered Nurse		1				1
Nurse Aides	3				1	2
Receptionist	1				1	
N	12	6	2	2	6	4	6

[a]AS Aboriginal staff
[b]NAS Non-Aboriginal staff

Table 37 clearly indicates that the majority of non-Aboriginal participants (N=4) believe other health staff unlike themselves to have **no understanding** of Aboriginal people. One participant, for example, believed strongly that in Country Town community most (health staff) don't understand poverty to start off with....

In contrast the majority of Aboriginal participants (N=9) believe that health staff generally have **either full or partial understanding** of Aborigines: "...I think they are starting to understand now...they're becoming more aware of them..."

It is clear from the data presented that the main type of cross-cultural (Aboriginal/non-Aboriginal) interaction for **all** staff at AMS is primarily in terms of their working situation. Although nearly a third of the staff (N=5) do have occasional/casual contact with each other outside of work, only one participant reports well established "friendship" relationships with people from the other culture.

Furthermore Table J-9 (Appendix J) indicates that professional cross-cultural interaction takes place in fairly compartmentalized and traditional patterns. Thus, all (N=4) of the medical officers interact most closely with qualified nursing staff, nearly all (N=3)

have close interaction with trainee nurse aides and health workers. Similarly, other members of the team interact most closely with the people in their immediate working situation i.e. registered nurse with nurse aides, dentist with dental nurses, health workers with medical officer and registered nurse.

In addition four participants note close interaction with their peers.

Perceptions of Health Care Provider Role

Given that professional interaction does take place in relatively restricted groups, it is not surprising that half of the Aboriginal staff (N=6) believe that non-Aboriginal staff have only **partial or no understanding** of their work, as outlined in Table J-10 (Appendix J).

This pattern is even more pronounced among non-Aborigines. Table J-10 clearly shows that here the majority of respondents (N-4) believe that Aboriginal co-workers possess only **partial understanding** of non-Aboriginal staff's duties and responsibilities.

However a somewhat different picture emerges when participants' perceived understanding of the AHW role is examined. AHWs themselves were excluded from this part of the inquiry, data from which are recorded in Table 38.

Table 38

Perceived Understanding of Aboriginal Health Worker (AHW) Role by Ethnicity: AMS Participants

Participants' ethnicity	Level of understanding		
	Full	Partial	None
Aboriginal (n=8)[a]	4	4	-
Non-Aboriginal (n=6)	4	2	-
N	8	6	-

[a]This question was not applicable to the four AHWs on staff.

Participants were accorded **full understanding** if the duties they attributed to AHWs coincided with actual duties as recorded in the AHWs' self reports (see Figure 5, p. 178). Participants were accorded **partial understanding** if only some of the perceived duties coincided with actual duties.

Table 38 clearly indicates that **all** participants have **some understanding** of the AHW role although comments range from:

> They (AHWs) are recognized as important people in the community...they are looked at as examples...(to they are) chaffeurs...drive cars and that's it!.

Indeed the majority (N=8) appear to have a fairly **full understanding** of the AHW role including such duties as providing a transport/courier service, following up patients, assessing the need for medical attention, giving simple pain relief (e.g., panadol), screening for ear infections, providing information and finding out what people in the community want, answering the phone/making appointments as well as ordering, unpacking and storing supplies.

Table 39 investigates whether or not respondents consider the AHW role an important one and whether they believe that their perceptions are shared by other health care providers not associated with AMS. Most Aboriginal participants (N=7) consider the role important and all (N=8) believe that other health care providers (particularly those in close contact with Aboriginal people) value the services of AHWs because "they can see for themselves...", "saves doctors a lot of time...", "they act as a mediator...".

Table 39

Perceived Importance of AHW Role: AMS Participants

Participants ethnicity		Importance attributed		
		YES	NO	UNDECIDED
Aboriginal (n=8)	Self perceptions	7	1	-
	Other health professionals perceptions	8	-	-
Non-Aboriginal (n=6)	Self perceptions	6	-	-
	Other health professionals perceptions	3	2	1

Non-Aboriginal participants, however, are less optimistic. While these respondents appreciate the value of AHWs half (N=3) are less sure about other health staff's reactions.

Further, non-Aboriginal respondents associated with AMS appear to value the AHWs' **potential** role more than their current activities. Thus Table 40 which outlines suggested areas of involvement for AHWs shows that non-Aboriginal participants place high value on clinically oriented work in the community:

> Get health workers involved in asssessment, weights, heights, vaccination. I'd like to see them know enough to be respected enough in their community to assess situations...
>
> Diagnostic skills for basic and common things...
>
> Greater involvement in screening programs...

In contrast Aboriginal participants appear to place greater emphasis on training and staff development in order to increase their role in mediation and education in the community. Only two highlight more training in and greater involvement with clinical aspects (see Table 40).

Table 40

AMS Participants: Suggested Extension of Aboriginal Health Staff Role

Participants ethnicity	Areas of involvement	N
Non-Aboriginal (n=6)	Assessments/screenings	2
	Environment/hygiene assessment	2
	Early problem intervention/ management	1
	Counselling	1
	Diet education	1
	Follow-up care	1
	Knowledge/referral to local resources	1
Aboriginal (n=12[a])	Staff training	5
	Community education & liaison	3
	Emergency intervention	1
	Routine clinical assessment	1
	Increase liaison/contact with other health services	1

[a] Number includes the four AHWs.
Three participants believe AHWs should be doing "nothing" more than what they are already doing.

Both non-Aboriginal and Aboriginal staff seem to feel that only **limited understanding** of their work is prevalent in their respective communities. The majority of Aboriginal participants, however, indicate that their families possess at least **full or partial understanding** of what they do in their work (see Table J-10, Appendix J).

As participants do not rate either their co-workers' or their communities' understanding of their role very highly, it is important to investigate the level of importance participants perceive other staff to attribute to their work (see Table 41). Such perceptions have implications for both the nature of staff interaction and levels of job satisfaction.

Table 41 indicates that half of the respondents are unsure, particularly when asked to evaluate whether or not staff from the other ethnic group consider their work important. This pattern certainly supports early statements about the relatively low level of perceived understanding of work performed by the two ethnic groups.

Table 41

Perceived Importance Attributed to AMS Participants Work

Group's evaluation of participants role	Aspects of work valued										
	Don't know	Un-important	Professional role/expertise	Curative/ pain relief	Help other	Enjoyment satisfying	Equal treatment	Keeps me	Helping own occupied	Satisfac-tion with Service	N
Aboriginal staff's perception of other staff's evaulation of self	6	1	1	3			1				12
Non-Aboriginal staff's perception of other staff's evaulation of self	3		3								6
Family's evaluation.	2					1		2	7		12
Aboriginal community's evaluation	3	3	1	3					7	1	18
General public's evaluation	1	1	1	3							6
N	15	14	3	10	3	1	1	2	14	1	

a Only Aboriginal participants were asked this question.
b Only non-Aboriginal participants were asked this question.
c Asked of both Aboriginal and non-Aboriginal staff.

Significantly too, one third of respondents are unsure or believe that the Aboriginal community adheres to a negative image of their work. The majority of Aboriginal respondents (N=7), however, report that the perceived importance of their role is associated with "helping our people". Curative/medical functions are cited as the second most important reason.

Such perceptions are supported in Table 42, which outlines AMS's health professionals' perceptions of Aboriginal clients' expectations. Both Aboriginal and non-Aboriginal respondents consider that client expectations focus on competent clinical attention. However four Aboriginal participants emphazise that by and large the community "expects a bit too much", "expects (doctors and nurses) to slave", "to be in all day...". Expectations, then, appear to be high. This pattern is reflected in one non-Aboriginal respondent's comment that "a lot expect a miracle worker".

Table 42

AMS Health Staff's Perceptions of Aboriginal Client's Expectations of Doctors and Nurses

Staff	Perception of client expectations	N[a]
Aboriginal (n=12)	Availability for immediate attention	4
	Competence in emergency/crisis	4
	Clients' health education	1
	Fostering of independent decision-making	1
	Community involvement	1
non-Aboriginal (n=6)	Cure illness	3
	Perform miracles	1
	Be male	1

[a]N represents number of expectations recorded.

Further, when Aboriginal participants are asked whether or not doctors and nurses are considered important in their community, 11 respond in the affirmative. Only one participant reports that "they (clients) talking all the time...they're never got a good word for them (doctors and nurses). They don't appreciate what's being done for them...".

To some extent, this comment finds support in Table 43 where Aboriginal participants outline perceived reasons for doctors and nurses' importance to and in the community. Most frequently their comments centre on free, fast and efficient service.

Table 43

Aboriginal Staff's Perception of Reasons for Importance Attributed to Doctor/Nurse Role by Aboriginal Clients

Perceived Reasons	N[a]
Provide essential service	3
Provide efficient/fast service	2
Provide help when people are sick	1
Treat clients as people	1
Provide a choice of different doctors	1

[a]Six participants did not state reason but implied that clients considered the work that doctors and nurses do is important because it meets clients expectations.

Not surprisingly, four non-Aboriginal respondents comment that "Aboriginal people are a little spoiled because they get things too easy...they can be a bit demanding..." and "at times patients here tend to take you very much for granted...at your door at 6p.m....it happens fairly regularly".

The high level of uncertainity about whether or not others consider participants' work important must find reflection when job satisfaction is examined.

Job satisfaction

Self reports of actual and preferred duties of all (N=18) staff engaged at the AMS are outlined in Figure 5. The level of job satisfaction can be gauged by comparing respondents self-reports of actual and preferred duties with self-reports of their most time consuming activity.

It is evident in Figure 5 that actual and preferred duties coincide only in three cases, resulting in a **high level of job satisfaction.** Thus one medical officer who said "I just like doctoring full stop" spends most of her time in clinical work particularly with women and children.

Staff positions	N	Actual duties	Preferred duties	Most time consuming activity	Level of job satisfaction		
					High	Medium	Low
Administrator	1	General administration Items to DAA Photocopying, phone enquiries, etc.	Budget priorities Appropriate allocation of resources	"Worrying" about budget/ staffing			1
Medical Officers	4	G.P. Duties and responsibilities: clinical assessments, diagnosis, treatments, counselling and patient referral	Preventative health: Increasing community awareness of its health needs & encouraging people to take greater responsibility for their health	Clinical Assessments	1	1	1 1
Registered Nurse	1	General nursing care & procedures: ECG, injections, dressings, B.P., T.P.R., suturing emergency treatment, ordering drugs, stocking drug room	As stated for actual duties	Stocking drug room		1	
Nurse Aides	3	Assisting RN & MO as requested General nursing & sterilizing duties, laundry & procedures: dressings, blood sugars immunizations.	Meeting expectations of RN & MO. Reassuring people about procedures	Assisting RN & MO as requested		1 1	1
Health/field Officers	5	Transport/courier service, assisting MO & RN. Procedures: simple dressings, removal of P.O.P.	Helping own people to help themselves. Practising competent first aide	Transport Courier Service		1	1 1 1
Dental Nurses	3	Assisting dentist in clinic & field, cleaning/sterilizing instruments, receptionist duties, laboratory testing	Helping own people, encouraging people Reassuring people re: dental treatments, teaching preventative dental health	Assisting dentist in clinic & field	1 1	1*	
Receptionist	1	Typing, filing, answering phone, recording patient visits	As stated for actual duties	Answering phone			1*
Dentist	1	Dentures, relieve pain banding, field trips	Preventative education Increasing awareness to bring attitude change to dental health & habits, encouraging/ reassuring patients	Pain relief		1	

* Aim of work "nothing".

Figure 5 ARS participants: Employment duties and ascribed level of job satisfaction

Further, two of the dental nurses find that their actual duties of assisting the dentist in the clinic and on field trips provide ample opportunity for them to "help Aboriginal people", to reassure them and also to teach them about dental health.

Seven of the staff appear to achieve a **medium level of job satisfaction** because, even though their actual duties differ from their preferred duties, they find the latter take up most of their time. One medical officer, for example, at times achieves a high level of job satisfaction from clinical intervention. She states that "often people really are sick...you sometimes see rewarding and dramatic results". However, this is thwarted to some extent by the fact that in her present working situation "the potential for teaching ... opportunity to educate people about their general health" is limited. Nevertheless counselling duties which occupy most of her time do provide some opportunity to encourage people to take greater responsibility for their health.

The registered nurse also derives a medium level of job satisfaction. She sees the main aim of her work as "being here to help people medically" but points out that her most time consuming activity is "keeping the drug room stocked".

Similarly two of the nurse aides who enjoy patient care and "helping the sister" and "other people in your area" find only limited opportunity for these activities because their most time consuming activities:

> Sittin' down waiting for a patient ... don't get very many ... helping the doctor ... like if someone needs a bandage on their leg. Gets pretty boring when you've got to wait for someone to come in ...or ... doing cleanin' in the morning ... just hanging around...seeing patients who come in.

However both the above members of staff like the variety and challenge of their work when they are busy.

> There's always different things I like doing ... I like it all ... I enjoy doing it ... I've got somewhere to go ... I'm helpin' my own people ... some of them appreciate it.

Similar patterns are evident in responses recorded from one of the health workers, one of the dental nurses as well as the dentist. All are ascribed a medium level of job satisfaction because, although they enjoy providing an efficient service and helping people, much of their time is devoted to tedious tasks. For the Aboriginal respondents their level of job satisfaction would be increased if they were "allowed to go to training courses" to become more skilled and competent as a health worker.

It is apparent in Figure 5 that just under half (N=8) of the participants' self-reports suggest a **low level of job satisfaction** in that actual duties which are the most time consuming differ from respondents' preferred duties. Comments from those participants who exhibit a low level of job satisfaction indicate that they tend to become enmeshed in time consuming routine work at the expense of interpersonal relations, education and preventative services.

For example, two medical officers who spend most of their time meeting the demands of clinical work face real dilemmas and general frustrations which result in low job satisfaction because as one points out "I'm not really close to anyone...". The other, who is primarily concerned with influencing change by "increasing peoples'awareness of their health needs" explains:

> While I like the idea of community control and being an employee I get frustrated in the decision-making process... in not having a say...I swing from one extreme to the other. From (seeing my work as) very important...to just a waste of time...if you tend to want immediate results (problems arise)...as long as your expecting change you never get it".

Five Aboriginal participants with low job satisfaction highlight worry, passive acceptance or indifference to their work routine. Thus, one says "I

just come to work and whatever happens for the day I just have to do that...". Another when asked the main aim of her work replies "nothing...just answering the phone...". One of the Aboriginal health workers relates:

> I couldn't get interested in doing things ... got into that habit ... pickin' people up ... done nothing (really) ... yu'd go with the doctor once a week on field trip ...(or here) sat around all day ... phone rings ....

The administrator who attempts to provide "whatever the doctors want" spends most of his time worrying about "funding...and workers not turning up".

Consequently it is important to gain some measure of how important participants consider their work, particularly as a significant minority are unsure about other people's perception of their role.

Self reports of factors contributing to perceived importance of current work and the aspects of present position most liked are outlined in Table 44.

Table 44

AMS Participants: Self Reports of Factors Contributing to Importance of Participants Current Work and Aspects of Present Position Most Liked

Factors contributing to perceived importance of work	AS (n=12)	NAS (n=6)	Aspects of work most liked	N
Affective factors	3	2	Meeting different people Atmosphere No client fee required Everybody treated as equal Reassuring people	5
Professional satisfaction	1	3	Achievement/challenge Clinical aspects/visible results Acquiring new knowledge Potential for teaching Provision of fast/efficient service Role in problem solving Budgeting/resource allocation	4
Work satisfaction	8	-	Helping the needy Family-care of the elderly Helping/Available to Aboriginal people Helping the nurse/doctor being occpied Positive client response/ appreciation Keeping records	8
Other	-	1	Nothing	1

Note. n Represents total number of Aboriginal staff (AS) and non-Aboriginal staff (NAS).
N Represents the number of participants referring independently to the particular aspect of their work most liked. Several participants noted more than one aspect.

Despite the fact that almost half of the participants exhibit low job satisfaction in terms of the criteria outlined previously, the vast majority (N=15) consider their work important. Two thirds (N=8) of the Aboriginal staff attribute this to **work satisfaction.** Nearly all (N=7) of these participants describe the enjoyment/satisfaction they receive from helping people, especally Aborigines. "I like helping a lot of people", "I'm helpin' my own colour..." and "just working with Aborigines...it's good".

In addition three Aboriginal participants emphazise the **affective rewards** of their work as being most important. For example "I like meeting all different people...knowing that you're there helping people makes you feel good". Only one Aboriginal participant highlights the **professinal satisfaction** of her role in problem-solving and providing an efficient service to clients.

It should be noted that at least five Aboriginal participants offer a combination of reasons for being satisfied:

> Helpin' other people as well as yourself...learning a bit more as you go along...
>
> Well I think it is important... well it's helpin' people...you go out and meet all the people...that's the best thing about it.

> Yes it's important...there's always someone there...to pick 'em (clients) up...take their medicine out to them...just some little thing like that. And meeting different people...being up there with the doctors and learning things".

Half of the non-Aboriginal staff too offer a combination of reasons for considering their work important; however their satisfaction tends to revolve more around professional issues.

> I like achieving things ...I like the fact that it's a challenge...not always the same...an interesting job.

One medical officer stresses the affective rewards of his work but also highlights professional and work satisfaction:

> Well, I like the fact that I meet Aboriginal people and find out things I wouldn't otherwise find out...also working with a needy section of the community..helping people who need to be helped. I like being in a salaried position where I don't have to ask for money for services...I like not having to do that.

Similarly, the registered nurse reports a variety of reasons for considering her work important:

> I like mainly the atmosphere of the place...not being formal...everybody is treated as equal. Doctors don't get any better treatment...treated the same...and spoken to the same...all called by Christian names...also Aboriginal people look after their elderly more than whites...they don't put them in a

> nursing home...they don't have people zonked out as much (with anti-depressants) like white people. I just get a lot of pleasure and fulfilment out of my work.

Only one non-Aboriginal participant is doubtful about the importance of his work. Some of his comments introduce concerns which later became apparent when other staff report on aspects of their work which they dislike most (see Table 45). He states:

> I don't think it (AMS) is working in the way that those who designed the scheme wanted it to work...there is frustration in that way...but if it (AMS) didn't exist things would be a lot worse off...it's not easy work...it's frustrating work...I don't think that one sees the same people frequently enough to establish a relationship with them...I had closer relationships in a mixed community. The practice (here) is fragmented...too many field trips away...out of the community...so you're only half a doctor...not even that...

Table 45

AMS Participants: Self Reports of Aspects of Work Most Disliked

Type of Aspect	AS	NAS	Reported aspects most disliked	N
Institutional	4	7	Limited or non-involvement in community Lack of staff training Job insecurity Funding/political problems Non-involvement in decision-making Administration Bandaiding/curative emphasis Fragmentation of service delivery Small working space	11
Staff and/or duties	4	2	Unpleasant procedures Conflict of staff interest Negative staff attitudes/ interactions Boring routine	6
Clients	2	3	Demanding/inpatient clients Lack of close doctor-patient relationship Lack of individual responsibility for health	5
Other	3	1	Nothing	4

Although other respondents are less pessimistic, Table 45 indicates that over half (N=11) of them also experience frustrations which are mostly related to the institution or the system administration and/or service delivery. Further a third of the participants (N=6) also report aspects of their work most disliked in terms of staff interest/interactions or their duties. Just under one third (N=5) also dislike aspects related to client interaction/expectations. Three participants in this group in particular resent client attitudes and demands.

> People coming in and abusing you if there's not a car around to pick them up...
>
> Here people want to get quickly served...in and out in a hurry ... if problems are not solved in a few minutes ... they get impatient.

Interestingly Table 45 indicates that non-Aboriginal participants are proportionally much more frustrated by institutional/system related aspects of their work than Aboriginal participants. Proportionally the latter appear to find staff and work related aspects more unpleasant.

This pattern finds support in two related aspects: respondents' reaction to working in an Aboriginal Organization and their perceptions of Aboriginal clients' expectations.

Table 46 records participants' reactions to working in an Aboriginal dominated agency. Not surprisingly all Aboriginal participants like the situation because it gives them a chance to be more relaxed, more "themselves". Only one expresses some caution that "feeling good" can easily lead to one person becoming responsibile for everything while the others chat and socialize.

Table 46

AMS Participants Reaction to Working in an Aboriginal Organization

Ethnicity of participants	Reactions			Reasons				
	Good	No Different	Not Good	Reservations	Boost self-esteem	Increased social contact	Too much reliance on one person	Less reliability
Aboriginal (n = 12)	12	-	-	-	2	9	1	
Non-Aboriginal (n = 6)	2	3	-	1		2		1

Table 46 also indicates that non-Aboriginal respondent's reaction to working in an Aboriginal Organization are mixed. Only two respondents really enjoy the relaxed social atmosphere, the other four are either at pains to explain that "it makes no difference", or that they have reservations.

To this point the discussion has focused on respondents' roles, perceptions about their work and beliefs about what others think of them. The next sub-section considers how participants perceive the experiences of clients in the health system.

Experience in the Health Care System

Table 47 outlines participants perceptions of the Aboriginal community's understanding of the hospital system. Importantly no respondents believe that there is **full understanding** of the system by Aboriginal clients. Further, although two Aboriginal respondents are undecided, the majority of participants (N=9) indicate that Aboriginal clients demonstrate **no understanding** of the hospital system. Seven participants believe that most people in the Aboriginal cummunity possess **partial understanding** of how the hospital works.

Table 47

AHS Participants: Perceived Level Aboriginal Community's Understanding of Hospital System

Participants	Perceived Level of Understanding				
Participants	Undecided	Full understanding	Partial understanding	No understanding	N
Aboriginal staff	2	-	4	6	12
non-Aboriginal staff	-	-	3	3	6
N	2		7	9	18

When participants are asked to identify those aspects of hospital life most frequently misunderstood by Aboriginal people, (see Table 48) Aboriginal respondents focus on the rules and regulations of the institution. Thus, one participant states "probably just what they're allowed to do while they're in hospital". Other participants provide specific examples:

> You know kids runnin' up and down. Down there (at the hospital) they have to restrain kids and that...when yu're visiting (with them)...the nurses and sisters get a bit snooty and that cranky...at the front desk part...that paper business (is) too hard (to understand).
>
> That admission procedure...waitin' in outpatients, one hour or more... too many questions asked at outpatients all the time....

Table 48

Rank Order of Aspects of the Hospital System Most Misunderstood by Aboriginal Patients: Perceptions of AHS Participants

Participants ethnicity	Factors most misunderstood	N
Aboriginal (n=12)	Hospital system/rules and regulations	4
	Lack of rapport with nurses/methods of of communication	3
	Waiting time	1
	Food	1
	Nothing	3
Non-Aboriginal (n=6)	Lack of knowledge about health and the purpose of the hospital	3
	Hospital system/rules and regulations	2
	Lack of rapport with staff	1
	Nothing	1

Non-Aboriginal respondents also mention the institution's rules and regulations among aspects misunderstood by Aboriginal clients utilizing the hospital system. However they place greater emphasis on such factors as basic knowledge about health and the purpose of hospitals in general.

> Aboriginal people probably feel more intimidated than the general population. On the other hand, my experience is, they know all the ins and outs and know how to bend the rules more than the general public.

> Young Mums are getting very demanding. I've never come across that with white patients. So many (Aboriginals) are very young...no life except for the bubs...see the hospital as a way that bub can be looked after...use it as a baby sitting service.

Thus when participants are asked to compare factors which contribute to those which inhibit understanding of the hospital system by Aboriginal patients and the general public, Aboriginal and non-Aboriginal participants record similar as well as divergent perceptions, as outlined in Table 49.

Table 49

Factors Perceived to Enhance or Inhibit Patients Understanding of the Hospital System by AMS Participants' Ethnicity

Participants ethnicity	Factors contributing to understanding			Factors inhibiting understanding		
	Affecting Aboriginal patients only	Shared	Affecting non-Aboriginal patients only	Affecting Aboriginal patients only	Shared	Affecting non-Aboriginal patients only
Aboriginal (n=12)	Knowledge of available emergency care		Able to rely on family members more		← Idea of being hospitalized →	
	Frequent utilization		Early presentation for minor complaints		← Stress (especially re family) →	
	Doctors authority (e.g. immediate admission)		Less disruption to family life		← Fear (e.g. dying) →	
				Long waiting time		
				Negative hospitalization experiences		
				Client attitudes/ feelings		
				Negative staff attitudes		
				Late presentation		
non-Aboriginal (n=6)		← Knowledge that care not available at home will be given →			← Narrow view of aim of hospital (i.e. curative only) →	
	AMS Outpost Clinic		More trusting		← Impersonal care →	
	Frequent utilization		More compliant		← Lack of information from institution →	
	Ability to manipulate the system		More appreciative		← Rules and regulations →	
	Long-term stays			Fear		
				Ignorance/ misunderstanding of system		
				Client attitudes (e.g. demanding)		
				Negative staff attitudes		
				Ignorance about stress and diet		

Aboriginal participants highlight frequent utilization, doctors' authority and knowledge of available emergency care as factors contributing to Aboriginal client's understanding of the hospital system. Non-Aboriginal respondents support these views. The groups do, however, diverge on their perceptions of factors contributing to non-Aborigines' understanding of the hospital system.

Here Aboriginal participants perceive many more factors than do non-Aborigines. Conversely Aboriginal participants are able to identify far fewer factors **inhibiting** non-Aboriginal understanding of the institution and fewer aspects shared by both Aboriginal and non-Aboriginal clients than non-Aboriginal participants.

Both Aboriginal and non-Aboriginal participants do, however, agree on many factors inhibiting Aboriginal clients' understanding of the institution, including communication difficulties, fear and negative experiences. This is borne out in Table 50 which records perceived concerns recorded for Aboriginal as well as non-Aboriginal clients.

Table 50

Common and Different Areas of Concern AMS Participants Believe Aboriginal and non-Aboriginal Patients have about Hospitalization

N	Perceived Concerns		N
	Non-Aboriginal patients	Shared	Aborignal patients	
1	←	Unpleasant associations and negative past experiences	→	2
3	←	Fear of hospitalization	→	5
1	←	Family concerns	→	2
1	←	Fear of labour pain	→	1
2	←	Fear of death	(especially the elderly)	2
1	Fear general sickness		Emergency sickness/admission	5
			Staff attitudes and inferior inferior medical/nursing care	4
			Isolation from community	2
			Fear long-term stay.	1
			Fear of unknown	1
			Hospital food	1
			Fear of unfamiliar environment	1
			Fear of immobility/confinement	1

. participant undecided whether this applies to non-Aborigines.

Table 50 clearly shows that only five areas of concern: fear of hospitalization, fear of dying, fear of labour, family concerns, unpleasant associations and experiences are thought to be common to both groups of clients.

Non-Aboriginal clients are thought to worry about only one additional aspect of hospitalization, general sickness. Aboriginal clients on the other hand, while sharing five concerns with non-Aborigines, are thought to be worried by a further ten factors including fear of unfamiliar and impersonal threatening environments.

Importantly, half (N=6) of the Aboriginal participants are undecided about what might worry non-Aboriginal patients. As one of these respondents points out ...it's (just) more convenient for whites to go into hospital....

Consequently it would seem that, at least among Aboriginal participants, non-Aboriginal clients are perceived as having far more knowledge about the system than Aboriginal clients.

Participants' Recommendations

Through their comments and discussions about many issues raised during interviewing, respondents have made a substantial number of recommendations. These recommendations are presented in the following format:

* Staff preparation and training
* Factors Aboriginal and non-Aboriginal health care providers need to appreciate about each other's culture
* Factors AMS staff believe other health professionals need to appreciate about Aborigines
* Advice to new staff
* Staff Selection
* Aboriginal health professionals
* Preferred ways for non-Aboriginal Health professionals to learn about the local Aboriginal community.

Staff preparation and training

It is evident in Table 51 that only two Aboriginal staff members have been trained for the work they are doing.

Table 51

AMS Participants: Position by Input on Aborigines/Aboriginal Health

Participants ethnicity	Type of position	Stage of Input							
		General professional training		Job Orientation		On-the-job training		Workshops inservices	
		Yes	No	Yes	No	Yes	No	Yes	No
Aboriginal (n=12)	Administrator			-	1		1	-	1
	Dental Nurse Assistants			1	2	3	-	-	3
	Health/field Workers			2	2	3	1	2	2
	Nurse Aides	1		1	2	3	-	-	3
	Receptionist[c]			-	1	1	-	-	1
	N	1		4	8	10	2	2	10
non-Aboriginal (n=6)	Dentist	1	-		1				1
	Medical Officers	-	4		4				4
	Registered Nurse	-	1		1				1
	N	1	5		6				6

a Not asked of Aboriginal Staff except the one trained nurse aide
b Not asked of non-Aboriginal staff
c Secretarial training only

Similarly, although most Aboriginal participants are receiving on-the-job training of some kind, few (N=4) have had any orientation to their present position and only two have had an opportunity to attend inservice training.

The position is similar for non-Aboriginal participants associated with AMS. As Table 51 indicates, only one participant has had any input specifically related to Aboriginal health.

All non-Aboriginal participants consider it important for health professionals to receive input on Aboriginal health in their general training as well as inservice/workshops (see Table 52). Only one participant considers himself adequately prepared, through his personal study and self-orientation, for work at AMS. All others stress the importance of cultural or communication factors.

Table 52

AMS Participants: Perceived Need for Input in Aborigines/Aboriginal Health

Participants ethnicity	Type of position	Recommended Stage of input							
		General professional training		Job orientation		On-the-job training		Workshops inservice	
		Yes	No	Yes	No	Yes	No	Yes	No
Aboriginal (n=12)	Administrator			1		1		1	
	Dental Nurse Assistants			3		3		3	
	Health/Field Workers			4		4		4	
	Nurse Aides	1		3		2	1	3	
	Receptionist			1		1		1	
	N	1		12		11	1	12	
non-Aboriginal (n=6)	Dentist	1		1				1	
	Medical Officers	4		3	1			1	
	Registered Nurse	1		1				1	
	N	6		5	1			6	

a Not asked of Aboriginal staff except the one trained nurse aide
b Not asked of non-Aboriginal staff
c Respondent believes her training as an enrolled nurse aide is adequate preparation for her job.

Similarly, most (N=11) Aboriginal participants report that they need input in Aboriginal Health in their on the job training and continuing education as outlined in Table 52. Most generally, they seek enhanced clinical and other job related skills (e.g. emergency first aide, typing/administrative) to perform better in their work.

Table 53 indicates that, when participants are asked to consider subject matters which might be important inclusions in inservices for Aborigines and non-Aborigines working in Aboriginal Health, both groups highlight cross-cultural understanding, rapport and communication. Aspects related to medical/clinical factors in Aboriginal communities are also listed but considered to be of secondary importance.

Table 53

AMS Participants: Subject Area Suggestions to be Included in Inservice/Workshop

Participants ethnicity	Subject areas/suggestions	N
Aboriginal[a] (n=12)	Cross-cultural understanding/ contact	4
	Social contact	2
	Learn and work together	1
	Special Aboriginal heatlh problems	1
non-Aboriginal[b] (n=6)	Cross-cultural understanding/contact	5
	Social contact	1
	Learn and work together	1

[a] Four Aboriginal participants were undecided
[b] One non-Aboriginal participant offered two suggestions

Aboriginal respondents reiterate this pattern when they outline aspects of Aboriginal health to be included in general medical/nursing training. Their statements, rank ordered in Table 54, highlight their concerns for greater cross-cultural understanding.

> They should know Aboriginal people are a different culture from white...old Black fellas don't know the lingo...it's pretty hard on them in hospital.

Their culture and how to get on with them and understand them as a person.

Table 54

AMS Participants: Important Factors to be Included in Medical/Nursing Training

Participants ethnicity	Most important factors	N[a]
non-Aboriginal (n=6)	Cognitive emotional differences	5
	Physical manifestations of illness	3
	Psycho-socio-economic aspects	2
	Community medicine	1
	Traditional Aboriginal culture	1
Aboriginal (n=12)	Aboriginal culture/lifestyle/ history	10
	Cultural differences: education, expectations, medicine	9
	Communication	6
	Affirmative action	1

[a]N several respondents suggest more than one factor

Non-Aboriginal participants do not minimize the need for greater cross-cultural understanding. For example they stress that white health professionals should learn about:

> The way Aboriginal people believe...their attitudes to sickness, to the doctor, to medicine..to taking pills.
>
> Mainly bringing themselves to the way Aboriginal people think. They do think differently to white people...and white people don't understand it.

However, for general medical/nursing training, Table 54 indicates that these health care professionals also stress clinical areas related to Aboriginal health for inclusion in basic training courses.

> The special physical illnesses particularly peculiar to Aboriginal people...the different manifestations of illness.
>
> Things about skin disorders learn what can look different on dark skin and white skin...the psychological differences...ways of approaching people.

Factors Aboriginal and non-Aboriginal health care providers need to appreciate about each others' culture

Non-Aboriginal participants (N=6) have been asked to identify aspects of their **own culture** which they would like Aborigines to appreciate. These aspects include non-Aborigines' preference for quick and definite decision-making, interactions which are assertive but non-conformative and their strong belief in the work ethic. Interestingly only

half (N=3) of these respondents have any concrete suggestions to make.

Three other respondents are undecided and qualify their indecisions by such statements as:

> ...Aborigines should look at our culture and if they see anything in it...(then that's) up to them....
>
> ...I'm at the stage where I'm starting to question a lot of my own culture...

These patterns are very different from those found when Aboriginal respondents record what they feel non-Aborigines should appreciate about their culture (see Table 55). Cultural beliefs, personality factors and Aboriginal political issues are among some of the factors they cite.

Table 55

AMS Participants: Perceptions of factors staff need to understand about Aborigines

		Perceptions of factors		
N	Aboriginal participants	Shared	Non-Aboriginal participants	N
2	Aboriginal feelings/moods	Communication	Aboriginal lack of	1
1	Fear of whites	Fear	Fear of procedures	1
1	Shyness/patience	Disposition	More casual approach of Aborigines	1
			Aboriginal mobility	1
2	Cultural beliefs and behaviour in relation to health			
1	General culture (everything)			
1	Affirmative action (employment)			
1	Community control			
1	Aboriginal authority		Effects of stress/frustration	2
			Poverty	1

N represents factors noted by participants. Some participants noted more than one factor. Three Aboriginal participants and two non-Aboriginal participants believe there is nothing in particular other staff need to understand. A further two other participants are undecided.

Advice to new staff

However, when asked to indicate what kind of advice they would give to new staff, non-Aboriginal respondents are able to list significantly more items as recorded in Table 56.

Table 56

AMS Participants: Advice to New Staff

Participants ethnicity	Advice to new staff	N
Aboriginal (n=12)	Reassure them re: staff communication and patients	5
	Teach them on-the-job/practical work	3
	Teach them the rules re-dress code and working hard	1
	Tell them not to work too hard	1
	Don't know/nothing	2
non-Aboriginal (n=6)	Don't expect too much too quickly	3
	Show patience and tolerance	5
	Be honest re working conditions	1
	Basic practical advice	3

Interestingly, while both groups tend to centre their advice on interpersonal skills, non-Aboriginal respondents place much greater stress on developing tolerance of frustration:

> ...I think mainly that they would need patience and be prepared not to see results immediately...
>
> ...It's hard here at the moment, morale's pretty low...

> ...Tell him not to expect to achieve anything...

In contrast, Aboriginal respondents generally offer encouragement/reassurance coupled with straightforward, practical advice.

> ...I'd show them what's to be done ...how to go about it...show them what the doctor needs...

> ...Tell'm I'd be there to help'm...I'd help'm along and its not that hard.

Only one Aboriginal respondent (reported earlier as expressing very low job satisfaction) replied that:

> ...I'd tell him don't take the job, I wouldn't know what to say to him...tell him,. you're still back where you started (if you take this job).

Factors AMS staff believe other health professionals need to appreciate about Aborigines

Half (n=3) of the non-Aboriginal participants believe that other health staff do not understand nor are aware of the effects of "the general frustration level", "poverty" and "stress" that Aborigines experience. One of these participants suggests that if they did understand "they would be a bit more tolerant of things that go on".

Although two non-Aboriginal particpants believe there is nothing in particular other staff need to understand about Aborigines they present quite different

positions in relation to this question. One takes the opportunity to point out that non-Aborigines need to change their attitudes "they can't bring themselves down to the level of the next one ... they think they're a bit better than the next one".

The other states that "I don't see myself that Aboriginal culture is quite so relevant in this situation ...'cos I don't think there is much left". It is clear in Table 55 that this view is not shared by Aboriginal participants who identify distinctive cultural areas and suggest that "they (other staff) should learn what's going on".

Further, Aboriginal participants identify personal areas of potential conflict and suggest that other staff should "just know that Aboriginal people (feel)... what they're like... they frighten fellow when they're talkin' shy... got to have a bit of patience with them".

Two participants, however, highlight Aboriginal reaction to their perception of majority attitudes towards them. Thus they concentrate on establishing Aboriginal authority and emphasize white exclusions. "They've just got to realize it got nothin' to do with'm down there...it's (AMS) community-controlled...they're not our boss...just because they hold medicine."

Staff selection

Two thirds of Aboriginal participants (N=8) and non-Aboriginal participants (N=4) believe that ethnicity should **not** be a major factor when choosing someone to work in Aboriginal health. Two participants are undecided and four Aboriginal participants believe that it is preferable to employ an Aboriginal person. They qualifiy their response by stating "Not a smart one...", "It's got to be one that understands them...","Got to be a Goorie...a Black fella...I think Aboriginal people might be frightened to ask white nurses...things".

When participants are asked to outline qualities they believe health professionals should possess if they are working with Aboriginal clients, responses invariably cluster around affiliative factors. Thus Table 57 shows that both Aboriginal and non-Aboriginal respondents highlight the importance of personal, attitudinal qualities and communication skills.

Table 57

AMS Participants: Rank Order of Preferred Qualities of Health Professionals Working with Aborigines

Participants ethnicity	Preferred suitable qualities	N
	Personal qualities	
Aboriginal (n=12)	Easy going/patient/understanding	11
	Aboriginal person	4
	Tolerant/accepting/flexible	3
	Personality, sense of humour, good nature	2
	Tolerant/accepting/flexible	4
non-Aboriginal (n=6)	Easy going/patient/understanding	3
	Personality sincere/sympathetic/ sense of humour	2
	Professional qualities	
	Motivated to achieve	1

A very different pattern emerges when participants are asked to outline factors which should determine Aboriginal people's employment in health (see Table 58).

Table 58

AMS Participants: Rank Order of Factors which Should Determine Aboriginal Employment in Health

Participants ethnicity	Preferred qualities	N[a]
Aboriginal (n=12)	Experience/skills in health care	8
	Preparedness to meet needs	4
	Knowledge of the community	3
	Good work habits	3
non-Aboriginal (n=6)	Good work habits	6
	Communication skills	4
	Education	3
	Sound character	3
	Community acceptance	1

Table 58 clearly indicates the importance placed by non-Aborigines on such qualities as "good work habits".

> Someone willing to work hard...most important...someone interested in what the work is about...prepared to put up with the tedious bits....

In contrast Aboriginal participants stress the importance of qualifications, education and experience in health.

> You should go by the skills and that...if they can handle the job...if they had qualifications and experience...person who knows what he's talking about...had a bit of experience....

Aboriginal health professionals

It is clear in Table 59 that nearly all (N=5) non-Aboriginal participants and a third (N=4) of Aboriginal participants believe education is the main reason contributing to the fact that there are few Aboriginal health porfessionals. Interestingly though the following comments reveal quite different perspectives on how education affects the situation. There is consensus of opinion between Aboriginal and non-Aboriginal respondents in relation to some of the points they make about education.

Aboriginal respondent:

> I reckon Aborigines couldn't be bothered going through all those years of schooling...

Non-Aboriginal respondent:

> Because of their education...they don't want to really go to school...and motivation (too)...some can't see the point.

Table 59

Perceived Reasons for few Aboriginal Health Professionals

Perceived reasons	Participants' ethnicity	
	Aboriginal staff (n=12)	Non-Aboriginal staff (n=6)
Education	4	5
Lack of confidence	3	-
Lack of motivation	2	5
Lack of parental encouragement	1	2
Prejudice	-	2
Expense	-	2
Community pressure	-	1
Lack of role models	-	1
Don't know	4	-

Further some non-Aboriginal participants express doubt about the degree of family support and general value Aborigines accord to education.

> I'm not sure if amongst Aboriginal groups doing well at school is a top priority. To do medicine you must be extraordinarily motivated...and have extremely good family support.
>
> Few cope with pushing through school. They don't get great support from family.

In contrast, Aboriginal participants highlight general lack of self confidence when elaborating their thoughts about the lack of educational qualifications:

> Mainly because they don't think they can get that far...
>
> Some think they haven't got any brains to cope with it...
>
> Probably think that they never went to schooling, don't know anything...just stupid...

All participants see value in more Aboriginal representation in the health profession. Table 60 rank orders perceived benefits for both Aboriginal and non-Aboriginal respondents.

Table 60

AMS Participants: Perceived Benefits of Having More Aboriginal Health Professionals

Perceived benefits	Participants' ethnicity	
	Aboriginal staff (n=12)	Non-Aboriginal staff (n=6)
Better rapport/understanding	12	3
Prove ability/increase self-esteem	-	3
Provide role models	1	-
Increase Aboriginal expertise in community	1	-
Increase initiatives in health	-	1
Increase utilization of services	1	-
Improve Black/White interactions	-	1
Undecided	1	-

Clearly better rapport, including greater understanding and less conflict, emerges as the benefit most frequently thought likely to accrue from greater Aboriginal involvement in health. This response is, however, twice as frequent among Aboriginal as among non-Aboriginal participants, indicating the value placed on good inter-personal realtionship by Aboriginal respondents.

Preferred ways for non-Aboriginal health professionals to learn about the local Aboriginal community

Half (N=6) of the Aboriginal respondents believe the best way for white people working in health to learn more about the local Aboriginal community is by working with them.

> Yu'd have to work with him to know how he works...
>
> Work amongst 'em...
>
> Maybe (by) being sent out to work in something like _____(AMS)...

Further, five participants emphazise the need for a white health professional to work through a **cultural broker.**

> Ask one of the health workers to take yu' into the house...get one who know the community...(to) take yu' 'round...someone who is well liked...talk to one of the elder people...

Two of this group of participants suggest that new white staff should accompany the doctors or the community nurse on field trips because they are "accepted" by people.

The importance of personal contact/communication is implied in the comments of **all** participants.

> Go up and talk to them...some can be really friendly...
>
> Explain it to them...what you're there for and that...
>
> Just get out there and mix with them and get to know them...

In addition one participant suggests that contact via social activity is desirable because "if yu'(get to) know 'em...they'd take you out to meet 'em...in the community.

SECTION C

LOCAL HOSPITAL PARTICIPANTS

Demographic Data

Twenty (N=20) female respondents were interviewed at Country Town Hospital. Table 61 outlines their ages and positions in the hospital system. All respondents are of Anglo-Saxon extraction (see Table K-1, Appendix K). Only two were born outside of Australia, one in New Zealand and one in the United Kingdom. The majority have lived in Country Town for a period of more then ten years as outlined in Table K-2 (see Appendix K). Education standards in the group are high. All have completed at least an intermediate highschool level to enter the nursing profession. Since completing basic nursing training 16 have undertaken post-graduate nursing courses or diplomas. Further, 6 out of 20 have completed or are completing technical, college or university study.

Table 61

Age by Position of Respondents Country Town Local Hospital Participants

	Position			
Age	Administrator	Charge Nurse	Registered Nurse	N
20-29			5	5
30-39	1	1	3	5
40-49	2	3	2	7
50-59	2			2
60+			1	1
N	5	4	11	20

The majority of respondents (N=14) have qualified more then ten years ago and have been in their current positions for less then five years as outlined in Table K-3 (see Appendix K). Significantly, 50 per cent of nursing staff interviewed were actually trained at Country Town hospital. Half the administrators (N=2) and three quarters (N=3) of the charge nurses i.e. those people who hold positions of power fall into the Country Town trained group. Table K-4 (Appendix K) indicates that 50 per cent of staff interviewed have been working at the hospital for longer than six years.

Only two of the respondents interviewed have been employed previously in Aboriginal health. However, they both worked interstate in circumstances very different from those which characterize Country Town.

General and Specific Culture Contact and Interaction

Only six of the respondents interviewed report contact/interaction with people of Aboriginal descent (N=2) or other cultures (N=4) during their school years as outlined in Table 62. One of these respondents describes a mutual supportive relationship with an Aboriginal "friend" while a second relates past occasional/casual contact with an Aboriginal "class mate". Thus the majority of respondents (N=18) had no contact with Aborigines when they were at school.

Table 62

Present Position by Culture contact and Interaction with Aborigines

Time of contact	Present position	Contact		Frequency and type of Contact			
		Yes	No	Occasional		Frequent	
				Casual Contact	Mutual support	Casual contact	Mutual support
At School	Nursing Staff	2	18	8	-	-	4
Since Leaving School	Nursing Staff	8	11	1	-	2	6
Current/outside of work	Nursing Staff	1	19	1	-	-	-

However, more then half of the respondents (N=13) report that they have either lived or worked with someone from a culture different from their own since leaving school. Further, just under half of the respondents (N=8) have had some contact with Aborigines. Most of these respondents (N=6) describe mutual supportive "friendship" relationships within a working environment. Only one respondent out of the 20 interviewed currently has contact (occasional/casual) with an Aboriginal person **outside** of the working situation.

However, although the majority (N=19) have no contact/interaction with Aborigines outside the work environment Table 63 shows that just over half of the respondents (N=12) believe they have **very good** or **good** relationships with Aboriginal people.

Table 63

Perceived Relationship with Aborigines: Country Town Hospital Respondents

Type of perceived relationship	N	Reasons for perceived relationship								
		Get along well	Problem-free interaction	Unsure	Treat the same	Wary/ guarded	Only problem oriented	Credibility	Pity	Aboriginal Response
Very good	1	1								
Good	11	2	1		4			1	2	1
Acceptable	3		2	1						
Fairly distant	5a				2	4	1			

a Two respondents offer two reasons.

Just under half of these respondents (N=4) emphasize that their relationship with Aborigines is "as good as with other people" and they "treat them the same (i.e. as they find them). Two respondents indicate they always try to compensate for Aborigines being the "underdog" and thus treat them as they would "less fortunate members of the white community". Further, one respondent believes her positive interaction with Aborigines is due to the credibility which a close relative has among Aboriginal people. Indeed, only two of the 11 respondents, who report that they have a "good relationship" with Aborigines, describe positive unqualified interactions.

Nearly all the respondents (N=4) who describe their relationship with Aborigines as **fairly distant**, relate being "wary" or "guarded" because of their personal experiences or genuine lack of contact with Aborigines. For example, one respondent who admits a lack of understanding of Aboriginal culture says "I'm a little bit apprehensive of them...I don't really know how they tick".

> As a nurse and caring for people...you treat everyone as equal...I'm not close to them...I'm a bit stand-offish with them from my personal experiences with them but they are all different

And another more common experience:

> I never see any of them...but I'm very wary of them now...my only contact (really) is when there are problems...
>
> I take it as it comes really...I try not to be discriminating...but probably in ways I am...But mainly I just take them as it comes...some are nice...some abrupt...some you can talk to but I don't seek their company outside of work.

Similar patterns emerge when respondents record their perceptions of the levels of understanding between other health staff and Aborigines (see Table K-5, Appendix K). Only five respondents interviewed believe other health staff have a **full understanding** of Aborigines. Three of these respondents attribute this understanding to the fact that a large proportion of the staff have worked at the hospital or lived in the town for a long time.

"Yes, here they do because they have been here forever...". One respondent states that by and large Aborigines are "treated the same as whites" and that this must indicate a high level of understanding.

Two respondents attribute health staff's **partial understanding** of Aborigines to their observations that Aborigines are "treated the same", that staff are open-minded (not prejudiced) and that positive interactions occurs between Aboriginal nurses

and other health staff.

However, the majority of respondents (N=12) clearly believe that other health staff have **no understanding** of Aborigines. Some of their reasons are apparent in the following comments:

> They understand them...but don't like them...it's just a feeling around the place.
>
> No, I don't think they want to (understand them)...they want to sweep them under a carpet and wish they weren't here...that's what I see anyway.
>
> They have no patience with them at all...I get so wild with them (other staff)...they become so aggressive...bark at them...talk to them incorrectly.
>
> Here, in the hospital they tend to treat Aborigines the same as they do whites...whether they understand them...that they're a shy people or not...I don't know...if you take time to sit and talk to them they show interest.

And from a different perspective:

> They don't want to understand because of the attitude of the Aboriginal person. I might as well be honest. I tell you I don't trust them...the more education they get the more cunning they become...too many hand outs and that's detrimental...

Although six respondents were reluctant to state why they believe Aborigines are misunderstood by other

health staff it is clear from the above responses that staff preconceptions (some confirmed by individual experiences) of different values, attitudes and habits, and lack of communication skills (e.g., empathy and patience) play a significant part in Aboriginal/non-Aboriginal interactions. The following comment summarizes this pattern "..they (the Aborigines) are lacking a sense of responsibility to themselves."

In addition, one respondent points out that most staff have not experienced the unemployment and poverty to which Aborigines are subjected and therefore could not begin to understand them properly.

Job Satisfaction

The main duties and responsibilities of respondents are in accord with their positions at the hospital. This is apparent in their self-reports of most time consuming activity noted in Figure 6 and close professional interaction with other staff (see Table K-6 Appendix K).

The main duties and responsibilities of all administrators (N=4), for example, are related to efficient administration and staffing of the hospital; a secondary emphasis is placed on nurse teaching and supervision, patient care ad public relations. The majority (N=3) of administrators interact most closely with their immediate peers (other nursing administrators and supervisors) and the director of nursing. One administrator reports that her closest interaction is with the nurse aides.

Charge Nurses (N=4) are primarily involved in administration, organization and management of their departments; a secondary emphasis is placed on patient care, nurse teaching/supervision, public relations and staff liaison. Three quarters (N=3) of charge nurses interact most closely with other trained nursing staff (registered nurses and enrolled nurses). In addition, half note close interaction with doctors and student nurses.

More then three quarters (N=10) of registered nurses interviewed are directly involved in patient care; a quarter (N=3) also report duties and responsibilities related to nurse teaching/supervision and ward management; one respondent notes liaison as an important part of her role.

Half (N=6) of the registered nurses interact most closely with nurse aides and student nurses. Just under half (N=5) interact primarily with their peers (other registered nurses), while a minority (N=4) also identify a superior (e.g. the charge nurse) as the person with whom they work most immediately. Only one registered nurse, indeed only one respondent out of the total 20 interviewed, mentions working closely with an Aboriginal staff member.

Self-reports of factors contributing to importance of current work and the aspects of present position most liked are outlined in Table 64.

Table 64

Self Reports of Factors contributing to Perceived Importance of Respondents current Work and Aspects of Present Position Most Liked, Country town Hospital Respondents

Factors contributing to perceived importance of work	N	Aspects of work most liked
Affective features	9	Providing care/satisfying needs Meeting different people Keeping people happy and contented Maintaining amicable staff relationships
Professional satisfaction	8	Achievement/challenge Clinical aspects/visible results Stimulations, acquiring new knowledge Role in problem-sovling Public relations
Work Satisfaction	3	Being occupied/employed Being involved with and acceptable to people Helping people Positive responses to care (especially with the young)

Just under half (N=9) of respondents note **affective reasons** for considering their work important. Nearly half (N=4) of these respondents, describe the enjoyment/satisfaction of caring for children and babies. Others (N=4) simply "love giving care", "meeting different people" as well as "satisfying people's needs". Similarly eight participants receive most enjoyment from the **professional satisfaction** inherent in their work.

Only three respondents report **work satisfaction** as the main reason for considering their work important. As can be seen in the following comment, they offer a combination of affective and practical reasons for being satisfied:

> I (like) the stimulation, mental and physical...(and) meeting people...(but) mainly the activity...I also enjoy nursing and helping people.

Although, all respondents consider their work important it can be seen in Table 65 that most (N=19) also report aspects of their work which at times detract from their positive attitudes. Interestingly, Table 65 clearly indicates that the majority of aspects most disliked in their work (N=15) are related to other staff and/or the institution rather than clients. Thus seven participants report lack of staff discipline, conflict

of interests, inefficient administration/organization and negative attitudes as major concerns. In addition five respondents highlight tedious non-nursing, administrative work, while three respondents note the unpleasantness of certain nursing duties/clinical procedures such as collecting sputum. Only, one respondent, a recently qualified graduate, reports a lack of self-confidence in managing emergency situations.

Table 65

Aspects of Work Most Disliked as Recorded by Country Town Hospital Participants

Aspects of Work Most Disliked	N
Negative staff attitudes and interactions	7
Clerical work	5
Unpleasant nursing duties/clinical tasks	3
Job insecurity/lack of permanent staff	2
Lack of self-confidence	1
Shift work	1
Nothing	1

Level of job satisfaction can be gauged by comparing respondents self-reports of actual and preferred duties with self-reports of their most time consuming activities. It is evident in Figure 6 that actual and preferred duties of more then half (N=12) of the staff interviewed coincide. However, only half (N=6) of this group spend most of their time fulfilling these duties and thus have a **high level of job satisfaction.**

Staff position	Actual Duties	Preferred Duties	Most time consuming activity	Level of job satisfaction		
				High	Medium	Low
Nurse Administrator/ Supervisor (N=5)	. Hospital administration, . organization and management	Promoting & maintaining staff welfare	Posters, ward rounds, staff records			1
	. Hospital administration/ management . Problem solving/mediating	Promoting & maintaining staff welfare	Counselling Problem-solving	1		
	. Patient care supervision	Patient care	Patient care supervision	1		
	. Hospital administration, organization & management . Co-ordinating nurse training	Co-ordinating nurse training	Staff complaints Hospital			1
	. Nurse education	Nurse education	Nurse education committees	1		
Charge Nurse (N=4)	. Ward management/staff supervision & education	Patient care/well being	Patient care staff education		1	
	. Ward management/staff supervision (doctors rounds/ staff reports)	Patient care/well being Staff welfare	Communication Counselling relatives			1
	. Ward management/staff supervision & education	Ward organization staff and patient education	Direct patient care			1
	. Patient care/well-being	Patient care/well-being	Ward administration			1
Registered Nurse (N=11)	. Patient care/well-being	Patient care/well-being Educate doctors	Paper work			1
	. Patient care/well-being Nurse training	Patient care/well-being	Paper work			1
	. Patient care/well-being	Being occupied	Patient care well-being paper work	1		
	. Patient care/well-being Ward administration	Patient care/well-being	Patient care well-being	1		
	. Patient care/well-being	Patient care/well-being	Patient care well-being	1		
	. Organization and supervision of patient care/well-being	Direct patient care well-being	Administration			1
	. Staff mediator	Patient education	Paper work			1
	. Patient care/well-being (assessment/emergency intervention)	Patient care/well-being	Paper work			1
	. Ward organization/ administration	Patient care/well-being	Paper work			1
	. Ward organization administration	Patient care/well being	Ward organization administration			1
	. Ward organization/ administration	Patient care/well-being	Patient care well-being		1	
N				6	2	12

Figure 6 Country Town Hospital Participants: Employment Duties and Ascribed Level of Job Satisfaction.

Reports of two respondents suggest a **medium level of job satisfaction**, because, even though their actual duties differ from preferred duties, they find the latter takes up most of their time. Thus, more then half (N=12) of respondents' self-reports suggest a **low level of job satisfaction** in that actual duties, which are the most time consuming, differ from respondents' preferred duties. Interestingly, the most time consuming activity for the majority of these respondents (N=10) is administration/paper work.

When such a relatively low level of job satisfaction appears to exist, it is important to examine how participants feel others in the community evaluate their work.

Perception of health care provider role

The majority of respondents (N=19) believe that the general public considers their work important. Similarly most respondents (N=17) believe that the Aboriginal community and Aboriginal staff (N=16) value their work.

It is however apparent in Table K-7 (Appendix K) that there are some differences in participants' perceptions of why the general public, Aboriginal people and Aboriginal staff consider their work important.

Thus most (N=11) participants find it difficult to specify a reason for the importance attributed by Aboriginal staff to respondents' work.

This is not the case for the Aboriginal community or the general public. In both cases curative care/pain relief are thought to enhance respondents' role.

Aboriginal staff, however, are thought to respect participants' expertise, professional role, problem-solving abilities as well as their authority--being "the boss".

Further, the number of participants who believe Aborigines do **not** value their work is three and four times the number of participants who feel the general public does not appreciate the importance of their work.

Similarly, when respondents indicate their perceptions of others' undestanding of their profession, most believe that only partial understanding exists (see Table K-8, Appendix K).

Further Table K-8 indicates that participants accord full understanding of their role most often only to health staff , particiularly Aboriginal nurses.

Just as they are uncertain about whether non-nursing staff values their role, so participants indicate that they themselves have limited understanding of the roles of Aboriginal paraprofessionals e.g., Aboriginal health workers (AHWs). This pattern is clear in Table K-9 (Appendix K) which analyzes respondents' perceived understanding of the AHW role.

Only one out of 20 respondents interviewed believes she and other health staff have a **full understanding** of the role of the AHW. This is confirmed by the fact that most respondents find it difficult to describe the work of AHWs.

Although seven respondents maintain they have some idea of what the role entails only two demonstrate some knowledge of services provided by AHWs, while only one respondent describes the whole spectrum of services in which AHWs are involved including nutrition clinics, dental work, providing transport, breaking down barriers

and acting as intermediaries.

Over half of the respondents (N=12) indicate that they themselves are either not familiar with the role, or have no understanding of it. Further, the majority of participants (N=16) believe this would also be true of other health staff. These respondents primarily attribute the lack of knowledge and understanding of the AHW role to the general lack of contact with Aboriginal staff, rapid staff turn-over and the failure of authorities to provide a job description or general information about the role (not only of AHWs but of all non-nursing Aboriginal staff employed at the hospital).

Further, three respondents believe that some staff are simply not interested or have negative attitudes about Aborigines. This is evident in some of the comments:

> You're never really told what is happening through the Aboriginal community...that they get this and that. As far as health it's never really discussed.

Although such limited knowledge of the AHW role appears to exist among respondents and their peers, all respondents (N=20) consider the AHW role important. This belief is not perceived to be shared by other health staff, however, as outlined in Table K-10 (Appendix K). Respondents feel that the AHW role is

important because, as outlined in Table 66 it is likely to enhance communication between clients and the health system and may lead to increased knowledge of resources.

> It breaks down the barriers...a photo...contact link to the community.
>
> Probably serve as an intermediary role between health people and Aborigines themselves...
>
> Would give me a better understanding of what's available for them...if it's not available at ____ (AMS)you could then look elsewhere...
>
> They should be more involved in the hospital...assess situations in the hospital...to see if something more can be done in the home situation... to prevent this (reason for hospitalization) happening.
>
> It takes a lot off the doctors shoulders really...
>
> Everyone agrees that health wise...their (Aborigines') health has improved so much since Aboriginal people have been working in health.

Table 66

Country Town Hospital Participants: Reasons for Importance Attributed to AHW Role

Reason(s)	N
Better communication	9
Increase knowledge of resources	2
Improve health standard/hygiene	1
Do everything	1
Has a place in the system	1

Indeed, it is evident in Table 67 that respondents can identify a fairly extensive and valued role for the AHW. Ironically, the areas identified by respondents correspond closely with those in which AHWs **should** be involved already according to their duty statements.

Table 67

Country Town Hospital Participants: Suggested area(s) of involvement for AHW

Area of involvement	N[a]
Preventative education	11
Liaison/Communication	6
Community health	2
Counselling	3
Hospital work	4

[a] Several respondents suggested more than one area AHWs could be involved in.

Experience in the health care system

Country Town hospital's respondents record their perceptions of clients's understanding of the hospital system in Table 68.

Table 68

Perceived Level of Clients' Understanding of the Hospital System: Country Town Hospital Participants

	Perceived Level of Understanding			
	Full	Partial	None	N
General Public	9	4	7[a]	20
Aboriginal Community	8	8	4[a]	20

[a]Two respondents indicated that those who use the hospital frequently should have a full understanding but that most people in the general public and Aboriginal community had no understanding of the hospital system.

Most respondents (N=12) believe that Aborigines need a better understanding of the hospital system; a similar number (N=11) feel that this need is shared by the general public.

Table 69 investigates factors believed to contribute to, or to inhibit, understanding of the hospital. Both Aboriginal and non-Aboriginal clients' understanding of the system is thought to be enhanced by frequent utilization, public awareness through the local paper and publicity about Medicare.[a]

[a]Australian National Health Insurance Scheme

Table 69

Factors Perceived to Enhance or Inhibit Clients Understanding of the Hospital System by Ethnicity: Country Town Hospital Participants

Factors Contributing to Understand			Factors Inhibiting Understanding		
Aboriginal	Shared	Non-Aboriginal	Aboriginal	Shared	Non-Aboriginal
		Medi-care	←	Stress	→
← (acutek chronic patients)	Frequent utilization	(esp. chronic patients) →	Staff attitudes (impatience)		
			←	Sickness	→
Ability to manipulate system		Local paper health coverage			Ignorance of outpatient hours
		Satisfaction with service			Lack of information leaflets
←	Positive hospitalization experiences	→	Infrequent or non-utilization by some		
Better general knowledge of hospital routine				Negative hospitalization experiences →	
			←		
←	Knowledge of location of hospital →		Failure to read local paper (lack of education)		Medi-care
←	Knowledge of purpose of hospital →			Occasional long waiting time →	
		Informal communications between staff/ family & friends			

When considering Aboriginal clients' levels of understanding participants place more emphasis on frequent utilization and resultant knowledge of hospital routines. Paradoxically hospital rules and regulations are thought to be most misunderstood by Aboriginal clients according to respondents (see Table 70). Similar comments are made about the general public who, like Aborigines, are perceived to find it difficult to cope with waiting time and hospital hours (see Table 70).

Table 70

Rank Order of Factors Most Misunderstood by Aboriginal Patients as Reported by Country Town Hospital Respondents

Factors Most Misunderstood	N
Visiting restrictions	7
Purpose of the hospital	6
Hospital rules/routine	5
Sickness/medical tests/treatments	4
Separation anxiety Effects of hospitalization	2
Need for emergency contact number	1

Interestingly, although many factors are thought to be shared, "staff attitudes" are cited as negative factors influencing only Aboriginal perceptions of the system (see Table 69). Not surprisingly such staff attitudes will at times generate negative reactions:

> I do note a certain arrogance/defiance in Aboriginal people...like a child, not sure of self...

Thus similar numbers of respondents consider that both Aboriginal and non-Aboriginal clients need to learn more about the health system and similar aspects of the system are perceived to lead to misunderstanding in both groups. This pattern does not, however, hold true when respondents record perceived areas of concern exhibited by Aboriginal and non-Aboriginal clients. These concerns are recorded in Table 71.

Table 71

Country Town Hospital Participants: Common and Different Concerns About Hospitalization Attributed to Aboriginal and Non-Aboriginal Patients

N	Perceived Concerns re: Hospitalization			N
	Non-Aboriginal	Shared	Aboriginal	
4	← (especially in regard to children)	Fear of unknown	→	9
3	← (especially labour)	Fear of illness/pain	→ (especially if child seriously ill)	3
1	←	Lack of communication	→	3
			Isolation from community	6
			Fearful of whites (institution/staff attidues)	7
1	Resent authority			
1	Expect isolation in institution			
			Fear loss of identity	1
1	Fear loss of coping ability			
1	Worry about being adequately prepared e.g. toiletries etc.			
12				29

* One respondent believes for unspecified reasons hospitalization is the same for both Aboriginal and non-Aboriginal patients. A second respondent states it is no more worrying for one group than the other* as long as their own visit*.

Although many of the worries people have when they go into hospital are thought to be shared (fear of unknown, fear of illness, lack of communication), Table 71 clearly indicates that respondents perceive these concerns to be weighted much more heavily on the side of Aboriginal patients. Thus fear of the unknown, lack of communication, isolation, fear of whites, fear of loss of identity are cited 26 times while comparable worries for non-Aboriginal people are mentioned only 5 times. Indeed overall respondents provide 29 different reasons why Aborigines are worried in hospital, while they offer only 12 reasons for non-Aborigines being worried.

This heavy emphasis on Aboriginal people's stressful experiences is reflected in respondents comments:

> (They worry)...wondering what the attitude of the staff would be towards them...rather then fear of what's going to happen to them...they prefer to be at home.
>
> Yes they worry a lot...but they don't come out and tell you what they're worrying about...they're a bit frightened...there's a lack of communication.
>
> Oh, yes they worry...the quicker in...the quicker out...sometimes you have to drag them in...very few come in unless they absolutely have to...they're surrounded by white people...fearful of the nurses...of others not of their own culture...

> It depends on how sick they are...if very sick...they look to here...come in quite happily, especially the older people...they get very frightened of intensive care. Families worry...young people don't like being here...they often abscond...it they were confident and happy they wouldn't...they want to be with their own people...

Other comments show how respondents' perceptions of Aborigines in hospital are constantly interweaving with their fears/experiences (or perceptions) of racial conflict in the community.

> They sort of think it's like a holiday place...a motel...T.V. and that. The older Aborigines--the true blue Aborigines, males and females, are really nice people...the younger ones are the real problem at the moment...no one feels safe really...it's scarey...cars broken into..bags stolen...(that has) a lot to do with my answers.

Perceptions of the Aboriginal Medical Service (AMS)

Only four participants have visited the local AMS (two very briefly and two for one day during general nurse training); the majority of respondents (N=18) interviewed demonstrate a limited and generalist knowledge of the aim of the service. This is not surprising as none of the respondents have received formal communication or information about the service.

Nevertheless, most correctly assume that AMS is there to help Aboriginal people improve their general health and welfare (see Table K-11, Appendix K). In particular, three participants note that the aim is to deliver accessible/acceptable health care in an atmosphere where people feel more secure than when attending conventional mainstream héalth services. Two of these participants have visited the local AMS.

Although four respondents relate some uncertainity about the actual aim, they point out:

> It's upgraded the people a lot...people rely on the (AMS) clinic. I know the kids ward is a bit empty now (compared to what it was like before ____ (AMS) started)
>
> _____(AMS) has taken a good load from outpatients here...you'd go up to outpatients of an afternoon and (it) would always be full...since ____ (AMS) has moved out there you don't see them (Aborigines) so much.

Thus, these respondents have observed reduced hospitalization and utilization of hospital services since the advent of the local AMS. Other participants assume this to be the aim:

> To keep them out of hospital as much as they can...that's why they built ____ (AMS)...also trying to educate them.

One participant, familiar with the general aim "to teach them (Aborigines) to look after themselves" offers

a different opinion about the service:

> It's wrong...all you're doing is segregating them, instead of mixing them in to the community...it's not the way to do it.

Further, some respondents who are vague about the service assume:

> They work in the same way as this place...a casualty type thing with doctors on call...it's a little set up of their own I think...

Only two participants state they are totally unaware of the aim of AMS.

Participants' Recommendations

Staff preparation and training

Most participants (N=18) report no general or special input on Aboriginal culture or health during their professional training. Although just over a quarter of participants have received some input on Aborigines during their orientation to Country Town hospital, it has been minimal according to participants' comments. Since graduating none of the respondents have had an opportunity to attend a workshop/inservice related to this area (see Table K-12, Appendix K).

Some participants, a minority (N=4), believe that such input is not warranted. Thus they state:

> Personally I can't see that there should be anything...colour of skin, race, creed etc. shouldn't make any difference...

However, Table 72 clearly indicates that the majority of participants (N=16) comment that input on Aborigines/Aboriginal health during general medical/nursing training would indeed be appropriate.

Table 72

Perceived Need for Input on Aboriginal Health: Country Town Hospital Participants

Type of Position	Stage of Input: General Training Yes	General Training No	General Training U.	Orientation Yes	Orientation No	Orientation U	Workshops/Inservice Yes	Workshops/Inservice No	Workshops/Inservice U
Nurse Administrators/ Supervisors	3	2		3	1	1	5	-	-
Charge Nurses	3	1		2	1	1	1	2	1
Registered Nurses	10	1		9	2		10	1	1
N	16	4		14	4	2	16	3	1

.U stands for undecided.

> Yes...it should be included...I've had not much to do with Aborigines...they're a different culture...different race of people. Sure...there would be something they could offer...background information...things which Aboriginal people wish we knew about them.

Table 73 rank lists the factors participants consider most important to include in their general training. Most frequent reference is made to the need for input on cultural background, history and lifestyle; communication patterns and cultural differences are also highlighted.

Table 73

Country Town Hospital Participants: Most Important Factors to be Included in Medical/Nursing Training

Most important factors	N
Aboriginal history, culture and lifestyle	6
Communication: empathy, understanding, tolerance stereotyping	6
Cultural differences	5
Assimilation	3
General input on culture	2
Pathology	2
Observation/practical experience in different settings	2
Aboriginal concept of ownership and Land Rights	1
Stage of development/government policy	1
Aboriginal spirituality	1

A few respondents who agree that input on Aborigines is necessary present different reasons which highlight their own attitudes to the group.

> They are different...get to understand them better...look for what they really need...prevention. Today you must have a firm manner and let them understand that you're there to help them but only as far as they'll let themselves be helped.

> To accept them ... just trying to "cultivate" a few really...

Furthermore most respondents (N=14) indicate that an introduction to Aborigines, in particular the local Aboriginal communities, would be a useful part of orientation to Country Town hospital (see Table 72).

> It would be valuable...lots come from Sydney...never had to deal with them...just (input) on the area, population, services available...
>
> Knowing that people are like _____ (Aboriginal Welfare officer) in community health...liaison person...if you've got problems...they understand the situation...with parents...know how to get in contact...and ____(AMS) too. They seem to have extended families...really strange to me when I came here...mothers wouldn't come (visiting)...aunties and uncles would come...they function as a community...we should learn about fears that Aborigines have...what they're scared of...

Not all respondents, however, believe that input on Aborigines during orientation would be useful, nor do their comments reflect positive attitudes towards Aboriginal people:

> No...not really...only here a week and you know all there is to know about them anyway...
>
> Ones around here are all half caste...they're not the real ones...don't think it would be much value.

> Don't think you'd get many takers...to tell you the honest truth.

However, the majority of participants (N=16) believe learning about Aboriginal culture and health should be a part of the continuing education of all health care providers (see Table 72). A rank listing of the subject matter they suggest should be included in workshop/inservice education is recorded in Table 74

Table 74

Subjects to be Included in Inservice/Workshop: Country Town Hospital Participants

Subject Matter/Suggestions	N
Intercultural communication/interaction	6
Socializing/personal interaction	3
Culture/way of life/priorities	2
Experience(s) of Aboriginal Nurse	1
Community reaction to Aboriginal Nurse	1
Visit AMS	2
Living conditions (visits to homes Aboriginal and non-Aboriginal	1
History	1
Visit and work with Aboriginal people	1
Input from DAA	1
Panel/Questions to Aborigines	1
Psycho-social-cultural aspects	1
Help Aborigines understand our aim	1
Educate to overcome preconceptions	1
Aboriginal attitudes towards whites/sickness	1
Share common aim/acceptance of each other	1

Clearly, once again participants consider culture, general and intercultural communication important priorities. They pinpoint particular areas of interest and suggest that these could best be addressed by input from appropriate Aboriginal resource people as well as visits to the Aboriginal community and Aboriginal organizations such as AMS.

Staff selection

Although responses highlight a variety of attitudes and opinions nearly all participants (N=19) believe that ethnicity should **not** be a major factor influencing selection of health care providers to work with Aborigines (see Table K-13, Appendix K).

Most respondents point out that appropriate personal qualities, especially attitudinal and communication skills are much more important than ethnicity (see Table 75).

Table 75

Preferred Qualities of Health Professionals Working with Aborigines:Country Town Hospital Participants

Preferred Suitable Qualities	N
Tolerant/accepting of differences/understanding	9
Easy going/understanding/patient/approachable	7
Respectful/honest	3
Open-minded (non-judgemental)	3
Compassionate	2
Not dominating	2
Ability to treat all the same	1
Gullible	1
Personality	1
Firm and authoritative	1

> You need an easy going...not dominating person...not at all...someone asking instead of telling...they (Aborigines) resent you telling them anything...a white person seems to shake it (their behaviour) off easier...an Aboriginal person would sort of feel hurt.
>
> It's good to have a mixture...they (Aboriginal patients) trust Aborigines well...and with them working with whites...they'll gain confidence in whites...that could make communication easier when they do come into hospital...they (Aboriginal patients) might learn to trust us a bit more...

Only one participant definitely believes that it is preferable to employ an Aboriginal person to work with Aborigines.

> Their own people they love most and trust them...there's understanding between their own people. An Aboriginal nurse should be there...for the trust.

All participants have quite definite suggestions to offer about the most important factors which should determine Aboriginal employment in health at the hospital. Table K-14 (Appendix K) indicates that appropriate qualifications and work related attitudes feature prominently among respondents' comments.

Aboriginal health-professionals

As can be seen in Table 76 respondents offer a combination of reasons to account for the fact that there are relatively few Aboriginal health professionals in Australia.

Table 76

Perceived Reasons for Few Aboriginal Health Professionals: Country Town Hospital Participants

Reasons	N[a]
Education	13
Prejudice/no equal opportunity	7
Home environment	6
Lack of commitment/motivation	6
Low self-esteem	3
Poor health status	3
Peer/family pressure	2
Lack of role models	1
Expense	1

[a] Several respondents state more than one reason.

Low educational attainment and lack of support within the school system are perceived by the majority of respondents (N=13) to be the main factors contributing to the problem. Further, just under half of these respondents (N=5) believe that Aborigines are family-oriented and that the conventional western style of education is not highly valued in the Aboriginal family. The following comments demonstrate this pattern as well as the fairly stereotypic and frequently

negative picture many respondents hold of the Aboriginal family.

> They're not reaching the level of education...there's not the same pressure on Aborigines to get a good schooling...there's not the same family influence...they probably don't see our style of education as one of the important things in life.
>
> The average five year old child starting school is already behind the average five year old white child...it's to do with the home background...they are not academically oriented like whites are...for Aborigines as a whole it (education) is not important to them. A lot are interested in sport...but they are not competitive in the same sense as we are...diet comes into it too...they are disadvantaged from the outset.
>
> Because they're not interested in working...they don't stay at school long enough really.
>
> They're too lazy...

Other comments display plain ignorance of Aboriginal people and their socio-economic-cultural traditions:

> Probably because of the environment they grow up in...if there are few sons in the family and the eldest is not bright...the other ones are not allowed to excel the eldest one...and probably opportunities too...they say that it's all there for them...school is there...and yet motivation isn't there...

Some comments also attribute the situation to lack of parental discipline and responsibility:

> There's a lack of parent interest...I don't really know...it's only an observation on my part...there's a big alcoholic problem amonst Aboriginals...kids go to school with snotty noses, no breakfast...some have pants on...some don't...I could be wrong (but) people who really care about kids...(don't behave like that)...there's a lack of parent supervision and care...look at the rate of theft...and at the baths you see dozens of kids...rarely see a parent with them...usually older teenagers watching all these kids...dozens of them.

A more positive view is evident in the minority of comments:

> Because of their education...they don't get the normal education that white people get...I think it's prejudice...that's all. Also from the home background...if parents aren't well educated...the kids won't be...same with us.

All respondents see some value in having more Aboriginal health professionals in the hospital system and community health service. This is evident in Table 77.

Table 77

Perceived Benefits of Having More Aboriginal Health Professionals: Country Town Hospital Participants

Benefits	N[a]
Better rapport with own	13
Aid integration	4
Encourage independence/help	4
Prove ability/provide role model	3
Increase self-esteem	3
Increase initiatives in health	1
Don't know	2

More then half of the respondents (N=13) believe that Aborigines are better able to relate to their own people. Nine of this group emphazise the strong empathy between Aborigines in situations of stress caused by cross-cultural interaction, partcularly in the face of illness. One respondent, for example, believes that:

> Perhaps the Aboriginal people would identify better (with their own)...the nurse aides in the children's ward are part of the community...they're known in the community...they can talk better on a one to one basis then we can...it must be more comfortable for Aboriginal people coming in (to have Aboriginal staff there)...any balance is good...the more balance the better.

The comments of the remaining four respondents refer to the rapport between Aborigines, especially in situations of conflict caused by **intergroup** perceptions of **"them** and **"us".** For example, one respondent indicates that having more Aboriginal health professionals "would help them to understand that we are not all big ogres..."

Aspects of respondents' culture considered important for Aborigines to understand

The majority of hospital respondents (N=14) suggest that there are important aspects of their own culture that Aborigines need to appreciate. Most of this group (N=9) cite aspects related to the work ethic and materialism (see Table 78).

> They (Aborigines) would have to know that the majority of white people are materialistic...most like to get somewhere...they're (Aborigines) quite happy to sit back and get the dole. Our culture is almost the opposite to theirs.
>
> What they'd like to get is money...(but the) concept of ours and theirs are two different things...

Table 78

Aspects of Respondents Culture Important for Aborigines to Understand: Country Town Hospital Participants

Aspects of respondents' culture	N[a]
Work ethic/materialism	9
Belief in equality	2
Belief in differences (values)	2
Altrusism	2
Independence/trust/confidentiality	2
Victim of socialization	1
Inhibitions	1

[a] Some respondents suggested more than one aspect of their culture Aborigines need to understand.

Other participants too offer comments which reflect intercultural differences and interpretations.

> Aborigines don't stand up as much as individuals in the white community but they have to...
>
> We're much more inhibited then they are...
>
> We are **not** as communal as they are...more isolated as individuals within the community...we're not as answerable to the community as they are...

Although five participants believe there is nothing in particular Aborigines need to understand about their culture, comments reveal varying attitudes. Two respondents indicate that they really cannot identify significant aspects of their own culture because they have always "lived in a majority...never with another culture."

In addition, one respondent points out problems associated with race relations. Two participants emphasize the need for the majority to understand the minority rather than vice versa.

Factors other health staff need to appreciate about Aborigines:

The overwhelming majority (N=17) of respondents believe that there are specific things other health staff do not understand about Aborigines. The most frequent comments relate to Aboriginal culture and lifestyle, personality and disposition (N=8), and a need for greater understanding generally (N=5). Problems (living conditions, poverty, unemployment) related to repeated hospital admisssions and Aboriginal intelligence are commented on less frequently (see Table 79).

Table 79

Country Town Hospital Participants: Factors Other Health Staff Need to Appreciate About Aborigines

Factors	N
Cultural beliefs, behaviour, lifestyle, family, home environment	8
Need for greater general understanding	5
Priorities/language differences	1
Intelligence	1
Need for affirmative action	1
Problems behind repeated admissions	1

However, a significant number of comments (N=5) emphasize the extent of white backlash in Country Town.

> A lot of people felt that going up and handing money and things out wasn't assisting them (Aborigines). They weren't competing to get positions. We had to work hard...compete...whether they (Aborigines)...pass or drop out...the job might be created just for them...that's resented by some.

Only two respondents felt that there was nothing specific other health staff should understand about Aborigines.

Further comments reflect strong internalization of attitudes based on ignorance. For example, one

respondent pointed out that other staff did not understand Aborigines "...not turning up...or wondering away. They (other health staff) gauge expectations of Aboriginal culture on their own. But more understand that **this is sort of in their make-up".**

Advice to new staff about Aborigines

Attitudes and experiences in Country Town are also clearly revealed in the advice participants would offer to new staff who have not previously nursed Aboriginal patients.

Table 80 indicates that their advice primarily centres around majority/minority communication and interaction.

The most frequent advice to new staff (N=10) emphasizes treating Aboriginal patients "the same".

> Don't treat then any different from anyone else ... there's lot of ill feeling amongst some people about them...
>
> I've never treated them any different to anybody else I hope ... one of the main things is that you don't patronize them.

Table 80

Advice to New Staff re Aborigines: Country Town Hospital Participants

Advice to New Staff	N
Treat the same	10
Communication	8
Cautious	7
Personality/disposition	3
Encourage independence	2
Cultural differences	2
Encouragement interaction between Aboriginal patients and Aboriginal staff	2
Personal hygiene	1
Home situation/background	1
Health problems	1

Communications--explaining to Aboriginal patients what is happening to them--and caution are also considered important in advising new staff:

> Be patient, talk to them...be gentle, explain, ask if they have any questions, be happy...be bright, even be "stupid" with them...
>
> I'd tell them to be wary and to feel out the situation...
>
> Have to just sort of talk to them and explain things--most will do things that you say, just tell them how...

Table 80 clearly shows that only the minority of comments relate to cultural/lifestyle or health differences. Again perceived and experienced local intergroup tensions appear in comments:

> I'd say you've to be careful in your approach--don't come on too heavy--always explain what you're going to do...
>
> ...To try and understand (especially about) visitors...allow them in... they have extended families...not nuclear like us. I see them (other staff) chucking them out...they don't understand it's an important factor for the patient to get better.
>
> Explain that there are real health problems in the Aboriginal community...a high percentage of Aboriginal patients have alcohol...and paediatric problems...worms and that...I'd give my insight into their differences...families come from near and far...they're attentive to the sick...

SECTION D

SITUATIONAL DILEMMAS

Participants have been asked to identify real or perceived conflict in four kinds of interactions: staff/patient, staff/staff, staff/job and self/job. Table 81 records the number and kinds of dilemmas identified.

Table 81

Self Reports of Situational Dilemmas Encountered by All Respondents

Group	Type of Situational Dilemma				
	STAFF/PATIENT	STAFF/STAFF	STAFF/JOB	SELF/JOB	STAFF/SELF
Aboriginal Staff, AMS (n=12)	5	4	9	8	4
Non-Aboriginal Staff, AMS (n=6)	6	4	4	4	n/a
Aboriginal Community (n=19)	11	n/a	n/a	n/a	6
Non-Aboriginal Hospital Staff (n=20)	18	4	10	11	n/a

Table 81 shows that most cases of conflict or misunderstanding are related to non-Aboriginal staff interaction with Aboriginal patients or Aboriginal staff. Table 81 indicates that 18 out of 20 non-Aboriginal hospital staff and all (N=6) non-Aboriginal staff employed at AMS are able to recount situational dilemmas involving themselves and an Aboriginal patient.

Aboriginal staff at AMS, on the other hand, recount situational dilemmas related to their work. Over half (N=11) of Aboriginal community numbers describe general conflict situations; while just under a third (N=6) describe such a situation in their own lives.

Table L-1 (see Appendix L) provides a more detailed look at the types of conflict encountered. A frequently appearing category in Table L-1 (see Appendix L) is "general misunderstanding". This category includes "didn't understand what they were saying, wanted, what needed to be done". Another frequently mentioned category is "inappropriate expectations". Almost a quarter of all cases mentioned fall into this category. Aboriginal respondents most generally refer to white staff's expectations of them. Non-Aboriginal respondents most frequently refer to Aboriginal patients' expectations. Thus, for example, Aboriginal staff point out:

> Don't think it's our job to clean the toilets out. Reckon it's the cleaners's job. Told her I'm not doing it-that's what the cleaner is employed for...

Non-Aboriginal staff on the other hand explain that patients demand non-medical attention such as:

> They ask if I could ask around if anyone has any clothes for children...get medication that I don't think they should have...
>
> Ask you to go and cash a cheque, write out something to say that Mum's in hospital and can't get down to cash the cheque...do shopping for them...
>
> Ring me a taxi, give me some money, smokes, get the taxi to stop on the way home...

Less frequently occuring, yet quite disturbing categories are "suspected malpractice" and "patient distrust/ignorance". These categories are confined to staff/patient interaction and are reported by Aboriginal community participants as well as non-Aboriginal staff at AMS. Whether malpractice has actually occured or not or whether patient ignorance has led to such suspicions, the incidences are unresolved and thus continue to influence people's opinions and attitudes.

I can't remember how long ago...I went with my best friend (to outpatients)...and she was sick... waited three hours...they (staff) told her she had to go downstairs ...to the blood place or somewhere ...that night she died. I've never been back there since and I never will...that made me get _____ (AMS) going...so we don't have to wait ...she might have been alive if they had attended her.

My little boy was knocked with a car...wouldn't admit him...why couldn't they admit him? He died two hours later. I took him to _____ (AMS)...the white doctor...said he was just in shock...we took him home. We went to court over it and all... I asked the lawyer why (the doctor) wouldn't admit him ... anyone with own sense would admit him...and Xray him...he had a punctured lung and something wrong with his kidney ...nothing happened to the doctor. It happened because he was Black... court only finished last month.

There was more misunderstanding on her part...her husband went to a private doctor...he admitted him and treated him for an illness and he got better...meantime he collapsed and died in hospital. The wife is bitter against the doctor because she thinks it was his fault...thinks he neglected her husband. She's very wary of this particular doctor... doesn't trust him like she did before...hasn't been back to see him since that incident...the doctor isn't aware of what the lady is thinking...he probably doesn't know why she isn't his patient.

> In one family...one of the family members died from a disease...not curable but it was misdiagnosed in the early stages...he went to Sydney and died after an operation. After that another family member who urgently needed a heart operation refused to go to Sydney and ended up dying...I spoke to the family... explained it to them...got other doctors to speak to him so he didn't think it was just us...got the family to talk to him. I still see the other members of the family ...they knew it was his decision.

Although perceived prejudice is not a commonly occuring category, it does colour some perceptions of interaction among Aboriginal community participants as well as hospital staff. As one Aboriginal lady points out:

> At outpatients, was one female doctor there when M took X (her son) up with the measles, the doctor said..."He's too dark...you can't see the spots!" My daughter swore at the doctor. One of the nurses there said to M she knew she was in the right...that doctor shouldn't have said it. If X was dark like Y (other son) she would have hit her...
>
> ...Then when I had the gastric, I couldn't walk, was using the toilet all the time. The only way I got in (to hospital) was ringing the ambulance. They had to admit me then. They wouldn't admit me at the outpatients...they gave me medicine...takes so long to work,was better off in hospital...

> In the early days in the hospital, people were given their own plates, cutlery and that...in the town they wouldn't let'em in the baths...in the shops you couldn't drink anything unless you had a straw...

A number of interactions reported by non-Aboriginal staff also highlight the ease with which perceived slight will be interpreted in racial terms.

> They tend to take that you're pushing them away just because they're Aboriginal. Elderly lady in medical ward was my patient for the day. Tried to fix her up...she thought I was leaving her to last. I was doing the pills..."Here's your pills Mrs X"! She picked up the walking stick, nearly hit me over the head...I stayed away from her, only did what I had to do...

> ...Man in outpatients, 56 years old came in. I felt really confident ... known him for years. I looked down and said "JB, why don't you go and see X at (AMS), ask her to do your nails", I said "you do go to AMS don't you?". A 20 year old Aboriginal bloke in outpatients chipped in (I wasn't talking to him). "Of course he goes to (AMS) you...white bitch, wouldn't be here myself if (AMS) was opened".

> They get rather upset sometimes if you close the door on them and ask them to wait outside for a minute...get aggro...think you're going to do something...they want four or five to come in...

It is perhaps not surprising that suspicion thrives in an atmosphere where general misunderstanding is common. Patients points out that, "Dad's always

getting pretty confused, medicines and Medicare and that" or "I remember a baby dying because the mother couldn't make the doctor understand how sick the baby was...".

Similarly health professionals maintain:

> Problem is just trying to get through they're to take medicine at home and not just forget about it. They come back two weeks later...you tell them again and again...they don't want to know, they don't listen...

The majority of all participants believe that although these patterns are not uncommon among non-Aborigines, they seem to be more prevalent among Aboriginal people. Table 82 investigates how such situations are reported to be solved.

Table 82

Strategies Employed to Cope With Situationl Dilemmas

Group	Resolution of Conflict.					
	Withdraw	Not Resolved	Argument	Talk it out/ explain	Ask for help	Gave in
Aboriginal Community (n=19)	11	1	1			
Aboriginal Staff AMS (n=12)	3	1	6	10	4	2
Non-Aboriginal Staff AMS (n=6)		1		8		3
Hospital Staff (n=20)	2	4	2	13		2

. Not all respondents could recall how the situation was resolved; cases refer to all four kinds of interaction.

Solutions based on "talking it out", "explaining" appear to be much more prevalent among non-Aboriginal than Aboriginal respondents. Although Aboriginal staff at AMS appear to favour this approach, it should be noted that the high number of responses in this category refer most frequently to conflict related to work situations rather than interpersonal contacts.

In contrast, Aboriginal participants appear to deal with conflict more frequently by withdrawing or having an argument.

No matter how respondents deal with a situational dilemma Table 83 indicates clearly that most remember the incident with feelings of frustration and anger. Only a minority of incidents (N=13) are recalled as having been resolved so as to make the respondent feel "all right".

Table 83

Feelings Associated With Situational Dilemmas

Group	Feelings associated with situational dilemmas					
	All Right	Humiliated	Angry	Frustrated	Part of Job	Don't care
Aboriginal Community (n=19)			11	2		
Aboriginal Staff AMS (n=12)	5	2	4			1
Non-Aboriginal Staff AMS (n=6)					4	
Hospital Staff (n=20)	8		4	11		

CHAPTER V

DISCUSSION

Introduction

The purposes of this project, detailed in Chapter I, were to collect data that would provide a basis for:

1. Describing interactions between health care providers and Aboriginal clients.

2. Developing some understanding of "pressure points" in communications which may lead to misunderstandings and potential conflicts between health care providers and clients.

3. Drafting guidelines for discussion re: staff orientation/inservice training and community orientation.

In particular, an attempt was made to find out:

1. What factors impede or facilitate interaction between health care providers and Aboriginal clients?

2. How do health care providers believe they can be better prepared to work with Aboriginal clients?

3. How do Aboriginal clients believe health providers can be better prepared to work effectively with the Aboriginal community?

4. What approach is needed to increase professional awareness and effectiveness in Aboriginal health?

To this purpose Chapter V is divided into four main sections.

Section A reviews the research problems and sub-problems in terms of comparison of data collected among the three sample groups. Special attention is paid to Research Problems 1, 2, 3, as well as Sub-problems 1, 2 and 3.

Section B examines and refines the conceptual framework outlined in Figure 2, Chapter II. Particular reference will be made to the promixal attitudinal, behavioural and service delivery variables influencing Aboriginal Health status in Country Town in the light of the data presented in Section A. This prepares the way for Section C.

Section C considers participants' recommendations regarding staff training in terms of the principles of cross-cultural training. Recommendations are made for appropriate effective approaches. Special emphasis is placed on addressing Research Problem 3 and Sub-problem 4.

In conclusion Section D reviews this research project's significance, limitations and implications for nursing as well as future research.

SECTION A

REVIEW AND COMPARISON OF DATA

Cross Cultural Interaction

[Research Problem 1, Sub-Problem 1]

In seeking to understand interaction between health care providers and Aboriginal clients Bochner's (1982) major dimensions of cross-cultural contact outlined in Chapter III provide a useful basis for examining Aboriginal and non-Aboriginal interaction as reported by Country Town participants.

The **contact variables** identified by Bochner include:

* On whose territory
* Time span
* Purpose
* Type of involvement
* Frequency of contact
* Degree of contact
* Relative status and power
* Numerical balance
* Visible distinguishing characteristics

His theory goes beyond the narrow view of just concentrating on the attitudes, perceptions and feelings of people in contact with a culture different from their

own. It is based on general principles of social psychology and in particular assumes that:

* Cross-cultural contact involves an **encounter** between at least two people.

* Individuals will either undergo or resist changes to their cultural identities as a result of the encounter.

* The cultural composition of a setting directly influences the individuals in it.

* When people interact they will respond to each other not just as individuals but as members of a particular group. They will ascribe to each other personal qualities that are supposed to be characteristic of the group.

* In and out group distinctions are more likely to be reinforced when (real or imagined) differences between the groups interacting are perceived to be great.

* Unless members of the out-group are redefined in some sense as belonging to the in-group, or given special status/recognition to be acceptable, contact is unlikely to be harmonious.

* Territorial intrusion is a possible outcome of interaction between culturally disparate groups. At times it is likely to "generate anxiety and defensive

reactions including hostility, derogation and withdrawal" (p. 35).

* It is possible to draw certain implications from the outcome of cross-cultural contact. Such implications may be used to reduce prejudice and ethnocentrism.

* Although cross-cultural conflict is often based on realistic conditions such as an imbalance of power "or genuine irreconcilable differences in the goals and aspirations of groups" (p. 37) most conflict is generated by imagined rather than real causes.

Table 84 summarizes the outcome of applying each of Bochner's contact variables to general and specific culture contact and interaction among Aboriginal clients, Aboriginal staff and non-Aboriginal health professionals who participated in this project.

Table 84

Dimensions of Cross Cultural Contact Between Non-Aboriginal Health Professionals and Aborigines

Contact Variables	Type of Cross-Cultural Contact			
	Aboriginal Community Participants	Aboriginal staff AMS	Non-Aboriginal Staff AMS	Non-Aboriginal Participants Country Town Hospital
On whose territory	← Hospital/private clinic/doctors residence	AMS/clients home → ← Local Aboriginal communities →	Hospital	Hospital only
Time span	Short term Occasional long term	Variable Short term ↔ Long term		Short term Occasional long term
Purpose	Seeking help/ medical attention	Helping/assisting white health professionals	. Clinical intervention . Seeking help/ advice from Aboriginal staff	Nursing care/patient patient teaching
Type of involvement	← Professional/work related casual occasional mutual supportive →			
Frequency of contact	Variable occasional-frequent	Occasional to frequent during working hours only		None-occasional-frequent
Degree of intimacy between participants	← Perceived relationship → Acceptable	good	good - very good	good - very good
	high ← social distance → high			
Relative status/ power	← Unequal → dep.client/patient	Helper/assistant worker	"boss"/expert/ professional	Carer/giver/expert professional
Numerical balance	Majority-AMS communities Minority - other health care settings	Majority	Minority AMS Majority - Private Medical Clinic	Majority
Visible distinguishing characteristics	← Skin colour → ← Race → ← Language →			Dress (uniform)

The **level of interaction** detailed in Table 84 between the **majority** of participants is minimal, and tends to be confined to occasional/casual short term contact in work situations. Not surprisingly, **social distance** is high.

Interestingly, however, although participants recount various types of perceived relationships within and between groups, most non-Aboriginal participants perceive their rapport with Aborigines to be good. Similarly Aboriginal staff are reasonably positive about their interaction with non-Aborigines.

Aboriginal community participants were not directly asked "How well they felt they got along with most white people?" because of reactions to this question during piloting (see Chapter III). However, the majority volunteered comments during interview when relating their interactions/experiences with white people which suggested they perceived their rapport to be **acceptable** or just "all right". Support for this supposition was found in a number of different questions. For example,when asked to compare their own concerns or understanding of health situations, with white people's understanding, consistently just over a third of community participants indicated that they were either uncertain or simply did not know how white people felt.

A typical response, for example, was "I don't know...never thought about their view about it".

Bochner's model is particularly relevant when attempting to understand the effects of contact between culturally disparate individuals and groups such as Aborigines and non-Aborigines.

The outcome of group contact between the majority/minority parallels the history of contact, conflict and government policies (attempted genocide, assimilation, segregation, integration) detailed in Chapter I and II. This global picture (i.e. Jessor and Richardson's **distal variables**) has to be continually borne in mind when analyzing the dimensions of contemporary contact/interaction between individual Aborigines and non-Aborigines.

It is clear, for example, in Table 84 that the **territory** on which contact occurs may influence the level and type of interaction, especially people's feelings and attitudes detailed in Chapter IV. However, the **ascribed or perceived status and power** of individuals in a majority/minority setting (regardless of the **numerical balance**) appears to be a much more important factor influencing perceptions and the outcome of individual contact.

Thus, Aboriginal clients are **always** in a dependent power relationship with non-Aboriginal health professionals. Similarly Aboriginal health care providers frequently are "helpers" or "assistants" to their more powerful white counterparts. This relationship is prevalent even in a situation such as the AMS, where Aborigines are in the majority and "in control" of their own organization and the whites they employ. Historical interactions/attitudes, dependency, as well as lack of professional knowledge and skills ensure that their subordinate status is maintained.

In the hospital setting the relative status/power imbalance between all clients and health professionals of course is sanctioned by the institution. It is, however, heightened by negative past experiences and attitudes of both Aboriginal clients and white health care providers.

Further, the **purpose of contact** for all the situations outlined in Table 84, except perhaps for occasional advice sought by health professionals from an AHW, tends to reinforce the relative status/power of the participants.

Another dimension is added by the constant **visible distinguishing characteristics** including skin colour, race and language. These obvious differences, which

separate Aboriginal and non-Aboriginal participants, must be considered when attempting to understand interaction between the two groups because they reinforce in-group/out-group, "us" and "them" categories. Thus Bochner (1982) suggests:

> Intergroup conflict stems from the participants making "us" and "them" differentiation, in effect a distinction between who belongs to the in-group and who is a member of the out-group. (p. 11)

Situational Dilemmas

[Research Problem 2, Sub-Problem 1]

Analysis of situational dilemmas between health care providers and Aboriginal clients (see Chapter IV, Section D) reveals that **"pressure points"** in communication are often perceived or explained in terms of such categories of "them" and "us".

Participants' perceptions of health care providers' roles provide some insights into the factors underlying these situational dilemmas. Thus, the majority of non-Aboriginal health professionals believe that most Aborigines (including Aboriginal staff) have **only partial or no understanding** of their work. Aborginal staff on the other hand, as well as Aboriginal community participants, believe that they possess at least a **partial**, if not a **full understanding**, of the

duties of doctors and nurses. Aboriginal people may exert demands and expectations in accordance with their perceptions. Such expectations may not be acceptable to non-Aboriginal health professionals' perceptions of their roles. Consequently, as the situational dilemmas suggest, Aboriginal expectations may be rejected, and/or resented by non-Aboriginal staff.

This "lack of fit" is also evident when non-Aboriginal participants' perceptions of the AHW role are considered. Those non-Aborigines employed at AMS claim a **full or partial understanding** of the AHW role. Aboriginal staff at AMS do **not** concur and a significant number (N=4) indicate that they are uncertain about non-Aboriginal staff's level of understanding of their work. Again, such a situation increases the chances of situational dilemmas based on unrealistic expectations. In the hospital, the patterns are even more pronounced. Here, the majority of respondents indicate that they have **no understanding** of the AHW role[a]; a situation which **all** non-Aboriginal participants believe to be common among health professionals generally.

[a]Excluding Aboriginal Nurses.

Such varying levels of understanding give rise to "pressure points" -- discrepancies in role expectation which may lead to conflict, even though all participants, Aboriginal as well as non-Aboriginal, consider the role of the AHW an important one. What then is the extent of the mismatch between expectations?

Table 85 indicates that community participants' expectations of doctors and nurses reflect a strong **personal/community** orientation. Non-Aboriginal health professionals at both AMS and the hospital emphazise only the **clinical/curative** expectations of their role. Aboriginal staff, on the other hand are able to perceive expectations common to both groups. Thus, at times they face real dilemmas at work in attempting to meet the demands and expectations of **both** their "in-groups". Attempts to reconcile the differences often lead to frustration, anger or withdrawal.

Table 85

Aboriginal Clients' Expectations of Doctors and Nurses Versus Perceived Expectations

Participants	Expectations
Aboriginal Community (clients)	Interpersonal communication skills Cross-cultural communication skills Desirable personal qualities Community involvement Non-discriminative medical treatment Knowledge of Aboriginal environmental living conditions
Aboriginal AMS Staff	Availability for immediate attention Competence in emergency/crisis Clients' health education Fostering independent decision-making Community involvement
Non-Aboriginal AMS Staff	Cure illness Perform miracles Be male
Non-Aboriginal Hospital Staff	Curative

Although, as pointed out earlier (see Chapter IV Section D), perceived prejudice is not commonly cited as a cause of conflict, Bochner in his analysis of cross-cultural contact highlights conditions likely to increase prejudice. Some of these, emphasized earlier, are inherent in the situations described by participants in this project. Thus, "unequal status between participants, or where the contact lowers the status of one of the groups; unpleasant, involuntory frustrating or tension-laden contact" (p. 16) typifies many of the early experiences recalled by Aboriginal clients. Rules and regulations of the time, including separate facilities for Aboriginal patients, reflect social norms that overtly promoted or approved of racial inequality.

Perception and Experiences in the Health Care System

[Research Problem 2]

Although the situation today has improved, and the majority of Aboriginal clients express satisfaction with hospital services, several still experience uncertainity, confusion and stress when placed in the unfamiliar and at times threatening hospital environment. Importantly, just under half of community participants (N=9) speak of their present hospital experiences in terms of the past.

Thus, in recalling "separate wards for Blacks" one Aboriginal lady points out:

> ...those things are still there in the back of their minds...today they know they have the rights of anybody else...they demand their rights regardless of whether it is trivial.

The past has certainly left a residue of suspicion. As one Aboriginal woman relates:

> If you go there first...(to outpatients)...and there was white fellas come in...I'd watched to see if they put white fellas in first...but they didn't.

Although the reality of the past is not generally apparent in the explanations and perceptions most non-Aboriginal staff have of Aboriginal clients' behaviour in hospital, staff interviewed are not oblivious to Aboriginal people's concerns about hospitalization.

It is clear in Table 86 that some of the concerns are similar to those white patients are thought to experience. However, **negative staff attitudes** are listed as a major area of concern by both Aboriginal community and hospital participants. Indeed, hospital respondents indicate that such a concern would influence **only** Aboriginal patients. Further, **isolation from their community** is also believed to affect **only** Aboriginal clients according to hospital respondents' perceptions.

Table 86

Country Town Participants' Perceived Hospitalization Concerns of Aboriginal and Non-Aboriginal Patients

Concerns	Aboriginal Community		AMS Staff		Hospital Staff	
	Aboriginal Patients	Non-Aboriginal Patients	Aboriginal Patients	Non-Aboriginal Patients	Aboriginal Patients	Non-Aboriginal Patients
Family Concerns	5	3	2	1		
Language/ Communication	2	1			3	1
Serious Illness/ Operations	3	1	6	1		
Fear of Dying	3	1	2	2		
Fear of unpleasant procedures	1	1	2	1		
Fear of unknown	1	1	2		9	5
Premature discharge of children	1	1				
Fear of hospitalization	1	1	5	3		1
Negative staff attitudes	3	2	4		7	
Fear of Inadequate Care	1	1				
Dislike of Food	1		1			
Fear of Pain			2	1	3	3
Isolation from Community	3		2		6	
Fear of Loss of Identity					1	1
Resent Authority						1
Nothing	7	4				
N	35	17	28	9	29	12

Aboriginal community participants, on the other hand, stress the fear of **inadequate care** and likelihood of **premature discharge** as concerns which apply only to Aboriginal patients. Thus perceived concerns about hospitalization vary somewhat between the groups interviewed.

Non-Aboriginal professionals tend to identify a number of **unspecified fears** -- fear of the unknown, fear of isolation apart from fear of negative attitudes. AMS health care providers, the majority of whom are Aboriginal, tend to stress more **concrete concerns** --fear of serious illness/operations, hospitalization --apart from negative staff attitudes.

Aboriginal community participants similarly stress **concrete fears** -- of dying and illness, of leaving their families to care for themselves, as well as of negative staff attitudes. Importantly, almost a third (N=7) of Aboriginal community respondents maintain that they experience no fears or concerns associated with hospitalization.

Further, community respondents identify many more concerns **shared** generally by patients being hospitalized, rather than affecting **only** Aborigines. Thus Table 86 shows that although community respondents feel that non-Aborigines are affected by fears similar

to their own, AMS and hospital staff both feel that Aboriginal clients are more vulnerable than non-Aboriginal patients.

This pattern is clearly evident in Table 87 which outlines aspects of the hospital system perceived to be most misunderstood by Aboriginal patients.

Table 87

Country town Participants: Aspects of Hospital System Most Misunderstood

Participants	Factors Most Misunderstood	N
Aboriginal Community (n=19)	Language and communication	3
	Medical treatments/procedures	2
	Discharge/follow-up	1
	Medicare/card	1
	Routine and rules	1
	Need for hospitalization	1
	Doctors role	1
	Purpose of hospital	1
	Nothing	5
	Don't know	4
Aboriginal AMS Staff (n=12)	Hospital system/rules and regulations	4
	Lack of rapport with nurses methods of communication	3
	Waiting time	1
	Food	1
	Nothing	3
Non-Aboriginal AMS Staff (n=6)	Lack of knowledge about health and purpose of hospital	3
	Hospital system/rules and regulations	2
	Lack of rapport with staff	1
	Nothing	1
Non-Aboriginal Hospital participants (n=20)	Visiting restrictions	7
	Purpose of hospital	6
	Hospital rules/routine	5
	Sickness/medical tests/treatments	4
	Effects of hospitalization (Separation anxiety)	2
	Need for emergency contact number	1

Just on half (N=9) of community respondents believe that they **don't know** or that there is **nothing** about the hospital system which they misunderstand. A smaller proportion (N=4) of AMS participants agree with them. However, **all** hospital respondents can identify aspects of the hospital system misunderstood by Aboriginal patients. When those areas perceived to be misundestood are examined, **all** groups interviewed identify hospital rules, regulations and routine. Aboriginal respondents, both in the communiy and AMS, however, also outline cultural aspects such as language and communication styles. Non-Aboriginal respondents tend to highlight aspects related to their own culture of health and medicine (e.g. separation anxiety) rather than to that of Aboriginal clients.

Consequently the everyday practices of many of the nursing staff interviewed assume that Aboriginal patients while in hospital should be "treated the same".

Client Utilization and Satisfaction with Health Services

[Research Problem 2, Sub-Problem 3]

Client self-reports of their experiences in the health care system provide suggestions for **improvement of services.**

The level of satisfaction with health services attended is generally high. Indeed, a majority (N=13) of Aboriginal community participants believe the particular health service they choose to attend could **not** be improved. However, what clients like about **their** services (choice of doctor, personal attention, staff attitudes, privacy/confidentiality and in particular at AMS the cost/convenience and friendly, efficient service) they perceive as lacking in the health services they prefer **not** to utilize.

Thus 11 respondents make suggestions about how, in particular, AMS services could be improved. The majority would like to see a **more efficient service** (prompt attention, shorter waiting time and availability of transport increased), as well as **more skilled staff employed.** Just under half believe staff attitudes/interactions could be more positive and client privacy and confidentiality should at all times be maintained. Failure of the service to observe the latter is one of the main reasons several clients (N=7) currently prefer to attend the downtown private medical centre.

Underlying their response and rejection of AMS is the factionalism that plagues Country Town Aboriginal Community (see Chapter IV, Section A).

The Australian federal government recognized the need to incorporate Aboriginal organizations (like AMS) when it passed the Aboriginal Councils and Association Act (1976). The Act assumes that Aboriginal organizations operate on the same premises as mainstream institutions. Governments have internalized the stereotype that Aboriginal groups are "community oriented" and therefore the legislation encourages them to act as "one". Thus the system ensures that existing lines of authority and communications will not be disrupted, nor need to adapt or accomodate to the interests of differing Aboriginal groups in any one community.

A very different analysis was presented by Eckermann (1984) who has pointed out that Aboriginal community relations are characterized by a "balanced state of anarchy" where individual interests continually exert themselves against group interests.

Consequently, she argued that it may be very wrong to visualize "the Aboriginal community"; it may be a figment of our imagination. Instead, it would appear, every "community" is composed of various interest/kin groups; alliances between such groups are somewhat fluid and depend on personality factors rather than issues. If this argument is valid, it has important implications

for understanding the patterns of interaction between Aboriginal groups and their reactions to Aboriginal organizations. Clearly defined factions will attempt to control an organization, to the point of manipulating the time of elections, for as long as possible. Should they lose control of the organization, the faction will then withdraw its support from the organization. Indeed, counter pressures to regain power may even involve reporting the agency to outside funding authorities.

> If we don't do something (they ask) like runnin' 'em out to cards...if we say no...one old chick said she wanted to see the doctor...I knew she didn't...she rang up over _____(DAA, Regional Office) and got us all into trouble!

Thus the seven respondents who previously attended AMS now maintain:

> A lot of other people (besides the ruling faction) in the community put a lot into it (AMS)...we feel it's not being used now for the people...a lot of people who used to be members have had their names marked out (they just scratched them out)...it could be sorted out...there's enough in the district to put in a new Board of Directors.

> My husband was in the first (Board of Directors)...they got out voted by 'em Elders...election comes up in October...they're so cunning they won't shift it from that long week-end...they all go away (to the football)...hardly anyone back here to vote...they'll probably get in (again)...it's not runnin' properly.

Although the majority of Aboriginal community participants are satisfied with hospital services, just under half (N=9) of the group believe inpatient care could be improved and over half (N-12) emphasize the need to improve outpatient services.

Participants again are critical of perceived long and unnecessary waiting times but in contrast to AMS most of the suggestions for improvement of hospital services relate not to the institution but to staff attitudes and communication.

Staff Selection and Training

[Research Problem 3, Sub-Problem 2 and 3]

Almost all respondents (N=52) agree that there should be input related to Aboriginal culture and Aboriginal health during general medical/nursing training. Most respondents (N=49) also believe that such information would be especially useful during orientation periods as well as on-going staff workshops and inservices.

Further, there is considerable agreement about the type of input which would be appropriate into these various aspects of training. High priority is afforded by **by** all groups interviewed to Aboriginal culture, lifestyle and history as well as cross-cultural communication.

Further comments by Aboriginal staff do highlight some differences and perhaps difficulties they have experienced, especially in communicating with non-Aboriginal staff. Again the data point out a high proportion of "inappropriate expectations" identified by Aboriginal staff as leading to situational dilemmas involving non-Aboriginal staff.

Consequently Aboriginal staff emphasize the need for colleagues "to get to know each other better" and suggest that this goal could best be achieved by "learning and working together". Community respondents support this pattern. However, they feel strongly that the onus is on non-Aborigines to learn about Aboriginal culture and people, especially their environmental/living conditions, coping skills and crisis intervention. Most advocate that personal contact and communication are essential for better understanding (see Table 88).

Table 88

Country Town Aboriginal Participants: Preferred Ways for Non-Aboriginal Health Professionals to Learn About Local Aboriginal Communities

Participants	Preferred Ways
Aboriginal Community	Personal contact and communication Use a cultural broker Visit Aboriginal organizations Work **with** them, not **for** them
Aboriginal AMS Staff	Work with them Personal contact and communication Use a cultural broker Social activity

Thus the need for understanding is in many participants' comments. The reasons for such understanding do, however, appear to vary. Discussions with and comments from non-Aboriginal respondents indicate that some are interested to learn about Aboriginal people in order to make it easier to fit them into the existing system. Cultural awareness is sought, not to adapt the system to differing needs, but rather to provide a basis for compromise. Again the situational dilemmas provide rich insights. One non-Aboriginal respondent in a senior position has obviously learned about and been sensitized to Aboriginal traditions related to death and dying. In such circumstances **all**

relatives, from far and near, will come and try to see the patient before death --irrespective of hospital rules which normally permit only two visitors at a time who should always be immediate family members. This respondent recounts the dilemma she faced attempting to be "respectful" to the system as well as the relatives concerned:

> A dying patient; it's more important to the family that they be with them. I went to the older family members and explained the situation as simply and as fully as I could...I suggested they work out a roster...

Such a compromise may sound admirable; indeed in her eyes it may be the only viable solution of the dilemma where hospital rules and expectations from superiors exert pressure towards conformity. It does, however, little to cater for the needs of Aboriginal families whose traditions do not easily accomodate a "roster system".

Cultural awareness is sought for non-Aborigines by Aboriginal respondents in order to highlight their needs as well as differences between and within their groups. Such a need is clearly related to the distal variables of history and contact. For some 200 years non-Aborigines have classified and categorized Aboriginality by means of special policies and Acts. Today Aboriginal people's

reactions are clear:

> They should learn our background mainly...the way we live, we don't live the way they live.

All participants also agree on the importance of the AHW role. However awareness of the duties and responsibilities associated with this position varies greatly. Thus the majority of hospital respondents (despite the fact that an AHW and other Aboriginal staff are employed in that institution) display **no understanding;** while the majority of community respondents **"don't know"** or have **no understanding** of the AHWs' role; only AMS participants claim **full or partial understanding.**

Similarly respondents vary in their perceptions of the areas in which AHWs might productively be employed (see Table 89). Community and hospital respondents stress liaison/educational aspects; Aboriginal staff at AMS suggest clinical and educational areas; non-Aboriginal staff at AMS prefer clinical aspects with some emphasis on education.

Table 89

Country town Participants: Suggested Areas of Involvement for Aboriginal Health Worker (AHW)

Participants	Area of involvement
Aboriginal Community (n=19)	Home visits Liaison/resource person Health education Hospital visits Emergency transport service
Aboriginal Staff AMS (n=12)	Staff training Community education/liaison Emergency intervention Routine clinical assessment Increase liaison/contact with other health services
Non-Aboriginal Staff AMS (n=6)	Assessments/screenings Environment/hygiene assessment Early problem intervention/management Counselling Diet education Follow-up care Knowledge/referral to local resources
Non-Aboriginal Hospital participants (n=20)	Preventative education Liaison/communication Community health Counselling Hospital work

Interestingly all the areas identified for potential AHW involvement are or should be part of the AHW's duties. The fact that so many respondents (N=20) in this relatively small sample display no real

understanding of the AHW role may be related to four factors:

* AHWs may not be particularly "visible" and therefore their work goes unnoticed.

* AHWs are not fulfilling their duties.

* AHWs are deployed by superiors to carry out work which is not part of their responsibilities.

* AHWs possess limited skills because they are employed without training and no compulsory, accredited training programs exist for them in NSW. They are therefore deployed to do nothing but relatively uncomplicated tasks.

Further the majority of respondents in all groups agree that ethnicity is not of major importance when selecting health care providers to work with Aboriginal people. Desirable personal qualities are identified as of paramount importance. Such qualities include: easy going, patient, understanding, acceptable and tolerant (see Table 90).

Table 90

Country Town Participants: Preferred Qualities of Health Professionals With Aboriginals

Participants	Preferred Qualities		
	Personal Qualities	Professional Qualities	Other
Aboriginal Community (n=19)	Easy going, acceptable, flexible, patient and understanding, caring	Knowledge of Aborigines Qualifications Motivation/interest to learn	Communication styles/ attitudes
Aboriginal AHS Staff (n=12)	Easy going, patient, understanding Aboriginal person, tolerant, accepting, flexible, personality. sense of humour, good nature	Community involvement Helpful, efficiency/ competence	
Non-Aboriginal AHS Staff (n=8)	Tolerant, accepting, flexible Easy going, patient and understanding, personality; sincere, sympathetic, sense of humour	Motivated to achieve	
Non-Aboriginal Hospital Staff (n=20)	Tolerant/accepting of differences;understanding Easy going/understanding, patient, approachable Respectful/honest open-minded (non-judgemental) Compassionate; not demanding Ability to treat all the same Gullible, personality Firm and authorative		

Aboriginal participants, however, also stress the importance of education, formal professional qualifications and knowledge about Aboriginal people. This heavy emphasis on **qualifications** is in contrast to non-Aboriginal respondents' perceptions of the importance of education to Aboriginal people.

Thus when asked to consider why there are so few Aboriginal doctors and nurses, all groups acknowledge the lack of appropriate educational background among Aboriginal people (see Table 91).

Table 91

Perceived Reasons for Few Aboriginal Health Professionals

Perceived Reasons	Aboriginal Participants (n=31)	Non-Aboriginal Participants (n=26)
Education	12	18
Lack of Motivation	8	12
Lack of family support (home environment)	1	14
Prejudice	1	9
Family/peer/community pressure	-	4
Expense	1	3
Poor health status	-	3
Lack of confidence (lack of self esteem)	8	3
Lack of role models	-	2
Unsuitable temperament	2	-
Nature of training	1	-
Don't know	5	-

Several non-Aboriginal respondents, however, appear to ascribe this pattern to "deficiencies" within the Aboriginal community, family, parents or individual. Consequently comments reveal a pattern of "blaming the victim" Ryan (1976) or the "within-skin approach" Mann (1969). As Bochner (1982) points out:

> The within-skin approach attributes the causes of behaviour to internal aspects of the **person**, and therefore regards behaviour as being determined by the individual's personality traits, dispositions, character...racial characteristics and other features inherent in the individual. (p. 19).

Only a minority (N=9) of non-Aboriginal respondents acknowledge the influence of outside pressures such as majority prejudice.

Aboriginal respondents do not minimize "deficits" e.g. lack of parental encouragement or peer/family pressure. However, their perspective is quite different. Nearly always it encompasses historical black/white interaction, especially in the school system or parental experiences. Thus situational factors often outside the family or community are cited.

However **all** participants perceive **better rapport** as the major benefit accruing from an increase in Aboriginal doctors and nurses. Interestingly, participants believe that such rapport will be of benefit to Aboriginal clients rather than **all** clients; the underlying assumption is that Aboriginal health professionals will work best and only with other Aborigines. Experience among Aboriginal teachers has shown that this may by no means always be the case even though both ethnic groups hold to such an expectation.

Thus, although ethnicity is not highlighted as an important factor for staff **selection,** it is obviously perceived to be a significant factor influencing the outcome of health as well as educational **encounters.**

SECTION B

REVIEW OF CONCEPTUAL FRAMEWORK

Previous comparisons of the responses of Aboriginal and non-Aboriginal participants belonging to the three groups involved in this project provide a basis for a more detailed analysis of the factors influencing Aboriginal health statuts as outlined in Figure 2, Chapter II.

Analysis of the field data allows further exploration and expansion particularly of the **proximal variables** identified in Figure 2 and inherent in the socio-interpersonal political environment of Country Town. Jessor and Richardson (1968) suggest that proximal variables, in contrast to the more distal variables discussed in some detail in Chapter II, are likely to have a much more immediate and direct influence on the central issue (Aboriginal health status). Further, in the long term such variables can be manipulated or changed to improve the situation.

Thus Figure 7 presents a model which will explore the relative importance and interrelationship of **proximal attitudinal/ behavioural and service delivery variables** operating in Country Town.

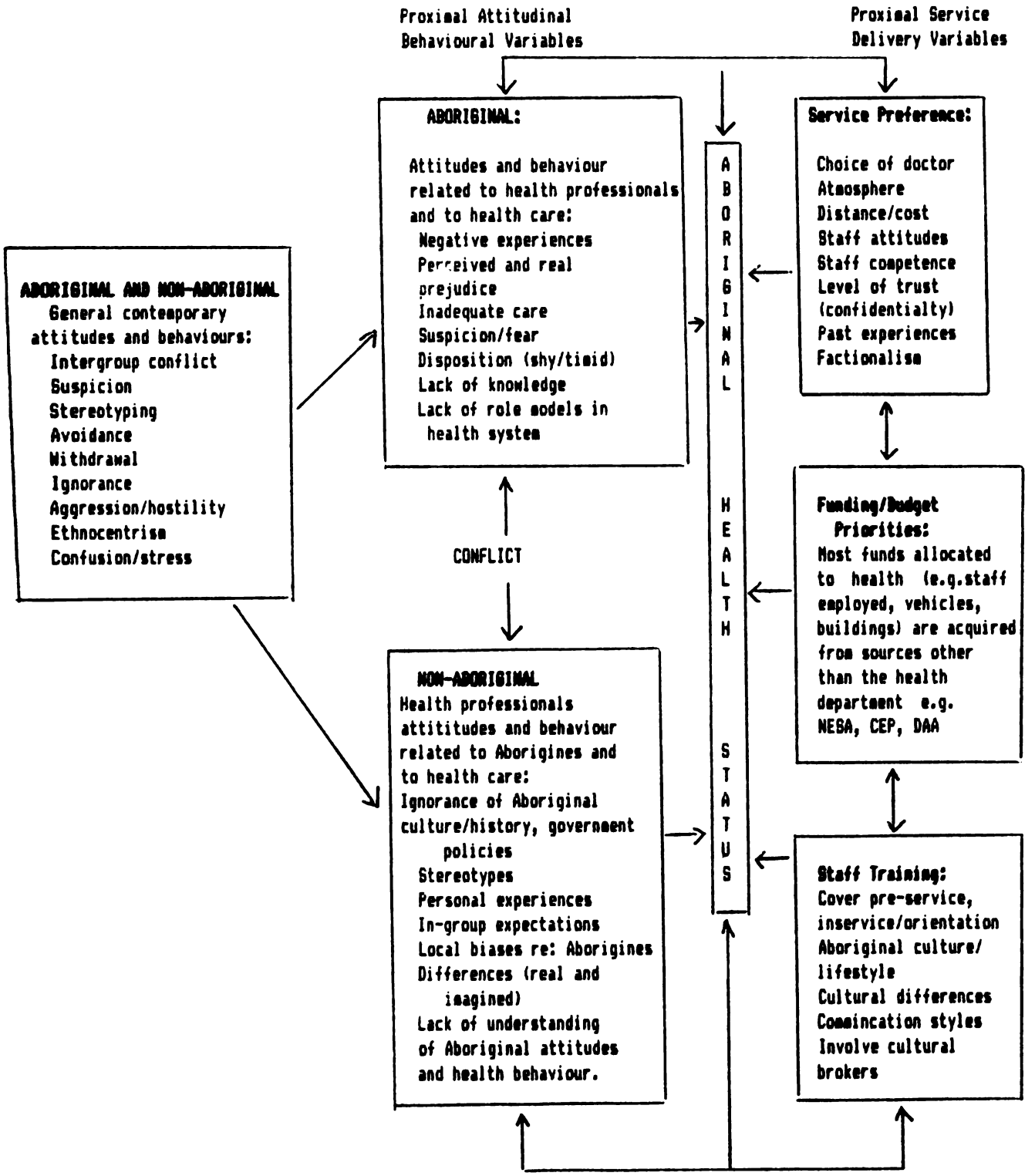


Figure 7 Interrelationship of proximal variables influencing Aboriginal health status, Country Town, N.S.W.

Proximal Attitudinal/Behavioural Variables

In relation to **attitudes and behaviour** the most significant factor emerging from the data is the influence of majority/minority attitudes. Such attitudes, although not directly related to health or health care, appear to strongly influence the delivery of health care and in some cases also health seeking behaviour. Thus, several hospital participants point out:

> They treat Aborigines the same...but there's just some sort of thing missing there...here they segregate them in a room...because they get a whole lot of visitors...bags get pinched...not by the girls (staff)...the police are scared stiff of them (Aborigines)...things are really bad...bad...snatching purses off old ladies...even if they lay charges...nothing happens...it's getting worse...everybody says so.

Many responses/comments both inside and outside of interview situations reinforce this viewpoint and clearly reflect the tense intercultural climate in the town.

> If they're a patient...they'll get the care...but as far as going further about their problem...the attitude is "Why should I be doing this when they're going to be back with something else?" It's a vicious cycle...there's so much prejudice...especially lately when it's getting so bad ... robberies ...not all Aborigines...but as soon

> as people hear about it...they'll decide it was a Black person involved even if it wasn't.

The Chief Executive Officer of the hospital indicated that he was aware of only one incident being reported involving an Aboriginal person (an assault which occurred in the nursing residence during the time of this field research). As a general statement he said:

> You could say the number of minor thefts and trespassers had increased over the September-October (school holiday period)...two white boys were in fact caught stealing recently...it probably surprised some as many assumed they'd be Aborigines. On most occasions there is no proof who does what because no one sees the person...

There is no doubt that non-Aboriginal respondents' general feelings about Aborigines will influence their perceptions regarding Aboriginal patients.

> Depending on what's wrong... half the kids (Aboriginal) are put in here to get baby sat...the mothers are piddling themselves laughing...

To some extent negative race relations in the town are fuelled by the local media. Thus, the Aboriginal co-researcher reacted with alarm to the contents of the local paper:

> No wonder Whites hate Blacks in this town ...there's nothing good said about them at all in here...it's different in _____

Besides numerous articles on theft, assault and drink driving relating to people known by the locals to be Aborigines the following media headlines (August-November, 1984) convey the tone of racial undercurrents and white backlash in Country Town.

Handouts a threat to Aboriginals

Squatters now on _____(Aboriginal reserve)

Land grab fears

Another rash of thefts

Vigilante group for _____(Country Town)

Vigilante group has tremendous support

Can it be a price too high to pay?

Moves for neighbour watch

Minister pledges aid on self-help crime fight

Hospital participants' comments reflect the influence of this media coverage:

> I don't know what it comes back to but they...why do they abuse you when you try to help someone? Why are they here? We're doing our best to help them and why are they coming behind and taking advantage of a situation for their own good when we are out there trying to help their own people?

Staff comments and general community concerns were in fact related to the neighbourhood in which the hospital is located. Consequently the perceived "threat" was very real indeed.

On arrival at Country Town Hospital one of the domestic staff advised me with a degree of hesitancy to move my car off the street because " it wouldn't be safe...the Black fellas would take your petrol...they come in here (hospital grounds) too...no where is really safe".

Pat Dixon was confronted more than once by nursing staff in the nurses'residence "And where are you from...?" Such questions followed staff handbags being stolen "by a big Black man" while people were on duty.

Other staff commented to me:

> It is terrible...they (Blacks...especially teenagers) break in anyway...smash your windows...it just isn't safe...you report them to the police and they don't do anything. Old pensioners just get knocked around and stolen from...you can change the locks on your house...it doesn't do any good.

Obviously, some of the fears hospital staff express are well grounded and triggered by real experiences. As one respondent points out:

> The discrimination problem is increasing...lack of tolerance by people...they fear what will happen...there is discrimination ...but I was hopping mad when I had my milk pinched (by two young Aboriginal boys)...last Monday...I chased them...it makes you very angry.."

Other comments appear to be based on very little knowledge or "hear say". Indeed, although we were only in Country Town for a relatively short period of time, we directly encountered stereotyping which developed without any basis in reality. Thus, for example, I was told during interviewing that under a government scheme to resettle Aboriginal families in Country Town

> 2000 Blacks...(I shouldn't call them that)...Aboriginals I mean are moving in from Redfern (Sydney)...we'll have to move out...you won't be able to live here!

The previous discussion fully supports many of the elements inherent in cross-cultural interaction outlined in Bochner's (1982) model, particularly those related to territoriality, in-group/out-group perceptions and the influences of "imagined" or perceived conflict.

In this project only a minority of Aboriginal participants overtly refer to contemporary racial attitudes and white backlash in the general community. However, they too emphasize that the media is responsibile for "a lot of the problem"

> If we do anything good...the media very rarely...we rarely hear about it or read about it...if we do anything worry they blow it up...a lot (people working in health) read horrible things about us...only read when the Blacks do things wrong.

Further, Aboriginal participants are well aware that these attitudes and feelings will affect non-Aboriginal health professionals:

> I went up to the hospital and visited the kids once...talkin" about us only bringin' the kids in only to have a good weekend...it goes on a lot with nurses up there...I don't like my kids goin' in there

Other participants who have obviously experienced white backlash in Country Town ask that health professionals:

> Try to treat each Aboriginal person as you find them...that's a good attitude...when they meet Aborigines to treat 'em as they find 'em.

At least some non-Aboriginal hospital participants echo similar sentiments in the advice they would offer to new staff who have never worked with Aborigines:

> They should come in with an open mind but be aware of the problems that could arise...
>
> If she was from around here...she'd know the local biases...to find out herself what the Aborigines are really like...all you hear is the bad things...

Proximal Service Delivery Variables

Service preference

In relation to **proximal service delivery variables,** the data highlight that for most clients **choice of doctor** is the major factor determining their choice of a particular service. **Proximity, costs, convenience** as well as **staff attitudes, perceived professional competence** and **level of trust (confidentiality)** also contribute to their decision. Further, participants who choose to attend the AMS emphasize the **friendly informal atmosphere.** Some clients relate **past experiences** at a particular service as an important variable affecting their current choice of service. In addition community factionalism previously discussed is also a factor.

Funding/budget priorities

The data suggest that funding and budget priorities in relation to AMS and Country Town Hospital are ill-defined. It has been impossible to gather any data about private health services; however,

difficulties experienced by AMS as well as the local hospital must affect Aboriginal health.

At AMS funding problems are a constant and recurring concern. AMS receives funds through channels other than the local hospital. At AMS, the Commonwealth Department of Health provides monies for the salaries of health staff which amount to about one quarter of the agency's budget. The bulk of AMS's funding, including salaries for AHWs, comes via the Commonwealth Department of Aboriginal Affairs (DAA).

The title of AMS, which comes from the Aboriginal Gumbangeri language (now spoken by only a few in the district), reflects the general aim of the service in that it stands for "better or good" health. All of the agency's objectives reflect a desire to implement better health practice and education (either for staff or people in the community).

Thus AMS's constitution states that the agency is established to:

1. Administer and operate to cater for the health needs of Aboriginal people in the area.

2. Improve the health status of Aboriginal communities on the reserves, in the town and surrounding areas through the implementation of appropriate medical care and disease prevention programs.

3. Involve Aboriginal people in the planning and provision of health care in their community.

4. Train Aboriginal people as field officers and health workers.

5. Teach Aboriginal people to better utilize existing health and social services.

AMS's budget priorities should, theoretically reflect these aims. Instead, because AMS receives the bulk of its finances through DAA, the budget priorities reflect DAA's rigid funding categories set down in the Aboriginal Councils and Associations Act (1976) which provides for the agency's organizational legitimacy. DAA's funding categories include allocation for wages and salaries, equipment and supplies, building and vehicle maintenance and operating costs. No allocation is possible for staff training, buying or developing educational materials or deploying staff to carry out regular community education programs.

Information emerging from interviews at AMS, together with that gathered by personal contact and discussion and through internal documentation reviewed, shows that AMS aims and AMS staff's **preferred duties** do in fact coincide. Staff at the agency would prefer to work in health prevention/education. Funding categories/ priorities set from **outside** the agency appear to be

frustrating their efforts.

Further, it should be emphasized that funds to Aboriginal organizations like AMS are only allocated on an annual basis (handed over to the agency at three monthly intervals) and can be withdrawn at any time. This pressure on the agency further ensures conformity with the funding body's expectations rather than adherence to the agency's aims and objectives.

At the local hospital, interviews have **not** investigated questions of funding. However discussions with senior resource personnel reveal the following patterns. Until 1983 Aborignal health was funded through the DAA. The State Department of Health contained an Aboriginal health Unit, staffed by one Aboriginal health nurse (white) and an AHW who were attached to the local Community Health Service.

Since the integration of Local Area Health Services in Country Town district, the Aboriginal Health Unit has been disbanded; the staff have become part of the Community Health branch of the new Local Area Health organization. Funding for the AHW employed continues to come via DAA and the Aborignal health nurse position no longer exists. As yet no special priorities have been set by Country Town's Local Area Health Service with regard to Aboriginal Health. Instead of committing

its own funds, the local service is attracting short term grants through National Employment Strategies for Aborigines (NESA) and Community Employment programs (CEP) in order to employ other Aboriginal staff.

However, existing budget priorities and staff ceilings at this time prevent permanent positions being created for Aboriginal staff employed under temporary outside funding. Consequently there are few permanent Aboriginal role models or cultural brokers at Country Town Hospital. There are no preventative programs to reach out from the hospital to the community. There are no accepted Aboriginal colleagues or peers to influence non-Aboriginal attitudes. All of the above factors must influence Aboriginal health status.

Staff Training

Previous discussion has shown clearly how important **all** participants in this project consider staff training at all levels, including pre-service, in-service and orientation. Further, concrete suggestions about the content of such programs have been recorded.

A more detailed plan to develop staff training programs and thus address Research Problem 3--Sub-problems 2, 3 and 4 will follow in the next section.

SECTION C

GUIDELINES FOR TRAINING PROGRAMS

[Research Problem 3, Sub-Problem 4]

The majority of participants in this project involved in health care definitely believe that they can be better prepared to work with Aboriginal clients. Further, the need for understanding and in particular cross-cultural awareness and sensitivity is strongly emphazised by **all** three sample groups.

However, participants' recommendations as well as the general picture emerging from the data, especially in relation to the proximal attitudinal and behavioural variables (discussed in the previous section), indicate the need for such training to be carefully planned.

In particular, the preceding analysis clearly shows that a number of points need careful consideration **before** training guidelines are developed. These points include:

The implications of majority/minority interaction:

Most participants believe staff training would not easily be implemented because of prevailing attitudes, conflict, hostility and system rigidity.

Participants have minimal contact with each other. Interaction is frequently problem-oriented.

The necessity of including Aboriginal people in the development and delivery of any training program:

Although all participants believe it is essential to involve local and well informed Aboriginal resource people in staff training some hospital participants have reservations about who might be "suitable" and "acceptable" to the hierarchy.

Aboriginal representation and status at the hospital is low and they are not in positions likely to influence decision making about staff training.

The necessity of providing non-Aborigines with an opportunity to meet Aborigines outside the confines of a hospital/work oriented situation.

Aboriginal participants (both community and staff) suggest the use of "cultural brokers" and Aboriginal organizations to facilitate introduction of staff to Aboriginal communities. This again raises the issue of "acceptability".

While most community participants believe concerned and interested health staff would be welcomed in their communities. Most hospital participants have reservations about meeting Aboriginal people in their communities. Some express concern that their motivation will be questioned or that they might be victims of aggression or hostility.

3. Content Components

* The curriculum must:
  - have clearly defined objectives, selection critera and evaluation criteria (Blake and Heslin, 1983)
  - anticipate conflict and build in strategies for conflict management (Appleton, 1983)
  - address practical concerns/questions (Parlett, 1981) and therefore be useful and beneficial not only to individuals but the institutions and communities they represent.
* Strategies/experiences must:
  - encourage mutual/reciprocal learning (Lippmann, 1977)
  - include cognitive as well as experiential and affective input (Biocchi and Radcliffe, 1983) in order to develop cultural empathy and rapport (Townsend, 1981), as well as create awareness and lead to change (Biocchi and Radcliffe, 1983).

It is clear from the field research in Country Town that participants express many concerns/reservations about intercultural training. Even if some are not warranted, they nonetheless have important implications, not only for planning and developing training strategies but, perhaps more

importantly, for "marketing" or advocating the need for intercultural training.

Further, the tense racial relationships in Country Town are likely to magnify responses to the idea of intercultural training. Townsend (1981) identifies four typical reactions of potential participants or users of intercultural training programs:

* They do not understand what intercultural training, education and consulting means.

* They do not see how useful intercultural services could be to their own institution.

* They perceive intercultural activities as "soft" (interesting to talk about but not that important).

* They have been "burned" in the past with programs and projects which failed and put them into an awkward position (p. 251).

Such responses and others need to be anticipated. The field research for this project is the first step toward establishing the need for intercultural staff training and identifying possible reactions.

It would be possible to extract from the data the elements of a training program. However, I believe such a step would be premature without further feedback, consultation and collaboration with the Aboriginal

experiencing and therefore responsible for solving them. It would be in the interest of any pilot workshop to address this issue and to encourage Aboriginal participants to consider their position, input and influence.

SECTION D

CONCLUSION

In addition to the methodological limitations noted in Chapter III there are doubtlessly other variables which are likely to have influenced this research. Primarily these relate to the socio-emotional environment in Country Town, especially Black/White interaction. It would be naive to think that the "visible distinguishing characteristics" (Bochner, 1982) of the research team as well as co-researcher interaction, for example, did not at times intensify or suppress participants' spontaneous reactions and interview responses. Often, although not within the scope of this project, and indeed quite difficult to record, was the unspoken language exhibited by several respondents.

Co-researchers' reactions, although monitored to some extent, undoubtedly led to unnecessary biases and distortions. At times we became quite concerned and over-anxious about the picture emerging from our inquiries.

However, if understanding interaction is the goal of field work, then co-researchers' attempts to cope with their own feelings, misapprehensions, anxieties, and at

times, sheer stupidity must be an important step towards understanding.

The health institutions visited in Country Town are staffed by individuals committed to delivering quality care to all patients.

However, the majority of nurses interviewed (N=12) display a **low level of job satisfaction** which warrants closer attention because of its implications to delivery of quality care.

The type of work that nurses generally do is, or has the potential to become highly stressful. In Country Town, nurses are subjected to even higher stress levels by cross-cultural encounters which create additional "pressure points" and conflict which often remains unresolved.

Some nurses cope by resorting to their authority, status/power within the system; others simply become detached or avoid close "unnecessary" contact with Aboriginal clients.

However, an important minority manage conflict well and display increased cultural sensitivity, awareness and motivation to learn more about Aboriginal culture. Thus, within the institution itself, there is a core group of people who have acquired skills, largely on their own initiative, to ensure Aboriginal clients

are not disadvantaged by the systemic and cultural biases inherent in any mainstream institution.

Further work is necessary to develop a series of pilot workshops from which a model inservice program may be developed. Such an inservice program would need to be evaluated in a number of different settings before it could be made available to hospitals for regular staff development.

Thus this research has implications for **all** health care providers (regardless of their ethnicity) in that it is the first step in involving staff in determining their own training needs.

Of equal importance is the involvement of Aboriginal clients in decision-making about intercultural training for health personnel.

Hall (1976) suggests that:

> Ultimately, what makes sense (or not) is irrevocably culturally determined and depends heavily on the context in which the evaluation is made. The result is that people in culture-contact situations frequently fail to really understand each other.

Clearly, health professionals, especially nurses, who act as major "gatekeepers" to the health system, do not always share the values and attitudes of Aboriginal para-professionals or clients.

Similarly, meanings attributed to the behaviour of non-Aborigines by Aboriginal people are culturally determined. Hall (1976) points out that we **all** have a tendency to become "culturally irrational" because we wear "culturally imposed blinders" which ensure that our view of the world does not ususally transcend the limits imposed by our culture.

However, culture is learned and sound educational principles do exist (Lippman 1977; Pedersen, 1981) to help individuals to see that they do indeed as Townsend (1981) points out have:

> The ability to become different and in so doing to understand others from their own perspective. To foster that kind of learning is the issue. (p. 228)

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APPENDIX A

DEFINITION OF TERMS

Aborigine or Aboriginal refers to a person who identifies as an Aborigine.

Aboriginal communities refers to kin groups of Aboriginal people resident in Country Town.

Aboriginal health worker (AHW) is an official classification for an Aboriginal person employed in the State Health Department as a paraprofessional to manage illness and disability, provide preventative services, resolve social problems, to become involved in community organization and development and education and administrative duties (Goldstein, Hunt & Sharkey, (1981).

Aboriginal health workers or field officers are also employed by the Aboriginal Medical Service (AMS). No duties statements were available from AMS Country Town. However, discussion indicates their work revolves around transport/courier services, assisting the nurse and doctors, helping Aboriginal clients entering the mainstream health system and liaisonng in the local Aboriginal community.

Accredited training does **not** exist for either group of AHWs.

Assimilation. The policy of assimilation seeks that all persons of Aboriginal descent **will choose** to attain a **similar** manner and standard of living to that of other Australians and live as members of a single Australian community - enjoying the same rights and provileges, accepting the same responsibilites and influenced by the same hopes and loyalities as other Australians. Any special measures taken are regarded as temporary measures, not based on **race**, but intended to meet their need for special care and asssistance and to make the transition form one stage to another in such a way as will be favourable to their social, economic and political advancement. (Gale & Brookman, 1975: 72)

Community health setting describes a community-based health centre or any other location in the community (such as the client's home) where health care is provided.

Client refers to someone in need of health care or a recipient of it.

Exemption papers. Aborigines who wished to be "free" (from Government control on Aboriginal settlements or reserves) had to apply for exemption papers. People generally had to prove first that they were capable of coping with their own affairs, and could demonstrate sobriety and industry. (Eckermann, 1973: 61, my brackets)

Integration. It means that Aborigines may choose their own life style, but it carries with it an implicit agreement from non-Aboriginal Australians that Aborigines will have equal access of opportunity to participate in the social institution of the nation. (Smith & Biddie, 1975: 5)

Health care provider denotes any person in the hospital or community-based health centre who provides care. The term includes administrators, doctors, nurses, Aboriginal health workers, and other Aboriginal staff employed in health related areas.

Health professional is a health care provider with formal accredited qualifications.

Interaction refers to verbal and non-verbal exchange between client and health care provider.

Perception refers to the one's understanding or intuitive feeling about a described situation.

Self-determination literally means that Aboriginal people should have the right to choose their destiny, with Government help in an enabling role, providing finance, technical skills, and social and economic support. (de Hoog & Sherwood 1979: 31)

Self-management is the current Federal policy, has somewhat similar stated aims (to Self-Determination), but stresses that Aboriginal groups must be held accountable for their decisions and management of finance. (de Hoog & Sherwood 1979: 31, my brackets).

APPENDIX B

MAJOR CATEGORIES OF INFORMATION

1. Background
2. Culture contact
3. Employment
4. Job satisfaction
5. Staff selection
6. Staff preparation and continuing education.
   - general training
   - orientation
   - workshops/inservice training
   - on-job-training
7. Staff contact
8. Doctor/nurse role
9. Aboriginal health worker role
10. Experience in the health care system
11. Situational dilemmas
    - staff-patient
    - staff-staff
    - staff-job
12. Future ideas re: staff selection and training.

APPENDIX C

SCHEDULE 1

Community Interview

No: Date

BACKGROUND

1. Age:
2. Number of children:
3. Ages of children:
4. Children's place of birth:
5. Household composition:
6. Length of residence in Country Town:
7. How far did you go in school?

   Probe: what age were you when you left school?
8. Where did you do most of your schooling?

CULTURE CONTACT

9. When you were at school did you have any close friends who weren't Aboriginals? Yes - No

   If 'NO' go to Q10.

   If yes - what nationality were they?
10. Since you left school have you ever worked or lived with people from another culture? Yes - No

    If 'NO' go to Q14.

    If yes - where were they from?

EMPLOYMENT

11. What jobs have you had since you left school?

12. Have you ever been employed in health? Yes - No

If 'NO' go to Q13.

If yes - probe:

a) Who employed you?
b) What was your position?
c) How long did you work there?
d) What did you do in your work?

13. What is your occupation now?

14. What is the longest time you have been out of work?

EXPERIENCE IN HEALTH CARE SYSTEM

15. Have you ever been a patient in the local hospital?
Yes - No

If 'NO' go to Q16.

If yes - probe:

a) When was the last time you went into hospital?
b) What was wrong?
c) How long were you in for?
d) How did you find it?
e) Were you pleased with the care you got at the hospital? Yes - No - Undecided
Probe reasons for opinion
f) Is there any way that it could have been better? Yes - No - Undecided
Probe reasons for opinion

16. Have you ever had to go up to outpatients?
Yes - No

If 'No' go to Q17.

If yes - probe:

a) When was the last time you went?
b) Were you sick or did you take someone in your family along?
c) What was wrong?
d) When you went up to outpatients how did you find it?
e) Were you pleased with the care you got?
Yes - No - Undecided
Probe: reasons for opinion
f) Is there any way that it could have been better? Yes - No - Undecided
Probe: reasons for opinion

17. Where do you usually go when you or someone in your family is sick? (Hospital, Medical Centre, AMS, Own doctor).

Probe:

a) What do you like about going there?
b) Are you usually pleased with the care you get?
Yes - No - Undecided
Probe: reasons
c) Can you think of any little thing they could do to make it better for you when you go there?
Yes - No - Undecided
Probe: suggestions

18. Do you worry much about having to go into hospital?
Yes - No - Undecided
Probe: what kind of thing bothers you?

19. Do you think it is the same for white people?
Yes - No - Undecided

If 'YES' go to Q20
If no or undecided, probe: in what way is it different?

20. How well do you think most Aboriginal people understand how the hospital works?

Probe: Is there any little thing that Aboriginal people find hard to understand about the hospital?
Yes - No - Undecided.

21. Do you think it is the same for white people?
Yes - No - Undecided

If 'YES' go to Q22.

If No or Undecided - probe in what way is it different?

DOCTOR/NURSE ROLE

22. What sorts of things do you think doctors and nurses should do in their work with Aboriginal people?

23. Do you think that the work doctors and nurses do is important? Yes - No - Undecided
Probe: reasons for opinion

24. How come we haven't got many Aboriginal doctors and nurses?

Probe: do you think more Aboriginal people should go into these sorts of jobs?
Yes - No - Undecided
Probe: reasons for opinion

ABORIGINAL HEALTH WORKER ROLE

25. What about the Aboriginal health workers - what sort of things do they do in your community?

Probe:
a) Is there anything else you would like to see them doing? Yes - No - Undecided
Probe: reasons and/or suggestions
b) Do you think their job is important?
Yes - No - Undecided
Probe: reasons for opinion

26. Do you think most doctors and nurses understand what the Aboriginal health workers do?
Yes - No - Undecided
Probe: reasons for opinion

27. Do they think the health worker's job is important?
Yes - No - Undecided
Probe: reasons for opinion

SITUATIONAL DILEMMAS

28. Has there ever been a time when you felt someone working in health didn't really understand you or someone in your family? Yes - No - Undecided

If 'No' or 'Undecided" go to Q29

If yes - probe:

a) Can you tell me what happened?
b) How long ago was that?
c) How was it sorted out?/How did you feel about that?
d) What do you think should have been done?
e) Is that the only time that sort of thing has happened to you? Yes - No - Undecided

If 'Yes' go to Q29
If 'No' - repeat probes a) - d).

29. Do you know of this kind of thing happening to someone else? Yes - No
If 'No' go to Q30
If yes - probe:

a) Can you tell me what happened?
b) How long ago was that?
c) How was it sorted out? (probe how did you feel about that?)
d) What do you think should have been done?
e) How often do you think this kind of thing happens?

31. Do you think this kind of thing happens just as much with white patients as it does with Aboriginal people? Yes - No - Undecided.
Probe: reasons for opinion.

PERCEIVED UNDERSTANDING OF ABORIGINES

31. Do you think most people working in health understand Aboriginal people?
Yes - No - Undecided
Probe:

a) Is there anything special you think they don't understand? Yes - No - Undecided
b) Reasons for opinion

TRAINING NEEDS

32. Do you think that when doctors and nurses go through their training they should learn about Aboriginal people? Yes - No - Undecided.°

    Probe: reasons for opinion

    If 'No' or 'Undecided' go to Q33.
    If yes - probe: What are the most important things they should learn?

STAFF SELECTION

33. What do you think a person has to be like to work along well with Aboriginal people?
    Probe:
    a) Personal qualities
    b) Do you think it matters whether it is an Aboriginal or a white person?
       Yes - No - Undecided
    c) Reasons for opinion.

34. How do you think people who work in Aboriginal health should be picked for their job?
    Probe: method of selection and criteria for selection

RECOMMENDATIONS

35. What do you think would be the best way for white people working in health to learn more about the Aboriginal community?

APPENDIX D

SCHEDULE 2

Aboriginal Staff Interview

NO: DATE:

BACKGROUND

1. Age:
2. Sex:
3. Marital status:
4. Number of children:
5. Ages of children:
6. Household composition:
7. Length of residence in Country Town:
8. How far did you go in school? Probe: what age were you when you left school?
9. Where did you do most of your schooling?

CULTURE CONTACT

10. When you were at school did you have any close friends who weren't Aboriginals?
    Yes - No

    If 'No' go to Q11
    If yes - what nationality were they?

11. Since you left school have you ever worked or lived with people from another culture?
    Yes - No

    If 'No' go to Q12
    If yes - where were they from?

EMPLOYMENT

12. What jobs have you had since you left school?

13. Did you have any training for these jobs?
    Yes - No.
    If yes - probe for length and type of training.

14. Have you ever been unemployed? Yes - No

    If 'No' go to Q15
    If yes - what is the longest time you have been out of work?

15. Have you ever worked in health before?
    Yes - No

    If 'No' go to Q16
    If yes - probe:

    a) Who employed you?
    b) What was your position?
    c) How long did you work there?
    d) What did you do in your work?

16. What is your position here at the hospital/centre?
    Probe: how long have you worked here?

17. Have you always been in the same position?
    Yes - No

    If 'Yes' go to Q18
    If no - how long have you been working in it?

18. What sorts of things do you do in your job?

19. What would you see as the main aim of your work?

20. In your work what takes up most of your time?

JOB SATISFACTION

21. What other staff do you work closely with in your job?

22. Do you feel the work you are doing is important?
    Yes - No - Undecided
    Probe:

    a) Reasons for opinion
    b) What do you like about your work?
    c) Is there anything you don't like about it?
       Yes - No - Undecided
    d) Are there any changes you would like to see in your work?

23. Do you feel other people working in health understand the work that you do?

    Yes - No - Undecided
    Probe:
    a) Do you think they consider your work important?
       Yes - No - Undecided
    b) Reasons for opinion

24. How does your family feel about the work you do?
    Probe:

    a) Do they see your work as important?
       Yes - No - Undecided
    b) Reasons for opinion

25. What about the Aboriginal community - do they know what you do in your work?
    Yes - No - Undecided
    Probe:

    a) Do you think they consider your work important? Yes - No - Undecided
    b) Reasons for opinion.

26. What do you feel the community think you <u>should</u> be doing as a .....worker?

    Probe:
    a) Do you find it hard to do what they expect?
       Yes - No - Undecided
    b) Reasons for opinion

STAFF SELECTION

27. How were your picked for the job here?

    Probe:
    a) When the job came up how did your hear about it?
    b) Who interviewed you?
    c) What were the interviewers looking for?

Trainees Only - Questions 28-30

28. When did you start your training?

29. Do you know who provides the funds to employ you?
    Yes - No - Undecided

30. Will you have a job at the end of your training?
    Yes - No - Undecided

    Probe: how do you feel about that?

STAFF PREPARATION AND CONTINUING EDUCATION

ORIENTATION

31. When you started your job did you have any special introduction or orientation. Yes - No

    If 'No' go to Q33
    If yes - probe:

    a) What type of orientation was it?
    b) How long was it?
    c) Where did you do it?
    d) Who provided it for you?
    e) What kind of people were teaching you?
    f) Were any Aboriginal people involved?

32. Did you find what you learnt during your orientation helpful when you started your work?
Yes - No - Undecided

If 'No' or 'Undecided' probe: reasons for opinion then go to Q33.
If yes - probe:

a) How did it help you?
b) How could it have been improved?

ON-JOB-TRAINING

33. Do you get on-the-job training. Yes - No

If 'No' go to Q34
If yes - probe:

a) Who teaches you as you are working along?
b) Can you tell me how you find it?

WORKSHOPS/INSERVICE TRAINING

34. Have you been to any workshops/inservice training since you started working here. Yes - No

If 'No' probe: Is there any reason you haven't gone to any workshops or inservices?
Then go to Q36
If yes - probe:

a) When did you last go to one?
b) What was it on?
c) Where was it held?
d) How long was it?
e) Who was it run by?
f) What kind of people were teaching you?
g) Were any Aboriginal people involved?

35. Did you find what you learnt helpful?
Yes - No - Undecided

If 'No' or 'Undecided' go to Q36
If yes - probe:

a) How did it help you?
b) How could it have been improved?

All Respondents:

36. Would you like to have more training for the job you are doing? Yes - No - Undecided

Probe:
a) Reasons for opinion
b) Is there anything special you would like to learn that you think would help you in your work? Yes - No - Undecided

STAFF CONTACT

37. How do you feel working in a centre where there are only a few Aboriginal people?

38. Do you ever meet up with other staff out of working hours? Yes - No

If 'No' go to Q39
If yes - probe: in what situations would you meet?

PERCEIVED RELATIONSHIP WITH NON-ABORIGINES

39. How would you say you get along with most white people?

DOCTOR/NURSE ROLE

40. What do you feel people in the Aboriginal community think doctors and nurses should do while they are working along with Aboriginal people?

41. Do you think that most Aboriginal people consider the work that doctors and nurses do important?
Yes - No - Undecided

Probe: reasons for opinion

42. How come we haven't got many Aboriginal doctors and nurses?

Probe:

a) Do you think more Aboriginal people should go into these sorts of jobs?
Yes - No - Undecided
b) Reasons for opinion

ABORIGINAL HEALTH WORKER ROLE

All respondents except Aboriginal health workers

43. Do you know what Aboriginal health workers do in their jobs? Yes - No - Undecided

Probe: is there anything else you would like to see them do?
Yes - No - Undecided

44. Do you think most doctors and nurses understand what the health workers do?
Yes - No - Undecided

Probe:
a) Do you think the health worker's job is important?
b) Reasons for opinion.

EXPERIENCE IN THE HEALTH CARE SYSTEM

45. Have you ever been a patient in hospital?
Yes - No

If 'No' go to Q47
If yes - probe: how did you find it?

46. Have you ever had to go up to outpatients?
Yes - No

If 'No' go to Q49
If yes - probe: how did you find it?

47. Do you think most Aboriginal people worry much about having to go into hospital?

If 'No' or 'Undecided' probe reasons for opinion
Then go to Q48
If yes - probe: what really bothers them?

48. Do you think it is the same for white people?
Yes - No - Undecided

If 'Yes' go to Q49
If no or undecided probe: in what way is it different?

49. How well do you think most Aboriginal people understand how the hospital works?

Probe:
a) Is there anything that you can think of that they find hard to understand about the hospital? Yes - No - Undecided
b) Reasons for opinion

50. Do you think it is the same for white people?
Yes - No - Undecided

If 'Yes' go to Q51
If 'No' or 'Undecided' probe: in what way is it different?

SITUATIONAL DILEMMAS

STAFF-PATIENT

51. Has there ever been a time when you felt health staff didn't really understand an Aboriginal patient or someone in their family?
Yes - No - Undecided

If 'No' or'Undecided' go to Q52
If yes - probe:

a) Can you tell me what happened?
b) How long ago was that?
c) How was it sorted out?
d) What do you think should have been done?
e) How often does this kind of thing happen?

52. Has something like this ever happened to you as a patient or to someone in your family?
Yes - No - Undecided

If 'No' or 'Undecided' go to Q53
If yes - probe:

a) Can you tell me what happened?
b) How long ago was that?
c) How was it sorted out?
d) What do you think should have been done?
e) Do you think this kind of thing happens as much with white patients as it does with Aboriginal people?
Yes - No - Undecided

Probe: reasons for opinion

STAFF-STAFF

53. In your work have you ever been misunderstood by someone else on the staff?
Yes - No - Undecided

If 'No' or 'Undecided' go to Q54
If yes - probe:

a) Can you remember what happened?
b) How long ago was that?
c) How was it sorted out?
d) How did you feel about that?
e) What do you think should have been done?
f) How often has this kind of thing happened to you?

STAFF-JOB

54. Have you ever been asked to do something by other staff that you felt wasn't part of your job?
Yes - No - Undecided

If 'No' or 'Undecided' go to Q55
If yes - probe:

a) Can you give me an example of something you were asked to do?
b) How long ago was that?
c) How was it sorted out? (Probe how did you handle it?)
d) How did you feel about that?
e) Why do you think you were asked to do it?
f) How often has this kind of thing happened to you?
g) If it happened again what would you do?

SELF-JOB

55. Have you ever felt uncertain about how to do something someone on the staff asked you to do?
Yes - No - Undecided

If 'No' or 'Undecided' go to Q56
If yes - probe:

a) Can you give me an example of something you were unsure about?
b) How long ago was that?
c) How was it sorted out? (probe how did you handle it?)
d) How did you feel about that?
e) Did you ask anyone for help?
f) How often has this kind of thing happened to you?
g) If something like this happened to you again what would you do?

PERCEIVED UNDERSTANDING OF ABORIGINES

56. Do you think most people working in health understand Aboriginal people?
Yes - No - Undecided

Probe:
a) Is there anything special you think they don't understand? Yes - No - Undecided
b) Reasons for opinion.

RECOMMENDATIONS

57. Do you think that when doctors and nurses go through their training they should learn about Aboriginal people? Yes - No - Undecided

If 'No' or 'Undecided' probe: reasons for opinion

If yes - probe: what are the most important things they should learn?

58. What do you think a person has to be like to work along well with Aboriginal people?

Probe:
a) Personal qualities
b) Do you think it matters whether it is an Aboriginal or a white person?
Yes - No - Undecided
c) Reasons for opinion

59. How do you think people who work in Aboriginal health should be picked for their job?

Probe:
a) Method of selection and criteria for selection
b) Reasons for opinions

60. If another Aboriginal person was going to do a job like yours - what sort of tips or advice would you give them about the work?

61. If a workshop was being planned for Aboriginal and white health staff to get to know each other better what would you like to see included in it?

62. What do you think would be the best way for white people working in health to learn more about the local Aboriginal community?

APPENDIX E

SCHEDULE 3

Non-Aboriginal Staff Interview

NO: DATE:

BACKGROUND

1. Age:
2. Sex:
3. Ethnic background:
4. Length of residence in Country Town:
5. Education:
6. Occupation: (probe: time in)
7. Training: (probe: length and type of training)

CULTURE CONTACT

8. When you were at school did you have any close friends from another culture? Yes - No

   If 'No' go to Q9
   If yes - probe: what nationality were they?

9. Since leaving school have you ever worked or lived with people from another culture? Yes - No

   If 'No' go to Q10
   If yes - probe: where were they from?

EMPLOYMENT

10. Have you ever been employed directly in Aboriginal health or worked with Aboriginal people?
Yes - No

If 'No' go to Q11
If yes - probe:

a) Who employed you?
b) What was your position?
c) How long were you there?
d) What did you do in your work?

11. What is your present position?
Probe: how long have you worked here?

12. Have you always been in the same position?

If 'Yes' go to Q13
If no - probe: how long have you been working in it?

13. What sorts of things do you do in your job?

14. What would you see as the main aim of your work?

15. In your work what takes up most of your time?

JOB SATISFACTION

16. What other staff do you work closely with in your job?

17. Do you feel the work you are doing is important?
Yes - No - Undecided

Probe:

a) Reasons for opinion
b) What do you like about your work?
c) Is there anything you don't like about it?
Yes - No - Undecided

18. What understanding do you think Aboriginal staff at the hospital/centre have about the work you do?

    Probe:

    a) Do you think they consider your work important?
       Yes - No - Undecided
    b) Reasons for opinion

19. What understanding and expectations does the general public have about the work that you do?

    Probe:

    a) Do you think they consider your work important?
       Yes - No - Undecided
    b) Reasons for opinion

20. What understanding and expectations do people in the Aboriginal community have about your work?

    Probe:

    a) Do you think they consider your work important?
       Yes - No - Undecided
    b) Reasons for opinion

AMS Respondents Only

STAFF SELECTION

21. How were you chosen for the job here?

    Probe:

    a) When the job came up how did you hear about it?
    b) Who interviewed you?
    c) When they interviewed you what sort of things do you think they were looking for?

22. Do you know how the Aboriginal staff here were chosen for the positions they are in?
Yes - No

If 'No' go to Q23
If yes - probe:

a) Who interviewed them?
b) What kind of things do you think they were looking for when they interviewed them?

All respondents

STAFF PREPARATION AND CONTINUING EDUCATION

GENERAL TRAINING

23. Did your professional education include any input on Aborigines or Aboriginal health?
Yes - No

If 'No' probe:

a) Do you think something should have been included?
Yes - No - Undecided
b) Reasons for opinion

Then go to Q24

If yes - probe:

a) What kind of things did you learn?
b) At what stage of your training was that included?
c) How much time would have been involved?
d) Have you found what you learnt during your training helpful in your work with Aboriginal people?
Yes - No - Undecided
e) How could it have been improved?

ORIENTATION

24. When you started your job did you have any special introduction or orientation?
Yes - No

If 'No' - do you think it would have been helpful to have had some input on Aborigines or Aboriginal health? Probe reasons for opinion - The go to Q26

If yes - probe:

a) How long was the orientation?
b) Where was it?
c) Who was it run by?

25. Did it include any input on Aborigines or Aboriginal health? Yes - No

If 'No' go to Q26.

If yes - probe:
a) Who provided the input?
b) Were any Aboriginal people involved?
c) Did you find what you learnt during your orientation helpful?
Yes - No - Undecided
d) How could it have been improved?

WORKSHOPS/INSERVICE TRAINING

26. Have you been to any workshops/inservices on Aborigines or Aboriginal health since you started working here? Yes - No

If 'No' - Is there any reason you haven't gone to any workshops or inservices? Then go to Q28
If yes - probe:

a) When did you last go to one?
b) What was it on?
c) Where was it held?
d) How long was it?
e) Who was it run by?
f) What kind of people provided the input on Aborigines?
g) Were any Aboriginal people involved?

27. Did you find what you learnt helpful?
Yes - No - Undecided

If 'No' or 'Undecided' - probe reasons for opinion. Then go to Q28

If yes - probe:

a) How did it help you?
b) How could it have been improved?

All respondents

28. Would you like to have more training for the work you are doing with Aboriginal people?
Yes - No - Undecided

Probe:
a) Reasons for opinion
b) If yes - type of training

ON-JOB-TRAINING

29. Does your work involve teaching people on-the-job?
Yes - No

If 'No' go to Q30
If yes - probe:

a) What kind of skills do you find you need for teaching people on the job?
b) How do you usually know if your teaching is effective?

30. Are you currently working with an Aboriginal person? Yes - No

If 'No' go to Q32 or 33
If yes - probe: what work do you do together?

31. Do you train the person on the job?
Yes - No

If yes -probe: can you tell me how you find it?
If 'No' -probe:

a) Who provides the training for the person?
b) Are you familiar with the training they have received? Yes - No

STAFF CONTACT

AMS Respondents Only

32. How do you feel working in a centre where there are only a few white people?

All Respondents

33. Do you ever meet up with Aboriginal colleagues outside of working hours? Yes - No

If 'No' go to Q34
If yes - probe: in what situations would you meet?

PERCEIVED RELATIONSHIP WITH ABORIGINES

34. How would you generally describe your relationship with Aboriginal people?

Hospital Respondents Only

35. Do you know what the aim of AMS is?
Yes - No - Undecided

Probe: level of understanding and contact

All Respondents

36. Why do you think few Aboriginal people train as doctors and nurses?

Probe:

a) Do you think more Aboriginal people should go into these sorts of jobs?
Yes - No - Undecided
b) Reasons for opinion

ABORIGINAL HEALTH WORKER ROLE

All respondents except AHW

37. Do you know what the Aboriginal health workers do in their work? Yes - No - Undecided

Probe:
a) Do you think the role of the Aboriginal health worker is important?
Yes - No - Undecided
b) Is there anything else you think they should be doing?
Yes - No - Undecided
c) Reasons for opinions

All respondents except doctors and nurses

38. Do you think most doctors and nurses understand what the Aboriginal health workers do?
Yes - No - Undecided

Probe:

a) Do you think most doctors and nurses see the job of the Aboriginal health worker as an important one?
Yes - No - Undecided
b) Reasons for opinion

EXPERIENCE IN THE HEALTH CARE SYSTEM

39. Have you ever been a patient in hospital?
Yes - No

If 'No' go to Q40
If yes - probe: how did you find it?

40. Have you ever had to go up to outpatients?

If 'No' go to Q41
If yes - probe: how did you find it?

41. Do you think most Aboriginal people worry much about having to go into hospital?
Yes - No - Undecided

If 'No' or 'Undecided' go to Q42
If yes - probe: what do you find they are usually concerned about?

42. Do you think it is the same for white people?

If 'yes' go to Q43
If no or undecided probe: in what way is it different?

43. How well do you think most people in the general public understand the hospital system?

Probe: reasons for opinion.

44. What about Aborigines?

Probe: reasons for opinion.

45. Can you think of anything in particular that it is important for Aboriginal people to understand about the hospital? Yes - No - Undecided

Probe: reasons for opinion.

46. What about white people?

Probe: does this apply also to them?

SITUATIONAL DILEMMAS

STAFF-PATIENT

47. Has there ever been a time when you felt an Aboriginal patient didn't understand you or another member of the health staff?
Yes - No - Undecided

If 'No' or 'Undecided' go to Q48
If yes - probe:

a) Can you tell me what happened?
b) How long ago was that?
c) How was it sorted out?
d) What do you think should have been done?
e) How often does this kind of thing happen?
f) Do you find it happens just as much with white patients as it does with Aboriginal people? Yes - No - Undecided

STAFF-STAFF

48. In your work have you ever been misunderstood by an Aboriginal person on staff?
Yes - No - Undecided

If 'No' or 'Undecided' go to Q49
If yes - probe:

a) Can you remember what happened?
b) How long ago was that?
c) How was it sorted out?
d) How did you feel about that?
e) What do you think should have been done?
f) How often has this kind of thing happened to you?

STAFF-JOB

49. Have you ever asked an Aboriginal person on the staff to do something that you felt they were uncertain about doing? Yes - No - Undecided

If 'No' or 'Undecided' go to Q50
If yes - probe:

a) Can you give me an example?
b) How long ago was that?
c) How was it sorted out?
d) How did you feel about the situation?
e) How do you think the Aboriginal person felt?
f) Do you find that Aboriginal staff usually ask for help when this type of thing happens? Yes - No - Undecided
g) How often has this happened to you?
h) If it happened again what would you do?

SELF-JOB

50. Have you ever been asked by an Aboriginal person to do something that you felt wasn't part of your job? Yes - No - Undecided

If 'No' or 'Undecided' go to Q51
If yes - probe:

a) Can you give me an example?
b) How long ago was that?
c) How was it sorted out? (probe: how did you handle it?)
d) How did you feel about that?
e) Why do you think the person asked you to do that?
f) How often has this type of thing happened to you?
g) If it happened again what would you do?

PERCEIVED UNDERSTANDING OF ABORIGINES

51. Do you think most people working in health understand Aboriginal people?
Yes - No - Undecided

Probe:

a) Is there anything in particular they don't understand?
Yes - No - Undecided
b) Reasons for opinion

RECOMMENDATIONS

52. Do you think all doctors and nurses should learn about Aboriginal people in their training?
Yes - No - Undecided

Probe: reasons for opinion.
If yes - probe: what are the most important things they should learn?

53. What do you think a person has to be like to work along well with Aboriginal people?

Probe:

a) Do you think it matters whether it is an Aboriginal or a white person?
Yes - No - Undecided
b) Reasons for opinions

54. What qualities would you look for if you were choosing an Aboriginal person to work on your staff?

Probe:
a) Method of selection and criteria for selection
b) Reasons for opinions

55. If another white person was coming into a job like yours - what sort of tips or advice would you give them about the work you do with Aboriginal people?

56. If a workshop was being planned for Aboriginal and white health staff to get to know each other better what would you like to see included in it?

57. Is there anything in particular about your own culture that you would see as important for an Aboriginal person to appreciate?
Yes - No - Undecided

Probe: reasons for opinion.

APPENDIX F

ABORIGINAL CO-RESEARCHERS PERCEPTIONS OF TEAM WORK IN FIELD RESEARCH

Introduction

From July, 1984 I spent about three months as co-researcher visiting Aboriginal homes, community groups and organizations in Country Town.

Toni Dowd and I visited a cross-section of people and groups who were connected with Aboriginal health to find out their thoughts about cultural differences in health and training needs in Aboriginal health.

Preparing for the task

I had lots of roles to play while I was doing my pilot interviewing and discussions.

Toni and I would meet to work out how we were going to tackle this project. My feelings at that time were so jumbled up, because I knew of the commitment of staying away from home some weekends. That was a strain to me and my family. That's when I had to prepare my home before I went on this experience.

Toni and I had to get to know one another better. We had to go beyond being friends. So much of our experience tells us that white people are the boss, and that I loved it sometimes because it saved me pushing myself. It's draining to watch what you are doing wrong

or right, and easier to rely on somebody else.

Starting the field work

It was hard to take everything into my mind. Toni would repeat it over to me in different ways. Sometimes I would try too hard and block myself out from thinking.

We did lots of ground work before we started. And worked out how to approach each person and what direction we needed to take. I know I have the ability and skills to approach Aboriginal people. But sometimes, when you are feeling stressed and your self esteem is not too good, it is hard to feel positive. It helped that we would go about everything together -- meeting people, eating together, talking together. This was specially important because of my negative feeling about Country Town.

I grew up on a reserve just outside Country Town. We never ever mixed in with white people we were segregated in the pictures, the swimming pool, hospital, schools. Most of them bad things happened in Country Town in the 50s. I never ever went back much.

The research process

Each day we would work along together. My mood used to change, sometimes I couldn't respond very good to my co-worker. I was learning too many new things at once. Toni would snap me out of that by watching me closely.

We would talk to women that were so shy, but they would relate to us good, once we would do the interviewing. I learned that even though some people might be very quiet and stand-offish, they've got lots of ideas, but they never have the opportunity to have their say before.

When we were talking in the community we had to talk to a whole lot of people, instead of going to key Aboriginals in the community. With each interview the role had to be changed. The interview would come out with the thought of that person, not mine. But sometimes you needed to talk out with each other how to do that. So while Toni and I were working along, each interview we would do, we would talk about it and everything like meeting somebody. No matter who or what we would talk and discuss it. We had to have our mind thinking all the time. Sometimes I knew I would make a mistake when meeting people. When we approached a group of Aboriginal people, I as an Aboriginal, felt relaxed. But my co-worker needed to be introduced. I kept forgetting that I needed to do the introducing. Instead of me thinking about the two of us I was just forgetting about Toni and she'd pull me up over that afterwards because it was important for both of us to feel comfortable and I knew myself if I didn't people would

think the project that we were doing wasn't very important. But sometimes still I'd just forget she wasn't part of the scene. So I had to put all my skills and knowledge together.

The same happened when I needed to be aware when knocking on each door to ask people if they wanted to be interviewed. Because everybody got different ways. But in the days when I lived on an Aboriginal mission, I learned how my family used to act if a stranger approached the door. This helped a lot to understand how the people felt. They would come to the door to look you up and down with the door not quite open and then you needed to communicate fast in a way that they understood you. They will accept you a little bit better as you are telling your story.

Even though the biggest majority are living in homes in streets, they are still self-conscious about their homes, or their children running around making noise. I had to be very careful with my approach. It was draining to a certain extent, especially if I had to repeat what we were on about, and not sound threatening to them. It used to be fulfilling to me, when I could persuade the person at the door to co-operate with the interview.

Each day I would go over my work load, because of myself making decisions and playing a big part in this project. But sometimes I would have liked to put the decision-making back on Toni. Especially if we couldn't find the place or couldn't catch the person at home. It encouraged me to know that most people had respect for me. The biggest majority knew where I come from by the time we were finished.

But it was different when we were working in the hospital. When I first started off it was frightening. You think to yourself you'll never understand what is going on in the system. But when you start learning all these things it's very exciting. When I had to meet the hierarchy of the hospital. I remember how Toni and I addressed them we had to play the part.

Myself as an Aboriginal person working along with a white woman in Country Town

The white people had never seen me before here in Country Town. The first day was hardest for me. I knew that I would be me threatening to white people working in the system. I knew that they would be looking me up and down wondering what I was doing there. In their minds they would be thinking I would be looking for problems. I had to learn more about addressing people -- we talked and thrashed it out. When hospital staff

got used to me being around, the feeling got better and people were accepting me being around.

It was fascinating how we worked together. Maybe because we were watched closely by hospital staff and Aboriginal community. Once Aboriginals understood what we were doing, they seemed to settle down. But here I was working along with a white woman; Aboriginal people accept it more quickly than a white person in the end. It's harder for white people to accept me so I had to fit into their system. That's something Aboriginal people learn to do early and my observations were exciting. I was finding out that you need to respect everybody's beliefs.

APPENDIX G

CONSENT PROCEDURE

Official approval for the project was sought from the NSW North Coast Region, Department of Health, Country Town District Hospital and Country Town Aboriginal Medical Services.

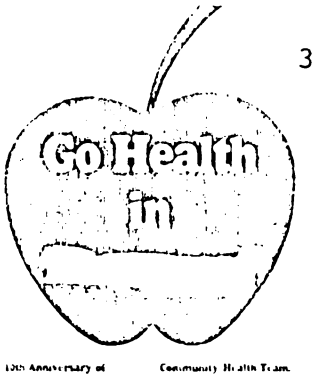
In each case, approval was first sought from governing bodies however, procedures varied between non-Aboriginal and Aboriginal agencies.

In terms of Country Town Hospital, the Region provided substantial support for the project after a number of consultations and lengthy discussions with the Regional Director of Medical Services. The Region then informed the hospital of its approval and asked the hospital to support the project, should it wish to do so. After extensive discussions with the Chief Executive Officer and the Director of Nursing Country Town Hospital permitted me to contact staff in order to ask them whether or not they would wish to participater in the project.

The attached consent letter from Country Town hospital sets out the conditions under which consent was granted. These same conditions were then circulated among nursing staff before I approached them. A written consent form inviting their participation was not

necessary. However they were assured that any information given about the themselves or others in the community or the work place, would be considered priviledged communication. Review of internal documentation was also possible with the institution's support. In documenting findings, strict confidentiality has been maintained.

Country Town Aboriginal Medical Services' Board of Directors was also formally approached by letter. However, Aborinigal supporters of this project - particularly Mrs. Dixon's kin group - had already "paved the way" by the time official consent was sought. Thus Country Town (AMS) granted us entry to the agency, permitted us to contact staff in order to ask them to participate in the project, and provided access to internal documentation. In most cases, Mrs. Dixon sought consent from individual staff at AMS as well as the community. She has detailed her approach in the attached outline. Again it would have been superfluous as well as alien to seek written consent from participants. Again they were assured of complete confidentiality and anonymity.



AREA HEALTH SERVICE

INCORPORATING
DISTRICT HOSPITAL
COMMUNITY HEALTH SERVICE
DENTAL SERVICE
HOSPITAL LINEN SERVICE

12th March, 1985

Ms. T. Dowd,

ARMIDALE, N.S.W. 2350

Dear Ms. Dowd,

This is to confirm the basis of our consent for you to conduct a Nursing Research Project at the District Hospital during the period July - November, 1984.

The hospital participation is based on the following points of agreement.

1. Participation is voluntary and as far as possible anonymous.
2. The aim of the project is clearly understood.
3. The project invites people to talk about their work to help develop ideas for planning appropriate staff training.
4. Interviews are conducted at a time and place convenient to the individual and the hospital.
5. Staff participation in the project is not detrimental to their present or future working position.
6. Confidentiality is assured.
7. People are not asked to answer questions that they regard as intrusive or otherwise offensive. They are free to withdraw from the interview at any time.
8. Approval is also given for you to review appropriate internal documentation concerned with this project.
9. A copy of both the draft and final report be made available.

Yours faithfully,

Chief Executive Officer

Aboriginal Community Participants

My name is Pat Dixon. I'm from _____, but originally I came from here in the first place. My name was Quinlan before I was married, my father was John.

We are down here doing a project. I'm here with my friend Toni. We are working together.

The main thing about what we are doing is how different people can work together or get to know one another better, especially if you are working along with a white person. And in reverse (too), if white people want to get to know us.

We will be only spending about one hour of your time in the interview. You don't have to answer any of the questions if you don't want to. Everything is confidential, between Toni and myself.

Your name came to be picked when Toni and I put every surname of every family that lives in Country Town into a hat. Then we picked so many surnames from East, West and South and North _____. That's why we picked you. And that will give different people a chance to tell us how they feel.

APPENDIX H

CO-RESEARCHER EVALUATION

ACTIVITY DATE:

For me, this activity has been (check as many words as apply):

hard _____
motivating _____
useful _____
confidence-building _____
one of the best _____
too demanding _____
embarrassing _____
enjoyable _____
boring _____
tiring _____
exciting _____
informative _____
confusing _____
interesting _____
frustrating _____
easy _____
a waste of time _____
co-operative _____
disappointing _____
encouraging _____
unorganized _____
upsetting _____
.....
.....

Note. Adapted from Evaluation handbook for cross-cultural training and multicultural education. (p.19) by G. W. Renwick, 1979, Illinois: Intercultural Network. Inc.

Find the point on the following scale that best describes your feelings about how the activity went:

worst
possible 1 2 3 4 5 6 7 perfect

1. What contributed to the way you rated the activity? (list as many points as you can in order of importance)

2. How could you improve your performance next time? (list as many points as you can in order of importance)

3. Self contract - how would you set about improving your performance?

Note. Adapted with permission: Royal Australian Community General Practitioner (RACGP) Family Medicine Programme

APPENDIX I

COMMUNITY RESULTS

Table I-1

Place of Birth: Aboriginal Community Participants' Children

Place	Number of children
Local hospital	73
Other country town hospital	18
City hospital	12
Interstate	7

Table I-2

Number and Type of Household Composition: Aboriginal Community Participants.

	Frequency of different household compositions			
	Nuclear	Extended	Compound	Single parent
N	8	8	2	1

Table I-3

Aboriginal Community Participants: Age by Number and Age of Children

Age of Mothers	Number of children by age								
	0-4	5-9	10-14	15-19	20-24	25-29	30+	N	X
30-39 (n=8)	4	8	14	12	1			39	4.9
40-49. (n=6)		2	6	7	6	6	2	29	4.8
50-59. (n=4)			4	7	4	4	7	26	6.5
60+ (n=1)						2	7	9	9.0
N	4	10	24	26	11	12	16	103	5.4

. Seven children belonging to women in these age groups have not been recorded because one woman was unable to recall ages of four children and one woman reported the deaths of three of her children.

Table I-4

Aboriginal Community Participants: Age by Type of Past Employment

Age	Type of job				
	Domestic/ factory work	Nursing	Teaching aide	Seasonal work	Never worked
30-39 (n=8)	4	1	2		2
40-49 (n=6)	5			1	1
50-59 (n=3)	4				
60+ (n=1)	1				
N	14	1	2	1	3

Number of jobs does not correspond to total N because some respondents have had more than one job during the total period of their employment.

Table I-5

Aboriginal Community Participants: Present Occupation and Longest Period Unemployed.

Age	Present Occupation				Longest period unemployed (years)								
	Pensioner	Housewife	Land Council	Teaching Assistant	<1	2	3	4	5	6	7	8	N/A
30-39 (n=8)		4		3			1			1			6
40-49 (n=6)	3	3							1				5
50-59 (n=3)		3	1			1							3
60+ (n=1)	1												1
N	4	10	1	3	1		1	1	1		1		15

APPENDIX J

AMS RESULTS

Table J-1

AMS Participants: Length of Residence in Country Town

Participants	Length of residence in years						
	<5	5.9	10-14	15-19	20-24	25-29	30+
Aboriginal staff (n=12)			1	1	8		
Non-Aboriginal staff (n=6)	5						

Table J-2

Aboriginal Participants (AMS): Age and Sex by Educational Standard Attained.

Age	Sex	Education	
		Lower High School	Intermediate High School[a]
20-24	M	2	1
	F	1	5
30-39	M	2	
	F	1	
40-49	M		
	F		
50+	M		
	F		
N		6	6

[a]School Certificate Level.

Table J-3

Number of Years in Profession by Number of Years in Present Position: Non-Aboriginal Respondents.

No. of years in profession	Number of years in present position: non-Aboriginal respondents				
	1	2	3	4	5
1-4	1				
5-9		2			
10-14			2		
15-19					
20-24					
25-29			1		
30+					

Table J-4

Length of Employment in Present Position: Position by Time at Institution: Aboriginal Respondents (AMS)

Position	Length of employment in present position					
	<6/12	1	2	3	4	5
Dental Nurse Assistant	1	1			1	
Nurses Aide	1			1	1	
Receptionist						1
Health/Field Officer		11	1			1
Administrator		1		1		

Table J-5

Present Positions by Past Employment and Longest Period Unemployed; AMS Aboriginal Participants

Present Position	Past employment						Longest period unemployed				
	Secretarial	Store Attendant	Nurses Aide	Cleaner	Aboriginal teaching aide	Labouring	>6 mths	6-1 yr	1-2 yr	3 yr +	None
Dental nurse Assistants	2	1			2			1	1		1
Nurses aides	1		1	1			1	1			1
Receptionist	1							1			
Health/Field						4			1	1	1
Administrator						1		1		2	

Table J-6

Present Position by Relevant Past Work Experience/Training: Aboriginal Respondents (AMS)

Present position	Work experience/training	
	Yes	No
Dental nurse assistants (n=3)		3
Nurses aides (n=3)	1	2
Receptionist (n=1)	1	
Health/Field Officers (n=4)	4	
Administrator (n=1)	1	
N	2	10

Table J-7

Present Position by Previous Employment in Aboriginal Health: Non-Aboriginal Participants (AHS)

Position	Previous employment in Aboriginal Health	
	Yes	No
Dentist		1
Registered nurse		1a
Medical officers	2	3

a Participants cared for Aboriginal patients during long-term nursing career at Country Town Hospital.

Table J-8

Position by Professional Interaction with Other Staff: AMS Participants.

Type of position	Administrator	Dentist	Dental nurse assistants	Medical officers	Health/ field workers	Registered nurse	Nurse aides	Receptionist	No-one	All staff
Administrator										1
Dentist			1							
Dental nurse assistant		2	1							
Medical officers					3	4	3			
Health/field worker				3	2	1			1	
Registered nurse							1	1		
Nurses aides						2	1			
Receptionist	1.									
N	1	2	2	3	5	7	5	1	1	1

Note. Some respondents work closely with more than one member of staff.
.Respondent noted she previously worked closely with the last administrator but now works mainly by herself.

Table J-9

AMS Participants: Ethnicity by Level of Perceived Understanding of Work by Other Groups.

Group	Participants	Level of understanding				
		Full	Partial	None	Don't know	Diverse
Other Health Staff	Aboriginal	6	4	2		
	non-Aboriginal	1	4		1	
Family	Aboriginal staff only	10	3		1	
Aboriginal community	Aboriginal	6	4	2		
	non-Aboriginal		4		2	
General public	non-Aboriginal staff only		4	1		1

APPENDIX K

HOSPITAL RESULTS

Table K-1

Age by Place of Birth: Country Town Hospital Participants.

Age	Place of Birth			
	Australia	New Zealand	U.K.	Asia
20-29	5			
30-39	5			
40-49	6		1	
50-59	2			
60+		1		
N	18	1	1	

Note Two respondents born overseas have lived in Australia for 14 and 46 years.

Table K-2

Age by Length of Residence in Country Town: Country Town Hospital Participants.

Age	Length of Residence							N
	<5	5-9	10-14	15-19	20-24	25-29	30+	
20-29	3	1		1	2	1		8
30-39	1		2				1	4
40-49		1	1	1		2		5
50-59		1			1			2
60+							1	1
N	4	3	3	2	3	3	2	20

Table K-3

Number of Years in Profession by Number of Years in Present Position: Country Town Hospital Participants.

No. of years in profession	No. of years in present position											
	<1	1	2	3	4	5	6	7	8	9	10+	N
<1	2											
1-4	3	1										
5-9						1						
10-14	1					1						
15-19	1		1		2			1				
20-24					1		1			1		
25-29											1	
30+			1				1					
N	7	1	1	1	3	2	2	1		1	1	20

Table K-4

Position by Time at Institution and Place of Training, Country Town Hospital Participants

Position	Time at institution								Local Training
	<1	1-5	6-10	11-15	16-20	21-25	26-30+	N	
Nursing Administrators/ Supervisors		1	2			2		5	2 (40%)
Charge Nurses		1	2	1				4	3 (75%)
Registered Nurses	1	7	1	2				11	5 (50%)
N	1	9	5	3		2		20	10

Note. 50% of staff interviewed trained at Country Town Hospital.

Table K-5

Country Town Hospital Participants: Perceived Understanding of Aborigines by Other Staff.

Participants	Perceived level of understanding		
	Full	Partial	None
Nursing staff	5	2	12

Table K-6

Country Town Hospital Participants: Position by Professional Interaction with Other Staff.

Professional interaction with other staff	Type of position			Total
	Nurse administrators/	Charge nurses	Registered nurses	N
Nurse administrators supervisors	5		2	7
Nurses aides	1	3	6	10
Medical officers		2		2
Registered nurses		3	5	8
Student nurses		2	6	8
Social worker			1	1
Trainee Aboriginal welfare worker			1	1
Charge nurses			2	2

Table K-7

Perceived Importance Attributed to Respondents Work by Others, Country Town Hospital Participants

	Don't Know	Unimportant	Professional role/expertise	Curative care pain relief	Authority	Satisfaction with service[b]
Self						
Aboriginal staff	11	4	2	-	2	1
General public	4	1	5	7	1	2
Aboriginal community	4	3	3	7	2[a]	3

[a] One respondent relates that Aboriginal parents frequently use the hospital for social reasons (i.e. as a "baby-sitting service").

[b] Satisfaction with service includes acceptability/availability to clients.

Table K-8

Level of Perceived Understanding of Respondents Work, Country Town Hospital Participants

	Level of Understanding			
	Full	Partial	None	Don't Know
Aboriginal nurses	10	9	-	1
Other Aboriginal Staff	3	5	2	10
General public	-	16	4	-
Aboriginal Community	1	17	1	1

Table K-9

Perceived Understanding of AHW Role, Country Town Hospital Participants

Participants	Level of Understanding		
	Full	Partial	None
Self	1	7	12
Other Staff	1	3	16

Table K-10

Country Town Hospital Participants: Perceived Importance of AHW Role

	Importance			
	Yes	No	Undecided	N
Self	20	-	-	20
Other staff	8	6	6	20

Table K-11

Country Town Hospital Participants: Participants Understanding of and Visits to Local Aboriginal Medical Service (AMS)

Knowledge of AMS		Perceived aim of AMS	N	Visited AMS	
Yes	No			Yes	No
18	2	Improve Aboriginal health and welfare	11	4	16
		Provide acceptable/accessible community health care	3		
		Reduce hospitalizations	3		
		Preventative health education	3		
		Encourage self help/care	2		
		Provide emergency/casualty service	1		
		Curative intervention only	1		

Table K-12

Position by Input on Aboriginal Health: Country Town Hospital Participants

Type of position	Stage of input					
	General training		Orientation		Workshops inservice	
	Yes	No	Yes	No	Yes	No
Nurse administrators/ supervisors		5		5		5
Charge nurses		4		4		4
Registered nurses	2	9	6	5		11
N	2	18	6	14		20

Table K-13

Country Town Hospital Participants: Preferred Ethnicity of Health Professionals Working With Aborigines

Participants	Preferred Ethnicity of Health Personnel		
	Aboriginal	Non-Aboriginal	Either
Nursing staff	1		19

Table K-14

Country Town Hospital Participants: Rank Order of Factors Which Should Determine Aboriginal Employment in Health

Factors/Preferred Qualities	N
Education/qualifications	9
Character/personality	6
Motivation/self-development	6
General attitudes	5
Practical experience (efficiency/reliability consistency)	5
Communication skills	4
Dress, appearance, level of personal hygiene	4
Degree of assimilation	2
Community contact/involvement	1

APPENDIX L

SITUATIONAL DILEMMAS

Table L

Detailed Outlines of Situational Dilemmas Reported by All Participants

Group	Type of Dilemma									
	Staff-patient	N	Staff-self	N	Staff-staff	N	Staff-job	N	Self-job	N
Aboriginal Community (n = 19	Suspected malpractice	5	Suspected malpratice	1	N/A		N/A		N/A	
	Lack of attention	2	Lack of attention	1						
	Prejudice	1								
	General misunderstanding	2	General misunderstanding	3						
	Unspecified	1	Unspecified	1						
HMS Aboriginal staff (n = 12)	General misunderstanding	5	General misunderstanding	2	Dress code	1	Inappropriate expectations	9	Job uncertainty	5
			Inappropriate expectations	1	Inappropriate expectations	1			Jobs too demanding	2
			Unspecified	1	Unspecified	2				
HMS non-Aboriginal staff (n = 8)	General misunderstanding	1	N/A		Aboriginal staff resisting direction	2	Job related difficulties	3	Inappropriate expectations	4
	Difficult patient	1			Lack of communication	2	General misunderstanding	1		
	Patient distrust/ ignorance	4								
Non-Aboriginal hospital staff (n = 20)	Assumed prejudice	4	N/A		Medical care	2	Treatment	8	Inappropriate	14
	Hospital rules	3			Hygiene	1	Resisting direction	1		
	Medical procedures	5			Rules	1	Unspecified	1	Unspecified	1
	Difficult patient	1								
	Medical terms	1								
	Unspecified	2								
	40		10		12		23		22	

APPENDIX M

COUNTRY TOWN PARTICIPANTS' STAFF TRAINING RECOMMENDATIONS

General Aims

Learn to understand and be accepted by each other

Learn to develop tolerance and coping skills

Encourage motivation and interest in Aboriginal culture

Recognize and accept differences

Encourage non-judgemental attitudes and educate to overcome preconceptions

Help Aborigines to understand our aim

Create awareness and sensitivity

Learn to question your own culture

Become informed/gain a basic knowledge

Encourage independence and self-help

Develop cultural empathy

Learn to communicate

Introduce strategies to increase self-esteem

Content

Aboriginal culture/lifestyle

General and intercultural communication

History of Black/White contact

Aboriginal coping skills/crisis intervention

Environmental living conditions

Unemployment/poverty

Cultural differences

Aboriginal education

Aboriginal health problems

Government legislation and policy

Aim of health service

Role of health professionals

Aboriginal attitudes towards Whites

Motivation/interests

Needs/expectations

Affirmative action

Land Rights

Strategies

Personal contact/interaction

Visit Aboriginal organizations (e.g. AMS)

Visit Aboriginal and non-Aboriginal families in their homes

Visit and work with Aboriginal people

Panel/Questions to Aborigines

Discuss common goals

Small group discussion

Use a "cultural broker"

Attend Aboriginal meetings

Talk to Aboriginal patients

Socialize

Invite special guests e.g. Aboriginal Nurse, CAA representative, interested community members