The Prejudices of Good People: Breaking Down the Barriers
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It is not only bad people who are prejudiced, that would not have such a strong effect. Most people would not wish to imitate them – and so, such prejudices would not have much effect- except in exceptional times. It is the prejudices of good people that are so dangerous.

Vikram Seth, *A Suitable Boy.* London: Phoenix, 1993.

Among the most universal and persistent inequalities in health are those based on race and ethnic group. In Australia, we are all too familiar with the extreme health disadvantage of Indigenous people. Explanations range from differences in genetic susceptibility to the experiences of dispossession and removal. Poverty is frequently invoked as a major causal factor. In particular, reference is often made to increased exposure to environmental hazards, poorer diet, overcrowded housing and the effects of lower education levels on health literacy and health related attitudes and behaviours (e.g. smoking).

The sneaking suspicion that the poorer health of racial and ethnic minorities is partly due to the fact that they actually receive poorer quality care has only recently attracted serious attention. The authors of one U.S. review of over 100 studies[1] on healthcare delivery reported that they were "struck by the consistency of findings" that "minorities are less likely than whites to receive needed services, including clinically necessary procedures" (p 2). The disparities occurred irrespective of disease type or type of procedure, appearing in the treatment of cancer, cardiovascular diseases and mental illness and in major interventions as well as routine procedures for common health problems.

Similar results have been obtained in Australia. Despite excess mortality and morbidity, Indigenous people actually receive *less* specialist healthcare both as inpatients and outside hospitals. Cunningham[2] showed that Indigenous patients were less likely than other patients to have a major procedure, even after adjusting for patient, episode and hospital characteristics. These findings held for most diseases and conditions and the author concluded that there were "systematic differences in the treatment of patients identified as Indigenous".

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[1] Institute of Medicine (2002) *Unequal Treatment: What Healthcare Providers Need to Know about Racial and Ethnic Disparities in Health Care.*

[2] Cunningham, J. (2002) Diagnostic and therapeutic procedures among Australian hospital patients identified as Indigenous. *Medical Journal of Australia*, 176 (2): 58-62.

Other studies have also shown differences in treatment, including for cancers, and unequal access to cardiovascular healthcare. A recent exploratory study[3] in W.A. reported that Aboriginal people with lung or prostrate cancer were less likely to receive a surgical procedure for their cancer than the non-Indigenous population. It is now generally agreed that the phenomenon of fewer and poorer health care services for racial and ethic minorities is real, and not explained by the behaviour of the recipients. As well as systemic factors prevalent in the operation of many health care systems – such as cultural and linguistic barriers and fragmentation of care - provider behaviour in the clinical encounter also appears to be implicated.

When doctors and other health care workers interact with people from racial and ethnic minorities both uncertainty and stereotyping appear to influence their behaviour. There is a considerable body of evidence from a variety of countries that health care providers *do* hold stereotypes based on patient race, class, sex and other characteristics and that these stereotypes *do* influence their interpretation of patient communications and symptoms and, inevitably their clinical decisions, often to the detriment of the minority group member.

One U.S. study found that doctors rated black patients as less intelligent, less educated, more likely to abuse drugs and alcohol, less likely to comply with medical advice, lacking in social support and less likely to participate in cardiac rehabilitation.[4] Even people who express explicitly egalitarian views may hold negative ethnic and racial stereotypes of which they are unconscious. Such unconscious biases - sometimes called aversive racism - may be just as destructive as those which are more obvious. Usually, such attitudes do not result in expressions of hatred or open contempt, but rather in anxiety and discomfort, which lead to avoidance.

Whites tend not to recognise when their actions are racially biased but they inevitably provide nonverbal cues which may signal negativity and produce distrust. One of the common findings in the U.S. research on prejudice is that whites often report feeling anxious while interacting with blacks, leading them to seek to avoid such occasions. In the clinical encounter, this may result in White doctors and nurses engaging in avoidance behaviour, including spending less time with the patient. The discrimination is subtle yet systematic, influencing judgments and interaction, including cues to

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[3] Hall, S. Bulsara, E, Bulsara, M, Leahy, T, Culbong, M, Hendrie, D & D'Arcy, C. (2004) Treatment patterns for cancer in Western Australia: does being Indigenous make a difference? *Medical Journal of Australia,* 181 (4):191-194.
[4] van Ryn, M., & Burke, J. (2000) The effect of patient race and socio-economic status on physicians' perceptions of patients. *Social Science & Medicine,* 50, 813-828.

friendliness of lack of it. Such responses are especially likely when practitioners are under time pressure to solve complex diagnostic problems. If the patient is alert to signs of prejudice, then such avoidance will be interpreted as reflecting hostile attitudes and so compromise the patient-provider relationship.

Aversive racism in this more subtle and indirect form, which we know also occurs amongst Australians, is most likely to produce poorer treatment when doctors are required to exercise considerable discretion – such as recommending a test or making a referral – and least likely when little discretion is involved – such as emergency surgery. For example, Black women are less likely than White women to be tested for osteoporosis and less likely to receive appropriate medication, once they have been diagnosed.[5]

One study[6] found that doctors were less likely to refer black female patients - actually videotaped actors trained to display the symptoms of cardiac disease – for cardiac catheterization than white females "exhibiting" the same symptoms. Similarly doctors[7] presented with hypothetical descriptions of cardiac patients showed more implicit negative attitudes toward blacks and stronger stereotypes of blacks as unco-operative patients. The more negative the attitudes, the less likely they were to recommend appropriate drug therapy. There is a lack of similar research in Australian medical settings, but no reason to believe that our responses would differ markedly.

A major review[8] of studies of consultations involving minority group members concluded that such patients are less likely to engender empathic responses from doctors, less likely to receive adequate information and less likely to be engaged partners in medical decision making. Comparisons of videotaped recordings of White doctor-Black patient interactions with White on White interactions have also shown shorter consultations, greater verbal

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[5] Dovidio, J., Penner, L., Albrecht, T., Norton, W., Gaetner, S. & Shelton, J. (2008) Disparities and distrust: The implications of psychological processes for understanding racial disparities in health care. *Social Science & Medicine*, 67: 478-486.

[6] Schulman, K., Berlin, J., Harless, W., Kerner, J., Sistrunk, S. & Gersh, B et al (1999). The effects of race and sex on physicians' recommendations for cardiac catheterization. *New England Journal of Medicine,* 340: 618-626.

[7] Green, A., Carney, D., Pallin, D., Ngo, L., Raymond, K. & Iezzone, L et al. (2007). The presence of implicit bias in physicians and its predictions or thrombolysis decision for Black and White patients. *Journal of General Internal Medicine, 22: 1231-1238.*

[8] Ferguson, W. & Candib, L. (2002). Culture, language and the doctor-patient relationship. *Family Medicine,* 34: 353-361.

dominance by the doctor, the provision of less information and fewer attempts to engage the Black patient in joint decision making.[9]

Given such experiences, it is not surprising that members of minority groups have been shown to have less trust in the health care system and in health care providers than the rest of the community. This is all the more important because there is evidence that the worse the doctor-patient relationship, the poorer the recall of medical information, the poorer the adherence to recommended treatment and the poorer the health outcomes. Added to this, of course, are the direct effects that experiences of racism and discrimination have on health and wellbeing.[10]

Without acknowledging such behaviours, we are unlikely to do anything to reduce them.

But even when prejudicial ideas are largely unconscious, strategies and skills can be taught[11] to reduce their effect in relationships between service providers and racial and ethnic minorities. Hiding out collective heads in the sand certainly won't help.

Added to this are the direct effects that experiences of racism and discrimination have on health and wellbeing – and most Indigenous Australians experience racism on a regular basis. A recent review[12] of 138 empirical studies of the association between self-reported racism and health showed that the most consistent findings related to negative mental health outcomes and health-related behaviours such as smoking and alcohol consumption. Furthermore, the longitudinal studies indicate that the experience of racism precedes ill health rather than vice versa. Research by Larson et al[13] examined whether the experience of interpersonal racism had a measureable effect on the health of Aboriginal West Australians. They found higher rates of racially based negative treatment for Aboriginal people than

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[9] Johnson, R. L., Roter, D., Powe, N. R., & Cooper, L. A. (2004). Patient race/ethnicity and quality of patient–physician communication during medical visits *American Journal of Public Health*, 94, 2084–2090.

[10] Paridies, Y. (2006). A systematic review of empirical research on self-reported racism and health. *International Journal of Epidemiology,* 35: 888-901.

[11] [11] Burgess, D., van Ryn, M., Dovidio, J & Saha, S. (2007) reducing racial bias among healthcare providers: Lessons from social-cognitive psychology, Society of general Internal Medicine, 22: 882-887.

[12] Paridies, Y. (2006). A systematic review of empirical research on self-reported racism and health. *International Journal of Epidemiology,* 35: 888-901.

[13] Larson, A., Gillies, M., Howard, P & Coffin, J. (2007) It's enough to make you sick: the impact of racism on the health of Aboriginal Australians. *Australian and New Zealand Journal of Public Health,* 31 (4): 322-329.

for others interviewed (40% within the previous four weeks) and such experiences were significantly associated with poorer physical health and mental health.

Some researchers have suggested that the mechanism for this relationship is the same as for many chronic psychosocial stressors: changes to the neuroendocrine, autonomic and immune systems which ultimately compromise the individual's health. Laboratory studies and some epidemiological investigations have found that perceived discrimination is associated with increases in blood pressure and hypertension. When the perceived discrimination is persistent, it appears to predict coronary artery calcification and coronary events.[14]

One of the other consequences of being subjected to pervasive negative stereotypes is that such views are actually internalised by members of the minority group. This means that those who are subjected to constant negative stereotypes come to accept as valid the dominant culture's views about their inferiority. Research has shown that those who do internalize these views about themselves are more likely to consume alcohol to excess, to exhibit psychological distress and psychological problems such as low self esteem, feelings of isolation and identity crises.[15]

Although I have focused on health, this is not to condemn healthcare providers, many of whom work very hard under challenging conditions to ensure that patients get the best care possible, nor to suggest that they are alone in expressing such bias. The same tendencies almost certainly exist with other professionals who have been less extensively studied. It is certain that stereotypes and prejudice toward Aboriginal people, both overt and covert, operate in most areas of policy development and service delivery. This is nowhere more evident than in the NT intervention and the public discussion surrounding remote Indigenous communities.

The conclusion we were invited to draw from the style and content of the intervention was that the Aboriginal people in such communities are so completely debased that there are none among them capable of being partners in addressing the depressing catalogue of disadvantage; only outsiders could properly diagnose the problems and devise the solutions. As

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[14] Lewis, T, Everson-Rose, S., Powell, L., Mattews, K., Brown, C Karavalos, K et al. (2006) Chronic exposure to everyday discrimination and coronary artery calcification in African-American women: The SWAN heart study. *Psychosomatic Medicine,* 68: 362-368.

[15] Taylor, J & Jackson, B. (1990) Factors affecting alcohol consumption in black women, part II. *International Journal of Addiction,* 25: 1425-1427.

anyone who has ever worked to reduce socially destructive behaviours will bear witness, reinforcing a sense of powerlessness is precisely the opposite of what is needed to generate sustained change. What's more at the core of the policy which provided for uniform constraints to be placed on welfare is the racist assumption that "all blackfellas are the same"; Indigenous people in remote communities are stereotypically portrayed as violent, abusive, drunks entirely dependent on welfare.

Apart from the sharp insult, what message does it send parents who are providing good care for their children when they are placed on the same quarantining regime as those who abuse and neglect their children? This is the antithesis of making people responsible for their lives; it reduces their ability to take control. While some would argue that the breakdown in social controls within Indigenous communities has been so complete that nothing short of the surrender of key decisions to others will suffice to engender change, it is precisely the corrosion of self efficacy – and the knowledge that you are not respected - which is at the root of much of this social collapse.

My prediction is that any gains which rely on coercion are likely to be short-lived, not least because the psychology underpinning the measures is perverse: there may be compliance with the measures – indeed, by definition, people have little choice but to comply – but once the restrictions are removed, or those affected remove themselves from their coverage, no fundamental change in attitudes or behaviours will have occurred. In fact, what this element of the intervention will do is to reinforce the sense of powerlessness which is already so pervasive amongst the people now subject to the intervention. And this is not the first time they've been subjected to the will of others, with painful consequences; decisions about their lives have been taken from their hands many times before: the appropriation of land, the removal of children, the forced relocation of families and communities, the attacks on language and culture.

Much government policy in Indigenous affairs reflects the failure to apply even the most rudimentary principles of social science to understanding why there are so many social problems and what should be done to reverse them. Understanding concepts like learned helplessness, locus of control, self fulfilling prophecies and attribution theory, for example, would undoubtedly assist in devising better policy.

In "Why Warriors Lie Down and Die", Richard Trudgen drew attention to the pernicious effects of "learned helplessness" amongst the Aboriginal people of Arnhem Land. It is a concept well understood in psychology and encompasses research which shows that when people repeatedly experience unpleasant events over which they have no control, they will not only experience trauma, but will come to act as if they believe that it is not possible to exercise control over any situation and that whatever they do is largely futile. As a result, they will be passive even in the face of harmful or damaging circumstances which it is actually possible to change.

Evidence given by the Australian Indigenous Doctors Association to the Commonwealth body appointed to review the effects of the NT intervention underlined this problem. The doctors argued that the intervention had 'created a feeling of "collective existential despair" … characterised by a widespread sense of helplessness, hopelessness and worthlessness, and experienced throughout entire community(s)'[16] Similarly, research on black American students has shown that those who experience discrimination and powerlessness are more likely to attribute their successes – or failures - to outside forces than those who do not; they exhibit what is called an "external locus of control" which is, in turn, related to poorer academic performance and poorer health care. There is no reason to believe that results would be different for Indigenous Australians.

Coming to accept that others control your life and that nothing you can do will really make much difference is already a crippling combination of attitudes. Add to it the well known effect of the "self fulfilling prophecy" and you have a recipe for the social disorder evident in varying degrees in many Indigenous communities. A self-fulfilling prophecy occurs when expectations about an individual's behaviour cause that person to act in ways which confirm the expectations. The phenomenon has been measured in many situations and it is clear that minority groups in any society are the most vulnerable to such effects, especially if the expectations are negative and constantly repeated.

[16] Northern Territory Emergency Response Review Board 2008, *Report of the NTER Review Board*, Australian Government, Canberra; AIDA 2008: [17]).

So often do Indigenous Australians hear that they sick, lazy and unproductive that they internalise these opinions and become convinced of their own unfitness. African Americans told in advance that blacks perform more poorly on exams than whites had lower scores on an examination than control subjects who were not confronted with such a prejudiced claim about intellectual inferiority[17].

Research in the U.S. has shown that the more people internalize racist ideas about their group, the higher the level of alcohol consumption and psychological distress, including depression, low self-esteem and feelings of isolation. Dependency is an inevitable by-product of learned helplessness; many Indigenous people are now so accustomed to having things done to them and for them, rather than being active participants, that they have lost their sense of mastery, competence and self respect. The key elements of the intervention almost seem to have been designed to reinforce this dependency rather than to cultivate a relationship between government and Indigenous people which will enhance their social responsibility and their willingness to exercise it.

These effects are unlikely to be modified unless serious efforts are made by government to engage Indigenous people in ways that were not contemplated in the initial action. As Treasury Secretary Ken Henry argued, Indigenous Australians must 'own' both the problem and solution if behavioural and attitudinal change is to be achieved. Imposed solutions are unlikely to be real solutions at all.

Fred Chaney suggested in the 2007 Lingiari Lecture, that the intervention is sanctioning "an absurd and unattainable level of micro management of Aboriginal lives" far beyond the capacity of the federal bureaucracy to deliver. And we might add that despite their avowedly good intentions, their actions are likely to be guided by the same racial stereotypes and prejudice uncovered in medical encounters and evident in the design of the intervention.

As NT and Indigenous parliamentarian Marion Scrymgour made clear "everyone supports a serious and properly resourced set of initiatives to combat child sexual abuse" – and I would add community violence more generally. But the previous government's program did not even begin to meet that description. To do any better, the new government would be wise to

[17] Steele, C.M (1997) A threat in the air: How stereotypes shape intellectual identity and performance. *Am Pshcyol,* 52: 613-29.

heed Fiona Stanley's advice: "measures that exclude the views and involvement of Aborigines will serve only to further diminish their capacity, exacerbate marginalisation and add to the damage in these vulnerable communities."

What can be done?

Policy makers are now at least prepared to name racism as one of contributing factors to health disparities and other disadvantage faced by racial and ethnic minorities. To address these inequities requires change at every level of society, from the individual through to our national government. The ideas and values which underpin our institutional and public policy need to be tested – and continually tested - for prejudicial and racist attitudes.

Such a re-examination cannot take place without governments' participation and leadership. The task is to dismantle institutionalised racism and discrimination in Australian public policy and to reduce racial bias amongst service providers and policy makers – not to mention politicians and the media.

Even when prejudicial ideas are largely unconscious, strategies and skills can be taught which prevent these prejudices from adversely affecting relationships between service providers and racial and ethnic minorities. Following the suggestions of Burgess and her colleagues[18], these can include programs to:

1) Motivate providers to reduce bias – research shows that with sufficient motivation people are able to focus on the unique characteristics of each individual rather than on the groups they belong to;
2) improve providers' understanding about the psychological bases of bias, enabling them to understand their own potential biases in a more open way and without shame and denial;
3) enhance providers' confidence in their ability to interact with people who are culturally dissimilar – the best way is through regular contact and discussion;
4) improve emotional regulation skills, including developing greater empathy and better understanding of the perspective of minority group members; and
5) develop the ability to build partnerships with service users - it is particularly important to redefine the relationship as one between

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[18] Burgess, D., van Ryn, M., Dovidio, J & Saha, S. (2007) reducing racial bias among healthcare providers: Lessons from social-cognitive psychology, Society of general Internal Medicine, 22: 882-887.

> collaborating equals rather than between one high status person, the provider, and one low status person. We know that privileging one's own group is a near universal occurrence and hard to resist, so creating a partnership is also useful because it facilitates common group identity and reduces both conscious and unconscious racial biases. In policy making, this means fully engaging Indigenous people in planning and service delivery.

In doing this we need to insist that the needs of indigenous people are accorded the same priority as are those of the rest of the community. Community safety is just as important in a remote Indigenous community as it is in suburban Sydney; treatment and rehabilitation for chronic drug and alcohol abuse as necessary in Palm Island as in North Ryde. In both communities it is obvious that such help will be of little use unless it is provided with respect and compassion, in a culturally appropriate manner by people who are trusted and who are alert to their own prejudice.