

LIME GOOD PRACTICE CASE STUDIES

RACE AND RACISM

Keynote Presentation: Race is real and so is racism – Making the case for teaching race in Indigenous health curriculum

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Introduction

One could well argue that the case has already been made for including the study of race and racism within the Indigenous health curriculum. More than a decade ago the Committee of Deans of Australian Medical Schools developed the Indigenous Health Curriculum Framework, which recognised the importance of teaching students about racism. The framework states that health services, systems and professionals should be free of racism (Phillips 2004:7), and that key student attributes and outcomes should include the ability to identify features of overt, subtle and structural racism or discrimination in interactions between patients and health professionals and systems, ways of addressing such occurrences, and the acquisition of skills to advocate both for their resolution and to explain the connection between history and present health outcomes – including the forms and impacts of racism.

In 2011, Universities Australia developed a National Best Practice Framework for Indigenous Cultural Competency in Australian universities and identified key content areas which included:

- concepts of culture, race, ethnicity and worldview
- myths and misconceptions about, and stereotypes of, Indigenous people
- notions of whiteness, white privilege and power
- reflection on cultural identity, whiteness, privilege, values, beliefs, attitudes, prejudices and propensity to stereotype
- racism and anti-racist practices (Universities Australia 2011:72).

Yet there remains a deep level of discomfort among health educators in teaching race and racism, as evidenced in a recent national consultation to develop the Aboriginal and Torres Strait Islander Health Curriculum Framework (Taylor, Kickett & Jones 2014). Commissioned by Health Workforce Australia the consultations revealed significant concerns among health educators with teaching content that included 'racism', 'whiteness' and 'stereotyping' as they were deemed to be 'negative'

and focused on 'deficit' (2014:38). Health education stakeholders expressed their discomfort with teaching the concept of whiteness arguing that it 'promotes colourism' (2014:75) and 'binary or reductionist thinking' (2014:46). One health education stakeholder pointed out that 'not all privileged students are white and not all white people are privileged' (2014:49). Others suggested abandoning the term 'race' in favour of 'culture' because race is an 'ideology rather than a biological fact' (2014:73). Respondents also raised concerns about the student learning experience, suggesting there was a need for 'moving away from blaming and shaming' and 'guilt and berating' (2014:6), and that educators should 'keep the politics out of content and education' (2014:7) and ensure 'students aren't polarised' (2014:12).

Instead, health education stakeholders argued that the curriculum should emphasise 'good news statistics/positive stories of shared history and programs which have positive outcomes' (2014:12), and avoid 'historically polluting' in favour of 'recognising – and celebrating history as a shared experience' (2014:17). Health education stakeholders cautioned about the 'delicate nature and potentially offensive associations that may occur by using contentious or "coloured" words such as "white" and "black"' (2014:14), and expressed concerns with the 'saturation of too many facts and figures where "white people are seen as evil and Aboriginal people as fragile"' (2014:21).

While these concerns did not prohibit the inclusion of racism, anti-racism and white privilege as core curriculum themes within the recently released Aboriginal and Torres Strait Islander Health Curriculum Framework (Department of Health 2016), the consultations that led to its development provide revealing insights into the ways in which health educators are thinking about race and racism. We witness in the consultations various attempts by health education stakeholders to minimise race and racism as categories of analysis in understanding Indigenous health inequality through a pedagogical logic of student 'comfortability', and more specifically white student 'comfortability'. Several claims made by health educators demonstrate a lack of conceptual understanding of race, racism and whiteness, which undermines attempts to understand how race works to produce health inequalities.

Rather than make a case for excluding the teaching of race and racism within Indigenous health curricula the Health Workforce Australia consultation findings demonstrate the critical and pressing need to develop race scholarship within health so as to counter the resistance and reticence among many health educators to exploring race and racism. This paper examines some of the claims about race and racism made by health education stakeholders consulted in the development of the Aboriginal and Torres Strait Islander Health Curriculum Framework, and offers three counter-claims that evidence the 'realness' of race and racism – as lived, as a field of academic inquiry and as a determinant of Indigenous health inequality.

Race is real

The revelation that race isn't real biologically has led to the insistence that race isn't real altogether. We observe in the Health Workforce Australia Consultations the recommendation by health education stakeholders that race be avoided in favour of culture because race is an 'ideology' rather than a 'biological fact' (2014:73). However, just because there are no 'immutable, biologically based differences between "racial" groups' (Smedley & Smedley 2005:16) does not make redundant the concept of race as a category of analysis within the health sciences. Socially 'race remains

a significant predictor of which groups have access to societal goods and resources and which groups face barriers... to full inclusion' (Smedley & Smedley 2005:22). The profound health inequalities that Indigenous people experience is evidence of the pervasive nature of race as a social construct – not talking about race does not render it less powerful or less real. Proclaiming that race is not real does not minimise racism as a lived experience; instead it trivialises the trauma of those who experience it and enables indifference to the very real and ever-present racialised inequalities that exist in our society.

The insistence that culture is an appropriate replacement for race in explaining differential health outcomes is a discursive shift that does not remedy the biologically deterministic claims of race that we are seeking to avoid. While Indigenous people are not a 'race', 'Indigenous status' is a racial category and Indigenous bodies are inscribed with racialised logics, which are not absolved by using the term 'culture'. Let's consider the issue of patients discharging from hospital against medical advice. A recent analysis of data collected between 2011 and 2013 (Department of Prime Minister & Cabinet 2015:146) found that:

Indigenous status was the single significant variable contributing to whether a patient would discharge themselves from hospital against medical advice, even after controlling for the other factors [emphasis added].

If we focus on culture as an explanation for this behaviour, we can locate the blame with the Indigenous patient and/or Indigenous culture via discourses of compliance and/or cultural misunderstandings and miscommunications. However, focusing on culture instead of race prohibits us from understanding how health care services work systematically to produce this racialised health outcome.

Race, culture and ethnicity are not interchangeable concepts and the task of differentiating between and disentangling them often proves difficult. Indigenous health curricula must provide greater conceptual clarity around these terms if it is to provide students with the 'critical ability to read and interpret the world through the category of race' (Headley 2014:115). Within our health disciplines, we can observe strong disciplinary traditions of operationalising race according to imagined biological, social and cultural differences. However, we have yet to achieve strong disciplinary traditions of attending to race as a category of analysis in furthering our understanding of the production of health disparities.

Teaching race is not teaching guilt

Within the Health Workforce Australia report, student 'comfortability' emerged as a priority in the development of Indigenous health and medical curriculum, which according to health education stakeholders was undermined by the introduction of University Australia's proposed teaching principles of 'stereotyping', 'whiteness' and 'racism and anti-racism practices' (Taylor, Kickett & Jones 2014:67–8). These stakeholders felt that the task of developing students' racial literacies was polarising and politicising as well as guilt inspiring and pedagogically problematic. The insistence that Indigenous health inequality, and any analysis of the conditions that have produced it, be taught in a celebratory and apolitical way is most puzzling.

We all embody racialised positions, and we all hold 'strong emotional ideological commitments... to positions about race' (Hall 1983:259). Thus, conversations about race and racialised inequalities may well be uncomfortable for students (and health educators) because it shifts the gaze away from the culture of Indigenous people and requires us to think critically about our social world and our place within it. Di Angelo (2011:60–1) argues that the expectation of comfort in conversations about race is unrealistic, and is a further example of white race privilege enabling conversations about racism to be avoided.

Health educator inferences that teaching about race and racism is synonymous with teaching blame and guilt demonstrates that health educators are engaging with race and racism emotionally rather than intellectually. As health educators we need to make clear our own commitments and feelings about how we address race and what we say about it, but we also must recognise that teaching about race and racism it is not simply a matter of how we or our students 'feel' about it. Hall (1983:263) advises against teaching race in terms of attending exclusively to discriminatory attitudes, feelings and prejudices, stating:

We have to uncover for ourselves in our own understanding, as well as for the students we are teaching, the often deep structural factors which have a tendency to persistently not only generate racial practices and structures but reproduce them through time which account for their extraordinarily immovable character.

The task of developing and implementing the Aboriginal and Torres Strait Islander Health Curriculum Framework is paradoxically placed in that it is informed by the experiential knowledge of health care educators who are not trained in critical race studies, and thus fail to discern between 'race talk' and 'racist talk'. The challenge remains for us, then, as to how we can have informed debate about the inclusion of race and racism or race pedagogies if we, as health educators, have limited intellectual engagement with these concepts? How might we get to a position which recognises that to teach about race is not racist, but rather that pretending race doesn't structure health outcomes is?

Remedying racism beyond the Indigenous body

The Health Workforce Australia findings posed important questions regarding the requirements placed upon Indigenous bodies in remedying racialised health inequalities via health curriculum content. Health educators recommended that students be exposed to 'good news statistics' (Taylor, Kickett & Jones 2014:12), and insisted that articulations of Indigenous health inequality should focus on shared celebratory historical narratives and avoiding 'too many facts and figures "where white people are seen as evil"' (2014:21). Given the current state of Indigenous health, these requirements by health educators suggest a preoccupation with preserving the moral virtue of white people in the task of teaching about the health inequalities that Indigenous people experience.

The focus on Indigeneity as a means of moderating the health effects of racism is hardly surprising given that much of Australian public health interest in racism and Indigenous health outcomes attends to Indigenous bodies as the site of intervention. Although the international public health literature refers to racism as operating both structurally and at the level of the individual to produce poor health (Smedley 2012), much of the Australian Indigenous health literature focuses on the incapacity of Indigenous bodies and minds (Paradies 2005; Larson et al. 2007; Ziersch et al. 2011;

Priest et al. 2011; Bodkin-Andrews et al. 2013; Australian Government 2014). Intervening in structural and institutional racism demands of us an understanding of the health effects of racism beyond the Indigenous body. Yet the Australian Indigenous health literature is largely preoccupied with the mental incapacities of Indigenous bodies to withstand racism evidenced by findings which suggest that Indigenous people need to be taught how to be more resilient to racism (Bodkin-Andrews 2013), and/or that Indigenous parents be supported to teach their children how to cope with racism better (Paradies 2005:15). This literature's fixation on strengthening the minds of Indigenous peoples as an effective anti-racist health intervention bears a disturbing similarity to the racist pseudo-scientific theories that insisted Aboriginal people were 'feeble minded' (Anderson 2006:217).

However, the causal pathway between racism and racialised health inequality is not due to Indigenous imaginings or interpretations of racism. Therefore, its health impacts will not be remedied through the better behaviours of Indigenous people either in everyday life or in their presentation within Indigenous health curricula. Race shapes the way in which our world is structured. Even anti-racist discourse in Indigenous health – with all of its good intentions – cannot escape reproducing the racialised logics of the 'Indigenous problem', which 'assume that the locus of a particular research problem lies with the Indigenous individual or community rather than with other social or structural issues' (Tuhiwai-Smith 2012:95). Thus, in the process of teaching about racism we must also be critically conscious of the racialised logics we are deploying.

Conclusion

Race is real, and so is racism, in producing the profound health inequalities experienced by Indigenous Australians. As such, the development of an Aboriginal and Torres Strait Islander Health Curriculum Framework and the teaching of Indigenous health cannot be solely informed by the emotional and experiential knowledge of race and racism. Despite the inclusion of race and racism in successive Indigenous health curriculum frameworks, these Health Workforce Australia consultation findings demonstrate the need for tools and training that will enable health educators to develop conceptual frameworks and cognitive devices to teach race in ways that support students to move beyond their feelings to an informed understanding. It is worth noting that some Australian institutions have already taken up the challenge of engaging in a deeper criticality of health inequality in Indigenous health and medical education (McDermott & Sjoberg 2012).

However, important conversations among health educators about the pedagogics of teaching race, as well as more critical conversations about the various causal pathways between racism (individual and systemic) and health within our classrooms and our research, awaits initiation. This paper contends that our ability to partake in these conversations is hindered by the absence of critical race studies within public health, and Australian scholarship more broadly. As a result, the Aboriginal and Torres Strait Islander Health Curriculum Framework, which could be a critical tool in reducing Indigenous health disparities, remains immobilised by the sector's inability to move beyond the embodied consequences of racism and race as emotive and experiential responses.

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