Cultural safety and work practice

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Robyn Williams' paper,[1] 'Cultural safety: what does it mean for our work practice?' is an interesting and relevant piece of work. However, it is based on a simplistic binary model which is inadequate to deal with the complexity of contemporary Australian society.

While the non-Indigenous population of Australia is predominantly Anglo-Celtic and Christian, it also has an enormous number of groups from European, Asian and African backgrounds representing most of the world's major linguistic and religious groups. There are also considerable differences in terms of education, English-language skills and socio-economic background.

This diversity is generally ignored in cross-cultural training programs which are an important strategy for health professionals to identify and deal with difference. Programs generally use binary models, i.e. 'white' (essentially Anglo-Saxon) versus either Indigenous or non-English speaking backgrounds (NESB). The differences within each of these categories, and complex dynamics among the non-Anglo-Saxon groups remain unexplored.

Anecdotal evidence indicates the relationship between Indigenous and NESB groups, particularly those who belong to what are termed 'visible minorities' to be particularly complex. Both groups are physically distinct from the dominant culture. Many visible minority groups come from countries which have been subjected to some form of European colonisation. However, these commonalities do not necessarily create a bond between the two. On the contrary, the relationships between Indigenous and visible minorities may be even more fraught with tension than the relationships between each and the dominant culture. This could be attributed to several factors:

- Colonisation and dispossession of Indigenous peoples which have relegated the majority to the lowest socio-economic and political rungs of Australian society.
- The planned migration program which has created anomalies (until 1967) such as migrants being able to acquire citizenship while Indigenous peoples could not.
- Some visible minority groups (such as Indians or Chinese) occupy a high status in the socio-economic hierarchy; others, such as the Vietnamese, are at the bottom end. Both may be viewed as competing for scarce resources with Indigenous groups.
- Regardless of their socio-economic status, visible minority groups are generally not included in mainstream perceptions of the 'real Australian'. The tensions created in the quest for identity within the Australian context may inhibit inclinations to recognise discrimination against Indigenous communities and to participate in processes aimed at redressing this situation.
- Stereotyped perceptions about Indigenous peoples among visible minority groups which is probably due to a mix of prejudices inherent in their ethnic and cultural make-up (many come from countries with their own histories of the oppression of Indigenous communities), as well as the internalisation of dominant culture attitudes.
- Negative attitudes towards visible minority groups among Indigenous communities which are created by all of the abovementioned factors.

Despite this, there exist many positive kinship and friendship ties among Indigenous peoples and visible minorities. In recent years, many non-European groups have articulated support for Indigenous aspirations and begun participating in the reconciliation process.

For people from non-European backgrounds (and perhaps non-English Speaking Backgrounds [NESB] in general), to participate in the process of ensuring cultural safety for Indigenous people, it is necessary to develop programs which recognise this diversity and complexity.

A viable policy of cultural safety would need to be underpinned by a code of conduct that stresses the need for respect for all cultures, irrespective of one's own ethnicity or level of disadvantage. Overlaying this would be the need to impress non-Indigenous people of the need to respect Indigenous communities as the First Peoples of Australia, to learn about their history and culture, and the structural barriers that impede their achieving equity within the wider Australian system.

References

1. Williams R. Cultural safety: what does it mean for our work practice? *Aust N Z J Public Health* 1999; 23: 213-4.

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R. Williams' response:

Space did not permit me to specify that my Point of View was based on a much longer and more detailed paper delivered at the 30th Annual Public Health Association of Australia (PHAA) Conference 1998.

In this paper, I clearly stated that I was only writing from my perspective as a non-Indigenous person working in Indigenous health and education in the Northern Territory. Therefore, I was not going to include anything other than my personal and political perspectives in that context.

My experience and reflections in this Point of View are specific to health and education service delivery for Indigenous Australians, and are not based on a 'simplistic binary model'.

History of contact and interaction between people from NESB and Indigenous peoples in Australia is a hugely complex area which requires analysis and comment from those more appropriate than myself.

At a general level it would be difficult to have a Code of Conduct for all in terms of respect for other cultures, as Indigenous peoples in Australia do not start from the same premise as migrants for example.

My main aim in writing on cultural safety is to encourage people to examine the issue in relation to their own work practice,

especially (but not exclusively) those in cross-cultural environments. My aim is not to 'identify and deal with difference'. I have huge questions about my work practice and I am merely looking for ways to provide a more effective, appropriate and useful service. This is becoming increasingly difficult in the face of the 'normalisation' agenda of the Federal Government and the national competency juggernaut in industry and education.

I welcome the comments about my Point of View, particularly in relation to the people from non-English speaking backgrounds and so on. This is an aspect or avenue of the debate which needs much more exploration. May the dialogue continue.

Childhood leukaemia and TV towers: the debate continues

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In 'Childhood leukaemia and TV towers revisited',[1] Hocking et al. attempt to refute doubts raised by McKenzie et al.[2] regarding their claims that radiofrequency radiation (RFR) from television towers in Northern Sydney is linked to elevated incidence of and mortality from childhood leukaemia and brain cancer.[3] The 'refutation' is based essentially on four broad grounds (although these were repeated a number of times under seven points), which we answer in turn:

1. "That it is not only bad practice but dangerous to search for observations with a view to omitting them from the analysis: the inferences drawn from such an analytic strategy may be quite misleading"; i.e. there was no *a priori* reason to single out a local government area (LGA) with a high disease incidence because a heterogeneity test failed to reach statistical significance when comparing the incidence in the LGA with the remaining 'high exposure' LGAs. Furthermore, we are accused of 'testing individual LGAs for time trends is a post hoc analysis at variance from the a priori hypothesis'.

We agree that it is indeed bad practice to search for observations with a view to omitting them, and that there is no *a priori* reason to single out an LGA for omission with a high incidence. However, this is not an argument for not subjecting the data to the normal epidemiological criteria for causation, as outlined by Bradford Hill for example.[4] These include relating disease outcomes to exposure levels, both cross-sectionally and over time. As we showed in our original paper, and again below, cross-sectionally, the relationship fails to stand up. With regard to a possible dose-response relationship occurring over time, essentially we are accused of assuming that for a dose-response relationship to exist it should be linear. That dose-response relationships are not necessarily linear but may be subject to 'saturation' threshold effects, by interactions with other exposure conditions or by whether exposures are intermittent or constant, is not the issue. As for childhood leukaemia incidence, there was a decrease in the number of incident cases over the period coinciding with increased RFR exposure (when television transmissions became 24-hourly). The issue is that if a positive dose response exists (i.e. increasing cases with increasing exposure, which can be consistent with a linear or a non-linear relationship), then there should, at the very least, be no decrease in the number of cases with increases in exposure. That there was no significant time trend of increased leukaemia incidence with increased exposure illustrates the lack of an association. The term for this kind of relationship is 'null', not whether it is linear or non-linear. Accordingly, Bradford-Hill's basic criteria of a positive dose-response relationship over time was not met.

Hocking et al.[1] quote non-significant p-values (0.10 and 0.13) for their test of heterogeneity "within the inner and outer areas for total childhood leukaemia incidence and mortality" to justify not looking more closely at the data. In our original paper,[2] we explored the extent of homogeneity under the null hypothesis and under Hocking et al.'s hypothesis[3] and showed that under both assumptions there was statistically significant heterogeneity in childhood leukaemia incidence among the LGAs, sufficient to cast doubt on Hocking et al.'s *and* the null hypothesis. Because of these findings, the present authors concluded that the television tower hypothesis was much weaker than that claimed by Hocking et al.

The table presented by Hocking et al. in their 'refutation' of our claims is suitable for illustrating the extent of 'homogeneity' of childhood leukaemia incidence risk, since it is possible to estimate this by simple chi-square statistics directly from the table (since none of the expected values in the table is less than five). Our calculations show that the chi-square value for Hocking et al.'s 'Inner' region of LGAs was 28.1 (2 df, $p<0.001$), and for the 'Outer' region was 3.6 (5 df, $0.5<p<0.75$). That is, there is highly significant heterogeneity in the 'Inner' LGAs due overwhelmingly to the single outlier LGA, but not in the 'Outer' LGAs – contra Hocking et al. From a hypothesis-free perspective, it would be difficult to conclude on *a priori* grounds that the clear excess in the single LGA was due to television towers. Conversely, from the television tower hypothesis perspective, *a posteriori* the absence of a leukaemia excess in the similarly highly exposed LGA again makes it very difficult to support the television tower hypothesis. These considerations throw into grave doubt, on both *a priori* and on *a posteriori* grounds, any relationship between broadcast tower radiation and childhood leukaemia.

2. Our figure denoting a relationship between socio-economic status of suburb and incidence of childhood leukaemia is criticised as 'misleading' because confidence intervals were not inserted around the incidence rates, and that differences in the underlying variance of childhood leukaemia incidence between