RESEARCH DISCUSSION PAPER

Back to Redfern
Autonomy and the 'Middle E' in relation
to Aboriginal health

Ernest Hunter
Regional Psychiatrist, Queensland Health
Adjunct Professor, School of Population Health,
University of Queensland

AN AIATSIS RESEARCH DISCUSSION PAPER

Back to Redfern:

Autonomy and the 'Middle E' in relation to Aboriginal health

Ernest Hunter

Regional Psychiatrist, Queensland Health;
Adjunct Professor, School of Population Health, University of Queensland

Contents

ABSTRACT

ABC's flagship current affairs program *PM* for 21 June 2006, juxtaposed three Indigenous items. The first recorded the launch in Canberra of *Australia's Health 2006* by the Commonwealth government minister of health, Tony Abbott, in which he called for a new form of paternalism ("a paternalism based on competence rather than race") to address unrelenting Indigenous health problems associated with failed past policies including 'self determination'. The item also included the immediate reactions of Indigenous spokespersons who, in noting that self-determination had never been realised in practice, objected strenuously to further erosions of autonomy. The second item presented evidence of adults exchanging petrol for sex with children and young people, and the impunity of perpetrators, in Central Australian Aboriginal communities. Perhaps to mitigate the sombre tone of these two stories, the third item recounted the successes of the Aboriginal Employment Strategy in providing real employment opportunities for Aboriginal residents of Moree. Paternalism, autonomy, vulnerability, opportunity – these terms are ambiguous and contentious in relation to Indigenous affairs. While the terms are malleable to political purposes the concepts involved are critical in terms of Indigenous health and all relate to the fundamental issue of 'control of destiny'.

This discussion paper is based on the Redfern Oration to doctors of the Australasian Faculty of Public Health Medicine (Cairns, 9 May 2006). In it I frame discussion of these and related concepts by challenging medical practitioners to consider what striving for a just society means in relation to Aboriginal and Torres Strait Islander health. Conventional conceptions of medical ethics fail to resolve competing values and responsibilities at the clinical coal-face, and I draw on the concept of 'fair equality of opportunity', which emphasises the critical importance of education and health as social determinants and social rights. I highlight the importance of child development and use Indigenous suicide to exemplify the impact of disrupting the neuro-psycho-social developmental milieu, and the consequences of this across generations. Suicide also illustrates the problems associated with the medicalisation of complex social issues and the narrow conceptualisation of 'risk'. For medical practitioners, the particular vulnerabilities of Aboriginal children raise challenging ethical questions, both in terms of prioritising social goals over patient needs, and in regard to paternalistic interventionism. This is, of course, a critical issue for a profession in which paternalism is inevitable. In this regard, I consider the difference between paternalism that supports autonomy and paternalism that undermines autonomy, particularly as it relates to the critical issue of real 'control of destiny'.

Introduction: William Redfern

> The test of a first-rate intelligence is the ability to hold two opposed ideas in the mind at the same time, and still retain the ability to function. One should, for example, be able to see that things are hopeless and yet be determined to make them otherwise. [F. Scott Fitzgerald cited by Rescher 1987]

William Redfern was born around 1774. What is contentious – it may have been Trowbridge in Wiltshire, it may also have been Canada. He passed the examination of the Company or Surgeons in January 1797, days later joining *HMS Standard* in the North Sea Fleet based at The Nore in the Thames estuary. The country was newly at war, isolated from Europe and socially volatile. The economic crisis compounded the appalling conditions in the Navy, with the Channel Fleet at Spithead near Portsmouth, and the Fleet at The Nore petitioning the Admiralty for relief. Since the reign of Charles the First such acts had been regarded as treason (Rodger 1997). Negotiations resolved the situation at Spithead, but events spiralled out of control at The Nore with Fleet ships blockading the Thames. Ultimately the mutineers surrendered and were court-martialled, Redfern being sentenced to death. Some 36 were hanged but Redfern's sentence was commuted to transportation and he arrived at Port Jackson in the convict transport *Minorca* on 14 December 1801.

Pardoned on Norfolk Island in 1803, Redfern returned to Port Jackson and was involved in farming and business, some minor political intrigues, a vaccination campaign, and was appointed assistant colonial surgeon at the General Hospital where he met Governor Macquarie in 1810. Redfern had come a long way since surviving transportation. The death rate in the First Fleet was one in seventeen. In the Second Fleet it soared to one in four. Between 1801 an 1814 it fell from one in ten to one in 46. However, in 1814 Macquarie called on Redfern after 88 deaths in three transports, *Three Bees*, *Surrey* and *General Hewitt,* and his report brought about changes in hygiene, diet, access to fresh air, medical assistance, and independent medical monitoring, measures credited with reducing mortality from 1 in 30 to 1 in 120 (Hughes 1988). In December of that year he was invited to join "a committee for conducting and directing all the affairs connected [with] ameliorating the very wretched State of the Aborigines" (Jones 1999a).

We do not know much about his involvement with Aboriginal affairs, but he was instrumental in improving the rights of emancipists, petitioning the king to restore full rights to those pardoned (Torney 2001). He was a key driver in the formation of an obstetric ward in the Female Factory, in bringing a modicum of humanity to the care of the mentally ill at the Castle Hill Asylum, and was a foundation director of the Bank of New South Wales. He had his share of controversy, accused of using public medicines in private practice and financial impropriety, which brought him into court on charges of defamation and, later, assault of an editor of the *Sydney Gazette*. He left Australia in 1828 to take his eldest son, William Lachlan Macquarie Redfern, to Edinburgh where he was visited by Mrs Macquarie who commented that he was keeping questionable company, gambling and borrowing money, including from her. He died there, of causes unknown, on 17 July 1833 (Jones 1999b).

The other Redfern

Redfern was not the first doctor to be concerned about the welfare of the Aboriginal populations around Port Jackson. Inga Clendinnen's *Dancing with Strangers* provides an insightful picture of Surgeon-General John White who arrived with the First Fleet and whose unorthodox approaches inspired confidence and trust (Clendinnen 2003). But there are other connections to Aboriginal affairs. The area of central Sydney that bears his name is on a property that had belonged to Redfern. In the late nineteenth century it housed employees at the Eveleigh Railway Workshops. Aboriginal movement into the area began in the 1920s, and it was a centre of political activism by the 1960s. In 1972 plans for demolition were opposed by Indigenous leaders, the Builders Labourers Federation and others. In the following year, the Aboriginal Housing Company purchased a series of row houses to become the first urban land-rights claim in Australia. The early 1970s also saw the first Aboriginal legal and medical services, both in Redfern.

As the 2004 riots affirm, Redfern remains a site of protest and symbol of injustice. It was fitting that Paul Keating launched the Year for Indigenous People there on 10 December 1992 with a speech that Noel Pearson stated "was and continues to be the seminal moment and expression of European Australian acknowledgement of grievous inhumanity to the Indigenes of this land" (Pearson 2002). Keating (2005) said:

> And, I say, the starting point might be to recognise that the problem starts with us non-Aboriginal Australians. It begins, I think, with that act of recognition. Recognition that it was we who did the dispossessing. We took the traditional lands and smashed the traditional way of life. We brought the diseases. The alcohol. We committed the murders. We took the children from their mothers. We practised discrimination and exclusion. It was our ignorance and our prejudice. And our failure to imagine these things being done to us. With some noble exceptions, we failed to make the most basic human response and enter into their hearts and minds. We failed to ask – how would I feel if this was done to me? As a consequence, we failed to see that what we were doing degraded all of us.

Towards a just society: professional 'responsibility'

Keating's acknowledgement is also a statement of hope and justice. "If we can imagine the injustice" he emphasised, "we can imagine its opposite. And we can have justice". Justice and hope (or optimism) in relation to Indigenous health is what I will consider in this talk. My reason for doing so is that last year I attended a conference – *Towards a just society: Issues in law and medicine* – where Professor George Hampel presented a figure and a challenge. The figure was the letter 'E' repeated three times and superimposed (Figure 1). He explained that 'E' stood for ethics and that in terms of our respective professions the smallest 'e' represents 'professional ethics' or codes of conduct – What is the responsibility of the individual as a professional? The largest, outermost 'E', represents those principles of universal ethics which are often incorporated into 'mission statements' – What are the responsibilities to humanity and, indeed, the biosphere?[i] The challenge presented was to unpack the 'middle E' which is somewhere between prescribed and proscribed behaviours, and ultimate principles. The 'middle E' is about responsibilities rather than ideals or praxis.

Figure 1. The 'Three E's'

There is a precedent; the American Institute of Architects identifies: canons, which are broad principles of conduct; ethical standards which are goals towards which professionals should aspire; roles of conduct, violation of which results in disciplinary proceedings (Lichtenberg 1996).
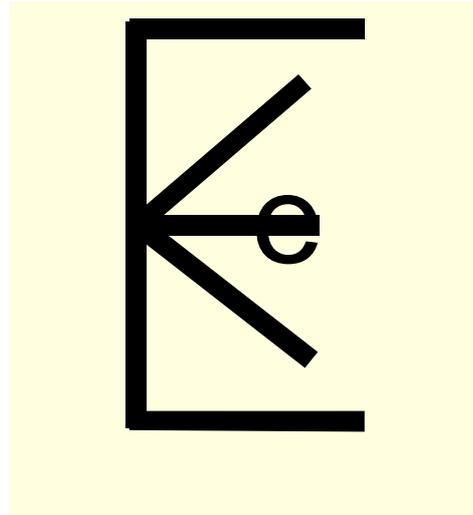
But medicine and law view 'rights' differently – law privileges negative rights – the right not to be subject to arbitrary arrest, to refuse treatment, and so on. By contrast, medicine privileges positive rights – the right to make informed decisions, to receive treatment, to best practice and, controversially, to health. Regardless, the consensus was that medicine and law should strive for a just society. Does this suggest that doctors and lawyers are, in some way, ethically 'privileged'?

A decade ago I answered this question in the negative. Around that time I wrote about three Jewish doctors who survived Auschwitz (Hunter 1997). I had already written on the role of German professionals, particularly anthropologists and psychiatrists, in developing the ideology of medical and race-based murder (Hunter 1993a). In relation to the Jewish doctors (one was a public health doctor, one a psychiatrist and the last a forensic pathologist), I was exploring how professional identity was used in the service of survival and I drew on the typology – perpetrator, victim and bystander – which I have used in considering the roles of health professionals in relation to Indigenous Australians (Hunter 2001). The third Auschwitz survivor was Miklos Nyiszli, a Hungarian forensic pathologist who became personal assistant to Josef Mengele. Nyiszli's (1973) book, *Auschwitz: A doctor's eye-witness account*, is chilling, but the critical issue is that he was profoundly compromised by his association with Mengele and by his conflict in reconciling doctor as murderer. Indeed, psychoanalyst Bruno Bettleheim, a pre-war concentration camp survivor, commented in the foreword to a reprinting, that Nyiszli "… volunteered to become a tool of the SS to stay alive" and that he repeatedly referred "to his work as a doctor, though he worked as the assistant of a vicious criminal".

Bettleheim is scathing of Nyiszli. But is this reasonable? I thought not as this means judging Nyiszli primarily as a doctor rather than a victim, essentially blaming him for surviving. However, it also presumes a greater capacity for ethical behaviour or altruism of doctors – even under extreme adversity. I won't go into my rejection of this position, but, in doing so I was considering medical identity as a personal attribute. I realise now that I had confused, as I believe had Bettleheim, the practitioner and the profession. Indeed, in the death camp the latter ceased to exist save as a parody, either in the rationalisation of murder or in the service of survival.

Clearly, the training or position of a medical professional does not necessarily confer ethical competencies. However (the extreme circumstances of Nyiszli aside) by accepting the responsibilities and privileges associated with those roles in terms of

public support and trust, and the asymmetrical relationships of power that characterises the doctor-patient relationship, the medical profession does have responsibilities, which include ensuring that individual members of the profession are aware of and responsive to their obligations regarding ethical practice. This demands ensuring access to the means (information, debate, guidance…) that supports reflection on the ethical implications of professional practice and the ability to make informed judgements, both in working with individual patients and in terms of the wider social implications of professional practice.

Towards a just society: Aboriginal health

Thus, I contend that medical practitioners do have a responsibility to strive towards a just society and to make judgements based on an awareness of the social implications of professional activities. In this paper I explore this issue as a medical professional working in an area of stark inequalities that challenge any sense of Australia as a just society – Indigenous health.

I will start with three vignettes. The first was a meeting in Normanton in 2005 to discuss mental health with Indigenous residents of the Gulf, where services are poor. Trying to be optimistic, I outlined the growth of mental health services in Cape York. But I was silenced when a man from Mornington Island commented ironically: "things must be a lot better in those Cape communities". Of course, they are not, and I was reminded of one troubled community in which an audit of mental health-related service activities was undertaken following a suicide in 2003. Twenty-two providers were noted across seven agencies – for a community of 1200 souls. The problem was not lack of services, and the solution was not more of the same.

The second vignette relates to a meeting in 2005 in Lockhart River attended by Jim Varghese, previously Director-General of Education, and the mayors of Lockhart and Napranum. The topic was education, an attendee noting that only in the last two years had the first Lockhart student completed secondary school. This was attributed to a boarding school support program that recently had lost funding. However, the non-Indigenous school principal commented that, save for a small group of high achievers, it was inappropriate to send youth to boarding school as they would be homesick, fail academically and miss out on cultural activities. He added that to make the local curriculum more 'relevant' for those returning, cultural education was emphasised and that each student had a small farm plot to tend.

The response was telling. Those who spoke up made it clear that they wanted their children to get an education that gave real opportunities. They did not see this as possible locally and stated that supporting children at boarding school was their priority. The Mayor of Napranum related that the school in his community had been closed and that the children now attended the mainstream school in Weipa. This was, he added, appropriate, as the standards of teaching, expectations of students and outcomes were dismal in the community by comparison to the mainstream. His focus was on outcomes.

The final vignette stems from meeting the United States Surgeon-General, David Sacher, in Alice Springs in the late 1990s. He had asked the then Health Minister, Michael Wooldridge, to give him exposure to Indigenous issues. Wooldridge took him to Central Australian communities where the backdrop included pot-bellied children

with runny noses, scabies and cans of petrol; where the legacy of abuse and violence was etched into battered faces and deformed limbs, and where there were few surviving elderly. At one point Dr Sacher commented: "you don't have a health problem here – you have an education problem". I don't know what Wooldridge's response was; he had his own ideas and in the 1998 Redfern Oration stated: "The truth is we do know what can fix Aboriginal health" (Wooldridge 1988). Manifestly, that knowledge was not sufficient.

It might be argued that the issues described reflect injustice and that, invoking the categorical imperative, as rational and autonomous beings who are also privileged and empowered professionals, we should be guided by moral precepts to rectify the situation. However, that is the 'Big E' – it does resolve competing motivations and values on the ground. These vignettes also touch on the four deontological principles commonly identified in discussions of medical ethics – autonomy, beneficence, non-maleficence and justice[ii] (Bloch and Chodoff 1981; Gillon 1985; Beauchamp and Childress 1994; Coady and Bloch 1996). The Aboriginal man in Normanton was pointing out that outcomes were less evident than good intentions. He might have added that without outcomes, creating dependency on external services is harmful, undermining family and community roles (Trudgen 2000). This raises questions about beneficence and non-maleficence as well as autonomy, all of which were also at issue in the Lockhart education debate. But this last was also about opportunity and the freedoms that brings. Freedom as equitable opportunity is increasingly invoked, including by certain Indigenous leaders (Gerard 2005; Stannard 2005). Finally, David Sacher's comment in Central Australia involved failures with respect to all four – manifest injustice, impotent beneficence, maleficence of neglect, and autonomy as illusion of choice and control of destiny. It was also a warning regarding medical hubris.

Of course, we are aware that real improvement will require more than health sector investment (Wilkinson and Marmot 2003). The major reductions in Indigenous perinatal and infant mortality through the 1970s and 1980s came about primarily because of the extension of basic services. However, the perinatal and infant mortality rates remain two and three times higher, respectively, for Indigenous versus non-Indigenous populations (Trewin and Madden 2005). Indeed, recent reliable data demonstrates that the Indigenous: non-Indigenous perinatal mortalities have increased over the last two decades being worse in remote areas (Fremantle et al. 2006). While service access is important, this persisting gap reflects social determinants (Booth and Carroll 2005).

Is it reasonable to expect heath professionals to take this on? What do our professional bodies say? While the Royal Australian and New Zealand College of Psychiatrists' (2004) Code of Ethics deals almost exclusively with practice, the College also has 'ethical guidelines' on a range of topics, Number 11 being "principles and guidelines for Aboriginal and Torres Strait Islander Mental Health" (RANZCP 1999). Item 4.1 states:

> Health professionals need to be aware that interventions within the arena of Indigenous health necessarily have political implications. Involvement in this area of professional practice often involves challenging government policy and community attitudes which have the potential to impact negatively on Aboriginal and Torres Strait Islander social, emotional, cultural and spiritual wellbeing.

The AMA (2005:4) *Position Statement* on Aboriginal and Torres Strait Islander Health affirms "That Aboriginal peoples and Torres Strait Islanders will not achieve equal health outcomes until their economic, educational and social disadvantages have been eliminated".

'Overcoming disadvantage' is also central to current Commonwealth policy in Indigenous affairs (Anon. 2005). However, as Aiden Ridgeway (cited by Arabena 2005:14) has stated:

> The classification of Indigenous peoples as simply 'disadvantaged' does not address the real structural and systematic barriers that have contributed to the situation we are now in. We are all being co-opted into over simplified debates about our needs which is based on language benign in appearance but loaded in meaning.

That 'loaded meaning' includes understandings of citizenship that have been debated since the demise of assimilation, specifically equality, equal rights and sameness, versus difference, Indigenous rights and uniqueness (Sanders 1998; Anon. 1998; Arabena 2005), which, in turn, informs arguments regarding separatism versus incorporation into the mainstream (Altman 2005), and Indigenous citizenship and rights as a collective, versus as individuals, which has become particularly salient in relation to the wider Australian economic and welfare systems (Sanders 1998; Rowse 1998). The 'loaded meaning' also relates to the tension between privileging autonomy versus prioritising outcomes.[iii]

To return to the Lockhart River vignette: Providing opportunity by sending children to boarding school, it might be argued, smacks of paternalism. The same could be said for alcohol management plans and Shared Responsibility Agreements which justify restrictions in 'autonomy' by recourse to a utilitarian conception of justice. However, in relation to 'opportunity' health and education are rights that share special features that set them apart, best grasped using a contractarian, more specifically a Rawlsian, egalitarian, or 'fair go' view of justice (Rawls 1999). In this, justice is served through equality of opportunity, for which health and education are unique as fundamental building blocks, placing them in a special 'rights' category (Daniels 1985). Furthermore, as strategic 'social goods', additional responsibilities apply in relation to disadvantaged groups. From a Rawlsian, egalitarian view, health and education resources should be distributed so as to ensure access to the normal range of opportunities available in that society. That this is not the case in relation to Indigenous education was fore-grounded in Bob Collins' (1999) report on Indigenous education, which stimulated the AMA (2001:2) *Position Statement on The Links Between Health and Education for Indigenous Australian Children*; this recommends that "service delivery in health and education to Indigenous children should be seamless, both in theory and in practice". Dream on.

Rights and opportunities

Health and education are powerfully related (Crombie et al. 2005), particularly maternal education and child survival in the Third World (LeVine et al. 1994). I will give three examples across the lifespan for Indigenous Australians. First, in the late 1980s, my brother and I surveyed a random sample of six hundred Aboriginal Kimberley residents aged fifteen to eighty years, including physical and mental health status, and demographic and social factors (Smith et al. 1992a; Smith et al. 1992b; Hunter et al. 1992; Hall et al. 1993; Hall et al. 1994). After thirteen years, an intra-sample analysis

of social variables (Calver et al. 2005) included: income; incarceration; childhood environment; traditional language fluency; 'Christian' identification; and, level of schooling. Morbidity outcomes were all causes, alcohol-related, and injury-/poisoning-related first hospital admissions. The most consistent finding was that having some secondary schooling demonstrated a strong negative relationship with all three (Wiltshire and Hunter 2004). Second, the Western Australian Child Health Survey (Zubrick et al. 2004), the most detailed and comprehensive survey of Indigenous children and families to date, identified that higher maternal education is associated with lower prevalence of substance use among children. Third, an analysis of 672 births to Indigenous women in Brisbane between 1996 and 1999 revealed a significant relationship between maternal education and intra-uterine growth retardation. Even adjusted for alcohol, tobacco and drug use, the difference in rates between those with Year 12 compared to those with less than Year 10 schooling was almost three-fold (Craig 2000). These findings should be no surprise.

Clearly, social determinants are critical in relation to Indigenous health, and education is a key determinant with particular status from a social justice perspective. Further, both health and education are necessary preconditions of fair equality of opportunity. From the policy documents cited, this is a field in which medical professions and professionals should be engaged – But how? Should elimination of health differentials be both goal and justification – a utilitarian and paternalistic approach? Or, should we be guided by principles – of autonomy and social justice? Does this boil down to a tension between an 'ends justify means' paternalistic interpretation of beneficence, and autonomy as means and ends? In reality, these principles are not necessarily incompatible, and in relation to clinical practice Beauchamp and Childress (1994:272) have commented that:

> The debate between proponents of the autonomy model and the proponents of the beneficence model … has often been confused by a failure to distinguish between a principle of beneficence that competes with a principle of respect for autonomy and a principle of beneficence that incorporates the patient's autonomy.

While this relates to patients' rights, it is relevant to current Indigenous affairs policy, which appears to have shifted from the latter to the former. Regardless, while "beneficence that incorporates autonomy" might be an ideal, on the ground there remains a vigorous debate between those prioritising autonomy or self-determination (however conceptualised), and those calling for 'real outcomes' – whatever it takes.

Remote 'liabilities'

Of course, Indigenous Australia is a diverse tapestry. While I worked briefly in Redfern, my career has been in remote Indigenous Australia, largely in communities whose history, particularly in Cape York, is of concentration in isolation, and that have been called "outback ghettos" (Brock 1993). It has been argued that the structure and governance of such settings is primarily driven by bureaucratic expedience to facilitate collective engagement with the welfare system and mechanisms for 'consultation' with individuals whose authority lies in a 'democratic' process that has often been divisive and has marginalised traditional authority and landedness (Macdonald 2001). I recall a conversation in one such community with an Aboriginal nurse and her South African husband who commented: "You've been more successful at apartheid here than in South Africa". His point was that while civil and political rights had been won by Indigenous Australians before the dismantling of apartheid, social rights had not, at

least in ex-mission communities set up away from the economic mainstream from which, for most, there was no escape save for brief sojourns to the parks of Cairns – or jail. It might be argued that this is a matter of 'choice'. But, deprived of enabling education or skills, choice is an illusion. While the disadvantage of urban Indigenous communities is real, albeit less 'visible', remote communities confront particular difficulties. This has long been recognised in policy, and informed the setting up of Community Development Employment Projects (CDEP) (Sanders 1998). Unfortunately, the situation is now often compounded by reliance on non-Indigenous intermediaries with the skills to manage escalating administrative and technical demands (Palmer 2005).

According to some, such settings are 'liabilities' and it has been suggested that government policy, implicitly, incorporates "categories of competence" (Arabena 2005), being (1) competent Indigenous people who reside in urban areas and who should have no access to Indigenous specific funding; (2) those who live in remote areas and lack competence due to disadvantage-related circumstances and should be helped; (3) those who continue to choose to live in disadvantaged communities and who choose to lack competence, that is, those who cannot be helped at all. This is powerful language, now echoed in the media with headlines such as on page 1 of *The Australian* – "Aborigines choose welfare over work" (McKenna 2006). 'Choice' can be similarly invoked in relation to the burden of chronic disease, with 'lifestyle' used in such a way that the context of social disadvantage is reduced to irresponsibility (Hertzman et al. 1994).

Thus, they are not only the least 'competent', they are least 'deserving'. From an economic perspective, persistent dependence in remote settings seems incontestable. Indeed, Jon Altman, staunch critic of economic rationalist arguments regarding the viability of remote Indigenous communities, had admitted that in these settings, even with a "hybrid economy" incorporating "non-monetized" inputs, "so-called 'welfare dependence', will not decline markedly". Altman (2005:42) went on to state, however, that "there is a strong moral, political and economic argument for using a different nomenclature for such state support. It could be defined as regional fiscal subvention". While I understand this argument and appreciate the importance of non-stigmatising language, it is not JUST about economic viability, OR "unrecognised productive activity". It is about what it means, at a personal and group level, to be denied real choice and control in what is, regardless of location, a globalised world.

Health and social change: suicide

I will now consider a health issue related to these psychosocial consequences – Aboriginal suicide. In Queensland the Indigenous suicide rate for 1999 to 2001 was fifty-six percent higher than for the State as a whole, with the rate for young males aged 15 to 24 years 3.5 times higher. Some eighty-three percent of Indigenous suicides were less than 35 years of age (42% for the state) with ninety percent of these deaths by hanging (De Leo and Heller 2004). However, suicide is unevenly distributed. The total number of Indigenous suicides increased nearly four-fold in the period 1992 to 1996 (accounted for by an increase in young male hanging deaths), a disproportionate number occurring in the north of the state where three communities contributed to this excess at different times, overlapping 'waves' of suicides suggesting a condition of community risk varying by location and time (Hunter et al 2001).

Aboriginal suicide was rare before the late 1980s, before which it tended to be men in their third and fourth decades in non-remote settings (Hunter 1993b). That changed with the Royal Commission into Aboriginal Deaths in Custody (Johnston 1991), which investigated deaths in detention, one-third of which were suicide. The intense media focus informed constructions of hanging that fore-grounded oppression, associating 'meaningfulness' with hanging. Since then, suicide has increased in the wider Aboriginal population, the highest rates being teenage and young adult males, now increasingly in remote populations (Davidson 2003), sometimes taking on 'traditional' meanings (Parker 1999; Parker and Ben-Tovim 2002; McCoy 2004). But, the patterns continue to change. In the first months of 2004, four children aged 12 and 13 died by hanging in four communities in Far North Queensland. To explain these changes I will use trend data from the Kimberley and Cape York.

Across Indigenous Australia the 1970s ushered in turbulent social change that has been described as 'deregulation' (Hunter 1999). This most immediately impacted young adults for whom onerous controls were lifted, with entry into the cash economy through welfare, and unrestricted access to alcohol. However, while discriminatory legislation was revoked, other barriers, less tangible but robust, persisted, what has been called "cultural exclusion" (Brody 1966). The social and behavioural consequences were evident in the Kimberley with a dramatic increase in deaths from external causes (accidents, motor vehicle accidents and homicide, largely being of young adults) from two to four percent of deaths in the fifteen years to 1971, to fifteen percent of female and twenty-five percent of male deaths in the fifteen years following (Hunter 1993b). Suicide did not increase until the late 1980s – some fifteen years delayed (one suicide in the 1960s, three in the 1970s, twentyone in the 1980s and forty-six in the 1990s). These were teenagers and young adults – the children of that earlier generation exposed, as young adults and new parents, to deregulation and its social consequences. The young suicides were from the first generation to have been raised in that environment of unremitting instability. Not only were they at risk of self-harm but also petrol-sniffing, sexual abuse (as victims and perpetrators) and self-destructive confrontations with increasingly reactionary authorities (Hunter in press).

Self-harm is no longer uncommon and its visibility in remote communities exposes children – from other children wandering the streets with cans of petrol, to violence to self and others, to threats, acts and representations of suicide. Indeed, among the child hanging-deaths described earlier, all had been exposed. They belong to the first generation in which many children's early development includes exposure to the threat or act of self-annihilation (Figure 2).

Key mediator: child development

The effects of social change on patterns of self-harm are mediated by their impacts on early development, which is critical for realising health and educational potential – that is, for optimal opportunity in life. The effects of prenatal environmental factors (including social adversity) on the development of diseases including diabetes and hypertension later in life is well known (Gluckman et al. 2005). Similarly, from conception through infancy, neurological, cognitive, affective and social development is an interactive process between a phase-sensitive evolving system and the environment (Schore 1994; Keating and Hertzman 1999). This includes the 'embedding' of experience in biology through processes of selective activation and neural sculpting, and

Figure 2. Changing patterns of self harm: generational effects (schematic representation combining trend information from the Kimberley and elsewhere).
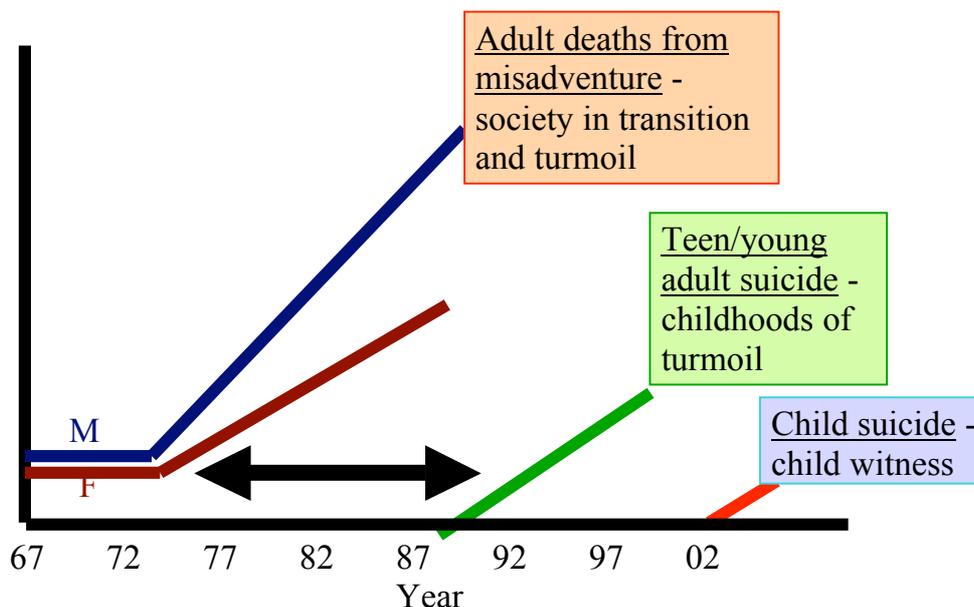
the transmission of emotional and social capacities through what has been called "reciprocal, co-regulated emotional interactions" (Greenspan and Shanker 2004). Extensive developmental neurobiology research now also informs our understanding of social gradients in health (Kelly et al. 1997). Indeed, it has been noted that "the effects of these early developmental processes can be observed in the health and competence of populations" (Keating and Miller 1999:220).

Longitudinal studies demonstrate that failure to provide for early phase specific needs is consequential for the later development of serious emotional and behavioural problems, including violence (Tremblay 1999; Hertzman and Power 2003; Schore 2003). Ultimately, as Keating and Hertzman (1999) have noted:

> … over time, the physiological aspects of less than optimal neurophysiological development, chronic stress and its psychological impacts, a sense of powerlessness and alienation, and a "social support" network made up of others who have been similarly marginalized will create a vicious cycle with short-term implications for education, criminality, drug use, and teen pregnancy, and with long-term implications for the quality of working life, social support, chronic disease in midlife, and degenerative conditions in late life.

This sounds like the Aboriginal communities in which I work, and I am acutely aware of the levels of stress therein. That stress impacts health is well known (McEwen and Norton 2004) as it is that stress in early life, including pregnancy, can have long-term consequences for emotional development and capacities to respond to stressors later in life (Cynader and Frost 1999). Although Indigenous data are limited, the Western Australian Aboriginal Child Health Survey (Zubrick et al. 2005) demonstrated elevated risk for clinically significant emotional and behavioural disorders for Aboriginal children aged 4 to 11 (26%) and 12 to 17 (21%) compared to non-Indigenous peers (17 and 13% respectively). Among associated social factors were poor-quality parenting, poor family functioning, being raised by a sole parent or a non-parental carer, a history of parental forcible separation, and the number of life stress

events in the prior twelve months (22% of children were living in families with seven or more life stresses).

So, stress is common in Indigenous families and associated with negative childhood outcomes. One mediating pathway is prenatal exposure to stress hormones (Cynader and Frost 1999; Weinstock 2004). Studies from the Kimberley have shown levels of glucocorticoid excretion during normal life higher than any other researched population, and of catecholamines also high by world standards (Schmitt et al. 1995; Schmitt et al. 1998). Sequential measures of urinary and salivary cortisol (Schmitt et al in press) revealed a pattern that the researchers associated with the stress of the welfare economy cycles in resource-poor communities where 'demand sharing' (Peterson 1993; Macdonald 2000, 2001) pressures are intense. Among those affected are young women and the pregnancies they carry. So, even prenatally the stress of disadvantaged communities impacts neurodevelopment – this before considering other factors that inform poor perinatal outcomes, including the neurotoxic effects of alcohol, for which there is now evidence of substantially higher levels of harm among Aboriginal compared to non-Indigenous children (Bhatia and Anderson 1995; O'Leary 2002). How, then, do we conceptualise the capacity to exercise informed and healthful 'choice'?[iv]

But – children are resilient. Indeed, this is one of the key findings of the Kauai Longitudinal Study which followed a cohort of 698 children born on that Hawaiian island in 1955 (Werner 1989). That research showed that for children at risk a key resilience factor is supportive relationships (Power and Hertzman 1999). In reviewing outcomes at age 40, Werner (2004:492) noted that poor outcomes were associated with:

> … prolonged exposure to parental alcoholism and/or mental illness – especially for the men. Individuals who had been born small for gestational age and those who received a diagnosis of mental retardation in childhood had a higher incidence of serious health problems in adulthood, including serious depression. They also had higher mortality rates. … Men and women who had encountered more stressful events in childhood reported more health problems at age 40 than those who had encountered fewer losses and less disruption in their family during the first decade of life.

Some decades ago I worked in disadvantaged native Hawaiian communities. I assure you, circumstances are significantly harsher in remote Aboriginal Australia. Werner's study is repeatedly cited to emphasise the importance of a 'good enough' start to life. This is equally or more critical in Indigenous Australia. While Aboriginal children are not condemned to poor health and social outcomes, they are more at risk than their non-Indigenous peers due to socio-environmental adversity, which also compromises those factors that could support resilience – risk amplification.

Social justice and medicalised solutions

In terms of responses to the tragedy of Indigenous suicide, what is NOT being addressed are the developmental precursors of risk. Instead, the focus has been on discrete risk or group 'trauma'. With respect to risk, this has been conceived narrowly as risk of suicide rather than lifestyles of risk, leading to 'treatment'-oriented interventions – counsellors, life-promotion officers, early-intervention programs and so on. The premise is that these are vulnerable young adults who need help. Other approaches start from the premise that risk is a consequence of 'trauma', a concept with currency in Aboriginal Australia since the 'stolen generations' were identified in the

1980s (Read 1981) and, particularly, since the release of the Human Rights and Equal Opportunity Commission's (1997) report on the removal of Indigenous children from their families. This is an important issue that demands a brief digression. The Commission recommended a framework for reparation involving:

1. acknowledgment and an apology;
2. guarantees that human rights won't be breached again;
3. restitution (or restoration);
4. rehabilitation; and
5. compensation.

Compensation is due for breaches of human rights. This is the big issue, adroitly evaded by the Government through two mechanisms. First, by focusing attention on Howard's refusal to apologise which, I contend, then Prime Minister Paul Keating did in Redfern (Pearson 2002). The emotions unleashed in the wider Australian public were powerful, but did more to sentimentalise symbols (Gaita 1999) than support understanding, and were unsustainable. Second, by emphasising and medicalising consequential harm which, in thereby trivialising human rights violations (Hunter 2002) is a form of denial (Hunter 1996).

I am not suggesting that medicalisation is necessarily harmful. Brady (2005:132) noted that "For many Aborigines seeking solutions to their chronic health problems, better and more thorough medicalisation is desired, not less", the doctor's status providing authority and legitimation supporting decisions, for instance, to control drinking.[v] This brings me back to paternalism, as this might be considered an example of justified paternalism, that is, a coercive intervention in relation to an informed, voluntary and autonomous decision (to drink to excess) which is made in the best interest of the patient. However there is a difference between *acts* of paternalism and "public and institutional *policies*" of strong paternalism (Beauchamp and Childress 1994:282).

Brady's use of medicalisation is consistent with an *act* of 'justified paternalism'. While subject to abuse, such acts are inevitable in medical practice. The medicalisation of social injustice is another matter. Medicalisation operates through the "exercise of institutionalised power" (Parker 2004), whereby the social context of disease is diminished and/or social phenomena are subsumed within a hegemonic, biomedical discourse (Filc 2004).[vi] In relation to 'trauma', the process was driven by political expedience and supported through the health sector, with funding for grief- and loss-counsellors the major response of the Commonwealth government. Subsequently, 'grief and loss' has come to represent both a psychological state (of distress) and a symbol (of social injustice), with a parallel confusion in terms of 'trauma' with inter-generational trauma also understood as both a state and a process (Hunter in press). What has disappeared is the breach of rights, replaced by grief, loss and trauma which, because legitimacy is conferred by demonstrated harm, is articulated as depression, anxiety and post-traumatic stress disorder. Indeed, Christine Adams (2005:184) has argued that "social distress and dissent are thus reduced to biological dysfunction and psychological pathology for which short-term, politically-neutral technical solutions like medication and counselling are deemed most appropriate". With the past now made present in disorders of mental health, Aboriginal Australians, Adams (2005:330) anticipated, "may find it difficult to relinquish their now-medicalised melancholia as a basis of political agency". Ironically, the Commonwealth funds grief- and loss-counsellors to address the mental health consequences of past policy, and lawyers who vigorously resist personal or group claims on the basis of harm so caused.

I am not trying to minimize emotional pain but to problematize the obfuscation of violation in a fog of medical disorders. If post-traumatic stress disorder or depression signify violation, what does recovery signal? I am also not denying inter-generational effects. The changing patterns of harm and self-harm over successive generations identified earlier is one example. But, the *mediating* factor is developmental, specifically the impact of the developmental milieu – from amniotic to family and social environment – on neuro-psycho-social development.

Social transformations vs 'modest but practical ways'

Earlier, I suggested that remote communities are particularly impacted. I will explore this in more detail. A review of health and education outcome data for the period 1971 to 2001 shows that by comparison to non-Indigenous Australians, while Indigenous health parameters have not improved significantly, there has been a dramatic increase in participation in education (Table 1) (Altman et al. 2005).

Table 1: Ratio of Indigenous to non-Indigenous education and health outcomes 1971 to 2001 (derived from Altman, Biddle and Hunter 2005)
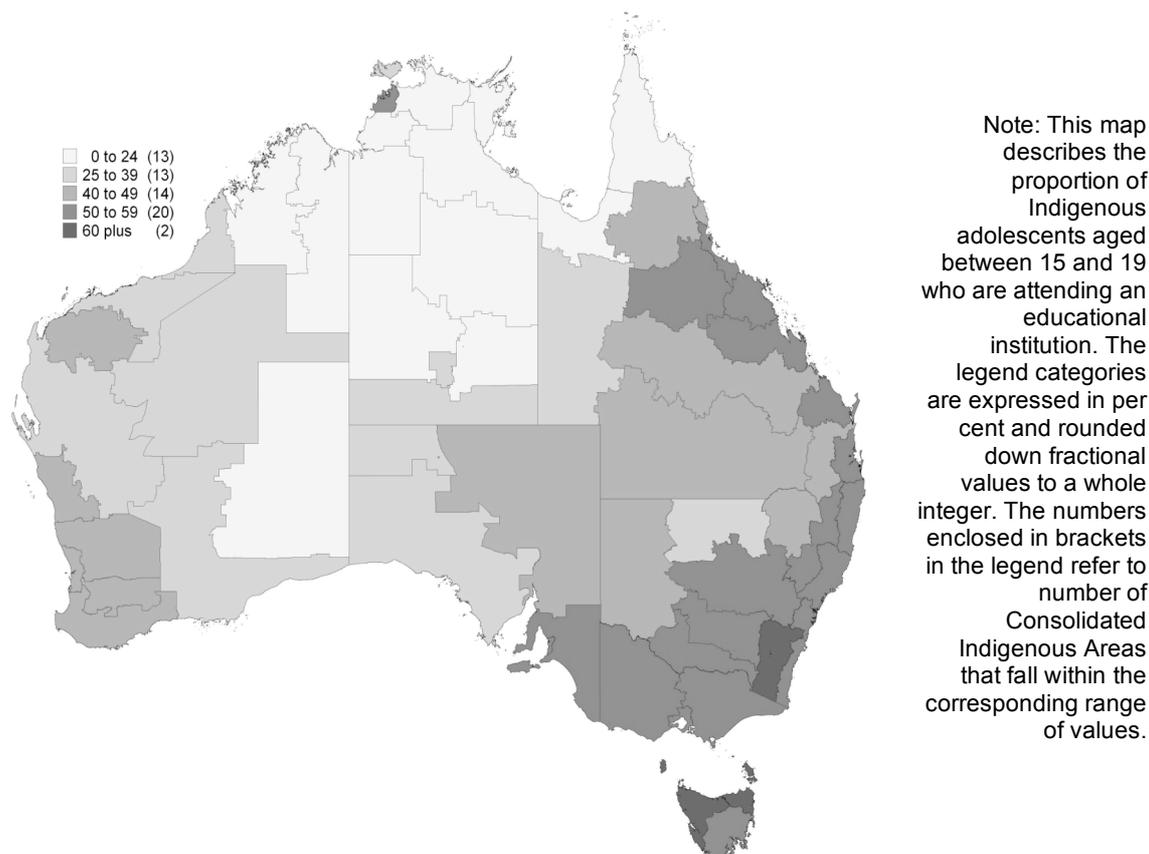
Ratios of	1971	1981	1991	2001
Never attended school (of % adults)	39.32	14.42	5.21	3.14
15 to 25 year-olds attending educational institutions (of % non-secondary students)	not available	0.38	0.35	0.43
Post-school qualifications (of % adults)	0.13	0.18	0.30	0.44
Male life expectancy at birth (of years)	0.73	0.78	0.77	0.74
Female life expectancy at birth (of years)	0.67	0.81	0.79	0.77
Population aged over 55 (of % > 55y)	0.43	0.34	0.31	0.31

However, while education participation is a predictor of employment generally, that is not the case in remote settings. Data from the 2001 census (Figure 3) reveals that retention of Indigenous adolescents in the education system is much lower across remote northern Australia, the predictors of poor participation being: limited education

access; domestic disruption; being Aboriginal rather than Torres Strait Islander; lack of access to electronic resources; and with presence of the CDEP scheme (Biddle et al. 2004). The authors comment on the disadvantage for remote Indigenous Australians of being isolated from the wider, globalised society.

Lest we be seduced by the aggregate improvement in attendance, the recently released education report from the Western Australian Aboriginal Child Health Survey (Zubrick et al. 2006) shows that academic performance for Aboriginal children is significantly below that for the State as a whole, and that this relates to: poorer academic performance among parents; poorer attendance at school; and higher proportions of Aboriginal children with emotional and behavioural difficulties. Furthermore, while Western Australian absentee rates were less than in New Zealand or the United States, rates were considerably higher for Aboriginal compared to Maori or Native American children. This report concludes that there has been no obvious progress in terms of outcomes over the last thirty years, that poor academic performance is being passed down inter-generationally, and is set during early school years. Finally, while physical health problems and poor nutrition clearly impact education, they are not the major factors holding back the performance of Aboriginal children in school.

Figure 3. Indigenous adolescents attending educational institutions, 2001 (from Biddle et al 2004).

Legend:
0 to 24 (13)
25 to 39 (13)
40 to 49 (14)
50 to 59 (20)
60 plus (2)

Note: This map describes the proportion of Indigenous adolescents aged between 15 and 19 who are attending an educational institution. The legend categories are expressed in per cent and rounded down fractional values to a whole integer. The numbers enclosed in brackets in the legend refer to number of Consolidated Indigenous Areas that fall within the corresponding range of values.

Obviously, attendance is necessary but not sufficient to secure educational outcomes – and outcomes remain poor. Exiting school does not improve the situation. For instance, the Indigenous youth detention rate is some twenty times greater, nationally, than for non-Indigenous young persons (Charlton and McKall 2004; HR EOC 2005a). Unemployment is common and more so in remote areas. Indeed, at a national level Indigenous engagement in the workforce, as with education, has not shown significant improvement over the last thirty years. If CDEP is removed, employment has fallen, which is accentuated when considering 'non-elite' employment, that is, removing those Indigenous workers in the top thirty-percent income-bracket nationally (Figure 4). This raises important and difficult questions for remote communities – does CDEP constitute an economic lifeline where there are no opportunities – or does it cement locational disadvantage by dissuading engagement in education and the mainstream economy? (Gregory 2005). Probably both.

What I want to impress is that key indicators of disadvantage and determinants of opportunity are not improving, and particularly compromise remote Indigenous populations. I have avoided graphic anecdotes to exemplify the stress and turmoil impacting these populations, but turmoil there is and it is not 'here today and gone tomorrow'. Without significant changes, it will be there for decades to come. That is,

Figure 4. Indigenous employment 1971 to 2001 with projections to 2011 (Gregory 2005)

Per cent — Time

Legend: ◆ Total ■ Mainstream ▲ Non-elite
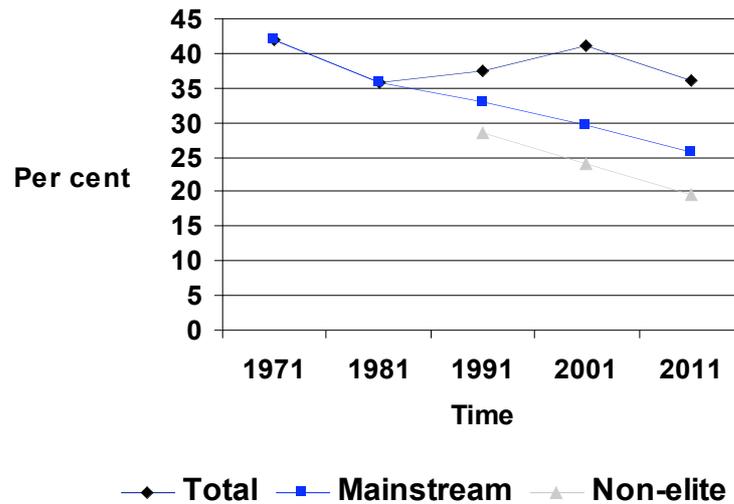
unless, going back to Paul Keating's Redfern speech, we can "imagine its opposite" and make it happen.

Making it happen

So, how to 'make it happen'? Well, that demands goals, and the means and motivation to reach them. In terms of goals, while there may be debate about those chosen, key indicators for overcoming Indigenous disadvantage have been developed, and health and education are prominent (Anon. 2005). In terms of motivation, because health professions have strategic influence over an area that is a precondition of equality of opportunity, there is a responsibility to strive for a just society in which that is realised. However, there is a circular cause-and-effect relationship between health and a just society that involves more than semantics. How this is constructed has significant implications for 'making it happen'. For instance, the Aboriginal and Torres Strait Islander Social Justice Commissioner, Tom Calma, has focused on Indigenous health in the *2005 Social Justice Report*, utilising a human-rights framework to inform recommendations that foreground equitable access to effective primary care (HREOC 2005b). The report is powerful and persuasive – that is, to those motivated by human rights. However, it can be argued that if the purpose is to harness public opinion and galvanise political will, justice is less suasive than health. While poor school attendance, unemployment and overcrowding may reflect disadvantage, for many Australians they are also understood in terms of choice and this can be used for political expedience – blaming the victim (Das 1994). By contrast, nobody would invoke choice to explain dead babies and foreshortened lives.[vii]

This has a further implication. Health and education are special 'rights' in terms of fair equality of opportunity. Education is a key determinant of health status and, as suggested by David Sacher, may be the critical factor in addressing the injustice in which both are embedded. But, health may be a more suasive and potent political lever – it contributes to all 'rights' and, more importantly, is manifest and measurable. Indeed, health may provide the most powerful argument for investment in Indigenous education as a necessary precondition of a just society that includes significant improvements in the broad social determinants of health and wellbeing.

However, I am also mindful of Syme's (1997:9) caution regarding being immobilised by the task of social change: "If we really want to change the world we may have to begin in more modest but practical ways". Sustaining such modest but practical ways demands challenging inertial fatalism (Hunter 2000), and nurturing optimism. So, how does one remain optimistic? Well, there are three types of optimism (Rescher 1987). First, actuality optimism – things are good, let's ride the wave. This is manifestly not the case. Second, tendency optimism or meliorism – things are getting better, let's just hang in there. Given the persistent Indigenous: non-Indigenous health gap in Australia compared to New Zealand, Canada and the United States (Ring and Firman 1998; Ring and Brown 2003; Lavoie 2004), this is questionable. However, Ian Ring[viii] has made the point that this may be beginning to change and he emphasises the importance of clinical best practice, for instance ACE (Angiotensin Converting Enzyme) inhibitors, and end-stage renal disease (Thomas 2004, 2005). This is important and per Syme it is practical, but it is also very modest. Finally, prospect optimism – the future will be better contingent on suitable actions. That is, effort will make a difference. This, I suggest, is our only basis for optimism.

So, how should that effort be directed? In terms of both modest but practical ways and influencing social determinants, we need to consider whether this is driven by values, such as social justice or autonomy, or by a utilitarian, 'outcomes' approach. While the former appeals to our ethical sensibilities, there are examples of policies and programs informed by wider-societal concerns for social justice which, in Indigenous settings, have had untoward outcomes (Hunter 2006). Examples include welfare support, royalties, revocation of prohibition, victim compensation, fostering autonomy without capacity, and privileging customary legal defences. All of these are rights which should not be revoked – but they are not unproblematic. This may also be extended to certain 'traditional' practices (Sutton 2001, 2005) that "now exist under conditions that differ significantly from those of the pre-colonial era" (Sutton 2001:140).[ix] Indeed, in the face of "rhetoric about empowerment and self determination" (Sutton 2001), and the continuing failures of Aboriginal affairs policy, particularly in relation to remote communities, some informed and sympathetic commentators have called for a drastic review of priorities including "artificially perpetuating 'outback ghettoes'" and even support for Indigenous service delivery (Sutton 2001). Basically – 'whatever it takes' – paternalism in the service of outcomes. Of course the same argument, invoking best interests and using the same indicators of disadvantage, can rationalise conservative economic agendas (Hughes 2005). It is then a short step, using entirely legal means within provisions of the Native Title Act, to "develop and divide", further ghettoising and impoverishing Aboriginal groups – as happened to the traditional owners of Australia's most resource rich real estate – the Burrup peninsula in the Pilbara (George 2003).

Regardless, there are issues, such as education and the developmental vulnerabilities associated with changing patterns of self-harm that involve vulnerable children's fundamental rights. In seeking to resolve the conflict between principles of autonomy versus beneficent but paternalistic intervention, we might reflect on the position we would adopt if foetal alcohol syndrome increased by fifty-fold in our neighbourhoods (O'Leary 2002). Or if the majority of children who should be in high school were not.[x] Or if notifications for gonorrhoea and chlamydia among junior high school children increased one hundred-fold (Anon. 2001). Or if children were found hanged.

# Autonomy, paternalism and the capacity to choose

I am not seeking to trivialise autonomy and underline its importance with research on Indigenous suicide in British Columbia (Chandler et al 2003), which has similarities to Aboriginal suicide (Figure 5) with wide inter-group variations (Figure 6). Michael Chandler and Chris Lalonde examined six "cultural continuity markers" which might be understood as autonomous control variables: self-government, land rights litigation, control over education, health and police, and cultural facilities. For each, suicide rates were higher for communities without the particular factor than for those where it was present (Figure 7). However, more startling was the demonstration of a linear relationship with rates from almost none for communities with all six factors, to nearly 140 per 100 000 for communities lacking any (Figure 8). Further research (Chris Lalonde, personal communication September 2005) has demonstrated the salience of two other factors – control over child welfare services and elected Band Councils with more than fifty percent women.

Figure 5. British Columbia suicide rate (per 100 000), 1987 to 1992 (Chandler et al 2003).
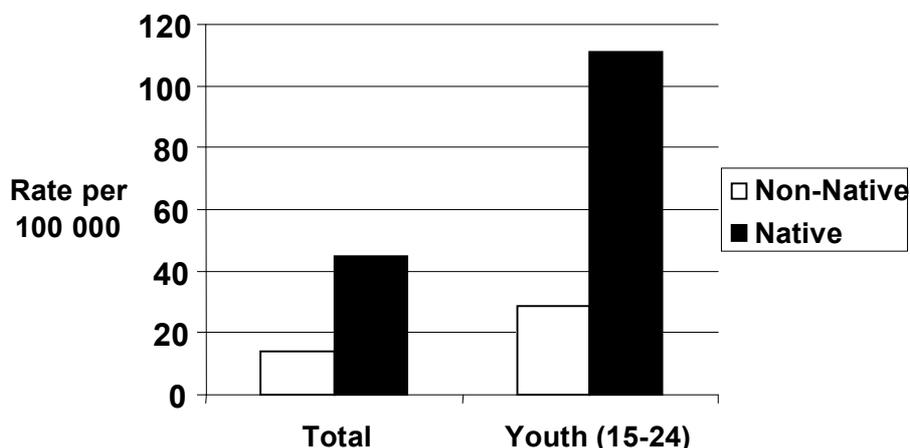
We should not be surprised. "Autonomy is closely linked with self esteem and the earning of respect", Michael Marmot (2003:574) insisted, adding that "Both are basic and … linked. Low levels of autonomy and low self esteem are likely to be related to worse health". In 2005, Chris Lalonde visited Cairns and I asked if his research could be done in Queensland. It can't. What passes as Indigenous control in Australia is a veneer, as the demise of ATSIC and the vulnerability of 'community controlled' services attests. As is much of the rhetoric of self-management – as Gaynor Macdonald (2001:16) aptly observed in relation to remote communities: "People cannot self-manage without something to manage. They are managing their own welfare dependence". This is, of course, the issue raised in objection to Tony Abbott's call for a new paternalism to address the 'failures' of 'self-determination'. So, for medical professionals and professions, what would it take to support real autonomy, and, is that

Figure 6. British Columbia Aboriginal youth suicide rate (per 100 000), by language group, 1987 to 1992 (Chandler et al 2003).
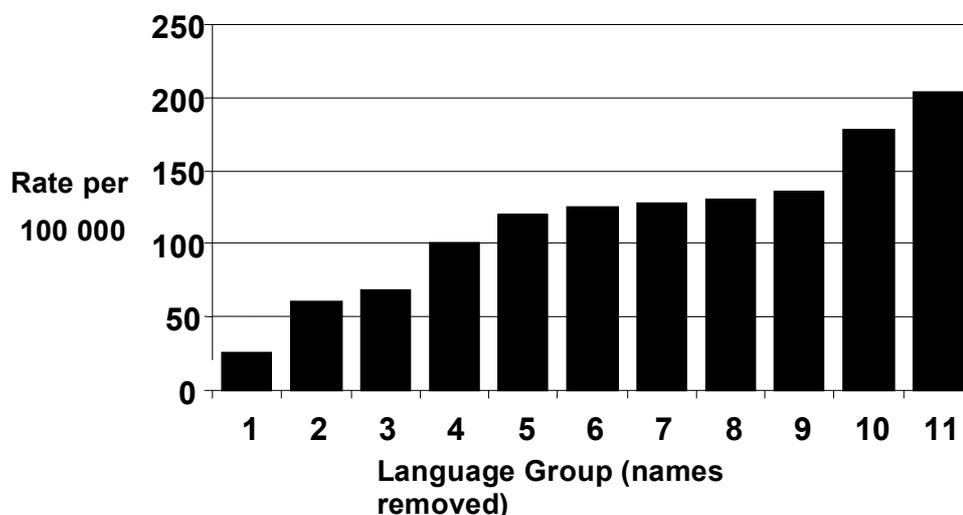
precluded by the paternalism that characterises medical practice? A key question. I have invoked 'choice' repeatedly in this presentation. Autonomy is about the ability to conceive choices and exercise them. Failure to provide 'choice' has also been invoked as a criticism of government 'paternalism', for instance in relation to Shared Responsibility Agreements (Collard et al 2005). But choice is also invoked to the opposite ends, Noel Pearson (ABC TV 2005) commenting that "We first need to arm young Indigenous people with the ability to choose. And that ability to choose comes from a proper engagement in mainstream education and a proper investment in their health, and the proper capacity to choose". Pearson rejects that this is assimilation. It is, rather, bicultural empowerment. He also defends assertive childhood intervention: "I'm prepared to be paternalistic in relation to an early intervention because the ultimate paternalistic act … is the State stepping in and taking children away from their families" (ABC TV 2005). Indeed, he and Pat Dodson (Dodson and Pearson 2004:17) also have noted: "Given the collapse in expectations, we believe the government has a role in assisting Aboriginal communities to restore responsibility through mutual obligation" – albeit not in a manner that further erodes family and community responsibilities.

This is a contested position but, clearly, interventionism and 'paternalism' are now on the national Indigenous affairs agenda. Medical professionals should be involved in that debate and consider what informs the positions they adopt. We should reflect on the 'politicisation' of Indigenous health which, it has been argued, has obstructed addressing key child socialisation determinants of the persisting Indigenous health differential (Sutton 2005). On the other hand, we should also resist medicalising social justice issues, such as of human rights violations into diagnoses which, I contend, supports victim rather than survivor status. Judgements and actions informed by such reflection are difficult but necessary. As doctors, caring (and occasionally curing) involves asymmetrical and thus paternalistic relationships. As it is unethical to ignore the rights of vulnerable individuals by rigidly invoking a chimera of autonomy or empowerment paternalism is inevitable in clinical practice. At a wider policy and political level, contributing to the creation of autonomy with real options and choice will also involve paternalism. However, to the extent that medical professionals and

Figure 7. British Columbia Aboriginal youth suicide rate (per 100 000) by presence or absence of specified cultural continuity factors in communities (Chandler et al 2003).
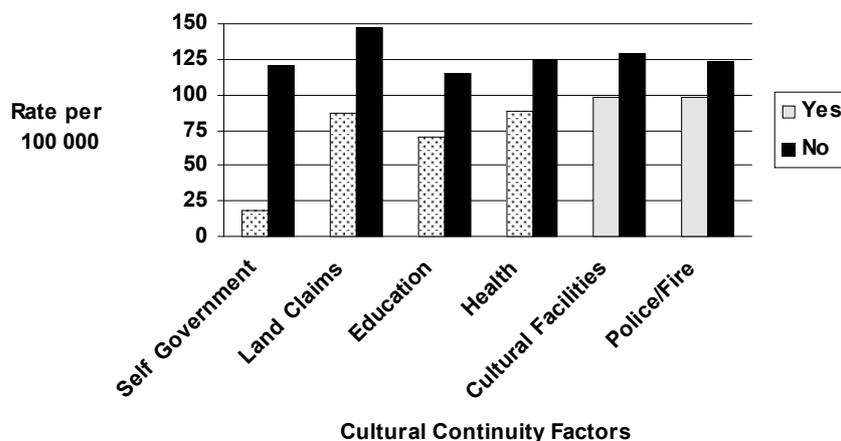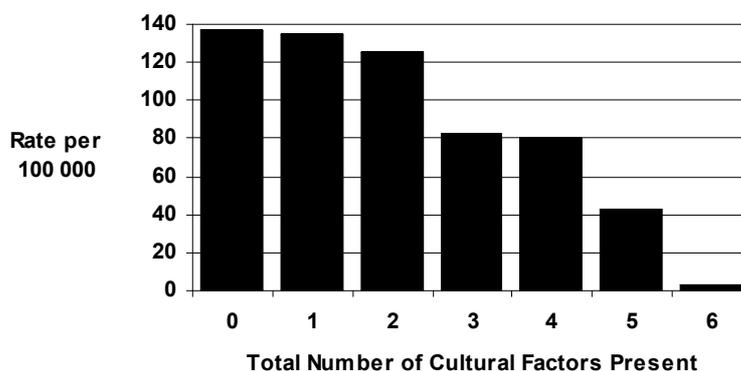

Figure 8. British Columbia Aboriginal suicide rate (per 100 000) by total number of cultural continuity factors present in communities (Chandler et al 2003).

professions contribute to this, it must be through influencing Indigenous agendas and in support of Indigenous leaders. To that end, as non-Indigenous professionals we should be engaged through "ethical relationships", as has been recommended in terms of a values-based approach to Aboriginal and Torres Strait Islander health research by the National Health and Medical Research Council (NHMRC 2003).

Back to Redfern: atonement and autonomy

To move on requires going back to Redfern – to Keating's acknowledgement and then on to the other recommendations of the Stolen Generations Inquiry. Colin Tatz (1983) anticipated this two decades earlier when he stated that atonement (in the sense of reparation and reconciliation) demands acknowledgment, restoration – returning what can be, and restitution – compensation for what cannot. That will be a major issue for

the nation. It may involve a treaty, Indigenous political representation, or sovereignty, as in Canada, the United States and New Zealand (Hocking 2005). It will entail a cost. Mindful of Sacher's assessment that "you have an education problem", I suggest that one component should be **sustained** commitment of **sufficient** resources to ensure parity in educational **outcomes** between Indigenous and mainstream children – compensation for the violation of past generations by empowering those of the future. We should note societies, for instance New Zealand and Hawaii, where this has strengthened culture. It will certainly strengthen Indigenous agency and, ultimately, Australia. Education is important for health and both are critical to fair equality of opportunity, but health may be the most potent stimulus for public support and political will.

I have suggested that in addition to our 'modest but practical ways' as doctors, which we should do well, the 'middle E' in relation to Indigenous Australia relates to the relationship of health and other rights, particularly education. I have also tried to articulate how I have sought to resolve the tensions between the competing values and motivations that challenge me in my work – particularly that between supporting autonomy versus "justified paternalism". What medical professionals can provide is theory, expertise, evidence and advocacy. As Robert Beaglehole (2006:260) recently commented, the critical question for public health practitioners: "is how to build the social movement to support nascent political efforts to address the unacceptable levels of health inequalities in all societies". We should also respond opportunistically to political winds. For instance, in relation to recent suggestions of "shutting down" 'dysfunctional' remote communities such as Palm Island (Anderson 2006; Gerard 2006), or of rationalising economic dependence (Altman 2005), I think that we should argue that both are unacceptable. Regardless of its obvious problems, so is shutting down CDEP without alternatives – as is happening now. Rather, policy and effort should be directed towards enabling choice and providing the means to influence individual and collective destinies. However that is done, it will demand educational outcomes. We owe this as a nation and can advance it through health advocacy as a profession. In practice, I consider that the conflict between actions driven by outcomes versus autonomy or justice can only be resolved through reflective practice, including awareness of our capacity to cause harm despite best intentions. The 'middle E' will not be found in inflexible investment in either values or outcomes, but in recognising the limits of such certainties in the face of social complexity and the need, then, for reflection-based judgement informed by an awareness of our own limitations.

Australian doctors are almost all non-Indigenous. While with time that will change, I have avoided the safe option of saying: "it's not for us to decide". As doctors we must make decisions, hopefully based on informed judgements. And while we belong to what Noel Pearson (2002) calls "the progressive, liberal-minded intellectual middle class", it might be recalled that it was from this group that a lawyer, Hal Wooten, and a doctor, Fred Hollows, thirty-five years ago took a critical look at the performance of their respective professions in relation to Indigenous Australians and enabled a paradigm shift with the formation of Indigenous services – in Redfern (Jennett 1999). Maybe that was their 'middle E'. Whether or not, they would have agreed with Paul Keating's plea in that place twenty years later for imagination and ideals. Finally I leave you with the words of Nicholas Rescher (1987:83):

> The useful work of an ideal is to serve as a goad to effort by preventing us from resting complacently satisfied with the unhappy compromises demanded by the harsh realities of a difficult world.

AUTHOR

The author is an Australian medical graduate trained in adult, child and cross-cultural psychiatry and public health in the United States who has been working in Aboriginal and Torres Strait Islander health in remote northern Australia for most of the last two decades. He is currently Regional Psychiatrist with the Remote Area Mental Health Service of Queensland Health and Adjunct Professor of Public Health (Mental Health) in the North Queensland Health Equalities Promotion Unit in the School of Population Health of the University of Queensland based in Cairns.

Ernest Hunter, Remote Area Mental Health Team, North Queensland Health Equalities Promotion Unit, PO Box 1103, Cairns 4870 / 07 4046 8568 / 0409 347 870 / ernest_hunter@health.qld.gov.au

References

Adams, C. 2005 Melancholic attachments: the making and medicalisation of Aboriginal 'loss', Unpublished Doctoral thesis, The Australian National University, Canberra.

Altman, J. 2005 Development options on Aboriginal land: sustainable Indigenous hybrid economies in the twenty-first century. Pp.34-48 of *The Power of Knowledge: The Resonance of Tradition,* edited by L. Taylor, GK Ward, G Henderson, R Davis and LA Wallis. Aboriginal Studies Press, Canberra.

Altman, J., N. Biddle and B. Hunter 2005 A historical perspective on Indigenous socio-economic outcomes in Australia 1971-2001. *Australian Economic History Review* 45(3):273-295. 2005.

AMA 2001 *AMA Position Statement: The Links between Health and Education for Indigenous Australian Children*. Australian Medical Association, Sydney.

AMA 2005 *Position Statement on Aboriginal and Torres Strait Islander Health*. Australian Medical Association, Sydney.

Andersen, J. 2006 Lindsay wants Palm closed. *Townsville Bulletin*, 5 January 2006.

Anonymous 1998 Introduction. Pp.1-32 of *Citizenship and Indigenous Australians: Changing conceptions and possibilities*, edited by N. Peterson and W. Sanders. Cambridge University Press, Cambridge.

Anonymous 2001 *First Steps: Report of a workshop to plan training for those responding to disclosures of child sexual abuse in Indigenous Australian contexts*. Sexual Health Program, Communicable Disease Control Branch, Health Department of Western Australia, Perth.

Anonymous 2005 *Overcoming Indigenous Disadvantage: Key indicators 2005*. Productivity Commission, Canberra (Steering Committee for the Review of Government Service Provision).

Arabena, K. 2005 *Not Fit for Modern Australian Society: Aboriginal and Torres Strait Islander people and the new arrangements for the administration of Indigenous affairs.* Australian Institute of Aboriginal and Torres Strait Islander Studies, Canberra (Research Discussion Paper 16).

ABC TV 2005 Kerry O'Brien speaks with Noel Pearson. *7:30 Report* 14 November 2005, Australian Broadcasting Commission, accessed 15 November 2005 <http://www.abc.net.au/7.30/content/2005/s150651.htm>.

Beaglehole, R. 2006 The challenge of health inequalities. *Lancet* 367 (9510):259-260.

Beauchamp, T.L. and J.F. Childress 1994 *Principles of Biomedical Ethics* (fourth edition). Oxford University Press, New York.

Bhatia, K. and P. Anderson 1995 *An Overview of Aboriginal and Torres Strait Islander Health: Present status and future trends*. Australian Institute of Health and Welfare, Canberra.

Biddle, N., B. Hunter and R. Schwab 2004 *Mapping Indigenous Education Participation*. Centre for Aboriginal Economic Policy Research, The Australian National University, Canberra (Discussion Paper 267).

Bloch, S. and P. Chodoff (eds) 1981 *Psychiatric Ethics*. Oxford University Press, Oxford.

Booth, A. and N. Carroll 2005 The heath status of Indigenous and non-Indigenous Australians, Forschingsinstitut zur Zukunft der Arbeit (Institute for the Study of Labour), Bonn (IZA Discussion Paper 1534).

Brady, M., S. Kunitz and D. Nash 1997 WHO's definition? Aborigines, conceptualisations of health and the World Health Organization, Pp.272-290 of *Migrants, Minorities and Health. Historical and Contemporary Studies*, edited by L. Marks and M. Worboys. Routledge, London.

Brady, M. 2004 *Indigenous Australia and Alcohol Policy: Meeting difference with indifference*. University of New South Wales Press, Sydney.

Brady, M. 2005 Making use of medics: Overcoming cultural constraints in alcohol interventions, Pp.130-140 of *The Power of Knowledge: The Resonance of Tradition,* edited by L. Taylor, GK Ward, G Henderson, R Davis and LA Wallis. Aboriginal Studies Press, Canberra.

Brock, P. 1993 *Outback Ghettos: A History of Aboriginal institutionalisation and survival*. Cambridge University Press, Melbourne.

Brody, E.B. 1966 Cultural exclusion, character and illness. *American Journal of Psychiatry* 122(2):852-858.

Calver, J., A. Wiltshire, C. D'Arcy J. Holman, E. Hunter, C. Garfield, D. Rosman 2005 Does health assessment improve health outcomes in Indigenous people? An RCT with 13 years of follow up. *Australian and New Zealand Journal of Public Health* 29(2):107-111.

Chandler, M.J., C.E. Lalonde, B.W. Sokol, and D. Hallett 2003 Personal persistence, identity development, and suicide: a study of Native and non-Native North American adolescents. *Monographs of the Society for Research in Child Development* 68(2):vii-viii, 1-138.

Charlton, K. and M. McKall 2004 *Statistics on Juvenile Detention in Australia: 1981-2003*. Australian Institute of Criminology, Canberra (Technical and background paper 10).

Clendinnen, I. 2003 *Dancing with Strangers*. Text Publishing, Melbourne.

Coady, M. and S. Bloch (eds) 1996 *Codes of Ethics and the Professions*. Melbourne University Press, Melbourne.

Collard, K.S., H.A.D'Antoine, D.G. Eggington, B.R. Henry, C.A. Martin and G.H. Mooney 2005 'Mutual' obligation in Indigenous health: can shared responsibility agreements be truly mutual? *Medical Journal of Australia* 182(10):502-504.

Collins, R.1999 *Learning Lessons: An independent review of Indigenous education in the Northern Territory*. Northern Territory Department of Education, Darwin.

Collman, J. 1979 Women, children and the significance of the domestic group to urban Aborigines in Central Australia. *Ethnology* 18:379-397.

Collman, J. 1988 *Fringe-Dwellers and Welfare: The Aboriginal response to bureaucracy*. University of Queensland Press, St Lucia.

Craig, E. 2000 Growing to Term: The Determinants of Low Birth Weight among Indigenous Babies in an Urban Queensland Community. Unpublished MPH Thesis, University of Queensland, St Lucia.

Crombie, I.K., L. Irvine, L. Elliott and H. Wallace 2005 *Closing the Health Inequalities Gap: An international perspective*. World Health Organization, Geneva.

Cynader, M.S. and B.J. Frost 1999 Mechanisms of brain development: Neuronal sculpting by the physical and social environment. Pp.153-184 of *Developmental Health and the Wealth of Nations: Biological, Social and Educational Dynamics*, edited by D.P. Keating and C. Hertzman. Guilford. New York.

Daniels, N. 1985 *Just Health Care*. Cambridge University Press, Cambridge (Studies in Philosophy and Health Policy edited by D. Wikler).

Das, V. 1994 Moral orientations to suffering: Legitimation, power, and healing. Pp.139-167 of *Health and Social Change in International Perspective*, edited by C. Chen, A. Kleinman and N. Ware. Harvard University Press, Boston.

Davidson, J.A. 2003 Presentation of near-hanging to an emergency department in the Northern Territory. *Emergency Medicine* (Fremantle) 15(1):28-31.

De Leo, D. and T. Heller 2004 *Suicide in Queensland 1999-2001: Mortality rates and related data*. Australian Institute for Suicide Research and Prevention, Brisbane.

Dodson, P. and N. Pearson 2004 The dangers of mutual obligation. *The Age*, 15 December 2004, p.17.

Evans, R. and B. Stoddart 1994 Producing health, consuming health care. Pp.27-64 of *Why are Some People Healthy and Others Not*, edited by R. Evans, M. Barer and R. Theodore. Aldine de Gruyter, New York.

Filc, D. 2004 The medical text: between biomedicine and hegemony. *Social Science and Medicine* 59(6):1275-1285.

Fremantle, J., A.W. Read, N.H. de Klerk, D. McAullay, I.P. Anderson and F. Stanley 2006 Patterns, trends, and increasing disparities in mortality for Aboriginal and non-Aboriginal infants born in Western Australia, 1980-2001: Population database study. *Lancet* 367 (9524):1758-1766.

Gaita, R. 1999 *A Common Humanity: Thinking about love and truth and justice*. Text Publishing, Melbourne.

George, K. 2003 Exclusive rights: ongoing exclusion in resource rich Aboriginal Australia. *Australasian Psychiatry* 11 (Supplement): S9-S12.

Gerard, I. 2005 Boarding key for our kids: Pearson. *The Australian*, 7 December 2005, p. 2.

Gerard, I. 2006 Remove Palm Islanders: Lib MP. *The Australian*, 6 January 2006.

Gillon, R. 1985 *Philosophical Medical Ethics*. John Wiley and Sons, Chichester.

Gluckman, P.D., M.A. Hanson, H.G. Spencer and P. Bateson 2005 Environmental influences during development and their later consequences for health and disease: implications for the interpretation of empirical studies. *Proceedings of the Royal Society* 272:671-77.

Greenspan, S.I. and S.G. Shanker 2004 *The First Idea: How symbols, language and intelligence evolved from our primate ancestors to modern humans*. Da Capo Press, Cambridge MA.

Gregory, B. 2005 Asking the right questions. Presentation to Conference on Indigenous Socioeconomic Outcomes: Assessing Recent Evidence, Centre for Aboriginal Economic Policy Research, The Australian National University, Canberra, 11-12 August 2005.

Hall, W., E. Hunter and R. Spargo 1993 Alcohol-related problems among Aboriginal drinkers in the Kimberley region of Western Australia. *Addiction* 88(8):1091-100.

Hall, W., E. Hunter and R. Spargo 1994 Alcohol use and incarceration in a police lockup among Aboriginals in the Kimberley region of Western Australia. *Australian Journal of Criminology* 27:57-73.

Hamilton, A. 1981 *Nature and Nurture: Aboriginal child-rearing in north-central Arnhem Land*. Australian Institute of Aboriginal Studies, Canberra.

Hertzman, C., J. Frank and R. Evans 1994 Heterogeneities in health status and the determinants of population health. Pp.67-92 of *Why are Some People Healthy and Others Not? The Determinants of Health of Populations*, edited by R. Evans, M. Barer, and T. Marmour. Aldine De Gruyter, New York.

Hertzman, C. and C. Power 2003 Health and human development: understandings from life-course research. *Developmental Neuropsychology* 24(2-3):719-44.

Hocking, B. (ed.) 2005 *Unfinished Constitutional Business? Rethinking Indigenous self-determination*. Aboriginal Studies Press, Canberra.

Hughes, R. 1988 *The Fatal Shore*. Pan, London.

Hughes, H. 2005 *The Economics of Indigenous Deprivation and Proposals for Reform*. The Centre for Independent Studies, Sydney.

HREOC (Human Rights and Equal Opportunity Commission) 1997 *Bringing them home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*. Australian Government Publishing Service, Canberra.

HREOC 2005a *Indigenous Young People with Cognitive Disabilities and Australian Juvenile Justice Systems*. A Report by the Aboriginal and Torres Strait Islander Social Justice Commissioner. Human Rights and Equal Opportunity Commission, Sydney.

HREOC 2005b *Aboriginal and Torres Strait Islander Social Justice Commissioner: Social justice report 2005*. Human Rights and Equal Opportunity Commission, Sydney.

Hunter, E. 1993a The snake on the caduceus: dimensions of medical and psychiatric responsibility in the Third Reich, *Australian and New Zealand Journal of Psychiatry* 27(1):149-56.

Hunter, E. 1993b *Aboriginal Health and History: Power and Prejudice in Remote Australia*. Cambridge University Press, Melbourne.

Hunter, E. 1996 Denial, rationalisation and trivialisation of state intrusion into Aboriginal family life. *Family Matters* 44(2):16-19.

Hunter, E. 1997 At the healer's limits: Three medical survivors of Auschwitz. Pp.231-262 of *Genocide Perspectives 1: Essays in Comparative Genocide*, edited by C. Tatz. Centre for Comparative Genocide Studies, Sydney.

Hunter, E. 1999 Considering the changing environment of Indigenous child development. *Australasian Psychiatry* 7(3):137-40.

Hunter, E. 2000 Unmet need in Indigenous health. Where to start? Pp 356-362 of *Unmet need in psychiatry: Problems, resources, responses*, edited by G. Andrews and S. Henderson. Cambridge University Press, Cambridge.

Hunter, E. 2001 "…the deep sleep of forgetfulness": reflecting on disremembering. *Proceedings of: Advanced Study Institute: The mental health of Indigenous peoples*. Culture and Mental Health Research Unit, Division of Social and Transcultural Psychiatry, McGill University, Montreal.

Hunter, E. 2002 'Best intentions' lives on: untoward health outcomes of some contemporary initiatives in Indigenous affairs. *Australian and New Zealand Journal of Psychiatry* 36(5):575-84.

Hunter, E. 2006 Social engineers and bystanders: the limits of 'responsibility' in Indigenous affairs. *Australian Psychiatry* 14(1):24-32.

Hunter, E. in press The protracted dawning of the 'Bran Nue Dae': Aboriginal suicide in social context. *A Global Perspective on Problems of Identity and Suicide in Indigenous Minority Youth*, edited by M. Chandler, C. Lalonde and C. Lightfoot. Lawrence Erlbaum and Associates, Mahwah NJ.

Hunter, E.M., W.D. Hall and R.M. Spargo 1992 Patterns of alcohol consumption in the Kimberley Aboriginal population. *Medical Journal of Australia* 156(11):764-8.

Hunter, E., J. Reser, M. Baird and P. Reser 2001 *An Analysis of Suicide in Indigenous Communities of North Queensland: the historical, cultural and symbolic landscape*. Commonwealth Department of Health and Aged Care, Canberra.

Jennett, C. 1999 Policing and Indigenous peoples in Australia. Paper presented to the History of Crime, Policing and Punishment Conference, Australian Institute of Criminology, and Charles Sturt University, 9-11 December, Canberra.

Johnston, Elliott F. 1991 *Final report of the Royal Commission into Aboriginal Deaths in Custody*. Australian Government Publishing Service, Canberra.

Jones, A.R. 1999a William Redfern (1775?-1833): Mutineer to colonial surgeon in New South Wales. Part 1: Shock and recovery. *Journal of Medical Biography* 7:35-41.

Jones, A.R. 1999b William Redfern (1775?-1833): Mutineer to colonial surgeon in New South Wales. Part II: Promise and default. *Journal of Medical Biography* 7:78-85.

Keating, D.P. and F.K. Miller 1999 Individual pathways in competence and coping: From regulatory systems to habits of mind. Pp.220-233 of *Developmental Health and the Wealth of Nations: Social, biological and educational dynamics*, edited by D.P. Keating and C. Hertzman. Guilford, New York.

Keating, D.P. and C. Hertzman 1999 Modernity's paradox. Pp.1-17 of *Developmental Health and the Wealth of Nations: Social, biological and educational dynamics*, edited by D.P. Keating and C. Hertzman. Guilford: New York..

Keating, P. 2005 Speech at the launch of the Year for Indigenous People. Pp.135-142 of *Great Speeches: Words that made history*. Viking, Melbourne.

Kelly, S., C. Hertzman and M. Daniels 1997 Searching for the biological pathways between stress and health. *Annual Review of Public Health* 18:437-62.

Koch, T. 2006 Circuit breaker. *The Australian*, 2 May 2006, p.11.

Lavoie, J. 2004 Governed by contracts: the development of indigenous primary health services in Canada, Australia and New Zealand. *Journal of Aboriginal Health* 1(1):6-22.

LeVine, R., S. LeVine, A. Richman, F. Uribe and C. Correa 1994 Schooling and survival: The impact of maternal education on health and reproduction in the Third World. Pp.303-338 of *Health and Social Change in International Perspective*, edited by L. Chen, A. Kleinman, and N. Ware. Harvard University Press, Boston.

Lichtenberg, J. 1996 What are codes of ethics for? Pp.13-27 of *Codes of Ethics and the Professions*, edited by M. Coady and S. Bloch. Melbourne University Press.

Macdonald, G. 2000 An economy out of kilter: demand sharing among the Wiradjuri. Seminar presentation to Department of Archaeology and Anthropology, The Australian National University, Canberra.

Macdonald, G. 2001 'Policy is for the policy makers': the cultural cost of different visions, Paper presented to National Social Policy Conference, Competing Visions, Sydney, 4-6 July. Accessed 12 July 2006 <http://www.sprc1.sprc.unsw.edu.au/nspc2001/abstract.asp?PaperID=62>.

Marmot, M. 2003 Self esteem and health: autonomy, self esteem, and health are linked together. *British Medical Journal* 327:574-575.

Martin, D. 1993 Autonomy and Relatedness: An Ethnography of Wik People of Aurukun, Western Cape York Peninsula. Unpublished Doctoral thesis, The Australian National University, Canberra.

Martin, D. 2001 *Is welfare dependency 'welfare poison'? An assessment of Noel Pearson's proposal for Aboriginal welfare reform*. Centre for Aboriginal Economic Policy Research, The Australian National University, Canberra (CAEPR Discussion Paper 213).

McCoy, B.F. 2004 Kanyirninpa: Health, Masculinity and Wellbeing of Desert Aboriginal Men, Unpublished Doctoral thesis, Centre for the Study of Health and Society, School of Population Health, The University of Melbourne.

McEwen, B. and L.E. Norton 2004 *The End of Stress as we Know it*. Joseph Henry Press, Washington DC.

McKenna, M. 2006 Aborigines choose welfare over work. *The Australian*, 22 February 2006 p.1.

Myers, F. 1986 *Pintupi Country, Pintupi Self: Sentiment, place and politics among Western Desert Aborigines*. Smithsonian Institution Press, Washington DC.

NHMRC 2003 *Values and Ethics: Guidelines for ethical conduct in Aboriginal and Torres Strait Islander Health Research*. National Health and Medical Research Council, Canberra.

Nyiszli, M. 1973 [1946] *Auschwitz: A doctor's eye-witness account*. Grafton Books, London.

O'Leary, C. 2002 *Foetal Alcohol Syndrome: A literature review*. Commonwealth Department of Health and Ageing, Canberra (Report for the National Expert Advisory Committee on Alcohol).

Palmer, K. 2005 Dependency, technology and governance. Pp.101-115 of *The Power of Knowledge: The Resonance of Tradition,* edited by L. Taylor, GK Ward, G Henderson, R Davis and LA Wallis. Aboriginal Studies Press, Canberra.

Parker, M. 2004 Medicalizing meaning: demoralization syndrome and the desire to die. *Australian and New Zealand Journal of Psychiatry* 38(10):765-773.

Parker, R. 1999 An Audit of Coronial Records for the 'Top End' of the Northern Territory comparing factors in Aboriginal Suicide against other Suicides in the Region. Unpublished dissertation, Royal Australian and New Zealand College of Psychiatrists, Melbourne.

Parker, R. and D.I. Ben-Tovim 2002 A study of factors affecting suicide in Aboriginal and 'other' populations in the Top End of the Northern Territory through an audit of coronial records. *Australian and New Zealand Journal of Psychiatry* 36,(3):404-10.

Pearson, N. 2002 The need for intolerance. Pp.21-30 of *The Best Australian Essays,* edited by P. Craven. Black Inc, Melbourne.

Peterson, N. 1993 Demand sharing: Reciprocity and the pressure for generosity among foragers. *American Anthropologist* 94(5):860-874.

Power, C. and C. Hertzman 1999 Health, well-being and coping skills. Pp.41-54 *Developmental Health and the Wealth of Nations: Social, biological and educational dynamics*, edited by D.P. Keating and C. Hertzman. Guilford, New York,

Rawls, J. 1999 *A Theory of Justice* (revised edition). Belknap Press, Harvard University Press, Cambridge, MA.

Read, P. 1981 *The Stolen Generations: The removal of Aboriginal children in New South Wales 1883-1969*. Ministry of Aboriginal Affairs, Sydney (Occasional Paper 1).

Rescher, N. 1987 *Ethical Idealism: An inquiry into the nature of functions and ideals*. University of California Press, Berkeley.

Ring, I. and D. Firman 1998 Reducing indigenous mortality in Australia: lessons from other countries. *Medical Journal of Australia* 169:528-533.

Ring, I. and N. Brown 2003 The health status of indigenous peoples and others. *British Medical Journal* 327:404-405.

Rodger, N.A.M. 1997 *The Safeguard of the Sea: A naval history of Britain 660-1649*. W.W. Norton, New York.

Rowse, T. 1998 Indigenous citizenship and self-determination: the problem of shared responsibilities. Pp.79-100 *Citizenship and Indigenous Australians: Changing Conceptions and Possibilities*, edited by N. Peterson and W. Sanders. Cambridge University Press, Melbourne,

RANZCP 1999 *Ethical Guideline # 11: Principles and guidelines for Aboriginal and Torres Strait Islander mental health*, Royal Australian and New Zealand College of Psychiatrists, Melbourne.

RANZCP 2004 *The RANZCP Code of Ethics*. Royal Australian and New Zealand College of Psychiatrists, Melbourne.

Sanders, W. 1998 Citizenship and the Community Development Employment Projects scheme - equal rights, difference and appropriateness. Pp.141-153 of *Citizenship and Indigenous Australians: Changing Conceptions and Possibilities*, edited by N. Peterson and W. Sanders, Cambridge University Press, Melbourne,

Schmitt, L.H., G.A. Harrison, R.M. Spargo, T. Pollard and G. Ungpakorn 1995 Patterns of cortisol and adrenaline variation in Australian Aboriginal communities of the Kimberley region. *Journal of Biosocial Sciences* 27(1):106-116.

Schmitt, L.H., G.A. Harrison, and R.M. Spargo 1998 Variation in epinephrine and cortisol excretion rates associated with behaviour in an Australian Aboriginal community. *American Journal of Physical Anthropology* 106(2):249-253.

Schmitt, L.H., G.A. Harrison and S. Hisheh [in press] Cortisol and daily life in an Australian Aboriginal community.

Schore, A.N. 1994 *Affect Regulation and the Origin of the Self: The neurobiology of emotional development*. Hillsdale, Erlbaum.

Schore, A.N. 2003 Early relational trauma, disorganized attachment, and the development of a predisposition to violence. Pp.107-167 *Healing Trauma: Attachment, mind, body, brain*, edited by M.F. Solomon and D.J. Siegel. WW Norton, New York,

Smith, R.M., R.M. Spargo, E.M. Hunter, R.A. King, R.L. Correll, I.Hamilton Craig and P. Nestle 1992a Prevalence of hypertension in Kimberley Aborigines and its relationship to ischaemic heart disease. An age-stratified random survey. *Medical Journal of Australia* 56(8):557-62.

Smith, R.M., R.M. Spargo, R.A. King, E.M. Hunter, R.L. Correll and P. Nestel 1992b Risk factors for hypertension in Kimberley Aborigines. *Medical Journal of Australia* 156(8):562-6.

Stannard, B. 2005 Labour's great black hope. *The Weekend Australian*, 31 December 2005, pp.20.

Sutton, P. 2001 The politics of suffering: Indigenous policy in Australia since the 1970s. *Anthropological Forum* 11(2):125-171.

Sutton, P. 2005 The politicisation of disease and the disease of politicisation: causal theories and the Indigenous health differential, Paper presented to Eighth Rural Health Conference, Alice Springs.

Syme, S. 1997 Individual vs. community interventions in public health practice: some thoughts about a new approach. *Health Promotion Matters* 2:2-9.

Tatz, C. 1983 Aborigines in the age of atonement. *Australian Quarterly* 55(3):291-306.

Thomas, M. 2004 Antecedents of renal disease in Aborigines. *Nephrology* (Carlton) 9 (Supplement 4):S113-S116.

Thomas, M. 2005 Deprivation and dialysis: pathways to kidney failure in Australian Aborigines. *Advanced Chronic Kidney Disease* 12(1):84-87.

Torney, K. 2001 William Redfern. *The Oxford Companion to Australian History*, edited by G. Davison, J. Hirst and S. MacIntyre. Oxford University Press, Melbourne.

Tremblay, R.E. 1999 When children's social development fails. Pp.55-71 of *Developmental Health and the Wealth of Nations: Social, Biological and Educational Dynamics*, edited by D.P. Keating and C. Hertzman. Guilford, New York.

Trewin, D. and R. Madden 2005 *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*. Australian Bureau of Statistics and the Australian Institute of Health and Welfare, Canberra.

Trudgen, R. 2000 *Why Warriors Lie Down and Die: Towards an understanding of why Aboriginal people of Arnhem Land face the greatest crisis in health and education since European contact*. Aboriginal Resource and Development Services, Darwin.

Weinstock, M. 2004 The potential influence of maternal stress hormones on development and mental health of offspring. *Brain, Behaviour, and Immunity* 19(4):296-308.

Werner, E.E. 1989 Children of the Garden Isle. *Scientific American* (April):76-81.

Werner, E.E. 2004 Journeys from childhood to midlife: risk, resilience, and recovery. *Paediatrics* 114(2):492.

Wilkinson, R. and M. Marmot 2003 *Social Determinants of Health: The solid facts* (second edition). World Health Organization, Geneva.

Wiltshire, A. and E. Hunter 2004 *Evaluation of Population Health Research as a Health Intervention: Follow up thirteen years after a survey of alcohol, health and lifestyle of Aboriginal residents of the Kimberley*. A Report of Results Prepared for the Brewers' Foundation, School of Population Health, University of Western Australia, Perth.

Wooldridge, M. 1988 *William Redfern Oration*. Royal Australasian College of Physicians Annual Conference, 12 May 1988.

Zubrick, S.R., D.M. Lawrence, S.R. Silburn, E. Blair, H. Milroy, T. Wilkes, S. Eades, H. D'Antoine, A. Read, P. Ishiguchi and S. Doyle 2004 *The Western Australian Aboriginal Child Health Survey: The Health of Aboriginal Children and Young People*, Telethon Institute for Child Health Research, Perth.

Zubrick, S.R., S.R. Silburn, D.M. Lawrence, F.G. Mitrou, R.B. Dalby, E.M Blair, J. Griffin, H. Milroy, J.A. De Maio, A. Cox and J. Li 2005 *The Western Australian Aboriginal Child Health Survey: The social and emotional wellbeing of Aboriginal children and young people*. Curtin University of Technology and Telethon Institute for Child Health Research, Perth.

Zubrick, S.R., S.R. Silburn, J.A. De Maio, C. Shepherd, J.A. Griffin, R.B. Dalby, F.G. Mitrou, D.M. Lawrence, C. Hayward, G. Pearson, H. Milroy, J. Milroy and A. Cox 2006 *The Western Australian Aboriginal Child Health Survey: Improving the educational experiences of Aboriginal children and young people*. Curtin University of Technology and Telethon Institute for Child Health Research, Perth.

---

[i] Of course, some have argued that broad concepts of health and health responsibilities, such as flowing from the WHO definition of health, can lead to inertia as EVERYTHING becomes health policy (Evans and Stoddart 1994). Maggie Brady has raised this as an issue in relation to incorporation of the WHO definition into Indigenous constructions of health in Australia (Brady, Kunitz and Nash 1997; Brady 2004).

[ii] These may be compared to the six 'values' underpinning the National Health and Medical Research Council guidelines for ethical conduct in Aboriginal and Torres Strait Islander research: spirit and integrity; reciprocity; respect; equality; survival and protection; and responsibility (NHMRC 2003).

[iii] Autonomy in this sense relates to its usual usage as a quality or right of self-governance. However, it is also used in terms of personal freedoms, particularly in the context of the tensions between autonomy and relatedness in the construction of Aboriginal identity and definition of a sense of 'self' (Hamilton 1981; Myers 1986; Martin 1993). While both levels are related, in this paper autonomy is used, primarily, in the first, self-governance sense. Further, at the individual level, autonomy and 'control' are often used interchangeably. However, at least in terms of the above discussions of Indigenous identity construction, autonomy refers to personal freedom of action, which is quite different to control in the sense of control of destiny.

iv As noted by Jeff Collmann (1979, 1988) 'choice' is also confounded by the constraints of the welfare economy and Indigenous responses to the social and economic controls of bureaucracy.

v Obviously this does not necessarily apply to all doctors or doctors' recommendations. Such suasive effect is also informed by structural issues and personal attributes that, in the case of recommendations that involve significant changes in 'lifestyle', depend on the nature of the relationship between the doctor and Indigenous patient.

vi Filc (2004:1277) stated that "medicalization has two major aspects. The first one is the desocialization of illness and disease so as to obscure the social processes working in their production. The second one is the explanation of social phenomena in biomedical terms". It is in this latter sense that the term is being used here.

vii I am grateful to Daniel Tarantola for these insights (personal communication, 10 March 2006).

viii Presentation at the launch of the *Social Justice Report 2005*, Sydney, 10 March 2006.

ix In relation to Noel Pearson's proposals, David Martin (2001) has argued that some of the values associated with 'passive welfare dependence' have arisen as a conjunction of the effects of the policies of the last three decades and pre-existing Aboriginal values and practices.

x The rights of school children to be adequately fed vs of parents to discretionary non-sustenance use of welfare income was recently the focus of an article in *The Australian* (quoting Noel Pearson at length) in support of opinions ("not government policy at this stage") voiced by Indigenous Affairs Minister, Mal Brough, regarding quarantining payments to ensure child nutrition and, thus, school attendance (Koch 2006).