Abroad thoughts from home

T G Ashworth

A sabbatical on the NHS? None of my colleagues could offer advice, but on inquiring from our man in Birmingham I was told that it would be possible provided that I did not need to be paid. Over a year before leaving I set the wheels in motion to join the department of health as a locum pathologist in Darwin in the Northern Territory of Australia. Why Darwin? Having spent the first 20 years of my professional life in Africa I wanted to return to somewhere similar, a bush sabbatical in fact. A colleague, an ex-student, had invited me and I was curious to know what it was that made some people compare South Africa with Australia in its treatment of the indigenous inhabitants.

I had three immediate impressions. Firstly, the birds were all novel and exciting in their spectral colours and strident noises. Secondly, the Royal Darwin Hospital was distinctly non-Third World and far removed from a bush hospital. There was a computed tomographic scanner, an intensive care unit, and the best departmental library I had known on site. Thirdly, aboriginal patients were sitting on the ground outside the hospital in the shade, some attached to their dripstands and others enjoying a cigarette, denied them upstairs. This made me feel that I had returned to the Third World.

With only 145 000 inhabitants in the Northern Territory, which is 960 km by 1600 km, and several other smaller hospitals the surgical pathology was not as varied as in Coventry. But compensation came from being one of three pathologists and thus having duties in clinical pathology, which I had not quite forgotten. The major interest for me was in the necropsies, performed mainly for the coroner and rather delightfully referred to as "coronials."

Violence, of one sort or another, dominated. A hedonistic lifestyle, no real speed limit on the excellent straight roads, arguments that tended to be settled by physical means, and alcoholic excess were not conducive to peaceful coexistence.

Many people think that those who spend only a few months in some foreign place should not pronounce on the problems. I believe the reverse to be true. I realised soon after my arrival that it would be difficult to get to know an aborigine personally. There were hardly any working in the hospital and very few "full bloods" working anywhere. It also became apparent that I did not know what an aborigine was. At the top of the hospital request forms were two little boxes for ethnic origin—"aboriginal" and "other." When I tried to describe someone as "Euro-aboriginal" or "Indoaboriginal" I was asked to avoid such terms, they were either aboriginal or other.

Claiming aboriginal status in the Northern Territory, however far your genes are diluted, is a plus so far as social security and welfare is concerned and "sit down" money is the main source of income for the majority. So emotive is the subject that attempts to categorise population data according to racial mix, lifestyle, diet, etc, are fraught with difficulties. However inaccurate these epidemiological factors might be, the stark reality for most major diseases, both of the West and the Third World, put aborigines way ahead in the morbidity and mortality stakes.

So I read, I listened, and observed. The problem was never far removed from day to day conversation.

Health care is of the highest order notwithstanding the vast distances and logistics required to get patients to hospital. Leprosy is controlled, measles largely eradicated by immunisation, and hookworm anaemia is no longer the threat of the past. But infections jostle with malnutrition in its widest sense. Obesity, alcoholism, chronic obstructive airways disease, diabetes, hypertension, and coronary artery disease are all added to the Third World background.

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The juxtaposition of the two cultures is hard to comprehend for an outsider, so I will describe one such scene. One afternoon an elder in a remote community died, and as he had not been seen in the past three months by one of the "Air Med" doctors his death became a "coronial." We were taken by four wheel drive vehicle across a flat plain, dotted with horses and cattle, to the spotless clinic run by an aboriginal health assistant. On the wall was a framed certificate, testifying to her undoubted ability. I perused the clinic notes of the deceased, with details going back 15 years, including immunisations, blood antibody status, and treatments for various minor conditions. In these notes were details of three separate transfers to Darwin Hospital. One was for iron deficiency anaemia (hookworm), another for accidental poisoning by duplicating fluid, acquired by breaking into the local school storeroom. The dead man had been left nearly blind and hemiplegic by the spree. The third and most recent admission had been to assess his chronic obstructive airways disease.

With all this relevant information, an account of his recent illness, and aided by samples taken from the body without recourse to necropsy, I was later able to give a valid cause of death, so avoiding the cost of transporting the body to Darwin and, more importantly, preventing the breach of a tribal taboo. What was so striking, however, was that this isolated community of 700 people, with next to no source of income, had been provided with cyclone withstanding houses, locally powered electricity, a radio telephone, and a satellite television dish, not to mention schools, clinic, water, sanitation, and regular visits by "Air Med" doctors.

The government, in its altruistic and supportive role, attempts to promote multiculturism, but what is the result? Education is available to all but poorly used and the aborigines' undoubted artistic ability is kept alive by white paternalism. Travel to aboriginal lands is by permit only: "It is an offence to bring . . . sell . . . consume alcoholic drinks . . ." is a common notice. This is a law made by aborigines themselves, the enforcement of which forms a major part of the work of the hard pressed (mainly white) police force. Petrol is banned on one island because of sniffing abuse; elsewhere, it is duplicating fluid. In sincere attempts to replace alcohol with something less toxic, missionaries introduced the Kava plant, a mild intoxicant. It is now being consumed in excess and found to cause its own long term toxic effects. Death in custody is at the moment the subject of a judicial commission, largely because of suicides among aborigines, some of whom may have been arrested for no more serious a crime than being drunk and disorderly. I do not envy the authorities in their attempts to cope with what seems to be a hopeless task. I can understand the frustrations of the "others" who think aborigines are being mollycoddled and given too many handouts—"the nation may have a guilty conscience but I have not. I am not responsible for what my grandfather did or did not do."

There were positive achievements in artistic subjects and in Australian rules football, where there is integration with white society.

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The overall impression was one of gloom and despair, a sort of corporate depressive illness, reflected in expressions on adult faces. Responses were not those I was used to. Eye contact was avoided and there was little laughter in each other's company, even when joined by alcohol. Perhaps the only answer is to let the aborigines be, support multiculturism, and allow time to heal, however many generations it may take. The real danger is that governmental largesse will destroy—some say it has already destroyed—the aborigines as a community. Although some might define their treatment as a form of apartheid, there is no real comparison with what is being practised in South Africa. However counterproductive present policies may be, they are being practised by a government that cares and it is the aborigines themselves who have requested a return to their isolation.

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