

From Northern Ireland to northern Australia: medicine in the Top End



R G Peter Watson

On 8 June 2009, I started work as a locum gastroenterologist on the other side of the world and in a very different environment to the one I was used to. The inspiration for my visit came from an article in the careers supplement to the *BMJ*.¹ A specialist trainee in infectious diseases wrote of his experiences working in Royal Darwin Hospital in the “Top End” of Australia’s Northern Territory. He described the hospital as modern and well equipped, but lacking a full-time gastroenterologist. On an impulse, I offered my services for 3 months, and my offer was accepted. I applied for a 3-month sabbatical — my first sabbatical — from my post of 18 years as a gastroenterologist at the Royal Victoria Hospital, Belfast, and a senior lecturer at Queen’s University Belfast, Northern Ireland, United Kingdom.

I must confess that I wasn’t entirely naïve about life and work in Australia. I had previously worked at the Austin and Heidelberg Repatriation hospitals in Melbourne for 18 months in 1990–1991, and I had been back “Down Under” on holiday in 2007, visiting Sydney and Melbourne, as well as Uluru (Ayers Rock) and Port Douglas. Having enjoyed both my previous trips to Australia, I was keen to work there again, especially in the Top End with its particular challenges, not least of which is its remote tropical location, far from Australia’s major cities.

After my impulsive decision, I had plenty of time to get used to the idea — negotiating my leave of absence and completing all the necessary paperwork for the Australian authorities took almost 2 years. With Australia’s NT designated as “an area of unmet need”, I was sponsored by the NT Government to obtain an advanced competency registration with the Australian Medical Council and a temporary residency visa for 3 months.

I arranged to go during the European summer so that my wife and our two youngest children (who were on school holidays in July and August) could join me for a good part of the time. This also meant we would be in Darwin in the dry, winter season, when the daytime temperature is a comfortable 32°C with moderate humidity, and avoid the very humid wet season.

On my first day at the hospital, I was given the role of general physician and put in charge of one of four admission teams, each consisting of a consultant, a registrar and one or two junior

doctors. Each team was on duty for 24 hours one weekday per week, and one weekend day for three out of four weekends, and responsible for 15–30 patients at any time, with up to 15 patients admitted on a take-in day. The hospital has an excellent emergency department as well as a rapid assessment planning unit, which was used jointly by physicians and surgeons to assess their patients in the first 24 hours after admission.

I soon discovered that there were three main categories of patients at Darwin Hospital: Aboriginal people from the Darwin area and much further afield; other local Darwinians, most of whom had moved to Darwin from other parts of Australia and South East Asia; and older, retired Australian tourists who come to the NT to escape the southern winter (the “grey nomads”). Patients from outside Darwin are brought in by air ambulance. The Royal Flying Doctor Service (RFDS) does not operate in the Top End of the NT, which has its own air ambulance service, but occasionally patients are flown to Darwin by the RFDS from Alice Springs or from areas of Western Australia and Queensland. It is often quicker to fly to Darwin than to one of the other major cities because of the immense distances involved.

Although about 30% of the NT population are Aboriginal and Torres Strait Islander people, most living in remote areas, they make up a disproportionate 40%–60% of the patient population at the hospital. This reflects the relatively poor health status of Indigenous Australians compared with the non-Indigenous population. Their high level of diabetes, chronic renal disease, hypertension, heart failure and alcoholism is a disturbing fact, as is their lower life expectancy; the life expectancy gap at birth between Indigenous and non-Indigenous people is 12 years for males and 10 years for females.² Furthermore, perinatal and infant mortality rates are two to three times non-Indigenous rates.² My stay helped me to appreciate the complex reasons for this situation, which encompass social and economic as well as educational factors, not to mention the difficulties of delivering health care to remote communities.

I greatly enjoyed the challenge of medical practice in a new environment. As well as the usual presentations of patients with neurological, cardiorespiratory and hepatic conditions, we were faced with cases of severe sepsis, tuberculosis, melioidosis (*Burkholderia pseudomallei*), rheumatic heart disease, severe complications of diabetes, meningitis and infected scabies. The radiological

Murals promoting Aboriginal health and reconciliation at the Oenpelli (Gunbalanya) Health Clinic, West Arnhem Land, NT (published with permission).



findings discussed at multidisciplinary meetings seemed to have been drawn from a textbook of septic complications. This contrasted with multidisciplinary meetings in the UK, which have been specifically set up to deal with patients with cancer. I rapidly learnt to prescribe ceftriaxone with or without gentamicin as the initial antibiotic regimen, which proved to be life-saving in many situations. My sabbatical coincided with the height of the swine flu outbreak; typically, six or more patients with this condition were admitted each day. The severity ranged from relatively mild to critically ill, with patients in the latter category requiring ventilation and intensive care.

Darwin is soon to have its own medical school, but for many years it has functioned as a satellite centre for training students from the medical schools at James Cook University in Townsville, Queensland, and Flinders University in Adelaide, South Australia. I was hugely impressed by the high level of medical care delivered by all the staff in the hospital. Their dedication and professionalism were very evident and, in conversation, I became aware of a strong vocational motivation that elsewhere is becoming lost in an increasingly cynical world. Many of my colleagues relished the challenges of working in Darwin. They were all Australians but, with the exception of the senior physician, Dr Diane Howard, none were originally from Darwin. Their experience of medicine in the major cities in Australia, where they had previously trained and practised, was similar to mine in the UK. They looked upon their time in Darwin as something of an adventure, not dissimilar to my own experience.

Of particular value were the hospital's cultural awareness seminars, which enabled new staff to gain some understanding of the culture of Indigenous people. The key points that I gained from these seminars were an appreciation of the complexity and richness of Aboriginal culture, and the profound personal disruption for Aboriginal people that admission to hospital entails. Hospital admission is traumatic for anyone, but for people who live in small, isolated communities with strong family relationships, it is deeply disturbing and bewildering. First, they have to cope with being unwell, and then with being flown several hundred kilometres to a place which must seem alien in virtually every respect — uncomfortably cold air-conditioning, different food, a different language, and frightening procedures. I learnt that even small things like eye contact, which we regard as a polite courtesy when talking to another person, may be threatening and confrontational to Aboriginal people. Great efforts are made to bridge this cultural gap by providing interpreters and Aboriginal liaison officers, and by encouraging a friend or relative to travel with patients and stay with them at the hospital.

These current efforts contrast with some of the misguided government interventions of the past, most notably in relation to the "stolen generation", when Aboriginal children were removed



from their families "for their own good". I found that these events are still vividly remembered and resented.

During my trip, I was fortunate in being able to visit a health clinic in Oenpelli (Gunbalanya), in West Arnhem Land, about 300 km from Darwin. I particularly noticed a mural in the clinic, prominently displaying the word "Reconciliation". Coming from Belfast and having lived through "the Troubles", I could not help thinking of the parallels with the situation in Northern Ireland, with our community also struggling with reconciliation — two cultures trying earnestly to understand one another and come to a working arrangement. Health care is often on the frontline of cultural divisions. In Northern Ireland, the health service served both sides faithfully and impartially and was undoubtedly a force for good. I sensed that the health services in the NT are in a similar position.

I have now returned to my normal job in Belfast, facing up to old challenges and some new ones. On reflection,

I consider myself very fortunate and privileged to have practised medicine in Darwin, to have been accepted so generously by new colleagues, and to have learnt so much from them and from the patients we cared for. I found it refreshing, humbling, often thought-provoking and at times inspiring. It is an experience that I and my family will never forget.

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Competing interests

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