A different kind of treatment
Health professionals’ duty of care includes combating racism in society as well as in health care settings

The Australian Government’s proposed changes to the Racial Discrimination Act 1975 and the repeal of section 18C has transfixed national debates on legally defining racial discrimination. Under these changes, racial discrimination would no longer include acts that “offend, insult, humiliate or intimidate” a person based on the person’s race, colour or national or ethnic origin and instead be limited to acts that “incite hatred” or “cause fear of physical harm”. These proposed changes have been framed in the context of enabling “free speech”, yet, evidence presented in this issue of the Journal shows that they have potential to cause harm. In this issue, Kelaher and colleagues highlight the prevalence of racism as experienced by Indigenous Australians and its deleterious effects on mental health. Alarming, almost every Aboriginal Victorian participating in this study reported an experience of racism in the preceding 12 months, which included jokes, stereotypes, verbal abuse and exclusionary practices. The experiences of racism reported here neither incited hatred nor caused fear of physical harm, yet resulted in harm such as psychological distress, especially when meted out in our health care system. These findings are a stark reminder that racism is indeed an important health issue, and as health professionals, our duty of care extends to contributing to these broader policy discussions.

This study also highlights the importance of addressing racism in the health care services that we work in, as the association between racist encounters and increased psychological distress was even more pronounced within our own settings. The mandated shift in medical training to be inclusive of Indigenous health is a critical step forward in enabling culturally competent practice. Yet tackling racism is a complicated task; not least because, paradoxically, it requires us to “remain conscious of race while at the same time challenging the common sense presuppositions of racial rule”. The debunking of race as a biological construct has not deterred sociological meanings of race, which infiltrate everyday explanations of physical, social and cultural differences, and form many of the racist encounters Indigenous people experienced in this study. Addressing racism thus requires us to see race and think critically about our own imaginations of racialised bodies rather than purport to be “race or colour blind”. Unpacking one’s own cultural values and assumptions can be an uncomfortable experience, but health practitioner discomfort should not inspire inaction. Culturally safe care through practitioner reflexivity is a vital instrument of good medical practice.

As the Journal celebrates 100 years, the Inala Indigenous Health Service in Queensland is on the eve of celebrating 20 years of service, and provides a powerful example of the importance of culturally safe health care for Indigenous Australians. In 1994, the Inala Health Centre General Practice, a mainstream practice, was not accessed by the local Indigenous community because they felt humiliated and insulted by staff. People did not feel cared for and therefore did not access the health care on offer. Under the stewardship of Noel Hayman, the service responded by critically reflecting on its culture and engaging in honest, albeit uncomfortable, conversations about its “treatment” of Indigenous people. Resulting changes included employing and collaborating with Indigenous people, alongside systematic cultural awareness training that was taken seriously. Since 1995, the Inala Indigenous Health Service has increased from 12 to over 10000 registered Indigenous patients and has become a Centre of Excellence in Aboriginal and Torres Strait Islander Primary Health Care. Improved health through improved access to health care came about through improved relationships between health practitioners and Indigenous people. Quoting from one patient of the service, we got the best doctors in the world here … Not talking down to us, talking to us, do you understand? This is what a black fella can’t take, he can’t take it when a man talks down to him … he’ll get up and say, “Yeah, yeah, yeah,” walk out and do the same thing. But when you sit down and talk with him, talk to him, he takes notice. That’s what these fellas do here honestly, I tell you the best staff in the world here …

Both the Inala example and the study by Kelaher et al highlight how influential culturally safe health care is in addressing Indigenous health inequality. While race and racism operate as powerful ideological and structural tools of oppression within and outside of the health setting, there remains tremendous capacity in our health system and within the scope of individual health practice to mitigate the effect of racism on Indigenous health outcomes.

Competing interests: No relevant disclosures.

Provenance: Commissioned; not externally peer reviewed.

From what is published in surgical journals and presented at surgical meetings, you might think that surgeons typically consider that the real changes currently happening in surgery relate to how we do things. Without doubt, this is of some importance. The development of minimally invasive therapies such as laparoscopic surgery, stereotactic surgery and endoscopic procedures has an important influence on the sharp end of surgical management. The new frontier in delivery of surgery is “robotic surgery” — perhaps better called “computer-assisted surgery” — where surgeons can (as proponents claim) use robotic instruments to orchestrate an operation with more precise movements and better range of motion, assisted by three-dimensional video imaging. The advent of telementoring and telesurgery — perhaps even with the use of Google Glass — means that capabilities will exist to provide training and assistance, and improve surgical performance undertaken at remote locations. These technological advances are seen not just by the surgeon but also by the media and, by extension, the public, as an improvement in surgical care.

There are also other changes afoot in surgery — delivering improved work–life balance, as desired by many younger surgeons, encouraging and retaining female surgeons, rethinking surgical education and training, and engaging surgeons into hospital and professional management. But when it comes down to thinking about the current and future roles of surgery, how we do things really does not matter as much as what we do and why we do it.

Surgery in general is increasingly about doing less for many disorders that can be effectively managed in other ways. It is sometimes true that opportunities for new surgical disciplines arise to replace obsolete uses, creating a continuing demand for particular surgical subspecialties. For example, in the field of thoracic surgery — which almost died out with the advent of medical therapy for tuberculosis — lung cancer surgery and coronary artery bypass surgery filled a gap and kept thoracic surgeons busy.

But such substitution does not always occur. Hepatobiliary surgery for hydatid disease is all but gone. Gastric cancer is becoming increasingly uncommon thanks to the identification of the role of Helicobacter pylori and its medical treatment. Statins, stents and antiplatelet medications profoundly affect the demand for coronary artery bypass surgery. The use of immunomodulators has much diminished the need for surgery to manage inflammatory bowel disease. But, in the future, we may gain more medical understanding of many other conditions, obviating the need for surgery. For example, what if the cause of bowel cancer turns out to be an infection and can be treated by immunisation at a young age? What potential exists for other conditions to be prevented or treated non-surgically? The future role of surgery may very well be more likely to be determined by scientists than surgeons. The basic sciences are still where the big answers are to be found. Consequently, funding for not-very-sexy basic science research matters as much if not more than that for robotic, glass-eyed wizardry.

While the surgical management of some diseases has become less common, it has become more “fashionable” for some conditions to “go under the knife”. Just as the advent of cardiac surgery filled an activity gap for thoracic surgery, the reframing of obesity as a surgical disease has created an opportunity, through bariatric procedures, for gastric surgeons otherwise displaced by the decline of gastric cancer and the need for surgical treatment of peptic ulcer.

Not only are the diseases we are operating on changing but so are our patient populations. Increased life expectancy has brought older patients with more comorbid conditions. Different diseases affect older people and appropriately tailored procedures are needed to obtain the best quality of life. However, despite the new challenges in this population of patients, surgery has much to offer them. Modern cataract surgery and joint replacement have substantially improved quality of life for many older patients.

What role does research in surgery have in the discipline’s evolution? As alluded to above, research has...