
"Mums and bubs" clinic

The general practitioner

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Helping patients sort out the complexities of life, even if in small steps, can be a source of great satisfaction

ABORIGINAL COMMUNITY CONTROLLED health services (ACCHSs) across Australia are supported by predominantly non-Indigenous doctors. As of 2005, there were between eight and ten Indigenous doctors working in ACCHSs.

For many non-Indigenous doctors, working in an Aboriginal health service has been a choice to do something different and to try to make a difference. One of us (K S P) moved to Townsville from Sydney. Working for the Townsville Aboriginal and Islanders Health Services (TAIHS) provided an opportunity to combine general practice with interests in maternal and child health and clinical research.

For Indigenous doctors, the reasons for working in an ACCHS are varied, but generally centre on wanting to work closely with their community. The other author (M W) is one of two Aboriginal GPs working at WuChopperen Health Service. Communities and family members, but also the medical community and government, expect Indigenous doctors to work directly in primary health care. In taking on this role, Indigenous doctors need to be able to respond to a variety of community, leadership and role-model pressures, but their value to the local community is measured not only by their natural cultural communication skills, but by the capacity development among Indigenous people that they represent.

Opportunities

Individual level: the art of medicine

The practice of medicine in an ACCHS challenges even the most highly trained clinician. The number, complexity and interaction of problems presenting in any one consultation[1] require listening skills, a depth of clinical knowledge, familiarity with evidence-based medicine, and the ability to formulate feasible management plans[2] — and all these skills are needed all the time. A constant challenge is to tease out the subtleties in communication. Inherent in this is the ability of the practitioner to engage in empowerment strategies with Indigenous patients, and a big part of the job is advocacy on behalf of patients, helping them to negotiate parts of the health system compromised by institutionalised racism.[3]

Diseases such as impetigo, diabetes, and chronic obstructive airway disease are well recognised, but often not only their prevalence but their severity at initial presentation is overwhelming. There is also the need to rapidly acquire the knowledge to manage less familiar diseases, such as rheumatic fever (and its sequelae), syphilis and tuberculosis.

Working with teams

ACCHS doctors work in multidisciplinary teams. Aboriginal health workers' and registered nurses' knowledge of both the cultural and social aspects of a patient's background are vital to patient management, and they often work independently on aspects of the care plan. ACCHSs are often well supported by visiting specialists and allied health professionals, allowing GPs to work within a truly multidisciplinary primary health care team.

Outreach work

It is unlikely when working in an ACCHS that the whole week will be spent in the same office. Visits to "parkies" and "grass camps" (people living in town parks and fringe dwellings), sessions in jails, and visits to outlying communities are just some of the possible outreach scenarios.

Quality improvement, population health and research programs

The futility of practising medicine only on an individual level quickly becomes apparent and, once an ACCHS doctor is established within a community, it is possible to branch out into quality improvement and population health programs. This requires working with the community and the myriad funding bodies to develop, for example, programs for Pap smear screening, smoking cessation or diabetes care. This not only benefits the community and enhances service capacity, but also allows GPs to develop skills that may prolong their involvement in Indigenous health. It is relatively common to conduct research in larger ACCHSs, and opportunities exist for GPs to access research funding and training.

Difficulties

Cultural safety

There are two relevant aspects of cultural safety. The first is the more traditional view of cross-cultural communication;[4] the second concerns the culture of being a doctor.

In the ACCHS setting, doctors will often have a different cultural background to their patients, and English may not be the first language of the patient or the doctor. Consequently, cross-cultural training programs provide orientation in cultural background, language concepts, communication and relationships within the local Indigenous community. Cross-cultural education outlines the history of white colonisation of Australia, the effect of subsequent government policies on the local community, the cycle of poverty, local communication issues, and local customs for births, deaths and illness. Not all cultural awareness programs are alike, so, while education provides an important introduction, cultural awareness accumulates with experience, but only develops fully if the doctor is prepared to respect and learn from the community and, importantly, if the community will mentor and assist the doctor.

The second aspect of cultural safety is the culture of medicine that many doctors are used to and have been trained in. This can cause difficulties coping with the unfamiliar clinic environment — its very high workloads, poor infrastructure, multiple and chaotic medical records, lack of structured clinical sessions with no appointment systems, patients arriving en masse in bussed transport, and apparently poor patient compliance (which often can be explained by difficult dosing regimens, and a lack of common reality and priorities). While these issues may appear insurmountable to a new GP, leadership and a quality improvement approach can result in more controlled working environments.

Trauma and grief

The recent history of Queensland Aboriginal and Torres Strait Islander communities, like those in Townsville, is one of loss of land (often accompanied by violence), forced removal, and detention of differing clans in missions and reserves, with consequent loss of culture, autonomy, identity and life skills. Many patients come from such traumatised family backgrounds.[5,6] Dealing constantly with traumatised patients and the resulting problems of unemployment, poor education, substance misuse and violence can become a threat to the wellbeing of the ACCHS staff, especially the GPs.

The high mortality rates in Indigenous populations become starkly evident. In any context, it is difficult for GPs to see relatively young patients die of preventable diseases, but the monotonous regularity of community funerals can become depressing. Indigenous doctors, who may also be from the local community, can experience this from both a medical point of view as well as from family involvement. It is important that GPs are able to recognise their own reactions to trauma and grief and take appropriate action. While counselling is available, regular periods of leave are probably necessary for survival in the job.

Lack of autonomy

The stressors of mainstream general practice — job demands, time pressures and perpetual change — are well known. These also affect GPs working for ACCHSs, but the strongest predictor of job satisfaction has been identified as being in control of the job.[7] The major stress for GPs working for an ACCHS is the loss of autonomy in practice management. ACCHSs are governed by community-elected boards, who make many of the decisions GPs in mainstream practices would ordinarily make themselves. Some board members are highly trained in the health field, others are not, and their decisions may or may not be in line with GPs' perceptions of how a medical clinic should operate. This lack of autonomy can make the implementation of change difficult when the ultimate decision for acquisition of equipment, recruitment, conference attendance, or participation in research and population health programs lies with the board. The stress is minimised if GPs enjoy good working relationships with their senior managers, chief executive officers and boards. Community politics may also influence some decisions, which can be difficult to comprehend until an understanding of the broader context of Indigenous control and empowerment has been gained.

Remuneration

While remuneration levels in some centres are improving, through support from, for example, the Rural Incentive Payments Scheme,[8] GPs in the larger urban ACCHSs are often not as well paid as their mainstream colleagues. This reinforces the perception that the work they are engaging in is less valuable and has led to a high turnover of doctors and difficulty in attracting Australian-trained GPs. To attract and retain more Australian-trained doctors, a review of remuneration is needed.

Career paths and ongoing training

The better supported ACCHSs are an ideal environment for training, not just in general practice, but also in specialties such as public health, general medicine and cardiology. This would provide a new source of doctors for the Indigenous community. The burden of disease encountered on a daily basis would, with remote supervision, provide excellent training for registrars. While there is growing support from the Royal Australian College of General Practitioners in cultural safety, peer networks and mentoring, in many areas GP registrars are not allocated to ACCHSs as a priority. If the Colleges could develop training paths that encompass terms in ACCHSs, it would not only enrich the pool of doctors trained in caring for Indigenous people, but also enhance the quality of medical care for Indigenous communities.


Outreach van

Public health registrars, with their population health skills, could be a valuable asset to the larger ACCHSs. There have been some moves to offer integrated general practice and public health training, but this has left many GPs in the ACCHS sector faced with the decision of whether to stay or leave when they reach an advanced stage of their training.

Conclusion

While every GP will have a different experience within an ACCHS, a few will truly become part of the community. Many doctors will develop close friendships with both staff and families that can be especially rewarding. Sharing the highs and lows of the Indigenous community, especially with respect to sport and music and their role in mainstream Australian culture, strengthens the bonds some doctors have with their roles in ACCHSs.

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