

Part 1: #BlackLivesMatter – A starter pack for Australian junior doctors

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Personal reflections from a term as a Medical Registrar in Alice Springs

“The failure over the past 12 years to close the gaps in Aboriginal and Torres Strait Islander health inequality, and other measures of social and economic disadvantage, cannot be justified by more rhetoric or data in another report. Over the years we have seen so many of these gaps and measures ignored, overlooked and disregarded. Aboriginal and Torres Strait Islander peoples are not deficits or statistics. These just hide the truth of our lived realities. For us, the harrowing failure to [close the gap](#) is felt through sorry business, the countless funerals of family and friends, the hospital visits and the coronial inquiries that we continue to painfully endure.”

Ms June Oscar AO, Aboriginal and Torres Strait Islander Social Justice Commissioner, and Mr Karl Briscoe, CEO National Aboriginal and Torres Strait Islander Health Workers Association, Co-Chairs Close the Gap Campaign, [Close the Gap 2020](#) (1).

This article will use the word ‘Indigenous’ to encompass Aboriginal and Torres Strait Islander people of Australia while recognising the diversity of members of this group and the communities and language group with whom they identify.

The #BlackLivesMatter movement

I am currently working in London on an overseas medical oncology fellowship, and like everyone else have been watching the growing #BlackLivesMatter movement with interest. In the UK, there have been multiple demonstrations, statues of significant benefactors from the past who had links to the slave trade have been taken down (e.g. Cecil Rhodes, the namesake of the Rhodes Scholarship) and UK is once again asking the tough questions about race, equity and fairness. It is all the more startling that this movement is occurring despite the [coronavirus pandemic](#), but particularly timely as multiple enquiries in the UK have shown the disproportionate effect of coronavirus on BAME communities (black, Asian, minority, ethnic) with [black people almost 4 times likely to die from coronavirus as white people](#) (2).

#BlackLivesMatter is [a movement that was founded in 2013](#) in response to the acquittal of the police officer who had been involved in the death of Trayvon Martin (3), and has recently been reignited with the death of George Floyd at the hands of police in America. The movement calls for a radical rethink of all sectors of society – criminal justice, politics, employment, education, and relevant for us, healthcare. The excessive

impact of common health conditions on black people has been well documented in the literature with higher rates of [kidney disease](#), hypertension, heart disease (for an excellent personal account – read [Black Man in a White Coat](#) (4)).

In the field of cancer clinical trials which is my interest area, it has been repeatedly documented that there is [an under-representation of black people and ethnic minorities in these clinical trials of cutting edge cancer treatments](#) that often represent the future of cancer medicine (5) – again, a clear inequity.

#BlackLivesMatter in Australia

How does #BlackLivesMatter affect Australia then and why should Australian doctors consider it? [Thousands came out to protest recently in Australia](#) (6) and Indigenous people have seen #BlackLivesMatter as an opportunity to remind Australian society of the continuing, and comparable injustices they face on a daily basis on a background of historical and structural discrimination. While there are specific differences, the situation in Australian society in respect to Indigenous Australians shares strong similarities to the #BlackLivesMatter movements across the world – extraordinary disparities in criminal justice, education, poverty and of course, healthcare.

Indigenous healthcare has long been recognised as an issue in Australia, and during Australian medical school teaching we are taught about [closing the gap](#) and the tremendous differences in life expectancy between Indigenous and non-Indigenous populations.

Indigenous healthcare issues

I learned these facts a decade ago during medical school, and today, the overall picture remains one of utter and complete disparity, and the most recent [Close The Gap 2020 report](#) (1) documents that despite 12 years of action, little progress has been made and the gap is widening. The report contains many positive stories of progress but highlights the ongoing effects of colonisation and its consequent prohibition on Indigenous cultural practices and ongoing disparities in social and cultural determinants of health.

- Life expectancy gap of 8.6 years for indigenous males and 7.8 years for indigenous females.
- In 2018, Aboriginal and Torres Strait Islander (ATSI) children were **10.2 times more likely** to be living in out-of-home care than non-Indigenous children. ATSI children represent 37.3% of the total out-of-home care population, including foster care but only 5.5% of the total population of Australian children. Without urgent action, this number is expected to double in the next 10 years.
- ATSI people represent **28%** of the total adult prison population despite making up **2%** of the total Australian adult population.
- ATSI young people are **17 times** more likely to be under youth justice supervision than non-Indigenous young people.
- ATSI people are **5 times** more likely to experience mental illness than other Australians.

Many doctors in training, myself included, learn the statistics, shake our head, and move on with our busy medical careers filled with networking, research, clinical work and preparing for professional examinations. Indigenous health could be seen as someone else's problem and there definitely was not as much glamour associated with pursuing this as there might be in writing up a case report in a specialty we aspired to get into, becoming friendly with a prominent consultant, or being selected for an important hospital committee which would look great on the CV.

Personal experiences from working in Indigenous health

If we read the statistics carefully, and the situation is really that awful, and we feel compelled to do something – what can we do? This question has been on my mind for a few years and it only really became apparent to me when I developed some experience in treating Indigenous patients after a resident term at Dubbo Base Hospital, a medical registrar at Dubbo Base Hospital and finally came to a culmination when I completed a three-month term in Alice Springs as a medical registrar in 2016. I have a clear memory of the radically different [healthcare pathways](#) in place compared to a metropolitan hospital. Diseases all but eradicated from advanced economies such as rheumatic heart disease or tuberculosis were once again present, 25 - 40-year-olds presented with issues such as diabetes, [hypertension](#) or heart disease, problems which usually affected 55 - 70 year olds in metropolitan cities.

It was truly extraordinary and saddening to see that after a 6-hour flight from Sydney, an almost entirely different world was existing in parallel, one with much poorer health outcomes for an entire group of people. Ever since then, and I think seeing the human face of the awful statistics made a key difference, I have always felt that while it is crucial to advance the cutting edge of medicine, it is equally vital to remember the enormous disparity in health in Indigenous populations and the importance of each of us using our privilege to speak up and speak out persistently about this – it is our problem, and it is our lane.

I would not say that my time in Alice Springs was solely one of learning about deficits and healthcare disparities – working with Indigenous populations for that three months provided a valuable insight into the assumptions that I made about health while working within Sydney. I vividly remember one example of a relatively young Indigenous man suffering from a ST elevation myocardial infarction. We had managed his chest pain and his troponins were in the thousands – every medical bone in my body told me that my priority was to ensure this man received percutaneous intervention as soon as possible, and that every delay was causing additional damage to cardiac muscle – unfortunately the nearest PCI facility was in Adelaide and he would need to be airlifted.

Cultural differences and their impact

I imagined it would be a straight forward conversation – however, the answer was a firm no. His family had gathered around, the Aboriginal Liaison Officer was present and he was refusing. In summary, he was worried about the possibility of dying away from his community – later I came to realise that notions of community and country were pivotal

to some Indigenous people's understanding of themselves, and that they came before individual considerations of mortality.

This was such a radical shift from my own personal experience growing up in a Western culture which is individual focussed and death is seen as the ultimate defeat and that everything medically possible, must be done, prior to death. It provided me with a better understanding of how notions of health and illness are not simply medical or biological as taught in medical schools, but also social and cultural. Ultimately two members of the patient's family travelled with the patient to Adelaide and we were able to reach a compromise, the patient had a satisfactory outcome and shortly returned to Alice Springs to be with his community.

I also saw that Indigenous patients routinely could not access the best of Western healthcare for a range of structural reasons – I remember seeing a young patient with end-stage renal failure and I enquired about transplant list – for a variety of reasons the team thought this would not be feasible ([there are recognised barriers to this](#)) (7).

The prevalence of 'the gap'

Overall, my experience was that healthcare workers were tired of seeing repeated presentations of conditions that did not exist outside of Alice Springs, and should not be existing in an advanced economy such as Australia – sometimes there would be a creeping sense of nihilism and that the gap was actually not going to be closed. Recently I came across [this article on Moral Determinants of Health](#) (8), and it put into stark relief my experience – “mostly, circumstances outside health care nurture or impair health...most hospitals and physicians offices are repair shops, trying to correct the damage of causes collectively denoted “social determinants of health” – these include conditions of birth and early childhood, work, and community resilience amongst other things.

Working at Alice Springs Hospital felt like working at a repair shop, regularly reviewing the downstream consequences of decades of historical and structural inequity – it was really no wonder that a feeling of nihilism would occasionally creep into the conversations of healthcare workers.

Supporting the #BlackLivesMatter movement

So if we decide against nihilism, and think that doing nothing is not really acceptable, what can we do? What can we do, even though we are all so busy? Watch out for Part 2 on our series of #BlackLivesMatter – A Starter Pack for Australian Junior Doctors.

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