Safeguard or mollycoddle? Medical student placements in Aboriginal communities

Adrian N Winsor

To the Editor: I spent my fifth-year medical student elective at Alice Springs Hospital and a remote Aboriginal settlement in the north-west of South Australia in the early 1980s. I organised this myself and came away with a fairly firm belief that the health of the Indigenous population in remote areas was unlikely to improve.

Between 1995 and 2009, I visited remote Aboriginal settlements and hospitals in Darwin and Alice Springs as a specialist physician. Nothing I have seen in that time has changed the view I formed as a student.

During my time in these settings, I have seen in the Indigenous population extreme examples of poverty, severe neglect of children and adults with disability, and examples of physical and sexual abuse. On

occasions I have been threatened, and at times I have needed to be escorted for my safety. When staying overnight on settlements, I have been provided with secured accommodation. I have walked in fear of feral and diseased camp dogs and have been hurried along in my work to avoid cultural incidents.

The article by Patel and colleagues explores some of the issues in this area as they affect medical student training.[1] I think it is good that they have done so, but to dress it up with quasi-scientific methodology is unnecessary.

My view is that it is not possible to provide or sustain health services of any reasonable standard in small and remote communities that have no economic basis for development and where the population is poor, poorly educated and has little prospect to share in this country's fortune.

There is a reason that we are failing to improve the health of the Indigenous population in remote areas, and that is that we cannot. It is an unrealistic expectation. This needs to be acknowledged, and we all need to move on.

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1 Patel A, Underwood P, Nguyen HT, Vigants M. Safeguard or mollycoddle? An exploratory study describing potentially harmful incidents during medical student placements in Aboriginal communities in Central Australia. *Med J Aust* 2011; 194: 497-500. ❑

Andrew W Nielsen

TO THE EDITOR: In their editorial about risks to medical students in rural and remote placements, Peachey and McBain-Rigg stated:

> But there is a danger that, in focusing only on possible harms, we underestimate the power of difficult circumstances to enhance the very attributes that are required for the long haul in rural and remote practice.[1]

They referred to such issues as a "philosophical quandary" and went on to use a metaphor about a breaking bungee rope. The editorial conflated two important issues: safety and character-building experiences. The safety of visiting medical students and workers is not a philosophical quandary. Requirements of occupational safety are a practicable matter and a matter of law. Employers are required to assess and manage risks. The editorial's authors are from Queensland, where the current relevant legislation is the *Workplace Health and Safety Act 1995*. Assistance is available from state workplace safety bodies, such as Workplace Health and Safety Queensland.

Patel and colleagues made a good empirical assessment of adverse events that have happened to medical students in remote areas.[2] Such an assessment could contribute to a safety management plan and system. Patel et al stated that "a 'distressing' incident does not necessarily lead to an overall negative placement and may in fact be a powerful learning experience". They gave the example of a female student who was not met when she got off a bus at a remote community at 3 am, which concluded with the student's words that the placement was a "good placement medically". A worker might implicitly or explicitly approve of any risk that he or she is exposed to, but this does not relieve the employer of its obligations to the worker's safety.

Inviting readers to look on the bright side of safety shortcomings is not in the best interests of medical students, the permanent workforce or the population of rural and remote areas.

Competing interests: I have received payment for providing expert testimony for workers compensation reports.

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1 Peachey LG, McBain-Rigg KE. The challenges of remote area medical education [editorial]. *Med J Aust* 2011; 194: 495-496.
2 Patel A, Underwood P, Nguyen HT, Vigants M. Safeguard or mollycoddle? An exploratory study describing potentially harmful incidents during medical student placements in Aboriginal communities in Central Australia. *Med J Aust* 2011; 194: 497-500. ❑

Ameeta Patel and Margaret Vigants

IN REPLY: It saddens us that Winsor's experiences as a remote visiting specialist are so depressingly familiar, but his nihilism is even more disturbing. There has in fact been improvement in the health of the Indigenous population in remote communities; examples of this include the evidence provided by articles in the very same issue of the Journal, by Margolis and colleagues (falling rates of serious injury retrieval) and Ward and colleagues (declining syphilis rates).[1,2] An understanding of the social determinants of health is essential to accepting that we can indeed work towards improving health, perhaps not through focusing on specialist medical services but rather in the broader primary health care context. Our students and patients deserve clinicians and mentors who might inspire and look for solutions, rather than retreat into despair. Progress in closing the gap will be far slower than many imagine, but it is not impossible, as we have already seen.

We totally refute that we used a "quasi-scientific methodology". Our study is a simple retrospective audit with not a *P* value in sight,[3] and it has no pretensions to be otherwise. It aims to present a clear story from a defined group, and to add to the many individual anecdotes, such as Winsor's, that on their own do not gain the attention of employers, policymakers, or government. By building a body of evidence, surely we will be able to more effectively advocate for systemic changes. Collaborating with interested colleagues such as remote area nurses who have published more widely on their own adverse experiences[4] is another key strategy in influencing change.

We agree wholeheartedly with Nielsen's viewpoint that obligations to workplace health and safety legislation and to company policy and procedures should be paramount. However, this breaks down when individuals employed or contracted in various capacities are incompetent, ignorant, stupid or just have a sheer disregard for the rules. In addition, there appears to be a lack of scrutiny in remote areas where lower standards are somehow acceptable, and legal frameworks somewhat more fluid. The romanticisation of the bush and the culture of "making do" is partly responsible for the laissez-faire attitude to occupational health and safety. Perhaps our metropolitan colleagues could assist in challenging the status quo and the deeply entrenched beliefs, attitudes and systems that collude in silencing questioners and burnt-out staff.

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1 Margolis SA, Ypinazar VA, Muller R, Clough A. Increasing alcohol restrictions and rates of serious

injury in four remote Australian Indigenous communities. *Med J Aust* 2011; 194: 503-506.
2 Ward JS, Guy RJ, Akre SP, et al. Epidemiology of syphilis in Australia: moving toward elimination of infectious syphilis from remote Aboriginal and Torres Strait Islander communities? *Med J Aust* 2011; 194: 525-529.
3 Patel A, Underwood P, Nguyen HT, Vigants M. Safeguard or mollycoddle? An exploratory study describing potentially harmful incidents during medical student placements in Aboriginal communities in Central Australia. *Med J Aust* 2011; 194: 497-500.
4 Cramer J. Sounding the alarm: remote area nurses and Aboriginals at risk. Perth: University of Western Australia Press, 2005. ❑