

POMMIES AND PENIS GOURDS IN THE ANTIPODES: A PERSONAL PERSPECTIVE

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During the 1990s more and more junior doctors are talking about the great lands 'down under' that have been described as the lands of milk and honey (or is it milk and money?). Curiosity got the better of me and in 1993 I decided to have a taste.

I worked for six months in paediatrics and six months in obstetrics and gynaecology in a large teaching hospital in Newcastle, New South Wales, then intermittently as a locum in a country hospital for two months before travelling back.

These personal experiences have been broadened by the impressions of fellow Manchester graduates out there.

HEALTH CARE

Australia is big. Obvious – or so I thought until I got there. In fact it's huge, and has 17 million people on a land mass slightly bigger than the United States. The delivery of healthcare is, therefore, stretched. The population of the east coast is served by 'state of the art' tertiary referral centres interspersed with rural clinics. The experience to be gained is excellent from an academic point of view, but not so good from the 'hands-on' point of view, probably because more responsibility is shouldered by the younger consultants.

This is in complete contrast to country hospitals, where you may be the only doctor for hundreds of miles, so "you're it, mate". This experience can grow hairs on your chest at an alarming rate. One of the 1990 graduates found himself as a medical director of a hospital in Queensland's back of beyond, sorting out nursing disputes, in charge of the hospital budget and doing theatre lists. He now has the hairiest chest I've seen!

PROBLEMS

Distance

Delivery of healthcare and transport of patients relies very heavily on air transport, so well depicted in those 1960s Australian soaps in which sweaty brows were mopped by equally sweaty nurses. Putting on a brave face despite air sickness is the hardest job, and finding time to excuse yourself for a quick stemetil injection is imperative.

The Aborigines

This is a sensitive issue, but the original Australians do appear to be second class citizens in their own country. They are a cultural entity within themselves with their own particular set of problems: poverty, alcoholism, drug abuse and the mental illnesses associated with a nomadic people confronting the twentieth century. There is also an increased incidence of diabetes, gonorrhoea, congenital syphilis and TB. There is a high perinatal mortality rate and many other problems. Many solutions have been suggested and money

spent with varying degrees of success.

Aborigines' feelings about hospitals are generally those of bewilderment and claustrophobia. The latter was most marked when, on more than one occasion, labouring Aboriginal women went walkabout to complete their labour outdoors, giving a truer meaning to natural childbirth.

Private medicine

Private medicine is much more commonplace in Australia than in the UK, giving a more financially rewarding job for doctors but, in my opinion, putting the delivery of healthcare on a level below that of the NHS.

GPs are financially rewarded per patient seen, and there is no incentive to take on the chronically sick, elderly or mentally ill.

In hospital the first page of patients' notes has the 'cost code' on it. "00" means a public patient, "01" a privately insured one. This gave rise to the description of a patient as being tested 01 positive – a good prognostic sign. Privately insured paediatric patients tended to get more time spent with them so parents would bring them back to the consultants' private clinics, thus earning even more money for the senior doctors. Unfortunately, in general the "01" negative patients, usually from lower socio-economic groups, often requiring more explanation and reassurance, did not get the same treatment.

Private medicine did have its benefits for obstetric patients who could afford the two thousand dollars (about £1,000) for confinement: it meant that the consultants would be there for the deliveries whatever the hour (explaining why so few new graduates were contemplating a career in obstetrics and gynaecology).

GETTING SORTED

The Australian government states that Australia trains enough doctors at present – true – and therefore has no need for foreign doctors – false. Australian doctors are unevenly distributed around the cosmopolitan areas of the east coast and are not interested in the conditions of rural towns which may have an effect on social life and on-call commitments. This can be proved by looking in the back of the BMJ at the packages offering houses, cars and film star money.

Speciality training or general practice? Speciality training is widely recognised; healthcare in Australian cosmopolitan areas is second to none. There are plenty of British anaesthetists, physicians, surgeons, paediatricians and obstetricians at various stages of their training who have no problem in getting their experience accredited for UK training.

General practice training is relatively easy to come by. It tends, however, to consist of the jobs Australian graduates do not want. In theory any job a foreign graduate gets is supposed to be given only if it cannot be filled by an Australian graduate: this is not so in practice.

Most UK graduates extend their experience by doing various rotations. Rather than six month rotations, these are ten-weekly spells at SHO level in several specialities. This gives a taste of the minor specialities, useful for general practice but obviously very frustrating. Just when you're getting the hang of it, it's time to move on. It is, however, possible to organise six month posts of equivalent experience.

Locum jobs abound, as can be seen from the BMJ, but tend to involve night work, and if you're not going through an organisation that takes care of the paperwork, it can be a big hassle doing it yourself.

Working visas are usually granted only after you have confirmation of an offer of a job. Some hospitals will only offer you a job if you can provide evidence of a working visa – Catch 22! It is worth saving up and reading the BMJ adverts or getting addresses by word of mouth and blanketing a number of hospitals for a job. Many medical staff departments in hospitals will sort out the paperwork – a big bonus. Apart from the working visa, the medical degree obtained must be recognised by the state in which you'll work. Medical Boards are getting stricter.

The laws are in a constant state of flux depending on the need for foreign graduates. Most medical boards, as of last year, have made sure that if you want to stay longer than two years you have to sit the AMAC exam (Australia's equivalent to PLAB). It's a matter of striking lucky with a hospital that can deal with the red tape.

If bureaucratic hurdles bring a sweat to the brow, the hassle-free way is the glossy BMJ adverts for SLADE, an Australian recruitment agency specialising in placing British doctors in unfilled posts in Queensland. They pay your airfare and sort out paperwork, usually for one year and occasionally for two year contracts. But beware – they specialise in sending their recruits to distant outback places for at least half of the time.

THE PROS

Imagine doing the job you're doing now. Cut the hours in half and still receive the same pay at the end of the month.

Imagine opening the curtains on days off and knowing that what you planned to do does not depend on the weather.

You broaden your horizons with a different work environment and, in a literal sense, in the variety of scenery from the tropical rainforests of the Daintree, through the desert opal mining towns to the rolling green Tasmanian mountains.

Property is approximately half the price of the UK and it is not unusual to meet a couple in their early 30s with a plot of several acres, a house with many bedrooms and a swimming pool.

Eating out is often cheaper than cooking in; the choice is limitless from Malaysian and Japanese to Mexican and Vietnamese. In close proximity are some of the best vineyards of the world, where crisp wines are sold for half of UK prices.

THE CONS

OK, you jumped-up little sales rep, if it's that good why didn't you stay over there? Why did you have to come back?

To emigrate or not to emigrate? It's a serious question. There is a hard choice between starting a new social circle and leaving your family (although it does depend on your family!). It is increasingly difficult to emigrate and, as I understand it, being a doctor does not count for many positive points on the residency application.

Permanent emigration is a hit and miss affair. In theory you apply for residency and then sit the AMAC I exam (preclinical syllabus) which must be applied for outside Australia. Some people have found loopholes and have done this without sitting AMAC. Another way, of course, is to fall in love with a citizen and walk down the aisle...

I would recommend training and staying there for a year or two without any reservations. But to stay any longer involves a lot of multi-factorial decisions based on personal preference, lifestyle and needs.

HOMEWARD BOUND: PENIS GOURDS IN IRIAN JAYA

Travelling back involved stopping in Irian Jaya, the easternmost point of Indonesia, by its neighbour Papua New Guinea. This 'lost' civilisation of central Irian Jaya was only stumbled upon by Westerners in 1938 and practised cannibalism until the 1970s. There are still uncharted areas in Irian Jaya, thanks to its rugged terrain and high mountains (which include the highest mountain between Everest and South America).

The Balim Valley offers a spectacular introduction to its fantastic scenery and peoples. Flying into small villages involves clearing the runway of animals by banging on metal pots and being greeted after touchdown by athletic-looking men sporting nothing but penis gourds, trying to sell curved pig bones. It was only after politely declining the offer to purchase the bargain pig bones that we realised where they normally belonged – through their noses!

Dani tribe

These are the people around the Balim Valley, famed for their friendliness and penis gourds (Fig 1). The gourd often has feathers at the end and is 1-2 cm in diameter, tapered and two feet long. This is in comparison to the nearby Lani tribe, their traditional enemy, who wear their penis gourds much wider but smaller.

Healthcare

The health care of these peoples is reduced to missionary flights by international organisations arriving sporadically on surprisingly well-maintained strips of land. There seemed to be very little in the way of structured primary health care, with immunisation schedules revolving around plane arrivals. Transport is by Shank's pony and the nearest hospital is hundreds of miles away. Diseases such as trachoma, untreated trauma and helminth infestations are obviously common. Malaria and other mosquito-borne illnesses, however, are rare in the highlands and the staple diet of sweet potato and pig meat seems to keep malnutrition at bay.

Dani customs

The wishes of the deceased are respected and the process of



Fig 1 (a) Dani Elder

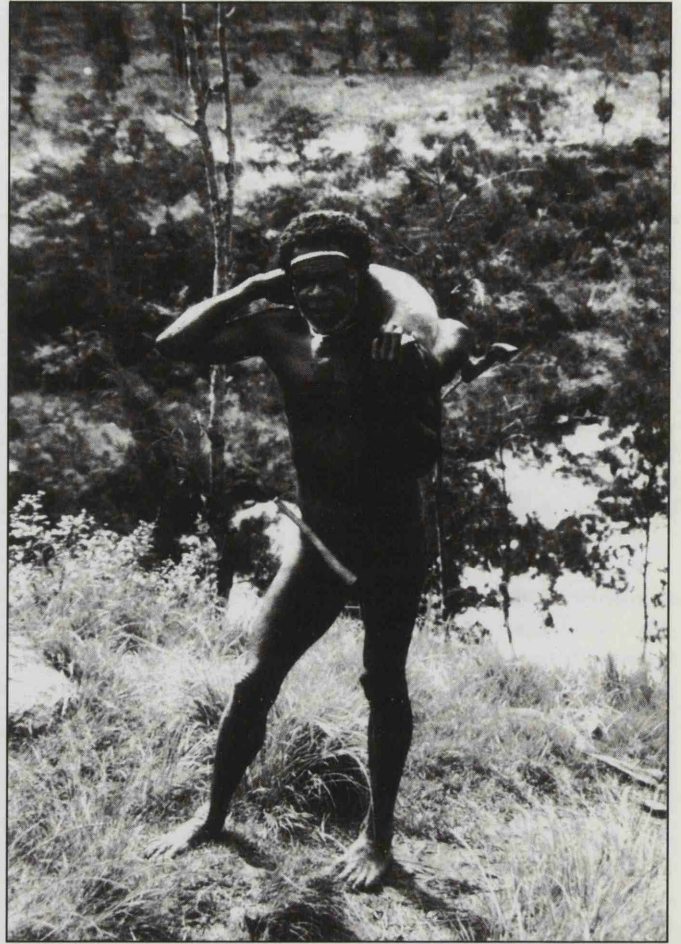


Fig 1 (b) 5 pigs = 1 wife

mummification takes place by smoking the corpse for preservation. This ensures that the deceased never leave village social life and gives a new meaning to visiting Granny – ‘smoked Granny’! (Fig 2).

The main currency is pigs. Being a polygamic culture, wives are bought and sold for four, five or six pigs.

Women who have just had a baby are not allowed to have sex for two to five years. This taboo ensures that the child has sole access to the mother’s milk and may explain why many Dani women manage to live well into their sixties. Unfortunately, this custom may also explain the high incidence of polygamy and divorce.

Respect for the elders and the deceased rests in the women’s hands – quite literally. As each relative dies it is customary for the women of the family to have a phalanx cut off – pity the women who have an extended family. It is not unusual to see the elderly women with no remaining fingers. At first I made a mistaken diagnosis of leprosy.

FINALE

Irian Jaya was the highlight of a five-month trip taking in the now well-worn route of Indonesia, Malaysia, Thailand, Vietnam and India. Others who have spent time in Australia return this way or via the Pacific groups of islands and either north or south America. All have commented on how travel has broadened horizons and given the ability to think more laterally, not always an opinion shared by senior colleagues at interviews!

We have all had the privilege of our elitist and exclusive training that has given us the nuts and bolts for practising

medicine. It is, however, what we do with those nuts and bolts which is most important.

If we think we can practise medicine simply by reading books and blindly following protocols we are mistaken. We must read novels, cultivate our friendships, never miss an opportunity to travel and above all be alert and curious. Then we may gain a priceless therapeutic asset: *a rich and compassionate personality*, which I believe is far more important than any training.

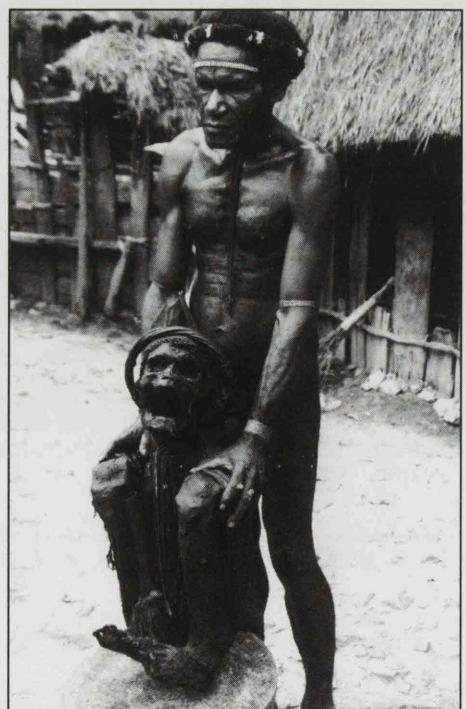


Fig 2 – Smoked Granny