

# Aboriginal women's health: The Perspectives of a Trainee and a Fellow

*In April 2004, Marilyn Kong and Hamish McGlashan, Membership Trainee and retired Fellow respectively, were invited to discuss issues in Aboriginal women's health by teleconference. The aim of this interview was to not only encourage both doctors to talk about their experiences of working with Indigenous women, but to encourage free discussion and comment about practice issues and dilemmas in Indigenous obstetrics and gynaecology. It also enabled Trainee to question Fellow and facilitated a comparison of practice from coast to coast.*

## The Participants



### Marilyn Kong

Marilyn Kong is a third year Membership Trainee at the Department of Obstetrics and Gynaecology, John Hunter Hospital, Newcastle. She hails from a family whose involvement in medicine now spans two generations. Her father is a general practitioner who is still practising in his native Malaysia. Her mother, Grace Kinsella, is an Aboriginal registered nurse and midwife. Her twin sister Marlene is a Diplomate who works at Newcastle's Awabakal Aboriginal Medical Service and her brother Kelvin is a second year ENT registrar. Dr Kong describes her mother as the major influence in her decision to pursue medicine and to train in obstetrics and gynaecology.

Dr Kong and her sister were the first Indigenous medical students to graduate from the University of Sydney. When she completes her training, Marilyn Kong will be Australia's first Indigenous obstetrician and gynaecologist. There are currently 50 Indigenous doctors in Australia, with another 70 medical undergraduates following in their footsteps.



### Hamish McGlashan

Hamish McGlashan has been a consultant obstetrician and gynaecologist for over 30 years. Having trained and qualified in the UK, he emigrated to Australia from Kenya in 1973 and has practised both in Perth and the wider expanses of Western Australia. Over a 15 year period, he worked as a locum in the Kimberley and then spent five years as the consultant obstetrician and gynaecologist in Derby. This brought him into contact with numerous Indigenous communities and patients. Aside from a keen interest in Aboriginal women's health, he has also worked in East Africa, both in the early and latter stages of his long career.

Dr McGlashan was also a representative of the College's Indigenous Women's Health Committee from 1988 to 2002. He retired from practice in 2002, but has continued to work in part-time, volunteer and locum capacities. He also received a Distinguished Community Service Award from FIGO in 2001 for his work in rural communities.

When he was interviewed for this feature, he had been lured out of retirement one last time to work as a locum at Derby Hospital and had three weeks of his contract to run. He will be retired (definitely, he insists) from May 2004.

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## DIFFERENCES IN URBAN AND REMOTE COMMUNITIES

Although the Department of Obstetrics and Gynaecology at John Hunter Hospital receives referrals from within Newcastle and the northern coast of New South Wales, Aboriginal women do not make up a large proportion of Marilyn Kong's current patient load. However, as a medical student, she previously worked in a small community near Katherine in the Northern Territory and at Darwin Hospital, experiences which she describes as a 'real eye-opener' in terms of women's health.

'Aboriginal health is not a homogeneous area,' she comments, 'there are regional variations, particularly between the urban and the Territory. You see more infectious diseases in the Territory, compared to chronic diseases such as heart disease and diabetes in urban areas.'

Hamish McGlashan agrees with Marilyn Kong that in remote areas 'infectious diseases are more prominent both in obstetrics and gynaecological work. There are formidable problems in both those particular areas, but overall, I would say that people are the same and they have the same pathologies as one sees in Aboriginal communities or Caucasian communities in the city. It's just the ratios of one to the other may be different.

'The pathology you see may be more advanced, but this is in some ways more rewarding for the practitioner. The more advanced the pathology, the more you can really help and do something about it, in contrast to working in the urban environment in private obstetrics and gynaecology, when one is mainly dealing with the "worried well".'

## WHY ABORIGINAL HEALTH IS NOT 'THIRD WORLD'

Dr Kong asks Dr McGlashan to elaborate on his work in East Africa and whether he perceived similarities in the pathology of African and Aboriginal women. Dr McGlashan replies that 'it is very, very difficult to compare'.

'It is often said that Aboriginal communities here are Third World', he explains, 'but having been to the Third World, I can honestly say that they are not. If we talk about more advanced pathology among Aboriginal communities, it really doesn't compare with what is happening in Africa. The distances and lack of transport, the poverty and the poor facilities in Africa make comparisons very difficult. In Australia, you may be working hard to prevent maternal deaths, but maternal deaths very seldom occur here. In Africa, on the other hand, you are fighting to prevent maternal deaths. When the registrars made their handover on the Monday morning after my first weekend in Africa, they reported three maternal deaths and we had a ward with 12 vesico-vaginal fistula patients in it, so many things were very different over there.'

Dr McGlashan adds his belief that 'in many ways, medical and specialist facilities are more readily available to Aboriginal people in the outback than they are to most people in the city. The waiting time to be seen, if any, is short and surgery is done promptly. If people are in trouble, even in a remote community, the Flying Doctor Service goes in and brings them out. So, on that level, people are very well off.'

Having also worked for a year in Papua New Guinea as a resident, Dr Kong agrees that there is an unfair comparison between Aboriginal health and developing countries. 'I think it is quite different. Working in PNG gave me a real taste of what it was like to work in a developing country. I had some maternal deaths there as well. The situation in PNG is

down to an absolute lack of resources, whereas in Australia, we're very lucky. We have a lot of health resources and it's really a matter of utilising those resources in a better way'.

Dr Kong adds that urban Aboriginal communities are more likely to be crying out for appropriate cultural services than their remote and regional counterparts. 'There is a perception that remote Aboriginal communities have very poor access to services and that impacts on the burden of illness we see', she says. 'That is probably true to an extent, but I think people also underestimate the lack of accessibility in urban areas. Although in physical distance terms there are services present in urban areas for Aboriginal patients, there are other barriers to accessing services such as finances and cultural appropriateness of services. For example, there is evidence that Aboriginal women in urban areas are still under-screened in cervical screening, and we clearly have to identify what the barriers are that are discouraging them from presenting for tests.'

## DEFINING CULTURALLY APPROPRIATE SERVICES IN INDIGENOUS WOMEN'S HEALTH

Hamish McGlashan agrees that the effective utilisation of resources is a key issue by saying that the policies addressing Indigenous women's and maternal health in Australia are not culturally appropriate and need further evaluation.


'I think that policies addressing maternal health - though not primarily the specialist obstetrician's role - are not in place and they are not given high priority. There are so many different agencies involved with so many different agendas and no co-ordination between them towards a common goal,' Dr McGlashan elaborates. 'This means there is a lack of medical and administrative support at the top organisational level, and equally there is a lack of consultation, understanding, rapport, feedback and discussion with individual

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Aboriginal communities about what they see their particular needs to be and how to address those needs. Quite obviously the way that we manage things, which is based on the Western model of health, is inappropriate in many of the Aboriginal community settings.

'For instance, the major challenge in the Kimberley is to optimise the birth weight of Aboriginal babies', Dr McGlashan states. 'Has anybody ever heard of a smoking prevention campaign suited to Aboriginal women in pregnancy? Now that might make a difference of 200 to 250 grams in the birth weight, but we've never really addressed that problem in the Aboriginal community context.'

Hamish McGlashan and Marilyn Kong agree that rethinking the approach to Aboriginal maternal health will have long-term benefits for the treatment of adult disease. 'If we are thinking about the intrauterine origins of adult disease', explains Dr McGlashan, 'the problems that we're seeing from chronic diseases in the thirties and forties, such as heart attacks and diabetes, can all be traced back to maternal health while the baby is *in utero*'.

Marilyn Kong adds that how well Aboriginal adult diseases can be prevented will 'stem from addressing broader aspects in Aboriginal health and well-being such as employment and housing. Better social conditions and healthier living will impact on maternal health'.

As part of the discussion about culturally appropriate services, Dr Kong asks Dr McGlashan whether he has worked closely with Aboriginal health workers. She

explains that John Hunter Hospital and Coffs Harbour Hospital (where she has worked on secondment) run an antenatal care program – Biralee – that is staffed by two midwives and two Aboriginal health workers (AHWs). She describes these services as invaluable, particularly in terms of an AHW's knowledge of local families and politics and their ability to locate patients. Marilyn says that the AHWs are an underutilised and underestimated resource among health professionals.

Dr McGlashan comments that in the northern parts of Western Australia, there is a shortage of Aboriginal health workers, both in terms of sheer numbers, and in seniority and experience. 'My direct contact with Aboriginal health workers has been small, but I've been fortunate to work with some very good, senior Aboriginal health workers with a strong and intimate awareness of the situation in each community. In fact, they frequently have had a greater impact on health than visiting GPs.'



Marilyn Kong sees a 'spectrum of complaints that are common to all women' in her consultations.

'I think problems may arise though with younger Aboriginal health workers. Though generally better educated and with literary skills, they are not always the most appropriate people in the Aboriginal community to speak to women, particularly older women, about women's health problems. It shouldn't be forgotten that in Aboriginal communities, there are cultural barriers to young people teaching elders.'

Dr McGlashan believes that the key to providing culturally appropriate services, at least in remote Aboriginal communities, is to use Aboriginal health workers as liaisons in a consultation process between the health policy makers and the leaders of each community. They would act as intermediaries 'between Western medicine and local cultural perspectives'.

## PRIORITIES IN INDIGENOUS WOMEN'S HEALTH

Hamish McGlashan cites low birth weight, prematurity and pre-term labour, repeat caesarean sections, inconclusive cervical screening and infertility as key issues that he has encountered in treating Aboriginal women.

He says that the cervical screening rate in the Kimberley has been very uneven and the service should be an indicator of the use of other services by women, not just screening for cancer.

'The index of cervical screening is more a reflection of the accessibility of women's health care and it reflects that if women are not being regularly screened, then they are not having appropriate access to other important forms

of care such as contraception or counselling for domestic violence. Cervical screening can be a very important marker. If your cervical screening rates are low, then that means the rest of the services are either not present or they are not being accessed sufficiently.'

Hamish McGlashan suspects that premature births and pre-term labour are higher among Aboriginal women because of infection. 'That's a very, very difficult problem, as late presentation in pregnancy means that we aren't always able to screen appropriately for STIs, nor do the screens that we have for STIs always tell us really what we want to know. Even if they do tell us of some of the pathogens, subsequent antibiotic treatment may be problematical and difficult.'

The Kimberley also has an extremely high multiple caesarean section rate. A lot of patients have been presenting for their fourth, fifth, or sixth caesarean section.

'In the past there has been a reluctance to allow women to have a trial of labour after they had a caesarean section at the first birth, so they would have a second caesarean section', explains Dr McGlashan. 'The problem is if women have had two caesarean sections, they will almost automatically have a third caesarean section and then a fourth caesarean section.'

Marilyn Kong asks Dr McGlashan if he believes part of the reason for such an extraordinary number of caesarean sections could be a lack of understanding by the patients about the procedure. 'I wonder if they are fully aware of the consequences of procedures', she says. 'I've found that Aboriginal patients in general are passive and not very assertive; they can be very intimidated by authority figures. If someone says to them, "You will need to have a caesarean because you've had a caesarean before", they will just accept it. They won't necessarily question it like other informed patients might. I think the reality is that Indigenous

patients are not as well informed as we might believe.'

'You're absolutely right', Dr McGlashan concurs. 'We provide extensive paperwork for informed consent, but I'm not sure if, in the Aboriginal context, we are obtaining complete patient satisfaction and understanding. Marilyn, as a registrar, you would know about counselling people who have had previous caesarean sections and certainly, when I came up here, the counselling was along the following lines: "You've had a previous caesarean section. Now what you've had before may not happen again this time. We would encourage you to have a vaginal delivery, but the choice is yours. You have a scar on your uterus and there is a possibility that that scar could split apart during your labour and the baby could die and you could be very, very ill indeed." And of course, in nearly every instance, as soon as we've warned them that there might be adverse consequences – no matter how small or unlikely – the patient opts for a caesarean section. After this, trying to obtain informed consent for a trial of labour is awkward.'

Dr Kong comments that in her obstetric work, she sees a 'spectrum of complaints that are common to all women', but she has seen a higher incidence of pre-term labour, premature rupture of membranes and low birth weight babies among her Indigenous patients. She admits, though, that she has not seen enough women to identify whether there would be a definite trend of polycystic ovarian syndrome (PCOS) among Indigenous women, although she believes that PCOS would probably be 'more common in the whole hyperinsulin syndrome'.

Dr McGlashan replies that incidences of PCOS and anovulatory infertility are a 'burgeoning problem' in the Kimberley. 'Anovulatory infertility is common here and although it can be treated with a variety of medications, such as Metformin, I have no evidence that anyone ever

became pregnant due to taking those medications. Anovulatory infertility can be a lifestyle condition. Many of our Aboriginal patients are pre-diabetic or type 2 diabetics, are often overweight and have a generally sedentary and unhealthy lifestyle, so it isn't always the specialist gynaecologist who is the person to intervene, it again goes way back to educating people about their health and well-being.'

## **INFORMED CONSENT AND PRESENTATION**

While believing that expert investigation, supervision and IVF may be the only way to overcome most of the infertility problems, Hamish McGlashan doubts the practicability of bringing IVF services to Aboriginal communities. He adds that it can be a challenge to obtain a semen analysis, let alone organising for an Indigenous couple to visit Perth for intensive investigation and testing. He again cites the challenge of seeking informed consent while having to explain about techniques and procedures of an extremely complex nature in terms that will be understandable to the patients.

Marilyn Kong states that in her experience, eliciting informed consent from an Aboriginal patient is easier if someone else is present for the discussions. 'If it's just the doctor and the patient, I think it can be very intimidating for the patient. It's much better if someone else can be there as a support person, whether that be another health worker, a partner, a family member or a friend.'

'If we are seeking consent for a gynaecological procedure, such as sterilisation', Dr McGlashan explains, 'by the time the patient sees the specialist, she will have probably seen a health worker, a community nurse and the general practitioner in her community or local Aboriginal Medical Service. She will have already made an informed decision to proceed. On the other hand If there is a difficulty

in diagnosis and a procedure to follow that, then every patient is individually assessed as to what their level of understanding could be and an explanation given within that level of understanding. That varies from individual to individual, and no two people are the same, but that principle is not any different from any other patient. It is certainly a challenge to obtain informed consent which is both suitable to a patient's needs and compatible with current legal requirements.'

Hamish McGlashan and Marilyn Kong agree that Aboriginal women need to be encouraged to use the resources and services that are available to them in both urban and remote areas. Dr Kong indicates that follow-up with patients can be frustrating because 'Aboriginal people can move around quite a bit and tracking them down can be difficult'. She recommends that the best way to encourage frequent participation is for health

services to 'consult with the communities' and identify 'what the barriers are to participation'.

Dr McGlashan describes the dating of pregnancy as a particular problem. 'If a patient presents early in pregnancy, we can usually assess the dates for delivery accurately and organise an ultrasound before 20 weeks. Late presentation makes obstetric care very, very difficult. We need to know when a patient is due and that is particularly important in the Kimberley because people may have to travel several hundred kilometres. If you don't know when a woman is due, it's potentially thousands of dollars used up in travel

expenses that could have been spent on more needy patients.

'How we can address that problem is extremely difficult. How do you persuade people to use the available services? There are many factors to take into account, particularly the confidence of each community. The services are theoretically there, but getting people to access them and stressing the importance of that is



*'I have a great rapport with my non-Indigenous patients' says Marilyn Kong.*

difficult. We need to convey that message in a culturally sensitive manner but as part of an overall strategy to appropriately address the primary care needs of the community.'

## PATIENT PERCEPTIONS AND RECEPTION

Marilyn Kong's Indigenous background has enabled her to build a good rapport with Indigenous and non-Indigenous patients. 'I think all my patients have been thrilled to see a female practitioner. Aboriginal women who make the journey from out of town to see me are very pleased and proud that there is an indige-

nous person in a position of authority, so to speak. But I have a great rapport with my non-Indigenous patients too.'

As there has been extensive media coverage of her family's achievements in medicine in recent years, Dr Kong has modestly accepted that some people will hail her as a professional role model for Indigenous people. 'I never quite feel comfortable being in the limelight, but I think it's important for Aboriginal youth to have positive role models. I know that made quite a difference to me while I was growing up. Sandra Eads and Louis Peachey, who were the first Indigenous medical graduates from the University of Newcastle, were a huge inspiration for me. I've appreciated the importance of setting an example for other young people and I enjoy talking to Aboriginal kids at career talks or youth events.

'I think the media coverage about my family has been good for both Indigenous people and also for non-Indigenous people. I think it's important that non-Indigenous people can see us as positive role models as well, especially as the coverage of Aboriginal issues is often negative. I would hope that I have had a positive influence on my colleagues and I hope that I can educate them in some ways about Aboriginal culture as well.'

Hamish McGlashan believes his age and seniority have contributed to the positive reception from his Aboriginal patients. 'Being an old man with white hair means that I am probably a grandfather figure to some of the younger patients - or in Aboriginal terms, more like a great, great



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grandfather!' he jokes. 'The gender threat is partly removed because of my age. Also, as Aboriginal people have had contact with the pastoralists who have been in the Kimberley for 100 years and as they have been in regular contact with white people and culture, including doctors, over the last 70 years they may be more amenable towards having a white gynaecologist compared with Indigenous women in some other parts of Australia.'

'I don't think hope is lost if there are practitioners who are interested in working with Aboriginal women, but are not Aboriginal or female,' says Dr Kong. 'One of the important things about working with Aboriginal women is the willingness to be patient and they do respond to that. You can still have quite a satisfying relationship with the community, regardless of gender or culture.'

Both Marilyn Kong and Hamish McGlashan agree that specialists and Trainees who are interested in Indigenous women's health should consider undertaking programs in cultural awareness. The best advice that Dr Kong has for her peers is not to expect an instant rapport with Aboriginal patients. 'In my experience, it takes time to build trust, even if you think you are doing all the right things. The

earning of trust and respect is really out of your hands and as long as you work hard and use your expertise, people will see that you are genuine and will respond to that. You just need to be patient.'

Dr McGlashan recommends Richard Trudgen's book *Why warriors lie down and die* (Aboriginal Resource and Development Services, Darwin, 2000) as a starting point for anyone interested in cultural awareness issues. 'Richard Trudgen spoke at a conference I attended in Darwin about communication, and he was inspiring. I thought I'd been very much in tune with Aboriginal attitudes through my work with patients over the years, but I think that book drove home a whole number of messages that I had not considered. I think it is a "must read" for anyone who's coming up to northern Australia to work with Aboriginal communities.'

## FUTURE HORIZONS

As the discussion draws to a close, one doctor looks back on his career and the other looks to her future horizons.

After she earns her Fellowship, Marilyn Kong hopes to practise on the mid-north coast of New South Wales, which encompasses Kempsey, Taree, Foster and Port

Stephens, where she grew up. 'I haven't had extensive experience in working in an Aboriginal community yet,' says Marilyn, 'but I enjoy the holistic approach of Aboriginal health. It's not just the health of the individual, but how they fit into the community and how their ill-health can disrupt the community and the community dynamics.'

Hamish McGlashan sums up his time working in provincial and Indigenous women's health as follows:

'One is really thrown back on one's own resources to deal with quite serious medical problems here; that's the challenge and the satisfaction of this work. You can't just refer patients on as easily as you can in the city and you are often dealing with quite sick people and quite advanced pathology. The ability to see and deal with that, see the improvement or the cure, see a happy outcome from a difficult pregnancy, or deal successfully with a labour ward emergency, all those things are extremely satisfying.'

'That is the great satisfaction of it: that at the end of the week, the end of the month, I can say, "Yes, I made a difference", what I did was of some value, either to the individuals or the community. That I found far more apparent and evident than I did working in the city.'

**Damian Christie,**  
**Publications Co-ordinator**