Remote Obstetric and Gynaecological Services to Indigenous Communities

by

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The Chairman of the meeting was Mr. William Wilson.

Remote area indigenous health care is a very difficult and complex subject and I hope that I can at least give you some glimpse of the problems that there are, and the enormous amount of work that has to be done.

I think back to the day that I left Melbourne 10 years ago. At that stage I was working as a Specialist Obstetrician at Monash. I'd felt that I wasn't using my skills in the way that I wanted to but I wasn't quite sure what I wanted to do. I had announced that I was leaving and going to work in Brisbane. Syd Allen, Executive Director of Medical Services at the Monash Medical Centre said to me, "You'll be back, son. Queensland's too small for you." Well, I am now responsible for care in an area that is bigger than Victoria, and there are only three of us. I think that one of these days I'm going to get Syd up there and just show him what life's really about.

I thought that I would talk to you about FROGS, the Far North Regional Obstetrics & Gynaecological Service. The Peninsula and Torres Strait Region of far north Queensland is about 335,000 square kilometres, and yet there are less than 200,000 people there. About 165,000 of those people live within 100 kilometres of Cairns, but the rest are scattered all over Cape York and the Torres Strait. More than 15 per cent of these people are indigenous people, and as I'm sure you know their health problems are amazing. To quote our Director of Surgery, "These people have pus in places where there aren't even places." The diseases that we see, the things that we see, I have never ever seen before.

In terms of women's health care the problems that I struck when I arrived in Cairns in 1990 were extraordinary. The stillbirth rate was two to three times the national average. The incidence of major complications of pregnancy was extraordinary. Things that we would see on a daily basis were things that I saw at Monash maybe once a month or once a year. To give you some idea of the problems that indigenous people face in the 20-year period from 1970 to 1990 in Australia, indigenous people made up less than 2 per cent of the births in our country, but almost 10 per cent of the maternal deaths. An indigenous woman has a five-fold increased chance of dying during childbirth.

This graph shows the incidence of stillbirths and newborn babies dying, that is, perinatal mortality in Queensland. The Caucasian levels are on the national average at about 10 per 1,000 births. Aboriginal people have more than three times the risk of losing their baby. There

are also major women's health problems not associated with pregnancy. Sexually transmitted diseases are endemic, and I don't believe this is because indigenous people have any different sexual morals to the rest of us, but that they don't have access to reasonable health care. Again, there are things that I had never seen when I left here. I had never seen a patient with syphilis. One in five of the women I look after has had syphilis at some time in her life. Ectopic pregnancy is an every day occurrence in my unit. We've become almost blasé about it. Certainly the end results of sexually transmitted diseases such as infertility and chronic pain are enormous problems. Carcinoma of the cervix is thought to be about five times more common in the Aboriginal women of Cape York than it is in the Caucasian population of Australia.

I moved to Cairns in 1990 and I set about looking at how I could do something to fix the problem. I tried to quantify the risk characteristics of the women concerned. There were almost no professionally trained carers for pregnant women. There were only a handful of midwives in the whole of the Cape York and there were very few obstetrically trained doctors. I had to try and get a handle on those who most needed specialised care. No one could tell me what the problems were. No one could even tell me how many perinatal deaths there were. No one had collected data. So I started setting up a database.

Most importantly, I think, is the training of rural GPs. One in five Australians lives outside the metropolitan area. They are looked after by an eighth of the medical work force and in our speciality, by a fifteenth of the obstetricians and gynaecologists. Rural GPs who are well trained in procedural medicine are few and far between. We conceived FROGS as a means of going out to look after the women in their communities rather than requiring them to come to us. Prior to going to Cairns there had been three obstetricians in Cairns who were in private practice. They were doing their best in their public sessions to look after the women of the far north Queensland, but they were not able to leave Cairns.

I believed that antenatal standards needed to be supervised, because most of the people providing antenatal care had never been trained. Certainly there were a huge number of women with very significant problems in their pregnancy who were not being given anything like the standard of care that you would expect in Melbourne or Sydney, or elsewhere. Most of the women had no idea how pregnant they were. That didn't matter if they were labouring spontaneously at the

end of their pregnancy, but if there was a problem with their pregnancy and you were trying to balance up the risk of delivering the baby and you didn't know how mature the baby was, you really were in great difficulty in making a correct decision.

Women with gynaecological problems and abnormal Pap smears have little or no chance of getting the sort of consultation that a woman in Melbourne can get, pretty well at the drop of a hat. Certainly the very small number of staff giving care in Cape York and the Torres Strait, and there are only about 40 remote area nurses looking after these people, had virtually no opportunity to have on-going continuing education.

We wanted a system where we could try and provide equitable access to specialist care which would discriminate positively in these women's favour. We conceived a system of going out and doing clinics in the communities, and we hoped that this - and it's turned out so - for a State like Queensland with a small number of towns down the seaboard and a large number of people out the back, would become a model for other people providing health care.

How do you make a FROG? This was the problem. We didn't really know how to do it. The first thing we did in view of the fact that no one knew how far pregnant they were was to buy this most valuable instrument. It only cost about $12,000. It's nothing like the cost of the great big things that fancy radiology and ultrasound departments have. But this video printer, which can give the women a picture of their baby, has radically transformed things. In traditional Aboriginal culture a pregnant woman did not accept that she was pregnant until her baby was moving. So she was often not turning up for her antenatal care until two-thirds of the way through her pregnancy, if at all. That is far too late to accurately find out how far pregnant she is. Now if it's blackmail that giving women a picture of their baby has them now turning up at 10 or 11 weeks pregnant, then I'm guilty and that's fine.

The next thing I needed was a colposcope. And again, not the great big colposcopes that the specialists have in their rooms in Melbourne or Sydney to look at the cervixes of women who have abnormal Pap smears, but this little thing that only cost $2,000, and packs up into a little suitcase. It's just a little pair of binoculars with a light source on the top and you move it around like a joystick, but again it's been invaluable in dealing with women with abnormal Pap smears who live 400 kilometres away from the nearest specialist hospital.

The third thing I needed was a colleague because I couldn't leave Cairns Base Hospital unattended. One in 10 of the women who are cared for in our maternity unit are emergency referrals from some other

place in the Cape, and so I could not leave that place. I eventually found another obstetrician, who was working in Derby. We were both on our own and we said, "Okay are you going to Derby or am I going to Cairns?" We eventually decided that Cairns was nicer than Derby, and so Graham came to work with me.

My alternative office is the cockpit of Julia-Whisky-Oscar, which is affectionately known as "The Black Duck." Theses slides show the communities that I visit by plane. The west side of Cape York is almost invariably flat and green in the wet season and very brown in the dry season. If you're flying west from Cairns to Cape York you come to Kowanyama which is the biggest of the communities on Cape York. It has about 1,400 people and like most of the communities in Cape York it's an artificial community which became about in the 1930s when the Queensland Government sent armed troopers out into Cape York to "deal with the Aboriginal problem." Those armed troopers burned out the Aboriginal camps and herded the people together into a series of mission communities.

Kowanyama was the first community I ever got to. At the airport my first meeting with an Aboriginal person, I'm sorry to say, was with a very drunk man who walked out onto the tarmac just after we'd landed and asked me whether I'd bought his booze supply for him. Unfortunately that is one of the biggest problems, and I have no smart answers about how to deal with it. Going north from there up the coast is a lovely small community called Pormpuraaw, with about 400 people. It used to be called Edward River. The large river delta community called Aurukun gets into the news from time to time. It is an extremely violent community where nine tribes have been put together into this artificial community, and they've now divided themselves into two groups which regularly have wars. It is not a very nice place to stay in I'm afraid. Weipa has open cut bauxite mines and a riverside community at Napranum, which is the indigenous community.

The other side of Cape York is quite different with beautiful beaches. Lockhart River is a community which is set in rain forest and very lovely indeed. Right on the tip of Australia is Bamaga, a mixed community of Aboriginal and Torres Strait Islander people, who if you don't realise it, do not like each other, and do not get on well together. For goodness sake don't ever call a Torres Strait Islander person an Aboriginal, because you're likely to have a fairly hot time of it.

We use just about every technique in travel you can think of get around. We use the Torres Strait ferry to get to Thursday Island. We use helicopters, 4 wheel drives, you name it, we use it to get somewhere.

In doing so we now visit 20 Health Centres and hospitals apart from Cairns Base Hospital. From my point of view getting the wheel of the aircraft on the ground is one of the nicest things. Flying around Torres Strait and Cape York in the wet season can be quite terrifying and we've had some close calls. Some of the airstrips are good. At the Lockhart River air strip which is an ex-World War II bomber strip, a third of the runway at one end and a third of the runway at the other end is now unusable, and there is just enough room to get in. There is a huge air base that has been built near Weipa, but it's not available for us. The Prime Minister opened it a week ago. At Coen, a tiny little township in the middle of Cape York, we have to buzz the airstrip to get the cattle and the horses off before we can land. It has a hill in the middle so when you're landing you can't see what's at the other end. The best airstrip is at Pormpuraaw, where if you make an aborted landing the crocodile farm is right at the end of the strip. In the summer bushfires produce smoke haze that makes visibility very bad and in the winter wet season tropical storms can be quite terrifying. We lost our radios, radars and the strobe light off the end of one wing tip from a lightning strike.

When I first went out there the Health Centres were interesting and variable. Kowanyama was quite nice, tropical looking with palms around it. Coen was an old mission station. The worst was Lockhart River. The morgue fridge was right next to the front door, hardly a wonderful way to get people to come in, people who are naturally suspicious of white people's medicine. I'm told it was a great place to keep your beer because no one would go near it. The conditions under which the remote area nurses have lived and worked have been appalling. You wouldn't put your dog in the nurses' quarters at Lockhart River. Without these 30 to 40 women and a couple of guys who work on Cape York the people there would be in dreadful trouble. I have to take my hat off to them; they are wonderful people. At Weipa Hospital we managed to get the operating theatre equipped so we could use it. And in the last two years we had $1million spent in each community to build new Health Centres. So, at least the facilities have improved over the period of time that I've been there.

It was not at all uncommon that the first time we saw somebody was when they were in labour, or they had a dead baby in their uterus, or they had some other amazing complication. We had no idea how far pregnant most of these women were. They had appalling other co-morbidities, women with severe heart disease related to rheumatic fever, women with end stage renal failure, and as I mentioned earlier, syphilis. Syphilis has been a particular soapbox of mine, in that if

you diagnose syphilis in a pregnant woman and you treat it before she's mid-pregnant it will not affect the baby. I remember before I left Monash the obstetricians at Monash were talking about not testing pregnant women in Victoria any more for syphilis because they hadn't seen it for so long. Well, I'd very much suggest that it is not a smart thing to do. In far north Queensland in the last 4 years, to my knowledge, there have been 15 stillborn babies due to this diagnosis alone, simply because the women have not been accessing antenatal care. We have been trying to think about what to do, how to get people who are suspicious of Caucasian medicine to come. And the first thing that we really need to do is take the care to the women, because traditionally the only time they ever got to see a specialist was when somebody rooted them out of their community, put them in an aeroplane, probably for the first time, flew them to Cairns, probably the first time they'd ever been to a city, and put them into a hospital with things like lifts and air-conditioning, which are totally inappropriate to them.

We also needed to educate the people who were giving them care, in terms of behaving in a culturally appropriate way. I found it extraordinary when I went to Cairns Hospital that although 20 per cent of the births were Aboriginal, no one had ever bothered to try and teach the staff about Aboriginal cultural issues. And certainly somehow or other - and if anyone can come up with the money for this I'd be really grateful - I need money to do proper public health education programs to help the women understand the consequences of not accessing antenatal care.

Hospitals are very frightening places to indigenous people who have lived all their life in a community of maybe 1,000 people, a long way from anywhere. Surprisingly, although this hospital I work in has some 300 beds with at least 1 in 5 of the admissions being indigenous people, there is only one indigenous member of staff. Only one health worker is employed to be a liaison officer for all these people. Getting money out of bureaucrats to change this is nigh on impossible. I've already mentioned the need to educate the staff. We are now starting to get our staff going through cultural awareness courses, but again that has been very difficult. We're building a new maternity unit, and everybody wanted to have it all nicely air-conditioned, except that people who have never been used to air-conditioning don't like that.

Traditionally older women, aunties and grandmas, have looked after births in the indigenous communities and there have been a number of ceremonies surrounding the birth of the baby, particularly the cutting

of the cord, the naming into the baby and dealing with the placenta. None of these things have even been thought about. A good example of how bureaucracy makes it almost impossible to try and improve things for people is the birth certificate. The current birth certificate in Queensland says that; Joan Smith gave birth to her baby, Fred, at Cairns Base Hospital, and Joan by the way lives at Hobsons Creek. Now, to an Aboriginal woman, or an Aboriginal family, where the baby is born is of no importance whatsoever, but it is absolutely vital that this is a Hobsons Creek child. We put it to the Registrar of Births, Deaths & Marriages in Queensland that we should simply change the wording. There's no difference in the information. We simply want it to say; Joan Smith, who is a Hobsons Creek woman, gave birth to her baby, Fred, and by the way it happened at Cairns Base Hospital, in small letters down the bottom. The answer was, no we can't do that. The people aren't thinking about the welfare of these people and why they are so unenthusiastic about the care that we give.

There is a big drive at the moment for birthing in homeland communities, and I must tell you right from the start that this frightens the pants off me. How am I going to look after, or how am I going to give appropriate emergency care to, say in Kowanyama, where even if the aircraft was sitting on the tarmac fully fuelled ready to go it would take me at least 2 hours to get there, there are no facilities to do anything when I get there and if I take the woman back to Cairns it's going to take about 5 hours. How can you give emergency care? There are all sorts of reasons pushing homeland birthing. Land rights have got something to do with it. Some Aboriginal people, and in particular Aboriginal people who I call blue-eyed Aboriginal, who are the ones in Canberra and Brisbane who've never lived in an Aboriginal community are using it as a political football. Women in Kowanyama have to leave Kowanyama at 36 weeks pregnancy, and have to sit in Cairns, a totally foreign place, for up to 4 weeks waiting for the birth of their baby. They are not surrounded by their family and their traditional birth attendants. The family isn't able to bond with the new child. While they are away there's a distinct possibility that others might molest their children in the community. And certainly they are not able to undertake any of their ceremonial activities during the birth of their child.

In many ways hospital births in Queensland are very inappropriate for Aboriginal people. The birth attendants, as I said, traditionally were auntie or granny aged people, not youngsters, not Caucasians, certainly not males, and certainly not people who didn't understand the cultural

needs. And I've already mentioned that the surroundings aren't very conducive either. These are big problems, and it's almost impossible to make Health Departments understand that these things need to be dealt with. So will community birthing come? I guess it will. The people are moving that way. I think they need encouragement, but there are a few infrastructure problems along the way. You need midwives. In many of the communities with four or five nurses providing the total medical care in that community, none of the nurses have midwifery training. The average time that remote area nurses stay in the community is about four months. Continuity is difficult. Who's going to give the care? There are only three of us. We certainly have not got the ability to do a flying squad like there is in England, and in England it's 10 miles up the road at the most and around the corner. Most importantly I'm quite certain that if birthing occurs in remote communities that the maternal mortality rate and the perinatal mortality rate are going to rise again. And one of the important issues in Aboriginal culture is called payback. If something happens to you somebody else is responsible, and you pay that person back. I certainly don't want to be a remote area nurse in a remote community when something goes wrong with a birth.

Infertility is a big problem. Mainly because of the high incidence of pelvic inflammatory disease from sexually transmitted diseases. It's a great cause of domestic violence towards women. Because of course it's only the woman's fault that she doesn't get pregnant. It couldn't possibly be the man's fault or the STDs that he gave her along the way. There is a huge number of people wanting treatment for their infertility, and absolutely no ability on our part to give it. One of the saddest and angriest days of my life was sitting in Weipa overnight between communities, and I turned on the television and there was my home university, Monash, advertising in far north Queensland for people to donate funds to the Monash IVF Service for research. And I thought, this is great. We can't even give treatment for infertility. I must say I wrote the Vice Chancellor a very angry letter that night suggesting that maybe Monash IVF Service would like to come to far north Queensland and help treat the women, and then we might have a different attitude.

Pelvic inflammatory disease is the second commonest reason that women are admitted to my unit. I have seen the most appalling infections, things that I've never ever seen in my life before I went to Queensland. In Monash if somebody came in with a lump, well Mr Day down there would be the one who'd deal with it, I might have

gotten to be third retractor holder if I was lucky. I average one lump the size of a baby's head at least once a week. And thank you, Mr Day; if you had not trained me as well as you have I would never have known how to deal with them.

These issues are huge. The women end up with amazing menstrual disorders. By the age of 30 most of the women have had 5 or 6 pregnancies, at least one ectopic pregnancy, numerous bouts of pelvic inflammatory disease, and they need a hysterectomy. Carcinoma of the cervix is the other major issue. And it's really difficult. How do you screen for carcinoma of the cervix? Well, we all know we do Pap smears. Whilst the women have got to know me over the last 7 years, and they now accept that this white male gynaecologist is the only one who is going to come and look after them when they know they've got a problem – they tell me I'm now an honorary black female - they certainly won't come to me for routine screening. I know of two female remote area doctors. We just cannot get remote area doctors, and we certainly cannot get females who want to work there. There's one female in my speciality, and she's just started working out of Darwin, and I am so pleased to see her doing it, but we desperately need more and we don't know how to attract female doctors who the women of remote Australia would relate to well.

I've already mentioned that remote area nurses have a high turnover rate, and only a few of them have been appropriately trained to take Pap smears. I have worked very hard to get indigenous health workers to undertake training, but so far I've been very spectacularly unsuccessful. So, it's very hard to get proper screening done for a start, particularly older women. They just won't come near us. So, what do you do? You can have visiting teams of female doctors and practitioners who come in and out. But what's happened is the government gives seed funding for two years and just as you get something going and it's starting to work, they say, "Well it's obviously very valuable, you can fund it out of your own budget from now on." I've already said that whilst they'll come to me, if I'm sick or on leave they certainly won't come to my locum. At times there have been fly-in teams that have come from other places. I remember vividly our Director of Gynaecological Oncology in Brisbane took a team of a cytologist and 2 nurses and himself, and flew into Mornington Island, because people were complaining. In a week they saw 3 people.

Aboriginal people don't understand medical urgency the way we do. If you think about it for a minute, Caucasian medicine is a little bit like, "How's your gall bladder?" whereas for Aboriginal people

it is, "How is your family, how is the tribe, how is the community?" Whether you've got an abnormal Pap smear, well it depends on whether there is a house smoking next month, because someone died there 6 months ago and that's got cultural significance, or whether there's a dance festival next week. You have to stop being irritated if you tell somebody they really need to have something done tomorrow, and they say, "Well I don't want it done tomorrow." A lot of medicos are taught to say, "You've just got to, it's terribly important." If you try and do that you're going to lose instantly. Trying to treat people is also a difficulty. Without that little portable colposcope of mine everyone would have to be shipped out. Every time they had an abnormal Pap smear they'd have to be shipped out several hundred kilometres just to have a diagnostic test done, which can be done around the corner here. And if you're going to send somebody several hundred kilometres away from their home to a culture that they're totally unused to, and subject them to radical surgery, or several weeks of radiotherapy, or chemotherapy, and there's nobody of their culture there to support them, they are not going to stay. We have a tremendous problem with people "defaulting from treatment."

So, what have we done? We see an average of thirteen patients a day. You might think that's not much. Sometimes that means I only see three or four people in one community. Sometimes twenty. Is that really cost effective? When I set the service up the Health Minister said, "Yeah all right you can do it for one year and unless you can prove to me that you've saved more money from the patient transit scheme" - the scheme which involves paying your transport if you live further than 100 kilometres away from your nearest specialist - "then it will be cut after one year." In the first four years we saved over $1million, as well as taking the care to the people. You know all those millions and millions that the government says that they're spending among health care? Well if you can tell me where it goes I'd be very happy, because we certainly don't see any, and don't hold your breath to see it get down to the line to delivering health care to indigenous people.

Are we doing any good? I guess this is my real pride. Not many doctors in Australia are really able to see what's happening these days. We've almost halved the perinatal mortality rate and we're only slightly above the national average eight years into the program.

To again stress the difference in the view that Aboriginal people have about health from that which we have, Aboriginal people really see health as a whole of life, a whole community thing, and not just the well-being of one of your organs. Regular clinics work better than

visiting firemen going in and out. But I guess anything is better than nothing. I still don't understand why I can't get Aboriginal health workers to work with women's business, as it's called. And I certainly don't understand why I can't get any government or research funding to even start the health worker training program in women's health. There's really nothing being done to encourage indigenous people, first of all, to become educated to the point where they can go to medical school, and secondly, to get them into medical schools.

If anybody wants to undertake cross-cultural work there are a few things I'd suggest. The most important thing would be to take a cross-cultural training course. The things that I didn't realise you shouldn't do. I'd always been brought up by my parents to look somebody in the eye when I'm talking to them. That's regarded as a sexual come-on in Aboriginal communities. It's not the correct thing to do. It's very easy to make mistakes. It's not appropriate any longer to be going into the communities and saying, "This is what should be done." Somehow or other we've got to encourage the Aboriginal people to take over the delivery of their own health care, and then work with them as they want.

It's very important that it's the same person who goes each time. I now walk down the street in Cairns and all the time I hear "Hey, Humphrey!" The first time I went to Kowanyama the remote area nurses had made twenty appointments, not one woman came in and saw me. A couple came in and looked around the door. The next time I went two women came and spoke to me, but would not let me examine them. Gaining trust is important. And certainly if you break appointments, if you don't go when you say you're going, or if you don't do what you say you are going to do, then you'll lose out very quickly.

I guess I've been a bit depressing with some of what I've said, but in fact it's been a great eight years. I think that it would be wonderful if just one person here could convince one young doctor to go and work in remote area Australia because we certainly could do with every bit of help.

QUESTION: Is there a very high incidence of diabetes amongst the Aboriginal community in the far north?

PROFESSOR HUMPHREY. Diabetes is a huge problem, particularly in the Torres Strait. In the Torres Strait where you have people who are of Polynesian origin, about 1 in 4 adults has diabetes. About 1 in 6 Aboriginal adults has diabetes. Although, in article that's

about to be published from my unit, the incidence has about halved in the last 10 years. We don't quite understand why. We can't identify any lifestyle things that have happened, but certainly it's so. The incidence of gestational diabetes, or diabetes which occurs temporarily in pregnancy has halved.

QUESTION: Why do the nurses only stay for four months? Having made the effort involved in going up there and changing your life to be a remote area nurse, why have you come back after four months?

PROFESSOR HUMPHREY. Until very recently the terms and conditions were pretty awful. Someone would go there having little if any idea of what they were letting themselves in for, and unless they lived there for a year they were not even guaranteed a return air fare to Cairns. They had to get themselves out if they didn't like it. Many of the remote area nurses have been the subject of physical and verbal threats and abuse. Several have been quite severely assaulted. Their workload is huge. In Pormpuraaw, for example, there are three nurses. That means that every third night you are on call and you are probably up all night suturing drunken people, getting abused, getting threatened, and not getting very much for it, and, this is the worst, getting very little support from the health authorities. I have vivid memories of two extremely remote area nurses who ran Aurukun Health Centre at some time. Now, their child became ill, having eaten some bush medicine berries. At the same time there was a death of a child in the community from untreated gastroenteritis. The people of the community were threatening John and Jenny quite severely while they were trying to look after their own quite desperately ill child, and the health authority wouldn't send anybody in to help them or evacuate them. Their conditions they work in are dreadful. They are better now than they were two years ago, but as I said earlier, there are only about 40 of them on Cape York, and without them the whole health system would just break down completely. They're wonderful people.

QUESTION: DR CLARKE. It sounded as you described FROGS that you were flying by the seat of your pants a bit. Is there any body of literature, any accumulation of knowledge, about developing services in the Third World?

PROFESSOR HUMPHREY. There is very little. I suspect it's mostly because there are very few people doing it, their workloads are enormous, and getting around to writing it up, or going to meetings is almost impossible. In the Third World of course getting the money to do it is difficult. I have a lot of interaction with Papua New Guinea,

and I have one of their specialist trainees in my unit all the time. At the moment in Papua New Guinea there are only five PNG born specialists in Obstetrics and Gynaecology. This is for the whole of Papua New Guinea. There are about four ex- pats. One other person in Queensland is doing it and that's Jim Baker. Jim flies out of Roma, and looks after the whole of West Queensland, and he's a worse workaholic than I am. He does a 24 hours a day, 7 days a week service on his own, and he runs a Hereford Stud and a trucking business. And he wonders what to do with his spare time.

QUESTION: MS WEARNE. I was a midwife at the Broome Hospital for 10 years in the 1970s. I can remember the syphilis being a dreadful problem, but I can't remember losing many babies. I guess we weren't as outback as you.

PROFESSOR HUMPHREY. I'm sure that's right. But you would have had people coming in from Fitzroy Crossing and Derby and the problems are still there. No-one was trying to document things. When I went to Queensland this whole area had been looked after obstetrically by three obstetricians in private practice in Cairns, who in their spare time looked after the public health system. They had their eyes hanging out on stalks. They were having a hard enough time trying to keep the service going, and they had no idea what was happening. It was only when we started gathering the data in perinatal mortality that we found out there was one here and one here and one there and one there and one there and one there. Each person didn't realise that they were happening all over. I suspect you might have found if you'd been able to go around to all of the other places that syphilis really was a problem in infant mortality.

QUESTION: Do you test routinely for HIV as well?

PROFESSOR HUMPHREY. Yes I do. We routinely offer HIV screening to every pregnant woman. We have no idea what the incidence of HIV is in our area. We certainly know it exists, because we've had two HIV positive babies born in the last year where the mothers were not known to be HIV positive. The difficulty, of course, is if you follow the National Guidelines for HIV Screening that means that we would have to spend at least a quarter of an hour counselling every woman before she has an HIV test, and that's next to impossible. But we certainly offer, and actively encourage every woman to have HIV screening.

Recently we got the Royal College of Obstetrics and Gynaecology to agree to this, and I have had a lot of criticism since then. But I believe

that every pregnant woman should at least be asked whether she thinks she might be at risk of HIV, and whether she wants to be screened because we can actively change the outcome of the babies. We don't have to have HIV positive babies born.

QUESTION: My understanding of the Aboriginal woman is that she doesn't understand what bacterium bugs are about. They don't fully understand what infection is about.

PROFESSOR HUMPHREY. Most Aboriginal people's view of disease is poori poori; that somebody has "pointed the finger" or "pointed the bones" at you. Basically you get sick because somebody else has got it in for you. Most Aboriginal people don't have an understanding of disease process like we have. So, treatment is difficult. To try and get a person whose education has maybe been to 2nd or 3rd Grade standard, to give informed consent is interesting to say the least. I suspect that if I had to go to court to defend how I got informed consent I'd probably fail most of the time. It is a very difficult concept.