FIFO's

THE FORGOTTEN MINORITY GROUP

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The Pilbara – a place many have heard of, but few have ventured.

Fifty thousand people call the Pilbara their permanent home, but due to its rich sources of iron ore, crude oil, salt and natural gas deposits it means thousands of workers are flown in and out every day to service the area's massive mining industry - also known as FIFO's.

I have become increasingly concerned over the past few months about the health of the much needed members of our economy and am increasingly asking if their health needs are being met.

A case in point would be Bob, a 54 year-old-man, who presented to the Emergency Department with an ingrown toenail. He claimed to the triage nurse that he was otherwise 'fairly well' but had a bit of diabetes. His work medico had checked his sugars morning BSL and it was found to be 21.6.

Bob stated he was a FIFO engineer from New Zealand who worked 12-14 hour days in 3 weeks-on, 1 week-off swings. He had made the seven hour long journey from New Zealand only two days prior. Together, Bob and I sorted out a plan of action for his ingrown toenail but my other agenda was to attempt to sort out his diabetes.

In further discussion with Bob, he was pretty naïve about his health condition.

He had had diabetes for three years, did not know what medications he was taking and in fact had left all his pills at home. He did know his latest HbA1c though (which I thought was promising,) at 10.6 per cent, which demonstrated things had been fairly out of control for some time. He did no exercise, ate whatever was served up at camp and drank quite heavily with the other 'boys'. To his credit he was a non-smoker.

Bob's case is not an isolated one. In fact, it seems there are increasing numbers of intelligent; predominantly middle age males in our community who are suffering significant chronic health conditions that are poorly managed predominantly due to the nature of their work-life arrangements.

Like many men in Bob's situation there is potential for patients to not seek health care, ignore advice or not take responsibility or ownership for their medical issues.

According to Bob, he had never had education about his disease or discussions about the cause or lifestyle factors that could prevent progression in the future.

This got me thinking further, how do our FIFO men access this education? They work such long hours, there is minimal time to attend appointments unless in an emergency and when they reach the end of their swing, exhausted, they pack up and off home they trot. Much of the time at home is spent resting and recovering with possibly a little time with the wife. Time with the local GP or diabetes educator would be way down on their priority list.

So how do these workers have their conditions followed up?

A couple of casual repeat scripts provided by an unsuspecting ED RMO who sees the file and thinks, excellent, this will be a quick case, could see the patient having no review for months. Who then makes sure that this patients HbA1c is improving, that the urine protein/creatinine ratio is adequate, that their fasting cholesterol result are within limits and that they have had their annual eye check, podiatry visit etcetera.

From the patient's perspective there are other underlying factors that lead to concern, for example their desire to keep sick days to a minimum and the fear of losing their jobs due to their conditions.

I also consider the invincibility belief by some of my patients. The fact that some can work for exhaustingly long hours and can continue to drink and smoke and consume a myriad of other "black market" substances that they can pick up along the way.

I do however understand that at some point our patients need to take responsibility for their own health and lifestyle decisions.

This is where direction from a discerning local doctor can go a long way. Education about disease, management and prevention is super important. The issue for our fly-in fly-out workers here in the Pilbara is the same for the rest of the Pilbara population. There is a screamingly obvious lack of availability of a stable GP workforce.

Patients can wait for one to two weeks to get an appointment, take time off work, sit in the waiting room for up to two hours to be greeted by a fresh face who they have to repeat their story to all over again. On top of that waiting time they then have to pay $80 plus for the pleasure. I am certainly not undervaluing the excellent service provided by our GPs as there is very little time to delve into chronic disease management when the first 10 minutes of the consultation is taken up getting acquainted with the patient and catching up on the previous notes - if there are any - or worse still take a full medical history. I wish the patients would better understand this fact.

Instead patients prefer to come and sit in our emergency department waiting room when their conditions are interpreted by themselves as really pressing. On a rare occasion they might have to wait four hours to be seen, keeping in mind they are in and out under that time to comply with the new 4 Hour Rule policy and not have to pay... bonus!! The issue is that most ED practitioners are only interested in sorting out the patient's most acute problem, and rightly so due to funding constraints, but a good practitioner would then safety net and end the consultation with a referral back to a trusty local GP to sort out their other non-pressing medical issues and the cycle begins again.

When will our FIFO workers, with potentially preventable/manageable predominantly lifestyle related diseases, have time to visit their GP? They often go without much needed chronic disease management, as realistically the GP follow-up for the non acute matters rarely happens. I wonder if the patients themselves have considered the overall health and lifestyle impacts of not taking their disease states seriously.

So a problem has been identified. How can we attempt to develop a solution?

Does it come in the form of better patient education from the practitioners that see the patients in the emergency department? What about the role of community health educators on mine sites tackling chronic disease issues and preventative health measures? What about electronic medical records as a condition of employment to allow better health information access? Or better funding arrangements so that in rural areas - where GP DMO's run the ED's - can function more like GP's?

Should this education come from their local GP from their home towns perhaps?

Is the problem big enough to bring about a broader community public health message via education? This is not an easy issue to tackle but I would like to propose that some of the State Government's Royalties for Regions money should be spent educating workers, not just about injury prevention, but on disease prevention and management. This should have a major impact on helping to create a healthy, happy and sustainable workforce.

After all it is the very same patients that are assisting us to keep our whole economy booming – lest we not forget them. ’