Queensland Perspective: Dr David Bradford
Life member of SHSQ

Thank you for the opportunity of speaking this morning on the interesting topic which has been given to each of us three speakers and which I understand is up for discussion in the Forum that will follow the presentations. My brief is to outline the situation as I see it in Queensland. In preparation for this talk I have had helpful chats face-to-face and on the phone with quite a number of people. I would like to thank them all for their insights and their time. I want to stress however that anything I say today is entirely my own opinion and does not represent any particular person's point of view. Any factual errors are my fault and I will be only too happy if people want to correct them in the discussion time. Only one person can be held accountable for what I say and that's me!

I want to start up-front with three quotes. I hope in the course of my talk to draw lessons from the quotes and to indicate how they are relevant to the situation in Queensland today.

The first comes from the December 1972 Jubilee Issue of the British Journal of Venereal Diseases. The quote is taken from an article entitled "Venereology – A backward look" written by one of the grand old men of British Venereology, Ambrose King, then nearing retirement. Ambrose King started life as a surgeon but became Director of the Venereal Disease Clinic at the London Hospital in Whitechapel. This is the quote:

"I am often asked why I decided to go into a subject which was then regarded as highly distasteful and quite unworthy of the attention of anyone who had hopes of becoming more than a medical hack. It is a complicated story and there were various reasons for my decision, some more edifying than others. At this stage there were doubts in my own mind of my ability to make the top grade as a surgeon. In fact, on closer acquaintance, I did not even like the subject much. On the other hand, venereology, most neglected and despised of subjects, seemed to offer a considerable challenge. I asked advice from a lot of people, including all the Chiefs I had worked for. They all said 'No', with the single exception of the Professor of Bacteriology, a world-famous and rather blunt Scotsman from Aberdeen, of the name of William Bulloch. He listened to my problem and after a few moments thought, said: 'King, if you take up this work you will have an interesting life and your future will depend on human nature. Human nature will never let you down.' He was a true prophet."

The second quote comes from an article by James Schafer in the March 1954 edition of the American Journal of Public Health. It is reproduced in Alan Brandt's magnificent book "No Magic Bullet" about Venereal Disease in the USA. The quote reads as follows:

"Five years ago the forces of VD Control were on the offensive; in state after state aggressive control programs were gaining the advantage. Before an integrated

system of information, case-finding, referral, and rapid treatment, the venereal diseases were melting away. The resulting optimism proved disastrous. Forgotten, even by some health officials, was the carefully pitched epidemiological apparatus that brought the patient and the penicillin together. The infectious syphilis rate was pitched so sharply downward (and the gonorrhoea rates had also started down) that it was inconceivable they would stop, even if all programming ceased. Anyone could get and take penicillin.

The intervening years and the painful review of some carefully documented hindsight have established the fact that drugs alone do not stop venereal disease."

For my last quote I turn to something much older, much more venerable and much more succinct. The book of Proverbs, Chapter 29, verse 18 (just eight words):

"Where there is no vision, the people perish."

As I have said, I mean to return to those quotations a little later. For the moment I want you to let them rest in your mind.

My talk is divided roughly into three parts – the Past, the Present and the Future.

First – the Past. I don't mean to linger long in the past you'll be relieved to hear. Of course it's a strong temptation for old people like me to live in the past for nostalgic reasons. I must firmly resist that temptation. But it is beneficial to trace very briefly how we got to where we are today.

Our story begins one hundred and one years ago when the British Government in 1913 set up a Royal Commission on Venereal Diseases. The Commission was specifically instructed that a punitive approach was not to be taken, because the government had had its fingers severely burnt by the total failure of the notorious Contagious Diseases Acts of the nineteenth century.

The Commission was composed of six doctors, two MPs, two civil servants, two clergymen and two worthy ladies who were described as 'social purity campaigners with deep moral convictions', and the Chair - Lord Sydenham an ex-soldier, colonial governor and businessman.

David Oriel in his history book "The Scars of Venus", comments:

"It is remarkable that this disparate group of people who no doubt, like the rest of us, had personal problems and prejudices, produced such an enlightened document."

The Commission produced their report in 1916. The government accepted it and it became law as the Public Health (Venereal Diseases) Regulations 1916.

David Oriel again:

"The most important recommendation was that local authorities should provide a FREE service for the early diagnosis and prompt treatment of venereal diseases, three quarters of the cost to come from central funds and the remainder from local taxes. The service would be strictly CONFIDENTIAL, and available ON DEMAND. This proposal was the cornerstone of future policy towards patients with venereal diseases in the UK, and was widely followed throughout the British Empire."

Each state of Australia had, and still has, ultimate responsibility for the Public Health of its citizens so it came as no surprise that the various states of Australia all based their VD Regulations on the British regulations and set up free clinics - at least in the respective capital cities.

For the next stage of our story I hope you will forgive me introducing a personal element. I want to fast forward to the end of 1979 when for family reasons, my partner Michael and I decided to return to Australia after being in England, in my case for almost eleven years.

After training and qualifying as a surgeon, in 1973 I gave it up in favour of general practice. But I'd always maintained an interest in STIs and I successfully completed the Diploma of Venereology. I decided I wanted to work full-time in STI medicine on return to Australia. Accordingly I wrote to several doctors I knew in Sydney and Melbourne to ask their advice. The tone of the answers was pretty much the same as Ambrose King got so many years before: *"There are no openings in Venereology in Australia. The standard of the public free clinics is terrible and there is no specialty recognised here. Stay in general practice if you want a future. If you must do venereology, stay in Britain."*

But someone – an old family friend who lived in Melbourne and who later went on to become Federal Minister for Health in John Howard's government – told me the Victorian Health Department wanted to upgrade their public clinic and would welcome an approach from a doctor interested in the specialty. And so to cut a long story short, in March 1980 I started work as an MO at the newly refurbished clinic – the 'Melbourne Communicable Diseases Centre' and when the old Director retired in August that year I stepped into his shoes.

I found that what I had been told about venereology in Australia was only partially true. While public clinics were run down, staff attitudes were poor and there was no recognition by the medical profession in Australia of Venereology as a specialty, there were some hopeful signs. A young GUM physician from Glasgow (Anne Walker) had been appointed Director of the Sydney Clinic and she was said to be making a difference and attracting some keen young doctors to work there one being a chap called Basil Donovan. In the West there was a dynamic fellow called Morris

Gollow in charge of the Perth Clinic. There was an ID physician called Ross Philpot interested in Venereology in Adelaide.

In June 1981, clinic directors from all the states (including Darcy Kelly from Brisbane) came to a Commonwealth-initiated Communicable Diseases meeting in Melbourne. From that meeting the National Venereology Council of Australia (NVCA) was born. The NVCA was an unwieldy sort of organisation of interested doctors, nurses and laboratory people but it provided the opportunity for us all to get together once a year, hold a scientific meeting and plan a future. The fact was that even back in those days, we did have a vision for the future. We recognised that however difficult and unlikely it seemed at the time we needed to set and maintain standards of excellence and we desperately needed a training program for both doctors and nurses.

And then AIDS came, and the climate changed. Money started to flow from governments, including a seeding grant for the NVCA from the Commonwealth which allowed us to appoint a fulltime secretary. In 1988 the NVCA decided that we needed to maintain good professional standards for doctors working in the field and to introduce a training program, so under its direction five of us medicos on the Council founded the Australasian College of Venereologists (ACV).

Now I am sure all of you who are clinicians appreciate that you can't work long with clients with STIs and HIV without realising that their sexual health needs go a long way further than just the infectious diseases. Dr John Moran, the secretary of the ACV summed it up well in 1996:

"Twenty years ago I was a venereologist, occupied predominantly with diagnosing, treating and otherwise managing STIs and other genital infections. This is no longer so. While viral STIs, particularly HIV ensure a venereological component to contemporary practice I am just as likely in clinic to be responding to a request for post-coital contraception, injectable contraceptives, sexuality issues, genital dermatology or numerous other non-STI sexual health problems."

Everyone in the NVCA and the College had come to that realisation. In fact, it was a young hot-head trainee with a broad Scots accent from Queensland who at the College's 1993 AGM in Melbourne successfully forced through a motion to change the College motto from *"Miseres succeremus"* (which was supposed to mean *"we hasten to help the unfortunate",* but which a Latin scholar boy-friend of one of the Fellows pointed out was incorrect Latin) to the much more meaningful *"Sexual Health for All".* Thank you David Jardine!

And so, on the 16th November 1996, with a majority (84% of Fellows) in agreement the Executive Council changed the name of the College to The Australasian College of Sexual Health Physicians (ACSHP). Our focus was no longer to be mainly on diseases but on the promotion of health in the field of sexuality.

The rest is recent history. In 2004 the College became a Chapter of Sexual Health Medicine in the Royal Australasian College of Physicians and more recently we at long last achieved specialist recognition.

Enough of the Past – what of the Present in Queensland?

The overall impression I get is that here in Queensland we are still reeling in shock. To quote someone I spoke to in Brisbane: *"To tell you the truth, I still feel numb."*

I'll briefly reiterate what has happened. First of all, in line with an initiative from the Commonwealth (brain-child of Mr Kevin Rudd I am told), the government restructured Queensland Health, and set up Hospital and Health services (HHSs) across the state, each being governed by a local Board. This had the effect of reducing the power of Queensland Health at a central level quite markedly, particularly in the area of public health. There were many redundancies in public health and health promotion positions. The Minister himself is said to have proclaimed: "*preventive medicine is a luxury we cannot afford in this state".* As well, the loss of a powerful central health department presence took away the support Sexual Health Clinics had enjoyed from the Communicable Diseases Branch and made sexual health clinics much more vulnerable to the whims of individual HHSs, which began acting like individual fiefdoms. All was well if the HHSs remained committed to maintaining a public Sexual Health Service (as in Cairns and on the Sunshine Coast), or where the Sexual Health Service was able to negotiate some sort of give-and-take arrangement (as in Townsville and the Gold Coast).

Secondly, within a month or two of taking office the new Minister defunded QAHC – the then-named Qld Association for Healthy Communities, now reverted to its former name QuAC (the Qld AIDS Council). For a Minister who professed a determination to get the rates of new cases of HIV down, this seemed an entirely inexplicable decision, given that QAHC was the only NGO organisation then working with the lesbian, gay, bisexual, transgender, intersex (LGBTI) communities in the state. Despite protests, the Minister remained adamant. He set up a Ministerial Advisory Committee (MAC) which has since morphed into something called the HIV Foundation Queensland (HFQ), of which more later.

Thirdly, about sixteen months ago the Metro North HHS announced that it proposed to close Biala, the Brisbane Sexual Health Service. There was a predictable public outcry and the Ministerial Advisory Committee stepped in to ensure that at least the HIV service at Biala was saved. The MAC managed to get Metro North HHS to arrange a review of Biala services and a report from Deloittes followed which did recommend that part of the services provided at Biala, especially the HIV service, remain open. There was a considerable reduction in staffing however, and it was made plain that people with STIs or presenting for sexual health screens were to be directed to general practitioners. In passing, it may be noted that in my opinion this

was a direct abrogation of the state of Queensland's public health duty and responsibility to provide a service for people with, or at risk of STIs, which was FREE, CONFIDENTIAL and available ON DEMAND.

The upshot of all these unexpected and drastic changes undoubtedly has been very damaging to our specialty. Some of the outcomes have been as follows:

1. Loss of morale by affected staff, especially in Brisbane, but to a greater or lesser extent more generally across the state.
2. Shrinkage of services, (especially in Brisbane) but notable almost everywhere, so that the holistic sexual health approach which we struggled in Australia to develop over a number of years has been whittled down in many places to a mere concentration on rapid screening (point of care testing) for STIs and HIV, and treatment of those infected.
3. Less attention paid to the public health aspects of sexual health. There is less time and there are fewer resources in clinics now for preventive education – this at a time when the defunded QuAC has far less capacity to concentrate on this role in the LGBTI community than they did before. Contact tracing officers remain in a couple of key areas, but I think it is fair and accurate to say that there is less contact tracing done now in Queensland than there was even five years ago.
4. An almost total loss of training positions for doctors and nurses. As we speak, there are no doctors formally training in sexual health in this state and only two nurses training to be SH or womens' health nurse practitioners. It's a concern that with the closing of the Griffith University course and so far the failure of Family Planning to fill the gap, no nurses are training to become accredited SH prescribers. As far as doctors are concerned, there remains a training position in Cairns, currently filled by a non-trainee doctor, and a training position (on paper anyway) at Biala, currently not filled. I am told both may be filled by trainees in the future, although the Biala one may become a joint ID and Sexual Health trainee, given that Biala since 1st July has come under the fold of the hospital ID service. The third trainee medical position at the Gold Coast is no longer funded and therefore lost.
5. I sense a temporary (and I hope it is only temporary) loss of vision on our part.

There is a further development in HIV prevention throughout the entire world (as revealed at the recent Melbourne International Conference on HIV/AIDS), but also very strongly and stridently manifest right now in Queensland, which I personally find extremely worrying. This is an undue (to my mind) emphasis on 'treatment as prevention' (TASP) - i.e. testing (especially rapid or point-of-care testing) and immediate treatment for HIV. To a lesser extent, (and not a practical concern in Australia at the moment due to lack of funding), is a concentration on PrEP – pre-exposure prophylaxis - to prevent HIV in people at high risk. In other words, there is an undue emphasis, almost to the exclusion of everything else, of the

implementation of a purely biomedical model for control of HIV, something a friend of mine expressed very aptly in a recent Facebook quote as “the biomedical stampede”.

And I want now to return to the last part of my second (1954) quote:

“The intervening years and the painful review of some carefully documented hindsight have established the fact that drugs alone do not stop venereal disease.”

You may well ask me why I feel like this. After all, the science is sound – a well-controlled randomised clinical trial demonstrated without a shadow of doubt that when HIV positive people were put on immediate, as opposed to delayed treatment, transmission to their HIV negative regular partners did not happen. And even without complicated mathematical modelling, common sense tells us if you can test everyone remotely at risk of HIV and, if found positive, put them straightaway on effective antiretroviral therapy then you will stop HIV dead in its tracks.

The reason for my caution is simply *human nature*! Every clinician knows about the little matter of adherence to HIV treatment. To keep even sick people taking a pill consistently every day, year in and year out is no mean task; how much more difficult is it going to be with HIV positive people who are well and asymptomatic? And from a public health point of view, unlike other medical conditions e.g. hypertension where missing a daily pill here and there will have no real drastic consequences, missing anti-HIV pills here and there may result in viral rebound, development of resistance and the potential for transmission of infection to sexual partners.

Please note - I am not saying treatment as prevention is impossible. I am just saying it will prove more difficult than we have been led to believe. And what is certain is that for it to be an effective preventive strategy, it will require loads of support for our more vulnerable and less obsessional clients so that their adherence can be maintained – medical and nursing support, counselling support, follow-up for those who tend to drop out of treatment programs, and dare I say it – peer-based community support. All this at a time in this state where just such support services, rather than being supported, enhanced and even increased, have been substantially cut and reduced.

I rest my case!

Are there any positive signs right now in Queensland? The answer is a rather cautious ‘yes’. I will detail some of them although some of you may be able to expand further in the subsequent discussion period:

1. Despite its defunding, QuAC managed to commence and has maintained an evening clinic in Brisbane for testing for STIs and rapid testing for HIV. In fact, QuAC, rolled out rapid testing for HIV before any other service in the state. The

clinic is funded by Medicare bulk-billing. The evening clinic is well attended by people at unequivocal risk for HIV and positive cases have been detected and referred on for treatment. QuAC aims to expand the service into a day time clinic as well.

2. With the loss of their ability to provide a full sexual health service, both Biala and the Gold Coast Clinics had to cease providing services for trans people. QuAC has in part met this need by establishing a part-time trans clinic serviced by a doctor with considerable expertise in the area. I am told this outreach is proving popular and is well attended.
3. Several NGOs including the Brisbane Youth Service have managed to combine resources and cobble together an ad hoc one evening a week service for STI testing in Brisbane. It is hoped that with assistance from Metro North a GP registrar might be attracted to provide this service regularly with funding by Medicare bulk-billing.
4. In the private sector, some general practitioners have been prepared to take up some of the gap left in sexual health services by the reduction in Biala's services. In recent months in Cairns, Dr Heather McNamee has opened a new private sexual health service.
5. The government-backed HIV Foundation Queensland (HFQ)has started to make its presence felt. With some publicity, at the recent International AIDS Conference in Melbourne Darren Russell, the Chair of the Foundation together with the Qld Minister for Health signed a Memorandum of Understanding with Dr Julio Montaner of the British Columbia Centre for Excellence in HIV for the purpose of developing, implementing and evaluating a strategy of 'treatment as prevention' (TASP) for HIV in Queensland. The stated aim is to get 90% of HIV positive people in the state on antiretroviral therapy and to eliminate transmission of HIV by 2020. Despite my reservations in principle about TASP it would be churlish not to welcome this development. Time will tell if all the hype generated by this publicity exercise has been justified.
6. Finally, Professor Charles Gilks, Head of Population Health at the University of Queensland has recently taken on the additional role of Qld Health Professorial Chair in HIV/AIDS and STIs. Darren Russell tells me the aim is ultimately to provide him with a full-time Associate Professor clinician to head up a research program under Professor Gilk's direction. It is obviously too early to do anything but acknowledge Professor Gilk's appointment and to hope that this newly created post will attract keen and competent researchers to Queensland. It is however perhaps noteworthy and from our point of view, disappointing that the title of Professor Gilk's Chair is 'HIV/AIDS and STIs' rather than 'Sexual Health'.

And now, a few remarks about the Future and how perhaps we should proceed.

I am no prophet, but there <u>are</u> a couple of things I can say with certainty:

1. Lawrence Springborg will not always be Health Minister and his rather curious obsession with HIV, his lack of interest in sexual health and public health, and his hatred for QuAC will not always be around either.
2. Given Qld Health's track record for restructuring, HHSs won't be around forever either. When I first arrived in Cairns twenty-one years ago, I was employed by the Peninsula and Torres Strait Regional Health Authority. Who remembers the old Regional Health Authorities now?
3. Human nature won't change. Ambrose King's advisor was correct. People will continue to have sexual health needs into the future and they will seek out professionals who will provide the services they need and then wear a path to their door, no matter who the health minister of the day, nor what particular structure the health authority decides to follow.

So take heart everyone!

But more seriously, I think the future of sexual health in this state lies largely in our own hands. The big question is: do we still have a commitment to and a vision for sexual health, rather than accepting just a narrow focus on HIV and STIs?

I am sure Kuong Taing from the Sunshine Coast won't mind my quoting him. He asked me on the phone: "*What good was it for me to do all that broad training in Sexual Health Medicine, if in practice I'm restrained from doing anything but diagnose and treat HIV and STIs?"*

I will have the temerity to make one prediction: at some future International AIDS Conference (perhaps not the next one in two years' time, but certainly thereafter) the optimism over a purely biomedical approach to HIV prevention will be considerably tempered. Ending HIV, even here in Queensland, will prove more illusory I think than anyone ever bargained for.

Finally, a few suggestions to consider:

1. It's time collectively to recover from our shell-shock and to start having a vigorous debate about sexual health itself and the possibility of continuing to provide comprehensive sexual health services in this state. Is it still possible in the public sector? If it is, how can we promote and advance the idea in the present climate? If it's not, how best can we go about encouraging it in the private sector? We need to ask ourselves whether we still believe there is validity in the motto of the old College of Sexual Health Physicians: *"Sexual Health for All"*?
2. We need to stand together and support each other. Someone told me on the phone the strategy of our opponents (i.e. those who oppose sexual health services) to date has been to "divide and conquer" and I think there is some truth in that. We need therefore to come together and resist being divided.

3. We must fight hard and long to retain our training positions both for doctors, nurses and nurse practitioners in sexual health medicine and the Australasian Chapter of Sexual Health Medicine must assist us in every way possible.
4. We need to maintain flexibility and optimism. We must at the moment keep an open mind on the HIV Foundation Queensland, the MOU with British Columbia, and the new Qld Health Professorial Chair at UQ. It's just too early to say how useful, or at the very worst, how antagonistic they may prove to the discipline of Sexual Health Medicine in this state. We need to look out for and take advantage of any opportunity that presents itself with these new ventures. After all if we can't learn to "ride the tides", as the title of today's theme puts it, there's only one alternative….and that's to go under!
5. We need to support the re-development of a strong community sector response to the sexual health needs of LGBTI people. It is inconceivable to me that 'Treatment as Prevention' for HIV can ever be successful without getting the most affected community unequivocally on side.
6. At all times we need to keep the needs of our clients/patients (call them what you will) at the forefront of our minds. We are trained and we have a duty to assist them in their quest for sexual health, no matter how awkward, messy or downright difficult they may be. One of the hall marks of good sexual health practitioners, be they doctors, nurses or counsellors is our willingness to listen to and learn from our patients. It's one vital thing I believe we have to salvage from the recent wreckage inflicted on us.
7. Finally we should remember Proverbs 29.18 – *"where there is no vision, the people perish".* If we lose our vision, not only do we suffer, because we no longer have the "interesting life" Ambrose King's advisor promised him, but far more importantly our patients suffer. And it's our patients ultimately who matter.