Canberra DOCTOR
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# In the fourth in a series on Canberra's hospitals, this month we feature Calvary John James Hospital

Calvary John James Hospital will next year celebrate 10 years of providing medical, surgical, obstetric and rehabilitation services to the Canberra and surrounding communities. Our staff of 467 strives to provide the best care and service to our patients.

In conjunction with the John James Memorial Foundation (our landlords) we have refurbished much of the patient accommodation to provide a more Hotel like feel. We have also upgraded two of our operating theatres to the latest Stryker iSuite digital technology providing the highest level of image to our surgeons. We have also upgraded our Central Sterilising Department to meet the growing demand for sterilising services.

Our Hospital Services:

Aubrey Tow Ward is our 25 bed Acute Medical Ward and provides treatment for all medical conditions. The dedicated nursing team is supported by a complete allied health team of physiotherapy, dietitian, occupational therapy, social work, pastoral care and speech pathology.

The medical unit also accepts direct referral patients from general practice to eliminate the need for patients to visit the emergency department. for direct referral of a patient please contact the bed manager on 6229 2110.

Our recently refurbished 26 bed maternity Unit has 4 delivery suites delivering 1150 babies last year. the unit also has a level 2 special care nursery able to manage preterm babies from 32 weeks; the unit is also supported with paediatrician cover available 24/7. A full range of antenatal services are offered by our midwives including breast feeding workshops run by a lactation consultant.

We have recently introduced a new service for post natal women. One of our physiotherapists has designed a six session class for women who are deemed fit for exercise. This six session exercise program is tailored to post natal women to help them strengthen pelvic floor and hip muscles. It has received great feedback from participants who are enjoying the opportunity to exercise with other women in the same condition – and they can bring their babies with them!

Deakin Ward is our 20 bed inpatient rehabilitation service providing a full range of services including post operative, stroke and amputation rehabilitation. The team consists of nurses, doctors, physiotherapist, occupational therapist, dietitian, social workers, pastoral care and speech pathology. We also offer a full range of day rehabilitation programs and have an onsite hydrotherapy pool.

Garran Ward is our 24 bed orthopaedic unit; the patient accommodation is all single rooms with ensuites which will be refurbished December 15 – January 16. The medical, mursing and allied health team work together to ensure a smooth recovery and safe discharge home for our patients.

Curtin Ward provides post operative surgical care for ENT, gynaecology, general surgery, urology, vascular, paediatric, oral maxilla, plastics and thoracic specialties.

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# Capital Conversations with President, Dr Elizabeth Gallagher

The good thing about having this column to write is that sometimes I can break some good news! I am really excited to be able to make some significant announcements this month.

### Board appoints new CEO

Firstly, I would like to welcome Mr Peter Somerville whom the board has appointed as our new CEO. Peter has extensive experience working at CEO level for both professional and labour organisations. Some of you would know him from his work as the executive director of ASMOF. This and his other roles have given him an impressive understanding of the AMA and the importance of providing services to members and potential members. The Board and I look forward to hearing his plans to make the CEO role his own, and helping him implement them. Peter will spend a few weeks in July learning "the ropes" from our incumbent CEO Christine Brill who will retire from the role at the end of July. He will then start in early September.

### New President Elect announced

Secondly, Associate Professor Stephen Robson, the former chairman of the Advisory Council has taken on the role of President Elect. For those of you who don't know him, Steve has spent the past few years as the Vice President of RANZCOG, and currently works in private practice in obstetrics and gynaecology and IVF in Deakin, as well as a VMO at TCH. I look forward to working closely with Steve over the next 12 months before I hand over the reins. Steve's new role means we will now need to elect a new Chairman of the Advisory Council who will also join the Board.

So, at the end of my first year in the job, – at what at what I thought would be a stable time, I am overwhelmed by new people! A new Health Minister, new Director General of ACT Health, new CEO and a new President Elect. Thank goodness I have the stable, talented and supportive Board behind me.

### Workplace issues – public and private medicine

There are a few local issues of relevance that I should bring to your attention. We are still waiting for the Fair Work Commission to release its findings into the ongoing salaried medical officers' dispute. Hopefully a solution can be agreed as the agreement has already been significantly delayed, and the next round of negotiations is due to commence in about 18 months! We remain concerned that protected industrial action not impact on our final year medical students or our doctors in training. No impact is anticipated on patient wellbeing as the action has been limited to administrative tasks.

The bargaining period for the VMO contracts starts in August, with arbitration set to be heard in February. The arbitrator is yet to be appointed. This time we do not have to spend effort collecting nominations, as the legislation provides that bargaining status continues unless revoked by the Minister. We can direct the effort straight to dealing with contract issues raised by our member and non-member VMOs covering the range of specialties.

### Training for general practice

The Government released the new general practice training boundaries in early April. The main difference was the consolidation of a number of Rural Training Programs. The ACT has been significantly affected by this. The boundaries have been changed so that the ACT is now associated with western NSW, and has lost its long association with neighbouring towns that the ANU Medical School and ACT Health have nurtured over many years. Of particular concern is that Goulburn, Bega, Batemans Bay, and even Queanbeyan have now been placed within the boundary that serves from Southern Sydney, through the Illawarra and down to the Victorian border. It also does not take into account patient flows to the ACT from these rural areas. The concern is that it will impact on GP training here in the ACT as well. Unfortunately, despite impressive lobbying by the ANU and ACT Health, the tenders have now been issued, without a change in boundaries, and close in mid July. We therefore plan to lobby the Commonwealth in conjunction with our partners as once the tenders are decided, we will be stuck.

### AMA members meet at National Conference

I attended the AMA Federal Council meeting followed by the National Conference in Brisbane at the end of May. It is always very tiring, but also very inspiring.

Here are a few titbits that may be of interest.

Our own Dr Iain Dunlop was admitted to the Roll of Fellows for his significant contribution to the AMA. More on this award later in this edition.

There were a number of policy sessions exploring general practice funding models and GP training. Certainly general practice, and in particular gap payments, rebate freezes, and funding of chronic health conditions has taken a lot of effort and time over the past 12 months, with a few wins, and much more advocacy and lobbying to be done in the next year or two.

There was also a policy session summarising the key AMA public health advocacy topics. These included an update on where things are with the Ebola epidemic in Africa – and reassuringly things are coming under control, although complacency could easily see this trend reverse. COAG has committed to address the problem of violence against women, and the AMA has joined with the Law Council of Australia to combine forces and address it from the health and legal perspectives as well. Climate change and its impacts on society, food supply, extreme weather conditions and health both globally and in Australia were also explored.

Medibank has abandoned its trial in Queensland to give members priority access to bulk billing general practice in Queensland. They acknowledged that this was perceived as the start of a two tiered medical system, and that there were better ways that health insurers could support primary care.

There were a number of Urgency Motions passed at the end of the conference. The first called on the Government to amend the Australian Border Protection Act which could see doctors who speak out about failures in health care delivery in immigration detention centres face jail time. There was also a call to review the policy of detainees, and in particular children in immigration detention centres, especially in the light of growing evidence of ongoing and permanent damage being inflicted as a consequence of the policy.

The second condemned the decision to fund a new medical school in Western Australia at a time when quality and vocational training of existing graduates is not guaranteed, there is a bottleneck to employment at the end of University, and at the end of prevocational training, and work force planning to make sure there are adequate numbers of well-trained doctors to meet community needs are still not sorted.

So that's probably enough new for this month. I am about to undertake one of those "bucket list" trips and spend the next 4 weeks exploring Alaska and Arctic Canada, so may only have news of bears, salmon, moose and glaciers (I hope) for the next edition! Enjoy the cold winter weather!

# In the fourth in a series on Canberra's hospitals...*continued*

***...From page 1.***

The patient accommodation was refurbished at the beginning of this year and all rooms are single with ensuite. Calvary John James Hospital is the only private hospital in Canberra providing paediatric surgery.

Our operating suite complex has 7 operating theatres; one procedure room; day of admission and day surgery facilities. We have the latest digital technology available to ensure our surgeons have the best image capture available.

The hospital is also supported with a 6 bed level two intensive care unit able to provide long term ventilation if required. Our trained nursing and medical staff are available 24 hours a day to deal with any complex patients.

The hospitality team provides a full range of nutritious cook-fresh meals made on site and our team of chefs can provide tempting meals for all appetites. Our dietitians have reviewed our menu to ensure it meets national nutrition guidelines.

Calvary John James Hospital is also able to offer that special touch with our pastoral care team. Pastoral care services provide a standard of care based on holistic care of every patient – care of the whole person, body, mind and spirit. Pastoral care practitioners work alongside other clinical staff to create a holistic and caring environment which enhances the personal dignity of the individual. The individual's choice of faith tradition and spirituality is respected at all times.

To enhance the patient stay we are currently installing a Continuous Ambient Relaxation Environment or 'CARE Channel' for patients to access via the patient entertainment system. CARE is a unique integrative therapy tool designed to comfort patients and families; reduce suffering and promote healing through guided imagery; relaxation programs; soothing music and beautiful natural landscapes.

Here at Calvary John James Hospital we look forward to many more years of service to the Canberra and surrounding communities.

*Copy supplied by Shaune Gillespie, CEO, Calvary John James*

# Support for owners of 'Mr Fluffy' houses

**By Dr Paul Kelly and Dr Sue Packer AM**

Many residents of houses affected by loose-fill asbestos insulation (Mr Fluffy) who are participating in the ACT Buyback and Demolition Scheme have started moving from their houses.

Throughout Canberra's established suburbs, there are 1021 affected houses. Of the 1021 affected houses, over 800 have already accepted the ACT Government's buyback offer. With demolition commencing in June 2015, it is anticipated that you, as a medical professional, may see more presentations for mental or physical issues.

Patients may experience frustration, anger and sadness. Interrupted sleep has been a frequent concern. They may have underlying feelings of helplessness and sometimes despair when it all seems too much. They may feel a sense of loss of control over their life or worries about the future – health, finances, accommodation. Some houses may remain vacant for a long period of time until they are demolished which may also contribute to distress.

Children may tune in to their parents' or grandparents' distress and worry about asbestos related issues. Neighbours may also worry about the loss of community connectedness or the changing character of their neighbourhood and loss of friends. Physical injuries could result from the process of moving house for people unused to such things.

Some options that are available to assist those who may be experiencing distress are outlined below.

- The NewAccess Program is provided at no cost through the ACT Medicare Local and offers support from trained coaches for those who are experiencing mild anxiety or depression. People registered with the Asbestos Response Taskforce (the Taskforce) can self-refer to this service by phoning the central intake number on 6287 8066. The coaches provide evidence based, low intensity psychological strategies and support, either face to face or over the phone, for up to 6 sessions. Free sessions are also available to any other member of the community who may need support.
- For anyone who is experiencing moderate anxiety or depression, GPs can complete a mental health treatment plan and provide referral for free sessions with a psychologist under the ACT Medicare Local's HealthinMind program. For those registered with the Taskforce, any 'gap' fee for the GP visit for referral to this service will be reimbursed to ensure that there is no out-of-pocket expense.
- ACT Medicare Local will ensure priority access to NewAccess coaches and HealthinMind psychologists for eligible people registered with the Taskforce.
- For any urgent/crisis mental health concerns, particularly in relation to acute stress and/or risks to the immediate safety of individuals, please contact the Mental Health Triage intake line on 1800 629 354. Other community supports available include: Lifeline (24 hours) 131114, School Counsellors and Employment Assistance Program (EAP).

More information is available on the Taskforce's website – www.asbestostaskforce.act.gov.au

Further questions can be directed to the Taskforce: Call Canberra Connect on 13 22 81, email asbestostaskforce@act.gov.au or follow on Twitter @TaskforceACT.

Department of Health and Ageing – EnHealth: Management of asbestos in the non-occupational environment. 2005.

*Dr Paul Kelly is the ACT Chief Health Officer and Dr Sue Packer AM, is Chair, Community and Expert Reference Group of the Asbestos Response Taskforce*

# Internationally acclaimed cancer control expert named as new Cancer Council Australia CEO

Cancer Council Australia recently announced the appointment of Professor Sanchia Aranda as its new Chief Executive Officer.

Currently Director of Cancer Services and Information and Deputy CEO at the Cancer Institute NSW, Professor Aranda will take up her new role in early August.

Professor Aranda has had an impressive career spanning 36 years in cancer control, including as a clinician, researcher, educator and health administrator. She has also made an enormous contribution to the control of cancer on leading state, national and international advisory committees and boards.

Professor Aranda is President-elect of the Union for International Cancer Control, Geneva, a Member of the Cancer Australia Advisory Council and Immediate Past President of the International Society of Nurses in Cancer Care. In 2013, she was awarded the Peter MacCallum Cancer Centre Distinguished Fellow.

From her early training as a Registered Nurse in New Zealand, Professor Aranda developed a specialisation in the control of cancer and palliative care, completing a Bachelor of Applied Science, a Master of Nursing and a Doctor of Philosophy.

Widely published in Australian and overseas health journals, she has also conducted research reviews for the National Health and Medical Research Council, Australian Research Council, state Cancer Councils, state Nursing Boards and for private sector research funding bodies.

Cancer Council Australia's Chair, Mr Stephen Foster, said the organisation was 'tremendously fortunate' to have found a candidate of Professor Aranda's calibre, who would lead Cancer Council Australia in the next stage of its development as the nation's peak independent cancer control body.

"Professor Aranda's wide-ranging experience means she understands the challenges and opportunities for the control of cancer and the differing perspectives of patients, their families, clinicians, researchers and health administrators," Mr Foster said.

# NCDI – Woden now home to the latest Breast Cancer Detection Technology

The state-of-the-art medical imaging technology which topped TIME magazine's list of "11 Remarkable Health Advances from 2014" is now available in Canberra.

Female patients are set to benefit from more accurate Breast Imaging with 3D Mammography, also known as 3D Breast Tomosynthesis, now available at NCDI in Woden.

This is the first time this valuable service has been available to women in Canberra and will help reduce 'false positive' findings and the risk of missing cancers, decreasing the need for additional invasive tests and reducing patient anxiety.

The sophisticated 3D Mammography technology is a major advancement on traditional Mammograms. The new scanner allows NCDI's expert radiologists to quickly and precisely examine breast tissue images in thin slices, typically of one millimetre thickness. During scanning, an X¬ray arm sweeps in a slight arc over the breast and takes a series of pictures at various angles which are then reconstructed into one high quality 3D image.

Regional Manager, Mark Duggan said the NCDI team is excited to be able to deliver the most advanced Breast Mammography service available to patients in Canberra.

"This technology reinforces NCDI's reputation for excellence in imaging and provides local patients with access to cutting edge mammography scans. Our skilled radiologists are available onsite to provide same¬day reporting and ensure patients are at ease during their appointment. We are proud to be the first to bring this world class radiology service to our community," said Mr Duggan.

Specialist Radiologist, Dr Iain Stewart, said the new equipment delivers more precise images, ultimately helping to improve diagnosis and patient outcomes.

"Our new service will help decrease 'false positive' findings and reduce problems caused by tissue overlap and structural noise which can occur in 2D Mammography imaging. Scans are completed in just seconds and the image quality is quite remarkable. It will help doctors to identify breast cancer with increased precision, ultimately improving outcomes for women," said Dr Stewart.

*NCDI is located at the Woden Specialist Medical Centre 90 Corinna Street, Woden, ACT; Phone 02 6214 2222.*

*Copy supplied by NCDI.*

# ACCC releases Statement of Issues on Ramsay's proposed acquisition of Wollongong Day Surgery

The Australian Competition and Consumer Commission has issued a Statement of Issues on the proposed acquisition by Health Care Corporation Pty Ltd, (Ramsay) a subsidiary company of Ramsay Health Care Ltd (ASX: RHC), of Wollongong Day Surgery (WDS).

The Statement of Issues seeks more information on the competition issues that have arisen in the ACCC's review to date.

"The ACCC is concerned that the proposed acquisition is likely to substantially lessen competition in the supply of day surgery services to private health funds and the Department of Veteran Affairs," ACCC Chairman Rod Sims said.

The proposed acquisition would see Ramsay acquire its closest competitor. The only other significant provider of day surgery services in the Wollongong area is Shellharbour Private Hospital, located approximately 20km away from WDS.

"Health funds need to ensure adequate day surgery coverage for members. The ACCC is concerned that this increase in market concentration would enable Ramsay to demand higher rates from health funds for the supply of day surgery services in Wollongong and its surrounding areas," Mr Sims said.

As negotiations are also conducted at a national level, any increase in Ramsay's market power in Wollongong may also give it the leverage to negotiate higher prices from health funds at other locations in Australia where Ramsay supplies day surgery services.

"The ACCC is also concerned that the proposed acquisition is likely to substantially lessen competition in the supply of day surgery services to patients in Wollongong, which may increase prices for uninsured patients or reduce the quality of facilities and/or services available to doctors and patients," Mr Sims said.

"Absent sufficient competitive constraints, we are concerned that the proposed acquisition is also likely to reduce Ramsay's incentive to invest in and improve the quality of its day surgery services to patients."

The ACCC's preliminary view is that Shellharbour Private Hospital would not provide a sufficient constraint to replace the competition lost due to this merger.

The ACCC invites further submissions from interested parties in response to the Statement of Issues by Thursday 2 July 2015. The ACCC's final decision will be announced on Thursday 27 August 2015.

WDS operates a day-only procedure centre in Wollongong. Ramsay owns and operates Figtree Private Hospital (Figtree), which is located approximately 5km from WDS. Ramsay is also developing Wollongong Private Hospital (WPH), located immediately adjacent to WDS. WDS and Figtree provide day surgery services across a range of overlapping surgical specialties. Ramsay intends to open WPH in early 2016, at which point Ramsay will transfer the majority of Figtree's services (including both day and overnight hospital services) to WPH. Figtree will then be transformed into a rehabilitation facility.

*The Statement of Issues is available athttp://registers.accc.gov.au/content/index.phtml/itemId/1185232/fromItemId/750991*

# AMA publishes updated position statement on Informed Financial Consent and has released new position statement on Setting Medical Fees and Billing Practices

The AMA has revised its position statement on informed financial consent (IFC) and has released a new position statement that separately deals with setting medical fees and billing practices.

The new documents are shorter and clearer about the responsibilities of medical practitioners and their patients in discussing medical fees and the cost of medical services.

IFC is an important part of the doctor/patient relationship.

All medical practitioners should have processes in place to ensure that their patients know about their fees for a medical procedure or treatment and have information about other likely costs.

IFC will become more important as patient out-of-pocket costs increase as a result of the Government's four-year freeze on Medicare rebates.

IFC assists patients to better understand how their Medicare rebate and private health insurance benefit funds their medical care, and to make informed decisions about their health care.

Good IFC practice is a shared responsibility between doctors and their patients.

Doctors are responsible for initiating the discussion with their patients about fees. They may use their practice staff to do this.

Patients are responsible for actively participating in the IFC discussion, including seeking clarification of any information they don't understand. Patients should also contact the other medical practitioners who will be involved in their care to confirm their potential fees and their private health insurer to confirm their cover and the benefit payable for their treatment.

The position statement *Setting Medical Fees and Billing Practices* recognises that medical practitioners should independently set a fair and reasonable fee for their services, having regard to their practice costs.

Every medical practitioner has the right to place their own value on their professional skills and expertise.

The AMA encourages medical practitioners to provide information to their patient about how they set their fees, and their billing policies and payment terms.

In highlighting that there will be circumstances where IFC will not be possible before the procedure takes place, the position statement states at paragraph 3.7 that one in 38 patients can expect to have an emergency procedure or treatment. This has been calculated using data in the Australian Institute of Health and Welfare *Admitted patient care 2013-14: Australian hospital statistics* report – it helps to quantify the episodes where IFC may not be possible.

*The Informed Financial Consent and Setting Medical Fees and Billing Practices position statements the can be found at www.ama.com.au*

# Dietitians appalled at plan to scrap subsidy for special diet foods

Nutrition experts have appealed to the Federal Government to reconsider plans to scrap a subsidy set-up to help sufferers of rare genetic disorders access the special medical foods they need to manage their conditions.

The Dietitians Association of Australia (DAA) said the recent Federal Budget confirmed the Government plans to abandon its Inborn Error of Metabolism Programme, which has been in place since 2001, by the end of the year.

The peak nutrition body said sufferers of an inborn error of metabolism (IEM), which includes phenylketonuria and maple syrup urine disease, cannot break down certain amino acids and require a strict, lifelong low-protein diet to prevent serious medical and intellectual disabilities.

DAA Senior Policy Officer Annette Byron said any group with evidence of special dietary needs, requiring food products at a greater cost, should receive government support, in the same way that other groups with special needs have been recognised.

According to the Metabolic Dietary Disorders Association (MDDA), around 900 sufferers currently rely on the $256 per month subsidy to purchase special low protein foods, which are expensive and not available in supermarkets.

An analysis by the MDDA found the special medical foods needed by people with an IEM are on average 714 per cent more expensive than standard supermarket products, with staples like a loaf of low-protein bread costing around $10, compared with $2.50 for regular bread.

DAA said it is wrong of the Federal Government to suggest that these medical low-protein foods can be substituted with regular supermarket foods accessed by other Australians.

'An inborn error of metabolism is not a lifestyle choice, nor is it created by a lifestyle choice. The disorders are incurable and require lifelong treatment'.

'The plan to scrap the subsidy will mean greater financial stress to families already burdened with living with a serious medical condition,' said Ms Byron, an Advanced Accredited Practising Dietitian.

According to DAA, it makes economic sense to continue what is a relatively small cost to the government of around $3 million per year, compared to the additional health and welfare costs that would result from cases of poorly managed IEM.

DAA has written to Federal Treasurer Joe Hockey with its concerns.

The Association also supports a submission on this issue by the Australasian Society for Inborn Errors of Metabolism and the Metabolic Dietary Disorders Association of Australia to Federal Health Minister Sussan Ley.

# Homeopathy treatment not effective and should not be prescribed

GPs should not prescribe homeopathic remedies for their patients and pharmacists should not sell or recommend the use of homeopathic products, according to the Royal Australian College of General Practitioners (RACGP).

Releasing its position statement on homeopathy, RACGP President Dr Frank R Jones said GPs practiced in evidence-based medicine and there was robust evidence homeopathy had no effect beyond a placebo as a treatment for various clinical conditions.

"Given this lack of evidence, it does not make sense for homeopathy products to be prescribed by GPs or sold, recommended or supported by pharmacists," Dr Jones said.

The RACGP position statement maintains that homeopathic alternatives should not be used in place of conventional immunisation.

"It is irresponsible to claim that homeopathic vaccines are a proven alternative to conventional vaccination. The reality is that these alternatives do not prevent diseases or increase protective antibodies and there is no plausible biological mechanism by which these alternatives could prevent infection.

"Individuals and the community are exposed to preventable diseases when homeopathic vaccines are used as an alternative to conventional immunisation," Dr Jones said.

Another risk of homeopathy is that people delay or avoid seeing a GP – exacerbating their condition through delayed care – and reject conventional medical approaches.

"Spurious claims made by homeopathic practitioners and retailers can mislead people about the effectiveness of conventional medicine and this can result in serious health consequences," Dr Jones said.

The position statement also outlines that many private health insurers subsidise homeopathy through 'extras' cover when alternative evidence-based treatment methods are available.

"Whilst we appreciate and recognise the right of patients who may choose or seek homeopathy, unfortunately all taxpayers are funding homeopathy via the Federal Government's private health insurance rebate," Dr Jones said.

"The RACGP is concerned that health insurance premiums continue to rise as significant subsides are paid for homeopathy and other natural therapies. In 2013-14 health insurers paid out $164 million in benefits for natural therapies, an increase of almost 60% from 2010-11."

Earlier this year the National Health and Medical Research Council (NHMRC) analysed the scientific evidence for the effectiveness of homeopathy in treating a range of clinical conditions. It concluded that homeopathy produces no health benefits over and above that of a placebo, or equivalent to that of another treatment.



# 'No one is immune to the experience of grief'

**By Sonia Fenwick and Mandy Cox**

To be human is to connect; to form bonds and elationships with others. When these connections are disrupted and challenged by death, we experience a sense of loss.

We might experience a shift in our sense of self and our understanding of our world can suddenly seem unclear and uncertain. Our personal experiences and reactions at this time are what we understand to be grief.

Grief is a unique, individual response to loss. This uniqueness is shaped by many elements of our being; age, experience with death and dying, relationships, nature of the death, concurrent stressors, personality, social, professional and cultural constructs and spirituality. Further, our response to the loss of one person in our life may not be how we respond to the death of another. Every relationship in our life has different meaning, brings different memories and connection.

Grief is part of our everyday life. In a lifetime we may experience loss of health, relationship, financial security, self esteem, social status and hopes. In most cases, we manage to navigate our way through these losses without too much disruption. Yet the death of a person can unravel us. Our experience of grief may be heightened or challenged if our social, professional and/or cultural supports are in conflict with what is needed at the time. We may feel "stuck" and have a sense of "not coping" as we experience the conflict between our internal and external worlds. We may feel disorientated, not knowing how to behave or respond to our grief.

Death can force us to confront change. It becomes a period of transition from living with the deceased in an environment that felt familiar, known and perhaps predictable, to living without the physical presence of the deceased, facing many unknowns and uncertainties. As we reflect on this change without the deceased, we are gently invited to consider and explore what this change represents for our future.

No one is immune to this experience of grief. In the practice of medicine and delivery of health services, we are frequently exposed to loss. Yet most of this loss remains unacknowledged and at times unrecognised. 'The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet. The way we deal with loss shapes our capacity to be present to life more than anything else. The way we protect ourselves from loss may be the way in which we distance our self from life' DR Rachel Naomi Remen, M.D.

We can learn much about self, others and living when we befriend grief. It re-connects us with the things in our life that have real meaning and value. In the process of seeking to understand our experience of grief, it connects us with our humanity and allows us to speak from a place of compassion when we are in the presence of grieving others. Perhaps this is the only place that real change and growth occurs!

Canberra Grief Centre is managed and owned by Sonia Fenwick and Mandy Cox, both registered counsellors with over ten years' experience working around, death, dying and loss. Referral to the Centre can be facilitated by any health or other professional who recognises that grief may be inhibiting a client's ability to function and recover. Clients can also choose to self-refer.

As practising mental health practitioners, Sonia and Mandy are aware of the vicarious and real experience of repeated exposure to the suffering of others. They have worked hard to ensure the support they offer to fellow health providers is delivered in a confidential, safe, non-judgemental and respectful environment.

*Further information about the Centre is available at www.canberragriefcentre.com.au or if you would like to speak directly with Sonia or Mandy you can contact them at 0409 966 515 or 0401 344 577 respectively.*

# AMA conference highlight: President, A/Prof Brian Owler addresses the year in review

**The following is an edited version of the address given by A/Prof Brian Owler to delegates at AMA National Conference held in Brisbane in May.**

The AMA has faced one of its most difficult years, but also one of its most successful years.

When I was given the honour becoming AMA President this time last year, we faced an enormous task.

We had been blind-sided by a Federal Budget that was an unwarranted attack on GPs and other specialists, on hospitals, on health prevention and public health measures.

It was an assault on the Australian health care system. It was an attack on the health of our patients. While these challenges seemed daunting, as doctors we are used to doing what is hard.

Every day in our consulting rooms, in our hospitals, in our general practices, and in our operating theatres, we do what seems impossible. We face challenges, we work together, and we don't give up. We have taken this determination to fighting to improve our health system.

The most public and most important battle of the last 12 months has been the GP co-payment.

In the first week of being President, I went to see the then Health Minister, Peter Dutton.

I outlined our concerns and then I was presented a choice. The AMA could work with the Government, and support the co-payment proposal, and there may be some funding that the Minister had some discretion over, or we could simply oppose it – but the AMA would have to do that from the outside. Well, that was no choice. It was no choice for the medical profession. We chose to oppose the GP co-payment proposal because it was bad policy.

It placed a financial barrier to accessing care for the sick and the vulnerable. It went directly against all modern health policy by ignoring prevention and chronic disease management; and it jeopardised practices that served the most vulnerable and disadvantaged communities.

However, the AMA did not blindly oppose the Government proposals. Rather, we went to the Prime Minister, we offered our help, and even, at his request, provided an alternative proposal. The AMA's alternative proposal did include a co-payment for those patients who could afford to pay. It recognised the value of general practice and provided the investment that it needs. That proposal was ultimately treated with contempt.

We went on to defeat the introduction of the Government's first co-payment proposal only to have a second, even worse, co-payment proposal put up in its place.

While some other GP organisations quickly and publicly supported the changes to the Level A and B fees, we took the time to ask our members what they thought.

Their response was immediate and overwhelming. The proposed changes to the Level A and B fees, combined with the Medicare rebate indexation freeze, were going to destroy their practices – and they were angry and ready to fight.

Armed with this support, I went to the media calling the changes a 'wrecking ball'.

The strong and united voice of our members allowed me to speak for GPs everywhere.

We swung into campaign mode and GPs across the country galvanised into action. GPs met with local MPs, they signed petitions. During a few short weeks, more than 7000 emails were sent to MPs by GPs through the AMA's 'email your MP' service. GPs set up iPads on their reception desks to encourage patients to email MPs. We did more than 600 media interviews and reached an audience of more than 44 million media consumers.

In December last year, we had a new Minister for Health. In a pleasant change, we had a Minister who wanted to work with the AMA and other health groups. We had a Minister who has been prepared to listen, and who understands that the AMA will work to support good policy. Minister Ley announced that the changes to Level A and B would not proceed.

Likewise, shortly after the leadership spill motion, the Prime Minister and the Government decided not to proceed with the $5 co-payment proposal.

This was a victory for general practice and for our patients. It was a victory for the AMA.

But this was a victory for which all of the AMA should be proud – from grassroots members to our committee members and our councillors.

We have a long way to go to rebuild general practice. The indexation freeze imposed by both sides of politics is harming general practice. It is making it hard for GPs to decide if they can afford to take on a registrar or invest in more allied health or equipment or services.

It hits hardest at practices and patients in disadvantaged areas.

This cannot be allowed to continue. We need investment in general practice. With investment, GPs will continue their work in providing world class, patient-centred care.

With investment in general practice, there would be no need for fragmented care in pharmacies or other clinics.

So to Minister Ley and Shadow Minister King, I say to both of you if you want to improve care and drive lasting change in the health of all Australians, don't waste your money on fragmenting care in other settings. Invest in general practice – general practice will deliver for you.

The indexation freeze is also impacting on specialists and their patients. For private health insurers, there will be upward pressure on premiums as they index their own 'no gap' schedules, and absorb the lack of MBS indexation.

The only alternative for them is not to index, in which case patients' out of pocket expenses for in-hospital procedures will skyrocket as the providers move away from 'no gap' arrangements. The longer the freeze continues, the more damage is being done. And this is a question for both sides of politics.

While the co-payment has taken most of the airtime, we have not forgotten about the other cuts to health contained in the 2014 Federal Budget.

This is especially true of public hospital funding. This year, our annual Public Hospital Report Card rang the bell on the impending crisis facing our public hospitals. We put the spotlight on the perfect storm of increasing demand for services, a system that is struggling to meet targets for performance, and a change to public hospital system funding.

The combination of these factors will have devastating consequences for our public hospital system. Pushing responsibility for public hospital funding back to the States and Territories without remedies to allow them to generate revenue is irresponsible. I am even more worried about those smaller States and Territories with smaller economies, where patients' access to services is not equitable with the larger States.

## Speaking up for those without a voice

However, another key role is the power to stand up for


those who cannot speak for themselves.

I used my first speech to the AMA Parliamentary Dinner last year to explain to politicians why I and my colleagues become advocates. I told the story of the days in the Children's Hospital Emergency Department when I saw once again the death and destruction caused by road trauma. Those experiences led to the *Don't Rush* road safety campaign.

The power to speak for those who cannot speak for themselves is one of the great privileges of being a doctor. It is a privilege we can exercise every day in large or small ways. It is the basis of much of our public health advocacy.

It is the reason I felt compelled to speak out so strongly on Ebola.

It has been suggested that I spoke out on Ebola on the basis of party politics. I spoke out on Ebola simply because it was the right thing do to.

I was watching CNN and I saw the coverage of the crisis in West Africa. The images were horrifying. Adults and children were wandering the streets, many were naked because of their persistent gastro symptoms. There was no care for them and they were simply being left to die, as they were, in the streets.

I also saw the evidence from the experts that if Ebola was not managed and contained in West Africa, it would become a serious health risk for Australia and other countries.

At the same time, my colleagues in Australian hospitals were calling me to tell me that the preparations in Australia were also not sufficient.

Australia has a proud history of contributing to international disasters. We do so despite distance and our small population. My call to the Australian Government was to simply allow those doctors and nurses who wanted to serve to do so. I acknowledge that the Government did step up and join the international effort, and that this has made a significant difference to the people of West Africa.

## Public health

We have also been active on public health for Australians.

We held a major Alcohol Summit last year to highlight the impact of alcohol on the health of Australians.

We have supported imroved vaccination rates, end of life care, and organ donation. At this Conference, we will launch a national resource for doctors on domestic violence.

We have also talked about the health impacts of climate change. This is an issue that always gets lots of letters and comment.

I have come to realise some AMA members and many members of the public don't like us talking about climate change. However, our job is to look at the evidence and to speak to that evidence.

We proudly stood beside the Australian Academy of Science to support their evidence on vaccination. We cannot then stand by and refuse to acknowledge the same body's scientific evidence on climate change.

Where there is evidence of health impacts, we will speak because that is what is right. That's what the AMA does.

## Collegiality in medicine

The responsibility of collegiality is especially important for our young colleagues, our doctors in training and our students. We must protect and nurture them as our junior colleagues.

In recent months, we have seen coverage of the impact on our colleagues who have not received that care and support, or who have been directly sexually harassed or bullied. On behalf of the AMA, I say again to you all that sexual harassment and bullying are unacceptable. The AMA firmly rejects any behaviour that bullies or intimidates people, whether it is on the basis of gender or any other reason.

While this issue is challenging, it is an issue that the profession must confront.

While the issues of harassment have been prominent in the media, achieving cultural change is not just about stopping bullying and harassment.

It is about promoting female leaders and championing gender equality.

It is about ensuring that all doctors – male and female – can access appropriate parental leave and, if they wish, flexible work arrangements.

In all of my travels, I have been struck by the commonality of the issues facing the medical profession.

Leading from the front is sometimes hard. This last year has been hard at times. The year ahead will be just as hard. But the AMA does not stop when it gets hard.

As doctors, we consider the evidence, and take a position. We will work for good policy.

But when there is bad policy, when it affects our members' ability to practise good medicine, when it adversely affects our patients, we will say so without fear or favour, just as we have done this year.

The AMA does not stop because it gets hard.

We have fought hard for our members. We have fought hard for our patients. And we have been successful. I am proud of the past year and the AMA's achievements, and you should be too.





# New principal medical adviser for Department of Veterans' Affairs

It has recently been announced that Dr Ian Gardner will take up duty as the new Principal Medical Adviser for the Department of Veterans' Affairs.

Dr Ian Gardner is an Australian medical specialist with more than thirty five years global experience in Occupational, Environmental and Public Health Medicine.

He has degrees in Medicine and Surgery as well as a Masters Degree in Public Health and professional Fellowships from Australia, the UK and the USA. He has held an academic appointment as Adjunct Professor in Occupational & Environmental Medicine at the University of Queensland Centre for Military and Veterans' Health. He has also been a visiting professor and external examiner in Occupational Medicine at the National University of Singapore and the Chinese University of Hong Kong in Shatin.

His current major appointment is as Senior Physician in Occupational and Environmental Medicine, Defence Centre for Occupational Health and Safety, Canberra. He has worked with Defence since 2001 and is a member of the Defence Senior Leadership Group.

His previous appointments have included thirteen years with IBM culminating in appointment as Program Director, Health Safety and Environment Management, IBM Asia Pacific, Japan. Previous jobs were with IBM Australia, ICI Australia and Alcoa of Australia. He has significant senior management and consulting experience in both the public and private sectors, and holds a number of advisory positions in Occupational and Environmental Medicine with major Australian companies and State Governments.

Ian has twice been elected as President of the Australasian Faculty of Occupational and Environmental Medicine of the Royal Australasian College of Physicians.

He is a joint editor of the textbook, "International Occupational & Environmental Medicine".

He was the government-appointed medical member of the New South Wales "Workers Compensation and Occupational Health and Safety Council until 2012, and chairs the NSW Public Service Commission's Health Review Committee. He is also the ministerially appointed member to the Council of the Asbestos Safety and Eradication Agency, and also the Specialist Medical Review Council.

Dr Gardner is a Fellow of the Australasian Faculty of Occupational and Environmental Medicine, a Fellow of the American College of Occupational and Environmental Medicine, a Fellow of the Royal Society of Medicine, and a Member of the International Commission on Occupational Health. In 2003, he was awarded the College Medal by the Royal Australasian College of Physicians.

Dr Gardner has extensive experience in the health field across the public and private sectors. For the past 14 years, Dr Gardner has worked in the Department of Defence and most recently has been the Senior Physician in Occupational and Environmental Medicine at the Defence Centre for Occupational Health and Safety in Canberra. In his previous roles, Dr Gardner worked for thirteen years with IBM Asia Pacific as director of health, safety and environment as well as previous significant roles with ICI Australia and Alcoa of Australia.

Dr Gardner has a strong understanding of the national health environment and has twice been elected President of the Australasian Faculty of Occupational and Environmental Medicine of the Royal Australasian College of Physicians.



# Former President, Dr Iain Dunlop admitted as AMA Fellow

The Board of AMA (ACT) Limited nominated Dr Iain Stirling Dunlop for admission to the AMA Roll of Fellows. The Fellowship was conferred at the recently held National Conference by President, A/Prof Brian Owler.

The ACT Board considered that Dr Dunlop was deserving of the highest honour the AMA can bestow upon a member having fulfilled the criteria of "providing conspicuous, excellent service to the Association (ie, Federal AMA)".

Dr Iain Dunlop has served his colleagues through his leadership and involvement with the AMA, AMA (ACT) Limited and the Royal Australasian College of Ophthalmologists, as well as through other related organisations, such as Vision 2020 and the Sight for Life Foundation, where he served as a director.

Dr Iain Dunlop is known locally as a privately practising ophthalmologist in Canberra and Sydney and perhaps less well known is that he is the recipient of awards, both national and international; including recently for his work in encouraging relationships with Asia-Pacific ophthalmic societies and his contribution to international organisations to ensure ophthalmology is at the global planning table in terms of advocacy, training support and development work with partner countries, for his commitment to his field of medicine and to advocacy, training and support and development work with partner countries to prevent blindness. Dr Dunlop has had papers published in national and international specialist medical publications.

Dr Dunlop was elected President of the AMA (ACT) Limited in 2010 for a two year term. During his term he was appointed to Federal Council as nominee director for AMA (ACT) Limited. Dr Dunlop contributed to Federal Council and served on the Economics and Workforce Committee, under the Chairmanship of past president, Dr Steve Hambleton, where he made a valuable contribution, whilst at the same time providing leadership to the Board of AMA (ACT) Limited.

In 2013-14, Dr Dunlop served the AMA as Chair of Federal Council, (and National Conference) having been elected to this role by his peers. Dr Dunlop carried out this role with his trademark professionalism, courtesy and consideration to the benefit of the Association and Federal Council. His contribution to the deliberations and outcomes of Federal Council discussion is highly regarded. Dr Dunlop's experience in Federal medical politics and his parliamentary relationships has been of benefit to the profession and to the AMA.

With the 2014 constitutional changes to the AMA, Dr Dunlop was nominated by the Board of AMA (ACT) Limited as its director to the new Board of the Australian Medical Association, where Dr Dunlop contributes further through his chairmanship of the newly constituted Audit Committee.

Dr Dunlop has demonstrated his support of the AMA through active involvement for many years which has included serving as President Elect and subsequently President of AMA (ACT) Limited for a period totalling four years in addition to his role and responsibilities to AMA. During this time, he provided sound stewardship for the VMO negotiations, the Salaried Medical Practitioners Enterprise Agreement as examples of further commitment to his professional organisation and to the members. Dr Dunlop continues to serve as a director of AMA (ACT) Limited whilst at the same time contributing to other AMA and professional roles.

AMA (ACT) congratulates Dr Dunlop on being admitted to the Roll of Fellows of the AMA. Other recent ACT AMA Fellows include: Dr Paul Jones, Dr Charles Howse, and Dr Ian Pryor.

# Poor health will prevent one in four Australians from saving enough money for retirement: AMP.NATSEM Report

In 2035, one in four men and one in five women aged in their sixties will be in fair or poor health, reducing their ability to work and save for a quality retirement, according to the latest AMP.NATSEM Income and Wealth report.

Against a backdrop of increasing life expectancy and a proposal to increase the Age Pension to 70 years in 2035, the report: Going the distance – working longer, living healthier, looks at how Australians age through their sixties and whether they will be healthy enough to work longer.

Modelling in the AMP.NATSEM report found:

- Working longer will be a challenge for one in four (25.6%) men and one in five (20.4%) women who are predicted to be in fair or poor health when aged 60-69 in 2035.
- For Australians currently in their forties and in fair or poor health, it's predicted the majority of men (65.1%) and women (72.1%) will be unemployed when in their sixties.
- Close to half (48%) of Australians currently aged 40-54, who are in very good health, are likely to see a decline to fair or poor health by 2035.
- For those currently aged 65-69 and in good health, 33.1% are likely to be working, compared to only 15.7% if in fair or poor health.

AMP Chief Customer Officer Paul Sainsbury said the report showed health will be an important factor in the later years of working life and our ability to save for retirement.

"The good news is that Australians are living longer. But we know more years in retirement places more strain on our superannuation balances so it's likely many of us will need to work longer.

"This raises some confronting questions, in particular, how healthy we will be in the later years of our working life and what our financial position will be.

"Rather than simply working longer, we need to re-think our approach to retirement. Reaching a certain age shouldn't mean we need to leave the workforce entirely. Early years in retirement should be a transition period with reduced levels of work, giving people more time to focus on their interests and wellbeing, while still saving money," Mr Sainsbury said.

Professor Laurie Brown, of NATSEM, said: "The report shows that Australians in good health are more than twice as likely to be in the workforce compared to those in poor health.

"Currently, the majority of Australians leave the workforce before the age of 65. With the possibility of this increasing to 70 over the next 20 years, younger Australians need to consider the importance of their long-term health and its impact on career, wealth and retirement," Professor Brown said.

## Key findings:

**Australians are living longer…**

Australia is ranked fourth for men and fifth for women for life expectancy compared to other countries in the OECD. Australian men currently aged 65 can expect to live to 84.8 and women to 87.4.

**…But we're still retiring young**

For Australians who have retired in the last five years, the average age of retirement for men is 63.3 years and 59.6 years for women.

**The majority of Australians have left the workforce by age 65**

Currently, 83% of men and 92% of women older than 65 years are no longer working. This is a significant decline from people aged 60-64, where 40% of men and 60% of women are unemployed.

**The health of Australians as they age**

More than one in five (23.6%) of men and one in four (24.9%) women who said they were in good health at age 65, were in fair or poor health by the time they reached 70 (data from 2008 to 2013).

**Projecting our future health state**

By 2035, only one in three (35%) Australian men and 28% of women aged 40-54 are likely to have the same health status when they are in their sixties. For Australians currently aged 40-54 with very good health, it's likely their health status will decline to fair or poor by 2035 for 49% of men and 47% of women.

**Health impacting ability to work**

Currently, 72.2% of men aged 60-64 years and 41.5% of men aged 65-69 with very good or excellent health are likely to be in the workforce. If in poor health, this reduces to 34.8% and 22.5%, respectively.

The trend is higher for women, with 55.4% aged 60-64 and 24.7% aged 65-69 with very good or excellent health likely to be working. If in poor health, this reduces to 17.8% and 8.9%, respectively.

**Female participation in the workforce is increasing**

When looking at gender, female labour force participation in the 60-64 age group has increased significantly – tripling from 12.8% to 45.1% between 1979 and 2014.

**International comparison**

Australia's self-assessed health status is ranked fourth in the OECD and similar to that for Switzerland, Sweden and the United States. Canada and New-Zealand are healthier than Australia.

**Jobs for older workers**

The majority (53%) of workers aged 60-69 are professionals. Manufacturing, electricity and construction sectors employ one in four men aged 60-69. The education and health sectors dominate the employment of women with 49% aged 60-69 working in these industries.

**Education and employment**

People with tertiary qualifications are more likely to be employed at older ages with 49% of those aged 60-69 years with post school qualifications still employed compared to only 30% whose highest education is year 12.

**State by state**

The Northern Territory, Western Australia and the Australian Capital Territory have higher labour force participation rates, including for people in their sixties, than in the other states. This may reflect the specific nature of the labour markets in these regions such as the strength of the public sector in the Australian Capital Territory and the strong mining economy in recent years in Western Australia.

## About AMP.NATSEM

Since 2002, AMP and the National Centre for Social and Economic Modelling (NATSEM) have produced a series of reports that open windows on Australian society, the way we live and work – and our financial and personal aspirations.

AMP publishes these reports to help the community make informed financial and lifestyle decisions and to contribute to important social and economic policy debate.

*Download a full copy of the report at: www.amp.com.au/media*

# OPINION: visual impairment and the artist

**By Rachael Heath Jeffery**

While it may seem patent that art is fundamentally a visual medium for both the artist and the viewer, it is by no means sufficient to define it solely as such. Art can also employ the other senses in both obvious and subtle ways. The visual aspect of art for the artist, however, is of paramount importance and this makes the presence of ocular dysfunction and disease, as well as whatever correction or treatment if any, was available at any given time throughout history, a critical determinant of the form and volume of the artist's work.

This article will focus on the influence that disease, as well as other problems associated with aspects of ocular function, has had over time, on selected artists' vision. Depending on the type and severity of ocular disease, vision may be blurred, colour perception altered, light and glare sensitivity induced, depth perception impaired or a combination of these.

## Colour perception and deficiency

Colour perception is understood to be a neural process requiring light to be absorbed by the three cones on the photoreceptor layer of the retina. As the neural signal produced does not carry information about the colour itself, information about colour is dependent upon which cone cell is signaled and its frequency. Therefore, in order to distinguish a particular colour, the visual system needs to be able to compare the activity in a least two different cones.

The visual spectrum will appear differently to people with different colour vision deficiencies, with the type of colour vision defect depending on the presence or activity of the cone pigments. A lack of or mutation in a cone pigment gene implies that person will have difficulties in distinguishing between certain pairs of colours, with some even appearing identical to each other.

Historically, painting was mostly representational so those with moderate to severe colour deficiency were discouraged from becoming artists. However as colour deficiency is not rare amongst males and severity can vary significantly, it can be reasonably concluded some artists must have had colour deficiencies. In this regard, a Dresden study of artists found the prevalence of colour vision deficiency among males was nine per cent.

It has been suggested that John Constable could have had a long- or middle-wavelength colour deficiency as his landscapes favoured brownish-green and lacked strong colours. Fellow painter Henry Fuseli commented, 'I like the landscape of Constable, but he always makes me call for my great coat and umbrella'. However, an artist's colour choice is complex and personal and does not necessarily imply a colour vision deficiency.

Charles Meryon is a recognised example of an artist with a congenital colour vision deficiency. Meryon mostly worked in black and white etching. The Australian painter Clifton Pugh, who won the Archibald Prize for portraiture on three occasions, was believed to be a protanope. Paul Henry is also known to have a colour vision defect with evidence coming from the records of his ophthalmologist, Dr Beecher Sommerville-Large, which state that he had never revealed this during Paul Henry's lifetime because it could have affected his reputation as a painter. Most of Henry's paintings display monochromatic colours and an understanding of his visual limitations adds insight but does not detract from the value of his work.

## Cataract

One of the best-known examples of the effect of visual impairment on an artist's work over time is that of Claude Monet who was known to have developed bilateral nuclear sclerosis by 1912. Monet's cataracts reduced his ability to discriminate colour. This is partly explained by the increased absorption of blue light as a result of the accumulation of yellow pigments in the lens. 'I no longer painted light with the same intensity, I no longer painted light with the same accuracy. Reds appeared muddy to me, pinks insipid, and the intermediate and lower tones escaped me…. What I painted was more and more dark, more and more like an "old picture", and when the attempt was over I compared it to former works, I would be seized with rage and slash all my canvases with my pen knife'.

Monet was said to be initially reluctant to undergo cataract surgery and for some time he persisted with eye drops. In 1913, Monet's ophthalmologist, Richard Liebreich, himself an artist, recorded no useful vision in Monet's right eye. However, it was not until 1923 that Monet agreed to undergo surgery in that eye by Dr Charles Coutela. His recovery was complicated by posterior capsular opacification and he subsequently refused to have his left eye operated on. Yet, in 1925, Monet wrote to Coutela 'I have finally recovered my true vision and that nearly at a single stroke... happily seeing everything again and working with ardor'.

The outcome was not so fortunate for the artist Mary Cassatt. She too had recorded her quickly deteriorating eyesight that, in 1912, was attributed to posterior subcapsular cataract. 'My eyes have been greatly changed, my eyesight disturbed.' In 1915, she stated in a telegram, 'Sick eyes. Iritis with adhesion under treatment. Famous ophthalmologist if he succeeds'. In 1917 Dr Louis Borsch, operated on her cataracts but the surgery was unsuccessful and her career consequently limited.

## Retinopathy

Hermann von Helmholtz did not invent the ophthalmoscope until 1850. Accordingly, strong evidence of the occurrence of macular degeneration in artists does not exist before that time. Edgar Degas and Georgia O'Keeffe are two artists who were afflicted by macular degeneration causing them to alter their styles but in different ways.

O'Keeffe experienced this disease at a much later age (85 years in 1972) than

Degas, who first reported his sensitivity to light around 1871 (age 37). Following this, most of Degas' paintings were of interior scenes. In 1873, Degas described his condition, 'This infirmity of sight has hit me hard. My right eye is permanently damaged.'

He also reported 'he could only see around the spot at which he was looking, and never the spot itself.' Degas later used an occluder over his right eye, indicating that some peripheral vision and fusion was present. Degas' cousin had very similar retinal problems and visual impairment, suggesting hereditary macular dystrophy. While Lanthony proposed that Degas had a corneal abnormality or iridochoroiditis, there appears to be no evidence Degas had any anterior eye treatment. Furthermore, the treatment prescribed by Landolt, namely tinted lenses, avoidance of strong light and bed rest, strongly suggested retinal disease. Degas' works post-1871 demonstrated a remarkable adaptation to a chronic and progressive visual impairment.

In 1972, O'Keeffe's eyesight deteriorated as a result of macular degeneration, leaving her with only peripheral vision. She ceased using oils in 1972 but continued using pencil and charcoal until 1984. With assistance, she was able to paint watercolors.

Paul Cezanne's was supposedly diagnosed with diabetes around 1890. Some, including Joris-Karl Huysmans, French writer and art critic, attributed his innovative painting style to diabetic retinopathy. Huysmans described Cezanne as an "artist with a diseased retina." If Cezanne did suffer from this disease, he must have adapted to it because he continued to paint until a few days before he died.

Given the paucity of evidence it is difficult, from a historical perspective, to accurately assess the overall extent and nature of the effect of ocular disease and visual dysfunction on many artists' work, as distinct from their exploration of different methods and styles. Clearly though, in some cases medical opinions at the time and later, together with the artist's own account of their affliction, has given a reasonable picture of the degree of visual impairment. In any event, deterioration in eyesight and its consequent effect on an artist's work may not detract from but indeed enhance that work to the viewer. Furthermore, knowledge of an artist's visual impairment can assist in the greater acceptance and appreciation of his or her work and lead to an understanding that deteriorating eyesight does not, as a consequence, necessarily lead to inferior art.

*Rachael Heath Jeffery is a year 3 student at the ANU Medical School. References available on request from the author*

# New smartphone App 'Re-Focus'

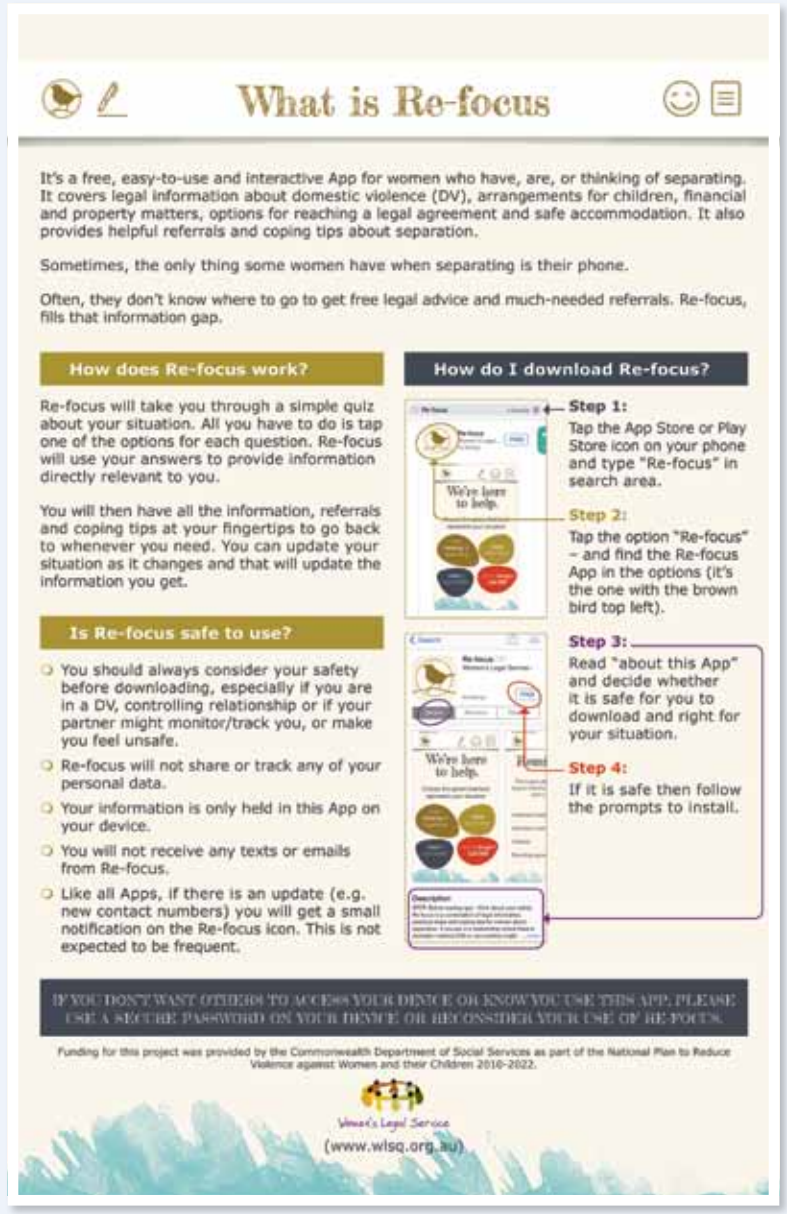
The Women's Legal Service in Queensland has developed a new smartphone app 'Re-focus'.

Re-focus is a free, easy to use and interactive smartphone app designed to be of assistance to women in Australia who have separated or are thinking of separating, especially in situations where domestic violence is present.

It covers legal information about domestic violence, arrangements for children, financial and property matters, options for reaching a legal agreement and safe accommodation. It also provides helpful referrals and coping tips about separation.

Sometimes, the only thing some women have when separating is their phone. Often, they don't know where to go to get free legal advice and much needed referrals. Re-focus fills that information gap.

The app was developed as a strategy under the *National Plan to Reduce Violence against Women and Children 2010-2022*. The development of this app has taken into account issues of safety for women. See the adjacent Fact Sheet: 'What is Re-focus'.

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