Dr John Boully

September 30, 2009.

The Committee Secretary
Senate Community Affairs References Committee
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Sir/Madam,

RE: Inquiry into Hearing Health in Australia

I note your Inquiry into Hearing Health in Australia and write to make a submission thereto.

I am a General Medical Practitioner, a Graduate of The University of Adelaide, 1974.

I have worked for about 35 years in the fields of urban and rural general practice and Aboriginal health. I am currently working in Whyalla, S.A. as a rural locum GP.

With regard to the Terms of Reference of your Inquiry, I note that you are looking into the following:

a. the extent, causes and costs of hearing impairment in Australia;
b. the implications of hearing impairment for individuals and the community;
c. the adequacy of access to hearing services, including assessment and support services, and hearing technologies;
d. the adequacy of current hearing health and research programs, including education and awareness programs; and
e. specific issues affecting Indigenous communities.

I wish to concentrate my remarks on one form of hearing loss, acquired hearing loss, often referred to as Otitis Media, and it's sequelae.

I submit that further understanding of this condition, it's causes and it's improved management, have the potential to significantly improve hearing health PROVIDED THAT IMPROVEMENTS IN LIVING CONDITIONS ARE MATCHED BY THE ADDITIONAL ADAPTATION OF PRIMARY HEALTH-CARE SERVICES AND WORKERS (INCLUDING DOCTORS) to MORE FOCUSSED AND DELIBERATE PREVENTION, MEDICAL MANAGEMENT AND FOLLOW-UP STRATEGIES IN ALL AFFECTED CHILDREN AND THEIR FAMILIES.

Regarding a. – the extent, causes and costs of hearing impairment in Australia

I am sure that figures pertaining to the extent of and costs of hearing impairment will most likely be supplied by State health agencies. I can only state that, as a GP, I see evidence of hearing health issues in children almost every day.

With the respect to the causes, I will summarise my input on this matter in subsequent pages.

Regarding b. - the implications of hearing impairment for individuals and the community

Hearing ability is a major contributor to personal ability. Hearing loss is a significant cause of social isolation, limited education and personal autonomy.

I am sure that other submissions will address this issue.

Regarding c. – the adequacy of access to hearing services, including assessment and support services, and hearing technologies

This has improved in recent years. In the field of Aboriginal Health I made submissions on this matter to Mr Robert Tickner when he was Minister for Aboriginal Affairs.

Mr Tickner has been the only Minister (amongst several I have approached) that took my applications seriously. His subsequent actions added to submissions being generated by the education sector in New South Wales and led to the establishment of several Indigenous Health Hearing Programs. These have been replicated around Australia.

So there has been some improvement and dedication to this issue by many workers.

I am concerned, however, that Otitis Media and Otitis Media with Effusion (OME), presenting every day to clinics and surgeries around the country, in urban and rural locations, is often under-diagnosed. It is often inadequately treated, thereby leading on to more chronic and serious forms of disease, surgery, hearing loss and so on.

I have worked in many, many different medical practices. Whilst I concentrated on this condition in Aboriginal health, and set myself up with tympanometers and a selection of remedies as well as an educational approach for parents, it is more common for many GPs to make a specialist referral for those most severely impacted whilst limiting standard treatment to just another course of antibiotics with little care given to follow-up or more complete assessment.

This approach, which is possibly fairly standard, causes delays in assessment and treatment, and a high rate of grommet insertion and other surgical approaches. In many cases, less than optimal effective medical care leads to higher rates of surgery.

I once worked as a locum GP in Port Pirie South Australia, for a period of 3 months. I was concerned that there was minimal support for the investigative services of audiology and tympanometry for the investigation of glue ear there, except in conjunction with the Visiting Ear, Nose and Throat Specialist on a rotational basis. It seemed that the 'private sector' was holding the reins on this issue.

I suspect that Otitis Media is often regarded as an 'ear disease', and the expectation follows that ENT specialists are best able to address it. But ENT specialists are actually surgeons, and they review their daily list concentrating mainly on patients that might require surgery.

In actual fact, Otitis Media is part of a more generalised condition, that associated with runny noses, coughs and colds etc. It is an ear condition (not an ear 'disease', unless chronic and serious) resulting from respiratory ill-health.

ENT specialists look into all conditions from the outer ear down to the level of the vocal chords. Unfortunately, the respiratory illnesses often extend well below the vocal chords, and ENT surgeons rarely, if ever, work to manage the respiratory condition that underpins recurrent otitis media in it's various forms.

This is not to deny the usefulness of many ENT procedures.

Doctors, nurses and health care workers are in a position to address this issue provided they are conscientious about their work and diligent in it's application. These are the staff who would benefit from further emphasis and support in this area.

Regarding d. - the adequacy of current hearing health and research programs, including education and awareness programs; and

Despite many attempts over many years to focus attention on the underlying illness causing Otitis Media, I find myself unable to find many colleagues who care much for my arguments or submissions.

A rare exception has been Dr Doug Shaw, Medical Consultant, Public Health, Communicable Disease Control Branch, Department of Health in South Australia. Dr Shaw has advised me of this Inquiry and made it possible for me to make a submission.

In 1994, I attended a seminar conducted by the Menzies School of Health Research on the topic of Otitis Media and was disappointed that no-one seemed to be considering fundamental questions such as the varied nature of mucous membrane inflammation that is fundamental to the condition.

If 'colds' could be treated more effectively, there would be much less ear disease. This points to the need for more adequate primary health care services (with well educated, fully conscious, equipped and dedicated staff) on a continuing basis.

Whilst infections are clearly important for many, much inflammation is not infective but viral and/or allergic, so approaches limited to the use of antibiotics and vaccines are unlikely to be successful. Yet, this seems to be where the emphasis lies, along with education and attention to the living environment. I contend that addressing this gap in medical knowledge and analysis of the underlying inflammation could bring great benefit.

It is also my contention that respiratory illness is often inadequately addressed. It is likely to be the most common form of presentation to general practitioners almost every single day, and leads to a huge drain on the health budget, day in and day out. This occurs in every location.

I am tired of all the presentations by the public, and the repeated nature of these presentations. I contend that many doctors fail in assisting patients to recover sufficiently, hence the succeeding re-presentations. Too many doctors are quick to treat (or attempt to, as their attempts often fall short) and too many of them fail to educate. It makes me wonder how much they really know.

Whilst respiratory health is often inadequately addressed (measured by how many times patients attend with the same or similar illness) , it follows that Otitis Media in babies and young children parallels and gets it's impetus from these respiratory illnesses.

I am sure that a lot of good work is being conducted in the fields of education and awareness. I certainly do my bit! But your question related to the ADEQUACY of current health and research programs.

Some areas have made significant advances, particularly related to improved awareness and living conditions.

Yet, clearly, with so much preventable deafness about, the programs are NOT ADEQUATE SO FAR. Here, I am expressing my concern for all those children and adults that are adversely affected. There are plenty of those, evidenced by the high rate of repeat presentations.

I would like to see more research into the details of what I am arguing for here.

Regarding e. – specific issues affecting indigenous communities

Many or most indigenous communities are adversely affected to a much greater extent than the mainstream population.

It is not uncommon for 80% or more of the children to suffer from some form of ear pathology, and this has a devastating effect on their lives and future prospects.

I spent about 30 years focussing on this condition whilst working as a community-based medical practitioner in Aboriginal communities in 3 states. I experienced first-hand the nature of the health picture in these communities, and developed an approach to addressing the serious health picture as best as I could.

I have summarised my approach in an article 'Towards Aboriginal Child Health' which I will attach as part of this submission.

Summary

I submit that there is a need for further development of primary health care services that are attuned to the needs of children in the first 3 years of life, in particular.

It is in the first 3 years that the opportunity exists for dedicated intervention into the high rate of respiratory illness that commonly leads to middle ear infection, and other serious sequelae including enteric, heart and kidney disease.

A more dedicated intervention will also involve an expansion of medical care beyond the individual patient to include the patient's context, their families. This will require a behaviour change for some practitioners.

More successful prevention/intervention into the high levels of preventable deafness in the population will require greater attention to bringing 'colds' to an earlier conclusion whilst, at the same time, working to meet the health care needs of those already seriously and adversely affected.

There is a need to concentrate more on seriously re-evaluating standard medical approaches that do not address the full health picture involved.

Whilst standardised protocols are extremely valuable in enabling effective treatments for many serious conditions, less apparently serious conditions are left out. An example of this is the CARPA manual that has a protocol for pneumonia but not for the common cold.

If ‘colds’ were better managed there would be less pneumonia and less ear disease. So why is this item not given more consideration?

Whilst we have a system that prides itself on working to reduce mortality levels, we really need a system that is focussed primarily on addressing morbidity levels. If we were better able to address morbidity, then mortality levels would decrease as a follow-on effect.

Addressing actual morbidity levels will require a re-orientation of approach, and a more serious attempt to enable the attainment of real health, not just the alleviation of sickness.

Dr John Boully.

30/9/09.

# TOWARDS ABORIGINAL CHILD HEALTH
Questioning the standard approach

## INTRODUCTION

Whilst there is now considerable interest in Aboriginal health, much of the debate concerns the extent of financial support provided to the various services administering to Aboriginal people and communities.

One aspect of Aboriginal health which has not yet received sufficient attention is the nature of medical, nursing and health worker training and how this impacts on the style of health-care practice that is conducted.

As a general medical practitioner with long-standing practical experience working in Aboriginal health, I have written this article to raise questions concerning the in-effectiveness of much current medical practice. I argue for a modified approach, targeted to early childhood, with the aim of reducing the high morbidity levels that are so prevalent in Aboriginal children.

Whilst standard medical practice is often beneficial for children living in more comfortable circumstances, that same form of practice is often ineffective for children living in circumstances of disadvantage. This is especially so with regard to respiratory and ear disease, an important focus of my concern.

Whilst some of the views expressed here may be considered controversial, such controversy may be a necessary step towards a significant re-orientation of approach with the aim of better health care for children whose current health status is poor.

This article calls for a deeper analysis of the health picture and a qualitative re-evaluation of the effectiveness of conventional diagnostic and management approaches.

## EXPOSURE TO THE PROBLEM

Aboriginal children suffer from chronic respiratory infections, otitis media, gastro-enteritis and bowel infestations, lactose intolerance, anaemia, skin and eye infections, renal disease, and so on.

When I was first exposed to this unhappy situation, I tended to treat the illnesses in isolation, as they arose. Medical training had taught me a 'germ theory' of causation, and a consequent set of practices (antibiotics, analgesics, sterile procedure, etc.) which were constantly in demand. I would now summarise this as a 'reactive approach'.

After several months in the one community it was obvious that, although I was fully engaged in providing medical care, I was not able to effect a lasting health improvement.

# TOWARDS ABORIGINAL CHILD HEALTH

## CAUSES

Clearly the real causative factors of the sicknesses I was treating were the changed socio-cultural conditions of traditional people facing major difficulties in adapting to new circumstances. Such changed circumstances and conditions meant that the underlying parameters for health had also changed. Traditional concepts and practices could no longer cope with the altered health picture. It seemed to me that the system of services I was contributing to was also inadequate, as the health of the people was so poor.

## CHANGED PERSPECTIVE

Once I realized this I began to expand my understanding of the health situation beyond simple medical explanations to include historical and ecological/adaptive aspects. It was clear that significant nutritional and lifestyle changes were affecting body metabolism, leading to poor healing and high levels of physical pathology. Other complex socio-political changes and difficulties were contributing to major personal and group stresses, evidenced by occasions of inter-personal conflict and episodes of violence.

## DIET AND LIFESTYLE

Clearly, dietary change had had a devastating effect. Rations of flour, sugar and meat, combined with a sit-down-in-one-place lifestyle (with consequent diminution of a natural plant diet) created metabolic changes which still predominate. Heart disease, diabetes, renal disease, stroke, cataracts, pneumonia (and so on) were all rife. In addition, a more static population living in unsanitary conditions created significant hygiene problems. Scabies, impetigo and boils were constantly present.

## GENETICS

Could it be that genetic factors have also played a part? After all, Aborigines lived here in isolation from most of the rest of the world for centuries. They had evolved and adapted to the circumstances of the times. The arrival of the Europeans brought a host of new circumstances and diseases to which the Aborigines, except by the processes of Natural Selection, had little resistance.

Nutritional, environmental, socio-cultural and political factors are all important contextual factors for health (or sickness), but it is likely that genetic factors do also play a part, with some children doing better than others with regard to inherited factors.

# TOWARDS ABORIGINAL CHILD HEALTH

## INDIVIDUAL VARIATION

One thing is certain - there is a great deal of variation in immune capability of individuals within the same genetic pool, even within the same family. Let me illustrate :

I once visited a remote community. The ten children I examined all shared the same environment and presumably ate similar food. Nine of the ten were ill in some way.

Three of the youngest were feverish and irritable with respiratory and ear infections. Two of these had diarrhoea. Six of the others had coughs and runny noses, ear drums were
scarred and dull, sometimes perforated and discharging, but these children, not acutely ill, were considered to be in reasonable health.

Surprisingly, one of the ten was in good health with no sign of respiratory infection and eardrums that were clear and shiny! I could only conclude that this child had been fortunate to inherit strong immune capability for the harsh circumstances of his life.

## THE SICK CHILD

How does all this influence my approach to the sick child? Consider this case study, typical for many Aboriginal infants.

A child presents to you aged 7 months with:

- cough and runny nose for most of it's life
- diarrhoea for several days
- fever, breathlessness and irritability on day of presentation.

Further history reveals that the child is breast-fed, has been 'routinely-immunized' and has been given several courses of oral antibiotics and regular paracetamol.

## CONVENTIONAL MANAGEMENT

Most medical staff would first take the history with the aim of making a 'diagnosis'. Such a diagnosis would be a description of the illness at that point in time, e.g. gastroenteritis, pneumonia, otitis media. One or other of these may be the principle diagnosis, and management would follow, e.g. breast milk without solids for 24-48 hours, some antibiotics for pneumonia or acute otitis media, and so on.

These measures are necessary but often insufficient because the child will commonly re-present with the same or similar illness soon after, or simply not improve to a level of true health. I have known many children to have been discharged from hospitals despite their continuing poor health status. Getting them well provides a further challenge.

Many medical staff feel unable to do much while the child must return to the harsh environmental and nutritional circumstances which helped to cause the illness in the first place.

The conventional approach, in it's desire to make a diagnosis, will often localize the problem to one or more specific body parts, e.g. otitis media is considered a separate

entity from gastroenteritis. Compartmentalisation of the problem, however, does not solve it. A medical diagnosis and consequent short-term treatment may not solve it either.

## A MODIFIED APPROACH

An approach I have found useful is to develop an understanding of the overall situation, plus a sense of the coping ability (immunological capacity) of the individual child. It can take some time to get a real sense or 'feel' for this as a working knowledge in this area does not occur with one-off consultations.

A child who has been unwell for several months with a history (say) of repeated courses of antibiotics or whose developmental progress is impeded is representative of the group of children I am concerned about. It is likely that this child's immune system is being repeatedly challenged and quite possible that the child's diet is less than optimal. It is important to consider the many factors that might be affecting the health status of that child and to work with the parents to bring about a greater awareness of the importance of these factors. Personal and home hygiene and household smoking remain matters of considerable importance.

It is also important to recognize the inter-connectedness of many medical conditions. From my own and others' observations, many episodes of diarrhoea and recurrent otitis media follow on from respiratory illnesses or infections that have become increasingly recurrent, severe or persistent. I look at the triad of ear, chest and gut disturbance as a 'syndrome' of inter-connected illnesses.

I have worked to diagnose and treat a wide range of established conditions. I have also worked to counter the inflammation at the cellular level (mucous membranes) by attending to viral, bacterial and allergic contributors to illness, to nutritional factors, parasites and infestations, and feeding disorders. I have worked to increase awareness of the importance of factors such as smoking, hygiene, cross-infection, noise and sleep.

I have prescribed lots of antibiotics, for their antibacterial function. I have also encouraged the use of Vitamin C, Pentavite and other nutrients in measured doses to act as anti-inflammatory and anti-viral agents in an effort to bring illness to a successful resolution (as signified by a completely dry nose). I treat 'colds' as serious illnesses and work to bring them to a conclusion.

I have aimed at returning the mucous membranes to a non-inflamed state, a healthy state. Unfortunately, the nutritional supplements I have found most beneficial are generally not available in most areas I have worked, so I have had to be somewhat resourceful and inventive in this area of my work. I view this item as a significant ‘gap’ in the system of health/medical care.

I have attended to the health status of the child’s immediate family members, for a child has little or no chance of becoming healthier if his/her parents and/or siblings are unwell with related conditions.

I have shared basic information with family members so that, as the key care-givers, they can understand, then, supported by new information, take on their responsibility for addressing the pre-determinants of health for themselves and their children.

In the case of respiratory and ear disease, I emphasise the differences between viral, bacterial and allergic symptoms and encourage strategies for the management of each of these, often simultaneously, as appropriate.

The allergic aspect of illness may be seen as an extra sensitivity that causes mucous membranes to be inflamed in circumstances such as the occurrence of viral and/or bacterial respiratory infections. Colds can often trigger asthma episodes, so asthma needs, in these circumstances, to be seen as a part of the condition, not the condition in it’s entirety.

On occasions when I encourage nutritional supplements to assist the children during their times of need (during illnesses especially), I emphasise the link of these supplements to the consumption of actual fresh foods.

The time of teething is important for, at this time, illness often occurs. The time of vaccination and the post-vaccination period (lasting several weeks) is also an important time during which critical attention to those children whose health is sub-optimal is indicated. Failure to address the illnesses in these babes and infants is likely to lead to continuing poor health in the young children, and the development of real pathology.

The focus is on health, not just sickness. Each child is an individual, and each family provides the context for health improvement, with health-care staff assistance. In my case, such assistance is provided through the means of long consultations, even for ‘colds’, which are commonly considered ‘routine’, even trivial, by standard medical practice. Colds, in fact, are the precursors of subsequent serious conditions and need detailed attention and resolution.

Before long, my messages are understood by a significant number of parents for them to make a real difference. In these and other ways, management continues until an improved standard of health is achieved. This does occur in those children whose families avail themselves of the services. Of course, there are families who do not attend and, as a consequence, do not benefit.

# TOWARDS ABORIGINAL CHILD HEALTH

## SPECIFIC POINTS

In considering the poor health status of many Aboriginal children, I ask you to consider the following points :

1. Many children develop signs suggesting a ‘cold’ by the age of 4 weeks, or even younger. The illness we call a ‘cold’, indicated by inflammation of the mucous membranes, needs deeper analysis and consideration. It needs to be fully resolved (again and again) if a child is to be truly healthy.

2. Left untreated, or ineffectively treated, the clinical picture usually progresses. The time of ‘teething’ is a critical time when this illness can develop further. The result can be respiratory, ear, and intestinal disturbance related to widespread mucous membrane inflammation. This inflammation forms an illness complex that would benefit from a new name as a means of highlighting it’s importance.

3. Improvements can be expected with improvements in living conditions and standards of nutrition and education. However, the patterns of illness are similar, though varying in severity, with differing circumstances. This means that even the well cared-for children of ‘model’ parents living in good homes can suffer with chronic illness of this type.

4. The diagnosis and management of established medical disorders is important for the health and welfare of the children. There will always be room for appropriate diagnosis and treatment for the many conditions affecting the children. There are clear limits, however, to the effectiveness of standard medical practice, this being demonstrated by high levels of morbidity despite repeated medical interventions.

5. An assessment of the child’s immunological capacity, or how the child is coping, is important. This is understood by taking the history and by following progress. Weight for age charts and other developmental measures are most useful indicators.

6. A more thorough assessment of the family and social environment may reveal important factors that would benefit from more attention, intervention or support. Such
interventions are usually beyond the scope of standard medical practice but need to be further developed.

7. The first three years of life are critical. ‘Colds’ occurring during these times often herald ear, chest and gut disturbances which can become chronic and serious. Consider ‘colds’ as markers of mucous membrane inflammation and watch out for complications. Runny noses lasting longer than a few days indicate that children are having difficulties. This outward sign is clearly visible and is a marker that often points to additional internal problems as well as the need for further intervention.

8. There is a case for the use of intra-muscular antibiotics for ear and chest disturbance in babies, rather than oral antibiotics which are more likely to cause gastrointestinal
disturbance and subsequent illness. Chronic diarrhoea in a high antibiotic-use environment is a major cause of under-nutrition.

9. Nutritional and vitamin/mineral or other supplementation (e.g. traditional medicines) as an adjunct to therapy can be considered. This raises the question of the usefulness of 'complementary medicine' in its various forms. Vitamin A, cod liver or fish oil, vitamin
C, zinc, herbal and homeopathic medicine, acidophyllis and bifidis yoghurts and other pro-biotics, nutritional supplements and apetite stimulants are all substances now being used for conditions similar to those common in Aboriginal children. Knowledge of the practical use of these substances may well benefit children with immune systems struggling to meet persistent and/or recurrent challenges.

10. Try not to break the mother-child bond. Breast feeding is obviously important and so is a consistent mother-child bond. Avoid shifting blame onto the mother and adding to her confusion and feelings of inadequacy by hospitalizing the child, unless clearly indicated. Remember also that the mother's health and nutritional status may need your attention if you are to improve the child's health.

11. Consider the impact of vaccinations. The high priority given to vaccination programs indicates genuine concern for a vulnerable group. Measles epidemics need to be prevented, for instance. The presumed positive benefits, however, need to be balanced against some potentially damaging effects in some children. A combination of vaccines given to a sick child, a practice which is still prevalent in many remote communities where poor health is a fact of life, may sensitize some children and affect them adversely, leading to a deterioration in their general health condition. Those responsible for the implementation of vaccination programs are in the best position to assist the children, and need to be sensitive to the requirements of the individual child. I prefer not to immunize sick kids and have delayed vaccination and worked on improving their health as the first priority, with catch-up vaccinations to follow. In my opinion fixed vaccination schedules should not have the highest priority and are not always beneficial if a healthy child (not just a fully vaccinated one) is the desired outcome.

12. The more subtle forms of ear disease need attention, as even 'minor' hearing loss can interfere with the cognitive recognition of the softer sounds thereby impeding childhood auditory and language development to a marked degree. Impedance tympanometry and otoscopy (pneumatic or otherwise) are very useful tools for diagnosing eustachian tube dysfunction, otitis media with effusion (glue ear) and/or other serious conditions and for measuring the response to medical management. Results of serial impedance testing are very useful in encouraging education of parents about hearing loss and the importance of adequate medical management and of follow-up. The skilled use of otoscopes and impedance tymanometers should be learned and practiced as an integral component of primary health and medical care in all clinics serving Aboriginal communities.

13. Surgical management (grommets) can help but this type of intervention fails to treat the underlying (respiratory) condition and often comes too late to avoid the damaging effects of hearing impairment during the early years. It is a pity that so many children
come to need surgical intervention which indicates, in my view, a failure to manage preventable or medically manageable conditions in their earlier stages. This is not to deny the benefits of surgery for those who need it.

14. Families need to be included in the management, as the child's sickness quite possibly emanates from other sick family members. If the family is not involved they will not learn to understand or deal with the various causal factors involved. Treat the whole family in a comprehensive way. Greater knowledge of respiratory illness, hygiene and nutrition and the adverse effects of smoking provide important foci for intervention. Simple health practices and principles can be learned quite quickly and the conscious involvement of parents in the health care of their children is the most important factor in developing community confidence and ability in this area.

15. Keep an open mind. This article would not need to be written if we were already successful in our approach to Aboriginal child health. Opposition to new approaches, the standard conservative response, acts to defend the status quo. Unfortunately, defense of current practices without consideration of additions or alternatives will only maintain continuing poor health status in the children. The status quo helps many children, it also
fails to deliver to a great many children who access the services, but remain chronically unwell.

16. Consider the necessary components of a 'pro-active' approach to complement the standard 'reactive' one. This can only occur at the community level, but starts in the minds of the health service providers and the parents. It could be supported through health and child-care services and their staff who are in a position to provide continuing care. Early intervention, continuing care and partnership with families will provide the means for advancing the health status of the children.

17. Work towards a wholistic rather than a reductionist approach. Medical training and specialization usually emphasizes the latter. The former will require some fundamental re- thinking and some modifications of practice. A willingness and an ability to adjust to community realities, to accept community advice, to pay attention to public health concerns, to undertake an educational and development role, to question and to learn are all requirements for those who seek to work effectively in Aboriginal health.

TOWARDS ABORIGINAL CHILD HEALTH

## SUMMARY

Mortality and morbidity with their life-long consequences remain unacceptably high among Aboriginal children. I have briefly described some of the patterns of illness in these children and mentioned some important factors involved in understanding this situation.

I hope that readers will consider these various factors and ask themselves to modify a strictly compartmentalized and purely reactive text-book approach. Adaptations to Aboriginal circumstances are necessary for effective intervention. Some additions to standard practice are needed if we are to be more successful.

Health staff have a crucial role to play. Present approaches, although labour-intensive, often fail to deliver real health, evidence of which is the high rate of hearing deficit in Aboriginal children (80% or more in some communities), as well as high rates of pneumonia, bronchiectasis, rheumatic carditis and glomerulonephritis.

Staff who are willing to work in areas of need and of high morbidity are asked to re-consider and modify their approaches. Equipped with greater understanding, they are more likely to make a genuine contribution, one that will enhance the lives of the emerging generation, and our society as a whole.

In summary, this article requests your consideration and more effective management of the lesser forms of inflammatory conditions (suffixed by the term '-itis') so that children might be spared the many and serious conditions that are likely to follow, unless these lesser forms of illness can be resolved in full.

## CHECKLIST OF QUESTIONS

Consider the following questions pertaining to the issues raised in this article. These questions are best considered when addressing real life presentations and situations. These questions can be discussed in small groups.

1. What is the diagnosis? Confronted with the high levels of morbidity Aboriginal children experience, what, would you say, is the diagnosis? For each diagnosis (where there is more than one), what is your proposed management strategy?

2. Are you familiar with the necessary protocols for the management of the various presentations common in remote Aboriginal communities? Are you able to deal with the acute forms of these presentations? If not, what do you need to learn? (It might be helpful to list the conditions you need to be familiar with).

3. Do you and your staff tend to manage individuals on presentation, or do you work with whole families? If you tend to manage children separately (individually), how do you expect them to improve if other family members are unwell with a related condition?

4. Would you be prepared to contemplate the nature of inflammation occurring in the mucous membranes of the children? What is the cause of this inflammation? How would you propose to restore the mucous membranes to a healthy state?

5. How do you manage or treat colds and 'flu? Does your treatment work? What suggestions do you have for the effective resolution of recurrent and potentially chronic
viral illness? Do you have the means to be effective in this endeavour? If not, what additional remedies would you encourage?

6. Are you responsible for immunizing children in your care, or does that responsibility fall to others? Do you take the time and make a real effort to establish a child's immunization history before vaccinating? Are you working with updated immunization guidelines? Do you agree with vaccinating sick children, or do you work to get them well first? Exactly how do you get them well first? If a child had suffered adverse effects from an earlier vaccination, would you know about it? Are you comfortable with what you do? If not, why not? What need you do to resolve the matter?

7. What is your attitude to complementary medicine? Do you have experience with nutritional therapies or other modalities? What therapies do you or your patients utilize to maintain health and well-being? Which of these might be useful?

8. Are you fully engaged in a clinical situation with little time for anything else or are you able to participate in a community-development approach to health? What would a community-development approach to health look like in your community if there were more people involved? What could you do to make this happen?

9. What questions, concerns or comments come to mind? What other issues need consideration? Who can you find to discuss them with? What further actions are required to progress these matters?

## FINAL COMMENTS

This article has been prepared out of concern for the many children who continue to suffer extra-ordinary levels of acute and chronic illness and disease.

I thank those who have taken the time to read this article and hope that these comments will assist staff working in indigenous communities to make inroads into the sad health picture that confronts them.

Feedback on the issues raised in this article are welcome (email to johnboully@hotmail.com).

Dr John Boully.
Adelaide. South Australia.