The HIV/AIDS epidemic has had its share of heroes, some of them who sadly have died from the disease, others who have remained involved since the beginning, working incredibly hard to fight the virus and improve the lives of those affected by it. Whilst her humility would probably have her resiling from such a description, Associate Professor Anne Mijch from Melbourne’s Alfred Hospital, is one of those heroes.

Anne has been involved at the frontline since before HIV even had a name, working as an infectious diseases physician, firstly at the Fairfield Hospital and then the Alfred. As someone who has had a major impact on Australia’s role in fighting HIV/AIDS, for her clinical excellence and research input but especially for her passionate advocacy for HIV-positive people and others affected by the virus, we spoke to her on the eve of her departure to work in the field in Papua New Guinea.

Farewell interview with Anne Mijch
David Menadue interviews Associate Professor Anne Mijch as she prepares to depart for a new role in Papua New Guinea

What are your strongest memories that you carry with you from the earlier period of HIV/AIDS, up until the present day?

My earliest memory goes back to 1983 when I remember receiving letters from the then Clinical Director at Fairfield Hospital, Dr Ron Lucas, visiting the Communicable Diseases Centre in Atlanta at the time, about a serious condition called “Gay Related Immune Deficiency” (GRID) which was affecting gay men in the USA. Dr Lucas said we needed to find the gay community and warn them of the possibility that the problem could come here, too.

I had no idea where to find the gay community. I had led a sheltered life as a young Catholic girl from Wagga Wagga so I asked Jan Watson, a social worker at the hospital to see if she could identify some gay community representatives we could talk to. One wintry Tuesday night we ventured into a dark street in Northcote to meet these guys – and were met at the door by a guy dressed in full leather. They included Ian Goller and his partner who were quite versed on the problem, having been very worried about it for some time.

Another strong memory of what we went through at Fairfield to try to set up a clinical service. Dr Suzanne Crowe was a hospital registrar at the time and as the viral laboratory at Fairfield Hospital had managed to import some of the earliest virus samples (then called LAV) into the country from the USA., we were able to offer individuals testing. While the tests were not 100% reliable (with about 25% returning false...
positives) there was enough known to start a clinic at the hospital in early 1984.

Of course there was little we could do for patients in terms of treatments. A lot of the patients in our waiting rooms at first were pregnant women or women with newly-borns wanting to know if they had picked up the virus somehow. There were worried blood transfusion patients and of course gay men who were showing some of the symptoms. Our first case of PCP was exasperating as we realised that little could be done to stop the progression of the underlying disease.

As I got to know how the virus worked in different people I was struck how malevolent it seemed to be. If a person had a particularly attractive face, they were more likely to get it covered in spots from Kaposi Sarcoma lesions. If the person had been a ballet dancer, it seemed almost a surety that the legs would be affected first. The virus seemed to attack people’s best feature.

What have been some of the real successes of our HIV response?

The partnership between the affected communities, doctors, researchers, nurses and public health officials has been a hallmark of the Australian response. The gay community and other affected groups were wonderful with the way they overcame fears about the virus’ transmissions, they informed themselves on the latest developments and they were committed to providing the best quality care, sometimes to people who had no one else, no family or friends to support them through their final months.

For me this was a very collaborative time, working with a range of agencies and community figures to get the response working on different fronts. My colleagues and I talked to HIV-positive support groups, to doctors in other hospitals, to politicians and bureaucrats. The most important people in all of this were the patients. I have made some strong friendships, learnt so much about others point of view and how we can all work together to achieve a common goal – good care for people with HIV and good science to keep improving that.

The community mobilised to change government policy on a range of areas, including access to drugs when they came along, which was amazing. I don’t know of other patient groups and their affected communities who have thrown themselves into such advocacy with passion and purpose. We had Act Up! when the Government wasn’t listening and it all leant itself to good outcomes in the end.

I consider Fairfield to have been blessed to have had such committed infectious disease physicians working there at the time the epidemic began, many of whom are still involved all these years later. People like Jenny Hoy were there from the beginning. Kate Cherry, Olga Vujakovic, Edwina Wright, Stephen Kent, to name a few. We’ve been able to provide a consistently high standard of care and treatment that has transferred over when Fairfield Hospital was closed in 1996 and shifted mainly across to the Alfred.

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We cannot forget the nurses either. To get such committed professionals working at the coalface with patients, despite the pressure involved, was a saving grace. Nurses understand life experiences better than doctors as a rule and they were essential in a disease that involved so much suffering, grief and loss, such a big emotional experience. It was testament to the attachment of so many nurses working at Fairfield that they found it hard to move to a larger hospital when the closure happened. They loved the staff, the patients, the grounds, the fact that everyone knew each other.

Do you think it was the right decision to close Fairfield Hospital?

As the epidemic turned out, it was right. If the government wasn’t prepared to put resources into keeping the hospital as a centre of excellence with all the appropriate diagnostic equipment and the associated specialist expertise then changes had to be made.

The Alfred is able to provide all the specialists in areas like cardiology, diabetes, plastics, neurology, and so on. We need them now, given the side-effects of the antiretroviral on patients and the long-term effects for PLWHA.

There are advantages to working in a smaller hospital. As a member of staff, whether a nurse, doctor, social worker or lab technician, you feel that you can have a say in the decisions made that affect patients. I had no trouble leading a group of staff and patients in to a Fairfield Hospital Board meeting to protest at their treatment of the Clinical Director at the time. It provided some amusement when one Board director reacted very angrily, demanding that the police be called to remove us. “But we can’t,” said another Board member, “they work here.”

A large hospital like the Alfred is harder to turn around on an issue and over recent years HIV issues have struggled to get a look-in. Initially of course the Alfred welcomed us as their own future was on the line with hospital closures at the time. The hospital staff responded well to taking on HIV patients and there have been few cases of bad or inferior treatment. The hospital administration knows they have highly skilled staff in the area that will fight for their resources. We worked with the community to get Fairfield House opened, which has provided much needed respite and palliative services over the years. Even so at times, I feel there is a pressure for staff to move on from a concentration on HIV with some cries that we are making our patients “exceptional” in the care delivered.

How has HIV care changed since the advent of HAART?

Obviously significantly with so few people dying and people living longer, generally healthier lives, but with a range of co-morbidities that we didn’t see earlier. It has been frustrating to see the side-effect profiles of HIV treatments provide people with further headaches after some have already been through so much. I don’t like to see patients with pronounced body shape changes, diabetes and cardiac complications but we all know the alternative is much worse.

There is a stronger need for a broad range of services related to mental health to be provided to some of today’s patients with HIV. There are still significant social problems for our patients who have experienced stigma, discrimination and rejection because of their lifestyles. Hospitals need to break down the barriers that have existed between them and the community to have a greater partnership with community agencies to treat HIV, including its psychosocial aspects, effectively these days. All the available skills and resources are need to further HIV prevention and care and hospitals as well as community agencies must find means to share these.
What do you tell newly-diagnosed patients these days?

Well the latest research says that the median survival with HIV is likely to be as much as thirty-one years. Even so HIV is going to affect every area of your life, your relationships and at times will test your patience with its management. I tell them not to hurry to make decisions, get good advice, find time to hear what others have done and learn about your options for self-care.

Over the years you have developed such strong attachments to patients and vice-versa. You said to me recently that you have known some of them since before you met your husband in 1988. How are you handling the process of separation and the level of emotion that people feel about you moving on?

It has been awfully hard. I have developed such strong relationships over so many years. But I tell myself that no one person defines anyone’s health care. I am doing my best to find my patients doctors who they will be happy with. Some want doctors who are scientific in approach, others want an empathetic ear. I’m doing my best to see that their care is in good hands.

Why have you decided to go to Papua New Guinea? Do you worry it might be like going back to the early days?

The epidemic is so bad there, I felt compelled to do something. I walked into a ward at the hospital in Port Moresby and 80% of the patients, many of them young, had AIDS but most of them didn’t know it. I thought, “God, you’ve got to do something to stop these people coming into these beds”.

One of the reasons I want to be involved is that PNG is just starting with its response and I’d like them to avoid some of the early mistakes we made here as well as benefit from some of the excellent measures we put in place.

It will need to have a different treatment model to tackle HIV there. The epidemic is 80% rural and I think the only way to tackle it effectively is to go to where the people are. There are clinics set up in Goroka and Mt Hagen. I will be working with others to help set up clinics on some of the islands, including Bougainville.

It will be all right if the antiretrovirals keep coming. The Clinton Fund and the World Bank have made promises to provide the necessary funds. These people are our next-door neighbours. They see Australia as a part of their history and culture and they are looking to us for help in this crisis. I am keen to do my bit.

Is there any chance you will come back to Melbourne?

I intend to work for at least twelve months in PNG (that could be extended). I have been offered sessions here and if I came back to Melbourne, I would certainly consider that. I won’t be doing a clinical administration job like I am now, though. It takes a lot of your energy doing the administrative stuff, taking you away from the work I most enjoy, treating patients. I think my voice has become a bit of a continuous sound to the administrators around here. There is a need for a new voice now. They will get plenty of support from the excellent staff that is still here.

There is a lot more that could be said about Anne Mijch and her contribution to HIV in Australia. About her passionate advocacy, thumping the tables of bureaucrats, hospital administrators and politicians to get changes to the care and treatment of people with HIV. About how she made herself available for any community education forum or exercise, regardless of the hour and the impost on her own private life. About how she was awarded an Order of Australia for going the extra mile in her work in HIV. About the respect she has from her peers, nationally and internationally for her clinical expertise and experience. Most of all though, I think Anne will be remembered by her patients for her warm, caring nature, her total commitment to their needs and the quality of their care and for her great humanity. You only have to talk to a couple of her patients, contemplating their world without Anne as their rock solid ally, to know that she will be sorely missed. - David Menadue

Photos by Andrew Henshaw