Pathogeni-city

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Mornings in cities in Australia and elsewhere are a microcosm of early 21st century urban lifestyle, in the making since at least the 19th century — streetscapes dominated by slow-moving cars and trucks, paths occupied by workers, smokers, snackers and runners, and cyclists negotiating traffic. This consumption-dense, movement-poor environment affects our health and our efforts to prevent and manage smoking, obesity and diabetes.

Smokers these days participate in what is increasingly an activity of the outcast — a far cry from the 1960s and 1970s, when (as recent television series remind us) smoking was integral to working and urban culture. Now, Australia's plain packaging legislation is forcing out, at an individual level and a community level, an activity that shortens and worsens lives, and costs a great deal of money. In this issue, Daube and Chapman (*page 191*) spell out the clear downward impact that plain packaging has had on smoking rates. The effect is so obvious that simply presenting the facts and adhering to widely accepted editorial standards is all that is required to get the message out — qualities that *The Australian* doubtless aspires to as it passes its 50th birthday.

I bought and ate a very nice muffin on my way to work today, even though it was packaged very plainly and was not the product of a multinational muffin company. Tackling unhealthy eating clearly requires very different approaches. Nevertheless, as with smoking, putting primary responsibility on the consumer to "quit" unhealthy consumption is counterproductive. Instead, as suggested by Harris and Spooner (*page 184*) in their editorial on helping patients manage their weight in general practice, modifying a patient's social environment is a valuable initial step. This can involve mobilising social support and implementing behavioural interventions. Specific dietary, medical and surgical interventions have a scope of use limited to patients with more severe obesity. Perhaps doctors, as part of their patients' environment, should consider whether they themselves do what they ask their patients to do.

This environment has deep roots in the economics and organisation of modern society. Leeder and Downs (*page 185*) argue that many aspects of it are obesogenic — economic and commercial models of food production, a built environment discouraging healthier work and leisure, and a lack of public infrastructure to enable people to get about efficiently. Together, these conspire against weight control and better lives. It is too hard to cycle, walk or run along city streets, and too easy to stop and eat, because communities, cities and their food supply lack human scale and responsiveness to real needs. This makes primary care much harder.

Diabetes is one of the more visible manifestations of our current situation. But the threshold for intervention to reduce its development and complications is contestable, and particularly so for gestational diabetes. In two other articles, the authors argue that the most recent international and Australian guidelines, with lower threshold criteria for diagnosis, may result in overdiagnosis, overtreatment and attendant harms. Kevat and colleagues (*page 204*) highlight the increased risk of maternal hypoglycaemia from treatment, the potential to overlook other important aspects of maternal and fetal wellbeing, and medicolegal implications. D'Emden (*page 209*) points out that the additional people captured by the new criteria are women for whom risk of adverse neonatal outcomes has not been established.

But, looking beyond smoking, obesity and diabetes, the medical profession could also have a great impact by supporting people to have better health by advocating for a better environment. Doctors as "environmentalists", perhaps — an idea that has been around since the time of Rudolf Virchow in the 19th century (*J Urban Health* 2003; 80: 523-524).

Lighting the path to sexual health

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Sexual health physicians used to spend half their working lives dealing with genital warts, but thanks to the advent of the human papillomavirus vaccine those days are rarer. Today a sexual health physician can expect to talk to patients about sexually transmissible infections, including HIV/AIDS, hepatitis, gonorrhoea, syphilis and chlamydia, but those conversations can also cover gender identity, sexual assault, reproductive health … in fact, every aspect of life related to sexuality. And they're happy in their work. "We get to talk about sex all day", says one practitioner. "Why wouldn't we be happy?" Dr Darren Russell, director of sexual health at Cairns Hospital, Dr Lynne Wray, president of the Australasian Chapter of Sexual Health Medicine, Professor Basil Donovan, head of the sexual health program at the Kirby Institute, and Dr Robert Finlayson, from the Taylor Square Clinic, talk about their chosen field (*page C1*). Our regular events calendar can be found on *page C3*.

Careers follows p 236