Academy Travel’s residential-style tours feature extended stays in carefully selected centrally located hotels. Rather than spending your days packing and unpacking, we give you the time to relax, enjoy and understand in depth some of Europe’s greatest cities.

VENICE: CITY, REPUBLIC AND EMPIRE
MARCH 2011 $5,750 twin share (land content only)
Tour leader: Dr Kathleen Olive
Unpack your bags for 14 nights and explore the city that ruled a Mediterranean empire for 1,000 years. Includes excursions to Ravenna, Padua and the Palladian Villas. Boutique 4-star hotel.

ROME: FROM ANTIQUITY TO THE BAROQUE
MARCH 2011 $5,400 twin share (land content only)
Tour leader: Angus Haldane
In the company of art historian Angus Haldane, take an in-depth look at the eternal city. Walking tours and museum and gallery visits are complemented by excursions to Etruscan Tarquinia and Tivoli with accommodation in a centrally located 4-star hotel.

FLORENCE AND THE ITALIAN RENAISSANCE
MAY 2011 $5,750 twin share (land content only)
Tour leader: Dr Kathleen Olive
Discover the art, architecture and history of a city which was the jewel of Renaissance Italy through a program of walking tours and museum and gallery visits. Day trips to important sites in Tuscany and accommodation in a lovely 4-star hotel complete the experience.

PARIS: REVOLUTIONARY CITY
JULY 2011 $5,495 twin share (land content only)
Tour leader: Dr Michael Adcock
With 14 nights in a centrally located hotel, this tour examines Paris before, during and after the French Revolution. Walking tours to key sites such as the Louvre, the Left Bank and the Bastille are complemented by day excursions to Versailles, Fontainebleau, Vaux-le-Vicomte and Rouen.

For detailed itineraries and booking information visit www.academytravel.com.au

ALSO AVAILABLE IN 2011
- Berlin to the Black Forest
- Grand Tour of Italy
- Iran: Civilizations of Persia
- Istanbul to Moscow
- North East USA
- Sicily and the Islands
- Southern China
- Verdi and Puccini’s Italy

KEEP IN TOUCH!
Get our latest brochure and keep in touch with our regular newsletter. Delivered by email or post. Sign up at: www.academytravel.com.au

TAILORED SMALL GROUP JOURNEYS
- EXPERT TOUR LEADERS
- MAXIMUM 20 IN GROUP
- UNHURRIED ITINERARIES
CONTENTS
SYDNEY MEDICAL SCHOOL MAGAZINE NOVEMBER 2010

radius
The magazine of the University of Sydney Medical Alumni Association and Sydney Medical School

Radius Editor
Beth Quinlivan beth.quinlivan@sydney.edu.au

Associate Editor
Lise Mellor lise.mellor@sydney.edu.au

Radius Office Room 204 Edward Ford Building A27 The University of Sydney NSW 2006 ph 02 9306 6528 fax 02 9351 3299

Editorial Committee Tom Rubin, Dr Paul Lancaster, Clinical Associate Professor Charles George, Professor Robert Lusby

Alumni News and Enquiries Diana Lovegrove Room 210 Edward Ford Building University of Sydney, 2006 New South Wales ph 02 9114 1163 email diana.lovegrove@sydney.edu.au web www.alumni.med.usyd.edu.au

Design 10 group Publisher Paul Becker

Published quarterly by 10 group for University of Sydney, Sydney Medical School. 10 group Level 1, 30 Wilson Street PO Box 767 Newtown NSW 2042
www.10group.com.au

Advertising Enquiries radius@10group.com.au ph 02 9550 1021
The support of all advertisers is welcome, however publication of an advertisement does not imply endorsement by University of Sydney, Sydney Medical School or the Medical Alumni Association. Member of the Circulation Audit Board. Audited Circulation 14,570 copies.

features
12 COVER STORY: LOOKING FORWARD TO LIFE AFTER MEDICAL SCHOOL By Melissa Fagan
14 LOOKING BACK LONG HOURS AND FINGER BUNS
16 INTERNATIONAL INTERNSHIPS: THE BIG DISCONNECT
18 CHRISTINE BENNETT GETTING ON WITH HEALTH REFORM By Beth Quinlivan
20 SACS APPEAL THE FASCINATION OF LUNG FUNCTION By Norbet Berend and Stephan Leeder
22 WHEN THE PATIENTS IS A DOCTOR By Narelle Shadbolt
24 STRETCHING STEM CELLS TO GREAT HEIGHTS By John Rasko, Tony Weiss and Jeff Holst
26 WOMEN DOCTORS MAKING A DIFFERENCE By Clarissa Fabre
30 SPOTLIGHT ON SCHOLARSHIPS

regulars
4 MESSAGE FROM THE DEAN WHY EDUCATION REFORM IS NECESSARY Professor Bruce Robinson
5 SCHOOL NEWS From the Senate/Indigenous Health Promotion/Students Global Health Conference/Research Funding Successes/ New Postgraduate Degrees in 2011/ Terminal Decline: A Surgeon’s Diagnosis of the Australian Healthcare System/Michael Field Changes Course/RACGP Practice of the Year
29 MEDSOC REPORT PROGRESS AND REFLECTION Jon Noonan

alumni news
31 PRESIDENT’S REPORT Dr Catherine Storey
32 DOCTORS AT WAR By Lise Mellor
34 CASE NOTES
35 WEARING GLASSES OR NOT By Sue Ogle
36 REUNIONS
38 OTHER PASSIONS EAST MEETS WEST: YOGA AND MEDICINE

Do we have your email address?
To update your details go to: sydney.edu.au/medicine/alumni
WHY EDUCATION REFORM IS NECESSARY

The education of clinicians, researchers and public health advocates by providing foundation knowledge and skills, as well as a desire for lifelong learning, is one of Sydney Medical School’s core roles. It requires innovation, imagination, passion and commitment from a range of health professionals. The challenges are many – system flaws, financial constraints and time pressures to name just a few. Changing generational expectations also necessitate regular re-thinking of current programs, preserving and defending the best, and looking for new opportunities.

The recent debacle over management of intern placements for our international students has highlighted some of these problems. Everyone has acknowledged the madness of denying internships to our international graduates, over 50% of whom want to stay to practise long term in Australia, when at the same time we import over 4000 doctors each year to work (largely in areas of need). Yet it has taken intense lobbying to secure internships for our own graduates. Unless urgent creative thinking is applied to this issue, it will occur again next year and will affect even more graduates, both international and domestic. We will be training doctors but not registering them.

So what are some of the issues in developing and providing high quality education programs for health professionals, and what are the possible solutions?

First, we need to know what it costs to educate health professionals and researchers and then fund or charge appropriately for it. The current system is regularly described as a “house of cards” with “bad weather” approaching. It is built on enormous goodwill, but also underfunding, cross subsidy and historical deals and is doomed. Knowledge of the real costs of teaching medical, public health and research students will provide us with the ammunition we need to lobby for proper funding of our programs.

Second, medical schools should take responsibility for the lifespan of health and research education. Internships, residencies and specialist training should be the responsibility of universities with royal colleges assessing and setting standards.

Internships and ongoing training need to be deregulated. It is a complete falsehood to suggest that the public hospital system is the only legitimate training ground for health professionals. The private sector, general practice, international partners and research institutes can, and should, participate in providing learning opportunities and trainees should be given greater responsibility for their own education. Regulation of education is killing innovation and the excitement of medical education. Researchers, in contrast, plan their education independently with spectacular success.

While we advocate and strive for reform, I thank all of our teachers for their ongoing contributions to our current “house of cards”. Without the support of those who teach for us, either in lectures, tutorials, laboratories or clinical settings, we would certainly not be able to provide the programs which will train the people who will care for us and for our children’s children.

To 2011

With another year rapidly drawing to a close, can I also take the opportunity to thank not just staff but alumni, community supporters and our students for their commitment and contribution. It has been a year of many changes, including plans which we hope will consolidate our position as one of the country’s leading tertiary research and education institutions. It is a privilege to have the opportunity to lead this School, and to work with passionate, talented clinicians, scientists, researchers, administrators, students, alumni and supporters.
FROM THE SENATE

Firstly congratulations to year one medical student Ben Veness, elected as Undergraduate Representative to the Senate. Prior to medicine, Ben gained an accounting degree from UTS and has recently produced the Medical Revue ‘Cadavater’ at the Seymour Centre. There is only one undergraduate Senator and he beat the current SRC President, which is no mean feat. The Medical School and Alumni now have five members of Senate - the Chancellor, Michael Copeman, Simon Chapman, myself and now Ben.

The Senate has now formally adopted the Vice Chancellor’s new strategy as per the White Paper which evolved from the Green Paper. In addition to laying down the direction for the University, it includes some significant management changes.

Faculties are grouped into administrative divisions in order to achieve economies of scale and to share infrastructure. Medicine is grouped with Dentistry, Pharmacy and Nursing. Each will retain their own identity but will work together in areas including international marketing of courses, student administration and in global health.

The other major and perhaps more interesting change is the way the faculties are financed. In the past, revenue was collected by the University which extracted all the central costs before allocating the remainder to each faculty or school. In the future, the revenue will come directly to each faculty which will be charged for central services. This will be a far more transparent approach and should create more accountability.

This year international student fees generated $260m for the University. In Medicine 17% of the students are international fee paying, generating 37% of the revenue the School receives to run its medical program. This is a highly competitive market with both local and global competition. The rising $A does not help, nor does the publicity associated with assaults on students.

In NSW we have another crazy difficulty with the Health Department refusing to guarantee intern places to international students, and actually giving preference to foreign trained graduates seeking internships. The majority of our international students come from North America. Most want to do their internship here and many want to stay permanently. By offering these graduates internships we are not only encouraging recruitment and improving the overall quality of interns but also adding significantly to the Country’s GDP. A recent study by Salkeld and Schofield showed that if 80% of international students were given an internship they would contribute in net terms $11.3M to the GDP and if 50% joined the medical workforce they would add $5.67M p.a. to the GDP.

Seems a no brainer...know any pollies?
Barry Catchlove
October 2010
barry.padua@yahoo.com.au

INDIGENOUS HEALTH PROMOTION

Students in the School of Public Health’s Graduate Diploma in Indigenous Health Promotion, have been learning the skills necessary to use the media to best advantage.

“We have 16 Aboriginal and Torres Strait Islander students enrolled in the Graduate Diploma in Indigenous Health Promotion. They’re from all over the country - Redfern, Badu Island, Darwin, Longreach and elsewhere,” said course co-ordinator and lecturer Suzanne Plater. Students spent block periods at the University, and complete the remainder of the course through online tutorials and assignments.

“We’ve partnered with Radio 2SER’s Jailbreak program to develop a radio sting about hepatitis C for inmates in NSW prisons,” she said.

With help from communications expert Simon Westaway, and Dr Gary Egger, they have learned practical skills in using the media as a tool for health promotion.
STUDENTS GLOBAL HEALTH CONFERENCE

Medical students from all corners of Australia visited Hobart from July 1-4 for the Australian Medical Student’s Association Global Health Conference. Through four intense days of lectures, forums, tutorials and networking opportunities, we learnt about medicine in the broadest possible context. Issues covered included the impacts of climate change, nuclear technology, poverty, and war on health.

Dr Helen Caldicott opened the conference on Thursday morning with a gripping lecture on nuclear power. An inspiring paediatrician, she has advocated against nuclear technologies for 40 years.

A running theme of the conference was that doctors have the ability, and responsibility, to educate society about health issues, and to be engaged in debate about political issues.

Greens Senator Bob Brown, a Sydney Medical School graduate, explained that while he is no longer a General Practitioner, he considers the environmental advocacy he does as preventative medicine.

We also learnt about refugee health, remote Indigenous health and the impacts of the Northern Territory Intervention in Australia.

A challenge for Sydney University is that 90% of the medical research done globally benefits only 10% of the population, and only 10% of drugs on the market treat diseases that comprise 90% of the global disease burden.

The conference expanded our knowledge about global issues, and exposed us to some influential role models. Next year’s Global Health Conference will be in Sydney.

Professor Michael Kidd, the World Health Organisation chair for General Practice, encouraged us with the words of Albert Schweitzer:

“I don’t know what your destiny will be but one thing I do know. The only ones among you who will be truly happy are those who have sought and found how to serve.”

Samantha Sundercombe (Med 1)

Pictured above: conference delegates on the final morning

RESEARCH FUNDING SUCCESSES

The National Health and Medical Research Council’s competitive grant schemes are the most significant source of funds for Australia’s medical researchers. In the recently announced 2010 round of project grants, Sydney Medical School was awarded a record 82 new project grants.
John Malkovich in *The Giacomo Variations*  
Concert Hall, Sydney Opera House, January 20-22

Emmylou Harris & her Red Dirt Boys  
State Theatre, January 9 & 10

**sydney festival 2011**  
January 8-30

The Red Shoes  
Kneehigh Theatre  
York Theatre, Seymour Centre, January 18-30

An Evening of Chamber Music with Philip Glass & Wendy Sutter  
City Recital Hall Angel Place, January 18

[Book your tickets](sydneyfestival.org.au)  
| Ticketmaster: 1300 723 038  
Sydney Festival: 1300 668 812

Leadership Partner

**THE UNIVERSITY OF SYDNEY**

Principal Sponsor

**Zip**  
Instant Boiling Water
NEW POSTGRADUATE DEGREES IN 2011

Sydney Medical School offers 26 postgraduate degree programs. Some, including surgery and ophthalmology, are only open to medical graduates. The majority of courses do not require a medical degree, and students include health professionals, scientists, statisticians, journalists and more. Two new courses have been approved and are on offer from 2011.

Clinical Trials Research

The Master of Clinical Trials Research is run by the NHMRC Clinical Trials Centre, which has been leading trials for 20 years. It gives candidates the skills to design and lead clinical trials, as well as to collaborate in larger multicentre trials.

“I have worked collaboratively with CTC for 10 years and initiated eleven trials during this time” said Professor Michael Friedlander, founding chairman of the Australia and New Zealand Gynaecological Oncology Group and President of the International Gynaecological Cancer Society. “I am delighted to see CTC launching this program as they have significant expertise in the field.”

The course is geared towards clinicians, researchers, consultants, health care professionals, data managers and nurse practitioners. It is delivered entirely online. It is run in parallel with the Clinical Trials Practice course, on offer through Sydney Nursing School.

Genetic Counselling

The Master of Genetic Counselling is a 2 year program providing candidates with advanced knowledge of medical genetics and genomics, community genetics and genomics, clinical practice, ethical, legal and social issues and research skills.

As a member of a medical genetics team, genetic counsellors provide individuals and families with information about conditions due to inherited variations in single genes, multi-genes and gene–environment interactions; the availability of appropriate screening and genetic testing; test results, diagnosis or estimates of risk; and provide support for decision making, dealing with the impact of test results and family communication.

“Genetic counselling gives me the opportunity to engage with individuals, couples, and families, making profound decisions about themselves and their future;” said Ron Fleischer, Genetic Counsellor at Royal North Shore Hospital.

“Helping people understand the significance of genetic testing gives you an insight into what makes people tick. It is fascinating to explore these issues with a patient and help them reach the decision that is right for them.”

For information on all postgraduate courses, visit: sydney.edu.au/medicine/future-students/
Pictured above: Ron Fleischer and Michael Friedlander

TERMINAL DECLINE: A SURGEON’S DIAGNOSIS OF THE AUSTRALIAN HEALTHCARE SYSTEM

Is the national healthcare system in terminal decline? Professor of Surgery at Nepean Clinical School, Mohamed Khadra, has taken a scalpel and dissected the Australian healthcare system in his recently-released book, Terminal Decline. The book, his third (after Making The Cut and The Patient) looks into the history of healthcare in Australia, most especially the decisions made in the 1970s and 1980s which have resulted in the current national system today.

Terminal Decline is a controversial and topical book, which includes case histories and interviews with key players in the development of Australia’s current system. Professor Khadra presents the case for returning to simpler healthcare principals which were in use prior to the centralised bureaucracy of modern healthcare governance today.

“As a practising surgeon now, I see great differences between the system as it is currently, and the system in which I trained in the 1980s,” he said. “The overwhelming difference is the lack of empowerment I see in the faces of all those around me who are working in the clinical interface.”

In 2011, Professor Khadra’s first play will be part of the line up at The Ensemble Theatre. Written with Australia’s best known playwright David Williamson, and called At Any Cost?, it tackles some of the most compelling questions of modern medicine. Medicine can prolong life, but is there any point if the life prolonged is poor?
Named after one of Australia’s most successful Test captains and Cricket NSW Hall of Fame member, the Mark Taylor Club is the official membership of Cricket NSW. This is an exclusive membership with only 400 seats.

The Mark Taylor Club is a fully transferable membership and secures your own seat (with your name on it), for all International cricket matches played in NSW for the next three years, including the highly anticipated 2010 / 2011 Vodafone Ashes Series.

FOR MORE INFORMATION OR TO JOIN THE MARK TAYLOR CLUB, CALL (02) 8302 6011 OR VISIT WWW.MARKTAYLORCLUB.COM
I have had a 42 year association with the University of Sydney’s medical school, initially as a student (from 1969 to 1975), and since 1985 as a member of the academic staff.

While much has changed over this time, the core missions of the school have largely remained the same: pursuing our goals in teaching and research to the highest possible standard, and contributing to leadership in professional affairs at a national and international level.

One of the highlights of my own period on the academic staff has been the opportunity to develop both research and teaching programs in my own field of nephrology. Having completed a BSc in epithelial transport in John Young’s laboratory, and a doctorate in renal physiology at Yale, I was in a good position to re-energise the renal components of our original (undergraduate) curriculum, and to set up a renal laboratory in my first position at Concord Hospital, where Jim Lawrence had done such a lot to develop the potential of that institution as a major University Hospital. That lab achieved national attention and attracted a sequence of talented clinicians into PhD studies, the first of whom, Carol Pollock, remains my chief scientific protégé and continuing colleague.

My interest in curriculum structures led to me (along with Ann Sefton and Jill Gordon) becoming involved in leading the reform of our very conventional undergraduate medical course, which we replaced with the Graduate Medical Program in 1997. There was much satisfaction in changing both the admission model and the curriculum design, especially as we were well placed to be one of the first medical schools in the world to realise the potential of the new web technology in delivering high quality course materials. While there have been important modifications to that original plan in the meantime, it’s gratifying to see that the basic principles of the program survive to this day.

When Kerry Goulston announced his retirement in 2001 from his position as the inaugural Associate Dean of the Northern Clinical School, based at Royal North Shore Hospital, I was attracted to take over that role, in which I have remained till my own forthcoming retirement. It has been a satisfying job to further enhance the School’s reputation in teaching and research, especially as I had the opportunity to be closely involved in its relocation into a spectacular new home in the Kolling Building in 2008.

My retirement marks more a change in the balance of my pattern of activities than a retreat into some other world of inactivity. On the medical side, I will keep up a strand of clinical practice and teaching, and am keen to become involved in the outreach programs of our Medical School’s Poche Centre for Indigenous Health, especially given the critical need that Aboriginal communities have for renal services. After many years of working with the Australian Medical Council, I will remain involved in medical school and specialist college accreditation, and will be able to further develop that interest in the international domain in my capacity as the Vice-President (and President-Elect) of the Association for Medical Education in the Western Pacific Region. This is the largest regional division of the World Federation for Medical Education, a body affiliated with WHO involved in medical school development around the world.

But as many people know, I am also looking forward to giving more time to my longstanding interests in the humanities, especially in music. After a number of years involved in presenting the Music and Medicine unit of the Master of Medical Humanities program at USyd, I look forward to developing further course offerings in music for the University’s Continuing Education program. I’m also hopeful of getting a spot in radio broadcasting about classical music, and even writing about it. I have other smouldering passions which I want to pursue, in classical literature (especially the Roman poets of the first century BC), and in Shakespeare studies, which I plan to follow up through some time in overseas courses. And there’s always the lure of travel and family, especially with two of my three children currently living overseas!
DEAN’S STUDENT PUBLICATION PRIZE

PhD student Michael Huang has received the Dean’s Research Publication Prize for his research into Friedreich’s ataxia, a condition characterised by progressive neurological and cardiodegeneration. The prize is offered for the best student research paper published in a peer-reviewed journal in 2009 and aims to encourage students to publish their research and participate in scientific conferences early in their research careers.

Michael’s paper describes how the gene frataxin, whose mutation causes Friedreich’s ataxia, plays an important role in processing of iron in the mitochondrion.

“The mutation of frataxin leads to decreased iron utilisation in two major mitochondrial pathways, which could contribute to the loading of mitochondrial iron,” he said. “The effect is compounded by increased cellular iron uptake and targeting of cellular iron to the mitochondrion. The resultant loading of toxic iron in the mitochondria leads to substantial damage to the cell, leading to its death.

“This finding has identified several novel players in the underlying cause of Friedreich’s ataxia and we hope that this finding can help towards the development of a cure for this devastating condition.”

Michael hopes to present his findings at the conference for the Society of Free Radical Research Australasia in New Zealand.

CADAVATAR, THIS YEAR’S MED REVUE, RAISES $40,000

Medicine’s talented students are no surprise to teachers and staff. This year’s Med Revue was another great example.

Cadavatar raised more $40,000 for charity (The Fred Hollows Foundation and Milk Crate Theatre) by filling 2,600 seats across the four nights it played at the Seymour Centre. The storyline was a parody of James Cameron’s Avatar and the show boasted everything from acrobatics to bagpipes to Glee-inspired chorus numbers.

The 100 first year medicine students involved produced a highly entertaining and varied show. Cadavatar was successful with its sponsorship (Douglass Hanly Moir Pathology donated $10,000) and media coverage (mX, The Sydney Morning Herald and 2SER radio all promoted the show). A DVD is not far off.

SYDNEY MEDICAL SCHOOL
EDWARD FORD BUILDING A27
THE UNIVERSITY OF SYDNEY NSW 2006
sydney.edu.au/medicine

Dean Professor Bruce Robinson
Deputy Dean Professor David Cook, Professor Ben Freedman

ASSOCIATE DEANS AND HEADS OF SCHOOLS
Professor Glenn Silkfield - School of Public Health
Professor Michael Field - Northern Clinical School
Professor Craig Mellis - Central Clinical School
Professor Chris Murphy - School of Medical Sciences
Professor Kathryn North - Children’s Hospital at Westmead Clinical School
Professor Michael Peak - Nepean Clinical School
Professor David Harris - Westmead Clinical School
Associate Professor Tony Brown - School of Rural Health
Professor Robert Lusby - Concord Clinical School

ASSOCIATE DEANS
Professor David Burke - Research Integrity
Professor David Cook - Research
Professor David Handelsman - Research Strategy
Associate Professor Graham Mann - Research Strategy
Professor Michael Frommer - Learning & Teaching
Dr Narelia Shadbolt - Student Support
Professor Simon Wilcock - Postgraduate Medical Education & Training
Professor Jillian Kril - Postgraduate Studies & Chair, Board of Postgraduate Studies
Professor John Christodoulou - Postgraduate Studies
Associate Professor Brett Hambly - Postgraduate Student Recruitment
Professor Robert Cumming - Postgraduate Coursework
Professor Robyn Norton - Global Health
Associate Professor Lyndal Trevena - International
Associate Professor Gareth Denyes - Information Technology
Professor Chris Liddle - Information Technology Development
Professor Carol Armour - Career Development
Associate Professor Chris Roberts - Educational Development
Professor John Fletcher - Surgical Sciences
Professor John Watson - Sydney Adventist Hospital
Visiting Professor David Tiller - Planning & Development, School of Rural Health

ASSOCIATE DEANS, SYDNEY MEDICAL PROGRAM
Professor Stewart Dunn - SMP Admissions
Professor John Mitrofanis - Stage 1 Coordinator
Professor Michael Frommer - Stage 2 Coordinator
Associate Professor Chris Dennis - Stage 3 Coordinator

FACULTY EXECUTIVE
Tom Rubin - Executive Officer Sydney Medical School
Dominic Curtin - Finance Director Faculties of Health
Ria Deamer - Manager Sydney Medical School
Vera Terry - Director, Research and Education Business Development
Beth Quinlivan - Director Marketing and Communications
Joanne Elliot - Executive Officer Office Research & Research Training
Karen Scott - Executive Officer Office of Medical Education
Kay Wint - Director Student Services
Diana Lovegrove - Manager Alumni Relations & Events
“I’m really excited about starting internship next year at North Shore. After eight years at University, it is a wonderful feeling – and a paid job will be also be really good.”
When Professor Bill McCarthy graduated from Sydney Medical School in 1959, he had spent minimal time in hospitals or with patients throughout the course. For him and so many other graduating students in past 40 years, the excitement of graduation and work after so many years at university, was tempered with concern about feeling unprepared and unsure about skills and responsibilities. (See accompanying recollections).

In 2010, the story is the same – but different. Sydney’s graduating students express similar excitement about the transition from student to junior doctor. In the graduate medical program, all have spent a minimum of seven years studying (many much longer) and are looking forward to the new responsibilities, greater autonomy, feeling like a useful member of a health team, and of course a pay check. They are older than previous medical students, and the average age of graduates this year is 27.

By and large, Sydney’s students also express nervousness about how they will cope when they meet the reality of the public health system as interns, and when they are asked to make decisions and take responsibilities.

“The challenge is going from being a student where you’re allowed to be not sure, to being in a position where you should have answers. It’s one thing to know everything academically, it’s another to apply it. I do worry about not having someone to fall back on, and certainly don’t want to make small mistakes on something that seems quite basic but does affect people,” said Aruvi Thiruvurarudchelvan from Central Clinical School, graduating this year.

But students are also well prepared, including for interactions with patients. Since the first year of their course, they have been in hospitals and with patients. They have spent a day in their clinical school in stages one and two of the program, and are based in clinical schools full time in the two years of stage three. In their final term, pre-intern or PRINT term, they spend two months working in hospital as part of a team, and are introduced to the work they’ll be doing as interns. Under supervision, they play the more autonomous role they will have as an intern.

“PRINT has been great, it has given us a really good understanding of what we will be doing next year” said Kate Allan, based at Concord Clinical School. “Before I started, I didn’t really know what would be expected and it was a bit daunting. I’m working with the respiratory team at Concord, and they have been fantastic, I feel part of the team and I have learned such a lot in just a few weeks.”

Sydney’s graduating class of 2010 is the first to have benefited from changes introduced as a result of a major review of the curriculum in 2007. The changes have primarily affected their course in stage three (years three and four). For students completing their studies next year (2011), the review resulted in widespread change across the four years of the course.

The most significant change for the 2010 graduates has been to the timetabling of core medical and surgical rotations through stage three. Previously, the core medicine and surgery rotations were completed in the first year of stage three, with the specialist rotations of paediatrics, psychiatry, obstetrics and gynaecology, and community, all in the final year. Given that medicine and surgery are the core subjects, and the basis of much of the work of interns, the feedback from students and clinical staff was that they would prefer to have some more recent exposure. Medicine and surgery rotations, as well as the specialist blocks, are now spread across both years of stage three.

“For students, it was a smooth transition and it was better than having the core blocks all together, then speciality,” said Andrew Caterson, based at Nepean Clinical School. “It will be much more useful as far as next year is concerned, and the organisation allowed students to study properly and experience the specialties and core.”

In October, the 261 students in Sydney Medical School’s graduating class commenced their pre-intern or PRINT term in the School’s teaching hospitals. It is the final stage in what has been a long period of study on the road to medical professional. Next January, graduates will take up their positions as interns in hospitals around the country – excited, nervous but well prepared for the challenges ahead.

By Melissa Fagan
LOOKING BACK
LONG HOURS AND FINGER BUNS

PETER HAERTSCH
CLASS OF 1968, SYDNEY MEDICAL SCHOOL
Professor Haertsch is a burns surgeon and the founding Chairman of the NSW Severe Burn Injury Service and the Sydney Burns Foundation, and the founding head of the Department of Plastic, Burns and Reconstructive Surgery at Concord Hospital.

“I completed my junior residency at Concord Hospital. It was difficult transitioning from being a student to being a full time clinician. The difficulty arose by virtue of lack of confidence, and an ill-preparedness for the responsibilities involved especially on-call, out of hours, where it was just you initially, and a decision had to be made. Coupled with this was the fear of the unknown and uneasiness (fear!) when associating with the senior clinicians.”

BEN FREEDMAN
CLASS OF 1973, SYDNEY MEDICAL SCHOOL
Professor Freedman is a cardiologist at Concord Hospital and Deputy Dean of Sydney Medical School.

“I commenced work as an intern in 1973 at the tender age of 23 and lived in a room in the RMOs quarters at RPA. Of course hospital medicine was different then, with Florence Nightingale wards, and a different pace to admissions. The main weekly consultant ward rounds in my first medical term of the Stan Goulston team started with a morning tea of finger buns, presided over by the ward charge nurse, with all of the main medical consultants present, the registrar (Alex Bune), the intern (myself) and an entourage of medical students, followed by the round itself at a respectable pace, with all of the patients seen and discussed by the large group, accompanied by the charge nurse (Sister Sales) wearing a starched cap.

I graduated in a small cohort and as a result we were able to form an action group to campaign for better conditions as interns. The group was called the IRA (Incoming Residents Association). For the first time we were able to achieve payment for working overtime. It signalled an end to the 1 in 2 rosters that had been de rigueur, and the start of night residents performing shift work, to reduce the overtime costs to the hospitals.”

KIRSTY FOSTER
CLASS OF 1977, COLLEGE OF MEDICINE, UNIVERSITY OF EDINBURGH
Dr Foster is the Sub Dean (Education) and a senior lecturer in Medical Education in the discipline of Obstetrics, Gynaecology and Neonatology at the Northern Clinical School.

“When I turned up for my first day at work as a doctor I felt reasonably confident that I could cope with all the routine bloods, organising x-rays and the 101 other tasks expected of me in a ward full of patients. I was not as sure, however, about the average of over 100 hours a week I was expected to work; or of how I was going to find time to get to theatre to assist at operations along with everything else. There would certainly be no time for any social life! The ward sisters were warm, welcoming, supportive and very helpful, especially in the first few days. It turned out to be exhausting but at the same time fascinating, challenging and humbling. I loved it!”

WILLIAM McCARTHY
CLASS OF 1959, SYDNEY MEDICAL SCHOOL
Professor McCarthy is an Emeritus Professor of Surgery in Melanoma and Skin Oncology at the University of Sydney and Director and co-founder of the Melanoma Foundation.

“When I graduated, the undergraduate curriculum had no hospital exposure whatsoever, so we arrived at the hospital in January totally unknowing of what we knew, how good our skills were, with no significant contact with patients prior to that day, and thus feeling totally unprepared for what was to come. However, we all basically knew that we would be working with senior residents and registrars and expected that they would help us over any bad spots, which they did. It took very little time for us to become aware that we really did have enough knowledge and skill to get by at the level expected of us.”

BRUCE ROBINSON
CLASS OF 1980, SYDNEY MEDICAL SCHOOL
Professor Robinson is an Endocrinologist and Dean of Sydney Medical School.

“The 30 years since graduation have gone in a flash but I remember the incredible excitement of starting work at Sydney Hospital in Macquarie Street, shortly followed by a term at Balmain and then at the Royal Alexandra Children’s Hospital. Each one has provided memories. Sydney was a wonderful hospital and a great place to learn, and it is a real loss that it no longer provides the services of those days. It was an inner city hospital and we saw a lot of homeless people and alcoholics who were placed on low beds – literally beds just off the floor – while they sobered up. A really vivid memory is running across The Domain one day, summoned to a cardiac arrest in The Eye Hospital, then down in Woolloomooloo.

I spent a second internship at the Children’s Hospital, and thought at the time that paediatrics was a possible career. Three months in the “crying baby clinic”, and I realised paediatrics wasn’t for me. One of the strongest memories of that time was that paediatrics was not related to medicine at all, but the ever present smell of biscuits being baked at the Peak Freans factory over the road.”
It was a busier program though. “You had to be organised. There were multiple tasks for each term so if you weren’t keeping up to date with it you could get to the last week and not be prepared. Constant updates from admin and fellow students helped but the major challenge was keeping on top of it.”

Assessment – a moot point – has also been increased. There are now assessments and barrier exams at the end of each year, as well as exams at the completion of each of the speciality and core blocks through stage three.

The new curriculum has been beneficial, according to Aruvi Thiruvarudchelvan. “There has been a greater emphasis on knowledge that is necessary in a clinical setting and it is good to have an idea of what they (the hospitals) think we should know,” she said.

Aruvi, who majored in French and Psychology at an undergraduate level, can also see the advantage in having more basic science training. “Just talking to students a couple of years below, they have learnt more anatomy and basic sciences. For us, there was a lot to learn in a very short space of time.”

The curriculum review was initiated by Dean, Professor Bruce Robinson, and conducted in 2007 by Emeritus Professors Kim Oates and Kerry Goulston. Recommended changes, including increased anatomy teaching and an emphasis on basic sciences in the early years of the program, have been phased in from early 2008.

**INTERNSHIPS**

All graduating medical students this year have been caught up in the stressful situation for international students regarding internships (see following article). With the number of medical students increasing at a greater rate than intern positions, there was no certainty that all international students would be able to secure an internship in NSW hospitals. For the future, there is general concern that the shortage of places for international students will extend to domestic students. Currently, the NSW Government has guaranteed domestic graduates an intern place.

Andrew Caterson is returning to Orange, where he undertook and enjoyed a rural placement during the course. “I can’t wait to be responsible, make my own decisions and get paid.” He’s not too concerned about being overworked. “I’m sure there are fall back mechanisms or people we can see about sharing the load.”

For Aruvi medicine was initially a means to an end – a pathway to becoming a psychiatrist. Ultimately it was a revelation.

“Medicine changed the way I looked at the world – it made me think about things and why they are the way they are. We all know that cancer is a foreign growth in your body but it never occurred to me that it’s our own cells growing in an unregulated way. I can remember sitting in a lecture and hearing this for the first time – it’s like when you’re a child and you learn the alphabet. One moment it’s just a series of letters and the next you’re reading whole words. The only thing difference is someone said put them together.”

Aruvi hopes to specialise in Anaesthetics, or perhaps Emergency Medicine. She is doing her internship at RPA.

Kate Allan has loved obstetrics and gynaecology, and considering that as her career. “I’m really excited about starting internship next year at North Shore. After eight years at University, it is a wonderful feeling – and a paid job will be also be really good.”

“There has been a greater emphasis on knowledge that is necessary in a clinical setting and it is good to have an idea of what they (the hospitals) think we should know.”
International internships: The big disconnect

By Bruce Robinson

Sydney Medical School believes that we need, as a matter of urgency, a major overhaul of postgraduate training, including reviewing the intern program, developing a new funding model for internships and a national system of allocation of intern positions.

We know from surveys that more than 80 per cent of international medical students wish to undertake their intern training in Australia. At least 50 per cent say they would like to remain in the country permanently. Meanwhile, Australia has significant health workforce shortages, and advertises widely internationally for medical practitioners to fill those gaps.

There might seem an obvious solution to the above but the big disconnect between state and federal governments is preventing rational action.

After another year when the drawn out and stressful process for allocating internship positions to international students – watched nervously by domestic students keenly aware of all impending postgraduate training bottlenecks – still there is no clear agenda for change to postgraduate medical training.

In 2009 medical graduates from Australian universities were all provided intern positions. In 2010 only after extensive lobbying were NSW’s international graduates who wished an intern place guaranteed a position. But with graduate numbers increasing in 2011 and again in 2012, when new medical schools of Notre Dame, Wollongong and University of Western Sydney are all graduating students, significant increases in intern places will be required if all medical students are to gain medical registration.

INTERNATIONAL STUDENTS: DIVERSITY AND FINANCIAL BENEFITS

As government funding has declined, Australian universities generally have used international student fees to subsidise the education of all domestic tertiary education. Most Australian universities have between 20% and 30% international student enrolments, some universities significantly higher. In 2010, 22% of University of Sydney enrolments were international students, generating $260 million in fees.

Government funding does not cover the cost of medical education. For Sydney Medical School, international students make up 17% of total medical students but their fees account for 37% of total fee income ($6.2 million of $16.4 million in 2010) received by the School to run the medical program.

An added benefit is that international students bring a diversity to student experience. We live in a world which is increasingly international, and international education enriches our nation. Our own students are better educated and more worldly as a result of sharing classes and experiences with students from non-Australian backgrounds.

MEDICAL STUDENTS GRADUATING FROM AUSTRALIAN UNIVERSITIES

<table>
<thead>
<tr>
<th>Year</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic graduates</td>
<td>1,914</td>
<td>2,264</td>
<td>2,667</td>
<td>2,912</td>
<td>3,045</td>
<td>3,108</td>
</tr>
<tr>
<td>International</td>
<td>478</td>
<td>512</td>
<td>468</td>
<td>518</td>
<td>678</td>
<td>678</td>
</tr>
<tr>
<td>Total AUS graduates</td>
<td>2,392</td>
<td>2,776</td>
<td>3,135</td>
<td>3,430</td>
<td>3,723</td>
<td>3,786</td>
</tr>
</tbody>
</table>

PGY1 POSITIONS AVAILABLE

<table>
<thead>
<tr>
<th>Year</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>Increase 2005-09%</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Australia</td>
<td>1,622</td>
<td>1,711</td>
<td>1,776</td>
<td>2,030</td>
<td>2,243</td>
<td>38.3%</td>
</tr>
</tbody>
</table>

Source: MTRP 13th report
"Every graduate of an Australian medical school should have the opportunity to continue their training in this country, regardless of their residency status. We need urgent action on a national scale to halt the rapid expansion of medical student numbers, expand postgraduate training capacity and reform the uncoordinated and inefficient state-focused intern allocation systems to cope with the current crisis in medical education”

Jon Noonan, President MedSoc

INTERNATIONAL MEDICAL STUDENTS

By not providing internships to international graduates, Australia is turning away the opportunity to fill workforce gaps with well trained young professionals.

Australia has a shortage of medical practitioners and even with rising numbers of medical students, the country will not be able to provide sufficient practitioners for the population for some time to come.

Workforce gaps are filled by internationally trained medical professionals, about 4,000 of whom come to Australia on 457 visas each year.

INTERNATIONAL STUDENTS ECONOMIC BOOST

It is well recognised that international students, through their course fees and general living expenses, make a significant contribution to universities and to the economy more broadly. What has been less well appreciated is that international medical graduates who remain in the country as interns continue to provide a boost to the economy.

Professor Glenn Salkeld, Head of the School of Public Health, and Professor Deborah Schofield, both health economists, have used the Australian Government’s modelling methods (used for the Intergenerational Report in 2002-03 and 2007) to calculate the economic contribution of international medical school graduates who are provided internships in 2010. Providing an internship to 80 per cent of international student graduates would add $11.35 million to national gross domestic product (GDP) in one year. If 50% of those international interns were able to remain in Australia (an underestimate of the number who in surveys have indicated they would like to become permanent residents) the annual GDP gain for the country would be $5.67 million. radius

INTERNATIONAL MEDICAL STUDENTS COULD FILL WORKFORCE GAPS

The fundamental disconnect between medical training where the Commonwealth funds university places and state governments fund intern positions, is also a recipe for instability.

The rate of increase in the number of intern positions (state government) has been slower than the rate of increase in the number of domestic medical graduates (Commonwealth government). The number of PGY1 positions has grown 38.3% between 2005-09, but is still lagging behind both the 45% growth in domestic medical graduates and 50% growth in total medical graduates, over the same period. Internships are also sought by Australian Medical Council doctors.

To accommodate all 2,776 expected to graduate nationally in 2010, the country has needed around 400 additional intern places compared with 2009. A further 400 places will be needed in 2011.

INTERNATIONAL STUDENTS ECONOMIC BOOST

1. The Government commit to the expansion of internship positions to accommodate all domestic and international medical school graduates and thereby provide certainty for medical students.

2. The number of places for international medical students in universities be capped to allow state authorities to plan sufficient internships.

3. A new funding model be established. Options include:
   (i) to incorporate the recommendations from the National Health and Hospital Reform Commission which argued for reform of postgraduate training and for funding to follow the intern whether in public and private sectors.
   (ii) medical schools be directly funded to cover intern training and the schools determine rotations through hospital, clinics and centres, based on the learning opportunities they offer.

VIAS GRANTED TO MEDICAL PRACTITIONERS (MTRP 13TH REPORT)

<table>
<thead>
<tr>
<th>Visa class</th>
<th>2007-08</th>
<th>2008-09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total 422, 442, 457</td>
<td>4,930</td>
<td>4,080</td>
</tr>
</tbody>
</table>

VISA HOLDERS WHERE OCCUPATION IS MEDICAL PRACTITIONER (MTRP 13TH REPORT)

<table>
<thead>
<tr>
<th></th>
<th>30 June 2008</th>
<th>30 June 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>422</td>
<td>832</td>
<td>691</td>
</tr>
<tr>
<td>442</td>
<td>654</td>
<td>389</td>
</tr>
<tr>
<td>457</td>
<td>4,681</td>
<td>5,060</td>
</tr>
<tr>
<td>Total</td>
<td>6,167</td>
<td>6,140</td>
</tr>
</tbody>
</table>

Australian medical education is among the best in the world and students educated in the Australian system are:
- Clinically well trained
- Culturally aware
- Abreast of the latest medical advances at time of graduation
- Familiar with the Australian and State health systems
- Able and trained to participate in health care teams, and to be respectful of the roles of all health professionals
- Aware of contemporary ethical issues
- Aware of and understand safe medical practice

The average age at graduation from Sydney Medical School is 27 years, which offers significant productive capacity in years ahead.
Getting on with health reform

By Beth Quinlivan

It is just over a year since the National Health and Hospital Reform Commission handed down its third and final report, including 123 recommendations for change to Australia’s health system. As Chair of the Commission, Dr Christine Bennett lived and breathed health reform for 16 months. Now back in her role as Chief Medical Officer at Bupa Australia, she is hopeful that Julia Gillard’s new government will pick up the change baton. If the reform agenda fades, however, don’t expect her to sit quietly on the sidelines.

Dr Christine Bennett.

After more than 30 years working in the health system, across clinical and management roles, Christine Bennett is very passionate about health reform. “The health system as it is structured, financed and delivered is not sustainable. Problems are not going to go away, inequities will widen, waste and inefficiencies will continue,” she said. “Reform will have to happen.”

Established in early 2008, the NHHRC was one of the key initiatives of the newly elected Rudd government. After 16 months of work, including accepting more than a thousand submissions and direct discussions with hundreds of health professionals, managers, community groups and patients, the ten NHHRC commissioners signed off on a third and final report on 30 June 2009.

That Reports set out a reform agenda with three primary goals, based around four themes. Big ticket recommendations included for the Commonwealth to take all responsibility for primary health care, Dentalcare, plus initiatives on Indigenous, mental, and remote and rural health.

Twelve months after handing in the final document, and with government reform agenda overtaken by the election, Christine Bennett is hopeful that the next year will see the implementation pace pick up. But she is also watchful. There is no sign of action on some of the more expensive recommendations, including “Dentalcare”, but the National Health and Hospitals Network agreement, signed in April this year, has established the Commonwealth as the majority funder of public hospitals.

“The government was probably right to start with the new funding and governance arrangements for public hospitals. But while structural and governance changes are important, the NHHRC also made recommendations on prevention, primary care, health workforce, mental health, sub-acute care, aged care, indigenous health and e-health, to name just some areas.”

“My head is down now but it will be up if the reform flame dies. It is over to the government but it also up to us to keep the momentum going. We do need to get one with it,” she said.

A BACKGROUND FOR CHANGE

It’s hard to imagine someone with a better background for a job which brought together the eclectic cohort of NHHR commissioners, to undertake a wide ranging review of the health system.

Christine Bennett graduated MBBS from University of Sydney in 1979, completed her internship at Royal North Shore before training as a paediatrician.

She has held a number of senior positions in public sector management, including General Manager of the Royal Hospital for Women, and Chief Executive of Westmead Hospital. Before taking on her current position at Bupa, she was chief executive of Research Australia. She has held a number of directorships including Symbion Healthcare Ltd, and the Schizophrenia Research Institute.

“I was contacted in late 2007 to see if I was available so I had an inkling that I could be asked to join the Commission.” The opportunity was exciting and a chance to advocate for health in a broader context.

In early March she received the terms of reference, the budget and was introduced to the other commissioners. The first report was due just six weeks later.

THE COMMISSION

One of her most significant achievements as Chair, she believes, was that all commissioners signed off on all three reports.

Commissioners included medical and health academics (Professor Justin Beilby, Dr Stephen Duckett and Associate Professor Sabina Knight) two former politicians (The Hon Geoff Gallop and The Hon Rob Knowles), Professor Ron Penny, former AMA president Dr Mukesh Haikerval, and health policy specialists Mary Ann O’Loughlin and Dr Sharon Willcox.

“I do regard it as a huge achievement that ten people, all with strong opinions and none of them shrinking violets, were able to agree on each of the reports.”

“There were differences of opinion but they were eventually differences of emphasis rather than fundamental opposition. Where there were differences, it always came back to the question of ‘what is best for people and families?’”

The 16 months of the commission was also not an easy time for the group, with a number of personal disasters including the terrible bashing of Dr Haikerval.

“With something as big and complex as health reform, it was always going to end with a large number of recommendations for change, and with debate and controversy.

“We were all clear that we needed to include more than the regular stakeholders – we wanted to talk to patients, members of the community and all health workers.

“When we began to talk with people, their main issues of concern were not waiting times at emergency departments. They were ‘how do I get to see a GP?’ or ‘how do I find accommodation in aged care?’ Waiting lists and hospital beds have become the public currency for judging the performance of the health system, but individuals had very different measures.

“We all know that ‘health’ is about much more than ‘health care’. Health involves how we live life, the choices we make, the environment we live in, and many in the community were also of that view. Individually and collectively, we have to take greater responsibility for health, and make prevention a high priority.

“Reducing the pressure on public hospitals largely requires solutions outside the hospital system - strengthening and integrating primary care, providing more choices in aged care, and more sub-acute care capacity.

“Recognising and responding to inequities in health care is essential if we wish to have a health system which caters for all Australians. And we have to have the best leadership and systems available if we are to improve performance. We don’t use the information that we have already as effectively as we could. Personal controlled electronic health records, if done well, is game changing.”

“Change is needed and reform will come, I hope it is on its way now and that we take the first real steps to change. To delay will only cause us grief.”
“Being asked to chair the Commission was a once in a life-time opportunity to do something big about something you’re passionate about.”

Dr Bennett.
Sacs appeal: The fascination of lung function

By Norbert Berend and Stephen Leeder

The University of Sydney has an enviable international reputation for its comprehensive research program in respiratory function, disease, prevention and clinical care. Engineers, basic scientists, respiratory physicians and other clinicians and public health academics combine to lead cutting edge research.

I like how the morning’s rain, having weakened the soil’s raw materials, sends a root smell into the air around us,

I like my lungs and their conversions to the gospel of spring.

- from Robert Wrigley’s I like the Wind, The New Yorker, September 6, 2010

The lung could be arrested for public exposure. The surface area its air sacs present to the air is the same as the centre court at Wimbledon. Miraculously, this paper thin membrane is resilient and can function happily for decades even when assaulted by clouds of tobacco smoke. Well, not entirely happily: tobacco control is the single biggest preventive challenge in preserving lung health. Lifelong efforts of Simon Chapman and his colleagues in health promotion and advocacy research and application show up in Australia’s smoking rates now hovering around 17%, among the lowest in the world.

Shane Hearn and his Smokecheck team are also making gallant strides in reducing the prevalence of smoking in Australia’s indigenous communities. Smokecheck provides culturally appropriate resources and an effective training program, which has to date trained over 800 health workers who work with indigenous patients, aimed at closing the gap between indigenous and non-indigenous smoking rates.

In Australia, experts who measure the burden of disease by combining the amount of human suffering that a health problem causes together with the years of life lost from premature death, rank chronic lung disease as sixth top villain for men and seventh for women.

For men, ischaemic heart disease still takes first prize, as for women do anxiety and depression. And there are few things as potent as chronic lung disease to make you feel anxious and depressed, especially in the small hours.

In global terms, with the wretched tobacco industry tooling up to flog its wares now in developing nations, the toll of chronic lung disease is set to rise despite the WHO’s recently enacted first-ever international treaty having to do with tobacco control, the WHO Framework Convention on Tobacco Control (WHO FCTC). Not that tobacco, although major, is the only problem.

In the back blocks of the world heating and cooking are still fuelled with smokey biomass products such as cow pats used in poorly ventilated shanties and huts with antiquated stoves. New biomass fuel stoves are much better, but they cost money. So there are three billion people exposed to the acrid smoke that these fuels produce, accounting for two million deaths a year. These fuels also cause a 30% increase in acute respiratory infections in children less than three years of age.

In low income countries – most of Africa and parts of Asia – WHO reported for 2004 that chronic obstructive pulmonary disease (COPD) and tuberculosis each caused nearly a million deaths or 4% of all deaths each year, which, when combined exceed the number of deaths due to HIV.

It is true that HIV death usually comes earlier than death due to COPD but things are changing. HIV is becoming more of a chronic disease with the life-extension afforded by anti-retroviral treatment. In middle income economies from Albania and Angola to Venezuela and the Yemen via China and India – COPD accounts for 8% of deaths and tuberculosis for 2%, with heart disease and stroke dominating the death stakes. When combined with the figures from high income countries, 3 million deaths a year occur from COPD, that is, 5% of all deaths.

Now if you add deaths from lower respiratory infections (LRTIs), including pneumonia and bronchiolitis in children, the figure doubles. In fact, LRTI is the leading cause of global disease burden especially in the very young and in older people. With the population above 65 years set to double in the next 40 years, LRTI together with COPD will outstrip heart disease as a cause of death by 2020.

The Sydney Medical School (SMS) has had a long and distinguished interest in the lung in both health and disease. The epidemiology of asthma, the physiology of the lung, the cellular mechanisms leading to asthma and COPD, tuberculosis and the clinical management of lung disorders are among its areas of concentration.

Contemporary lung research excellence builds on the seminal contributions of giants in their fields, now deceased, whose names are celebrated in the establishment of a number of facilities across the SMS - the Ludwig Engel...
Centre of Respiratory Research at Westmead, the David Read Laboratories on the central campus and the Woolcock Institute of Medical Research in Glebe.

The late Professor Ann Woolcock spanned laboratory, clinic and community. She explored lung disease in Papua New Guinea with her husband Emeritus Professor Ruthven Blackburn who was interested additionally in liver disease. Indeed, Ann’s description in 1970 of chronic lung disease in the highlands of New Guinea was one of the first in the world including detailed lung function assessment and pathology. She speculated then that the condition may be related to prolonged exposure to wood smoke in the thatched huts and contributed to by lung infections during childhood. Her work highlighted the scourge of respiratory disease in developing countries: tuberculosis continues to be a major problem in the Asia Pacific region and in Africa. A team led by Warwick Britton from the Centenary and Guy Marks from the Woolcock Institutes have been working to improve the management of tuberculosis in Nepal and Vietnam and are now considering expanding their reach into China.

Ann Woolcock made major contributions to the management of asthma. It is such a treatable disease but the patterns of care have not always reached their full potential. Asthma management plans and the advent of inhaled steroids have had positive and lasting effects. Young deaths from asthma are now much reduced.

The SMS is also a leading world centre of research into sleep apnoea, not strictly a disorder of the lung but of the upper airway that collapses repeatedly during sleep. This collapse causes transient partial or total obstruction of breathing. Episodes of sleep apnoea cause tiredness and loss of cognitive function during the day and so contribute to motor vehicle and industrial accidents. Think Mt Everest and you get the picture of the low levels of oxygen that occur in sleep apnoea.

Snoring is the cause of innumerable jokes and marital annoyances. Now, snoring vibrations and possibly associated sleep apnoea are thought to cause abnormalities in the carotid arteries and may lead to stroke, according to John Wheatley’s research at Westmead, while Colin Sullivan, Ron Grunstein and others beaver away on sleep disorders at the Central Clinical School. Sullivan’s work on the development of devices to manage sleep apnoea – sleeping masks and so forth – has had global impact. And there is more.

Peter Cistulli’s group at Royal North Shore Hospital is testing jaw advancement splints to alleviate sleep apnoea. At the Woolcock Institute sleep researchers study cardiovascular, metabolic, hormonal and psychological aspects of sleep apnoea using an interdisciplinary approach with sleep physicians, psychologists, psychiatrists, ENT surgeons and dentists contributing to research and clinical management of complex sleep problems. The group has recently been enhanced by the recruitment of Peter Liu, an andrologist, to add strength to the endocrine/metabolic aspects of sleep research.

Beyond the world of sleep and very much in the waking world, a strong epidemiology team, led by Guy Marks at the Woolcock Institute has researched for decades the epidemiology of asthma – the most common chronic disease in childhood and COPD all over Australia and in PNG, Indonesia and India. The environment is critically important and studies include the effects of Sydney road tunnels and unflued gas heaters in schools on lung health. Trials of asthma prevention have not yet provided the answer as to how this scourge might be halted, so the work goes on.

At the Bernie Banton Centre at Concord Hospital the University of Sydney affiliated Asbestos Disease Research Institute (ADRI) is the world’s first, and largest, stand-alone research institute focusing solely on asbestos disease. Under the direction of Nico van Zandwijk the ADRI are conducting groundbreaking research to lessen the devastating health impact of asbestos, likely to peak over the next two decades. The ADRI have assembled an impressive tissue bank and are developing new treatments for mesothelioma drawing on their genetic research.

Environmental factors have, ultimately, to be translated into cellular and physiological events that are damaging to health and so the Cell Biology group under Judy Black and the Physiology and Imaging groups under Cheryl Salome and Greg King are investigating the mechanisms leading to airway obstruction in asthma and COPD.

Another terrible disease of childhood is cystic fibrosis. A team of researchers at Royal Prince Alfred Hospital led by Peter Bye seeks to find ways to clear the viscid mucus from the airways that is the hallmark of cystic fibrosis and bronchiectasis. Discoveries such as these now mean that children with cystic fibrosis are surviving well into adulthood.

Two major health issues in society, not confined to Australia, are the ageing of the population and the increase in obesity. Christine Jenkins and Helen Reddel at the Woolcock are addressing the needs of elderly patients with airways disease and are looking at factors leading to poor adherence with treatment, while Cheryl Salome is studying the impact of obesity on lung function.

The research activity at the SMS can also be exotic. Matthew Peter’s team at Concord Hospital has been studying free divers and how they pack large additional volumes of air into their lungs to enable them to hold their breath for so long. This is tricky physiology!

There is now great strength in respiratory and sleep research at all the teaching hospitals of the SMS and its associated research institutes. Much of it is led by students or disciples of the great people named above. For some of us it is hard to believe that when we commenced our medical education there was no Westmead Hospital!

The late John Read had a vision of a centre of medical excellence in western Sydney that he pursued with utmost vigour at great personal cost. He did not live to see his dream come true. He would likely be delighted and amazed at the achievements of the Westmead Clinical School and the Millennium and Children’s Medical Research Institutes. Being John Read, though, we both feel he would not have been lost for constructively critical comments – rather like Jørn Oberg Utzon with the Sydney Opera House – about how they might now be improved!

Tucked away out of sight, the lungs, despite their radius November 10  21
When the patient is a doctor

By Narelle Shadbolt

David (age 30) has just graduated with his FRACGP and has started working in a practice. When he was a medical student aged 22, he was learning to take the blood pressure and discovered that his BP was 180/100. He was alarmed by this and checked it many times. He went to his text books and the latest online evidence and decided that the best treatment would be an ACEI. As fortune would have it, the local drug rep was at the hospital the next week and he was able to get a supply of perinopril. This worked to reduce the BP and it has been relatively easy for him to get supplies of the drug either by writing himself a script, asking a more senior doctor for a script when he was a student, or stocking up at drug company lunches. He has never had any investigations.

This is not an uncommon situation for doctors. Self diagnosis, self treatment and self referral are the usual. Sometimes this results in the worst medical care. Research in the area of doctors health care behavior tells us that some doctors are uncomfortable with the concept of being ill – ‘Illness doesn’t belong to us, it belongs to them, the patients’ – and therefore carry on working when they are not fit to do so and well beyond the point that they would recommend their patients stay off work.1-3

FITNESS TO PRACTISE

Regulators (Medical Boards and Councils) around the world, increasingly operate within a fitness to practise framework, where practitioners (and students) are required to be:
- fit for purpose – able to do their job based on experience, knowledge, professional development and supervision
- able to demonstrate personal fitness including mental health
- able to demonstrate professionalism – ethics, behaviour and attitudes

In this fitness to practise model, it is clear that doctors have responsibility to be both medically and psychologically fit to do their job. This includes appropriate management of illness, fatigue, stress, anxiety and depression, all of which have been demonstrated to negatively affect patient care.

THE NEW AMC GUIDELINES FOR GOOD MEDICAL PRACTICE GIVE CLEAR GUIDANCE:

As a doctor it is important for you to maintain your own health and wellbeing. This includes seeking an appropriate work-life balance

Good medical practice involves:
- Having a general practitioner
- Seeking independent, objective advice when you need medical care, and being aware of the risks of self-diagnosis and treatment
- Making sure you are immunized against relevant communicable diseases
- Conforming to the legislation in your state or territory in relation to self-prescribing
- Recognising the impact of fatigue on your health and your ability to care for patients and endeavoring to work safe hours wherever possible
- Being aware of the doctor’s health program in your state or territory
- If you know or suspect that you have a health condition or impairment that could adversely affect your judgment, performance or your patient’s health
- Not relying on your own assessment of the risk you pose to patients
- Consulting you doctor whether and in what ways you may need to modify your practice and following the doctors advice

Doctors have a responsibility to assist medical colleagues to maintain good health.

Good medical practice involves:
- Providing doctors who are your patients with the same quality of care you would provide to other patients

As a group medical practitioners around the world demonstrate poor health statistics particularly in the area of psychological illness and addiction. This may in large part reflect the difficulty doctors have in managing and prioritizing their own health.

We have to ask why doctors find it so hard to be a patient?

DOCTORS AND ILLNESS

We actually have very little information about the management of illness in doctors. There have been no prevalence studies of chronic illness in doctors and we know very little about the true rates of mental illness or outcomes. Nor do we have evidence about how this affects practice. In a small review of doctor-patients in a psychiatric practice, 82% had a chronic mental illness, 30% of those had a concomitant chronic physical illness but only 5% had ever taken any time off work related to those illnesses.4 This supports anecdotal reports that doctors ‘soldier on’.

Many doctors will anonymously admit to having suffered from a condition they would like to have discussed with a doctor but didn’t do so because they were a doctor.5 Doctors who have been ill report that because they were doctors, they weren’t given adequate information, follow-up or psychological support.6 Doctors have concerns about confidentiality, embarrassment, how to behave in the consultation and lack of confidence in the treating doctor.

DOCTORS AS PATIENTS

Undeniably, it is a unique therapeutic situation when the

patient is a doctor. Doctors are different from other patients and yet they are patients none the less. In the usual medical model and the one in which we feel most comfortable, the doctor is healthy, knowledgeable and trained; the patient is unwell, naïve and untrained. When the patient is a doctor both sides of the equation may have changed.

When the patient is a doctor, they may have expertise and strengths beyond that of the treating doctor. They may also have limitations that make them feel uncomfortable. Both may feel self conscious and insecure, fearing criticism and exposure of areas of weakness. This very special patient has selected the treating doctor which is flattering but may increase pressure. Doctors can act to over or under compensate for this.

UNDERSTANDING SOME THINGS ABOUT DOCTORS
Doctors tend to be conscientious and perfectionists. They like to be in control. So in the patient role, they may feel exaggerated responsibility and guilt. They want to be the ‘best patient’, just as they want to be the ‘best doctor’. This can result in heightened disappointment and guilt if things don’t go well, and the non-disclosure of symptoms or worsening signs.

Doctors often delay seeking treatment, not wanting to appear as if they are over-reacting. They may be worried about a wrong self-diagnosis and have commenced investigating and treating themselves. They may not disclose this. In wanting to be ‘good’ patients, they may down-play symptoms so as not to ‘bother’ their colleagues. They also tend to prioritise their own health well below that of other factors and ignore signs and symptoms that would bring others to seek medical help.

PRACTISING WHAT I PREACH
An interesting recent study reports that doctors differentiated between themselves and patients in terms of treatment. Doctors may treat themselves in ways that would be regarded as inappropriate from a medical perspective. Doctors were more likely to take a multi-vitamin for tiredness than they were to recommend that to a patient. In terms of stigmatized problems like depression, doctors were less likely to accept the patient role, preferring not to engage in counseling, exercise prescription or medication but adopt the ‘soldiering on’ approach.6

When a doctor finally takes the step of seeking medical advice it is often well down the track from other patients. They may present in crisis. So, as much as doctors should be treated as any other patient, in this regard there may be some urgency to make an assessment. The treating doctor cannot make assumptions about what the doctor patient will or won’t disclose. The thought process goes something like – ‘I don’t need to ask them about that symptom because of course they will have reported that’; countered by ‘I’m really embarrassed that I haven’t presented with this symptom, so I wont say anything and see how it goes.’ Assessment needs to be thorough and inclusive.

CONFIDENTIALITY
This is a very important issue and is the biggest barrier to doctors seeking professional help. It is worth discussing what will happen in social and medical education situations. However, just as for any other patient if their safety or that of their family or patients is at risk appropriate steps need to be taken. radius

SOME RULES FOR BEING A PATIENT
• Find a doctor you feel comfortable with and confident in and who can be objective – this is unlikely to be a family member or practice colleague
• Establish the relationship when you are well – go for a check up
• Let the doctor know you are a doctor but that you want to be treated like any other patient and then…
• Let yourself be treated like any other patient
• Apply the same rules to yourself and your family – don’t self prescribe or organize your own investigations
• Prioritise your own health

PROVIDING GOOD MEDICAL CARE TO DOCTORS
• See doctor-patients quickly
• Talk about confidentiality
• Be very thorough in assessment and investigation
• Don’t make any assumptions
• Make it easy for them to be in the patient role
Stretching stem cells to greater heights

A major challenge in regenerative medicine is growing enough stem cells outside of the body to transplant into patients. To help overcome this hurdle, recent research published in *Nature Biotechnology* has uncovered a novel way to stretch stem cell growth to greater levels. Professor John Rasko and Dr Jeff Holst from the Centenary Institute and Professor Tony Weiss from Molecular Bioscience at the University of Sydney discuss their findings.

When our research team investigated the effects of a new super-thin, springy material called tropoelastin on growing haemopoietic or blood-forming stem cells outside of the body, we found it had the power to boost the numbers significantly.

The findings from the research published in the premier biotechnology journal *Nature Biotechnology* in October received widespread media coverage in newspapers, radio, TV and online news. Journalists were intrigued by the research, conducted at the Centenary Institute, Royal Prince Alfred Hospital and the University of Sydney, which found this stretchy substance could produce a ‘super effect’ in the creation of stem cells. But of most interest was the potential for these findings to improve the outcomes of stem cell transplants and gene therapy.

**RECREATING A HOME AWAY FROM HOME**

Haemopoietic stem cells (HSCs) or blood-forming stem cells play a critical role in creating the blood cells in our body. In order to expand the number of these cells, researchers have attempted to reproduce the unique environment where stem cells live inside the body – the so-called ‘stem cell niche’. In the past we have learnt how to use hormones and drugs to influence these microenvironments but less is known about the effect of physical forces.

What we have demonstrated – for the first time – is that the physical forces created by elasticity play a key role in the growth of blood-forming cells because it may mimic the environment where the stem cells reside inside our body. We’ve discovered that blood-forming stem cells like it to be super stretchy because, like a cat on a sofa, they like to pull on their environment and it seems to be this ‘pulling’ force that is encouraging the stem cell growth.

We relied on a version of tropoelastin that was developed in the Weiss lab in our research. We then combined routinely-used cell hormones with tropoelastin to coat the plates on which the stem cells were grown. We found when we grew the stem cells – both murine and
human – on the tropoelastin only plates we could create the same amount as the current hormone-based methods. But the combination of the two produced a super effect and we found we could create up to three times as many stem cells than using standard methods on their own. Our colleagues at the University of NSW and the University of Texas Medical Branch at Galveston performed atomic force microscopy and physical measures to determine the viscoelastic properties of tropoelastin.

**IMPROVE STEM CELL TRANSPLANTS**

These findings could be good news for the 1100 Australians who receive life-saving stem cell transplants (bone marrow and cord blood transplants) each year to treat diseased, damaged or faulty stem cells caused by various conditions or treatments such as leukaemia or chemotherapy.

By increasing the number of stem cells we can grow outside of the body we could effectively use less bone marrow or cord blood to get the same result or use the same amount to get a much better result. For example, the small quantity of blood obtained in a cord blood donation often makes it suitable for small children only. Two cord blood donations are usually required to achieve safe transplants in older children or adults. However, in the future, we could use the blood from just one umbilical cord and then increase the number of stem cells to a viable level outside of the body before transplanting these life-saving cells into adult patients.

**BUYING TIME FOR GENE THERAPY**

Gene therapy could also benefit from these findings. Gene therapy performed on blood-forming stem cells ex vivo may be important for the cure of many hereditary diseases in the future. However, those attempting ex vivo gene therapy have had to race against time to introduce therapeutic genes outside of the body as they usually only have just a few days before attrition reduces the number of stem cells to the critical level required for a successful transplant.

By increasing the number of stem cells we can grow outside of the body we effectively increase the time we have to modify genes outside the body to correct serious genetic diseases, such as sickle cell disease and thalassemia, which affect millions of people worldwide.

**FUTURE WORK**

Our team is now looking to trial the technique in humans but we estimate it will be five to ten years before the method could be used to treat patients.

In both haemopoietic stem cells (HSCs) and mesenchymal progenitors we are working to optimise gene transfer using retroviral and adeno-associated vectors.

**UPDATE ON GENE THERAPY**

One of the major challenges for researchers working in the field of gene therapy is overcoming the skepticism and reputation held by other researchers and the general public. This view is a result of the initial hype surrounding early gene therapy trials that did not live up to its promise due to technical difficulties, setbacks, serious side effects and, sadly, deaths in young trial participants.

Thankfully, a number of recent clinical successes in gene therapy have demonstrated, without much fanfare, its potential as a safe and effective treatment for many serious inherited diseases. For example, Maguire and colleagues observed clinical improvements in 12 patients with a congenital blindness who received gene therapy. There were no safety concerns identified in a two-year follow up. This success, seen in smaller clinical trials as well, means that gene therapy is beginning to fulfil its original promise as a safe and effective treatment for many serious inherited diseases.
This is the title of a report published last year by the UK Department of Health. The proportion of women medical students has been increasing steadily over many years, but seems to have stabilised. Women now make up 58% of medical students in the UK. Most of these women will want to have children and, because the burden of childcare falls disproportionately on mothers, they will want to work part-time for at least part of their careers. Workforce structure and planning will have to adapt to the changing demographics. Women do not enter all the specialties equally, and currently are not well represented at the top of the profession. These are the issues I plan to discuss.

As far back as 1988, Professor Isobel Allen was commissioned by the Department of Health to assess the implications of the fact that women would soon account for half of medical graduates 1,2. The male doctors in her study were very sympathetic on the whole to the career problems of women doctors – perhaps not least because so many were married to them (current figure 40%).

Since 2007 several excellent reports have been published about women in medicine – two reports on Women in Academic Medicine in 2007 3 and 2008 4, the MWF report ‘Making Part-time Work’ in 2008 5, and in 2009, the Royal College of Physicians’ (RCP) report ‘Women in Medicine: the Future’ 6 and the CMO report ‘Women Doctors: Making a Difference’ 7.

SOME KEY POINTS FROM THESE REPORTS
• The proportion of women entering medical school has increased from 24% in 1960/61 to 57% of the total in 2008/9. It appears to be levelling off at 58-60%. Women are not taking over - they are catching up.
• Women are not moving into all the specialties in proportion to their numbers. Fewer women go into academic medicine. It is interesting that Paediatrics with its substantial on-call and out-of-hours commitment – things that women are supposed to shun – is one of the leading specialties for women (44% of consultants). Women are moving in increasing numbers into acute specialties like Obstetrics and Gynaecology (33% of consultants) and Emergency Medicine (23% of consultants). Surgery remains a male preserve, with only 8% of consultants being female, but the number is increasing.
  • There is no evidence to support the idea that some specialties are more suited to ‘male’ or ‘female’ attributes. It is nevertheless true that some specialties attract proportionately more men than women, and others more women than men. Is this career choice dictated by prejudice, incompatibility with family life or gender-based differences in personality or preferences? It matters only if prejudice is playing a role.
  • Female consultants make up 28% of the consultant workforce, while 55% of ST1 doctors (first year of specialty training) are women (62% in general practice, 72% in paediatrics and 27% in surgery). As the pool of older women grows, so too will the proportion of women in the more senior grades.
  • Many women have chosen to move into General Practice in the last ten years. There are currently far more women GP Registrars than men. However, with the current system of remuneration, opportunities for partnerships have dwindled, and there is a risk that general practice will become a salaried service staffed by a largely female medical workforce and run by entrepreneurial GPs and private companies.

WORKFORCE ISSUES
The main recommendations of the reports relate to Workforce Needs and Workforce Planning. Across the NHS, 43% of women doctors are under 35, and this percentage is increasing. Many of these women will want to work part-time while their children are young. More doctors will be needed to cover the full-time equivalents required.
LEADERSHIP AND MENTORING
Currently, although women are well represented at consultant level, they are less likely than men to reach leadership positions, such as presidents of the medical royal colleges or deans of medical schools. Only 13% of professors in the UK’s medical schools are women compared with 36% of clinical lecturers. Most of the men holding these leadership positions are over 55, and were trained at a time when women doctors were a small minority. There is evidence that women are less likely to stand for election. However, they will often put themselves forward for such positions if actively encouraged to do so. Not only do holders of these positions help to define the future policy and direction of medicine, but they are powerful role models for young women in medicine.

PARENTHOOD AND MEDICINE
Studies on work-life balance have usually focused on women. The Fathers, Family and Work Report published by the Equality and Human Rights Commission in October last year (8) attempts to redress this emphasis on women, looking at men’s attitudes to work and family life, and finding fathers equally under pressure. The UK Deputy Prime Minister, Nick Clegg, said he empathised with the portrait of men battling to reconcile professional and family commitments. ‘It looks like ideas on how to ‘have it all’ are finally no longer confined to the pages of women’s magazines,’ he said.

It is essential to look at ways to facilitate career development for doctor mothers, optimise childcare, and make rotas and hospital placements family-friendly, never forgetting that women doctors always have to pull their weight, and remembering also that fathers have a role to play.

LIFELONG LEARNING IS ESSENTIAL FOR HEALTH PROFESSIONALS

Sydney Medical School has postgraduate and short professional courses for medical practitioners and others who work to improve health outcomes in this and wider communities. Our courses provide skills and knowledge professionals need in a time of unprecedented change.

Information and contact details for all courses are available on sydney.edu.au/medicine

THINKING OF FURTHER STUDY?

Shining stars. Bright minds.

Through the Elite Athlete Program, Sydney Uni Sport & Fitness supports the University’s top performing student-athletes in concurrently achieving their dreams both on the sporting field and in the classroom.

Support us in fostering the next Sydney Uni Wallaby, Olympian or world champion, by making a tax-deductible donation to the University of Sydney Sport Foundation. Whether it’s a small gift or a naming rights scholarship, your contribution is greatly appreciated and does make a difference.

For details call or visit us online today.

Sydney Uni
SPORT & FITNESS

+61 2 9351 7958
www.susf.com.au
PROGRESS AND REFLECTION

As a member of the first cohort to go through the medical school’s revised clinical curriculum, I was one of the first to experience a mix of core and specialist rotations over the two years of the new stage 3. The new curriculum was introduced to replace old stage 3 and stage 4 split of hospital-based core rotations and specialist placements in response to student feedback on losing hospital skills prior to the intern year.

The change has come with added learning activities, assessment tasks and forms to sign and has dramatically increased the workload of students compared to those who completed their studies in 2009. This is not necessarily a bad thing, but has left students with much less free time for extracurricular activities and has made it difficult to find people willing to take on certain responsibilities. Our yearbook, which traditionally demands a considerable time commitment, has gotten off to a slow start this year but we expect momentum to build now that our barrier exam is behind us.

CONSTITUTIONAL REVIEW

Alumni of the medical school may be interested to note that the Medical Society recently adopted a modified version of the University of Sydney Union model constitution for clubs and societies. As a result of this change, we now have a clearly defined executive comprised of a President, Vice President (Education), Vice President (Social), Treasurer and Secretary. The previous Vice President positions reserved for two third and two fourth year students have been reclassified as year representative positions. An anomaly requiring Senate approval to modify our constitution was addressed to direct changes through the clubs and societies office, as is done for other faculty societies. Finally, eligibility for ordinary membership of the Society was amended to medical students currently enrolled in the four-year Sydney Medical Program.

THE END OF AN ERA

Another major development in recent months has been the apparent sudden collapse of the Medical Society Bookshop. The Bookshop has been a much-loved institution since its inception in 1949 by Mrs Sheila Nicholas OAM, who was the driving force behind the business until her passing in 2004 at the age of 89. Following the appointment of our most recent General Manager earlier this year, significant financial problems within the business became evident and the board of directors resolved to place the co-operative into voluntary administration, which is where we find ourselves today.

A number of factors contributed to this situation. Fierce competition from online booksellers overseas and a strong Australian dollar made it impossible for the Bookshop to compete on price. The expansion of e-books through the library website reduced the need for students to buy their own books, while the increasing availability and circulation of pirate electronic books took business away from retail outlets. Ultimately, the Bookshop could no longer rely on the business of the students it was created to serve.

INTERNSHIPS

The other major issue occupying our time recently has been the short supply of internships for medical graduates. Our international students have had a very difficult time finding intern placements for 2011 and although it seems that everyone will be accommodated this year, next year’s graduating cohort is unlikely to be as fortunate unless there are some drastic changes. We have been successful in raising this issue, with mentions in the Sydney Morning Herald, ABC Radio and MJA InSight, and will continue to advocate for a positive change to the current system.

HANDOVER

I am amazed at how quickly this year has flown past. Soon we will have our executive elections and a new leadership team within the Society. There is no doubt that this has been a challenging year, but I am incredibly grateful for the experience and the privilege of leading Australia’s oldest medical society. There is a great depth of talent in the program and I am confident that whoever leads the Society will do a great job of representing medical students at the University of Sydney.
Sydney Medical School Foundation’s new scholarship committee, chaired by Ms Louise Sylvan, is seeking to expand the number and range of scholarships available to students. The Foundation has nominated several priority areas: research scholarships which top up the income students receive through government or other programs; scholarships which provide researchers and medical students with the opportunity to gain international experience; and scholarships for post-doctoral fellows seeking to establish their career.

**SCHOLARSHIPS PROVIDE OPPORTUNITIES**

**AM Taylor Scholarship in Orthopaedic and Traumatic Surgery**
The AM Taylor Scholarship was established by the estate of the late Beatrice Mary Taylor in 2008 to enable medical students to undertake an elective term in orthopaedic and traumatic surgery. Since establishment, 14 students have received the scholarship for elective terms in Australia, Canada, Israel, New Zealand, Papua New Guinea, South Africa, Spain and the UK.

John Morellato, Stage 3, completed his elective in South Africa and Canada. My first elective was in trauma surgery at Chris Hani Baragwanath hospital in Johannesburg. “Bara” as it is colloquially known, is one of the world’s largest hospitals with 3400 beds and has been the training ground for some of the world’s foremost trauma surgeons. The sheer volume of interpersonal violence and road traffic accidents make this a place like no other. We were lucky enough to see the opening of the new state-of-the art trauma department which included an 8 bed resuscitation bay. The hands-on experience with critically injured patients was one that is unique to Bara. This was exemplified on New Year’s Eve when over 50 critically injured triage category 1 patients came through the doors in 24 hours.

**SUMMER RESEARCH SCHOLARSHIPS**
The Summer Research Scholarships are an opportunity for undergraduate students to obtain research experience. Sydney Medical School offers 60 scholarships and projects are undertaken over a period of eight weeks under the supervision of some of the School’s leading researchers. The Dean’s Prize was introduced in 2007 to showcase the high quality projects by scholarship holders.

Stephen and Barbara Penfold donated $25,000 towards the 2009 scholarships, supporting students undertaking projects at the Westmead Campus.

Candy Pang was awarded equal second place for the 2010 Dean’s Prize for her project *An analysis of Australian public media (newspapers and television news stories) on HPV vaccination*. She completed her project under the supervision of Dr Spring Cooper and Dr Julie Leask at the National Centre for Immunisation Research & Surveillance at the Children’s Hospital at Westmead.

I completed a research project into media’s influence on uptake of Cervical Cancer Vaccine. I had never taken my science research skills beyond the classroom previously so I was really eager and excited for this opportunity to work alongside senior researchers.

This project involved collaborating with my supervisors, in designing research strategy then collecting and collating data. When data gathering was completed, we would analyse and draw conclusions. I then partnered with my supervisors in writing an article for publication.

At the end of this project I presented my findings to sponsors, fellow hospital academics and the Dean’s Prize Panel. This project has been very fruitful and rewarding!
As President of the Medical Alumni Association, I was recently invited to address the graduating year of the Sydney Medical Program. The group came together from all five clinical schools to participate in their final conference week prior to the commencement of the PRINT term (when they are allocated to clinical units and spend time orienting themselves by beginning to carry out very basic duties), and then their intern year. It was a great privilege to speak to our newest alumni; to congratulate the Final Year on their achievements over the four years and to wish them all the very best for their future medical careers.

For the address I reflected on the very different path that our modern graduate takes in comparison to those of us who graduated many years ago. These graduates are more mature, with a prior degree and bring a range of alternate talents to the medical course. They are mostly starting their professional life in debt. However, I imagine that their fears and anxieties about starting their first placement in a hospital are similar to all those who have gone before. The other speakers at Conference Week were well chosen to provide excellent advice on conflict resolution, professional boundaries, managing adverse events, and the range of professional opportunities ahead. They will certainly be well prepared for their new role.

I reminded the newest alumni of the great tradition of medical graduates from Sydney University. There have now been around 24,000 graduates since the foundation of the faculty in 1856, and the opening of the medical school in 1883. From the earliest years, medical graduates have made important contributions in all fields of medicine, many very prominent on the world stage. A few examples that come to mind are Norman Gregg (1915), Gustav Nossal (1953) and Graeme Clark (1958). Some alumni have achieved prominence in other fields, particularly in public life. Her Excellency, the Governor of New South Wales, Professor Marie Bashir is one of our alumni. Some have achieved significant political fame. Earle Page, who graduated in 1901, holds the record as being the shortest serving Prime Minister; for a period 20 days in 1939. Dr Peter Baume (1959) was a Senator for NSW in Federal Parliament before taking up the position as Chancellor of ANU, while a currently serving politician is Robert Brown (1968), the leader of the Greens Party in Federal Parliament. Bob Brown is a Sydney alumnus.

Who knows who will emerge from the class of 2011?

Next year there will be another incoming group of new students and once more there will be a call on our alumni to provide the mentoring support; to consider financial support for the various scholarships on which many students rely and to continue to provide the excellent clinical teaching that has been such an important part of the medical school.
Sydney Medical School alumus Dr Malcolm Stening OAM (MBBS 1935) has just completed his second book *Doctors at War*, aged 98 years old. His book describes daily life in pre-WWII London and pays homage to his year at sea during WWII with the Royal Navy (during which time he survived the Battle of the Coral Sea). Whilst he pays tribute to the battles, the victories and the loss of good men and women in that war, Malcolm Stening tells another side of the story – how WWII changed the practices of medicine so we now live longer lives.

By Lise Mellor, who spoke with Dr Stening at the RSL nursing home in Narrabeen.

Dr Malcolm Stening was one of 45 medical graduates from the ‘Class of 35’ who served in the Armed Forces of Australia and Britain. In *Doctors at War*, he “attempts to recount the narrative of World War II in its entirety through the European and Pacific theatres of war with clarity, densely interwoven and embroidered by the experiences of members of the ‘Class of 35’”. The story, he says, is told primarily for the benefit of the Australian people who were more distant and unaware of the realities of war than those living in the climate of the European theatre of war due to a legal suppression of information in 1942. This material would be sufficient for the book alone, but Dr Stening uses these stories of war as his starting point to exemplify how that war changed medical practice and escalated the advances in medicine so that we have benefited from an “exponential escalation of the age of life expectancy.”

With the discovery of penicillin, the use of the first computer (the Enigma Machine), the development of nuclear physics and more, war enabled the rise of disparate medical and scientific fields to our post-war benefit. In *Doctors at War*, Dr Stening presents this information alongside his own account so that at each stage of his journey we are invited into the world of his daily life and the lives of other fellow graduates from the ‘Class of 35’.

The tranquil surrounds of his home in Narrabeen and his friendship with Stan – a tad younger and a tad more computer literate – have provided the mix of time, friendship and collaboration needed to complete such a monumental book project. Dr Stening’s age has provided more than just time on his hands to write; his wealth of knowledge spans through decades of medical change. He commenced practicing in the era before the discovery of penicillin. He is visibly moved when he describes how, in his third year of residency, he went to the Royal College of Surgeons of England. There, he says, he found a changing population of postgraduate young men studying Medicine, Law, Economics, Literature and Engineering. Although the possibility of war was in the air, the mood was high as these young postgraduate students found themselves amidst an era of thriving culture and live entertainment. In his words:

In the glorious summer of 1939, entertainment in London, whether on stage or over the radio, was at its zenith. Although television and cinema with the perfection of colour and sound were not part of the scene, variety entertainment or Revue, which consisted of music hall sketches interspersed with comedy, song and dance showing in the daily sessions of 5pm to 7.30pm and 8pm to 10.30pm was the prevailing mode of entertainment. The contributions to the pre-war era of pleasure were comedians, actors and actresses, novelists, singers, composers, playwrights, dancers, choreographers and band and orchestra leaders.

The tranquil surrounds of his home in Narrabeen and his friendship with Stan – a tad younger and a tad more computer literate – have provided the mix of time, friendship and collaboration needed to complete such a monumental book project. Dr Stening’s age has provided more than just time on his hands to write; his wealth of knowledge spans through decades of medical change. He commenced practicing in the era before the discovery of penicillin. He is visibly moved when he describes how, in his third year of residency, he went to the Royal College of Surgeons of England. There, he says, he found a changing population of postgraduate young men studying Medicine, Law, Economics, Literature and Engineering. Although the possibility of war was in the air, the mood was high as these young postgraduate students found themselves amidst an era of thriving culture and live entertainment. In his words:

In the glorious summer of 1939, entertainment in London, whether on stage or over the radio, was at its zenith. Although television and cinema with the perfection of colour and sound were not part of the scene, variety entertainment or Revue, which consisted of music hall sketches interspersed with comedy, song and dance showing in the daily sessions of 5pm to 7.30pm and 8pm to 10.30pm was the prevailing mode of entertainment. The contributions to the pre-war era of pleasure were comedians, actors and actresses, novelists, singers, composers, playwrights, dancers, choreographers and band and orchestra leaders.
The ebullient Leslie Henson and his straight man, Fred Emney, would come down to the audience and banter in the aisles, the diminutive Arthur Askey, ‘Playmates, I’ll tell you what I’ll do’, Cyril Fletcher, ‘Funny Fishes Eels’, the vulgarity of Max Miller and ‘Stinker’ Murdoch, the Yiddish humour of Vic Oliver, who married Winston Churchill’s daughter Sarah in 1939, the repartee, clowning and melodious singing of ‘Bud’ Flanagan and Chesney Allen, ‘Underneath The Arches Dreaming Dreams Of You’, the Liverpudlian George Formby, ‘It’s Turned Out Nice Again’, strumming on his ukulele rendering ‘I’m Forever Cleaning Windows’, the cabaret singing of Leslie Hutchinson, ‘Hutch’, sitting at the piano for his own accompaniment resplendent in white tie and tails; the versatility of Jack Buchanan in dance and song; the partnership of Jack Hulbert and Cicely Courtneidge in burlesque, in fact.

Malcolm Stening achieved his Primary Examinations in April 1939 and was prepared to sit his Final Examinations in November of the same year. At the declaration of war on April 1939 and was prepared to sit his Final Examinations in November of the same year. At the time of my arrival the beds were mostly vacant as there was a lapse of war activity... This was the time when the British Expeditionary Force had been in France on the Belgian border for six months and had not so much as seen the enemy. My duty was to study aircraft recognition and the manual received my full attention.

Gloom was in the wardroom late one afternoon and he was savouring his glass of sherry wine when through the window a squadron of heavy bombers were seen approaching from the horizon towards the hospital. Gloom questioned: “Stening, what are those bombers coming this way?” and my confident reply was “Wellington bombers, Sir.” At that very moment everyone in the wardroom was knocked off their feet as the Dornier 17 bombers unloaded their bombs at a low level on two trains, one up and one down to Plymouth, stationary at the platform of the station. From the floor came Gloom’s understatement: “I think you should brush up on your aircraft recognition, Stening.”

The war escalated and life became more serious. In response to a question about how he felt about the change from the life of London in the late 1930s to the terrible rupture of war, he surprises.

“I enjoyed it. I was a young man and I sailed every ocean from top to bottom; I sailed the Atlantic from the Arctic to the bottom. I sailed the Pacific from bottom to top. I have no doubt that seeing the world by sea is an experience that very few people have.”

This is a book by a man who, having seen the carnage of life through inadequate medical knowledge in the first part of this century, is well placed to understand the manner in which WWII, despite its human toll, made lives better. His story is well worth reading not only for its invitation into a distant milieu but also for the balance of information we are offered as readers.

Frankly, there are not many among us who will have the capacity to recall and reflect upon our lives at 98 and Doctors At War is a credit to Dr Stening, his family and his friendship with Stan. Dr Stening is still investigating publishing and printing options but readers who wish to acquire a copy of his book, please feel free to contact this author, Dr Lise Mellor by email lise.mellor@sydney.edu.au for assistance. radius
case notes

1960s
David Gibb
MBBS 1964

BRUCE CLIFTON - TUTOR EXTRAORDINAIRE
Our tutorial group at the Royal Prince Alfred Hospital in 1962 was extremely fortunate to be instructed by that anaesthetist/physician, enthusiast, wit, general good fellow and hospital personality Bruce Clifton. His tutorials, which were both outstanding and hilarious, were offered to us by him voluntarily, and were in addition to the normal medical school classes provided for fifth and sixth year students. When we asked him how we could reward his generosity he said “I only want a photograph of your group just before you sit for your final examinations”. The accompanying photograph, commissioned by grateful students, is what we sent to him on that occasion.

Back row: George Bautovich, Paul Roy, Richard Benn, Robert Ouvrier
Front row: David Gibb, Christopher Magarey, Philip Clifton-Bligh, Michael Marsh

1970s
Michael Ferres
MBBS 1975

I am a 1975 medical graduate of Sydney University and for some years I have been working part time at Tinsley Hospital on the Baiyer River in the Western Highlands of Papua New Guinea. The area is beautiful, fertile, almost an Eden-like valley surrounded by mountains. It is only sixty years since the first Christian missionary, an army chaplain who had been in the country during the Second World War, started work there.

Tinsley Hospital is a well-equipped but currently under-used facility. There are general wards, labour and maternity wards, an operating theatre with good sterilizing and anaesthetic equipment, and pathology lab and X-ray machine and dark room. A lot of isn’t being used, partly because often there is no doctor, but also because of problems of tribal fighting. There is a lot of excellent, unused accommodation, including internet access and good mobile phone coverage.

Although there has been some fighting in this area in recent times, the local people are beautiful – very welcoming and appreciative of whatever help we offer. They are very industrious, fruit and vegetables grow everywhere, and there are large coffee plantations.

There remains a culture of compensation, which in practice means that people have sometimes literally got away with murder. One man cut off his wife’s hand with an axe. Another murdered his wife. In both cases the problems were “solved” when the extended family of the perpetrator husband paid a large amount to the tribal family of the victim, and then both groups spent the money on a feast.

The Baptist Union of PNG manages most health facilities in that part of the country. Tinsley Hospital offers a great opportunity to practice interesting medicine. Those who can operate, and want to, could do almost anything there, and their work would be greatly appreciated. But one certainly doesn’t have to be a surgeon. Surgical and other specialist back up is only an hour and a quarter’s ambulance drive away at Mt Hagen hospital. Most cases we see are fevers (presumed malaria), chest infections, children with pneumonia and diarrhea, and possible TB. On average there is a delivery a day. The nurses seem to manage these on their own.

We are seeking doctors who may be able to spend some time – short or long – at Tinsley as part of a rotating roster, which could then provide a continuing medical presence. If interested, contact M. Ferres: serref5@bigpond.com.
Edwin (David) McIntosh
MBBS 1976
I obtained my AMusA in organ at high school in Sydney, then studied organ under Norman Johnston, the then University of Sydney Organist, whilst I was studying Medicine in the 1970s. I also met the late Dr Vincent Sheppard another University of Sydney medical graduate who was also an organist. On his death, I inherited Margaretta Cottage, an historic building in Glebe dating from the 1830s, along with a collection of keyboard instruments including an 18th Century Dutch chamber organ. When I was a trainee paediatrician at the Children’s Hospital Camperdown, Dr John Yu the Medical Director facilitated the formation of a small orchestra made up of trainees and staff. We played regularly at Margaretta Cottage in the 1980s.

These events were transformed into the Glebe Music Festival which I founded in 1990. Close partnership with the Sydney Conservatorium of Music, the Glebe Society and a host of local, and international, musicians has sustained the Festival, now in its 21st year:

www.glebemusicfestival.com

I live in London (where I have a Clementi 1809 forte piano) and Amsterdam (where I have an Erard 1859 bi-cord grand piano) but make frequent visits to Sydney and return each year to oversee the Annual glebe Music Festival.

21st Annual Glebe Music Festival 28th October - 28th November 2010. See www.glebemusicfestival.com for details or phone 02 9416 6136.

Michael Wilson
MBBS 1985

After graduating I completed my FRACS in general and cardiothoracic surgery at Royal Prince Alfred Hospital. In 1996 I held a Fellowship in Transplantation surgery at Stanford University before spending a year at Toronto General Hospital with a general cardiac surgery fellowship. From 1998 to 2004 I was Cardiothoracic and Transplant surgeon at St Vincent’s Hospital and 2005 to 2009 Cardiothoracic surgeon at Royal Prince Alfred Hospital.

Over this time I have had a diverse interest in most aspects of cardiothoracic surgery from ischaemic heart disease, including heart failure requiring SVR MV repair CAGS and CRT therapies, to aortic and valvular heart disease with recent experience in transcatheater aortic valves and minimally invasive mitral surgery.

My experience in a transplant unit nurtured interests in basic research in myocardial preservation and clinical experience with mechanical assist devices. Currently the RPAH and St Vincent’s hospital ECMO retrieval program has been very active with the Swine flu pandemic in Australia.

Thoracic surgery has also been an active interest with contributions in thoracic oncology and pulmonary failure requiring single, double lung or lobar transplantation. During my time at St Vincent’s Hospital I developed a pulmonary thromboendarterectomy program which I have continued at Royal Prince Alfred Hospital.

I live with my partner Helen Jeffrey and our three children Henry, Oscar and Lily.

Sue Ogle
MBBS 1971
Wearing glasses or not
Your first pair signals the end of your natural life. They are heavy and you feel conspicuous. A chain around your neck with dangling glasses, like everybody’s aunty, you really cannot tolerate. You stick them on top of your head so often that your hair stands up straight. A fright.

You go on the ward round and your glasses get tangled up with your stethoscope. To read the medication charts, you have to keep everyone waiting whilst you put on your glasses. There are some advantages to glasses. One of them is the ability to read print on the page.

At last you can empathise with the blind. You thought you had achieved that understanding as you attended a convent, which incorporated a school for the blind. The kids looked weird but they didn’t know. Their eyes flickered with nystagmus and they were unable to look you in the face. But they were fearless, laughing and running like the rest of us. When they banged into a wall or person, they seemed to bounce off and redirect themselves. The nuns secured the perimeter fence and left them to their own devices; we ignored them – a perfect environment to promote independence.

Julie approaches her time of declining visual function in quite a different manner. She comes from a family with non-existent eyebrows. Scandinavian stock. ‘Does nothing for the looks,’ said her mother when she handed over eyeliner pencils to her daughter, long before she was a teenager.

Glasses are an opportunity for Julie. ‘Wear them all the time,’ enthuses her mother, ‘your eyes look bigger and you seem so intelligent.’

Julie’s family were on the stage. Grandma Queenie sang, Aunty Gwen played bit parts, Cousin Gertrude was the wardrobe mistress, Olle sewed costumes and Uncle Fred painted props. Her mother, the showgirl, has transformed herself into a supremely elegant and coiffed older woman. At her insistence, Julie trained as a social worker.

The silk scarves, sequins, and embroidered coats stayed with Julie long after hippie fashion faded. Glasses have to match. When she discovered a rack of Singapore imports at the back of the Two-Dollar Shop she was ecstatic, bought 15 pairs straight away. Her favourites are the red ones with diamante studs; they could be worn with any of her outfits.

It goes without saying, that Julie needs a pair of every colour - ocelot, blue, green, orange, brown and black – and shape – angel-wing (à la Edna Everidge), hearts and mouse ears. It’s heaven for her and we now have glasses all over the house. Of course, she can never put her hand on a pair when she wants to write down a message.

You come down to breakfast, which you like to prepare and consume without glasses. When you put them on this morning to read a sweet note from Julie – it says, ‘money please’ – you make the mistake of glancing sideways.

In the split second it takes to remove your glasses, the damage has been done – your morning is ruined. Ingrained dirt, crumbs, grease. Yuk. Cleaning must be added to your weekend list.

The pleasure of glasses, you now see, is in taking them off.

Sue Ogle is a Geriatrician and Writing Co-ordinator of AMA NSW Creative Doctors’ Network.
reunion reports
REUNION OF 1946 MEDICAL GRADUATES

Twenty 1946 medical graduates, who together with their partners made a group of thirty one, celebrated their 64th reunion at the Concord Golf Club on Friday 24th September 2010. The group renewed old friendships over drinks and canapés. The group photograph, a wonderful reminder of the occasion, followed. The official welcome was made by the convenor, Jack Blackman. Then we progressed to our delightful lunch with much laughter and warm conversation.

There were many apologies which was not surprising as the average age was eighty seven. Messages from colleagues were delivered by Jack Blackman, Victor Bear, Roger Davidson, Alan Young, Grosvenor Burfitt-Williams, Ewen Sussman, and Joy Tibbetts. Phyllis Bauer wrote to tell us that Gaston was well and sent us his best wishes.

Peter Rogers spoke about our special year and referred us to our year book and the preface in which Professor Dow, the Dean of the Faculty of Medicine wrote “to the students of this year who may be called medical war babies, it marks the end of a very strenuous and difficult period, but they can, I think, face the future with evenness for they will very soon bring some relief to a sadly overworked profession”. Peter noted that a big proportion of the year went on to a distinguished career and made a major contribution to the community. Peter also spoke endearingly of Ruth Godden, the editor of our year book.

Alan Grant made a six word speech, “we have a dream to remember”. We were reminded that Doug Everingham was the Minister for Health in the Whitlam government, and John Austin remembers that he was a great talked. Warwick Williams spoke of friendship, boxing and training at Dunleavy’s gym.

Alan Young expressed our gratitude to Diana Lovegrove and the Medical Alumni for their great help with the mail out of invitations and for arranging the photographer. There is difficulty in keeping in touch with everyone and we were asked to supply any change of address or contact details and an email address or mobile telephone number.

We thank Victor Bear for being our treasurer, Roger Davidson for arranging the excellent venue at the Concord Golf Club, Alan Young for liaison with the University of Sydney and Jack Blackman for being our Convenor. Roger thanked the staff of the Golf Club for their help in making this such a memorable occasion.

It was agreed to have the 65th Reunion on Friday 23 September 2011 at the Concord Golf Club.

REUNION OF 1955 MEDICAL GRADUATES

Fifty graduates from 1955 and partners lunched elegantly at the Royal Sydney Golf Club on Saturday, April 10, 2010. Brilliant sunshine matched the warm companionship of those who re-lived older times and learned of their friends’ continuing interests and activities. David Glenn’s and Vera Gallagher’s toasts to the University and the Year earned great applause, encapsulating our communal respect and affection for all concerned. It was confidently decided that the 1955’ers would reconvene in two years and again count our blessings on being graduates of a wonderful university in an outstanding year.

John Wright

Does your graduating year have an important anniversary in 2010-11? Let us help you contact your fellow graduates, issue invitations and promote your event.

Please contact your alumni reunion manager, Diana Lovegrove, on (02) 9114 1163 or by email at diana.lovegrove@sydney.edu.au.

GRADUATING YEAR OF 1956
When: Tuesday 26 October 2010
Where: The Royal Sydney Golf Club, Kent Road, Rose Bay
Time: 12 noon
Cost: TBA
Contact: Diana Lovegrove

GRADUATING YEAR OF 1951 (FINAL YEAR OF 1950 CLASS)
When: Wednesday 24 November 2010
Where: The Holme Building, The University of Sydney
Time: TBA
Cost: TBA
Contact: Eleanor Dawson
eleddawson@iprimus.com.au

GRADUATING YEAR OF 1981
When: Saturday 19 March 2011
Where: The Great Hall, The University of Sydney
Time: TBA
Cost: TBA
Contacts: graeme.doherty@live.com.au or diana.lovegrove@sydney.edu.au

GRADUATING YEAR OF 1971
When: Saturday 19 February 2011
Where: The Great Hall, The University of Sydney
Time: TBA
Cost: TBA
Contact: Keith Hartman
keith@keithhartman.com.au

UPCOMING EVENTS

Biography writing workshop
We are calling for expressions of interest for attendance at a medical biography writing workshop in February or March next year. Many of our alumni have expressed a desire to write about their colleagues or other medical practitioners but feel they need some guidance as to how to go about it. Many of you have memories of your medical work that give us an invaluable insight into the life and understandings of doctors, and the changing ideas and ways of medical practice.

The intent of this first workshop is to stimulate your interest in researching and writing medical biography and give you the skills and support to feel you can commence. The curator of the Faculty of Medicine Online Museum and Archive, Dr Lise Mellor, will assist you with your research and writing. To express your interest in attendance, please contact Dr Lise Mellor by email on lise.mellor@sydney.edu.au

Lise Mellor by email on lise.mellor@sydney.edu.au
It was serendipity that led Nathan Jacobs to become a yoga teacher. Having completed a combined Bachelor of Commerce and Arts at the University of Sydney, he found himself working in Delhi where his flatmate had a yoga teacher come to the house regularly. He resisted at first, thinking it was ‘a bit girly and hippy’ but when he did decide one night to participate, he found it both mentally and physically challenging. More surprising, he says, was that he immediately felt calmed and energised. Convinced of yoga’s therapeutic effects, he researched yoga teachers and studios for his return to Sydney.

So began his journey towards becoming a holistic medical practitioner. He has attended classes 3 to 4 times a week for the last 8 years.

Keen to pass on his enlightenment and teach others the benefits of yoga, he studied the ancient yogic texts, yoga history and philosophy, and the applied anatomy and physiology of yoga with several teachers in Sydney. He completed his yoga teacher training at SYVASA Yoga University in India.

In 2004, while teaching yoga for a living, he completed Honours in Psychology at the University of Sydney before starting in the Medical Program in 2006.

That year, he established HolisticSoc (the University of Sydney Holistic & Integrative Medicine Society) and participated in the working party which considered how complementary and alternative medicine could be included in teaching of the medical program. The Society thrived, attracting large numbers of students from each year of medicine, presented posters at 3 international conferences, and hosted 28 events at Sydney University. He handed over the Presidency in early 2009.

Nathan is currently completing his internship at St Vincent’s Hospital, and is hoping to pursue a career in either psychiatry or general practice. As a doctor and a teacher of medical students, he wants to be a role model for his patients, and emphasises the importance of practising positive health behaviours.

“Yoga isn’t just good for patients, it’s good for us as doctors too. Yoga helps develop a strong, flexible, fit and agile body. And by increasing awareness of our bodily sensations, breath and emotions, yoga helps us identify and resolve internal tensions, and lead a healthier, calmer and more contented life. It’s the perfect antidote to the stresses of a career in medicine!”

Dr Nathan Jacobs does yoga on the ‘Charging Bull’ in Wall Street, New York (March 2010)
Invigorate your week

artwhatson.com.au

australia's online art space
sign up to our free e-news today

Graham Kuo, Shades #1 (detail), 2008, oil and acrylic on canvas, 229 x 351 cm. Courtesy of the artist and Wilson Street Gallery.
You are always welcome

When planning a trip to the Hunter be sure to visit Tintilla Estate, the quintessential home of contemporary Hunter wines.

Expand your palate - try our Sangiovese, Merlot and Pinot Noir.

Classic Semillon and Shiraz from our James Halliday Five Star rated winery.

Don’t miss out on our olives, tapenade, verjus and vincotto.

725 HERMITAGE ROAD · HUNTER VALLEY
OPEN 7 DAYS 10.30AM - 6PM · PHONE: (02) 6574 7093
www.tintilla.com.au