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JULY 2011

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SELECTING MEDICAL STUDENTS

Selecting students for our medical program is always difficult. Hundreds more apply than there are places available and we, like other medical schools, have developed criteria to assess candidates both for their ability to succeed in the medical program and, more ambitiously, as a medical practitioner.

It is, however, an inexact science. Testament to this are the many different methods used around the world to assess people who seek to undertake medical studies, including aptitude tests, prior university or school performance, different types of interviews, portfolios of volunteer work, and occasionally, even via a ballot. The selection criteria and process is very important since most of those admitted to study medicine graduate as medical practitioners.

When the graduate medical program started in 1996, we changed the type of person who entered this medical school. The decision to move to a graduate program was taken because we saw a value in having students who were older, had made a mature decision to study medicine and who brought a diversity of educational experiences to their medical studies. This year, we have implemented changes to our application process. Students now apply direct to Sydney Medical School rather than through the consortium of graduate medical schools.

An important component of the strategic planning undertaken in this faculty last year was to review and better define the key attributes we wished for in our graduates. In my view, good doctors have a knowledge of basic and medical sciences and excellent clinical abilities. They are ethical and compassionate, with a desire to care for people and alleviate suffering; good problem solvers, able to listen and process complex information and able to thrive in different settings and in a changing health environment. They also have a desire to add to the body of knowledge that we, and those who follow us, need to develop in order to improve health care in the future.

The result of the faculty discussions last year is that we are now able to say clearly that we are committed to graduating people who are good compassionate clinicians but who are also trained in research and who have had an international experience which makes them aware of the global context of medicine.

The obvious follow on was to review the admissions process, to enable us to select candidates with the same aspirations - or the ability to develop these desired attributes.

We have not changed the criteria for admission to Sydney Medical School. But we have withdrawn from the consortium of medical schools which has managed the student application preferences of all the graduate schools for more than a decade. We have been a part of the consortium since its inception in 1996, but now feel it is important to have greater control over our admissions. Over time, all medical schools had changed their selection processes significantly. We needed to be able to rely on the selection criteria which we believed in, and which we believed were important for Sydney Medical School. We wanted a process that was transparent and encouraged applications from people with aspirations for careers in medicine which fit with our own aspirations.

The change has been widely supported by students and this year more than 1500 people applied for the 240 places available. All could still apply through the consortium.

The doctors we graduate from Sydney Medical School are the product of the education we provide. They also a product of their own life experience, values, abilities and goals. With these changes, our goal is to encourage applications from people whose aspirations fit with our own, and to have a process which is open and transparent. Our new selection process coupled with our revised curriculum, should help us graduate doctors of whom we can all be proud.
FROM THE SENATE

Recently the head of the London School of Economics Sir Howard Davies resigned after damaging criticism of the School’s association with Libya. Despite the derogatory comments of Sir Humphrey in “Yes Minister”, the LSE has a global reach with 60% of its students from overseas. Sir Howard had, with the encouragement of the Government, developed links between the School and the Libyan Government. He had travelled to Libya accompanied by the British Ambassador and given economic advice to Libya and had promoted UK Universities. The Libyan Government had in turn made donations to the LSE and allowed officials selected by the LSE to enrol in management courses. One shouldn’t forget the British Government had only recently responded to Libya’s request to release the Lockerbie Bomber on compassionate grounds.

Despite no suggestion he had done anything wrong, Sir Howard felt he should resign to stop the negative press and the damage to the LSE’s reputation. The quality of the School and its programs were not at issue – it was brand reputation damage on Sir Howard’s mind.

As we compete nationally and globally, Universities are no longer cloistered academic environments of tenured academics sitting apart from the cut and thrust of the wider political, financial and media context. We now openly talk about the brand image of a university – distinct from its academic reputation.

The resentment that this word ‘brand’ evokes in some people reminds me of when we started to talk about patients as customers or consumers – the change in language heralds a change in the relationship.

Change in the relationship of a university and its students has well and truly come. Students – the consumers – clearly ‘shop’ for their university (and have done so for some considerable time); the best students are given more choice in this market with acceptances and scholarships to a wider range of institutions. I have spoken previously about how we compete both nationally and internationally for the best students and support. An important dimension to this competitive environment is the proliferation of new medical schools in Australia. The number of medical placements has doubled in the last 5 years and while this has tested the States’ capacity to provide clinical training, the real challenge will be the increasing demand for training places for specialists.

It is tempting to look negatively at these new Australian medical schools. But responding negatively is probably foolish and short sighted. Our best strategy lies in ensuring the Sydney Medical School brand remains strong and differentiated from the new and old competitors, that the quality of staff and the resulting research and teaching remains at a high level and is translated into our ability to recruit the best possible local and overseas students.

I recently gave the occasional address at one of the Medical School’s Graduation ceremonies. There were 31 PhD medical graduates in that graduating class. I assumed this was some sort of record but was told that another graduation ceremony later in the year would actually include around 100 PhDs. This level of research, funded in part from the generosity of our alumni and donors, is a tangible result of promoting quality and promoting our brand.

The Centre for Obesity, Diabetes and Cardiovascular Disease will create further scope for increasing the range of opportunities for post graduate research. This enormous project [the capital cost alone is $400M] is proceeding apace as will be apparent to anyone who wanders around the area between the University, RPAH and St Johns. This project will not only build on our great reputation but will also greatly enhance our brand image, the two being somewhat different.

You will have seen the proceeds from the sale of the Picasso painting is earmarked for the COCD. A few more donations like this would help. If you have any old masters in the attic…

Barry Catchlove, June 2011

SYDNEY MEDICAL SCHOOL GOES ITS OWN WAY ON APPLICATIONS

For the first time since moving to a graduate medical program, Sydney Medical School has accepted direct applications for admission.

Criteria for admission is unchanged: applicants still require a Grade Point Average of 5.5/7 in their undergraduate degree; a good score in the Graduate Australian Medical Students Admissions Test and perform well in interviews.

Final ranking is a combination of their GAMSAT and interview scores.

Applications have for more than a decade been managed by a consortium of graduate medical schools.

“The number of medical schools in the consortium has grown in recent years from three to 11, each with different programs and application criteria. We are looking to attract students to Sydney who are interested in the program that we run, and in the research and international opportunities we can provide. To do that, we need to be able to manage our own admissions,” said Dean Bruce Robinson.
POLLIES PEDAL FOR POCHE CENTRE

The 2011 Pollie Pedal, riding from Burleigh Heads to Sydney, has raised up to $300,000 for the Poche Centre for Indigenous Health. The ride, now in its 13th year, was again led by Opposition Leader Tony Abbott. Riders covered the 1000 kilometre course in nine days through wonderful scenery, varying weather, hills and potholes.

The only member of faculty to ride the full course was neurosurgeon Dr Michael Besser a triathlon enthusiast since his recent retirement from RPA. (Pictured).

...The major sponsor, again, was pharmaceutical company Amgen, with other support from Church of Jesus Christ of Latter Day Saints, Tourism Hospitality & Catering Institute; Alphapharm and Blackmores.

Over the past three years, the Pollie Pedal has raised more than $500,000 to sponsor student placements in NSW and NT through the Poche Centre.

SYDNEY UNIVERSITY MEDICAL SOCIETY MED REVUE: BEAUTY AND DECEASED

Sydney University Medical Society in conjunction with University of Sydney Union, proudly presents the 2011 Medicine Revue: Beauty and Deceased.

Produced, directed and performed by year one medical students, and with over $43 000 raised for charity last year, the Medicine Revue has a rich and colourful history that is set to continue.

Gripped by a fascination with death from a young age, Belle has completed her medical degree and has secured an increasingly coveted internship at Royal Prince de Beaumont Hospital – finally bringing her closer to the dead.

But all is not well in this house of healing. There are rumours of strange research being carried out in the morgue by Dr B. East and his group; experiments threatening to cure death. In what is definitely not the most beautiful love story ever told, and featuring the singing, dancing, and acting prowess of Sydney University medical students, Beauty and Deceased promises to make you laugh, sing, dance, clap and cry.

All funds raised from ticket sales will go to the Cure Cancer Australia Foundation and the Milk Crate Theatre. Performance dates: August 10-13, 2011. Cost: $20 Access, $25 Concession and $29 Adults

For more information on these charities, please see the following links; cure.org.au, milkcrate theatre.com

2011 JOHN YOUNG MEDAL FOR BRETT HAMBLY

Professor Brett Hambly, School of Medical Sciences, was awarded Sydney Medical School’s highest staff award, the Professor J A Young Medal, for 2011. The award was for excellence in research and exemplary service to Sydney Medical School and the University, in particular in the area of postgraduate scholarships and student recruitment, and the community.

Professor Hambly’s research has focused in the area of cardiovascular disease, and over the past 20 years he has been continuously funded for his research. He has supervised five successful PhD students and co-supervised another 11, as well as supervising and co-supervising dozens of Science and Medicine Honours students.

He is probably better known, though in his capacity as Associate Dean (Postgraduate Scholarships and Student Recruitment) and his membership of the Postgraduate Awards Sub-Committee of the Academic Board. He has worked tirelessly as an advocate for research students in the health faculties, in particular Medicine, and fought for recognition of their qualifications and professional and research experience in the University’s ranking system for Australian Postgraduate Awards and also International Postgraduate Research Scholarships. In 2010 the proportion of APAs awarded to postgraduate students in Medicine had risen from approximately 15% to 20%.

The award was made by the University’s Chancellor Her Excellency Professor Marie Bashir at Sydney Medical School’s 2011 Celebratory Dinner on March 24. The dinner was held to celebrate the achievements of faculty members and students.

“The highlight of the evening was the award of the Professor J A Young Medal to Brett, in recognition of his work over many years, and especially in his encouragement and support of young researchers,” said Dean Bruce Robinson.
SYDNEY SURGICAL SOCIETY GROWS RAPIDLY: NEEDS SUPPORTERS!

The Sydney University Surgical Society was established in late 2006 with the help and support from the Discipline of Surgery at Sydney Medical School. The society was initially formed by a group of medical students keen to encourage communication between surgeons and students allowing for educational exchange and mentorship. Since then the society has evolved to include formal lectures, skills workshops, professional development seminars and face to face learning opportunities in the operating theatre. The primary focus of the society is to promote and facilitate dissemination of surgical skills and knowledge to medical students interested in a career in Surgery.

Recently the society organised a number of suturing skills sessions facilitated by specialist surgeons from RPA. Due to overwhelming demand the society is working to organise a number of additional events scheduled for the coming year. These include basic suturing and wound management workshops; surgical training information night; a meet and greet event where students can meet surgeons from a number of clinical schools and specialties; basic surgical skills course; advanced surgical skills course; surgical anatomy lectures and tutorials; and surgical case presentations.

Members of the society will also be participating in the 2011 City2Surf event by running in surgical scrubs to raise funds for the plastic and reconstructive surgery charity Interplast. Staff, students and friends can support the society’s fundraising bid by contributing through the society’s fundraising event page at fundraiser.city2surf.com.au/sydney_university_surgical_society

The society would also like to invite Surgeons and Surgical Trainees interested in supervising or supporting any of the above activities to kindly contact the President, Vice President or Secretary. There are representatives for each Stage and in each clinical school: Arridh Shashank – President, Sydney University Surgical Society, asha8038@uni.sydney.edu.au; Rowan Stephenson – Vice-President, rste1096@uni.sydney.edu.au; Kate Kearney – Secretary, kkea3802@uni.sydney.edu.au

Call for Applications

Calling all scientists who think outside the square!
If you have a great idea for a scientific research project which is ahead of its time, read on …

The Sir Zelman Cowen Universities Fund is a Sydney trust funding medical and scientific research and promoting co-operative work between the University of Sydney and the Hebrew University of Jerusalem.

Recognising that many great scientific discoveries are based on once blue-sky, fanciful ideas looking for a backer, the Fund has established a grant, to provide such backing.

The Fund now seeks applications, made according to guidelines below, for the SIR ZELMAN COWEN UNIVERSITIES FUND Blue Sky RESEARCH GRANT

Guidelines:
1. The Grant will comprise an award of AUS$100,000 for 1 year, commencing January 2012, for a research project in an emerging area such as (but not limited to) organ/tissue regeneration where researchers will aim to use the funds to gain sufficient momentum to be competitive in larger funding systems. Preference will be given to imaginative proposals with good scientific rationale and potential to make a significant innovative advance in human health.
2. Applicants should have their primary appointment at the University of Sydney or the Hebrew University of Jerusalem. Preference will be given to joint applications for cooperative projects between staff of both Universities.
3. Applications should be made using the form available from the Fund’s office (see below).
4. Completed applications should be sent by email to the submission address below by the closing date.

Closing Date
Friday 26 August 2011

Applications & Enquiries Sue Freedman-Levy – Administrative Officer
Sir Zelman Cowen Universities Fund
University of Sydney, F13, NSW 2006, Australia
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East Timor Fellows: New Group for 2011

Mr Miles Armitage, Australian Ambassador to Timor Leste, held a reception at his residence in Dili for Sydney Medical School’s Timor Leste Health Leadership Program Fellows on May 17. It was attended by the 10 Timorese Fellows participating in the 2011 health leadership program, alumni from the 2009 inaugural cohort, and representatives from the Ministry of Health, AusAID, WHO, Health Alliance International and University of Sydney. Through the support of AusAID’s Australian Leadership Award Fellowships program, the Office for Global Health provides leadership training to Timor Leste’s health professionals.

“The main goal of the 12 week program is to identify and train current and future health leaders. It aims to build capacity providing placements and training programs in Australia that will enable the delivery of evidence based health care, management, education and policy within the health care system of Timor Leste. Each Fellowship plan is individualised to suit the learning goals and expertise of the Fellow. Emphasis is placed on exposing Fellows, to methods, theories, techniques and approaches that they can implement as well as use to train and lead others when they return to Timor Leste”, says Senior Manager – International Relations, Dr Dilhani Bandaranayake.

The ALA Fellowships program is made possible through the support of AusAID; Australian health organisations and mentors who provide guidance to the Fellows during their 12 weeks in Australia; the Timorese Ministry of Health and Timorese health organisations.

Vale Rowan Nicks

Rowan was one of the founding full time cardiothoracic surgeons at Royal Prince Alfred Hospital, and remained on the staff from 1956 to 1973. Educated in New Zealand, he did his post-graduate surgical training in London, and during the war, served as a surgical lieutenant in the Mediterranean theatres. With Charles Robb he established the Cardiothoracic Surgical Unit in Green Lane Hospital, Auckland, and nine years later moved to RPA. He was a pioneer in every sense of the word. He introduced many new techniques to surgery, championed new technologies, such as the first implantable pacemaker, but above all, had a passion for his trainees, and emerging surgeons.

Rowan had a particular interest in surgery in the developing nations, and sponsored innumerable trainees from many parts of Africa, India, and South East Asia. In each he took a personal interest, had them to his home, and followed their subsequent career in great detail. Well into his retirement he developed a number of scholarships with the RACS, and between 1991 and 2010, supported 48 international scholars.

But first and foremost, Rowan remained “a PA man”. He was always present, usually in the background, at any major function or meeting in which RPA featured, and always took an opportunity to talk about “the best cardiac surgical unit in the country”. It was a joy to be mentored by Rowan, a delight to listen to his innumerable and fascinating stories of travel, early surgery, people and places.

He will be sadly missed, but never forgotten.

Clifford F Hughes AO

Editors Note: In Sydney Medical School, Dr Nicks also supported the Rowan Nicks Russell Drysdale Fellowship, providing financial support for Indigenous people undertaking research or establishing projects which will make a tangible difference in Indigenous health and welfare. The program commenced in 2004 as a joint bequest from Dr Nicks and Lady Maisie Drysdale, wife of the artist Sir Russell Drysdale.
QUEENS BIRTHDAY HONOURS

Congratulations to all alumni and staff who were recognised in the latest Queens’ Birthday Honours.

Dr John Beattie OAM (MBBS 1970) was recognised for service to medicine through administrative roles and the disciplines of cardiology and general medicine.

Dr David Davidson OAM (MBBS 1963) was recognised for his service in orthopaedics.

Dr Michael Dudley AM (MBBS 1978) was recognised for his work as a clinician in the child and adolescent mental health area, to medical education, and to a range of professional associations.

Dr Kerryn Phelps AM (MBBS 1981) for service to medicine, particularly through leadership roles with the Australian Medical Association, to education and community health, and as a general practitioner.

Dr Harley Roberts OAM (MBBS 1959) for his work as an obstetrician and gynaecologist.

Dr Natale Romeo OAM (MBBS 1974) for service to the community through fundraising roles with the Italian Affair Committee.

Professor Nicholas Talley OAM (MBBS 1954) was recognised for his work in gastroenterology.

Dr Thomas Woolard OAM (MBBS 1955) was recognised for his work in rehabilitation in the Hunter region.

Dr James Wyllie OAM (MBBS 1967) was recognised for his work as a surgeon and in support for the profession.

Professor Lisa Jackson AM (MPHealth 1998) was recognised for her work in Indigenous health education.

Dr Anthony Kirkwood OAM (MBBS 1974) for his work as an anaesthetist.

Dr Paddy Lightfoot OAM (MBBS 1963) for his work in conservation and the environment.

Dr Edwin McIntosh AM (MBBS 1979) recognised for his work in infectious diseases and in the community through the Glebe Music festival.

Dr Catherine Storey OAM (MBBS 1972) was recognised for her work in neurology and education.

JIM BISHOP TO DELIVER LAMBIE DREW ORATION

This year Sydney Medical Society is looking forward to welcoming Professor Jim Bishop back to Sydney to deliver the prestigious Lambie – Drew Oration.

Professor Bishop was appointed Chief Medical Officer (CMO) for the Australian Government in February 2009, and left in May this year to take up the Executive Directorship of the $1bn Victorian Comprehensive Cancer Centre (VCCC). Professor Bishop was previously a Professor of Cancer Medicine at the University of Sydney and is a Fellow of the Royal Australasian College of Physicians (FRACP) and the Royal College of Pathologists of Australasia (FRCPA).

When: 7pm on Wednesday 12th October in the MacLaurin Hall at the University of Sydney.

For more information please contact Toby Hulf at lambiedew@sydneymedsoc.org.au.

SYDNEY MEDICAL SCHOOL
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sydney.edu.au/medicine

Dean Professor Bruce Robinson
Deputy Deans Professor Arthur Conigrave, Professor Ben Freedman

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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 Lushy - Concord Clinical School
Professor John Watson - SAH Clinical School

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Professor Carol Armour - Career Development
Associate Professor Chris Roberts - Educational Development
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Visiting Professor David Tiller - Planning & Development, School of Rural Health

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Beth Quinlivan - Director Marketing and Communications
Helen Triantaflis - Executive Officer Research & Research Training
Karen Scott - Executive Officer Office of Medical Education
Kay Winton - Director Student Services
Diana Lovegrove - Manager Alumni Relations & Events
Sydney Medical School secured two of the three NHMRC Centres of Research Excellence funded in NSW in 2010. The CRE scheme is highly competitive; the success of research groups in securing the funds is testament to the quality of their research, the ability of their research to be translated to directly improve health, and their international standing.

The aim of the CRE funding program is to improve health outcomes as well as promote and improve the translation of research outcomes into policy and practice. It supports the pursuit of collaborative research – with encouragement of international collaborations – as well as developing capacity in clinical, population health and health services research.

The two CREs awarded in 2010 are in infectious diseases, and maternal and child health. In 2009, a Centre of Clinical Research Excellence was awarded in sleep medicine.
Infection is the big killer in intensive care but research is difficult and underdone,” said Associate Professor Jon Iredell. “The critically ill are the most vulnerable people in our health system and caring for them is expensive. Most admissions to intensive care are complicated by infection which is the commonest cause of preventable mortality and adds billions of dollars to the annual cost of health care.”

Jon Iredell, with expertise in intensive care, infectious disease and clinical microbiology, last year led the successful application for a new Centre of Research Excellence focused on critical infection. The CRE was officially launched at Westmead Millennium Institute by the Federal Minister for Mental Health and Ageing, Mr Mark Butler, in April. Jon Iredell is Associate Professor in Medicine, Westmead Clinical School, heads the Bacteriology, Antibiotic Resistance and Rapid Diagnostics group at Westmead Millennium Institute and is Director of the Infectious Diseases Department at Westmead Hospital. No longer practising general intensive care, he still attends Westmead ICU in the capacity of consulting microbiologist twice a week.

Other investigators in the successful CRE application include Professor Tania Sorrell, head of the new Sydney Emerging Infections and Biosecurity Institute; medical virologist Professor Dominic Dwyer; Sydney Law School’s Professor Belinda Bennett; Professors Lyn Gilbert and Vitali Sitchenko from Westmead Clinical School, and Professors Cheryl Jones and Robert Booy from The Children’s Hospital at Westmead Clinical School, Professor Ian Kerridge from the Centre for Values Law and Ethics, and Professor Stephen Webb, chair of the Australia New Zealand Intensive Care clinical trials group.

In both paediatric and adult ICU, clinicians face unique and difficult problems, and Professor Iredell believes the establishment of a top level multi-disciplinary specialist research group focussed on critical infections is long overdue. There are very limited data on prevention, treatment and diagnosis of septic shock, severe pneumonia and, in children, meningitis and encephalitis. “We know that when people present with a life-threatening bacterial infection, the most important factor in survival is providing the right antibiotic. The cost of delay is a drop in survival rate of 7% per hour. The problem is that old-fashioned microbiology methods mean up to 24 hours delay before we identify antibiotic resistance, and if we don’t have an effective antibiotic until then, survival is as low as 10%.”

The revolution in recent years in genomics, biotechnology and informatics has provided doctors and researchers with new tools to better detect and manage infectious disease, and a significant focus of the new CRE is to use these tools to develop new diagnostic methods, better screening and tracking of pathogens.

“Better prevention and better outcomes of critical infections requires better understanding of pathogens and host indicators of disease risk, of co-infections, and of the epidemiology of agents such as bacteria and viruses with highly variable gene pools,” he said.

“Major illnesses such as influenza can overwhelm an entire health system, but a lot of serious infections such as pneumonia and encephalitis go undiagnosed.”

Work will therefore focus not only on scientific aspects of infection but also on improvements in diagnostics, as well as in understanding the social, cultural, ethical, professional and legal issues that surround treatment of critical infections and can even be a barrier to crucial research.

“There is a great deal of work already being done in Australia and internationally in infectious disease and immunology by people involved in this CRE. We are very closely linked with the new institute for emerging infections – SEIB – which has a similar brief of adopting a multidisciplinary approach to resolving complex challenges in infectious diseases.”

The aims are ambitious, he admits, but the opportunities to improve outcomes for people with critical infections are enormous. “Increasing survival of people with catastrophic infection - that is our challenge.”
The Centre for Integrated Research and Understanding of Sleep (CIRUS) was established in July 2009 from the National Health and Medical Research Council (NHMRC) Centre of Clinical Research Excellence (CCRE) scheme of $2.5 million over five years.

The interdisciplinary Centre’s aims are to investigate the biology of sleep, as well as treat and prevent a number of sleep disorders. Disordered or insufficient sleep is recognised as a major cause of heart disease, stroke, impaired mental health, metabolic dysfunctions, reduced alertness and fall-asleep crashes.

Professor Ron Grunstein who heads CIRUS explains “lack of sleep is strongly associated with errors or deaths in the workplace and increased risk of poor health outcomes and reduced survival in many chronic diseases.”

Previous research showed that nearly 20 per cent of Australians have reported sleeping less than six hours a night, five per cent have symptomatic obstructive sleep apnea (OSA) and six per cent have chronic insomnia issues.

CIRUS has four key research streams: reducing the cardio-metabolic impact of poor sleep; increasing the effectiveness of treatments for sleep disorders; determining the adverse consequences of insufficient or disordered sleep through novel approaches and biomarkers and improving the neurobehavioural performance of sleep deprived people.

“Our approach is a unique one, utilising interdisciplinary strategies – we implant physicists amongst clinicians, we have a clinic that combines people of different speciality backgrounds psychiatry and endocrinology and we have unique facilities in the ACCESS Centre [Australian Centre of Chronobiology, Endocrinology and Sleep Sciences] at the Woolcock Institute where we can house people for days in a research “hotel””, said Professor Grunstein.

Housed within the Woolcock Institute of Medical Research, the research “hotel” is a $10 million purpose-built research centre consisting of a 12 bed sleep research laboratory, a state of the art circadian research facility as well as equipment for sleep apnea and cardiovascular research.

While the studies on the biology and disorders of sleep have grown in the past 30 years, CIRUS is helping expand the field of future clinical sleep researchers by including the disciplines of endocrinology, metabolism, neurology, psychology, pharmacy, psychiatry and respiratory medicine. As well as research training, its focus is also to influence clinical practices.

The CIRUS team consists of eight chief investigators from the University of Sydney – Professor Craig Anderson, Associate Professor Peter Liu, Professor Peter Cistulli, Associate Professor Nick Glozier, Professor Carol Armour, Professor Peter Robinson, Professor Guy Marks and Professor Grunstein. In addition, CIRUS is part of an international network with eight associate investigators from international institutes including Harvard Medical School, University of Pennsylvania, University of Glasgow and Monash University.

The Centre has a strong focus on research training and career development. Funding from the CCRE scheme assists in supporting post-doctoral research and clinical fellows as well as PhD students by providing seed funding leading to more significant NHMRC and Australian Research Council (ARC) applications.

In addition to the interdisciplinary research collaborations with the University, CIRUS is also a part of an international network with affiliations with the University of Pennsylvania and Glasgow University, as well as a number of investigators being members of the World Sleep Federation.

“Australia has provided strong international leadership in clinical sleep research which has already been translated to a range of innovative clinical programs and strong commercialisation outcomes”, said Professor Grunstein.

This recognition was demonstrated this month, with Professor Grunstein the first ever recipient outside of North America being awarded the prestigious Nathaniel Kleitman Distinguished Service Award by the American Academy of Sleep Medicine for his significant contribution to professional development in sleep medicine, as well as for research into the relationships between obesity, metabolic dysfunction and sleep apnea.
“W e are a bit unusual for population health researchers,” said Associate Professor Christine Roberts, perinatal epidemiologist based at the Kolling Institute of Medical Research. “A lot of population health is done at some distance from patients and clinicians but our group is closely involved with doctors and clinics. That is stimulating; I leave every clinical meeting with so many questions, thinking ‘we should be looking at that’ or ‘if only we could investigate this’. The great benefit is that you never feel as if you are in an ivory tower; you start every bit of new research with real questions that will help clinicians or will help in developing health policy.”

Christine Roberts, who is based at the Kolling Institute, Northern Clinical School at Royal North Shore Hospital, led the successful application last year for a new Centre of Research Excellence, which brings her population research expertise together with clinical and laboratory perinatal researchers, all with the over-riding aim of better predicting, preventing and treating complications in pregnancy and childbirth. Christine Roberts is Research Director of Clinical and Population Health Research at the Kolling Institute, and an NHMRC Senior Research Fellow.

The CRE’s eight lead investigators come from the University of Sydney, the Sax Institute, NSW Health and the Australian National University, and bring strong academic and management experience, and expertise covering obstetrics, midwifery, epidemiology, public health, biostatistics, record linkage, health services research and translation into policy and practice. The CRE is supported by 13 associate investigators, comprising policy-makers, clinicians and consumer representatives.

Aside from the closer-than-normal links between population research and clinical work, the new CRE has a number of other attributes and assets which means it can bring new dimensions to perinatal research and real progress towards improving the health of mothers and babies. One of these is access to a collection of 35,000 early pregnancy serum samples from across NSW which have been archived since 2006. Using data from this large and growing collection in conjunction with population health data, researchers are able to undertake large scale studies, including identifying biomarkers which indicate at-risk pregnancies, without the enormous expense and time constraints of recruiting hundreds or thousands of patients for prospective trials.

The new CRE is also different in its expertise in using linked population health data, combining health records routinely collected on mothers and babies with data from the birth defects register, the death register and post mortem reviews.

“In NSW, we have the opportunity to use and build on the extensive repository of population health data held by the Department of Health. Our group doesn’t do the linkages but we have considerable expertise in analysing and interpreting the data,” Christine Roberts said.

The CRE’s research is focussed in three key areas: linking the serum samples with population health data to identify early indicators of health problems in pregnancy; using the population health data to investigate the impact of obstetric interventions on subsequent pregnancy outcomes; and using population health data to investigate emerging issues in perinatal policy and practice.

“Adverse health outcomes, such as fetal growth restriction or preeclampsia, are often unheralded and there is a real need for improved prediction of such complications.” The group will be testing a number of new biomarkers to identify women at risk of adverse outcomes.

“The increasing and now common obstetric interventions, such as induction and caesarean section at delivery, may have ongoing long term effects for subsequent pregnancy and maternal and child health outcomes. So we are looking to establish the effect of interventions on subsequent pregnancies, and provide better information for women and clinicians making decisions about obstetric care.”

A key strength of the CRE will be a program of work with policy partners and health services in NSW to transfer the research knowledge generated by the group into policy and practice.
Graduation 2011
Sydney Medical School graduation ceremonies on May 13 were, as ever, a mix of emotions, ages and awards. With increasing student numbers of recent years, Sydney Medical School now has three graduation ceremonies in May and a further two in December. Medical students account for only about one third of the School’s graduates each year, reflecting the higher numbers undertaking postgraduate degrees, both coursework and research.

At the recent May ceremonies, close to 500 graduates were presented with their testamurs in the Great Hall by the University of Sydney Chancellor, Her Excellency Professor Marie Bashir. Just over half or 253 were medical graduates, and 232 postgraduate degrees were awarded. The December graduation events have a greater emphasis on postgraduate degrees.

This year, addresses were delivered by Dr Barry Catchlove, an alumnus of Sydney Medical School and Fellow of University of Sydney Senate; Mrs Jillian Skinner, NSW’s Health Minister; and Professor Michael Field, who has recently stepped down as Associate Dean and Head of Northern Clinical School.

**DR SEGAL: THE OLDEST GRADUATE**

The May graduation also included a presentation to 89 year old Dr Harry Segal with his graduation testamur from the University of Sydney – just 69 years after he completed his medical course.

Dr Segal entered medicine in 1937, aged 15 years, having won a NSW Government ‘Exhibition’ for being one of the top 200 students in the state’s Leaving Certificate Exams.

He studied under Professors Lambie and Dew (and others) in the early years and commenced clinical training at the Royal Children’s Hospital, Prince Alfred Hospital and Sydney Hospital. “These were the days before antibiotics and the hospital beds were full of patients dying of tuberculosis, syphilis, chronic infections, and appendectomies. The doctors wrote out long Latin prescriptions, but in most cases nature took its course.” When World War II broke out, the University shortened the course and brought the exams forward so that Harry ended his medical studies three months before his 21st birthday.

“I received a letter from the University telling me I could not graduate with the rest of the students as I had not reached the age of 21 and that only after my birthday I would be granted the degrees, Bachelor of Medicine and Bachelor of Surgery in absentia. This was a rather unique situation, where I was working as a Doctor without having graduated in medicine or full registration. However, I was appointed Honorary Captain in the army reserve.”

Harry served in the Army and went on to a career as a cardiac surgeon and built his own hospital. His recently published book, “An Interesting Life”, chronicles his journey through medicine and life and is available through BookPal Publishing.

Dr Harry Segal finally received his graduation in May in the Great Hall at the University of Sydney, in the presence of his wife of 65 years, Patricia, and family: *radius*

1. Students at graduation. 2. Her Excellency, Professor Marie Bashir and Dr Harry Segal. 3. The Hon. Jillian Skinner, MP, Minister for Health and Minister for Medical Research. 4. Dr Barry Catchlove, Member of Senate, University of Sydney. 5. Emeritus Professor Michael Field.
General Practice placements: rewards for students and teachers

Sydney Medical School students complete two general practice attachments in the Community Term rotation, one urban and one rural. Students are given the opportunity to immerse themselves in general practice, and to receive one-on-one teaching from enthusiastic and committed GP supervisors who enjoy having students in the practice, and from patients who are happy to be included in developing the skills of the next generation of doctors.

By Sylvia Guenther, Narelle Shadbolt, Chris Roberts and Carol Kefford

During the placement students are encouraged to participate in the life of the practice. They benefit from and enjoy involvement in consultations, interviewing patients, learning procedures and attending home and nursing home visits. They are also involved in community visits with allied health providers.

SPECIAL RELATIONSHIP
“If you look at the Hippocratic Oath, the most important thing is the obligation to teach, to nurture young students coming up” – Sydney GP

Students and GPs value highly the relationship that develops over the course of the placement.

Steven Yeates, a student who has recently taken part in the community term describes this relationship: ‘There are comparatively few opportunities in medical school where teaching is continuous and a relationship between student and teacher can be established over a period of weeks. In my opinion, it is this relationship that facilitates a learning experience. The ongoing contact between student and supervisor creates a feeling of the student and GP ‘getting to know’ one another. This familiarity allows knowledge levels to be assessed and expanded, strengths and weaknesses outlined, and personal and professional interactions to be observed in action.’

MAKING A DIFFERENCE TO THE FUTURE OF GENERAL PRACTICE
“I hope to teach by example – to be a professional person with great respect for the patient” – Sydney GP

Literature from Australia and around the world reinforces that exposure to positive clinical experience and effective role models influences future career choice within medicine and general practice, and GP supervisors are conscious of promoting general practice to students. A GP put it this way – ‘I am fiercely determined that when the students leave, general practice is an option for them as a career – so it’s for general practice that I teach’.

GPs are passionate believers in general practice, and they wish to give students a taste of the whole experience of life as a GP. ‘So I find that when a student comes here, their eyes are opened as to what we do, how thorough we are, the variety we see, how far we investigate and treat’.

Students often remark that they are pleasantly surprised at the range and depth of medicine they observe and learn from, and they develop new insight regarding the challenges and rewards of general practice.

UNIQUE EXPERIENCE OF PRIMARY CARE
“One of the great pleasures of general practice is to make the difficult diagnoses” – Sydney GP

As the length of patient stays in hospitals shorten and care is transferred from hospitals, more emphasis is placed on prevention and management of chronic illness in the community. There is a need for students to work in the community and observe the co-ordinated care given by various members of the primary health team.

General practice gives students a perspective regarding health care that is different to what they have seen in the hospitals. A GP sees patients over the long term, and builds an unique therapeutic relationship with them and their families. Patients often present with an undifferentiated illness. Students are able to be part of the clinical reasoning process, observing and contributing to the pathway to diagnosis. Sharing this process with the student is a powerful educational lesson.
The general practice experience is a special one. It encompasses a broad range of medical, social and educational experiences.

Steven Yeates

Steven Yeates said he had been fortunate to have had clinical experiences with outstanding GPs.

“My urban supervisor, Dr Andrew Bowes was a committed and admirable doctor and teacher. He has the rare skill of condensing issues into something clinically relevant, digestible and palatable for students (and his patients). Dr Bowes involved me actively in every patient consultation, and questioned me on relevant diagnostic and management issues throughout patient consultations. I was also privileged to be given an insight to each individual patient, an essential component of the GP consultation.”

RURAL PLACEMENTS:
A DIFFERENT PERSPECTIVE OF PRIMARY CARE

Anthony Rososinski described his rural placement: ‘My experience in the rural community block was an exciting time with exposure to different experiences. I really enjoyed the skin cancer clinics where I was able to learn procedural skills such as suturing and techniques to remove skin lesions. The remote GP clinics were set up in a small community centre, and we saw a range of characters with their own unique story and medical complications.’

Abbey Baerlocher went to Wilcannia: ‘Wilcannia was an incredible location to spend my four week rural placement during my community term. The hospital in which I was placed is primarily run by nursing staff in conjunction with the Royal Flying Doctor Service and Maari Ma Health. Doctors are not permanent fixtures at the hospital and the task of primary health care falls to the exceptionally well trained nursing staff. During my time in Wilcannia I was fortunate enough to run most of the consults which came into the emergency department.

Initially the prospect of this was daunting and slightly terrifying, especially without the safety net of a doctor standing right beside you. However it soon became apparent that even though I was allowed to stand on my own two feet whenever I felt confident I was never left without exceptional support, whether that meant from the highly trained nursing staff or doctors on call at Broken Hill. I was involved in all aspects of patient care, from doing the initial assessment to explaining possible treatment options and goals to the patients. I was involved in flying patient’s to Broken Hill with the Royal Flying Doctor Service in critical situations and enjoyed on many occasions driving up and down the run way on the ‘Roo Run’ looking for stray kangaroo’s in the way of the landing plane. Overall it was an incredible experience that is hard to describe.

Working in community health is a completely different experience to what I have previously seen in hospitals in Sydney. It’s more personal and often patients become known to you on a different level. I felt that the community term provided me with the opportunity to not only experience medicine in a different setting but also to engage with the community in which I was staying. I often found myself during my time off being taught how to catch Yabbies in the river by the local children, being beaten at Wii at the teenager drop in centre or playing bingo at the local golf club.

This experience was an incredible opportunity that has given me the desire to seek further rural opportunities during and following my medical program. It has given me confidence and a vast amount of experience that I do not believe can be gained from a hospital placement. At the end of the day my time in Wilcannia is one of the most rewarding experiences I have undertaken during my medical degree so far.’

radius

For GPs interested in becoming a supervisor please contact your local clinical school:

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Vietnam is a developing country with a population of nearly 90 million people that suffer from a large burden of communicable disease. The World Health Organization has recommended that member nations should maintain functional laboratory surveillance systems to define disease burdens and trends, to identify epidemics and to monitor the effectiveness of public health interventions such as immunisation. The need for Vietnam to conduct pandemic surveillance has been highlighted by its central role in the SARS and avian influenza epidemics of the past decade.

At the commencement of the project, both the National Institute of Hygiene and Epidemiology in Hanoi and the Pasteur Institute in Ho Chi Minh City supported a small number of highly functioning laboratories that generated excellent surveillance data. A feature common to these laboratories was that they received external funding from WHO and the Global Fund, and were linked to international research and surveillance networks. Most of the laboratories, however, were poorly funded, received very few specimens for testing, experienced low staff morale and provided a poor quality of service. Further, senior management was not providing the leadership required to deliver the change necessary to improve their institute’s quality of service.

Thus the aim of the project was to embed international best practice in laboratory quality management at the two institutes. The primary goal has been to assist the institutes and laboratories achieve accreditation against the International Standards Organization standard for medical laboratory quality systems - ISO15189: 2007 Medical Laboratories - Particular Requirements for Quality and Competence. The project has received strong support from the Vietnamese Ministry of Health and the WHO, and has been funded by WHO and the Australian Government.

The first phase of the project involved the formation of writing groups comprising people from the University of Sydney, and senior staff from the laboratories in Ho Chi Minh and Hanoi. The groups met frequently to oversee the complex task of the drafting institute-specific quality manuals and associated documentation in both English and Vietnamese. Preparation of documents was central to the success of the project, so a 9-12 month period was set aside to ensure that the final documents met the needs of both institutes and were also compliant with ISO15189. It was also necessary to ensure that the Vietnamese translations
accurately reflected the meaning of technical documents initially drafted in English. This required translators who were fluent in both English and Vietnamese, and also trained and experienced medical laboratory scientists who understood the concepts outlined in the documents and possessed the required technical vocabulary in both languages. Needless to say, people with such a mix of skills are very rare!

During the period of document drafting, the Sydney team also developed a number of training courses and programs, including training-of-trainer programs in quality management, and training courses in quality auditing, equipment calibration and method validation. These focused on the technical and managerial requirements of ISO15189. Two adult educators from Learning Solutions at the University of Sydney were recruited to the project in order to ensure that best practice adult learning techniques were applied. The completed training course notes and presentations were then translated into Vietnamese.

Training of trainers in quality management was undertaken in Hanoi and Ho Chi Minh City in 2009-10. In December 2010, the first group of quality management trainers from laboratories in 20 southern provinces were trained at Pasteur Institute. Collectively, trainers from the two major institutes have trained more than 250 laboratory staff in the principles and practice of quality management in 15 separate courses. The first provincial laboratory Quality Management training course was held at My Tho, Tien Giang Province, in February 2011, with trainers from Pasteur and laboratories collaborating in the delivery of this course. It was very gratifying to observe the realisation of our goal of sustainability in quality management training in Vietnam.

QUALITY MANAGEMENT

Auditing is an essential aspect of laboratory quality management. It is necessary to audit each component of the quality system at least once per year to ensure its integrity and to identify and correct non-conformances. Audit training was provided at Pasteur in Ho Chi Minh in July 2010 and at National Institute of Hygiene and Epidemiology in Hanoi, and in the southern city of Can Tho in April 2011, resulting in a total of 68 trained ISO15189 auditors to date. Upon completion of training, the new auditors wasted no time in commencing audits of their quality system in preparation for ISO15189 accreditation. Training of trainers modules are being developed for the quality audit training course and training is planned for November 2011, which will further embed the sustainability of quality management training in Vietnamese public health laboratories.

Another essential requirement of laboratory quality management is enrolment in an external quality assurance program, in which the laboratory receives blinded specimens and is required to examine them and identify the unknown pathogen and/or cause of disease. These programs provide a rigorous test of the integrity of the quality system and participation is an essential prerequisite for ISO15189 accreditation. Currently, there is no external quality assurance program available in Vietnam. The National Institute in Hanoi has been directed by the Ministry of Health to develop a national quality assurance program over the next three years, but in order to ensure that the two reference laboratories comply with international quality standards in the short-term, the project has funded the provision of the Royal College of Pathologists of Australasia external quality assurance program to both institutes for a period of two years. This will be reviewed in 2013 and the need for an extension addressed.

The introduction and maintenance of laboratory quality management is a complex task requiring good leadership, communication and teamwork. Much of the workload is carried by designated institutional “Quality Managers,” whose task is to ensure laboratory and institutional compliance with the quality system and to prepare their institute for accreditation. In order to assist the National Institute of Hygiene and Epidemiology and Pasteur Institute in Ho Chi Minh City in this difficult role, a study tour of several large Australian hospital and public health laboratories was arranged in November 2010. Tour participants were given privileged access to a large amount of confidential information and documentation on how several leading Australian clinical and public health laboratories manage their quality systems and prepare for ISO15189 accreditation. They were also able to network with Australian quality managers which has provided an excellent source of advice and support in preparing for their own accreditation inspections.

In conclusion, the quality management capacity building project has been well received throughout the public health laboratory system in Vietnam, with 12 leading laboratories in Hanoi, Ho Chi Minh and in Tien Giang Province, achieving ISO15189 accreditation to date. Numbers are growing, with 13 more planning accreditation inspections in the coming 12 months. Other than Vietnam, the only countries in the Asia-Pacific region to have ISO15189-accredited public health laboratories are Australia, New Zealand, Japan, Singapore, Korea and Hong Kong. This is a major achievement for a developing country and has placed Vietnam in a unique position to serve as a regional leader in the global surveillance of epidemic and pandemic disease.

Acknowledgments: Quality management projects cannot be successful without good teamwork. The quality management teams at NIHES and PI-HCMC have worked tirelessly and enthusiastically to achieve their goal of institutional accreditation against ISO15189 and have been rewarded with outstanding success. I also wish to thank our translators and interpreters, Drs Tran Phuc Hau, Pham Ngoc Doan Trang and Dang Thu Ha, Mrs Trinh Quynh Mai and Mrs Tran Dieu Linh, whose painstaking work has been critical to our success. Finally, I wish to acknowledge the wonderful USyd team with whom I have worked closely on this project: Dr Monica Lahra and Ms Emily Bek from Infectious Diseases and Immunology, Mrs Jane Cox and Ms Nicola Reade from Learning Solutions and Ms Megan Brever and Mr Stephen Brancatisano from the Office of the Deputy Vice-Chancellor (International). Without their dedication, creativity, generosity and enthusiasm this project could not have been successful.
Eliminating female genital cutting in sub-Saharan Africa

The Partnership for the Abandonment of Female Genital Cutting in sub-Saharan Africa is one of eighteen Sydney Medical School projects to be successful in gaining support from the University’s International Program Development Fund for 2011. Led by Dr Nesrin Varol, International Development Manager (Africa), Office of Deputy Vice Chancellor (International) and Clinical Senior Lecturer, Sydney Medical School, the project is a joint venture between the University of Sydney, the University of Nairobi and the World Health Organisation. It will also involve collaboration with the United Nations Population Fund, the University of Washington and Ghent University, Belgium.

By Kirsten Wade

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For more information on our engagement with Africa, contact Mohsen Soliman: mohsen.soliman@sydney.edu.au

Funding from the IPDF and Sydney Medical School totaling $29,000 will contribute to a project aimed at eliminating female genital cutting (FGC) in sub-Saharan Africa through the establishment of an African Coordinating Centre. The Centre will act as the principal facility for partnership, research, capacity building and policy-making at the University of Nairobi with links to Kenyatta Hospital. The aim is to train health care professionals to care for women who have had the procedure, as they require specialised care, especially during childbirth. This training assists health care professionals appropriately deal with the long-term complications associated with FGC, including medical and psychosexual complications. A team of obstetricians, gynaecologists, scientists, anthropologists and psychologists has been assigned to the Centre to support the training of health care professionals to assist in the treatment of patients. Professors John Hearn, Bob Cumming and Lyndal Trevena, Mr Joel Negin and Mr Mohsen Soliman are part of the team from the University of Sydney.

Female genital cutting refers to all procedures that involve partial or total removal of the external female genitalia and/or other injury to the female genital organs for cultural or any other non-medical reasons (WHO 2010). The World Health Organisation identifies four main grades of FGC.

i. Clitoridectomy: partial or total removal of the clitoris.

ii. Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.

iii. Infibulation: narrowing of the vaginal opening through the creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without removal of the clitoris.

iv. Other: all other harmful procedures to the female genitalia for non-medical purposes, including pricking, piercing, incising, scraping and cauterizing the genital area.

FGC is performed on girls from birth to the age of 15. Dr Varol says, “It’s a deeply rooted cultural practice that pre-dates all the major religions and goes all the way back to the Pharaohs.” It is performed in the belief the woman will stay a virgin, that it will decrease her sexual urge and that it will ensure she is not promiscuous, which in turn makes her culturally more marriageable. “For many women in sub-Saharan Africa marriage is often the only means of survival” Dr Varol said.

Although culture and tradition are central to FGC, there are a number of complications associated with the practice. Often performed in unhygienic conditions and without anaesthetic, infection rates are high. In addition to infection, fistula, and haemorrhage, pain during urination, menstruation and sexual intercourse are also medical complications from FGC. For females who undergo the procedure, repercussions are long lasting and are often further complicated during pregnancy. A landmark prospective collaborative study by WHO involving about 30,000 women at 28 obstetric centers in six African countries has clearly shown that women with the most severe form of FGC have a 30 per cent higher risk of undergoing a Caesarean section, and a 70 percent increase in postpartum haemorrhage compared to women who had not undergone FGC. The perinatal mortality rate was 15, 32 and 55 percent higher in women with FGC type I, II and III, respectively. The practice can be a traumatising experience leading to possible long-term psychological conditions, including psychosexual and post-traumatic stress disorders.

The fifteen-year project to eliminate FGC recognises the importance of not simply imposing Western ideas and practices on communities of African countries. “It takes a long time to actually build relationships, establish trust, form friendship and only then can you start to discuss what you had in mind,” Dr Varol said. “Our discourse and engagement with sub-Saharan Africa, and in low income
countries in general, need to be collaborative. Programs need to be with people rather than doing things to them. “The programs that have been most successful in dealing with this particular issue are those that have been built around the principles of human rights,” Dr Varol said. Through education and health care promotion, the project has a particular focus on empowering women, which is in line with the United Nations Development Millennium Goals. Robert Cumming, Professor of Epidemiology in the School of Public Health and Chair, University of Sydney Africa Expert Group, explains, “Education of girls and women in Africa is the best way to produce results.”

This human rights focus is echoed by the term change from female genital mutilation to female genital cutting. In explaining the reasoning behind the term change Dr Varol, Professor Cumming and Mohsen Soliman from the Office for Global Health noted the judgmental characteristic that the term ‘mutilation’ carried. “‘Cutting’ doesn’t carry the same negative connotation that mutilation does, which is so important when you’re working with communities that carry out these practices,” Dr Varol said.

By working with community leaders to provide health care education and opportunities to discuss their cultural practices in relation to human rights, individuals and communities can determine for themselves the harmful physical and psychological effects of FGC. “If you communicate that they have the right to health care, the right to education, that mothers have the right not to subject their daughters to this procedure, not be ostracised and still be able to marry off their daughters,” Dr Varol said, then the community can work together towards the elimination of FGC. Dr Varol also credits the media for the role they have played in reducing FGC rates so far. Health care promotion through radio and television, as well as more recently mobile phones, allow even rural communities to stay in touch with changing societal practices, such as the elimination of FGC.

Professor Cumming explains a number of African countries, including Kenya and Uganda, have taken an important step in eliminating female genital cutting by outlawing the practice. In late 2001, the Kenyan Government passed a bill banning female genital cutting on girls under the age of 17. Harsh penalties were enacted, including a minimum one-year prison sentence, to act as deterrents for those engaged in the practice. While this ban has been seen as victory for women’s rights, Professor Cumming highlights the fact that “simply making it illegal is useless unless it is enforced.”

The FGC project is starting in Kenya as facilities are already well established and The University of Sydney signed a Memorandum of Understanding with the University of Nairobi in 2010 to signal a commitment of working together on issues pertinent to Africa. Once established, this project aims to extend beyond Kenya to Sub-Saharan Africa, then to other parts of Africa and the remainder of countries where FGC is practiced. “I believe we will see the end of FGC within a generation, which is 25 years, because we are already seeing a significant decrease in the practice,” Dr Varol said.

In October this year, Dr Varol and Professor Cumming, along with Professor John Hearn, Deputy Vice Chancellor (International), will travel to Nairobi to host an international conference on the FGC Project. It will be attended by the institutions already involved, including WHO and UNFPA, as well as non-government organisations, who already have established programs in the region, key researchers and funding bodies. The conference will provide opportunities for collaboration and proposals for further research, education and funding. Dr Varol reiterates the purpose of the project, “One person can do good things, but to do great things you’ve got to have a team.”

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**Our engagement in Africa**

**RESEARCH COLLABORATIONS**

**Kenya**

There are ongoing collaborations in the area of non-communicable disease (NCIDs) (diabetes, obesity, tobacco, hypertension). The University of Sydney is working with the University of Nairobi and the Ministry of Health to strengthen the evidence base for action in this area.

Mr Joel Negin is working with collaborators in Kenya, Uganda and Malawi on HIV among older adults.

**Uganda**

Professor Bob Cumming is a regular visitor to Uganda, where he teaches at Makerere and Gulu Universities. He is involved in research projects in Uganda related to control of non-communicable diseases and also the impact of HIV on older people. He is on the Scientific Programme Committee for the International Association of Gerontology and Geriatrics conference to be held in Cape Town in 2012 – the first ever conference on ageing in Africa.

**TEACHING AND LEARNING**

**Student Exchange**

Zambia with Mikuni Village Hospital.

**Uganda with Makerere University**

**Capacity Building**

Sexually Transmitted Infections Research Centre (STIRC), University of Sydney, led by Professor Adrian Mindel has been awarded Australian Leadership Awards Fellowships to run Short Intensive Professional Program in HIV (SIPP-HIV) for 15 fellows from the following countries: Botswana, South Africa and Zambibia.

The program will provide HIV-related knowledge and skills to two professional groupings:

1. A Medical Stream (targeting doctors, nurses and laboratory personnel).
2. A Program Delivery Stream (targeting educators, public health professionals and Program managers).

The short intensive course is expected to start in August this year.
MedSoc turns 125 years old!

On April 9, Medsoc celebrated its 125th birthday since Professor Anderson Stuart founded the society in 1886. The following is an excerpt from their publication The Centenary Book of the University of Sydney Medical Society:

For three years following his arrival from Edinburgh, Thomas Anderson Stuart, the young and forceful Professor of Anatomy and Physiology at the University of Sydney had taught, fought, planned, schemed and organised. He had founded a medical school and flattened opposition to his far-sighted prospects which many regarded as over-ambitious, even grandiose. By March 1886 plans were almost complete for ‘Stuart’s Folly’, the impressive stone building designed to accommodate many more students than the 39 then enrolled.

But Professor Stuart was a sad man. His young Scottish wife, lonely in a new land, had died in tragic circumstances. In the first weeks after his bereavement, he turned his active mind to a long-cherished plan to found at the new University a Medical Society founded on the ‘ancient’ Royal Medical Society of Edinburgh. He called a meeting of students and teachers to discuss the idea and the gathering took place on Friday, 9 April 1886, in the small cottage which then housed the medical school.

There and then was born the first faculty society of the University of Sydney. Its object was ‘to work for the intellectual and social improvement of its members by lectures, essays and discussions in any branch of medical science and by any other means calculated to advance the objects of the Society’. The annual subscription was fixed at 2s 6d and remained unchanged for many years. The first Honorary Secretary of the Society was a student, Arthur Henry, who recorded minutes in an ordinary exercise book that has been preserved. The first monthly meeting was held on 14 May 1886 in the Clinical Theatre at Prince Alfred Hospital, with Professor Stuart as Honorary President conducting proceedings.

Forty members and 18 visitors heard the paper ‘Medical Societies, Medical Students and Their Teachers’ read by Dr Scot Skirving. Other papers given during the year included ‘Anaesthetics’, ‘The Relation of the Medical Profession to Culture’, and on 12 November ‘The Story of My Life as a Medical Student’. This last (unfortunately now lost), was the first contribution by a student and was given by the rotund Reverend D. D. Rutledge MA, one of the four medical undergraduates enrolled at the time of the arrival of the first professor. He was, by late 1886, the ‘solitary senior medical man’, and had he not failed his final examination, he would have been the first graduate of the new school. Hermes (the University’s undergraduate magazine) tended to mock this ‘happily proportioned’ pioneer who had a wife and a family as well as clerical obligations to serve.

It was not always easy for members to attend evening meetings. The noble academic temple built on the hill which had been part of Grose Farm was surrounded by open fields. The low-lying ground between the main buildings, the colleges and Prince Alfred Hospital was swampy, traversed by rough and muddy paths. The ‘pests of darkness’ — local larrikin ‘pushes’ — were a real menace, especially the ‘Darlos’ of Darlington and the alarming ‘Stars’, who infested the dark lane between the hospital and St John’s College. The journey home for those not ‘in college’ was on foot for those who preferred not to pay a fare on horse bus or chugging, hissing steam tram to Redfern Station or Leichhardt. [More online].
LEARNING TO LEAD

Hi Everyone,

Well SUMS has been very busy the last few months with many activities having taken place. In February we had 0-week and MedCamp, both were a huge success with over 400 students at the 0-week lunch and 150 first years and 50 second and third year mentors at the 3 day MedCamp.

March had the excitement of Red Party, an inter-faculty and inter-university event to raise money and awareness of HIV and AIDS. March also saw the commencement of inter-faculty sport and all the fun that that entails. We had our 126th AGM on the 11th of March as well and this was attended by about 120 people all vying for positions. GlobalHOME started their lecture series and this has been met with much enthusiasm as they begin to demonstrate and highlight the inequalities in Global Health and, more importantly, what can be done to assist.

April was a great month for Medsoc as we had our inaugural Medical Leadership and Development Retreat in the Hunter Valley. This was an excellent weekend with almost the entire Council (38 people) present. We stayed in the beautiful Ironbark Hill Lodge in the Hunter Valley, a wonderful hideaway with tennis court, pool and an amazing relaxing environment where the council could get to know each other. In the past the retreat has been a time where council members get to know their portfolios and work out policy, this year we wanted to have more focus on supporting council members individually, creating and working on an effective team and building up the society so that it can continue to expand and represent our cohort.

Before the retreat began all the council members were required to complete a personality test supplied by our sponsors, Walkabout Consulting, and a facilitator came and explained character traits, helping us to understand and utilize our individual strengths. We spent Friday night playing team building games centered on communication and group activities and Saturday morning working through new policies and portfolio development.

The retreat also included a wine tour and a relaxing Saturday evening, capping off a highly productive and fun weekend that we hope will continue to be developed into the future.

MedBall, the main social event of every SUMS calendar year, was a huge success with over 500 people attending the sold out night. We wined and dined in Circular Quay at the magnificent Waterfront establishment. Thanks to everyone who made the night a huge success. We also had our annual Elective Snapshots night where fourth years come and inspire students about exciting elective opportunities. This was a great evening.

Coming up this year we still have many events including Medical Leadership seminars, the Women in Medicine Dinner on the 4th of August, the Lambie-Dew Oration on the 12th of October, and the 125th celebration week starting on the 10th of October and running until the 15th of October. The 125th Celebration week will focus on bringing together both Alumni and current students to share in the celebration of such a milestone.

Thanks and see you soon, Zac.
A major gift from the Thyne Reid Foundation will provide two years’ funding for a Fellowship in Osteogenesis Imperfecta, to be based at The Sydney Children’s Hospitals Network – Westmead Campus. The Fellowship will facilitate clinical research projects directly aimed at improving the well-being of children and adolescents with OI, known as brittle bone disease. Children and adolescents with OI have the most severe bone fragility of any disorder in medicine and require specialised medical care.

Thyne Reid is a private foundation established over 50 years ago, and a staunch supporter of Sydney Medical School.

A Trustee of the Thyne Reid Foundation, Mr George Reid, was the catalyst in bringing together Australia’s leading OI specialist, Associate Professor Craig Munns, with the resources of the foundation to enable Craig to recruit an Osteogenesis Imperfecta Fellow to undertake clinical research into the investigation and management of children and adolescents with the disorder.

The Sydney Children’s Hospitals Network – Westmead Campus provides ongoing care for all children and adolescents with OI in New South Wales and ACT, totalling over 150. This number is greater than any other hospital in the Southern Hemisphere. Associate Professor Munns has established a multidisciplinary management team including a Bone and Mineral Physician, Clinical Geneticist, Orthopaedic Surgeons, Rehabilitation Physician and Allied Health Professionals, all of whom are leaders in their field. Together the team provides world’s best care for children and adolescents with OI and other diseases that affect bone strength.

The Thyne Reid Foundation also recently provided further funding for the Chair in Adolescent Medicine, held by Professor Kate Steinbeck, through Sydney Medical School Foundation.

Established by the late Andrew Thyne Reid in 1944 and 1955, Thyne Reid encourages and supports projects in the fields of medicine, science, creative arts, environment, education, social and community needs.
Unveiling the Future

Everyone was young again. Inspired. Dreaming of what lay ahead and what could be achieved through hard work, dedication and the right opportunities.

The audience was enthralled with the story being told by a young scholarship winner and medical student, Arridh Shashank. A scholarship had enabled Arridh to accept an invitation to present his research paper on sensors in artificial hands to a major U.S. medical technology conference.

He spoke about the amazing opportunity that had provided him with the confidence and motivation to continue with his ground-breaking research in this field.

Arridh’s story epitomized two of the strategic priorities of Sydney Medical School for its students described by the Dean in his opening remarks: research capable and globally engaged.

And in the audience were the generous donors that had made Arridh’s scholarship and many others possible.

The occasion was the formal unveiling of the honour board to recognize the Dean’s Scholarship Fund Founding Contributors. The Board is located in the Burkitt-Ford Lounge in the Edward Ford Building.

Speaking at the unveiling, the Dean of Sydney Medical School, Professor Bruce Robinson spoke passionately about the need to provide opportunities and support to medical students and post-graduate researchers.

“Helping medical students become the doctors and researchers that the community needs is one of the most important contributions we can make to the future of medicine and healthcare. I invite you to continue your support of our scholarship program as demand for all kinds of scholarships still far outstrips the available resources,” he said.

SCHOLARSHIPS

Through Sydney Medical School Foundation, Sydney Medical School provides scholarships to students enrolled in medical and postgraduate research degrees. Some of scholarships we are looking to expand include:

- Undergraduate financial hardship
- Undergraduate honours research
- Indigenous
- International research
- Postgraduate research
- Postgraduate merit

For further information about how to support scholarships, please contact Melanie Balsom, Sydney Medical School Foundations melanie.balsom@sydney.edu.au or telephone: 02 9036 9181

Changing the Health Care System (or Swimming with Sharks)

By Stephen Leeder
Director of the Menzies Centre for Health Policy

It is reasonable to be sceptical about change in the organisation of the health system. There is nothing linear about its construction: it is highly complex. Change to it is not easily fitted into the tight jacket of a randomised trial so solid evidence is hard to find about what the best thing to do may be. And even when you are clear about the need to change something in it, it remains difficult to actually do it.

I recall a conversation with Brian Howe in 1992 when he was federal minister for health (1990-1993), a portfolio to which he moved following a highly successful reforming stint in social security between 1984 and 1990.

The morning we conversed the press had given him heaps over a major health budget blunder and he had ended the media conference by attempting to escape through a door only to find it led to a cupboard. “I came into health,” he said, rather testily, “thinking that there are all these levers and if you pull them, things would happen. But the fact is that when you pull them nothing happens, or something goes bang in an unexpected place!” I suggested a Heath-Robinson machine as an analogy. He was in no mood for jest but thought that accurate. If I had been quicker I would have suggested a new category of complex machinery – a Health-Robinson device, named after our current dean.

Howe was succeeded in the health portfolio by Carmen Lawrence and I don’t imagine her experience was all that different.

But change is in the air! New South Wales’ publicly-funded health system comprising 220 hospitals and 500 community health centres, ambulance service and care given to special groups including prisoners and asylum seekers, has been reorganised.

For six years the hospital and community health services in NSW have functioned as eight large entities, together with separate arrangements for ambulance services, Justice Health and the Westmead Children’s Hospital, each with a chief executive answering directly to the director-general for health and through him or her to the state minister. Now we are downsizing and decentralising.

Long, long ago, in late 2004, 17 smaller health areas were rolled into the larger areas that existed until March this year. The pre-2004 smaller areas had boards overseeing them and connection through them to local communities of interest, including clinicians. Their role in management was ambiguous because they were not governing corporate entities. They had limited control over budgets because income was determined by the health department and control over expenditure was incomplete. If an area health service decided to close, say, an obstetric service because it could not afford it and the number of deliveries did not justify retaining it, there may have been a central directive to keep it open, although this was not invariably so. But they did represent the local area and helped sort out local health care delivery problems.

The post-2004 larger areas were established to cut down on the costs of managing multiple small areas, to enable clinical services to be more effectively networked, extending access to specialised services to communities that previously were underserved, and increasing the power of director-general, department and minister to manage the system. Several areas had been managerial nightmares and bad things had happened. Take the power back to the centre was the credo.

But with increased centralisation, greater central accountability followed and so state ministers for health found themselves answering media inquiries about adverse events occurring in distant if not unknown parts of the realm. Why are people waiting six weeks for elective somethingotmy at Galarbanbone? Often the minister did not know and a flurry of bureaucrats was dispatched to find out.

The intention of greater centralisation was to draw back resources for such things as IT to the centre and to use these resources to better effect: uniformity of quality and greater efficiency for the whole state. Once every state in America had its clocks set to a different time, and railways operating on lines with idiosyncratic gauges. The big areas aimed to ensure a single clock and gauge, so to speak, throughout NSW.

In some cases, as with financial services such as payroll and aspects of procurement and purchasing, this made great sense and worked well. In relation to IT, the judgement about centralised services of those who use it for clinical purposes is mixed at best and intensely negative among others. Clinicians and community alike complained that their input into planning and finding new pathways to effective and efficient care had ceased. Their voices were not being heard, they said.

The huge size of several of the post-2004 areas meant that the chief executive had a parish that often proved too large to manage effectively and for familiarity to be...
The big challenges in health care today are two: first, the management of patients with multiple chronic problems is our core business for the foreseeable future. The two challenges converge as we seek better quality ways of assisting people to cope with these long-term health problems. Prevention in all its forms, beginning in the community and concluding in optimal palliative care, has much to offer.

A health service with a lively interest in effectiveness and efficiency requires innovation (for which clinical research and energised clinicians are critical elements) and quality that connects with the community. Tussles between Commonwealth and state, and competition for resources will always bother us, but less so if we have a single payer rather than two – Commonwealth and state – that shift costs and blame like Chinese checkers around the board. The new arrangement, though hardly informed by evidence of a quality that many clinicians desire, open pragmatic possibilities for better deals for patients, communities, clinicians and managers.

SWIMMING WITH SHARKS

Contemplating my fate as chair of one of the new health district boards, my imagination (Ah! The poetry of it all!) led me to consider the analogy of swimming among sharks. I am not inferring that my colleagues have double rows of razor teeth, but you get the drift. Accordingly, I consulted Google* for advice on how I might do this safely, or at least minimise my risk.

I found an essay written by Volatile Cousteau (both good names for such an inquiry) in the early 1800s for sponge divers. Cousteau began rather demurely by saying:

“Actually, nobody wants to swim with sharks. It is not an acknowledged sport and it is neither enjoyable nor exhilarating. These instructions are written primarily for the benefit of those, who, by virtue of their occupation, find they must swim and find that the water is infested with sharks.”

He then offered advice under the following headings:

• Assume all unidentified fish are sharks.
• Don’t bleed (apparently experts have a reflex ability to shut down wound haemorrhage – this made me wonder about the authenticity of the article).
• Counter any aggression promptly – by thumping the shark on the nose

I think there may be wisdom there. I shall ponder.

* www.apor.org/html/how_to_swim_with_sharks.htm

 established between management and clinicians, especially with the communities that were to be served.

Now the big areas have been chopped up into smaller ones. The draw-back to the centre has depleted the stock of middle management in the periphery, as one might expect because this was intended. But a challenge now, with the reopening of the smaller areas, will be to develop capacity to create local policy, oversee its implementation, and work with the state-wide institutions that persist after the Garling report into acute services, in quality, innovation, health service information and workforce development.

There is now convergence among the Roxon-Rudd federal health reforms, the Tebbutt-Kenneway changes and now the Skinner-O’Farrell legislation in relation to size of managerial units for the publicly funded health and hospital services. We have returned to the smaller health areas.

We have boards again, possibly with more autonomy and accountability than those pre-2004, and we await the effects of other federal changes. These include a greater dependence on funding for the volume of what is done in a hospital – activity based or case-mix funding – and the Commonwealth moving to provide a progressively greater share of funding.

In addition, there is hope that with greater public investment in primary care, partly managed through the formation of locality-specific organisations that bring general practice and community services together in Medicare Locals, better services will be offered to the community beyond the hospitals and greater harmony in care achieved between primary care and hospital/ community health services.

Our new state minister for health, Jillian Skinner, is also the minister for medical research. State research infrastructure funding will be returned to the health portfolio. She understands the importance of research as an element of high-grade clinical practice so this offers hope. Education is a huge budget item for NSW Health and this, too, will need to be adapted as the new structures take shape.

The big challenges in health care today are two: first, we must come to terms with unsustainable cost rises due to new technology, population ageing and rising community expectations. We need to be smarter, better informed and disciplined in the way we use resources. Second, boring and uninteresting though it may be, the management of patients
Dr Donald Kinsley Faithfull
MBBS 1959 FRACS, FAOrthA

In February 1995 I was in the autumn of my career in the Royal Australian Navy Reserve having been commissioned as a surgeon lieutenant commander in 1976 and still with the two and a half rings on my sleeve. I had enjoyed my time both on ships and as an orthopaedic consultant at HMBS Penguin the Balmoral Naval Hospital. It had been a pleasant but ordinary naval career. That changed when I received a phone call requesting me to report to Randwick barracks in April 1995 and be prepared for deployment to Rwanda as part of the medical support force in the U.N. peacekeeping operation UNAMIR II. It meant I would be away from my private practice and family for two months.

The Australian medical support force consisted of a group of dedicated doctors, nurses, medics and administrators along with a dentist, physiotherapist, Red Cross girl and a radiographer. We were supported and protected by an Australian rifle company. The specialist groups, which were rotated bimonthly, consisted of an orthopaedic surgeon, a general surgeon, an anaesthetist, an intensivist and a tropical medicine specialist. None of us had been in a war zone before so spent a lot of time learning about the history and geography of Rwanda and the genocide, equipping ourselves with camouflage uniforms and webbing, and finally learning how to strip, assemble and shoot a Styr rifle.

As a National Serviceman, I had learned to fire a .303 and a Bren gun. Both were heavy, unwieldy and had quite a kick. The Styr rifle was very light, being mainly plastic, and very accurate. When fired there was no kick and anything in the circle of the sighting was blown away. I spent one day on the rifle range learning to shoot my rifle and I admit I enjoyed every minute.

We arrived in Kigali on the Friday and spent the weekend the Rwanda Patriotic Army (Tutsi) exchanged places with the specialists. That and I admit I enjoyed every minute. I spent one day on the rifle range learning to shoot my rifle and had quite a kick. The Styr rifle was very light, being mainly plastic, and very accurate.

When fired there was no kick and anything in the circle of the sighting was blown away. I spent one day on the rifle range learning to strip, assemble and shoot a Styr rifle. Australians were the only group that carried rifles with twenty rounds of ammunition in the magazine. Before entering a building it was necessary to remove the magazine and fire into a sandbag to demonstrate that the rifle was now unloaded. It was a court martial if the rifle went off. We were not allowed to put strapping across the first round to prevent it going into the breach. The trick was to mark the top round in the magazine so you could see that when you removed the magazine there should not be a round in the breach.

Every member of the medical support force including doctors and nurses had to carry a loaded Styr rifle. Australians were the only group that carried rifles with twenty rounds of ammunition in the magazine. Before entering a building it was necessary to remove the magazine and fire into a sandbag to demonstrate that the rifle was now unloaded. It was a court martial if the rifle went off. We were not allowed to put strapping across the first round to prevent it going into the breach. The trick was to mark the top round in the magazine so you could see that when you removed the magazine there should not be a round in the breach.

On several occasions we were allowed to go down town to the markets and to a particular cafe. We had to go in a group. Girls were not allowed to go without male company. The locals were quite friendly but who wouldn’t be when they knew the person they were haggling a price with had a loaded rifle on his shoulder. When we were in the cafe we wanted to appear friendly so stacked our rifles under the table.

We were on call for the Central hospital casualty department so did see some routine orthopaedics. It meant we did rounds in the civilian wards and came in contact with some of the local doctors. There was one very good and experienced Rwandan surgeon who I had the pleasure to assist with some conditions straight out of the old surgical text books. His English was perfect and our relations ran smoothly except for one occasion when I complained about the conditions I was living under. He noted that in a short while I would be getting on a big white UN plane and would return to the good conditions I was used to.

During my deployment in Rwanda I had the honour of a field promotion to Surgeon Commander. The flag went up in the Officers mess for two hours during which time I provided drinks to all members. Also it was a great relief to get into the sling hammocks in the UN plane and insert the ear plugs for our journey out of Rwanda. Seeing the back door slowly swing up and feel the lurch as the Hercules ended our adventure produced a mixture of relief, release and relaxation as I looked forward to seeing my family and homeland.

because the Interahamway (Hutu militia) were hiding in the centre of the camps. They did this by lobbing mortars into the camps. A group of Australian journalists were in one of the camps and told the world what was happening. Australians suddenly became persona non gratis and our hospital was surrounded by a rioting mob telling us to go home. I was supplied with a blue helmet and a flak jacket. We were told that if the S H * T actually hit the fan our assembly point was the mortuary and we would be guided by a rifle company to Uganda “if at all possible”. Fortunately things didn’t get that bad. Carrying a loaded rifle and doing rifle drill seemed reasonable although it gave me an odd feeling to have a red cross on one shoulder and a loaded Styr rifle on the other.

We treated people coming out of the jungle with old infected wounds from the genocide, new gunshot and machete wounds, and children who had been playing with ordinance such as hand grenades and rifle rounds, lying around everywhere. The most ghastly were the land mine injuries usually caused to the young girls who were working in their vegetable patches unaware that a small plastic landmine had been washed in during the last rain storm.

The building we worked and slept in was the obstetric block of the Central Hospital Kigali. It was surrounded by barbed wire and with armed sentry boxes at the front and back doors. Our operating theatre was beyond the back sentry box which meant we had to take the rifles with us into the operating theatre and have them stacked up in the corner while operating. We were informed that if we came under attack we were to defend ourselves until the rifle company arrived.

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One of the highlights of the social calendar of the Medical Society of the Sydney Medical School is the Lambie-Dew Oration. Last year we were very privileged to have Professor Patrick McGorry, our own much esteemed alumni and Australian of the Year 2010, deliver this oration. Professor McGorry presented a review of his work on the mental health issues facing our young people. As I mingled with the medical students prior to the oration, I was surprised to learn that very few were aware of whom this oration honored. There was a feeling that it might indeed be one person, Mr Lambie Dew.

The Lambie-Dew Oration was established in 1958, to honour the first full-time Professors of Medicine and Surgery at the University of Sydney, Professor C.G. Lambie and Professor Sir Harold Dew respectively. They each retired in 1956. Both of these men had extraordinary careers. Charles George Lambie (1891-1961) was born in Trinidad, schooled in Scotland, where later he graduated from the University of Edinburgh (MBChB, 1914). Having served in the Royal Army Medical Corps during the First World War, Lambie returned to Edinburgh as a researcher/physician. He was awarded an M.D. in 1927. In 1929, he applied for the newly created G.H. Bosch chair of Medicine at Sydney University, was successful, and arrived to take up his post in 1931. Known affectionately as the ‘Wee Mon’ by his students, Lambie and his surgical counterpart Dew were responsible for the massive revision of the medical curriculum which remained in place until 1974.

Sir Harold Robert Dew (1891-1962), unlike many of the early academic staff at the Medical School, was an Australian. Dew was born in Melbourne, and graduated M.B., B.S., 1914 from the University of Melbourne. Dew sailed to England the following year and he too joined the Royal Army Medical Corp. In 1919, Dew returned to England, where he completed his post-graduate studies and was admitted as a Fellow of the Royal College of Surgeons. In February 1930, his application for the newly established Bosch chair of Surgery at the University of Sydney was successful and he joined Lambie in the expanding Faculty of Medicine. He later served as Dean of the Faculty and a Fellow of Senate of the University.

The first oration was delivered in 1958 by Professor Wintrobe from the University of Utah, but better known to all medical students as an editor of the popular text Harrison’s Textbook of Medicine. The Oration has continued to be delivered as an annual event. The orators have all been exceptional individuals, predominately, but not exclusively from a wide range of medical interests. An examination of the subjects chosen provides a snapshot of ‘hot topics’ of the times. A full listing of all the speakers can be found at sydney.edu.au/medicine/museum/mmwuseum/index.php/Lambie_Dew_Orators

Editors note: Congratulations to Clinical Associate Professor Cate Storey on her award of OAM, for service to medicine in the field of neurology, to stroke education, and to professional associations.
Helen Watts (nee Wood)
MBBS 1971

When I was a young doctor I came over to England and have been here ever since. My husband and I settled in a small village near Wootton Bassett in Wiltshire and this has been our local town ever since. However, Wootton Bassett has taken on a much greater significance and importance for me in recent times, for two different reasons. The town has become famous for honouring soldiers who have died in active service, as they pass through Wootton Bassett from Lyneham RAF Base, on their journey home. It started small but now each repatriation is attended by hundreds, sometimes thousands of people – family, friends, servicemen and women, high-ranking officers and dignitaries, and many ordinary people who wish to show their respect. People travel hundreds of miles to be there. With a strong military tradition in our family, including my husband and our son, we have attended many repatriations and have been glad to do so. In the simple, silent ceremony the dead and wounded are remembered, the family and friends are brought some comfort, and it has helped to restore national pride as the town is now synonymous with honouring dead soldiers, regardless of one’s political beliefs. After many years of a very busy work career, I took up the violin again; and when my teacher thought I was ready, I joined Wootton Bassett Orchestra.

Never having enjoyed the orchestra experience before, it has been a great thrill to me! I was initially amazed at the speed of playing, and have had to work extremely hard to keep up! We have regular concerts, have guest musicians and raise money for charity. This week, WBO is performing at a concert with a popular singer/composer, and our following concert includes Beethoven’s 5th Symphony. At times, I have felt moments of joy being part of a big sound and that is good!

Anthony Zehetner
MB BS 2001
BPharm (1996)
currently completing MM (Paediatric Medicine)

Since attaining my Fellowship with the Royal Australasian College of Physicians (FRACP) in 2010, I have been working as a Specialist General Paediatrician at Gosford Hospital, as well as a Staff Specialist in Adolescent Medicine at The Children’s Hospital at Westmead. There I run the Teenlink Service for 8-16 year olds who are from families affected by substance abuse. I also have interests in behavioural disorders and psychopharmacology, and have recently published a chapter in a textbook on the subject. I continue to pursue my research into breath-holding attacks in toddlers and have been busy establishing a paediatric practice on the Central Coast. The nature of ‘celebrity’ in our society is a poisoned chalice. Like progress in Medicine, it may be a force for benevolent altruism or great harm. When asked what they want to be when they grow up, today’s children will often reply with “famous” whereas their predecessors might have supplied a vocation such as a “fire-fighter”, “teacher” or “nurse”. The advent of the internet promises (unattainable) dreams of fame and stardom. Networking websites create a social paradox of increased ‘connectedness’ to others in the setting of an isolated user. Increasingly I am seeing young people with symptoms of ‘internet addiction’ in my clinic. Is our current generation of youth missing out on developing effective interpersonal skills?

My own brush with a public luminary came at the end of 2006 when I was working as a Paediatric Registrar at Royal North Shore Hospital (see photo). A visit from Paris Hilton was bestowed upon the staff and Children’s Ward inpatients at short notice. Outside a media circus had gathered. To her credit, Ms Hilton was gracious and considerate to the children she met, even though most didn’t know who she was. I am sure that many a signed photo and plaster cast was sold on eBay that day and made children happy that they could buy what they really wanted!

I still have (and use) my stethoscope which she wore for the photo. It didn’t end up on eBay, I hold onto it because it is a reliable tool rather than for any sentimental reason. I do recall asking Ms Hilton what she had wanted to do when she was a little girl. She looked pensive and thoughtful. I said, “If you ever wanted to be a medical receptionist, I will need one for my practice!” A genuine and heartfelt smile broke out. I thought I’d go in for the deal clincher. “I pay above the award wage”, I offered.

The grin deepened. She said, “I’ll think about it”. To this day she has not yet said no!

Peter Matthew Smith
MBBS (Hons) 2004

I am a currently serving Lieutenant-Commander in the RAN. I originally joined the Navy Reserve as a Psychologist 08 Jul 94 (after BA USyd ’92, MA (Psych) USyd ’94). I started medicine in 2001, coming into Navy full-time in February 2001. I completed my internship and was Resident Medical Officer at Westmead (and secondment hospitals). I returned to the Navy in January 07 and finished my Basic Officer training, then several qualification courses. I was deployed on operations to Middle East with HMAS Arunta in 2007, HMAS Parramatta in 2008 and HMAS Toowoomba in 2009. Since mid 2007, I have worked in diving and hyperbaric medicine at the Navy’s Submarine and Underwater Medicine Unit, and took over as head of the unit in Jan 2010. I have also worked at Liverpool Hospital and Prince of Wales Hospital as a part-time Anaesthetic Registrar (when not at sea). I am married with two children, a keen ocean sailor (but not enough time to do much sailing lately). Plans for the future include finishing anaesthetic training (hopefully on a full-time basis), and spending more time with my children. Above is a photo someone took of me on my way to review a patient in the North Arabian Gulf in August 2008.
REUNION OF 1956 GRADUATES

Our move to the new venue at the Royal Sydney Golf Club in Rose Bay was appreciated by all. We were fortunate in having a beautiful mid-spring day which showed the club with its surrounding golf course to advantage. For this reunion we extended invitations to the families of all graduates including our deceased graduates. Our seating was pre-arranged with graduates nominating guests at their table, and name badges with large letters aided recognition. The food, presentation, service and ambience were all excellent.

The attendance of 50 from our original 205 graduates was not as good as at our previous reunions, however a total of just over 100 were present at our function. Unfortunately our In Memoriam list has increased from 83 to 95 since our last reunion in 2005. We received apologies from 27 of our living graduates and a further seven apologies from the families of our deceased graduates. Surprisingly more than a handful of our graduates are still working.

The Governor of New South Wales, Professor Marie Bashir, who is one of our graduates, enthralled us with a talk on the fifth Governor of NSW, Major General Lachlan Macquarie, who was the King’s representative from 1810 to 1822. Macquarie took over the colony two years after Governor Bligh was recalled to England and during this interregnum the colony was managed by the military authorities. Macquarie arrived at a very crucial time when it appeared that the colony may not prosper, however, by the time he returned to England the colony had grown considerably and was very prosperous. Marie had, by request, given a similar talk at the recent Edinburgh Festival; it was received by a full house with a standing ovation.

We were honoured by the presence of Professor Bruce Robinson who is the current Dean of Medicine at our Alma Mater. The Professor informed us of the large part which our University in general and the Faculty of Medicine in particular are now playing in tertiary education both in Asia and in the Pacific region. Both Marie, in her capacity as Chancellor of our University, and Professor Robinson go to designated Chinese universities and conduct graduation ceremonies at which degrees are conferred on those Chinese students who successfully completed their medical education at the University of Sydney. The feedback from this initiative is very positive.

For light relief at the end of proceedings Michael Owen compared a competition amongst our graduates for the best personal story with a medical background. The bottle of Black Label was won by Jim Purchas for his story of a couple of red back spider bites in a little country outhouse over three generations and some 40 years.

Jim Purchas

REUNION OF 2000 GRADUATES

Anderson Stuart courtyard was the venue for our first reunion, well attended by those few graduates who had actually refused lucrative teaching and clinical positions overseas! There was a genuine atmosphere of warmth and enthusiasm even though some cynics would argue that the difference between a good and bad reunion is approximately 4.5 standard drinks (less on an empty stomach).

A quick scan of the room revealed a vast and impressive mix of medical professionals with life experiences as varied as being guest programmer on RAGE to working on Obama’s successful bid in the Illinois State Senate. (A busy GP practice precluding her from working on his 2008 presidential nomination.) Special thanks must be given to Benson Riddle for his witty impromptu speech and for leaving the duty of doing this write-up to a year 5 ‘ring-in’ whom three quarters of the year has never met.

Here’s to our 20 year reunion… only those directly involved in presidential campaigns of UN responsibilities shall be excused from not attending.

Sue Thanos

REUNION OF 1951 GRADUATES

On 24 November 2010, medical graduates of 1951 met for their 60 year reunion in the Refectory of the Holme Building, several decades after our last occasion at the university itself.
Traditionally we celebrate the anniversary of the Finals. Over seventy graduates attended, some with a partner of decades, others with a more recent one, a friend or younger relative. Some had overcome disability with remarkable effort to make it possible. Some came from interstate. Glen Duncan, our memorable wordsmith of early reunions, came as usual from California. We welcomed the Dean, Bruce Robinson and heard with interest about the faculty of today and the Dean’s Scholarship Fund. We appreciated his clinical intervention, for prompt care of one diner - and a good outcome within a few days. Dick Bull presented him with his recent book of poems “Wonder with a Sting”. The sunny day and pleasant lunch had tongues wagging, not only with reminiscence but with wonder about changes in modern medicine and tutelage. The organising committee, largely intact through the years, had enjoyed once again in a number of homes, months of understanding from tolerant families. At lunch some graduates regaled fellows for interest or entertainment, though it did become apparent that small group discussions in committee had been more audible! Joy Bearup (Boughton) read her amusing verse, keynoting envisaged reactions to our changing physical signs and likely difficulties in mutual recognition. Doug Casperson shared details of personal research into historical features of university and faculty. Fred Stephens read from his recent book “From Kurmond Kid to Cancer Crusader”, highlighting leadership challenges encountered as a youthful ship’s surgeon performing an appendicectomy at sea. Many messages of regret from other members of the year were duly shared. Sadly, some related unfortunate personal clinical events and frailty. Nevertheless we warmed to their continuing generous expressions of fraternity and goodwill. 

Eleanor Dawson (Shiels)

REUNION OF 1971 GRADUATES

Once again, and thanks to the sterling efforts of Keith Hartman, the graduating class of 1971 gathered at the Great Hall to celebrate our 40th anniversary of graduation from Medicine. Our thanks also go to the faculty staff for all of their help in the organisation of the Great Hall and the catering. 

It was a beautiful warm night and wonderful to see old friends and acquaintances again. Over 200 graduates, spouses and partners attended and included many of us who came from both overseas and from interstate. We were very privileged to have one of our distinguished alumni Clarissa Fabre speak on the role of women in medicine as she is now the President of the Women in Medicine Association of the United Kingdom. The faculty was toasted by media star John Darcy and a toast to the University was given by Doug Joshua, Chris Bambach and Michael Stevens provided musical accompaniments and helped us all sing with gusto the University and faculty songs.

To be able to reconnect with people whom we often have not seen for many years and to bring back the wonderful memories and the excitement of the times we had when studied medicine was certainly a fantastic experience. We graduated at a time when eccentricity was allowed, when career choice was open and we have all benefited immeasurably from our period of time at Sydney University. We look forward to meeting again at our 45th anniversary and Keith has promised to help with the organisation.

We can look back over the past 40 years and see how medicine and surgery have progressed. Research and technology have led to cures and surgical and radiological procedures have taken great strides. We all started our careers BC (before computers) and few of us can claim to have guessed or envisaged the remarkable medical environment we live in and practice in today.

Doug Joshua

REUNION OF 1953 GRADUATES

At Royal Sydney Yacht Squadron, Kirribilli

We were not an organised year in some respects. No ten year reunion; no fifteen year reunion; no Year book. We made a start after sixteen years when ten graduates formed the organising
committee for the first reunion. Some years later another successful reunion and then in 1990 (at 37 years) a reunion dinner in MacLaurin Hall at the University. Grey hair had become fashionable.

But the dramatic bit came with the fabulous “Reunion of Fifty Years.” To that, every living mortal graduate that was on Planet Earth made the effort to be present. From far and wide they flocked in. Some on crutches, in wheel chairs, hobbling, some still stalwart and youthful looking (or was I also going blind?). There were 120 graduates present. Lunch this time, not dinner.

Once more, heaps of congratulations, merry making, serious whispers, a few tears, bodies rapidly falling into decline, and the obit list getting inexorably longer.

Four years later – another reunion lunch. Numbers had fallen to just under 70, but the occasion was well worth the effort.

This year the Medical Alumni Association came to our rescue. They took over the “back office” work, getting address lists up to date, sending out invitations, receiving replies and subscriptions. What a marvellous organisation it is. Professor Bruce Robinson, Dean of the Faculty of Medicine, and good friend to many, and his team gave it full support.

So our 58 year reunion occurred on March 18, 2011. Numbers continued to decline, as time and illness took their inexorable toll. At this gathering, wives, partners, carers were also invited and, of the total attendance of 66, 55 were ’53 graduates. Previously it was strictly graduates only. Another great occasion. A number of brief “speeches” – Joan Ingham and Bernie Greer were notable and David Warden’s apology from Cooper Pedy was a stand-out.

John Knight for the "Graduating Class of 1953" Committee, the other members being John Cashman, Brian Morgan and Peter Geddes

Does your graduating year have an important anniversary in 2011-2012? 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.
Kevin Coorey began his love affair with classic cars back in 1950. His father lent the family garage to a young mechanic in the neighbourhood who was trying to make a living fixing and restoring cars. The deal was that this man could use the space, but keep an eye on young Kevin and look after the family car.

Despite the fact he didn’t drive, Kevin’s father bought a Morris Cowley. “Dad bought it cheap, but he couldn’t drive so I had to drive him around. It was a beauty, just right for two people, no doors, just a cockpit. Dad had a drapery business and I used to drive him about so he could carry out his business.”

“I must have been delirious when I went into medicine. I loved working on the cars. I was an expert panel beater and spray painter. I cleaned the metal meticulously and resprayed them just for fun. There were times when I should have been at lectures when I was in the garage – I nearly failed my exams in second year.”

The Cowley didn’t retain his interest long though and somewhere around the end of the 1950s, having passed his MBBS and becoming a Commonwealth Consultant Physician, Kevin bought himself two Cadillacs – quite rare in Australia at the time. One was damaged beyond repair, the other – a 1932 model – he kept until buying his 1954 ‘black beauty’. “The 1954 Caddy, which he has lovingly restored all of these years, was the first car with automatic transmission and airconditioning” he says. At the time, Kevin got enthusiastic and started a Cadillac owners club but found there just weren’t many in the country.”

Why the Cadillacs? “I looked at Rolls Royce’s but every time I saw one there was a gentleman alone, with no company and I found them a bit spooky. Now the Caddy, on the other hand, that was a car for the boys.”

“I’ve treated this car with the greatest respect. Early on I reupholstered the inside in the finest fabric. The interior does look like a bridal chamber. Which is the only downside – every time anybody remotely related to me has got married I’ve driven the bride to the church!

“I have the best memories of our trips in the country and down the coast. I’ve driven her to reunions and the 1932 model was used as a prop at Fox Studios.

“She’s a tough old car, still gets the pink slip each year. She does 85 miles easily but at 90 she starts singing ‘nearer my god to thee’.

“When the car dies, I’ll have to go with it. If I go first, I’m not sure what will happen.”
**Nominations are sought for the award of the Sir Zelman Cowen Universities Fund Prize, which recognises discovery in medical research at the University of Sydney. Nominations should be made according to the Prize guidelines, and sent by email to the Fund’s office by Friday 28 October 2011.**

**Guidelines**

- The Prize, which will comprise an award of $10,000 and a medal, will be for discovery in medical research performed principally at the University of Sydney.
- Nominees should have made a major contribution to the understanding or treatment of disease.
- The nomination should identify the potential or achievement of the discovery for therapeutic outcomes.
- Nominees should be under 45 years of age at the time of close of applications.
- It is anticipated that the award will be announced in April 2012.
- Nominations should be completed following these guidelines and a pro-forma available from the Fund’s Office.

**Enquiries**

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The 2012 Award of the Sir Zelman Cowen Universities Fund Prize for Discovery in Medical Research will be sponsored by The Schwartz Foundation.
PARIS AND NEW YORK
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$7,840 per person, twin share (land content only)

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Tour leaders: Archaeologist Dr Estelle Lazer and cultural historian Jeni Ryde.

THE FABULOUS