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Cover photo by Ted Sealey. Associate Professor Kevin Keay pictured with the internationally acclaimed preparation of the human sympathetic nervous system prepared by TK Potts in 1924, which is housed in the historical display cabinet of the JF Wilson Museum of Human Anatomy.

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SYDNEY MEDICAL SCHOOL ALUMNI AWARDS

We are once again calling for nominations for our alumni award program following the very inspiring inauguration last year. We would like to see many more nominations made this year as we know that graduates and postgraduates of the school are making extraordinary contributions to the University, their local communities and on the international stage on a daily basis. Sydney Medical School would like to honour these contributions with your help. Please nominate in the following four categories.

→ Community
→ Professional
→ International
→ Young alumni

Nominations close at the end of March, 2013

Information about the Sydney Medical School Alumni Awards can be found on the Medical Alumni Association website: sydney.edu.au/medicine/alumni
Welcome to the first issue of Radius for 2013 which has a particular focus on the benefits of philanthropy, past and present. The latest year has been an excellent one for Sydney Medical School’s fundraising, highlights include a pledge of $8m for general medical research, the largest ever from an alumnus, and the establishment of a philanthropic fund for current medical student donations. With new volunteer leadership and staff of Sydney Medical School Foundation, and with a greater focus on major and principal gifts, our philanthropic income grew 20 per cent in 2012. We raised $22.5 million; the number of donors supporting the Dean’s Priorities quadrupled; and the average gift increased 37 per cent to $8,969. During 2012, the university overall received more than $80 million in donations for the second year in a row.

Impressive though these statistics are, in my view what is meaningful about them is the benefits which flow to individual students and researchers, to the Medical School, and to the broader community, as a result of both recent and decades-old philanthropic support.

This Radius includes stories of some of these benefits. The careers of some of the country’s most highly regarded clinicians and researchers were fostered by scholarships and grants from SMS Foundation. All recipients acknowledge the important contribution of the Foundation in allowing them to gain international experience, to pursue ideas and programs which would not otherwise have been possible. A memorial gift to celebrate the life of a brilliant anatomist, John Irvine Hunter, has become a magnet for excellence in the discipline. The donation by Greg Poche is providing Indigenous people with health services which were not previously available in their remote communities.

There were many more stories that could have been included. Another recent example has been the success of our new cross-disciplinary centre focused on infectious diseases. In the wake of SARS and swine ‘flu, the Medical Foundation provided seed funding to establish the centre. In just a few years, it has become firmly established for excellence in infectious diseases, and was recognised in the latest NHMRC grants where people associated with it received excellent funding.

Philanthropy can and does play a transformative role. The recent $20 million gift to the University by John Grill, former chief executive of international resources and energy company WorleyParsons, will fund a new industry-oriented centre of excellence and allow the University to develop in the area of leadership in major infrastructure projects – a first in Australia.

Greg Poche’s donations to this and other universities, as well as to the Melanoma Institute, have been similarly transformative.

In an era of increasingly competitive research funding, we rely heavily on the generosity of supporters to fund exciting projects such as our centre for infectious diseases, to assist young researchers to establish themselves with a track record of successful research, and to direct funds into areas where we believe we can make a contribution to health and medical care.

The University is preparing to launch a major new fundraising campaign, in which the Medical School will play an important part. We are hoping for the continued generosity of past supporters and the engagement of new ones through the Sydney Medical School Foundation. I ask you to consider the role you could play in furthering medical research, contributing to our students success, and commemorating your time here.

On a personal level, I am acutely conscious of the benefits of philanthropy and forever indebted to the Medical Foundation for the support I received in 1986. Having just finished my FRACP, I received a scholarship from the Foundation which allowed me to travel to the United States to work with clinicians and scientists at Harvard Medical School, and learn about new directions in genetic research.

The experience was life changing, and has underpinned my clinical and research work of the past 25 years. So I encourage those who are in a position to do so, to support the work of young researchers and clinicians or one of the many other projects which are helping to improve the health of our community.

What could be a better legacy?
2013 promises to be an interesting year for the University – and of course the Senate. Over the next 12 months, we will see the completion of the infrastructure for the Charles Perkins Centre and the Lifehouse at RPA project to integrate cancer services on the RPAH site, and have the results of a major review of medical research across the University. The University has a new Chancellor, Belinda Hutchinson, and we have a Federal election in September.

This time last year, I talked about the ‘perfect storm’ in respect of the university’s finances. With a great deal of pain, perhaps some unnecessary, we managed to finish the year in reasonable shape and hopefully 2013 won’t be as painful. However, whichever political party wins the forthcoming election, I can’t see a lot of joy for tertiary education nor expanding support for medical research.

The recent debacle over funding intern places for all graduates is not a case study to fill us with confidence. Current and previous federal governments have doubled the number of undergraduate places but have failed to address the need for post-graduate training positions. The issue came to a head last year with the shortage of intern posts for foreign graduates from our medical schools. These students, who mostly come from North America and are our financial life blood, reasonably expected to be able to complete their pre-registration year as part of their training. Many would like to stay longer and perhaps become permanent fixtures. Modelling suggests they would be net economic contributors to say nothing of the benefits of locally trained graduates over foreign graduates whose training may be very different.

Despite these benefits, for the second year there was a bitter struggle to convince Governments - State and Federal - to provide support. Only after a huge effort from the Deans, the Australian Medical Student Association and other groups, have the governments provided places. I wrote my first letter, ever, to my local member on the subject. Needless to say, I didn’t get a response.

The next real issue will be whether additional vocational training places will be made available for the increased demand for College training programs. It seems obvious that if you double the number of undergraduate places you will create a significant demand for additional specialist training places.

I would like to extend a warm welcome to Belinda Hutchinson, whose appointment to succeed Marie Bashir as the University’s new Chancellor, was announced in January. The Chancellor fulfils the enormously important role of the embodiment of the university but also has the more mundane but equally important responsibility for the university’s management and financial survival, and to balance the potential conflict between the university as a ‘business’ and the special needs of a learning, research institution.

The other unique feature of the role is that it involves probably the equivalent of at least two days a week and attracts no remuneration.

I felt for Vice Chancellor Michael Spence with the very premature death of his wife after a short illness. The Reverend Beth Spence was very popular and, despite her five children and parish responsibilities, played a significant role in supporting Michael in his role.

Senate elections for graduate fellows will take place later this year. I will be completing my first four-year term on the Senate and will be eligible to stand again. I will be hoping to encourage your support and, even more importantly, to encourage you to vote. Voter turnout in the past has not been strong, which makes it hard to argue for a democratic process and also to avoid sectional interests being able to exert undue influence.

I hope 2013 is a good year for you and all the good people at the Medical School.

Barry CATCHLOVE
SYDNEY TOP IN RESEARCH EXCELLENCE

Sydney Medical School starred in the latest Excellence in Research for Australia (ERA) results. The results were excellent for the University of Sydney overall, but health and medical research was especially strong.

Among the highlights were Sydney’s 12 level 5 scores out of the possible 18 fields of health and medical research. Level 5 is the top score, characterised as well above world standard. This was more level 5 scores than any other Australian university in health and medical fields of research.

There was no Sydney field of health and medical research which scored less than 4 (characterised as above world standard).

In public health, Sydney was ranked equal first in the country (with ANU) and only two institutions received a score of 5. Other level 5 scores included medical and health sciences, medical biochemistry, cardiology and haematology, clinical sciences, medical microbiology, oncology, ophthalmology and pharmacology.

Overall, the strength of Australia’s health and medical research was evident with health/medical contributions to ERA approximately 25% of publications and 50% of income.

MD TO REPLACE MBBS

A proposed change from University of Sydney awarding Bachelor of Medicine and Bachelor of Surgery to Doctor of Medicine (MD) was approved by Sydney Medical School faculty in November.

Although the change is not expected to involve major restructuring of the medical program, it is planned to involve some expansion in the curriculum, including research training. These changes will be determined over the next year.

The essentials of Sydney’s medical program will remain: it will continue to be a four year program and open to graduates of any discipline. All domestic students will be in Commonwealth Supported Places, and numbers of domestic students will not increase and there will be no domestic full fee-paying students.

There will also be no changes in entry into the medical program – both current pathways will remain. A maximum of 30 high achieving students each year join the “Combined Medicine” program straight from school, where they complete an undergraduate degree and as long as they meet academic standards, are assured entry into the postgraduate medical course. The majority of students will continue to enter Sydney Medical School via the graduate pathway, where they apply and enter having completed their undergraduate degree. Sydney Medical School has 228 Commonwealth Supported Places for domestic students, and approximately 300 students in each year of the graduate program. This includes around 70 international students.

RHEUMATOLOGY APPOINTMENTS: PROFESSORS LYN MARCH AND DAVID HUNTER

Arthritis specialist and Professor of Medicine, David Hunter has been appointed Florance and Cope Chair of Rheumatology. Fellow joint and bone expert, Professor Lyn March will assume the role of the newly formed Liggins Chair of Rheumatology and Musculoskeletal Epidemiology. The Florance and Cope Chair of Rheumatology was formed almost 30 years ago and has been instrumental in advancing research and education in musculoskeletal sciences.

While Professor Hunter’s work has been focused on clinical and translational research in osteoarthritis, Professor March has been conducting clinical trials in fish oil, glucosamine and stem cells for osteoarthritis and leading an international group measuring the global burden of musculoskeletal disorders. Both will be based at the University’s Northern Clinical School within the Royal North Shore Hospital and will build upon the established research strengths of the campus which is internationally recognised for its expertise in musculoskeletal sciences.

“We are extremely grateful for the support of Arthritis Australia, which has provided funding for the Florance and Cope Chair and for the funds from the Liggins Bequest to the University of Sydney,” said Professor Bruce Robinson.

HELEN TRIANTAFYLLOU SCHOLARSHIP

The head of Sydney Medical School’s Office of Research and Research Training, and long-time member of the medical faculty, Helen Triantafylou died suddenly on 27 November 2012. Helen was a passionate supporter of early career researchers, and a scholarship program offering conference support grants for young researchers has been set up to honour her memory.

The grants are aimed at teaching and research academic staff in the first seven years of their PhD award.

For more information regarding gifts in memory of Helen Triantafylou, contact Sue Merrilees, Director of Sydney Medical School Foundation: sue.merrilees@sydney.edu.au
Ten years in the planning, the new Concord Clinical School – an $11.5 million state-of-the-art facility - was opened by Professor Marie Bashir, Governor of New South Wales, in December.

"The Concord Medical Education Centre, a partnership between the University of Sydney, the federal and state governments, and Concord Hospital, is a leap forward for medical education not only for Western Sydney but the NSW region,” said Associate Dean and Head of Concord Clinical School, Professor Robert Lusby.

“It will be of major benefit to regional students, giving immediate access via teleconferencing to the latest in research and teaching.”

Health Minister Tanya Plibersek MP and NSW Minister for Health Jillian Skinner MP attended the ceremony.

The purpose-designed building includes a simulation centre, a cardiac resuscitation training laboratory, surgical skills laboratory with 3D camera system, and video recording studio. Its facilities will be used by student doctors, nurses and allied health workers.

"A dedicated clinic for patients with psychosis, with the involvement of nine medical disciplines, is an example of the centre’s innovations. The cardiac and metabolic risk factors of psychotic patients are often high and currently are not well managed in the health system,” said Professor Lusby. "The multi-purpose centre will allow students to practice skills in a simulated environment including wards, operating theatres and recovery rooms."

The cardiac resuscitation training laboratory can simulate emergency presentations and features an operating theatre environment where a hi-tech manikin can be connected to monitors, injected with drugs or given cardiac massage."

The Concord Medical Education Centre’s recording studio can film and broadcast footage, including live streaming of patient consultations to regional and metropolitan teaching hospitals.

"For our more than 200 students, including international students, the centre means they will have access to the best in technology and training, in close proximity to the hospital, where patients provide the real life experiences so necessary for preparing the next generation of doctors,” said Professor Lusby.

The initial impetus and funding for the centre came from medical staff at Concord Hospital, Sydney Medical School and the local community, in memory of Associate Professor Geoff Marei, who died suddenly in 1999.

That first funding effort was followed by contributions from the University of Sydney, the Australian government (through Department of Education, Employment and Workplace Relations and Health Workforce Australia), Sydney Local Health District and the NSW Ministry of Health.

Dean of Sydney Medical School, Professor Bruce Robinson, said:

"I would especially like to thank Professor Bob Lusby and his predecessor, Professor Ben Freedman, for their efforts and persistence over many years in bringing this project to fruition.”

Congratulations to all alumni, staff and supporters of Sydney Medical School whose contribution to improving health and healthcare was recognised in the latest Australia Day awards. Those recognised included Professor Sally Redman, an Honorary Professor in the School of Public Health; Professor Helen Maria Zorbas, who has served as Chief Executive Officer, Cancer Australia; Professor Jonathan Morris, Associate Dean, Sydney Medical School at the University and Head and Chair, Obstetrics, Gynaecology and Neonatology; Professor David Owen Silience, Foundation Head, Discipline of Genetic Medicine at the University; Professor Roger Smith, who has served as Professor of Endocrinology, University of Newcastle, Faculty of Medicine; Clinical Professor Graeme Leslie Beadmore, and Visiting Dermatologist, Queensland Institute of Dermatology; Mr Graham Henry Felton, Patron, Ageing and Alzheimer’s Research Foundation; Mr George Klein, a teacher in the Graduate Medical Program; Dr Geoffrey Vernon Mutton, and orthopaedic surgeon, Orange Base Hospital; Dr John Charles Schwarz, a graduate who co-founded the African AIDS Foundation; 2001; Dr Anthony Rodham Wilson, founder the Tumut Family Medical Centre.

Professor Eddie Holmes joined the University of Sydney in October 2012, an NHMRC Australia Fellow with appointments in the School of Biological Sciences and Sydney Medical School. Previously at Pennsylvania State University, he held Verne M. Willaman Chair in the Life Sciences. Professor Holmes work has focused on viruses and other microbes. His current research focuses on the evolutionary genetics of RNA viruses, with special emphasis on the major mechanisms of virus evolution, the molecular epidemiology of important human pathogens, and the evolutionary processes that underpin viral emergence. He has published 335 refereed papers.

"I have spent most of my scientific career undertaking research aimed at revealing the principle patterns and processes of viral evolution and emergence. Although I still find work of this type fascinating, and I will continue to explore these themes, I want the molecular evolution and epidemiology I pursue to have a more direct and measurable impact on public and animal health. This will be my primary goal at the University of Sydney,” he said.
HUNTERS & DISSECTORS

By Aviva Lowy

“Few visitors to Boston of recent years have left so vivid an impression on our medical community as did the brilliant young anatomist whose untimely death from enteric fever on December tenth in his 27th year has recently been announced.”

– The Boston Medical and Surgical Journal, January 29, 1925
he brilliant young anatomist’, to which the publication refers, was John Irvine Hunter, and the epithet is far from exaggeration. Hunter, a University of Sydney medical graduate, had already been made Challis Professor of anatomy at the age of just 23.

Even earlier than this, when Professor Wilson left to take up a position at Cambridge shortly after Hunter’s graduation, he strongly recommended that Hunter succeed him - in spite of his youth. At the time, Hunter was made an acting Assistant Professor.

Hunter’s student years were filled with accolades, and he managed to win many of the prizes and scholarships on offer. These would have been particularly important to him, as he came from a poor family without the means to support his studies. He was only able to enter tertiary education through a university exhibition - a kind of bursary - for the outstanding ability he showed at Fort Street High School.

No doubt Hunter’s anatomical knowledge was improved by his financial hardship, for in order to earn money at university, he spent the last three years of his course working as a prosector and demonstrator in Anatomy.

The typhoid infection which cut short the life and career of the stellar young professor, was contracted while on a trip with his new wife, during which he had been pressed by colleagues to present results of his studies in Canada and England.

The Boston M & S Journal concluded its obituary on Hunter with the words: “The loss which medicine has sustained in (his) early death . . . is incalculable. But as it is, he is one of those few brilliant souls who, at an unusual age, through their personality and genius, manage to leave an indelible mark on their chosen profession.”

The story of Hunter might have ended with his death, had his ‘indelible mark’ not assumed a two-fold legacy: one establishing a family tradition of medical studies at the University of Sydney; the other, inspiring and encouraging a procession of bright anatomy students.

Hunter’s son, Irvine John Hunter (now in his 80s), also chose to practise medicine, as did his grandson, David Hunter, who won the University’s 2012 Alumni Award for International Achievement. An epidemiologist, Dr David Hunter is Professor in Cancer Prevention and Dean for Academic Affairs at the Harvard School of Public Health. He has undertaken pioneering leadership in researching the variety of factors that cause cancer, principally through his creation of global studies that have built huge rich databases of information.

Dr Hunter is also the principal investigator of a four-year grant, in 2010, from the US National Cancer Institute to study the genetic and biological mechanisms that contribute to breast cancer. He also collaborates with researchers in Tanzania in Africa to investigate the relationship between nutrition and the progress of HIV.

At the time of John Hunter’s death, nearly a century ago, his colleagues and friends established a fund to perpetuate the memory of his brief yet impressive career. The fund was first used to create a series of guest lectureships which would encourage imaginative student and faculty inquiry, sharing insights from research, scholarship and practice from around the world.

The inaugural John Irvine Hunter Memorial Lecture was given by Raymond Dart in 1950, who received 100 guineas to travel from South Africa. Subsequent lectures have been delivered by such world-class anatomists as Bradley Patten, William Trotter, Martin Raff and, most recently, Ray Guillery. This year’s lecturer will be decided by the anatomists of the discipline shortly.

In 1990, an additional bequest from Mrs Dorothy Fuller, sister of John Hunter, allowed for the establishment of the Professor John Irvine Hunter Prize. The Prize is awarded to the best student prosection of the head and neck/or brain. A second prize was established in 2002 for excellence in postgraduate anatomical research.

Kevin Keay, Associate Professor of Anatomy and Histology, is the principal administrator of the Prize.

“The winning head and neck prosection must be worthy of putting in the JT Wilson Museum of Human Anatomy,” says Keay. “The term ‘prosector’ is a conflation of ‘professional dissector’. You are awarded the title of prosector if you have achieved proficiency in dissection, such that the quality of your work can become a museum artefact.

“Professor Wilson first had the idea to bring in surgical trainees as tutors in anatomy. They would come here and teach for five shillings, and learn anatomy by teaching it, and go to hospital to learn surgery from the surgeons.

“Our students’ prosections are all done using classical dissection techniques. The dissecting assists them to acquire anatomical knowledge and exquisite fine motor skills.” Keay says that students also acquire practice with surgical tools, which they are likely to encounter in the future when operating on patients.

For a student prosection to win the Prize, it must exhibit high standards in three categories: demonstration of superb manual skills, a compelling intellectual focus on an anatomical region or surgical field, and an aesthetic quality.

Aesthetic? Can a prosection be aesthetically pleasing? For Keay, there is no doubt that it can.

Photos by Ted Sealey
“Personally, to observe a nerve in its anatomical position in its natural state - but in a somewhat unnatural context - there is a beauty in that.”

Judging of the prossections involves all the anatomists from the department, including the Head of discipline and the manager of the Anatomy Technical and Teaching Support Unit. The students have to write a report to accompany their prossections, saying why they revealed the elements they did, how they did it, and they have to label their work as you would find in an anatomical atlas.

The PhD Prize is no less rigorous in the judging. Students have to make a half-hour presentation to a board of assessors. “They have to give a great talk, have published a great paper, and give a great justification for how and why their work will have an impact on understanding of the anatomical sciences,” says Keay.

Vindication of the judges’ choices can already be seen in the achievements of the prize-winners. Michael O’Connor, the first to take out the postgraduate Hunter Prize in 2002, is now an academic at the University of Western Sydney where he is working in the novel and exciting field of regenerative stem cell transplantation. Cedric Bard (joint winner 2005) is working with Professor Fred Gage at the Salk Institute in San Diego on stem cell neurogenesis and Alzheimer’s. Daniel Vagg (2008), is a surgeon at Nepean. Paul Nash (2009), is at Stanford University’s Pain Clinic where he is at the forefront of employing MRI in spinal imaging (see story at right).
For the past four years, Professors Harry Lowe, Leonard Kritharides and, until recently, Dr Suchitra Chandar, have provided a regular two monthly cardiovascular clinic in Brewarrina, a remote township in the north-west of NSW.

“We fly-in and fly-out on a single day and see up to 20 patients a visit. We work closely with the one GP in town, and we are a cardio-vascular consulting service for him,” says Lowe.

“The Poche centre has allowed us to establish - and importantly maintain – a cardiovascular clinic for Indigenous Australians living remotely, providing care to a population with a high disease burden.

“Before this clinic, a patient might come to Royal Prince Alfred or Concord Hospitals for bypass surgery or a pacemaker, and on occasions, would never be seen again by a cardiologist, in part because of the distances needed to be travelled. This clinic now provides ongoing care, with the advantage that in-hospital care is provided by the same specialists that run the clinic.”

As well as making use of the Poche cardiac ultrasound or echocardiogram - which provides “city-quality care brought to your doorstep in a suitcase” – the clinic has access to a Holter monitor which the Aboriginal Medical Service bought following discussion with the cardiology team. The Holter is a portable device for continuously monitoring and recording heart rhythms over 24-hours.

With leads on their chest, a patient can be at home, going about their daily routine, and return to the clinic where a chip of their heart reading can be removed and read remotely by a cardiologist.

“We have also recently been providing a pacemaker checking service, taking a technician up with us every six months. Some people living remotely with pacemakers don’t have them checked. To do so would require an 800km round trip to Dubbo. We have seen people who haven’t been checked in five years, and we’ve picked up on pacemakers where the batteries were getting low and may have failed in a few years. It’s been very helpful.”

The team is also investigating remote access consultations which would allow for patients in Brewarrina to have face-to-face meetings with cardiologists in Sydney. If they are able to make it work, this would increase the number of patients they could see, improve the availability of specialist services to the community, and result in more frequent contact for patients requiring continuous monitoring.

“The clinic is the initiative of the Poche Centre, driven by consultation with local GPs and local health professionals who identified the need. Poche supplies the plane and logistics, and what we are able to do in Brewarrina is totally contingent on them. This wouldn’t be happening without Poche,” says Lowe.
Cardiologist Warren Walsh says he makes his visits to Central Australia to service the Aboriginal communities “because the need is enormous.”

“These people have an extraordinary burden of chronic disease. They have high rates of diabetes, chronic kidney disease, hypertension and heart disease,” says Walsh.

“Rheumatic fever and rheumatic heart disease - a disease associated with disadvantage and poverty - is also common. It’s appalling that it still exists in a country as advanced as Australia. Most of our doctors will never see a patient with rheumatic fever. It has disappeared from non-indigenous Australia because of significant improvements in the standard of living.”

Rheumatic fever begins from an initial Streptococcal skin infection or sore throat, but may result in damage to the heart valves, sometimes severely. What may start off as a simple problem, spreads because of overcrowding, poor personal hygiene, poor nutrition and reduced access to health care providers.

“There is an effective monthly penicillin prophylaxis program for rheumatic fever but patients often don’t manage to get their monthly injections.”

Walsh has been conducting Indigenous outreach cardiology clinics in Central Australia for 10 years, well before Poche started.

“Poche were interested in what we were doing and asked if they could provide additional support to those communities we were visiting and also if they could sponsor medical students to accompany us as an elective.”

Every three months, Walsh flies in to the Northern Territory for a week, spending three days in Tennant Creek and two days in Alice Springs. He is accompanied by a physician, Dr Susan Read, and they are joined by two cardiac nurses.

“We work hard, evaluating patients, performing cardiac ultrasound studies, organising investigations and management plans, as well as transfers to capital cities for surgery if required.”

A few years ago, Walsh approached the Poche Centre about the idea of purchasing a dedicated cardiac ultrasound for outreach cardiac clinics. They were very supportive and provided the necessary funds. Now it is used for Poche supported clinics in NSW and NT.

Walsh and Read also conduct outreach clinics in some of the Pacific Islands where they have been able to make use of this portable cardiac ultrasound machine as well.

“The medical students we started taking up to Tennant Creek with Poche support enjoyed it very much, though some found it somewhat confronting. The whole outreach experience is rewarding, but also can be frustrating and challenging at times,” says Walsh.
FROM STOREROOM TO SURGERY

When Dr Steven Naoum went to the Aboriginal Health Services clinic in Bourke to check out the facilities, he found two surgeries, one of which was being used as a storeroom.

He also found a desperate need in that community for the treatment of oral diseases.

Naoum had already been making regular clinic visits to Walgett when he was asked by the Poche Centre to visit Bourke and look at the facilities and the local needs.

“The problem has been that health professionals go out there and put in a few weeks of work, and then go home,” says Naoum. “There’s no follow-up, no comprehensive treatment, and no preventative strategies. You need to have regularity in order to make sustainable and lasting change to a patient’s health outcomes.”

With Poche Centre support and the dental assistant based at the clinic, he was able to return the storeroom to a surgery and restock it.

Naoum says that one of the major dental problems in the Indigenous community is lost teeth; many people, from teens to the elderly, have no teeth.

“Unless you have on-going and regular visits, you can’t make anything to replace these teeth. We are providing dentures and, so far, we’ve seen 20 patients. The waiting list has grown as word has got around and so we now have a priority list.”

The monthly service that Naoum has established means that patients are able to come for the mould-taking and fittings. Before he set-up, people in Bourke would have to go to Dubbo to get dentures and it would require five appointments.

Having a set of functioning teeth has huge ramifications for a person’s health and well-being.

“It enables them to function socially and to eat. Some of our patients hadn’t had any teeth for 10 years. There are nutritional issues and the risk of diabetes if you can’t get the proper dietary intake. Also, eating is a very social activity and it affects community life when members can’t share that experience. For young people, the impact on their self-esteem can be devastating if their front teeth are missing,” says Naoum.

The regular presence has allowed Naoum, along with senior clinical educators from the faculty of dentistry and final year dental students, to do more than just symptomatic treatment. They have been able to address oral hygiene, reinforce appropriate behaviour and undertake health promotion.

“We visited the high schools last year, talking to students, and we have made presentations to nurses at the base hospital about what to do when a dentist is not there and someone presents with trauma or facial swelling. Facial swellings due to a tooth abscess can be fatal if the airways become involved.”

Naoum has also organised a couple of mouth guard clinics for kids. “They love their sport, including boxing, and without a guard, it’s just a matter of ‘when’ . . .”

Apart from servicing the Bourke locals, the visits also provide the Sydney students with a unique challenge. “Maybe they will be part of the health workforce solution for remote Australia if they have a positive experience,” says Naoum.

radius
Betting on a good thing

By Vanessa Witton

PROFESSOR CHRIS GOODNOW
BVSc, BSc (Vet), PhD, FAA FRSC

Chris Goodnow is an NHMRC Australia Fellow, Distinguished Professor of Immunology, and Chief Scientific Officer of the Australian Phenomics Facility at ANU’s John Curtin School of Medical Research. He leads a research team which is seeking to better understand why the immune system sometimes attacks a healthy part of the body, and the genetic differences between people who suffer from one of the many autoimmune diseases and those without. His research contributions have been recognised by a number of awards, including the Pharmingen Investigator Award, Gottschalk Medal, Health Minister’s Prize, Ramaciotti Medal, Fellow of the Australian Academy of Science, and Fellow of the Royal Society.

In 1989, he was awarded a Medical Foundation Postdoctoral Fellowship which provided funding of $79,712 for a project on immunological tolerance in transgenic mice. The fellowship came at a critical point in his career, giving him time to rack up research runs on the board, it opened up an offer of a junior faculty position at Stanford University supported by the Howard Hughes Medical Institute. That allowed him to build a team and develop an international network of colleagues and perspectives, which he could then weave back into the Australian research and training system as a Professor.

“It gave me several years of ‘runway’ to build on the scientific momentum I’d established under Professor Tony Basten’s and Professor Ron Trent’s mentorship at the University of Sydney, enabling me to complete a series of experiments that yielded a string of publications that are now landmarks in the field of immunology.”

PROFESSOR DAVID CELERMAJER
MBBS (Hons I), MSC, PhD, DSC, FRACP
FAHA FCSANZ FHKCC FAA

David Celemajer is one of the few practising cardiologists to also be a Fellow of the Australian Academy of Science.

He is the Scandrett Professor of Cardiology at the University of Sydney with research programs in basic and clinical research. He has published over 300 papers on heart research and is on editorial boards of the major international heart journals. He has been recognised with numerous prestigious awards.

In 1991 aged 28, he was the inaugural recipient of the Medical Foundation Medical Research Fellowship for a project on pulmonary vascular disease at the Hospital for Sick Children, London.

The $45,000 one-year fellowship allowed him to travel to the UK to work on research into heart disease in children, and he received a further two years of funding from the British Heart Foundation. His research, published in The Lancet, showed for the first time that the earliest stages of atherosclerotic heart disease could be detected in children as young as 10 and under.

Celemajer’s study had far-reaching effects, opening new avenues for research groups in other parts of the world. It was used in public health campaigns showing passive smoking’s effect on children.

“Where I am today was certainly facilitated by that very critical Medical Foundation grant. By investing a relatively small sum at a pivotal time, you can start off a strong academic career.”

In 1996, he was awarded a much larger sum - $1.15 million - to focus on early detection and prevention of atherosclerosis. That Medical Foundation grant led to the publishing of 50 peer-reviewed journal papers. Since receiving the Foundation grant, Celemajer and his team of five have attracted NHMRC funding of $23M.

“The Medical Foundation support was pivotal in my ability to make a contribution to heart research for the people of Australia and beyond.”

PROFESSOR JILLIAN KRIL
BSc (Hons), PhD, FFSC (RCPA)

Jillian Kril is Professor of Neuropathology and Director of NSW Tissue Resource Centre, and Associate Dean (Postgraduate Research) at Sydney Medical School where she has responsibility for the admission, monitoring and award of higher degrees by research. She is also one of the country’s leading researchers into neurodegenerative diseases.

She has received two grants from the Foundation: the first was in 1994-95, shortly after she had completed her PhD, when she received $40,000 for a project studying changes in brain pathology in Alzheimer’s disease. The second was a program grant to fund further Alzheimer’s disease research in 1997-2001.

She describes it as “career changing,” because it allowed her to establish a dedicated neuropathology research laboratory at Concord Hospital. This led to better links with patients, and reduced the disconnect often experienced between clinicians and scientists. Her research enabled better characterisation of Alzheimer’s disease, and led to the establishment of the brain donor program for neurodegenerative diseases (in collaboration with Professor Glenda Halliday at the then Prince of Wales Medical Research Institute and now Neuroscience Research Australia).

“Fellowship support from the Sydney Medical School Foundation was a key factor in the development of my research career. As an early career researcher it gave me the opportunity to build a research team and strengthen collaborations which underpin my current research.”
For 54 years, Sydney Medical School Foundation has been supporting medical research and researchers with grants and fellowships. Many of Australia’s leading lights in medicine and research have benefited from Foundation support, often at a crucial time in their careers. So where are they now?

**PROFESSOR ALLAN GLANVILLE**
MBBS, MD, FRACP

Allan Glanville is Medical Director of Lung Transplantation and Director of the Department of Thoracic Medicine at St Vincent’s Hospital. He is actively involved with international trials into new immunosuppressive and anti-fibroproliferative agents and is the author of over 150 publications. He is President Elect of the International Society for Heart and Lung Transplantation and chairs the European and Australian Investigators in Lung Transplantation. He is the senior author of the International Guidelines for Lung Transplantation and foundation Director of Outcomes Australia and a foundation member of ShareLife Australia.

In 1986, he was awarded a $2,800 scholarship to assist with expenses researching his MD thesis on human heart lung transplantation.

Glanville gained his FRACP in 1985 and in the following years completed further education at the Brompton Hospital in London and Stanford University in California. At the time, Stanford University had begun its newly-established heart lung transplantation program and only a handful of transplants had been undertaken.

“This scholarship had benefits far beyond its monetary value. It raised and emphasised the importance of university and research support in terms of my career. Financial support is critical in order to travel and work in parts of the world where you can connect with concentrated groups of people working in the same research area; in my case in Brompton there were three or four Nobel-laureates working down the hall.”

**ASSOCIATE PROFESSOR GARY SHOLLER**
MBBS [HONS], FRACP, FCSANZ, FACC

Gary Sholler is paediatric and fetal cardiologist as well as Director of the Heart Centre for Children at the Children’s Hospital at Westmead, and Adolph Basser Cardiac Institute.

In 1986, having completed training in paediatrics and paediatric cardiology at the Royal Alexandra Hospital for Children, and about to travel to the US to an unfunded position, he was awarded a Foundation scholarship of $21,000.

The funding allowed him to work at The Children’s Hospital at Boston/Harvard Medical School in a combined senior clinical and research role. The scholarship had immense impact as his position introduced him to cutting-edge research and clinical practice, with a strong evidence-based frame of reference.

Sholler is currently working on the management of left heart obstruction ranging from valve narrowing to entire left heart chamber absence. The genetics and clinical management of this group of patients has resulted in the understanding of how and when to implement different therapies including catheter intervention.

The work has also resulted in several new collaborative strategies for care of complex congenital heart lesions such as ‘single ventricle’, improving medical outcomes and family emotional support.

“This has influenced all my work subsequently. I was able to participate in several research projects, had the time and support to write and publish extensively, and the colleagues and connections I made still resonate in my clinical and research activities now.”

**PROFESSOR KIM DONAGHUE**
MBBS, PHD, FRACP

Kim Donaghue is Co-Head of the Institute of Endocrinology and Diabetes, Head of Diabetes Services, and Senior Staff Endocrinologist at The Children’s Hospital at Westmead. Her research has resulted in 69 peer-reviewed publications, and her major achievements include the expansion of the Outreach Diabetes Service in NSW, and the establishment of the Diabetes Complications Assessment Service - the first of its kind in Australia.

Having earned her FRACP in 1986, Donaghue was awarded a Foundation Medical Research Scholarship $23,80 for her project: ‘Regulation of insulin-like growth factor by nutrition’ which led to her prestigious appointment as Harvard Research Fellow in Paediatrics at the Massachusetts General Hospital in Boston. Insulin-like growth factor is the hormone that makes children grow, and this was considered novel work at the time. She utilised an animal model and measured this growth factor in rats, managing them in an animal colony and giving them different diets. Donaghue claims the scholarship enabled her to establish excellent research foundations and the opportunity to liaise with her supervisor and other stellar clinicians in the field of paediatric endocrinology.

“Research scholarships allow young researchers to develop the skills to be granted further research scholarships, which then allow them to gain further research funding.”

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FEATURE
A tube with a round face: Is it an MRI or Thomas the Tank Engine?

Being in an MRI can be a daunting experience – confined in a tight tunnel space, remaining absolutely still, and wearing headphones to try and block out the extremely loud noise. It’s not pleasant for adults, much less children.

By Aviva Lowy

Enter the ‘training scanner’, a device that looks and sounds just like the real thing, to prepare patients for the main event.

“Simulation MRI machines allow us to acclimatise people to the scanning environment,” says Associate Professor, Jim Lagopoulos. “Or put another way, to make it less scary.”

Lagopoulos and his colleagues from the Brain and Mind Research Institute, Professor Ian Hickie, Associate Professor Adam Guastella, and Professor Max Bennett have been awarded a grant to study early childhood brain development.

To do so, they require a training scanner, and are hoping to raise the funds for one which might be a little more user-friendly for their target cohort.

“We want to put a face on ours of Thomas the Tank Engine. We don’t believe that anyone else has done that,” says Lagopoulos.

While it is common for paediatric specialists’ rooms to have posters and toys of characters from children’s media to make patients feel comfortable, the Thomas the Tank Engine training scanner will go one step further, by combining a familiar and friendly face with a medical device.

Lagopoulos and the team want to develop a better understanding of normal brain development in children, as well as brain development in children with disorders including autism and social anxiety.

As a child develops, the brain not only becomes bigger but its composition changes. The brains of young children have more neurons than those of adults, but there are fewer connections between the neurons. As early as three years of age, but possibly up to eight, around 70% of neural connections are pruned. It is thought that only unused connections are pruned, so that the remaining brain matter has improved efficiency.

It can be difficult to scan children in an MRI because they must be very still. “Normal children can be excitable, and with movement the scanning image is degraded. Too much movement and you lose that scan altogether, and you only know when the child comes out of the machine that the scan has been wasted.”

While clinical scans of children are relatively frequent, the cost involved in research scanning – around $815 per scan – and the high chance of getting a blurred image mean there are very few research projects involving child MRI studies.

The problems associated with taking MRI scans of children are exacerbated when those children have autism spectrum disorders. As well as a dislike of novel situations, these children often present with co-morbid anxiety issues, so being able to put them at ease and creating familiarity with the MRI process is particularly valuable.

“The training scanner is not just a passive device. The child is confined in a small space and speakers produce the correct sounds, just as they will hear them in the MRI. There are very sophisticated sensors inside, allowing us to monitor movement of the head and see just how still the child is. We sit at a console and have all this data fed to us. It may take a few practise sessions before the child is habituated and ready to move on to the real scan,” says Lagopoulos.

The team are still considering how they will incorporate Thomas’s face, but it will not be a permanent modification, allowing the face to be removed from the training scanner for adult use.

“It’s useful for adults with anxiety disorders as well. A person with claustrophobia wouldn’t be keen on going into a scanner!”

Anyone wanting to contribute to the training MRI should contact Sue Merrilees at sue.merrilees@sydney.edu.au

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RADIUS March 2013

THE UNIVERSITY OF SYDNEY
H is personal list of nots began with not visiting New Zealand with its bungy jumping, introduced he says to prevent bored, suiciding tourists in the south island damaging sheep when they fall. Glover also proposes not learning to ski or play golf, not viewing crocodiles at close range and not skydiving. ‘Ah,’ he concludes, ‘So few years left and so much to avoid.’

The 1998 Nobel Prize-winning Indian philosopher and economist Amartya Sen, whose advocacy for humane concern as part of economic development has had powerful international influence, stresses the value of thought experiments to avoid the side-effects that may follow in the wake of well-intentioned efforts. Results of these experiments may lead us not to do everything we first considered good. Additionally and more generally Sen's suggestion that we imagine what might go wrong in our best plans liberates us from inflated views of our own infallibility.

Much heartache and anguish could be avoided, Sen claims, if we experimented in our heads, exploring for each new proposal what its negative long-term consequences may be and assembling information from experience and history to assist us in the assessment.

Diverting this river, to irrigate these fields, may be an immediate virtue, but in the longer term desiccate and ruin other fertile farms. Think before you frack. The delusional thinking that ‘this will be good for people’ is demolished by disciplined thought, assembled experience and smart conjecture.

In medicine, we do these experiments a lot, reflecting on what has happened when an intervention like the one we have in mind was tried before. But we remember more easily historical successes rather better than we recall failures. This bias can easily lead to error in deciding whether to intervene.

We conduct trials to assess short-term efficacy, but these studies are not powered to detect long term detriment. This may not matter when we are treating people with serious illnesses that reduce life expectancy, but it could be a thalidomoidish-disaster if we are intervening in the lives of well people with the intention to prevent. We publish many more positive results than negative, thus biasing the way we learn from the past. But at least we generally publish: try searching for documents inside health bureaucracies. Much history in our expensive bureaucracies has been shredded, completely denying an analytical approach to learning from the past. The massive functional brief for the development of the Westmead Project (aka Westmead Hospital), prepared by the late Professor John Read, is nowhere to be found. Very few copies of the 1980s report

By Stephen Leeder

As the New Year dawned, Richard Glover, whose witty Herald columns enliven our mood almost as effectively as cappuccino on Saturday morning, suggested that this year we resolve what we will not do in 2013.
That strategic planning works – it makes the corporation option-blind, as it gets locked into a non-opportunistic course of action.

I don’t agree with Taleb that strategic planning is always worthless, even dangerous. It can be dreadful, I agree, but it can be very good indeed – when intentions are clearly declared, when there is trust, when teams are defined, when resources are measured and allocated to agreed priorities and where humility and ambition are mixed in a strong amalgam.

To summarise – the new year will doubtless bring challenges that none of us predict. To face these we need clarity and energy – clarity as to what we will not do and about what we will aim to do, and then energy to enact those decisions, and humility so that we do not overpromise. Playing with ‘what if’ scenarios make wise use of brains and experience.

Building antifragility by learning from experience with small challenges, doing thought experiments, developing flexible response capability, not eschewing the errors in our past, not deluding ourselves about the extent of our success (not claiming to solve all mysteries, at the very least) is probably the best we can do.

Sure, we can be strategic, but let’s be clear: there are limits and uncertainties and the big game-changers are usually not on anyone’s screen until they hit.

Do NOT go bungy jumping in New Zealand. Put it off for 2013 at least. Think about it. Please.
More than 60% of Sydney’s students participate in an international elective. The vast majority say the experience is beneficial, that they learn a great deal from being able to observe at close hand different ways of practising medicine. Over recent months, students have completed placements in a wide range of settings: in developing and developed countries, and in community and specialist teaching hospitals.

AIMEE WISEMAN - THE UNITED STATES
By Rebecca Crew

“At the hospital today everyone was like, ‘There’s going to be a blizzard, make sure you stock up on all your food!’” says Aimee Wiseman from her Weill Cornell Medical College dorm in a very wintery New York. She’s now halfway through her placement at the New York Presbyterian Hospital, her sights set on a career in global health work, which will combine her Law, International Studies and Medical degrees.

“There were a couple of reasons why I chose New York,” says Wiseman, who has also spent time in Vietnam recently as part of the Sydney Medical School’s Hoc Mai scholarship. “Cornell has a well-established Office of Global Health exchange program and also offered a unique public health internship in addition to clinical medicine placements which gave me the opportunity to combine my interest in public health advocacy and health policy with practical medical experience in one of the world’s leading hospital facilities, New York Presbyterian.”

For the past four weeks, Wiseman has been training in an outpatient paediatric program that offers urgent and general care, plus a number of specialties to the city’s lower income individuals and families. “It was something we don’t really have an equivalent of back home, which was good to see,” she says.

“In the Medicaid Clinic, it was quite a different demographic to what I’d expected, so it was kind of a reality check that the eastside Manhattan experience was really different from what I’d preconceived,” says Wiseman. “The immigrant population is huge and they come from quite a broad-ranging area - Queens, the Bronx, Brooklyn - and 85 to 90% didn’t speak English as their first language. So often it would be the child talking and then the parent, and then the translator, and then you, and then the doctor! I knew that there would be Spanish-speaking people in New York, but I hadn’t expected that there would be such a huge proportion of non-English speaking communities, so that’s been interesting.”

Wiseman has also had the opportunity to visit a number of organisations responsible for instigating President Obama’s new Affordable Care Act, including the Centres for Medicare and Medicaid, the Greater New York Hospital Association and the New York City Human Resources Administration. “Places that you’d never get to go to as a student,” says Wiseman. “They were really honest in talking about the challenges in implementing the Act and how it’s affected the greater population of New York and America, and they talked to us about the advertising campaigns and how we should best approach our age group, so that was really good.”

Unofficially, the program has given Wiseman access to the knowledge of many other international students who spend time at Cornell on exchange. “I’ve met students from Singapore and England and there’s some from Peru and South Korea, so I’m having that international experience of talking to them about their medical programs and what they’re used to back at home,” she says. “And there’s a couple of students from the University of Sydney over at Columbia University too, so we’ve met up with them a couple of times, which has been good.”
SIMON REID - ISRAEL
By Rebecca Crew

“I

srael is just such an amazing country,” says Simon Reid, current President of the Sydney University Medical Society, who has just finished a four-week elective placement in Jerusalem. “It has everything you want in a little, bite-size package. If you want rich history and culture, if you want great socialising and nightlife, if you want beaches or mountains . . . it just has everything.”

According to Reid, around 60% of fourth-year students head overseas as part of the Sydney Medical School’s elective placement program. Having never been to a Middle Eastern country before, Reid chose to base the first half of his program in Israel.

“I was quite worried,” he admits, discussing the conflict along the Gaza Strip nearby to where he would be. “In the weeks leading up, people were asking, ’Are you still going? Aren’t you scared?’ But when I got there, I honestly have really never felt safer. I would feel a lot safer walking around Jerusalem at night than around Sydney at night! It was so different from what I expected. It turned out that it was completely fine.”

Based in the haematology department of Hadassah Ein Kerem, a medical centre in southwest Jerusalem, Reid counts himself lucky to have been trained in a Nobel Peace Prize-nominated hospital that treats its patients equally, regardless of religion or culture. “Jerusalem is a holy city for Christianity, Islam and Judaism, and every culture is treated equally at the hospital, there’s no discrimination on that part. I was also really happy to hear that patients who were Palestinian could still get proper, good quality health care in Israel,” he says.

Along with the food – “I ate hummus at least twice a day” – the religious aspect of Jerusalem was what Reid enjoyed the most. “Jerusalem is phenomenal. Even if you’re not religious, going to their holy places, you feel this spiritual energy just by being there. I went to the Western Wall on a Friday night, which was the holiest time, and there are thousands of people there to pray and sing and worship. I must have looked so out of place, but it was just beautiful to be a part of all that culture and all that history.”

Reid says while he only had a pool of about six Hebrew words to pull from, language wasn’t an issue, and the doctors were kind enough to have their classes and meetings in English for him. He’s now carrying out the remainder of his placement in the medical wards of the Karolinska Institute in Stockholm, Sweden, where he’ll continue his interest in paediatrics. “I’ve been told I’d be perfect for paediatrics because I’m basically a big child. I’ve probably got the Swedish of a four-year-old, so while I can’t really talk to the parents, I can talk to the kids about cats and dogs and things,” he laughs.
MARTIN SENEVIRATNE – VIETNAM

Martin undertook a plastic surgery rotation in Hanoi

This summer, I was privileged to do a one-month clinical placement in a military hospital in downtown Hanoi as part of the Học Mãi program. The hospital itself was a picture of the eclectic history of Vietnam. There was a smattering of old French-style buildings – vine-covered relics of the Indochinese era – surrounded by a communist-style concrete megastructure with hammer-and-sickle symbols and gilded busts of Ho Chi Minh at every turn.

Although once a hospital for injured Viet Cong soldiers stretchered in from the frontline, today the hospital caters to civilian patients also. I spent most of my time in the department of plastic surgery – 10 elite plastic surgeons performing an amazingly diverse array of operations.

I witnessed some wonders of reconstructive surgery. Sculpting two new ears out of rib cartilage for a young boy born with microtia. Reconstructing a breast using a DIEP flap taken from the abdomen. Reanimating the face of a patient with Bell’s palsy using a nerve graft from the lower leg.

Surprisingly, there was also a lot of elective cosmetic surgery. The most common surgery was the blepharoplasty, where a small tract of epithelial tissue is excised from above or below the eye either to remove puffiness or, more often than not, to widen the eyes for a more ‘Western look’. The second most common was the nose augmentation, where a silicone nose is hand-carved by the surgeon and implanted above the flat nasal bone to give it a Western-looking bridge.

A few things impressed me about the hospital. I was struck by how hard these surgeons worked (often six and a half days per week) and how diverse their operating schedules were. Every surgeon would do both reconstructive and cosmetic across multiple sites – there were no super-specialists. I was also impressed by the level of technology available. The hospital had on-site a 3D CT machine, MRI, multiple cath labs, even a Cyberknife (a top-of-the-range surgical laser for inoperable tumours of which there are none in Australia).

It was also fascinating to see how a communist country operates with a user-pay healthcare system; the pros and cons of the less formalised surgical training pathway; and, the difficulties that arise from all major medical textbooks and journals being in English.

Overall, a magnificent experience! I owe a debt of gratitude to the Học Mãi program, which every year brings almost 30 Australian medical and allied-health students to Vietnam, and reciprocates by offering fellowships for Vietnamese doctors in Australia. All of the local doctors held the program in the highest regard, which was a great help to us as students.

PATRICK KROEK – VIETNAM

Patrick spent a week in Ha Noi before an eight-week elective in Hue

On the drive in to Hue I was struck by the stark contrast between it and Ha Noi – the roads had actual lanes, for one thing! Hue is a much slower-paced, quieter and less congested city than Ha Noi; I can’t help but liken the comparison to that of the difference between Sydney and Wollongong, my hometown.

I have only been at the hospital for one week now, but my first week has already presented numerous excellent learning opportunities to me. I spent the past week accompanying Dr Minh on his daily tasks around the hospital, such as: performing neurosurgical procedures, visiting patients post-operatively, having consultations with various teams in ICU and emergency and working in Hue University Hospital’s ‘Gamma Knife Centre’. Oh, and we got filmed for a news story, too.

Dr Minh spends most of his time working in the Gamma Knife Centre; a centre for planning and delivering a special form of radiotherapy used mostly for brain pathologies such as brain tumours. The major difference between Gamma Knife and conventional radiotherapy is that it is a targeted, three-dimensional exposure generally given on a one-off basis in which a large dose of gamma radiation is delivered with careful precision over one long, intensive session. It is employed where surgical intervention is difficult due to either the nature or location of the pathology – for example, brain tumours of structures around the brainstem are generally too deep and troublesome for Dr Minh and his colleagues to treat surgically. Hue University Hospital does not have the facilities to perform the same level of neurosurgery as is seen in Australian hospitals, which makes the Gamma Knife Centre all the more pertinent.

The stoicism of the Vietnamese people became bluntly apparent when the patients undergoing Gamma Knife therapy did not balk or protest in the slightest during their treatment. The procedure involves having an incredibly uncomfortable frame being literally bolted to the patient’s head before they are locked completely motionless in the Gamma Knife machine for up to 20 minutes at a time.
BROOKE SACHS – PNG

Brooke spent a month in PNG in obstetrics, paediatrics and emergency. The following are excerpts from her blog.

Our ward had 28 beds. A long corridor, with beds separated by a small table and the width of a sleeping parent on the floor. A half-size wall separating us from the ward just next door and a nurses’ station looking over them both from the front of the room. Fans spinning on high. Parents wandering to visit each other, chatting, eating, bringing food back from the markets to share. Each family set up in their space. Camping out until their loved one gets better.

As we continued the rounds, we noticed that pathologies tended to be similar. Complications of HIV, failure to thrive due to congenital heart defects, TB, malaria and typhoid. The doctors took time to explain different pathologies and local treatment regimes. They spoke of the difficulties in obtaining first-line drugs, in the capacity to often only deliver supportive care and the challenges of working in a limited setting. They’d accepted that many of the treatments they’d been trained to give weren’t available.

The doctor said we would begin with venepuncture and cannulation. I looked at the pile of resources laid out in front of me. No tourniquet, no tray for my sharps, or cotton buds or vials. And no butterflies. Only standard needles, one type of vacuum-sealed blood vial, sticky tape, gloves and alcohol swabs. When the doctor returned with his first charge of the day, I mentioned my difficulty in finding what we required. He looked at me in a way that said, you really are new here.

We don’t use tourniquets in this country. Just use a glove! On babies, tear off the beaded top part of the glove and tie that around their arm. And you don’t need a butterfly. Just pop the top off the vial. Don’t bother with a syringe for collecting the blood...you can drain it right into the vial. We watched as the doctor popped the plastic tip off a standard needle to drip blood from a tiny little baby’s arm and into the vial.

We watched the doctor do lumbar punctures on tiny children and babies. Because we have very few resources, lumbar punctures are performed either with standard needles or cannulas, depending on the size of the patient. And because there are never enough sterile drapes or kits, the doctors must improvise. Betadine all over the baby’s back and an alcohol wipe to remove excess from the injection site, lest the child have a reaction. Sterile gloves. Assess the position. Insert. Numerous times, patients required a lumbar puncture but the lack of an ophthalmoscope to perform fundoscopy meant we wouldn’t take the risk. There’s no use getting a positive CSF culture if the lumbar puncture will cause a herniated brainstem.

We walked past a man whose face had entirely been stitched back together after an episode of tribal violence. I wondered how the scars would heal. The first person we saw on our first trip to ED was a guy with a spear in his abdomen. A spear. In his abdomen.

Yesterday, we saw a tiny little tot in the NICU. The little thing needed the heat lamp on and a pair of gauze protective sunnies. Today, that bed was empty. He died. Life is so fragile.

Today, I assisted on my first ever surgery. A C-section. I was so excited to see how they do surgery here. And to bring a little baby into the world. But the baby was stillborn. Apparently gone for a few days. I can’t imagine what that must have been like for the mum.

... Emergency goes smoothly until it doesn’t. One morning, all the doctors disappeared by 10am. Night shift had gone home but day shift never came in. The afternoon came around and then the ambulances started arriving. Four patients rolled in our door at once. What had caused this sudden influx of patients? Later we learnt that ambulances from health clinics wait until they have a full car before heading down. Our motor vehicle accident patient with suspected basal skull fracture, had fallen out of the back of a ute around 7am. It was maybe 2pm when he arrived.

... My first charge was the tiniest of little babies, not yet two weeks old. He had a fever. He hadn’t breastfed for almost 24 hours, had refused all fluids and he had neck stiffness. As I took the history and did an examination, each finding made me more and more worried. In Australia, suspected meningitis is a very serious thing and a child with suspected bacterial meningitis should be seen within two minutes. The panic was rising. What felt like hours, but was only 15 minutes, the tiny baby got his cannula and fluids. He would be resuscitated with fluids before anyone attempted a lumbar puncture.

There is nothing like the joy of, first thing in the morning, seeing the mother of your tiny patient breastfeeding. He was feeling better. He wasn’t well yet but there was hope. And hope counts for a lot when you don’t have much else.

You can read more about Brooke’s time in PNG at www.brookesachs.org
He received the country’s highest honour, a Companion in the General Division of the Order of Australia (AC), “For eminent service to the community, particularly through contributions to the welfare of veterans, improved medical education in Vietnam and the preservation of sites of heritage and environmental significance.”

He modestly says his award has made him feel both “proud and humbled”. However, his road to distinction has been anything but easy. The foundation of his long, productive life stems from the years he spent on the Burma-Thai Railway as a prisoner of war. After two years of hard labour, he says he experienced an epiphany. It cleared his anger and hatred replacing it with a lifelong opposition to militarism coupled with a belief that we must co-exist peacefully with our neighbours.

“I realised it wasn’t the Japanese I hated, but militarism and fascism. I’ve been that way ever since,” he says.

It also gave him a lifelong respect and admiration of the medical profession. He is emphatic that “many more of us would have died, if not for the doctors in the camp.”

Many were left with permanent physical and mental health scarring, an issue he says the government of the time sidestepped.

“Research on the effects of POW internment never showed up in government reports,” he states.

However, when he found a publication by a then young doctor, Kerry Goulston, showing that former POWs had died at a rate four times faster than their former army colleagues who escaped such prisoner camps between 1945 and 1959, he had the evidence he needed to hold the government to task for the welfare of war veterans. It was also the beginning of a friendship that spanned many decades. When now Emeritus Professor Kerry Goulston and Sydney Medical School dean, Professor Bruce Robinson, asked him a decade ago to join the board of the Học Mại Foundation - a program they had started to improve medical education in Vietnam - he willingly accepted.

In the early days of Học Mại, Tom remembers the foundation building accommodation next to Hanoi’s largest surgical hospital, Viet Duc, so family members of patients could stay nearby. Often they had to travel hundreds of kilometres to visit. He recalls the camaraderie of a group held together by a mutual respect and desire to share knowledge and skills.

“Few of us could speak Vietnamese so we communicated with ‘smiles, hands and hearts.’ I have the greatest admiration for all the people involved in Học Mại. They have been the great men and women of my life.”

Asked if there is one key message he would like to make, Tom replies, “Giving is living. There is no progress in hate. It distorts the person and scars the soul.”

Tom Uren is an imposing man, despite his ninety plus years. The respected public figure, a World-War-II veteran and former minister in two Labor governments, was honoured in this year’s Australia Day Awards.

by Victoria Hollick
president’s report

My graduating class of 1972 recently celebrated its 40th reunion in Canberra at Floriade: an extraordinary venue for what was, in many ways, an extraordinary year.

By comparison with modern medical students, most of us were young and without responsibilities. Our tuition was free and we could enjoy our newfound independence with fellow students who would see us through those six (or, in some cases, seven) years of Medicine. Society was undergoing great change and these were remarkable times on campus. The Vietnam War was in full swing and some of the fellows in the year had the shadow of conscription following them in their clinical years; for women this was a time of unprecedented freedom, sexually and professionally.

We shared with our companions the rigours of the dissecting room years, and the basic sciences on campus brought us together in those endless practical classes in all the ...ologies. We had a strong sense that we were part of campus life. Then it was off to the clinical schools for three years. Old style clinicians, who relied on their clinical acumen supplemented by simple blood studies and emerging technologies, taught us the ‘tricks of the trade’.

Few of us had any idea what we would do after graduation and none of us had any inkling of the changes that were in store for the health professions in the coming decades. What a remarkable 40 years we have been privileged to work through. This graduating year has practiced in one of the most rapidly changing epochs of medical history. When we graduated the clinician was so dependent on his clinical acumen and experience alone.

Holding the meeting in Canberra over the ‘long weekend’ was an inspired choice. We had many opportunities to meet up, to socialise, to eat and drink far too much and far too often! Talks which provided updates on medical specialty areas as well as challenging the mind with the humanities, added to that charmed occasion.

Although we have had many reunions before on each of the customary anniversaries, it seemed that this was very special. For some, this was the first reunion; for several, this was a chance to come home from overseas positions; for most of us, it was the first reunion without the usual family or practice responsibilities. Yes, the 40th was very special.

So, if you are planning a reunion, may I suggest that you consider a big 40th? Make time to enjoy the company of long-lost friends, to reminisce and to remember the bonds first forged at the Faculty of Medicine at the University of Sydney. As a way of showing our appreciation to the Medical School, the 1972 alumni has provided a medical student scholarship.
reunion reports

1972 – FLORIADE, CANBERRA

We were treated to updates on disorders of the eye; treating migraine in general practice; the problem of non-communicable disease and cancer in the 21st century; the extraordinary advances in the treatment of vascular disease over 40 years; an update on genetics reminded us all of the progress since Mendel’s peas in our medical course; a discussion on modern concepts of pain management brought home the fact that whole new specialties have emerged since our undergraduate days.

We heard updates on teaching surgery and gynaecology to modern trainees, a vast sea-change from our own days; we listened with fascination as Dr Johns spoke of her experience in far off Aboriginal communities, and Dr Hodgkinson updated his work providing facio-maxillary surgical services to the underprivileged in the Philippines.

Then the session concluded with some topics for the mind. One of our colleagues had prepared a paper on ‘The Poetry of Medicine’, which was a very moving session. There was also a challenging look at the commonality of the Abrahamic religions by a Professor of Endocrinology who dabbles in history, and a discussion on the controversial essay ‘Fixed Period’ by Sir William Osler - a very unsuitable suggestion of what to do with those who have reached retirement age. This was a close call for most of the 1972 year.

Cate Storey

1977 – GREAT HALL

The invited speakers were Pat McGorry and Austin Curtin. Pat gave a memorable talk about his year in the spotlight as ‘Australian of the Year 2010’, leaving us with some sensible advice about how we should be behaving 35 years down the track. Austin gave an entertaining talk about life as a general surgeon in regional Lismore, where he advocated (with considerable success) for improved rural health services. Demonstrating his previously unknown ability to keep items of interest for posterity, he shared with the group the 1975 psychiatry exam papers, to general amusement.

The University songs were the usual hit with Amy, the organist, leading the rousing singers. Very special thanks are due to the Medical faculty and Alumni office for their superb organisation skills in bringing this event to fruition.

It was really lovely to see everyone in such good spirits and generally looking happy, youthful and well . . . at least in our presbyopic eyes. We are obviously doing something right!

Tony Joseph & Helen Somerville
1964 – LE SANDS PAVILLION, BRIGHTON-LE-SANDS

Imagine a light-filled room, with glass wall overlooking the bay, packed with happy, laughing people, and you can imagine how much joy it gave to the 63 grads and partners who were lucky enough to be there! As always with our year, there was plenty of warm camaraderie, banter and amusing tales told.

Even though we have known each other for such a long time, we still have a lot to share, with fresh enlightening glimpses of the past as well as interesting and often inspiring experiences since graduating.

We plan to make a grand production of the 50-year celebration, and hope all will keep in touch and assist us to find any meandering members!

Margaret Lorang 1964

2002 – NICHOLSON MUSEUM

When 70 alumni and partners from the second graduating year of the new University of Sydney Medical Program gathered, we had a lot to catch up on as many had not seen each other since graduation.

Music from our formative (the turn of the century) played while a power point presentation showed what some of us have been up to over the past few years. As expected, many had just completed their training, or were on the verge of completion. There was of course much talk of other major life events including travel, life partnerships and young families for us to share.

Time was a problem given our desire to catch up with everyone. When we finally had to leave the Museum, a large group continued to chat outside, in the cool evening. As was always the case during our university years, a core group carried on well into the night.

An interesting aspect of the reunion was comparing our own predictions made at the end of our degree (and subsequently published in our year book) with the specialty we ultimately pursued: 62 predicted incorrectly; 35 correctly. This may be a reflection of the importance of internship and residency in everyone’s journey to ensure they choose their vocation wisely with adequate exposure to a breadth of different specialties.

Luke Murtagh & Helen Benham

1987 – THE SYDNEY HARBOUR MARriott

About 120 people attended to catch up with colleagues, renew old friendships and test our memories of the names and faces of classmates whom we may not have seen for over 25 years.

It was an opportunity to reminisce about the university days when we were younger and fitter, but perhaps not particularly wiser, even though we thought we were at the time.

Graduates came from as far as Canada for the event, with a strong Australian contingent from Perth and Adelaide. Kerwin Shannon, the MC for the evening, reminded us of how it really was back in our university days, and how medicine and the world has changed so remarkably since we graduated.

We took some time to reflect on the life of our dear colleague Toni Medcalf who passed away earlier in the year and learnt about the formation of the Toni Medcalf Foundation in her memory.

Leena Gupta, Michelle Crockett & Anne Horsley
The Forgotten Dr Ellen Wood

Ellen Maud Wood was the daughter of Joseph Holden Wood of Neutral Bay, an executive with International Harvester Co and his wife Jane. She attended Sydney Girls High School before enrolling in Sydney Medical School in 1891. She failed first year and repeated it in 1892. She entered and completed second year in 1893 and then enrolled in third year in 1894 which again she failed and repeated in 1895. She did not complete her degree.

At this point, her career looks remarkably similar to that of Dagmar Berne who also failed to complete her degree and departed for the UK where she obtained an LSA (London) in 1893 together with Diplomas from the Royal College of Physicians and Surgeons, Edinburgh, the Faculty of Physicians and Surgeons, Glasgow and the Society of Apothecaries, London. (Berne probably realised the necessity of travelling overseas to finish her studies after being advised by the then Chancellor of Sydney University, Sir Normand MacLaurin, that he would not allow any woman to graduate in medicine.)

Like Ms Berne, after departing Sydney Medical School without a degree, Ellen Wood proceeded to the UK where she obtained an LSA (London) in 1893 together with Diplomas from the Royal College of Physicians and Surgeons, Edinburgh, the Faculty of Physicians and Surgeons, Glasgow and the Society of Apothecaries, London. (Berne probably realised the necessity of travelling overseas to finish her studies after being advised by the then Chancellor of Sydney University, Sir Normand MacLaurin, that he would not allow any woman to graduate in medicine.)

The conclusion of their 12 month appointment in Adelaide, Drs Wood and Biffin returned to Sydney where they established a medical practice in 197 Elizabeth Street. This practice did not succeed and in 1904, Dr Biffin, with no family money supporting her, established a practice in Lindfield which she successfully conducted for many years.

While there has been a focus on Dagmar Berne, the first woman to enrol in medicine in the University of Sydney, hers is not a unique experience. Louise Baur & Roderick Best believe that the story of Ellen Maud Wood, another medical student of the late 1800s, deserves re-telling.

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When their city practice folded, Dr Wood was a little more fortunate. She had already been appointed in 1903 as a medical officer for the Balmain United Friendly Society Dispensing Board. In 1904, in spite of threats from the British Medical Association (forerunner of the Australian Medical Association) to ostracise her if she was appointed as medical officer to Balmain Hospital, she gained the position. She remained there until 1909 when she established a practice in the then semi-rural Sydney dormitory suburb of Beecroft, arriving with ‘four horses and an up-to-date groom’.

Again, there appear to have been difficulties in gaining acceptance and patients because she left Beecroft in May 1910, with the Cumberland Argus saying that she “has shaken the Beecroft dust from her shoes.” This time she did find a Dr Elsworthy to take over her practice – but he only stayed for two months.

Her experiences in trying to establish medical practices in Sydney were now put behind her as she attempted to establish her career in country locations. After leaving Beecroft, she moved to Queensland, building her own private hospital in 1910 in Cooroy.
In October of 1910, The Chronicle and North Coast Advertiser reported:

We are informed by Dr Ellen Wood that her private hospital at Cooroy is now completed and quite ready for the reception of patients. Dr Wood also mentions that Mrs Bain-Smith has charge of the obstetric wards. Our representative reports that on his last visit to that conspicuously rising town, the premises were well on towards completion, and gave every promise that their comfort and convenience would be unsurpassed in the district, the building being specially planned by Dr Wood herself for the purposes for which it is now open.

She remained there until 1914 when she accepted appointment as government medical officer in Murgon, and in 1915 she had a position in Nanango. At some stage she re-located to Bungendore in NSW, leaving there in 1926.

She was the South Australian delegate to the British Commonwealth League's seventh annual conference in London in 1931 before being appointed as medical officer at Canungra District Hospital, Queensland in October 1934, where she died the following year of pneumonia after her peripatetic medical career.

Like so many of her contemporary female colleagues (such as Dagmar Berne, Harriett Biffin, Iza Coghlan and Lucy Gullett), she never married.

Louise Baur is Professor of Paediatrics and Child Health, and acting Associate Dean of the Children’s Hospital at Westmead Clinical School.

Roderick Best studied history and graduated in Arts and Law from the University of Sydney.

Above: Cooroy Private Hospital c1920. Photograph supplied by Cooroy-Noosa Genealogical & Historical Research Group Inc.
Grand Rounds

Recently I chanced to meet two senior medical colleagues who had participated in the Grand Rounds at Royal Prince Alfred Hospital for the years that I was a student and resident there in the late 70s.

By Andrew Byrne
Dependency Physician, MBBS 1978

These were Friday afternoon sessions in which two cases were presented plus one or two follow-up cases from the senior registrars involved.

The two regular attenders were Dr John Hallinan, chief radiologist and Dr John Emder, a senior local GP and probably one of the last GPs ever to be allowed in the doors of the hospital in the great age of the specialist.

Medical Grand Rounds was a long standing venerable tradition at the hospital according to my father who had been a resident there around 1950. The Scot Skirving lecture theatre was a windowless Victorian conclave between A2 medical ward and the small veranda ward used for peritoneal dialysis. There was an element of anticipation each Friday afternoon as hurried last minute pathology results or research papers were incorporated into the presentations.

Some of the more exotic diagnoses included myasthenia gravis, osteogenesis imperfecta (the only time in my experience that an actual patient was wheeled into the hall), lacunar stroke, dissecting aneurysm, carotid sinus syndrome, hairy cell leukaemia, cerebral lymphoma, mononeuritis multiplex, small bowel leiomysosarcoma, splanchnic claudication, ‘HHH syndrome’ (later called AIDS), methicillin resistant staphylococcus infection, cardiac tamponade, mixed connective tissue disease, idiopathic thrombocytopenic purpura, systemic lupus erythematosus and narcolepsy/cataplexy.

The main characters of this high academic drama included: Prof Ruthven Bickerton Blackburn (lord high physician and usual chair person), Prof Tony Basten (immunology), Prof Martin Tattersall (oncology: “I do not treat the relatives”), Prof Anne Woolcock (respiratory medicine), John Greenaway (possibly Macquarie Street’s last physician), David Tiller (who could derive a social profile from a biochemical one), and John Hassall (rheumatology).

The senior registrars at the time were amongst the most gifted young doctors in the country, including Michael Field, Michael Halmagi, Roger Tuck, Ian Caterson, Bill Bye, Stephen Lee, Sheryl Van Nuen, Geraldine Room, Paul Russell, Ben Freedman and many others.

Classic statements from that time include:
“Myaesthenia gravis is called gravis because it IS ‘gravis.’”
“Sjogren’s syndrome does not require the existence of a rash.” Response from up-start registrar: “When I worked with Dr Sjogren in Stockholm he used to say otherwise.”
“The only five medical causes of abdominal pain are myocardial infarction, diabetes, familial Mediterranean fever, porphyria and tabes dorsalis.”

After a tedious discussion about a patient with auto-immune cold agglutinins, cryoprecipitins and acute renal failure, Dr Jonathan Leicester, who wasn’t associated with the case, commented in his slow, measured way: “I wonder if the patient just had a chill on the kidney?” (laughter from audience).

Dr John Greenaway (leaning over the wooden railing, frowning sternly): “Mr Chairman, I would take to task the treating team over all these investigations!”

Mr Bruce Leckie (thoracic surgeon invited concerning a chest lump, possibly parathyroid): “Look, Mr Chairman I have been sitting here for 30 minutes listening to all these differential diagnoses, fancy test results, nuclear scans and other learned speculation. In that time, I could have made a small incision in the patient’s side, exposed the lesion and in all probability, cured it. I’m afraid I have to go back to work!”

I have always enjoyed being a fly on the wall but after three years of passive attendance I was finally asked to present a case when working for the neurology team in C1 ward under HMOs McLeod and Allsop. It may have been posterior inferior cerebellar artery (PICA) syndrome and I did not do the case justice.

I had the misfortune to speak French better than John Allsop which put me on the back foot as he looked after the private patients from Noumea who would be brought from the airport by ambulance once weekly for triage. John’s speciality was demonstrating gait disturbances, sure to trigger the funny-bone of each new cohort of students as he looked like Quasimodo lurching large.

In attending RPAH Medical Grand Rounds I was privileged to be witness to this magnificent piece of medical history the likes of which has probably not been seen before or since in this country. Who in their right mind would expect a high-powered group of people to muster at 5pm on a Friday these days unless it was for a keg of beer and a music box? In fact the latter occurred slightly later on a Friday at the Gross Farm Hotel nearby on Missenden road.
The Sir Zelman Cowen Universities Fund Prize for Discovery in Medical Research is awarded in alternate years at the University of Sydney and at the Hebrew University of Jerusalem. It recognises discovery in medical research by a researcher under 45 years of age who has made a major contribution to the understanding or treatment of disease. The inaugural award in 2006 was made at the University of Sydney.

The Trustees of the Fund are pleased to announce the award of the Prize for 2013 to:

Associate Professor Eran Meshorer, Department of Genetics, The Institute of Life Sciences, Hebrew University of Jerusalem.

Associate Professor Meshorer was nominated for his work on how embryonic stem cells (ESCs) maintain their dual capacity to both self renew, and differentiate to all cell types. Many of his studies have focused on the role of chromatin in this process as he believes that understanding the mechanisms that regulate chromatin function will enable intelligent manipulations of embryonic stem cells in the future. He has said, “If we can apply this new understanding about the mechanisms that give embryonic stem cells their plasticity, then we can increase or decrease the dynamics of the proteins that bind DNA and thereby increase or decrease the cells’ differentiation potential. This could expedit the use of embryonic stem cells in cell therapy and regenerative medicine, by enabling the creation of cells in the laboratory which could be implanted in humans to cure diseases characterized by cell death, such as Alzheimer’s, Parkinson’s, diabetes and other degenerative diseases.”

More information about the Prize and A/Professor Meshorer’s work is available from the Fund’s website and office.

The next call for nominations for the Prize will be announced shortly. It will be for scientists working at the University of Sydney.

The 2014 award of the Sir Zelman Cowen Universities Fund Prize for Discovery in Medical Research will be sponsored by The Schwartz Foundation.
Mrs Warren’s PROFESSION
By George Bernard Shaw

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