Radius

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Free trade and the PBS | Health in East Timor | Antibiotic resistant bacteria | Alumni reunions | Tours

Introducing Professor Andrew Coats

Dean of the Faculty of Medicine at the University of Sydney

Professor Coats has been appointed to steer health and medical research efforts to improve the focus and performance of medical research in NSW.

Professor Andrew J S Coats, MB BChir. (Cantab.), MA DM. (Oxon.), FRACP, FRCP, FESC, FACC, FAHA, MBA (London Business School) commenced his appointment as Dean of the Faculty at the beginning of 2003. Andrew is an Australian who trained as an undergraduate in medicine at Oxford (preclinical) and Cambridge (clinical years) before completing his general medical and cardiological training in Melbourne. He returned to the UK to undertake research under the supervision of Peter Sleight and James Conway in Oxford where he continued his interests in hypertension, heart failure and cardiovascular physiology.

From 1991-2003 Andrew was at the National Heart and Lung Institute, Imperial College School of Medicine and headed the Department of Clinical Cardiology - Heart Function as the first Viscount Royston Professor of Clinical Cardiology. He has been associate medical director in charge of research and development of the combined Royal Brompton and Harefield NHS trust and from 1996-2000 was director of Cardiology.

Since February 1999 he has been Editor-in-Chief of the International Journal of Cardiology.

He has more than 800 publications in the fields of heart failure and hypertension, and has been chairman or Steering Committee member of the following major morbidity/ mortality trials: EXIST, REPLACE, SENIORS, CHARM, OVERTURE, COPERNICUS, OPTIMAAL, and CHRISTMAS. His main research interests are in the pathophysiology and therapy of chronic heart failure, in exercise physiology and in the management of hypertension.

More information: www.medfac.usyd.edu.au/about/coatscv.html

Late breaking news

Science and Medical Research Minister, Frank Sartor has announced the appointment of Professor Andrew Coats as Chair of the new Health and Medical Research Ministerial Advisory Council.

Professor Coats has been appointed to steer health and medical research efforts to improve the focus and performance of medical research in NSW.

Membership of the Ministerial Advisory Council had been drawn from diverse areas including universities, medical research facilities.and area health services. The Ministerial Advisory Council, comprising 12 of the state's most eminent researchers, has been appointed to conduct a detailed statewide audit of the work being done by NSW's estimated 5000 medical researchers in an effort to provide high-level advice to the Government on what is needed to boost the state's research capabilities. This $220 million plan over five years is aimed at identifying and addressing critical gaps in NSW medical and health research efforts, achieving greater collaboration across disciplines, sectors and technologies, enhancing the development and retention of a skilled research workforce and expanding research funding sources.

Other Sydney University panel members include pharmacologist (and Chair of the Medical Research Committee of the NHMRC) Professor Judy Black, hypertension specialist Professor John Chalmers, public health specialist Professor Simon Chapman, virologist Professor Tony Cunningham, Chair of Medicine at Royal North Shore Hospital Professor Carol Pollock, and public health specialist Associate Professor Peter Sainsbury.

More information: www.health.nsw.gov.au

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Note from the Editorial Committee

Radius is published by the Medical Graduates' Association (MGA) and the Faculty of Medicine at the University of Sydney. From October 2003, the publication will include Medical Scripts, the occasional newsletter of the Faculty of Medicine.

We aim to make this an interesting publication and encourage your contribution of news items, obituaries and letters to the editor. We do not object to controversial articles. Indeed, we welcome them. The true role of a university is to provide a forum for ideas. Please note, however, that articles should follow conventional journalistic etiquette. We endeavour to publish all articles and ideas sent to us.

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Front cover: Traditional dancer – Manatuto (East Timor)

President's report

Dr Barry R Catchlove, Medical Graduates' Association

As they often say, necessity is the mother of invention, and so it has been with the MGA. The parlous state of our finances, which I have raised on a number of occasions, has forced us to introduce some changes which I believe are, by good fortune, in the long term best interests of the Association.

I must first however thank all those who have responded to our recent appeals. We have raised about $30,000 this year which helps enormously, but still leaves doubt about our capacity to remain self sufficient.

Our new Dean, Professor Andrew Coats, recognises the importance of a strong alumni and has given us tremendous tangible support. This support will allow us a sustainable future.

The key elements of the proposed changes are the integration of our administrative functions into the Faculty and the merging of Radius and Medical Scripts, the Faculty's internal magazine. We will, subject to sufficient funds being available, make a contribution to help offset some of the costs.

Wendy Marceau who has done a magnificent job managing the Association will maintain a close involvement as a Council Member representing the Medical Foundation. We are enormously grateful for the time and skill Wendy has given to the MGA. I must also again thank Peter Burrows, President of the Medical Foundation, for allowing Wendy to be involved with no cost to the Association.

I would also like to acknowledge the role Clarissa Chaloner has played over a number of years. Clarissa's association with the MGA concluded in July.

Ross Corrigan of the Faculty administration will be the new contact point.

The Council will continue its role stewarding the Association's activities. It remains important that we continue to raise funds, not only to cover the costs of other Council activities, but also to give us the leverage which comes from paying our own way.

At the end of the day it is my hope that these changes will further strengthen the relations between the alumni, the Faculty and the Foundation.

Our new Dean, Professor Andrew Coats, recognises the importance of a strong alumni and has given us tremendous tangible support. This support will allow us a sustainable future.

A bitter pill

Australia-US Free Trade Agreement and the Pharmaceutical Benefits Scheme

Talk given by Peter Sainsbury, President, Public Health Association of Australia, at the launch of 'Trading Australia Away' (AFTINET, May 2003) at NSW Parliament House, 19 May 2003

How many things can you think of that are Australian, good for patients, good for doctors, good for taxpayers, good for government, and widely recognised as one of the best in the world? Well, the Pharmaceutical Benefits Scheme (PBS) is one. It ensures that all Australians have access to essential medications when they are sick.

Specifically, but briefly, the PBS provides:

- An uncapped Federal Government subsidy of approximately $4.6 billion per year to the price of medications for patients
- Fixed out-of-pocket expenses for patients for the 600 drugs covered by the PBS
- A financial safety net for the very sick and chronically sick so that multiple small expenses don't add up to something unmanageable.

You might think that because the government subsidy is uncapped the total cost, to the government and hence also the taxpayer, of the drugs provided on the PBS would be skyrocketing. But it isn't and here's the real benefit of the PBS. Because the PBS also involves very strict controls on which drugs get onto the PBS list and because the government negotiates very good deals with the drug companies, Australia has one of the cheapest drug bills in the developed world.

We get the best drugs at the lowest prices. If a new drug is no better for patients than an existing drug, the PBS won't pay the producer any more for it. Or to put it another way, the price Australia pays for a drug is based on its usefulness to the patient (its therapeutic worth), not how much it cost the company to develop it. In fact, the system is so good that compared with the USA it saves Australians about $1-2.5 billion per year ('Trading in our health system?', The Australia Institute, May 2003).

The result is that every Australian can get drugs they need when they need them without going into debt, and without having to make impossible choices between essential medications and other essentials such as food or rent.

The PBS delivers great value for money, efficiency, equity and health.

But, surprise, surprise, the drug companies don't like this. They say:

- 'the PBS unfairly limits our freedom to charge whatever the market will pay';
- 'it doesn't allow us to recoup our immense investment in research and development (R&D) to develop new drugs' (this is like a company that produces washing up liquid saying that they've just spent billions of dollars researching and developing a new washing up liquid and so they expect consumers to pay three times the price of normal washing-up liquid regardless of whether it's any better at cleaning greasy plates);
- 'because the PBS uses very strict cost-effectiveness evidence to decide which drugs should be available on the PBS and how much they are really worth, this constitutes an unfair restraint on free trade'.

Basically, they are saying that they don't like the use of evidence-based decision making, they don't like Australians paying what drugs are therapeutically worth, and they don't like the Australian PBS limiting their ability to make even bigger profits than they already do. They want fewer limits in Australia on their ability to market whatever drug they want at whatever price they want.

And because many big pharmaceutical companies are American, they're pressing the US and Australian governments to include the PBS in the negotiations about the Australia-US Free Trade Agreement. The American government is receptive to these arguments because it wants even bigger profits for its companies. The Howard government is receptive, despite its denials, because it wants to reduce the government's contribution to the cost of drugs and make the user pay more.

But let's get real here. Why shouldn't we expect our government to negotiate the best deal it can with the drug companies? Isn't that its job? …To protect Australians' health and dollars.

And drug companies are hardly going broke:

- in the USA the pharmaceutical industry has provided the best return on investment every year for the last ten years;
- drug companies feature prominently among the ten most profitable companies worldwide;
- drug company executives are among the best paid in the world;
- as for their high R&D costs, yes they are high in comparison with many other industries but both their marketing and advertising expenses (approx. 27% of revenue for the nine major US drug companies) and their profits (approx. 18%) exceed what they pay in R&D (approx. 11%).

No one should shed any tears for the drug companies.

But tears will be shed if we allow the PBS to be destroyed because:

- sick people will go without essential medications because they can't afford them - just like happens now in the USA;
- sick people, mostly the poorer and older people in society, will have to pay 2-3 times more out-of-pocket expenses every time they get a prescription filled - just like happens in the USA now;
- Australia will be paying 25-50% more as a nation for our drugs;
- drug company profits will go even higher - they are principally interested in their profits, not our health, of course;
- we'll be transferring money from Australia's sick, Australia's old and Australia's poor to American pharmaceutical companies, American CEOs and American shareholders.

It is essential that we keep the PBS out of the Australia-US Free Trade Agreement. This requires us all to be vocal and active in demonstrating to our politicians the gross folly of destroying something good, something that benefits all Australians.

Peter Sainsbury

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More information

Further useful information can be found at:

1 www.aftinet.org.au

2 The Australia Institute (www.tai.org.au). See 'Trading in our health system?' (May 2003)

3 Doctors Reform Society (www.drs.org.au). See 'Submission to the Department of Foreign Affairs and Trade on the proposed Free Trade Agreement (FTA) between Australia and the United States' (January 2003)

4 National Centre for Epidemiology and Population Health (http://nceph.anu.edu.au). See 'Submission to the Senate Inquiry into the General Agreement on Trade in Services (GATS)' (2003)

Food (or not) for thought

News from Stephen Leeder in New York

This year Stephen Leeder is with the Earth Institute at Columbia University. He is working on the challenges posed by cardiovascular disease for low- and middle-income countries. Here he writes about nutrition - too little and too much - as matters of global health.

My work in New York with Columbia University took me to Fez in Morocco in June for a meeting of Eastern Mediterranean states.

Fez is as old as the moon hills among which it nests, built over dark, cobbled laneways that dip and climb like capillaries between rows of tiny houses that stay up because they have nowhere to fall. It is a huge catacomb.

There are no cars in the old city. Instead, donkeys with heads bowed blindly teeter under loads of gas bottles or fresh animal hides for the tannery. Yes, I bought a small overpriced carpet. I also ate a delicious lunch. That was a mistake. Within 48 hours I thought I had cholera.

The scope of the problem

Days later back in New York an Australian gastroenterologist friend 'scoped' me, generously waiving his fee. Lying there I felt, 'This is what it must be like in the Shuttle'. I hoped that there was no loose foam. The weird sedatives messed my mind for three days. God only knows what I said while I was asleep.

That's a long-winded (no pun intended) introduction to the subject of food. The *New York Times* for two weekends (12th and 19th of July) had big articles about food as a source of serious health concerns.

Starvation is complex and not nice

The first article explored why people still starve, and the second, a week later, examined the global epidemic of obesity.

Billions go hungry while one in three children and one in five teenagers in Germany are overweight. In Greece, over 70% of men and women are overweight (so much for the Mediterranean diet), as are 60% of women in Egypt. In the US 61% of people are overweight. In Australia the figure creeps steadily upward.

The two articles, about starvation and obesity, were connected by an editorial on Sunday 20th July, deeply critical of World Trade Agreements where the sequence all too often is this: wealthy world recruits poor nations such as the Philippines into the World Trade Agreement with blandishments that their farmers will be able to sell to new and bigger markets and then rich countries subsidise their own farmers and thus squeeze out farmers from poorer countries.

Each European cow attracts a subsidy per head of US$2 a day while 1 billion people live on US$1 a day.

The *Times* editorial compared the developed world's annual US$320 billion in farm subsidies with its annual US$50 billion in development assistance.

Being underweight accounts for 10% of the global burden of disease according to the *World Health Report 2002*. Undernutrition's effects are manifest principally in low- and middle-income countries with high mortality rates.

Barry Bearak, in his *Times* article *Why people still starve* on July 13, recounted his experiences in Malawi, a nation wracked with chronic malnutrition and episodic superimposed starvation.

He followed a family who had lost two members recently from starvation, an older man and his adult daughter.

'For the poor,' Bearak wrote, 'conditions began rapidly deteriorating in the 90s, during the last days of the "Lion of Malawi," Dr Hastings Kamuzu Banda, the Western-trained physician who was the nation's dictator for 40 years. Tobacco is Malawi's only major cash crop, and the doctor amassed a fortune by granting himself valuable licenses to grow it. At the same time, his government benefited from the foreign aid of prosperous friends. The West applauded his anti-Communism; South Africa admired his tolerance of apartheid. Banda ruled ruthlessly and myopically – until 1994 - long enough to take him well into his 90s and senility."

Then came a period of structural readjustment imposed by the World Bank and International Monetary Fund. The restructuring was built around privatisation.

'Restaurants are using larger dinner plates, bakers are selling larger muffin tins, pizzerias are using large pans and fast food companies are using larger drink and French fry containers.'

The impact of enforced economic restructuring

Government funding for farmers was withdrawn and the argument was put that 'the poor were best served through the efficiency of the free markets. The fine print in most loan agreements committed government to reduce subsidies, curtail spending and sell off monopolies.' The effects on small farmers were devastating. They could not buy fertilisers. They ate the sample seeds they were given because corn sent as aid did not reach them.

The story is one of multifaceted chaos, of governments dealing corruptly, storms that wash out bridges over which trucks are scheduled to bring corn to starving people, derailments and aid food stores that mysteriously catch fire. Bearak quotes the Nobel laureate economist Amartya Sen, a foremost authority on famine who claims that such catastrophes do not occur in functioning democracies with a free press and a government with strong incentives to take preventive actions.

People starve when politics, war, greed, corruption and the physical elements all work together against them. A colleague of mine at Columbia University, Awash Teklehaimanot, a malaria expert from Ethiopia, told me recently of the decades-long series of disasters that created starvation in that country. "Deforestation, over-farming, the loss of soil fertility, migration patterns and wars are all part of story," Awash says. If one then adds exploitative international economics, where will respite be found? In passing let me note that the Earth Institute, committed to sustainable development in low- and middle-income countries, has academic programs in soil science, geology, meteorology, economics, politics and public health because of the need for a comprehensive response to these problems.

But Bearak concludes that 'even if poverty and hunger seem unconquerable, famine surely can be overcome. Only our indifference – only our neglect – allows it to persevere. In Malawi, the timely distribution of fertiliser ought to be preferable to the inevitability of emergency food. That is what every farmer in the villages asked for: if you give us fertiliser, or a reasonable way to buy it, we'll manage for ourselves from one hungry season to the next.'

Dr Tom Frieden, the Commissioner for Health in New York City, young, bright and energetic, fresh from several successful years in India managing tuberculosis control, was discussing this article over dinner with me recently.

He was touched, he said, by the altruism of the old woman who was the central figure in Bearak's long article. She and her daughter had developed an ingenious trick which she felt every human being ought to know. 'If I were ever so hungry I could no longer work, [she] advised me, there was a way for a determined mind to outfox a hollow stomach. "Tie some cloth lightly around your waist right at the navel," Lufinenti said. Make it as tight as you can." For a few hours, you can fool your belly into thinking that it's full.'

"Fancy them thinking of others even in their own extremity," Frieden said to me, shaking his head in admiration.

Pray for April showers in Cancun in September

'A fair shot, more than charity, is what poor nations need,' says the *Times* editorial a week later. 'According to International Monetary Fund estimates, a repeal of all rich-country trade barriers and subsidies to agriculture would improve global welfare by about US$120 billion [a year].

'An uptick of only 1% in Africa's share of world exports would amount to US$70 billion a year, some five times the amount provided to the region in aid and debt relief. "Farmers in the US get help every step of the way," says Rudivico Mamac, a very typical, and very poor Filipino sharecropper, whose 12-year-old son is embarrassed that his family cannot afford to buy him a ballpoint pen or notebooks for school.'

When the World Trade Organization meets in Cancun in September, we may hope that they may find a way to make room for the world's poorest farmers. Without a drawing back on subsidies in the rich world, even by a few per cent each year, resentment will continue to build as globalisation progresses. Anyone worried about international disgruntlement, resentment and subsequent terror would do well to ponder.

Had enough to eat?

Meanwhile, back at the steakhouse, more than 25% of British men and women are obese, over 25% of Russian, Finnish, Estonian and Latvian women are obese (the rates are lower for men), less than 10% of men in France, Italy, Switzerland, Croatia and for 20% for women in France and Switzerland. The World Health Organization which drew attention to the impending problems that will follow over nutrition is about to release a set of recommendations to its 191 member states on what to do to combat the growing epidemic of overweight and obesity.

Many nutritionists see the changing food environment as a crucial element in the cause of this epidemic. Ever larger portions sizes are presented as tempting options. Research workers from the University of Minnesota, quoted in the *Times* article, have shown that relative cost is a potent factor in food choice.

Running out of room in the US, processed food manufacturers are increasingly turning their attention to European and other markets, exporting 130 billion dollars worth of food a year last year, 'everything from cranberries and candy bars to cereals and sodas.'

Not just what you eat, but how much

Serving sizes for many foods have increased, beginning with the introduction of the Big Mac in 1968. In a paper published in *The American Journal of Public Health*, nutrition research worker Dr Lisa Young of New York wrote, 'Restaurants are using larger dinner plates, bakers are selling larger muffin tins, pizzerias are using large pans and fast food companies are using larger drink and French fry containers.' Visit a 7-Eleven store here and you can buy a Double Gulp, 64 ounces of pop or 800 calories.

In the US food litigation could have profound effects if culpability for an individual's nutrition problems can be sheeted home, via the law, to over-zealous marketing of high-volume, energy dense foods by manufacturers and retailers

A frequent response to the argument that big servings press us to eat more is to say that we all have the ability to choose what we eat. But Dr. Brian Wansink of the University of Illinois showed in an experiment that if you give movie-goers an extra large tub of popcorn instead of a container one size smaller, says a *Times* article, they will eat 45-50 per cent more, even if the popcorn is stale!

"If you don't want a large hamburger in a restaurant usually there is a smaller hamburger," Stephen Anderson, president of the US National Restaurant Association told the *Times*. "You can get a grilled chicken sandwich in almost any restaurant I've ever been in. There are options there and it's for the individual to decide." Well, yes, I suppose so.

But as the late great London epidemiologist Geoffrey Rose said once, "It is possible to take carrots and lettuce into a smoke-filled pub and eat them while others smoke and drink. But it's hard and friends may well wonder if you've gone mad!"

Please read Eric Schlosser's *Fast Food Nation* or Marion Nestle's much longer *Food Politics: How the Food Industry Influences Nutrition and Health* - both excellent expositions. A former public health colleague and friend, Kerr White, to whom I lent the latter book, commented that it reminded him in its revelations of the corrupt world of the oil cartels of previous decades.

Europe is responding to the obesity epidemic by seeking to increase regulation in relation to food marketing and labelling. In the US food litigation could have profound effects if culpability for an individual's nutrition problems can be sheeted home, via the law, to over-zealous marketing of high-volume, energy-dense foods by manufacturers and retailers. What happened with regard to tobacco may happen with food.

Back in the Sunburned Country

Australia has a responsibility to its citizens and, I would argue, to the region in which we live. The latter responsibility goes beyond the provision of small dollops of financial aid to less advanced nations. It has to do with the equity that informs our trade with them. If we claim to favour an open market, we must provide opportunities and be willing to accept that our economy may need restructuring to accommodate them. We have done a lot in this regard, but more is needed.

In relation to overweight and obesity, we await a national response in Australia. This should not be deferred because the food industry holds political parties hostage. Yes, they are big business, but so is health. Agriculture and the food industry are not the whole game when it comes to macroeconomics. Encouragingly, the interests of the food industry and good health often overlap. In Poland, when subsidies for dairy and meat products were lifted in the 1990s and rape seed oil crops were introduced, consumption of animal fat fell and that of vegetable oils rose. Coincidentally heart attack death rates fell dramatically. Similar stories are reported from what was Czechoslovakia and Finland.

Whether our response to undernutrition and overnutrition will be appropriate comes down to politics. At first glance that may seem depressing. But on reflection, we can see that it creates possibilities for action. Politics is everyone's business.

As medical people we can adapt and modify the strategies we have used to win public and government support in relation to tobacco to other agricultural products but most importantly to advertising behind the relentless pressure to consume unnecessarily large quantities of energy-dense food.

Antibiotic resistant bacteria

The misuse of antibiotics in food production animals results in the needless exposure to these bacteria in the foods we eat.

Associate Professor Peter Collignon from the Department of Infectious Diseases at the University of Sydney's Canberra Clinical School, delivered this talk at the Faculty of Medicine Dean's Lecture in August 2002.

Dr Collignon is a 1978 University of Sydney honours graduate in Medicine and Medical Science and has been active in his field for more than 18 years. He has been a member of the National Health and Medical Research Council committees dealing with Communicable Diseases, Infection Control, antibiotic resistance, antibiotic use and meningococcus. He is Chair of the Australian Group on Antimicrobial Resistance (AGAR), and until recently Chair of The Australian Society for Microbiology Standing Committee on Clinical Microbiology. He spent four months in 2001 as a consultant to the World Health Organization and helped develop global principles on the use of antibiotics in agriculture.

Dr Collignon has subsequently been involved on two further WHO committees. One, in late 2001, made recommendations on measuring the use of antibiotics on a global scale. The second, a WHO expert panel in 2002, reviewed the experience in Denmark where all in-feed use of antibiotics was terminated in 1999. The report was released in July 2003. It showed little or no economic losses when the continuous use of in-feed antibiotics was banned in poultry and pigs.

There is now an extensive range of evidence linking the use of antibiotics in animals to increasing resistance to antibiotics in humans. Much of this use however has had minimal (if any) benefits for animals. The continued use of many of these antibiotics is therefore indefensible in the light of the importance of antibiotics for fighting infections in people.

Responsible use of antibiotics

Resistance is an inevitable consequence of use and therefore, not surprisingly, antibiotic resistance has been a problem since they were first used. Most of the antibiotic resistance problem in people is a consequence of their use in people. Therefore we as medical practitioners have a duty to minimise their use and use them wisely. Antibiotic resistance is an increasing problem around the world and exacerbated by international travel. Already, treatment is very difficult or sometimes impossible for infections caused by acinetobacter, Staphylococcus aureus, pneumococcus, E.coli, and enterococcus. While most of these resistant bacteria are human in origin, a number of resistant bacteria can be spread via the food chain (e.g. enterococcus, E.coli, salmonella) and can include "superbugs" such as VRE (vancomycin resistant entercoccus). VRE can be extremely difficult and costly to treat and has major infection control implications within hospitals. VRE has already occurred in more than 30 Australian hospitals in 10 cities. It recently was found in 13 per cent of retail chickens surveyed earlier this year in Brisbane and Sydney for the Australian Consumers' Association Choice magazine.

Since "resistance is proportional to use", overuse of antibiotics in animals especially as growth promoters poses unnecessary dangers to human health via the food chain. Even vegetarians are at risk, because the resistant bacteria that result from antibiotic use in animals flow into water supplies when manure washes into waterways, and when animal waste is used to fertilise fruit and vegetables - a common practice. One of the largest uses of antibiotics is their continuous in-feed use. This has occurred in agriculture since the early 1950s, especially with pig, poultry and cattle in-feed lots. There is also extensive use of antibiotics in the aquaculture industry.

Health cost outweighs economic benefit

There are a number of fallacious arguments used by agriculturalists and drug suppliers to defend the practice. Arguments that antibiotics increase body weight in animals while lowering the amount of food consumed are toppled when relative costs are taken into account.

Animal weights in most recent independent studies were not increased at all with antibiotic use. Even the most favourable data presented by the pharmaceutical industry itself usually show the gains of 2% or less (and usually none for their competitors' antibiotics!). At best this translates to 1 or 2 cents per kilo of meat but at the "health cost" to society as a whole because of the large numbers of "superbugs" in our foods.

Arguments that ceasing the continuous use of antibiotic as growth promoters in agriculture would decrease meat production in developing countries and thus lead to further malnutrition to the world's poor also do not hold up. The malnourished in these countries do not have access to these meats mainly because in the rural areas where most of the very poor live, these meats cannot be delivered and stored (e.g. lack of roads, infrastructure, refrigeration). Their lack of income also means that for the money they have available, it is much less expensive for them to get their calories and protein predominantly from vegetal sources. Vegetals are usually a fifth of the price (or less) for the same calorie content. The problem in developing countries is not a problem with production of meats but a "mal distribution" of food (and income). Many recent studies have shown that in the cities of most of these countries, the major nutrition problem is obesity rather than malnutrition and to which the high saturated fat content in meats is contributing. Using continuous antibiotics as animal growth promoters does nothing to remedy these nutritional problems. Instead it increases the risk that everyone will be exposed to more antibiotic resistant bacteria.

Questionable efficacy

In addition, use of antibiotics to prevent disease in animals is not very effective unless animals are malnourished, crowded and under stressful conditions. If relatively minor changes are made in animal husbandry practices there appears to be no or minimal benefits in countries like Australia using continuous in-feed antibiotics as growth promoters or as prophylaxis.

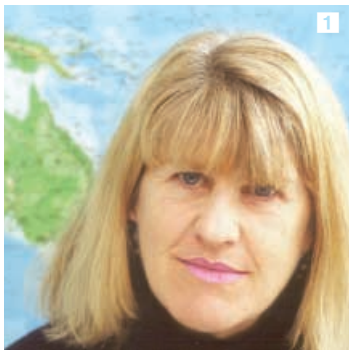
Internationally the use of some antibiotics in the therapy of animals is also a problem if they are "last resort" for human use because if resistance develops to these important agents then there may be no other antibiotics available to treat serious infections in people. Examples of such drugs are 3rd generation cephalosporins, glycopeptides, fluoroquinolones, and carbapenems. These antibiotics usually have restrictions on their use in people (e.g. in Australia an authority prescription is required) so paradoxically there may be less restrictions on their use in animals than in people! Fluoroquinolones fit into this group and they are very important in fighting salmonella which in western countries are nearly all derived from animals. Because of these concerns fluoroquinolones were not approved for livestock use in Australia, but pharmaceutical companies are defending their use in USA courts despite moves by the FDA to now stop their use.

Australia has the best environment to be relatively "antibiotic free" but still raise healthy animals and thus have the safest products for consumers. I believe we can do this without causing great harm to our industry economically and I think it will put our industry in a better trade position.

Australia lags behind

In Australia, much larger volumes of antibiotics are used per year in animals than people (in the 1990s over 500,000 kg per year and much of this as growth promoters). In Europe in recent years the mentality has changed markedly. In Sweden antibiotic use as growth promoters has been banned since the 1986. In Denmark over 300 million chickens have been raised since 1999 when that use stopped there. No loss of production has occurred there since this antibiotic "misuse" stopped. Australia lags well behind Europe in acknowledging and acting on the problem. The EU has now enacted legislation that stops this use. Even in the USA there is legislation before Congress on this issue.

The two major trading blocks (the USA and the EU), appear to be moving and legislating the right way. I'd like to think we could be ahead of them. Australia has the best environment to be relatively "antibiotic free" but still raise healthy animals and thus have the safest products for consumers. I believe we can do this without causing great harm to our industry economically and I think it will put our industry in a better trade position. If we don't do it sooner rather than later, we will not only



Rebuilding the health sector in East Timor

Sue Ingram served with two successive UN peacekeeping missions in East Timor from February 2000 to December 2002. She left Timor to take up a post as Senior Policy Fellow with the Institute for International Health.

On 20 May 2002 East Timor became the independent state of Timor Leste after almost 500 years of colonial administration by Portugal, 24 years as an unwilling and internationally unrecognised province of Indonesia and two and a half years under United Nations' administration. The armed conflicts that have punctuated Timor's history have also marked the points at which Australia has most closely engaged with the country: the landing of a small Australian military force in East Timor soon after Japan entered the war in 1941; the killing of five "Australian" journalists at Balibo in October 1975 by Indonesian forces; and the Australian leadership of the UN force mandated to restore peace after the outpouring of violence in the wake of the referendum on independence in August 1999.

These events are also threaded through my own association with East Timor. I first went there in July 1974 as a postgraduate anthropology student, and lived in a remote mountainous region which had sheltered the Australian soldiers in World War II and which welcomed me as their compatriot. I was forced to leave East Timor in August 1975 as the country erupted into civil war, and I returned in February 2000 as part of the UN peacekeeping mission to assist in rebuilding the civil administration of the country.

Timor was the poorest province of Indonesia, and it is now the poorest country of East Asia. Its population of around 800,000 is predominantly rural, with around three quarters living by subsistence farming. The formal economy is small, full-time salaried employment concentrated in the public sector and levels of urban unemployment alarmingly high.

In the weeks following the referendum on 30 August 1999, Timor's infrastructure was systematically and comprehensively destroyed and one third of the population fled or was pushed into West Timor. A similar number was internally displaced.

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By the time the UN forces arrived, almost all public buildings, between half and two thirds of all housing, and water, electricity and telecommunications systems in the capital and across the countryside had been wrecked or burnt. Central government simply disappeared and all government services ceased. Vehicles were looted and driven across the border, along with the contents of houses before they were burned. In the countryside, much of the livestock was rustled or killed.

This situation had all the makings of a humanitarian disaster: from malnutrition, exposure and disease. This is the inexorable multiplier effect of conflict: globally, for each death as a direct result of fighting, nine die from the indirect effects. In Timor, the flight of the population coincided with the leadup to the wet season, when fields are cleared and planted. As a result, even when people returned to their villages, the annual planting cycle had passed and emergency food distribution for several months was essential. The destruction of domestic housing left people without housing or crowded into the remaining shelter at the beginning of the wet season, when the incidence of diarrhoeal diseases and respiratory tract infections traditionally rises.

Photos

1. Sue Ingram
2. Dili harbour at sunrise
3. Dili hospital
4. Small mountain town (Ermera district)
5. Village leader (Ermera)
6. Padi fields (Manatuto)
7. Community clinic (Dili)
8. The post-independence generation

The huge challenge in this environment was to restore basic services while at the same time laying the foundations for a sustainable public health care system, managed and operated by East Timorese professionals.

Uncleared rubble multiplied the breeding grounds for mosquitos and damaged water reticulation systems left more of the population using unsafe water. Severely traumatised individuals and domestic violence were common – the typical aftermath of conflict. These factors added to the poor underlying health status of the population, with widespread undernutrition and stunting, under 5 mortality at 143.5, endemic malaria, dengue and tuberculosis, high rates of diarrhoeal diseases and significant rates of STDs.

The health sector itself was, literally, in ruins: the network of village clinics and district hospitals had been razed, equipment trashed or stolen, and records destroyed; the Ministry of Health had been sacked; and the clinical and administrative workforce had scattered. Six months after the referendum, when the first international staff arrived to begin the process of rebuilding a health administration, primary health care services were being provided by a patchwork of emergency NGOs, leaving significant gaps in coverage. Villages isolated by terrain or distance from the small towns in each district were worst affected. Hospitals were operating in the two major towns, managed by MSF and the International Red Cross, and other NGOs were managing a handful of smaller facilities with a few beds in the districts. Of 130 doctors in East Timor before the conflict, fewer than 20 remained; there was one specialist, and no dentists.

The huge challenge in this environment was to restore basic services while at the same time laying the foundations for a sustainable public health care system, managed and operated by East Timorese professionals. Immediate priorities included coordinating epidemiological surveillance, in conjunction with WHO; temporary recruitment of East Timorese nursing and administrative staff; and putting in place some basic arrangements for the supply and distribution of pharmaceuticals and for the provision of basic diagnostic services at district level. In parallel, work began on planning the shape of the future health workforce (clinical and administrative) and the network of clinical facilities around the country.

The reconstruction of the health sector was funded through the World Bank administered Trust Fund for East Timor, while day-to-day administration and funding for recurrent expenditure such as staff costs and pharmaceuticals fell to the United Nations Transitional Administration. In March 2000, a World Bank design mission arrived to plan the health sector reconstruction project, and in May 2000 the contract for the first phase of the project was signed – something of a record for those familiar with the usual leadtimes. At the same time, the nascent Ministry of Finance was developing the first Budget for the administration of East Timor, for the 2000/01 financial year commencing 1 July.

A feature of health sector planning was the sector-wide approach adopted, which encompassed the various players – UN, World Bank, bilateral donors and NGOs – within a single blueprint for sector redevelopment. This was not without its pain, but it avoided much of the duplication and the inappropriate investments that often plague development assistance.

One of the hardest fought battles was over a second hospital for the capital, Dili – a luxury in an environment where the national health spend would be of the order of US$12 per capita per annum, and health gains would be maximised through a concentration on basic public health measures and primary care.

Three years on, and one year after independence, Timor has a basic nationwide healthcare system in place. Capacity building – building the framework of law, policy, systems and procedures, as well as developing the workforce itself – remains a huge challenge. But it is a tribute to the spirit and the courage of the Timorese people that they have come this far in this short time. It was an immense privilege for me to share part of this journey with them.

Sue Ingram
Senior Policy Fellow
Institute for International Health

Rural matters

News from the Faculty of Medicine's School of Rural Health

The School of Rural Health

This is the first of a number of pieces about the Faculty of Medicine's School of Rural Health. This School was formed in 2001 and comprises four entities – the Dubbo Clinical School, the Broken Hill University Department of Rural Health, the Northern Rivers University Department of Rural Health and the Australian Centre to Agricultural Health and Safety in Moree. Each of the entities is unique although all are bound together by the word "rural".

The Dubbo Clinical School

In the 2000 Federal Budget, the Regional Health Strategy funded Rural Clinical Schools for nine Australian universities that have Faculties of Medicine. The University of Sydney was funded to develop the Dubbo Clinical School which has its primary campus in Dubbo and a secondary campus in Orange but which covers about a one quarter of the geographic area of the state.

The Dubbo Clinical School commenced operation in July 2001 with Rick McLean the first appointment as Associate Dean. Since that time, staffing levels both administrative and academic have grown and the School now has a significant presence in Dubbo, Orange and Bathurst.

In 2002, small numbers of students undertaking short rotations were located in both Dubbo and Orange and the numbers have increased during 2003. The Federal requirement is that by 2004, 25% of each year's intake will spend half their clinical training in the Rural Clinical School environment. For the University of Sydney, with a four year graduate entry program, taking approximately 200 students per year, this means that 50 students from each year will spend half of Year 3 and half of Year 4 in the Dubbo Clinical School.

Students will have a taste of hospital-based medical and surgical practice in larger base hospitals during Year 3 while in Year 4 they will have the opportunity to undertake a selection of the four rotations of Perinatal and Women's Health, Child & Adolescent Health, Psychological Medicine & Drug and Alcohol Studies and Community Practice. The latter rotation will be undertaken both in larger towns such as Dubbo, Orange and Bathurst as well as in the smaller towns such as Cowra, Parkes, Forbes, Mudgee and Coonabarabran in which general practitioners admit patients to hospital and undertake a reasonable amount of procedural work in surgery, anaesthetics, and obstetrics and gynaecology.

In addition, there are plans for some students to be rotated to Broken Hill where they will get a real taste of remote health.

Two attractions for students at Dubbo are the ability to have hands on experience with indigenous health and also the possibility of undertaking flights with the Royal Flying Doctor Service.

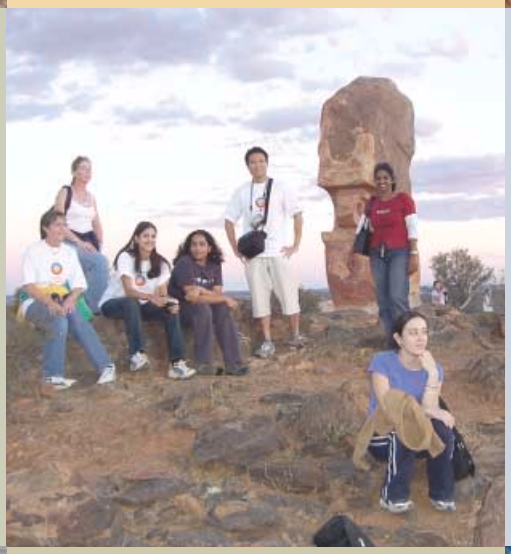
After a slow start, the feedback from "satisfied customers" is starting to make its mark and of the current Year 2 students fifty have volunteered to spend half of Years 3 and 4 in the Dubbo Clinical School environment.

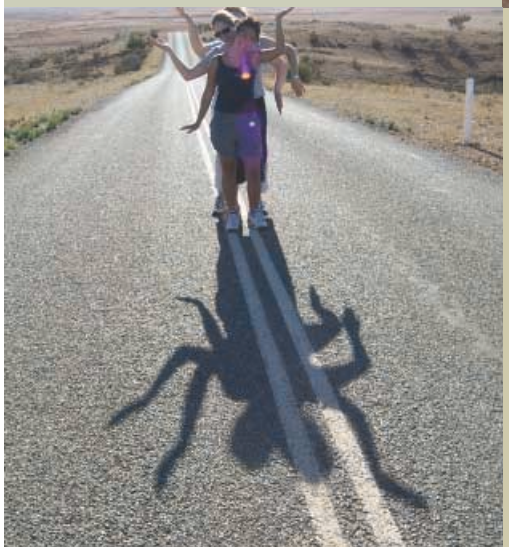
The aim of the Rural Clinical School program is two-fold – to create academic centres and attract new doctors to the area to be involved in the teaching program and also to entice students to consider a rural career when they finish training. The first is proving a little difficult to achieve thus far although we are confident that when a critical mass is reached, it will assist in the recruitment process. The second will take a number of years to determine but the intermediate outcome of satisfied students who are coming back for more rural training and will hopefully come back during their early postgraduate years is looking promising.

Rick McLean
Associate Dean Dubbo Clinical School and Head School of Rural Health

Go west young woman!

Dubbo Clinical School students on field trips to Broken Hill.





New course in medical humanities

As a medical student in the '60s I recall few opportunities and little encouragement to reflect on the place of medicine in relation to the social sciences, literature, history, art, music or philosophy.

Until 1997, when a new graduate-entry program began, the vast majority of us came straight from high school into a narrowly focussed six-year degree program. A few students took a combined Arts/Medicine degree and some academic pioneers, such as Yvonne Cossart and Ann Sefton, tried valiantly to introduce medical students to the history and philosophy of medicine in the early years of the course, but there were few opportunities to integrate this curriculum strand with other subjects.

There have been thousands of graduates from Sydney since I commenced my degree; thousands of graduates who have had almost no formal opportunity to study the arts, humanities and social sciences while taking the MBBS degree. Dr Stan Goulston is one of a tiny number who have undertaken formal study of the medical humanities. Stan completed a masters degree in the English Department at the University of Sydney and has for some years now provided a very popular option on the medical humanities for medical students.

The suggestion to develop a Masters of Medical Humanities degree came from Associate Professor Joanne Finkelstein, Postgraduate Coursework Coordinator in the Faculty of Arts. In designing the degree, our aim has been to emphasise the interdisciplinary nature of inquiry into the human experiences of health, disease, illness, medicine and health care.

The Faculty of Arts is the coordinating point for the degree, with input from the Faculties of Medicine, Science, Law and others. Our teachers are philosophers, historians, sociologists, public health physicians, biomedical scientists and specialists in English and Italian literature.

Shortly after beginning this project, we had another piece of good luck in the form of a chance meeting with an alumna Dr Rhonda Soricelli, who now lives and works in Philadelphia. Rhonda was asking for advice on a suitable way of saying 'thank you' to her parents, Harold and Gwenneth Harris, for supporting her undergraduate education at Sydney. Since she has a strong interest in the medical humanities, she was delighted by the suggestion that she might offer a gift in support of the new initiative.

Last year a small advertisement in *Radius* brought an encouraging response, with around 70 inquiries. Professor John Hickie, having retired from a large teaching hospital, decided that this represented an important opportunity "to keep the neurones in working order". While most of our students are medical practitioners the program has also attracted inquiries from nurses, social workers, artists, and medical students to name a few.

The introductory core unit ranges across three main themes: The Culture of Medicine, Medicine and History, and The Human Experience of the Body and Illness. Examples of the many elective courses drawn from across all faculties are *History of Science; Deconstructing Medicine; Professional Communication; Death, Dying and Mourning; Health, Culture and Gender and Policing Bodies: crime, sexuality and reproduction*. Courses in bioethics from a Masters degree in Bioethics will be cross-listed with the Medical Humanities program next year. Most of the units run as weekly seminars and the assessments are by seminar presentations and essay papers – an exciting challenge for doctors accustomed to multiple choice questions!

We also plan to develop units of study for flexible and distance learning. This will be a considerable challenge because the study of the medical humanities seems to be so dependent on real time, face-to-face conversations. However we are hoping to create some interesting alternatives for on-line learners who might not otherwise be able to participate.

For those whose curiosity and interest include the links between science, technology, medicine, the arts, humanities, and social sciences, this is a fine opportunity for intellectual nourishment and for interaction with others with similar interests.

Associate Professor Jill Gordon
Head, Discipline of Medical Education, Faculty of Medicine

Above: Students of Medical Humanties.
Back row (left to right) – Michael Izard, Theresa Pitt, Tim Saunders, Zewlan Moor, Peter Caspari, Barry Catchlove.

Seated front row (left to right) – John Hickie, Judith Fryer, Margaret Morgan.

Right: Judith Fryer, Tim Saunders, Margaret Morgan and John Hlckie

More information

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The website is at **www.medicalhumanities.med.usyd.edu.au**

Gaston Egon Bauer

Founding President of MGA steps down

Together, the current combined age of the Founding President of the University of Sydney's Medical Graduates' Association and its teaching program amounts to 200 years! Gaston Bauer's share of this is an impressive 80 years, so it is time to salute him, to thank him and to recap some of the many highlights of his service to the profession.

In some countries Gaston (GEB) would be regarded a "national treasure". This was the thought that flashed through my mind as I chatted to GEB on the eve of his 80th birthday. Twenty years earlier, to the day, we had resolved to launch a Foundation to support heart research. That initiative had prospered beyond all expectation and Gaston had nurtured and guided it through its formative years. A similar experience was repeated three years later with the University of Sydney Medical Graduates' Association (SU-MGA). But there had been and continued to be many other causes which GEB espoused during his long and remarkable career trajectory. His talents and personal attributes are so rich that it is futile to try to characterise this complex and remarkable man's contributions to the practice of medicine and the medical community. One of the lasting monuments to Gaston's influence will be the many founding initiatives which he lovingly guided along the path to robust success.

Gaston has always had a strong interest in medical history, which has given him a rare perspective on his beloved and noble profession. This has helped him, at times almost as a man possessed, to hand on the flame of knowledge and love of the art to his colleagues, and particularly to its younger generations. Thus, in 1986 GEB accepted the challenge, at the request of the Dean of the Faculty, Professor Richard Gye, to found and chair the SU Medical Graduates' Association. It would not surprise me if in fact the original idea had come from Gaston and returned via a "Dorothy Dixer" from the Dean. The initial Membership of the Council of the SU-MGA reads like a Who's Who of Sydney medicine at that time. It included the Chancellor, Vice Chancellor, President of the Medical Foundation and other illustrious and influential persons – in itself a clear indication of the respect in which GEB was already held at that time. By the time of its second Annual General Meeting the Association boasted 700 members who ranged from the USA, through Canada and to Hong Kong.

Gaston had the social and cultural background of the famous Viennese School of Medicine, whose leading influence had permeated medical knowledge and practice in the early 20th century. Additionally, he had an affectionate attitude to SU which had awarded him the University Medal. Both he and the Dean, who had spent time at Oxford, believed that the time had come to establish an organisation for past graduates. After all, the 100 yr old faculty could now be considered to have reached a degree of maturity. It was an altruistic step – in the days when Alumni Societies were not primarily seen as fundraising arms of Universities. In fact, Gaston recalls that "the Dean was apparently flush with money" and was even prepared to help financially to launch the venture!

It was hoped that this Association "with which all graduates could identify and through which they could practise and demonstrate allegiance to the Faculty" would achieve at least two aims.

Gaston's contribution to the medical fraternity and the University of Sydney through the Medical Graduates' Association can only be truly assessed when viewed in light of his multiple other founding, teaching, governance, scientific, cultural and humanistic contributions.

One was to add further lustre and cohesion to the body of U Syd medical graduates and the other was to create a vehicle through which they could play an active part in the life of their Alma Mater. It thus sought also to bridge the chasm that not uncommonly develops between universities and their graduates once they leave the Ivory Towers.

Gaston's contribution to the medical fraternity and the University of Sydney through the Medical Graduates' Association can only be truly assessed when viewed in light of his multiple other founding, teaching, governance, scientific, cultural and humanistic contributions. Probably, his years on the USyd Senate and as Warden of the RNSH Clinical School were the most public and visible among those that touched and inspired his colleagues and students. But he also put in tens of thousands of hours on more mundane committees, societies and associations where his counsel was invaluable and where he built the edifice of his profession.

His attendance at meetings sometimes bordered on the pathological but it also kept him immensely well-informed and well connected. It helped to inseminate the younger generations with an inquisitive, curious and healthy sceptical outlook. He always argued for a balance between the science and the art of medicine and he practised both to the highest standards. He adopted an approach to meetings that is now generally acknowledged to have been perfected by him. He would attend three meetings simultaneously while others were "trapped" in one. He would leave early from the first, ask the searching question during the second, and meet participants breaking from the third – all in one night! If this sequence included Committee meetings he would assure that he had the agenda and minutes to all of them. He was always well prepared and many of us greatly admired GEB for these skills. We learnt a lot about the purpose and machinery of meetings, about governance issues and about consensus – sometimes even leavened with a little medical politics. Gaston's preparation had no doubt included advice from Klausewitz and Machiavelli – but he practised those arts only when he had his back to the wall and when an important point of principle was at stake. The Medical Graduates' Association gave him the opportunity to apply all the "gentlemanly" skills that he had perfected in the more testing atmosphere of less collegiate meetings.

Gaston has only recently produced the series of articles of which he is most proud. They are also of the type that only he could write. Interesting, peppered with anecdotes, meticulously historically researched, illuminated with a cultural background that respects the old but is passionate about the future, written with the insights of one who has the knowledge but also the humanity that has characterised his medical practice. Publication of these articles in one tome could serve as a small, but greatly deserved and fitting tribute to this outstanding contributor to our profession.

Stephen N Hunyor
14 Feb 2003

The history of the medical curriculum at the University of Sydney

Occasional address by Professor J A Young AO FAA FRACP MD DSc to the Faculty of Medicine graduation held at 11.30am on 10 May 2002

† Emeritus Professor Young, who was a Professor of Physiology, served as Dean of the Faculty of Medicine from 1989 to 1997 and as Pro-Vice-Chancellor (Health Sciences) from 1994 - 1996 (part-time) and full-time from 1997 to April 2003. He first joined the staff of the University in 1966.

Chancellor, Professor Pesman, Professor Leeder, Ladies and Gentlemen. Today we witness the graduation of the second intake into the University of Sydney's graduate medical program, a program that has just been given an unqualified 10-year accreditation by the Australian Medical Council. It seems appropriate that I rehearse the history of the Sydney curriculum since 1859, so as to put matters in context.

At the time when the University was founded, a practical function for it was foremost in the minds of at least some of those involved. It was not seen primarily as a place where research would be done and scholarship fostered, but rather as a place where the sons of the gentry would be educated so as to take over roles in the next generation as part of the ruling élite. For this reason, therefore, the *Act of Incorporation* envisaged that the University would offer degrees in Arts (to train teachers and administrators) and in Law and Medicine (which specifically included Medicine, Surgery, Midwifery, Pharmacy).

The possibility of establishing a Medical Faculty arose soon after the University opened its doors with the appointment in 1852 of Professor John Smith as the foundation Professor of Chemistry and Experimental Physics. Smith held a Doctorate in Medicine from the University of Aberdeen and although he was appointed primarily to teach the physical sciences in the Arts curriculum, it was hoped by the professionally minded Fellows of the Senate that he might also initiate some training in Medicine at the Sydney Infirmary (now called Sydney Hospital). To this end, Senate appointed him Dean of the Faculty of Medicine in 1855, and established a Faculty of Medicine in 1856. The other members of the Faculty appointed at that time were all medical practitioners active in the community, including George Bennett, later to become famous as a naturalist, and Charles Nathan, the ancestor of the McLaurin/Mackerras family (and, incidentally, Australia's first resident opera composer). The wish to create a Medical Faculty was given some impetus by the fact that the Senate itself included a number of medical practitioners, in particular the Chancellor and Provost, Sir Charles Nicholson, the Government Medical Officer, Dr Bartholomew O'Brien, and a fairly flamboyant doctor/politician, Dr Henry Grattan Douglass. In addition, of course, W.C. Wentworth was a surgeon's son. The Faculty, presided over by Professor Smith as Dean, was charged with the responsibility of conducting examinations for award of the degrees of Bachelor and Doctor of Medicine. A curriculum (the first) was approved by Senate in 1859 although it was never implemented because Smith did not self identify as a medical practitioner and, in common with Woolley, the Professor of Classics, and Pell, the Professor of Mathematics, he opposed opening a Medical School, one presumes because he feared it would take resources from his own discipline.

Medicine was unregulated in Sydney at that time - although the NSW Medical Board had existed since 1838, and it gazetted the names of registered practitioners, this did not prevent other less respectable practitioners from operating. Registration merely offered some measure of social respectability. A pathway to yet greater social respectability was to obtain a University degree since at that time most medical practitioners, even respectable ones, were not graduates, but only Licentiates of the Society of Apothecaries or Members of the Colleges of Physicians or Surgeons of London, Scotland or Ireland. The Scottish Universities offered medical degrees, as, of course, did Oxford and Cambridge, but the number of English as distinct from Scottish doctors in the Colony with University degrees was very small. Even Charles Nathan, who was certainly respectable, held only an LSA and an MRCP. Despite the availability of the new Faculty examination process, only very few doctors from Sydney applied successfully to the Faculty for award of Bachelor or Doctoral degrees in Medicine. An entrance requirement mandating possession of an Arts degree and 10-years of practice will have restricted the field somewhat. The rate at which these degrees were awarded was increased slightly, however, by an interesting struggle going on in the 1860s and 1870s in Melbourne. There, a Medical School had opened (in 1863) and its examiners proved unwilling to grant degrees to existing non-graduate practitioners.

In consequence six of them came north and applied to be examined in Sydney; some came twice, to collect both Bachelor and Doctoral certificates.

In all, 14 practitioners got medical degrees from Sydney University before the Medical School opened in 1883. Presumably the examiners felt that the candidates had fulfilled the requirements of the first curriculum, even if instruction according to it was never implemented. We have no record of who failed the examination, but there must have been failures since only 7 of the 14 successful candidates practiced in Sydney. One of the Sydney graduates was James Houison who, before studying medicine in Scotland and obtaining his Bachelor's degree, had been one of the earliest graduates in Arts from Sydney University (in 1863); he gained an MD at Sydney in 1870.

All this came to an end around 1883 when the University of Sydney opened its own Medical School and T P Anderson Stuart at the age of 26 arrived from Edinburgh to take up his post as the Dean and foundation Professor of Anatomy and Physiology. In order to start operation, a curriculum had been developed in 1882 (the second curriculum) in advance of Stuart's arrival to cope with the first intake of students. We don't know what it was like but it must have been fairly demanding since all the students failed at the end of the first year. Anderson Stuart revised the course after his arrival in 1883 (the third curriculum) and, in the case of the following intake

(in 1884), most students passed first year and continued to progress satisfactorily. Eventually, five students from this second intake, plus one from the first intake who had repeated first year, graduated (after five years) in 1888. The graduation list included two outstanding students who went on to make international reputations for themselves: Peter Bancroft, who got first-class honours, went to Queensland and made a career in infectious diseases and public health, and William George Armstrong, who got second-class honours, pursued a career, also in Public Health, in England, New Zealand and New South Wales, where he became State Director General in the 1920s.

Nevertheless the early curriculum evidently needed adaptation, and further revisions were undertaken in 1885 and 1890 (the fourth curriculum). Before 1890 the students shared a common first year with Arts students, but from 1890 they had a separate five-year curriculum of their own. This fourth curriculum survived unchanged until the period of expansion following World War I and a major overhaul was not undertaken until 1922 (the fifth curriculum) after Anderson Stuart died, and again in 1926, when a six-year curriculum was introduced (the sixth curriculum).

It should be noted that, from the beginning, the shape of the curriculum was determined by the Scottish origins of most of the early teachers in the School, including of course Anderson Stuart himself. Scotland in the 1870s and 80s, had a first-rate general educational system and was at the forefront world-wide in its scientific approach to medical education. It pioneered a system in which basic physical sciences were first taught, followed by the medical sciences, and only when these had been completed did structured clinical training in the hospitals begin. A similar reform developed in North America after 1910 with publication of the report of Abraham Flexner from John Hopkins University, but there a graduate entry program was adopted, rather than a program for school leavers. For those who are interested, Anderson Stuart's own undergraduate lecture notes, which he had bound in red leather, are in the library of the Royal Australasian College of Physicians in Macquarie Street, and a set of histological sections prepared by him during his anatomy classes while a student at Edinburgh are in the Fisher Library Rare Book Collection. From these, one can easily see the nature of the educational program that shaped his own thinking before he came to design a curriculum for Sydney. His teachers included the surgeon Lord Lister, of antisepsis fame, and Cunningham, of *Cunningham's Anatomy*. From 1926 until 1937 the shape of the curriculum at Sydney remained unchanged, beginning with Physics, Chemistry, Botany and Zoology, progressing to Physiology, Anatomy, Pathology, Bacteriology, and then on to Medicine, Surgery, Obstetrics and Materia Medica. As new disciplines like Biochemistry and Pharmacology emerged, however, they were taken on board and the quantity of material that students were expected to master increased considerably. The sixth curriculum, which we used to call "the old curriculum", took on its definitive shape in 1937, although it did get revised periodically, in 1939, 1944, 1948 and 1960 and again in 1968, by which time I had joined the staff of the University.

For those who are interested in how the students lived and worked in those days I recommend to them two books of H.V. (Paddy) Moran, *Viewless Winds* and *Beyond The Hills Lies China*. In these, Moran describes his experiences as a medical student in the 1930s and as a recently graduated medical practitioner, working in Sydney and in country New South Wales.

A problem with the curriculum emerged slowly over time. In 1880 the useful knowledge base was quite small since the scientific base of medicine had only just begun to expand rapidly, and new knowledge could be incorporated into the course as it became available without greatly increasing the learning load on students. Because there was an unquestioning acceptance of the notion that all factual knowledge should be presented to students in lectures, however, the number of lectures that students were expected to sit through grew steadily until, by the time I came to the University in 1966, a second year medical student was expected to sit through 20 one-hour lectures each week together with between 8 and 12 hours of practical classes, and every other spare moment in the day was filled up with anatomical dissection. The course could not be expanded any more and a groundswell of opinion arose demanding curriculum reform.

In 1974 a new curriculum, the seventh, was launched. The driving spirit behind its introduction was the then Dean, the late Professor David Maddison, and its architects were the late Professor Ann Woolcock and Professor John Chalmers, then an Associate Professor in the Department of Medicine. Strangely, this curriculum was only 5 years long. The logic behind the introduction of a shorter five-year curriculum related to a change in the NSW School curriculum which retained students at school for a year longer, plus a Faculty decision to eliminate what was perceived to be unnecessary teaching in Biology, Physics, Chemistry and Anatomy. It was felt that these courses had retained too much time in the expanding curriculum and many thought that all that was necessary to achieve reform was to reduce these courses in size to make room for a few new topics. In my own student days at the University of Queensland in the late 1950s I studied anatomy for 780 hours so there was certainly scope for a reduction. I should say that such simplistic reasoning was not the vision of David Maddison or John Chalmers. They had a far-reaching inspirational vision of a complete change in the way Medicine would be taught. Nevertheless, the forces of reaction were substantial and they surfaced as soon as Maddison left (to found the Newcastle Medical School) and Chalmers departed for Adelaide (to help found the new Flinders Medical School). The old guard of teachers who had resisted the changes they had introduced, took advantage of their departure to undermine the reforms by crowding all the old factual information into the new compressed timeframe.

The launch of the new five-year curriculum coincided with the arrival of Professor Richard Gye, the first full-time Dean of Medicine at the University of Sydney. After 10 years of struggling with the five-year curriculum, he initiated a further attempt at reform and in 1984 the Faculty adopted a new six-year curriculum, the eighth. The new six-year curriculum persevered with the cuts to the basic sciences made in the five-year curriculum and retained many important initiatives that had been introduced by Woolcock and Chalmers, but the extra year made it possible to introduce the new disciplines that were emerging without rethinking what was already taught or how it was taught. The basic problem remained that the knowledge base on which medicine rested

was continuing to expand very rapidly and the obligation to present all this factual material in lecture format meant that the course was diverging more and more from one that would meet the expectations that the community had of what medical graduates should be trained to do.

When I became Dean in 1989 there was a very strong push for a further attempt at reforming the way medical students were trained. The late Professor Ann Woolcock, Professor John Turtle and the late Professor Rodney Shearman all urged reform on me and the vision of where we might go was provided by Professor Stephen Leeder, the then newly appointed Professor of Community Medicine at Westmead Hospital, who had come to us from Newcastle University only in 1985. Early in 1991 the Faculty established a working group to examine the possibility of abandoning the traditional course aimed at school leavers and, instead, of moving to a model of professional training for students who had already successfully completed an undergraduate degree in some other discipline. Parallel with the wish to change the intake from school leavers to mature, motivated adults, was a drive to change the style of teaching from didactic lectures to one based on Problem Based Learning. Stephen Leeder, who had been actively involved in the development of such a course at the University of Newcastle, provided inspiration for us to attempt a further development of this model at Sydney. The difficulties were very great however. Unlike Newcastle, which was a small single-hospital Medical School with an intake of 60 students, Sydney was a large multi-hospital institution with established programs of campus- and hospital-based teaching, and an intake of over 300 students.

The Faculty met on 22 October 1991 and after long debate voted in principle to establish the new course. It did so however with its fingers crossed metaphorically behind its back since many members of Faculty were nervous and deeply suspicious, and some were quite hostile. It was not clear what resources would be available but there was a strong feeling that they would be inadequate. The Faculty resolved to review the matter after twelve months and to charge the Dean and his advisers with responsibility in the meantime for demonstrating that the introduction of a new course of this kind was financially sustainable. The Faculty met again, exactly a year later, on 22 October 1992, with the largest attendance at a Faculty meeting ever recorded, before or since. The debate was long but in the end the decision to go ahead was endorsed: some 164 members of Faculty voted in favour, with six against and one abstention.

The rest is recent history. In due course we appointed Professor Stephen Leeder as Head of the Department of Medical Education, Professor Ann Sefton and Associate Professor Michael Field as Associate Deans responsible for curriculum development, and Associate Professor Jill Gordon as Head of the Medical Education Unit with a particular responsibility for training the teachers. Several hundred teachers had to be trained, new methods of selecting students had to be devised, and a curriculum created *ab initio*. Of course we had models to look to, in particular the so-called New Pathways curriculum at Harvard, and the five-year problem-based curriculum at Newcastle. As Dean, I had a role to play akin to that of the Producer of a Hollywood film, whereas, Leeder, Sefton and Field were the film Directors. As Producer I had to find resources, generate publicity and persuade all the stakeholders not to oppose the radical change: the three Directors had to articulate the vision and implement it. The number of stakeholders was considerable. Apart from the obvious players, such as the professional Royal Colleges, the AMA, the AMC, the Medical Board of NSW, and State and Commonwealth Departments of Health and Education, there were the Teaching Hospitals, the NSW secondary schools and even groups such as the Ethnic Affairs Commission, as well as numerous allied health groups. Within the University, the Vice-Chancellor had to be won over and the Academic Board, not to mention the governing body of the University, the Senate. Of course, resources had to be found: over a million dollars to build and fit out problem based tutorial rooms, and another million dollars annually for the ongoing employment of instructional designers, IT experts and other support staff. Critical to the development of the enterprise was the availability of new information technologies, particularly the emergence of the World Wide Web and its intra-institutional parallel, the Intranet. A young Senior Lecturer in Physiology, Simon Carlile, now Associate Professor Carlile, Assistant Pro-Vice-Chancellor for Information Technology, created an IT platform on which the curriculum could be delivered across New South Wales. It was a world "first".

The first intake of new students into the ninth curriculum was in 1997 and the first graduation was in 2001. Unlike the intake into the Medical School's first curriculum, where everybody failed, there were almost no failures or discontinuations in the ninth.

My audience today includes the second graduating class, their parents and their friends. You know what you have experienced and will make up your own minds about it. It is encouraging to note, however, that there has been universal enthusiasm from outside the University about the quality of the students and the quality of the course. When introducing a new curriculum, however, one needs to remember that any curriculum can ossify and it is only by embracing continuous change that one can hope to avert this risk. Today's "old" curriculum was yesterday's "new" curriculum. The course has been fully accredited by the Australian Medical Council for 10 years but, rightly, the Faculty is not planning to wait so long to review it, and the process of reassessment is about to begin. Soon we may see the birth of the tenth curriculum. The Faculty has been especially fortunate in that its current Dean, Professor Leeder, had previously been a major participant in shaping the whole enterprise. In the near future he will be moving to another role and I will be retiring so it will be left to our successors to continue the process. Fortunately the margin for error is considerable because the quality of our teachers and our students is so high. Soon after I came to the University in 1966, someone wrote on a whiteboard, or perhaps then it was a blackboard, that there has never been a curriculum devised that actually prevented students from learning. That truism protects us from the effects of even our most egregious mistakes. On the other hand we continue to be heartened by the thought that we can devise curricula that make it easier for students to learn and we believe we have done so. Unashamedly, we believe our course is one of the best in the world. If it is, it is because so many inspired people worked to develop it and to deliver it, and so many committed young professionals chose to enrol in it.

I don't need to say more about the curriculum - I need only thank you for choosing to enroll here and to thank my colleagues for their dedication and professionalism.

To all I say, goodbye and good luck.

Reunions – 2003, 2004, 2005

Let others know of your planned or past reunion by sending in a notice or short report (and photos!) of your celebrations. The MGA can assist in organising your reunion by publishing the date of your reunion, contacting graduates from your year and sending invitations.

Contact the MGA by:

Phone: 02 9351 8947

Email: mga@med.usyd.edu.au

Upcoming Reunions

2003

Graduating year of 1948 – 55 years

When: 15 November 2003
Where: to be advised
Time: 12noon for 12.30pm
Contact: Harding Burns, tel: 9327 6329
Cost: to be advised

2004

Graduating year of 1944 – 60 years

When: April or May 2004
Where: to be advised
Time: lunch
Contact: Drs Lewis and Stuart, tel: 9567 4191
Cost: to be advised

Graduating year of 1954 – 50 years

When: Friday 26 March 2004 (lunch)
Where: Royal Sydney Golf Club, Rose Bay
Time: 12noon for 12.30pm
Contact: Brian T Shearman, tel: 9498 2724 fax: 9924 3359
email: bmshearman@pip.com.au
Cost: to be advised

Graduating year of 1964 – 40 years

When: Saturday 24 January, 2004
Where: Shangri-La Hotel (formerly ANA Hotel)
Time: 7pm
Contact: Dr Jules S Black, email: jsblack@bigpond.net.au
Cost: $130

Graduating year of 1994 – 10 years

When: Saturday 13 March, 2004
Where: Sebel Pier One Sydney
Time: 6.30pm
Contact: Katrina Ison, tel: 9634 5229
email: katrinaison@optusnet.com.au
website: www.members.optusnet.com.au/~obeidj
Cost: to be advised

2005

Graduating year of 1956 – 50 years

When: July 2005
Where: to be advised
Time: lunch
Contact: Dr Michael Owen, tel: 9327 6236
Dr Edward Alam, tel: 9130 5678
Cost: to be advised

1943

Sydney medical graduates 60 year reunion 24 March 2003

Our 60-year reunion was held on 24 March 2003 at a luncheon at the Royal Sydney Yacht Squadron Neutral Bay. We were born soon after World War I, and lived though the great depression, W.W.II, wars in Korea and Vietnam and now war in Iraq. We saw the opening of the Sydney Harbour Bridge and the Sydney Opera House; the first Sputnik; the Space Age and the men on the moon; the advent of radio, television and the age of computers.

We enrolled in Medicine in March 1938, and ours was one of the accelerated courses during W.W.II: we did our 5th year exam in September '42, and our final in March '43, with a 2-week break over Christmas. As students we helped dig air raid trenches in the university grounds. After our obligatory hospital training many of our year joined the armed forces and served overseas, while those who remained carried on with blackouts, rationing, and staffs depleted of some of their most capable doctors. Our Final Year book lists 123 men and 22 women. Our latest contact list, which may be incomplete, shows that 38 men and 8 women are still with us. Twenty-two graduates and 16 partners attended the reunion including doctors from Bundaberg, Queensland and Berwick, Victoria; we had apologies from 22 others from every Australian state, not bad considering we are all over 80 and showing various signs of ageing.

We exchanged greetings and reminiscences. We had gathered a gossip column of what some of us have been doing and it is surprising how many of us are still active. Some of our members told stories of their quite alarming experiences and the responsibilities they had to handle in their early years. Four claimed that their hospital had been the first to use penicillin obtained from the American army hospitals in 1943.

We have been around now for more than a third of Australia's white settlement, we saw the introduction of antibiotics, blood transfusions, the contraceptive pill, keyhole surgery, organ transplants, IVF and gene therapy; we saw changes in the patterns of disease, disappearance of some infections and the threat of new ones; many of us walked across the Bridge for Reconciliation with our Aboriginal friends.

We had a delightful meal, lots of good chatter and much humour. We have decided not to wait 5 years for our next reunion but to meet again in 3 or even 2 years time. We thank the Sydney Medical Graduates Association for the help with our first mailing. The surplus funds from our reunion will go to the Association and to the Medical Benevolent Society.

Stefania Siedlecky AM for the 1943 Medical Graduates.

1953

Sydney medical graduates 50 year reunion 28 February 2003

When 120 friends of yester-year congregate, it is an event. A graduating class reunion is a very special occasion. Particularly when it is the fiftieth. The Graduating Class of 1953 met at the Royal Sydney Yacht Squadron on February 28, 2003 half a century later. The reunion had occurred every ten years, but next it will be five! It is incredible the good will and fellowship that takes place at these wondrous events.

This was especially notable, as the immediate post war years of 1946, '47 and '48 saw staggering university intakes. Returned servicemen came home in droves, and rightfully were offered positions, so competing with those fortunate students from high school who missed the war by months. First year figures were 729 students in 1946, an historic record. 1947 was much the same. All know there were probably 300 hospital positions available at the end of the course. Which meant failure rates had to be enormous. And they were. Who doesn't recall 48 students to a body when dissecting in anatomy Med II? One was lucky to see the body, let alone do any practical work, which at the time was the norm. Students crowded around hapless public hospital patients, sitting, standing, squatting, trying to write legible notes. It was physically impossible.

Fibro shed – notably "the barn" alongside the new med school was hastily thrown up, boiling and suffocating mid summer, freezing at 8am winter lectures. Textbooks were hard to obtain, supplies of anything disastrously short in the immediate post war years. But friendships were forged, mateship, the typical Australian way blossomed and grew. Most students delivered ten babies, probably assisted at maybe one operation (hanging onto a retractor two rows back), and took dozens of histories in super-human detail. Examined, poked and prodded countless patients.

Men floated around wards in short white coats (white dress for women) with a stethoscope hanging from the pocket. This was pre-TV days before it was 'hip' to be strung around the neck. Path tests were done manually. This did not change until the age of automation several decades later. Lectures were often unintelligible, depending on the PA system. This continued for six years, then suddenly vanished. All went a separate way.

The physical appearance and mental aptitude of the graduates fifty ears on was remarkable. All were mid to late seventies, many in their eighties. Although most had 'retired', many soldiered on, mainly with other outside interests. All had travelled widely. Most obvious physical defect was kyphosis, undoubtedly from sitting over desks for years. Osteoporosis seemed in excess of the national norm, 2 out of 3 women, 2 out of 4 men. Most had some hair, manly very little. Many had a regular exercise programme. Very few were overweight, surprise, surprise. In fact, most appeared much healthier on their 50th than their 40th reunion. About 90 had permanently departed life, another 80 were untraceable.

If and when you receive an invitation to attend a 'graduation anniversary' grab the opportunity with glee and attend. It is an event that bursts suddenly across the screen of time. It vanishes four hours later, to linger only as a memory.

Dr John Knight

1958

Sydney medical graduates 45 year reunion 8 February 2003

The dinner on 8 February 2003 at the American Club in Sydney was very successful and everyone enjoyed the evening. For the first time, we invited wives and partners and had about 80 altogether, including 60 members of our original year (graduated January 1958). Friends came from the UK, the United States, New Zealand, Singapore, Hong Kong and Norfolk Island, as well as from Melbourne, Adelaide, Perth, Canberra, Young, Grafton, Newcastle, Gold Coast and of course, Sydney.

It was a great pleasure too, to welcome Marjorie Roche, as Peter had passed away since our last dinner in 1998. Yvonne Cossart and Ted Wills were warmly greeted too – both started with us but dropped behind a year when they did their BScMed.

There was much laughter and great conversation all night and we were regaled during and after dinner by Bruce Adam, Graeme Clark, David Craigie, George Dunea, Robin Fraser, John Grausz and Earl Owen who all told fascinating tales of life since graduation.

Several of our class were unable to come at the last minute. We hope Bruce Shepherd's back is better and that Carolyn Nihill's (Simmonds) knee replacement has her running up and down stairs by now!

We received apologies from 22 of our class, including ones from Maurie Cleary who is a young 85, Rob Langley, a mere 83, and Helen Wechler, whose age is a secret!

We all would like to thank Wendy Marceau and Clarissa Chaloner at the Medical Graduates' Association for their invaluable help in organising our dinner.

Our 50th, THE BIG ONE, will be on the first or second Saturday in February 2008 at the American Club in Sydney. Jann Hunt (Porges) has offered to help me with "what we have all been doing since we graduated".

On the evening, I suddenly realised that a few of our class had not come – their big name tags were on the table!! and some days later I received a letter from Agnes Sinclair who said:

"Brian, I just don't know what to say about my monumental goof. I was really looking forward to this reunion, never having missed one of them. I had it all planned, got the dress, jewellery, and a hairdressing appointment, THE WORKS, all on the assumption it was the 15 February!! Your letter starts off saying it is on the 8th but down the bottom 15th January was highlighted as being the closing date for payment, so clever little me puts down the 15th February in the diary!!!

I was sitting down quietly on Monday night minding my own business when the phone rang and this little voice enquired if she was talking to Agnes. I immediately recognised Adela and was somewhat taken aback when she asked why I did not turn up. But it's next Saturday, says I. Oh no, it's been & gone. I was utterly devastated and speechless with horror, not only for having missed it, but also realising that I'm going senile.

At any rate she managed to come over for lunch yesterday and we spent a great day together. Before I took her back to the Union Club we drove around a bit as she wanted to take pictures of Middle Harbour, then we went to DJ's to pick up a whole gammon ham for her to take back to Singapore. (She dreamed this up about 11.30 and we had great fun ringing round butchers to try and get one).

While she dashed in for her meat I kept driving round the block. I was aware that my petrol was getting a bit low, and had every intention of filling up on my way home, but fate decreed otherwise. At 5 pm in the middle of the Harbour Bridge the car died on me. Mercifully I was just over the hump, so managed to coast down to the first emergency phone on the Warringah Freeway. And there I sat till the RTA towed me to a garage on Military Rd in Neutral Bay. They took about 1/2 an hour to get to me which was pretty good going in the heavy traffic. It was quite frightening to have all that traffic whoosh past me and every time a bus did it, my little car nearly took wing in their wake. But basically it was humiliating to have my stupidity confirmed.

Apart from this I had a few torrid years. I had bilateral cataracts done just 5 years ago. now no longer wear glasses, have perfect vision. Then in November 98 had an anterior infarct while swimming at high tide all by myself in Northbridge Baths (I still swim there each day every day of the year). This manifested itself in an attack of pulmonary oedema. I was fortunately at one of the ends so I could hang on for dear life while I was quietly choking. I eventually swam ashore and ended up in the San and had a stent put in. This episode slowed me down a bit, I get breathless on going up hills, and my bushwalking came to an end aided and abetted by increasing osteoarthritis which led to bilateral hip replacements in August last year. That really knocked me about, but I am over it now, and have almost regained full mobility. I managed to cut my toenails 2 weeks ago!

We are still culture vultures, go to the opera, ballet, concerts and plays, but have slowed down a bit with travel. I went to Vietnam & Cambodia last year and we both went to Morocco & Italy, and we are off to China at the end of March. Will be visiting Adela in Singapore on the way up.

I hear you are both in good health and about to go off on some trip. Would love to see you when you are down in Sydney next. Once again I'm so sorry.

Lots of love, **Agnes"**

1962

Sydney medical graduates 40 year reunion 8 February 2003

Above: 91 graduates of 1962 at reunion dinner

91 graduates of the 1962 Graduation from the Faculty of Medicine University of Sydney celebrated their 40th Anniversary Reunion Dinner in the Withdrawing and Refectory Rooms at the Holme Building at the University on Saturday the 30th of November 2002.

Together with wives and husbands a total of 141 persons attended and enjoyed a night of reminiscences, good food and a wonderful University venue. We were able to renew acquaintances and revisit familiar surroundings that had played an important part of at least six years of our early adult life. Many had not returned to the University since their graduation.

Unfortunately twenty-one of our graduate colleagues were deceased. Contact however was able to be made with 152 of the 178 surviving doctors who had graduated in 1962. Many were unable to attend due to distance and/or prior family or business commitments, and sadly seven were not well enough to attend. Graduates attended from London, Saudi Arabia, Western Australia, South Australia, North Queensland, Brisbane/Gold Coast, Victoria, ACT and Rural NSW. Twelve of those unable to attend lived overseas (Ireland, London, Israel, Canada, Singapore and the USA).

A selection of the 31 written apologies was displayed, on a pin-board, together with a collection of memorabilia – early student group photographs; the 1958 ethics exam paper; the Nov 1961 final year clinical & viva-voce exam timetable; final year exam results in the Sydney Morning Herald; entrance ticket and programme for the Graduation Conferring of Degrees Ceremony in the Great Hall on Wednesday 24th January 1962 at 3pm; copy of the Government Gazette No.27 of 23rd March 1962 which listed the names recently added to the Medical Register by The NSW Medical Board; a list of JRMO Hospital Placements for 1962; copy of the group photo taken at the 1992 reunion dinner.

The organising committee for this reunion would especially like to thank :-

The Medical Graduates' Association of the University of Sydney for their cheerfully and voluntarily given help and support in tracing graduate colleagues and advice on arranging the reunion – and - The University Venue Collection through whom the venue and function at the Withdrawing and Refectory Rooms was arranged.

The University was a popular venue and a successful and enjoyable evening was had by all. So much so that the general feeling on the night was that the next reunion should be held be in 5 years time, rather than waiting for the 50th Anniversary in 2012.

Pam MacDonald & **Bevan Stone**

1963

Sydney medical graduates 40 year reunion 29 March 2003

When we graduated in January 1963, we would never have anticipated the development of the Internet and the impact it has made on our communications. Nor at that time did we show much interest in the new specialties of Rheumatology or Gerontology.

But on 29th March 2003, thanks to the wonders of e-mail, 166 people including 96 of our original class of 199, gathered at the Sebel Pier One Hotel for a "great party". Many by then had personal experience of the two "ologies", but didn't let them intrude on the happy celebration.

Name tags in large print helped to identify faces which had changed a bit since the splendid occasion when we filed into the Great Hall to receive our MB BS, in front of our proud families. Despite the memories of 23-year-old minds and hearts now coming from 63-year-old bodies, the stories of those days "while we were marching through Medicine" were traded with gusto.

Pre-dinner drinks overlooking the beauty of Sydney Harbour as the sun set gave plenty of time for us to mingle, before being seated for the main course then mingling again for the rest of the evening. Black tie invitations brought the only formality to the night which otherwise was quite informal. There were no speeches (we could not have heard them anyway, such was the noise level of the chatter), no special guests and plenty of time to talk, take photos, and trade addresses. We were able to renew the friendships that had been made in our years at University and at the four teaching hospitals.

Some of our class were of mature age when we started, having left war-ravaged Europe to recommence their medical studies here. One, now nearly 80, summed up the evening when he wrote these words :

"Believe me, I can't thank you enough. To me that beautiful evening was something unbelievable – because I didn't think I would make it. This year I celebrate 40 years of my medical career and 50 years in Australia".

We hope to see him when we meet again in 5 years time for another "great party".

At the suggestion of the Dean, Professor Andrew Coats, we are donating $3,000 from the evening to the Medical Graduates' Association to go towards the refurbishing of one of the Victorian toilets in the Anderson Stuart building, suitably commemorated by a plaque. In future years, we may be grateful that we helped restore such a useful memorial.

Syd Nade, Ross Unwin, Mikki Jones and Erica McLerie.

Above: (left to right) Susan Kelly, Richard Jones and Helen Logan

1972

Sydney medical graduates 30 year reunion 5-7 October 2002

A 2 day scientific conference was held at the beautiful Cypress Lakes resort, Hunter Valley October 5th-7th 2002 to celebrate our 30 year reunion. The conference, which attracted 70 graduates and 60 partners, was our first organised entirely by e-mail.

The scientific program was conducted on 2 mornings and included a keynote address on "HIV/AIDS- A Global Public Health Emergency" by immunologist Professor David Cooper. The program was diverse and included presentations on such intriguing topics as "e-mail and the Killing of History", "The Shogunate Strikes Back" and "OZDOCSONLINE – Go Online, Be Rewarded" as well as more traditional presentations on advances in surgery, gynaecology and general practice.

A moving video presentation "Operation Restore Hope", honouring one of our late colleagues, Brian Horan – described a program which offers surgical correction for people with hare lip and cleft palate living in The Philippines, where the condition is very common. The program run by a team of Australian plastic, facio-maxillary surgeons and anaesthetists, is led by plastic surgeon Darryl Hodgkinson.

A novel feature of this year's program was talks on medical education, including 2 on The University of Sydney's Graduate Medical Program USydMP.

The standard of presentation was universally high, and comparable with that of a National Medical Conference. Delegate attendance at the scientific sessions was uniformly high. Three companies: GlaxoSmithKline; Merck Sharp & Dohme and Pharmacia sponsored the Reunion Conference – this should help provide a profit. The profits will be distributed to charities including Operation Restore Hope. It is planned to establish a Scholarship in honour of Brian Horan, which will enable an anaesthetist to travel to The Philippines and participate in this program.

There were many enjoyable social and sporting events, the highlight of which was the Dinner – with the reunion's conference chairman Harry Merkur as MC. Billie Fisher, selected as Australian GP of the year in 2001, was an excellent after-dinner speaker. The organising committee comprised Harry Merkur (Chairman), Tony Eyers (Desk Top Publisher), Les Schrieber (Scientific Program and Sponsorship) and their wives and Peter Ward.

Above: (left to right) Dr Tony Eyers, Prof Les Schrieber and Dr Harry Merkur.

Michele Bender and her staff of Conference Connections were our capable conference organisers.

With 13 of our graduating year now "In Memoriam" there was a strong body of opinion that our next reunion should be in 5, not 10 years. A remarkable spirit of warmth, friendship and camaraderie permeated the meeting and we look forward to the next rendezvous. The Reunion demonstrated that it is possible to combine scientific excellence with a high level of enjoyment and reconnection with old mates.

Harry Merkur, Tony Eyers, Leslie Schrieber, Peter Ward
Organising Committee

1973

Sydney medical graduates 30 year reunion 29 March 2003

A very successful 1973 30-year Reunion Dinner was held at Taronga Function Centre on Saturday 29 March. Planning commenced nine months beforehand. The Great Hall had been first choice but would have incurred a booking fee of $6,000 (reduced by 40% if booked through the Medical Graduates' Association) so an alternative venue was sought and we were not disappointed.

Two mailouts were sent to graduates followed by a ring around (MGA will help with mailout). Late acceptances were a nuisance but everyone was accommodated and 102 of an original 180 graduates attended - a good turnout. With partners we had 160 guests for the dinner and 75 stayed at the Marriott Hotel at Circular Quay which provided excellent central accommodation. The ferry trip to Taronga Zoo was a great start to the evening.

Above: 1977 – (left to right) Cathy Ruff, Leonie Murray and Agostino Ragusa

Taronga Function Centre is a spectacular setting but even more important for those trying to organise a large function is the professional approach of the staff. Menus were adaptable, alcohol all-inclusive with reasonable wines, final numbers adjusted easily, special menu orders served appropriately and the staff were unobtrusive on the night. Highly recommended. One hundred and thirty dollars per head covered all the additional costs such as mailouts, decorations, entertainment etc. Murrays coaches provided an economical and reliable return to the city.

The camaraderie on the night surpassed all expectations and planning is already underway for our next reunion in five years.

Phil Cocks (on behalf of the organising committee)

Above: 1977 – (left to right) John Cusack, John Fone, Ted Tepper, Jim Greenwood, Mike Edye and Phil King

1977

Sydney medical graduates 25 year reunion 30 November 2002

It would seem from all reports that a good time was had by all those who managed to gird their loins and stay up past 10.00 pm on a Saturday night.

There were a total of 184 attendees including 112 from the year and their partners.

The University is, as ever, an excellent venue although it did not pass unnoticed that the hiring fee for the Great Hall had more than doubled since the last reunion in 1997.

As usual Provin Catering did an excellent job in keeping the food and liquid refreshments up to the attendees. We were told that we broke the record for alcohol consumed in the Great Hall and one can only surmise that it was due to the heat and humidity of a balmy Sydney November night.

Five year members were invited to speak on any topic, preferably non-medical, and they all acquitted themselves in an entertaining manner which reflected the diverse interests of our group.

Mike Eadie who is now a Professor of Surgery in New York opened with a poignant description of September 11 and life in the Big Apple. Apparently his other career as a Rugby referee had its rewards in that it allowed him to meet his French wife.

Alan Secombe regaled us Oprah-like on his sporting achievements as a North Coast GP with some very descriptive accounts of activities whilst on tour.

Janet Reynolds showed us some very beautiful slides from her collection when she spent time in the Antarctic as the base medical officer.

Eileen Collins painted an accurate and humorous picture of our physical appearances then and now (and it was not all good news).

Pat McGorry, who is now a Professor of Psychiatry in Melbourne with an interest in prevention of mental illness, observed that he usually spends his time advising his patients and their families that they should avoid taking excess amounts of intoxicating substances. However, he noted that on looking around the hall, he might need to revise that opinion. He also reminded us that we should wish our children happiness as well as success.

A highlight of the evening was the (now) traditional rendition of the University songs accompanied by the University organist and ably led by Ernie Somerville and Richard Thornton. The Penguins provided very suitable classical music for the evening and were given the seal of approval by that notable music expert, Ted Tepper.

It was good to see a few familiar faces from out of town including Dave and Francesca Roberts (Perth, WA), Les Green (Townsville), Dave Moon (Darwin) and Catherine Houen (Adelaide).

I would like to thank the Organising Committee for their hard work in making this happen: (George Quittner, Helen Mackie, Ernie Somerville and, especially, Phil Barnes who showed supreme management skills in convening the first meeting).

George intends to post further information on the reunion web-site details of which may be obtained from him on 02 9968 2222.

We thank you for your support and enthusiasm and look forward to seeing you at the 30-year reunion in 2007

Tony Joseph (on behalf of the organising committee)

1992

Sydney medical graduates 10 year reunion
30 November 2002

Old friends gathered to party....

For most of us the last ten years has been a whirlwind, in which keeping in touch with old friends has often played second fiddle to more pressing matters. And so it was with great enthusiasm and good cheer that about 100 people attended the 10 year reunion of the 1992 graduating year. It was a lovely evening, the crisp and clear Sydney autumn kind. We gathered at Athol Hall and were able to enjoy beautiful views of the city skyline at twilight.

The hall is quite informal yet elegant and was a great backdrop to a very warm and affectionate encounter with old friends, catching up with news on personal developments, careers and postings as well as news of those who were absent.

It was great to see so many people who at one time or another had been part of our year!

As always many 'thank yous' are due: to those who travelled far or made great efforts to attend; to those who could not attend but sent word saying how sorry they were not to be there; to those who helped in tracking down contact details. Thank you also to the lovely staff at Athol Hall who looked after us so well.

Due to the great late response and to moderate alcohol consumption we made a profit of $1500. We plan to donate a third to Médecins Sans Frontières, a third to the Medical Graduates' Association and arrange for a third to be kept by the MGA as a float for future reunions. It was such a wonderful evening, I can't imagine waiting 10 years before the next one!

THANK YOU TO ALL WHO CAME!

Silvia Fragiacomo and John Kennedy

Notes from our correspondents

Graduating year of 1939

Re: Dr Walter Monz

I am writing to advise your Association of the death of my father, Dr Walter Monz, in Brisbane on the 29th January, 2003.

It may be of interest for the Association to know that he was in private practice at Yeronga in Brisbane for 52 years as a sole practitioner, closing the practice at the end of September, 2000, at the age of 86. He was still seeing patients who had been in his care for 50 years, and their families. He is fondly remembered by the local community and the profession in general.

Dad was a keen photographer and I have in my possession one of his many photo albums, which was given over entirely to shots of the University Festival procession in May, 1939. The photos are in black and white and in excellent condition – as clear as the day he would have developed them, all those years ago. Would your Association be interested in receiving this album for your archives? Please let me know and I will arrange to have it sent down to you.

Yours sincerely,
Pamela W Homes
Editor's Note: We have gladly accepted the photo album.

Please send any contributions to this page to Alumni News at the Medical Graduates' Association by:

Email: mga@med.usyd.edu.au

Fax: 61 2 9351 3299

Post: Edward Ford Building (A27)
University of Sydney NSW 2006

Graduating year of 1953

Peter Mervyn Elliott AM received was conferred with the Degree of Doctor of Medicine (*honoris causa*) in April.

Peter Elliott graduated from this University in 1953 with the MBBS Honours Degree. He was a resident medical officer at Royal Prince Alfred Hospital and trained in obstetrics in gynaecology in 1959. He undertook further training at University College Hospital, London, and at the Postgraduate Medical School and returned to Sydney in 1961. He was gynaecologist and obstetrician at King George V Hospital from 1961 to 1979. He was a lecturer in Clinical Obstetrics and Gynaecology at the University of Sydney from 1964 to 1992 and was Head of the Department of Gynaecological Oncology at King George V Hospital at the time of his retirement from the Hospital in 1992.

Join us on a learning journey

The Medical Graduates' Association in partnership with the Centre for Continuing Education at the University of Sydney is offering tours to medical graduates and their friends.

Arnhem Land and the Top End

The Centre for Continuing Education in association with the Medical Graduates' Association conducted a tour on Aboriginal art and culture in Arnhem Land and the Top End from 22 to 31 July 2003. Dr Garry Darby led the tour group.

Seven participants travelled in a private chartered aircraft from Darwin to remote communities in the Northern Territory and the Kimberley Ranges in Western Australia, visiting artists at work and enjoying some remarkable scenery. The tour included the Tiwi islands, Turkey Creek, Maningrida and Kununurra. Highlights also include a two-day 'safari camp' at Mt Borridale and an overnight camp in the Bungle Bungles.

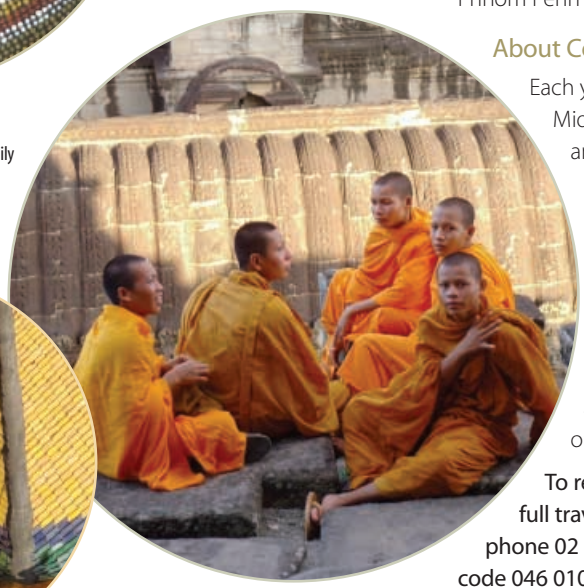
"This tour is excellently conducted by Dr Garry Darby. I think of it as a fabulous experience not to be missed. Good value! Money well spent!" Geoff Bernays

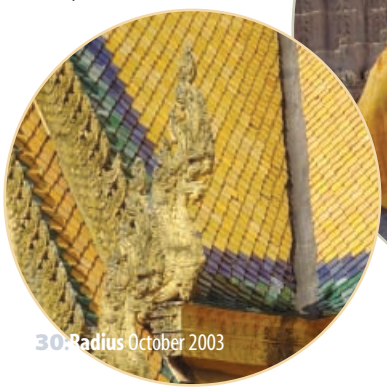
Proposed dates for the 2004 MGA Top End Tour are 22 June to 1 July. Quote tour code 046 0703

To register your interest and for further information please contact the Centre for Continuing Education by phone 02 9351 2907 or email:info@cce.usyd.edu.au

Left: Aboriginal art depicts much more than what is seen in the physical world. It tells us a story about their beliefs and kinship systems, their 'dreamtime' and spiritual connection to their ancestors. See the artists at work, meet with community art advisors and experience the beauty and diversity of Aboriginal art and this remote part of Australia.

Right and below: Buddhist monks are very much a part of Southeast Asia's modern daily life. They can be seen everywhere, even on rooftops basking in the sun and marvelling at the many ornate shrines and stupas.





Saigon, Luang Prabang, Hanoi: along the Mekong River

In association with the Medical Graduates' Association

Overview of tour

Dates:	November 2004
Tour Leader:	Dr Milton Osborne
Price guide:	$7,000 - $7,900 person (twin share, economy air travel)
Maximum group size:	24
Tour code:	046 0102

This tour offers the opportunity to experience the varied and fascinating world of the Mekong River, Southeast Asia's largest river and the 12th largest in the world. The tour commences in Ho Chi Minh City, better known by the name still used by its inhabitants, Saigon. After travel through the Mekong Delta we travel up the river to Phnom Penh, Cambodia's capital. Next the tour moves on to Laos's capital, Vientiane before reaching Luang Prabang, Laos's former royal capital and, in the judgment of many, the jewel of all cities along the Mekong. The tour concludes in Hanoi with an orientation visit around the Old Quarter, Hoan Kiem Lake and Van Mieu (Temple of Literature). There will also be an opportunity to visit a western and an eastern hospital in Hanoi. An optional four-night extension to Central Vietnam is available.

Tour leader

Dr Milton Osborne has been associated with Southeast Asia since being posted to the Australian Embassy, Phnom Penh, in 1959. A graduate of Sydney and Cornell Universities, he has lived in Cambodia for long periods and travelled widely in that country and in Laos. He is the author of eight books on Southeast Asian subjects, including *Southeast Asia: An Introductory History*, now in its 8th edition, and most recently *The Mekong: Turbulent Past, Uncertain Future*. Milton led a highly successful tour to Phnom Penh and Laos for the Centre for Continuing Education in 2002.

About Continuing Education's study tour program

Each year we conduct around 20 study tours to Europe, the Middle East, Asia and the Americas. With expert tour leaders and carefully planned itineraries we aim to help you and like-minded travellers gain an understanding and appreciation of the places you visit that would not occur on a commercial tour. Each tour has a special focus, ranging from ancient history and archaeology to culture and tradition, the arts and creative writing. Group size is limited to 12-24 participants. Tour fees for international tours range from about $6,500 to $9,900 and includes airfare, accommodation, sightseeing, background lectures on tour and selected meals.

To register your interest and be among the first to receive a full travel itinerary, please contact Continuing Education on phone 02 9351 2907 or email:info@cce.usyd.edu.au and quote tour code 046 0102.

Recent books by Faculty staff and alumni

The People's Health, Volume 1, Public Health in Australia, 1788-1950; Volume 2, Public Health in Australia, 1959 to the Present

Author: Milton J Lewis
Publisher: Praeger Press
ISBN: 0-313-31090-4 (vol 1)
0-313-32045-4 (vol 2)
0-313-32595-2 (set)
Pub Date: 30 March 2003
Type: Hardback
Price: $US69.95 per volume
Extent: 336pp (vol 1), 356pp (vol 2)
Illustrations: none

Micro-manipulation in Assisted Conception: a user's manual and troubleshooting guide

Authors: Steven Fleming & Robert King
Publisher: Cambridge University Press
ISBN: 0521648475
Pub Date: October 2003
Type: Paperback
Price: c. $160.00
Extent: 240pp
Illustrations: 13 line diagrams, 65 half-tones

Scientific Writing: Easy when you know how

Author: J Peat, E Elliott, L Baur
Publisher: BMJ Books
ISBN: 0727916254002797916254
Pub Date: June 2002
Type: Paperback
Price: £22.50
Extent: 292pp
Illustrations: Nil

Mouse Development. Patterning, Morphogenesis and Organogenesis.

Eds: J Rossant, P P L Tam.
Publisher: Academic Press, San Diego
ISBN: 0-12-597951-7
Pub Date: March 2002
Type: Hardback
Price: US$179.95
Extent: 712pp
Illustrations: many colour plates

Molecular interactions of Actin: Actin-myosin interaction and actin-based regulation

Eds: D D Thomas, C G dos Remedios
Publisher: Springer
ISBN: 3-540-67111-0
Pub Date: 2002
Type: Hardback
Price: US$129.00
Extent: 230pp
Illustrations: 52 illustrations

Textbook of Melanoma: Pathology, Diagnosis and Management

Eds: John F Thompson, Donald L Morton, Bin B R Kroon
Publisher: Maritn Dunitz
ISBN: 1901865657
Pub Date: 22 August 2003
Type: Hardback
Price: £185.00
Extent: 704pp (276 x 219mm)
Illustrations: 150 colour, 20 b+w photos and 130 line drawings

Enduring Memories: A Paediatric Gastroenterologist Remembers. A tale of Sydney and London.

Author: John Walker-Smith
Publisher: Memoir Club of Durham
Pub Date: 12 June 2003
Type: Hardback
Price: £17.50
Extent: 299pp
Illustrations: 26 b+w illustrations
Contact: memoirclub@msn.com
johnwalker_smith@hotmail.com

Calendar

Book drive

November 2003

Medsoc is holding a book drive to send pre-loved textbooks and medical journals to PNG and Vietnam in late November this year, where they are sorely needed. Books can be dropped off at the Medsoc bookshop. For further information please see the bulletin on our website: http://www.medsoc.usyd.edu.au/forum/read.php?f=1&i=74&t=74 Jennifer Reilly

Coppleson Committee for Continuing Medical Education (CCCME) courses for GPs

The Coppleson Committee for Continuing Medical Education (formerly the Postgraduate Committee in Medicine) has two courses for General Practitioners in November 2003. These courses are designed by general practitioners for general practitioners. Application will be made to the RACGP Continuing Professional Development program for 2 points per hour.

3-5 November 2003

New horizons in General Practice
Faculty of Education Building, Manning Road, University of Sydney

8 November 2003

Dermatology Update for GPs
Eastern Avenue Lecture Theatre, Eastern Avenue, University of Sydney

For more information please contact the Coppleson Committee for Continuing Medical Education on: Ph: 02 9351 3526 Fax: 02 9351 4160 Web: http://www.coppleson.usyd.edu.au

The Sydney University Graduate Choir

13 December 2003

The Sydney University Graduate Choir will perform Handels Messiah on Saturday, 13 December in the Great Hall, conducted by its Music Director, Christopher Bowen, with orchestra and soloists. The Choir has great pleasure in inviting interested alumni to become members of a guest chorale, which will join us for this performance to sing a number of the great choruses from Handels masterpiece. To find out details about what should be a most memorable and enjoyable event, including the entry fee and rehearsal arrangements, and to register, please contact John Bowan (02 9816 5973 or jbowan@bigpond.com). Numbers are limited so please be quick.

Festschrift for Professor Margaret Burgess AO

5-6 February 2004

A two-day program in honour of her retirement. Children's Hospital at Westmead and Children's Medical Research Institute. Guest speakers include Professor Felicity Cutts (UK) and Professor Stanley Plotkin (USA). Topics covered Vaccines for the 21st century and Congenital and neonatal infections. Please contact Jan Michniewicz for details.
Tel: 02 98453075 Email: JanM4@chw.edu.au

MGA tours 2004

June 2004

Proposed tour: Arnhem Land and the Top End

November 2004

Proposed tour: Saigon, Luang Prabang, Hanoi: along the Mekong River