→ Change and renewal
→ Sydney Health Partners
→ When medicine is a second career
Pathology Museum – new name, new home, new opportunities

The Interactive Centre for Human Diseases – Sydney Medical School’s much-loved Pathology Museum – has recently moved to a wonderful new home in the Charles Perkins Centre. After more than 80 years in The Blackburn Building the Museum is now housed in a prime location on the ground floor of one of the University’s new state of the art research and teaching hubs. Along with the new location we are close to finalising a new interactive web resource and are revolutionising the way we maintain the irreplaceable collection.

The new space has also given us the opportunity to expand our collection of historical medical equipment. Central to this is a flask of sterile broth prepared by Louis Pasteur in 1888.

The museum is accessible to students, staff and alumni. Members of the public can visit by contacting Murat Kekic (murat.kekic@sydney.edu.au) or Alfee Liau (lian.liau@sydney.edu.au). An official opening for the museum is planned early in the new year.
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SUMMER 2016

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→ KEEP IN TOUCH
If you have moved or have a new email address, please update your details on Sydney Medical School Alumni website. sydney.edu.au/medicine/alumni
Not alumni but would like to read about Sydney Medical School? Complete the form on the alumni website and we would be happy to send it to you.
Partnerships are the new black in health and medicine. Without taking advantage of the shared resources, goals and commitments we all have in the delivery of better education, research and health care, we lose a huge advantage. The newest of these partnerships, Sydney Health Partners, was recognised by the NHMRC earlier this year as being one of four world class national partnerships in health, as an Advanced Health Research and Translation Centre (AHRTC).

Sydney Health Partners brings together our three major Local Health Districts, Sydney Children’s Hospital Network, the University of Sydney and our affiliated research institutes, all with the commitment of sharing opportunities for advancement. Our priority research areas of cancer, obesity diabetes and cardiovascular disease, neuroscience and mental health, and infection and immunity, were pivotal in presenting our case for this recognition.

Recognised for excellence in all three domains of research, education and care, Sydney Health Partners has also developed ambitious plans for the future including joint projects in health informatics, professional education, and sharing experience in novel models of care delivery.

Of course many of our partnership opportunities are abroad and over the last decade we have built very valuable links that serve our students and researchers well. They also contribute to our national identity and stability.

Many of our partnerships are closer to home and not yet fully realised. Collaborations with other faculties are blossoming. Our links with Engineering and IT, Science and the humanities are strong as well as links with our other health colleagues. These partnerships will need to develop as funding bodies increasingly look to multi-disciplinary teams to answer larger complex research questions and our students enter a work environment where team work is ‘de rigour’.

Rethinking education

Many of the rapid advances in health and medical research and education have caused us to pause and question the need for a rethink of the curricula we teach our students in both our medical course, our postgraduate courses and how we meet the educational needs of our research students. This issue will be the subject of a discussion at our next Faculty meeting. Advances in ‘omics’, imaging, informatics, data collection and management, the development of super intelligent computing and other early gestation technologies will dramatically affect the way we undertake all aspects of our work whether as clinicians, researchers or educators.

How we prepare ourselves and our graduates for this changing and dynamic environment is a challenge we must meet. One of our medical students and one engineering student were recently supported by two benefactors to undertake an international review of recent developments in IT and computing, new technologies on the horizon, and to consider how we can engage and even help direct them. Their report makes great reading and forms part of the direction for change that we need.

New directions

As many already know, after close to ten years as Dean, I recently announced my decision to leave the University early in 2016. I will be working with the Provost and Vice Chancellor in the months ahead to ensure a smooth transition. I am delighted that Professor Arthur Conigrave has agreed to take on the role of Acting Dean from February. Arthur has been a friend and colleague for many years, he has significant experience in many leadership roles, and this appointment will ensure a very positive changeover.

It has been an enormous privilege to lead this wonderful faculty for the last near decade, to work with committed and talented staff and students, and to be engaged with the many thousands of alumni who support our teaching and research, and who contribute in such a positive way to health care in this country.

In the immediate future, I will be continuing my clinical practice and research. But my main focus will be the review of the Medicare Benefits Schedule. I was offered the opportunity to Chair the Taskforce reviewing the MBS, this is a major endeavour but one which I believe is absolutely critical if we are to ensure a sustainable, equitable, accessible and high quality health system.

I wish you all a safe and restful Christmas, and thank you for your support over many years.
I am delighted to be taking on the role. The faculty’s foundations in research, education and clinical service are strong and, under the leadership of Bruce Robinson and his Associate Deans, its work in all these areas has enhanced the international standing of the university. However, this is a challenging time in the funding of universities and in the funding of health and medical research. We need to ensure that we are ready to participate fully in the opportunities thatlie ahead,” Professor Conigrave said.

“I am delighted to be taking on the role. I have a strong attachment to the University and have been engaged in different capacities here for more than two decades - including most recently as a member of the Dean’s Executive. I am looking forward to working with members of faculty, our students, and with alumni to deliver on our mission: better health outcomes for all people. I am also looking forward to working with colleagues in the wider university and of course the community on the university’s broader educational and research goals.”

→ NMRC OUTCOMES FOR 2016

Sydney Medical School successes in the latest round of NHMRC grants include three Centres of Research Excellence, funding for a number of major trials, and accounted for the bulk of the funds secured by the University.

The University of Sydney was awarded $83.1 million of the $673.7 million announced on November 9, with 104 successful applications.

A major achievement for SMS was securing three Centres for Research Excellence – a total of only 15 were awarded nationally. Sydney’s new CREs were secured by:

• Professor Louise Baur, $2.48 million, for early prevention of obesity in childhood.
• Professor Tania Sorrell, $2.5 million, for protection for the public from emerging infectious diseases.
• Professor Alex Barratt, $2.49 million, for creating sustainable healthcare.

In the major category of Project Grants, Sydney was awarded $49.3 million with 49 projects funded, out of the total of $419.7 million funded by the NHMRC. The national success rate of Project Grants was down to 13.7%, with 3758 applications and 516 projects funded.

→ SMS BY STUDENT NUMBERS

After strong growth in postgraduate numbers, in 2015 Sydney Medical School had 5,025 students enrolled – in student terms, the fifth largest faculty in the university (in order, Business, Arts and Social Sciences, Science and Engineering with more students).

The School has 1,342 students enrolled in higher research degrees; 1200 medical students; and 2,400 students in post graduate courses.
WHEN MEDICINE IS A SECOND CAREER – IT’S A PASSION

Thea Manning spoke to students who had given up successful careers to study medicine. Has it been a challenge? Yes. Has it been worth it? Absolutely.

When Sydney Medical School moved from a six year undergraduate medical degree to a four year graduate entry program in 1997, at the same time allowing students with a broad academic background rather than more traditional sciences, one of the aims was to encourage those with a clear commitment based on their own life experience to become doctors.

The change opened the door for a new group of students, professionals who had already prospered in previous careers, often no way connected to medicine. By far the biggest group of students starting medicine continues to be those direct from undergraduate degrees – and the median commencing age for the program hovers around 24 years of age. But there is also a significant group who have had a solid stretch working at a high level in a previous career. For example, in 2015 there were 40 students aged 30 and above commencing medical studies – all with previous professional experience and roles.

LISA PRyor, 36 – GRADUATING 2015

After completing a Bachelor of Arts and Bachelor of Laws at the University of Sydney, Lisa Pryor was an accomplished journalist at The Sydney Morning Herald, with roles including investigative reporter and opinion page editor. She has also written two successful books, The PinStriped Prison – How Overachievers Get Trapped in Corporate Jobs They Hate (Picador) and A Small Book About Drugs – The Debate We Need to Have About Recreational Drugs (Allen & Unwin). Lisa is interested in psychiatry.

Was there a particular moment that made you decide to do medicine? Really it was the culmination of many moments, but there is one which stands out for me. It was New Year’s Eve 2009, when I was writing my book about recreational drug use. For research I spent the night with the doctors at the Emergency Department of St Vincent’s Hospital in Darlinghurst. I loved that night so much, the variety of patients and the calm control of the doctors. It seemed to me that medicine was a job where you could devote yourself to serious learning and intellectual development while still being among the cut and thrust of life. I liked that combination so started studying for GAMSAT, figuring it would be a worthwhile exercise to improve my grasp of science, even if I didn’t get in to med school.

What is it like going back to being a student after a professional job? It has been humbling but also exciting in a strange way. Humbling because of the loss of power, status and, let’s face it, income. This has probably been good for my character but there are still moments where I imagine what I might be doing now if I kept charging forward in my previous career rather than starting from the bottom in medicine. Exciting because it meant embarking on something fresh and surprising and worthwhile at an age when many people struggle with the sameness of life.

What have been some of the best experiences of the degree? The privilege of entering the lives of patients and seeing aspects of life many people never have the opportunity to see. This year has included experiences such as helping heroin users in the supervised injecting room in Kings Cross, talking to patients in an acute psychiatric unit and watching babies being born in obstetrics.

What have been some of the challenges? Is it worth it? I can answer this question very simply by saying I am the mother of a three year old and a five year old. I’m happy to say that they are great kids and have a wonderful life which is full of love but this is only possible because I am extremely fortunate to have a wonderful husband and very involved parents and parents-in-law. When I collect my degree in December (touch wood) I will be very conscious that it has been a team effort. As for whether it is worth it, yes it is, at the same time I sometimes feel like I have chosen a life which is full of meaning and purpose rather than a life which is easy. Personally I find it harder to live without purpose than to live without ease, so I am happy with my choices for now.

ESTELLE NOONAN, 34 – GRADUATING 2017

Estelle Noonan completed a PhD in the Department of Gender and Cultural Studies, lectured at the University of Sydney and coordinated the Medical Humanities Graduate Program. Estelle has recently given birth to her first child, Dominic.

Was there a particular moment that made you decide to do medicine? The role of Medical Humanities is to enhance health practice by teaching health humanities to health practitioners (literature and medicine, history of medicine etc.). So, in my job, the majority of my students were doctors, often quite late in their careers. I loved hearing their accounts of their work and was struck by how rewarding they found it. However, it wasn’t until I became a patient myself that I realised that I wanted to be doctor. There was a particular moment when it happened. I was 31, and I was about to undergo my second spinal surgery. I was terrified that it wouldn’t be successful. The night before surgery my surgeon came to visit me in my hospital room. After a few minutes I felt completely reassured that I was in good hands so to speak. I realised that I wanted to be a part of that process of passing on security to others. When the surgeon left the room, I turned to my (now) husband and said “I think I want to be a doctor.” We had never discussed it before. He said “great, you
should do that.” And that was that. I had five months to prepare for GAMSAT. 18 months later I was starting a medical degree.

What is it like going back to being a student after a professional job? I started out as a nerdy literature student doing an Arts degree. This path led me to complete a PhD in the Department of Gender and Cultural studies at Sydney University, where I lectured before getting a job coordinating the Medical Humanities Graduate Program at Sydney University in the Centre for Values, Ethics and the Law in Medicine (VELiM). I still do guest lectures for VELiM when I get the opportunity.

Going back to being a student wasn’t strange for me – I’ve studied in some form all of my adult life. It did feel frustrating in some senses, going ‘backwards’ from being a teacher to being a student again. I felt that transition quite strongly as Medicine is a more overtly hierarchical than academia/humanities teaching. I’m very used to it now. Studying science for the first time was also a real challenge. I didn’t even do science for my HSC, so becoming acquainted with that way of learning and thinking was new to me. It took a good year to get certain basic principles under my belt and even longer to feel like I was really capable of scientific reasoning.

What have been some of the best experiences of the degree? Connecting with patients at crucial, vulnerable, and reflective moments. It’s a privilege to share these times with them as a part of one’s training. I’ve also formed some very strong friendships with other students in the program.

What have been some of the challenges? Is it worth it? There have been many challenges. I gave up a previous career and, with that, ongoing income and possibilities of advancement. Luckily, my husband has been able to support me financially and emotionally in this endeavour; not all people can be that lucky. The experience has also been medically challenging. I was still recovering from back surgery when I started medicine, trying to rehabilitate myself through regular exercises and so on, which was difficult to balance with study. Finally, I felt a great deal of emotional pressure in the first year to determine whether or not I had made the right choice in abandoning my previous life and choosing medicine. Luckily, my answer came swiftly, I’ve never looked back.

In May this year, I gave birth to my first child, so I am currently on 12 months maternity leave, which poses challenges of its own! Is it worth it? Absolutely.

DAVID GRAHAM, 38 – GRADUATING 2016

David has over a decade of experience in the Department of Defence managing large research projects and providing advice to senior decision-makers in Australia and on operational deployments to Afghanistan, the Middle East and Pakistan.

He’s in the third year of his degree and hopes to specialise in Paediatrics or General Practice with special interest in child health.

Was there a particular moment that made you decide to do medicine? Medicine was a scratch that I always wanted to itch. I’d kept abreast of the major advances in medicine over the years, but I had thought it was a dream. Besides, I was reluctant to give up my career to start over. But when I returned from Afghanistan in 2010 I found myself struck down with illness that required 3 months recovery. During that time I took stock of who I was, what I’d achieved, and where I wanted to go. It wasn’t until I met a 45 year old intern at a friend’s place that I found the courage to start over. I studied hard for the GAMSAT as I knew I only had one opportunity to satisfy the 10 year rule. Would you believe I was in Afghanistan when my GAMSAT result came through and I was desperately trying to submit my application over a dodgy satellite link before hopping on a charter flight to Kandahar!

What is it like going back to being a student after a professional job? Starting from the bottom has been refreshing and the transition was relatively smooth. In fact I’m finding study second time round much easier as I’ve developed good time-management skills and the capability to quickly appraise and synthesise new information and communicate it in a timely manner. After all, it’s what I’d been doing for over a decade in situations that either lives or billions of dollars mattered. I found myself conducting extramural research and enrolling in an MPhil to really round out my studies!

What have been some of the best experiences of the degree? Medicine is a contact sport. So without a shadow of doubt, the clinical placements have been the best. Working alongside and learning from experienced physicians and surgeons has been invaluable and contact with patients has been immensely rewarding. Even as a student you can make a real difference in people’s lives and have input into the management of their health. It is a humbling experience being allowed into someone’s life when they’re at their lowest ebb.

What have been some of the challenges? Is it worth it? Time and money have been the biggest sacrifices. I feel that I’m recovering some of the taxes that I paid over the years! But we’ve had to dip into our savings. The real challenge has been striking a balance to make room for quality time with my young family. So this career change has needed sacrifices from my whole family. I cannot overstate my gratitude for my wife and daughter’s support.
Men for others

by Mohamed Khadra

Honour, Duty, Courage

Mohamed Khadra
Random House
pp 272
RRP $34.99

Among my colleagues, in the medical profession, are doctors, who, in addition to their daily toil against disease and suffering, serve our nation through military service. They, along with nurses and other health professionals, respond to a call and, often at a day’s notice, leave their families, their lives, their jobs and travel to places where natural disaster, war and man’s inhumanity to man overwhelms any form of medical service locally. They are prepared to place their lives in danger in order to carry out the true meaning of their profession: to deliver competent, timely and compassionate medical care to those in need. These doctors and nurses do not discriminate between friend and foe, ours and theirs, paid and unpaid. Along with the medics, the logisticians, the administrators, they set up forward surgical units, field hospitals, operating theatres, intensive care units and wards in desolate, forsaken places wherever our national interest decrees that our presence is needed.

These professionals see suffering that is unfathomable to those of us not involved. Their skills and training, their emotional and psychological strength and their ability to persevere and endure is tested far beyond what is humanly bearable and yet, many go back time and again for several more deployments. Theirs is not the politics of war. They don’t start them or fight in them. They simply patch up the carnage of war. They are also aware that the innocent people of so many of these suffering countries, the locals, mostly did not ask for war either.

I am honoured to count so many of these military doctors as my friends.

This book is the result of multiple interviews with many of these men and women. At first I was hesitant in my expectation that they were willing to talk about their experiences but for many of them, they told me that talking about it was the continuation of their healing.

It was interesting to see that all of them seemed to share some fundamental characteristics. Most were leaders in their hospitals, in the health system, in the medical professional Colleges or even in government departments and the Ministry. They did these other activities in addition to running busy clinical practices. All of them had a strong sense of duty, someone has to do this, might as well be me, approach. They all felt that their contributions were small and yet they had a sense that even small contributions make a difference.

I have been in medicine a long time and have seen the pretenders and the hypocrites. Iago tells Othello, Reputation is a thing oft got without merit and lost without deserving. I have seen so many around me whose undeserved reputations, got without merit, have gained them enormous personal fortunes. I was perhaps reaching a stage, personally, where my growing cynicism threatened my own sense of duty. I was unprepared for the changes their stories brought about in me. I found them inspirational and energising.

I cannot express how humbled I felt as they generously recounted, often at great emotional cost to themselves, their stories, the patients, the conflicts and also, their own suffering. These interviews allowed me to imagine and to try to relate to the reader what is must be like. It allowed me to re-create their life away from the hospital that they and I know so well, to one that only they know about; their other life, their military life.

Their names cannot be revealed and their stories cannot be identified with them. I have tried throughout this book to use their words, their expressions and their stories. I have tried, through omniscient narrative to relate their emotions and thoughts as they related them to me.

These doctors and nurses are also human, with their own frailties and doubts. All serve their country and humanity at their own cost; a cost that is also borne by their families, colleagues and friends. When they return, they take up their lives where they left off. After weeks or months away, they return to mow the lawn, take the kids to sport, do their ward rounds, operate on their patients and pay the bills. Some do not return the same person that went. This is the story of two such doctors. They are not real. Their hospital is not real and neither is the conflict real. Their friendship, their sense of duty, their courage and their compassion and honour is real.

They are truly, men for others.

ALUMNI AWARD FOR PROFESSIONAL ACHIEVEMENT

Professor Mohamed Khadra has received the University’s Alumni Award for Professional Achievement, in recognition of his outstanding contributions and varied career as a professor, surgeon, urologist, author and playwright.

Mohamed’s first book was Making the Cut (2009), quickly followed by The Patient (2010) and Terminal Decline (2010). In 2011, a play he co-wrote with playwright David Williamson (At any cost?), was performed at the Ensemble Theatre in Sydney.
A toast to Marmot

review by
Stephen Leeder

THE HEALTH GAP: THE CHALLENGE OF AN UNEQUAL WORLD
Michael Marmot
Bloomsbury
pp 387
RRP $35.00

Sir Michael Marmot, 70, ranks among the Sydney Medical School’s most distinguished alumni. During an internship at RPA Peter Harvey, a chest physician, recommended he pursue a career in epidemiology because he ‘was asking too many awkward questions’ about the influence of social class on the health of the patients he was seeing. So he went to America with that purpose.

At Berkeley School of Public Health he worked with Leonard Syme, epidemiologist and social scientist, comparing heart disease death rates among Japanese people who had migrated to California. Those who retained their Japaneseness had less heart disease than those who assimilated. This could not be explained by differences in dietary habits, smoking, blood pressure or obesity. This was not to say that the conventional risk factors were powerless but rather that societal factors were at work as well.

After a productive stint at Berkeley, Marmot moved back to London, where he’d been born and lived for his first four years. He was attracted to London’s social stratification as an object of study. He began working with epidemiologist Donald Reid at the London School of Hygiene and Tropical Medicine in 1976. He has settled in London, directing the Institute of Health Equity at University College London (UCL). In the 70s he showed that London civil servants at Whitehall differ in their health according to where they fit in the hierarchy. Again, conventional risk factors did not explain all the variations. Empowerment and control, more the higher up, modified their influence.

That a medical epidemiologist has not confined himself to the study of death statistics about men and women, broken down by age and sex, is itself remarkable. But Marmot has also led a tireless campaign for the recognition of the importance of social determinants of health and the necessity of social change for the achievement of equitably distributed health and health care. Medical interventions alone will not solve this problem. With age he has become, in his own words, more involved in policy and politics as powerful conduits for the evidence accumulated from social and epidemiological studies.

He was a keen commuting cyclist until a serious fall left him with a fractured femur in 2013. He is president-elect of the World Medical Association, having served as president of the BMA. Marmot’s career says much about his political skill for communicating his disturbing moral message without lighting fires in conservative tents. He has a prodigious research pedigree and yet also possesses the ability to lead the development of health policy — in the UK and through international commissions at the WHO — that expresses in readily understood and challenging terms the facts of social inequality, the horrible gaps especially in health that exist worldwide between the haves and the have-nots, the empowered and the disempowered, of which our Aboriginal health gap is a glaring and depressing example. Equally importantly he offers suggestions, based on evidence, on what can be done.

Marmot’s latest book, The Health Gap: the Challenge of an Unequal World, reflects what the BMJ describes as ‘his conviction that evidence should form the basis of policy and that people can make a difference’. In an interview with the BMJ in September this year BMJ 2015;351:h4577, Marmot was asked: What personal ambition do you still have? He replied, “Encouraging as many countries as possible to become active on social determinants of health: social justice demands it. As president of the World Medical Association I want the doctors to take action, too. Health equity is a global concern, and evidence shows that we can make a huge difference really quickly. My ambition? I want my evidence-based optimism to catch on.”

The Health Gap has 11 chapters. It is encyclopaedic — always readable, erudite, evidence-informed, warmly personal and frequently entertaining. Marmot begins with an examination of the factors that lead to health inequalities that are unjust — principally because they are amenable to change. These he refers to as health inequities, driving home the ethical dimension. The second chapter explores the tension between social and personal responsibility for health. Marmot came in for stern criticism for his advocacy for an understanding of health that was seriously socially determined, with the London Telegraph accusing him of leading an unholy alliance of ‘puritans, health fascists and nanny-state control freaks.’ The chapter concludes by quoting Amartya Sen’s words that our task is ‘to create the conditions for people to have the freedom to lead lives they have reason to value’.

In later chapters Marmot considers the power of early childhood experiences to shape our physical and mental lives. Marmot explores the interplay between health and education, and the reciprocal relation between work and health (or illness) and the importance of a sense of control for workers to remain healthy. The book concludes with an examination of the impact of the various reports and commissions that Marmot has inspired and worked on and their global reach. In October 2011, the First World Conference on Social Determinants of Health was held in Rio de Janeiro — a watershed event with wide international subscription and endorsement.

Marmot is an undentable optimist. With regard to overcoming the disempowerment that spins out from the way we organise and sustain our societies and damages health, Marmot has a message for everyone who occupies a powerful position, including doctors. “Do something. Do more. Do it better.”
This year, 2015, has been a year of major change in the School’s academic leadership. Three of Sydney’s eight clinical schools appointed new heads: Professor Fiona Blyth at Concord, Professor Roger Garsia at Central, and Professor Louise Baur at The Children’s Hospital at Westmead. Two new directors of Sydney’s Medical Program were appointed: Professors Jane Bleasel and Inam Haq. Dr Lilon Bandler was appointed as the faculty’s first Associate Dean (Indigenous).

In the mix have been several major Government appointments – the School of Public Health’s Professor Andrew Wilson as Chair of the Pharmaceutical Benefits Advisory Committee, and Professor Bruce Robinson to lead the Medicare Benefits Schedule Review Taskforce and as Chair of the National Health and Medical Research Council.

With challenges aplenty in higher education, medical and health education, health care, research and research funding, Sydney Medical School’s new appointments bring skills, experience and enthusiasm for the changes ahead.

**CHANGE AND RENEWAL**

A MEDICAL PROGRAM FOR THE 21ST CENTURY: JANE BLEASEL AND INAM HAQ

JANE BLEASEL
ASSOCIATE DEAN AND CO-DIRECTOR OF SYDNEY MEDICAL PROGRAM
Clinical training: rheumatology
Previous: Head of Department of Rheumatology, Royal Prince Alfred Hospital
Other interests: open water swimming, diving skiing and time with family (five children, including one doctor)

I was honoured to become co-director of the Sydney Medical Program in July 2015 with Inam. It is an unusual co-incidence that Inam and I are both trained as rheumatologists, with a strong passion for education. I was a medical student at Sydney University and trained to become a physician at Royal Prince Alfred Hospital. I had the opportunity to do basic research into the genetics of osteoarthritis at Case Western Reserve University in Cleveland, USA. I was awarded a PhD for this work at Sydney University. On my return to Sydney in 1995, I was offered a position in the Rheumatology Unit at Royal Prince Alfred Hospital. I became the Head of Department stepping down to take the current position in the Sydney Medical Program.

I have taught and mentored many students in the Sydney Medical Program and had the great pleasure of watching their transition to interns and registrars. I am also involved in post-graduate teaching for these doctors in the basic physician’s training program and as a member of the National Examining Panel of the Royal Australian College of Physicians. I have enjoyed teaching medical students from the University of Western Sydney and University of NSW, thereby obtaining a broad perspective of medical student education. In the last 3 years I have undertaken post-graduate studies in Health Professional Education at Monash University.

It is clear we need a competency-based curriculum, which prepares our students for future medical practice, with a strong foundation in basic and clinical science. I am committed to developing the medical program to ensure our students are compassionate, inquisitive, life-long learners, who can communicate effectively with their patients and peers and provide evidence-based treatment, safely and effectively. Inam and I are excited to work with the medical faculty, students, representatives of local health districts and others to create a 21st Century, innovative medical program.
Inam Haq
ASSOCIATE DEAN TEACHING AND LEARNING AND CO-DIRECTOR OF SYDNEY MEDICAL PROGRAM

Clinical training: rheumatology
Previous: Director of the undergraduate medical program at Brighton and Sussex Medical School in UK
Other interests: music (anything from country and folk to accadacca and techno!), keeping as healthy as I can at Camperdown Crossfit, bit of a sci-fi geek (as anyone who has been to my office is aware), and food – being in Sydney I am spoilt for choice

I joined the Sydney Medical Program on 1st September 2015 as Co-Director with Jane. My clinical training is in rheumatology and I was previously based at Brighton and Sussex Medical School in the UK where I was Director of the undergraduate medical programme from 2008-15. At the time of my departure, the Medical School had just been rated with the highest student satisfaction rate of UK Medical Schools, of which I am very proud, and reflected the commitment and enthusiasm of teachers and the true partnership between staff and students.

Over the last 2-3 months, in my travels around the clinical schools talking to staff and students, I can see a passion for delivering a high-quality medical program that ensures our graduates are well prepared for clinical practice.

Our graduates of the future will be providing care for an ageing population with one or more long-term conditions, in partnership with other health professionals, in hospitals, primary care and community settings. They will need to be able to use technology effectively to obtain information for themselves and their patients, and be able to understand and interpret the rapidly changing world of molecular medicine and its impact on the patient and personalisation of healthcare.

I will be working with Jane and faculty to develop over the next 2 years a refreshed curriculum that has a sound educational underpinning and that values biomedical science, significant clinical experience and development of individual values and behaviours, reflecting societal expectations of doctors and the patient’s journey through the healthcare system.

The next months will be the start of this process, meeting Faculty, patients, current and past students, Local Health District leaders in addition to looking at curriculum models in Australia, Europe and North America.

An exciting period, and one in which we look forward to working with you.
LILON GRETL BANDLER
ASSOCIATE DEAN (INDIGENOUS)
Clinical training: general practice
Previous: Senior Lecturer, Indigenous
Health Education and Centre for Values
Law and Ethics in Medicine
Other interests: As the daughter of a civil
design engineer whose passion was water,
she still enjoys visiting dams and reservoirs

Dr Lilon Bandler has been appointed as
Sydney Medical School’s first Associate Dean
(Indigenous). She has been with the faculty
for close to a decade, and among other roles,
has been responsible for teaching medical
students about Indigenous health in Australia, in
supporting Aboriginal and Torres Strait Islander
medical students in the course, and in working
with the School to address its role in working to
improve the health of Indigenous Australians.

“Lilon’s appointment as Associate Dean
(Indigenous) is one of our most important this
year,” said Professor Bruce Robinson. “It is
in recognition of the importance of educating
our students about the health of Aboriginal
and Torres Strait Islander people, in increasing
the number of Aboriginal and Torres Strait
Islander students, and the critical broader goal
of contributing to improvements in the health of
Indigenous people.

“Sydney has been able to make a
contribution to Indigenous health in a number
in different ways. Outside the medical program,
the Poche Centre and excellent courses run in
the School of Public Health are training people.
But with this appointment, we are looking to
build on our education, research and community
work – and with Lilon in the role, we are well
placed to really make some progress.”

Dr Bandler completed her medical degree
at University of New South Wales, and has
postgraduate degrees in health policy and
education. She has worked in general practice
for many years; most recently, she provides fly-
in-fly-out services for the Royal Flying Doctor
Rural Women’s GP Service, to rural New South
Wales. “I’m glad to have skills that I can offer
and I consider myself fortunate – to be involved
with students, with patients and with health.”

From an early age, Dr Bandler was exposed
to the realities of health for Indigenous people –
and also the ignorance and misreporting of their
situation. Her interest in Indigenous health was
influenced by her mother, the late Faith Bandler,
who was a political activist particularly involved
in the “yes” campaign for the 1967 referendum.

She says there are many aspects which make
the work inspiring: colleagues and students
who are deeply committed to improving health;
and the opportunities to develop and engage
students in new programs which introduce them
– for some for the first time – to Aboriginal and
Torres Strait Islander Australians. “Our medical
students visit art galleries and museums; they go
on walks; they have the opportunity to talk with
our presenters, and to write and think about
Aboriginal and Torres Strait Islander Australians
– their culture, their history and their
contributions to Australia. And they can start
thinking about Indigenous health in Australia.”

Dr Bandler acknowledges that she could not
achieve anything without the help of others,
particularly her EA, Lyn Chick, who keeps it all
ticking along.

From an early age, Dr Bandler was exposed to
the realities of health for Indigenous people –
and also the ignorance and misreporting of
their situation.

STORIES TO TELL – 132 YEARS OF CHANGE

Since the first intake of students in 1883, there have been over 25,000 graduates from the Sydney
Medical School; all have stories to tell. The curriculum has been constantly under review;
teaching methods have been changed and society’s expectation of a trained doctor has altered.
All of these factors means that the history of our Faculty from those first students (men only
need apply) to the modern era of graduate medical programme is fascinating and should be
remembered. When the Burkett-Ford Library closed several years ago, the empty shelving begged
to be re-stocked. The shelves have been slowly filling with the memorabilia and story boards of
our Faculty history. The grand opening will take place in February 2016 and the display will be
open for viewing from that time in the Burkett-Ford Lounge in the Edward Ford Building (old
Public Health and Tropical Medicine Building) on the Camperdown Campus.
NEW HEADS AT CLINICAL SCHOOLS

LOUISE BAUR
CHAIR OF PAEDIATRICS AND CHILD HEALTH; ASSOCIATE DEAN AND HEAD OF THE CHILDREN’S HOSPITAL AT WESTMEAD CLINICAL SCHOOL
Clinical training: paediatrics
Previous: Professor of Paediatrics and Child Health; Head of Weight Management Services, The Children’s Hospital at Westmead
Other interests: Director of World Vision Australia, and Director, Sydney Children's Hospitals Network

While I have been a member of the School for many years, and have even been Acting Head on many occasions, it is quite different when you have the permanent role. The Children’s Hospital at Westmead Clinical School does tremendous work. We have many highly skilled researchers, including clinician researchers, several of whom are international leaders in their respective fields. We have about 100 students undertaking higher degree studies, mostly PhDs, to whom we are very grateful.

At the beginning of this year, our School clarified our one-year and longer-term strategic plan, and have since re-organised some of our governance structures and teams to support our strategy. In addition, we have become further involved in the planning for the Westmead Precinct redevelopment while continuing to cement our many strong links across the Westmead Research Hub, at The Children’s Hospital/ Sydney Children’s Hospitals Network and across the Sydney Medical School and elsewhere. We need to continue to provide excellent medical education and research supervision and grow our research productivity, while developing new initiatives – and all in a tight budgetary environment!

You can sense the opportunities that we have at this time, and the issues we need to tackle. It’s a tremendous time to be Chair of Paediatrics & Child Health at the University of Sydney and leading The Children’s Hospital at Westmead Clinical School.

FIONA BLYTH
ASSOCIATE DEAN AND HEAD OF CONCORD CLINICAL SCHOOL
Clinical training: public health physician
Previous: Concord Clinical School
Other interests: music, bushwalking, reading, gardening, art (particularly the Arts and Crafts movement) and Labradors

My involvement in Concord Clinical School started in 2012, and my association with Concord Repatriation General Hospital dates back to 2005, Contributing to teaching within the Sydney Medical Program has been part of my professional life since the introduction of the graduate degree program.

As a public health physician whose research focuses on the public health burden of pain conditions, my background is unusual. I have been involved with initiatives including the Australian National Pain Strategy and the Global Burden of Disease Study that have brought into focus the enormous burden of pain-related disability. One of my particular interests is pain in older people, and is part of the broader research on healthy ageing conducted at the University’s Centre for Education and Research on Ageing at Concord Hospital.

Concord Hospital has a unique identity and vibrant internal culture. At Concord Clinical School I feel privileged to work with so many inspiring people – School academic and clinical staff members, dedicated clinical teachers and hospital staff, talented researchers, and extremely supportive hospital and District administrations.

There is a great deal of collegiality across the clinical schools and between the schools and the campus-based academic and professional community. The process of course reaccreditation by the Australian Medical Council during the year really brought home to me the strength and importance of the many internal and external partnerships that support medical education. Working with students and seeing them develop as they progress through the course is extremely rewarding for me.

ROGER GARSIA
ASSOCIATE DEAN AND HEAD OF CENTRAL CLINICAL SCHOOL
Clinical training: immunology and immunopathology
Previous: Senior Staff Specialist, Royal Prince Alfred Hospital
Other interests: the great Australian outdoors, snowshoe tracking, tennis spectating, jazz, cherished travel adventures with his wife and various of his four daughters

I graduated from the University of Sydney (MBBS 1978) and PhD (1990 in basic and applied immunology) and have been a research active clinical immunologist and immunopathologist at Royal Prince Alfred Hospital since returning from the National Institutes of Health, USA, in 1990 to be responsible for the oversight of the comprehensive multidisciplinary teams that have been the hallmark of the RPAH based HIV service. I have been involved in many pivotal multicentre HIV therapy clinical trials including with innovative new biologicals such as gene therapy altered blood stem cells. My practice has been broad -ranging from allergy to autoimmune neurological disorders.

It was in my in my role as Clinical Superintendent at RPA close to three decades ago when my interest in medical education was really sparked. In that capacity, I had responsibility for the post graduate training program for junior doctors and physician trainees – and have been engaged in different capacities ever since.

I am very excited by the new role in Central Clinical School and the opportunities ahead. It brings together my interest in medical education, research and multidisciplinary clinical care with the existing expertise and tradition of educational innovation which characterised the School during the tenure of its former leader, Professor Craig Mellis.
PROFESSOR GLENN SALKELD – HEAD OF SCHOOL OF PUBLIC HEALTH 2007-15

I arrived at University of Sydney in February 1992 as a junior lecturer with few publications, no PhD and the will of my colleagues for me to succeed in a job that came with no job description. Some things have changed – the publication track record is now respectable and the PhD awarded. Other things have not. Fast-forward to 2007. The Head of School position didn’t come with a job description, at least not one that resembled what I did. The will to succeed remained – my colleagues, academic and administrative, gave me their total support. Today the School of Public Health is thriving with postgraduate coursework student numbers more than doubling over the last 8 years, we achieved an Excellence Research in Australia top rating of 5 in the 2012 and 2015 assessments and the scope and impact of the School reaches well beyond Camperdown.

The highlights?
Finding myself along with Giselle Manalo, two of our Indigenous Health students and Jo Lander being taken from house to house by the Mayor of Cervantes – a community of 20,000 people in the mountains north of Manila, Philippines – and drinking the home made rice wine to celebrate our new found friendship. It was only the next day that I was told the custom was to sip from the cup and not drink the whole thing. The mayor left out that detail. Those friendships endure and the classroom in the field program allows our students to apply and practice their public health in settings that bear no resemblance to Camperdown.

It’s also the friendships made through the many research projects that I’ll remember. The most enduring and intellectually nourishing has been the STEP collaboration (Screening Test Evaluation Program), the continuous NHMRC program grant funded from 2001 to 2016. Led by Les Irwig with colleagues Petra Macaskill, Jonathan Craig, Paul Glasziou, and many others we have challenged the orthodoxy, developed new methods and provoked debate on the benefits and potential harms of population-based screening and diagnostic testing. And there’s more than the odd junior researcher who joined STEP with few publications and no PhD who themselves are now being awarded NHMRC grants and CReS. It’s the same virtuous cycle of mentoring and success that I see in all our groups in the School – the Prevention Research Centre, Menzies Centre for Health Policy, VELiM, Family Medicine Research Centre, and disciplinary and applied hubs – clinical epidemiology, biostats, indigenous health, health economics, cancer research, health literacy and decision making.

It’s hard to survey the full breadth of what we do in public health without wondering if the metrics fully capture the big picture. For that I head out to Broken Hill. If you want to see how health is a social construct then just observe the work they do in schools, with the local community, with students from all health disciplines, with the RFDS, the Maari Ma Aboriginal Health Service, the chamber of commerce and more besides. Same goes for Lismore. At the end of the day, the literal end of day sunset, nothing beats surveying the big picture with a couple of good mates – Alison Birt and David Lyle – and a glass of something cold at the famous sculptures outside Broken Hill.

Here’s cheers to the big picture and friendships made in the School of Public Health.

PROFESSOR LESLEY BARCLAY: HEAD OF THE NORTHERN RIVERS UNIVERSITY CENTRE OF RURAL HEALTH, 2008-15

I took this role without having any idea how beautiful the north coast was, nor of the calibre of the colleagues who also chose to live here and with whom I would be privileged to work. I had had the opportunity to contribute to remote services in the Northern Territory and learn about service delivery, but knew there was a lot to learn about communities living closer together with regional hospital support. I also wanted and to see if I could contribute personally, but amongst other goals, to establish a stronger scholarly presence for the university alongside...
my rural clinical colleagues.

At this time of my transition from the bush to the city and from a paid role to an unpaid role within the university; it is worthwhile to reflect on this goal. To see if we, that is the team on the North Coast (with my support an influence), have succeeded in strengthening the teaching presence of Sydney University and our scholarly performance in rural Australia.

Over 7 years we have placed nearly 5000 students across 12 or so health disciplines from over 10 universities. A placement with us is becoming aspirational and now competed for by medical students when previously it was difficult to fill places. This has been contributed to significantly by the Deputy Director Education; Dr Michael Douglas.

We have successfully completed 12 PhD student supervision since 2011 and one research masters. We have trained our own graduated staff as supervisors for other candidates.

We have introduced a very successful Early Career support program and student support network, led by Dr Shawn Wilson, which stretches beyond our own region to Broken Hill, Dubbo and sometimes other sites. Again our monthly research seminars, started around 7 years ago now stretch over the same footprint but with clinical and other colleagues coming in from the local health districts from Tweed to Port Macquarie.

We have a small staff and only very few of whom are working as self-funded researchers. Over the last 7 years we averaged around 45 publications a year. Of these 307 were refereed journal articles, 7 were books, 14 book chapters and 30 reports. Our first locally led NHMRC grant was awarded in this period with other staff serving as CIs on other NHMRC and ARC grants. Our second NHMRC fellowship was awarded to Dr Megan Passey. We also received an NHMRC ‘top ten award’ for a research project begun in the NT and completed at Sydney.

We have strong links with industry in our grants epitomized in a grant led by Megan Passey that has two LHD partners (Mid North Coast and Western Sydney), the Agency for Clinical Innovation and the North Coast Primary Health Network investing and funding this work.

Our team demonstrates the local leadership that universities can provide but often have not achieved in rural or remote Australia. We have good relationships with our regional university and clinical colleagues and excellent relationships with local government and politicians. Members of our staff contribute leadership in the health service as board members or clinically through pharmacy services, medicine and nursing.

I have loved living and working locally and with Sydney University School of Medicine and School of Public Health. Without exaggeration I can say this has been the most personally rewarding and best supported role I have had personally in a very long career. Thank you to all my UCRH, university and health service colleagues that have made this so role satisfying and helped us to achieve these goals.


Professor Bob Lusby retired as Professor of Surgery and Associate Dean and Head of Concord Clinical School in 31 December 2014. During his time, he was responsible for the successful delivery of the medical program to hundreds of students at Concord Repatriation General Hospital. His time was characterised by the fostering of a committed clinical teaching workforce, and a strong focus on professionalism in medical education.

Bob played a major role in obtaining funding and in the design and construction of the new Medical Education Centre, which opened in 2013.

Apart from his lifelong work in medical education and research, Bob was a major contributor in his military service. He was involved in five overseas peace keeping deployments, including Rwanda as a member of the UN Peace Keeping Force. He has been heavily involved in fundraising, including to support veterans and also young people in countries which have been impacted war.

**MICHAEL PEEK: CHAIR OF OBSTETRICS 2001-15; HEAD OF NEPEAN CLINICAL SCHOOL 2002-15**

Professor Michael Peek stepped down from the position of Head of Nepean Clinical School, after 13 years as Head of School and 14 years at Nepean Hospital. During that time, the number of medical students at Nepean significantly increased – to close to 200 in 2015 over the four years of the program – plus over 100 elective students each year.

Under his leadership, one of the dramatic changes was the increase in academic endeavour at Nepean. New academic positions established in Critical Care, Paediatrics, Obstetrics & Gynaecology and Medicine, more than 30 higher degree research students are now based at Nepean. His own research productivity remained high, with more than 200 papers, more than 30 research grants and five NHMRC grants.

A major achievement was the development of the new clinical school building, which opened in 2012 and which provides not just facilities for medical education but has become a centre for hospital and community education.

Michael continued to teach and to practice in NSW rural centres, including clinics at Bathurst Base Hospital, both Maternal Foetal Medicine ultrasound and high-risk clinics, and was strongly connected with the local Nepean community.
In March 2015, when the National Health and Medical Research Council notified that Sydney Health Partners was one of four groups in Australia to be recognised as an Advanced Health Research and Translation Centre (or AHRTC), a frequent response was “Sydney Health Partners – what is that?”. Sydney Health Partners was not a well-known name, but recognition by the NHMRC was no small achievement. The award was on the basis of demonstrated excellence in research, the translation of evidence into patient care and a strong focus on research and translation in the education of health professionals.

Of the twelve submissions made to the NHMRC for recognition as an Academic Health Research and Translation Centre, Sydney, along with Alfred Health and Monash Health and Partners, Melbourne Health Partners and a South Australian consortium, were judged against six criteria by an international review panel to be of world class:

> Leadership in outstanding research and evidence-based clinical care, including for the most difficult clinical conditions,
> Excellence in innovative biomedical, clinical, public health and health services research,
> Programs and activities to accelerate research findings into health care and ways of bringing health care problems to the researchers
> Research-infused education and training
> Health professional leaders who ensure that research knowledge is translated into policies and practices locally, nationally and internationally
> Strong collaboration amongst the research, translation, patient care and education programs.

“These centres are producing first class research, and they are succeeding in turning those research outcomes into improved patient care,” said then CEO of NHMRC Professor Warwick Anderson. “Being recognised as an NHMRC Advanced Research and Translation Centre acknowledges that their work is up there with the best in the world.”

SYDNEY HEALTH WHO?

Sydney Health Partners was formed in July 2014 to prepare the NHMRC submission. It comprises Northern Sydney, Sydney and Western Sydney Local Health Districts, the Children’s Hospital Network (Westmead), the University of Sydney and their related research institutions.

Its 2014 establishment recognises – and was only possible because of – long-standing collaborations and both formal and informal partnerships that have existed among the partners over many years.

In scale, Sydney Health Partners is impressive: between them, the partners employ 33,000 staff and provide health care to 2.6 million people, 50% of NSW population and over 10% or 1 in 7 of the Australian population.

It was clearly stated in the application that in line with the intentions of the NHMRC, Sydney Health Partners would seek to improve the quality of health care by applying the insights of research. Specifically, it will:

> Undertake research and translational activities that enhance what members do individually
> Add value to, and eliminate inefficiencies and duplication in, health research and translational activities of members including by sharing specific expertise, facilities and equipment; and
> Develop sustainable and innovative mechanisms for rapidly translating research and latest evidence into clinical and health practice to secure better health outcomes

Chief executive of Sydney Local Health District, Dr Teresa Anderson, said the recognition as an AHTRC was testament to the collective strength of the partners and also a pointer to the enormous future potential. “I am sure the formalisation of the partnership will be a great boost to the research, education and healthcare we provide.”

The view from the University and research institutes is similar – all are looking for the

SYDNEY HEALTH PARTNERS – VISION

“Through strong collaboration, inclusive thinking and a passion for overcoming barriers, Sydney Health Partners will transform the way we do things and together create solutions to meet the health needs of our community and the wider population wherever care is delivered.”

To achieve this vision, Partners will:

• Collaborate to synchronise our research, education and clinical agendas;
• Dismantle existing silos and barriers to improve access, efficiency and outcomes;
• Encourage free movement of data, people and resources;
• Introduce robust measurement, monitoring and evaluation systems;
• Partner with internal colleagues and external agencies alike.
closer collaborations enabled and fostered by the formalisation of the partnership to drive improvements in health care.

In bringing together such a large group, across such a range of research, education and health care, a not-insignificant challenge has been defining an appropriate governance and management structure.

A proposed structure, comprising a peak governing body – the Governing Council – and Executive Management Committee and a management team led by a Director, has now been developed, providing a strong base for future activities.

FUTURE PLANS
Being recognised as an Advanced Health Research and Translation Centre has provided impetus to clinicians and managers to collaborate more than ever.

Twelve thematic streams have been identified as flagships for collaborative translational research.

The first six discipline-specific themes are those identified as our research translation strengths in the NHMRC submission: cancer; cardio-metabolic; infectious diseases; liver; mental health and neurosciences; and renal transplant. The remaining six are cross cutting themes, considered to be integral to the future success of the partnership: biobanking; clinical trials; education; genomics; informatics; and operational enablers.

“While the twelve thematic streams are at various stages of collaboration, already we see exciting projects emerging,” Dr Anderson said.

The cardio-metabolic team are well advanced in establishing cross-campus rapid-access clinics for patients with cardio-metabolic disease. These are designed both to improve care for patients and to reduce long waits in the emergency department.

The liver team plans to measure, and increase the uptake of, new hepatitis B and C treatments across the partnership in a fine example of the translation of basic research (developing new personalised medicines) into clinical treatment and improved health outcomes.

The clinical trials thematic stream plans to improve the recruitment to, and outcomes from, clinical trials by introducing more robust monitoring and measuring systems, strengthening and harmonising the clinical trial governance and management arrangements and advocating more strongly with clinicians and patients to improve both the understanding of the importance of clinical trials and their integrity, number and size.

Operational Enablers is an important thematic stream that has already determined its priorities for streamlining research processes. These include strengthening the grant integrity assessment, submission standards and timing, and post award management and compliance; harmonising material transfer agreements and site-specific authorisations, streamlining research ethics approval processes, and modernising our communication systems.

NEXT STEPS
The next key activity is the first “SHP Annual Forum” will be held on the 25 - 26 February 2016 and will be an opportunity to showcase our achievements so far and reassess any areas that need reconsideration.

Sydney Health Partners looks forward to achieving our mutual aim of encouraging collaboration and strengthening the translation of basic research into health outcomes.

Dr Teresa Anderson and Professor Stephen Leeder.
In September 2014, research workers in three Sydney health districts, the Westmead Children’s Hospital and their affiliated institutes – all associated with the University of Sydney – opened the vaults of the translational research they had been conducting in recent years. The purpose was to provide an exhibition of the depth of research, the highlights and major achievements, and to demonstrate how this research has improved patient care and enhanced opportunities for prevention.

The exercise had elements of a grand art gallery fossicking in its stored collection for works that demonstrate the richness of its holdings.

I had the pleasure of working with a dedicated editorial team which, on behalf of the partnership drew together statements of achievement from their research groups. Sixty-six pages later we had documented a staggering array of research concerning virtually every aspect of contemporary health and disease.

THE AHRTC CONCEPT

This exercise was a response to a call from the National Health and Medical Research Council – NHMRC – to health organisations for recognition as Advanced Health and Translational Research Centres or AHRTCs. The NHMRC wrote: “We wish to promote stronger nodes of excellence in Australia’s health care system itself [not just in universities and institutes], so that research and its translation bring the best possible health care delivery [to] Australian hospitals, equal to the best in the world. To achieve recognition centres had to be renowned for the complexity of their clinical care, to demonstrate outstanding research capability and to show how this translated into innovations in disease prevention and management. Centres were also asked to indicate how they embedded capacity-building for future researchers into the enterprise. Twelve centres applied. Applications were assessed by an international panel and eight were invited to interview. In March 2015 we learned that Sydney Health Partners, as we call ourselves, was one among four successful applicants.

PUTTING IT ALL TOGETHER

The submission was not to seek money, although plainly the anticipation of funding in the future provided an incentive. Rather, our task was to demonstrate to the Australian community and to state and territory governments how active and useful the research conducted within our health system is.

As the inventorying and sifting concluded we were astonished by the massive contribution research is making to clinical care, here and now – much more than we ever recognised or talked about. And a lot of it crossed institutional boundaries. Research enterprise in relation to renal disease for example was present in all the health districts and frequently the clinical care based on the research improved right across Sydney as a result. Collaboration as well as competition was evident.
Translational research – the process whereby clinical questions trigger a research agenda and where in turn research findings activate changes in clinical practice – was obvious at every turn. Of course, the back-and-forth ferrying of research cargo between ward and laboratory has been a characteristic of clinical research from time immemorial. However, like the closed boxes of the paintings in the reserve collection, it is easily overlooked or even forgotten. The AHRTC exercise opened the repositories to reveal a fine display.

We wrote in the covering letter of our application to NHMRC about our hopes and aspirations.

“The exercise … has encouraged us to consider the future with fresh optimism: if we have achieved this much, then imagine what we might do in the future. The information science, genomic and neuroscience revolution in health and medical research is tantalising in what it offers and magnetic in its attraction to do more, to aim higher, to explore new frontiers. For those ineradicably committed to addressing the needs of sick people this is heady stuff.

“Einstein said 'Imagination is more important than knowledge. For knowledge is limited to all we now know and understand, while imagination embraces the entire world, and all there ever will be to know and understand.' We can imagine a positive future to which we contribute, built through collaboration and realised through research translation.”

The solid work of bringing this all together has already begun. The omens are good with strong support from all participant groups, upon whose creativity and energy, the enterprise will ultimately depend.

Stephen Leeder is Emeritus Professor in the School of Public Health, Chair of the Board and Director, Research and Education Network at Western Sydney Local Health District
Raging teenage hormones – fact or fiction?

By Aviva Lowy

We associate adolescence with moodiness, emotional outbursts and risk-taking. If the ‘twos’ are terrible, the ‘teens’ can be traumatic. And more often than not, this time of upheaval is blamed on the raging hormones of puberty.

“Puberty is a tremendously dramatic physical event,” says Professor Kate Steinbeck, Medical Foundation Chair in Adolescent Medicine. ‘Puberty hormones are produced in increasing amounts and cause the familiar physical changes of adolescence. There are receptors for oestradiol and testosterone, the main puberty hormones in most organs of the body. This includes in the parts of the brain which are especially associated with mood and behaviour.’

So it’s not unreasonable to think that puberty hormones play a big part in explaining the trials of being a teenager. However, we just don’t know the degree of that effect, which is why Steinbeck embarked on the ARCHER study (Adolescent Rural Cohort on Hormones, Health, Environments, Education, Relationships) looking at the true longitudinal effects of puberty hormones on adolescent health, wellbeing and mood.

‘In preparation for this study we did two systematic reviews of what is known about the effects of puberty hormones and basically, the data are just not there to confirm the role of puberty hormones on mood and behaviours.

‘Assumptions and attributions are made, but when you look at the studies, these were either not designed to answer the questions or were poorly designed or were cross-sectional,’ says Steinbeck.

‘We have been able to measure puberty hormones in the blood for over 40 years, but the frequency of blood sampling we needed to do was just not acceptable to determine the individual variability of puberty hormone change so we measured puberty hormones in urine using highly accurate mass spectrometry,’ says Steinbeck, who believes the impediment to this research was not just the technical capability but also the difficulty in recruiting adolescents into such an intensive cohort study.

The ARCHER study, based in Sydney’s School of Rural Health in Dubbo and Orange, has at last managed to do that. With 350 adolescents recruited, the investigators will be able to measure the pattern and timing of puberty hormones in individuals over three years.

‘The start of puberty can vary between the ages of eight and 13 in girls, and nine and 14 in boys. There is a wide variation in when puberty starts and also a wide variation in the time it takes to go through puberty, from having the physical development of a child to the physical development of an adult.

‘It is really impossible to understand the effect of puberty hormones unless you follow young people individually throughout their puberty. Hopefully, then we can show statistically that different puberty patterns have different effects,’ says Steinbeck.

Of the 350 children recruited to the program,
only 3% have been lost, which is an excellent retention rate for any study, let alone one requiring regionally dispersed teenagers to provide three-monthly urine samples - and all the logistics that entails.

So far, 97% of the samples have been collected. Steinbeck jokes that she believes they are all urine and no one has substituted apple juice, however she won’t know for sure until the sampling in completed because it is only then that all the hormone assays will be done using the same machine.

‘We can measure very low levels of puberty hormones in the urine which is of both technical and research interest. There is a lot of discussion about how accurate our previous lab techniques were at detecting low (early puberty) testosterone and estradiol levels. In the first year of the study when we were developing our essays, we looked at a subgroup of samples and it was only in less than 5% of samples that we couldn’t measure any level of puberty hormones. This showed our methods were on the right track. The other interesting finding in these preliminary data is that puberty hormones don’t apparently increase in a smooth line. It’s more of a stop start progression’.

‘We’ve known for some time that the timing of puberty onset can have long-term effects. Most people can give some indication as to whether their puberty was similar to their peers, or earlier or later, but of course this method is much less accurate than hormone measures. For example, girls who started their periods earlier compared to their peers are more at risk of depression, obesity and breast cancer. And we know that those who describe a later puberty are more at risk for anxiety and possibly lower bone density.’

It’s hardly a win:win situation. But Steinbeck hypothesises that a more significant risk factor than age of puberty onset will be the speed of puberty or perhaps even instability of hormone levels as these rise.

‘We see mood disorders in pregnancy and in menopause where there is rapid change in hormone levels, and also prior to menstruation. These are three normal physiological conditions where moodiness appears to be related to hormone change. And there is reasonable evidence that men who abuse anabolic steroids, which are testosterone-like compounds, suffer moodiness, aggression and even psychosis. But there is absolutely no evidence in normal community samples that the general presence of these hormones cause that.’

But it is more than moodiness that is associated with the teenage years. Everything from mental health to physical health begins to deteriorate.

‘Over the past 50 years we’ve made tremendous improvements in early childhood wellbeing through better pregnancy care, immunisation programs and improved nutrition. Early childhood intervention programs have also produced increases in children’s wellbeing and learning improvements. But as young people reach adolescence, many indicators of good health start to worsen, a pattern that continues into early adulthood’.

‘It is tempting to think that that mental health is the major health problem during adolescence. It certainly is the most common problem overall as over a third of adolescents will experience some problem with mental wellbeing. But I’m also concerned with risk-taking behaviours. Death through unintentional injury is the greatest cause of teenage death around the world and much of that mortality is related to risk-taking behaviours. Also the control of chronic illness often deteriorates during adolescence, also contributing to poorer health.’

The really worrying issue with teenage health problems is that, rather than being transient, these often persist past adolescence, establishing a pattern for the rest of that person’s life.

‘The major causes of morbidity and mortality in adults are tobacco, overweight and inactivity, and most of those health risk behaviours start in adolescence. Activity levels fall off in the teenage years. Puberty is a risk time for overweight and obesity. And if you are a lifelong smoker, you most likely started as a teenager,’ says Steinbeck.

‘My research interest is to consider at an individual level all the risk factors that might cause a deterioration in adolescent health and wellbeing and then to look at how we might intervene to improve health outcomes.’

How much puberty hormones figure in all this, we’ll soon know. ‘We might find that we are attributing too much to puberty and ignoring the fact that the behaviour, the mood, the risk taking, might in fact reflect something else going on in that young person’s life and to dismiss it as “just hormones” might be very unwise.

‘Whatever we find I suspect that there’s going to be no simple answer. That’s number one. Number two, we may be surprised how little puberty affects health and wellbeing, provided other indicators of potential problems are not part of that young person’s life. We know that what are termed the psycho-social determinants of health may also interfere with adolescent well-being and behavior. These could be poverty, isolation, being out of school, family disruption, drug or alcohol use in the adolescent or their parent, and parental mental illness. There are all situations that can affect a person’s physical and mental health. We want to show just what is attributable to puberty hormones and what is not.’

Once Steinbeck has defined the true impact of puberty in her cohort, she will continue to follow the group as they go through middle adolescence, looking at sleep, activity, cognition and risk-taking behaviour. She’ll also be looking at depression, self-harm, anxiety and what is changing for parents as well...

‘We’re continuing to monitor such things as risk-taking in parents. We want to know how much parental risk-taking behaviour around substance abuse and driving as examples might impact on similar adolescent behaviours.’

The ARCHER Team
A study like ARCHER is impossible without a committed team of investigators. The original idea for the ARCHER study came from a discussion between the Dean, Bruce Robinson, and Catherine Hawke, as an opportunity to develop research undertaken in rural campuses. ‘Associate Professor Catherine Hawke in particular has played a major role in the development of the study from its inception. She is the only study investigator who is based locally. Together with Karen Paxton, our project manager, who has also been with ARCHER from the beginning, she has helped achieve the continuation of a unique study,’ said Kate Steinbeck.
When an elite athlete drops dead on the sporting field, the community wonders why a young, seemingly healthy person can die so suddenly. Sudden cardiac death is a tragic and devastating complication of a number of cardiovascular diseases. The death is most often unexpected and has major implications for the surviving family and the community. In fact the first presentation of an underlying cardiac disease in up to 50% of people is cardiac death. In children and young adults, genetic disorders, such as inherited heart muscle and electrical rhythm diseases are a major cause. In those older than 35 years, coronary artery disease and myocardial infarction together comprise over 90% of sudden cardiac death cases.

Understanding the causes and arrhythmogenic substrates underpinning sudden cardiac death and elucidating what may trigger malignant arrhythmias is crucial for the development of treatment and prevention strategies in our communities.

Most recently, significant advances in genetic technologies have impacted on the number of cardiac genes that can be interrogated in the setting of families who have experienced sudden cardiac death. While the original molecular autopsy tested only 4-5 genes and took 6-12 months to perform, we can now use amazing new genetic technologies that can test all 22,000 genes that we have, to look for the genetic causes of SCD in the young. This next generation sequencing technology has led to whole exome and whole genome sequencing which can be performed in less than 6 weeks. Most recently, our group reported the first series of young sudden death victims where this latest whole exome sequencing approach was used. This involves obtaining a blood sample at postmortem, extracting DNA from the sample, and then performing genetic testing for key cardiac genes to identify a cause of death. The molecular autopsy, in conjunction with clinical screening of relatives of the deceased, has two major implications. First, the testing can reveal the cause of death in the victim, and second, provides an additional diagnostic tool in identifying other family members who may be at risk of SCD. The combination of clinical and genetic evaluation of families provides a life-saving platform for early initiation of therapeutic and prevention strategies, such as lifestyle changes, medications, and therapy with an implantable cardioverter defibrillator (ICD).

Major advances have been made in our understanding of the causes of sudden cardiac death in the young and in the identification of at-risk family members. However this focus should be part of a broader initiative to prevent sudden cardiac death in the community. Simply, education programs need to be developed to raise community awareness about the importance of a family history of sudden death or heart disease in a young relative; understanding of the important clinical symptoms such as exercise-induced dizziness or an unexplained collapse; and a greater education about the importance of cardiopulmonary resuscitation (CPR) skills. Public access defibrillators need to be more widely distributed, in all major public schools including sporting clubs and schools.

It is only through such a multifaceted public health approach that we have the best chance a successfully preventing SCD amongst the young in our communities.

References:

Chris Semsarian is Professor of Medicine in Sydney Medical School, cardiologist at RPAH, NHMRC Practitioner Fellow, and leads the molecular cardiology research program at Centenary Institute.
GETTING THE COMMUNITY ON BOARD

Professor Chris Semsarian is on a mission. He believes defibrillators should be made available in every NSW public school. He also wants mandatory CPR training to be delivered to all.

Up to four Australians under the age of 35 die every week of sudden cardiac death. Professor Semsarian says targeting the community in terms of training is key if we are to prevent sudden cardiac death in the young.

“All the evidence suggests that when someone has a cardiac arrest, I could do as much as I could with CPR and try to resuscitate you, but if you’ve had a true cardiac arrest the only thing that will actually save you is a shock by the defibrillator and every minute that passes the survival drops by about 10 to 15 per cent.”

Without early CPR and defibrillation, after four minutes brain damage is caused and after eight minutes there is little chance of survival.

Professor Semsarian says workplace and some health regulations are preventing the defibrillators being placed in public schools. However he won’t be deterred. “The only way we are going to do this is by legislation change. My understanding is there is this fear that if a person who has never used a defibrillator in a school setting uses one they are going to cause some sort of harm or damage.”

Professor Semsarian says this simply isn’t the case and they’re virtually foolproof. He’s dedicated to his campaign for change, appearing in the media and online to help raise awareness. His latest efforts include a YouTube video, which has been seen by nearly 4000 people, and a change.org petition which already has over 53,000 signatures.

Here, Professor Semsarian reflects on how his research program at the Centenary Institute and Royal Prince Alfred Hospital has identified new genes involved in hypertrophic cardiomyopathy, and in turn provided improved diagnosis, therapies to prevent complications, and better risk management to prevent heart failure and sudden death in patients with genetic cardiovascular disease.

Thea Manning

Simply, education programs need to be developed to raise community awareness about the importance of a family history of sudden death or heart disease in a young relative...
New engaging and flexible postgraduate vocational courses

By Annette Katelaris

Sydney Medical School has a growing number of targeted vocational degrees and short courses tailored to the needs of health professionals, based on their specialty and stage of career.

Sydney Medical School is committed to providing high quality, evidence based education for medical practitioners and allied health professionals throughout their careers. We have the most extensive array of credentialed postgraduate courses in the country and our successful degrees in surgery, paediatrics, ophthalmology, pain medicine and HIV, STIs and Sexual Health continue to flourish. This year, we have launched some new highly desirable vocational degrees and short courses.

The new master degrees are in critical care (emergency medicine, anaesthetics, intensive care), metabolic health and psychiatry. These courses are available as graduate certificates, graduate diplomas and master degrees and many units of study are listed across different courses. The new degrees have been specifically designed to meet the educational and vocational needs and preferences of students. All the units of study will be delivered through a combination of online and face-to-face teaching to allow students the flexibility to balance study with work and other commitments.

The online course content is supplemented with a combination of online discussion, webinar tutorials and intensive face-to-face sessions including simulations, mock vivas and workshops.

The core unit in the new master programs, Introduction to Clinical Epidemiology, provides our students with the knowledge required to understand and engage with clinical research and academic literature. We aim to produce graduates who are not only content experts in their area of interest but who also have highly developed critical thinking skills and a breadth of knowledge and understanding that will equip them for the challenges of clinical practice. There is an Advanced Master option for high performing students to undertake a supervised independent research project.

We are confident that these degrees will signal to employers that a candidate with this credential is committed to their chosen field and has the knowledge and skills that will enhance their clinical practice and their effectiveness in the workplace. In an increasingly competitive environment, this degree will provide a point of difference.

CRITICAL CARE

The critical care degree is unique in Australasia. It is designed and delivered by leading clinicians and academics from our Medical School and teaching hospitals in consultation with the Australian College Emergency Medicine, College of Intensive Care Medicine and the Australian New Zealand College Anaesthetics. The basic science units have been designed to assist candidates to successfully complete College primary examinations. There are options available to help the clinician broaden their skill base – such as units of study in retrieval medicine and pain management. Other units of study are aimed at diversifying skills and building competencies in non-technical skills such as communication, leadership and clinical teaching. For advanced trainees, completion of the degree will help fulfil requirements of the Colleges such as compulsory training in research skills.

“Students will develop knowledge and skills to make them critical and independent thinkers, able to lead their specialty in clinical practice, quality research and education. More than just a small step in specialty training, graduates will have taken a giant leap in shaping their future and that of their specialty.”

CRITICAL CARE COURSE COORDINATOR DR ROD BISHOP MBBS MPH (Hons) FACEM, Director of Nepean Hospital Emergency Department

DEGREES HAVE AN ARTICULATED STRUCTURE

- GRADUATE CERTIFICATE 24 credit points
- GRADUATE DIPLOMA 36 credit points
- MASTER 48 credit points
- ADVANCED MASTER 12 credit points
METABOLIC HEALTH

Our new course in metabolic health meets a growing need for clinical expertise in this area, given the increasing prevalence of diabetes and heart disease and the related complexity of therapy options. This degree focuses on evidence-based practical management of the all too common conditions of diabetes and pre-diabetes, obesity and metabolic cardiovascular disease.

Professor Stephen Twigg, Head of Department of Endocrinology at Royal Prince Alfred Hospital, is course coordinator. Many of our academic and clinical leaders in metabolic health are contributing to this engaging course, which is largely case based with online tutorials and opportunities for extensive discussion and analysis. It is of broad appeal to medical practitioners working in primary care or hospitals (eg RMOs, BPTs), including those planning to specialise in endocrinology, as well as nurses, pharmacists and other allied health professionals interested in this field.

PSYCHIATRY

The new coursework in psychiatry is tailor-made for psychiatry trainees and has been accredited and approved by the Royal Australian and New Zealand College of Psychiatrists as meeting the requirements of their Formal Education Course for trainees. The course is aligned with the new competency – based fellowship program of the College.

The course is also of interest to psychiatrists who are keen to refresh their knowledge. It can be completed as an enrolled student or as a short course student (who is not required to complete the assessment tasks).

Associate Professor Louise Nash leads a teaching team from one of Australia’s prominent neuropsychiatric institutes, the Brain and Mind Research Institute together with experts from our Discipline of Psychiatry. This degree is taught face to face in small groups, facilitated by experts and supported by online technology for those unable to attend in person.
Big data in healthcare

The amount of data being generated in society is growing at an exponential rate, promoting increased efforts to consolidate and analyse it. In health, a major source of this data is electronic medical records, already introduced in many countries. Genomic data has increased as costs involved have dramatically decreased. There is data streaming from sensing technologies, which are not currently suitable for clinical use, however have been popularised at the consumer level. Health-related data is also obtained from digital sources such as social media, blogs and Internet search results.

To be able to develop insights from the captured data, it must first be stored. While storage initially was an issue in because of the significant expense involved, the introduction of distributed and cloud computing has greatly improved feasibility of storage capacities. But the key issue for health remains the privacy and security of stored data.

A major current area of research is in analytical techniques, for example “machine learning” and “deep learning”, which are both ways of extracting meaning and insights from the data.

IMPACT ON MEDICAL DISCIPLINES

There will be many significant changes in medicine as a result of Big Data. The application of personalised medicine and clinical decision support systems will play key roles in clinical disciplines and practices, and doctors will need to develop strong technological proficiency and adopt the use of these systems in their practice.

Possible advancements in other areas of medicine include machine-aided identification in pathology and radiology. These are areas where computers currently do not have sufficient accuracy to automatically evaluate images, however it is expected that their performance will improve in the future to a level where they can provide additional assistance in image analysis. In the future, automated imaging analysis software has the potential to improve productivity, efficiency and effectiveness whilst reducing associated cost.

Epidemiological research is another area of medicine certain to be impacted. Skills as a data scientist will be at a very large premium, as it allows greater access and analysis of the large pool of available data. Across epidemiology, systematic approaches will need to be developed to manage, analyse, display and interpret large complex datasets. Epidemiologists will also need training to accommodate an increasing emphasis on collaboration and multilevel analysis.

Big data is a broad term for the use of large complex data sets, and with increasing relevance to health researchers and clinicians. In January 2015, Daniel Petre and Roger Corbett – both long term Sydney Medical School supporters – funded an international study undertaken by two Sydney students looking at developments in the world of health “big data.” The students – one medical, one engineering/IT – interviewed big data and medical specialists at universities and technology companies in United States and UK, an excerpt from their report is below.

RECOMMENDATIONS FOR MEDICAL EDUCATION

Doctors of the future will encounter a significantly different way of practising medicine compared to today. With the extensive advancements of various technologies and analytical techniques, the curriculum in medical education is bound to change.

In terms of teaching basic sciences, a more in-depth education on genetics may be required in medical curricula. This is due to the increasing availability of genetic information and the greater emphasis that has been placed on genetic research. With the application of personalised medicine, doctors of the future will benefit from advanced concepts in genetics. In particular, future doctors need to be skilled in interpreting results from genetic investigations and adept in basic genetic counselling.

It would also be advantageous for medical students to have an increased exposure to topics in Big Data, with introductory teaching in statistics and machine learning. In most medical schools, this does not necessarily require a significant change in the biostatistics courses that are offered, but merely a change in mindset of the lectures and teaching sessions. It would be optimal for courses to give students introductory exposure to the use of Big Data techniques (such as the use of extremely large cohorts or diverse data sources), ideally through problem-based learning, where experimental design techniques can be discussed.

Another aspect for education is gaining practical experience in dealing with technology and future innovations. Students will require a high degree of technological proficiency. The objective in this case is to ensure a minimum level of technological competence among graduates.

BLAKE LOUGHRAN
Year 4 Medical Student, Sydney Medical School

EDWARD TOTH
PhD Student, Faculty of Engineering and IT

In January 2015, Daniel Petre and Roger Corbett – both long term Sydney Medical School supporters – funded an international study undertaken by two Sydney students looking at developments in the world of health “big data.” The students – one medical, one engineering/IT – interviewed big data and medical specialists at universities and technology companies in United States and UK, an excerpt from their report is below.
A passion to improve the health of Australia’s international neighbours has, for many years, been an important motivation for Sydney Medical School alumnus Dr Haydn Perndt AM. Dr Perndt, a Hobart anaesthetist, has spent a significant amount of his professional life working in developing countries. This work includes teaching and training in Africa, Asia and the Pacific, as well as service missions with the International Red Cross and Médecins Sans Frontières to a number of countries in conflict.

Dr Perndt has used his professional career in medicine as a vehicle to make a contribution to the health of disadvantaged people around the world. Citing his parents as the source of this passion, Dr Perndt is a past Chairman of the World Federation of Societies of Anesthesiologists, Education Committee and currently an active member of the Australian Society of Anesthetists’ Overseas Development and Education Committee.

“I have been very fortunate in life; the work in developing countries has been an effort to redress, in a small personal way, some of the gross inequalities of circumstance and opportunity,” said Dr Perndt.

Dr Perndt has also given back via philanthropic contributions. His generous ‘top-up’ funding enabled the Sydney University Medical School Class of 1977 to establish an endowed scholarship for Indigenous medical students.

Dr Perndt’s second major gift was made to the University of Sydney’s Office for Global Health, and has established the Stevenson Perndt Global Health Fund. This money will boost the work of the Office of Global Health to support innovative research projects, educational exchange programs and travel for academics from developing countries.

Contributions such as these provide a legacy to international development and improve Australia’s relations with other countries.

The Office for Global Health organises much of Sydney Medical School’s health focused research, learning and teaching. It establishes and maintains links with key international associates and government agencies to contribute to the health and wellbeing of our region by working in collaboration with in-country partners to build human resource capacity, especially in maternal and child health and health literacy.

The Office of Global Health has already established important connections in several low resource countries, including Timor Leste, Myanmar and Vietnam, where we are actively engaged in capacity building, teaching and research activities.

“Education is the key to all development. Universities provide a powerful intellectual environment to inform both the content and direction of development,” said Dr Perndt.
Lambie Dew Oration – 57 years and 55 speakers

By Catherine Storey
President of the Medical Alumni Association

The Lambie Dew Oration has been delivered annually since its inauguration in 1958. There have been a total of 57 Orations and both this and last year have been very special indeed. The orator for 2015 was Professor Fran Baum, a distinguished researcher on the social and economic determinants of health. Professor Baum spoke passionately about Creating Healthy and Fair Communities.

In 2014, it was Dr John Yu, a University of Sydney Medical Alumni and distinguished paediatrician, who has been recognised for his dedication to Medicine and the Arts by the award of Australian of the Year in 1996. This was Dr Yu’s second oration (the only other repeat orator has been Professor Gustav Nossal 1972/1986 and on this occasion he chose to speak on Community values and the challenges of change.

THE TWO PROFESSORS, SO ADMIRABLY HONOURED BY THIS ORATION, WERE CHARLES LAMBIE (MEDICINE) AND SIR HAROLD DEW (SURGERY).

Dew was born in Melbourne and graduated from the University of Melbourne M.B. B.S. in 1914. He joined the Royal Army Medical Corps and served in France, Egypt and Palestine before returning to Melbourne, and for a time acting Director of the Walter and Eliza Hall Institute. In 1927 he published the work Hydatid Disease for which he became known internationally. He was appointed as the first full time Bosch Professor of Surgery at the University of Sydney in 1930 and retained this position until his retirement in 1956. Both he and Lambie set about restructuring the curriculum; encouraging research and taking the Medical School forward in the brand new Rockefeller (later Blackburn) building.

Lambie was a graduate of Edinburgh University, also graduating in 1914. He served with distinction in WW1. In 1921, he visited North America, where he spent time at the University of Toronto, Canada where Frederick Banting and Charles Best had just produced the first insulin. Lambie was the first person to introduce Insulin for the treatment of diabetes in Europe when he returned to Edinburgh with some vials of the precious substance. He published several papers on the topic of carbohydrate metabolism and in 1927 he was awarded an M.D. from Edinburgh University for his thesis entitled On the locus of insulin action. He was the successful applicant for the first full time Bosch chair of Medicine at the University of
In 1937, John Yu with his mother and sister arrived in Sydney, refugees from the murderous conflict in Nanking in the lead up to World War II. In his 2014 Lambie Dew address, Emeritus Professor Yu spoke of his own experience, the need for challenges facing Australia to be addressed with humanity, and critically, the need for leadership.

"I think of myself when in 1937 I arrived in Sydney with my mother and sister, refugees from the Japanese rape of Nanking. I arrived by boat albeit a passenger liner. Australia gave me refuge, Australia gave me free education from primary school through to Medicine at this University. I have always felt the obligation to give something back to this country, my country. I like to think that the investment by Australia all that time ago was worth it. Let us hope we can keep investing in people.

Professor Fran Baum delivered the Lambie-Dew Oration in 2015. Professor Baum is a Matthew Flinders Distinguished Professor of Public Health and is one of Australia’s leading researchers on the social and economic determinants of health. Professor Baum’s numerous publications relate to social determinants of health, including Aboriginal people’s health, health inequalities, primary health care, health promotion, Healthy Cities, and social capital. Her text book ‘The New Public Health’ is widely used as a core public health text.

Professor Baum’s significant contributions to the field of Public Health led her to being appointed as a Commissioner on the World Health Organisation’s Commission on the Social Determinants of Health from 2005-08.

The Sydney Medical School Heritage Collection is taking shape in the old Burkitt-Ford Library in Edward Ford Building, and will open in February 2016.
Life and early death of Clarence Cecil Haines: MB ChM 2016

By Catherine Storey

World War I was a brutal war. There were in excess of 37 million military and civilian casualties, with over 16 million deaths. Australians accounted for 60,000 of these deaths at a time when the total population of the nation numbered just 4.5 million. These are staggering statistics to comprehend. A great number of students, teachers and graduates from our own Medical School heeded the call to Empire and many are included in these figures.

Clarence Cecil Haines was one of these young men. He graduated MB ChM in 1916, joined the Australian Imperial Force the following year and on the 28th January 1918 he embarked at Sydney for the Western Front. In 1919 Captain Hains was stationed at the Belgium town of Charleroi, where on the 14th April he was fatally injured in an explosion at an ammunition dump. He was 25 years old.

His death has been officially recorded and the bland details of his service can be found on line. However, in our Alumni archives there is a slightly battered Cadbury’s chocolate biscuit box, a trove of biographical material that relates to this young man’s death. This unexpected find provides an insight into one family’s loss and makes his death a very personal affair, not just a vague statistic.

In this box we find a graduation photo of the young man full of hope; a studio photo of a confident soldier in his military uniform; many small photos, largely unlabeled which show places this young man visited, new friends he made. We see the dreaded ‘pink telegram’ sent to inform his parents of his death; a card to notify the site of his grave. There are official letters of condolences from Government House, on behalf of the Governor General; the University of Sydney signed by the Chancellor; an impressive scroll on behalf of George V. All are full of assurances that his death was for a noble cause.

One of the most curious mementos is a large bronze memorial plaque, often referred to as a ‘dead man’s penny’, inscribed Clarence Cecil Hains (see picture).

The most poignant of all are the letters. One of these is written in the most exquisite handwriting by the Prioress of the nearby convent; another by her brother, the local priest; one from a local resident who provide the details of the fatal accident and all reassure this young man’s parents that in the few hours prior to his death that he did not suffer and he was not alone.

Going through the contents of this little box, one can appreciate the tragedy of this young man’s death.

A display of these treasures will form part of our new Sydney Medical School – Heritage Collection that is taking form in the old Burkitt-Ford Library in the Edward Ford Building.
MBBS CLASS OF 1955 DIAMOND JUBILEE

By Dr John Wright

On May 2, 2015, some 38 graduates and 13 partners lunched in the ineffable Royal Sydney Golf Club to celebrate a Diamond Jubilee. From far and wide, we met again to relive some of the six long years we had shared, and to remember ourselves, and those who had retired early from student-hood, and particularly the 90 who had passed-on from their graduation years into fond and unforgettable memory. Twenty percent of those had been ex-service men and women for whom the burdens were heaviest of all.

John Wright reminded us that, in 1955, about 135 (22% of 610 starters in 1949) finished the course in triumph after terrifying, early fears of failure … just as had occurred in other Australian medical faculties. Even the belated introduction of enrolment “quotas” helped little to reduce failure rates until the early clinical years were reached by the survivors of pre-clinical culling. David Jeremy led us on to happier considerations of today’s thrilling and enlarging trends in medical education but warned of the dimly-seen effects of complex, mindless machines waiting to be further developed, let alone understood. They beckon us relentlessly into a new, tormenting world of genetics and electronics and robot surgery.

And so, another reunion finally went on its glowing way with haunting and hilarious memories of the times and tides and pleasures and pains of becoming doctors. We turned for home and pondered David’s wise vision. We had been taught to practice remarkable arts that we can never forget and may never see practiced again. Perhaps we had been fortunate to have lived our sort of student and doctoring days. Just maybe, today’s students will come to wonder how to touch their patients as gently and knowingly and kindly as we were taught and can never forget.

1974 – 40 YEAR REUNION

Maureen Palmer MBBS 1974

We gathered in the Great Hall at the end of March 2014 for our 40 year reunion. It had been 5 years since our last one and it was great to see everyone again and some new faces, too. With graduates and partners we numbered about 120.

Sydney Medical School had again been a great help to the organising committee, led by Greg Don, in planning the event. Everyone was keen to catch up with old friends so the formalities were kept to a minimum. Derek Raghaven, President of the Levine Cancer Institute at the University of North Caroline, who had spoken at an Alumni event a few days earlier on “Chaos in Health Care in the USA…Paying the Bills”, gave the address. He spoke of some of our graduating year who had gone on to have interesting and unusual careers. He also spoke of the opportunity we had as a group to set up a foundation offering financial support to students in need who otherwise would not have been able to graduate in Medicine.

We took time to remember those who were no longer with us and to reminisce about our student days but, for the most part, conversations were about retirement or retirement plans, families and hobbies outside Medicine. It was inspiring to hear how people were spending their free time and often taking on quite demanding activities.

We look forward to our next reunion and wish everyone good health and happiness until we next meet.
1964 – 50 YEAR REUNION
Margaret Lorang MBBS 1964

Our celebration started quietly on Saturday Sept 27th 2014 with morning coffee in a sunny corner of the Shangri-La Hotel, enjoyed mainly by the ladies, with 2 gallant gentlemen.

The noise level increased, however, as more members of the still-boisterous Year of ’64 gathered in the Quad in the late afternoon for a tour of the superb amber-walled Neo Gothic Old Med School (c.1889) History was added to nostalgia as Dr Cate Storey explained its development from the days of founding-Professor Anderson Stuart, to the recent restoration of some of its former glories, including a newly-liberated impressive stained glass window. It will never be again as we knew it, however, with steep wood-panelled lecture theatres and a vast dissection room. The courtyard, featuring palms and a spiral staircase copied from a French chateau, has a fabled appearance in sunset light.

Our venerated Great Hall then welcomed us for drinks and dinner; bright flowers in University colours and subtle organ music provided an ambience which contrasted happily with some student memories of the venue, associated with frantic scribbling. The delight of 103 friends greeting each other, some after 50 years, was vibrant, and we raised the decibel level even more by singing traditional medical songs between courses. We are grateful again to our organist, Amy Johansen who generously claims to appreciate her loudest choir, and adds such zest to our celebrations.

The 50 Year celebration address, delivered by Professor Donald Chisholm, winner in our student days of the Robin May Memorial Prize, was an enlightening and enjoyable selection of history, details of the outstanding achievements of members of our Year, and a very good joke about the “efficiency reports” which bedevil those of us who work in hospitals.

The climax of the evening came with a vocal rendition of Gaudeamus, rivalling all the power of the organ and its trumpets, and a final mighty burst of sound, metallic streamers and giant confetti exploding from the gallery.

The presence of so many grads and their partners, totaling 177, was a tribute both to the cohesiveness of our very friendly Year, and to the energy, sleuthing and persuasive abilities of our Committee and of Jules Black, our MC, Counsellor-in-chief and editor of the exceptional Very Senior Year Book. Jules and his talented wife Jenny, who provided the artwork, have created a magnum opus, comprising brief autobiographies and recent photographs of members of the Year, juxtaposed with the photographs and descriptions of our student selves from the original ’64 Yearbook. It is an engrossing read, and a fascinating revelation of gifts, adventures and achievements.

After all this excitement, we were content to relax next day in sparkling Spring weather on a luncheon Harbour cruise, which allowed another opportunity for quiet conversation and the camaraderie which after 50 years we so highly prize.

Thanks are due to everyone who worked for and supported this splendid weekend, many having come from overseas, and others with some difficulty.

We thank the Sydney Medical School for all the help we received, and request our members to keep in touch, as we look forward to many more scintillating reunions.

All suggestions and criticisms gratefully received!
## Reunions

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| Weekend 29-31 January | 1966     | 50 years  | Dr Paul Lancaster  
Dr Raema Prowse  
Dr Maureen Rogers | Novotel Sydney Manly Pacific  
Contact: pallancaster@gmail.com |                           |
| Thursday 11 February  | 1971     | 45 years  | Dr Keith Hartman               | MacLaurin Hall, The University of Sydney. | 6.30pm for dinner         |
| Saturday 16 April     | 1955     | 61 years  | Dr David Jeremy  
Professor Thomas Taylor | The Royal Sydney Golf Club, Rose Bay | 11.30am for 12pm lunch                 |
| Sunday 22 May         | 1961     | 55 years  | Dr Bob McGuinness & committee  | The Great Hall, The University of Sydney  | 12.00pm for lunch         |
| Saturday 11 June      | 2006     | 10 years  | Dr Jonathan Adams             | To follow – visit Faculty website for further information later in 2016 |                           |
| 2016                  |          |           |                                |                                            |                           |
| 2016 October          | 1956     | 60 years  | Dr Jim Roche  
Dr Richard Bailey | To follow – visit Faculty website for further information later in 2016 |                           |
| 2016                  | 1976     | 50 years  | Dr Barbara Walker & committee  | To follow – visit Faculty website for further information later in 2016 |                           |
| 2016                  | 1996     | 20 years  | Dr Reginald Seeto             | To follow – visit Faculty website for further information later in 2016 |                           |
| 2016/17               | 2007     | 10 years  | Dr Andrea Tomizawa            | To follow – visit Faculty website for further information later in 2016 |                           |
| **2017**              |          |           |                                |                                            |                           |
| 2017                  | 1967     | 50 years  | Dr Stephen Andersen  
Dr Colin Shepherd  
Dr Ian Stewart  
Dr Margaret Gates (Beral)  
Dr Charles Pidcock | To follow – visit Faculty website for further information later in 2016 |                           |

### Sydney Medical School Reunions

Reunions provide a wonderful occasion to reconnect with old classmates and friends as well as stay in touch with the University. Whether you’re looking to plan your next celebration, find out the details of your next reunion or simply get in touch with your classmates, the Reunions page on the Sydney Medical School website has everything you need: sydney.edu.au/medicine/alumni/reunions/

The following graduating years will be celebrating significant anniversaries in 2016, so if you are interesting in being involved in your class reunion, contact the Alumni Engagement team to discuss how they might support and help you celebrate your next reunion.


Email: alumni.medicine@sydney.edu.au telephone: 02 9351 0467 or 02 8627 1905
I have a skeleton in the closet. I really do. It is a human skeleton that I acquired as a first year medical student at the University of Sydney in 1981.

Back then, just about every medical student would own a half or full skeleton. They had to be real human bones as the quality of plastic models at that time was as good as useless, as they often lacked many of the essential markings seen on real bones. A half skeleton was a way to save money on the costs – instead of having a full set of bones, a half skeleton would be all bones except one pelvis, one set of ribs, one upper limb and one lower limb. In truth, it was more than half a skeleton.

Unless you were gifted a skeleton or purchased one from a more senior medical student or doctor, you would purchase one from the Sydney University Medical Society Bookshop. We would briefly pause to wonder where they came from and the rumour at the time was that they were harvested from rivers in India. To be honest, we did not give much further thought to it. We were naive, trusting and never considered that there could be anything sinister about the manner by which the company trading in human skeletons came to acquire them in the first place. Most of us were 18 years of age at the time and we were consumed with the excitement of coming to university and starting the medical course rather than to think about the ethics of human skeleton acquisition.

Once I completed the two preclinical years of my medical course, my half skeleton went into a box and into the closet. It sat there for another 5 years until, as a junior doctor studying for the anatomy component of the surgical primary examinations, it was once again of use. I passed my surgical primary examinations and it went back into the box and back into the closet.

It sat in the closet for another 25 years before I found it during a home ‘clean out’. Some things have happened since I first acquired ‘my’ skeleton. In 1985, the Indian Government outlawed the export of human remains and this created a market for ‘second hand’ skeletons. Over this time, plastic skeletons have vastly improved to the extent that there is no need to learn on real human skeletons.

On re-discovering the skeleton in my closet, a number of questions came racing through my mind. Who was this person and with what sort of existence? Did the family know of the fate of the original owner of this skeleton? Had the original owner of this skeleton or family given consent for use in medical education? The last two questions came back at me with an almost immediate NO. Much has been written about the illegal trade in human skeletons destined for medical education and I find it difficult to think that any aspect of this trade is absolutely above board.

Now that I have found this skeleton, what do I do with it? Do I donate it the local medical school? Do I dispose of it somehow?

As far as disposal is concerned, most jurisdictions have laws regarding the disposal of human remains. One thing that should not be done is to throw it into the trash or bury it. It would only be a matter of time before they would be uncovered to trigger off an unnecessary homicide investigation. Most laws necessitate that the bones be handed in to a relevant authority and following which arrangements would be made for cremation.

I feel that the skeleton in my closet has done its time in medical education and it is time to put it to rest. Further time in the closet gathering dust does not seem right to me. That time has passed. Do you have a skeleton in your closet?

Henry Woo is an Associate Professor of Surgery at the Sydney Adventist Hospital Clinical School of the University of Sydney. Opinions expressed are his own. He blogs at www.surgicalopinion.blogspot.com.au and is on twitter at @drhwoo
From adversity to a legacy: the Rudolph Brasch Scholarships

The Rudolph Brasch Scholarships for students in Sydney Medical School were established through a bequest of $6 million by Lisolette Brasch.

Lisolette grew up in Austria but was forced to flee as a young child with the imminent outbreak of war, before eventually immigrating to Australia. In Australia, she married Rabbi Rudolph Brasch AM OBE, a well-known Jewish Minister and author.

“Naming the scholarship after him was her way of honouring their relationship and keeping his name alive,” says Gary Bortz, Lisolette’s nephew. “She faced many obstacles in her life and I think that leaving this bequest is her way of easing the path of students experiencing financial hardship.”

For information on making a bequest or providing financial support, contact Sue Merrilees, Director of Development, Sydney Medical School.

sue.merrilees@sydney.edu.au or 02 9351 7315
The Poche Centre’s Healthy Teeth strategy was recognised for excellence in community engagement in the Australian Financial Review’s Higher Education Awards.

More than 10,000 services have been provided, and Aboriginal people have been trained and are now working in dental care.

PARTNERS IN HEALTHY TEETH

→ NSW Centre for Oral Health Strategy
→ NSW Dental Council
→ Armajun Aboriginal Health Service
→ Pius X Aboriginal Health Service
→ Ungooroo Aboriginal Health Service
→ Hunter New England Local Health District
→ Varley Hearing and Dental
→ NSW Tafe – Sydney Institute and OTEN
→ Faculties of Dentistry at University of Sydney, University of Melbourne and University of Western Australia
→ Australian Dental Association NSW
→ AITEC and the graduate dentist and oral health therapist programs
→ Co-founder Reg Richardson
→ Patron Tom Calma

Thank you to Greg Poche and Kay Van Norton Poche, who have donated more than $50 million to improving Aboriginal health. Their vision and personal commitment is an example to all Australians about how we can be part of positive change.