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radius

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PAST SUCCESSSES, FUTURE CHALLENGES

The beginning of the year is a time for reflection and planning, and I would like to take the opportunity of this first issue of *Radius* for 2009 to review highlights of the past year, and outline some of our plans and challenges ahead.

High on the list of achievements for the past 12 months was the successful introduction of reforms to the medical curriculum. A visit to our newly refurbished anatomy facilities during the Christmas break, where students who had jumped at the opportunity to spend their holidays improving dissection skills were working under the supervision of some of our most experienced surgeons, is just one indication of the support the changes have received at all levels.

The recruitment of a number of outstanding new staff members was a highlight of 2008, as was the success of our researchers who again fared well in securing competitive grants and publications. It was with great pride that I attended the graduation prior to Christmas of nearly 200 PhD, Masters and Diploma students from the Faculty of Medicine. No other Faculty in the University has a graduation solely for the purpose of research and postgraduate coursework students. This is a great achievement and congratulations must go to all of the supervisors of these students in our affiliated Institutes, clinical schools and on-campus disciplines.

The establishment of the Poche Centre for Indigenous Health was another of the successes of 2008, and is the beginning of a strong partnership with Indigenous Australians to help improve their health care outcomes.

International outreach has become an important part of the Faculty's community connection. We now have strong links with partner universities in China, Vietnam, Indonesia and Cambodia and are developing relations with key institutions in India. These links are important for the development of

our staff and students, and they enable us to contribute expertise, particularly in our region.

As we look forward to 2009 we can also remind ourselves of the strong links to the community that we have in NSW through our metropolitan and rural clinical schools. Members of Faculty make an enormous contribution to the health of the people of New South Wales and in many cases provide the leadership so sorely needed in the NSW health system.

For the year ahead, a key challenge is infrastructure, which is in need of upgrading in many locations. We have recently applied to the Federal Government for funds to cover the upgrading of several of our research and clinical school facilities. We are hopeful that these applications will be favourably received and enable us to build the facilities that are so urgently needed. The new Kolling Building at the Royal North Shore Hospital, which houses both researchers and the Clinical School, has set the standard for facilities needed at all of our sites.

One of the most distressing events of 2008 was the funeral of a dedicated colleague, who had taken his own life. Unfortunately, it was not an isolated case. Each year, too many of our most talented doctors are lost early to their families, the profession and the community.

This issue of *Radius* contains a number of articles on doctors and their health. I would particularly like to thank Ian McPhee, anaesthetist and senior lecturer in the Faculty, who describes his lifelong experience of living with, and overcoming, depression. The medical profession is one of the last to acknowledge and openly discuss the burden of mental illness on members, and Ian's story and his conclusions are compelling.

Bruce Robinson
Dean

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Pledge Signing 2006

“A Will and A Way”

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- Dubbo College—Get real Program
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- Warren Central School—Future directions Program

Louise Lawler - Coordinator

“A WILL AND A WAY”: THE SCHOOL PROGRAM THAT CHANGES LIVES

In March this year, about 380 Year 10 students from schools in a number of towns in the central west of NSW, will pledge to engage in a potentially life-changing program.

The program, called “A Will and a Way” is run by Faculty of Medicine lecturer Ms Louise Lawler, based at the Rural Clinical School in Dubbo.

The purpose of the program is to keep students at school in their senior years, essentially to use the senior years to provide life long employment.

“Too many students leave school prematurely each year into unemployment and uncertain futures,” Ms Lawler said. “Intervention while they are still at school is ensuring that students get the best opportunity to stay at school and pursue their education or be able to secure sustainable post-school employment.”

Ms Lawler established the program in Dubbo in 2005. It was funded in its first two years by the Faculty’s Rowan Nicks Russell Drysdale Fellowship. In more recent years, the program’s success in keeping young people engaged either at school and/or in meaningful employment has enabled it to attract Commonwealth funding. It now runs over four schools – Dubbo College, Wellington High School, Nyngan High School, and Warren Central School.

The program places a coordinator into schools to work with students who are at risk of leaving early or who have limited family or social support. The students frequently have low socio-economic backgrounds or belong to a minority group (including Indigenous). When students are identified as needing assistance, the coordinator will establish a relationship with the student and devise a plan which involves family and other support.

Since 2005, the program has assisted more than 300 students, including about 150 Indigenous students. About 80% were from disadvantaged or dysfunctional backgrounds. About 99% of students in the program have stayed at school to complete their school certificate at the end of year 10, and most of these have then stayed on to year 12.

news



Professor Jonathan Craig



Rahul Mainra

CLINICAL EPIDEMIOLOGY: 15 YEARS AND COUNTING...

It is 15 years since clinical epidemiology courses began at the School of Public Health.

“The courses we now offer are unrecognisable compared with 1994 when we began,” said Professor Jonathan Craig, director of the program. Students have options ranging from short courses up to graduate certificate and masters levels.

“The wide range should appeal to anyone who would like to

make better use of research in their clinical decision-making or those involved with clinical research on a day-to-day basis,” Professor Craig said. Students can choose from a variety of units, including new additions for 2009: Introduction to Genetic Epidemiology, Clinical Research Development and Practice, and Introducing Qualitative Research in Health.

Popular short courses include Introduction to Clinical Epidemiology, Literature Searching and Introduction to Systematic Reviews.

Today’s courses are also more accessible with options for

both full time and part time students. Many units are also now available via distance learning.

“There are many great aspects of the master’s program in clinical epidemiology: the excellent faculty, the relevant courses and the pragmatic statistical skills. It was the flexibility I appreciated the most,” said Rahul Mainra, Master of Clinical Epidemiology student.

For more information and to download a Course Guide, go to: www.health.usyd.edu.au [see ‘future students/coursework’]

STUDENT SNAPSHOT: MBBS 2009

The class of 2009 is one of the largest in years, with 299 students commencing their medical studies this year compared 270 last year.

The vast majority of this year's new medical students have completed first degrees in science or health, with less than 20% of students coming from previous studies in law, arts, engineering or commerce. Nearly 30% had an undergraduate degree in biological science, almost a quarter have a degree in human biosciences. Others have previous degrees in dentistry, physiotherapy, psychology, vet science and pharmacy.

The major source of international students continues to be Canada – 31 Canadian students started medicine in 2009. This year's internationals are, though, a more diverse group than in 2008 with students from Poland, Mauritius, Norway, Malaysia, Indonesia, Hong Kong, Singapore, the UK and the US.

In a change from recent years, males outnumber females in the class of 2009. The average age of students is 23 years.

| | 2009 | 2008 |
|---------------------------------|----------|----------|
| Total number of students | 299 | 270 |
| Local students | 246 | 227 |
| International students | 53 | 43 |
| Male/female % | 53/47 | 48/52 |
| Average age at enrolment | 23 years | 23 years |

CHANGES IN MEDICAL SCHOOL ADMISSIONS

Students applying to study medicine at Sydney University will, in future, have the marks from their previous degree rank equally with their scores achieved in the GAMSAT (the Graduate Australian Medical School Admission Test) and the MMI (multiple mini interviews).

After a lengthy and, at times, hotly debated review of admissions by Professors Kim Oates and Kerry Goulston, members of Faculty approved a number of changes late last year.

The most significant is that student applications will, in future, (probably for entry in 2011) be ranked according to a combination of their GAMSAT score, the grade point average (GPA) they achieved in their previous degree, and on their performance in the interviews. Each component will be given equal weighting in determining the student's ranking.

A combination of grade point average and GAMSAT scores are now used to determine whether students gain an interview for entry into medicine. To secure an interview, students have to have achieved a credit average in their first degree. The final offer of places in the medical program is determined based on performance in the interview and the GAMSAT score – not the GPA.

The question of whether Sydney should increase the number of places in medicine offered to school leavers, was also considered by the Review.

On that point, the Faculty decision was that Sydney should remain a graduate medical program but a limited number of high achieving school leavers would be guaranteed a place in the four year medical program when they started their undergraduate degree. This would involve a maximum of about 30 school leavers a year.

In a related move, a two-year pre-medical program will be offered for these students, allowing them to compress their medical degree into six years - not the seven years now required if they complete their undergraduate degree then graduate medicine.

news



POLLIES PEDALLING FOR THE POCHE CENTRE

This year's Pollie Pedal is raising funds for the Faculty's Poche Centre for Indigenous Health. The Hon Tony Abbott, Opposition spokesman on Indigenous Affairs, is leading a pack of dedicated riders out of Brisbane on April 27, expected to arrive in Sydney on May 5.

Cyclists will wind their way from Brisbane, via Lismore, Grafton, Dorrigo, Armidale, Walcha, Gloucester, Cessnock, Brooklyn to finish at the University of Sydney.

Money raised will fund scholarships for Aboriginal and Torres Strait Islander students, and will be administered through the Poche Centre.

The major sponsor for the ride is Amgen, which has donated \$60,000.

"Amgen Australia is proud to continue its association with the Pollie Pedal and to be able to support the valuable work of the Poche Centre," said Ian Thompson, Chief Executive of Amgen.

"The Pollie Pedal is a considerable physical and mental challenge, that makes completing the task and raising the money for the Poche Centre all the more special. That the ride will take us to visit some of the folk who will benefit from the fund raising and awareness raising effort makes the event even more rewarding."

Other supporters are Norgine, the Church of Jesus Christ of the Latter Day Saints, and Macquarie Foundation.

Participants are welcome to join the Pollie Pedal for anything from a single day to the full nine days, although the event is not for the faint-hearted or the unfit. Most days cover at least 100 kilometres.

Details of the ride, costs for participants, as well as donation and sponsorship forms, are available on Tony Abbott's website www.tonyabbott.com.au



Pollie pedallers 2008



Associate Professor Ngiare Brown

POCHE CENTRE CLINICS: CAN YOU CONTRIBUTE?

The Poche Centre for Indigenous Health is seeking expressions of interest from health professionals able to participate in clinical visits to communities in western New

South Wales and the Northern Territory.

"The core business of the Poche Centre includes the development of sustainable models of service delivery for Aboriginal communities," said Director Ngiare Brown. "The Centre will also contribute

to addressing gaps and priorities in clinical service delivery via support for existing practitioners, and the facilitation of regular clinical visits from primary care providers, medical specialists, nurses, midwives, dentists and allied health professionals."

"We are seeking expressions of interest from colleagues who are able to make a sustained contribution to these clinical services initiatives," she said.

Those interested should complete the Expression of Interest form, detailing their qualifications, experience

and availability. The form is available on the Faculty of Medicine website, or by emailing ancellac.cheung@usyd.edu.au.

For further information, contact Associate Professor Ngiare Brown on 02 91140829.



John Della Bosca looks on as chief executive of Ambulance Service, Greg Rochford, presents award to Ralph Nanan.

"OUTSTANDING COMMITMENT" AWARD TO NEPEAN CLINICAL SCHOOL

In December, the Nepean Clinical School received an award from the Ambulance Service of New South Wales for outstanding commitment and contribution to the Extended Care Paramedic (ECP) Program. The ceremony was attended by the Chancellor of the University of Sydney, Professor Marie Bashir, and Mr John Della Bosca, NSW Minister for Health. The award was accepted on behalf of the Clinical School by Professor Ralph Nanan.

Nepean Clinical School has been part of the ECP program since its inception in 2007. Working with the educators from the Ambulance Service, the participants in the program have been based at Nepean Clinical School for blocks of up to 12 weeks. The Clinical School assisted by providing tutorial rooms, clinical skills training and tutorials by specialists. While based at Nepean Clinical School, the ECP participants have also had placements in Nepean Hospital in conjunction with Sydney West Area Health Service.

The collaboration between Nepean Clinical School and the Ambulance Service in the ECP program has been rewarding for all parties. The ECP program will be running through 2009, with two groups scheduled to train in two rotations later in the year. This innovative program is helping to improve the delivery of health care to the people of New South Wales.

AUSTRALIA DAY HONOURS

Congratulations to all our members of faculty and alumni who were recognised for their contribution in the latest Australia Day Honours.

Professor Colin Sullivan AO (MBBS 1970) is Head of the David Read Sleep Laboratory. He was awarded the Officer in the General Division "for service to medicine as an innovator in the field of sleep disorders and the development of equipment and treatment practices".

Clinical Professor Phillip Harris AM (MBBS 1973) is Head of the Department of Cardiology at Royal Prince Alfred Hospital and was awarded "for service to medicine in the field of cardiology as a clinician, administrator and educator, through contributions to professional organisations, and to the community".

Clinical Associate Professor Stephen Lee AM (MBBS 1974) was awarded "for service to medicine in the field of dermatology as a clinician, mentor and educator and through roles with professional organisations". His research interests include melanoma and non-melanoma skin cancer, skin problems in diabetes and connective tissue diseases.

Clinical Associate Professor Brian McCaughan AM (MBBS 1975) was awarded "for service to medicine in the field of cardiothoracic surgery as a clinician, researcher and educator and through contributions to the delivery of health care services".

Dr Susan Rutkowski AM (MBBS 1970) is Director of the Spinal Cord Injuries Unit at Royal North Shore Hospital. She was awarded "for service to medicine in the area of spinal cord rehabilitation as a clinician, mentor and researcher, and through contributions to advocacy groups and charitable organisations."

Dr Malcolm Borland OAM (MBBS 1969) was awarded "for service to the community, particularly through the Australian Foundation for Disability, and to local government in the Penrith area".

Adjunct Professor David Cody OAM (MBBS 1965) was awarded "for service to medicine, particularly in the fields of cardiology and cardiac rehabilitation".

Dr Bernard Cormie OAM (MBBS 1968) was awarded "for service to the community as a general practitioner and through student support programs".

Dr Franciscus Junius OAM (MBBS 1965) was awarded "for service to medicine through research and clinical innovations in the use of the heart-lung machine and the improved outcome for patients".

Dr Malcolm Stening OAM (MBBS 1936) was awarded "for service to medicine as a gynaecological surgeon, and to the community through the recording of naval history".

Dr Harold Thurlow OAM (MBBS 1952) was awarded "for service to the community as a general practitioner and volunteer medical officer with a range of sporting organisations".



NEWS

\$99 MILLION KOLLING BOOSTS RESEARCH AND TEACHING

The new \$99 million Kolling Building has provided a major boost for the Faculty of Medicine's research and education at Royal North Shore Hospital.

The purpose-built facility was opened by the NSW Minister for Health John Della Bosca and Vice Chancellor Dr Michael Spence on November 18 last year.

Jointly funded by the University of Sydney and the NSW Government, who contributed \$32 million and \$67 million respectively, the building accommodates about 300 research staff and provides ultra-modern clinical and other teaching facilities for educating medical, nursing and other health students.

"The opening of the Kolling Building marks a significant new phase of cooperation between North Shore Health and the University of Sydney," said Dr Spence. "It is absolutely essential that research in this area is multidisciplinary and that it can be successfully taken from bench to bedside. This world-class facility provides the ideal environment to achieve this."

The building, named in recognition of the Kolling Institute of Medical Research, is part of the \$950 million redevelopment of Royal North Shore Hospital and community health facility, expected to be completed in 2013.

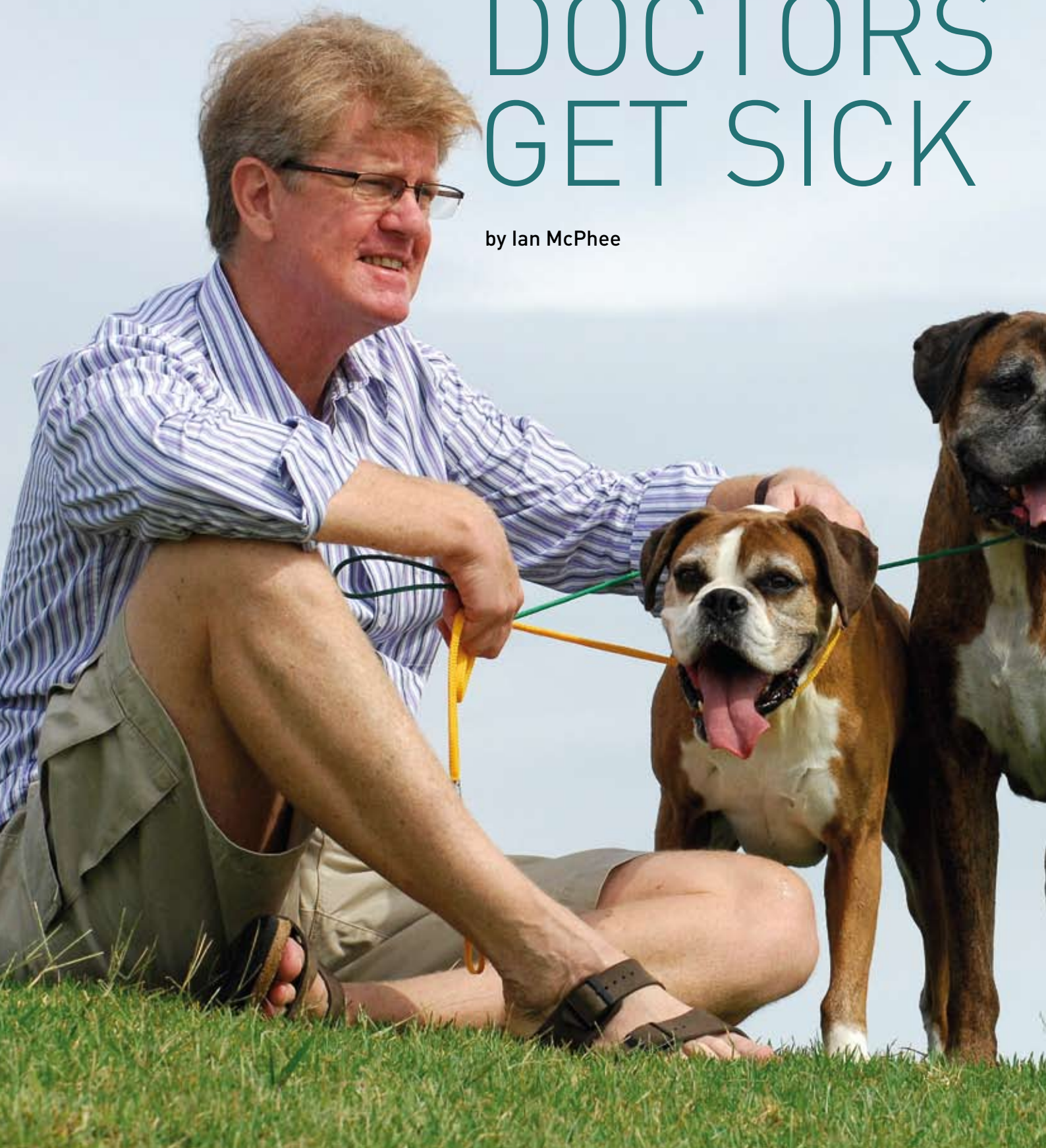
The main teaching spaces plus the state-of-the-art Sydney Clinical Skills and Simulation Centre and the Pam McLean Communication Centre (teaches clinical communication skills) are on the first three levels. Laboratory research is located over six floors, providing bench space for procedures and accommodation for research groups.

Top Right: Professor Michael Field, Dr Michael Spence, Professor Bruce Robinson



WHEN DOCTORS GET SICK

by Ian McPhee



The stigma of mental illness has all but evaporated in many professions - greatly helped by the many prominent people in business, government, sport, arts and elsewhere, who have freely discussed their experiences and, often, paths to recovery. That is not the case in medicine. To date, the medical profession has been far less open about mental illness and its impact on members.

Dr Ian McPhee, anaesthetist and clinical senior lecturer in the Faculty of Medicine, has spent most of his life in the shadow of the "black dog".

He tells his story to raise awareness and encourage greater understanding and support.



"... AND TODAY, I HAVE FELT THE WIND OF THE WINGS OF MADNESS ..."

These words from Baudelaire often ring in my mind. I first read them quoted by American novelist William Styron, as a preface to his frank account of the onset of depression when visiting Paris in 1985 at the age of 61.

I have also known periods of madness.

Unlike Styron, though, my experience has been lifelong. It is this aspect of my story that has brought me to participate in the Dean's initiative to raise awareness of a debilitating, potentially life-threatening, but ultimately conquerable illness.

There are elements of this account which will hold true for others in medicine. Discussions in recent years, when I have felt free to be open and honest, have borne this out. There are elements, of course, which will be unique. I will outline briefly aspects of a life lived in the shadow of the "black dog", in the hope that others might be encouraged to look differently and positively on their own circumstances, those of a loved one, or, especially, of a colleague.

Looking back from a position of wellness, and with decades - I am 54 - of exposure to help in myriad forms, it is possible to recognise some defining moments and evolving patterns.

I lived with significant periods of melancholy, just plain feeling "down", in my youth, always saying to myself that I'd feel better in a day or two. Most of the time, I did! Life was pretty good for a teenager in the late sixties and early seventies. I lived by the beach, surfed, had friends, enjoyed school and ... ended up in Medicine!

Initially these were good years. I spent time at St Andrew's College, later moving into digs in Glebe and immersed myself in campus life. I married during third year and within a year my first son was born. However by the time of my clinical years, spent at the Sydney Hospital Clinical School, things were beginning to get a bit tough. I was "down" often, more than my friends and somehow in a different way. It stayed for days and then weeks.

No one spoke openly of being depressed. This was a diagnosis that only patients had and we were not that - were we? Our exposure as students to the world of psychiatry was brief and focused on systems of classification, to the almost complete exclusion of issues of diagnosis and treatment. By this time, two classmates had committed suicide. I can still recall feeling a profound empathy with each of them. And while these events may have only acted indirectly to bring me to a decision, nonetheless I took it upon myself to seek answers to the question of what had brought me to the state of mind that I was in.

"JUST GET ON WITH IT"

The problem, of course, was where to go. I had no GP. "Student Health" seemed better placed to offer advice on travel ailments and the treatment of "social" diseases! I decided ultimately to seek the opinion of the Hospital's liaison psychiatrist, a young fellow who was easily accessible and in whom I had some confidence. I came away from our one and only meeting reassured that I was just reacting "normally" to the pressures of life as a husband, father and medical student. I should get on with it!

So, get on with it I did. Much to the surprise of some friends, I passed final year. To my pleasant surprise, my colleagues awarded me the Robin May Prize. Internship followed with pressures the like of which I had never experienced. Nothing had prepared me for the reality of work on the wards of a public hospital. If there were times when I felt it was all too much - and there were - I remembered the words of the liaison Psychiatrist ... and got on with it! It was normal, wasn't it?

At the end of my Intern year, my second son was born and I decided to pursue a career in Critical Care/Emergency Medicine, and to do this via Anaesthesia. I look back and reflect that it was easy to discuss career issues with friends and colleagues. It is only more than 25 years later that I am able to discuss matters with some of those same individuals that go beyond the professional. This is not to be critical of them. On the contrary, I valued greatly their willingness to offer advice regarding career objectives but in hindsight it was made from a perspective that only barely touched on the personal.

And then there was registrar training! By this time, the birth of twins meant that children numbered four and life was passing in a blur. I rode a bike to work, out of necessity rather than any veiled nod to political correctness. At the end of the day I would climb aboard and find myself crying for the duration of the 7km pedal home. Tears would flow uncontrollably. I could not accept that this was "normal". A local psychiatrist had presented a paper on the impact on staff of working in Intensive Care, and I sought him out. I was looking for an external cause for all of this. It was not to be so, and after two meetings it was decreed that I was unhappily married! My wife agreed that she certainly was, and asked me to leave. Depression? No sir! Again, I was to "get on with it".

To this point no one - friend, colleague or doctor consulted in the course of seeking help - had mentioned depression as a likely diagnosis for this equivalent of Styron's "storm of murk" that I found myself caught in. I moved on. I had a break from anaesthesia for

FEEDBACK

If you would like to respond to Ian McPhee's story or offer views on any matters raised, email radiuseditor@med.usyd.edu.au

a number of years before returning to finish training and exams, as well as spend a further two years as an SR in a metropolitan Intensive Care Unit. This was a time of relative stability. I had the opportunity to work with exceptional clinical colleagues and importantly, I had remarried – my wife, Kath, a partner with insight, understanding and compassion. Together we decided to move to a provincial centre where I could combine work in critical care and anaesthesia.

INSIGHT

This proved to be a difficult transition. In the North Coast community in which I was working, medico-political wrangling left critical care in great need but bereft of advocates. Never shy of a battle, after two years I found myself mentally and physically exhausted. But this was an exhaustion that I had never before experienced. I was emotionally paralysed. For the first time I was afraid that I simply could not go on. While not suicidal, I recognised that this was a state that threatened my very being. I was also able to recognise that I needed help. But in a small community, who do you turn to? Again, I had no GP!

However, within 24hrs of a call to the Doctors' Health Advisory Service I was in the consulting room of a Sydney psychiatrist. For the first time I heard words of insight and encouragement. For the first time someone dared tell me that I had a significant affective disorder that I would need to live with and manage. Assisted by a short course of medication, and further visits to that same comforting, Sydney consulting room, I was able to regain my feet and steer a course, admittedly a little circuitously, to the community in which I have now lived and worked for the last fifteen years.

Yet these past fifteen years have held further opportunities for insight into the nature of this seemingly relentless stalker. A black dog? Far too benign a metaphor in my view! Even as I write these words I find it hard to fathom that I had not learned from the painful mistakes made on my way through life, and life in medicine. I am reminded however of a quote attributed to poet Sylvia Plath, whose own life with depression has been extensively examined²: "When you are insane, you are busy being insane – all the time... when I was crazy, that's all I was."

And so I continued on in my own insanity. All I could see around me was work to be done, and I set about getting it done. Intensive care, anaesthesia, RMO staffing and recruitment, clinical training, IT, hospital-wide infrastructure development and more. This time I was made ready for the inevitable though. At a low point, with me suddenly overwhelmed by illness, Kath had been forced to intervene. Her call to the DHAS had meant that I was in contact with a psychiatrist outside the local area who I very cleverly saw on a prn basis – lest he truly mess with my insanity – and I had subsequently remained stable on a small dose of medication – or so I thought!

THE DISASTER OF ECT

When the crash came, I was beyond care in the community – suicidality now a feature. For the first of many times to follow, I was hospitalised. Initially terrified of the consequences, I was soon in a position to be able to relate to William Styron's positive take on hospitalisation as "a transfer out of the too familiar surroundings of home, where all is anxiety and discord, into an orderly and benign detention where one's only duty is to try to get well."

Wellness however was elusive. Months passed before I returned home and ultimately, to work – the very same work that I had insanely engaged in before I was hospitalised. The consequences of this, I can now see, were inevitable. To have expected medication to prevail over behaviour such as I was determined to maintain was naïve, but I was not alone. Sage-like, more than one consulting clinician during my subsequent hospital admission scratched his pate in bewilderment at the failure of medication to contain symptoms, one being heard to say: "This certainly is a bitch of an episode". The black dog had at least been assigned a gender.

Yet it went on. Many combinations of medication were tried, each change bringing renewed hope of stability, but inevitably the introduction also of a grab-bag of side effects. Some of these were tolerable, others debilitating. And with each change of medication came the physical and emotional torture that was withdrawal. I cannot begin to describe the horrors of this phenomenon, for me and for Kath, helplessly looking on.

It came then to the consideration of ECT. I look back and feel that I was perhaps something of a passive player in this. I was certainly unwell, and as a consequence poorly positioned to meaningfully participate in a decision to proceed. The consequences were dire. Retrograde memory loss was profound. I was devastated and searched for answers where my treating doctors could give none. And there, in the mainstream psychiatric literature was a superbly crafted lay person's account of the impact of this phenomenon on her life³. My experience mirrored exactly.

I was left then to claw back a life only half remembered. Faltering starts at a return to the non-clinical roles that I had previously taken on were made, only to fail. My former clinical colleagues, none of whom had made contact during the preceding years of hospitalisation remained aloof. One, on being told of my illness, replied: "Yes, depression is trendy nowadays". A very few others were more open. The Health Service, for which I had worked at different times as a VMO and Staff Specialist for over ten years, was openly hostile. There were later hearings in the Industrial Courts as a consequence.

RECOVERY

Again, I stumbled. Again Kath was forced to intervene. She sought the counsel of a senior clinical colleague and close friend in the environment of a Sydney metropolitan teaching hospital. I was referred to that centre's clinic where I found true respite and focussed care. Importantly, there was an opportunity to exercise and maintain physical health. As well, there were meetings with friends in medicine from the nearby general hospital who gave up their valuable time to join me for coffee. They were patient and accepting, willing to ignore my trembling hands and curious, drugged affect. This was marvellous therapy!

There was also generous assistance provided by the Medical Benevolent Association which allowed Kath to be with me for extended periods while so far from home. I had not worked for almost three years and was without income protection for this chronic condition.

The breakthrough came when I was challenged for the first time to consider the existence of a bi-polar element to my lifelong mood disorder. Treatment was modified to reflect this, at the same time as I was encouraged to begin to ready myself for a slow return to clinical work. This latter strategy, while seemingly farfetched at the time, was

Endnotes

1 William Styron. *Darkness Visible: A memoir of madness*. First Vintage Books, 1992

2 Cooper B. Sylvia Plath and the depression continuum. *J R Soc Med*. 2003 June; 96(6): 296-301.

3 Donahue AB. Electroconvulsive Therapy and Memory Loss: A Personal Journey. *J ECT* 2000; 16:133-143

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commenced as an integral part of an ongoing “treatment plan”. I had earlier self-reported to the NSW Medical Board and, once well enough, commenced in their impaired registrants program – to this day a very positive experience. I sought out the assistance of my own College in accrediting a re-entry program which was to take place in my former training hospital – the Director of the Department of Anaesthesia, fully aware of my circumstances, both understanding and supportive. A short time later a part-time VMO position became available in my local Health Service. I was granted conditional registration and within a year was back in part-time work.

Almost three years on, I am well! There were in the interim some difficult times. Memory loss required extraordinary levels of vigilance in clinical settings during the first months of my return to work. Before an adjustment in medication, tremor meant that some procedural tasks were “challenging”. I remain medicated – now comfortably with minimal side effects.

I remain in the care of a psychiatrist who I respect and trust – and for whom a partner, in this case my wife, remains significant in matters of treatment and surveillance. I have a GP who I also respect and trust. I am fortunate to have a mentor, friend and confidante in the workplace, outside the discipline of Anaesthesia. We meet regularly. I enjoy doing what I do and gone is the pathological craving for the challenges/ burdens of an overwhelming clinical and administrative workload. For a time, I admit, I did miss the “old me”. Crazy!!

“... And so we came forth, and once again beheld the stars⁴.”

LIMITING THE TOLL

Is it now for me to say: “if only...”? I firmly believe not. There is only now. My experience however leads me to consider that we must do more for our colleagues, and this in the spirit of the World Medical Association’s 1948 Declaration of Geneva⁵, which states: “My colleagues shall be my brothers”.

There are comprehensive data which suggest that a major depressive episode in adults aged 18-54 in the US has an annual prevalence estimate of over 5%⁶. Clearly, work in medicine should not be considered a mitigating factor in this – in fact, a Canadian study has found affective disorders among Family Practice Trainees to be three to four times more common than in the general population⁷.

We must be open to discussion of mental health issues in a way that nurtures insight and trust within the profession, and at all levels. It is time for more individuals in medicine to “come out”. As highlighted in a recent address by Gordon Parker of the Black Dog Institute⁸, no one of significant stature has yet done so, while in the other professions, in the corporate sector, the sporting world and in politics, many have.

We must continue to be there for individuals and their families. The invaluable work of the Doctors’ Health Advisory Service and Medical Benevolent Association should be acknowledged widely and supported by all. I would advocate also that those who have suffered, *if able*, are encouraged to be available for others, to share their experiences through programs of awareness raising and support, and that such programs, where they do not already exist, should be instituted by Faculty, Professional Societies and the Learned Colleges.

There is work to be done if this illness is not to continue to exact a toll on our profession.



Doctors represent an at risk group, yet there is little focus on how health outcomes can be improved.
Narelle Shadbolt



Dr Narelle Shadbolt, left, is a senior lecturer in the Faculty of Medicine, Discipline of General Practice and Associate Dean, Student Support. Understanding and assisting medical students and members of the profession who experience health problems, both physical and mental, is a long standing research and professional interest.

IS BEING A DOCTOR BAD FOR YOUR HEALTH?

by Narelle Shadbolt

PERCEIVED BARRIERS TO CARE FOR DOCTORS:

- Lack of time
- Confidentiality concerns
- Stigma
- Cost
- Documentation on academic record

DOCTORS HEALTH

- Cardiovascular disease: lower than general population
- Smoking related cancer: lower than general population
- Stroke: lower than general population
- Cirrhosis: lower overall, but higher in some groups (eg anaesthetists)
- Motor vehicle and other accidents: higher
- Depression: up to two times higher
- Suicide: up to five times higher

THE CHANCE OF DYING BY SUICIDE^{1,2}

- Males: 70% higher than non physician
- Females: 250-400% higher than non-physicians

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WHAT DO WE KNOW ABOUT THE HEALTH OF DOCTORS?

In recent years this has been the subject of discussion, surveys, research studies, concern and consternation. Studies from around the world are remarkably consistent in their findings: firstly, that doctors are people and therefore just as likely as anyone to suffer from medical problems. As a group, doctors are somewhat less likely to suffer from lifestyle-related illness such as heart disease and illnesses linked to smoking. But doctors also have much higher rates of psychological and psychiatric illness, drug related problems including alcohol; and tragically, greatly increased rates of suicide.

Doctors represent an at-risk group, and yet there is little focus on how health outcomes can be improved.

So we have to ask some questions. Who are doctors?

Is there something different about this group of people that makes them particularly vulnerable to psychological problems? Is there something about medical training and the medical work environment that affects the health and wellbeing of doctors? Why is the health and wellbeing of our medical workforce important? And how can we create a culture in the medical profession that promotes and fosters the health and wellbeing of its members?

Many of the traits that make doctors good at their jobs also make them vulnerable. They tend to be hard-working, pay great attention to detail, are well organised, self-sacrificing and confident. When paraphrased, many of these characteristics equate to the obsessive personality trait. In a study of medical students and junior medical officers up to 70% of the cohort met the criteria for this trait – the rate in the general community being around 30%.¹ These people are more vulnerable to depression and anxiety.

Medicine is a stressful job. This makes it interesting and exciting. Some stress improves performance. There are many external stressors for doctors: the health system, on-call demands, medico-legal issues, financial pressures, competing demands of job and family. When stress is unrelieved, it results in distress and other problems arise – physical illness, depression and anxiety, drug and alcohol use, relationship problems and withdrawal from work.

There is increasing evidence in the world literature that doctors who are unwell both physically and psychologically

may provide less than optimal care^{2,3} and that those who practice healthy lifestyles are more likely to promote preventive health practices to their patients.^{4,5} One very recent study makes a direct link between burnout in doctors and lower patient satisfaction and longer recovery times in patients. Several studies now link doctor fatigue to increased adverse clinical outcomes.

FOCUS ON HEALTH, NOT ILL-HEALTH.

Many of these factors are, no doubt, at work in other professions. An additional problem for doctors, though, is their attitude to their own health and their reluctance to behave like other patients. Many doctors are uncomfortable to ask for help or see another doctor for their own health, and may instead self diagnose and self treat or simply suffer in silence.

When talking about doctors' health, there is a tendency to focus on ill-health and impairment. This focus shuts the gate after the horse has bolted. As a profession we need to place more importance on health and wellbeing and sustaining a rewarding career in medicine. A culture which discourages inappropriate healthcare behaviours and places value on practices that maintain health and enjoyment in work must, in the end, be better for patients as well as doctors and their families. This will require a little soul searching.

Endnotes

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WHEN DOCTORS DOCTOR DOCTORS

by Narelle Shadbolt

*'Illness doesn't belong to us. It belongs to them, the patients.'*¹

Statistics from around the world confirm that doctors are an at-risk population, with higher rates of depression and anxiety, stress-related illness and, unfortunately, alcoholism, substance abuse and suicide.

And yet doctors find it difficult to access appropriate health care. Equally, when confronted with another doctor as a patient, the treating doctor can be overwhelmed, take short cuts, ask the doctor-patient to self-diagnose or just simply chat about the latest crisis in the health system and avoid the whole encounter.

Doctors who have been ill report both anecdotally and via surveys that because they were a doctor, they were inadequately informed about their progress and follow-up and were not offered enough psychological support. In studies of the health care behaviours of doctors up to 30% report having suffered from a medical condition they would like to have discussed with a clinician but did not do so because they were a doctor.² Those contemplating consulting another doctor for their own health express concern about confidentiality, lack of confidence in a treating doctor and embarrassment about how to behave in the consultation: "do I need to have made the correct diagnosis before I go?"

As much as we try to normalise the situation, there is something unique about the therapeutic encounter between a doctor and a doctor patient. The usual model: doctor – healthy, wise and trained; patient – sick, naive and untrained, no longer applies. The treating doctor has no specific training for this encounter and he or she may feel insecure and fearful of criticism. When your patient is a doctor there is a strong sense of identification with their situation which, together with an exaggerated sense of responsibility can result in a loss of objectivity.

Sometimes this results in the treating doctor unburdening their own issues and fears with the doctor patient. There may be a reluctance to ask about important

but sensitive areas such as drug and alcohol use, sexual problems or mental health issues. There may be a wrong assumption that the doctor patient would disclose any important symptoms and therefore these may not be specifically asked about as in any other consultation. There may be a reluctance to do a thorough physical examination.

When a doctor presents for medical attention they are often in crisis. They have usually waited too long and there is a need to respond quickly. They may have partially investigated and treated themselves and fear disclosing this. They often feel isolated and even ashamed. We know that doctors like to be in control, and this sense of lack of control is heightened by a fear of illness. Doctors may be obsessive and perfectionist and, as a patient, this means they want to get better immediately and may deny or minimise symptoms; they want to please the treating doctor and may not report treatment failures or non compliance.

TO BILL OR NOT TO BILL?

There is a question to be answered here. There has been a long standing tradition of not charging colleagues. However, non payment for a professional service, may lead some to devalue that service and the doctor patient may feel they are wasting time, that they have to organise part of the investigation or treatment themselves, or not ask questions, or come for follow-up. This may increase rather than decrease the difficulty and it is an area that should be discussed.

BEST PRACTICE

So there is learning to be done on both sides. When your patient is a doctor treat them as any other patient: with empathy, respect, confidentiality, thoroughness, and professional objectivity. Don't make assumptions and take responsibility for examination, investigation, treatment and follow-up. Give them permission to be in the patient role. Everyone is going to be sick sometime and everyone – even doctors – need to allow themselves to be a patient.

Endnotes

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WALKING THE TIGHTROPE OF A MEDICAL LIFE

by Katherine Jeffrey

On the 19 January this year, 670 new interns commenced work in the NSW health system. In recent weeks, they have faced front page headlines calling the health system a basket case, stories from across the state of failures of an under-resourced and over-stretched system. Imagine walking into this as a new intern, ready to use your medical knowledge but concerned about the pressure you will face working the wards. As a junior doctor myself, I faced these same pressures two years ago when I commenced my internship. I still see them today as a senior resident medical officer (PGY3).

In 2008, the Australian Medical Association (AMA) released a survey on the health and wellbeing of junior doctors.* It was an attempt to provide a snapshot of the health and wellbeing of junior doctors, and looked at how they were coping with pressures associated with a medical career.

Mostly junior doctors reported that their career in medicine was rewarding but demanding, with a cost to their emotional and physical health. This has been reflected by the increasing number of doctors, particularly junior doctors, seeking assistance from organisations like the Doctors' Health Advisory Service (DHAS).

What strategies can junior – and senior – doctors use to maintain their emotional and physical health while balancing the demands of medicine?

Have a good GP

71% of junior doctors surveyed in the AMA survey reported concerns for their physical or emotional health. 66% reported having their own GP. A GP is essential for continuing health and preventative health measures.

Take regular leave

77% of respondents had taken only one week of leave. Take your allocated annual leave and ADOs. It can be difficult to obtain but is essential for your own health.

Have a life outside of medicine

Social activities, hobbies, sport, reading, movies, theatre.

Find a mentor

Usually it is a senior clinician and can be an excellent resource. They can discuss career options, talk through concerns, advise on strategies for tough times. 5.9% of junior doctors surveyed had spoken to a mentor as a coping strategy.

Support network

30.3% of junior doctors spent time with family and 29.2% spent time with friends as a coping strategy for work related stress.

Regular exercise and sleep

16% of respondents used exercise as a coping strategy for stress. Not only is it a stress release, physical fitness improves your health. Get a personal trainer to motivate you.

45% report sleeping less than 6 hours a day. Sleep deprivation has similar effects on mental concentration as heavy alcohol consumption.

Look after you colleagues

63% reported concerns for the health of a colleague. If you think someone is struggling, provide support, offer help, encourage them to get help. If concerned for a colleague's health, contact the Doctors' Health Advisory Service (DHAS) in your state for advice.

Debrief

Formal or informal, with doctors or friends. Over coffee, in the common room.

Good time management

Organise your time so you can have time to relax/sleep and do the things you want to do.

Know where help is

DHAS (www.dhas.org.au) operates 24 hour help line on 02 94376552 in NSW. Confidential service.

Medical Board in your state.

The Resident Support Unit in your hospital.

Director of Clinical Training in your hospital.

Beyond blue www.beyondblue.org.au

Lifeline (www.lifeline.org.au, 24 hour help line on 13 11 14)

* AMA Survey Report on Junior Doctor Health and Wellbeing" (<http://www.ama.com.au/node/4217>) 2008.

Dr Katherine Jeffrey is a USydMP graduate (Class of 2006) and is Senior Resident Medical Officer (PGY3) at Westmead Hospital. She is the AMA NSW Chair of the Doctors in Training committee, and has a number of other appointments regarding junior doctor health and training.

STUDENT SUPPORT

Most medical students are happy to be undertaking their medical studies, but there is no doubt it is also a stressful time. Balancing study, family life, personal interests and confronting clinical experiences can, at times, be tough. Financial pressures, especially in the current climate, are also extraordinarily worrying for some students.

Supporting students to remain healthy and to keep their lives and studies in balance is important in the University of Sydney Medical Program. The new Student Support Website aims to collect together in one place a range of information that may assist students. This ranges from housing, employment, health and wellbeing, spirituality and many others. Students will be able to find links to services both inside and outside the University.

The website provides contacts for students who need advice or are having difficulties, also links to university policies and processes for those struggling with the academic progress.

Snap Diagnosis

A new photographic test to identify people with obstructive sleep apnoea follows years of research into the facial characteristics of people affected.

By Beth Quinlivan

AFTER CLOSE TO 20 years as a respiratory specialist, many of them spent researching and treating patients with the breathing disorder of obstructive sleep apnoea, Professor Peter Cistulli felt he could almost always identify those affected just by looking at them.

Normally, people are diagnosed with obstructive sleep apnoea or OSA after spending a night wired to a machine in a hospital sleep laboratory.

"I've seen thousands of patients with sleep apnoea and I've thought for ages that there were enough similarities in facial characteristics that we should be able to codify them," he said. "I tried to get a project up five years ago but couldn't get anyone interested. Then one of our PhD students, Richard Lee, recently took it on and he has done a fantastic job."

The result is a new photographic test to diagnose patients with sleep apnoea. It does that by measuring - among other things - the width of the face, the distance between inner corners of the eyes, the width of the nose, the length and width of the neck, the length of the lower jaw and the angle between it and the neck. In all, 71 measurements are taken for analysis, they capture many of the risk factors for OSA.

In January, the results of a trial where the photographic test was used on 180 patients referred for investigation of obstructive sleep apnoea, were published in the journal *Sleep*. * In 76% of patients, it provided the right diagnosis.

Across all facial regions, the test results revealed differences between people with and without OSA. In people with OSA, the mid and lower face, and nose were wider, the distance between the eyes was greater. They also had a shorter and retruded jaw, smaller enclosed area within the lower jaw. Necks were wider but shorter.

"We used to think of people with sleep apnoea as a homogenous group, typically short, overweight, with a thick neck. We now realise that there are other phenotypes, and they all get to sleep apnoea in a different way. In the highest risk group are people who are obese, fat on the neck is a strong predictor. But there are also all sorts of subtle and not so subtle characteristics which are indicative. A small skeleton, for example, is less forgiving in terms of weight gain so people can develop sleep apnoea without putting on much weight at all."

Despite the encouraging results, he says they are at an early stage in the development of the test. The first 180 patients were Caucasian and mostly male. "Next step is to collaborate with a group in Asia and we are doing that now. We also need to include women and children in future studies. But I believe the test has potential."

"There are a number of scenarios for a test like this: maybe a GP practice could use it to identify patients who should be referred on. Even at a consumer level, it might be possible to do it as an internet test so people can administer it themselves as a way of assessing their risk."

A CAREER IN RESEARCH

For Peter Cistulli, the development of a photographic test follows years of interest in facial characteristics as a predictor of obstructive sleep apnoea.

Since 2005, he has been Professor of Respiratory Medicine at the University of Sydney and Royal North Shore, Head of the Department of Respiratory Medicine and Director of the Centre for Sleep Health and Research at RNSH. In the role, he works in close collaboration with the Woolcock Institute of Medical Research.

He graduated MBBS from The University of New South Wales in 1985, and was exposed to the then fledgling world of sleep when he did his internship in respiratory medicine at Royal Prince Alfred Hospital. He was enthused, he says, after working with Professors Colin Sullivan and Ron Grunstein, and others in the "dynamic sleep laboratory team" during his specialist training.

The research for his PhD led to the discovery of OSA in patients with the genetic disorder of Marfan's syndrome. People with Marfan's syndrome, like Abraham Lincoln, are tall and thin, the polar opposites of the short, overweight men who line the waiting rooms in most OSA clinics.

"We had a patient in a clinic at RPA with Marfan's syndrome and he was a curiosity because he was tall, thin, snored and had OSA. After some initial digging and a subsequent formal prevalence study, it turned out that 60% of people with Marfan's syndrome had sleep apnoea. Partly that was due to the inherently floppy tissue in the throat but we then focused on the facial characteristics and asked whether that related to sleep apnoea."

An association with the Sydney Dental Hospital and orthodontist, Dr Richard Palmisano, followed. That in turn led to his involvement from the mid-1990s, while at St George Hospital, in the development and clinical testing of an oral device, worn at night, to prevent mild to moderate sleep apnoea. The device is superficially like a sports mouthguard, and works by shifting the lower jaw forwards just enough to prevent the throat tissues from collapsing and blocking the airways.

For scientists and researchers, the experience of commercialising health technology or medical devices is often an unhappy one. Inventors/researchers frequently find themselves at odds with investors/promoters who have



Peter Cistulli at The Woolcock Institute.

little knowledge of the field, and who are primarily looking to make a quick profit and move on.

The company established to develop and promote the oral device, SomnoMed, was publicly listed in 2004. As for many others, establishing a viable business has not been easy, although things have improved considerably following the latest round of management changes. Sales have grown steadily in the past two years and it is now operating in a number of major international markets. Professor Cistulli was chair of the medical advisory board until 2006.

From this vantage point, he describes the experience as “useful”.

“And I derive some satisfaction from knowing the device is making a difference to the lives of many patients all around the world,” he said.

ESTABLISHING THE DISCIPLINE OF SLEEP MEDICINE

You don’t need to have studied medicine to know that lack of sleep is not good for your health.

It is only in relatively recent times though, since scientists and doctors have been systematically studying the biology and pathology of sleep, that both the causes of sleep disorders and the health problems which result, have begun to be better understood.

Scientists have covered enormous ground in their knowledge of circadian biology, with the discovery of genes that regulate sleep and waking cycles, in the neurophysiology of normal sleep, and in the recognition of interactions between sleep and other body systems. Loss

of sleep for even a short time can lead to metabolic and endocrine changes that are precursors for specific disease states, for example diabetes and obesity.

Sleep loss and sleep disorders, as well as their comorbidity with other substantial health problems such as obesity, diabetes, stroke and depression, are clearly an enormous public health burden.

“Ten years ago, there was a low level of awareness of the burden of sleep disorders, but that has changed. Increased awareness created greater need for clinical services and that is underpinning the need for research,” he says.

Recognition of the need for more professionals dedicated to sleep research and clinical practice has been behind the decision in February by the Faculty of Medicine to establish a Discipline of Sleep Medicine. The steering committee for the new Discipline included Peter Cistulli along with other leading sleep researchers and physicians – Professor Ron Grunstein, Professor Colin Sullivan, Professor Karen Waters, Associate Professor Peter Liu and Associate Professor John Wheatley.

“The firepower in sleep medicine across this University is already second to none. If we can use the opportunity of a new Discipline to bring together the medical specialists and experts from across other faculties, then we are well placed for future success.”

*Prediction of Obstructive Sleep Apnea with Craniofacial Analysis, Richard Lee, Peter Petocz, Tanja Prvan, Andrew Chan, Ronald Grunstein, Peter Cistulli, and Craniofacial Phenotyping in Obstructive Sleep Apnea – A Novel Quantitative Photographic Approach, Richard Lee Andrew Chan, Ronald Grunstein, Peter Cistulli. Both published in Sleep Vol 32 No 1 2009.



New Bernie Banton Centre to Fight Asbestos Cancer

The Asbestos Disease Research Institute at Concord is the world's first stand-alone asbestos research facility.

Beth Quinlivan

PROFESSOR NICO VAN ZANDWIJK is hoping that within five years, the new Asbestos Disease Research Institute will have as many as 50 researchers dedicated to minimising this country's heavy burden of asbestos-related disease.

The Institute, housed in the Bernie Banton Centre at Concord Hospital and established in conjunction with the Faculty of Medicine's ANZAC Research Institute, is the world's first stand-alone research facility dedicated to the prevention and treatment of asbestos diseases.

Professor van Zandwijk, a thoracic oncologist and previously with the Netherlands Cancer Institute, was appointed as its Director in 2007. The ultimate purpose in setting up ADRI is to boost the national research effort in asbestos diseases - important because the human and health costs associated with Australia's early asbestos mining and usage are increasing rapidly.

Asbestos mining finally ceased in Australia just 25 years ago and the country has the dubious distinction of having had the highest per capita usage of asbestos in the world. The legacy is that it now also has the world's highest - and rising - incidence of the deadly asbestos cancer, mesothelioma. About 300 new cases are diagnosed each year in NSW alone, forecasts are that by the middle of this century, mesothelioma is likely to have killed over 20,000 Australians.

"Our aim is to find new ways to treat a disease that is resistant to almost all existing cancer treatments. Mesothelioma is among the most aggressive malignant diseases known, prognosis is typically less than one year from diagnosis to death," said Professor van Zandwijk.

"Despite its impact, we know too little about the mechanisms that produce asbestos cancers to develop effective screening and prevention campaigns."

Several characteristics of mesothelioma provide opportunities for research.

Firstly, the mineral fibre is relatively inert biologically so that the development of mesothelioma must involve

a chain of post-exposure steps. Second, only a small percentage of people who are exposed to asbestos ever develop mesothelioma. And, mesothelioma is almost always diagnosed in its late, untreatable phase, which can be up to 40 years after exposure to asbestos fibres.

But if researchers are able to understand the molecular processes which occur during the long period between exposure and diagnosis - as they have been able to do with, for example, colon cancer - they may be able to identify ways to stop or slow the progress of the disease.

With colon cancer, research has identified clear steps in the slow progression from normal cells to pre-malignant colonic polyps and finally to invasive, fatal colon cancer. Screening programs and early treatment if polyps are found, have been very effective in reducing the burden of fatal colon cancer.

"We are in the period of molecular medicine, and I am quite optimistic that we will in future be able to identify the critical pathways with mesothelioma," he said.

A priority is the development of a tissue bank, to underpin research efforts.

The Bernie Banton Centre was officially opened in January by the Prime Minister Kevin Rudd and NSW Premier Nathan Rees. The Prime Minister at the time announced a further \$5 million in funding, to go towards fitting out the Centre's research laboratories and to establish a new animal research facility.

The Centre was named in honour of Bernie Banton, who spent the last five years of his life fighting for compensation for people who had contracted mesothelioma or asbestosis through exposure to James Hardie products.

The University of Sydney contributed \$5 million towards the establishment of the Asbestos Disease Research Institute. Further funds came from the Dust Diseases Board of NSW, ANZAC Research Institute, James Hardie Industries, NSW Health and Sydney South West Area Health Service.



Professor Nico van Zandwijk.
The Bernie Banton Centre.

TAKE ON THE WORLD



Ineke Wever
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Sydney medical students taking over the world

We all know that this university's medical program produces outstanding students and graduates. Many apply to come to Sydney because of its history and the list of notable graduates. But this year, students really are making their mark on the world!

The General Practice Students Network (perhaps the most well funded medical student society after former Health Minister Tony Abbott's \$1 million parting gift) is being chaired this year by Elina Gourlas, a final year student from Sydney University. GPSN aims to get students thinking about General Practice as an attractive specialty choice, and to raise the profile and quality of teaching within general practice rotations.

The NSW Medical Students Council represents medical students on a state level and has been at the forefront on the contentious issue of intern training (NSW graduates will double from 2007 numbers, from 538 to 1042 in 2012). Sydney University final year student, Theresa Ly, will serve as Secretary for the NSW MSC in 2009.

The Australian Medical Students Association, the peak representative body for medical students nationally, is being run this year by a combined team from Sydney University, University of New South Wales and Wollongong University. Five Sydney University students, Genevieve Peek (Community Officer), Geoff Collins (Treasurer), Elise Coker (Public Relations), Jon Noonan and Jeff Ann (Marketing and Sponsorship) will contribute to this team for 2009.

Congratulations are in order for all of these champions for our cause. Sydney University Medical Society is well placed in NSW to engage with these key organisations, and other movers and shakers.

We have also said goodbye to the 2008 Council and welcomed in the 2009 Executive: Susanna Lam and Rahil Nagpal as 3rd Year Vice Presidents and Hugh Harricks and Tim Coughlan as 4th Year Vice Presidents. They will want to hear from you!

Student feedback

Within our own medical education world, we have seen the Curriculum Review of 2006 produce some significant changes. The revamped structure of Stage 1 was received positively last year, and this year will see the structure of Stage 3 (clinical years 3 & 4) change to have third and fourth year students together streamed into rotations, and have third and fourth year as a mix of general medicine/surgical attachments and specialty rotations (previously specialties were only in fourth year). I hope that MedSoc will be able to gather student feedback on this transition and take on a truly representative role to the Faculty.

2009, exciting electives, and more

The new first year cohort arrived on February 9, incoming second year students started Neurology on February 13. Our third year students started their clinical year on Jan 21.

As for my final year cohort, most spent their Christmas away somewhere very exciting in their elective term. I have friends who worked in public health in Rwanda, trauma in South Africa, internal medicine in Papua New Guinea, cardiology in Edinburgh and general practice in Exmouth - all of which makes for a very jealous time on Facebook when photos are shared.

I spent my time on campus, dissecting my way through the seven week full body anatomy-by-dissection course. Run by the ever enthusiastic and patient Professor George Ramsey-Stewart, it was a great way to spend my Elective. My appreciation for anatomy as the basis for the practice of medicine grew from the first week - as did my dissection skills (which were lacking!). This course is quite 'old school' since the requirement to dissect has not been compulsory for some time at Sydney University or any other medical school in Australia.

I have had the recent pleasure of meeting Paul Lancaster, President of the Medical Alumni Association and I thank this Association for its enduring support of medical students. MedSoc would like to build a good relationship between alumni and current students, any suggestions and ideas would be most welcome. You know how to find me.

Top: 2009 Medsoc Council
Bottom: Medical students voicing concerns



LEAVING A LEGACY

Each year, the Faculty of Medicine's research, teaching and clinical services programs are greatly boosted as a result of the bequests and memorial gifts received from alumni and friends.

In the latest year, income from such donations has funded a range of important initiatives. These include the establishment of a much needed centre to gather evidence on drug treatments in children, to support a number of new chairs, and a wide range of scholarships for students and researchers.

THE AUSTRALIAN CHILDREN'S CLINICAL TRIALS CENTRE

Established 2008, initial funding from the Jackson bequest.

One of the critical issues in contemporary drug treatments for children is the lack of evidence-based research. The inadequacy of current research on drug treatments, and the importance of having a specialist paediatric clinical trials centre in NSW, has been widely acknowledged for some years. A report in 2005 by eminent paediatric researchers in conjunction with the NSW Government, recommended the establishment of a formal network to exchange paediatric expertise, in particular research into children's medicines. Scarce health resources, though, meant such a specialist operation had struggled to secure public funds.

A \$540,000 bequest received late in 2007 from the Estate of the late Lesley Alfred Jackson, has allowed the Faculty to provide the seed capital necessary to establish the Australian Children's Clinical Trials Centre at The Children's Hospital at Westmead.

The director of the Centre, Professor Jonathan Craig, describes children as "therapeutic orphans."

"Eighty percent of the drug treatments that are given to children do not have any safety or efficacy data. The reasons for this are complex, but include the much smaller commercial market for drugs designed to improve the outcomes for children," he said.

"Unfortunately disasters occur like the grey baby syndrome and thalidomide babies. More recently the dangers of some antidepressants in adolescents have been recognised. The Jackson

bequest will allow the development of a clinical trials centre which will evaluate the safety and efficacy of older treatments, and of new and promising interventions, so that the health of children can be improved and not harmed."

Dr Kimberley Lilischkis has been employed as the project co-ordinator. A cancer researcher with local and international experience in coordinating medical research projects, she is confident that the work of the Australian Children's Clinical Trials Centre will improve child specific treatments and therapies for children around the world.

"Health experts agree a child should not be treated as a mini-adult and that children of different ages respond differently to adults in the way they absorb, distribute and metabolise drugs, and respond to therapies, many drugs prescribed for children have never been tested in children. This figure increases for specialty drugs. As adults we know any approved drug we take has met the rigorous standards of safety demanded by our regulatory system. Such is not the case for children," she said.

The Children's Hospital at Westmead is the perfect home for the Clinical Trials Centre. It has a long history of top level medical research, with more than 250 research staff working across 30 groups. With the Centre based at the hospital, multi-disciplinary teams of professionals with complimentary expertise – paediatricians, clinical pharmacologists, nurse research coordinators, and pharmacists – are well placed to work together to achieve the best possible outcome.



“I want my bequest to help students involved in important research so they can realise their potential and make a difference to people’s lives.”
 Jennifer Foong (MBBS 1988)

MELANOMA BIOLOGY RESEARCH

Donation in memory of Dugald Cameron

In November 2008, Mrs Janet Cameron, through Grant Broadcasters, donated \$500,000 to the Melanoma Foundation in memory of her late husband, Dugald. The donation will help to establish a Chair of Melanoma Biology within the Faculty of Medicine.

“Dugald was intensely interested in biological research and before his untimely death from melanoma, he had already funded four Cameron Melanoma Research Fellowships to encourage young researchers to make melanoma biology their field of interest. This new donation will greatly assist us in moving to provide full funding for a Chair,” said Professor William McCarthy, Treasurer and Vice Chairman of the Melanoma Foundation.

Professor William McCarthy and Professor John Thompson with Mrs Janet Cameron and her daughter, Ms Alison O’Neill.



young researchers and so we put in place a number of generous bequests in her Will”, he said.

These bequests included \$500,000 to the Medical Foundation for eye health and clinical ophthalmology, \$400,000 to the Faculty of Medicine to fund scholarships in child and adolescent health, and \$600,000 to the Faculty of Health Sciences for scholarships in rehabilitative therapy, speech pathology and physiotherapy.

For Kimberly, the scholarship has made all the difference. “It has enabled me to purchase textbooks, cover the cost of tuition and research materials, as well as take time out from my jobs to work on my thesis. I am so grateful to Miss Douglas,” she said.

Kimberly hopes to continue working in the field of paediatric rehabilitation and particularly with children experiencing disability and disadvantage.

Donations & Bequests

If you would like more information on making a donation or a bequest to support medicine, please contact Amanda Durack or Beth Quintlivan in the Faculty of Medicine Development Office on (02) 9036 7185.

LEAVING A LEGACY

Dr Jennifer Foong (MBBS 1988) recently contacted the University to put in place arrangements to leave a lasting legacy. Her generosity is much appreciated.

“Studying medicine was a personal goal and a family tradition. I hope that other alumni might consider a bequest to the University, if like me, they were lucky enough to receive an excellent education that set them on the path to a rewarding career. I believe Sydney is the best University and I want to give something back to help others. I want my bequest to help potential PhD students involved in important research so they can realise their potential and make a difference to people’s lives. In particular, I want to support those gifted students who might not otherwise have the financial means.”

Jennifer Foong



STUDENT SUPPORT

Research scholarships, from the Estate of Lola Douglas.

To complete her Health Science degree in Rehabilitation Counselling, Kimberly Dickens was having to juggle her full time University workload with two jobs.

“Finances had always been a concern to me as I had had to live away from home and support myself from day one. I had just about managed to do this for the first three years of my course by working two jobs and studying,” she said.

Approaching her fourth year, she particularly needed to put extra time into her honours thesis in paediatric rehabilitation and did not know how she would be able to keep the two jobs going. It was with this background, she applied for – and was awarded - the Douglas and Lola Douglas Scholarship in Child/Adolescent Health. The \$12,000 scholarship had been made possible through a bequest from the estate of Miss Lola Douglas.

“Lola Douglas gave generously to many charities over the years,” said her solicitor, Mr Neil Geikie. “She was particularly interested in children’s health and it was one of her great wishes to support

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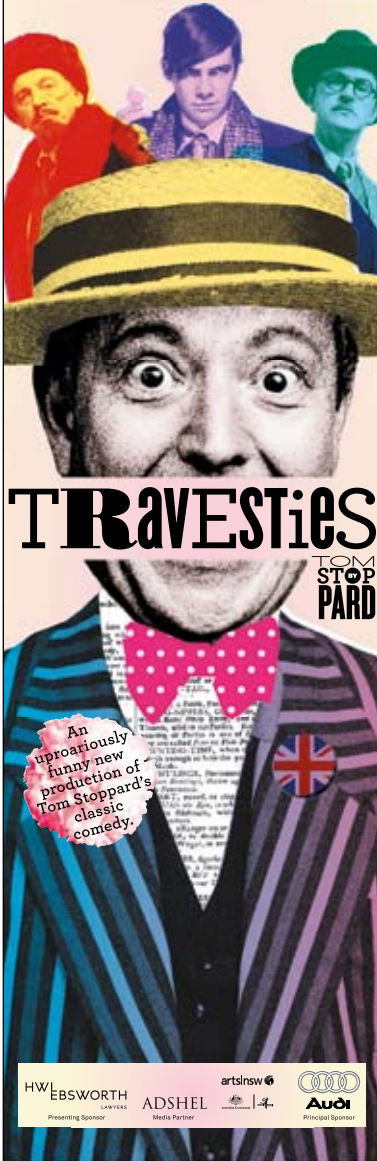
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| President's Report |
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president's report

Welcome to another year of Radius and to your Medical Alumni Association (MAA)!

Thank you to everyone who has complimented Beth, the editor of Radius, for its attractive and appealing presentation and content. I also thank those who responded with comments on issues raised in the December e-Newsletter, especially with suggestions for continuing education of retired colleagues.

As we plan for the year ahead, we are keen to offer our alumni many varied opportunities for participating in educational and social activities. These include continuing with medical education, student mentoring, becoming problem-based learning tutors, and coming back to your University for wide-ranging talks and other functions.

CONTINUING MEDICAL EDUCATION. Some members of the MAA Council think that we already have sufficient educational programs conducted by professional Colleges, the AMA and through hospital lectures and seminars. Yet many replies to the e-Newsletter indicated that the needs of retired and part-time doctors are not being met, also keeping in mind our colleagues beyond Sydney.

We are planning to organise educational programs on two weekends during the year, in May and in October or November. Another series of evening talks will keep alumni informed about current health and medical research within the Faculty, ideally to be held in various teaching hospitals as well as at the University.

Other general educational programs likely to be attractive to our alumni are held at the Menzies Centre for Health Policy, monthly Medical Humanities Nights, Medical Education Forums, and at the University of Sydney Institute for Sustainable Solutions.

For alumni in the United States and Canada (we think there are well in excess of 400), the initial meeting will be held in Los Angeles on 20 August, in conjunction with the annual meeting of the Sydney University Graduates Union of North America (SUGUNA).

STUDENT MENTORING. We are discussing with the Dean, Associate Deans and student representatives whether and how alumni can assist our students by advising them on their future careers and giving general advice about their GMP course and life in Sydney. Ideally we should begin with a pilot plan in one or several teaching hospitals. Please inform Diana Lovegrove if you would consider participating and send me any other comments on how a suitable scheme for mentoring could be implemented.

PROBLEM-BASED LEARNING (PBL) TUTORS. The Faculty often receives comments from students that they prefer tutors who work in clinical practice. Please contact Diana Lovegrove if you can assist with tutorials after completing a training session.

SYDNEY'S MEDICAL MOSAIC: TELLING OUR STORIES. We are planning to hold a symposium later in the year to encourage alumni who would like to contribute ideas and material on the role of generations of our alumni in clinical practice, professional Colleges, medical education, city and regional hospitals, and in the wider community. I have discussed ideas about this symposium with Stephen Garton, Challis Professor of History and Dean, Faculty of Arts, and Claire Hooker, Senior Lecturer, Medical Humanities, in the Faculty's Centre for Values, Ethics and the Law in Medicine. More details will follow.

FACULTY WEBSITE AND MAA E-NEWSLETTER. As it is published quarterly, Radius cannot provide regular information needed to inform you about these educational programs and other events. All these activities will be publicised through the e-Newsletter, and on the Faculty website (www.medfac.usyd.edu.au) which is now being redesigned. If you are not receiving e-Newsletters, remember to send your email address to Diana Lovegrove (d.lovegrove@usyd.edu.au). It can also be seen on the Faculty website. If you have suggestions or comments for the e-Newsletter, send them to me (pallancaster@gmail.com). If you do not have access to the internet and email, ask a friend to keep you informed!

Sam Stening

PAEDIATRICIAN,
NAVAL OFFICER,
POW SURVIVOR

by Ian
Pfnigwerth

Sam Stening was the medical officer aboard the HMAS *Perth* when it was destroyed in 1942 at a cost of more than 400 lives. Wounded but rescued, he spent the next three years in POW camps in Japan, caring for the sick and dying in often atrocious conditions.

When the war ended, he returned to Sydney to pursue a distinguished medical career as a physician, teacher and researcher. His life is the subject of a new biography: its author, naval historian Ian Pfnigwerth, is a former commander of HMAS *Perth* II. He is keen to make contact with medical colleagues, students and patients who can assist him in his research. His email address is pfnigns1@bigpond.com

SAMUEL EDWARD LEES STENING – Sam - was the second of four boys, all of whom became doctors. Even more remarkably, all four joined the armed forces during World War 2, all served overseas, and all survived. While researching my book on that most gallant ship and her company, Sam's escape from the sinking HMAS *Perth* in March 1942 drew my attention. Now I'm writing his biography.

Sam won a scholarship to the University of Sydney at age 15. He graduated from Medical School in December 1932, remarked upon in his Yearbook entry as 'Sam, with his snowy head, cheery countenance and happy care-free outlook on life'. After four years residency in three Sydney hospitals, and post-graduate studies in London in 1937 - 38, he set up in general practice in Sydney and also worked as a relieving assistant physician at Royal Alexandra Hospital for Children.

In September 1939 Sam joined the RAN Reserve and, after service in cruisers, he was posted to the destroyer HMAS *Waterhen* in the Mediterranean, ferrying men and supplies into and out of Tobruk. However, in June 1941, she was sunk by German bombers and Sam became Assistant Surgeon in the light cruiser HMAS *Perth*. She had been damaged during the evacuation from Crete in June 1941 but participated in the Syrian campaign in July, before returning to Australia for repairs.

In February 1941, *Perth* was ordered to the Netherlands East Indies to join a British, Dutch and American striking force defending Java against Japanese invasion. Stening was to have been relieved before the ship sailed but his relief did not arrive, so he was onboard *Perth* during her final battle in Sunda Strait. Loss of life was heavy and Sam was the only medical officer to survive. Picked up by a Japanese destroyer, he was imprisoned in Serang Gaol in western Java, where he did his best to minister to the needs of the survivors from his ship and USS *Houston*.

Stening was soon shipped to Japan, arriving in May. His post-release interrogation report has a certain amount of detail about his ordeal in Japan, but I needed more. I was fortunate in attracting a grant by the Australia-Japan Foundation to seek out Sam's camp sites and to interview Japanese associated with the camps or the POWs. Last year I visited Japan twice, becoming a lot more knowledgeable on the POW story. A lot is unpleasant, but not all. The Japanese people retained some sympathy for the plight of the prisoners, with many individual acts of kindness and marks of respect paid, at a time when life for the vast majority of Japanese was bad and getting much worse.

After interrogation at a special Navy camp, and a few months in a 'show' camp for Allied officers where he was not allowed to treat fellow prisoners, in late 1942 Sam



In later life.
Rowing for Sydney University.



COMPILING HIS BIOGRAPHY

My current task is to research Sam's subsequent medical career. The bare bones of it are that in 1946 he resumed honorary work at Royal Alexandra and in 1947 was a senior honorary paediatrician at Crown Street Women's Hospital – a role he continued in until 1983. In 1960, Sam became Chairman of the Medical Board at Royal Alexandra. He helped found the Australian Paediatric Association, served 10 years on Consultative Council for the Physically Handicapped, was an Examiner in Paediatrics for membership of Royal Australian College of Physicians, became a member of the Research Committee of Children's Medical Research Foundation, and was a lecturer in Paediatrics at the University of Sydney.

In this part of the research task I have kindly been offered the cooperation of many of the medical associations to which Sam belonged, but I would really like to make contact with people who knew him personally – colleagues, students, even patients who can bring to life the activities and achievements of this outstanding physician.

joined an Allied 'Emergency Medical Team' formed by the Japanese to stem the appalling death rate of POWs. As the casualties resulted from systematic starvation and ill-treatment, and withholding of appropriate medical treatment, the Allied doctors and corpsmen could do little. Sam's first experience was with survivors of a particularly gruesome 'hell-ship' whom he treated at Shimonoseki Quarantine Station, essentially making the dying comfortable and spending most time with those who might survive.

Sam was then detached to two shipyard camps in Nagasaki, where the POWs' work was dirty and dangerous, and camp personnel were reluctant or unable to provide adequate medical supplies. However, Sam was able to run an effective First Aid post at the more sympathetic shipyard. Then in May 1943, he was sent to the infamous Osaka Ichioka 'Hospital'. It was Shimonoseki all over again, with an appalling death rate and an uncaring camp staff who stole the meagre rations of sick prisoners.

Stening's most challenging assignment came in October 1943 as the only officer in a camp called Oeyama, near Miyazu on the Sea of Japan, where between 200 and 300 British and Canadian POWs worked in a nickel mine and smelter. During Sam's nine months at Oeyama, 38 prisoners died - 25 in February 1944 alone. With bad weather and worse food, little clothing in the bitter winter weather, and worked hard by the Japanese foremen and beaten by camp guards, prisoner discipline was poor, leading to more punishments. Stening asked for and was given responsibility by the Japanese for the prisoners' discipline, which he exercised through senior non-commissioned officers. While these sometimes abused their positions or did the bidding of camp guards, in general, this unique arrangement worked for the POWs' benefit.

Sam's last two camps were in Osaka Taisho and at Takefu in Fukui Province.

Taisho was a hard camp although an effort had been made to provide appropriate facilities for the POWs, comprising 200 Australian Army. The men worked in a nearby shipyard but an issue of Red Cross parcels softened the winter of 1944. A Japanese officer came to live in camp, curbing the guards' brutality towards the prisoners. The growing intensity of the American bombing campaign forced the evacuation of the camp to Takefu. The Australian officers were detached and from March 1945 Sam was again the only officer in the camp, with 167 Australian Army and 33 US Navy POWs. The prisoners worked in a carbide factory in dangerous, dirty and dusty conditions. Despite cramped quarters, food and clothing supplies were reasonable.

To the POWs' surprise, work ceased on 15 August 1945 and on 24 August they were allowed out of camp. Stening accepted control from the Japanese on 2 September, and the Australian and American flags were hoisted. Having treated Allied and Japanese casualties from the 44-gallon drums of stores dropped by the US Air Force, Sam departed with the other prisoners for Yokohama on 10 September. Following interrogation by Allied War Crimes Unit in Manila, he arrived in Sydney on 9 October 1945. He was promoted Lieutenant Commander from September 1945 and in May 1946 was awarded the Distinguished Service Cross for his conduct during and after Perth's last action – a remarkable event. [radius](#)



case notes

1950s



**Anthony Reading
(MBBS 1956)**

Living in Panama City Beach, Florida, USA. I retired 4 years ago after 28 years as Professor and Chair of the Department of Psychiatry at the University of South Florida in Tampa. I am currently reading a lot, writing a second book, and playing tennis 3 times a week. This book is about the nature of information; the title of the 2004 one was "Hope and Despair: How Expectations of the Future Shape Human Behavior." I am in reasonably good health and happily married, with two grown daughters and four wonderful grandchildren.
tonyto@comcast.net



**Robin Fraser
(MBBS 1958)**

At 75, I am still Coroner's Pathologist and Emeritus Professor of the University of Otago, Christchurch; passionate about research-

based teaching of medical students and also the public by hosting our research groups on TV. As Medical Director of the Canterbury Medical Research Foundation, I support diverse research, but the "liver sieve" is my baby. With David Le Couteur of the University of Sydney, Concord, we believe its porosity, which is influenced by nicotine, alcohol, worry, diabetes and ageing, balances dietary cholesterol with that synthesised by the liver, so linking lifestyles with atherosclerosis. (Google: liversieve).

Age has some advantages. Watching my children and students becoming teachers, researchers, historians, lawyers and engineers. Grandchildren on the beach. Proud of my wife Linda, previously hepato-ultrastructuralist, now a Director of Mary Kay. An ONZM for services to medical research (my hobby!) The Great Hall and graduations. Our happy 50th medical reunion, but sadly Hux, our class favourite and my best mate, has since died. Currently living at 45 Kidson Terrace, Christchurch 8022, New Zealand.
robin.fraser@otago.ac.nz

**Tibor Pietzsch
(MBBS 1959)**

Living in Townsville, North Queensland. I am in part time General Practice in a group practice in Townsville, semi retired, and only working 4 half days. I am a Designated

Aviation Medical Examiner for CASA as well as VMO to the Mater Hospital in Townsville. I have a University appointment to the James Cook University of North Queensland as a Senior Lecturer to the School of Medicine and am still very involved in teaching medical students. I am a life member of the Air Force Association (USA) and emeritus member of the Aerospace Medical Association. Also member of the Australasian College of Tropical Medicine. I have retired from the RAAF with the rank of Squadron Leader and have recently been awarded the Australian Defence Medal. I have two sons and two daughters. My youngest daughter is studying medicine at Griffith University in Brisbane and my other daughter works and lives in Dubai. Have just returned from Italy where my eldest daughter, Heidi, was married, near Siena, to Adam Kurth from the USA. They both now work in Dubai.
pietzsch@westnet.com.au



**William McCarthy
AM (MBBS 1959)**

I trained in medical education at the University of Illinois (M.Ed) and further surgical training

at Kings College Hospital and Whipps Cross Hospital before returning to Sydney University for an academic career in surgery. Surgical interest became entirely melanoma and I directed the Sydney Melanoma Unit for the last 15 years before retirement at age 70. Medical education was also an absorbing interest for me. I gained some public recognition for melanoma educational programs and received the Order of Australia in 1992 (AM). I initiated and developed the Melanoma Foundation, which has provided more than \$20 million for melanoma research and education in the last 25 years. I am happily married to Mavis with three daughters, one son, and six grandchildren. We have a small farm near Nowra, play tennis and enjoy movies, plays, opera, concerts, and travel.



**Diarmid Mckeown
AM (MBBS 1959)**

My wife and I moved to Canberra in 1969, to commence my practice in General Surgery. After 30 years, I retired in 1999, and spent a year at Sturt School for Wood to acquire the necessary skills to enjoy making furniture. Having both completed Arts

Degrees, majoring in Italian, Art History and Archeology, we have enjoyed many trips to Italy, looking at archeological sites there as well as in various countries. Our four children all left Canberra for Sydney and Melbourne, producing 2 grandchildren to date.

**James Graham McLeod
AO (MBBS 1959)**

After general medical training at Royal Prince Alfred Hospital 1959 - 63, I trained in neurology at the National Hospital for Nervous Diseases, Queen Square, London and the Harvard Neurology Department at the Boston City Hospital. I was appointed Professor of Medicine at Sydney Hospital 1972-8 and then Bushell Professor of Neurology and Bosch Professor and Head of Department of Medicine at University of Sydney and RPAH and in 1978 Head of Department of Neurology at RPAH. Sub-Dean (Clinical) and then Pro-Dean Faculty of Medicine 1972-1994. I retired 1997. Professional activities have included membership of the Australian Science and Technology Council (1987-1993), Medical Research Committee NH&MRC (1985-1993), and President Australian Association of Neurologists (1981-4). I married Robyn Rule in 1962, and we have four children and nine grandchildren.



**Howard Peak
OAM (MBBS 1959)**

My year was the first year of sub-specialties in medicine.

Until then, our Mentors were Physicians, usually with a special interest in which they excelled. After overseas training post-RPA, I came back as Hon Assistant Physician, only later being given a position as Hon Assistant Cardiologist.

The challenge came up in 1971 - to set up cardiology in Canberra. It meant I limited myself to only seeing cardiac patients, and I don't regret it.

Initially I was in private practice but in 1975, I became Director of Cardiology at the Royal Canberra Hospital.

Canberra was great for our 3 children, with its open spaces, good schools, and proximity to bushwalking and family bike trips. The arrival of the mobile phone at last gave freedom to move around.

I became a licensed Lay Minister in the Historical Anglican Church of St John the Baptist. It had a welfare arm "St John's Care" and I became chairman of the managing committee.

Looking back on my medical career, I feel we were fortunate to do it when we did, lucky to start with clinical bedside deduction

with Professor Lambie's two-tome guide! There was more thinking and fewer tests then.

I retired at midnight 1999, but continued for a couple of years in private practice until moving to Sydney.

1960s

**Frank Lumley
(MBBS 1961)**

Home is in Orange, NSW. Part time VMO Psychiatrist in community mental health in Orange & Cowra and filling in at Bloomfield Hospital. Teaching reading at local infants school, enjoying 13 grandchildren, cycle riding. Not sure about lawn bowls!

**Michael Marsh
(MBBS 1961)**

Living in Perth, WA and doing general surgery but also locums in the north-west at Port Hedland regional hospital. Have had my second book of a trilogy printed this year and have completed writing my third work "Gnosticism, the Essenes and Christianity. The last one is in the hands of the editor and should be printed in early 2009. marshmjr@iinet.net.au

**Ko Ing Diong
(MBBS 1967)**

I live in Sitiawan, Perak, Malaysia where I am a family physician and a company director of an oil palm plantation. I was recently re-elected as the President of the Malaysian Medical Association Manjung

Chapter and Perak Private Medical Society Manjung Branch. My job is to organise regular monthly continuing medical education, promote fellowship and solidarity among the local doctors, and to serve as a link with the parent organisations. I also serve as an Honorary Physician for the Sitiawan Maternity Hospital and the Manjung Haemodialysis Centre. I am Deputy President of the Chung Hua Association Manjung, besides being active as a Rotarian and in the Sitiawan Senior Citizens Club. I was recently awarded by the Sultan of Perak with an AMP.

1970s

**Roger Wyndham
(MBBS 1970)**

I live in Sydney where I am a renal physician in private practice. I have just completed a Masters in Medical Sciences (Clinical Epidemiology) degree at the University of Newcastle. I am now looking forward to using the degree to set up a community-based preventive program in renal disease in Sydney. wyndham@zip.com.au

**Ivan Goldberg
(MBBS 1971)**

Based in Sydney in tertiary referral private ophthalmic practice in Macquarie Street, subspecialising in glaucoma, engaged in clinical research with fellows and medical students, teaching at under- and post-graduate levels. Official positions: Head of the Glaucoma Unit, Sydney Eye Hospital, and Clinical Associate Professor, University of Sydney.

President of the Australian and New Zealand Glaucoma Interest Group, Immediate Past President of the World Glaucoma Association and the South East Asia Glaucoma Interest Group, and a Past President of the Royal Australian and New Zealand College of Ophthalmologists.

In September 2008, as Chair of the SEAGIG Working Party, released the 2nd Edition of the Asia Pacific Glaucoma Guidelines. These build on the 1st edition published in 2003, and which proved successful in facilitating upskilling of comprehensive ophthalmologists and other eye care workers in glaucoma management. As the core curriculum, these guidelines form the basis of the educational slide kit developed by SEAGIG for

teaching, with unrestricted access on the website www.seagig.org.

Panel member for the NHMRC project to develop Australian glaucoma guidelines and for the Federal Department of Health and Ageing to assess new technologies for the diagnosis and treatment of glaucoma. eyegoldberg@gmail.com

**Peter Wilkins
(MBBS 1972)**

Living in Canberra, ACT. Working in occupational medicine consultant practice with a large medico-legal component. RAAF Reservist work, contract epidemiological work for DVA, contract forensic work for Australian Federal Police. Enjoying travelling, theatre and concert going and wine collecting. Recently joined the Canberra Food & Wine Club and enjoying many new creations and gastronomic / oenological experiences. Completed Master of Letters at UNE in Old English and Medieval Literature. gawaine@bigpond.net.au

Are You Working Overseas?

For the next issue of *radius*, we are hoping to collect stories from our alumni expats.

Let us know what you are doing, how long you have been away from Australia, how you came to be working overseas, what about the experience has been challenging and rewarding.

radiuseditor@med.usyd.edu.au



case notes



**Tony Kwok Hung Chung
(MBBS 1977)**

Professor and Chairman, Obstetrics & Gynaecology and Associate Dean, Faculty of Medicine at The Chinese University of Hong Kong. Active in research; publishing under Chung TKH or Chung T. Currently President of Hong Kong College of Obstetricians & Gynaecologists. Enjoying golf.

tonychung@cuhk.edu.hk

1980s



**Lali Sekhon
(MBBS 1989)**

After working in Sydney at Royal North Shore Hospital, I moved into a private practice neurosurgery group in Reno, Nevada, USA three years ago. The American medical community is very welcoming and I'm having a great time. I married an American eight years ago and we have a one year old daughter and another baby

on the way.
sekhon@nevadaspine.org

1990s

**Michele Franks
(MBBS 1997)**

Living in Allambie, NSW. I completed Emergency Training in early 2004 and I am an Emergency Physician at Manly Hospital. I am also the Director of Prevocational Education and Training (DPET) at Manly. In 2008, I was given an academic title of clinical lecturer in emergency medicine at USyd. I am a clinical skills tutor at the Northern Clinical School. I have been doing a fair bit of overseas travel. Recently, I went on an expedition to Antarctica via South America. My children are now 21 and 15 years old. Am still married to Mark.
mfranks@nscchahs.health.nsw.gov.au



**Jane Gorman
(MBBS 1999)**

Living in Hobart, Tasmania. I quit the NSW orthopaedic training program in 2005 and worked as an ED registrar in 2006. I joined the GP training program in 2007-8 where I am also a medical educator.

I have 6 months to go of my training but am now on maternity leave. I am currently on the board of General Practice Training Tasmania which is great experience. I love general practice and Tasmania and am thoroughly enjoying the lifestyle and Tassie environment. I married another alumnus (Dr Matthew Clougher, BDent 2006) in Jan 2008 and we had our first child, Lucy, in September 2008. I am happily at home changing nappies, singing songs and going to playgroup! I am currently researching the benefits of cloth nappies in practical application.
jane_gorman@iprimus.com.au

2000s



**Anthony Ghaffari
(MBBS 2002)**

Currently doing residency training in neurosurgery in Basel, Switzerland.
anthony.ghaffari@gmail.com

Thank you to all who submitted *case notes*. Lack of space means some have been held over until the next issue.

reunions 2009

Does your graduating year have an important anniversary in 2009? Let us help you contact your fellow graduates, issue invitations and promote your event. Please contact your alumni reunion manager, Diana Lovegrove, on (02) 9036 3375 or by email at d.lovegrove@usyd.edu.au.

GRADUATING YEAR OF 1954

When: Friday, 20 March 2009
Where: Royal Sydney Golf Club
Time: 12 noon
Cost: TBA
Contact: Brian Shearman bmshearman@optusnet.com.au

GRADUATING YEAR OF 1959

When: Saturday, 28 March 2009
Where: The Great Hall, The University of Sydney
Time: 12pm
Cost: \$120
Contact: Bill McCarthy billmcca@bigpond.net.au
Diarmid McKeown dcmdesig@internode.on.net
James McLeod jmcl7953@mail.usyd.edu.au

GRADUATING YEAR OF 1974

When: Sunday 29 March 2009
Where: The Refectory, Holme Building, The University of Sydney
Time: 12 noon
Cost: \$100
Contact: Diana Lovegrove ph: 02 9036 3375
d.lovegrove@usyd.edu.au

GRADUATING YEAR OF 1969

When: Saturday 4 April 2009
Where: The Great Hall, The University of Sydney
Time: Cocktails from 6pm, followed by dinner at 8pm
Cost: \$150
Contact: Ellie Smith ellies@chw.edu.au
Paul Curtin paulcurtin@optusnet.com.au

GRADUATING YEAR OF 1979

When: Saturday 16 May 2009
Where: The Refectory, Holme Building, The University of Sydney
Time: 7:30pm
Cost: \$140
Contact: Marcella Roman mroman@bsp.cm.au

GRADUATING YEAR OF 1999

When: Mid to late October 2009
Where: The University of Sydney
Details: TBC
Contact: Paul Nicolarakis pauln@med.usyd.edu.au

reunion reports

60TH ANNIVERSARY OF THE 1948 GRADUATES

On the 8th of November 2008 at the open day for all graduates of years ending in "8", we were invited to morning tea in the MacLaurin Hall to meet the Vice-Chancellor Dr Michael Spence. Dr Spence welcomed us back to the University and encouraged us to be ambassadors for the University. He also valued our suggestions and criticism, and promised to reply himself to issues which we thought important.

We then proceeded to the Holme Building where a party of fifty 1948 medical graduates and their guests met for drinks on the verandah, before sitting down to an excellent lunch of roast duck followed by crème brûlée with wines.

Peter Harvey reminded us that we had met before in 1978, 1998, 2003, 2005, and 2007. Although our numbers are now smaller, there is a wish to continue.

Our guest was the Dean, Professor Bruce Robinson, who was introduced by Tom Nash. Professor Robinson engaged us all with the development of the curriculum and the opportunities for the wide range of off-campus experiences for undergraduates and the outreach associations that the Faculty has expanded in Asia. He invited us to offer our expertise in the role of mentors to students and teachers. In thanking the Dean, Herc Rose assured Professor Robinson of our interest and support. Names were offered at the end of lunch.

The toast of the year was proposed by John Hickie and G D Tracy (who finished the address cut short by a fire alarm in 2007). Colin McLachlan responded. Themes were the surprise and delight in year 1 at seeing women at lectures (after, for most of us, years in all male schools), our satisfaction in acquiring professional and practical skills as residents, the problems facing us now as doctors and patients, and the challenges of medical life outside larger centres.

At the end of the day, I recalled that an earlier Vice-Chancellor,

observing the present Faculty and students, said "We were all young". In youth there is always time, and the promise of endless possibilities for our energies. At 60 years on, we can look back on careers in teaching, research, practice and community service with some satisfaction.

We were reminded by the Vice-Chancellor of the uniqueness of the University in its foundation and charter as a leading university in the English speaking world, and one of the oldest after Oxford and Cambridge. Returning, we feel a sense of belonging here and in the Faculty. We voted this one of our most successful reunions and hope to meet again soon. *Et haec olim meminisse iuvabit.*

Harding Burns

1960 MINI REUNION

Celebrating a mini reunion at Peppers Hunter in October 2008 were Bob North, Gordon Stokes, Malcolm Tester and Ron Scott who graduated in 1960 before embarking on diverse career paths of surgery, medicine, ophthalmology and general practice. Gordon Stokes alone remained in Sydney while Bob went to Dubbo, Malcolm to Lismore and Ron to Young. The formerly close friends, who rarely get together in recent times, were joined by wives Jane, Toni, Yvonne and Jocelyn to spend three leisurely days visiting vineyards, drinking coffee and enjoying long lunches while reminiscing about their student days at Sydney Hospital in the late fifties and bringing each other up to date with anecdotes about their professional and extracurricular activities since graduating. Inevitably the ladies spent more time recounting Sydney Hospital Younger Set nights, Medical Balls, cocktail parties and the exploits of, now middle aged, children and talented, perfect grandchildren. It was a very enjoyable interlude and the four couples, who have been married for a combined total of 180 years, are planning to make this an annual event while looking forward to the prospect of a 50 year reunion dinner in 2010.

Malcolm Tester

1963 REUNION

On the evening of Friday 5th December, the graduates of 1963 celebrated 45 years as *medicos* when 45 doctors and 15 partners attended the Harold Park Harness Paceway. This location could be described as unconventional and for that I have to take the blame. The night started out with a little confusion due to difficulties with parking, which is located in the centre of the trotting track, as well as needing to queue for the meal ticket. Eventually, everyone found a place to be seated and enjoyed the seafood buffet. There was the opportunity to talk to our classmates and recall our past experiences. Unfortunately, many were unable to attend and some are no longer with us. I hope the photographs taken by my daughter Giselle will provide happy memories. I would like to thank Dr Richard and Dr Mikki Jones for helping me organise this reunion. My thanks also to Dr Roger Bartrop for the loan of the 1963 Year Book and Dr Henry Briggs for assisting me in locating some of my classmates. Class of 1963 keep well. I hope we will meet in five years for the big 50 year "get together." Please keep in touch. My email is harryhaber@hotmail.com.

Harry Haber

1978 GRADUATES CELEBRATE THEIR 30 YEAR REUNION

Sydney University's magnificent Quadrangle filled with camaraderie on the evening of 1 November 2008 as the Class of October 1978 – the slightly accelerated last cohort of the old six year medical course – gathered where they had graduated 30 years earlier. After renewing old friendships and acquaintances over drinks and nibbles outside, we moved into the wonderful Great Hall for a fantastic evening that was all over far too quickly.

Coming from far and wide, all over Australia and some scattered around the world, about half the class was able to join in the fun with many others sending messages as well as their apologies. Although most of our friends were

instantly recognisable, name badges were for some reason more often referred to, for reassurance, than at the 10 and 20 year reunions. Then there was the extra challenge of the colleague who came, literally, in a penguin suit!

Some had clearly done their homework, swatting for the event with the old red Year Book, source of so much trivia and dirt, as well as the photos that were being projected throughout the night, bringing to life the Editor's stated aim "to provide a reference in the future for indulging our nostalgia".

Lead by Lyn March, as the chair of the organising committee, and with Steve Williams as MC, the nostalgia was fuelled as Roger Garsia, David Mawter, Gavan Mackey, Roger Boyd, Allan Passmore and Greg Lewin recalled the personalities, antics and escapades that enhanced our time as undergraduates both on campus and at our clinical schools. Sadly, we remembered our five "absent" friends.

Although there was an excellent band playing during the night, leading to many having a whirl on the dance floor, there was another musical treat as The Papillomatas, relics of a Med Revue a long time ago, reformed for one more brilliant performance!

All this, with an excellent meal and a constant buzz of animated conversation, left no doubt that this was a successful and enjoyable celebration of our time together. There was general agreement that we should do it all again in five years, rather than waiting another decade.

Particular thanks must go to the Medical Alumni Association, who gave much appreciated assistance and made organising this much simpler than our past efforts. Remember to keep them up to date with your contact details so you don't miss out next time!

Roger Boyd

1998 REUNION

The 10 year reunion of the class of '98 was celebrated with great enthusiasm and a sense of nostalgia in the Great Hall, at

the University of Sydney. The highly successful event was attended by 120 alumni and their partners. With cocktails on The Quad kicking off at 7pm, the perfect spring evening was not over till after midnight. Alumni travelled from as far as London and Singapore to make it to the reunion. We would like to thank Professor Bruce Robinson (Dean) for his encouraging speech on expanding our horizons, as well as our sponsor, Mr. Ned Tivic from Pentagon Group. We would also like to thank Lay Kun for the heartfelt eulogy for one of our alumni, Bee Hooi Tan.

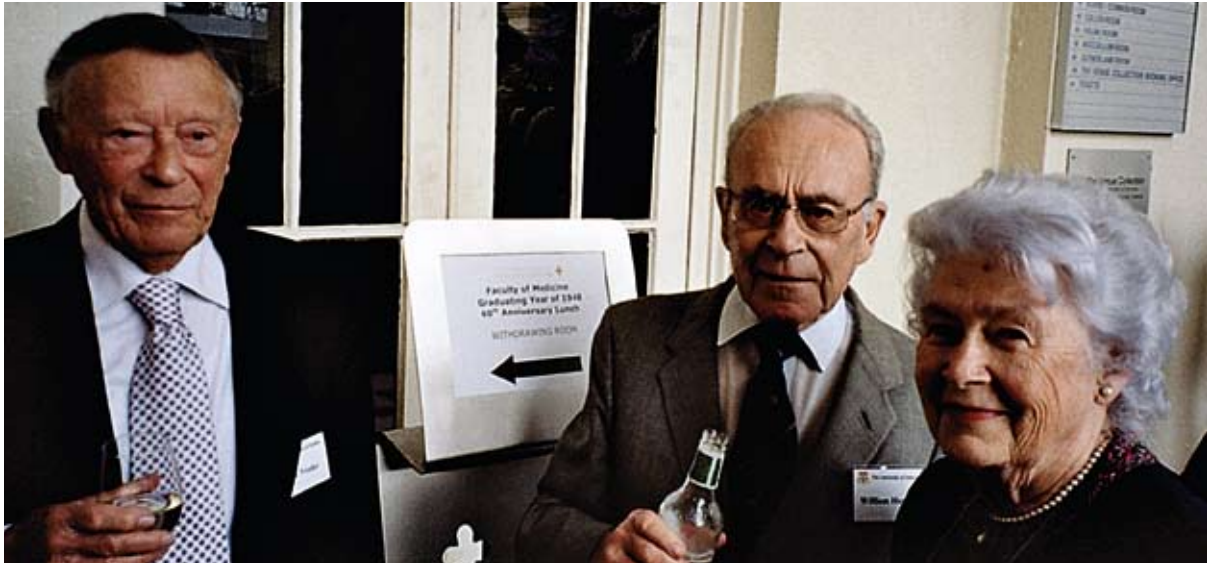
A quick trivia quiz reviving memories of the '90s kept everyone abuzz and bottles of wine were awarded to the winning table. A show of hands revealed that the class of '98 in the majority went on to careers in General Practice or Anaesthesia. In all, the much anticipated reunion exceeded everyone's expectations and five hours didn't seem enough time to catch up with old friends. Here's looking forward to the next reunion in 2018.

Naren Gunja

reunion reports continued

1948 REUNION

1. Bruce Noake, Bill Howell, Margaret Howell.
2. Alan Raine, Gwen Michael, Herc Rose.
3. Frank Buckley, Tom Nash & Noelle Magill.
4. Ivor (Tog) Wonders, Colin McLachlan.
5. Betty Marks, Joan Hunter, Bob Anderson.



1

1963 REUNION

1. Reunion group.
2. Gordon Sandes and John Vyden.
3. L to r: ohn Baker, Michael Chin, Virochna Kijvanit, Samuel Sakker.
4. Penny Hunter and John Hennessy.



1



2



3



4

1978 REUNION

1. Steve Williams, Carolyn Lechowicz, Phil Graham, Roger Boyd, Lyn March, Steve Allright, David Manter, Phil Hung, Annie Lim.
2. David Mawter, Sue and Gavan Mackey.



1



2



2



4



3



5



1960 MINI REUNION
 1. l to r: Ron Scott, Malcolm Tester, Bob North, Gordon Stokes.



1



1998 REUNION
 1. Maram Lam, Quy Lam, Kate Smart, Amutha Samuel, Sujatha Gunja, Narendra Gunja, Rebecca Betros, Fred Betros.
 2. Megan Ulrick, Kiril Goring-Siebert, Emily Ho, Angela Sumner, Tim Barling.
 3. Reunion group.



1

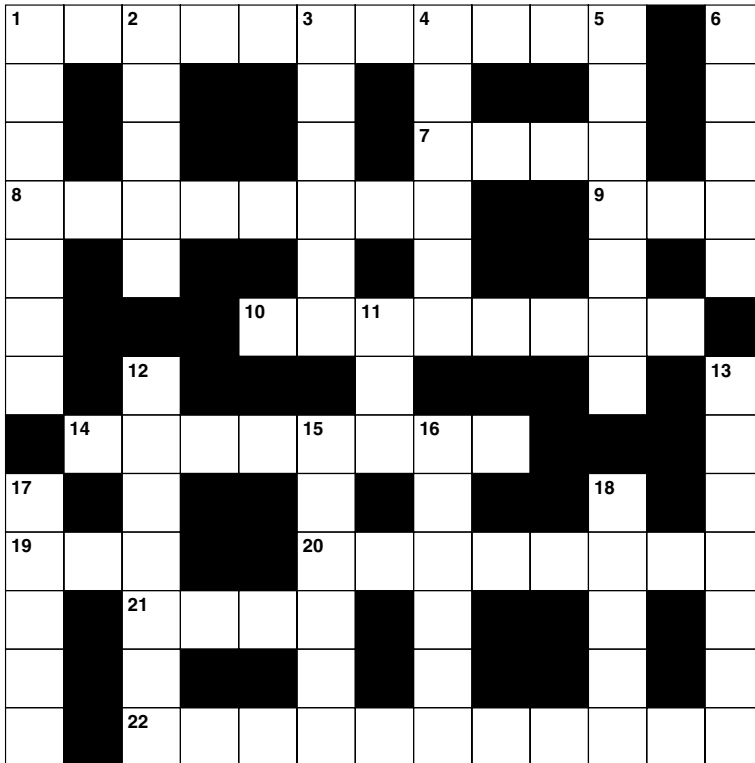


2



3

radius prize crossword 5



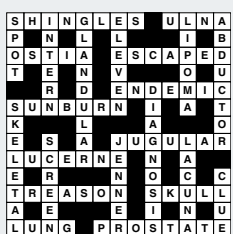
ACROSS

- 1 A mere putter melted in the heat (11)
- 7 There was no feeling in the laburnum branch (4)
- 8 Sleep can be induced by hyssop in pieces (8)
- 9 Not at home (3)
- 10 A laxative medicinal plant (8)
- 14 Hospital transport dropping church gains time for walking (8)
- 19 49 liberals are unwell (3)
- 20 Seeing double for this vitamin deficiency (8)
- 21 Sounds like a relative against (4)
- 22 Sedative causing pregnancy malformation (11)

DOWN

- 1 ___ Mary: a fever transmitter (7)
- 2 Viral disease for mothers having some quiet (5)
- 3 Right he's gone to the States for his blood (6)
- 4 These weights plus one on the left are in the throat (6)
- 5 This small round mass gave 'em a clot (7)
- 6 He dipped the oar at finding the great artery (5)
- 11 Confused eye means yes too (3)
- 12 Embed the IT with a thousand schemes lacking a saint (7)
- 13 Area of dead skin (7)
- 15 The ai played with the ball around its lips (6)
- 16 The upset rude poles were cared for (6)
- 17 Sounds daft a line of little hairs (5)
- 18 System of natural healing (5)

RADIUS SPRING SOLUTION



The first correct alumni entry received will win a Faculty history book. The winner's name and the solution will be published in our next issue. **SPECIAL STUDENT PRIZES: The first three correct student entries will receive a \$15 voucher for Ralph's Café.**

Entries to: RADIUS Prize Crossword, The Faculty of Medicine, Room 204, Edward Ford Building A27, THE UNIVERSITY OF SYDNEY NSW 2006.

Congratulations to our latest winners: Dr Lucy Shook Yiu Ng (MBBS 1967), Dr J D Williams (MBBS 1974) and Dr Vanessa Cree (MBBS 1988)

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Professor Michael Peek - Nepean Clinical School

Professor David Harris - Western Clinical School

Associate Professor Joe Canalese - School of Rural Health

Professor Robert Lusby - Concord Clinical School

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Paul Ruiz, *Untitled Man* (detail), 2007, oil on linen, 15" x 12",
courtesy of the artist.



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Driving Machine

Could a BMW X5 3.0sd really be the best value car in its class?

Wheels magazine certainly thinks so.



The BMW X5 3.0sd might not be the obvious choice for fuel efficiency, but at 8.8l* per 100km, it actually rivals many smaller sedans.

What's more, in the recent Gold Star Cars report, Wheels magazine analysed many of the hidden costs of ownership looking at factors like resale value, fuel economy, insurance premiums, finance costs, warranty and servicing. Outstandingly, the BMW X5 3.0sd came first in the "Medium SUVs" category. Proof indeed that sometimes the more expensive choices can also offer the best value.

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*Based upon combined driving test cycle from ADR 81/01.

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