

DECEMBER 2009:

→ HEALTH REFORM  
→ MONEY'S RUN  
OUT: TIME TO  
START THINKING →  
DOES DENTISTRY  
NEED REFORM  
→ A HEALTHIER  
FUTURE FOR ALL  
AUSTRALIANS?  
COURAGE, URGENCY,  
LEADERSHIP  
NEEDED →  
EHEALTH MUNDANE  
HO-HUMMERY

# *radius*

SYDNEY MEDICAL SCHOOL MAGAZINE



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SYDNEY MEDICAL SCHOOL MAGAZINE  
DECEMBER 2009

## radius

The magazine of the University of Sydney Medical Alumni Association and Sydney Medical School

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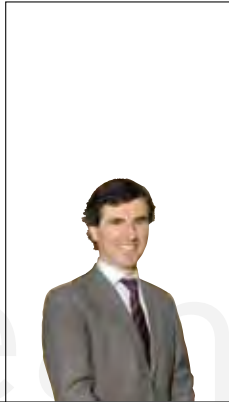
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**Bruce Robinson  
Dean**

**Thank you to everyone for their support this year. I wish everyone compliments of the holiday season and a relaxing break.**

# THE BIG ISSUES

**E**arlier this year, Dr Ian McPhee wrote of his lifelong experience of depression. It was a compelling story. Although in many professions depression is more widely acknowledged and understood than before, Ian is the first high level clinician I am aware of who has been so open about his struggles to overcome this debilitating condition.

The response was extraordinary. Several colleagues made contact to discuss their own situation and within the University, there has been interest from other Faculties and individuals. In his conclusion, Ian wrote that he hoped Faculty, Professional Societies, Learned Colleges and colleagues everywhere, would be more open to discussion of mental health, and he believed there was a need to see more programs of awareness raising and support.

Following publication, discussions in Faculty have led to a new initiative, Sydney Health Matters. It is being led by a committed group, and will focus attention on the physical and mental health of students, of doctors and of all members of Faculty.

One of its first tasks is to review the content in the Personal and Professional Development theme in the medical curriculum, specifically the first "P".

Our Associate Dean (Student Support) Dr Narelle Shadbolt is developing a mental health checklist to help us identify symptoms and signs in ourselves and colleagues that should prompt enquiry or referral to colleagues or the Doctors Health Advisory Service.

This initiative encompasses all members of Faculty and all students – not just medical students. More information will be published in Radius and on our website in the future. Our hope is that it will help to avert distress and tragedy, and it has my full support.

**I**n this issue of Radius, we are focussing on the most recent series of reports on reform of the health system.

After years of discussions about health reform, not to mention numerous reports, it is understandable if clinicians and academics prefer to focus on day-to-day urgencies rather than invest time in understanding reform committees or proposals.

This is a plea, though, for colleagues not to be so distracted by the immediately pressing needs of their medical practice, or other roles, that they don't consider the big picture. There are critical issues facing healthcare in this country, and change is happening. Whether that turns out to be fundamental change or more fiddling at the edges is not yet clear.

But as Professor Stephen Leeder points out in his incisive discussion of health reform, this is not the time for us to be sitting around and waiting for changes to happen according to others' agendas. We all need to be part of the debate. If we are not, we can scarcely complain if the changes which occur are not helpful to the care we provide for our patients or to our lives as health professionals.

Sydney Medical School, and our colleagues in Nursing, Allied Health, Dentistry and Pharmacy, play a critical role in producing graduates who will serve health needs and teach future generations of health professionals. We therefore must engage in debate about how reform is undertaken.

Steve has reviewed recent reform proposals, leading into commentary from others in Faculty including Professor Graeme Stewart, Professor Ian Hickie, Professor Mohamed Khadra, and Dr Clare Skinner. Thank you to Professors Jill White and Mary Chiarella in Nursing, Professor Jo-Anne Brien in Pharmacy, and Professor Hans Zoellner in Dentistry, for their perspectives.

# news



## → RESEARCH GRANT SUCCESS

Sydney Medical School has enjoyed considerable success with its NHMRC and ARC grant applications this year. In its main category of project grants, the School secured an additional \$10 million compared with 2008 – up from \$51.8 million to \$61.8 million this year, putting it well ahead of other major research universities in the category.

Among the groups which won major grants was the NHMRC Clinical Trials Centre, with \$2.4 million awarded for new research as part of its FIELD study. Led by Professor Anthony Keech, the research will look to identify genetic contributors to Type 2 diabetes, and whether the most important genetic factors can be screened for in simple blood tests.

A group led by Professor Alan Cass secured \$1.8 million to test a polypill strategy, which simplifies treatment for people at risk of cardiovascular disease. Professor Cass works predominantly in Indigenous health – cardiovascular disease is a major contributor to lower life expectancy of Aboriginal people compared with non-Aboriginal people. One of the identified problems is the gap between treatment guidelines (involving multiple medications) and actual practice.

Other large grants were awarded to researchers led by Professor John Myburgh from the George Institute for International Health (\$2.1 million) for Crystalloid versus Hydroxy-Ethyl Starch Trial; to a group led by Associate professor Kim Donaghue from the Children's Hospital at Westmead (\$1.2 million) into intervention to reduce the risk of diabetic retinopathy and early adverse retinal changes in type 1 diabetes. Million dollar plus grants were also awarded to groups led by Clinical Associate Professor Christopher Cowell from the Children's Hospital at Westmead (\$1.3 million), Professor Warwick Giles from the Northern Clinical School (\$1 million), Associate Professor Gordon Doig from the Northern Clinical School (\$1.3), and Clinical Professor Guy Marks from the Woollock Institute of Medical Research (\$1.2 million).

## → HOC MAI PROVIDES SAFE DRINKING WATER

A new water purification system which delivers potable water to Viet Duc Hospital and Hoc Mai House in Hanoi, Vietnam, was opened by the Chancellor, Professor Marie Bashir on November 9.

The water purification system is an initiative of Sydney Medical School's Hoc Mai Foundation, and was jointly funded by Hoc Mai, the Australian government, and Viet Duc Hospital. The plant removes chemicals and bacteria, to provide safe drinking water for the hospital and neighbouring Hoc Mai House.

"Diarrhea is one of the leading causes of morbidity nationwide. Partly as a consequence, Viêt Nam is maintaining one of the highest rates of child malnutrition in East Asia," said Professor Bashir.

"Although Vietnam has made rapid progress in improving its water supply situation over the past decades, water quality, particularly the contamination of groundwater with arsenic, remains a serious emerging issue."

"Access to water of the highest quality is absolutely essential for any hospital and we are delighted to be able to support this much needed water purification system," she said.

Hoc Mai this year celebrates 10 years of medical and healthcare exchanges between the two countries. Chairman of Hoc Mai, Professor Bruce Robinson, said the water purification system is one of many projects scheduled this year. Others include programs to build medical research capacity in Vietnam, maternal and child healthcare teaching in Dien Bien Phu, and the medical teaching program and curriculum development with Hanoi Medical University.



## → INTERNSHIPS WAKE-UP CALL

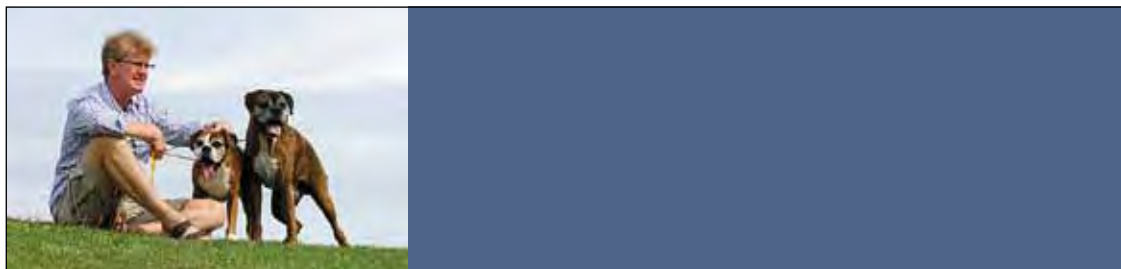
The recent difficulties for international students, who were not offered internship positions have been resolved with all graduating students securing places for next year.

The Dean, Bruce Robinson said the problems for students had served one useful purpose.

"They have been a wake-up call of the need to overhaul postgraduate medical training. Without reform, we are destined to see the events of the past months repeated with increasing severity in the years ahead, affecting local as well as international students."

"Just as important, without reform we will not be preparing young doctors well for the realities of modern health care and for the medicine most will eventually deliver," he said. A new approach was needed, which included providing clinical training in all health settings, both public and private, hospitals, primary care and community settings.

# news



## → WHEN DOCTORS GET SICK, by Ian McPhee

My contribution to *Radius* earlier this year generated considerable interest. Many people responded, sharing their stories and offering words of encouragement. There was contact with some for whom illness in family members had presented great tragedy and incredible upheaval. Others told of personal experiences that mirrored my own. It is clear that not everyone receives care that is focussed on living successfully with an illness that continues to menace from the sidelines, despite efforts to keep it in check.

Individuals, some complete strangers, continue to come up to me to thank me for speaking openly about a life with depression. Some have expressed the view that doing so has had the potential to influence many in the profession, while others have spoken of the positive effects that it has had on their own life. No one has been openly critical.

There has been contact also from people outside medicine who have had *Radius* passed on to them by a friend or relative, and in one case, a hospital maintenance manager who picked it up to read while on a ward of the hospital in which he worked! They too have responded positively, both to the sentiment expressed in the story and to me personally.

To all those who have made the effort to be in touch, thank you.

There were some, prior to the article's publication, who had questioned my wisdom in "coming out", genuinely fearing that it may have had a detrimental effect on my own health. It has been quite the reverse. There is a certain strength that comes with being open. Especially when expressed from a position of wellness, it confirms the reality of a life returned to "normal", free from the nagging burden of self doubt and self recrimination that is the hallmark of a major depressive illness. It flags also the return of a positive sense of self, so easily lost in the constant marauding presence of the black dog.

And what of effects beyond the initial impact of the *Radius* article?

Faculty has responded with the bringing together of individuals committed to seeing personal health matters more widely considered by undergraduates and alumni alike. There will be more from the Dean on this in the months to come.

Anaesthesia, a discipline with a regrettably high incidence of affective disorders leading to suicide, is, through the efforts of a highly motivated Welfare of Anaesthetists Special Interest Group within ANZCA, bringing focus to the issues of impairment, early recognition of symptoms and early intervention. At the Special Interest Group's most recent meeting I had the privilege of telling my story as part of a joint presentation with Gordon Parker of the Black Dog Institute. Importantly, this group is working to raise awareness amongst anaesthesia trainees and, not unreasonably has posed the question, as yet unanswered: Are all individuals suited to the role of anaesthetist?

These are small steps but clearly significant ones. In the meantime there exist the considerable resources of the *Black Dog Institute* and *beyondblue*, each with a substantial web presence, accessible to all. And a reminder for those students or graduates who believe they need confidential assistance either for themselves, a loved one or a colleague, there is the *Doctors Health Advisory Service* - a critical player in my own path to recovery. And for families of individuals in need of assistance there is the *Medical Benevolent Association*.

Of course there remains work to be done. I would again urge all to consider how they might play a part.

Websites for support and advisory groups mentioned:

- [www.blackdoginstitute.com](http://www.blackdoginstitute.com)
- [www.beyondblue.org.au](http://www.beyondblue.org.au)
- [www.dhas.org.au](http://www.dhas.org.au)
- [www.mbansw.org.au](http://www.mbansw.org.au)

Dr Ian McPhee is an anaesthetist and Clinical Senior Lecturer in Sydney Medical School.

## → SYDNEY HEALTH MATTERS

Following publication of Dr McPhee's story earlier this year, discussions in Faculty have led to a new initiative, *Sydney Health Matters*. It is being led by a committed group and will focus attention on the physical and mental health of students, of doctors and of all members of Faculty.

More information about *Sydney Health Matters* will be provided as it develops, in future editions of *Radius* and on the website. Information is also available from Dr Narelle Shadbolt, a senior lecturer in Faculty who has a long standing interest in understanding and assisting students and the profession who experience health problems.

To contact Dr Shadbolt, email: [nshadbol@med.usyd.edu.au](mailto:nshadbol@med.usyd.edu.au)



# news



## → FRONTIERS OF KNOWLEDGE AUSTRALIA CHINA PARTNERSHIPS

With senior research and education colleagues in China, Sydney Medical School hosted the Australia China Partnerships in Health Symposium, in Beijing in November, one of a series of events to celebrate the University's growing relationships in China.

Welcomed by Sydney University's Deputy Vice Chancellor, Professor John Hearn, and with opening remarks by the Vice Minister of Health in the People's Republic of China, Dr Huang Jiefu, the symposium brought together leading researchers, educators and government officials to discuss health reform in China and Australia, latest research, and medical education and collaborations between the two countries.

The presence of high level members from China's Ministry of Health, and the involvement of research leaders from the Chinese Academy of Sciences and from Peking University, is an indication of the strength of relationships.

## → CLINICAL CARE IN TIMOR LESTE

Timor Leste's Ministry of Health, the National Hospital of Guido Valadares and the Institute of Health Sciences in Dili, have joined forces with the University of Sydney to improve the capacity of the critical care workforce in Timor Leste.

"The workshop was a team effort with eight of our affiliated doctors and nurses providing specialist advice for development of the program and tutoring during workshops," said Dr Dilharni Bandaranayake from the Office of Global Health and program co-ordinator.

For more information about Timor partnerships, see the Office of Global Health website: [www.usyd.edu.au/global-health/index.php](http://www.usyd.edu.au/global-health/index.php)



## → CARL JACKSON SCHOLARSHIP

The Dr Carl Richard Jackson scholarship has been awarded for the first time, to two third year medical students, Adrian Lo and Katherine Miller. The scholarships will allow both students to travel to Cambodia for elective term placements.

Dr Jackson graduated from the University of Sydney in 2007, but died in July 2008 of cardiac arrest, just prior to his evening shift as a Resident Medical Officer at Gosford Hospital. He was 30 years old.

His parents, Mr Brian and Mrs Katherine Jackson, established an endowed scholarship in his name. The purpose is to provide annual awards to medical students who wish to gain experience in a developing country.

Carl completed a medical elective at the Rose Hospital in Cambodia, and gained greatly from the experience. In an obituary published in *Radius* last year, his family wrote that he had been deeply affected by the plight and stoicism of the Cambodian people, and the experience hardened his resolve to specialise in Orthopaedics.

Accepting the scholarship, Katy Miller thanked the Jackson family for their support of students wishing to work and learn from experiences in developing countries.

"I'm interested in Cambodia because it's an opportunity to learn about the challenges of healthcare in the developing world. I'll be based in Phnom Penh and hope to broaden my clinical skills and experience in the context of a resource-challenged system," she said.



## → STUDENTS CAMPAIGN TO REDUCE GLOBAL POVERTY

GlobalHOME, established in 2006 by medical students at the University of Sydney, used the opportunity of their recent conference to promote its Kevin 0.7 (kevinpoint7.com) funding campaign. The campaign is pressuring the Federal Government to boost its international aid to 0.7% of Gross National Income. It is an ambitious target - in the Budget this year, 0.34% of GNI was allocated to Overseas Development Assistance.

Students believe Kevin 0.7 is an important starting point for increasing discussion about international aid and national obligations. They hope it will encourage better understanding of Australia's aid expenditure and of the Millennium Development Goals.



# news



## → EXHIBITIONS BRING THE PAST ALIVE

Special exhibitions focusing on particular facets of medical history are a new activity of the Faculty. The displays are located in the magnificent cedar showcases which now dominate the Common Room on the ground floor of the Anderson Stuart Building. This was originally the anatomy and pathology museum for student teaching and research, but after completion of the Blackburn Building in 1936 the space became the Burkitt Library. It is now used as a gathering place for staff and graduate students working in the building and, increasingly for social functions associated with Faculty events.

The first historical exhibition "A Slice of Life" was prepared by Yvonne Cossart, Vanessa Whitton and Lise Mellor to coincide with the opening of the refurbished Wilson Museum in 2008. It included an account of Anderson Stuart's problems in establishing dissection in the Sydney medical curriculum, and show cased the work of all six Challis Professors of Anatomy.

Emboldened by the interest shown in the anatomy exhibition Yvonne and Lise embarked on a second, this time about Plague. "Rats in the Realm", which is now on display, crosses the boundaries between science and the humanities. It includes bacteria, rats, fleas, a plague doctor's mask and herbal remedies as well as a Justinian coin and a Bill of Mortality. The 1902 epidemic of Plague in Sydney featured period photographs of rats and rat catchers and political cartoons about quarantine and also included a hawser disc and Quarantine Station signage.

The interdisciplinary approach was carried on in the symposium about plague held in conjunction with the Medical Alumni History Day on campus. During the breaks, delegates were able to inspect a display of books about plague from the Rare Books Collection of Fisher Library. These included medical texts, herbals, tracts and fiction dating from the Sixteenth to Eighteenth centuries.

After the symposium delegates adjourned to the Museum to enjoy light refreshments and witness the world premiere of "Pepys Plague", an entertainment based on the events of 1665 in London. The "stars" were well known Faculty members and the text was devised by Yvonne from the famous Diary, excerpts from contemporary Royal Proclamations and the "Advices" of the Royal College of Physicians.



## → CELEBRATING ACHIEVEMENTS OF STUDENTS AND RESEARCHERS

Sydney Medical School's Scholarships, Prizes and Grants Reception 2009 was held in MacLaurin Hall on October 29. The evening celebrates the achievements of medical students and of the researchers who received Medical Foundation grants in the latest year. It also brings together the recipients of awards with donors, including alumni, friends and professional organisations.

Medical Foundation grants were presented by the recently elected President of the Medical Foundation, Mr Roger Corbett. Dr Paul Lancaster spoke about the contribution of alumni, and the Medical Alumni Association scholarships.



## → DEAN'S SCHOLAR: ARRIDH SHASHANK

First year medical student Arridh Shashank already has degrees in Biomedical and Electrical Engineering. He was awarded a grant from the Deans Scholarship Fund to fund the presentation of his research at the IEEE Engineering in Medicine and Biology Society (EMBS) conference in Minneapolis, USA. "I presented my research paper on the design, simulation and fabrication of a low cost capacitive tactile shear sensor for a robotic hand. Presenting my research at the conference provided invaluable experience and feedback that I could not otherwise achieve and this is definitely something that other students involved in research should undertake. I was also trying to identify areas in which I can carry out research and perhaps begin a PhD. The conference exhibited the latest developments in the medical application of engineering. I am grateful to the Dean's Scholarship Fund for the assistance."



# news



## → DEAN'S SCHOLAR: SAM LINDQUIST

Second year medical student Sam Linquist was selected to represent Australian medical students at the 58th International Medical Students Association's August General Assembly (IFMSA AM), in southern Macedonia. The Dean's Scholarship Fund assisted with expenses.

"The IFMSA is the largest student organization in the world, representing thousands of medical students from over eighty-seven countries. The IFMSA general assemblies are organised to facilitate discussion between medical students from all countries to share opinions on local and global issues. Students separate into standing committees which divide pertinent issues into more distinct categories. Public health, reproductive health and HIV, human rights and peace, and medical education are a few of the areas which provide direction to these sessions.

The focus for this General Assembly was paediatric health, especially children from developing and undeveloped countries. The appropriate title of "Investing in the health of children and youth" was used as the basis for theme sessions and breakout discussions.

Throughout the five days of the conference, we were lucky enough to be lectured by a range of inspiring speakers from global organizations including the World Health Organisation, Médecins Sans Frontières, and the United Nations International Children's Emergency Fund (UNICEF). In addition, I participated in discussions and workshops looking at medical education in a global setting. I also participated in small workshops on conflict prevention and management, leading small groups discussion, policy structure and drafting and effective lobbying techniques. It was amazing to see international bonds forged and political differences set aside.

Since returning to Australia, I have been able to share new knowledge with my Sydney colleagues and I have also been inspired to initiate some student-led projects focused on Australia's current organ donation policy and to start planning future global health initiatives. Thank you to the Dean's Scholarship Fund for this opportunity."

## → JOSH SMITH AWARDED JOYE PRIZE

The winner of the Joye Prize, awarded on merit to a final year medical student, was Joshua Smith.

Josh started in the Sydney Medical Program in 2006, having previously completed a Bachelor of Medical Science at the University. He is currently doing his pre-internship placement in general surgery at Hornsby Hospital and due to commence his internship at Royal North Shore in January.

"In the future I hope to pursue a career with a generalist flavour and find myself particularly interested in critical care areas such as intensive care. I would like to take this opportunity to thank the Joye family for their generosity in providing this prize and for the support that they thereby show to the achievements of students," he said.



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# HEALTH REFORM



## *Money's run out: time to start thinking*

By Stephen R Leeder

Stephen Leeder is Professor of Public Health and Community Medicine at the University of Sydney and Director of the Menzies Centre for Health Policy. Angela Beaton of the Menzies Centre helped prepare this article.

### HEALTH REFORM TAKES OFF IN AUSTRALIA

Google finds two million sources with the exact phrase "health reform". Australia has made substantial deposits to this cache in the past two years. The current Federal Labor government came to power frothing with dire threats about taking over the public hospitals unless the states lifted their game. Then after the federal election in November 2007 came the Australia 2020 Summit in April 2008. One of six streams in it dealt with health. Commissions of inquiry into hospitals, health care more generally, prevention, and primary care followed over the next year.

Nor has New South Wales been napping on the health reform stage: the Garling Report, a rolling, ponderous Tolstoyesque three-volume (12.6 Mb PDF file) work made 134 recommendations based on hundreds of pages of oral evidence from doctors, nurses and others about what needs to be done to improve acute care in our rather unhappy state.

This trumps the report, A Healthier Future For All Australians, of the National Health and Hospitals Reform Commission (NHHRC) published on June 30th this year: it has a mere 123 recommendations in a meagre 7 Mb PDF file. But if you add in the recommendations of the Preventative Services Taskforce report Australia: The Healthiest Country by 2020, a 1 Mb file with numerous targets and strategies to reduce obesity, smoking and harmful drinking also published recently, then the feds are back in front again.

### A FEDERAL TAKEOVER?

Following the publication of these documents the Prime Minister, Kevin Rudd, and other parliamentarians including the Federal Minister for Health and Ageing, Nicola Roxon, visited hospitals throughout Australia to discuss with clinicians and managers the major problems in health care provision. The discussion has concerned both the recommendations of the NHHRC and also whether public hospitals would fare better if financed directly from Canberra. The NHHRC has recommended a revised approach to hospital funding based more on performance - activity and



efficiency – consistent with direct federal funding. A federal takeover was Mr Rudd's pledge prior to the federal election unless the states and territories did better.

But there is more to health care than hospitals, as the NHHRC report recognises and as expressed in a further report, this time from the External Reference Group of the Primary Health Care Strategy. Both make a plea for better connections among general practitioners and other community workers, and suggest that those publicly-paid community workers not remunerated through Medicare should also receive their funding from Canberra directly rather than from the states.

Were this move to pay for all primary care from Canberra to happen, and were hospitals simultaneously to be federally funded, we would have for the first time a unified financing system. A single payer would reduce the state-commonwealth blame-game tensions: its superiority as a mode of financing is supported by evidence from many health systems.

While there is an ever present risk that hospitals would suck dollars from primary care into their coffers – Boyle's Law of joined-up small and large institutions – it is possible that the load on public hospitals might decrease. This would require enlightened, tough regional or area resource allocation to succeed.

### DENTICARE – A PROPOSAL WITH TEETH

A further likely outcome is public funding for dentistry. While details of Denticare are sparse, the principle is sound. At present millions of public dollars support dentistry, but only for those with private insurance: in 2004-05, 82% of Commonwealth expenditure on dental services was spent on the Private Health Insurance rebate; this accounts for 14 % of total spending on dental health, the majority of which is borne by the patient or their family. Under Denticare dental services would be supported irrespective of whether the patient had private insurance.

### INCREMENTAL CHANGE OR REFORM?

These changes may be all that is possible at the moment. They are more managerial than structural. Is this what we want? As my Canadian colleague Steven Lewis and I wrote in a recent article in the Medical Journal of Australia:

*There is a case against reform. In advanced countries, health status has been steadily improving. Life expectancy is up. Erstwhile rapid killers such as AIDS and several cancers are now chronic conditions. Heart disease rates have declined. Avoidable mortality has plummeted. Health technology is ever more dazzling, from high-resolution medical imaging to robotic surgery. There are more effective drugs than ever before. From diagnosis to surgery, health care is steadily less invasive. Health care practitioners are rigorously trained and entry-to-practice credentials are on the rise. Citius, altius, fortius: faster (technology, recovery, publication); higher (credentials, spending, intervention rates); and stronger (institutions, drugs, methods). Everything's coming up roses, so better to fine tune here, innovate there, and stick with a model of proven success.*

Well, quite frankly, wrong: we face problems that won't likely be solved by tinkering and simply trying to better with more of the same.

On the money side, we see demand outstripping supply, we have yet to take the social determinants of health seriously and spend money effectively on them, we do not have a preventive agenda, and perhaps strangest of

all, Australians take to their hospital beds in numbers that find no comparison in the rest of the world. It is as though, beside an entitlement to a few weeks at the beach every year, we consider it OK to pop into hospital for a few days. What on earth is that about? (In passing, let me tell you: it is about failure of our investment in primary care and community support, that's what.) And of course serious questions about safety, quality, efficiency, equity of access, and much else niggle away at our peace of mind.

### WHY YOU SHOULD BOTHER ABOUT REFORM

I hold the view that it is important for medical practitioners including medical academics to take a lively interest in the reform process, in part to inform it and in part to ensure that their interests and those of their patients are being served. Indifference of the sort that claims that all reports achieve nothing and simply gather dust is feeble and unhelpful. It fails to understand the policy process.

My professional judgement as one interested primarily in health, secondarily in the way we maintain it and manage illness, and then, thirdly, in the policies that determine the allocation of resources and shape the management of the system, is that we do need transformational change in the health system – not more fiddling at the edges on this occasion, useful though that generally is.

If I am correct, then this is no time for us to be sitting back and waiting for things to happen entirely according to others' agendas. It is one thing to advocate for 'clinicians being more involved in clinical governance' and altogether another to argue for those same clinicians to bend their admirably capable minds to larger questions of system change. It is the latter that is so hard and it is, at present, the latter that is most important.

### HOW REFORMS AFFECT US AND OUR PATIENTS

In this issue of Radius several members of your Sydney Medical School whose careers are in areas of special need in health discuss what they see to be the reform agenda. First, each of them comments on the need as they see it in their area of work. Second, they critique the current reform agenda and documents, providing us with insights into what they regard as good proposals. Third, they tell us where the lines of reform need to be stronger as they see it.

It is true that Australia does not have a fiscal crisis in regard to health care – yet. Several exuberant, detached and fantastical suggestions for changes in the way we finance health care may change that. But in any case with unbridged inequities in access to care, dangerous unresolved quality and safety issues, a preventive agenda that we have to grasp and finance, substantial changes in the demographic structure of our nation, mental health, dental health and Indigenous health all requiring more of us, we need to do more cerebrating about how we spend the health dollar in the future.

### TIME TO START THINKING

As Steven Lewis reminded our readers at the conclusion of our MJA paper on health reform, Nobel Laureate Lord Rutherford of Nelson (NZ), author of the planetary model of the atom that he then went on to split in 1917, said to his charges experiencing the constraint of scarce resources, "Gentlemen, we have run out of money. It is time to start thinking." So, too, it is time for us think very seriously indeed about health reform – new models for a new age, please – in Australia. 🍊

Korda RJ, Butler JR. Effect of healthcare on mortality: trends in avoidable mortality in Australia and comparisons with Western Europe. *Public Health* 2006;120:95-105.



## Does dentistry need reform or just inclusion in the health system?

By Hans Zoellner

Hans Zoellner is Associate Professor in the Faculty of Dentistry and Head of Oral Pathology and Oral Medicine, University of Sydney. He is Chairman of the Association for the Promotion of Oral Health.

Imagine if Medicare and public hospitals were limited to “basic medicine only”? Dental health needs to be part of the system but the Denticare proposal to fund basic dentistry only will institutionalise a two-tier system.

Australians enjoy enviously equitable and cost effective health services. Despite this, health reform reports should always be welcome because it seems sensible to periodically analyse our system and consider possibilities for improvement. However, it is also incautious to fix something that isn't broken, and this especially when the analysis seems incomplete.

Although current debate recognises alarming inflation of health costs, the monetary benefits accruing from improved health and delayed retirement seem disregarded. Dire predictions relating to over-population by 18th Century economist Thomas Malthus have failed to eventuate, because he could not anticipate the economic advantages of population growth and technological advancement. Dramatically restructuring health without first considering the benefits of an ageing demographic would seem a Malthusian mistake.

We dentists find unhappiness with Australia's health system odd because we experience the consequence of our own bizarre exclusion. Dentistry is not covered by otherwise universal Medicare. Our training is not supported by internships, conjoint appointments or registrar positions. Public services do not deliver comprehensive dental care. In our area of health, chronic failure is the accepted norm. By any measure, be it preventable hospitalisations, public waiting lists, access to services, active disease rates, or reports of uncontrolled pain, dentistry is a muddle. An obvious solution is to copy into dentistry those structures proven successful in medicine. Dentistry doesn't need reform, so much as to get into the system.

It is encouraging that the National Health and Hospitals Reform Commission recommends universal dental health insurance, but their 'Denticare' proposal is an ominously radical departure from the Medicare precedent. Under Denticare, a 0.75% Federal government levy would pay for risk-adjusted private dental health insurance. People without insurance would be directed to currently overwhelmed public services receiving new support via Denticare.

A 15% gap for privately delivered Denticare services is foreshadowed by the Commission but it is unclear if insurers are to pay 85% of whatever dentists charge, or if alternatively Denticare is to fix private practice fees. Either

interpretation seems unworkable.

It is worrying that Denticare would break the principle of community rated health insurance, which has thus far helped keep insurance affordable irrespective of personal health history.

Notably, Denticare proposes to fund 'basic dentistry only', and excludes many routine services including multi-canal root canal therapy, lower partial dentures, and crowns.

One thing I will share in common with most Radius readers is a full set of teeth, while another is that I would have suffered several extractions under Denticare. Imagine if Medicare and public hospitals were restricted to 'basic medicine only'. Patients would suffer, and practice would become professionally dissatisfying. Rather than eliminating current inequity in dental health, Denticare would institutionalise a two-tiered service, profoundly different from current arrangements in Medicine.

One welcome recommendation by the Commission is the establishment of internships for dental graduates. We have long canvassed in favour of dental internships because of the potential to both improve training and expand the public sector. It is consequently frustrating, that because Denticare would fund public dentistry for 'basic service only', newly graduated dentists would be formally deskilled during their internship.

Inclusion of dentistry in Medicare seems the most sensible alternative to Denticare, and would fund service in the private sector where most dentists work. Medicare would also liberate the public system to concentrate on high quality services for those who cannot be seen in private practice settings. Dental Medicare has already been trialled via the Enhanced Primary Care scheme, providing up to \$2,125 of Medicare rebate per year for people with chronic disease. Since establishment in November 2007, over 250,000 people have received comprehensive dental service under Medicare, so there is now sufficient experience to properly fine-tune the scheme. Expansion of dental Medicare over time to include the entire population would address current inequities, and bring dentistry into line with medicine. It would be a shame, however, if this achievement were undermined by overzealous reform of our essentially excellent health system. 🍊





## A healthier future for all Australians? Courage, urgency, leadership needed.

By Graeme Stewart

Graeme Stewart is a Clinical Professor in Sydney Medical School, and Founding Director of the Institute for Immunology and Allergy Research at the Westmead Millennium Institute.



Hospital clinicians look to the Rudd Government to implement once-in-a-generation reform of Australia's health service. Tinkering at the margins or incremental change will not pull the public hospital system back from the brink. The final report of the National Health and Hospitals Reform Commission fails to convey clearly either the sense of urgency or the scope of needed change.

I am now in my 40th year as a doctor in a public hospital system to which I have a passionate commitment. Over the past 10 years, I have become increasingly dismayed by the decline in once great institutions and, with many others, am fearful for the immediate future. Inadequate funding to hospitals and universities has resulted in a reduction of beds to unsafe levels, ageing equipment, unattractive work environments and an excessive reliance on overseas trained staff. University values of inquiry and scholarship are being marginalised along with teaching, training and research, the foundation stones for better health for the next generation.

Poverty of resources leads to clinician frustration and disengagement. In a recent survey, two-thirds of senior doctors indicated that they had seriously considered leaving the public hospital system in the past 12 months. A large number already have, at least in part and/or in spirit. The private sector offers an increasingly attractive alternative.

Commissioner Peter Garling SC put the NSW public hospitals under the microscope last year and concluded that it was 'on the brink'. Little has improved since; there is no money to do so.

### 'PUBLIC HOSPITALS AREN'T FAILING, THEY'RE JUST STARVED OF FUNDS'

Despite the difficulties, Australia still enjoys a remarkable public system. Paradoxically, the health outcomes delivered in public hospitals continually improves due to the remarkable pace of advances in diagnostic capacity and new treatment options. Miracles occur every day, even if the media reports only the mistakes. The questions, though, are how long will it last and how much better could it be? New clinical tools are costly and the number of people, often of advanced age, for whom there is clear benefit is growing. Increasingly, access means ability to pay as procedures become available only in the private hospitals. As a nation, we could do so much better. As Professor John Deeble was quoted recently: 'The public hospitals are not failing, they

are just starved of funds; the demand has overwhelmed them'. (*Sydney Morning Herald*, 9 Oct 2009).

### NOT A CLEVER COUNTRY

On this background, there remains a remarkably stupid aspect of health care funding that will not be corrected without the direct intervention of the Prime Minister, as a major part of his once-in-a-generation opportunity. Care outside hospitals looks after the less severe part of the disease spectrum and the worried well, is supported by Australian government funding and is essentially uncapped at the point of service. The public hospitals provide care for people at the severe end of the disease spectrum, with a state-determined budget that is capped. The correct balance can only be achieved through the establishment of a single funding agency, perhaps jointly administered by federal and state governments. The subsequent challenge - of avoiding the creation of an all powerful, remote bureaucracy and ensuring that responsibility and authority are aligned at a local level - is not beyond us.

But the starting point for reform must be the commitment of substantial new funds. These urgently needed 'pennies from Kevin' represent no more than the return to the public hospitals of the \$3 billion per year taken out during the past 10 years and given to the private sector. There are many options for this. The tax rebate for private health insurance alone costs over \$3.5 billion per year, money that would be better directed to the public hospital system. The proposed rationale of taking the strain off the public hospitals was proved untrue by statistics noted by Deeble in the article referred to above.

### IT'S NOT JUST ABOUT MONEY.

Reform requires much more than extra dollars. But with a funding balance restored, clinicians, planners and managers can work together to implement the major reforms needed to ensure best use of health resources and facilities, and at delivering safer and more effective care with appropriate

equity of access. This will not occur without the removal of barriers created by multiple jurisdictions, principally between the commonwealth and state; a single funding entity is a good start. This is equally true for workforce planning, teaching and research with the Universities and health services currently under separate and disconnected administrations, the differing rail gauges of the 21st century.

The issues raised in this article have been recognised in the final report of the NHHRC 'A Healthier Future for all

Australians' (June 2009) but I get no sense of the urgency needed. The report also covers major issues in community health care and prevention; my brief was to address the issues affecting the public hospital system, the better resourcing of which should not be seen as their enemy. There is substantial evidence that the Australian people are prepared to put more money into health care overall but are seeking reassurance that it will be governed wisely and spent well. 🍊



## Clinicians and managers need to work together

By Clare Skinner

Dr Clare Skinner is a graduate of the University of Sydney Medical Program. She works as an emergency registrar at Royal North Shore Hospital and is a founding member of the Hospital Reform Group.



There is a lot of talk about improving the health system at the moment, but not much of a sense that any change is actually taking place. There is almost nothing new among the recommendations presented to NSW Parliament by Mr Garling, or in the report of the National Health and Hospital Reform Commission. The same ideas have been spoken and written about for years by clinical leaders, academics and health commentators. What is lacking is political courage.

In the eight years since I graduated from the Medical Program at the University of Sydney, I have noticed a steady decline in the morale of public hospital clinicians. Many doctors do not feel valued, and as a result have withdrawn from all but immediate clinical care activities. A handful of specialty groups have almost entirely retreated to the private sector. The impact on patient care is potentially devastating. It is increasingly difficult to find doctors willing to take on managerial responsibilities, to attend hospital meetings, to participate in quality improvement activities, and to actively teach, supervise and mentor doctors-in-training. Further, the culture of disengagement is role-modelled to medical graduates, who quickly adopt the cynicism of their seniors, and plan careers which minimise their interaction with the public hospital system.

In order to effect real, sustainable, health system reform, frontline clinicians need to be re-engaged in decision-making. Clinicians and managers need to work together, towards an agreed set of goals. Managers need to respect that the primary responsibility of the clinician is patient care, and in turn, clinicians need to acknowledge the constraints of the system, and get involved in working out how limited resources can be effectively used, to provide the best care to the most number of patients.

This will be difficult. The current generation of clinician-managers are deeply suspicious of government-initiated reform. At present, they are busy explaining why they cannot meet demand-driven key performance indicators, while having only limited control over the supply side; budgets, equipment and staffing. Health management structures need to be flattened, such that decisions about what to achieve are made centrally, but decisions about how to achieve are made locally, by clinical directors working alongside 'business' managers. This will require honesty, transparency and respect in both directions. An end to blame and 'spin'.

In the meantime, the enthusiasm and intelligence of junior doctors should not be allowed to go to waste. Postgraduate medical training should be re-imagined, to better equip graduates for the challenges of the future. Programs should be clinically-focused, efficient, flexible in delivery and duration, should allow for different learning styles, and assessment should relate to clear educational outcomes. Trainees should demonstrate understanding of the basic principles of evidence-based practice and health economics. Those who show leadership aptitude should be encouraged to pursue further training in management and research, to lead our system into the future. 🍊



## Managing medications

By Jo-anne Brien

Jo-anne Brien is Professor of Clinical Pharmacology at St Vincent's Hospital and Pro-Dean in the Faculty of Pharmacy.

The Garling Report pointed out the high level at which mismanaged medications cause harm and death in hospitals.

In Australia, current discussion of health reform has been triggered by the report of the National Health and Hospital Reform Commission. Within New South Wales following the Garling Report, the implementation of health service changes has commenced. The Garling Report focussed on avoiding harm, often iatrogenic, and recognition of the complex social organisation and high risk environment that is a hospital.

The high risks and actual harm associated with medications was identified by Commissioner Garling, and he made a number of direct comments and recommendations for clinical pharmacy services to address these.

*"I heard evidence that 26% of the 27,000 hospital related incidents reported on the Australian Incident Monitoring Systems to 2002 were medication errors. The level at which medication causes harm and death within our hospitals has continued largely unabated. Clinical pharmacy reviews are known to reduce considerably these harms. Readmissions are materially reduced. The introduction of an electronic hospital pharmacy system would likewise be a major contribution to reducing the damage caused by medication error... the skills of clinical pharmacists are not being well used when they clearly should be."*

Reports such as Garling identify issues for health service providers and governments, and are meaningful for us all, as consumers as well as practitioners. The debate about healthcare reform is rarely around whether or not there is a problem. More often than not, the debate is around who and what changes are to be made. Robust discussions are appropriate but what is disappointing is where the heat is around a 'turf battle' rather than evidence-based, achievable, equitable, fiscally responsible models for clinical care. This is a political process that has little to do with the interests of patients.

There is an opportunity for health professionals to show leadership in the advocacy for patients and improved health outcomes. The development of models of change, and subsequent implementation, should not be left only to the politically active professional groups, particularly if those groups appear to advocate for the practitioners' incomes rather than patients. All practitioners who are at the 'coal face' are aware of patients' concerns and the need to appropriately respond in professional and effective ways.

### QUALITY USE OF MEDICINE

A component of healthcare that has relevance for both reports is the importance of achieving Quality Use of Medicines (QUM). Australia is fortunate to have an articulated policy for medicines use and health outcomes. The engagement of the Therapeutic Goods Administration and the Pharmaceutical Benefits Scheme to ensure timely and appropriate access to safe, effective, and cost effective, drugs is well understood. The partnerships between health practitioners and consumers to achieve Quality Use of Medicines are key. The National Prescribing Service supports the implementation of policy and through evidence-based practice initiatives.

'Quality use of medicines' means that medicines are used judiciously, safely and effectively to achieve a specific health outcome. Delivering QUM is difficult, given the complexities of both the health system and human behaviour, and that medicines may be expensive, may or may not deliver benefit, and may themselves cause harm. Both the use and lack of use of medicines may cause harm. Timely, accurate, reliable health information, including medication histories, is needed to manage medicines well.

### SOLUTIONS REQUIRE A WILL TO SUCCEED

Technology may be able to deliver 'personalised' medicines routinely in the future but right now we need basic clinical information available for our patients, whether they are an inpatient or in the community, and especially when they are transiting between one sector and the other, and have several health care providers. Recommendations for patient-held integrated electronic health records are not new. The hurdles in technology, incompatible information systems and privacy concerns can all be managed if there is a will to use this as an element to facilitate communication among providers and patients, and to see improvement in overall clinical management and medication use. This was just one issue in the Reform Commission recommendations. It will be interesting to watch! 🍊





## Mundane ho-hummery: the verdict on eHealth recommendations

by Mohamed Khadra

Mohamed Khadra is Professor of Surgery,  
University of Sydney, based at Nepean Clinical School.



Advances in information technology provide the basis for creative solutions to enduring health challenges. Against that potential, the eHealth recommendations of the NHHRC are laudible, but pedestrian and mundane.

When I worked as a urologist in Wagga Wagga, as part of my role as Director of the School of Rural Health for the University of New South Wales, I would see patients who had travelled to their appointment from such places as Hay, Denniliquin, Rand, West Wyalong and Tumut. There were general practitioners and small hospital facilities in each of these places but no specialist, and to see a specialist, patients had to travel. In the case of Hay, about 6 hours drive back and forth. Now, more than ten years later, as a Professor of Surgery at the Nepean Campus of the Sydney Medical School, I see patients who are travelling in excess of 8 hours to access my services as a urologist.

Geoffrey Blainey coined the phrase 'the tyranny of distance' in the late 1960's. Nearly forty years later, with all the advances in information technology as well the Googlification of our lives, little has changed for rural and remote patients seeking medical care. The 'tyranny of distance' remains a significant barrier to accessing specialist health care, continuing education and professional support.

The Federal Government has invested in the creation of the National Broadband Network, capable of providing the technological basis for as yet unimagined creative health solutions to many of the challenges in providing good quality health care to all Australians. The solutions are limited only by the imagination of clinicians and IT developers, and need to engage the clinicians and communities who will benefit from these solutions.

At the Nepean Campus of the Sydney Medical School, we have recently had a confluence of clinicians whose interest in eHealth and telehealth has created an intellectual eHealth primieval soup, whose evolutionary outcomes will be creative and useful technologies to help bridge the tyranny of distance. The newly proposed Institute of eHealth at the Nepean seeks to unite these efforts, couple them with information technology specialists, and bring the solutions that emerge to reality. Nepean is unique in that it stands at the gateway of rural and remote New South Wales.

One example is the virtual intensive care unit which was developed by Professor Pat Cregan and others. This allows a specialist at Nepean Hospital to receive 8 channels of information about a critical patient from a remote hospital, including sound and video, vital signs and pulse oxymetry. The specialist is able to advise and direct every step of the resuscitation, and apply their knowledge to the remote

incident. Another example is the utilisation of eHealth technologies to allow foetal health monitoring in remote sites of NSW, led by Dr. John Parady. A further example is the prenatal morbidity surveillance unit which seeks to establish a web portal for the collection of clinical data, and which is led at Nepean by Professor Michael Peek, in collaboration with researchers around Australia and in New Zealand.

Against this background, recommendations 115-123 of the NHHRC Report present a series of eHealth initiatives which are pedestrian and mundane. They include proposals for electronic health records for every Australian, a national system of unique identifiers that identify the patient, the provider and the facility, and they call for an investment in eHealth training, leadership and the develop of key health informatics tertiary qualifications. These are laudable initiatives and are definitely to be supported.

However, they are hardly solutions which will bring about a paradigm shift in the way we practice medicine, or solve any of the challenges of remote access or health outcomes. Further recommendations envisage 'that the Commonwealth Government mandate that the payment of public and private benefits for all health and aged care services depend upon the ability' of all health facilities and practitioners to share data across the national network - this to be established by 2012.

Integration between databases has been impeded throughout the history of computing by the economic advantages for companies that devise platforms and norms for datasets that are incompatible with those devised by other companies. Yet, the recommendation would see that all private and public health clinicians and facilities abandon current software platforms and adopt a national, universally compatible clinical information norm. The recommendation is unrealistic in the timeframe.

Perhaps one needs to look beyond the NHHRC and look to the National eHealth Transition Authority (NeHTA) 2009-2012 strategy which outlines how they will lead the progression of e-health in Australia.

We will all need to wait to see further developments of the Authority and hope that the natural processes of the bureaucratic-centred health departments do not obfuscate eHealth developments. Meanwhile, those of us in eHealth research and development will continue 'to strive, to seek to find and not to yield'. 🍊



## Real improvements require fundamental changes

By Ian Hickie

Ian Hickie is Professor of Psychiatry at the University of Sydney and Executive Director, Brain & Mind Research Institute



The National Health and Hospital Reform Commission is right to highlight mental health services as one of the major areas of ongoing health inequalities in Australia. But neither of the governance and financing models now being advanced will result in the substantive changes necessary.

In 1997-98, only 38% of people with a mental health problem received a service in any 12-month period compared with 80% of people with a common physical health problem. In 2007-08, despite a decade of improvements in public attitudes and changes in access to psychological services, the rate of service use had actually dropped to 35%.

Over 75% of mental health problems commence before the age of 25 years and yet only 13% of young men and 31% of young women with a mental health problem received any service in 2007-08. We have not rolled out evidence-based early intervention services for the major disorders, even though the relevant service models were largely developed in this country. The harsh reality for those consumers and families who are reliant on our various public systems, is that despite all the promises and good intentions, substantive changes have not been achieved. We continue to focus on late rather than early intervention and restrict our services largely to those who are in the acute phases of illness.

It is with this reality in mind, that those who work in mental health have placed great hope in the work of the NHHRC and the rhetoric of the Rudd Government. Mental health will not be improved without fundamental changes in the Australian health care system. From our perspective, we are stuck with two large and dysfunctional systems. The first is the underfinanced, overregulated and non-responsive public sector. Its mandate revolves around acute care services and hospital-based structures. Having grown out of the asylum era, this system is still poorly integrated with the remainder of the medical system or the community care sector. The second is the fee-for-service primary and specialist outpatient system. Due to the pressures of geography and finance, these services are closely tied to the economically-favoured areas of the capital cities.

The NHHRC has picked up some key elements of potential reform. The most notable recommendations are the emphases on youth-focused primary care services (based on the innovative Headspace model, in which the BMRI is a foundation member) and the national rollout of specialist early psychosis services. It has also continued to emphasise greater integration with other key social services, housing and employment, and improved consumer and carer participation. These are worthy recommendations and could be led by the national government at relatively little cost.

On their own, however, these service improvements

will not change the face of mental health. Much greater emphasis needs to be placed on new systems of accountability, new financing systems, support for innovation (particularly to support novel child and youth services), purchasing of collaborative rather than individual provider-based care systems and utilization of new technologies – particularly those that could use Australian-developed and tested e-mental health systems.

Mental health advocates are looking for strong leadership from the national government. The most substantive step would be towards single national financing of all levels of care. We need the Commonwealth to build the community capacity that would support not only early intervention but also less reliance on acute hospitalization. In my personal view, neither of the governance or financing models the Federal Government is now advancing (take-over of the community sector alone and/or partial funding of public hospitals) will result in substantive changes. They appear to perpetuate the current dysfunctional arrangements. Consequently, I have become much more interested in whether the third alternative originally offered by the NHHRC (competitive social insurance models) may represent the style of fundamental change that is required.

Perhaps what is most obvious is that those national health values that we say we value (e.g. universal access, reduction of health inequalities, minimal out-of-pocket expenses, regionally-responsive systems and person-centric care) are not at the heart of the current system. Out-of-pocket expenses now constitute about 30% of total costs and will continue to increase. The system is poorly equipped to deal with the coming tsunami of chronic diseases, complex comorbidities and demand for those procedures that people require as they age to maintain independent living.

In Australia, health inequities and breakdowns in the quality of care have been the immediate drivers of reform. In the next decade, however, the issues of rising costs, health inefficiencies and failures to introduce competition or support innovation are likely to bring our system to the brink. If the Rudd Government fails to implement fundamental reforms in 2010, it is likely that the whole system will slip towards the inadequacies that we are all too familiar with in mental health – declining access, greater health inequities, unacceptable variations in quality, greater out-of-pocket costs and increased reliance on acute care and hospitalisation. 🍊



## Mind the Gap: rhetoric and reality

By Jill White and Mary Chiarella

Jill White is Professor of Nursing and Dean of the Faculty of Nursing and Midwifery, University of Sydney.  
Mary Chiarella is Professor of Nursing and Midwifery, University of Sydney.

Redundancies, nursing positions replaced with administrators, more nursing assistants. Welcome to NSW post-Garling.

The recommendations of the Garling Inquiry in New South Wales held the potential to make a difference to the outcomes of care in NSW hospitals - for patients and staff. They were based on an enormous body of research evidence and the testimony of many expert clinicians. Now well past the initial excitement about the potential for change, some of the current initiatives being rolled out in the name of a "response to Garling" are puzzling at best.

Commissioner Garling acknowledged the pivotal role of the Nurse Unit Manager (NUM) in patient safety and the quality of care, and was concerned at the progressive clinical detachment of this role. He suggested the introduction of a role of "clinical support officer" to support NUMs in the administrative tasks that were taking them away from expert overview of clinical care at the unit level and the supervision of unit nursing care. What was never foreseen was that in implementation, the clinical support officer roles would be introduced at the expense of nursing positions rather than as a complement to them. The Inquiry was sparked by a growing public concern for patient safety and particularly, the recognition and action around the deteriorating patient. Watchful practice and early detection fundamentally rely on well educated, experienced nursing staff in sufficient numbers to be able to provide care.

### BUT WHAT ARE WE SEEING?

We are seeing clinical support officers replacing nursing positions, and very high numbers of assistants in nursing being introduced in substitution - not as adjuncts - to registered nurses. Perhaps the most worrying, we are also seeing many nursing positions in several Area Health Services (AHS) being made redundant. These redundancies extend across a wide spectrum of RN positions, including Clinical Nurse Consultants who provide expertise and support to clinical nurses. Two of the area health services in which this is taking place are areas of significant socio-economic hardship and that have traditionally had difficulty in attracting and retaining RNs. We understand that a number of these redundancies have been offered to very experienced 8th year RNs who are the backbone of the experienced clinical ward based workforce.



### WHAT A PERPLEXING CONTRADICTION!

The public rhetoric about a dire skilled nursing shortage and its impact on bed availability, the call for the government to educate more nurses, the department's drive to recruit overseas prepared nurses, the introduction of leadership programs such as "take the lead" and practice improvement programs such as "essentials of care". These, juxtaposed with the clinical reality of redundancies, substitutions and the introduction of a large cohort of assistants in nursing. In small numbers, assistants may be an adjunct to the care team but should by no means be a substitution. This situation has been compounded recently by a significant decrease in the number of available places in NSW public hospitals for new graduates in new graduate transition program, leaving many well prepared and eager newly registered nurses disenchanted and disenfranchised and who may never now enter the public health system.

The rhetoric around evidence-based practice is brought into sharp relief with actions such as these, which run contrary to the findings of a strong body of international research (Aiken et al, 2002,2003) and even to that commissioned by NSW Health itself, the major research project Glueing it Together, (Duffield et al, 2007). This NSW based research demonstrated that, at ward level, for every 10% increase in degree-prepared RNs in a unit, there is a concomitant 27% reduction in adverse events. It further showed that skill-mix (the proportion of RNs) is more critical to patient outcomes than the hours of care provided.

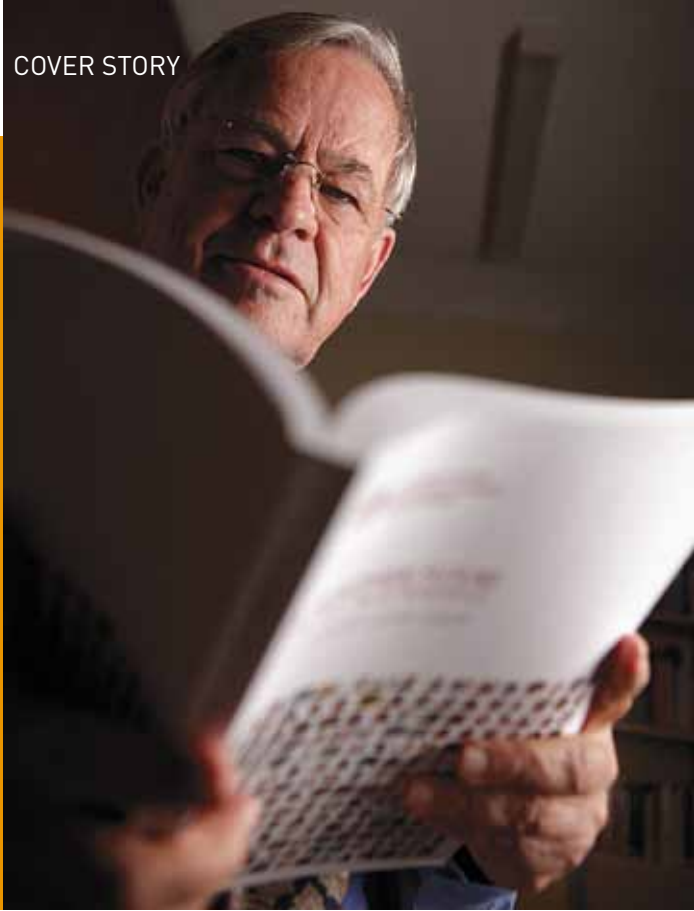
Commissioner Garling sought to improve clinician engagement, to improve flagging clinician morale and to reassert the place of the experienced multidisciplinary team at the centre of care. These redundancies, with their loss of experience and expertise, and the substitutions of uneducated pairs of hands are not only further demoralising for the workforce but are potentially compromising for patient care. The deteriorating patient - at the centre of Garling's concern - may be at further risk if we are not vigilant about changes related to cost savings, made in the name of patient care improvements, cloaked in the name of implementation of the recommendations of the Garling Inquiry. 🍋

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*The reasonable man adapts himself to the world; the unreasonable one persists in trying to adapt the world to himself. Therefore all progress depends on the unreasonable man.*

George Bernard Shaw,  
Man and Superman (1903)



## Progress

By Stephen R Leeder

The preceding contributions from correspondents in the far-flung corners of the health science faculties reveal the diversity of views about need for health system reform in Australia.

The articles give insight into the response that we are making as a community of patients, carers, health service professionals – private and public, managers and politicians to those needs.

Soon after this issue of Radius reaches you, we will know what conclusions prime minister Kevin Rudd, federal health minister Nicola Roxon and her state and territory counterparts have drawn from the year's commissions of inquiry into hospitals, community care and prevention. We may also know what they have in mind to do about funding and managing health care.

We know many of the problems and we have ideas about solutions. Ultimately health, illness, suffering and death are intensely human experiences to which every member of our

community is exposed. It is entirely right, therefore, that how we as a prosperous nation manage those experiences should be a political concern. It is also appropriate that we all have a say in the policies that will distribute our national resources in pursuit of better health.

Optimistic? Yes I am! The process of discussion, involvement, debate, rumination, lobbying, complaining, advising and sharing is the process of a democracy at work. Given that process, there is a big chance that improvements will follow. Maybe they will be big scale – a federal takeover – but maybe they will be relatively small, nibbling at the edge, improving this, fixing that. We shall see. This is a good space to watch. *radius*





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*“To have lived through a revolution, to have seen a new birth of science, a new dispensation of health, reorganized medical schools, remodeled hospitals, a new outlook for humanity, is not given to every generation.”*

William Osler, John Hopkins Hospital, 1913

# Shaking up medical education

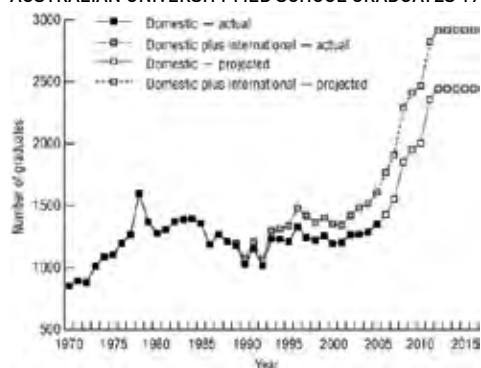
By Tessa Ho

Tessa Ho is Associate Professor in Sydney Medical School and Head of the Medical Program, Office of Medical Education.

An enduring feature of modern medicine is the constancy of challenges and change, and no more so than in medical education and training.

Australia is undergoing the first expansion of medical schools for 30 years. Changes in medical school intake are typically cyclical. From a baseline of 851 admissions to Australian medical schools in 1970, medical school intake rose to 1278 in 1980. In the 1980s and 90s, the Australian medical workforce was deemed to be adequate for the requirements of health services and the community, and for more than 20 years there was no political pressure to expand the capacity of our medical schools. In the mid 1980s, there was a reduction to intake so that by 1990, the 1030 annual intake of medical schools was deemed surplus to requirements.

## AUSTRALIAN UNIVERSITY MED SCHOOL GRADUATES 1970-2016



Sources: Karmel;<sup>2</sup> Doherty;<sup>4</sup> Medical Deans Australia and New Zealand;<sup>6</sup> Department of Science, Education and Training, University Statistics Section, higher education data (customised dataset RFI 03/312).

## MEDICAL STUDENT TSUNAMI

More recently, Australia, along with the rest of the world, has found itself in the grip of a serious medical workforce shortage. By the late 1990s, severe medical workforce shortages led to the decision to establish a number of new medical schools. By 2008, seven new schools had opened and there are now 19 Australian medical schools. With this unprecedented expansion, the number of medical graduates is set to rise from around 1600 in 2005 to about 3000 in 2012.

AUSTRALIAN MEDICAL STUDENTS	
year	total number
2005	6,622
2008	9,445
2009	10,405
2010	11,408
2011	11,922
2012	12,053
2013	12,296

## TSUNAMI REPORT

Not only are the numbers rising, those riding the wave are different from past medical graduates. There is an 81% increase in domestic medical graduates, from 1348 in 2005, to 2442 in 2012. We have an increasing number of international students who have been allowed to remain in Australia since 2003, with 260 in 2005, to 500 in 2012. Domestic fee paying students were allowed into Australian medical schools from 2004, although this ceased in 2008. There are more students in graduate entry medical programs (45%) and a steady upward trend in female medical graduates (55%).

There are certainly differences in the educational, training and work environment faced by the medical workforce in the 1980s and the 2000s. Interns and residents in the 1980s endured tight hospital rosters, days filled with unending administrative duties with the emphasis on service and scant attention to training or education. The command structure was hierarchical, progressing from short white coats for bottom of the rank, to long white coats for registrars, and finally, a suit for the consultant or "Sir". Today, the rosters are flexible, with more humane working hours and better pay. Mentorship, rather than humiliation, is the norm. White coats are out and "Sir" is a senior colleague on first name terms. Medical graduates of the 2000s expect, and receive, education, training and supervision.

What does the world look like for our current medical graduates? According to Leeder, there remains a significant disconnect between medical school and internship.

Our graduates tend to be older; many are married with children and burdened with debt. They are concerned with achieving and maintaining a work life balance, and are trained to think, criticise and challenge. Many are working in urban settings, although some are taking up the recent initiatives to move to rural preferential intern placements. They are keen to secure equitable training experiences with exposure to good clinical teachers, and are open to receiving that training in expanded settings outside the more traditional teaching hospital environment. They are strong advocates for patient safety and quality of care – and believe that intern education is critical to safe patient care and sound postgraduate education. Nevertheless, intern work remains mired in 'administrivia' – forms, logbooks, records, surveys, according to Leeder – 30% of the time of an intern's work has no clinical educational value.

After internship and residency, according to Harris et al (2004), more recent graduates (from 1996 onwards) decide on their specialties earlier compared to older graduates. By the end of the first postgraduate year (PGY1), 37% had chosen their specialty, 43% by the end of the second or third postgraduate years (PGY 2 and 3), 9% at the end of the fourth and fifth postgraduate years. Only 11% chose their specialty more than 6 years post graduation.



More controversial is the recurring issue of the extremely long length of training of specialist doctors, more recently raised by Peter Garling (26 October 2009) at a University of Sydney forum. This is not peculiar to Australian medical training. The Chair of Surgery at Eastern Virginia Medical School recently stated that the most wasted year in all medical education is the 4th year of medical school. The President of Association of American Medical Schools noted that some students would benefit from having 4th year of medical school count as the first year of residency. In some New Zealand medical schools, final year students are paid supernumeraries. In a paediatric clerkship in the United States, the senior year is designed as a bridge between the undifferentiated medical student and the focused postgraduate trainee. These senior medical students participate in portfolio and small group sessions to discuss senior curriculum in paediatrics, receive advice about electives, resumes and applying for residency programs. Australian medical schools and specialty colleges are exploring ways of providing educational modules credited by Colleges towards specialty qualification.

### RIDING THE WAVE

In all the fear and trepidation about the “medical student tsunami”, there is no systematic, considered discussion about the expectations and goals of this expansion. Surely, it is up to us, as medical educationalists, to set a timely educational mission to use this expansion to address new and unmet needs in medical education. In a recent discussion paper from the Josiah Macy Foundation, prominent medical educationalists pointed out that we should not be arguing about the projected numbers or estimates of medical students or graduates, nor the funding – who pays and how much. The core issue is to how to educate our doctors for the future. They argue that it is the responsibility of universities and their medical schools to prepare doctors to better meet the public’s needs and participate most effectively in a changing health care system.

In their collective wisdom, these distinguished medical faculty distilled the key educational changes that must be implemented by medical schools:

1. Ensure student diversity (racial, ethnic, social, geographic) so graduates can serve their community better.
2. Decrease the burden of student debt because debt acts as a deterrent to medical studies and has an adverse effect on career choices.
3. Truly integrate the teaching of science and clinical medicine.
4. Meaningfully use technology and educational theory for life long learning.
5. Incorporate principles of patient safety, quality improvement, public policy, public health into the curriculum for all students.
6. Meaningful interprofessional education, collaboration and teamwork as part of the medical program experience for all students.
7. Create clinical experiences which are less fragmented and more truly representative of the experiences and clinical problems of the patients they will serve.
8. Better integrate the whole continuum of education from premedicine to continuing education – allow a shorter duration, competency rather than time based and with better coordination of the transitions.
9. Influence student career choices to better match society’s needs.
10. Create educational models and environments which encourage the professional attitudes and behaviour we prize and our society desires.

Sydney Medical School has achieved much in its curriculum reform.

This extraordinary period of expansion of medical student numbers is an unparalleled opportunity for Sydney Medical School to take a leadership role in thinking beyond simply the numbers and the funding of places. Our focus is to make sure we have a better alignment of Sydney Medical School’s educational mission with the health needs of the community we serve. *radius*

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# Magnetic approaches to molecular medicine

The new \$3 million Tesla magnet enables researchers to understand complex molecular structures

**Y**ou might not be able to put a patient into it but the new three tonne 18.8 Tesla magnet that was recently installed in the basement of the School of Molecular and Microbial Biosciences (MMB) has the potential to make valuable contributions in the twin quests to understand the causes of human disease and to make diagnoses.

Every clinician is familiar with MRI (magnetic resonance imaging) scanners as a routine tool for imaging soft tissue and diagnosing conditions ranging from tumours to spinal injuries to damaged ligaments. The first MRI images were recorded in the late 1970's, and the technology was built on 30 years of development in nuclear magnetic resonance (NMR) spectroscopy. NMR spectroscopy, in which the magnetic properties of atomic nuclei are manipulated and detected, has long been used by chemists to probe the structures and shapes of molecules. Increasingly, biochemists and biomedical researchers have also been harnessing the power of NMR to determine the three-dimensional structures of proteins and other biomolecules.

NMR spectroscopy has been an important part of the research profile at the School of MMB (formerly the Department of Biochemistry) for nearly 30 years, since medical graduate Philip Kuchel was appointed as Professor of Biochemistry.

"Over the years, our NMR work has covered a broad spectrum of activities, from quite theoretical methods development through to literally dozens of collaborations with medical colleagues, who have been keen to understand the molecular foundations of the observations they had made in a cell-biological or clinical setting", says Professor Kuchel.

The new instrument is the most powerful NMR spectrometer in NSW and was purchased by a consortium led by the University of Sydney and including ANU, UNSW, Centenary Institute, Victor Chang Institute for Cardiac Research and the Garvan Institute for Medical Research. The spectrometer features a cryogenically cooled detection system that dramatically increases sensitivity, cutting data acquisition times by up to a factor of almost ten. This makes an enormous difference when you are talking about acquisition times of up to a week or more for some experiments.

"This is cutting edge technology", says Dr Ann Kwan, the NMR Facility Manager. "Your sample – usually a half-

millilitre or so of aqueous solution – sits comfortably at room temperature, whereas the detection system, which is only a matter of a millimeter or so away, is cooled to around -253 °C. It never ceases to amaze me how the manufacturers have managed to engineer a configuration like that".

The technology also dramatically reduces the sample quantities required to carry out experiments. "With this new instrument, it is feasible to determine the molecular structure of a small molecule or a metabolite with only a microgram or so of purified compound," says Associate Professor Joel Mackay, who led the application to the ARC LIEF scheme to purchase the new \$3M magnet. "Similarly, we can determine the high-resolution three-dimensional structure of a protein and investigate its function with as little as a few hundred micrograms of material."

The structure of a molecule is intimately related to its function, so mapping the structure of molecules such as proteins is vital to understand how organisms function, and how mutations can result in disease. Knowledge of molecular structure is also essential when designing drugs, and high throughput screening of small molecule libraries has become a common approach to obtain lead compounds (i). As an example, Abbott Laboratories in the USA used NMR spectroscopy to discover novel tight-binding inhibitors of the matrix metalloprotease stromelysin, which is involved in the pathogenesis conditions such as coronary artery disease (ii).

A recent exciting development has been the use of NMR spectroscopy as a tool for surveying the metabolic profile of a tissue or fluid (metabolomics), which can be a very powerful approach for disease diagnosis, drug profiling and even forensic detective work. For example, NMR spectra of human serum samples have been used as a rapid and noninvasive method with which to diagnose coronary heart disease (iii), and many other applications of this type have been developed (iv).

NMR methods can provide insight into a very wide range of biochemical and biomedical problems and, although researchers in MMB will be putting the new instrument through its paces over the coming months, they welcome opportunities to collaborate with outside users to provide a molecular perspective to their research. If you are wondering whether NMR spectroscopy might be able to provide answers to your questions, contact Dr Ann Kwan (02 9351-4120 or [akwan@mail.usyd.edu.au](mailto:akwan@mail.usyd.edu.au)). *radius*

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# Study online: clinical epidemiology more accessible

Sydney Medical School offers a wide range of postgraduate courses, many available entirely online, including “ClinEpi”.

Students studying clinical epidemiology programs at Sydney School of Public Health can elect to study by traditional face-to-face mode, or entirely by distance learning, or a blend of the two.

“By offering flexible study options we can attract students who may not have otherwise been able to undertake postgraduate study. Our part-time and full-time options, together with face to face or distance-learning possibilities allow students to choose study that best meets their needs and allows them to more easily manage their study, work and personal lives, no matter where they live” said Angela Webster, Senior Lecturer in Clinical Epidemiology

Clinical epidemiology has been offered by the School since 1994 and today it is the leading program of its kind in Australia. The program brings together world-recognised leaders in epidemiology and biostatistics.

Degree programs in Clinical Epidemiology on offer include a Graduate Certificate, Graduate Diploma and a full Masters degree. In addition to flexible study options for degree programs, many units of study are available as stand-alone professional development short courses. Units of study are continuously updated, and new options added ensuring the program remains at the cutting edge of modern clinical epidemiology. New options include units of study on genetic epidemiology and on qualitative health research.

“Students apply for our courses for one major reason: their vocational clinical training and other prior tertiary training does not equip them for what they want to do. Some students want to be able to tell potential employers that they have clinical research skills as well as core clinical competencies. Most want to interpret and use clinical research in their everyday practice, and some want to do high quality clinical research themselves.

Our alumni surveys consistently show that we can provide these skills,” said Professor Jonathan Craig, Director of the Program.

While the courses continue to attract applicants with a medical degree, they are aimed at all healthcare workers who have a clinical role. Past and current students include junior and senior doctors, nurses, midwives, pharmacists, physiotherapists and paramedics. *radius*

For more information about Clinical Epidemiology or to download a course guide, see [www.health.usyd.edu.au/future/coursework](http://www.health.usyd.edu.au/future/coursework)  
[clinepi@health.usyd.edu.au](mailto:clinepi@health.usyd.edu.au)

For more information about the full range of postgraduate courses on offer, please visit our website  
[www.medfac.usyd.edu.au/futurestudent/postgrad/coursework/index.php](http://www.medfac.usyd.edu.au/futurestudent/postgrad/coursework/index.php)

*“There are many great aspects of the Masters program in Clinical Epidemiology: the excellent faculty, the relevant courses and the pragmatic statistical skills. It was the flexibility I appreciated the most. The excellent on-line access allowed me to complete half my courses from Canada and the other half in Sydney.”*

Rahul Mainra  
 Master of Clinical Epidemiology student



# DONATIONS AND MENTORS



**Ineke Wever** President, Sydney University Medical Society - [iwev6767@med.usyd.edu.au](mailto:iwev6767@med.usyd.edu.au)

## → CELEBRATING SYDNEY MEDICAL SCHOOL'S COMMUNITY

This will be my last article for Radius as I am becoming an intern next year and handing the reins of MedSoc over to the new Executive who I am sure will continue the great work done by the 2009 MedSoc Council. I am immensely proud to be graduating from Sydney Medical School and joining the ranks of alumni who continue to impress and inspire me.

The Australian Medical Students' Association October Council was held in MacLaurin Hall and among the remarks of appreciation and comments about looking like Hogwarts, I took great delight in reminding the Bond University representative that 'this is what real sandstone looks like!' Prestigious architecture is just one difference. The newer medical schools also miss out on the sense of community that comes from being a Sydney University student and talking with past graduates who have spent decades in the health system, sharing a knowing tale about a particular building, teacher or tradition.

## → BOOK DONATIONS AND ALUMNI MENTORING: PROJECTS FOR NEXT YEAR

Another exciting project to come out of MedSoc recently is between GlobalHOME, our global health group, and the MedSoc Bookshop. Both entities independently came up with the brilliant idea of a book donation scheme, whereby books would be donated to developing countries that need them. While the project is still in the development phase, several ideas have already been proposed:

1. 'One textbook for you, one for the world' scheme whereby alumni buying textbooks for themselves buy another for the stockpile of new textbooks for a developing country medical school.
2. 'Donate your discount' scheme, whereby alumni can donate their MedSoc discount to a literacy good cause such as the Indigenous Literacy Project.
3. A second hand book donation scheme, where alumni can donate their textbooks to those in need (however would need to have some exclusion to ensure MedSoc did not become a repository for out-dated textbooks!).

One project which I would like to see get off the ground in the future, as it has had several false starts, is an alumni-student mentoring program. Students would benefit from having guidance in regards to career options, support from outside of

their immediate network and direction from the wise medical professionals who have gone before them. It would also be beneficial, I believe, for alumni to stay in touch with the younger generation who will be determining the future of the medical profession. This idea will be discussed at the next Medical Alumni Association meeting and I would encourage any alumni who have ideas as to the logistics of this challenging project to attend.

## → INTERNSHIPS AND INTERNATIONAL STUDENTS

MedSoc has continued its advocacy on internships and international students, hosting the NSW Medical Students Council 'The Medical Student Tsunami: Do you Have a future?' on October 29th. Generating some media coverage, we continue to advocate for increasing the number of internship spots while continuing their quality of teaching and supervision to cope with the increasing numbers of graduates.

## → THANK YOU TO 2009 MEDSOC

I would like to say a particular thank you to the MedSoc Council of 2009, all fifty-four of you! This years Council has been enthusiastic and far-reaching in their projects for this year and together we have achieved many good things. I wish them the best of luck for the future!



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## president's report

In a recent talk given mainly to medical students at the University of Sydney, Professor Sanjiv Chopra, Faculty Dean of Continuing Medical Education at Harvard Medical School, spoke on what he regarded as the ten tenets of leadership. Taking words beginning with each of the ten letters in 'LEADERSHIP', he cited the exemplary qualities and attributes of historic and contemporary leaders in all walks of life. These included the skills and attributes of: being a good Listener; Empathy and compassion; Attitude; the capacity to Dream expansively; Effectiveness in doing the right thing; Resilience and a Resolute determination; a Sense of purpose; Humility and a sense of Humour; Integrity, Ideas, Imagination and ability to Inspire; and Principles and People skills. (So how do you judge yourself on those characteristics?)

Professor Chopra asserted that anyone who followed his ten tenets would be on the path to becoming a better leader and that clinicians can use these principles in caring for their patients.

Our GMP students recognise that much can be learnt about leadership and recently organised a Medical Leadership Seminar. Those of us who had graduated in the generations before had heard virtually nothing on such topics! Perhaps it was just assumed that we would find suitable role models and informal mentors among our lecturers and tutors, within our extended families and among local doctors.

Through our proud history as Australia's first medical school, Sydney has spawned numerous leaders in clinical care, medical education, research, and public health. But we have been slow to develop effective programs of mentoring to advise our GMP students, and those doing public health and other postgraduate courses, on their student experiences and future career options.

In response to a request in a recent e-Newsletter several alumni have made suggestions about the desirable aspects of formal mentoring. I have also had preliminary discussions with the Dean, some of his advisers, student leaders, and the Medical Alumni Association Council. We aim to harness

the interest and enthusiasm of our alumni and also to take advantage of mentoring skills gained by our academic staff and alumni in other settings.

In developing an effective mentoring program for all students, we need to consider the needs of special groups – our international students, those who have never previously lived in Sydney, and our few Indigenous and refugee students.

In August our Vice-Chancellor, Dr Michael Spence, launched the University's alumni online networking community, called AlumniOnline. This will eventually enable you to search for colleagues and friends and to search, join and establish social and professional networks (see [www.usyd.edu.au/alumni](http://www.usyd.edu.au/alumni)). It also includes an option to mentor a student.

Fledgling efforts at mentoring have started in at least one clinical school. GMP1 students at Western Clinical School receive advice about their studies and student life from other students in GMP3 (aptly named 'Sherpas'). Also, students in GMP1 in all clinical schools prepare a Personal and Professional Development (PPD) portfolio. Some of our alumni have been voluntarily interviewing these GMP1 students towards the end of their first year. Interviewers offer friendly guidance to students and both then provide brief comments to Sydney Medical School.

Undoubtedly we will require a well coordinated approach to achieve effective mentoring of our students. While some in the wider University consider that much mentoring can be done by email, I think that face-to-face meetings should be an essential component, at least for initial discussions. So how is mentoring best organised? It seems most feasible to put students and mentors in touch with one another through each of the city and regional clinical schools, thus enhancing opportunities for mentors and students to meet regularly.

Please send your ideas and suggestions to me: [pallancaster@gmail.com](mailto:pallancaster@gmail.com), or call on (02) 9660 0576. We are keen to hear from alumni who would be happy to be mentors at the start of the GMP1 program in 2010.

# alumni news

PRESIDENT'S REPORT → ALUMNI ARCHIVE  
→ CASE NOTES → REUNION REPORTS  
→ REUNION DATES → OTHER PASSIONS

# Young Life Lost In Pursuit Of Medical Knowledge

THOMAS CARLYLE PARKINSON 1884 - 1909  
MB CHM 1906



Above: Parkinson in laboratory, Lister Institute.

Contents page: Thomas Carlyle Parkinson as prosector at the Sydney Medical School 1903. Parkinson is second from left.

So many of our pioneer doctors died untimely deaths whilst striving to find cures for diseases ravaging humanity at that time.

One hundred years ago, Thomas Carlyle Parkinson died whilst working as part of the Indian Plague Commission at the Lister Institute of Preventative Medicine in London. Parkinson lived through the outbreak of plague in Sydney in 1900 before moving to London. He contracted plague while working in the laboratory and died only three years after graduating from the Sydney Medical School.

By Lise Mellor

Carlyle Parkinson was born in Sydney and came to the fledgling Sydney Medical School in 1901. He was an enthusiastic and excellent student, coming first in his year in each of the five years he completed. Excelling in dissection, he became a prosector in 1903 with peers Arthur Moseley, George Bell, John Hill and John Harris. As an undergraduate, he gained the Renwick Scholarship for Natural Science and Comparative Anatomy and the John Harris Scholarship for Anatomy and Physiology. Parkinson graduated in 1906 and was awarded the University Medal with special distinction.

Leaving medical school, he became Resident Medical Officer at the Royal Prince Alfred Hospital and a year later, Resident Pathologist. In 1908 he transferred as Junior Medical Officer to Callan Park Hospital.

As a young doctor, Parkinson retained the interest for scientific investigation he had exhibited as a student and in 1908 successfully applied for the James King Travelling scholarship to further his studies in England. Parkinson had experienced the impact of plague outbreaks in Sydney in 1901-2 and had studied here under Sir Charles J Martin before Martin took up the Foundation Chair of Physiology at the University of Melbourne. When Martin returned to England and became director of the Lister Institute of Preventative Medicine in 1903, it became a magnet for young Australian doctors attracted to medical research. So it is not surprising that when Parkinson went to London to broaden his experience, he chose to join C.J. Martin's team at the Lister Institute where work on improved plague vaccine was a major preoccupation. Martin was renowned

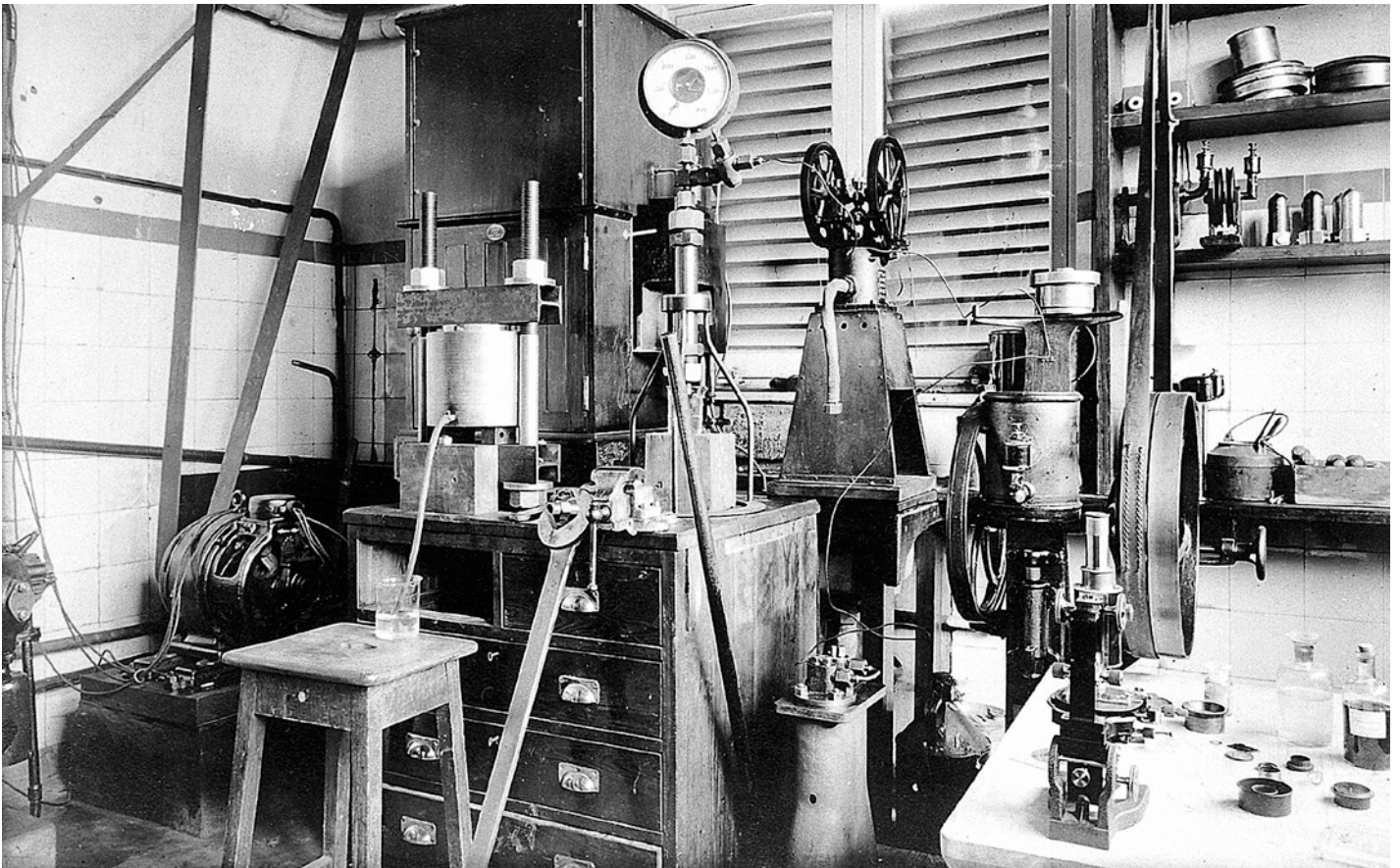
for making opportunities for Australian medical researchers and Parkinson joined his team.

Parkinson worked at the Lister Institute until October 1908, when he was appointed to the Indian Plague Commission. He worked alongside Sidney Rowland, a bacteriologist at the Lister's Isolation Laboratory at Elistree. The project involved growing large quantities of plague bacillus then grinding it before extraction by chemical treatment. The dangers of this technique were well recognized: two deaths already from typhoid at the Lister in 1903.

So far it has not been possible to find out the exact nature of Parkinson's work on plague, as the Lister Institute Archive was severely damaged by World War II bombing and there were no scientific publications identifying him as an author. However, we do know that in 1908, the Institute was involved in preparation and testing (in horses) of the potency of plague antiserum. This required mouse protection tests using injections of live organisms – potentially with a risk to the experimenter.

The other method of research into plague vaccines that was active at the Lister at that time involved growing and purifying large batches of organisms before grinding and extracting them. Centrifugation, pressure filtration and grinding all generate dangerous aerosols, and such work was conducted in ordinary laboratories with protective clothing limited to gowns. Reports of laboratory acquired infections and deaths are all too common in the early microbiological literature of the period.

Parkinson contracted pneumonic plague and died two and a half days later on February 4th, 1909, just before his



Grinding and extraction apparatus.

25th birthday. There was no coronial inquest.

Little is recorded about the manner in which he contracted plague, however, if an inoculation injury was the source of his infection it would have led to classical bubonic plague with a localised buboe as its first manifestation. That Parkinson suffered pneumonic plague suggests his illness was caused by inhalation of plague organisms.

Dame Harriett Chick was on the staff at the time and later co-authored *War On Disease: the official history of the Lister Institute* (1971). She describes the plague research being carried out and mentions Parkinson's death, but her description is oblique and only adds mystery to his demise:

*The organism...was grown in an isolated laboratory and if any worker suspected that he had received a small splash, for instance while inoculating a horse, he immediately had a bath of lysol. But close familiarity with the agents of death seems often to breed something close to contempt for danger, and even the best workers may, like rock climbers, have an off day and make a slip in a familiar practice.*

*In 1909, an Australian guest worker, Thomas Carlyle Parkinson, working under Rowland, complained of feeling desperately ill. He was living at the time in Queensberry Lodge, where several of the bachelor workers were accommodated. It was thought at first that he had influenza and Hartley and Rowland looked after him. When it was realised that his lungs were infected, (Sir) Martin came out from Chelsea and recognised that Parkinson had pneumonic plague. There was nothing they could do to influence the result; within three days of falling ill Parkinson died.*

Hartley was given large doses of Haffkine's plague serum

and neither he nor any the contacts became ill. Soon after, isolation bungalows were erected to house staff working with dangerous pathogens. Both Rowland and Macfadyen (who had invented the grinding technique) later died of laboratory infections while working on other organisms.

Minutes of the Lister Institute meeting of 1909 state that the Chairman referred in feeling terms to the lamentable occasion and moved "that the Governing body hears with deepest regret of the death of Dr Parkinson from an infection incurred during the performance of his scientific duties and expresses sympathy to the relatives of Dr Parkinson in their affliction".

Parkinson's obituary in *The British Medical Journal* said that his "acquaintances will remember him as a keen worker, but his comrades realise that they have lost a good and trusted friend. He lost his life striving in the interests of others, doing a man's work as a man should."

Back in Sydney, there was no obituary in the *Sydney Morning Herald* but subscribers to a memorial for Parkinson established the Parkinson Memorial Prize for Pathology. Established with a bequest of £225, the initial value of the prize was £5, awarded annually for proficiency in Pathology on the result of the Fourth Year Examination. Today the prize is awarded for meritorious performance in a pathology Quiz conducted by the department and is valued at \$750.

At the Lister Institute a plaque was erected in the Isolation Laboratory at Elistree to commemorate Dr Parkinson's death with the words "died in faithful discharge of scientific duties". The plaque is now housed with the Lister archives at the Wellcome Institute. [radius](#)

More interesting historical information about Thomas Parkinson and other alumni is available in Sydney Medical School's online museum: [www.medfac.usyd.edu.au](http://www.medfac.usyd.edu.au)

# case notes



## 1960s

Frank Stitt  
MBBS 1963



After graduation, I spent six years at Royal Prince Alfred Hospital as a house officer, Cardiology Registrar, and National Heart Foundation research fellow. At the end of this period, I moved to Sydney Hospital as a Fellow in Cardiology and sat for the Royal Australian College of Physician's (RACP) Membership exam, gaining recognition as a consultant physician.

I left for London and ended up with a joint appointment at the Medical Research Council (MRC) and the London Hospital (in the East End) as a Senior Cardiology Registrar. One of my research projects took me all over the UK for a study of risk factors for heart disease: I thought it was pretty good to be paid (albeit at UK rates) to be tourist, and went all over the British Isles. This work sparked a new interest in information technology and biotechnology innovation, skills that came in handy later on.

When other plans suddenly fell through, I was recruited by the drug industry, not something I had considered up to that point, but a quadrupling of my salary was compelling, plus the experience. So, I accepted a Medical Director's post for a Swiss company based in New York. Working in New York, with a virtually unlimited budget, was a revelation after the threadbare resources available in Australia,

London etc.

From there, I moved to California - two British pharmaceutical companies offered to fund a consultancy service so with some trepidation, I left full-time employment forever, something I have never regretted. I assembled a team from UCLA and we were never short of work.

Through most of the 1980s, I based myself in San Francisco and combined academic activities (research and teaching) at UCSF and UCLA with an active consultancy based on information technology in medicine. I was also heavily involved in AIDS research. My Spanish language skills drew me towards Latin America, and I carried out a number of studies in Mexico and Argentina. In 1988, I accepted an opportunity to move to Miami as a Professor of Medicine and Epidemiology, and physician at the Miami Veteran's Hospital centred on the AIDS research unit.

I was given funds by the government of Puerto Rico to develop a healthcare information model for the island, which I did with a team of collaborators. Part of the model included medical education and in 1998 we started the first Internet-based medical school in St Kitts and Nevis. With my colleagues, we were invited to contribute by invitation to the British Medical Journal's Millennium Edition. The paper, titled "Universities without walls: new paradigms for medical education", attracted a lot of attention, resulting in my subsequent pursuit of technology-driven medical education.

More recently, I have been Vice-Chancellor of new medical schools in Samoa and Vanuatu. I do work for WHO, and last year developed a faculty training package for the Fiji Schools of Medicine and Nursing. This was built upon my earlier work in Valencia, Spain, and Buenos Aires,

Argentina.

I remain a real Hispanophile, and very fond of warm weather! And warm water.

## John D Stephens MBBS 1967

President of BRM (Bellingham Railway Museum)

I am one of the founding members of an all volunteer run, non-profit organisation that started the Bellingham Railway Museum in downtown Bellingham, Washington, where I have been living for the past 12 years.

My interest started when I was quite young, around eight years old, when I was given a HORNBY train set. Life progressed in a new direction after I left Drummoynne Boys' High School and entered Sydney University School of Medicine in 1961. After graduation I did the usual residents training, and left Sydney in 1970 for Oxford UK, where I started OB/GYN training which led to MRCOG in 1973.

I left UK in 1974 and did a locum in Brandon Manitoba for 6 months while waiting for my position as a physician specialist at Stanford University Medical Centre in California USA. That lasted 4 years until I obtained a fellowship in obstetrical genetics at UCSF (University of California San Francisco) from 1978-1980.

I opened my own private practice specialising in prenatal diagnosis and ran a genetic amniocentesis facility

from 1980 until 1991. Then I got divorced and closed the California Prenatal Diagnosis Institute, my amniocentesis practice, and began exclusively focussing only on ultrasound for the practice of prenatal diagnosis. I divided my time between Palo Alto California (as a part-time parent and dad for my son Mischa, who showed no proclivity what-so-ever for medicine. He joined Google Co. in Mt. View immediately after he graduated from a liberal arts college, Swarthmore, where he remains today) and Bellingham, Washington State, where I now live permanently.

Six years ago, I opened up boxes of the trains that I had bought hoping to "play trains" with my young son - but the D put an end to that. So back into their gleaming red boxes they went, and into long term storage. (Train lovers may recognise that those RED boxes are all G scale LGB trains) When I reached age 60 yrs, I found myself looking for an opportunity to "play with trains again". A group of like minded retiree's decided to start a Railway Museum, and at age 66 years I feel it keeps me in touch with kids and parents of kids whom just love everything to do with trains, along with helping a new generation to come to value an alternative form of transportation to the almighty automobile. For more details, please see [www.bellinghamrailwaymuseum.org](http://www.bellinghamrailwaymuseum.org) and maybe come visit me at The Museum.







## AN UNUSUAL HOBBY FOR A RETIRED SURGEON?

James Edwin Wright MBBS 1955

Brought up on a farm at Boambee, on the north coast just south of Coff's Harbour, something sparked an interest in bees at the age of 12 or 13. Farmers on each side had bees and they were most helpful, one giving me a hive box and a homemade hive tool and the other the first swarm out of his hives in spring. And so I had my first beehive! Well may you ask why a boy would spontaneously develop such a passion when neither parent was interested. I can only answer in words from "South Pacific"

*Who can explain it?*

*Who can tell you why?*

*Fools give their reasons,*

*Wise men never try.*

My second swarm came shortly after, in very different circumstances. I used to ride a horse to school, and on the way I saw a swarm of bees hanging accessibly on a tree. I was late for school that day! This swarm, however, was very aggressive and I didn't like them much. Being inexperienced and with limited protective gear, I was timid and found the brood box rather daunting. (Now it's the most fun place to explore; it is the engine room of the colony.)

The nearest supplier of beekeeping equipment was Penders in Elgin Street Maitland where they had a

factory making all their own hives and tools on site. Penders are still in business, but hives are imported from New Zealand and mechanical equipment from Italy. Prices were stable then and relatively cheap. I used to save up my pennies, order from their catalogue, pay by postal note for delivery by train to Coff's Harbour.

At 16 years of age I went off to Sydney University and of course the bees had to go. Some 15 years later, when living in Newcastle, a swarm lobbed in my front garden. Of course, I had to have them but I had to get some gear. Penders was a wonderful firm, for when I rang I was delighted to find that I was still on their record books and my credit was good! And that was long before computerised records.

I've had bees in a suburban backyard ever since but it is only since retirement 14 years ago that I have been able to exploit the hobby to the full, gain confidence and reap maximum enjoyment from it. That was made possible by joining the Hunter Valley Branch of the Amateur Beekeeping Association of NSW, and I would strongly urge any budding beekeeper to start by joining this organisation. There is a lot to learn, support is needed to gain confidence and there is no better source of hands-on education than from other the friendly experienced beekeepers.

# Hot to go.

## Need motivated employees for the summer months who can contribute from the get-go?

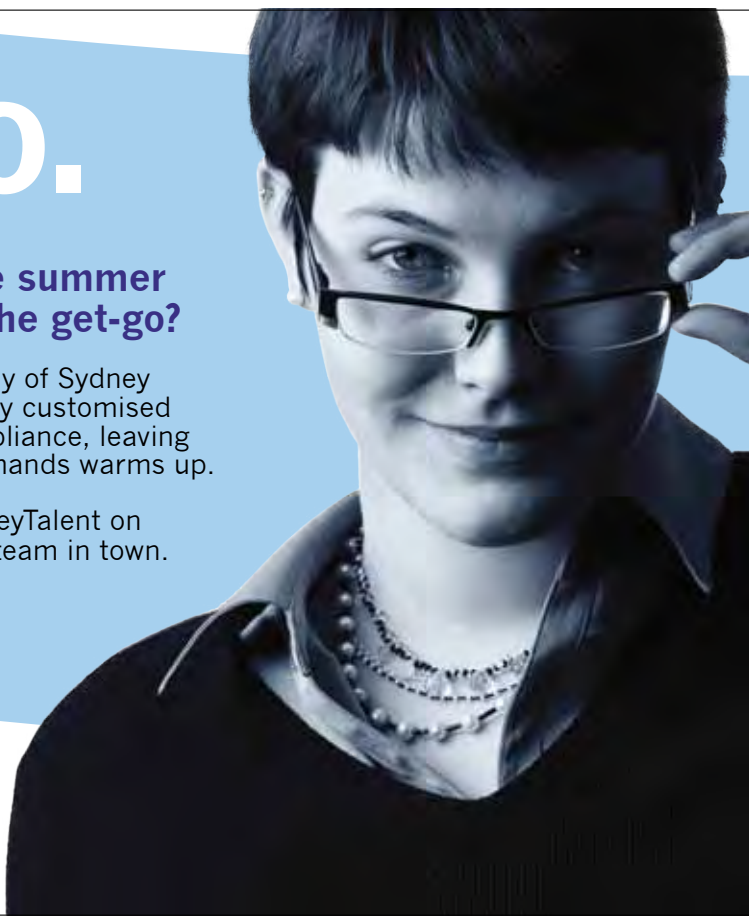
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### Alan Gale MBBS 1969



After initial career priming (MRACP - subsequently FRACP) at RPAH (and changing direction to FRACS) and St Vincents Hospital, I was the first Australian to be awarded the prestigious Everts A. Graham Fellowship of the American Association for Thoracic Surgery and spent several years in America in cardio-thoracic surgery culminating at the Mayo Clinic before returning to St. Vincents Hospital and subsequently RNSH. & the Sydney Adventist Hospital.

For the next 22 years I had the privilege of assisting in the development of cardiac programmes in nine countries from Pacific Islands & PNG to Mongolia, Nepal, Vietnam and Myanmar in association with Sydney Adventist Hospital & Rotary International. This led to numerous awards including from the late king of Nepal, the President of Fiji and the Shastin University of Mongolia as well as many Rotary awards. Receiving the International Medal of the RACS in 2007 was a career highlight.

Retiring from active surgery last year (after almost 35 years of surgery) allowed me to accept the position of Director of Clinical Training at the Royal Brisbane & Women's Hospital and Associate Professor in the School of Medicine at the University of Queensland, satisfying my passions for education & learning.

These onerous administrative tasks have limited my time (and expenditure) in restoring vintage motor vehicles and visiting with Helen, still my wife after 41 years, my two sons, one a lawyer in New York, the other a marketing director for an international company in Canada.

### Alexander Frank John Bell MBBS 1969



I did my residency at Launceston General Hospital, Tasmania and then went to Claremont Hospital, Perth, in 1970 as a medical officer. While in WA, I gained the DPM and MRCPsych, and went first to Parkville Psychiatric Unit as a registrar. I gained the MRANZCP, worked at Mont Park Hospital as a consultant psychiatrist, and then to Hobson Park Hospital as Psychiatrist Superintendent where I gained the FRANZCP.

In 1983 I went to Ontario, where I worked in various positions for 17 years, the last and most fulfilling as the psychiatrist for an Assertive Community Treatment Team.

In 2005 I returned to Launceston General Hospital as Consultant Psychiatrist and worked in that role until I retired in 2005, though I worked part time as Acting Clinical Director for a couple of years.

Music has always been an important part of my life. Shortly after we returned to Launceston, I took up the oboe and currently play in the Concert Band of the University of Tasmania Community Music Program. After I retired I started learning to play the piano.

The major passions in my life though have been social justice and peace.

I am a member of the Medical Association for the Prevention of War at [www.mapw.org.au](http://www.mapw.org.au) and of Physicians for Human Rights at [www.physiciansforhumanrights.org](http://www.physiciansforhumanrights.org), and am a corresponding member of Pax Christi at [www.paxchristi.org.au](http://www.paxchristi.org.au).

At the end of the year I am going to Cairo and then to Gaza to take part in the Gaza Freedom

March as described at [www.gazafreedommarch.org](http://www.gazafreedommarch.org) in an attempt to get Israel to lift the siege of Gaza. I expect to take with me as much as will fit into my backpack of some of the many items whose entry into Gaza is severely restricted, like toilet paper, children's schoolbooks and pencils, and children's shoes. Because I am so old and absent minded, it is quite possible that I'll forget to take the stuff out with me.

The church I attend is trying to set up a sister church relationship with Gaza Baptist Church, and I very much hope to visit them while I am in Gaza as well as the Community Mental Health Program.

### 1980s

#### Ferdinand Chu MBBS 1986



Since the age of 6, I have always been a keen swimmer. Other than swimming I have never taken other sports seriously.

I also have been working as a radiologist in Hong Kong for 19 years. During the S.A.R.S. epidemic in 2003, all swimming pools in the territory were closed for health and hygiene reasons. When I had no means to do my only sport, I turned to jogging which I have not previously contemplated doing. I started with 3 km, and participated in my first 10km race within 7 weeks and my first half marathon within 2 years.

Banking on my progress in the previous 2 years, I bought my triathlon bicycle, and have taken part in 3 half-Olympic distance races since. I am sure I would be able to complete my first full-Olympic distance race next month and my first full marathon in 5 months' time.

I firmly believe that the fun derived from triathlon training is beyond anything describable. It also spaces out the stress that one has on their body, thereby decreasing the chance of injury. In times of injury, which is an inevitable thing in sports, one can always take a component out

from his training and try to stay fit just with the others.

### 1990s

#### Loreto (Loren) Rose MBBS 1999



I'm back in Sydney after 4 years in Melbourne, and working part time since completing my specialty training in Ophthalmology. As a student, I had loved my experience working with kids and I have a sub-speciality in paediatrics. Im also busy raising 2 girls – Amelia, who is almost two and half years old, and Alyssa who is 6 months old. My private practice is in the west, south west and northwest and I have a public post at Bankstown Hospital.

In the decade since graduation, the highs have been marrying Nick during internship and recently, starting a family. In the middle, I finished the ophthalmology training program in Melbourne. My biggest low was the passing of my father 3 years ago.

Ten years after graduation, my best memories of medical school are the social networks: it was great to meet and get to know so many of my study mates. It was great to learn with such a diverse group and see us all grow. Unfortunately keeping up to date has not been that easy! I also have to thank those medical school parties where I met Nick!

### Other Passions?

*Radius will be running regular stories on "other passions". If you have particular interests outside health and medicine, let us know. We will also continue with regular Case Notes, and hope alumni will still keep us up-to-date with news of their career, family and other developments.*

[radiuseditor@med.usyd.edu.au](mailto:radiuseditor@med.usyd.edu.au)

# reunions 2010

Does your graduating year have an important anniversary in 2010? Let us help you contact your fellow graduates, issue invitations and promote your event.

Please contact your alumni reunion manager, Diana Lovegrove, on (02) 9114 1163 or by email at [d.lovegrove@usyd.edu.au](mailto:d.lovegrove@usyd.edu.au).

## GRADUATING YEAR OF 1965

When: Saturday 30th January 2010  
Where: Taronga Centre,  
Taronga Park Zoo,  
Bradley's Head Road, Mosman  
Time: 11am  
Contact: [r.wines@hcn.net.au](mailto:r.wines@hcn.net.au) or  
Diana Lovegrove  
[d.lovegrove@usyd.edu.au](mailto:d.lovegrove@usyd.edu.au)

## GRADUATING YEAR OF 1970

When: Saturday 20 February 2010  
Where: The Great Hall,  
The University of Sydney  
Time: 6.30pm  
Cost: \$130pp  
Contact: Diana Lovegrove  
[d.lovegrove@usyd.edu.au](mailto:d.lovegrove@usyd.edu.au)

## GRADUATING YEARS OF 1990 AND 1991

When: Saturday 27 February 2010  
Where: The Great Hall,  
The University of Sydney  
Time: 6pm  
Cost: \$140pp  
Contact: [reunion1990@live.com](mailto:reunion1990@live.com)

## GRADUATING YEAR OF 1960

When: Saturday 13 March 2010  
Where: The Great Hall,  
The University of Sydney  
Time: 6pm  
Cost: \$120  
Contact: Ann Sefton and Steven Kovacs (via [d.lovegrove@usyd.edu.au](mailto:d.lovegrove@usyd.edu.au))

## GRADUATING YEAR OF 1950

When: Monday 15 March 2010  
Where: Concord Golf Club,  
Majors Bay Road, Concord, NSW  
Time: 12.15 for 12.45pm  
Cost: \$80pp  
Contact: Brian Pollard  
[bpoll79@bigpond.net.au](mailto:bpoll79@bigpond.net.au)  
or 02 9436 3516

## GRADUATING YEAR OF 1955

When: Saturday 10 April 2010  
Where: The Royal Sydney Golf Club  
Time: 11.30am  
Cost: TBA  
Contact: John Wright  
[rebjohj@netspace.net.au](mailto:rebjohj@netspace.net.au)

## GRADUATING YEAR OF 1980

When: Saturday 1st May 2010  
Where: The Great Hall,  
The University of Sydney  
Time: 6pm  
Cost: TBA  
Contact: Diana Lovegrove  
[d.lovegrove@usyd.edu.au](mailto:d.lovegrove@usyd.edu.au)

## GRADUATING YEAR OF 1956

When: Tuesday 26 October 2010  
Where: The Royal Sydney Golf Club,  
Kent Road, Rose Bay  
Time: 12 noon  
Cost: TBA  
Contact: Jim Purchas  
[jimpurchas@netspeed.com.au](mailto:jimpurchas@netspeed.com.au)



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*"A good journey. You could only envy that." Vladimir Ashkenazy*

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MAHLER Songs of a Wayfarer | MAHLER Symphony No.1

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MAHLER Symphony No.8

**ON SALE 14 DEC**

### MAHLER 5 - TEARS AND ECSTASY

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Presented by Trust  
THU 20 MAY | 1.30PM

Emirates Metro  
FRI 21 MAY | 8PM

Great Classics  
SAT 22 MAY | 2PM

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# reunion reports

## 1964 REUNION

The jacaranda in the lawn bore the ethereal but ominous mauve cloud which used to herald the rapid approach of exams, at a time in history when med exams were truly fearsome events for most of us (they passed 30% of our Second Year).

But the carillon was playing and the sandstone in the Quad glowed a welcoming gold as the Year of '64 met in the early evening of 24 October for drinks and renewed friendships, some not having met for 45 years.

There was mild surprise on discovering how many of our cohort had achieved success and distinction in so many different fields, both locally and internationally.

Many faces were recognisable from the yearbook, and some less so, but with conversation the years fell away, so by the end of the evening we might have been about to head back to the dissecting room together, without feeling any different from our student selves. Thankfully, all that was safely behind us, but we did enjoy a tour of the newly-renovated Wilson Museum of Anatomy, in its old home in the Anderson Stuart Building.

Dining tables had replaced rows of desks in the Great Hall, and laughter the hectic scribbling and blank gazing for inspiration of our former visits. Some recalled in great detail the five-pronged gas jets flaming in winter, and the flags and statues which decorated the walls in those testing times and at our Graduation.

A stirring rendition of Gaudeamus was led by University carillonneur and organist Amy Johansen, who declared that our choral

efforts outperformed the organ. Marching Through Medicine and Our Varsity, nostalgic from med dinners, followed.

A few reminiscences from our year reps, Jules Black and Bob Bauze, completed the program (we had no idea how naughty some people had been) but the camaraderie lasted until it seemed the Yeomen Bedell himself would have to evict us with his halberd, with the moon rising over the turrets at the most photographic angle.

Many thanks for this memorable time of fellowship are due to committee members David Gibb and Peter Malouf, and to the Medical Alumni Association, without whom an attendance of 70 grads and 40 partners would not have been possible.

Retirement and privacy laws make contact difficult over the years, so we beg all grads to keep in touch through the Alumni Association, and to give us any information about "missing" members, or ideas to make our 50th anniversary in 2014 a spectacular production.

*Margaret Lorang*

The 45th reunion of 1964 medical graduates was held on the evening of Saturday 24th October at Sydney University. 110 graduates and guests assembled at 6.30 pm in the University Quadrangle for an hour of pre-dinner drinks and light refreshments with background music from the University Carillon provided by Amy Johansen. The graduates proved to be a lively group which revelled in renewing old friendships and reminiscing on the joys and hardships of undergraduate life.

This initial get-together was followed by a 3 course dinner in the Great Hall. Following the first course the congregation rose as one to sing, with great gusto and enthusiasm, three traditional university songs Gaudeamus Igitur, The Varsity and Marching Through Medicine accompanied by Amy Johansen on the Great Hall organ. The meal and wines were of a high standard, a fact that was remarked upon by many of those present.

A noticeboard was provided in the Great Hall with messages from colleagues unable to attend, requests for updated addresses for 1964 graduates who could not be contacted and a list of deceased members of the year.

Jules Black assumed his traditional role as Master of Ceremonies and Margaret Lorang provided useful reunion information together with recommendations for future reunions.

In summary: a great night was had by all. Gaudeamus Igitur!

*David Gibb*

## 1999 REUNION AND SENIOR YEARBOOK LAUNCH

Graced by a beautiful Sydney spring afternoon, the class of '99 - the penultimate full six year cohort prior to the introduction of the Graduate Medical Program - convened in the beautifully renovated Anderson Stuart courtyard with a punctuality that might have surprised our former gastrophysiology lecturer and Dean, Professor John Atherton Young.

Despite family and professional obligations, several had travelled

interstate on the night. A jazz trio (formed from three members of 1990s acid jazz charting band Directions In Groove) provided a chilled soundscape as we reconnected with faces not seen for 10 years.

As the buzz grew, we were escorted upstairs to tour the Wilson Museum of Anatomy, where we mingled with members of the year of 1964 who were holding their reunion on the same evening in the Great Hall. However the event wasn't only a reunion but also the long-awaited launch of our 1998 senior yearbook, so after our group photo and a toast to the University, the yearbook's eventual but reluctant editors, Tim Shortus, Phil Rome and Paul Nicolarakis, proceeded to hand out the long awaited tome to their gracious peers.

Few felt the urge to leave by the official conclusion of the evening with a merry band making their way to the Ancient Briton in Glebe to continue catching up through to closing time. Heart felt thanks to our generous sponsors, The Medical Society Bookshop, Experien Investec and The Pentagon Group, as well as to curator Marcus Robinson for opening up the Anatomy Museum, the Medical Alumni Association and the staff of the Medical Society Bookshop for coordinating the event. Proceeds from the evening will be directed to supporting indigenous medical students enrolled at Sydney Medical School and a Facebook group (Usyd Class of '99) has been established to share photos taken on the night, stay in touch and also make the next reunion just that little bit easier to organise.

*Paul Nicolarakis*

## 1948 REUNION

On 25 September, graduates of 1948 SU Med came to the University for the anniversary.

We met at the Art Gallery with Mr Justice Roddy Meagher to view and discuss with him his collection - started when a senior schoolboy - which was a singular experience. We then walked down Science Road in the spring sunshine to lunch at the Union Withdrawing Room. Peter Harvey welcomed us and presented apologies and best wishes from colleagues who were absent overseas, interstate or because personal commitments. The funeral of George Hall (MBBS 1946) who had been an esteemed teacher and colleague to many of our year was remembered.

During lunch, Roddy Meagher addressed his philosophy of collecting - it is indeed the essence of eclecticism. Eric Fisher, who grew up and later practised in West Wyalong close to Temora, Roddy's home town, thanked him on our behalf. This is an outstanding gift to the University and the generous terms of the bequest will benefit not only students and academics but will be made freely accessible to visitors to the University.

The 61st anniversary is not like the 50th, or even the 60th. It is not easy for some to come to the event and our numbers will decline. All are encouraged to tell others that there is continuing enthusiasm to revisit the University and to see again men and women whom we first met as freshmen in 1943.

There will certainly be future anniversaries. Linking our meetings to the splendid

exhibitions, concerts and lectures which are part of the University calendar can be an added attraction.

*Harding Burns*

## 1946 REUNION

Medical graduates of 1946 celebrated their 63rd reunion luncheon overlooking the beautifully manicured fairways of Concord Golf Club on Friday 25th September.

It was an exciting day with 22 graduates attending and a total complement of 34.

A photograph of our whole year at graduation was posted on the noticeboard together with some informal snaps and a list of surviving graduates, attendees and apologies.

After catching up over drinks and canapés, a group photograph was taken before proceeding to lunch. Jack Blackman welcomed the guests and asked them to think about future reunions. We sat down to a delicious lunch prepared by the chef and the warmth of the occasion was very evident from the chatter and some hilarious anecdotes afterwards.

Kevin White apologised for his tremor and said we would only hear every third word as the microphone passed his lips but he was looking forward to Dick Stephens' 100th birthday. Dick on the other hand was on cloud 9, admitted he was the only fossil present and promised he would be here next year.

Alan Young and John Austin reminded us that Cath Nicholson Hamlin was probably the most internationally known graduate of our year and was continuing her work

at the Fistula Hospital in Ethiopia. Grosvenor Burfitt Williams gave us an update on Don Dunlop and his family and Alan Young noted that Don was still working three days a week.

Bill Gilmour and Harry Moore came all the way from Perth, WA, and suggested the next meeting be in Perth. Harry declined to give us his rendition of Lovely Hula Hands which he sang at the Revue. Roger Davidson sent apologies for Julie Fitzhardinge who was busy with her horses west of Sydney and Joy Parry expressed her delight to be here and sent best wishes from Bettine O'Dea. After prompting from Jewell Duncan, Gertie Angel-Lord entertained us with some obstetric experiences. Ewen Sussman reminded us of his clinical group at Sydney Hospital – seven of the twelve still surviving. It was great to see Nev Newman who missed our last reunion due to a back operation. Peter Rogers quoted from the travels of Ulysses, Victor Bear spoke of the smooth running of the Committee and thanked Roger Davidson for arranging this very successful venue. Thea Robilliard spoke of her most happy and enjoyable life with us in Medicine having been to all of our reunions.

It was suggested that the next occasion take place in 12 months at a venue to be selected by the Committee – Jack Blackman, Victor Bear, Roger Davidson and Alan Young. At about 3pm we wended our way home and all agreed it had been a memorable occasion.

*Jack Blackman*

1. 1964 REUNION
2. 1995 REUNION
3. 1948 REUNION
4. 1946 REUNION



1



2



3



4

# Glenn Singleman

## EMERGENCY MEDICINE ADVENTURER

MBBS (Sydney) 1983

PG Diploma Communications (UTS) 1988

Pictured here flying his V2 over a sea of cloud.



It was his first attempt at abseiling shortly after graduation which ignited Glenn Singleman's passion for adventure. Since then, and following a great tradition of expedition doctors including, from this University, Douglas Mawson's chief medical officer Archibald McLean (MD 1910), he has been determined to combine a medical career with a love of the outdoors and adventure.



"As a medical student, I enjoyed cross country skiing and hiking but that was about it. Then just after graduation, a colleague invited me to go canyoning. The first time I had to abseil, I nearly freaked out but the experience was exhilarating and I was hooked."

Canyoning, for the uninitiated, involves walking, climbing or swimming in usually narrow rocky rivers, typically with steep descents which require canyoning to abseil or use ropes. "After that first experience, I started rock climbing then mountaineering. Then I met a guy who was a BASE jumper. The risk mitigation approach he took was similar to the process I use in rock climbing - and in medicine - to manage critical situations. He analysed the dangers from personal, environmental and technological points of view. He had a plan for predictable problems in each area."

In the 20 plus years since, minimising risk, controlling fear and stepping up to challenges, have become the themes of his adventuring life. They have also provided a link back to medicine, which he has continued to practise both as an emergency care doctor in Sydney and on more than 16 expeditions to all corners of the globe. Of special interest is how individuals respond to fear, including why some people are naturally less fearful and how far it is possible to increase control over primitive fear systems.

If you can develop a good risk mitigation process and control your fears - two big ifs - he believes that individuals can achieve almost unimaginable goals.

From that early exposure to BASE jumping, he moved on to BASE climbing - climbing mountains and leaping off with a parachute or in a winged flying suit. He claimed a

world record after jumping from a cliff, the Great Trango Tower, close to 6000 metres high, in Pakistan. A film made of the expedition and jump was seen by millions around the world and began a new career as an extreme sport and documentary film maker.

The discovery of a higher cliff in 2000, this time in India, provided a new challenge and eventually, his most rewarding adventure. After six years of preparation, he and his wife Heather Swan, in 2006 secured a second world record for climbing to 6604 metres and diving off in winged suits.

Aside from world records, other expeditions have included ballooning over Everest, working as doctor and camera operator on James Cameron's 'Live from the Titanic' project. More recently, he and Heather have been preparing to attempt a new world record for longest wingsuit flight (tip: long flight means starting high, in an early run he jumped from a balloon at 11,500 metres).

In among the adventures, he has continued to practise medicine, mostly in Emergency and most recently at the Sydney Adventist Hospital in Sydney's north. It is not for the money - their expeditions are funded by the rather more lucrative motivational/corporate speaking engagements.

"I still love to practise, I've never felt inclined to stop. I've always worked in Emergency and it suits me, I like the adrenaline rush and it provides you with a broad cross section of medicine. What I really love about medicine is the mental discipline, it is the most mentally rigorous scientific pursuit one can engage in, every patient is a new problem solving challenge. But pursuing adventure satisfies another side of my personality." *radius*

More information about Glenn's adventures can be found on his website [www.baseclimb.com](http://www.baseclimb.com) or in his wife, Heather Swan's book 'No Ceiling'.

Vincent van Gogh

Paul Gauguin

Paul Cézanne

Georges Seurat

Pierre Bonnard

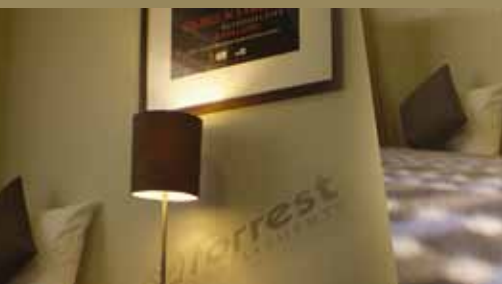
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Vincent van Gogh Van Gogh's bedroom at Arles 1889, Musée d'Orsay, Paris, © RMN (Musée d'Orsay) / Hervé Lewandowski

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