



RADIUS

Newsletter of the University of Sydney Medical Graduates' Association

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Editorial

Does Every Right Create an Equal and Opposite Wrong?

We live in an age of rights. Day in and day out, parliaments pass laws to grant and protect rights. Rights come, so it seems, very cheaply. The right to the protection of life. The right to have an abortion. The right to own property. The right to social security. The right to equality before the law. The right to education. And so it goes on. Rights here, rights there, rights everywhere, rights, rights, rights, rights, rights.

Rights, people assume, come very cheaply. A newspaper campaign for a few days. Agitation in the Letters to the Editor column. A few astounding exposés of those who have suffered wrongs. A press conference by a Minister of the Crown. The government will legislate. A law or two. And lo and behold, we have a new right. This process, one might almost think, is that of spontaneous generation of rights.

Biologists, though, are filled with suspicion of spontaneous generation of anything. A law of physics seems here to drive physiology. Every force creates an equal and opposite force. Is it, then, just possible that every right granted has an equal and opposite cost: that it generates an equal and opposite wrong?

Such issues have importance in two areas that impinge upon medicine and that have received recent publicity.

(continued on page 14)

Marie Bashir made Governor

by Luisa Cugno

Doctor Marie Bashir, a medical graduate of the University of Sydney, received the State's highest honour when she was sworn in as its first female Governor on 1 March 2001. Having served as Central Sydney Area Health Service's Director of Mental Health Services since 1994, Professor Bashir follows a long line of distinguished men, including her predecessor, Governor Gordon Samuels, as she undertakes her new full-time appointment.

The Governor was a clinical professor of psychiatry who earned an Order of Australia medal in 1988 for services to child and adolescent health, especially mental health. From 1972 to 1987, she was the founding director of the Rivendell Child Adolescent and Family Unit. As the Lady Mayoress of Sydney from 1971 to 1973, she assisted her husband, Sir Nicholas Shehadie, during his term as the city's Lord Mayor. This period included the gala opening of the Sydney Opera House.

She will become the nation's third female Governor, after Leneen Forde in Queensland and Dame Roma Mitchell in South Australia. She said she was "delighted" but "initially somewhat overwhelmed" to accept the post as Governor of New South Wales. "I'm fully aware of the historical significance of this high appointment and of being the first woman to follow many outstanding men," Professor Bashir said. "Our State has an illustrious history and today it is

Dr Marie Bashir, Governor of NSW

(continued on page 2)

(continued from front page...) characterised also by considerable cultural diversity. In addition, it is home to so many important Aboriginal communities. All of these issues mean a great deal to me." After having the privilege of working in the fields of public and mental health, she said she was keen to see disadvantaged and marginalised people have greater access to opportunities in an inclusive society. "Every child should have the opportunity to realise its full potential," she said.

Named Mother of the Year in 1972, and the grandmother of six, she is passionate about reducing depression in the nation's young, which is frequently related to negative health outcomes, including suicide. Thanks to a childhood growing up in Narrandera, in country New South Wales, Professor Bashir remains an advocate for people living in rural areas.

She wants to see them have greater access to the health and education benefits that are available to their city cousins.

She is inspired by the creative and scientific talents of Australians and believes that greater value and attention should be given to the nation's research communities. Professor Bashir said that Australia had a dynamic artistic talent, as evidenced by the successful Sydney 2000 Olympic Games, but society was sometimes in danger of taking these riches for granted. "This quality and talent also exists in Australian theatre and opera and in an extraordinary range of musical offerings," she said.

Although Professor Bashir was uncomfortable to be called a role model for the fairer sex, she said women were making immeasurable contributions across all fields of contemporary Australian society.

This article is adapted from "CSAHS Newsworks", February 2001, with kind permission from the author and coordinator, Luisa Cogno.

45 Year Reunion

by John Wright

On Saturday, 18 November, about one hundred January 1955 graduates and their ladies, from all parts of Australia, Britain and North America, assembled in the Great Hall for their forty-five year reunion.

Orations delivered by Vera Gallagher, John Jefferis and John Watson were received with great enthusiasm and warm nostalgia.

The Medical Graduates' Association had facilitated arrangement at every point and splendid catering, atmosphere, music and services were provided by "The Venue Collection".

As graduates made their way out into the night from the majestic venue with its memorable associations and recollections, vows were made to plan a fiftieth reunion early in 2004.

Note from the Editor

Radius welcomes contributions from its readers. We aim to make this an interesting publication. Please contribute news items, obituaries and letters to the editor. Provided that they are polite, we do not object to controversy; indeed we welcome it. The true role of a university is to provide a forum for ideas. This is the magazine of the medical graduates of Sydney University, many of whom must have many ideas. If you send them to us we shall strive to publish them.

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Dean's Message

by Stephen Leeder

Thirty five years on, our year 'reunited' on the long weekend at the end of January. The event owed much to the splendid efforts of Paul Lancaster, Raema Prowse, Judy Gardiner, Maureen Rogers and others, enthusing, chasing, cajoling, organising venues, meals and accommodation, arranging speakers on life inside and outside medicine and much more. In our cohort the casualty list is beginning to gather momentum. I can understand those who choose to stay away from such events, if only to avoid a confrontation with their mortality!

How much happier (at one level, anyway!) then, to meet as I did in late February with our recent intake of first year students! Here is youth rampant! I chortle at the notion that these are 'mature age entry students': even their parents strike me as young!

The new students have splendidly varied backgrounds. I spoke with several at my welcome to them and at two barbecues later in their first week. One had a degree in fine arts, another had completed honours in environmental biology and spent several years in South America, learning Spanish and working in environmental management. One was a physio, another a dentist, a third a pharmacy graduate, a fourth a nurse with overseas experience, and several were recent science and biomedical science graduates, often from other universities. We have a contingent of over twenty Canadians in our course this year as well! For the first time our students are sharing much of their initial two years with the graduate-entry dental students. These diverse backgrounds mean that they will learn an immense amount from one another during their four years with us, as

well as what they acquire from the formal curriculum.

It is upon the shoulders of this group of students that the future of our profession rests. Many of us worry about the future of *all* professions, including medicine, with increasing constraints, paper-work, loss of lifestyle flexibility, and such horrors as litigation. A new look at professionalism will be essential if medicine is to flourish in this century.

It's all very well for people of my vintage to gather and chat: indeed, it is thoroughly agreeable. But for the future we must equip our students with new and different skills.

In the new curriculum, our Faculty has taken unprecedented action in favour of a way of learning that enables students to face the future confident that they can keep their knowledge and skill up to date, as masters of contemporary communication and information technology. The new disciplines that underpin this educational approach need to be secured within our organisation.

I am confident that our Faculty continues to be well placed to face the future. There are many features of both research and education, not only in content but also in style, that are different to those that applied when my cohort passed through the University. Yet the hallmark of any profession — its capacity to participate in and lead constructive change — is on full display.

*Professor Stephen Leeder,
Dean, Faculty of Medicine*

President's Report

by Barry Catchlove

It is now nearly twelve months since I succeeded Katrina Loveridge as President. Katrina put an enormous amount of work into the Association and I was personally delighted she agreed to stay on the Council as Vice President.

I have written separately to all Graduates seeking your financial support. As I said in that letter, the strength of the Association is that all Graduates are automatically members. The one downside of this is the fact that we don't have any tracking mechanism for such a mobile cohort. Because we do not want to discriminate in favour of financial members we are therefore asking all Graduates to help support the Association with tax deductible donations preferably on an annual basis.

We have been sad to lose the services of Clarissa Chaloner who has provided the Association with administrative support for 12 months under difficult circumstances with no base or support within the University. At the last Council meeting we thanked and acknowledged the work she has done, probably most visibly with the organization of Reunion functions.

This change has however coincided with some very positive initiatives. Through the support of Peter Burrows, Chair of the Medical Foundation, we have been provided with accommodation and administrative help by

Wendy Marceau, the Foundation's manager.

I am personally pleased the Association and the Foundation are working more closely as I believe ONE of our roles should be to support the research activities of the University.

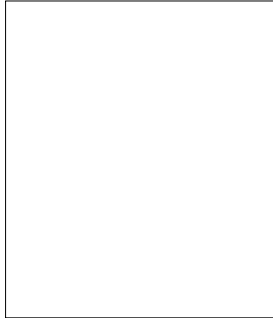
While I can't comment on past Councils I am delighted at the enthusiasm and commitment of the Executive, particularly Andrew Eakin, David Duke and Charles George who has taken on the arduous task of editing *Radius*.

Our challenges for the next few months are to establish the new infrastructure, to gain the necessary financial support to underpin our work and to improve our database of Graduates.

We will continue to support Reunion functions but I intend to talk to the year organizers to find out exactly how we can best assist. In addition we will of course continue our small but important support for students who have real difficulty in covering the costs of their educational material.

Our ultimate goal is to create a much stronger link between Graduates and the Faculty. The continuing support of Professors John Young and Stephen Leeder shows the importance they place on the work of the Association.

Lastly I hope as many of you as possible will respond to our appeal for financial support.



Dr Barry Catchlove,
MCA President

Details of a forthcoming Reunion

Dr John Kennedy is currently looking into organising the 10 year reunion for 2002 (for 1992 graduating year)
Contact: Dr John Kennedy E-mail: drjfk@bigpond.com.au

Radius encourages any reunion organisers to contact us with details of upcoming reunions or reports on those recently held.

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The Medical Foundation

by Wendy Marceau

The Medical Foundation, established in 1958, contributes over \$2.5 million annually to medical research and education at the University of Sydney through the Faculty of Medicine. The Foundation's total funds have grown from \$15 million in 1993 to around \$36 million currently.

The Foundation has a focus of attracting high quality medical and health researchers to the Faculty from diverse fields of medicine through its peer reviewed senior Program Grants scheme. This scheme offers one of the most generous privately funded granting schemes for medical research in Australia. Each Program Grant offers \$825,000 over five years.

Currently the Foundation supports twelve Medical Foundation Fellows under this scheme and through other grants ranging in value from

\$35,000 to \$180,000 per annum. Research areas include the early detection and treatment of heart and vascular disease; the prevention of asthma in newborn infants; improved treatment options for shingles; correlates of brain atrophy in Alzheimer's disease; prostate physiology and disease; new therapies for degenerative retinal disease; developments in pain relief and understanding the mechanisms of addiction; improving the treatment of hydrocephalus in children; understanding

how influenza virus causes pneumonia; and the development of new therapeutic strategies for lung diseases such as mesothelioma and pulmonary fibrosis.

The funding program is augmented by the Medical Foundation's support of Postgraduate and Combined Degree Program Scholarships totalling \$225,000 in 2001.

In addition the Foundation endows the Douglas Burrows Chair in Paediatrics and Child Health at the New Children's Hospital, currently held by Professor Craig Mellis, and the Robert W Storr Chair of Hepatic Medicine at Westmead Hospital, held by Professor Geoffrey Farrell. The Foundation is also raising funds to support in perpetuity the Chair of Clinical Ophthalmology and Eye Health for which some \$2.3 million has already been provided.

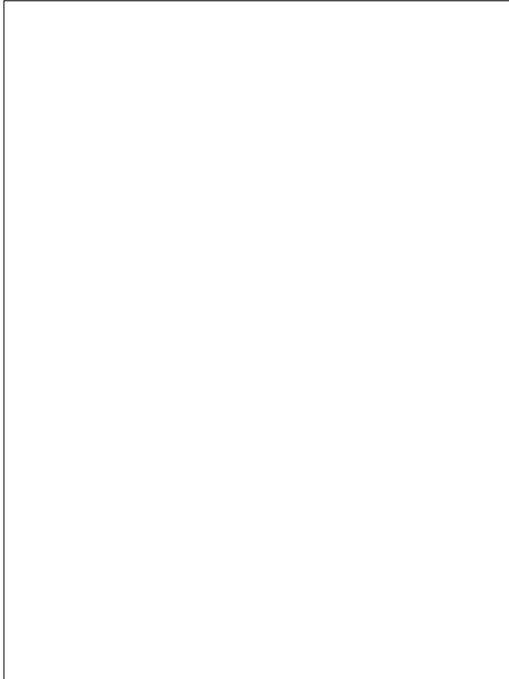
Mr Peter Burrows, the President of the Medical Foundation, strongly supports the development of research within the Faculty of Medicine. He has recently announced the Foundation's willingness to invest \$10 million for the provision of research facilities and infrastructure through the purchase of the Worksafe Building on Parramatta Road, Camperdown. "This modern 8000 square metre building with more than 100 undercover car spaces is right next door to the University campus and could provide us with an ideal environment for our vision of a genomic and post-genomic biomedical research centre for NSW," he said.

The Medical Foundation relies only on donations and bequests to fund its programs of research.

Wendy Marceau is Manager of the Medical Foundation.

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Peter Burrows is the President of the Medical Foundation

50 Year Reunion Address

*Reprinted here is the address given by Geoffrey Kellerman at the 50 year reunion,
held at the Royal Sydney Yacht Squadron in November 2000.*

Let me commence with a quotation from Verse 2 from Chapter 14 of the Gospel of St John :

In domo Patris mei mansiones multae sunt, translated from the Latin by Tindale for the Authorised version in 1611 as “In my Father’s house are many mansions”. From my vantage point as the editor of our Jubilee Yearbook, this could certainly be the ideal description of the medical profession in general and of this group in particular. Our choices have included the frequently grossly undervalued specialty of general practice, specialist medicine, surgery, obstetrics and gynaecology, paediatrics, psychiatry, rehabilitation, all the subspecialties such as orthopaedics, cardiology, skin, eyes, ENT etc, as well as pathology with its branches of morphology and numerology, and the even more basic areas such as biochemistry and physiology. Several of us have had major roles in quite new organisational aspects, even in starting new specialties. Some of us have concentrated on using the established body of knowledge, some have in addition dabbled in research, and some have spent most or all of their careers in research. All of us have contributed to varying extents to the education of our successors. While not denying the satisfaction that has come to each of us from the sensation of a job well done — even well paid — if pressed we will all aver that our main purpose has been for the patient as the ultimate recipient of the distilled wisdom of our complex health system, a mosaic to which each of the above moieties contributes one or more tiles.

If this model is true then we, either approaching or enjoying a well earned retirement, could feel happy and confident that we have done a worthwhile job and

can hand over to Year 6 1951 and followers and their equivalents from other medical schools.

However, I do have some problems with this rosy view of the future. As one who has spent a disproportionate amount of time at the educational end of the spectrum, I insist that it is appropriate, if not mandatory, to look to the future of our profession.

To return to the analogy of the house and its mansions, the current translation of “mansiones” uses the words “dwelling places” rather than “mansions”, a word that, especially in Australia, has largely come to connote a palace rather than a motel room or small flattette. In religions, we have assumptions and articles of faith that are mostly presented as eternal truths. That people do not accept these as immutable perhaps helps explain all the schisms and brands of religion. However we in medicine really do accept that our house must be in a constant state of repair, refurbishment and reconstruction, with additions and demolitions resulting from our growing understanding based on effective research. We can live with this — even welcome it, even when the pace of change accelerates as it has over the last 20 years or so — if it is clear that the increased knowledge and consequent specialisation leads to better care for our patients. No one now wants the local general practitioner, however competent in that particular constellation of skills, to do the MRI scan or the coronary bypass operation. But who would want the MRI expert or the coronary surgeon to be the first contact doctor when the problem is a pain in the right gluteal region (or even the left)? One of the weaknesses in the dwelling place model is that people do not necessarily

leave their own turf, so that contact and interaction with the neighbouring inhabitants may be less than optimal for the patient outcome. The specialisation, with attendances at meetings with the peer group, coupled with pressure of work, of report writing, of defensive strategies and legal problems etc makes this interaction even less effective.

Another major defect in my house model of medical practice is that it can be seen as a model from the viewpoint of the profession, which does not explicitly recognise the changes occurring in the surroundings, i.e. in the community that supplies the patients. So let us have a brief look at both the medical point of view, and the community's perceptions, and their implications for the future.

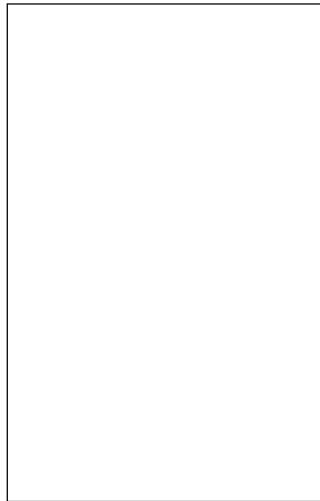
From our viewpoint, there has been an accelerating accumulation of knowledge during our working lives, and each of us will have a personal list of major advances. My list would include such discoveries as antibiotics, the birth control pill, advances in anaesthetics and extracorporeal circulation, renal dialysis, microsurgery, organ transplantation, cell signalling including receptors, the genome project and especially the progress in pharmacology leading to the current "pill for everything" including anticholesterol, antidepressants, antihypertensives etc, often based on rational utilisation of the growing chemical understanding. And, of course, we must not forget the delights of AIDS, multiple resistant bacterial strains, drug reactions, bubble brains, diagnosis related groups, business activity statements etc.

In parenthesis, can I ask how many of us have survived this far without taking any regular medication — not even the almost mandatory "half aspirin a day"? Am I the only therapeutic nihilist? A show of hands?

The risk of this viewpoint, to us and to our patients, is that it can result in a completely mechanical concept of medicine and its function. On the one hand, we can lose the personal and behavioural component of the doctor/

patient relationship — even forget the importance of compliance with advice — and achieve a degree of hubris that would be a credit even to a politician. On the other hand, the patient can be so seduced by our claim to infallibility that totally impossible expectations of immortality are raised — and often followed by litigation when reality strikes. Many of us would probably be delighted with the emergence of a virus that selectively killed lawyers, and liberated a lot of money for genuine health care that now goes in litigation costs. The enormous growth in the established knowledge base means that it is increasingly obvious — even to professors of medicine — that the student curriculum must be designed differently, with more emphasis on processes of learning, selection and priority setting of goals, modes of access to data including electronic retrieval, assessment of the evidence for particular strategies and so on. In particular, some way must be found to make graduates aware of the preventive strategies available and necessary. As Kerr White wrote, we must heal the rift between public health and curative medicine. After graduation there is increasing pressure for specialisation, and for continuing education — even mandatory programmes — mostly, to our credit, doctor instigated. But there is a down side to all this progress. We joke about the cardiologist who is really a left ventricle expert, mainly the left coronary artery and preferably the circumflex branch rather than the anterior descending — but it may well come about that way, and woe betide the patient if the decision tree among the rest of us that gets him to see this particular specialist has goofed, and he really has herpes zoster before the rash appears. We also have less and less time to do our work and more and more of the day is diverted to the paper war.

The community has probably altered even more than we have, in structural, behavioural and attitudinal ways. Partly, even largely, due to our success, the



Geoffrey Milton Kellerman, AO, a Sydney graduate, was Senior Lecturer in Biochemistry at Sydney University before becoming Foundation Professor of Biochemistry and Dean of the Faculty of Medicine at the University of Newcastle. He remains a VMO in Clinical Chemistry at the Hunter Area Health Service.

pattern of disease has altered enormously over the last 50 years, with increased longevity, less death in children, and the emergence of accidents, suicide, drug addiction, depression, dementia and especially multisystem disease in the elderly as major areas of concern. The very success of some of the technological advances has led to the problem of unfulfillable patient expectations, of the need for rationing of services however achieved, of the worship of the bottom line and the emphasis on the counting of beans. It has led to the emergence of ethics committees and even of concerns about ethics to a degree unimaginable when we were students and had to concentrate on the permissible dimensions of our brass plate and red light, and its wattage. We have to know about advanced directives and not for resuscitation orders, and the ever increasing mechanisation of what used to be personal judgment. We have to become embroiled in arguments with governments about funding for health issues, of public versus private institutions and so on. We, and the Government, have still not resolved the public health/curative medicine divide and the proper funding of this issue. I see part of this divide as resulting from the impossibility of anyone receiving thanks, and the warm inner glow that thanks generates, as a reward for having prevented something unpleasant from happening, because we cannot identify the beneficiary. What irks so many of us is the development of health policies that decide all priorities on the basis of money, that seem to view the community interests as subservient to the financial outcomes instead of the reverse.

The interaction between us and the community has resulted in changes in the optimum training paths and practice structures, to which our profession has not been able to adjust as fast as desired. A major example is the increased proportion of really old people, many of whom have multisystem disease, set against the policies of our Colleges to train a high proportion of what are irreverently called by the acronym SODs — single organ doctors.

The only time I feel young is when I attend the morning medical admission review session — most of the patients are older than I am. We need more geriatricians, at GP and specialist level, with really broad education in all systems of the body, and, especially at the rehabilitation level, with properly funded infrastructures and interactions with members of the other health professions who have a real role in this area, which will approximately double in the next 30 or so years. We need better structures for interaction between hospitals, community practice and the intervening things such as hostels and nursing homes. And we really must learn to cope — as doctors and community — with the computer age, the possibility of proper data bases, automatic warnings of drug interactions, reminders for Pap smears etc, against the Big Brother options also possible from these systems. Another major problem is service for the non-city dweller — so important that it threatens the reelection of some politicians and so it has even made an appearance in this year's federal budget. I am sure that you will all have your pet hates and problems that you could add to this list, the mere enumeration of which would make me exceed my allotted time to-day.

So, many thanks for listening to my reminiscences of 58 years since my first chemistry lecture on March 5 1943. It has been a good life for most of us, full of interest and challenge, with much success, and we hand over to the coming generations of doctors a healthier community, but with plenty of problems to keep them busy for their working lives. Let me conclude by balancing the quotation from John 14 at the beginning with one from the ancient Jewish blessing at the harvest festival, presumably with food for the winter ensured, which thanks God

shehecheyonu vekiyemonu vehigiyonu lazeman haze

“who has kept us in life, and preserved us, and enabled us to reach this season”.

35 Year Reunion

Sydney University's 1966 medical graduates (the Final Year students of 1965) held a 35-year Reunion Conference from 26 to 28 January at the Novotel at Brighton Beach. Paul Lancaster and Raema Prowse were the principal organisers, but they had much assistance from many others. They designed an ambitious program, and they carried it off with aplomb.

They planned it for the Australia Day long weekend to give those who had to travel long distances the best opportunity to attend. Several travelled from overseas, a number from interstate, and others from country New South Wales.

The Conference itself ran throughout the Saturday from 10am to 5pm. The speakers all came from the Year and provided a range of enlightenment and entertainment about which only a grump could have complained. Their presentations, indeed, consisted of a sparkling variety of medical and non-medical performances that amazed many in the Year

Speakers

John Ziegler set the tone with an opening speech on *Humour in medical teaching*. We cannot reveal here anything much of what he said: suffice it to say that it was brilliant and anyone wanting to hire a good after-dinner speaker for a function that they are organising should think about contacting him! Well juxtapositioned with that was a talk by George Chu on a much more serious topic, *How can we look after our intellectually disabled children?* He made many of those present realise how fortunate parents are who do not have the task of dealing with children with these types of disabilities. Then Vanda Lennon, who presently holds a senior academic position at the Mayo Clinic asked *Does it take a brain to fight cancer?* She outlined the fundamental work that her colleagues and she are undertaking into the immunology of paraneoplastic autoimmune disorders.

This graduating Year produced several people who have influenced the administration of health care throughout Australia. Two of them spoke about aspects with which they

have become familiar. Ross Kalucy, who lives in Adelaide these days, addressed *Workforce studies: right numbers, wrong places*, giving insight into the ways in which numbers entering various specialties work out and some factors that influence the distribution of doctors within the Australian community. Barry Catchlove then examined *Corporatisation of general practice — good, bad or inevitable?* He spoke about the market power of general practitioners and how their field is moving from a cottage industry to better management (which he pointed out is one form, and a desirable one, of managed care). He suggested that the trend to corporatisation is inevitable, but that if doctors take the responsibility in this move it should provide them with the opportunity to generate considerable improvements in the quality of the care that they can deliver.

Social Context

During the afternoon session, a different theme prevailed. John Wong came from Hong Kong, where he is now Head of the Department of Surgery in the University of Hong Kong, to speak on *The Asian patient*. Among his many fascinating insights was the throw-away comment that in the West, people eat to live, whereas in the East they live to eat. Ian Ring, who is now Head of the School of Public Health and Tropical Medicine at James Cook University in Townsville spoke in contrast about *What to do about Indigenous Health*. He emphasised its appalling state: the world's highest death rate in middle-age among Australian aborigines; their average life-span of 16 to 19 years less than the population as a whole; the consequences of loss of control over their lives upon their health; and the impact of injuries, of diabetes and of respiratory diseases upon their lives.

As though that message was not bleak enough, Sue Packer, a community paediatrician in Canberra then spoke about *Children and Abuse* in the nation's capital. On the basis of her experience with the 3000 to 4000 abused children whom she has seen there in the past eleven years, whom she described as "the

concealed soft underbelly of Canberra". She went on to point out that "we are not very good at picking up the competent abusers". Think also of the consequences for the abused child in the family of a foreign diplomat once the father is obliged to return to his homeland in disgrace, taking of course with him the very child that was the subject of his abuse and thereby the cause of his disgrace. The implications for such a child when beyond the reach of Australian law are horrible. She then went on to set out her views on the crucial importance to life-long mental function of undamaged early development of the brain.

After that, Alistair Barron, who is now the Director of Adolescent Health Services at Royal Brisbane Hospital cautioned *Don't be too thin*, giving an overview of anorexia nervosa and his approaches to it. Two further speeches rounded the afternoon off. Paul Lancaster spoke about *Norman McAlister Gregg: Sydney's most notable medical graduate?* providing a fascinating biography of that great man. After that, Robert Clancy, who is now Professor of Pathology in Newcastle provided a beautifully illustrated talk on old maps, with particular attention to those that deal with the discovery of Australia.

Passions Outside Medicine

As though all of this was not enough for a Reunion Conference, Maureen Rogers organised two sessions entitled *Passions outside medicine*. In these, seventeen volunteers regaled their former classmates with insights into the aspects of life that have enthralled them in recent years. For Warwick Gordon-Smith, it is Armstrong-Siddeley motor cars, 'what I would have aspired to as a med. student'. For John Harding, serious ophthalmologist that he now is, it is cattle breeding, or more precisely, artificial insemination of cattle (and to quote him, 'it has been very good for us and the family'). For Jim Rohr, for whom the implications of having nine children are impeding retirement, golf provides relaxation. Bill Herlihy, in contrast, revealed his love of water-colour painting, whilst Ross Macleod is a devotee of singing, Brian McGregor of music, Peter Arnold of black and white photography, and Alan Concannon of collecting art. Each illustrated his hobby.

Peter Eisman spoke of his love affair with Bondi Beach, its scenery and its people around the year. He also announced his discovery in that venue of a new disease: *sipsomania*. This condition, that he observes particularly to affect females in the 18 to 25 year-old age group, manifests itself by the necessity of drinking sips of water after every 200 meters that the victim walks. He provided colourful illustrations, observed on the promenade at Bondi, and commented ominously about its epidemiology: he believes that the condition may now also be spreading to males.

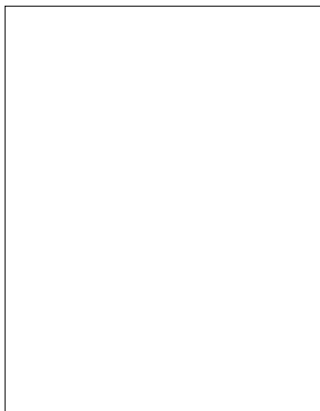
Nic Jouls described a special quilt that he has made out of all the neckties that he has accumulated during the past 41 years. In contrast to such indoor activities, Richard Hawker indulges in off-shore cardiology in tropical places, Ros Lloyd-Williams in scuba-diving in equally exotic surroundings, Dick White in exploring New Mexico, and Maureen Rogers (McGhee) in hiking in many parts of the world. Two of the most unusual passions, perhaps, are those of Jock Anderson and Heather Fogerty (Branson). Jock spends his spare time building and flying aeroplanes of progressively larger sizes. Heather spends hers train-spotting. The pathognomonic symptom of the latter disease, she thinks, is visiting disused railway lines. She, as a Queenslander nowadays, notes that New South Wales is full of these. She also thinks that the complaint can be either inherited or acquired. When inherited, it is usually father-to-son, but can be mother-to-daughter. When acquired, she thinks it is often sexually transmitted from husband-to-wife.

The Dinner

Well, after a Reunion Conference like that throughout the day, people may have expected the Dinner in the evening to be an anti-climax. It wasn't: more than 80 graduates attended, most bringing their partners. The food was good, the music was quiet, Dennis King gave the toast to the University and Faculty; Stephen Leeder responded in his joint roles as Dean of the Faculty and a member of the Year; Paul Lancaster handed a donation from the graduates present to the Medical Graduates' Association; and Barry Catchlove responded in his joint roles as President of the MGA and a member of the Year.

The New Graduate Medical Program: A Perspective

by Ben Reidy, Third Year Student



Ben Reidy is in Third Year at Concord Hospital. He graduated from UTS Kuring-gai in 1995 with a Bachelor of Business in Finance which included an exchange to Denmark. He commenced the USydMP in 1999 after working for a stockbroking company and then travelling.

One hundred and forty-four years of building a reputation and they've risked it all. The Faculty of Medicine's reputation is on the line with the new four year graduate medical degree.

This year as everyone knows the first doctors from the new degree have rolled off the Faculty's assembly line. The spotlight is on them, and they know it. Expectations are heavy, the curiosity immense, comparisons of new and old will abound.

How will the new breed cope with the realities of the real world? Quite well in many respects. How can I be so sure of this?

What has changed? The name for one thing... twice! "Graduate Medical Program" (GMP) was the initial name, however being the first postgraduate undergraduate degree with graduate in the title meant nightmares for bureaucrats worldwide. "University of Sydney Medical Program" (USydMP) has come to the rescue.

The aims of the USydMP state, "at the same time as producing practising doctors with the highest academic standards and integrity, the Faculty assists students to develop an insight into the role of medicine in society, values and attitudes which promote caring and concern for the individual and society, and a sense of responsibility and support for patients and their families."

The Faculty now selects students to fulfil these aims via an entrance exam (the GAMSAT), an interview and one's previous tertiary record. The result of

this has been that in 1998 there were more women enrolled in medicine than men for the first time: 58 percent women and 42 percent men. 72 percent of those starting first year were between the ages of 20 and 24 years, a further 20 percent started between 25 and 29 years old. 19 percent of students had a Tertiary Entrance Rank higher than 98, while 23 percent had a TER less than 90 and 10 percent had no TER. In terms of past degrees, 74 percent had a biological science degree background and a further 17 percent had a health and community services background. Hence around 10 percent did not have a medically related degree. Each year also has approximately twenty international fee-paying students.

The basic structure of the course can be seen in detail at our website, which is worth a visit, www.gmp.usyd.edu.au. The essence of the new course is the problem based learning approach which means students study the issues arising from a new patient presentation each week. The old subject structure has given way to four themes: Basic and Clinical Science; Community and Doctor; Patient and Doctor; and Personal and Professional Development, all with a heavy emphasis on evidence based medicine. The year is broken up into systems groups — respiratory, cardiovascular, etc. The first two years are mainly on campus with one day a week at hospitals, the final two years are based full-time at hospitals. Students are graded with only pass or fail, or more accurately 'satisfactory' or 'not satisfactory'.

The emphasis of the new course has shifted from the old didactic lecture-based approach, with exams heavily testing the brain's memory circuits, to a more open-ended, self-directed approach testing clinical reasoning, evidence and with a patient focus. With the new course there are good and bad points depending on whom you talk to. Some of the "hot issues" include the grading of students, the number of exams, and the depth of study in anatomy, immunology, pharmacology, biochemistry and psychosocial issues.

There is no doubt in my mind that the Faculty has changed for the better. The current challenge is finding the right balance between old and new, and the staff realise this. Feedback mechanisms are everywhere for students to say what they think, and believe me, they do. The framework of the new course is well designed to be able to cope with additions and subtractions, so it will be able to evolve rapidly and optimally over time.

The Faculty took a big risk and should be applauded for it. One must remember that all great achievements require great risk, and often the biggest risk is not taking any risk at all.

Although many things have changed, some have not. The current students feel honoured and privileged to have been accepted into the course — a course which has such a prestigious tradition — knowing many more were vying for their spot.

All the current students had to jump many hurdles to get to where they are now. They are sacrificing money and lifestyle to do what they are doing, but at the same time they wouldn't have it any other way.

I can be sure that the new graduates will be a success, because they are determined to be, and their attitude will be more important than their knowledge.

So to all the current graduates out there, your Faculty's reputation is in our hands. Work with us, have confidence in us, we won't let you down.

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(continued from page 1)... that have received recent publicity. They are those of the right to receive a university education, and the right to sue doctors.

Some whistle-blowers at one or two universities (not ours, thank heavens, although perhaps only by the grace of God) have drawn attention to the inflation of marks of inadequate students to gain undeserved passes in examinations. This, one could argue, is a case of the practical application of rights. The Australian community seems now to believe that a university education is a universal human right for anyone who wants it. To deny a person a university education, however moronic he or she might be, is a form of discrimination that in our politically-correct society is close to intolerable. Then, once a student is in a university, to pass every examination has become another fundamental human right. If a student fails, some seem to argue, then someone must be discriminating against that student. The student has a fundamental human right to pass. Many seem to reason that if academics do not pass their students, then the academics are at fault. In the fashionable dialectic, the academics are powerful; the students are weak; the weak must be honourable, the powerful dishonourable, and society should support the weak. That then means granting all students a right to pass.

This populist argument, nevertheless, is fatuous. Why? The reason is somewhat unpopular in egalitarian Australia of the new millennium where 'democracy' (for which, read 'majoritocracy') reigns supreme. It is that acquisition of knowledge requires devoted intellectual work. This makes it elitist; and the higher the education the more elitist it becomes. To grant a right to entry to the higher levels of education to those who do not measure up on the lower levels; and to grant passage to those at higher levels who do not warrant it, devalues all education. Granting the right to the unworthy wrongs the worthy; and the greater the right granted to the unworthy, the greater the wrong to the worthy. Every right in this field creates an equal and opposite wrong. If our university wishes to avoid creating wrongs, it must keep its standards very high. High standards are the true right of the good student.

A similar argument applies to another

area that has recently gained some publicity. Patients have taken to suing doctors to an extent that has never before happened in Australia. The right under which the patients act is that of gaining recompense for alleged negligence on the part of some doctor. Everyone, some would argue, must have the right of recourse to law to gain compensation for alleged harm incurred. This right would seem to be one of the most fundamental that every legal system seeks to uphold. In the present circumstances, however, something wrong seems to be occurring. In at least one medical specialty in New South Wales, one hears, every practitioner is presently facing legal proceedings for alleged negligence. In another, the number of trainees entering is only a little above half of the vacant training positions, and of the number necessary to replenish the stocks of existing practitioners as they retire. Even then, a number of new trainees apparently hold dual citizenship of some other country apart from Australia, to which they can promptly flee with their assets if threatened too severely at law. Other practitioners find themselves trying to manage two or three legal actions simultaneously whilst also still trying to concentrate on their medical work to earn a legitimate income.

In this circumstance, the right of many to take someone to court has created the wrong of harassing the small class of people taken to court. It seems plainly unbelievable that every practitioner in some major medical specialty is negligent. Far more likely, there is a system failure that is allowing this gross wrong to occur.

What is the failure? One might argue that the medical defence organisations have failed to fight sufficiently effectively in the courts to win cases in the past and so they are seen by potential antagonists as soft touches. Certainly, the rumour has got around that they will make commercial judgements as to the cost of defending a legal action then offer to settle out-of-court for a little less without admitting liability. Financially that may seem smart, but it overlooks the fact that practically every medical consultation and procedure provides some grounds on which to allege a complaint, however far-fetched, so an avaricious patient has little to lose by starting an action. What he or she used to have to lose was the cost of their own legal expenses, but the relatively recent amendment of the law covering the way in which lawyers can charge fees, permitting them

to take cases at no charge to the client if they lose, has changed all this. With such lawyers, the avaricious patient has nothing to lose; the lawyer for a small outlay of time in preparing the case can then hold the doctor and medical indemnity organisation (which also relies on doctors' premiums to fund it) to ransom. Thereby, the patient becomes financially overwhelmingly powerful against the doctor. And thereby, the right recently achieved for the patient has created a terrible wrong against the doctor.

What is the solution to this right creating a wrong? It is not to abolish the right to go to law for recompense against negligence, since negligence does occasionally occur, with emphasis on the word *occasionally*. Instead, the solution consists in rescinding the regulations that allow lawyers to charge differential rates for their work based upon the outcome of it. The recently created situation in Australia resembles the situation that existed in the pre-Enlightenment Era in European countries. Those countries then controlled that situation to prevent just this type of abuse from occurring. The then newly-independent United States of

America inherited the older system, however; and the constitution of that country has ever since prevented it from escaping from the problems thereof. Australia inherited a more enlightened system, which it has recently abolished. Whatever the motivation for that abolition, the obvious solution is reversion to our former legal code.

The rights granted by abolition of that legal code have created great wrongs against the medical profession. If they go unchecked, they will eventually destroy every medical practitioner. Then, when they next get sick, the people will realise the grotesque wrong that they have created from which eventually they too will suffer. From that wrong, however, they will not so easily escape: to destroy the medical profession is the work of only a decade; to build a new medical profession will take them generations. Far too many will suffer and die in that time.

The people need to realise that in both these fields of education and medicine their populist new rights are creating equal and opposite wrongs with potentially dire consequences for civil society.



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