RADIUS

Newsletter of the University of Sydney Medical Graduates' Association

Volume 14, Number 2
October, 2001

Editorial

Wither Medicare?

One senses that an election must be approaching. Health has reached the front pages of the nation's newspapers. Emergency Department waiting times have once again become important. Horror, horror, horror! Our politicians have become desperately concerned that underfunded public hospitals are keeping sick people waiting for attention. A politician's daughter had to wait a massive three and a half hours for the staff of a public hospital to deal with her appendicitis. And even then she had not reached the operating theatre! Such intolerable delay on the part of the hospital, the loving father alleged, indicated the appallingly impecunious state that his opponents' government had visited upon the Australian healthcare system. The hospital should, the implication ran, have been standing ready to whisk his daughter — who had walked unannounced into the Emergency Department — off to the operating theatre within minutes of her arrival for a quick and perfect appendicectomy. He implied that it is clearly unacceptable to spend three and a half hours taking patient's history, and performing their physical examination, and collecting their blood, and performing the laboratory tests, and taking the X-rays, and interpreting them, and fasting her for the anaesthetic, and getting the Theatre staff ready, and administering...

(continued on page 14)

High Altitude Doctors

by Dave Duke

It is ironic that a country whose highest point is a mere 2228m (Mt Kosciuszko) should produce any mountaineers. Against the odds, there have been numerous world-class Australian mountaineers. This has been accompanied by a strong involvement of Australian medical practitioners who have been expedition doctors, climbers in their own right, or who have studied high altitude physiology.

One of the world's leading researchers into high altitide medicine, John B. West, graduated from Adelaide University in 1951. He has written or edited numerous research articles and papers, including: *High Altitude Physiology - Benchmark Papers in Human Physiology Series; High Altitude and Man; Everest - The Testing Place; High Altitude Medicine and Physiology*; and *High Life: A History of High-Altitude Physiology and Medicine*. He has been Professor of Medicine and Physiology at the University of California, San Diego in the United States since 1969.

A climber on the north face of Cornice Peak, 5900m, Snow Lake, Pakistan.

Keith Burgess (University of Sydney, 1975) is a respiratory physician and intensivist at Manly Hospital. He has an ongoing research interest in sleep at altitude, looking particularly at periodic (Cheyne-Stokes) breathing and central sleep apnoea in subjects at altitude compared with sea level. He has carried out field experiments in Nepal.

A relatively common way Australian doctors have sought to combine work and holidays is as doctors on mountaineering

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expeditions. For the most part these doctors have an established interest in rockclimbing or hiking but are usually not one of the climbing members of the expedition. An example is Jon Leicester (neurologist at Royal Prince Alfred Hospital), who went as doctor on an Australian expedition to the West Pillar of Makalu (8,463m in Nepal) in 1993. He has rock-climbed for many years.

Finally there are those doctors who aspire to be a full climbing member of their expedition as well as acting as team doctor. A prominent example is Jim Duff. He is currently a General Practitioner in Bellingen, NSW, and was doctor on the highly successful Australian Everest Expedition of 1984. On this trip Tim McCartney-Snape and Greg Mortimer became the first Australians to climb Everest (8,848m) and did so by a new route and without use of supplemental oxygen. Jim has climbed for many years with (most notably) new routes on Changabang (6,864m, Garwhal Himalaya, India) and Khumbutse (6,665m, Nepal).

Toby Johnson on the summit of Workman's Peak, 5950m, Biafo-Hispar region, Paksitan. The author went as doctor on the New Zealand Alpine Club Snow Lake Expedition to the area in July 2000.

Leonard Harvey, a respiratory physician Wollongong is an accomplished mountaineer, having climbed, amongst others Cho Oyu (8201m, Nepal) and Ama Dablam (6,856m, Khumbu region, Nepal). Dave Tingay is an advanced trainee in Neonatal Medicine in Melbourne, and was expedition doctor and a climbing member of the 1995 Australian Makalu Expedition. This saw the first Australians summit Makalu (8481m, Nepal), although one died on the descent. Andrew Peacock, a graduate of Flinders University in South Australia has combined roles of climber and doctor successfully as medical officer for the Australian Army Alpine Association Expedition to Shishapangma (8010m, in Tibet), where he summitted with the rest of the team. He has since climbed Khan Tengri (7,010m, in the Tien Shan mountains of Kazakhstan), and is doing locum GP and Emergency work between trips to the mountains.

This article is simply a survey of the possible ways in which doctors can be become involved in high altitude medicine, are there are undoubtedly many more Australian doctors who are not mentioned. It is a fascinating field and anyone wishing to find out more, or to contact the author or those doctors mentioned in the text, may do so at *dduke_k2@hotmail.com*.

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 endeavour to publish them.

Radius is published by the University of Sydney Medical Graduates' Association (MGA) twice each year.

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President's Report

by Barry Catchlove

Since last reporting to you the Association has been continuing its efforts to become the bridge between a wide variety of University activities and the Medical Alumni.

The linkages with the Medical Foundation are strengthening and are already proving positive with Wendy Marceau providing the Association with strong administrative support. I have recently joined the Executive and Council of the Foundation, which will again strengthen the ties between the two organisations. The acquisition of the old Worksafe Building on Parramatta Road is nearing completion and will be renamed "The Medical Foundation Building", giving the Foundation a new home and a higher public profile.

You will see from other pages of *Radius* that we are organising our first Graduates Room Seminar to be given by Dr Ben Haneman. The afternoon will include a tour of the restored Anderson Stuart Building organised by Professor Jonathon Stone.

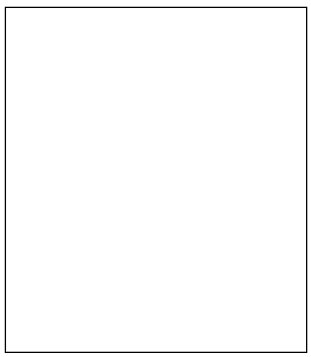
This issue also contains the preliminary notice for our first joint venture with the University's Centre for Continuing Education. This medically orientated tour of Turkey and Greece coincides with the 38th International Congress on the History of Medicine to be held in Istanbul from 1-6 September 2002.

We are also developing ideas as to how we can better serve our 'expatriate' alumni. The Association database shows there are over 600 medical graduates working (or living) overseas. We have had initial discussions about developing a network which can easily put members in touch with graduates working in overseas countries.

With the last *Radius* I made an appeal for donations (in lieu of the former subscription). While the appeal generated $24,400 it is not sufficient to allow us to achieve all the things we believe would be of benefit to members. On a per capita basis I would have to say it was disappointing. While I have always believed we are an impecunious lot, I think we could do a little better. We are therefore enclosing another copy of the begging letter for those of you who would like to support us.

Lastly I would like to remind graduates that they will shortly be asked to vote to elect Senate Fellows to represent the graduates. Given the turbulence of the last twelve months, which I am sure has been detrimental to our University, it is essential we have a strong Senate, which provides leadership and recognises its role in relationship to the Vice-Chancellor.

I would encourage you to exercise your democratic right and to give thought to whom of the candidates might be part of the problem and who might be part of the solution.



Dr Barry Catchlove, MGA President

Bernard Lake Memorial Award

The work and interests of the late Dr Bernard Lake inspired his friend, Peter North, to establish a fund within the Medical Foundation at the University of Sydney to commemorate Dr Lake's lifetime contribution to the understanding and use of alternative therapies to enhance conventional methods.

Dr Lake, the brother of famous wine-maker, Max Lake, was a widely respected physician, particularly in the field of musculo-skeletal medicine and rehabilitation.

Dr Lake was one of the early proponents of the value of exercise for preventative and therapeutic medicine, and the value of regular rhythmic physical activity for maintaining health and for treating some of the effects of musculo-skeletal problems.

The annual prize will be named the Dr Bernard Lake Memorial Award and be for the publication of significant original work undertaken in Australia on the integration of alternative therapies into the practice of traditional medicine.

Those interested in receiving further information on the award should contact the Medical Foundation on (02) 9351 7315.

The Senate

by Stephen Leeder

Our Editor, Charles George, asked if I would write about events in the University of Sydney Senate, leading to the retirement of Dame Leonie Kramer on 6 August this year and the appointment of a new Chancellor The Hon. Justice Kim Santow, OAM, a judge of the Supreme Court of New South Wales, on 12 September. Charles told me that many alumni were interested to know what had occurred and its significance for the future of the University of Sydney. As I have served as an academic staff representative on the Senate for six years, this is not an unreasonable request. Tough, but not unreasonable.

The University of Sydney Act (1989), as amended, provides that "there is to be a Senate of the University" and that "The Senate is the governing authority of the University and has the functions conferred or imposed on it by or under this Act". The Act subsequently outlines the functions, which, in addition to matters relating specifically to the financial transactions of the University, include the following:

16. *(1) The Senate:*

a) may provide such courses, and may confer such degrees (including ad eundem degrees and honorary degrees) and award such diplomas and other certificates, as it thinks fit;

b) may appoint and terminate the appointment of academic and other staff of the University;

c) has the control and management of the affairs and concerns of the University and may act in all matters concerning the University in such manner as appears to it to be best calculated to promote the objects and interests of the University.

Clearly, however, one would not expect a governing body, even one with wide-ranging powers such as above, to be involved in the day-to-day management of the University.

The Act prescribes that the membership of the Senate shall include the Chancellor who "has the functions conferred or imposed on the Chancellor by or under this or any other Act". Schedule 1 to the Act states that the "Chancellor is to preside at all meetings of the Senate at which the Chancellor is present" and may preside at any meeting of a committee established by Senate of a faculty or board. The Chancellor is elected by the Senate for a four-year term; the person elected may or may not have been a Fellow previously.

In any troubled circumstance each person involved has their own interpretation, their own history, and so what I write is properly read as my view alone. I did not serve on Senate as a representative of the Faculty of Medicine or as dean of that faculty, but as an elected representative of the academic community.

The bottom line in the University's recent and widely publicised troubled circumstances is that the Senate and the Chancellor came into irreconcilable conflict over several matters, and the Senate expressed its loss of confidence in the Chancellor in a motion in July. In August, when a second such vote of no confidence would have led to the dismissal of the Chancellor, Emeritus Professor Dame Leonie Kramer chose to retire. She did so, she said, with the interests of the University foremost in her mind, and I believe her.

Some time ago the law decided that, in relation to divorce, fault would not be contested and that evidence of irreconcilable differences would be sufficient ground. In many respects the same should apply in this 'divorce'. The nub of the problem can be described as a loss of confidence. Confidence has to do with trust and mutual respect. In the period up to 6 August, the majority of Fellows of Senate lost confidence in the Chancellor. The points of view of the Chancellor and the Senate have been aired in the various media with each party disputing the interpretation and attitude of the other. Foci for the dispute included arrangements pertaining to the vice-chancellor's contract and remuneration, the method of award of honorary degrees and the management of aspects of an adverse report on University finances from the NSW Auditor-General. Fellows of Senate did not feel that they were included by the Chancellor when making several important decisions such as the determination of the terms of the Vice-Chancellor's contract and the methods whereby decisions over the award of honorary degrees were made. The Chancellor took a contrary view. Supporters and opponents of the Chancellor argued their cases strongly, sometimes publicly and sometimes with a significant degree of vehemence. As a result compromise became increasingly difficult.

In family law, wrangles have occurred over custody of a goldfish, fought at great expense and with intense acrimony. It would be easy, then, to argue that perhaps *Kramer v The Senate* was simply an exceedingly unfortunate example of people of good intention falling out with one another and behaving vexaciously over matters of trivial importance. Couldn't we just agree on the fate of the goldfish and get on with it? I do not believe the matters of conflict were that insubstantial (no disrespect: some of my friends own goldfish).

I have heard some Fellows of the Senate described as 'evil', but I do not accept that either. Or that there was a grand political purpose underlying it all – Left versus Right, republican versus monarchist, business versus academic, State government versus the University - and so on. That assumes all sorts of things (including coherent political agendas) that I did not see at the time. Perhaps they are beyond the reach of my perception. True, the Senate comprises people representing the alumni, the academic staff, the general support staff of the University, students and State government. Each has his or her own agenda and it would be foolish to believe that conflict will never occur.

Views vary about the consequences of this eventually very public stouch. The most loudly voiced view both within and outside the University is that it did the University considerable damage in the eyes of government and the wider community. Some argued that the Senate's resistance to the Chancellor revealed unconscionable disrespect. She is, without dispute, an outstanding Australian academic, having served with distinction as a public intellectual, chair and expert critic of Australian literature. The Senate was portrayed as a group of misbehaving cads, insubstantial by comparison, disrespectful, and pumped up. Others considered that the Chancellor, after years of service had unwisely overstayed her welcome and should have stepped aside earlier and more willingly. With increasing pressure on all public institutions to account for their use of resources and to make their process of governance visible, the Chancellor's approach was overtaken by contemporary practice.

Some who heaped abuse on me as a Fellow of Senate for my part displayed a remarkable lack of understanding about the public image of the University prior to this conflict. One would imagine from what they said that the University of Sydney held a place of iconic virtue, second only to the Queen Mother, as an organisation of unalloyed excellence, humility, responsiveness and innovation. In my experience of rubbing shoulders with many people in many different social categories that view is uncommon. So while I do not disagree at all with the view that this conflict was regrettable because of the manner of dispute and confrontation and what was said in private and public, and that its public portrayal was damaging to all concerned, I am not sure that it upset the apple cart of the University's image as much as some critics insist.

Another line taken in criticism I found disturbing. Markers of the University's performance – in research and sport for example – are all positive. The University is travelling well compared with other Australian universities (international comparisons are deeply worrying as our Vice-Chancellor frequently reminds us). Why then worry about the behaviour of the Chancellor? Why not simply accept things as they are and relax?

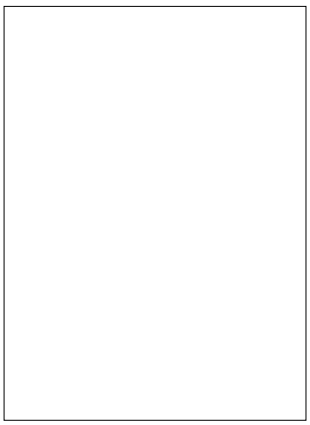
I do not believe that is a responsible attitude if one has an interest not only in what is done but how it is done. History is littered with examples of societies where preoccupation with ends combined with an indifference to means led to breakdown.

What can be rescued from this event? The Senate membership will change, perhaps substantially, as a result of forthcoming elections for Fellows. A new Senate, together with the new Chancellor, will be able to move forward. My (some would say, hopelessly naive) belief in the Senate incorporates the notion of better times ahead. I have confidence in the process whereby the next Chancellor has been selected and there was no shortage of worthy candidates.

The current Senate has begun a review of the functions and governance of Senate and the role and responsibility of Chancellor. On the latter the University by-laws are sparse, as noted, referring to the function of Chancellor as chair of Senate and of committees which extends to presiding over ceremonies for the conferring of degrees (technically meetings of Senate as well). Greater clarity would be helpful. The relation between the Senate and the University needs repair. There has been loss of confidence there, too. Presumably the elections will help rectify that.

One day, when the tree of peace once again puts out its leaves and the fires of war are dead, a political science doctoral student could write a thesis (or three) on the recent events within the Senate. They would have the distinct advantage of dispassion and indifference. I have neither. I have a great sense of relief that it is over. I believe the battle was necessary, but I also hold to the view that things could have been different if several decisions had been taken earlier, e.g. seeking details of the original Vice-Chancellor's contract when it was agreed upon.

For the moment, I am pleased that we can look forward to new things – a Senate and Chancellor who respect one another, are open with each other and who can handle conflict with the ethical tools of what ethicist Alisdair MacIntyre called 'constrained disagreement'. For MacIntyre, being able to take another to task in vigorous, strong, dissenting debate was the central hallmark of a thriving, thrusting academia. I share his view. For me, the way the University lives its life matters more than numerical markers of financial stability and academic and other forms of success.



Professor Stephen Leeder, Dean, Faculty of Medicine

Reunions

2001

Graduating Year of 1961

When: 9 November, 2001 7pm - midnight
Where: Withdrawing Room and Refectory, Holme (Union) Building, University of Sydney
Contact: Professor Saxon White
Email: hpsw@mail.newcastle.edu.au

Graduating Year of 1977

We have an overseas member interested to hear of any proposed plans to celebrate the 25th year of graduation of the "Class of 1977".
If you are interested in organising a reunion call the MGA (9351 8947).

Graduating Year of 1981

When: 3 November 2001
Where: MacLaurin Hall, University of Sydney
Contact: Dr Ann Allsop
Telephone: 8969 5000

2002

Graduating Year of 1952

When: Friday 22 February 2002, 12 noon.
Where: Royal Sydney Yacht Squadron, 33 Peel Street, Kirribilli.
Contacts: Dr Monica Bullen, telephone: 9969 3206
Dr Joan Croll (02) 9817 1692
Facsimile (02) 9879 7545, croll@ozemail.com.au
Do you know anyone who has changed address or taken the High Road? All information will be welcome.

Graduating Year of 1992

When: April/May 2002
Where: to be announced
Contacts: Silvia Fragiacomo, telephone: 9713 6459
Email: angusandsilvia@aol.com
John Kennedy, telephone: 02 6766 7962
Email: drjfk@bigpond.com
Please contact Silvia or John if you have changed address or if you would like to assist on the organising committee.

Dermatology Update for General Practitioners

Skin diseases are the second commonest cause of morbidity in Australia after respiratory diseases, and are a major component of general practice. Also, it is well recognised that Australia has the highest incidence of skin cancer in the world. There have been significant recent advances in treatment modalities. This seminar provides updated information for general practitioners concerning dermatology.

List of topics: Acne and rosacea
More surgical tips for the GP
Less common tumours of the skin
Birthmarks
Diseases of the palms and soles
Urticaria: diagnosis and treatment
Quiz and case presentations

When: Saturday 3 November, 2001.
Time: Registration 0830-0900 Sessions: 0900-1700
Where: Eastern Avenue Lecture Theatre, Eastern Avenue, The University of Sydney.
Cost: $176 (inclusive 10%GST) includes morning tea, lunch and notes.
CME: Application will be made to the RACGP QA and CE program for CME classification (2 points per hour, total 13 points).

Convener: Professor Ross Barnetson, Raymond E. Purves Professor of Dermatology, The University of Sydney; Head of Department, Royal Prince Alfred Hospital
Co-convener: Dr Greg Heron,General Practitioner in private practice
Chairman: Dr Norman Walsh,General Practitioner in private practice
Speakers:
Dr Kenneth Ho,Dermatologist, Hurstville; VMO, Royal Prince Alfred Hospital and St George Hospital
Dr Michelle Hunt,Dermatologist; Mohs Surgeon at the Skin and Cancer Foundation Westmead; VMO, Royal Prince Alfred Hospital
Dr Maureen Rogers,Head, Department of Dermatology,Royal Alexandra Hospital for Children, Westmead
Dr Anthony White, Dermatologist; VMO, Royal Prince Alfred Hospital

For more information please contact the Postgraduate Committee in Medicine on 02 9351 3519 or visit the website www.pgcm.usyd.edu.au

Emails to the Editor

To the Editor of "Radius"

I feel that I must take issue with your April editorial over a number of points. The first half of your editorial seriously misrepresents the facts in the recent controversy regarding altered marking of university students' marks. The crucial piece of information that you have not included in your column is that the reports centred on favourable treatment being given to full fee-paying students rather than to students as a whole. The issue at stake is not one of a supposed new right of all students to pass their exams. The more important issue is different treatment being given to students, depending on whether they pay full fees for their education or not, and the reasons behind this. The underlying problem is that universities and other educational institutions have had their funding from government reduced so that they must obtain revenue from elsewhere; one such avenue is to take on full fee-paying students. The side effect of this is that there is a perception among some staff and administrators that to obstruct the passage of these students through their courses by failing them could threaten the revenue base of the university. This has nothing whatsoever to do with the "rights" of students to education and has even less to do with "our politically-correct society". It is another example of how money takes precedence over merit in enabling people to advance themselves in life. If you want to see another example of this, look no further than the current occupant of the White House.

I also object to the use of the term "politically-correct", even when used sarcastically as in your column. This is a term bandied about far too frequently and loosely, in my opinion. Originally the ~k 'c' term seems to have been used to refer to changes in language designed to eliminate terms considered sexist, racist and so forth, but now seems to have a broader meaning, encompassing basically all of what one might call "warm fuzzy Leftist rhetoric". In fact, it is my experience that the term "politically-correct" is now used almost exclusively by conservative columnists to damn anything that they happen to dislike, regardless of what the term, oxymoronic as it is, happens to mean.

Finally, and more fundamentally, I would also disagree that we live in a "politically-correct society". We have been living for many years (at least since 1975 in Australia and probably since 1968 in the USA), in an era of a conservative backlash against perceived past overreaching socialism. The people who rail against "political correctness" for the most part are those who are most enthusiastic about the conservative rollback and whose chief complaint is that it hasn't gone fast or far enough. These are the people who are the keenest supporters of "market-driven, small-government, user-pays" ideologies. Our current Federal government follows this ideology and is responsible for forcing our tertiary institutions to seek other forms of funding, such as fee-paying students. The controversy over favorable marking of these students is one example of the collateral damage arising from the indiscriminate application of this (Right-wing, not Leftist and definitely not politically-correct) ideology.

Regards,

Mark Formby
Southern Pathology

Dear Editor,

I enjoyed your editorial in the recent magazine. I too despair at what is becoming of our society, and in particular, our high profession. Keep up the good work!

Regards,

Cholm Williams
Hornsby

The Expert Witness Code

by Anthony Scarcella

Anthony Scarcella is a solicitor and specialist in Pesonal Injury Law. He heads the Court Disputes team at Heazlewoods Solicitors in Epping, NSW.

As a result of the common law's pre-occupation with truth of facts, evidentiary rules were developed to create the best means of proving facts on which a party relied to establish its case or defence. Opinions were not admissible. However, an early exception was the reception of opinions of witnesses who possessed special skills or knowledge.

Today the test remains whether the expert opinion is a necessary aid to the Court because it provides relevant technical or scientific knowledge, which the Court does not itself possess.

Who is an expert witness?

Usually, the identification of an expert does not create any difficulty. In most instances one is dealing with a witness who has academic and/or professional qualifications in an established faculty. The opinions of doctors, engineers, valuers and accountants is admissible, subject to relevance, upon proof of their holding the requisite academic qualification or membership of the appropriate professional body.

Why Have an Expert Witness Code?

The official reason for the introduction of the Expert Witness Code is a concern that expert witnesses may be uncertain about their role in giving expert evidence. The unofficial reason is that it will restrict parties from "rounding up the usual suspects" to give expert evidence to suit their respective cases.

Where does the Code apply?

- Federal Court of Australia from Oct 1998
- Supreme Court of NSW from Jan 2000
- District Court of NSW from July 2000

Using Expert Evidence

The only reason for engaging an expert witness to give evidence is to have his/her opinion accepted by the Court and so aid in obtaining a favourable verdict. The opposing litigant engages experts who will only be called if their opinions controvert the other party's expert. Usually, the Court is left with choosing between two eminently qualified experts expressing, in some cases, extremely diverse opinions on a subject about which the Court may be ignorant.

What does the Court do in such circumstances? It has to apply logic and common sense to the best of its ability to decide which expert opinion is to be preferred or which parts of the evidence are to be accepted. Other factors are the qualifications and experience of the experts and the extent to which they have managed, or failed, to demonstrate a correct grasp of the basic objective fact relevant to the problem or the theory of their own field of expertise.

Another factor which is much relied upon by Judges in tending to reject the views of an expert is that the witness lacks impartiality or appeared an advocate for the litigant in whose case the expert was called. In *Clarke v Ryan*, Windeyer, J quoted from Taylor on evidence:

> *These witnesses are usually required to speak, not to the facts, but to opinions; and when this is the case, it is often quite surprising to see with what facility, and to what an extent, their views can be made to correspond with the wishes or the interests of the parties who called them.*

A Judge must assess the relative value of the lay and expert's evidence and weigh such evidence up. A Judge may reject an expert opinion in preference to the evidence of eye witnesses. A Judge may also resolve a conflict between experts by reference to lay evidence. A Court may also decline to accept the opinion of the only expert called on a particular topic.

Application of the Code

The Code applies to any expert engaged to provide a report for use in evidence, or to give opinion evidence, in proceedings or proposed proceedings.

The Expert's General Duty to the Court

There is an overriding duty to assist the Court impartially on matters relevant to the area of expertise. The paramount duty is to the Court, and not to the person retaining. The expert is **not** an advocate for a party.

The Form of Experts' Reports

At or as soon as practicable after, the engagement of an expert as a witness, whether to give oral evidence or to provide a report for use as evidence, the person

engaging the expert must provide the expert with a copy of the Expert Witness Code of Conduct.

The expert must, by way of Annexure or in the body of the report, specify:

- his / her qualification (a Curriculum Vitae may be attached);
- the facts, matters and assumptions on which the opinions in the report are based (a letter of instructions may be annexed);
- the reasons for each opinion expressed;
- if applicable, that a particular question or issue falls outside his / her field of expertise;
- any literature or materials utilised in support of opinions;
- any examinations, tests or other investigations on which he / she has relied and identify and give details of the qualifications of the person who carried them out; and
- an acknowledgment that he / she has read the Code and agrees to be bound by it.

Whilst experts format reports to suit their own style, the above specifications are crucial to ensure compliance. Further, the expert should not ignore the specific questions raised by the person engaging the expert in the letter of instructions.

If an expert believes that his / her report may be incomplete or inaccurate without some qualification (due to lack of data or otherwise), that qualification must be stated.

An expert, having provided a report, who changes his / her opinion on a material matter shall forthwith provide the engaging party with a supplementary report to that effect in the form referred to above.

The Experts' Conference

An expert witness must abide by any direction of the Court to: confer with any other expert witness; endeavour to reach agreement on material matters for expert opinion; or provide the Court with a joint report specifying matters agreed / not agreed and the reasons for any non-agreement. In these experts' conferences, the expert has a duty to exercise independent and professional judgment at the conference and in the joint report, and must not act on any instruction for request to withhold or avoid agreement. In practice, experts' conferences are rarely ever used despite having been around in some jurisdictions for quite some time. However, they may be a tool of the future used to reduce Court hearing time in appropriate cases.

The Effect of Non-Compliance with the Code

- The Expert's Report is not to be admitted into evidence!
- The expert is thus not permitted to give evidence!
- An extremely upset instructing solicitor and client!
- The expert's time has been wasted!

Conclusion

Compliance with the expert witness code of conduct will save the expert's time. It should also make cross examination much easier for the expert. It most certainly involves a shift in the mind-set of the expert from the traditional feeling of a duty to the person retaining them to the paramount duty being owed to the Court.

History of Medicine

Ben Haneman — 1943 Graduate

When considering the whole body of medical education, there are many who see history of medicine teaching as an appendix, and like the appendix, something we can well manage without.

The Australian Society of the History of Medicine (ASHM) is a learned association, comprising doctors, historians, nurses, sociologist and educationalists who take a contrary view and believe that history of medicine teaching should be an integral part of the medical curriculum. The assertion is that society in general, secures a better doctor, (without putting too fine a point on an interpretation of the word better) if he or she has an appreciation of the history of the profession, the science and the art.

There is a "space" in the total preparation for our lives as doctors, which is left uncovered by the usual albeit thorough technical education we receive. That conceptual space would be filled by the sub-disciplines of medical ethics, medical humanities and medical history. If only to meet society's expectation of us, medical ethics must be taught and learned. Medical humanities would produce a more sensitive and compassionate doctor whereas a knowledge of medical history would make for a more complete doctor and as a result a more effective one. Of course, one has to be realistic. I doubt a patient has ever been prejudiced by his or her doctor not having heard of Osler or Sydenham or Boerhaave, to mention but as few names. (For that matter neither has any patient been disadvantaged by the doctor not knowing the Embden- Myerhof pathway.) Those passionate about medical history believe strongly that both the profession to which we belong and the society to which we minister, is enriched by having men and women who can take a long view of the medical problems which confront our world. To which can be appended the secondary argument that history of medicine is a most enjoyable intellectual pursuit.

In response to this quixotic stance the pragmatist would point to a congested curriculum and possibly quote the line that history of medicine is fine for retired doctors who can't play golf and don't like gardening. It is true that some medical historians are doctor dilettantes. One hastens to add, dilettantes at their history but not their medical work. Admittedly no description can be black and white but doctors tend to be hagiographers and tend to write about the good doctor Bob Brown and the clever doctor John Jones. In passing, may it be said that some of our colleagues moonlighting as historians become impressively competent and skilful, some acquiring university qualifications in history. But within the history of medicine discipline we have also nurses, pharmacists, dentists, sociologists and historians. These scholars tend to be less starry eyed about doctors and write "history from below" for instance, the patients' experience of the healing art.

History of medicine has many sections, Graeco-Roman medicine of course, mediaeval, 19th, 20th century, diseases, discoveries, medical personalities. But even if we limit our vision to our own region, Australian medical history includes naval medicine, aboriginal medicine, pioneering, hospital, university, medical societies development, war medicine and I have not yet mentioned nursing history. Nor have I listed New Zealand which the ASHM has within its remit. Medicine does not exist in a social vacuum. A nice example of the complexity of the issues dealt with in medical history is provided by a paper given in Darwin by Dr Suzanne Parry at the 5th Biennial Conference of the ASHM in 1995. Her paper entitled "The Discourse of Tropical Medicine" argued that our national concern for tropical health was really a reflection of our national ambitions and fears about the populating of our empty northern "emptiness". The latest issue of the society's journal "Health and History" is devoted to the history of Maori health. Last year the journal carried an article "Diphtheria, Immunisation and the Bundaberg Tragedy: A Study of Public Health in Australia". The author was Claire Hooker who at the time of writing was Senior Research Associate with the History of Material Culture of Public Health in Australia Project, a collaborative venture between the University of Sydney and the Powerhouse Museum.

The ASHM had its first formal biennial conference in Sydney in 1989, at Sydney University as it happened. The theme was "New Perspectives in the History of Medicine" There was a session on the undergraduate teaching of the subject and this task has remained a preoccupation of the Society ever since. There had been three earlier Australian national meetings in Sydney, Melbourne and Adelaide. The ASHM subsequently held meetings in Perth (July 1991) and every two years successively in Hobart, Norfolk Island (a particularly felicitous affair and anyhow the Island is rich in historic associations.), Darwin, Sydney in 1997 , the theme being *Individuals and Initiatives in the History of Medicine*, This year there was a successful conference in Adelaide and planning is already proceeding for the Melbourne conference in 2003. The dinner associated with the Sydney conference in 1991 was held in the magnificent

main reading room of the original Fisher's library, during which due tribute was paid to Sir Henry Normand MacLaurin (1835-1914).

Most states have their individual History of Medicine Societies. Ours meets in the Faculty of Nursing building of the University of Sydney.

As already realized, the ASHM sees two of its main activities as arranging national conferences and publishing a refereed journal. In addition it encourages scholarship in its field, has a policy of helping students and advocates the teaching of history of medicine in university curricula.

At our university one of the first teachers of history of medicine was the flamboyant Florentine doctor, Thomas Fiaschi who in 1902 became Honorary Lecturer in the History of Medicine. Later Leslie Cowlishaw was lecturer. In his salad days he was honorary secretary of Sydney MedSoc. He had collected a considerable library which came to find its home eventually with the Royal Australasian College of Surgeons in Melbourne and that's a story of itself. In later years Professor Yvonne Cossart has been a catalyst in encouraging the teaching of medical history to our undergraduates. One of the great men of Australian medical history was Sir Edward Ford, one time Dean of the medical faculty. He was professor of Public Health. He was a keen bibliophile, a bachelor too which is a help rather than a hindrance for the book lover. He set the whole profession an example that you could be an OK doctor and a medical historian too. Indeed one argument for having practising clinicians teach history of medicine to undergraduates is to demonstrate that there need by no paradox between being both cultivated and competent. Sir William Osler in his turn had played that role magnificently for Anglo-American medicine.

Dr Milton Lewis in our School of Public Health is a much published and respected doyen of the history of medicine fraternity. But going back in time Sir Herbert Schlink, remembered perhaps better for administration and gynaecology, he published a splendid paper on Imhotep, the Egyptian God of Medicine, when the god's statue was unveiled in the grounds of Gloucester House.

By way of epilogue, must mention the strong rumour that the world famous history of medicine library of the Australasian College of Physicians presently housed in the College building in 145 Macquarie Street, will soon find a new home at the University of Sydney. I hope the University will rise to the challenge of nurturing this collection which, without exaggeration, is a national treasure. It contains by the way, the bulk of the Sir Edward Ford unique collection. I hope that our University encourages scholarship in the history of medicine and I hope that the readers of Radius will find fresh interest, pleasure and fulfilment by interesting themselves in the field of History of Medicine.

Health Care in Uganda

by Moses Wavamunno, Concord Hospital

Uganda lies between the two arms of the East African Rift valley. Roughly the size of Great Britain, it is bordered by Kenya, Sudan, the Democratic Republic of the Congo, Tanzania and Rwanda. It is crossed by the Equator and is also the source of the River Nile that runs from Lake Victoria to the Mediterranean Sea.

Uganda has a population of 23 million, with 56% below the age of 19 and only 3% aged over 65. Eighty six percent of the population lives in rural areas. Kampala, the capital, has a population of two million.

Mulago Hospital, a university teaching hospital attached to Makerere University, is the tertiary referral centre. Specialist services there include paediatrics, internal medicine and obstetrics and gynaecology. However, there is still a need for more specialist services: the government spent about US$2 million for the treatment of senior government employees abroad in 1994. The public health sector funds over forty major district hospitals and dispensaries, with several regional hospitals. The private sector runs several hospitals in the capital and in some of the rural areas where there is a lot of need; these offer more services for a higher fee.

The year 2000 went without "Health for All," as the WHO would have wished. However population indices show that things are getting better. Of every 100,000 women who give birth in Uganda today, 500 die of complications related to delivery; this compares with a rate of 700 per 100,000 in 1990. Infant mortality has decreased from 122 per 1,000 in 1990, to 85 per 1,000 today. True, the figures are still very high but the trend is a positive one.

Over the past fourteen years a lot of effort has been put in improving the capacity of the health sector, reactivating disease control programmes and reorienting services towards primary health care. This improvement is shadowed by the high prevalence of communicable diseases, the rising incidence of non-communicable disease, the increasing demand for services due to rapid population growth and HIV/AIDS. The largest contributors to mortality and morbidity remain malaria, acute respiratory tract infections, HIV/AIDS, tuberculosis, malnutrition, maternal and pre-natal conditions, trauma and accidents.

Daily medical practice depends on one's ability to elicit clinical symptoms and signs in order to make diagnoses and formulate treatment plans. This only differs from the practice in developed countries in the sense that we often use the third piece in the puzzle — the chest x-ray, the blood test, etc — to clinch the diagnosis. Obviously these diagnostic tests make for better and safer practice, but in situations where a result often cannot be obtained within 24 hours clinical skills carry the day.

Medical training in Uganda is five years' duration, followed by twelve months as an intern, at the end of which one should be competent in all aspects of medicine. Most doctors are then posted to upcountry stations where they may be the only doctor. This is when surgical skills like appendicectomy, bowel resection, hysterectomy and ceasarian section come in really useful. Often one is the pediatrician, surgeon and internist! The idea is to be able to handle the emergencies, then refer to the nearest hospital. Thus, every intern makes sure they can do these emergency procedures on their own by the end of the intern year.

I still remember stories about appendices that could not be found, breech presentations that were difficult to deliver, and colleagues who had to deliver the anesthetic and perform the surgery at the same time. Internal medicine is not much different, with transfusions on the basis of mucosal membrane pallor: if you wait for the haemoglobin result you might be too late!

Finally, HIV/AIDS has had an enormous impact on health system in terms of resources and approaches to health problems. In the past few years, however, HIV rates have fallen significantly as a result of a massive health education campaign, a model for preventive medicine. The overwhelming number of patients in hospitals with HIV-related illnesses, will remain a huge burden for years to come.

Around the University:

Department of Pharmacology

by J Paul Seale

The teaching of pharmacology has occupied a central position in the medical course since the degrees of Bachelor of Medicine and Doctor of Medicine were established at the University of Sydney by Royal Charter in 1858. In those days it was described as *Materia Medica*. Pharmacology emerged as a distinct discipline in 1918 when Professor Chapman was appointed to the inaugural Chair. In 1920 he resigned to become Professor of Physiology.

The next appointment was Professor Roland Thorp in 1949, a position he held until his retirement in 1975. During the 26 years of his headship, the Department expanded, offering teaching in the Faculty of Science, to Veterinary Science and Dentistry students, in addition to its core commitment to medical students. Professor Thorp was instrumental in introducing the Bachelor of Pharmacy degree and close links with the School (now Faculty) of Pharmacy have continued since then. Thus, the Department's teaching responsibilities extend across several faculties and our graduates follow diverse career paths. Many of our Science graduates who have taken a pharmacology major join the pharmaceutical industry, where they have occupied senior positions in clinical research, marketing and management.

Many of the medical students who undertook study for a Bachelor of Science (Medicine), the so called BSc(Med) in the Department of Pharmacology forged careers of distinction, such as Barry Firkin, a former Professor of Medicine at Monash University, the late Victor Chang, who pioneered cardiac transplantation at St Vincent's Hospital, and our current Dean of Medicine, Stephen Leeder.

During the expansive era of the 1970s, Clinical Pharmacology gained recognition as a specialty in internal medicine. The pharmaceutical company, Reckitt and Colman endowed the Chair of Clinical Pharmacology in the Department of Pharmacology in 1979, providing strong leadership for the Department with two professors.

During the 1980s, the Department developed research strengths in neurochemistry and neuropharmacology under the leadership of Graham Johnston. A strong focus on respiratory pharmacology was fostered in the early 1980s and it now enjoys international recognition under the leadership of Professor Judith Black. The cellular and molecular basis of addiction is the theme of Professor Macdonald Christie's research programme, which is funded by the Medical Foundation.

Although the Department is located on the main University campus (in the Blackburn and Bosch Buildings), it has a presence in each of the teaching hospitals of the University with senior appointments in Clinical Pharmacology. Professor Gillian Shenfield at Royal North Shore Hospital has played a major role in the profile of the discipline and has had a positive influence on countless groups of medical students and junior doctors, to whom she has taught the principles of rational prescribing of medications. Professor Chris Liddle at Westmead has run a successful teaching program in clinical pharmacology and a research program related to drug metabolism, which has attracted international interest from the pharmaceutical industry.

The Department played an important role in creating the curriculum for the graduate medical program (now called USydMP). The principles of pharmacology and therapeutics are woven as strands throughout the four years of the course. With funding from the National Prescribing Service (an initiative of the Commonwealth Department of Health and Aged Care), the Department is collaborating with other Australian Universities in developing a common curriculum of rational prescribing for senior medical students. It is envisaged that this curriculum will extend into resident medical officer training.

Members of the Department enjoy success in teaching and research, and the Department is well positioned to continue its important role in the education of medical, pharmacy, science, veterinary science and dentistry students. Under Professor Macdonald Christie, who is a Medical Foundation Senior Research Fellow, the Department's direction has been set for the next three to five years with the intention of fostering excellence in research, providing high quality courses for our students, contributing to the collegiate life of the University and forging strong links with allied clinical disciplines.

Professor J Paul Seale is Professor of Clinical Pharmacology and Pro Dean of the Faculty of Medicine.

(continued from page 1)...the anaesthetic. No one should have to wait three and a half hours for anything, in this super-efficient society in which we now live.

Just imagine how offended one would be if one had to wait a whole three and a half hours after being involved in a motor vehicle accident for the panel beater to get one's car back on the road in pristine condition. Would it not be entirely unacceptable if one had to wait a whole three and a half hours for the cheque to arrive from Medicare for the service one had rendered to some patient who chose not to pay at the time? Can one imagine ever being kept waiting three and a half hours listening to recorded music on the Department of Veterans' Affairs Transport telephone line as one organised a Commonwealth car to take one's patient back home after an appointment? The only place where a wait for a whole three and a half hours might occur in contemporary Australia is in the queue at a bank or a post office, but then everyone knows that they are socially unacceptable organisations. Public hospitals should be different. They at least should render instant alleviation of the sick, if not gratification.

One can easily seem cynical of such criticisms of hospital services, but they do carry an important message. The public hospitals of Australia receive their funding through the Medicare system. Opinion polls, on the one hand, demonstrate that Australians love Medicare. Its level of acceptance within the community is invariably very high. All major political parties signal their unalloyed support of it in their platforms. The Australian Labor Party basks in the glory of having devised it. The Coalition parties pride themselves that one of their governments ultimately passed it. The loss of votes that would hit any party that dared to criticise Medicare would destroy all its electoral prospects. The public believes most criticisms, on the other hand, of the very hospital system that Medicare provides.

What is the basis of such a schizophrenic set of views on the part of the public? One might hope that our Parliaments would discuss such issues, but of course they cannot as to do so would open their Members to the risk of criticising Medicare, and that would invite electoral annihilation. Nor do such issues seem to grip the national press. Some explanation of this unbridgeable dichotomy of attitudes must, however, exist and to understand it is a matter of interest at least to many of those who work within the health-care professions. Could Medicare possibly have some imperfections?

A critic might indeed suggest that Medicare has two fundamental imperfections that drive these divergent public attitudes.

Firstly, Medicare is an unfunded insurance system — it has little capital so pays its claims out of contemporary income. No government would permit any private company in other forms of insurance business to conduct its affairs in such a manner. It would refuse to issue a licence to underwrite insurance to a company incapable of demonstrating that it had sufficient capital to meet all foreseeable claims for long periods in advance. Several centuries have now passed since governments would permit unfunded insurance companies to exist since to permit them runs too great a risk of bankruptcy and disadvantage of their clients. Medicare, one might claim, cannot go bankrupt because the Commonwealth owns it, but the Commonwealth obtains much of its income from taxes, an increase of which is hardly electorally popular. The Commonwealth therefore must always squeeze Medicare somewhere to keep it inexpensive and so keep taxation down. Squeezing the reimbursement rate to individual patients for consultations would attract immediate attention from voters. Squeezing reimbursements to hospitals, however, is an obscure area of activity and electorally much less threatening. If, of course, Medicare was a properly funded insurance system then squeezing anyone should be unnecessary, although the premiums (the Medicare surcharge on income tax) might have truly to reflect the high cost of modern hospital treatment and the maintenance of a Government monopoly insurance company. That too would attract political opprobrium. What this really means is that each successive Commonwealth Government finds itself in an intolerable position of conflict of interest. It is simultaneously the proprietor of a monopoly health insurance system and it claims to

police the marketplace in which that monopoly trades. That conflict of interest is too great a burden even for such morally impeccable people as the Members of the Commonwealth Parliament to bear.

Secondly, Medicare carries a powerful message to individual Australians. Our politicians imply: Dear Australian, under our system you no longer have to worry about ill-health; whatever happens to you, the doctors will fix you up and we politicians (the board of directors of Medicare) will pay for it. That beguiling message, of course, is totally flawed. Even if the politicians could and would pay for it, the doctors often cannot fix it. So many members of the public, however, just do not want to know that. They do not understand much about the complexities of medicine and surgery, and they do not want to have to bother learning. They find it much more sophisticated to smoke their lungs out, to drink their livers out, to smash their bodies up in fast cars, whilst believing that the doctors will fix it (and claiming incompetence remediable by a lawsuit if they do not). Every medical practitioner knows full well that there are so many things the doctors cannot fix, but many Australians no longer want to hear that. Rarely now does one hear them saying 'Being rich is great, but having good health is far more important than money'. Good health under systems like Medicare has become a fundamental human right granted to almost every newborn baby that many individuals find unappealing to conserve. If it is lost, the doctors will fix it, Medicare will pay, and if it doesn't work out, then sue them. The fundamental flaw makes such a philosophy unsustainable.

Do our politicians understand these basic imperfections of Medicare? We have no way of knowing as none of them dares to discuss the issues. To do so would merely lose them votes. No wonder then that they cynically play the health card when elections loom. The bottom line is that belief in Medicare has now become a stronger symbol of patriotism to many Australians than is loyalty to their Sovereign.

united med protect