



RADIUS

Newsletter of the University of Sydney Medical Graduates' Association

Volume 11, Number 3

Editorial Thinking in systems under a coconut palm

by Stephen Leeder

First, an apology. The delay in the mailing out of the last issue resulted from problems with the distribution of the *Gazette*; *Radius* was prepared well in advance. We are sorry that a number of members were unable to make it to the successful Lambie-Dew Oration by Peter Doherty which packed the Great Hall. We will endeavour to provide our readers with more notice next year. The Oration stimulated the memories of John Wright who sent us in his recollections of Lambie and Dew, published in this edition.

We are pleased to be able to report some important good news - the last two years of the Graduate Medical Program were accredited by the Australian Medical Council during 1998 (the first two years of the new medical course having been accredited in 1996).

In this issue we bring you a variety of articles, as well as the regular features. Any frustrated journalists out there - particularly those who now live and practise overseas - are encouraged to write for us and particularly to send news of activities and events involving Sydney graduates. In particular, we are keen to publish the details of upcoming reunion dinners. Our next issue will be out early next year, so please contact us before then.

Ann Sefton
David Duke

Yes, I confess: recently I've been junketing in Melanesia. But I'm not sorry.

In August the medical deans from Australasia held their annual therapeutic group meeting in Fiji. The Fiji School of Medicine has achieved autonomy, at least from the health department although it remains outside the university structure, and a new dean is soon to take over from the long-serving and personable Jimmy Samisoni. The Australasian medical deans are not always stimulating when you get them all together in a room, but at least this year we had the distracting pleasures of the Shangri-La Resort on Yanuca Island to make it bearable! And then early in September I went to Port Moresby for the 34th Annual meeting of the Papua New Guinean (PNG) Medical Association.

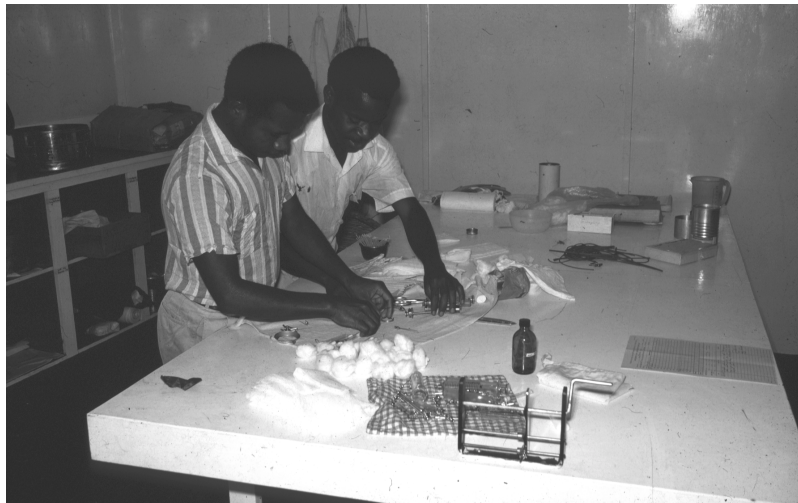
I have a longstanding interest in Melanesia, and PNG in particular. In 1968 with my then wife, Dorothy, I worked in a small mission hospital in Baiyer River in the Western Highlands. That's not strictly correct - it was a health service, with 40 monthly mobile clinics for mothers and babies and 14 aid posts, a training program for 30 aid post orderlies and another for 25 maternal and child health nurses. And I spent a lot of time renovating and managing while Dorothy did far more clinical and educational work than I did. The hospital, with one hundred beds if you could call them that, drew much of its identity principally from those non-hospital, community and staff development functions.

(continued page 2)



The Tinsley Memorial Hospital in the PNG Western Highlands circa 1968

It was what I saw achieved through the work of our predecessors and the nursing staff that completely overturned my previously limited view of the potential of medicine in combination with public health. I was gobsmacked by the fact that through such a relatively simple and certainly straightforward combination, assuming a background of high-quality family and tribal relations (not magical but solid), pretty good food and a benign physical environment, health status could be so high. The excellent records at that time in Baiyer River revealed an infant mortality rate the same as Australia's. I saw an epidemic of whooping cough tear through neighbouring areas and pass the Baiyer Valley unscathed because of regular



The preparation of surgical instruments in Tinsley Hospital

immunisation. Impressive stuff! And here I was in September this year, an unimaginable 30 years later, returning to Moresby to speak about the relation of public health to clinical medicine! What could I say other than that I first learned the lesson in PNG!

There's more to it than that. Until my PNG experience in 1968 my eye had been set on a research career in neuroscience, relating in no small part to my mother's fraught and destructive suffering from schizophrenia. But in PNG my ideas shifted, and it was at the 4th (not the 34th!) Annual Meeting of the PNG Medical Association that Professor Richard Lovell from Melbourne, who was the guest speaker, asked me over dinner to consider a career in epidemiology. Not only had I not thought about it - I really had no idea what it was! I had been talking with Dick about the importance of accurate observation in relation to health status and its determinants and also in planning an appropriate health service. Some of the decisions coming out of Moresby astonished me because if the people making them had known more of the situation in which their decisions were to be implemented, they would have decided differently. For example a new block built at Goroka Hospital had flushing toilets which were completely culturally inappropriate and soon clogged with banana

leaves. But that question from Dick crystallised my experience and the crystal reset my compass.

So it was the combination of the full spectrum (well, not quite - we did no heart transplants!) of care ranging from community hygiene through immediate emergency care and triage (for pneumonia, meningitis, trauma) to preventive care for mothers and children, immunisation, pretty basic medical, surgical, obstetric and paediatric (with occasional psychiatric) services which formed the backbone of what was, in 1968, an effective service.

In August this year we took a bus for the hectic two hour drive along narrow roads from Yanuca Island to Suva to see the parliament and meet folk from the medical school,

past villages made of galvanised iron, with lots of uncultivated arable land, sugar cane fields, and people ploughing with oxen. Fiji looked distinctly like parts of PNG in 1968. I guess I could have found much the same in PNG in 1998! It takes a long time to get economies into shape, but this is *not* a justification for medical or public health indolence. When thinking through the health needs of any community we have to be very canny about the way we do it, and not fall into the trap of economic despair ('unless these people can pay for x, y and z, we can't help them'). The World Bank survey of nations four years ago emphasised the importance of education

(general and health, of women especially) and not simply total income in setting levels of health. Costa Rica, with a heavy investment in education and no army, did very well even though much of it was 'poor'.

Is it too long a bow to consider the Melanesian scenery in relation to our own setting? Before answering look at what is happening in the US as it moves to control medical expenditure. A refreshed and major interest in the value of general medicine is the first port of call in an integrated

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Pager: (02) 9214 0259 carried by MGA President

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system of care is developing, reflected in radical changes in medical curricula. In the UK, a resurgent interest in wise investment in health care is proceeding in interesting ways, many of which are built on sophisticated approaches to care auspiced by general practitioners with access to a wide array of community, public health and hospital services.

In our Graduate Medical Program we have a theme that runs through the four years called Community and Doctor which captures some of these insights into the importance of thinking in systems - not body systems but systems of care that range from the clinical to the public health elements. It addresses many of these issues, and reaches across to the learning in the Patient and Doctor Theme, and the Basic and Clinical Sciences Theme and Personal and Professional Development Theme. It reminds students of the context of medical practice, of the ways in which the world and its several environments - physical, social,

political, economic - set the health agenda and acquaints them with ways in which, as future doctors, they can make the system work to best effect. Our students spend at least six weeks working in rural settings, thanks to the generosity of a host of tutors who add them to their busy schedules in both hospitals and practices.

Melanesia? Much remains to be done. We have contributed as Australians, but my sense is that much more could be done, but we need to be smart about it. Service, informed by research into what works, is the way to go, and that includes proceeding with cultural care of a high order and not barging. I know many of our alumni have worked and contributed charitably and effectively to this part of the world. Our task is to ensure that our successors can follow in that tradition - whether in Australia or beyond our fortunate shores - by equipping them with the skills and insights of public health and medicine in effective combination.

Upcoming Reunions

The MGA is strongly committed to publicising and assisting in the organisation of reunion events. Anyone interested in organising an event or seeking information about upcoming events is encouraged to contact us. Following is a list of upcoming reunions and contact people. These people may be contacted through the MGA (pager number 9214 0259) or individually where a phone number is supplied.

1998 50 Year Reunion (Graduates of October 1948).

This is being organised for some time in October.

Contact Doug Tracey 9332 6641 or Frank Harding Burns 9906 2333

1999 Please contact following people with regard to organising the following potential reunions

10 Year Reunion - Donald Kuah (is organising)

20 Year Reunion - Richmond Jeremy (still to be organised)

30 Year Reunion - Norm Olbourne and Paul Curtin (still to be organised)

40 Year Reunion - Kerry Goulston (still to be organised)

50 Year Reunion - no graduating class

60 Year Reunion - Paul Brennan (not planned)

Please note - there is no planned 25 Year Reunion.

Goals Achieved

by Katrina Loveridge

The recent response to our call for active membership and additional generous donations from Graduates has enabled the Association to achieve the goals set for this year.

We are now able to establish several book and computer scholarships for students in financial need for 1999 and we have taken several steps forward in developing, restoring and refurbishing the Graduates' Room in the Anderson Stuart Building. We hope this work will be completed by February of next year at which time we will invite our members to review the work at a special opening function.

In addition to the projects mentioned above, we are at present focusing on achieving further benefits for our members and developing educative seminars for 1999 with the cooperation of various corporate bodies. We would particularly like to thank United Medical Protection, the Medical Society Bookshop, AMP and Home Corp for their continuing support of *Radius*.

During September and October there were several graduate reunions, one of

which commemorated sixty years. In future editions of *Radius* we will endeavour to report upon these events and keep you up to date with some of your colleagues. To that end we would welcome any articles or photos, past and present, from you. The details of the various future reunions will appear regularly in the *Radius* and any further queries can be made to the MGA on pager (02) 9214 0259.

Over the next three years particularly, it is planned that the Association will develop into a functional body with an infrastructure capable of supporting its graduates, the Faculty and University. It is an important period and the best way of contributing to this process is by becoming an Active Member of the Association by completing the form below, if you have not already done so.

This is the last edition of *Radius* for 1998. Although it seems a little distant yet, on behalf of the Council I wish you a Happy Christmas and hope to bring you good news of the Association and its progress in the New Year.

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Area of Practice

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What's up Doc?

Issues affecting junior doctors

by Andrew Eakin

Junior doctors are now beginning to feel the impact of the Federal Government's restrictions on the allocation of Medicare provider numbers, which were introduced in legislation passed back in November 1996. However, the mood among this group is certainly less sour than it was eighteen months ago, with a number of concessions being gained from the Minister and more cohesion and communication among junior doctors' groups.

This slight optimism among junior doctors arises from a recent verbal assurance from the Minister for Health, Dr Wooldridge, to allow limited access to provider numbers for certain areas of supervised medical practice including some surgical assisting and GP locum work. However, we are waiting for that assurance to be worth the paper it hasn't (yet) been written on. The Minister also agreed to abandon the unpopular idea of introducing salaries for GP Registrars while they are undertaking the GP Training Programme.

Despite the long-term outlook for junior doctors becoming slightly more optimistic, the story is not quite so bright in the short to medium term. There is a feeling that some junior doctors are now missing out on an opportunity to undertake any form of postgraduate training. Whilst the mystery of issuing accurate medical workforce statistics remains within the (as yet unfulfilled) brief of the Medical Training Review Panel, which was established by the same statutes which spawned the Provider

Number restrictions, the general feeling amongst junior doctors is that there are now significantly fewer training positions than the number of doctors competing to fill them. There is increasing competition for training positions in certain fields which only a few years ago were relatively uncontested. Whilst there is not yet evidence of doctors missing out on resident employment in the public hospital system, it appears that there is only a short time until the backlog of doctors in the public hospitals squeezes the newer junior doctors out of a job.

The Health and Research Employees' Association of NSW (HREA) and the AMA are campaigning around the period of the Federal Election. The stated aims of this campaign are, firstly, that all Australian graduates of Australian Medical Schools can, after a satisfactory internship and registration, enter some form of supervised practice with patients able to access Medicare rebates. Secondly, we wish to ensure that there is access to postgraduate training, leading to independent practice, in all branches of medicine (including sexual health, Aboriginal health and rural health) and where patients are able to attract Medicare benefits.

Although the illogical and unfair 'provider number legislation' has not been overturned, there are signs that at least *some* headway is being made towards cleaning up the considerable mess which was created when that legislation was enacted.

Andrew Eakin is an intern at Gosford Hospital

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The Seven Wonders

The following address was given by Tony Basten at Medical Faculty Graduation, 30 April 1998

Deputy Chancellor, Fellows of the Senate, Pro-Vice Chancellor Young, Mr Dean, Graduands, colleagues and friends. It is a privilege for me to be with you today to celebrate this milestone in your careers. May I begin by adding my warmest congratulations to those of the Chancellor, to everyone of you on your graduation and to your families and friends for supporting you so well.

It is now 40 years since I graduated and 28 years since I joined the staff of this, your University. In the words of Oscar Wilde

which the late Chancellor, Sir Hermann Black liked to quote so much "You, Tony Basten have a great future behind you". On the other hand all of **you** have a great future ahead of you. At first glance, the world of medicine may look daunting. Healthcare along with education has become a political football, alternative therapies costing the community a billion dollars per annum are rife; litigation against doctors is rising every year and society is divided about whether euthanasia should be left in the hands of our profession or enshrined in legislation. But at

the same time the advances in medical science have been little short of breathtaking and when all these facets of medicine are put into the one basket, the opportunities for those of you embarking on your career have never been more diverse or challenging.

One way of putting our profession into perspective and of illustrating the challenges it presents to you is to ask the question "what are the seven wonders of the world of medicine"? Everyone present will no doubt have their own selection of topics, but for what it is worth here are my seven wonders in some sort of historical sequence:

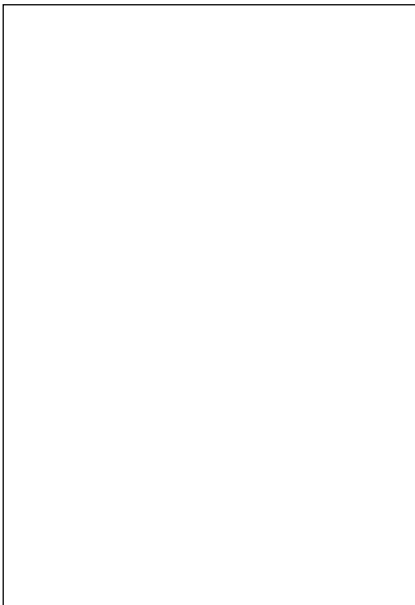
My first choice is the **Hippocratic oath** which has governed the ethics of medical

practice for the past 2500 years. Two excerpts are worth quoting: "pure and holy will I keep my life and my art" is the first and is straightforward, but the second is more contentious: "I will give no deadly drug to any, though it be asked of me, nor will I counsel such, and especially I will not aid a woman to procure abortion". These words highlight how opinions change and the challenge for you to adapt best practice to the society of today.

My second choice is the discovery of the **circulation of the blood** by Sir William Harvey who published his famous book *De Motu Cordis* in 1628 and whose bust adorns the front of the new medical school. Like Hypocrates, Harvey was a physician who practiced medicine as well as conducting experiments, epitomising the essential nexus between healthcare and research. The challenge for you is to take the cardiovascular diseases off top spot on the mortality table. Lipid lowering drugs are only part of the solution; even more important is persuading your patients that fast food with or without exercise is bad for the arteries.

My third choice may surprise you but I have selected it since it is in one sense close to home. I am referring to the **controlled clinical trial** and one of the best known, if not the first such trial was performed by Captain James Cook on his first voyage to Australia in the mid-18th century. He placed half his crew on limes (hence the American whalers term of endearment 'limey' for the British sailor) and the other half on standard fare. The result: conclusive proof that scurvy was due to a nutritional deficiency and could be prevented. What a wonderful example of best practice and preventative medicine. The challenge for you now lies in participating in similar trials within the limits of modern ethical standards.

Hygiene is my fourth choice for want of a better single word. The initial dramatic reduction in infectious diseases in the late 19th and early 20th centuries — then by far the commonest cause of death was not due to antibiotics, but to two other sequential



*Deputy Chancellor Daphne Kok presenting Andrew Eakin with his *testamur* at this year's Graduation*

events. The first was the recognition of a link between disease and the water supply and sewage. The second was the germ theory of disease. Although many famous names are associated with these discoveries I shall mention only two: the Austrian obstetrician, Semmelweis who showed that the washing of hands by accoucheurs reduced the incidence of fatal puerperal sepsis after child birth from 30% to less than 2%; the second is Louis Pasteur who not only raised the quality of French beer to that of the German through his studies on the fermentation process — his initial goal, but who showed conclusively that anthrax and rabies were diseases transmitted by living microorganisms. Appropriately his bust stands on the other side of the portal of the new medical school from that of Sir William Harvey. Despite the advances in modern therapeutics, however, infectious diseases remain the scourge of the developing world and the underprivileged in our **own** society. The challenge for your generation is to succeed in improving the lot of the underprivileged where Governments and politicians have failed.

The remaining three wonders of the world of medicine are even more difficult to choose as the past 100 years has seen so many spectacular discoveries. What about anaesthesia, blood transfusion, even the contraceptive pill? Well, I have selected three others, the first being **antibiotics** and I am sure everyone of you in the Great Hall today will know that one of Australia's most famous sons, Nobel Prize winner, Sir Howard Florey was responsible for developing penicillin for clinical use. When I was studying in Oxford I had the chance to read the case notes of the first two patients in the world to be treated with penicillin. The first a burley policeman was given 100,000 units and died, the question being was it penicillin poisoning or inadequate treatment of the infection that led to his death. Florey, dubbed the Bush Ranger by the British medical aristocracy had the conviction to give the second patient, a young woman with septicaemia 10 times the dose or 1 million units (still a minute dose by modern day standards) and she survived. What would have happened if she too had died is too terrible to contemplate,

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particularly just after ANZAC day which reminds us that almost as many soldiers died of wound infections in World War I as of the wounds themselves. The challenge for you of course is to cope with the problem of antibiotic resistance which will depend more on innovative ways of managing patients infected with vancomycin resistant organisms than trying to discover yet another antibiotic.

My sixth choice comes from our Dean, namely the **eradication of smallpox** in the mid 1970s by vaccination — at a cost to the World Health Organisation of a mere \$300m. The smallpox vaccine was first used by Dr Edward Jenner, an English country general practitioner, in the latter part of the 18th Century and is a remarkable story in itself. What is less well known about Jenner is that his spare time was devoted to classifying the collection of botanical specimens brought back by Joseph Banks who accompanied Captain Cook on his second voyage to Australia. **Now**, thanks to Australia's most recent Nobel Prize winner, Prof Peter Doherty and his Swiss colleague, Rolf Zinkernagel, we are looking at the prospect of being able to vaccinate not just against infections but against cancer, asthma and autoimmune diseases like diabetes as well — as an immunologist I envy you this challenge.

Finally comes the **double helix** or the discovery in the 1960s of the structure of DNA of which our genes are made by Frances Crick and James Watson who was recently lecturing in Sydney. This discovery set the scene for the

truly remarkable expansion in our knowledge of the genetic basis of disease over the past thirty years. Thanks in no small part to James Watson the decision was taken in 1987 to learn all that is to be known about the 85,000 odd genes in the human body at an estimated cost of \$3billion — ten times that spent on eradicating smallpox. The body responsible for this programme is known as the Human Genome Organisation and the current President is an Australian, Professor Grant Sutherland from Adelaide. Progress has been spectacular and it is predicted that the structure of the 85,000 genes within the human body will be known by the year 2003 — the prospects for curing genetic diseases are enormously exciting but with this knowledge comes the numerous ethical, social, and legal issues requiring resolution not just by the medical profession but by society as a whole. Remember the Boys from Brazil and Dolly the sheep. These make up your seventh and final challenge.

Well, I have done and no doubt one reason why you are stirring restlessly in your seats is that you disagree with my selection — but thinking and challenging are what modern medicine is all about. To quote once again from, Sir Hermann Black, “your degree is uniquely a personal accomplishment”. May I wish you all well in the future. You richly deserve it.

Tony Basten is Professor of Immunology and Director of the Centenary Institute of Cancer Medicine and Cell Biology.

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A memoir of Lambie and Dew

Seeing the advertisement for the 1998 Lambie-Dew Oration stimulated some memories...

by John Wright

Although I had been lectured by both men as an undergraduate, like all other medical students in The University of Sydney for so many years (and cherished a complete, typed set of "Lambie's lecture notes", surreptitiously acquires), it was not until later that I got to know much of either man.

As a student at the Royal Prince Alfred Hospital, I was once required to make a case presentation to Lambie, and a large student group, based on his own, heavy, two-volume text book of systemic physical examination methods, which requires reading. What I didn't know was that my presentation had to be word-for-word, precisely in order and detailed in accord with his textbook format, give or take nothing. Within one minute of beginning, it became clear to me and even clearer to Lambie, that I had not believed that such pedantry could possibly be necessary. He stood up, a small, neat, bald man in his buttoned white coat, smiled politely, apologised to the patient lying on a stretcher, and left the room, pleasantly instructing me to do the job "properly" on the next morning. Needless to say, I did, but I never forgot Lambie's response. I certainly forgave him, as I think he did me. He just wanted me to show him I had read "the book" carefully.

In 1954 I did my finals, dreading my "viva" with Lambie. We never know if the legendary "draw me a measles" question meant imminent doom. I hoped he would ask me something searching rather than derisive like the measles question might have been. His only question was "how would you treat my swollen, uninjured, red knee". A half-hour later, I no longer thought it was a "push-over" question.

During 1955, Gus Nossal, James Wright and I were appointed "professorial" residents to Lambie, Dew and Mayes. That meant getting to know each of them a great deal better. I soon discovered in Lambie a depth of humanity and humility I had never

expected. I can never forget a young woman in his ward with acute leukaemia, destined to die quickly, frightened, anxious about her family, in pain and demoralised. None of us had been able to comfort her. But on his daily round with us all, and with her husband, he sat by her bed and held her hand. In the simplest language, with his soft, gentle, Scots brogue, he told her she would die sooner than she wished, but that he would be there to see her every day until the end. He was the only physician I had ever known who said just that to someone like her. She seemed suddenly peaceful for the first time and died so, as Lambie sat by her bed next morning. He insisted on interviewing her family, himself.

Dew was a much different man but no less humane. His published specialties were testicular tumours and hydatid disease. He had few formal notes for undergraduates. He was a burly, waistcoated, gruff but always very friendly man, bald, pipe-smoking, rarely visiting the operating room but relying on his junior staff to attend to the day-to-day surgery. He taught at the bedside, sitting by the patient, eyes usually closed as he spoke. He was much interested in the occupational consequences of illness and injury. He taught large principles, indelibly. He called everybody by their surname.

If there were surgical cases concerning his special interests, he would actually scrub up and show everybody how to do the operations. Removal of a diseased testis involved scissors and one, large, all-encompassing ligature. Once I assisted him in evacuating a hydatid cyst from a liver. As I approached the table to begin, I inadvertently contaminated my gloves against his back as he turned suddenly to say something. When I had regloved and gowned, apologising profusely across the table, he said to me quietly: "bloody fool, nobody saw what happened and I wasn't going to tell anybody!"

On his last day at the hospital, he came to the ward for “nourishment’s” as he always called morning tea. As she poured his tea, the sister in charge remarked on the coldness of the day. He responded: “I can stand the weather, sister, but not the bastards you meet in the corridors !”

At the end of rounds that day, he asked me to walk with him back across the overpass leading to the “old medical school” where he had his office. On the way, he invited me to a cocktail party that evening, at his home, “black-tie if you’ve got one.” In due course I was introduced to a very large number of the distinguished knights of the realm (as Dew was), and their ladies. When I was offered caviar, I was taken aback, but the follow up question devastated me:

“Russian or French?” I think I said “both” to be on the safe side. All I could then do was withdraw to a quiet corner and pretend to like caviar while I vainly tried to participate in conversation with people who spoke of the ways of Dew’s world, of which I, a callow junior surgical resident, knew so little but was just setting out to learn.

Like all others who knew them, I have the fondest personal recollections of them both. I think their greatness came from their modesty, graciousness, standards and substance. With those, they began the enduringly distinguished lineages of their schools. Like countless others, my life was informed and enriched by knowing them. I hear them still.

John Wright is a consultant surgeon in Sydney

GMP Accreditation

by Ann Sefton

The last two years of the Graduate Medical Program (GMP) were accredited by the Australian Medical Council during 1998. The team (headed by Professor Bob Porter) “commended the Faculty on its progress to date” and “remained impressed with the demonstrated capacity of the Faculty to realise its vision”. They also referred to the “exemplary processes put in place to achieve the objectives”.

The major issue that preoccupies the Faculty at the moment is the detailed planning for the next two years (Years 3 and 4) of the GMP. While there has been an outline in place since the beginning, the hard work is now in full swing as the staff in the different clinical schools plan exactly how to implement the original ideas. For most of the third year, the students will be attached to wards, but learning will be centred around integrated services (such as cardiology and cardiac surgery). New methods of teaching are being developed, building on the experiences of problem-based learning with which the students are now thoroughly familiar after two years. Once again, the Faculty’s MedEdNet will deliver aspects of the problems/cases to

be considered each week and will be available for them to access a rich array of learning resources.

To those intimately involved in the GMP, it seems unbelievable that here we are approaching the end of the second year. The second year students are preparing actively for their barrier assessment; some things don’t change, and the tensions and anxieties are building up. Those of us who have watched the forms of examinations change from essays to multiple-choice papers over the years see quite a change in the newer forms of assessment. No longer are there papers called “Physiology” or “Anatomy”: all are integrated across disciplines and a mix of questions is used. Each set of related questions is headed by a short clinical scenario and the emphasis now is on clinical reasoning and applying knowledge, rather than on the recall of isolated facts. Students are also tested on clinical skills, even at this early stage of the program.

At the same time, the staff have continuing responsibilities for students in the Undergraduate Program; the last of the full-sized groups is currently in Year 5 and there are two smaller cohorts following.

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Computerising your practice

by John Lambert

Welcome to the first part of a three part series on computerising your practice. Doctors have been taken advantage of to a large extent by the developers and retailers of practice management software (PMS) due to their lack of training in the area of computers in medicine, and this series of articles attempts to redress the imbalance.

Another cause of the many tales of woe I hear from practitioners who have tried to computerise their practice is the lack of effective communication between the end-users and the developers. This is not surprising, because as a rule, doctors know very little about programming, and likewise, programmers know very little about medicine.

This set of articles is written from the perspective of a doctor who also happens to be a programmer, and attempts to arm you with information to ensure you get what you want in medical computing.

Why would you want to computerise?

Medicine is a service industry, so the ultimate aim of any change in your practice should be to improve service. The target of service improvement may be different in different practices - a GP may want to concentrate on improving service to patients, whilst a specialist may also be interested in his or her referring practitioners.

Of course, you may want to simply improve the service you get as the owning practitioner of a practice, in terms of free time, income, or the quality of information at your disposal for decision making or audit.

In later articles I will delve into the specifics of what computers can do to improve the service quality in your practice.

Why would you not want to computerise?

Lack of need! If you are happy with the way your practice is functioning, and you have good staff and a sensible paper

based practice system in place, then there is no need to change! It doesn't matter how good the PMS is; the change from paper to a computer system is a traumatic event.

Cost

With any significant investment of time & money, you have to look closely at the benefits you expect from your outlay. Many failures of computer system installations arise from a lack of vision of what is expected from the installation.

Most doctors seem to expect simply a reduction in their bad debtors from computerising their practice, and overlook the more significant benefits that can be obtained from reductions in typing time, optimisation of appointment schedules, elimination of duplication of work, and the timely access to clinically relevant patient information. The reduction in bad debts alone may not cover the cost of computerising your practice.

If the cost of legal action is included in any calculations, systems that minimise the chance of patients "slipping through the net" and suffering an adverse outcome further improve the cost-benefit ratio.

No time

To sensibly assess the various offerings on the market, and to plan the introduction of a new way of running your practice takes time, and many practitioners don't allow themselves this time. Remember that one of the reasons you're getting computerised should be to gain time, but this will only come after you have put some hours in early on.

It is also vital to allow enough time to train all your staff in basic computer use, and in the specifics of the PMS purchased.

If you aren't prepared to make the time, don't bother with computerisation.

Poor practice management

A well-designed PMS should be flexible, to fit in with different practice styles and differences in work flow, but should embody sound practice management techniques.

In many ways a good system can improve the quality of the practice procedures, but only if staff are receptive and willing to change their ways where necessary.

If your practice is not running well on paper-based systems, it is often helpful to try to improve the situation whilst still using a paper based system before trying to add the complexity of a computer system to the problem.

Staff opposition

It is an unfortunate reality that the installation of a computer system is often associated with a significant change of staffing. Most often the finger is pointed at the computer software in this instance, but in reality the software is often just the catalyst for change, which can be for the better.

In practices with sound practice management and sensible procedures and protocols (even if informal), the change to a computer system should cause much concern, especially if the practice staff members are allowed to play a part in the decision making processes.

It is a sad fact that many systems are purchased on the assessment and opinion of the practitioner, even though he or she will probably be lucky to spend 10% of his or her working time using the system. The staff members that will spend 80% of their time using the system are often not included in the software assessment process.

If you haven't already thought about computerising your practice, hopefully this will have given you a framework for decision making. If you have already computerised, you can probably identify some of the issues I have discussed in your own practice. Either way, the next article will be of use as I discuss in more detail what computers can do for your practice, and what areas of your practice you should consider computerising.

John Lambert is an anaesthetics registrar at RPAH

Letter to the Editors

Dear Professor Sefton and David Duke,

Please publish this as an invitation to your readers to suggest someone interested in helping to develop a primary and secondary school curriculum to help children understand basic psychology, simple psychopathology and sociology to offset the immature bias, bullying, blind obedience and apathy that lead to social breakdown and war.

G. Brock Chisholm was the first Director-General of the World Health Organization, Director-General of Canadian Army Medical Services in World War II, Deputy Minister of Health and President of the National Committee for Mental Hygiene. He proposed such education in his William Alanson White Psychiatric Foundation lectures "The Psychiatry of Enduring Peace

and Social Progress", *Psychiatry*, 1946,1-3.

Those he appealed to (psychiatrists, politicians, educators and economists) largely ignored him. Now I find interest among a few foreign policy advisers of various disciplines and would like to follow this up.

Sincerely
Doug Everingham

E-mail: dnevrghm@powerup.com.au
1972-75 Minister for Health.
1975 West Pacific region's vice-president, WHO Assembly.
1982 Parliamentary Adviser, Australian UN delegation.

A Significant Victory for MedSoc

by Simon Rodda

Since 1994, the number of medical students at Sydney University has approximately halved and the average age of those students has increased by several years. This is naturally the result of the transformation of the 6-year undergraduate course (UMP) into the 4-year graduate program (GMP). The first graduate students began the new curriculum in 1997 and gave MedSoc its first glimpse of what would be the needs of Medical Students at Sydney University in the new millennium.

It has been difficult to establish what those needs are. A clearer picture may emerge when the teething problems associated with the introduction of a completely new curriculum and the inherent difficulties of conducting concurrently the last years of the UMP are past. It is apparent, at least to me, that in essence the GMP student is very similar to the traditional medical student. Hence the nature of their needs, that can be met by MedSoc, are essentially unchanged.

Unfortunately the conundrum for MedSoc is not being able to identify the needs, but how to meet the needs given significantly lower student involvement. While the same proportion of students is becoming involved, there are fewer students in the course. Also the students that become involved have fewer years on campus, a more demanding course and naturally commitments apart from university. While the Medical Revue and the Medical Society Journal have been casualties and Innominate looks in jeopardy, several other activities have reemerged.

For the first time, in a number of years, there was a first year orientation camp at Minto. It was very successful with a range of activities on offer including trivia, the Revue video, golf, wine tasting, swimming, theatre sports, volleyball and eating. Over half of first year turned out for the rebirth of Minto and as usual there was copious quantities of social lubricant applied.

The Lambie-Dew Oration was immensely successful, as was the 1998 Medical Ball held at the Sheraton on the Park Hotel. An

enthusiastic bunch of students from Sydney and NSW medical schools attended the ANZAC sports day. This year's hosts (UNSW) were unable to secure a venue for the annual clash. Their Sydney counterparts organised an alternative venue and several friendly games of touch footy, egg and spoon racing and tug-of-wars were played on a very muddy pitch. The victors on the day were everyone who attended.

In July, AMSA convention was on the Sydney leg of its national rotation. The academic program was full to the brim with excellent presentations and among the interesting speakers were John Yu, Michael Reid, Tim Costello, Stewart Dunn, Bob Batey, and John Eden. The social program did not fail to delight as everyone danced, crawled, cross dressed, cruised, screamed, played and drank their way to happiness at a memorable Convention '98.

Recently, a joint event of the NSW MedSocs and AMSA provided information about medical work force issues to medical students. The seminar entitled "Careers and the Community" held at Clancy Auditorium at the University of NSW attracted over 500 medical students. There were speakers from the Australian Medical Workforce Advisory Committee, the Commonwealth Department of Health and Family Services, Doctors Reform Society, Australian Medical Association and RACGP. In a very limited question time there seemed to be a preoccupation with the future of health care in Australia rather than the future of providers of health care.

Finally in a dazzling display of community spirit the Sydney MedSoc rugby team recently defeated the Queensland MedSoc visitors at St Johns Oval. Between the tries and goals the sound of bagpipes roused a huge number of spectators to urge the lads on in their brand new team jerseys. A BBQ at the grandstand followed and Prof. Seale presented the trophy for the inaugural match win to the Sydney team captain. Congratulations Lads!

Simon Rodda is MedSoc President and a fifth year medical student

Central Clinical School – RPA

by David Tiller

Royal Prince Alfred Hospital – RPA in current media news – has been involved in the teaching of medical students and graduates since the opening of the medical school at Sydney University in 1878. There is a long tradition of teaching at all levels in the staff of the hospital which continues with enthusiasm. Sometimes the age of the facilities is a disadvantage, but the tradition of “teaching at the bedside” remains the cornerstone of obtaining clinical skills. The unique experience of some thirty two departments covering all aspects of internal medicine, surgery, obstetrics and gynaecology, anaesthetics, emergency and intensive care, paediatrics, psychiatry and community and public health make the RPA experience a unique one.

The administration of the hospital, often under fire for current political or financial reasons has always supported and continues to support the educational facilities at RPA.

The new “Clinical Education Centre” is home to an educational program which brings together pre-graduation programs and programs that are designed to provide doctors with first their basic training and then their specialist training. This process will be seamless and will take into account what has been taught and learnt before, so that unnecessary repetition and time wasting will be avoided.

The Central Sydney Area Resource Transition Program in cooperation with RPA have designed what will be at completion, the most modern educational facility made available for medical students and graduates probably in Australia. It will open in 2001. In the mean time the first phase has been completed in the old Accident & Emergency Department. It provides four Problem Based Learning Rooms, a Clinical Skills Laboratory, two Computer Laboratories and a new Seminar Room and includes offices for the Associate and Sub-Dean, the Director of Clinical Training, the Coordinators of Undergraduate and Graduate Courses, and Chief Residents in Medicine & Surgery as well as all the support staff for these activities.

Some of the personalities of the Education Centre include: Associate Professor Warwick

Britton whose background is Immunology, a world expert in Leprosy and the mycobacterium; Dr Steve McNamara who is a Respiratory Physician, Coordinator of the Graduate Medical Program, and doctor to the Parramatta Rugby League team; Maryanne Zhang who is our computer wiz and keeps us on line; Associate Professor David Hill, Trauma Surgeon and expert on SCORPIOs and who is an innovative teacher; Dr Annette Britton,



Geriatrician and Director of Clinical Training and a keen generalist to keep the superspecialists in order; Dr David Kandiah, Physician Rheumatologist, responsible for the undergraduate program that will be complete in 2001; and Dr Martin Stockler, Senior Lecturer in Medicine, Oncologist and evidence-based medicine disciple. All these people have support from a very keen and enthusiastic staff in the Education Centre. The mix of interns, RMO's, registrars and medical students provides a unique atmosphere. If only we had a big coffee lounge. We house a small area for coffee etc, perhaps this is for the future.

Pamela Stuart-Brown keeps a watch over the whole Education Centre and assisted by Jo-Anne Milne. The residents are cajoled and their problems dealt with by Dr Annette Britton and Sue Alexander. These and others provide vital support for the functioning of the Centre.

Students and all medical and allied health staff are assured of a warm welcome.

David Tiller is Associate Dean of RPAH Clinical School and Clinical Professor of Renal Medicine.

Tim Loke (left, GMP 2), Justine Garvey (centre, UMP 6) and Loe Van den Heuvel (right, GMP 2).

Genetic Blueprints to Artificial Organs Medical Research at RPAH

by *Richmond Jeremy*

Innovative medical research has been a characteristic activity of Royal Prince Alfred Hospital throughout the twentieth century. As we approach the new millennium, those research activities are more vigorous than ever and continue to address the frontiers of knowledge. The breadth of research activity in the Hospital and its affiliated Institutes is so vast that only a large treatise could fully do justice to that activity. In this brief article, therefore, I can only touch upon some research efforts that serve to illustrate this rich tapestry of medical research.

Molecular Genetics - The Blueprints of Life

The explosion in knowledge of molecular genetics is well known. At RPAH, molecular genetic research has identified the gene mutations responsible for inherited cardiac diseases, such as hypertrophic cardiomyopathy. Continuing research in this area is examining the effects of gene mutations upon structure and function of important proteins within the heart. These efforts hold the promise of more accurate diagnosis for individuals at risk and potential new treatments targeted at the very origin of the disease.

Mending Broken Hearts

Most of us are familiar with coronary bypass surgery and angioplasty of coronary arteries, but what happens if you have severe angina and neither of these procedures is suitable for you? Until recently, the only course was large amounts of medication and a life crippled by chest pain. Recent clinical research by the Departments of Cardiology and Cardiothoracic Surgery has now provided an alternative. Transmyocardial laser revascularisation with a high-powered

carbon dioxide laser (the only one of its type in Australia) has been shown to provide dramatic relief of angina and a new lease of life for patients with previously disabling symptoms. In this field, RPAH is the leading centre in Australia.

The Price of Our Sunburnt Country

Malignant melanoma is one price we pay for our outdoor life in this country. The Sydney Melanoma Unit is the largest centre in the world for the diagnosis and management of melanoma. This unit has a long track record of innovative research. Recent projects include the study of gene defects associated with an increased risk of melanoma and study of immune responses to melanoma cells, which may lead to a vaccine against recurrent melanoma. The treatment of melanoma in the Unit has been enhanced by their development of unique techniques for local perfusion with chemotherapeutic drugs of limbs with melanoma lesions.

How to Fix a Blow-out

Localised dilatation (aneurysm or blow-out) of the aorta or major arteries often requires surgical correction. In most centres this has usually meant extensive open surgery, but not now at RPAH. The Vascular Surgery Unit is acknowledged as the world leader in endovascular surgery. The Unit's research has resulted in the development of new prosthetic devices that can be inserted within an artery and seal off an aneurysm.

A Unique View

Positron emission tomography (PET) is a unique radionuclide imaging technique, which allows study of regional brain metabolism and function. The information provided by PET is complimentary to the

structural information obtained from CT and magnetic resonance imaging of the brain. One of only two PET facilities in Australia is located at RPAH. Researchers are using this tool to study responses of malignant brain tumours to new treatment regimens. Neuropsychiatric research studies have used PET to address novel questions about language acquisition and processing in the brain, attention and memory.

A Matter of Balance

The research program of the Eye and Ear Research Unit has been recognised by award as an NHMRC Centre of Excellence. The study of the relationships between balance sensation in the inner ear and eye movements has required development of highly specialised new set of diagnostic procedures and three-dimensional tracking of eye movements. Patients are studied using a human centrifuge, in which the subject is rapidly rotated whilst sitting in a chair. The Unit is amongst the world leaders in these studies, which are progressively unraveling the physiology of balance and the control of eye movements.

An Artificial Liver

The Australian National Liver Transplant Unit at RPAH and the New Children's Hospital is the major clinical liver transplant program for Australia and also serves New Zealand. Patients with liver failure require transplantation, but unlike patients with kidney failure, no artificial support has been available to help these patients while they await transplantation. Researchers in the Unit have been working to develop a reliable artificial liver which can support patients. This ground-breaking development, which is centred around a "bioreactor" containing living liver cells, has now reached the stage of clinical trial.

These are just a few of the many outstanding research programs at Royal Prince Alfred Hospital. The next generation of medical researchers is now receiving training at the University and in these research programs, so that the productive research of the Faculty will carry on in the decades ahead.

Richmond Jeremy is Associate Professor of Cardiology at Royal Prince Alfred Hospital

Options and Option Terms

The following is an account by a current student of the "old" undergraduate degree about his Option Term (elective term at the end of 5th year), and by a GMP student about her Option (of which students have to do three each year in the first two years of the course). Any graduates who would like to offer ideas or placements for future students are encouraged to make contact with the MGA.

Learning Auslan

by Lynn Glass

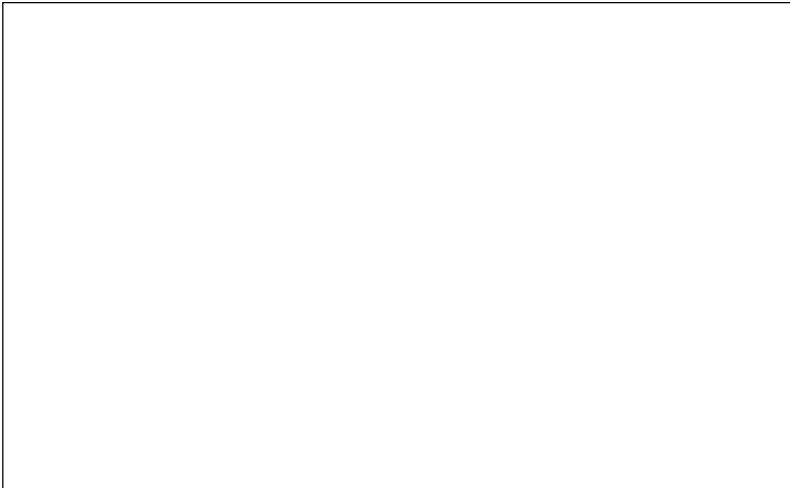
In his book, *Seeing Voices*, Oliver Sacks writes of the importance of language "our utterances express ourselves, as does our inner speech. Language often feels to us, therefore, like an effusion, a sort of spontaneous transmission of self." Many of us take the gift of language for granted - and with this, the substrate for basic thought. Without language there can be no thought and abstraction, without language there can be no meaningful interaction between people. Even emotions of the higher order, that are perceived as being

merely "felt" or experienced, require the substrate of language to convey those emotions to those that surround us.

In multicultural Australia, we are accepting of the languages and cultural identities of the communities that make up our greater society. Language is part of a cultural whole, an element that serves to unite individuals, along with other cultural entities like religion and the interaction of the arts and sciences. It is the communities that are denied the right to express themselves in their language that become

marginalised. In becoming marginalised they lose contact with, and individuality from, the greater society, and those communities lose their cultural identity and become amorphous, lost and culturally bereft.

The Deaf community in Australia was for many years denied opportunities to utilise the Deaf language, forced through the mandate of oralism to speak and not to exercise their cultural right to use Deaf language. The language of the Deaf is Sign, in Australia it is known as Auslan. It must be noted that, despite community perception, Auslan is not merely a gestural language, nor is it a translation of English words into signs.



Auslan classes with instructors from the Deaf Education Network

There is a version of Signed English, used predominantly for education purposes, but this Signed English is **not** a language. Auslan is a self-consistent language, with internal structure and is able to be modified grammatically and spatially.

As part of the Graduate Medical Program (GMP), students are required to undertake study in an area of interest that we personally identify as being important to our practise and understanding of medicine. For example, some people who have not studied anatomy in previous degrees may undertake a dissection option to further the anatomy taught as part of the medical degree. There are many varied options which depend on the needs of the student.

A few students elected to study Auslan - the Australian sign language - as our option. We wanted to be able to communicate with the Deaf in a manner that does not disempower them. This will lead to better patient care through effective communication. It is recognised that there are not enough doctors and para-medical professionals that

are able to communicate with the Deaf in Auslan. Thus, we would gain an awareness of the issues facing the Deaf community and be in a unique position to communicate with, and therefore understand, the medical issues that the Deaf experience.

The Auslan course was run by the Deaf Education Network (DEN) for 40 students. A modified introductory Auslan course (16 hours over 8 weeks) was planned by the DEN, and in it contained the usual introductory material, as well as a medical component that would allow us to understand and complete a basic medical consultation in Auslan. One of the instructors of the course commented how excited the Deaf community is at the prospect of having some future medical practitioners able to sign and understand the needs of this community.

I felt very strongly from the beginning that lack of students' individual finances to be an impediment to learning Auslan. The financial cost of the courses (2 classes) was significant, and so funds had to be found. The Faculty of Medicine was unable to fund the course, but a member of the faculty, Dr Brendan O'Sullivan awarded us some of his grant money which partly paid for the course. Dr O'Sullivan, a psychiatrist and research scientist at RPAH is one of the few signing doctors in Australia. He also spoke at our graduation dinner and inspired us to keep up Auslan. The remainder of the funds were obtained by a ministerial grant from Dr Andrew Refshauge, Deputy Premier, Minister for Health and Minister for Aboriginal Affairs.

Faculty support for the Auslan course cannot be underestimated. Professor Ann Sefton provided encouragement and acted as the overall Auslan options supervisor.

Having organised and then completed the course, I feel that much has been achieved. Nearly 40 medical students now have rudimentary knowledge of another language, and so will be able to interact more effectively with people who use that language. As Michael Ondaatje writes, we are now "those who are magical [who] break from silent structures after years of chrysalis", where the silence is of the mind to the needs of the Deaf community. So through language, through communication, the hope is that our understanding of the Deaf will result in more effective medical care.

Lynn Glass is a GMP 2 student

Shamans and Healing Ceremonies

by Matthew Watts

My option term was an observation of how South American healers, or *shamans*, deal with the 'drug induced psychoses', which may occur during healing ceremonies. The research was carried out in Ecuador, Peru and Colombia, in the Andes and the Amazon Basin. The Faculty of Medicine provided financial support with a Tapping Bequest.

My supervisor in the field, Robert Agnew was working in South America as an anthropologist. He had drawn my attention to the use of hallucinogens in healing rituals. Metta MacNeil was a co-worker on this project.

After being impressed by florid psychoses during my psychiatry term, I thought it would be worthwhile to document any traditional supportive strategies or antidotes to drug-induced psychoses.

The shamans I visited view illness as being an affliction by external malevolent forces or spirits, which may have originated from the environment or been caused by another person (shaman). Both highland and Amazon basin shamans have a broad knowledge of plant medicines. These are used in conjunction with healing ceremonies where shamans consume hallucinogens to access the spirit realm, in order to expunge any malevolence.

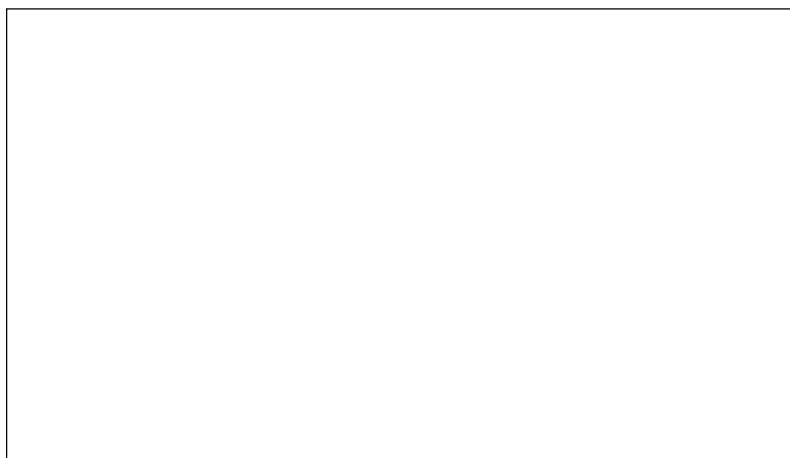
Shamans are often well respected in their communities. They are very serious about their role which is an integral part of the local culture. To meet them, they seem very practical and experienced in dealing with human suffering.

In order to gain a greater understanding of shamanism and to facilitate interviews, it was necessary to partake in rituals. Interviews required considerable planning as the shamans had no concept of 'drug induced psychoses'. Based on the presumption that fear and hallucinations would be cross-cultural, I asked the shamans how they would assist clients who became very afraid while they were seeing spirits.

Highland healing ceremonies often use an hallucinogenic cactus (*Trichocereus pachanoi*). This has been used since pre-Inca times. The ceremonies in the Amazon Basin may utilise a variety of plants including vines of the Banisteriopsis genus. Some shamans have a

mesa (table) which contains culturally significant 'power objects'. The client may be rubbed down with these in a ceremony, the choice of object depending on the affliction. Tobacco is also widely used and regarded as a sacred plant.

Rituals consisted of incantations and sometimes being 'cleansed' with smoke or with types of perfume and rose water. One of my more memorable experiences involved swimming naked in a sacred lagoon and



standing in the cold for the hour-long ceremony. However, the liquid tobacco which I had drunk through each nostril from the horn of a black bull, did provide a sensation of warmth. Another episode involved being struck repeatedly on the chest and back with stinging nettles (which are also used for back pain and to discipline children) as part of a cleansing ceremony.

The approaches to drug induced psychosis ranged from "supportive" measures such as the use of power objects and incantations, to traditional plant antidotes such as *Croton lecheri* (known as 'sangre de drago') which is also used to facilitate wound healing and *Ilex guayusa* (guayusa) which is used as tea and for abdominal pain. David Caiceolo Clarke, a jungle guide with an interest in medicinal plants, said that if these antidotes were consumed psychotic phenomena would subside within half an hour.

I found my option term a very interesting and broadening experience and would like to follow up this work in the future.

Matthew Watts is a Med VI student

A cold Matthew Watts undergoing a 'cleaning' ritual by Leonardo Zurita, at Laguna Shimbe (4000m), Las Huarinas, Peru (Photo Robert Agnew).

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