As we prepare to mark the 150th anniversary of the Melbourne Medical School in 2012, several new Australian medical schools are just getting underway. Our advantage of a wonderful tradition should be treasured and celebrated, but should not prevent us from being innovative and leading change. This issue of Chiron acknowledges people and buildings that have been part of our tradition, while outlining ambitious new approaches to Aboriginal child health development.

The superb essays from medical students in this issue, describing their research domains described in this issue will inevitably influence the content of a medical curriculum where the teaching is informed by research.

The theme of international engagement is also likely to permeate our curriculum. As one of the world’s leading universities and medical schools, we need to think globally, a compelling reason for continuing to attract overseas students.

The superb essays from medical students in this issue, describing their international elective and advanced medical science experiences, are a strong endorsement of providing opportunity for international engagement and research experience at an individual level.

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Between 1967 and 2004, Aboriginal and more than four times the burden of diabetes; four-and-a-half times the burden of disease. It sees an average, for 17 years less than other Indigenous person bear five times the burden of disease. It sees an

The Indigenous health gap sees an

The Indigenous health gap

The PhD Anderson, a strong advocate of Aboriginal-led health initiatives for Indigenous people, has worked in Aboriginal health for 22 years as a health worker, educator and general practitioner. Ian is director of the Centre for Health and Society and policy and practice. Ian Anderson, a strong advocate of Aboriginal-led health initiatives

A key factor in closing the Indigenous health gap is ensuring that all students—both Indigenous and non-Indigenous—have a solid grounding in Indigenous health needs. of the inclusion of Indigenous content in medical education, which we then used to inform the development of a national Indigenous health curriculum framework. This framework, which articulates learning objectives, key pedagogies and the institutional reforms needed to support them, has been adopted by the Australian Medical Council and is the only such nationally agreed curriculum of its kind.

Research processes must generate knowledge and analyse problems in a way that is appropriate and relevant to those working in Aboriginal communities, health services and the policy sector. They are to cultivate the knowledge, contribute to problem-solving, and produce the workforce that underpins the innovation needed to close the Indigenous health gap. They will be responsible for training

both Indigenous and non-Indigenous—have a solid grounding in Indigenous health needs. Currently, Onemda works on a range of teaching and learning initiatives across the health professions. In 2004, we undertook a national audit of university teaching about Indigenous health. That is a need for research that evaluates the impact of health interventions or policy reform—rather than research that just describes the problem.

Universities can also extend their relationships with Indigenous communities, government stakeholders, professional groups and service providers, providing the foundation for effective communication about ideas and knowledge—processes that are critical to innovation.

Indigenous communities are also sources of innovation and play a critical and active role in the production of knowledge. Innovation and its uptake in Aboriginal Australia must be founded on an approach that fosters Aboriginal leadership, supports the development of community capacity and engages with our intellectual world.

Onemda’s approach to developing our research and teaching work is framed by broad community development principles involving multi-layered partnerships with Aboriginal people, communities and agencies in Victoria, in Australia and internationally. Our researchers ask communities to tell them what knowledge they need to develop better health services, to build capacity and to generate policies that will enable improvements in Indigenous health. We then develop researchable projects to address these needs.

By beginning the research process with the Indigenous people who will ultimately be the end-users of the research, by the time the research is finalised a strategy for its implementation in a real-world situation is already in place.

Successful projects recently undertaken by Onemda include ‘Sharing Our Stories and Building on Our Strengths’, a program supporting Indigenous participation in a major international health conference, and a series of community research workshops culminating in the report We Can Like Research…In Koori Hands, which was launched at the Koorie Heritage Trust in October.

The full text of The Knowledge Economy and Aboriginal Health Development is available at www.onemda.unimelb.edu.au/docs/aboriginal-health-development.pdf
Onemda’s subsequent research, teaching and learning, and community development agenda, particularly in the area of health ethics.

Community development is a key plank of Onemda’s work, according to Angela Clarke, a community development lecturer and deputy director of community programs at Onemda and one of the report’s project managers. ‘Our workshop sessions are a crucial part of our work with communities, and a way for Koori researchers to present how they use Koori methodologies in their work and highlight positive research stories.’

In the current report, workshop participants voice their concern that without Koori communities directing and controlling research in Indigenous health, population health improvements are unlikely to significantly narrow the health gap between Indigenous and non-Indigenous Australians.

Koori Elder, Aunty Melva Johnson, of the Njernda Aboriginal Corporation in Echuku, reflected the views of workshop participants when she said, ‘Research is fine as long as it’s handled by our people’.

The clear message out of these workshops is that participants want Koori health research to be controlled by Kooris.

A strong belief exists among Indigenous people that, historically, health research and its applications have not benefited them and they remain suspicious about mainstream research, its intentions, and impact on communities.

The workshops, nevertheless, revealed an air of guarded optimism among participants—a momentum for positive change—about the future of Indigenous health research. Recognition is slowly growing in the broader research and health sectors that Indigenous health research needs to be linked to Indigenous people having the resources, research capacity and leadership roles in setting the Indigenous health research agenda.

According to Paul Stewart, a research community development officer at Onemda who helped to organise and moderate the workshops: ‘The clear message out of these workshops is that participants want Koori health research to be controlled by Kooris, but not just in the usual sense. Aboriginal community organisations need to play a key role in research and in its dissemination, implementation and evaluation, and need to be resourced to do this.’

The two reports can be ordered from Onemda or downloaded from: www.onemda.unimelb.edu.au/publications

With support from the Victorian Health Promotion Foundation, Onemda approached Indigenous professionals working in a diverse range of community programs, and offered workshops in writing abstracts and conference papers, presentation skills and logistical support. Several Onemda staff and associates acted as mentors to the participants, supporting them in writing and presenting their papers.

‘The presenters were proud to talk to us about what their health and wellbeing projects are achieving for the communities they work and live in,’ says project officer Ngara Murray, who coordinated the workshops and conference attendance.

Indigenous professionals taking part were:

- Belinda Briggs, Rumbalara Football and Netball Club, Shepparton
- John Cusack, Family and Youth Services Team, Top End Association for Mental Health and Wellbeing for Young Indigenous People, Victorian Aboriginal Health Service in Northcote; and Helen Kennedy, Neighbourhood Justice Centre, Aboriginal Victoria,
- Daniel Mulholland, AIMHDI (Australian Integrated Mental Health Initiative) Program, a partnership between Top End GPs and the Tiwi Island communities
- Gregory Phillips, Abstrak Consulting, with David Dryden and Ross Morgan, Maui Living Free Healing Centre, Thornbury
- Marcus Stewart, ‘I’m an Aboriginal Dad’ project, Child and Parent Services, Mercy Hospital, Melbourne
- Onemda’s Paul Stewart also ran a forum ‘Indigenous Social and Emotional Wellbeing: Identity, Culture and Heritage’ with presentations from Troy Austin, president of the Fitzroy Stars Football Club; Anthony Brown from Mental Health and Wellbeing for Young Indigenous People, Victorian Aboriginal Health Service in Northcote; and Helen Kennedy, Neighbourhood Justice Centre, Aboriginal Victoria,

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NEW APPROACHES TO ABORIGINAL CHILD HEALTH

Jonathan Carapetis

Professor Jonathan Carapetis (MBBS 1986) is director of the Menzies School of Health Research in Darwin. His research in group A streptococcal diseases in the Aboriginal population led to the establishment of Australia’s first rheumatic heart disease control program in the Top End. He later co-founded the Department of Paediatrics’ Centre for International Child Health at the Royal Children’s Hospital. His research is focused on population led to the establishment of Australia’s first rheumatic heart disease control program in the Top End. He later co-founded the Department of Paediatrics’ Centre for International Child Health at the Royal Children’s Hospital. His research is focused on group A streptococcal diseases in the Aboriginal population.

When I first accepted the invitation to deliver this lecture earlier this year, I had no idea it would be scheduled at a time of such upheaval in our nation. First came the Australian Government Intervention (AGI) in the Northern Territory (NT), then came a change of leadership of the Australian federal election, and then came a change of leadership of the Australian Government in the NT, then, to top it all off, came the Australian federal election in the NT, then, to top it all off, came the Australian federal election, then came a change of leadership of the Australian federal election.

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disadvantage, and to do so in partnership with Aboriginal and Torres Strait Islander people.

NEW APPROACHES TO ABORIGINAL CHILD HEALTH

When I returned to the Menzies School of Health Research as director in 2006, I laid out a challenge to the staff. I pointed out that, from the earliest days, Menzies publications have almost invariably finished with a paragraph stating something like this: “The ultimate solution to (x disease) lies in solving the issues of poverty, unemployment, poor housing and appalling educational outcomes. This will be difficult to do and will take a long time.” In the meantime, our study has demonstrated important interventions that can help to alleviate the problem somewhat in the short to medium term.

Why are the big issues not the first paragraph rather than the last? At Menzies, we are continuing to do what we have always done well—high quality quantitative and qualitative research spanning the laboratory, clinical and public health domains—but increasingly we are trying to tackle the difficult but perhaps more important ‘big-picture’ issues.

When experts have attempted to quantify the determinants of health, the health care system usually can take credit for only about 25 percent, and biology for another ten percent. The remaining 60-65 percent is due to social and economic factors and the physical environment in which we live.

What can researchers offer beyond the laboratory and the health care system? For a start, we can offer evidence. For an example, let me cite a recent study that Menzies can take no credit for. The Health Habitat study (Pholeros, Torzillo, et al), took teams to document the health infrastructure in more than 4000 houses in remote Aboriginal and Torres Strait Islander communities around the country, and even more importantly they also took people (plumbers, electricians, builders etc) who could fix a lot of problems on the spot. This incredibly important study documented very high rates of disrepair that is not compatible with healthy human existence (e.g. only eleven percent of houses were considered electrically safe, and only five percent had the infrastructure to store, prepare and cook food safely) but also documented that the majority of problems could be repaired on the spot. They also explored the myth that Aboriginal people destroy their houses: only eleven percent of disrepair was due to damage by the residents, whereas 27 percent was due to water leaks, poor construction, and an appalling 62 percent was due to normal wear and tear and lack of maintenance. This is the sort of evidence we need. Sure, we need to build new houses in remote communities to the need to make sure that the high quality and built to last—let’s not start considering flimsy kit homes or other cheap solutions)—but we can also do a lot by fixing the housing stock that is already there.

Back to the children. Why have I focused largely on children, and child health? If you look at the statistics, it is clear that the majority of deaths in Aboriginal people occur in adulthood, and largely from chronic diseases. Doesn’t this argue instead for a concerted focus on adults? I say no. It is very difficult to change the trajectory of a child who, by that or even early adulthood, already permanently lower cognitive function—to the age of 16 years and beyond—compared to normal birth weight children. But much more important than this was the effect of an early life, such that the affluent, low birth weight children still performed well above average for cognitive function at age 16, whereas the poor, normal birth weight children performed well below average at the same age. In other words, there are many influences in the early years that have the potential to permanently damage the developing child’s brain, but the most influential are those related to socio-economic circumstances.

What can we do about this? Again, this is where researchers can offer evidence. There are many potential interventions in the early years that can change the trajectory of a child, but two in particular are supported by solid, randomised controlled trial evidence. As a result, both of these are of great interest in Australia. The first—nurse-led home visiting in the first two years of life—is just beginning to be rolled out in Aboriginal communities, albeit with some uncertainties about how the proven American model can be adapted to these very different Australian circumstances. The second—two years of quality early childhood education—has also been targeted by the new government as a priority for all Australian children. Actually delivering this to children in remote Aboriginal communities will be an enormous challenge.

Which brings me to my most important point. If someone had asked me ten years ago what would be the single thing we could do that would have the greatest effect on Aboriginal health, I would probably have suggested something like stopping smoking or immunisation. It is now clear to me that the correct answer is to give every Aboriginal child a good formal education.

Educational outcomes among Aboriginal children are a national disgrace. This is not surprising when we consider that in the ten years that reasonable data have been collected. Only about one in five children in remote Aboriginal communities in the NT reaches the basic benchmarks for literacy and numeracy in grades three and five—benchmarks that more than 90 percent of non-Aboriginal children reach.

Nobody has been able to make clear to me how removing the permit system and acquiring communal land in townships will help to reduce child sexual abuse.

As my friend Tio Lea says, ‘these results ring-bolt Aboriginal kids to a permanent deadend’. This is the real crisis, and we need to base new approaches on the best possible evidence. We cannot accept approaches to Aboriginal and Torres Strait Islander educational reform that are based on anecdote or case series. Health researchers must accept that education is perhaps the most important determinant of health, and that we have something to offer. Health researchers can provide the rigour of high quality scientific research, but applied to educational research in partnership with educators. We also have decades of experience with the principles of evidence-based practice, and translating research findings into interventions. And of course, we can do what we know best—making sure that children are healthy, developmentally appropriate, and ready for school in the early years.

Let’s not apologise for being interested in education, or believe the right should lead us down the path of least resistance.

It is no wonder that health services in remote communities have little time to devote to preventative care, when they are dealing with such a burden of acute illness.

about the AGI, and eagerly await the plans of the Rudd Government for the next stages. I suspect that the current review of the intervention to date will be unable to document any substantial progress, and that there is inadequate attention being paid to prevention (rather than diagnosis and treatment) of ill health. Although my countrymen may think that we have yet to see a cohesive plan to deal with Aboriginal disadvantage—I am also more optimistic than I was then. The current Australian Government has taken some important steps of apologising to the Stolen Generations, and has set itself ambitious targets to close the gap in Aboriginal and Torres Strait Islander life expectancy within a generation. Exactly how they will do this is yet to emerge, but you don’t get anywhere unless you set yourself goals.

In closing, I would like to point out that in delivering this lecture and writing this summary, I have joined the ranks of myriad whitefellas who pretend to be ‘experts’ on Aboriginal and Torres Strait Islander health. I do not suggest for a moment that we should pretend to understand the field of education or pedagogy as the education experts do. Instead I propose that we begin a dialogue with the education sector to bring health and education research together. This is the real challenge for the next decade in Aboriginal and Torres Strait Islander health.

POSTSCRIPT—AUGUST 2008

Nine months have passed since I delivered this lecture. We continue to learn lessons from chronic diseases. Of course, I am not arguing against the need for adult health programs, and the need to try to reduce the burden of these factors such as smoking, alcohol and other substance misuse, obesity, poor nutrition, sedentary lifestyles, etc., but I am definitely arguing that it is much more cost-effective to focus on the next generation, on the kids.

We now have all the evidence we need to prove that the vast majority of causes of morbidity and mortality in adulthood have their roots in early life. Some of these influences in early life are brief but have permanent effects, and others occur over a longer period. The wonderful 1958 British birth cohort study elegantly demonstrated that children who were born with low birth weight (a marker of insults to the foetus in the womb) were left with

2008 UMSMS EVENTS

The Melbourne Medical School lecture and function for UMS members will be held on the evening of 27 November at which Professor Doris Young, director of the Faculty’s Graduate Programs Unit, and Professor Geoff McColl, director of the Medical Education Unit, will talk about the future of medical education at the University of Melbourne. Details are as follows:

THURSDAY 27 NOVEMBER

Comencing at 5.30 for 6.00 pm, the presentations will take place in the Sunderland Lecture Theatre. At 7.00 pm, UMS members will move to the Harry Brown Allen Museum of Anatomy and Pathology to discuss the evening’s presentations informally, over drinks and finger food. Please RSVP on (+61 3) 8344 5888.

HONG KONG ALUMNI AND FRIENDS MORTARY

James Best, head of the Melbourne Medical School is pictured here (centre) with Hong Kong University’s Vice-Chancellor Professor Lap-Chee Tsui and Professor Karen Lam at a function for Hong Kong alumni held in March this year.

A second function for Hong Kong alumni will be held on Friday, 5 December 2008 from 6.30pm on the 3rd Floor, Butterfields, 2/F-4/F Dorset House, TaiKoo Place, 979 King’s Road, Hong Kong.

This occasion presents Hong Kong alumni with the opportunity to hear Professor Graham Brown, director of the Nossal Institute for Global Health, speak about work undertaken by the Nossal Institute aimed at combating infectious diseases in the Asia-Pacific region. Alumni will be able to meet and talk with Graham about important developments in health in the region.

Further information: E: martial.alumni@ummb.edu.au T: (+61 3) 8344 5888
When I started my MBBS degree back in 2005, the University of Melbourne offered the only medical program in Australia that incorporated a compulsory year of research—the Advanced Medical Science (AMS) year. In fact, as an interstate student, the AMS program is the main reason I chose to study medicine at the University of Melbourne. I approached my research year determined to make the most of this opportunity.

One of my areas of interest in medicine is toxicology. I am particularly interested in venomous animals and the envenomation syndromes that may cause. I was very privileged to have been accepted as an AMS student by the Australian Venom Research Unit and the Cardiovascular Therapeutics Unit in the Department of Pharmacology, under the supervision of Ken Winkel, Christine Wright and James Angus, dean of the Faculty.

My project investigated the venom of the ‘Broue Irukandji’ (Malo maxima), focusing on its cardiac and vascular pharmacology. ‘Irukandji’ is the colloquial name for several species of small box-type jellyfish (a mere few centimetres in length) that cause an unusual and potentially lifethreatening envenomation syndrome. Every summer in Australia’s tropical north, beach goers and divers alike are subject to the sting of such jellyfish. Many go on to develop the dazed Irukandji syndrome, which may involve nausea and vomiting, severe muscle spasms, exucrating back pain and a potentially fatal increase in blood pressure.

As a part of my research, I was fortunate to have the opportunity to travel to Broome and Cairns over the summer to collect additional specimens for my project. Dragging a custom designed net through water surrounded by deadly jellyfish is quite an experience! In fact, our research caught the attention of the local newspaper and I ended up as front page news on the Cairns Weekend Post.

This demonstrates the extent of public apprehension towards Irukandji syndrome in Far North Queensland. However, despite the severity of the syndrome and its infamous reputation in the tropics, remarkably little is known about the underlying envenomation mechanism or the causative species.

Recently, the pharmacological basis of a Queensland species of Irukandji (Carukia barnesi) was published by our group. However, Irukandji syndrome is not limited to Queensland waters and in fact a particular problem in Broome—a popular tourist destination in Western Australia. No research has been published on the Broome species other than its original taxonomic description, and the suspicion that Malo maxima is responsible for Irukandji syndrome in Broome is purely anecdotal.

Furthermore, there is no specific antivenom available for Irukandji envenomation. However recent clinical evidence has suggested that intravenous magnesium infusion appears to be a ‘miracle’ treatment for Irukandji syndrome, eliminating both the severe pain and the life-threatening hypertension, although this has never been investigated experimentally.

Accordingly, the aim of the project was to determine the basic pharmacological mechanism of Malo maxima venom on isolated mammalian tissues in vitro, and also to investigate the effects of magnesium in this context. My study provided the first analysis of venom from any jellyfish species suspected of causing Irukandji syndrome in Western Australia, and confirmed that Malo maxima venom causes effects consistent with Irukandji syndrome in vitro. The results also suggest that magnesium is highly effective in countering the effects of this venom. In addition, this study is the first to implicate the involvement of sensory neurotransmitters in Irukandji syndrome caused by any of the Irukandji species.

In a day and age where medical research and clinical medicine are becoming increasingly segregated, the AMS year provided me with invaluable insight and experience. It has strengthened my passion for research, and I plan to continue to pursue research alongside clinical practice in my career as a medical practitioner.
My four weeks in the Hospital Britanico, in a very un-British suburb in Buenos Aires, was a fantastic lesson in the proper greeting of one’s fellows, a testament to Norbert Elias, my favourite sociologist, and a practical demonstration that perfect coffee can be made entirely out of substitute ingredients. The beverage in question consisted of instant coffee, milk powder and liquid sugar substitute, and was carefully prepared each morning by Celeste, a resident, for the rest of the team, to be drunk during our post-ward round meeting dedicated to writing up the clinical notes. My role, as novice Spanish-speak, was to write out the simple recipes on a scrap of paper and, once thoroughly checked by Celeste or the intern Gaston, transcribe my creations to the official clinical notes. My role, as novice Spanish-speaker, was to write out the simple recipes on a scrap of paper and, once thoroughly checked by Celeste or the intern Gaston, transcribe my creations to the official clinical notes.

When Norbert Elias, the German sociologist, was in his late eighties he wrote a book called *The Loneliness of the Dying*. After a life of rational deliberation on the formation of modern society, he poignantly turned to the issue of his own death in the same rational manner, detailing a register of the horrors and palliation of dying in the late twentieth century. His greatest concern was not physical suffering, masterfully managed by modern medicine, but was with the progressive withdrawal of those close to death to a realm behind the scenes of social life, where they died alone in a hospital ward isolated under a barrage of medical equipment, ward rules and visiting hours. His fear was loneliness.

I was reminded of Elias every morning as I watched Anna’s decline. I would hover in a corner of her dark room, next to the cards and the photos, as Celeste or Gaston, but usually Celeste, bent over for what little examination was required. Usually Anna would try to say something, to tell whoever would listen about the pain she was in, and her husband would elaborate with details from the night before. After the visit, we would huddle in a corner outside her door. On one occasion an intern had to go to the next room, which luckily was empty that day, and cry in the bathroom.

Anna also made me think again about that custom which had first appeared confronting, and then simply amusing. For every morning, before leaving for the coffee room, in a gesture that seemed a deliberate disavowal of isolation, both a bestowed and recognition of Anna’s previous resisting humanity. Celeste, like a mother to a hurt child, would bend slowly down and kiss her. When Norbert Elias, the German sociologist, was in his late eighties he wrote a book called *The Loneliness of the Dying*. After a life of rational deliberation on the formation of modern society, he poignantly turned to the issue of his own death in the same rational manner, detailing a register of the horrors and palliation of dying in the late twentieth century. His greatest concern was not physical suffering, masterfully managed by modern medicine, but was with the progressive withdrawal of those close to death to a realm behind the scenes of social life, where they died alone in a hospital ward isolated under a barrage of medical equipment, ward rules and visiting hours. His fear was loneliness.

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chips and food writer, Stephanie Alexander, introduced to 40 Victorian primary schools and 150 schools throughout Australia. The evaluation will assess the impact of the kitchen garden on the school and participating students’ wellbeing, learning and attitudes towards fresh, seasonal and healthy food. It is a longitudinal study including a sample of six program schools and six matched comparison schools. The theme of child mental health is addressed through a number of programs. Of particular relevance is the Indigenous child health and wellbeing 2005–2008 study. This study sought to identify dimensions of wellbeing from the perspective of Aboriginal parents in urban locations. It is a partnership between the Victorian Aboriginal Controlled Community Organisation, the Victorian Aboriginal Health Service and the University.

**SCHOLARSHIPS FOR HONOURS STUDENTS**

When Francis Elizabeth Thomson died in 2006, her will provided that a trust be established, the annual income from which was to provide scholarships to students of the University of Melbourne Faculty of Medicine, Dentistry and Health Sciences, as recommended by the dean. The distribution from this trust has enabled us to offer 28 honours scholarships of $5000 each for 2009 and approximately that number each year into the future.

Our extensive research programs in biomedicine and the health sciences are crucial to our ability to deliver superior medical and allied health education programs and train the research leaders of the future. Honours programs offer an important avenue for graduates wishing to explore the potential of a career in research. Students undertake an original research project, with the opportunity to be supervised personally by one of our many world-class researchers. Many also get the opportunity to present their findings to an even wider audience, either by attending at a national or international conference, or having their work published.

This will greatly assist us in attracting and encouraging students to pursue honours and, hopefully, continue with further higher degree studies in the faculty.

**APPOINTMENTS AND DEPARTURES**

**Successor to the Ringland Anderson Chair of Ophthalmology, and new head of the Department of Ophthalmology and Centre for Eye Research Australia, is Professor Tien Wong.**

Tien, a graduate of the National University of Singapore, trained in clinical ophthalmology at the Singapore National Eye Centre and in medical retina diseases at the University of Sydney. He holds an MPH and a PhD from the Johns Hopkins University School of Public Health, USA, and undertook research fellowships at the Dana Center, Wilmer Ophthalmological Institute, Johns Hopkins University School of Medicine and at the University of Wisconsin, Madison.

Tien’s clinical and research expertise is in the area of retinal vascular diseases, including diabetic and hypertensive retinopathy, retinal vein occlusion, and age-related macular degeneration with particular interest in the relationship of retinal vascular signs as predictors of cardiovascular disease.

Professor Stephen O'Leary has been appointed to the William Gibson Chair of Otolaryngology, based at the Royal Victorian Eye and Ear Hospital.

Stephen gained his PhD at Melbourne under the mentorship of Professor Graeme Clark and undertook postdoctoral research at Oxford University, UK, and the University of Utrecht, in the Netherlands. He has worked both as a surgeon and a scientist at the University, the Bionic Ear Institute and the Royal Victorian Eye and Ear Hospital, since 1999. Known for his clinical and research activities in ear disease, hearing and balance, Stephen is recognised for his contributions to auditory neuroscience, and in particular for his research on the bionic ear, and inner ear regeneration, protection and repair. He led the development of a virtual reality simulator to teach ear surgery in collaboration with CSIRO, which was recently licensed for commercial development to an Australian company, Medevision.

Early this year Professor Graham Brown, foundation director of the Nossal Institute for Global Health, stepped down as James Stewart professor and head of the Department of Medicine at the Royal Melbourne Hospital/Western Hospital to lead the Nossal Institute on a full-time basis.

A 1970 MBBS graduate, Graham’s unique medical career has spanned nearly 40 years of clinical medicine, basic and clinical research, both nationally and internationally. His commitment to public health, particularly in developing countries, has been extraordinary and inspiring. His first seven years after graduation were spent working in the public health department of Papua New Guinea, and he lectured in medicine at the University of Dar Es Salaam in Tanzania, 1975-1977.

This early exposure to public health in developing countries had a profound influence on Graham’s medical training and career. It influenced his interest in infectious diseases, his PhD project at the WEHI and his dominant 25 year research career in cell biology of malaria and vaccine development, which culminated in 1996 when the Royal Melbourne Hospital was selected as the inaugural Victorian Infectious Diseases Service (VIDS), taking responsibility for many services after the closure of Fairfield Hospital.

Graham’s extraordinary research career has seen him publish over 200 papers in peer reviewed journals, mentor 15 PhD or MD students, and VIDS has supported advanced trainees in infectious diseases. He has served on national and international editorial boards, and university committees. He has been honoured with numerous awards and is a much sought after keynote speaker at national and international meetings.

An inspiring teacher, Graham’s mentor program, run with Geoff McColl, for medical students, and his commitment to RACP basic physician training and clinical exams, bear testament to his role as the ‘professor educator’.

The Nossal Institute for Global Health operates on three key fronts: program development, research and training. These fields of operation will be amply met by Graham’s commitment to health equity, his formidable background in research and his passion for training global health leaders for the future. He maintains a

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**Professor James (Jim) Best has been appointed to head the Melbourne Medical School as it enters a new and challenging phase of development.**

Jim has a long association with the University of Melbourne. He graduated MBBS in 1972 before training in endocrinology at St Vincent’s Hospital then in diabetes research at the University of Washington, Seattle, USA.

He worked as an endocrinologist at St Vincent’s from 1982 to 1989 then joined the Department of Medicine at St Vincent’s as deputy head. He was appointed as professor of medicine and head of department in 1999. He has also been deputy dean of the Faculty from 2004 to 2006 and subsequently associate dean (resources).

Jim has taught extensively during his career, especially on the topic of diabetes and metabolism, as well as on the medical interview. He was actively involved in development of the current MBBS curriculum, particularly the subject ‘Nutrition, Digestion and Metabolism’. His research has involved physiological and molecular studies of glucose disposal, as well as studies of lipid biochemistry and epidemiological and clinical studies of risk factors for cardiovascular disease in diabetes. He is CIA for the NHMRC Centre of Clinical Research Excellence in Clinical Science in Diabetes.

Jim has been on the board of directors of three different health services and a medical defence organisation. In 2006 he was appointed to the council of the NHMRC and chair of the NHMRC Research Committee.

Professor Hugh Taylor AC left the Ringland Anderson Chair of Ophthalmology and the Centre for Eye Research Australia at the end of last year to take up his appointment as inaugural Harold Mitchell Chair of Indigenous Eye Health and lead our new Indigenous Eye Health Unit.

This significant initiative in Aboriginal health is offering to assist the Federal Government develop a targeted and dedicated solution to eliminate trachoma from Australia’s Indigenous communities.

Hugh took up the Ringland Anderson chair of ophthalmology in 1990 and directorship of the Centre for Eye Research Australia in 1996. He is a world authority on trachoma and has chaired or served on many national and international advisory committees and boards involved in eye health, receiving many awards for his work in ophthalmology.

Made a Companion of the Order of Australia in 2001, in part for his contributions to the prevention of river blindness and to eye health in Indigenous communities, Hugh’s research focuses on blindness prevention strategies, infectious causes of blindness and the interaction between medicine, public health and health economics.
Diarrhoeal Disease Vaccines, World Health

member of the council of the University
clinical, academic program in
drastic improvements in quality
response in patients with early rheumatoid
A 1988 graduate of Monash Medical
one of Australia's most highly regarded
is professor of medical
eight years at the RCH Glenn

A paediatric gastroenterologist, Julie heads
and the Intestinal Failure and
itself, the University and the
Guardian Medical Course at the

Julie Bines, the Victor and Loti Smorgon
in one of the Royal Children's Hospital to take
Paul Monagle recently left the Department
Diabetes and Health Sciences.
Glenn is a medical graduate who trained in

MELBOURNE MEDICAL SCHOOL 16
presence in the department with research

in the field of foetal

In phase 4 of the course, students will

in the Royal Children's Hospital (RCH), Melbourne. At the RCH, Glenn established the Centre for Adolescent Health, the nation's first clinical, academic program in youth health, and became the University's inaugural professor of adolescent health. During his 16 years at the RCH Glenn held a range of executive leadership roles including chief medical officer, executive director and, more recently, Stevenson professor of paediatrics and head of the department of Paediatrics.

Glenn has served on the boards of many organisations committed to serving children and young people. He is an elected

A 1988 graduate of Monash Medical School, Paul worked as a research fellow in the Department of Paediatrics at McMaster University, Hamilton Ontario, completing a Masters of Science (Health Research Methodology) before returning to Melbourne to the Women's and Children's Health Care Network where his rebuilding of the network's laboratory led to considerable improvements in quality systems, clinical interfacing, management and financial accountability. In 2001 Paul was awarded the RCH gold medal, the youngest ever recipient, for his efforts in dealing with the organ retention after autopsy issue. He is an active educator, involved in undergraduate and graduate teaching.

Paul is a reviewer for many international journals and has published extensively in the fields of developmental haematosis and paediatric thrombosis and anticoagulation. He is principal investigator of the Fontan A study, the only currently open multinational RCT of anticoagulation in children with cardiac disease, and has significant international collaborations.

Recognised internationally for his clinical service, Paul currently chairs the American College of Chest Physicians antithrombotic guidelines paediatric chapter, and is co-chair of the International Society Thrombosis Haemostasis paediatric subcommittee. He is a director of the Murdoch Childrens Research Institute and Royal Children's Hospital Foundation.

Paul is married with four children and spends all his spare time devoting his children to their respective sporting competitions.

Geoff McColl, professor of medical education and training, is the new director of the Medical Education Unit in the Melbourne Medical School.

Geoff graduated MB/BSc from Melbourne in 1985, trained at the Repatriation and Austin Hospitals and specialised in rheumatology. His PhD, examining antigen-specific immune responses in patients with early rheumatoid arthritis, was undertaken at the Walter and Eliza Hall Institute. He is currently president of the Australian Rheumatology Association and a member of the Pharmaceutical Benefits Advisory Committee.

As senior lecturer in the Centre for Rheumatic Diseases at the Royal Melbourne Hospital, Geoff examined the efficacy of patient self management programs and coordinated trials of new drugs for the treatment of patients with arthritis.

Geoff moved to the Medical Education Unit from the position of clinical dean at the RMIT/WH clinical school, which he had held since 2001. He has also been associate dean (academic) of the Faculty since 2006. His Master of Education, completed this year, examined how clinical educators teach diagnostic reasoning to medical students.

Geoff's attention is currently focused on the development of the new graduate medical program and continuing his research in the area of diagnostic reasoning.

Phase one, based at the University, will be delivered over one intensive year and combine case-based integrated learning with discipline specific programs in anatomy, physiology, biochemistry, microbiology/immunology, pathology and pharmacology. Early clinical experiences and contextual learning in the enabling social and psychological sciences will also be a feature of this year. In addition, the bioscience curriculum delivered in phase one will be reinforced and explicitly built upon in subsequent phases of the course.

Phase two is a clinical program, delivered over two years in the University's established and new clinical schools. The clinical placements will acknowledge the importance of learning medicine in a variety of environments and from teachers with different expertise. These clinical years will focus on the patient at the centre of student learning and use our newly developed Curriculum-Connect® e-learning platform which seamlessly connects patient data to the student's prior experiences and learning as well as new evidence-based practice resources. Critical areas such as clinical reasoning, professionalism, clinical simulation and cultural competence will be highlighted during this phase, enhancing the students' ability to function in a contemporary health care environment.

The principles of the University's new Melbourne Model have particular significance in the development of phase three of the course during which students undertake comprehensive study in a particular area of medicine, culminating in the production of a scholarly document (e.g. minor thesis, research paper, quality audit, clinical case series). For some students this could be an opportunity to study clinical programs aligned to those of the professional colleges with the potential to gain credit towards basic training programs. Likewise, international students might focus on acquiring skills most useful for future careers in their home countries.

As the dean completes his description of the new course he concludes by emphasising the responsibilities to themselves, their families, the University and the community at large as they set their feet on the path of those who have gone before. He then steps away from the podium and establishing a growing chorale of excited voices, eager to get on with it!

Geoff McColl (MB/BSc, 1984, MBBS 1983, PhD 1997) is professor of medical education and training and director of the Medical Education Unit.

To keep abreast of the development of the new medical course at the University of Melbourne go to:

www.med.unimelb.edu.au
On 13 September 2007 the Department of Biochemistry and Molecular Biology bid an official farewell to the Russell Grimwade School of Biochemistry. Within a few days, the doors were locked and the building began a demolition site. Paul Gleeson takes the opportunity created by this event to reflect upon on the extraordinary activities that have taken place within the building’s walls over a period of some 50 years, activities which have had a major impact on shaping biochemistry in Australia.

We shape our buildings then after that they shape us. Winston Churchill

As I put pen to paper the last remaining sections to the entrance to the Russell Grimwade School of Biochemistry building at the University of Melbourne are under the wrecker’s hammer. The building on Royal Parade is soon to be razed and will become the footprint for a new neurosciences institute.

The Department of Biochemistry and Molecular Biology is now split across two sites: its research activities largely relocated to the Biocity Institute and teaching activities to the Medical Building.

The Russell Grimwade School of Biochemistry was the first building dedicated to a scientific discipline constructed at the University after the Second World War. It was the first building on the south-west corner of the campus which, prior to its construction, was largely open sports fields. It was also the first building in Australia dedicated to the then emerging discipline of biochemistry, its construction and maturation paralleling the emergence and blossoming of the discipline.

In 1944, Sir Russell Grimwade made a gift of £50,000 to the University to go towards a new home for biochemistry. Victor Trikojus had recently taken up the appointment as the second chair of biochemistry, heading a department which then consisted of one full-time lecturer, one part-time lecturer, two demonstrators, two technicians and one administrative staff member. He led the department for an amazing 25 years and was principal driver in creating the Russell Grimwade School of Biochemistry, nurturing all the stages of the prochoes design, fundraising and construction.

There were extraordinarily long delays during which biochemistry was scattered across four sites. A great deal of difficulty was encountered at the site for the new building, which was finally ended when, with the lobbying of Pansy Wright, the site on Royal Parade was chosen: a tennis court flanked by hockey fields. The architects were Bates, Smart and McCutcheon who, according to Trikojus’ biographer, became ‘the victims of Trikojus’ pursuit of perfection!’

The building was erected in two stages. Stage one, opened in 1958 and consisted of the first two floors, used primarily for teaching. Stage two included the upper three floors and penthouse, and was opened in 1961 by Sir John Eccles, neuropathologist, president of the Australian Academy of Science, and soon to become noble laureate for physiology/medicine. The penthouse included a mechanical plant room, a toxic laboratory and a general laboratory that housed the Sugar Research Unit of CSIRO and included Harald Hatt, a polysaccharide chemist, and Richard Jago, an enzymologist. Trikojus was passionate about translating practical outcomes from biochemical research and it is likely that the inclusion of CSIRO activities was to provide a bridge between these activities.

The advanced laboratory and large lecture theatre, subsequently named after Trikojus, opened in 1966. The total cost of the building was approximately £700,000. Estimated costs to demolish the building are approximately $5m.

The department flourished in its new building rapidly expanding its research and teaching activities. Between 1958 and 2007 more than 25,000 undergraduate students (science, medicine, dentistry, agriculture, optometry) have been trained in biochemistry and approximately 500 postgraduate students have completed MSc and PhD degrees. Numerous young biochemists established independent careers within the building, many subsequently going on to become academic leaders around the country. For example, Pat Carnegie became foundation professor of biochemistry at La Trobe University in Victoria; Peter Dunkley was head of medical biochemistry at the University of Newcastle; and Michael Birt, head of biochemistry at ANU then vice-chancellor of the University of NSW.

At the farewell celebration a number of those present shared their reminiscences. In 1966, Beverley Bencina entered the second year teaching labs in the new building and fell in love with biochemistry. Still teaching in the department today, Beverley recounted those early undergraduate practical classes, where the second year group of 40-50 students performed their experiments under the supervision of Mary McQuillan. If lessons got a little weary it was always easy to get distracted by watching the hockey games through the windows on the south side of the classroom. In Beverley’s third year BSc there were 24 students in the practical classes, held in the Young laboratory on the ground floor under the supervision of Jack Legge, Bruce Stone and Frank Hird. The range of practical exercises included the interminable Warburg manometry measurements and visiting the animal house on the fourth floor for the rat dietary experiments. As a special treat, at the end of the year, students were invited into the staff tea room for lunch and taken up to the roof of the building by Trikojus, to check out the wonderful views of the city.

One of demonstration Beverley Bencina’s prac students from the middle 1960s was Mary-Jane Gerling (head of department 2000-2004). Mary-Jane recalled her very positive experience of the biochemistry lectures, particularly the third year lectures which included recent research advances, such as the latest mechanism of chymotrypsin action. When the honours year, which had lapsed in 1959, was re-established in 1968, the class included Tony Burgess, Richard Simpson and Geoff Howlett. Mary-Jane Gerling was in the honours class of 1969 along with Elizabeth Blackburn and Barbara Ellis (Howlett). The honours students were housed together in a single laboratory at the western end of the second floor. She recounted Trikojus giving the group of honours students a working over after walking in to find all the students sitting on the benches!

The department has a proud tradition of providing outstanding undergraduate and postgraduate training and Mary-Jane warmly recalled the wonderful teaching she and her fellow students received, in particular, that she learnt how to design experiments and, most importantly, include all the appropriate controls. Indeed, these skills of experimentation ensured that Australian biochemists were strongly sought after by overseas laboratories!

Bill Sawyer (head of department, 1983-1986) arrived in the department as a lecturer in 1968. He had previously encountered the Russell Grimwade building as an undergraduate agriculture student where his practical classes were under the guidance of Frank Hird and a young post-graduate student, Barry Davidson. Bill recalled the strong collegial atmosphere and, in particular, support for young staff. As a young lecturer he taught medical students in the Young laboratory (named for William Young, founder professor of biochemistry) with Jack Legge, where he had devised experiments to measure the O² binding curves to haemoglobin. Lindsay Rayner, who has run the undergraduate practical laboratories for 40 years, was involved in the finicky calibration of the apparatus used for these experiments. In 1974, Bill was instrumental in introducing the use of computers in laboratory sessions, and carried out one of the first experimental assessments of computer-aided teaching in the University.

Dick Wettenhall, who took over as head in 1986, commented on the strong family spirit to the department that had been cultivated over many years and reminisced on the great changes in the University during his period as head. One change was the introduction of the performance appraisal process. On one of his first appraisals, Max Margison admonished Dick for not participating in a greater number of University House activities! The department had a great tradition in University House involvement, with many past presidents being staff from the department. Dick also highlighted the pioneering developments that had occurred, particularly in the determination in the department during the 1990s.

A lasting memory of the Russell Grimwade building for Dick was the trip where he and his wife took up the roof of the building to see the whole of Melbourne, it was a place to be revered. For many it is with some sadness to consider that the building has disappeared. Of course, it’s not just the bricks and mortar but about the people and their activities and interactions within the walls of the building over many decades. The bricks and mortar provide a physical context to house the memories of so many achievements that have influenced so many careers. As the building disappears, hopefully this article will go some way towards sustaining those memories for many years to come.

With many department colleagues for their contributions in gathering the background information and photographs, to Bruce Stone for sharing his insights concerning the early period of the building, and to Jacqueline Munro-Smith for assistance with the manuscript.

A similar article has also been published in the Australian Biochemist.

REDEFINING RESEARCH

INTRODUCING RESEARCH DOMAINS

Meryl Fullerton, Head, Faculty Research Unit

Fundamental to the acceleration of biomedical discovery for the benefit of human health in the twenty-first century has been the phenomenon of research teams cooperating in major collaborative inter-disciplinary settings. The success of the human genome project is an outstanding example of this approach. Although not all scientific questions are as large and complex as unravelling the human genome, the speed of generation of significant research outcomes, where experts across a range of disciplines work on different aspects of a particular biological question, is a recognised advantage of the big-team approach.

At the same time, capturing maximum returns for every dollar spent on biomedical research is occupying national thinking in many countries, including Australia, and our national funding bodies now direct major funds specifically to this type of team-based research. The University of Melbourne’s agenda also emphasises the quality of research outcomes by fostering greater strategic focus in fewer research areas. Accordingly, the Faculty of Medicine, Dentistry and Health Sciences has developed a new concept of research domains which is aligned with these objectives and consistent with examples of successful international practice.

This strategy will transcend our traditional organisational arrangements of schools and departments, instead presenting a coherent picture of our research effort across eight major research domains. All Faculty researchers, including early career researchers, located in numerous disparate geographic locations will be organised ‘virtually’ according to their research themes. This will allow people’s overlapping interests and skills to be developed in the context of greater critical mass and cross-discipline expertise, particularly important to younger researchers.

The Faculty’s 1,450 researchers have recently been invited to nominate at least one and up to three of the eight domains (comprising Biosciences, Cancer, Cardiovascular, Clinical Sciences and Health Practice; Diabetes, Obesity and Endocrinology; Infection and Immunity; Neurosciences and Behavioural Sciences; and Public Health, Epidemiology and Health Services) to which they would like to belong.

The domains will also provide much greater visibility and access to other interested parties such as students and other scientists, both national and international, who may be looking for collaborative partners. Stronger links will be fostered with researchers in our affiliated organisations, and our research will benefit from greater visibility to potential industry partners, philanthropists and donors.

The domain structure will also assist us to publicise our research achievements and international standing to greater numbers of potential research higher degree students and potential staff as well as to governments and the public.

Some domains may evolve into institutes or physical aggregations of ‘like researchers’ in their own right, as is already occurring in the neurosciences. Others, such as many of the clinical researchers dispersed across numerous hospitals, will remain part of virtual domains.

The ‘virtual’ website part of the research domains project was dispersed across numerous hospitals, will remain part of virtual domains.

The ’virtual’ website part of the research domains project was launched in October. The project will be underpinned by face-to-face launch functions, symposia, management meetings and strategically directed financial assistance. These features will provide an impetus for the development of the domains and, we expect, an increase in high quality research and, ultimately, faster delivery of health outcomes to the community.

Finding out who does what and who is willing to do things, was the most difficult thing when I arrived’, recalls Andrew Hill, who returned to Melbourne University in 2003 after ten years in the United Kingdom. ‘This is where the domain project will make things easier.’

‘The biosciences domain is so broad, most researchers doing basic research will identify with it in some way,’ Andrew says.

‘My own research also intersects neurosciences and to some extent infectious diseases and immunity, as well as public health.’ Andrew studied prions as a cause of Creutzfeldt-Jakob Disease (CJD) at the height of the bovine spongiform encephalopathy epidemic in the UK. In CJD, prions enter the brain and aggregate; damaging the brain tissue and forming holes. Andrew’s recent work shows that prions spread from cell to cell when they are released in small vesicles known as exosomes. His lab also conducts research on two other protein-misfolding diseases: Alzheimer’s and Parkinson’s.

The media attention surrounding prions and CJD sparked Andrew’s interest in communicating science to the public, for which he received a Young Tall Poppy Award in 2006. He already uses interactive online tools to communicate within his laboratory group and sees their potential to enhance communication within and across the research domains. ‘I see this project as a good chance for people to get more involved and to promote their work both within the University and throughout the world’ says Andrew.

‘Nothing is worse than working in isolation. It’s important to have people to talk to and to know the people to talk to,’ says Kate Drummond, coordinator for the cancer research domain.

With a background in clinical cancer management, cancer administration and research experience, as well as being a full-time cancer neurosurgeon at the Royal Melbourne Hospital (RMH), Kate is aware of the large task at hand. ‘Here in Melbourne we have all the resources to do world class research and make a real difference to cancer patients. But we haven’t been good at coordinating all these resources for the best outcome. We have world class researchers and clinicians and large hospitals with huge numbers of patients: we can make a difference on the world scale.

Kate, who now heads the central nervous system tumour stream in the Department of Neurosurgery at RMH, was encouraged by a high school teacher to study medicine. ‘She said to me: “You can do it” and so I did!’ Once Kate began medicine she discovered a love for neurosurgery, an area in which she can make a big difference to patients’ lives: ‘They are such sick patients; the sickest of the sick with the grimmest outlook. You really want to do all you can for them.’

When Kate came to the RMH she was only the fourth woman in Australia to complete neurosurgical training. A clinical research fellowship allowed her to work at the Brigham Women’s Hospital, Harvard, for six months learning intra-operative MRI, developed at Harvard. Upon her return she spent three years researching the invasion of astrocytomas for her MD.

Kate believes that success in cancer research lies in ‘creating networks, more promotion of the work being done around us, more collaboration and more translational research’.

CANCER

Louise Burrell

An example of our continually developing collaborative links is the proposed Global Medical Excellence Cluster, which will connect Melbourne with London in a major international linkage across several biomedical themes, including cardiovascular. Top researchers from each location will synergise in a major push to further the development of personalised medicine in a cardiovascular context.

Louise Burrell’s vision is to make cardiovascular research a major goal of the University. Louise says, ‘It is a challenge to bring together researchers within the domain that are geographically separated.’

As coordinator of the cardiovascular domain, which has an impressive rating of international collaboration among its research outputs, Louise is herself well focused on the international scene. She is the newly elected treasurer to the International Society of Hypertension, fellow of the American Heart Association and member of the British Society of Endocrinology. Louise is an all-round clinical researcher with credentials in grant acquisition, research higher degree supervision and a high national as well as international profile.
Her challenge in running this domain will be to bring together the scattering of cardiovascular researchers across large geographic distances within the Faculty, and linking with collaborators across Melbourne, Australia and throughout the world. Close links with other domains such as diabetes, endocrinology and metabolism, and clinical sciences and health practice give this domain the broadest coverage of basic and clinical interests. These interests are reflected in Louise’s profile: her research interests lie in studying the mechanisms involved in heart disease and high blood pressure, as well as how diabetes can impact on heart disease.

CLINICAL SCIENCES AND HEALTH PRACTICE

Peter Ebeling

‘The days of the single researcher are gone: the bigger the team, the better,’ says Peter Ebeling, coordinator of the clinical sciences and health practice research domain.

Peter is professor of medicine and head of endocrinology at Western Health in Sunshine, near where he grew up as a child. There were no general practitioners in Deer Park, but the family’s doctor in Sunshine made a big impression on him.

During his MD, Peter shared in the local effects in bone and other tissues. ‘I was looking for something more applied’, this led her to study the effects of drugs that delay the absorption of carbohydrates into the body and sparked her interest in diet, insulin and heart disease. Kerin then spent a year in Paris and two years in the Cleveland Clinic in the USA.

In Australia, Kerin has pursued this interest, applying her knowledge to study the health of Indigenous communities. She looked at the impact on the health of Aboriginal people when they returned temporarily to live a hunter-gatherer lifestyle in the Kimberley. In only seven works they demonstrated remarkable reductions in all the major metabolic abnormalities of diabetes and risk factors for cardiovascular disease. She has continued to work on the relationship between lifestyle and health outcomes in Indigenous populations in northern and central Australia.

More recently, Kerin has developed a research interest in the diet of migrants from southern Europe, a group with significantly lower rates of cancer and heart disease. ‘People living traditional Mediterranean lifestyles have fresh fruit with every meal and many more vegetables than most Australians.’

Kerin is keen to identify the positive models of healthy lifestyle: ‘It’s important to think holistically about food and nutrition, in tackling the problems of diabetes and obesity,’ she says.

INFECTION AND IMMUNITY

Liz Hartland

‘The domains are about bringing researchers together—we need to think about ways in which we can encourage and reward collaboration,’ says Liz Hartland, coordinator of the infection and immunity domain.

Liz did her BSc(Hons) and PhD degrees at Melbourne University, but took the opportunity to undertake her postdoctoral studies abroad. She won a fellowship to work at Imperial College London, UK, for two years before returning to Australia and building up a research group at Monash. She recently moved her group back to the University of Melbourne. ‘It’s hard work building up your own lab independently. It’s a time in your career when you are looking to expand your team and can benefit greatly from collaborations.’

Liz and her team study Legionella pneumophila, the bacterium responsible for Legionnaires’ disease and pathogenic types of E. coli that cause diarrhoea. ‘We’re particularly interested in bacterial proteins that interact directly with human proteins and subvert their function. This allows bacteria such as Legionella to interfere with our normal cell processes so they can multiply before detection by the immune response.’

Liz emphasises that infection is the result of both bacterial and host factors, a constant battle where both sides are trying to outsmart the other. Therefore, both microbiologists and immunologists need to talk together about developing new ways to combat current and emerging infectious diseases. The infection and immunity domain is based around this fundamental idea.

NEUROSCIENCES AND BEHAVIOURAL SCIENCES

Trevor Kilpatrick

‘The main challenge is coordinating and providing leadership to research in the neurosciences that is dispersed among multiple centres’, says Trevor Kilpatrick, coordinator of the neurosciences and behavioural sciences domain.

As director of the University’s Centre for Neuroscience, leader of the Multiple Sclerosis (MS) Group at the Howard Florey Institute and head of the MS CARE unit at the RMIT, Trevor is experienced in forming alliances and collaborations. ‘A clear voice is needed for the neuroscience research being conducted by the University of Melbourne.

Trevor is a clinician scientist whose basic research focuses on the neurobiology of MS, in particular oligodendrocytic biology, and upon regenerative medicine. He has initiated a number of multicentre collaborations to study the genetics and epidemiology of MS, and is developing translational platforms for therapeutics that target neurodegenerative diseases. His epidemiological research currently concentrates on an incident case-control study examining environmental risks for the onset of first demyelinating events. A major a priori focus of the study is to clarify whether there is an inverse correlation between levels of ultraviolet irradiance, and risk of MS.

Trevor’s MS group won this year’s Australian Museum Eureka Prize for Medical Research in recognition of their significant work into finding treattments for sufferers of MS—an example of the power a collaborative approach has to produce results.

‘Being involved in the Research Quality Framework project in 2007 meant I met some fantastic people. I enjoyed getting an overview of what was going on,’ says Jane Pirks, coordinator of the public health, epidemiology and health services domain.

‘This overview will help me draw together the large numbers of people working in this area.’

Jane studied psychology, going on to do a Masters in psychology and a PhD in epidemiology. She was awarded the prestigious Harkness fellowship in health care policy and worked in the Division of Adolescent Medicine, University of California at San Francisco. Her current NHMRC career development award allows her to examine the epidemiology of suicidal behaviour to inform policies aimed at prevention. She evaluated the First National Mental Health Plan and conducted a review of the National Youth Suicide Prevention Strategy. Jane studies media portrayals of suicide and supervises a number of student projects in this area. Through her work in this area she feels that she can make a difference to the lives of many people.

Her experience in building collaborations has developed through her role as the chief investigator on the evaluation of the Partnership Project, a collaborative initiative conducted by St Vincent’s Area Mental Health Service and the Melbourne Clinic, aimed at improving linkages between the public and private mental health sectors.
A dinner for Melbourne MD graduates was held in August this year, celebrating the achievements and seeking the continuing involvement of our alumni in the training of future medical practitioners and the support of our research endeavours. MD graduates Ian Gust and Christine Kilpatrick both addressed guests about how their medical doctorates had helped shape their work and careers and versions of their talks are published in this issue of \textit{Chiron}. The photos on these pages were taken at the dinner.

David Penington, Dean of Medicine (1978–85) and University of Melbourne Vice-Chancellor (1988–95) talks with Donald Hossack. Donald Hossack’s honorary MD was awarded in 2006 in recognition of the major contribution made by his work and research, as consultant surgeon to the Melbourne city coroner, to the subsequent Victorian Government’s legislation for compulsory seat belts and drink driving restrictions.

David Taylor’s MD was awarded in 1978 for his research on the impact on cardiovascular risk factors by modification of the type of dietary fat in residents at an Antarctic station. He is now director of emergency medicine research at the Austin Hospital.

John Kelly, who received his MD in 1953 and is now semi-retired from general practice, was delighted to have the opportunity to discuss John Tiller’s research into electroconvulsive therapy. John Tiller was awarded his MD in 1990 and now heads the University’s Department of Psychiatry.

Kate Leslie and Andrew Davidson are both working in anaesthesia and pain management. Kate at the Royal Melbourne and Andrew at the Royal Children’s Hospital. Kate’s MD was awarded in 1998, on aspects of propofol pharmacology and Andrew’s in 2005, on the awareness and depth of anaesthesia in children.

Doris Young joined with Maurice Eisenbruch, professor in the School of Psychology, Psychiatry and Psychological Medicine at Monash University (left) and James Tatseln, director of cardiothoracic surgery at RWH and chief medical advisor of the National Heart Foundation (right), talks with Wendy Brooks, director of advancement. Doris has recently taken up leadership of the Faculty’s new Graduate Programs Unit as associate dean (academic).
Has there ever been a generation more fortunate than those of us lucky enough to have been born in Australia during the 1940s—blessed with boundless opportunities and six decades of peace and prosperity, the first generation to be liberated from fear of pregnancy by the pill, the last to grow to maturity before the shadow of AIDS?

By the age of 16, I had decided on a career in medical research and applied for, and was offered, a scholarship to become a cadet biochemist at the Commonwealth Serum Laboratories. However, talking about that plan, which my cadet biochemist, a trainee cardiologist, he said: ‘You’re mad! If you want to do medical research, do medicine, it opens up so many options.’

As a medical student, I was fortunate to have a mentor, a professor at the University of Melbourne, a charismatic, enthusiastic Gus Nossal, super-salesman, even in his 30s, for the possibilities of medical research. I graduated, started work at the Alfred Hospital and decided to pursue a career in microbiology. Mac Burnet was surprised because, in his view, the major problems of microbiology had been solved: vaccines and antibiotics were controlling many common infectious diseases and public health authorities only needed to apply existing principles. This view, echoed by the US surgeon general, was widespread at the time: even Nobel laureates and surgeons general sometimes get it wrong.

Cell culture technology had revolutionised virology; every few months a new virus or class of viruses was discovered. It seemed like a field with a future, a field that would benefit directly from the great advances that were occurring in biochemistry and immunology. Most importantly, it held the intriguing prospect that if you were smart enough, or lucky enough, you might be able to do something which benefited large numbers of people.

Making the decision was one thing, turning it into a reality proved more difficult. In the mid-1960s, medical virology virtually disappeared as a discipline in Australia. Syd Rubbo persuaded me of the value of broad training before specialising, so, on completing my residency at the Alfred, I applied for and was appointed as pathology registrar at Fairfield Hospital for Communicable Diseases. Fairfield had opened in 1904, funded by donations to Queen Victoria’s Diamond Jubilee Fund and levies on local councils. In 1963, it was already a relic of a bygone era: a series of red brick buildings and pavilions with high ceilings and wide draughty verandas scattered over a 15-acre site and linked by windblown covered walkways. It’s hard to explain to young graduates how things were 40 years ago. Most large cities had a hospital for the isolation and care of patients with communicable diseases; the causative agents of most of the childhood infectious diseases had not been identified, pathology services were rudimentary and treatment often symptomatic.

While smallpox, polio and influenza vaccines existed, everyone expected to encounter measles, mumps, rubella and chicken pox during childhood, sometimes with serious consequences.

I enrolled as a trainee pathologist with the Royal College of Pathologists of Australia, starting and finishing my training at Fairfield Hospital, broken by two and a half years in the UK—first at the London School of Hygiene and Tropical Medicine, then with Norman Grist at the Regional Virus Laboratory in Glasgow.

During my time in London, I followed developments in viral hepatitis, reading with interest two important papers by Baruch Blumberg, noting his discovery of the Australian antigen, and by Fred Prince, demonstrating that the presence of this antigen was a serological marker of the presence of the hepatitis B virus.

While in Glasgow I watched the field closely and wrote to Fred Prince who invited me to visit him at the New York Blood Centre on my way home to Australia, which I did. I left with a wonderful gift: four sealed ampoules of reference sera, two containing Australia antigen and two, antibodies directed against it, wrapped in cotton wool, packed in a blue and white cigarette box and crossed the country with the tin in my luggage and flew back to Australia, walking through customs with the tin in my pocket. Today, I probably would be arrested as a bioterrorist! Returning to Fairfield Hospital at the end of 1969, I plunged straight into hepatitis work. We did a lot to define the natural history and mode of spread of the disease. As a result, our laboratory was designated as a WHO Collaborating Centre for Viral Hepatitis, gaining us entrance to the international hepatitis community.

Within a year of my return, Alan Ferris joined the Department of Microbiology at Monash University as a senior lecturer and, as the hospital had little choice, I was made head of the virus laboratory, at that time numbering six people: four senior scientists and two technicians. Although winning the respect of the senior staff took some time, it was a fabulous opportunity. I was like a boy let loose in a lolly shop! I’m eternally grateful for the opportunity and am forever wary of comments at selection panels that ‘so-and-so is very talented but not quite ready’. Whenever I’ve had the opportunity I’ve pointed out to others whose promise was fearfully ahead of, not behind, them.

In 1983 the hospital’s new board moved to formalise its commitment to research and established the Fairfield Hospital Medical Research Centre which I was asked to head. Mac Burnet graciously agreed to be our patron. The new centre brought together the laboratory’s grant supported research but no sooner were things back on an even keel than we hit with a tsunami—the pandemic of AIDS.

Every generation has its defining moments. For my parents it was probably the Depression and Second World War. Most of my generation know where they were when JFK was assassinated, when Neil Armstrong stepped onto the moon and when the first plane hit the Twin Towers. Sometimes, equally important moments sneak up on you and are only apparent in retrospect. That happened to me in April 1981 in the peaceful, sleepy, city of Auckland.

Several of our team were attending the scientific meeting of the Australasian Society for Infectious Diseases and, as a casual conversation, heard from the guest speaker Morton Schwartz, an American infectious diseases physician, of the first cases of an apparently new disease among gay men in New York and San Francisco. The disease was characterised by enlarged lymph nodes, skin sores, severe, and recurrent opportunistic infections and a profound suppression of the immune system with a selective depletion of CD4 cells. Despite the best treatment, the disease, initially labelled Gay Related Immuno Deficiency (GRID) seemed to be invariably fatal. It was discussed as a curiosity and we speculated that it might be the result of the toxic effects of some of the drugs the affected were known to use to enhance sexual performance. None of us thought the disease was particularly important or had any idea how it would transform our lives.

Over the next two years the disease was seen more commonly among homosexual men in the UK and Hawaii. However, it was not until cases began to occur among intravenous drug users and haemophiliacs, that it became clear that we were probably dealing with a blood-borne viral infection. Working with Montagnier and Luc Montagnier, I had identified the causative agent, which he called the lymphadenopathy-associated virus by electron microscopy. Unfortunately his observations were heavily criticised.

I was sympathetic for his position because, not only did the data pass the sniff test, but I had previously been a victim of the ‘not invented here’ syndrome. In 1973 our paper on the identification of the virus was rejected by Nature. In 1983 our paper on the identification of the virus was rejected by Lancet. Several years later, when I questioned the referee, Jane Almeida, about her decision, she said simply, ‘it was such an important paper we had identified the causative agent, which he called the lymphadenopathy-associated virus by electron microscopy. Unfortunately his observations were heavily criticised.

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Two other aliquots made from this unit had back, both donations had been obtained premature and both had received ‘top up’ features and found that both had been autopsy on a child with similar features. The attending physician had never seen a single facility, out of the public gaze, Fairfield Hospital saw AIDS as a means hard to pick up a newspaper or periodical publicity. As with the recent hysteria being unable to save the lives of young, a gruelling period for all of us, especially judgemental staff. It was an exciting but resources we needed. I guessed a figure and added fifty percent. He said, ‘OK, get on with it’. Early the following morning the hospital’s CEO, Bill Phillips put all the relevant resources at my disposal. Requisitioning an old animal house we converted it into a, not posh but functional laboratory, allocated staff to the production of coded panels of test sera and negotiated with the blood banks in Sydney, Melbourne and Adelaide and the laboratory at St Vincent’s Hospital, Sydney, to join us in the evaluation. For the diagnostic manufacturers, this represented the first systematic and independent evaluation of the operational characteristics of the manufacturer’s, the potential for an important endorsement as well as a significant commercial opportunity. Testing a coded panel of 1000 sera, with five assays in five separate sites, took some months, after which the results had to be collated and analysed. When we broke the code in May 1985, two assays stood out. Within days the Government had issued the proposal. It was agreed, with our laboratory responsible for overseeing the process. Tom Roper turned and asked what...
When asked how my MD had influenced my career, my initial response was that it had not had much impact, particularly given my recent change of career direction. On reflection, however, I think it has been considerably more relevant than would first appear.

My training as a neurologist in the 1980s was somewhat unusual in that I did not go overseas and I completed my MD on a part-time basis over a number of years. My MD was clinically based, assessing the relevance of protein binding of AED. It didn’t exactly result in a cure for epilepsy but it did have some impact on how AED monitoring was used in the management of epilepsy, an investigation which remains extremely over-utilised.

My MD experience gave me an understanding of the role of research in improving clinical practice, and helped me to develop a critical mind in assessing new clinical information. Importantly, it also gave me credibility in the clinical arena. Rightly or wrongly, people do focus on credentials when assessing ability. It helped establish myself as an academic neurologist specialising in epilepsy and, although I was predominantly clinical, I led a clinical research program and was involved in the training and education of undergraduate and graduate students in clinical epilepsy.

In the past, people often saw the MD as something to tick off after your fellowship, before getting on with clinical practice. This is less so today—for many it marks the beginning of a significant research career. People sometimes criticise those who complete an MD then do not continue in research. This is unfair; although they may not continue in research, they have gained the ability to critically appraise research—a very important skill in specialty practice. They also tend to be attracted to work in the public sector and are often involved in training and education skills critical to the ongoing success of the medical profession.

Although for many, the MD is the first step in a life long stellar career in medical research, for me it has been somewhat different.

About eight years ago, after 20 years of academic and private neurology practice, I became restless. I didn’t want to retire from neurology but wanted to do something else, causing much consternation amongst my colleagues. I was attracted to the organisational aspects of health care delivery, particularly the delivery of tertiary services in the public sector.

I went over to the dark side. I undertook an MBA, which gave me the formal knowledge and credentials I needed, and went on to executive appointments at Melbourne Health and, more recently, the Royal Children’s Hospital.

My experience working as a neurologist in a tertiary environment involved in research, education and private practice, has put me in an unusual position as a CEO. I have a clear understanding of the work of a tertiary hospital from a clinician’s point of view, and my MD and academic career has assisted me to understand the vital roles played by research and education in a tertiary teaching hospital.

There is no doubt that medical research and education have an integral role in the delivery of high quality health services within a tertiary referral hospital. There is good evidence that research led and informed, and education driven, health services improve patient outcomes. Not only does research result in knowledge which improves clinical care, and hence outcomes, but it is also recognised that clinical services delivered in a research environment have a greater uptake of the best clinical practice. A recent report from the Cancer Institute NSW and Access Economics Health Returns in Investment in Cancer Research shows not only improved clinical outcomes from research but also economic benefits to the community.

To maximise the impact of clinical research in improving patient outcomes, research should not be seen just as an individual, CV developing activity, but rather as answering questions of clinical relevance to improve patient outcomes—be it therapeutic drug trials, outcome studies, pathogenesis studies or studies of health service delivery. To achieve this we need to ensure that health services take a strategic approach to research, and place the address areas of need, not just researcher’s interests. Researchers must not only undertake their own but also inspire others to do research, value research and make sure that research leads to improvements in patient outcomes.

A critical issue of health service delivery and medical research is putting research findings into clinical practice. We all know it is often difficult to engage clinicians to incorporate research findings into their practice. We need more formal processes to make certain this happens. An area of considerable need is health services research. This requires the involvement of clinicians, well-trained in research principles and with a strong knowledge of clinical practice, particularly in the hospital setting.

There has been considerable discussion recently of the role of a university hospital. I believe this does not just mean a hospital that undertakes teaching of medical students. A university hospital should be a hospital where the teaching of health professionals—medical, nursing and allied health—is integral to the mission of the health service; where education moves seamlessly from undergraduate to graduate and to continuing education, and where there is a strategic, planned and coordinated approach to education. It should be a hospital where research underpins clinical practice, informs clinical management and improves patient outcomes and the health service has a strategic approach to research which addresses areas of need. In a university hospital the university departments—medicine, surgery, radiology, psychiatry, paediatrics etc.—should be integrated into the life of, and promote academic excellence throughout, the hospital. We should be striving to make this a model for all the University of Melbourne tertiary referral teaching hospitals.

So, although an MD is not a conventional credential for a hospital administrator, in my case it has significantly influenced my career and, now, my vision for the Royal Children’s Hospital.

There is no doubt that medical research and education have an integral role in the delivery of high quality health services within a tertiary referral hospital.
REUNIONS

MBBS 1941
September each year sees the MBBS graduates of 1941 gather together, to reminisce about their medical student days at the University of Melbourne, their subsequent careers and family lives and the year which has passed by since their last reunion.

Pictured here at their reunion last year are: Back—Peter Bird, Clarice Heatherington, Brian Costello, Frank deCrespigny and James Guest. Front—Mary Wheeler, Doug Atkinson, Alexe Gale and Ida Seward.

MBBS 1947
The MBBS graduates of 1947 at their sixtieth year reunion lunch held at the Melbourne Club on Saturday 13 October 2007. Pictured are: Standing (L-R)—Harry Buckstein, Tom Hurley, Ian Rowe, Philippa Conrie, Ralph Clark, Derek Denton, Bernard Neale, Noel Ramsay, Cedric Vear, Peter McMahon, Harold Story, BM Han and Ric Bouvier. Seated—David Bartram.

MBBS 1952
In November 2007, the MBBS graduates of 1952 celebrated their fiftieth anniversary with a dinner for graduates at the Melbourne Savage Club, followed the next day with a barbeque for graduates, families and friends.

Our reunions always attract a good attendance and this year was no exception. Fifty-seven graduates attended the dinner and 54 people, the barbeque. We have lost track of five of our number over the years and 72 are deceased.

During the dinner, Nan Ferguson gave a very amusing tale of her life as a medical student and as an anaesthetist. Photo: Ben Waldern. Hugh Hadley

MBBS 1977
What do you produce when you send a fake recall for a repeat final year exam to 200 Melbourne MBBS graduates from 1977? Initially, transient palpitations, sweatiness, even a momentary chest pain ... followed swiftly by 50 new dresses, 90 trips to the barber, 51 bottles of hair dye, 100 gym memberships, 140 name badges in size 72 font and ... one noisy, happy reunion!

Our class was actually recalled for a repeat final year medicine paper in 1977 so our reunion theme song just had to be ‘Let’s Do It Again’ by the Beach Boys.

And so we did ... with an afternoon ‘exam preparation’ session in the Sunderland Theatre, followed by a gala ‘exam dinner’ at Ormond College. We even organised an afterparty, much to our teenage children’s astonishment.

Everyone looked fabulous and had not aged a bit. Consequently, all candidates were awarded honours.

PS: Unfortunately the afterparty had to be abandoned due to exhaustion. A DVD of the 30 year 1977 MBBS reunion is available by emailing Katrina Watson at katrina.watson@svhm.org.au. The cost is $30 with proceeds going to the Tom Benson Bursary Fund for Melbourne University students with physical disabilities.

Pictured are the graduates of 1977 in younger days, before the days of hair dye and gym memberships.

Katrina Watson

MBBS 1957
The fiftieth year reunion dinner of the MBBS graduates of 1957 was held at the Kooyong Lawn Tennis Club on 27 October, 2007. Of the 126 people who attended, 74 were 1957 graduates. From all reports the event was a great success. Photo: Snappy Pics, Sandringham. Gabriel Kune

MBBS GRADUATE ANNIVERSARIES
University House is a beautiful Victorian home dating from 1885 situated within the grounds of the University of Melbourne’s main campus in Parkville. It is the sole survivor of a number of Victorian professorial houses that once lined Professors Walk. Five minutes from the city’s centre, University House features function rooms that can cater for from six to 300 guests. For information about using University House for your next graduate reunion contact the functions manager on T: (+61 3) 8344 5254 or visit the website at: www.uniclub.com.au

If you are planning a reunion for 2009 please contact the Advancement and Communications Unit to discuss how we can help. To ensure you continue to receive information about reunions, please let us know of address and email changes.

UMMS, Advancement and Communications Unit, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne, VIC 3010, Australia
T: (+61 3) 8344 5888, E: mdhs-alumni@unimelb.edu.au
OBITUARIES
RECORDED WITH REGRET, THE PASSING OF:

Mervyn T Fish (MBBS 1950)
David N Fearon AM (MBBS 1951)
Elsbeth M Dougall (MBBS 1942)
John F Connelly (MBBS 1956, MD 1970)
Neil T Cheshire (MBBS 1955)
John E Cranswick (MBBS 1949)
Peter J Canty (BSc 1965, MBBS 1967)
Allan M Beech AM, KSTJ, RFD (MBBS 1951, G Dip Anaesthetics 1956)
Sheila M Barr (BSc 1937, MBBS 1940, Dip Psych 1944)
Bill Breidahl (MBBS 1953)
Richard Bell Bachelor (MBBS 1962)
Alfred D Atkinson (MBBS 1941)
Joseph R Aarons (MBBS 1949)
James C Grimwood (MBBS 1963)
Douglas L Gordon (MBBS 1943)
Herbert W Hardy (MBBS 1944)
Ronald G Henry (MBBS 1954)
Edith J Hewitt (MBBS 1946)
John D Hollaway (MBBS 1966)
Ronald A Hurley (MBBS 1958)
Molly Longfield (MBBS 1949)
George C Jago (MBBS 1925, G/Dip Psych Med 1944)
Clairinda B Jelbart (MBBS 1937)
Cyrus A Jones (MBBS 1937, Dip O&G 1947)
Elizabeth M Kenny (MBBS 1941)
Peter G Long (MBBS 1961)
Margaret M Lowing (MBBS 1970)
Ian G Lyall (MBBS 1951)
Colin F MacDonald (MBBS 1949)
Joan A Marsden (MBBS 1944, MD 1951)
FR (Skipto) Martin (MBBS 1935, MD 1957)
Euan J McColloch (MBBS 1945, MD 1951)
Peter J Mortensen (MBBS 1949)
Charles R Morton (MBBS 1972)
Graeme Nicholson (MBBS 1957)
Una O'Day, MBE (MBBS 1939)
Barry J Orme (MBBS 1957)
Peter J Parsons (BSc 1937, MBBS 1938, MD 1948)
Maxwell A Prace (MBBS 1950)
Winston S Raddats AM (MBBS 1943, BSc 1969, Research Scholar, Maney Phys Med 1951)
Ian S Reid (MBBS 1937)
Warren R Saunders (MBBS 1938)
Peter Schap (MBBS 1957)
R L Sleeam (MBBS 1949)
Bill Shoss (MBBS 1941)
Neil S Smith (MBBS 1949)
Kenneth N Speed (MBBS 1942)
William T Strange (MBBS 1950)
Geoffrey M Suable (MBBS 1947, G/Dip Ophth 1954)
Boyed T Tait (MBBS 1935, G/Dip Diaq 1957)
Linh T Tran (MBBS 1955)
Judith M Walker (MBBS 1968)
Ormond A Whitney (MBBS 1946)
Peter G Wilson (MBBS 1973)
Albert T Wolf (MBBS 1948)

GERARD WILLIAM CROCK AO 1929–2007

Gerard Crock, who died peacefully at home on 23 December 2007, was a compassionate and considerate physician, an extraordinarily gifted clinician, a highly innovative surgeon and an inspiring teacher. Born in Perth to Vernon and Annie Crock, he was one of identical twins and enjoyed a remarkably close bond with his equally talented brother, Harry. They were educated by the Jesuits then, after beginning studies in dentistry, there being no course in medicine in Western Australia at the time, were supported to study medicine at Melbourne University. Their dissenting skills in anatomy saw them each appointed as ‘prosector’ in 1950. They graduated in 1953, Gerard with the Exhibition in Medicine and Harry with the Ryan prizes in Medicine and Surgery at St Vincent’s Hospital. The two were remarkably similar in appearance, and enjoyed a legendary ability to finish each other’s sentences. Mistaken so often for each other, they adopted a lifelong policy of acknowledging salutations from confused strangers. In 1956 Gerard married Jacqueline Bladin, founding a great partnership that defined a life brimming with personal and professional achievements.

Gerard’s specialist training at Moorfields Eye Hospital in London was followed by a senior lectureship in ophthalmology at the University of London and a year in America on a Harkness Foundation Fellowship at Johns Hopkins Hospital in Baltimore. At the age of 34 he was appointed foundation Ringland Anderson professor of ophthalmology: the first medical specialty chair in Australia and only the second chair in ophthalmology in the British Commonwealth. He established the University’s Department of Ophthalmology and much of the Royal Victorian Eye and Ear Hospital. He founded and directed the hospital’s cataract unit, initiated and supported the development of the other specialist units for and a time was chair of the hospital’s senior medical staff. Gerard ‘retired’ in 1987 to a busy private practice, specialising in retina, cornea and glaucoma. He was also Melbourne’s leading cataract surgeon. A world leader in retinal imaging and a pioneer of fluorescein angiography, retinal photography and retinal laser photo coagulation, Gerard spent many hours taking photographs and movies of the back of the eye with his team, including photographer, John Scrimmegrour. He introduced these techniques to Australia, establishing them initially in his beloved department. He and Nance Carroll did amazing work with Australia’s first advanced scanning electron microscope including quality control for the bionic ear that Professor Graeme Clarke was developing on the floor above. He supported the new Department of Optometry and its head, Barry Cole. Together they established the new world-famous Low Vision Clinic at Kooyong for the Association for the Blind (now Vision Australia).

Gerard’s team worked with Bernard O’Brien, Australia’s pioneering microsurgeon at St Vincent’s Hospital, to develop micro-sutures—needles and threads so fine that veins the size of a pinhead could be repaired or joined. With the department’s two brilliant engineers, Jean-Marie Parel and Ljubomir Pericic, with the Department of Ophthalmology and much of the Royal Victorian Eye and Ear Hospital.

When Andrew commenced as director of the Department of Ophthalmology in 1973. He ran fieldwork projects in the Philippines, the Cook Islands and India and was hospital mentor for St John’s Eye Hospital in Jerusalem for over 30 years.

His contributions were recognised by appointments as an Officer of the Order of Australia (AO) in 1985, and as a Knight of the Order of St John of Jerusalem in 1990. Gerard’s generosity and hospital were legendary. Rodney Wesmor, an ophthalmologist in Launceston and a former student, wrote to Gerard shortly before his death:

It was almost routine that patients with retinal detachments would turn up on Friday afternoon. There was no surgical team in Tasmania, and your invariable response on telephoning was, ‘Send them over, Rod. You never once asked if they were private or public, and I suspect you did a lot of public surgery over those years.’

Gerard’s long battle with cancer brought sadness relieved by periods of deep joy for his family. In December 2006, he and Jacqueline celebrated fifty years of marriage with their six children and 17 grandchildren, then celebrated the arrival of another grandchild the following year. Gerard was sustained in his final months by many wonderful friendships and by the remarkable palliative care provided by his niece, Susan, her partner, Giancarlo Di Stefano, and Mary Cook and Hugh R Taylor AC.

ANDREW DENT AM 1955–2007

Andrew Dent, formerly director of Melbourne’s St Vincent’s Hospital emergency department, died on 30 June 2008, at age 53. Andrew was a great man whose leadership, clinical example, research and advocacy developed emergency medicine and medical education in Australia and the Pacific region. He inspired the hum of activity and the buzz of enthusiasm made it hard to understand the family was sustained in his final months by many wonderful friendships and by the remarkable palliative care provided by his niece, Susan, her partner, Giancarlo Di Stefano.

Andrew commenced as director of the emergency department at St Vincent’s in 1995. With strengths in medical education, academic research and reading naturally.
personal charisma and integrity. Andrew established a cohesive, compassionate and innovative department during his twelve years of leadership. He was forced to step down from this role last June, with the sudden and devastating diagnosis of colon cancer. True to his great strength of will and character, Andrew continued to teach and work at St Vincent’s throughout his illness and treatment, maintaining a presence there until shortly before his death. The great number of awards and qualifications achieved by Andrew were largely unheralded during his life, mainly through his own preference. Apart from his fellowships in surgery and emergency medicine, Andrew was also a fellow of the Australasian College for Public Health (International Health) at Melbourne. His Australasian College for Medicine, Andrew was also a fellow of the Council of Victoria and its education subcommittee, where he led national projects investigating the educational needs and activities of prevocational doctors and the capacity of emergency departments to provide training opportunities. Andrew was central in developing the Melbourne undergraduate emergency medicine curriculum, overseeing its delivery and assessment. He was a creative educator, making use of new techniques, such as simulation, to provide learning opportunities for medical students, prevocational doctors, emergency medicine trainees and specialists, and rural GPs. The theme of selfless service pervaded Andrew’s farewell, which hundreds of people representing family, medical, corporate and social services attended. His untimely death at the peak of his career is a great tragedy but his life inspires us to carry on his vision of compassionate care, clinical excellence and selfless advocacy. Geogina Phillips and Brendan Costi.

Andrew Dent

IN BRIEF

CONGRATULATIONS TO ALUMNI, STAFF AND STUDENTS

Dominic Barbero (MBBS 1970)—AM for service to medicine as a general practitioner, through professional roles with a range of health and aged care organisations, and to the Italian community. James Bishop (MBBS 1972, MD 1990, MMed 1999)—AO for service to medicine, particularly in the field of cancer treatment and research and through the development of innovative policy, improved public awareness and service delivery programs. Elizabeth Carew-Reid (MBBS 1970)—OAM for service to medicine as a general practitioner, particularly through the provision of paediatric palliative care, and to the community. Chaoung Foo (MBBS 1969)—OAM for service to medicine. As a general practitioner, educator and advocate of traditional Chinese medicine, and to the community. Michael Good (PhD 1983)—AO for service to medical research, particularly in the fields of infectious disease immunology and vaccine technology, through leadership roles at the Queensland Institute of Medical Research and contributions to education. Jane Gunn (MBBS 1987, PhD 1998, General Practice)—BioMed Hot 100 author. Jack Hancky (MBBS 1956)—AM for service to medicine in the field of gastroenterology, particularly through research and clinical practice. Jonathan Rush (MBBS 1961)—AM for service to medicine, particularly in the field of orthopaedics, as a clinician, researcher and educator, and through monitoring and review of the quality of surgical care in Victoria. Jonathan David Schertzer (PhD, Physiology)—Chancellor’s Prize. Robert Thomas (MBBS 1965, MS 1990)—OAM for service to medicine through the field of gastroenterology; particularly through research and clinical practice in the treatment of gastric bleeding, to medical education, and to the community. William Heath (PhD 1988, Microbiology & Immunology)—elected Fellow of the Australian Academy of Science. John Hopper, (MEGA Centre, Population Health)—AM for service to public health and the biomedical sciences, particularly in the field of genetic epidemiology as an academic and researcher, and to the Australian Academy of Science (WEHI)—commendation, Premier’s Award for Medical Research. Gordon Lynch (PhD 1992, Physiology)—Research Higher Degree Supervision Award, University of Melbourne Awards for Excellence in Teaching and Supervision. Patricia Mackay (G Dip Anaesthesics 1952)—OAM for service to medicine in the field of clinical anaesthesia, particularly as a contributor to the improvement of quality and safety of patient care, and to the community. Hugh McDermott (PhD 1989, Otolaryngology)—Inaugural Callier Prize in Communication Disorders. John McNeil (PhD 1982)—AM for service to preventive medicine and to epidemiology as a researcher and educator and as a contributor to the development of public health policy. Spiro Marouis CBE (MBBS 1957)—AO, for service to the Greek community through a range of executive roles with migrant assistance and aged welfare organisations, and to medicine as a general practitioner. Peter Phelan (Paediatrics)—AM for service to medicine, particularly in the area of paediatrics as an academic and administrator and through contributions to the development of health care delivery and clinical practice management. Jonathan Rush (MBBS 1961)—AM for service to medicine, particularly in the field of orthopaedics, as a clinician, researcher and educator, and through monitoring and review of the quality of surgical care in Victoria. Jonathan David Schertzer (PhD, Physiology)—Chancellor’s Prize. Robert Thomas (MBBS 1965, MS 1990)—OAM for service to medicine through the field of gastroenterology; particularly through research and clinical practice in the treatment of gastric bleeding, to medical education, and to the community. William Heath (PhD 1988, Microbiology & Immunology)—elected Fellow of the Australian Academy of Science. John Hopper, (MEGA Centre, Population Health)—AM for service to public health and the biomedical sciences, particularly in the field of genetic epidemiology as an academic and researcher, and to the Australian Academy of Science (WEHI)—commendation, Premier’s Award for Medical Research. Gordon Lynch (PhD 1992, Physiology)—Research Higher Degree Supervision Award, University of Melbourne Awards for Excellence in Teaching and Supervision. Patricia Mackay (G Dip Anaesthesics 1952)—OAM for service to medicine in the field of clinical anaesthesia, particularly as a contributor to the improvement of quality and safety of patient care, and to the community. Hugh McDermott (PhD 1989, Otolaryngology)—Inaugural Callier Prize in Communication Disorders. John McNeil (PhD 1982)—AM for service to preventive medicine and to epidemiology as a researcher and educator and as a contributor to the development of public health policy. Spiro Marouis CBE (MBBS 1957)—AO, for service to the Greek community through a range of executive roles with migrant assistance and aged welfare organisations, and to medicine as a general practitioner. Peter Phelan (Paediatrics)—AM for service to medicine, particularly in the area of paediatrics as an academic and administrator and through contributions to the development of health care delivery and clinical practice management. Jonathan Rush (MBBS 1961)—AM for service to medicine, particularly in the field of orthopaedics, as a clinician, researcher and educator, and through monitoring and review of the quality of surgical care in Victoria. Jonathan David Schertzer (PhD, Physiology)—Chancellor’s Prize. Robert Thomas (MBBS 1965, MS 1990)—OAM for service to medicine through the field of gastroenterology; particularly through research and clinical practice in the treatment of gastric bleeding, to medical education, and to the community. William Heath (PhD 1988, Microbiology & Immunology)—elected Fellow of the Australian Academy of Science. John Hopper, (MEGA Centre, Population Health)—AM for service to public health and the biomedical sciences, particularly in the field of genetic epidemiology as an academic and researcher, and to the Australian Academy of Science (WEHI)—commendation, Premier’s Award for Medical Research.
Palliative Care and Psychiatry of Old Age Prize—Ingrid Laemmle-Ruff. Rehabilitation Medicine Prize—Ingrid Laemmle-Ruff. RL Simpson Memorial Fund—Victoria Snowball & Nazila Jamshidi; Robert Garrly Healy Prize in Medicine—Sophie Oldfield; Robert Garrly Healy Prize in Obstetrics—Jodi Keane; Robert Garrly Healy Prize in Surgery—Hannah Skrzypczek; Robert Yee Prize in Medicine—Andrew Woolfrey, Royal Australian and New Zealand College of Ophthalmologists’ Prize—Dai Ni (Dianlie) Zhang; Royal Children’s Hospital Paediatric Handbook Award—Fairlie Wayne & Kacey Williams; Sir Albert Coates Prize—Stavroula Papapostolou; Smith and Nephew Prize—Allison Mo; The Ilana Rischin Award for Outstanding Achievement by an International Student in Medicine—Shuli Cheng; Therapeutic Guidelines Award—Mary Quinn; Thomas and Elizabeth Ross Scholarship—Mali Okada; Vernon Collison Prize in Paediatrics—Vi Hoang Kieu; Victorian Metropolitan Alliance Prize in General Practice—Meryn Kyi; Walter & Eliza Hall Exhibition—Stavroula Papapostolou.

2007 DEAN’S HONOURS LIST Semester 12. Colleen Chow, Daniel Mark Golshovsky, Mervyn Kyi, Debra Weng Sue Leung, Allison Gwon-Yee Mo, Stephanie Ailsa Muller, Elizabeth Kate Nairn, Andrew Jonathan Neal, Sophie Bridge Oldfield, Warrick James Pill, Kate Joanna Robson, Dilraj Sidhu Singh, Bridget Oldfield, Warrick James Pill, Stephanie Ailsa Muller, Elizabeth Kate Nairn, Andrew Jonathan Neal, Sophie Bridge Oldfield, Warrick James Pill, Kate Joanna Robson, Dilraj Sidhu Singh, James Robert Stegeman, Jason Anthony Trubiano, Fairlie Frederique Wayne, Jennifer Pui Jan Yan, Sarah Ann Yong.

2008 DEAN’S AWARD FOR EXCELLENCE IN A PHD THESIS Each year five Faculty PhD candidates are selected for the Dean’s Award for Excellence in a PhD Thesis. The following citations outline the theses submitted by the winning candidates for 2008. The top two candidates are selected to the University for consideration for the Chancellor’s Prize for Excellence in a PhD Thesis in the category Medicine, Dentistry and Health Sciences, won this year by Jonathan Schertz.

Non-viral gene transfer of growth factors in skeletal muscle: implications for injury, regeneration and disease

Jonathan David Schertz, Department of Physiology

Jonathan developed a new method of non-viral gene therapy to deliver growth factors and therapeutic agents that can enhance skeletal muscle growth and repair. This method of gene therapy has significant implications for improving muscle function, and for treating muscle injuries and muscle diseases such as muscular dystrophy. His thesis has resulted in 21 publications in international, peer-reviewed journals including eight first-author papers in some of the most prestigious journals such as American Journal of Pathology, Molecular Therapy, Pharmacology & Therapeutics and Endocrine Reviews, a testimony to the international standing of the work. Both examiners praised the significance and excellence of Jonathan’s outstanding thesis, commenting on the technically complex and ultimately successful approach taken and the important and original contribution his work has made to the field of muscle biology.

The evolution of mammalian noncoding RNAs and their expression in development and immunity

Kenneth Chung-Ren Pang, Department of Medicine, Austin Hospital/Northern Hospital

The discovery and elucidation of the functional biology of ncRNAs is a key objective in biology, as their reach into fundamental cellular processes seems endless. Providing ncRNA database resources, identifying new groups of ncRNAs and proving their functional role in specific cellular functions are high priorities in the area. Kenneth explored the hitherto hidden role of non-protein-coding RNA in mammals. In studies carried out in Melbourne, Brisbane and Tokyo, he showed that most of the genome is transcribed, identified thousands of new genes, and developed new databases, leading to eight publications in prestigious journals, including the journal Science.

Allosteric modulation of G protein-coupled receptors

Lauren May, Department of Pharmacology

Lauren comprehensively investigated the allosteric modulation of G protein-coupled receptors, using prototypical receptors for this field. Her examination included the role of cysteine modification in the actions of allosteric regulation of A1 receptors. This work has resulted in important new insights into receptor function and the development of novel drugs. Her thesis has resulted in six first-author papers in journals including British Journal of Pharmacology, Journal of Pharmacology and Experimental Therapeutics and Molecular Pharmacology.

The potential of stem cells for neuronal replacement in the deafened mammalian cochlea

Bryony Coleman, Bionic Ear Institute

Bryony investigated the potential of stem cells to provide replacement auditory neurons to the deaf cochlea. These studies describe important cues for the differentiation of auditory neurons in vitro, and suggest strategies for their successful engraftment in vivo. A more robust auditory nerve may improve cochlear implant performance. International recognition of her research included publication of papers in high impact peer-reviewed journals, including the journal Stem Cell and funding to attend international conferences. Following the completion of her PhD, Bryony received a Victoria Fellowship which she used to complete an advanced stem cell training course in Los Angeles before spending time at Harvard University and Johns Hopkins University. Her research has the potential to achieve significant public health benefits in hearing science and has the potential for application in other areas of medical biomics and neuronal degradation.

On the autonomy and specificity of human mirror system - neural and behavioural studies on the perception and execution of action

Trevor Yihan-Jia Chong, School of Behavioural Science

Trevor investigated the properties of the human ‘mirror neuron system’—a network of brain areas underlying our ability to execute actions and perceive those of others. Over the course of his doctoral degree he completed an extensive series of behavioural and neuroimaging investigations exploring the parameters which govern the function of the mirror system in humans. The findings of these studies have important implications for theories of action recognition, imitation, socialisation and language evolution. His research facilitates a deeper understanding of the evolutionary links between mirror neurons and the human capacity for imitation, empathy and language and provides important clues concerning the neural basis of such clinical syndromes as autism and apraxia, which are thought to be due to lesions in the putative human mirror system. His thesis has resulted in publications in journals including NeuroImage and Psychological Inquiry.

FROM OUR COLLECTION

THE GERARD CROCK COLLECTION

The compact lens corneal cutter (see page 34) and stereo fundus camera, developed by Gerard Crock and his team at the Department of Ophthalmology, both form part of a large collection of over 1000 items, comprising photographs, documents, design drawings and instruments, which he offered to the Medical History Museum in 2003. Funding for the huge task of sorting, identifying, cataloguing and preserving the collection was provided for by the John Reid Charitable Trusts, whose generous donation of $10,000 has seen the project completed, culminating in a commemorative exhibition, Microsurgical Innovation: Ophthalmic Instrumentation, currently on display at the Medical History Museum.

Many of the instruments and diagnostic methods and equipment Professor Crock introduced are still in use today. Some have found application in areas other than ophthalmology, most notably in reconstructive micro-vascular surgery, whilst others have provided the basis for subsequent research and development by later ophthalmologists and biomedical scientists.

This exhibition, and the Gerard W Crock collection from which it is drawn, are a wonderful resource to inspire and attract the attention of future designers and researchers as an example of what can be achieved through fine leadership and the enquiring minds of a team of highly talented and original thinkers.

The Medical History Museum is located on level two of the Brownlee Biomedical Library on the University’s Parkville campus, and is open from 9am to 5pm, Monday to Friday.

Contact details:
T (61) 3 8344 5719  F (61) 3 9347 7762
E brohacs@unimelb.edu.au
W www.cfish.unimelb.edu.au/programs/mhm/museum
**Books**

**Holding Men: Kanyirminpa and the Health of Aboriginal Men by Greg de Moore, Aboriginal Studies Press, 2008**

Paperback, pp296, illustrated, rrp $34.95

True wellbeing and happiness come from understanding the history of medicine or health care development, the result of what we do to maintain our physical, emotional, intellectual and spiritual fitness. However, acquiring and keeping that balance isn’t always easy. Popular chef Gabriele Gaté and Rob Moodie (MBBS 1976) have drawn on their vast experience in these areas to help their readers get the most out of life. The result is a collection of nourishing recipes—each a difference—uniquely combining Gabriele’s inspiring and healthy food recipes, and Rob’s stimulating step-by-step recipes for body and soul.

**Trachoma**

A blinding scourge from the bronze age to the twenty-first century by Hugh N Taylor, 2008.

**TRAUMA & INJURIES**

**R&D**

**OUR SUPPORTERS**

We are very grateful for all the support we receive from alumni and the wider community and pleased to be able to list here those who have donated $500 or more between 1 June 2006 and 30 September 2006. Thank you all dedicated donors who wish to remain anonymous.

**Luminaries ($100K+)**

- Allan J Myers, AO, QC & Maria J Myers AO.
- Everdureh Pty Ltd

**Visionaries ($50K-$99,999)**

- Australian Health, Australian Rotary Health Research Trust
- Grant by Professor C V Brown, Inner West Australia, Patrick M Donlon, Robert N Gibson, Melbourne Pathology Pty Ltd

**Principals ($25K-$49,999)**


**Benefactors ($10K-$24,999)**

- Joan A Anderson, Hamilton, Queensland, Australian Society of Endodontology, Australian Society of General Dentistry, Australian Society of Orthodontists Inc, Bay Street Pry Ltd, Everdureh Pty Ltd, James J Tobin, Heston BCB, Corporation Pty Ltd, Footwear Pediatric Laboratory, Andrew A Heggie, Charles Holcoker, JAG Projects Pty Ltd, JGI Investments Pty Ltd, Department of Victorian Railways, Kalgan Pry Ltd, LJCR Investment Group, Medorabin Australia Pty Ltd, Modern Pines Pry Ltd ATG The GE, Opthalmic Laboratories Pty Ltd, John E Permezel, Raministrator Pry Ltd, James B Simpson, TAC, Sunny S Viraraddi, Merrel Wilmot-Weight, Denis Y Young

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