The recipe for an overseas medical elective

Fire off an email or front up in person?
It’s all a matter of preference

Most university students would rather email staff members than go to their office but more than 80% of staff prefer face-to-face communication.

A prompt reply and friendly tone from staff in their emails encourage students to go to see them, an interaction which is seen by staff as more personal, effective, efficient and enjoyable.

These are among the findings of a study by Ms Rachel Dennis, a fifth year Health Science and Commerce student.

Sound communication skills, including appropriate use of language and correct grammar, were cited by both staff and students as factors that enhance email communication.

SMS style language and a lack of courtesy are particular factors that staff believe hinder it. Similarly, one or two word responses by staff members to students have negative impacts.

Ms Dennis said the findings showed it was important for staff and students, who had differing preferences for communicating, to keep their audience in mind.

“Students shouldn’t feel intimidated about going to talk to staff members in person because often they will actually like that,” she said.

“And I think it is really important for staff - and many of them do this anyway - to portray, when they start a unit, what they do prefer and make that clear to students. Some staff do still prefer email because they are too busy to have people coming into their office all the time. They can say ‘Send me an email first and then make an appointment’ or ‘You can come in any time on this day’.”

Students should be mindful that staff were busy and not waste their time by sending “silly” emails, asking for information such as the unit outline, Ms Dennis said. They could also use the WebCT discussion board so that if the question affected all students, the staff member had to reply only once.

Continued page 13

One-stop clinic to detect urinary tract disease

WA’s first one-stop haematuria clinic to enable rapid access to diagnosis for patients with blood in their urine has been established at Fremantle Hospital by a Professor who heads the urological research team in the Faculty’s School of Surgery.

Professor Dickon Hayne, consultant urological surgeon at Fremantle Hospital, said haematuria was a symptom of prostate, renal or urothelial cancer or other diseases but early diagnosis of malignancies could enable prompt treatment.

Data from the first 500 patients through the clinic show about 13% of clinic attendees have a new urological cancer and 1% a new non-urological cancer.

The data also show that 40% of patients attending the clinic are discharged immediately, 22% are discharged after further investigation, 14% will have a non-cancer related operation and about 10% need a further outpatient appointment, of whom 3% need to see a urologist again.

Continued page 11
The building of the Claremont Community Health Centre (CCHC) was a result of the 1973 “Karmel” report into Medical Education in Australian Universities. It recommended the development of departments of community practice that were to be situated in teaching community health centres that would have an educational role analogous to that of the teaching hospital.

A committee of University of WA, Royal Australian College of General Practitioners, Australian Medical Association and Department of Health (WA) representatives chose the Tunbridge Dale and Burns Practice at 328 Stirling Highway, Claremont as the site for the teaching health centre. Their practice was in a Californian Bungalow style house erected in 1920. This architectural style was preserved in the design of the new building and it won the 1979 Western Australian Architects’ Society award. All the building funds came from Whitlam Government project grants.

I was appointed Foundation Professor of General Practice in 1976. I was unhappy about the choice of venue and wanted it to be in an area of unmet medical need where UWA-affiliated GPs could develop a new kind of community-based practice. But the project was too far advanced to stop it. That was the impetus to set up a UWA practice in Lockridge. CCHC was planned to cater for a coterie of allied health professionals and for 150 medical students at the one time. That is why it had 23 toilets. The landlords were jointly DoH (WA) and UWA.

The medical practice still functioned as an independent entity and the obligatory community advisory committee allocated rooms, car parking spaces and bean-bags to a host of local groups that wished to use the centre’s facilities. A children’s playgroup organized by two lawyers took over the western side of the building and refused to leave. They knew the law and how difficult it was for landlords to deal with “adverse possession”.

The community health nurses were fully occupied and their Stroke Club was very successful. The two social workers were underused and utilised their time in developing a Community Resource Index and starting The Aged Persons’ Support Service (TAPSS) that continues to be a boon to the elderly in the western suburbs.

The University Discipline of General Practice (UDGP) and the DoH (WA) had different functions and aims and petty conflict was inevitable. It did provide some light relief from the serious business of patient care and gaining a toe-hold in the medical curriculum. A persistent DoH (WA) complaint was that students drank their Nescafe. This eventually resulted in correspondence between the Vice-Chancellor and the Commissioner of Health. On another occasion DoH (WA) complained to the Medical Board that UDGP was teaching alternative medicine. It was difficult to get the Board, and the then Dean, to understand the difference between teaching alternative medicine and teaching about it.

By 1982 DoH (WA) regarded the CCHC as a white elephant. It removed its staff and handed the lease of the CCHC to the UDGP. The DoH (WA) had different functions and aims and petty conflict was inevitable. It did provide some light relief from the serious business of patient care and gaining a toe-hold in the medical curriculum. A persistent DoH (WA) complaint was that students drank their Nescafe. This eventually resulted in correspondence between the Vice-Chancellor and the Commissioner of Health. On another occasion DoH (WA) complained to the Medical Board that UDGP was teaching alternative medicine. It was difficult to get the Board, and the then Dean, to understand the difference between teaching alternative medicine and teaching about it.

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By 1982 DoH (WA) regarded the CCHC as a white elephant. It removed its staff and handed the lease of the CCHC to the UDGP. We ran the building at one sixth of its previous overheads. In 1988 DoH (WA) tried to give the building to UWA. Negotiations broke down and in 1990 it was put on the market as part of the State Government’s WA Inc. asset sale.

There was no interest in it and UWA finally bought the building for a song. Thus it became, not an endowment property, but a UWA investment property.

My intention was to get all the GP teaching groups under the one roof. For almost two decades CCHC housed the UDGP, its Community Health, Research and Training Unit run by Associate Professor Peter Underwood, WA Centre for Remote and Rural Medicine (WACRRM) directed by Dr Bill Jackson and then Dr Brian Williams, the RACGP, its Family Medicine Program run by Dr Richard Nowotny and an After Hours Medical Service. All students, GPs and the public knew it as the centre where GP educational activities took place, the staff were helpful, information and a library were available, and where parking was easy. From my point of view CCHC had metamorphosed from a lemon to a grade 2 navel orange.

But, differently funded, General Practice organisations have always had a
Teamwork is the key to better patient care

By Winthrop Professor Fiona Lake, Head of the School of Medicine and Pharmacology

It is a great privilege to be a doctor. Stimulating. Challenging. Satisfying. It allows me into people’s lives, thoughts and stories and through those vicarious experiences, my own life becomes richer. It is fully absorbing and a part of my work I would not change.

I felt I worked well with other health professionals, especially physiotherapists and nurses, completing research and of course caring for patients in hospital settings over many years. But it is only in the last 10 years I have really understood the roles we all play as regards patient care. Although I was open minded and worked hard at communication, I was time poor and too focused on my own decision making and provision of care to truly understand what everyone else was doing. Two events matured my understanding of the complementary contributions health professionals make to patient care.

Firstly, when we established the COPD (Chronic Obstructive Pulmonary Disease) Community Linkage Service set up in the community and linked to Royal Perth Hospital, two nurses, a physiotherapist and I worked as a team. We saw (and measured) the significant benefits with quality of life, exercise capacity and reduced admissions and length of stay. We ensured patients understood and adhered to treatment, be it stopping smoking, exercising or using puffers. One patient spoke little English. In a review, planned treatment included nurse follow-up at home. The nurse was greeted repeatedly by a scowling patient who spoke no English. But she persisted and he gradually thawed. One day she was greeted by a smiling, welcoming patient who spoke English! Persistence paid off and trust was established. I could never have achieved that in a few, short clinic appointments. Yet when the program was evaluated, the patients recognised the impact of the nurse and physiotherapist but it was me, the doctor, they wanted to see more of. Although that felt good, it was more important to educate patients about the team, the limits of my role and the important role of others.

My second experience was sitting at the bedside of my very elderly mother-in-law, who was not dying quickly enough for her liking and with her persistent demands that God take her, could be challenging. She was a lovely lady but in truth, let us face it, getting old is not beautiful. Yet it was the continual patient loving touch of the nurses, speech pathologists and so forth that gave her what she needed, with dignity. Sitting with the elderly ladies, I realised it was the doctor’s visits they looked forward to, usually lasting a few minutes, but I could see the hard yards being put in by the nurses, who really got to know patients’ needs and fears.

Better than isolation

Interprofessional care that is patient focused provides safer, better care than when we work in isolation. Interprofessional education is the flavour of the month (well year[s]), and an essential ingredient of many grants. It is defined as when “two or more professions learn with, from and about each other to improve collaboration and quality of care.” (CAIPE, UK). But can interprofessional education get students up to speed quickly? Mature them rapidly?

The evidence is mixed, many studies of poor quality and terms are confusing. But when students have clinical placements together, it improves not only their knowledge and attitudes but those of teachers. So placements where students have authentic tasks, that meet both individual profession and interprofessional outcomes, seem most successful. Attachments where students have to perform other disciplines’ tasks are evaluated poorly, re-emphasising this is not about a generic workforce but multiple professions with complementary roles.

So what is happening here in WA? In 2007 the Department of Health held a Clinical Senate on educating the workforce and recommended “that IPL (interprofessional learning) should be mandatory... Every entry level health professional must achieve competency...they must pass before they work in Western Australia.”

Many champions

A range of champions of IPE (interprofessional education) are in Perth, at all universities, in the Health Department and health services. Associate Professor Denese Playford, of the Rural Clinical School of WA, was a founding member of the Australasian Interprofessional Practice & Education Network (AIPPEN). At UWA, Professor Sandra Carr, Associate Dean (Teaching and Learning) and colleagues have defined the interprofessional outcomes to be embedded in the new course and which are being addressed in the current course. The foreshadowed addition of Pharmacy to our School offers excellent opportunities, with medication error being a major problem as regards patient safety. This year has been an exciting year. With grants totalling more than $1 million obtained by our School from the Department of Health and Ageing (and Health Workforce Australia), along with nursing at UWA, we have interprofessional groups of students in Sir Charles Gairdner Hospital Outpatients, with Dr Sarah Pickstock, placements in Silver Chain and with the support of Dr Penny Flett, in the Brightwater Group facilities, placed with Curtin University students from a range of professions. At Royal Perth Hospital, thanks to the drive of Dr Ted Stewart-Wynne, a student training ward has been established with students from a number of universities. Associate Professor Rosemary Saunders, Course Coordinator of the Master of Nursing Science, has obtained more grants to work with Bethanie Health Care to establish an interprofessional simulation ward linked to the adjacent aged care facility.

Student feedback is mostly positive but many challenges remain, including having a shared understanding between different institutions of what interprofessional education is; making timetables fit so teams can form, meeting both interprofessional and profession specific outcomes and working in new settings where staff development is essential. Perhaps it is paranoia but the elephant in the room is the undercurrent that maybe the need for all of this is because of doctors with their desire to hold onto power and concern they now appear champions of the cause. But indeed those who feel threatened come from many professions and it is personality rather than profession that may be more important.

So when you are next forced to slow down and take up the role of a family member or even a patient, I hope you can look around and see how all health professionals are frantically busy, but with good teamwork and recognition of the complementary roles we play, patients will be better off in the future. If you can see this, then make sure all our students understand it too.

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R

esearch findings ranging from optimal use of emails between staff and students to the success of a new Institute for psychiatry were highlighted at a new Faculty annual event.

The inaugural Education Research Symposium provided a forum for the dissemination from all the Faculty Schools of projects and best practice across many areas of medical and health professional education.

The symposium, held earlier this year, featured 25 presentations by staff and students.

Some of the research is featured in the following pages.

The topic of “Fitness-to-practise policies in Australian medical schools – are they fit for purpose?” was covered in the March 2011 issue of MeDeFacts and the subjects of “Evaluation of an innovative approach to recruitment of medical students to a career in psychiatry” and “Web-based learning modules in surgery” are covered in wider features in this issue of MeDeFacts (see pages 5 and 6).

All at the symposium were asked to vote for the best staff and student presentations on the day.

Associate Professor Prudence Manners, of the School of Paediatrics and Child Health, was awarded the Best Staff Presentation for her talk “Can clinical medicine be taught effectively totally online?” The development of the virtual clinical course for the Graduate Certificate of Paediatric Rheumatology was featured in the September 2009 issue of MeDeFacts.

The Best Student Presentation was won by Rachel Dennis, a fifth year combined Health Science and Commerce student, for her talk on “Perceptions of how email affects student-staff interactions beyond the classroom: expectations and criteria” (see page 1).

Other topics presented on the day were Virtual reality teaching tools for dentoalveolar oral surgery; A pilot study of the use of peer assisted learning (PAL) in the teaching of musculoskeletal medicine; Student access to patients in an emergency department; Teacher perspectives of the first year experience; Ensuring quality graduates of pharmacology: a survey of Australian students; Answering Clinical Questions: a web based resource for evidence based practice [EBP] teaching and learning in the FMDHS; The use of the audience response system for medical student participation and learning; Curriculum development – preparation for internship with student grand rounds; Interprofessional learning and collaborative practice in the Faculty of Medicine, Dentistry and Health Sciences; Using “PROMPT” simulation training for medical students; Making a difference: evaluating the impact of an Aboriginal health undergraduate medical curriculum and its translation into other health professional degrees; Peer-assisted learning in teaching clinical examination to junior medical students; Health industry practicum: preparing health science students for employment; Is MCQ marking without negative marking fair, is there an inconsistent bias; Feeling of otherness: non English speaking background (NESB) overseas; Does peer observation of teaching with feedback create an improvement in teacher performance?; Correlation between the self reflection and insight scale with admission processes for entry to the UWA MBBS course; and Evaluation and review of the SWIH LMS/ CATL project.

A Faculty rich in research

25 top projects highlighted

Award winners:

- **Individual Teaching Award (UWA employee)**
  Winner: Assistant Professor Helena Iredell

- **Individual Teaching Award (Sessional staff and non-UWA employees)**
  Winner: Dr Karen Moore

- **Team Teaching Award**
  Winner: Associate Professors Dianne Cammody and Alexandra Tregonning
  High Commendation: Associate Professor Rosemary Saunders and Assistant Professor Olivia Hill

- **Small Group Teaching in a Clinical or Practicum Setting (UWA employee)**
  Winner: Associate Professor Richard Turner
  High Commendation: Associate Professor Jennifer BaZen

- **Small Group Teaching in a Clinical or Practicum Setting (non-UWA employee)**
  Winner: Dr Jason Tan

- **Small Group Teaching on Campus**
  Winner: Associate Professor, Anna Parker

- **Postgraduate Coursework**
  Winner: Associate Professor Barbara Singer
  High Commendation: Dr Rebecca Crawford

- **Early Career Award**
  Winner: Dr Anastasia Phillips

- **Outstanding Contribution to Student Learning**
  Winner: Professor Jane Heyworth
  High Commendation: Assistant Professor Helena Iredell

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2011 Excellence in Teaching Awards

The Sub-Dean for Health Science has had back to back wins in this and last year’s Excellence in Teaching Awards ceremonies held by the Faculty.

Professor Jane Heyworth, of the School of Population Health, was the recipient this year of the prestigious award for Outstanding Contribution to Student Learning and last year she was awarded the Individual Teaching award.

Professor Heyworth was also nominated for a 2011 Australian Learning and Teaching Council Citation for Individual Teaching Excellence.

The Faculty awards were presented at the conclusion of the Education Research Symposium. This year 47 staff were nominated for an award with 30 accepting their nomination. Nominations are now open for the 2012 Excellence in Teaching Awards until 31 October. The link to the nominations page is http://www.meddent.uwa.edu.au/staff/teaching/awards
A program designed to attract medical students to a career in psychiatry - the first of its kind in Australia - is proving so successful that students are competing to attend the week-long program.

In the four years since the Claassen Institute of Psychiatry for Medical Students was established by the School of Psychiatry and Clinical Neurosciences, 66 students, including some international students, have attended the free program. It involves interactive seminars on topics including forensic psychiatry, cultural psychiatry and women’s mental health. Also, elective sessions are arranged with local mental health service providers such as an accommodation provider for people with schizophrenia and a carers’ organisation.

Assistant Professor Zaza Lyons, of the School of Psychiatry and Clinical Neurosciences, said participation in the program was becoming competitive. “I receive more applications than I have places available,” she said.

One of the main aims of the Institute, which is based on a Canadian concept and is widely supported by psychiatrists, registrars and mental health professionals locally, is to encourage more students to choose psychiatry as their specialty - and feedback suggests it is succeeding.

“Psychiatry isn’t a very popular career choice for students and this results in a shortage of psychiatrists to work in public hospitals and other mental health services,” Assistant Professor Lyons said.

“And we know the prevalence of mental health illnesses is high and growing.”

Some sub-specialties, including child and adolescent psychiatry, were severely affected.

But research shows that the Institute is having an impact. Data on the 50 students who attended in 2008, 2009 and 2010 show that interest in psychiatry and knowledge of psychiatry increased significantly.

The number of students “definitely considering” a career in psychiatry increased by 38% at end of the program.

Assistant Professor Lyons said the Institute enabled organisers to introduce students to areas of psychiatry to which they may have had no exposure in the undergraduate medical course, and also to mentors and potential colleagues.

In addition, the program gives students an idea of the role of some of the community organisations that provide mental health services. For example, in the first three years of the program, the students visited 20 different mental health service providers around the metropolitan area as clinical elective options.

“For students interested in psychiatry, attending the Institute is a fantastic opportunity to enable them to explore the wonderful world of psychiatry and what it has to offer, and see if it’s for them,” Assistant Professor Lyons said.

“It is getting a good reputation among students.”

Assistant Professor Lyons and Associate Professor Kellie Bennett, also of the School of Psychiatry and Clinical Neurosciences, are co-authors of an overview of the Institute.

A group of students who attended this year’s Institute were so motivated by their experience of the week’s events that they have set up a student organisation called “Students Passionate About Mental Health”.

SPAMH aims include “raising awareness about the link between mental health and general health and wellbeing and promoting a positive perception of mental health services.”

The vision is to develop a community-based approach to mental health characterised by easy-access, low stigma and optimism.

The students joined the School of Psychiatry and Clinical Neurosciences at the recent UWA Open Day and organised several activities for visitors to participate in. Further activities are planned including a Q & A panel discussion to be held during Mental Health Week in October.

“It’s very impressive that the students have been inspired to address important issues in mental health such as reducing stigma and demystifying psychiatry,” Assistant Professor Lyons said.

“They are very committed and have achieved a lot in a short time.”
Online learning for surgery

Interactive web-based learning modules for fourth year medical students have been developed by a WA team, led by the School of Surgery.

Professor Dickon Hayne said the modules included videos, interactive diagrams, clips of endoscopies and other information.

His group received a teaching and learning grant two years ago, which helped them produce four urology modules and two more are being planned.

A further grant enabled them to develop four general surgery modules, which were released recently. All modules cover clinically relevant topics, can be readily updated, and have been made available free to medical students at UWA and the University of Notre Dame.

“The aim is to have core content available 24/7 (to students) but the modules also include a pre- and post test,” Professor Hayne said.

Industry sponsorship has meant DVDs can be produced for distribution to senior urological and surgical nurses around Australia.

Mental health of medical students under the ‘scope

Non-migrant medical students suffer more psychological distress than migrant students, according to surprise findings of a recent study.

Females and students in pre-clinical rather than clinical years are also more likely to be distressed.

The study also found that although coping mechanisms were largely similar between migrants and non-migrants, there was a statistically significant increased use of denial/blame and religion/faith among migrants to help them cope.

Dr Joseph Luo, a former Faculty medical student who graduated last year, conducted an exploratory study into psychological well-being and coping styles in UWA medical students, comparing migrants and non-migrants.

He was asked to present his findings at the New Zealand conference of the Royal Australian and New Zealand College of Psychiatrists held in September.

Dr Luo, an intern at Sir Charles Gairdner Hospital, said some of the findings were unique.

“What we would usually find in most of the other literature is that migrant mental health tended to be poorer and this study proved otherwise,” he said.

The study was also unusual in that it compared pre-clinical with clinical years, finding that those in the clinical years fared better stress-wise.

Dr Luo said the links between immigration, mental health outcomes and coping mechanisms had never been thoroughly investigated in medical students.

In the study, 114 migrant and 93 non-migrant medical students in the Faculty were assessed for mental health status using the Self-Reporting Questionnaire (SRQ), an established screening instrument devised by the World Health Organisation, which consists of 20 simple yes/no questions relating to the participant’s experience of life over the past 30 days.

The students also completed a Coping Checklist (CCL-II), which involves 70 yes/no questions on each participant’s habits in dealing with stressful situations and difficult problems. The results of the two groups were compared statistically.

The average SRQ scores were 3.09 in migrants and 4.18 in non-migrants.

Continued page 7
An online tool box to solve clinical conundrums

A n open online resource is helping students and staff in medicine, dentistry and all other areas of health care to answer patient problems around the clock by improving their skills in using the world’s evidence base.

Professor Anna Nowak, of the School of Medicine and Pharmacology, said that patients did not necessarily fit into a simple mould and some clinical problems needed an individual search for answers. The new web-based resource, called Answering Clinical Questions, was available 24/7 and filled a gap for students and practitioners.

“Rather than memorising the facts, they really need to have in their tool box ways to find the answers to patient problems, because medicine is too broad now for anyone to know or understand everything,” she said.

The same went for dentistry, podiatry, nursing, physiotherapy and all health care practice.

“Information is so readily available that we need to be able to efficiently find it and assess it to make the right decisions, even if it is in a field we don’t know or understand well,” Professor Nowak said.

From the time the website went live in January last year up until the end of November, there were 3,144 hits from 40 countries.

The team who developed the resource consists of Professor Nowak, Associate Professor Diana Jonas-Dwyer and Ms Fiona Leece, both of the EdCentre, Dr Carol Newton-Smith, former chief medical librarian, and librarians Ms Belinda Shilkin, Ms Gina Sjepcevich, and Ms Felicity Renner.

The four modules in the resource that guide practitioners to answer clinical questions using an evidence based practice approach are: Formulate a clinical question, Find the best evidence, Appraise the evidence, Apply the evidence.

Professor Nowak, a medical oncologist at Sir Charles Gairdner Hospital, said she told students that answering clinical questions was like clinical examination.

“When you start out, you are going through the whole routine, step by step, but you need to take those baby steps first and when you are a practitioner, you will be picking and choosing what you need from the clinical examination,” she said.

It was the same with evidence-based medicine. “If we get people to understand the more laborious step-by-step approach, then when they are in practice they can put it all together and quickly and efficiently retrieve and appraise the information,” Professor Nowak said.

The development of the resource was prompted by the fact that previously there was poor student knowledge and skills in how to find quality information, interpret it and apply it in clinical practice.

“There wasn’t a culture of training when the students actually needed it. Although they received training in the early years, by the time they went to clinical years, the emphasis was more on teaching from the experts – the ward teaching, the apprenticeship model and textbooks,” Professor Nowak said.

“But there are so many combinations and permutations of biology that you can’t always fit your patient into something that other people have seen or that you’ve learnt about in textbooks.

“So you have got to be able to go to the literature and look at what is most important for that patient.”

Professor Nowak said students had been very positive about the online resource.

“But many staff are still teaching the way they’ve always taught, although they have now incorporated the website address into the student workbooks and handbooks,” she said.

It would be helpful if staff embraced it more fully, such as by referring students to the website as the resource to help them answer a problem posed by the staff member.

One of the barriers to using evidence based practice to answer clinical questions was a perceived lack of time, Professor Nowak said.

The solution was to understand the resources available to find answers quickly and effectively.

The Faculty Dean, Professor Ian Puddle, had kindly given the team a grant from the Faculty which had enabled them to hire a web designer and fund an evaluation of the resource, she said.

The next goal was to develop an iPad app of the resource, if a funding partner could be found.

Overall, the use of religion/faith was associated with less mental stress while denial/blame was associated with more stress.

Dr Luo said the better mental health among migrant medical students might be due to a number of factors, including increased family linkages, increased financial support, religion/faith based coping mechanisms or non-disclosure.

The findings could help staff by giving them a greater awareness of the differences in mental health among migrant and non-migrant students, Dr Luo said.

“It also gives them a bit of an idea of what kind of coping mechanisms are used and how different students might respond differently to the stresses of university and medical school,” he said.

The findings were likely to be applicable to other Australian medical schools, he said.
Tips on dental problems that could crop up in a country practice were given by three third-year dentistry students to medical students attending an annual rural health conference held in Fremantle last month.

Jenny Hanna, Ryan Moldrich and UWA medical graduate Dr Jen Martins ran a workshop at the conference, which was organised by SPINRPHEX (Students and Practitioners Interested In Rural Practice Health Education Xcetera) and WAALHIIBE (WA ALlied Health Interested In Bush Experience) and held at Notre Dame University.

The conference is a day-long mixture of workshops and presentations by speakers from medicine, dentistry, nursing and allied health.

Dr Martins said the aim was to alert medical students to the fact that they needed to look into the mouth when doing a check-up because of the potential health problems that could be picked up.

“We did oral hygiene and what to look out for in the mouth,” she said. They also went through a fissure sealant preparation with the students to show them a simple dental procedure that is a preventative measure against caries.

“We were trying to explain that in a rural setting it is not always easy to get to dentists and access dental care and you need to manage things in the rural setting before you send them to a dentist,” Dr Martins said.

Associate Professor Alistair Devlin, of the School of Dentistry, said he was impressed that the three students had given up their time when dental students had the highest workload of any on the campus.

“ar see these students to go out and do this over and above an already very full timetable, I was pleasantly surprised,” he said.

There is a useful life for extracted teeth - and our future dentists are the ones using them.

Under a project initiated just over 12 months ago, a School of Dentistry Associate Professor has been sent almost 1000 teeth from about 45 WA dental practices.

The donated teeth are used in the training of dental students in their pre-clinical years and have enabled the number of exercises to be increased.

Associate Professor Erica Yates, Co-ordinator for Operative Dentistry Units, said it was very important that students had the opportunity to work on natural teeth in preparation for their clinical practice.

“When plastic teeth are used, each tooth type is reproduced in the manufacturing process so that there is no variation, whereas in real life clinical practice, variations in teeth occur between each patient treated,” she said. “Nothing quite matches up to the real thing.”

In addition, the students needed to experience first-hand the different textures of diseased tooth structures and learn to differentiate between healthy and unhealthy dentine and enamel.

“It cannot just be explained to the student,” Associate Professor Yates said.

The teeth were used across the first three years of dentistry by about 170 students in courses ranging from the introduction of basic drilling to some of the specialised disciplines such as endodontics, when students learnt root canal and other treatments.

Before the donated teeth were handled by the students, they were rigorously sterilised.

Associate Professor Yates said although there had been a trickle of donated teeth for many years, the formal project dubbed “Put Some Teeth Back Into The School of Dentistry” started last year.

She had originally driven to practices all around the metropolitan area to collect the teeth but it was too time-consuming so now dentists were sent an Australia Post-approved, postage-paid package which they returned with the collected teeth.

“We are so grateful to those dentists and practices who participate,” she said.

Although there had been significant support from dentists, the School was always in need of more teeth.

If you are willing to take part in the project, please e-mail Sheona Harrison at sheona.harrison@uwa.edu.au or call her on (08) 9346 7676.
Tap into an app for Dx

Doctors, medical students and other clinicians will be able to consult their iPads for a bundle of instant information to guide them to the most accurate diagnosis and appropriate treatment for patients, if a Faculty professor and others have their way.

The package would include evidence-based information on pathology testing, diagnostic imaging and clinical referrals.

An iPad application to help clinicians choose the most appropriate and cost-effective diagnostic imaging examinations is already a reality and is being scooped up by users worldwide at a rate of 3-6 downloads a day.

The app, called Diagnostic Imaging Pathways (DIP), was developed by Clinical Professor Richard Mendelson, of the School of Surgery, with other doctors and the UWA Centre for Software Practice (CSP). It was launched in July and costs $25.

Clinical Professor Mendelson, who is a consultant radiologist at Royal Perth Hospital, said the goal was to combine laboratory test guidelines with the diagnostic imaging guidelines.

“So it will be a more comprehensive diagnostic guideline rather than a diagnostic imaging guideline,” he said.

“And clinical referral guidelines could go even one step further.”

A package of combined guidelines would help doctors to investigate and prioritise patients clinically, Clinical Professor Mendelson said.

Development of the new apps would depend on funding, which was mainly coming from the sale of the DIP application at present.

Clinical Professor Mendelson said although the app was new, DIP had been available on the internet with an image gallery for about nine years and was widely acclaimed.

“We get over five million hits a year from all over the world,” he said. “It has a dual functionality. It is partly a decision support tool to help doctors decide the most appropriate examinations but it is also very much geared to be an educational tool for junior doctors and medical students.”

The stand-alone iPad app had the advantage of not requiring internet access once downloaded and it was hoped a similar app for smartphones would be developed soon.

DIP, which includes more than 130 pathways covering the major organ systems and common clinical scenarios, is updated about every three months.

Clinical Professor Mendelson said diagnostic imaging accounted for 15% of the Medicare budget and the associated technology was becoming increasingly complex and expensive.

“There is more and more choice for referring doctors,” he said. “It is hard enough for people in the field like myself who are radiologists to keep up to date, let alone people who aren’t in the field, like GPs or general physicians.”

It was known that a high percentage of diagnostic imaging requests were incorrect or inappropriate. “It may be the wrong test or it may be that there is no test actually required,” he said. “So this is to help doctors choose the right test or indeed no test if that is appropriate because the tests have costs and risks and we don’t want that cost or risk to be without potential benefit.”

CSP director Associate Professor David Glance said DIP included best-available evidence for the various types of diagnostic imaging. “For example, if you have a particular condition, you may not need to take a CT scan,” he said. “An ultrasound might give you just as much information and it can be done in a clinic or as a walk-in patient.”

Last year, the CSP launched iPad and iPhone apps for its web-based clinical system called Medical Message Exchange (MMEx), used by more than 7000 health professionals in Australia for information sharing and clinical patient management.

MMEx users include GPs, specialists, the WA Health Department and Aboriginal health services including the Kimberley Aboriginal Medical Service.

The apps allow doctors and other health workers to access clinical information such as patient records, pathology and X-ray results, and medications, wherever they happen to be.

One of the apps is Wounds West, a wounds advisory service used by the WA Health Department. “It allows nurses to take photographs of wounds and send them through to the wound specialists, who can track the healing and give advice on the management,” Associate Professor Glance said.

“An iPad application also hooks up with a retinal camera. So diabetic patients, especially Aboriginal patients, are checked and a photograph is taken of the retina which is sent down to the opthalmologist to have a look at.”

The ophthalmologists, based at the Lions Eye Institute, review and send back referrals.

Another app plays a role in screening for hearing. Photos of ears are taken with a video camera built into an otoscope and specialists at the Telethon Speech and Hearing review the images in Perth.
A nationwide research collaboration for paediatric anaesthetists is one of the priorities of the inaugural Chair of Paediatric Anaesthesiology in the Faculty.

Winthrop Professor Britta Regli-von Ungern-Sternberg said there was no framework at all because she was the first Chair. “But one of my goals is to establish a good working research group with local, national and international collaborations,” she said.

The scheme could involve academics as well as clinicians from universities and teaching hospitals around the country that offer specialist training in the area. “The Chair could be a linkage point to make it happen,” she said. “It is a very small population of paediatric anaesthetists so with research we have to work together.”

Professor Regli-von Ungern-Sternberg also has her sights on helping formulate guidelines for paediatric anaesthesia that aid knowledge and training.

“I want to help set up guidelines with my clinical colleagues,” she said. “The advantage in WA is that we are part of an environment bringing together highly skilled paediatric anaesthetists from around the world who bring different ideas, views and experience into our workplace. This allows us to discuss the best approach for certain clinical scenarios.”

The professor, who hails from Switzerland, took the role on last August, four years after moving to Perth. The mother of two returned to clinical practice at Princess Margaret Hospital for Children this month, after six months’ maternity leave. She is part of the School of Medicine and Pharmacology, spending half her time doing clinical work and the remainder as an academic with research and teaching.

Her main interest in research is preventing respiratory complications, which account for more than three quarters of all critical incidents in paediatric anaesthesia and nearly a third of all cardiac arrest during paediatric anaesthesia. Her ultimate goal is to encourage research that will make anaesthesia safer for children.

“It is a hugely important topic and we don’t know a lot about it,” she said. “We knew of some factors which might have an impact but didn’t know how big that impact was.”

She was lead author for a study which appeared in The Lancet last year, which found that a risk assessment questionnaire could be used in everyday clinical practice to identify the likelihood of anaesthetic complications in children before they underwent surgery. (See MeDeFacts, September 2010). Between 11,000 and 12,000 children are anaesthetised at Princess Margaret Hospital each year.

Professor Regli-von Ungern-Sternberg said paediatric anaesthesia was safe. “It is very rare for a child to have a serious event during anaesthesia because compared with adults, children are in general more healthy,” she said. “Adults who undergo surgery often have other illnesses, which may make the adult risk higher.”

In addition to clinical medical students, she now has 12 research students under her wing who do research projects in their fourth year of medical studies.

“We had to create more positions because of the overwhelming interest,” she said. “Initially we just put it out for two to three students but we got 40 applicants.”

The professor also currently supervises 11 anaesthetic trainees who are doing research as part of their formal project during their anaesthesia specialist training.

- By Amanda Saunders
**One-stop clinic to detect urinary tract disease**

Continued from page 1

“So if you have visible blood in your urine and you are referred by your GP to the haematuria clinic, you have got about a one in five chance of having cancer,” Professor Hayne said. “Unfortunately a lot of patients with blood in their urine don’t get referred immediately.”

At the one-stop clinic, patients are assessed, see the urologist, undergo imaging and cystoscopy and, if surgery is indicated, they go straight to the pre-admission clinic.

“So theoretically, they can have one trip and be on a waiting list for surgery,” Professor Hayne said. Previously, there was a 1-2 month wait to be referred to the urology outpatients department and a further wait if tests such as imaging were needed.

The clinic, which was set up using a $30,000 grant from the WA Cancer and Palliative Care Network, is run weekly and six patients are seen each session.

Statistics show that about 12 per 100,000 people are diagnosed every year with bladder cancer in Australia. But Professor Hayne said the prevalence of cancer of the bladder was under-estimated by about 50% because cancer registries did not include non-invasive bladder cancer in their statistics.

“Bladder cancer is a significant cause of male cancer death, causing a similar number of male deaths as melanoma,” he said. “Bladder cancer survival in Australia is actually getting worse and is one of only a very few cancers where this is the case.”

Professor Hayne said he feared this was due to inadequate referral of haematuria. It was to try to redress this that he set up the clinic at Fremantle Hospital.

He hopes also to establish a one-stop prostate cancer diagnosis centre to give country patients rapid access to services. “They could come directly to see a urologist and there would also be a specific prostate clinic nurse,” he said. “They will be assessed and if they need a biopsy, they will have one. If they don’t have prostate cancer, the clinic nurse will be able to tell them directly their results so they don’t have to fly down again to Perth just to get their results. The nurse will also arrange any other appropriate urological follow-up with their GP.”

However, if the patient was diagnosed with cancer, they would need to make further trips to Perth for treatment.

Professor Hayne said the aim of the proposed centre was to reduce the chance of country patients being lost to follow-up.

Professor Hayne said urology was a very under-represented surgical specialty. “If you exclude squamous cell carcinoma of the skin and are counting invasive and non-invasive cancers, we actually see more cancer than any other specialty,” he said. “More than 20% of the oncological throughput in the state actually comes through urology services.” Urologists deal with prostate, bladder, kidney, renal, testicular and penile cancer.

- By Cathy Saunders

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**Bladder cancer trial mooted**

Research into optimal treatments for bladder cancer is on Professor Hayne’s agenda. He leads a group planning a national trial of intravesical (into the bladder) therapy in which chemotherapy will be added to the standard immunotherapy treatment of BCG in patients with high-risk, non muscle-invasive bladder cancer.

Professor Hayne said BCG was the only treatment to date that had been shown to stop the progression of the cancer. The innovative aspect of the trial was the addition of a chemotherapy component using mitomycin.

A successful pilot study of the combination treatment, the first of its kind in Australia, had led to the formation of a national group, which had applied for funding for the national trial. The aim is to recruit 500 patients. The control group will receive BCG only.

If progression of the cancer could be halted, it could prevent the need for radiotherapy or for a cystectomy, resulting in a stoma, Professor Hayne said.

But 40-50% of patients with high-risk, non muscle-invasive bladder cancer did progress, even with best treatment, he said.
by Robert Marshall

I decided to undertake my six-week medical elective in Haiti on my way home from a year abroad in France, after reading the front cover news story about the earthquake that had devastated the Caribbean nation just two days earlier.

It wasn't the natural disaster that inspired me to go, or that Haiti is a French-speaking nation, or even the prospect of learning about medicine in a developing country, the poorest in the Western hemisphere. It was the photo.

A young woman, maybe in her late twenties, is emerging from the rubble in the capital, Port-au-Prince. Around her, large slabs of concrete are broken into pieces as if they were scraps of paper. Her expression is of absolute disbelief as the world around her had literally come crashing down.

How could this happen? What would happen to a country with no infrastructure and virtually no health system when the thousands of injured and dying earthquake victims needed medical help?

I decided to find out for myself.

Over the course of the year as I organised my elective, the situation in Haiti went from bad to worse. The death toll rose to a staggering 230,000, but the short attention span of the world had begun to wane. It wasn’t until later last year that further disasters drew attention back to the struggling nation. Flooding caused by the hurricane season washed out many of the temporary homes set up in crowded “tent cities” around Port-au-Prince. The mass homelessness due to the combination of the quake and crippling poverty had reached the 1.6 million mark and unemployment was up to 80%. Moreover, an epidemic of cholera broke out in October that has killed almost 5,000 people to date. Haiti was also struck by a political crisis due to disputed presidential election results. Mass rioting, road blockades and political unrest ensued.

It was among this political, medical and environmental chaos that I finally landed in Port-au-Prince to start work in a free, volunteer-run primary care clinic in the neighbouring suburb of Croix-des-Bouquets. Signs of overwhelming poverty and the remnants of fallen-down buildings surrounded us as we drove along pothole-ridden gravel roads. I asked our driver/security guard (you have to be both if you work in Port-au-Prince) what life had been like since January 12. His reply, "Haiti was a disaster zone, and then it was struck by an earthquake." The next six weeks that I spent working alongside nurses and doctors at the clinic seemed to confirm this fact. In a nation with a complete lack of basic infrastructure such as running water, building codes, ambulances, electricity or roads, our clinic was overrun everyday with complaints far beyond the scope of primary care it was established to provide more than 10 years ago. At 7am, the gates open and patients from far and wide pile in and form lines depending on their complaint. We saw more than 200 patients a day, ranging from minor complaints like coughs and colds, ulcers, skin infections and reflux to the serious complications of malignant hypertension, malaria, cholera, typhoid, HIV and tuberculosis. The lack of resources meant we had only a set number of medications to give the patients, all of which were donated to the clinic, and investigations were also very limited.

One of the most common presentations didn’t require complex investigations or management. Cholera has a simple and lifesaving treatment: sugar, salt and bicarbonate of soda dissolved into clean drinking water. One little girl came in with a pink ribbon in her hair, so dehydrated from cholera that she looked like a skeleton, with retracted eyelids and lips, dry skin clinging to her face and limbs that were skin and bone. Oral rehydration wasn’t enough so we set up IV fluids and left her with the nurse for monitoring. When we checked on her a short while later, I asked the nurse what had happened to the little girl and who this other happy young girl was who had also been given an IV. The nurse said she was the same girl. If it weren’t for the pink ribbon in her hair, I would not have believed it, such was the incredible transformation that simple rehydration had offered.

None of my reading or information had prepared me for my experiences there. Being a part of the relief effort was immensely rewarding and, importantly, I was able to stick to the same code of ethics and scope of practice that I would at home. With an open mind, a value of culturally-appropriate and ethical healthcare delivery, and a good mosquito net, a medical elective in a developing country can be an experience that is challenging, educational and might even change your view of the world.

I learned a lot in Haiti - about medicine, disease, poverty, politics, health care and myself. I learned that you miss resources in medicine when you don’t have access to them and that it is impossible to separate the medical conditions and the health needs of a person from their social, cultural, political and economic environment.

And I learned that when you have literally nothing else, you can still have hope. And hope gives life.

Robert Marshall, final year medical student and President of the Australian Medical Students’ Association, is this year’s winner of the Alan Charters Elective Prize. The prize is named in honour of Dr Alan Charters (1903-1996) who practised and taught medicine in East Africa and WA and is fondly remembered by generations of WA medical students whom he taught through his long career, continuing to do so even into his nineties.
It’s all a matter of preference

Continued from page 1

Ms Dennis said previous research showed that interactions beyond the classroom were positively associated with student outcomes, including academic skills, intellectual development, social outcomes and student satisfaction.

But a Survey of Student Engagement conducted at The University of Western Australia in 2005 and 2007 found a decline in student-staff interactions external to the classroom, which was a concerning trend, she said.

“With every student at UWA being issued with an email account, this technology should not be ignored,” she said.

In her study, 649 undergraduate students (403 females, 234 males and 3 “other”) from all Faculties and 48 staff from four Faculties responded to an online survey.

Students identified four main purposes for using email to communicate with staff members - to clarify details of an assignment or assessment, ask a question about course content, for administration purposes (such as timetable clash, attendance issues and re-enrolment), and arrange a meeting or tutorial session with a staff member.

Most students sent emails to faculty “occasionally” (about once per month), most commonly between 4pm and midnight, and they checked their university emails most days.

Most students indicated they expected a response to their emails within 24 hours (49.1%) or within 2-3 days (48.1%). Staff sent emails to students more frequently, on a daily or weekly basis, mostly to inform them of opportunities such as scholarships and information sessions, or provide information about course content requirements, or for administrative purposes.

“There seemed to be little evidence of staff engaging students in a personal discussion which could possibly assist in learning,” Ms Dennis said.

Almost all students (94.6%) and most staff (85.4%) viewed email as a convenient and efficient form of communication.

They liked the fact emails allowed time for a considered response, provided a written record and could be less intimidating for the student than a face-to-face meeting.

The disadvantages listed by students included an increased chance of misunderstanding, delayed or no responses from staff, inconsistencies in the way email was used by staff or a personal preference for face-to-face interaction.

Staff disliked the fact that emails could be time consuming and used inappropriately by students.

For example, one staff member remarked:

“Overuse by students is a terrible time sink for staff so can be effective from the student’s view but is a terrible strain on teachers of large classes”.

About 60% of students thought emails helped foster a relationship with staff for reasons such as “any communication is beneficial”, “identification (staff can know your name, signals interest of student)”, and “can lead to face-to-face communication”.

Some students felt emails could act as a precursor or “ice-breaker”.

Rachel Dennis won the Best Student Presentation award at the Faculty’s inaugural Education Research Symposium for her study, titled Perceptions of how email affects student-staff interactions beyond the classroom - expectations and criteria - what are they? Her presentation was based on a project she completed as part of the Undergraduate Learning and Teaching Research Internship Scheme in 2009, when she was the student representing the Faculty. Her supervisor was Professor Sally Sandover.

Tips for students:

1. Be aware of teachers’ preferred means of communication and availability.
2. Use email for purposes such as asking simple questions or arranging meetings. Be aware that anything complex may be time consuming and better explained in person.
3. Keep in mind that most staff members prefer to explain things in person. (Most emails by staff members are “information” emails.)
4. Use appropriate language when sending emails including correct spelling and grammar. Employ a polite and friendly tone as well as a greeting and a closure. (Avoid SMS language).
5. Include details such as your full name and student number in emails to staff.
6. Spend some time composing emails to phrase questions clearly.

Tips for staff:

1. Inform students of your preferred means of communication (face-to-face or email) and for which purposes you like to use each.
2. Students are more likely to use email if they feel staff are approachable. Being perceived as approachable in the classroom will often determine interaction via email.
3. Make your email address easy for students to access (eg. on unit outline, WebCT).
4. Let students know how quickly they can expect a response from email.
5. Try not to send emails that are too brief as these can be misunderstood and be perceived negatively by students.
Clinical Professor Steven Webb, of the School of Medicine and Pharmacology, is QAS a US study might be trying to provide a solution to a problem that did not necessarily exist. The study in the Archives of Surgery of 902,852 patients found the optimal emergency department systolic blood pressure (BP) cut-off value for predicting mortality in patients aged 65 years or older was 117 mm Hg. The authors said the current threshold of 90 mm Hg, which might suffice in the younger trauma population, was not a reliable predictor in the geriatric trauma population. The optimal cut-offs were 85 mm Hg for patients aged 18 to 35 years and 96 mm Hg for patients aged 36 to 64 years, leading the authors to recommend that the classic definition of hypotension as an emergency department systolic BP less than 90 mm Hg remained optimal for patients younger than 65 years. But they found that about two-thirds of patients older than 60 years had pre-existing systolic hypertension, leading them to suggest elderly trauma patients with normal BP measurements might actually be in a significant state of shock. Clinical Professor Webb, senior staff specialist in intensive care medicine at Royal Perth Hospital, said it might not be as BP thrombosis, but that different factors drove mortality in different age groups. “Death in the elderly after trauma may be much more driven by comorbidity, noting that (the study) reflects the study of the 11-year-old falls,” he said. Also, the nature of the trauma was quite different in the three age groups, with much less penetrating trauma. “Certainly, making it a plausible explanation for the different relationship between threshold BP and mortality, he said.

Winthrop Professor Philip Thompson, director of the Lung Institute of WA, is QAS that asthma isn’t one disease. “The end product looks the same but the pathways that we are following are completely different,” he said. He was commenting on a study which found that severe asthma treated with a new monoclonal antibody drug showed improved lung function after 12 weeks. The research, which was described as adding to the growing understanding of asthma as a heterogeneous disease requiring personalised treatments.

In the trial, published in the New England Journal of Medicine, 219 people with severe asthma were randomised to receive either subcutaneous lebrikizumab (a monoclonal antibody to interleukin-13) or placebo, monthly for six months. The researchers hypothesised that the role of interleukin-13 could explain variation in treatment response in their subjects, so patients were stratified according to their serum periostin level, which was used as a marker for interleukin-13 activity. After 12 weeks, the average increase in forced expiratory volume in 1 second (FEV1) from baseline was 5.5 percentage points higher in the lebrikizumab group than in the placebo group. For patients with the highest levels of periostin, the increase in FEV1 from baseline was 8.8 percentage points higher in the lebrikizumab group than in the placebo group. “These results are consistent with the hypothesis that phenomena driven by interleukin-13 are clinically important in such patients,” the researchers wrote. Professor Thompson said the research fitted in the context of growing interest in monoclonal antibody treatments for asthma.

The West Australian

Winthrop Professor Tim Davis, head of the School of Medicine and Pharmacology Fremantle Hospital unit, is QAS doctors should consider lowering the bowel cancer screening threshold for type 2 diabetes (a marker for obesity, the researchers said), which found men with type 2 diabetes were twice as likely to develop potentially fatal bowel cancer as those without the type 2 diabetes condition. The WA study involving about 1300 people with type 2 diabetes. “It might be that the risk factors for the two conditions, including obesity, are the same and that we need to develop better screening for both, or it may be the factors associated with diabetes trigger bowel cancer,” Professor Davis said. According to global literature, GPs were often too busy managing a patient’s diabetes to consider screening for cancer, he said. Research Assistant Professor Wendy Davis, of the same unit, is QAS fewer cases of bowel cancer were found among women involved in the study.

Clinical Professor Trevor Parry, of the School of Paediatrics and Child Health, is QAS the shortage of 107 child health nurses means crucial checks are not done at the correct time and, if and when problems are identified, children have to wait up to a year for assessment. “We’ve got the staff and the training to do what needs to be done,” he said. “We just haven’t got enough of them to do it in the appropriate timeframe.” State Auditor-General Colin Murphy’s report last year into free universal health checks found only 30 per cent of children had their hearing screened at 18-month-olds and nine per cent for three-year-olds.

Winthrop Professor Geoff Riley, head of the Rural Clinical School of WA, is QAS GPs have problems like anyone else, including marriage hiccups and children with eating disorders. Specialists tended to become driven, setting up practices in their 30s and “flogging their guts out for a decade to get the BMW and nice house in the western suburbs”. He was commenting on the high rate of suicide among doctors – reportedly up to twice the rate in male doctors compared to other men and up to four times higher in female doctors compared with women generally. Doctors can seek confidential advice from Doctors Health Advisory Service at www.dhas.org.au or on 9321 3098.

The Weekend Australian

Winthrop Professor Fiona Wood, head of the Burn Injury Research Unit in the School of Surgery, is QAS her personal passion now is to understand better the brain’s response to injury and how that can be used to develop new strategies. She is testing brain training treatment techniques developed at Adelaide’s Neuro Orthopaedic Institute on burns patients. The aim is to find out if people recover more quickly and work better if the central nervous system is targeted. “I sort of fancifully say we can think ourselves whole,” Professor Wood said. “We need to understand how visualisation impacts on healing.”

1. One of the consequences of living longer is that more people are being exposed to age-related diseases such as Alzheimer’s. The latest research into the early detection of Alzheimer’s disease and possible future treatments and prevention will be presented by internationally-renowned psychiatrist Professor David Ames at a free public lecture.

The lecture by Professor Ames, Director of the National Ageing Research Institute and University of Melbourne Foundation Professor of Ageing and Health, is described as adding to the growing understanding of dementia as a heterogeneous disease requiring personalised treatments.

2. The WA Centre for Health and Ageing is also focusing on the need for microbiological contribution to microbiology. The article is titled Keryn Christiansen: a household name in microbiology. The article was published in the Lancet on May 28. The honour was in partnership with Sir Charles Gairdner Hospital. Christiansen among a group of distinguished members of the School of Population Health.

3. A profile on Clinical Professor Keryn Christiansen, of the School of Pathology and Laboratory Medicine, appeared in the prestigious journal The Lancet (Kirby T, 2011, The Lancet, vol 377, p1827) on May 10. The paper was(member of the WA Centre for Health and Ageing and the Institute of Advanced Studies. Why does Alzheimer’s disease matter and what do we do about it? will be presented on Thursday 13 October at 6pm in the Social Sciences Lecture Theatre, UWA.

4. A profile on Clinical Professor Keryn Christiansen, of the School of Pathology and Laboratory Medicine, appeared in the prestigious journal The Lancet (Kirby T, 2011, The Lancet, vol 377, p1827) on May 10. The paper was in partnership with Sir Charles Gairdner Hospital. Christiansen among a group of distinguished members of the School of Population Health.

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The profession of podiatry has its roots in the 17th Century in England when the care of the foot and of the mouth was carried out by street traders, the “corn cutters” and the “tooth pullers”, Professor Bryant told the guests at the launch of the Podiatric Medicine alumni group.

Eventually the corn cutters became the chiropodists, later called podiatrists, and the tooth pullers turned into dentists. “Even today, we share many similarities with the dental profession,” Professor Bryant said.

In Australia, WA was the first State to initiate a course in podiatry at a tertiary institution in 1972 with a three-year Diploma of Chiropody at WAIT, and Curtin University started the first postgraduate program in Australia, a Master of Science in Podiatry, but there was no alumni group in 33 years.

However, the Bachelor of Podiatric Medicine which started at UWA in 2006 could boast it was the first program conducted within a Faculty of Medicine and now, after only five years, an alumni group had been formed, Professor Bryant said.

“As for our achievements... the Podiatric Medicine Unit operates from the Park Avenue Building, which has been fully refurbished over the past three years,” he said.

The team interviewed 48 people, including academic and support staff, clinical instructors, students and recent graduates.

The assessors said the podiatry program was situated in a large, prestigious University within a well resourced Faculty and School (of Surgery) of high standing.

“The Podiatry Program is centred on a quality curriculum with a strong vocational focus,” the assessors said.

“The non-podiatry support teaching was delivered by highly experienced medical and science academic staff and offered podiatry students the opportunity to undertake studies with medicine and dentistry students.

“Additional educational and mentorship contributions from specialty centres, such as the Centre of Aboriginal Medical and Dental Health (CAMDH) and CTEC, are noted as a unique and highly valuable offering of the program.” Staff morale was high and the Podiatric Medicine Unit attracted experienced practitioners as academics and clinical supervisors, the assessors said.

They also praised Professor Bryant for his vision and strong leadership that had “contributed significantly to the successful implementation of a quality Podiatry Program at UWA in a relatively short period of time.”
WA’s first Podiatric Medicine alumni group in 39 years has been launched at The University of WA - and they are wasting no time.

Since their start in June, they have signed up more than 40 members, including graduates from other universities interested in becoming involved in the UWA network.

Inaugural alumni president Mr Andrew Knox said the formation of the alumni had been prompted the fact there had been no formal facilities in WA for mentoring or help for graduates.

“We want an avenue to provide ongoing reassurance and networking for people,” he said.

The group has already held a continuing professional development seminar with four specialists presenting on a “biomechanically-related disorder of the lower extremity”. Other seminars are in the pipeline.

Another key aim is to set up a program with experienced podiatrists volunteering to mentor graduates.

“By the end of the year, we are hoping to have the program in place and at least have 10 mentors who can provide assistance to people by phone or email,” Mr Knox said.

“Informally, a lot of graduates do provide mentoring to current students but we want to put something formal in place.”

The alumni also want to establish a scholarship for students in financial hardship, or a prize.

“The whole purpose of this alumni is really to give something back to the uni, not just in terms of mentorship and ongoing networking but providing something students can aspire to,” Mr Knox said.

The first UWA Podiatric Medicine students graduated two years ago and the total number of alumni is now 40. There are also more than 20 post-graduate students.

Podiatry in WA began in 1972 when the then WA Institute of Technology introduced a three-year Diploma of Chiropody but no alumni group has ever been formed before in the state.

Professor Alan Bryant, Head of Podiatric Medicine, congratulated the Podiatric Medicine alumni committee for having the foresight to form the group.

“One of its greatest strengths will be the potential for mentoring younger members of the profession in the years to come,” he said.

Faculty Dean Winthrop Professor Ian Puddey told the launch he was very proud to see the alumni group set up.

During his time as Dean, the course has been established, he has seen the first students graduate and now the first alumni group has been established.