

# CHIRON

JOURNAL OF THE UNIVERSITY OF MELBOURNE MEDICAL SOCIETY • VOL 4 NO 1 MAY 1998

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# CHIRON

CHIRON THE CENTAUR, TEACHER OF MUSIC, MEDICINE AND HUNTING

Vol 4 No 1

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Front Cover: The new Medical School Building extension  
with the Melbourne skyline in the background

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## THE INTERNATIONALISATION OF THE FACULTY

Bruce Singh, Cato Professor of Psychiatry and Associate Dean (Internationalisation) with the assistance of Lesleyanne Hawthorn, Senior Lecturer, Centre for Cultural Studies in Health

IN 1996, FOLLOWING A RESTRUCTURE of the functions of the Assistant Dean positions the then Dean, Professor Gordon Clunie, created three Associate Dean positions - Academic, Research and Internationalisation. The establishment of this third position was evidence of the Faculty's acceptance of its need to develop a more formal internationalisation agenda in line with University policy. We have been influenced to make a strategic response by significant changes in the international student market.

By 1996, 3096 undergraduate and 988 postgraduate international students were enrolled in Australian higher education health courses, representing 5.6 per cent of all students. The most popular fields of study were medicine and nursing at the undergraduate level and dental science and physiotherapy for postgraduate students.

The University of Melbourne already played a dominant role attracting 21 per cent of undergraduate international medical students in addition to significant numbers enrolled at the postgraduate level. Within the School of Medicine, undergraduate international students were derived from more than forty-three countries, with Malaysia supplying 64 per cent, followed by Singapore and Sri Lanka. Somewhat different patterns prevailed at the postgraduate level, with international students attracted to the Faculty's Dental Science courses from primarily Thailand, Singapore, Iran and Indonesia. The presence of such students contributed to the extraordinary ethnic diversity of the Faculty. In 1996, out of a total undergraduate Medical enrolment of 1297 students, 204 were international students, in addition to 458 who were first generation migrants or refugees. Cultural diversity is thus a major issue for students and staff within the Medical School.

Since 1996 the Faculty has made a significant commitment to enhancing the range and scale of its internationalisation activities. The first year international student intake for the School of Medicine was 73 this year, compared to 46 in 1997 and 33 a year earlier, despite the Asian economic downturn. In 1997 the Faculty established the Centre for Cultural Studies in Health, under the leadership of Associate Professor Harry Minas. The Centre has appointed lecturers to provide English as a Second Language and cross-cultural support to overseas-born students studying on campus and in clinical settings, pioneering a level of specialist service without precedent in Australian medical schools. From 1999 it is envisaged the Centre will make a significant contribution to teaching on cultural issues related to health within the new medical, dental and physiotherapy curricula.

Until relatively recently the Faculty's primary internationalisation focus has been catering to international students' needs

on campus. It is important, however, for universities to consider broader modes of service delivery, including modifying course content and delivery in response to international student demand. Given this, the Faculty has embarked on a range of initiatives designed to transform its internationalisation strategy over the next decade. One of the most important is the formation of the University of Melbourne's Australian International Health Institute. This corporate arm of the Faculty will have a global capacity to deliver Faculty expertise through a flexible range of partnerships, for example with governments, with non-government organisations and with other tertiary institutions. Rhonda Galbally, formerly of VicHealth, takes up the position as the Institute's Foundation Director and writes about the Institute in this issue of *Chiron* (p19). Discussions have also occurred with a commercial provider about the use of telemedicine for educational purposes in an international context. Faculty distance education and short course task forces have been set up drawing together senior academics from across the five schools to research the potential for internationalisation via different modes of course delivery. Substantial initiatives are already under way spear-headed by individual schools and supported by the Faculty's Bio-medical Multimedia Unit. The Key Centre for Women's Health in Society has built up an exceptional reputation for catering to regional training needs through short courses on issues such as women's health and HIV AIDS and the Department of Psychiatry's Office for Gender and Health is currently leading the development of a Commonwealth accredited degree course related to gender and health.

Additional strategies also under way include:

- strategic relationship building with select countries and institutions, and the enhancement of alumni structures within the Asia-Pacific region;
- ongoing development of international exchange programs;
- exploration of exchange opportunities, including access to cross-disciplinary credit subjects of value to pre-medicine and health sciences students from the United States;
- design of a language and communication skills screening test for all students entering the Faculty, with the aim of providing adequately targeted ESL and cross-cultural training;
- research on the cultural implications of the introduction of the new problem-based learning curriculum.

Initiatives such as these are designed to ensure the Faculty is comprehensively and proactively involved in the internationalisation process - producing local and overseas graduates who are both outward-looking and adequately prepared to work as global professionals in the medical and health sciences.

## HAROLD ATTWOOD

HAROLD ATTWOOD'S LONG HISTORY of association with the School of Medicine started in 1961 when he started as Senior Associate and Tutor in the Department of Pathology. He will be known to many UMMS members as teacher, colleague and friend as well as Editor of *Chiron*.

Taking a great interest in *Chiron* from its earliest stages, Harold first started contributing in 1985, reporting on the Medical History Museum collection and exhibitions. He came onto the Board of *Chiron* in 1987.

A true bibliophile, Harold began editing the Books section of the Journal in 1991 and the section grew and developed in accord with Harold's broad and cultured interests.

In 1995, when Peter Jones died and Maggie Mackie retired, Harold stepped into the breach and added his reputation to the changing role of *Chiron* while continuing his work at the Medical

History Unit. His interest in the character and the characters of the Medical School has been important in the development of the Journal, his knowledge of the history of the School and the University, invaluable. Harold will track down an elusive piece of information assiduously and his excitement at piecing a tale together is caught by all who are regaled by his description of the hunt.

Harold retired from *Chiron* and from the Medical History Museum at the end of 1997. We are sure his retirement will be busy visiting grandchildren, caring for and entertaining friends, travelling, and pursuing his numerous hobbies and interests, not least among them books, woodcarving and the study of medical history. His wisdom, enthusiasm and nose for a good story is missed but we hope *Chiron* will continue to benefit from his knowledge and contributions.

EB & RL

SEMINAR

25 JULY 1997

HEALTH CARE IN A MULTICULTURAL SOCIETY

Convener

Professor Richard Smallwood

Professor of Medicine, The University of Melbourne

Austin and Repatriation Medical Centre

*The Government Approach*

The Honourable Dr Michael Wooldridge

Federal Minister for Health and Family Services

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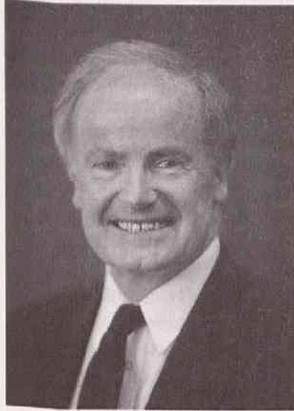
Boyce Gibson Professor of Philosophy  
and Director, Centre for Philosophy  
and Public Issues,  
The University of Melbourne

DISCUSSION

## HEALTH CARE IN A MULTICULTURAL SOCIETY

### INTRODUCTION

Professor Richard Smallwood



PROF RICHARD SMALLWOOD

AUSTRALIA IS A SOCIETY of very diverse origins. Nearly four million of us were born overseas: the top nine countries in order are the United Kingdom, New Zealand, Italy, Vietnam, Greece, China, Germany, the Philippines and the Netherlands. One in twenty Australians was born in Asia and over ten per cent of the population of Sydney was born in Asia. After English, the principle languages spoken in this country are Italian, Greek, Cantonese and Vietnamese. Our Aboriginal community numbers 350 000 or thereabouts - roughly

two per cent of the population - and we are all, I think, painfully aware that our efforts to deliver care to this community have

been woefully inadequate.

In Victoria we really are an ethnic melting pot. Nearly a third of Melburnians were born overseas: sixty per cent from Europe, twenty-five per cent from Asia and five to ten per cent from the Middle East and North Africa. Again, the most widely spoken languages after English are Italian, Greek, Cantonese and Vietnamese.

Over two thirds of us acknowledge allegiance to Christianity (twenty per cent these days claim no religion) but five per cent of Victorians follow Islam or are Buddhists or Hindus.

Are we looking after our cultural minorities appropriately? Do we know what their needs are? If we have got things wrong, then how do we begin to put them right? Have we comprehended how a particular cultural background might clash with this society's social, ethical and health norms? How then, if we have comprehended that, do we lessen the likelihood of these clashes occurring? Our speakers will point the way towards some solutions to these questions and look forward to comments from and discussion with the audience.

### *The Government Approach*

Dr Michael Wooldridge



DR MICHAEL WOOLDRIDGE

IN 1990, the poet, Vaclav Havel, made his inaugural speech as the newly elected President of Czechoslovakia. To a people who had triumphed over communist oppression, Havel spoke with moral vision and moral courage. Communism may have gone, swept aside by an irresistible and peaceful revolution, but Havel saw that communism had bequeathed a legacy as potent and dangerous to Czech society as its now rejected Marxist ideology.

The worst thing about the end of communism, said Havel, is that

'we live in a contaminated moral environment. We learned to ignore each other, to care only about ourselves. Concepts such as love, friendship, compassion . . . lost their depth and dimensions and for many of us they . . . resembled gone astray greetings from ancient times, a little ridiculous in the age of computers and spaceships.'

Within two years, Havel's beloved Czechoslovakia was split in two. His people held a referendum and voted to divide the nation into its ethnic parts: the Czechs and the Slovaks were to be separate countries and separate people.

It was too much for Havel. He resigned as President. He could not in conscience preside over a country governed by a mind-set which encouraged people to care only about 'ourselves'. He could not stomach the thought that compassion was restricted to an 'us' and a 'them'.

Today Australia is facing a similar challenge. The voices of a strident few have come into prominence; most notably those of a noisy and resentful minority represented by Pauline Hanson and the One Nation Party who are now trying to split this country into an 'us' and a 'them'.

Just as Havel rejected this mind-set in his own Czechoslovakia, I - along with the vast majority of Australians - similarly reject it in Australia. It is painfully wrong and misleading to describe the most disadvantaged group of Australians, our indigenous people, as the beneficiaries of reverse racism. It is wrong to reject as 'them' those people who have come to our shores to make a home here. Wrong, too, to single out people from our neighbourhood of Asia for hatred. Wrong to describe migrants as taking our jobs. Wrong to say we have reached 'compassion fatigue', as though compassion had defined limits.

It is not 'one nation' which that misnamed party stands for. Rather it is two nations. Like Czechoslovakia, there are to be two Australias divided between the so-called mainstream, 'us', and 'them'. I find these views morally repugnant. Like Vaclav Havel, I cannot and will not be part of a nation which discriminates on the basis of race. Nor will I let it happen.

As Minister for Health, I reject the view expressed in Pauline Hanson's now infamous maiden speech which parodied Aboriginal people as beneficiaries of reverse racism, especially while the opposite is tragically true.

According to the most recent figures, for every government dollar spent on health for non-indigenous Australians, indigenous Australians receive just eighty cents. Yet their health needs are enormous. Indigenous Australians live an average of 15-20 years less than their fellow Australians and it is

unconscionable that the original Australians experience third world rates of disease in the so called 'lucky country'. These Australians rightly deserve the attention this Government is giving to improving their lives and their health.

As a Member of Parliament for a constituency not twenty minutes away from here, which comprises twenty-two per cent of people from non-English speaking backgrounds and thirty per cent of people who are first-generation migrants, I reject the view that Australia should turn its back on its commitment to a non-discriminatory immigration policy, on its proud record of welcoming people from other countries and of building a society where racial harmony and a celebration of diversity does work.

*... it is unconscionable that the original  
Australians experience third world rates of  
disease in the so called 'lucky country'.*

To subscribe to these narrow minded and racially discriminatory views would not only be wrong in principle. It would overlook the distinguished contribution which migrants have made to this country.

Take my own area of responsibility, health, where Australia owes a great debt to migrants who have come to Australia: the 1996 Australian of the Year, John Yu from the Children's Hospital in Sydney, whose work in paediatrics made Australia world-renowned in this field; Victor Chang, whose pioneering work in heart surgery has contributed to Australia's proud reputation for excellence in this field; Gus Nossal, who fled his native Austria and the oppression of Nazi Germany to come here as a seven-year-old refugee in 1939; and South African born Priscilla Kincaid-Smith, one of the world's leading figures in kidney disease. It is unthinkable to imagine even today's meeting without acknowledging the contribution of Malaysian born Dick Smallwood, head of Australia's National Health and Medical Research Centre from 1994 to March 1997.

Just as it is unthinkable to imagine Australia's medical and scientific community without acknowledging the contribution of these immigrants, I challenge those who argue that Australia should withdraw into itself, 'look after our own', and turn our back on our own region and the wider world. Australia cannot afford to lapse into a mind-set that our backyard is the only place which matters. We cannot afford to think that we have to withdraw from the United Nations and other international organisations, end overseas aid and re-erect tariff walls to keep them - in particular our Asian 'competitors' - out.

If only it were that simple. If only it was possible to turn the clock back and fix Australia's jobs problem by such measures. But it is not the answer. Raising new trade barriers would only inevitably invite others to re-erect their own and deprive us of vital markets we need to create the new jobs we so desperately need. By one estimate, twenty per cent of Australians' jobs already depend on exports, a figure which has doubled in the last twelve years. In short, Australia cannot afford policies which would make us isolated, insular and backward-looking, and make us a stranger in our own region.

Australia has an historic opportunity to work closely with other countries - to offer its expertise in addressing region-wide health issues such as the common threat we face from the pandemic HIV/AIDS, and in providing services and 'know-how' to assist those countries in developing their own health and medical systems. In fact, it would be hard to imagine a more important contribution we could make to our region than to assist other countries in these ways. Health has the potential to be one of our most invaluable links to the region. It has the potential to be more than simply an export market, more than simply a way Australia can provide much needed jobs. Ultimately, our endeavours in health could directly improve the lives of people in other countries and could be one of the most profound links we could ever establish with our regional partners.

Yet all this undoubted potential is threatened by the very views espoused by the One Nation Party which would have Australia cut itself off from the world and care only for ourselves. Perhaps the greatest threat these views pose is to the most precious feature of Australia's health system, namely our commitment to certain basic moral values: humane principles such as human dignity, compassion, a 'fair go'.

This mind-set of 'looking after our own' threatens our commitment to providing a health system which is based on respect for human rights of all people, whatever their racial and cultural background. It threatens the basic principle that health care in this multicultural society is founded on: that our society provides care to people on the basis of need. That means not only to seek to protect those people who are vulnerable, those people, for instance, with a mental illness or a disability, and strive to provide them with decent care, but, in a particular way, to actively seek to uphold the rights of those of differing cultures to be treated with full regard to their cultural backgrounds, with sensitivity to their history and identity.

It is these principles which form the bedrock of our health system and of our society. It is these principles we need to keep firmly in mind and work hard to preserve and protect when any discussion of health care in a multicultural society takes place.

There can hardly be a more important time to discuss these vital issues and to reflect on the core principles of respect for all people and their cultural backgrounds which underpin our health system and indeed our country.

Just this week I visited St Vincent's Hospital in nearby Fitzroy. In the new sandstone courtyard, just outside the entrance to the casualty, there are some words inscribed in large letters on the ground: 'Compassion, human dignity, justice, unity and excellence'. These are not words which 'resemble gone astray greetings from ancient times, a little ridiculous in the age of computers and spaceships'. They are words that I, that Vaclav Havel, and that the vast majority of Australians would regard as the basis of both a fair health system and a just society. We must work hard to make sure that they remain the values of the only Australia worth living in.

## COMMUNITY EXPERIENCES

### *To Whom Does My Body Belong?*

Mrs Marion Lau



MRS MARION LAU

I HAVE CHOSEN this title because I am sure that, regardless of whether you are from a non-English speaking background or an English-speaking background, many of you would have experienced the feeling of losing control on your very first visit to a doctor, and being medically examined. I have had that experience.

When one first walks into a health care environment, whether it be a doctor's surgery, x-ray or pathology service, one is confronted by many reminders of barriers between the professionals and the patients. We

are processed by an officious looking receptionist, who questions us about our personal details in what sounds like a booming loud voice for everyone else in the room to hear, and then told to sit down and wait for the doctor to call our name.

The fact that both parties within this setting have their own sets of valuable information - the health professionals have general knowledge based on medical training and the patients have special and necessary knowledge about their own bodies and experience - does not seem to be taken into consideration by many health professionals within this environment.

An environment which makes them feel inferior makes it

difficult for people to find an answer to their health concern. Although I speak and understand reasonably good English even I am made to feel this way whenever I access these services. So, how do you think a person who does not speak English will feel? Very intimidated I am sure. And frightened at the prospect of a strange superior person invading the privacy of their body and telling them what to do with it. The language barrier also makes it more difficult for the non-English speaking person to challenge the professionals' interpretation of what is happening to their bodies.

The management, diagnosis, prevention and screening for cancer is affected by the lack of provision by the mainstream health care system of culturally relevant health care for both non-English-speaking-background (NESB) immigrant groups as well as for Aboriginal groups.

The system's inadequacy in addressing the lack of understanding about regular check-ups to screen for potential health problems is a major issue. Many NESB community groups still do not understand that early detection could result in a possible cure of their medical condition and many ethnic communities report structural barriers perpetuated by the inadequate training of health professionals.

Many NESB women rarely discuss sexual health matters because in some of their cultures, this is a closed subject. Women from some of these communities have been brought up to protect their bodies until they are married after which their bodies will belong to their husbands. They will be reluctant, therefore, to submit to breast or vaginal examinations carried out by a male or even a female physician. (It took me a long time to attend to one of these examinations myself, and the experience was not pleasant).

The display of services and the promotion of some health care issues are often intimidating and inappropriate for the traditional migrant woman. For example, the television advertisement on breast self-examination. It would be very embarrassing, and in some circumstances, unacceptable, for some women to be watching this advertisement on the television screen in the same room with their parents, parents-in-law, male relatives and children.

The lack of culturally sensitive information regarding pap smears and breast cancer screening has resulted in very few NESB women undertaking these screening procedures.

I believe that some of the measures being introduced for screening, and the early detection of breast and cervical cancer may be difficult to implement amongst women from NESB migrant groups without major changes to the thinking behind our health care system, and the provision of culturally appropriate educational programs.

There are many people who come from cultures which do not encourage their members to go searching for 'bad things'. Certainly, to consciously take action to find out if you have cancer or not is not seen to be a positive activity by some. This attitude has discouraged many migrant women from accessing available screening services, particularly those relating to sexual health care.

There are many migrant women who have refused to participate in discussion/support group workshops or other forums on women's health issues. They perceive that English-speaking women do not understand what the NESB women are trying to convey. Even in 1997, I still hear NESB women criticising health care providers who do not understand their cultural concerns. Some NESB women, encouraged by their Australian friends to attend sexual health services, have found that the providers of these services have difficulty working with them because of language and lack of cultural understanding. As a consequence these NESB women have been referred back to doctors from their community, most of whom are male, defeating the purpose of their attending these services in the first instance.

The lack of patience exhibited by many professionals when they feel they are not understood properly, and their reluctance to use professional interpreters are major reasons why many NESB people are not happy to seek health services.

The respect afforded to the aged in European and Asian countries does not appear to be relevant here, and many older

migrants feel that being bullied by younger service providers just is not acceptable. This creates a further barrier, as many older migrants are reluctant to access some of the available services.

I would like to conclude with the following points:

- The non-English speaking community is not a homogenous group. While each community is unique, there is also diversity between and within different cultural groups.
- Non-English speaking migrants, particularly women and the aged, from rural and remote areas may have different information and service needs to those in urban communities.
- It is very important that relevant and linguistically appropriate services are available to meet the needs of non-English speaking women with breast and cervical cancer.
- Health professionals need to recognise that cancer is viewed in different ways by some cultures or segments of some cultures and may be seen as a stigma or taboo topic. Some people from migrant communities may have a fatalistic attitude towards cancer.
- People from non-English speaking backgrounds, particularly women, are often concerned about confidentiality when using formal or informal interpreter services.
- The priorities of the non-English speaking communities are not necessarily related to health but may focus instead on unemployment, learning English, housing and education.

### *The non-English speaking community is not a homogenous group.*

I hope that some of the issues I have raised today will be addressed by this Faculty as part of their preparation for future health services providers. I look forward to the day when there will be as a matter of course:

- culturally appropriate obstetric and gynaecological services for women;
- access to female personnel in all medical areas for those who need them, but particularly in obstetrics and gynaecology;
- improvement in communication between health professionals and their NESB clientele; and
- acceptance and understanding by all health care providers of the cultural diversity of our society.

#### MEMBERS' VALUED SUPPORT

The Committee of the University of Melbourne Medical Society would like to thank the many members who have made generous donations to support the activities of the School of Medicine and the Society. These donations support scholarships and fellowships for young researchers and the following special student prizes: the UMMS Bachelor of Medical Science Prize and the Peter G Jones Essay Prizes.

The UMMS Bachelor of Medical Science Prize is awarded annually to the student whose BMedSc research report is judged to have made the most important contribution to knowledge. UMMS BMedSc Prize was awarded in 1996 to Rathan M Subramaniam (see p 42 in this issue of *Chiron*).

Up to three Peter G Jones Essay Prizes are awarded each year for the best essays from final year students, describing their elective experiences. The 1997 prize-winners were David Iser, Megan Rees and Marilla Druitt (see pp 32-35 in this issue of *Chiron*).

Donations to UMMS can be made on your annual renewal form. You can contact Ms Robin Orams at the School of Medicine, on (03) 9344 5889, for advice about donations and bequests.

## The Impact of Culture in the Treatment of Mental Illness

Mrs Kaliope Paxinos



MRS KALIOPE PAXINOS

**M**Y EXPERIENCES during the past fifty years have indeed been varied. I have had the opportunity to meet many different people from all walks of life; to enter their homes and to meet with their families during very stressful periods. The most fascinating and interesting aspect of this is to have lived through years of great changes and to see Australia become multicultural.

The passage of time and my journeys into the lives of non-English speaking people has reinforced in my mind that all of us have feelings, emotions, needs, fears, love, a desire for happiness

and good health, but above all the need to be understood and respected for who we are.

The thread connecting these journeys was that we were bound together by language and culture and the knowledge that in each circumstance the families could identify something of themselves in me.

There is no more important place in our lives than our health. For us to maintain good health we need to cooperate with all sections of the health professions. They, too, need to cooperate and work with families; this is especially important in mental health.

In recent years my involvement in mental health as a carer has given me insights into the problems that can occur when there is a lack of understanding of cultural diversity in our community by health professionals, particularly the lack of recognition of the role of families in caring for mentally ill people.

We often think of culture as being cooking, national costumes and dancing, but nowhere is it more important that we understand what culture means than in mental illness. Culture is our language, the way we live, what we value, our attitudes, our family structures and dynamics, our beliefs and our ethics. Unfortunately there has been a great deal of negative labelling in mental illness when dealing with ethnic groups. My own experience occurred during the early days of my son's illness. I was so anxious to understand and support my boy during his serious illness that both a psychiatrist and social worker labelled me an 'over-protective Greek mother' when all I was doing was giving him the love and security he needed during those stressful episodes. Would I not do the same if he had another equally serious illness?

The role of the mother in my culture is to take responsibility for the family in times of great distress, regardless of age. This responsibility was misinterpreted. A culture clash can occur between clinicians and families in terms of what each considers to be the more appropriate method of treatment and the roles of family members in the life of the person with a serious mental illness. An example is the western value of independence for the sufferer over the family's interdependence. Who should decide if the sufferer should be supported to live independently when the family believes it is their role to care for their family member who is ill? We need to understand these differences well before decisions are made.

Eleni's story is another example. Eleni is middle-aged, married with two daughters and speaks very little English. The family has lived very traditional lives, similar to the village life they left behind in Greece. Their eldest daughter, Marina, had behaviour problems in her late teens. Their family doctor told them that Marina was behaving this way because as a protected Greek girl she wanted to have the freedom of her Australian girlfriends. Marina's behaviour changed and became quite bizarre. Eventually she was diagnosed as suffering schizophrenia and hospitalised.

After a few weeks in hospital Marina wanted to go home, but the advice of the treating psychiatrist and social worker was to place her in an accommodation home so she could learn to become independent. This placement caused an enormous conflict in Eleni's extended family: they blamed her for not taking responsibility for her daughter.

Marina's condition deteriorated during this placement. She felt abandoned by her family in spite of the fact that they visited her often. Even though she was confused by her delusions, she understood the reality of what her mother had taught her; that she would leave home only when she married.

A worker at the home rang me to help the family. It seemed that during the month that the family had been involved, none of the ever-changing health professionals had really sat with them and explained the real nature of their daughter's illness, or given them any kind of education or support. Eleni noticed that Marina was not responding to the medication but, possibly because of her limited English, her observations were not listened to. Eventually Marina returned home and with the help of a bilingual worker her medication was changed. She improved to a level where now she attends rehabilitation and, with support, her family has learnt to manage. Eleni's story shows the impact on a family when their cultural beliefs are not recognised.

In the treatment of mental illness we must remember that the comfort of language and acceptance of the behaviour that comes with culture is vital. How families of cultures other than our own interact, particularly in crisis, is important to understand because family dynamics will change at that time. We need to understand family structures within various ethnic communities because when mental illness surfaces these structures intensify. The first generation bring with them their traditions and beliefs which have served them well in their home country. The new generation, with Australian education, often experience conflict adjusting to these new values. In a family which consists of three generations living either together

*In the treatment of mental illness we must remember that the comfort of language and acceptance of the behaviour that comes with culture is vital.*

or in close proximity, which migrant families tend to do, problems can arise within the family because of the different values and education of the younger generation. Grandparents could possibly think there is nothing wrong and insist that the parents keep the person home without seeking help, whereas the parents understand there is a problem without understanding the illness.

Clinicians need to be aware of these differences and counselling should try to involve the extended family.

Nadia came from the former Yugoslavia. Her husband showed serious signs of illness soon after their marriage. Nadia told her family of her concerns but was told she may be the cause of the problem. It came to a point where Nadia had to seek help from the crisis team. Her husband was hospitalised. In Nadia's culture it was seen that she had betrayed her husband. Her family and friends did not support her, so she became a victim too. Unfortunately she hid these problems from the treating teams because she was ashamed to talk about them.

Our cultural beliefs can be so strong that we cling to them with a ferocity that defies logic. As I was reliving my experiences for this talk I remembered two striking examples of the power of culture.

It was a very cold day in the Supreme Court. As a probation officer I described the family dynamics and culture in a case where the father had attempted to kill a man who had encouraged his disturbed and mentally ill daughter into prostitution. In evidence the father explained that the honour of his family had been damaged by the actions of this man. When

he gave his judgement, the judge showed that he understood the traditions and culture of this man. He spoke of the laws of the land and said that the man had committed a crime. However, he went on: 'I salute you old soldier' (both judge and father had fought in the Second World War in Crete, one an Australian, the other a Greek) 'that you had the courage to protect your daughter and your cultural beliefs. Go home and embrace your child and hold your head high, you have been punished enough.'

The judge understood.

I was supporting a young family who had migrated from Macedonia. We were in the consulting room at the Royal Children's Hospital - the parents, their baby son, the resident doctor and the surgeon. I acted as interpreter. The medical resident explained that their seven year old daughter had been diagnosed with bone cancer and that the treatment would be the amputation of her right leg if the child was to survive.

On hearing the cure the father stood up. He was a handsome man with a very broad moustache and with tears in his eyes he made this statement to the doctor. 'No one, doctor, is going to touch my daughter. You have to understand, doctor, that by telling me that you will cut off my daughter's leg you will destroy her future. How can I marry her without a leg?'

The resident and the surgeon looked at each other lost for words! What an ethical dilemma.

I believe that to bring better outcomes in all areas of health, but especially in mental health, there needs to be a working relationship between medical staff, the person who is ill, the family and carers or friends, and above all, an educated, understanding, compassionate community.

## *The Right to Health: an Aboriginal Perspective*

**Ms Marjorie Thorpe**



MS MARJORIE THORPE

**F**IRST OF ALL I'd like to pay my respects to the Koolan nation - the indigenous people of the Melbourne metropolitan area whose land we are on today - and through that land pay my respects to those people. They have indeed survived.

I was first asked to speak at this seminar as an Aboriginal patient attending Aboriginal health services, and I'm afraid, at that particular time, although it was only a few months ago, I didn't think I had anything positive to say about being a patient of Aboriginal health services. A dilemma I face as an

Aboriginal health worker is that I question the role of Aboriginal health services in their current structure. My mother and grandmother were instrumental in the establishment of the Victorian Aboriginal Health Service in Fitzroy: the second Aboriginal health service established in the country and a forerunner to many established since. I am also a member of the Aboriginal Reconciliation Council and was a Commissioner for the Inquiry into the Removal of Aboriginal Children, so it causes me great concern to be able to stand here and make that statement.

Our Minister for Health raises concerns that the Federal Government have about the racism in this country but doesn't realise the importance of land to health. That really goes to the heart of my teaching, my understanding and my experiences over the last twenty-five years as an Aboriginal living and working in an Aboriginal community.

The Aboriginal health service established some twenty-five years ago was a community controlled Aboriginal health service where people had ownership and control over how their health service was delivered to them. It was a unique concept and quite unusual in those days.

Some of the harshest assimilation policies in this country have been perpetrated against Aboriginal people. When I see

people affected by those assimilation policies, particularly those people who were removed from their families and communities; when I read questions in the paper about the validity of the Report of the Inquiry into the Removal of Aboriginal Children - reports that people were lying or were coerced by interviewers; when I see the Prime Minister, the leader of this country, give a qualified apology on behalf of the Australian people - that shows me the attitude of this country towards Aboriginal people, and it worries me. It worries me not only for myself but for my children. It has probably worried my mother and my grandmother and her grandmother before her, and its no different for any of my brothers or sisters or cousins or aunts and uncles.

Even though I'm able to get up here and speak to you, I too have suffered discrimination when taking myself and my children or other Aboriginal people to see a doctor. I have been to casualty and been subjected to attitudes questioning why we should waste the valuable time of the medical profession and the hospital (not only of the nurse at the reception desk but also of the doctor when treating us). And these are recent experiences.

*Aboriginal health services have never had an infrastructure adequate to ensure the delivery of health programs...*

So when we talk about the establishment of services where we have an ownership and control over how those services are delivered to us, its vitally important. At the same time the assimilation process in this country has affected not only the education of non-Aboriginal people in this country but the education of our own people. Whether by forced removal or by the non-recognition of our values, our culture and our customs, some of our own people have been affected so that the values they aspire to aren't Aboriginal values but white middle-class values - and sometimes those values are then imposed on us. Unfortunately, some of our health services are in that situation.

We need to look carefully at the development of service delivery to Aboriginal people and we need to go back into the history of Aboriginal health services and look at the vision which was originally put forward by Aboriginal people. I don't believe anyone has come up with a better model than those original Aboriginal health services. In many cases what we have now is a sanitised version of those services.

Aboriginal health services have never had an infrastructure adequate to ensure the delivery of health programs, so we don't get the maximum value out of our health dollar. For seven years I've worked as a manager in Lake Tyers trying to get a middle management so that we can at least have somebody to coordinate and facilitate the actual implementation of health programs. We still don't have one. Historically, places like Lake Tyers have suffered from terrible Aboriginal health. Look at some of the health commission records and information relating to the tragedy and the history of Lake Tyers - only one example of many. Look at the glaring neglect and ignorance - no regard for the importance of middle management or a proper infrastructure to be able to deliver any service or any program. We're talking about dollars, health dollars in particular, and we have to make sure that those health dollars are put to the maximum advantage, otherwise we're forced to endure a repeat of history.

Health statistic reports say that the Aboriginal people in Morwell and Gippsland where I live, suffer from the same health problems as developing countries. Well, that makes me wild! It makes me angry because I just wonder to myself, as an Aboriginal mother, and as an Aboriginal grandmother, how long is it going to take before some reasonable and rational and responsible health policy for Aboriginal people is worked out?

Being a Council member on the Reconciliation Council shows me that we have something to contribute to this country. We need to be respected and we need to be recognised as

having unique and different cultural values. We need to sit down and work out, the best way that we can, the middle ground; the common ground. We certainly need to work together to ensure that the health policy and the delivery of health in this country, not to mention the education of health professionals, both Aboriginal and non-Aboriginal, is done in a collaborative way with the people who are going to be receiving those services.

## PROFESSIONAL RESPONSIBILITIES

### *Cultural Diversity: Ethics and Practice*

Associate Professor Harry Minas



ASSOC PROF HARRY MINAS

**M**OST COUNTRIES today are culturally diverse. The world's 184 independent states contain approximately 600 living language groups and 5000 ethnic groups. Australia is among the most culturally diverse of these countries. Within a secular democracy such as our own, this diversity gives rise to series of important and potentially divisive questions. These questions include issues of identity; distribution of resources; the legitimate role of government; and the purposes, operations and structure of our social institutions, including the

health system. The Hanson debate is an expression of substantial uncertainties in the population about issues such as national identity, the desirability of cultural diversity and how such diversity is to be interpreted and managed. The task of finding morally defensible and politically viable answers to these issues is the among the greatest challenges currently facing liberal democracies. (Kymlicka, 1995)

Medicine is not exempt from these debates. The fact of linguistic and cultural diversity has had surprisingly little impact on our conceptions of medicine, on the structure and operations of medical institutions and health care systems, and on medical education and clinical practice.

In this paper I will present some ideas concerning the relevance of culture to clinical practice, the challenges of cultural pluralism, minority rights in a culturally diverse society, and the implications of these issues for health care in a multicultural society.

### Culture

Since the term 'culture' has been used to cover all manner of groups, from teenage gangs to global civilisations (Kymlicka, 1995), we would do well to begin by specifying what we mean by this term in the context of our discussion.

Culture is the means whereby the infinite complexity of the world is reduced to a manageable simplicity. It provides a map that guides us in how to see, what to believe, what to value, how to behave, how to interpret the world of others and the environment, and how to think about ourselves. One's culture provides off-the-shelf answers to some of life's most complex problems and dilemmas. Culture also provides a means whereby one effortlessly belongs to a group, and derives security and purpose from such belonging (Kymlicka, 1995). Without the framework provided by culture, the world would be experienced as 'chaotic, random and meaningless'. (Dana, 1993)

### Culture and illness

How is culture relevant to health and illness? What we think medicine is determines what we think physicians ought to know and what they do. Each philosophy of medicine creates its own model of disease and health, of resource allocation and public policy. Most critically it also shapes the relationships of

physicians to patients and to society. The crucial element of clinical medicine is the physician-patient relationship, through which the work of medicine is done. All of the impressive medical science and the sadly diminished art of medicine converge and are expressed in this healing relationship. It shapes, directs, and bounds the physician's work, education and ethics.

However, it is in the relationship between physician and patient, where cultural considerations are of such critical importance, that the most serious problems are to be found in the provision of effective health care in a culturally diverse society. It is here that the failure of medicine to acknowledge and to come to terms with cultural pluralism is most apparent.

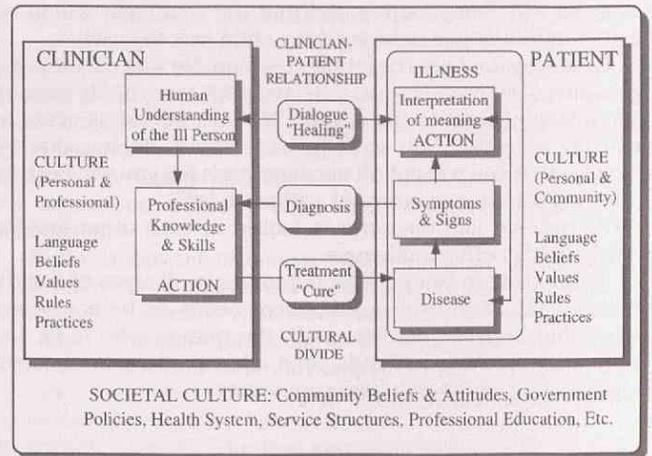


FIGURE 1

A narrow view of medicine (Figure 1) as a natural science discipline suggests that medicine consists of the application of medical knowledge and skills to the task of discerning the presence of disease, diagnosis, and treatment that will either cure or ameliorate the effects of the disease. The clinician's natural science perspective serves to identify certain data as relevant, to abstract from the complex totality of a sick patient, to interpret the abstracted data and to construct a clinical reality, the disease, which becomes the object of therapeutic endeavour. The interpretive task is diagnosis and explanation, the identification of a disease entity which provides a causal explanation of the clinical phenomena and a guide for therapeutic action. Within this natural science framework, a symptom is a meaningless effect of some underlying causal process. In this view, disease and its manifestations, and the body of medical knowledge and skills, are universal. It therefore matters little who the patient is and who the doctor is. Each becomes an abstraction. It is an essentially technical view of the nature of medicine and the role of the physician. This view, although it is greatly over-simplified here, underlies the bulk of medical education.

However, the culture of the patient has a profound influence on the nature, shape and consequences of the person's experience of illness (Figure 1). Illness consists of more than the disease and its symptoms. The perception of illness, its labelling and the evaluation of its meaning for the person are processes embedded in a complex family, social and cultural matrix. Illness is constructed from popular medical culture, as the sufferer draws on available theories, beliefs and networks of meaning to interpret and communicate his distress. Each culture provides distinctive interpretations of human suffering and of healing. Each provides explanatory models of illness and forms of dealing with illness, grounded in particular beliefs and values. These beliefs, values and health-related social practices will influence the particular expression and course of illness, patterns of help-seeking, the patient's expectations of the doctor and of the health system, the nature of the patient-doctor relationship, and matters such as compliance with treatment recommendations. A focus only on the disease and on what is

technically possible in terms of treatment will result in a poor understanding of the person who is ill. In such circumstances the doctor may make correct technical decisions but will often make poor ethical decisions. His knowledge and skills will enable the physician to answer the question 'What can be done?' but he will have no basis for answering the question 'What ought to be done for this person in these particular circumstances?'

In order to answer this essentially ethical question the doctor must bring to bear his human understanding of the sick person as well as his understanding of disease process (Figure 1). In this he will be profoundly influenced by his own personal and professional culture, including his ethical stance.

To make a technically correct decision the physician must be competent and objective. To make an ethically good decision, he must be compassionate. It is in the tension and integration of these opposing attitudes that the end of clinical medicine is fulfilled. On the one hand the physician must be able to stand back, analyse, classify, measure and reason. On the other, he must be able to feel something of the experience of illness felt by the patient. He must literally suffer something of the patient's pain along with him (Pellegrino, 1983).

To gain an understanding of another person when that person comes from a different culture, speaks another language and does not share the assumptions and values of the clinician presents particular challenges to the skill and humanity of the clinician. The challenge is in knowing the patient as a person when much of what contributes to the individuality of that person is unfamiliar to the clinician.

*To make a technically correct decision the physician must be competent and objective. To make an ethically good decision, he must be compassionate.*

In culturally diverse societies, where there are no fixed, universally acceptable criteria for ethical judgment, physicians and patients are likely to hold diverging views with regard not only to the moral probity of interventions such as contraception and abortion, but also with regard to the moral significance of pain, suffering, death, and life itself (Engelhardt, 1983). In these circumstances, irreconcilable differences in the ethical perspectives of doctor and patient are likely to occur with considerable frequency.

In the cross-cultural clinical encounter, one of the key difficulties is that the physician and patient meet as moral strangers, in that they cannot assume what the moral viewpoint of the other will be. Their views of what constitute the good life and the purposes of health care are likely to appear strange and exotic to each other. The moral commitment of the physician in these circumstances must be to the good of the patient as the patient conceives it. An unequivocal criterion of an ethically good decision is the enhancement of the patient's moral agency even when this goes against what science might dictate. The patient is the one who must balance his vision of the good life, the life he considers worth living, with the realities illness forces upon him (Pellegrino, 1983). Physician and patient will need to fashion a joint understanding of their relationship, its goals, and the methods to be used in pursuit of those goals.

At a more general level (Figure 1), societal culture influences how we respond to the sick person in our midst. Culture defines attitudes toward the dying and sick, how the aged and disabled are treated. It prescribes the behaviour of others toward the sick person and that of the sick person toward himself. Cultural norms and social rules regulate whether someone can be among others or will be isolated,

whether the sick will be considered foul or acceptable, and whether they are to be helped, pitied or censured (Cassell, 1976). The influence of culturally derived beliefs, attitudes and values is nowhere more clearly exemplified than in relation to AIDS and those suffering from this condition.

### **Cultural diversity and secular, liberal democracy**

How is a secular, pluralist democracy to deal with the diversity of needs among the various cultural groups that constitute the society?

The paradox of multicultural states is that they have a unitary legal/state framework, yet they contain within that frame, a pluralism of normative or ethical cultures. The conundrum of the multicultural states is: how, at all, are they possible? When different cultural orientations clash, the temptation is to universalise one or other cultural form - that is, legislatively, administratively, or juridically impose it on everyone (Murphy, 1995). In the context of this discussion, this means to provide to all a health service that has been designed by and for the majority, and then to be satisfied with the assertion that every individual, regardless of cultural background, English proficiency and so on, has equal access to this system.

The ethical basis for a liberal democratic society is belief in the primacy of individual autonomy and freedom, and in the equality of its citizens (Kymlicka, 1995). On this basis it is frequently asserted that common citizenship and the protection of individual rights is all that needs to be done to ensure justice.

However, it has always been recognised that a majoritarian democracy can systematically ignore the voices of minorities (Kymlicka, 1995). Decision-making by the majority within a state renders cultural minorities vulnerable to significant injustice at the hands of the majority, resulting in systematic disadvantage. If we take mental health as an example, this disadvantage is expressed as follows. Immigrant communities have generally higher rates of mental illness, they utilise community and hospital based mental health services at substantially lower rates than do the Australian-born, they are more likely to be treated with psychotropic drugs, are more likely to be admitted to hospital as involuntary patients and, once admitted, are likely to stay in hospital for substantially longer periods.

I would contend that it is legitimate, and indeed unavoidable, to supplement traditional individual human rights with minority rights. A comprehensive theory of justice in a multicultural state will include both universal rights, assigned to individuals regardless of group membership, and certain group-differentiated rights for minority cultural groups (Kymlicka, 1995).

Group-differentiated rights can be made to compensate for unequal circumstances which put members of minority cultures at a systematic disadvantage regardless of their personal choices. The freedom and autonomy of individual members of minority groups require not identical treatment but rather differential treatment in order to accommodate differential needs. Such differential treatment can support the common rights of citizenship through promoting equal access to mainstream culture and its benefits (Kymlicka, 1995). In the health system, this has implications for the distribution of resources, and the establishment and support of services that meet the needs of particular groups.

### **Conclusions**

If we are to have a health care system that is appropriate to a society characterised by cultural diversity, we must attend to issues at the level of the doctor-patient relationship and at the broader social level of service design and provision.

In our education of doctors we must focus less on medicine as a technical discipline and more on medicine as an essentially moral practice, that is, a practice that exists for the good of others. We must teach students that the application of medical

## ETHICAL DILEMMAS AND SOLUTIONS

### When Cultural and Medical Perspectives Clash - Where does the Doctor Stand?

Professor Bruce Singh



PROF BRUCE SINGH

THE SUCCESSFUL practice of medicine in a multicultural society is often simplified as being no more complicated than that the doctor be 'culturally sensitive'. In practice, this means that the doctor grasps the cultural matrix in which the patient is embedded; a matrix which may include powerful health belief models and attributions.

Many practitioners would be unaware of how far western medicine has deviated from, and devalued traditional folk models of disease and disease causation.

They have been inculcated in a very linear and mechanistic view of normal and abnormal body function, as reflected in the traditional sequence medical training where the pre-clinical basic sciences illustrating normal body structure and function are followed by the clinical sciences of medicine and surgery.

Much of the world has a far more holistic view of illness and in fact, even in so-called developed societies, many individuals retain folk theories of the causes of illness. In some instances these are maintained at the same time as the acceptance of the biomedical model. A recent Australian study which demonstrated that one hundred per cent of parents of severely asthmatic children had sought some form of alternative care or treatment in addition to their acceptance of the conventional treatment offered illustrates this tendency, as do many others in the literature, where folk remedies are used simultaneously with conventional medical treatments. But where does the doctor stand when what is accepted as a cultural norm is in stark conflict with his medical knowledge, or indeed, his moral and ethical sensibilities? Where does the doctor stand when patients seek, at best ineffective and at worst harmful treatments, or when a community endorses practices which the doctor finds unacceptable and perhaps offensive?

There are a number of examples of this. The most provocative and controversial is infibulation or female genital mutilation, (widely practiced by many societies) in which a young girl's clitoris is excised in order to minimise her capacity for sexual pleasure. This practice, as its name implies, is mutilating and of no demonstrable benefit. It is in conflict with western perceptions of acceptable behaviour and in conflict with our perception of fundamental human rights. And yet, as unpleasant as this practice is, it comes out of a particular philosophical view of the world; perhaps a patriarchal view in a world dominated by men, but nonetheless one that has some rationale and justification within a particular cultural context.

Why does the practice continue when the personal, psychological and health complications are severe? The World Health Organization has taken a stand against genital mutilation, but has acknowledged that attempts to outlaw it have met with strong opposition from both men and women in countries where it is practiced and an insistence that westerners should not interfere with the cultural practices of other nations.

In early 1994, the Family Law Council published a discussion paper on this issue. The framework adopted in this paper, consistent with analysis elsewhere, is that the practice is contrary to a set of universal fundamental human rights transcending cultural distinctions. Nonetheless, a recent critic of the criminalisation of female genital mutilation has suggested that to speak about this practice and those who practice it as violating the cultural norms, (as 'un-Australian'), fails to

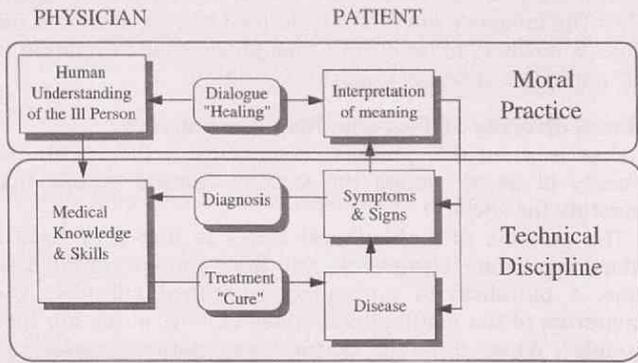


FIGURE 2

knowledge and the exercise of skills must be embedded within a healing relationship and a conception of medicine as moral practice (Figure 2).

At the same time, we must acknowledge that, in a secular, pluralist society, there are many conceptions of what is of value and of what sort of life is worth living. In the cross-cultural clinical encounter, the doctor must be able to create a therapeutic relationship in which a central task is to discern and to understand what is good for the patient as the patient conceives it. The patient's therapeutic goals must then be allowed to frame the joint therapeutic endeavours of patient and physician.

The design and operation of health services in a multicultural society must be informed by a comprehensive political theory of justice. A continued reliance only on individual rights will fail to protect minorities against the unjust consequences of majority decision-making. Justice will only be possible through the recognition, as part of a liberal democratic society, of group-differentiated rights and special provisions for minority communities which are subject to disadvantage, in order to redress such disadvantage. This will mean the provision of services that are designed for, and effectively respond to, the specific needs of minority cultural communities.

Matters of practical conduct have nothing invariable about them, any more than matters of health. This is true of ethics in general, and it is true even more of moral issues arising in particular cases. These are not a scientific or technical matter: rather as in medicine or navigation, they require human beings to consider what is appropriate to specific circumstances and to specific occasions.

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recognise that these are, in themselves, a highly complex set of cultural practices, consistent with neo-colonialist attitudes to third world countries; an attitude that sent Christian missionaries around the world railing against pagan and heathen practices.

This brings up the issue of cultural relativism and the consequences of accepting this perspective indiscriminately - namely that no culture can be validly criticised by another. The solution is seen to be in an acceptance of universal human rights which serve as a check on the excesses to which radical relativism can lead. Let us not forget, however, that the concept of universal human rights itself is to a large extent a western, Judeo-Christian ideal now enshrined in the United Nations Universal Declaration of Human Rights. Other societies might well have put rights of parents, families, or tribes ahead of those of the individual and highlighted individual obligations more than rights.

Nonetheless, it is within this ethical framework that one solution can be found; namely that there are a few basic rights (as in the UN Declaration) which are universally applicable. The remainder of rights are made up of local exceptions to these universal rights to account for specific cultural values and institutions.

In other instances there are practices which are widely believed by certain cultures to be beneficial and which are clearly harmful. We occasionally hear of situations such as children being immersed in dung in order to cure severe conditions, and certain rare instances where the treatment itself has been fatal. While most folk remedies are either ineffective or have primarily placebo value, some can be toxic.

*As medical professionals we are and will be caught more and more in the bind between what we have been taught and 'know to be right', and what the patient accepts and believes.*

But as modern views of transcultural medicine have emphasised, 'transcultural' is now used to refer to more than differences across cultures, it also refers to different ideas within cultures and between various groups in a society whether divided on socio-economic factors, gender or age. Perhaps the most dramatic examples of this are the beliefs held by various subgroups or cults within western society, for example the recent Heaven's Gate group's attempt to express their aberrant belief through mass suicide. There are numerous groups in our so called homogenous communities who have particular views about their bodies and the ways that they use them. The widespread habit amongst a subgroup to insert rings into various sections of their anatomy for ornamental reasons, which have no possible medical benefit and may in fact cause medical harm, can provide a major challenge to a doctor's view of the advice he should give when his opinion is sought by a distressed parent of such an adolescent. The application of tattoos to various parts of the anatomy, with all the attendant risks in an AIDS conscious era, is again widely adopted, in fact approved of, by a section of the community who see this as a way of expressing their individuality.

Any discussion on practicing in a more culturally sensitive manner must take some of these brutal facts into account. Doctors are professionals bound and immersed in their cultural matrix as are the patients that they see. The aspiration of being culturally sensitive is one that we all would endorse, but it does cut across the notion of cultural superiority and cultural dominance. This is the view that one culture, namely the one we endorse, has greater knowledge, virtue or validity of its ideas than others: that its premises are more legitimate and its concepts more acceptable to us.

As medical professionals we are and will be caught more and more in the bind between what we have been taught and 'know

to be right', and what the patient accepts and believes. The recent debate about euthanasia in Australia has illustrated this dilemma. I raise these issues in an ethical seminar such as this to provoke discussion and debate. What is the ethical position of doctors when confronted with these dilemmas, in particular, health belief models of other cultures, or in fact, of subcultures within our own culture which challenge their medical knowledge and are at variance with their belief system?

Although the issue of the universalistic versus the relativistic nature of medical ethics has been raised in the literature, the range of relative differences which has been considered is extremely narrow. Medical ethics today are almost exclusively western and based largely on the technocratic culture of the practitioners.

We take as a working hypothesis that the high level of apparent agreement on the nature and content of medical ethics is a result of the diffusion of western ethics with western medical technology and medical social organisations, rather than a cultural universal which is characteristic of all societies at all times. Non-western systems of medical ethics have scarcely been looked for much less studied. Whilst we know a great deal about definitions of illness and health and healer-patient relations in other cultures, there is a surprising omission in regard to the socio-cultural aspects of medical decisions. Perhaps this seminar will stimulate that work.

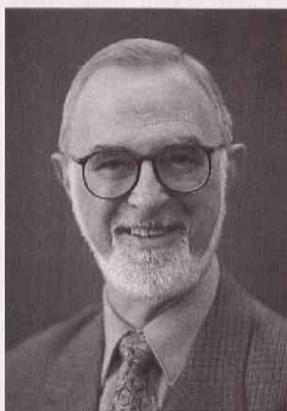
These dilemmas are with us today and are likely to increase as society gradually demands a greater say in its own activities, where requests for individual human rights tends to transcend all other value systems and where modern medicine is struggling to come to terms with the patients' wishes to re-exert control over their bodies and their minds from what they perceive as the medical profession's dominance over them.

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## Culture, Care and Reason

### Professor Tony Coady



PROF TONY COADY

IT IS A DATUM of any discussion of this sort that we live in a society marked by a degree of value pluralism. This is not a fact that I shall contest, but I want to look more closely at its meaning and the sort of problems to which it gives rise. In recent years, awareness of this fact and its significant ramifications has led to a great stress upon 'difference' and upon cultural identity. As some of the cases we have had before us today make clear, this stress remains important and necessary for a variety of reasons. In particular, in medicine, it is significant for the understanding of patients, of what they say, think, feel and mean. Culture is not the only thing that is important for such understanding, but it is one of the circumstances and contexts that needs to be taken into account in order to understand an individual's speech, silences and needs. Other such circumstances include temperament, sexual orientation, age and particular history.

It should be clear that I do not want in the least to belittle the genuine importance of an understanding of culture in the cause of understanding patients. I do, however, want to raise the question whether the overwhelming stress on cultural difference has prevailed to such an extent, especially amongst

theorists and commentators, that certain counterbalancing facts have become ignored or obscured. In raising this question, I hope to contribute to a better understanding of the significance of culture for treatment.

The points I want to make about the impact of cultural difference upon ethics, and especially medical ethics, fall naturally under five headings: 1. the fluidity of cultures; 2. the amorphous identities of cultures; 3. the unholiness of identity; 4. the similarities between cultural problems; 5. the need for public reason in ethics and politics.

### 1. Fluidity of cultures

In much contemporary discussion of cultural difference and its significance for ethics the word 'culture' has assumed an almost mantra-like status that tends to stifle serious discussion. There is seldom any attempt to present definitions or even rough identity-conditions for cultures (Harry Minas, drawing on the philosopher Kymlicka, is a notable exception) so that the reverence accorded the notion is often a source of confusion and a stopper to discussion. Partly because of this, the picture is commonly presented of cultures as static, monolithic entities, especially in their evaluative aspects. The individuals belonging to the cultures are therefore seen as somehow 'constituted' by their cultures, 'situated' within them, irretrievably deriving their 'identities' from the culture, morally dependent upon the fixed norms of the culture, and so on. But close attention to realities, rather than to ideologies and jargon, surely reveals the absurdity of all this. Let me take a culture that I am familiar with: Catholic culture (or should I say Australian Catholic culture?). This is no single fixed entity that has never varied through the years, nor is it such a single phenomenon at any given time. What it means to be a Catholic (or an Australian Catholic) is a contested matter and always has been. There are points of convergence and common focus amongst Catholics but also passionate divergences, and the same is true of anything that gets itself called a culture in current debates. The same is true of all religious cultures; it is true of all intellectual cultures

*It is particularly important that public authorities not reinforce or condone group oppression.*

(liberalism, for instance); it is true of all national cultures. Particular circumstances (such as oppression) might paper over these fissures for a time but they are always there, and it is arguable that a culture is only healthy when they are vigorously present.

### 2. The amorphous identities of cultures

My discussion of (1) already suggests that the question of what constitutes one single culture for individuals to belong to is no easy question to answer. To know that someone is a Moslem is yet to be ignorant of whether they are a Suni or a Shiite, a Turkish, an Iranian or an Indonesian Moslem, nor at what end of the liberal/conservative index they position themselves. To know that someone is Irish is to remain so far ignorant of whether they are Catholic or Protestant or Atheist, or whether the adjectives Australian, English, American or Jewish are also appropriate. Nor do we know anything about the intensity of their membership of quite other communities, such as the international chess community, the train freak fraternity, the gay community, the euthanasia society or the university community. The word 'culture' has plausibly been applied to all these groupings and many more. From the point of view of ethics and values generally, all these overlapping, intersecting, sometimes conflicting loyalties can provide significant ethical resources to an individual. But an individual is not passively bound to any of them. When conflicts arise between the demands of these diverse affiliations, the individual thinks about them and shapes a policy or a decision that makes sense to them. In so doing, the individual not only has recourse to ideas, concepts, theories and values that are part of her culture,

but also to those that are the common stock of human kind - such as pleasure, pain, happiness, concern for kin, concern for consistency and a respect for argument - and also to novel concepts and values that she will grasp and employ through her encounters with other cultures. The individual does not act and think alone, of course, but her social interactions are not restricted to her family or her ethnic group, nor should they be. The idea that we cannot understand, criticise and learn from other cultures is as silly as the idea that we cannot do the same with our own cultures.

### 3. The unholiness of identity

The idea that we are 'constituted' by our culture, obscure as I hope it will now begin to seem, gives rise to the thought that we must adhere to our culture through thick and thin, else we will somehow disappear: we will lose our 'identities'. But cultural identification, especially when it involves basic values, is not such a magical nor sacred thing. The neo-Nazi skinhead groups in contemporary Germany (and elsewhere) have a very distinctive, and very nasty, culture and the best thing that could happen to them is to abandon that identification. The case of Nadia, described by Kaliope Paxinos, shows how a cultural attachment can be destructive and contribute to tragic outcomes. The clash of old and new values will always make for complex and difficult choice situations. It may be that old ways and values need to be abandoned or that they offer a better solution than the new; more commonly, some compromise, some development and synthesis will be more appropriate. What is required is a complex and subtle weighing up of costs and benefits, perhaps seeing old comforts in a new light as delusive, or new excitements in an older light as superficial and damaging. There is no simple rubric that will eliminate the need for careful attention to the circumstances of each case. What I want to stress is that our primary upbringing and enculturation is not the whole of us, though it often deserves the respect due to healthy traditions. Even here, what is appropriate is respect, not worship and not bondage. Moreover, respect for cultural membership should never be so strong as to neglect those trying to break free of, or change, their cultural inheritance. It is particularly important that public authorities not reinforce or condone group oppression.

### 4. The similarities between cultural problems

There is a tendency accompanying the tendencies mentioned above for people to believe that the goals, norms, constraints and dilemmas faced by people of different cultural backgrounds are uniquely theirs and have no counterparts in other cultures, especially the 'home' or 'dominant' culture. Sometimes this may be so, but it is overwhelmingly likely that behind the superficially vast differences there are underlying similarities with the life-choices and predicaments of those in quite different cultural settings. During Marion Lau's discussion of the way women in some ethnic communities have great difficulties with examination for breast and vaginal disorders, I was struck by the degree to which similar sensitivities amongst women within the prevailing culture were ignored for so many years by the male-dominated Australian medical profession. At another recent conference, an example of cultural difference was given of an Ethiopian Moslem woman who wanted to be a second wife to a much older man. This invokes a cultural institution, polygamy, that Australia does not have, but the *menage à trois* is not at all unknown in our cultural history. Whether polygamy is a good idea or not really needs further debate and argument, and much of this will advert to circumstantial background facts, such as the balance of men and women in any given region, the standing of women in the relevant group, the political traditions of the group, various supernatural beliefs or those related to them, and so on. Debates like these are complex, but there is no reason to think that they are not worthwhile, cannot be rationally resolved or anything of the sort. Furthermore, there may be a powerful moral case against some practice, but it need not follow that there should be legal sanctions against it. Lying, verbal cruelty, indifference to the sensitivities of other, sexual promiscuity, adultery and idleness may all be morally wrong, even very morally wrong in context, without there being a convincing case

for involving the law. We may have reason to think that the Ethiopian woman and others engaged in consensual menage à trois are foolish, headed for trouble or whatever, but also think this no reason to call the police.

#### 5. The need for public reason in ethics and politics

The last point in (4) brings me to my final heading. Morality involves many things: it involves instinct, heart, conscience, sensitivity, good upbringing, and even luck, but pre-eminently it involves reasoning. Moral outlooks and views provide techniques for criticism and appraisal, but they are also eminently evaluable themselves by processes of thinking, reflection and reasoning. If one announces that IVF or human cloning is wicked, or a bad thing, or immoral, one is obliged to say more. 'Why?' is the eminently natural response to such an announcement. Of course, particular passages of reasoning may be fruitless, but this is true in every area of thought and practice, and there are many explanations for such failures. Sometimes, indeed, reasoning between people about moral matters comes up against genuine brick walls - as when someone declares that their view is based upon a divine revelation, for example, the ordination of women in the Catholic Church. But reasoning is insidious: even with such cases the declaration is seldom the end of the matter. Where is this revelation? Is it in the scriptures? In tradition? Then why is this tradition so powerful when that one (on usury, for instance) has been overturned. And so on.

Nonetheless, the fact remains that there will be controversial moral and lifestyle matters upon which no agreement currently exists between different groups within the one pluralistic political society. This is clearly the case in Australia and it often affects medical and health care areas. Rather than defer totally to cultural, religious and other divergences, and rather than simple imposition of majority views, we need a capacity to resort to what the American philosopher, John Rawls (following Kant) has called 'public reason'. Essentially this requires that the liberal state extend tolerance to various 'reasonable' life styles within its jurisdiction, remaining 'neutral' as to the validity of various comprehensive 'conceptions of the good', but insisting that the basic institutions of society be grounded in certain rights and protections that it is reasonable for all the different groups to respect. This constitutional core will be supported by an 'overlapping consensus' from the different groups. For reasons that I cannot now develop, I am not satisfied with Rawls's own account of public reason. Suffice it to say that I think Rawls's version of liberalism attempts to be too 'neutral' about the moral basis of the liberal state. We may have to build more moral commitments into the basis of the liberal democracy than Rawls supposes. If so, the need for public discussion, reasoning, debate, and a capacity to compromise in as principled a way as possible, will all be central to the resolution of the various medico-ethical problems that cultural pluralism involves. But then, to modify somewhat the wisdom of a former Prime Minister: 'Ethics wasn't meant to be easy'.

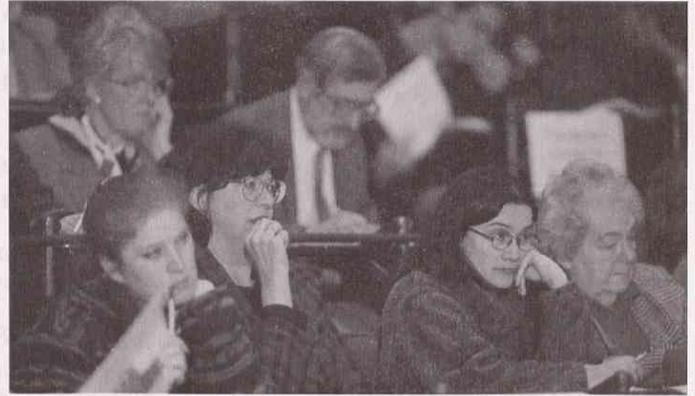
## DISCUSSION

**Associate Professor Warwick Anderson**  
**Director, Centre for the Study of Health and Society**

Although there were three separate discussions, it seems on reflection that we were engaging in one long conversation about health care in relation to culture, communities, languages, generations and migrations. At times all these terms became identical; on other occasions they each gave rise to quite different issues and concerns. Some may suggest that 'ethics' was submerged in the ocean of 'culture,' bobbing up rarely in discussion, each sighting more perplexing than reassuring. But, as Harry Minas pointed out, we were always talking about the ethical basis of practice, the fundamental respect that is required to do what we do ethically - even if at times we didn't realise it.

Many of the themes of the day emerged at the very beginning of the discussion. The value of 'community' was one. Michael Wooldridge emphasised the importance of building

communities and supporting community control in Aboriginal health services. Later, Marjorie Thorpe came back to the need to allow 'self-determination' if Aboriginal health is to improve. She remarked on the special understanding that comes from being a part of a community and knowing how to look after one's own. It is important, therefore, that all practitioners, whether non-Aboriginal or Aboriginal, show respect for the community in which they work, and ensure that their interventions are 'culturally appropriate'.



In the second part of the discussion, Marion Lau pointed out the importance of speaking a common language in clinical encounters: too often a failure of communication will cause a breakdown in the therapeutic relationship. Harry Minas also thought that language differences make it much harder to bridge a cultural divide. Kaliope Paxinos reminded us that many health care providers were the children of migrants and some of them were bilingual. But a number of discussants then pointed out that sharing a language does not always lead to good rapport between patient and practitioner. Marion Lau suggested that there was often a considerable cultural gap between first-generation migrants and their children.

Notions of cultural 'gaps', 'divides', 'barriers', and even 'gulfs' came to animate the discussion. How do we bridge (or undermine) them? Harry Minas urged greater cultural sensitivity, but observed that there was no simple checklist available. Bruce Singh and Tony Coady reasserted a liberal humanism, suggesting that our common humanity gave us reason to believe that cultural similarity was as likely as cultural difference. Nor should we assume that all cultural differences were worthy of respect; sometimes support for human rights was more important than sensitivity to cultural traditions.

As we neared the end of the discussion I began to wonder what we mean when we say 'cultural difference'. Do we mean a difference in language? In traditions? In generations? Do only migrants and Aboriginal Australians have 'culture'? We all know difference when we encounter it, but do we really understand how it is organised in the world? Anthropologists writing in the 1950s used to describe cultures as static and bounded, as coherent wholes. Most of the discussants seemed to endorse this view of culture. But what if cultures are not like this any more? What if we are increasingly post-ethnic? How do we deal with increasing cultural heterogeneity and fragmentation? What would it mean to be 'cross-cultural' in these circumstances? How will a health care system built on liberal humanism recognise and treat cultural difference in these - or in any - circumstances?

The discussion thus raised a number of questions fundamental to clinical practice. Yet how often are these issues discussed in classes and clinics? Perhaps more than they once were. It is surely, too, a good sign that the University of Melbourne recently has established the Centre for Cultural Studies in Health and the Centre for the Study of Health and Society, both of them dedicated to asking what it means to provide health care in a multicultural society. At least we have the questions now. The answers, as this seminar has indicated, are still out there.

## HALFORD ORATION

PILGRIMAGE AND QUEST  
JOURNEY IN THE WORLD OF HORMONES  
OR

LIFE IN THE SALT MINES

PROFESSOR J P COGHLAN AO  
Department of Anatomy and Cell Biology  
The University of Melbourne

*Successful research requires one to see what everybody can see but to think what nobody else has thought.  
Szent-Gyorgi 1935*

### PILGRIMAGE

*Any journey taken for nostalgic or sentimental reasons  
Life viewed as a journey*

### QUEST

*The act of seeking or pursuing something - the Golden Fleece or as in the medieval myths 'The Holy Grail'.*

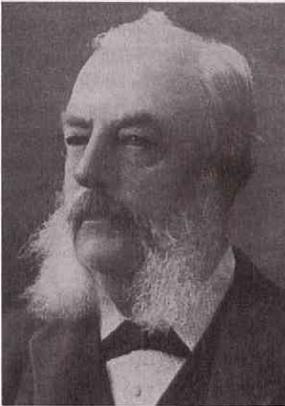


Photo of Halford from the University of Melbourne Medical School Jubilee. Pub Ford and Sons Melbourne 1914

**G**EORGE BRITTON Halford Esq, MD was the inaugural professor in the first medical school in Australia in 1862. He was appointed to the Chair of Anatomy, Physiology and Pathology. He was a protege of the famous anatomist Richard Owen, but because of that he was slow to accept Darwinian Theory.

In 1864 he was involved in controversy over the head of a hanged man, claiming the head had been given to him by its former owner. The sheriff came to the University and contended, with much force, that the brains were the 'Government's brains' and that a convict on a scaffold had no property, not even his own brains. Halford's effort was wasted because the brain was normal. The Chancellor, Sir Redmond Barry was put out by this incident and admonished Halford saying 'when the sheriff called on you to deliver the brain to him, a most unbecoming scene occurred . . . this proceeding has brought great scandal to the University'.

In 1870 Halford wished to give a public lecture on protoplasm. Council, led by Redmond Barry, forbade the

lecture on the grounds that it would touch on religious principles. No doubt they considered the awful word redolent of Darwinian theory. That Barry, with his special training and outlook, could understand the attitude and enthusiasm of a man of science was not to be expected. In fact, Halford was anti-Darwinian and orthodox in faith.

Enough of anecdotes.

Halford became the first Dean of the Faculty of Medicine in 1876. He held various posts in the Medical Faculty. He died aged 86 in 1910.

He was remarkably successful and did fascinating and internationally renowned research on: the comparative anatomy of man and the monkey; snake venoms and their action on blood . . . like 'cholera toxin'; the heart and comparative heart sounds.

His organisation of the Medical School with Brownless is his greatest achievement. It is worth noting that he was forward-looking enough to have allowed entry of women to the medical course in 1887.

In 1928 the Halford family made a bequest to the Institute of Anatomy, Commonwealth of Australia, Canberra for an annual lecture. Because of Halford's close association with the Medical School of the University of Melbourne the Oration was transferred here in 1949 and became triennial in 1956. The first Oration was on 26 November 1928.

'The First Halford Oration'. *George Britton Halford: His Life and Work*. By Osborne, W A.

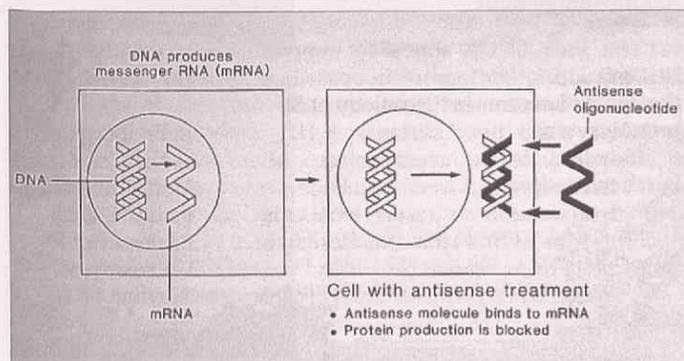
*Medical Journal of Australia*. p. 64 29 January 1929.

**M**Y LIFE IN endocrinology started in 1952, when I joined the Department of Physiology as an animal technician, while continuing my science course part-time. I did a Master's degree on the action of Aldosterone which had only recently been discovered. This work observed a remarkable increase in the sensitivity of the action of aldosterone during sodium deficiency. Aldosterone and the regulation of sodium was to be central to my scientific career for the next forty years. My colleagues in the Department of Physiology and the Ionic

Research Unit had created sheep with Wright parotid fistulae and auto-transplanted adrenal glands. The challenge now was to measure aldosterone in adrenal vein blood and systemic blood so that the physiological correlates of the regulation of its secretion could be established.

In 1959 I spent about six months in the Endocrine Department, Cornell University Medical School at New York Hospital to observe isotopic steroid measurement 'Double isotope derivative assay' in particular for aldosterone. In this

laboratory I met my life-long friends Professor Jurg Muller and Dr Hortense Gandy. On my return home a new laboratory had to be commissioned as no work of this type was being done anywhere in Australia and in only one or two laboratories overseas. Completely new instrumentation had to be established and a fully automated liquid scintillation spectrometer was installed. I had been factory trained at the Packard Instrument Company, La Grange Illinois, to do this complex installation and to service the machine. If this servicing was beyond me, telephone and telegram to the machine designer usually solved the problems quickly. We made a major contribution to the design of these machines as an in-house modification to make the channels independent was later



Blocking gene expression either by use of antisense oligonucleotides or by the formation of a triple helix is likely to be the basis for the most exciting pharmacological developments in the next century.

adopted by the manufacturer. Intuitively, once I was home I opted for a steroid measurement method which had the loss marker included from the outset: 'double isotope dilution derivative assay'. By 1961 we had these complex, technically demanding and rather tedious assays running like clockwork using the time honoured principle of the production line.

By 1964 this double isotope dilution principle had been applied to reliably measure testosterone in urine and blood for the first time. Our late colleague Bryan Hudson was the driving force behind these studies of androgen secretion and we subsequently went on to create a renaissance of interest in testosterone secretion and production. We were the first to demonstrate non-glandular production of testosterone from precursor steroids. This concept of local production of hormones at sites other than endocrine glands is central to the understanding of modern endocrinology.

Dr Sandy Skinner had introduced an effective assay for renin but from 1960 onwards there was an urgent need to measure the immediate effector hormone of the renin angiotensin system, angiotensin II. In 1966 we announced two critical developments; firstly, our ability to measure aldosterone in peripheral (systemic) blood as a routine procedure and secondly, a radioimmunoassay for the measurement of angiotensin II in blood. Both of these procedures were more workable and more reliable than others developed about this time. Many collaborations from international centres were started eg Harvard University Medical School, Queen Mary Hospital Hong Kong and many others. It is important to recognise that the generation of antibodies to the non-antigenic small peptide angiotensin II was the forerunner of the explosion of methods based on radioimmunoassay of non-antigenic compounds by coupling them to a foreign protein.

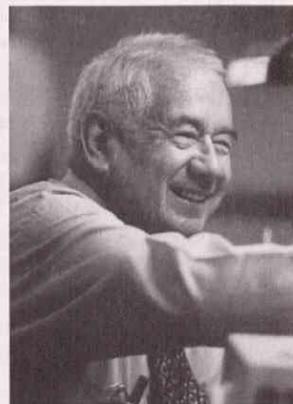
For basic experimental physiology the measurement of angiotensin II brought a quick demonstration that there was a good correlation between prevailing aldosterone secretion or concentration and the contemporaneous angiotensin II concentration. This was what people wished to hear as it confirmed the emerging dogma that angiotensin II controlled aldosterone during sodium deficiency. There was strong evidence that angiotensin II had a critical and vital role in aldosterone secretion. Of course other factors were implicated under special circumstances. e.g. [K] or ACTH, but the fact that

the correlation frequently broke down was not experimentally explored except by the Howard Florey Group. These studies continued even in the molecular idiom up to the present time. There are other sodium status related factors which turn off aldosterone secretion, which change the synthetic mechanism for aldosterone biosynthesis and change the sensitivity of target tissues for aldosterone and angiotensin II; at least according to my laboratory. These assays were not able to demonstrate florid derangements of either angiotensin II or aldosterone in essential hypertension or high blood pressure one of the major public health problems of the twentieth century.

By 1972 two important developments were made. Although aldosterone induced hypertension is rare, it can be caused by tumours of the adrenal cortex which produce abnormal amounts of aldosterone and cause excessive sodium retention. These tumours are often very tiny and thus hard to visualise at surgery. This syndrome of over-production is called Conn's syndrome after the first clinician to make a definitive observation of the disease. We developed a technique to lateralise the tumour by measuring adrenal vein aldosterone concentration. This procedure has been used in hundreds of cases with a very low error rate and is still being used even in the face of modern super imaging technology. David Fei and I were able to show that most of the angiotensin in blood was not made in circulating blood or in the lungs, but was made locally in vascular beds and what appeared in blood was merely the overflow. Was abnormal local production the cause of many cases of hypertension in the community? When introduced angiotensin converting enzyme inhibitors were not aimed specifically at the local production of angiotensin but it is recognised widely that this is an important part of the action of ACE. ACE inhibitors as a class of therapeutics are possibly one of the most successful ever introduced.

In 1978, as a consequence of studies of the morphology of the sheep kidney and adrenal with Professor Graeme Ryan, the peripolar cells were discovered. These cells are arranged as a cuff round the complex of afferent and efferent arteries on the inside of Bowman's capsule. They contain secretory granules which have been observed to enter the urinary space following exocytosis. The cells and their granular contents are geographically placed to influence tubular function but the contents of these peripolar cells and the nature of the secretory granules remains unknown. However as the result of painstaking work over many years Donna Butkus was able to show a correlation of peripolar cell granularity with negative sodium status, once it was recognised that at very high degrees of sodium deprivation the granularity falls, possibly because secretion exceeds synthesis.

Later, in an attempt to develop technology to help identify peripolar cell granules during the 1980s, we developed Hybridisation Histochemistry (HH) initially using cDNA but later using synthetic oligonucleotides. We have been granted world wide patents for the use of synthetic oligonucleotides in Hybridisation Histochemistry. The technique of Hybridisation Histochemistry has been developed based upon the intrinsic property of cDNA or synthetic desoxyribonucleotides to hybridise with its complementary mRNA. The technique locates specific cell populations in which a particular gene is being expressed. HH is a valuable tool for the study of gene expression especially in functionally complex, morphologically heterogeneous tissue. It can provide cellular location as well as intracellular location with modification to the procedures. It has been particularly valuable in embryology and developmental biology. There is hardly a niche in the whole of biology where this procedure has not found an



PROF JOHN COGHAN

application. It is interesting to reflect on our rejection slip from *Nature* asserting that our technology was 'far too specialised'. We have applied HH successfully to locate the expression of many hormonal genes and those for receptors and channels.

Much of my work during the late eighties and early nineties addressed gene knockout procedures which we were extraordinarily good at, achieving some six gene KOs. Other projects with institute teams concerned hybrid molecule synthesis where oligonucleotides were linked covalently to peptides. The aim of this 'hybrid' program was to get anti sense oligo's into cells to exploit the therapeutic potential.

Other long-term projects came to fruition. The fish hormone 'Stanniocalcin' which we were the first to clone, was found to be expressed at multiple sites in the mammal and in particular in the kidney. A major protein product of the kidney secreted into urine was identified as GM 2 activator, a critical part of maintaining membrane integrity.

Recent important studies of the effect of steroid hormones in-utero have shown that glucocorticoids have a persistent effect on increasing blood pressure in the adult. This is an important finding and adds to the recent plethora of data demonstrating that in-utero 'exposure' can have long lasting effects of an unwanted nature in the adult.

The above five projects are on-going and all have exciting potential. Some of these projects seem to have wandered away

from sodium homeostasis but the underlying theme is still sodium regulation. To be successful in medical research, one must go where the science leads and not where committees or boards direct.

My mentors and critical collaborators over this forty year period were Professor Pansy Wright, Drs Jim and Sylvia Tait, Dr Ralph Peterson, Dr Jurg Muller, Dr Hortense Gandy, Dr Bruce Scoggins, Dr John McDougall, Dr E Marelyn Wintour, Professor Iain McIntyre, Professor Bryan Hudson, Dr Donna Butkus, Professor Graeme Ryan, Dr Christina Wang, Professor Daine Alcorn, Professor Felix Beck, Professor Geoff Tregear, Dr Hugh Niall, Dr David Fei, Dr Ross Fernley, Dr Wah Chin Boon.

#### Acknowledgement

The bulk of the funds to support this work came from NHMRC with other important contributions from the University, the State Government, from the philanthropic trusts and the private sector.

#### Further reading

*Trends in Endocrinology and Metabolism* vol. 9 1997  
Annual Reports of the Howard Florey Institute 1995 and 1996.  
Coghlan, J P et al. Control of Aldosterone Secretion. *J.Endocrinol.*1979; 81:55 - 67p

## HOWARD FLOREY CENTENARY

### TALL POPPY CELEBRATIONS

The centenary of Howard Florey's birth will be celebrated on 24 September 1998. A series of special events are planned throughout 1998 to promote recognition of Florey as a great Australian scientist; to increase interest in primary and secondary schools; and to celebrate Australia's achievements in biomedical and scientific research.

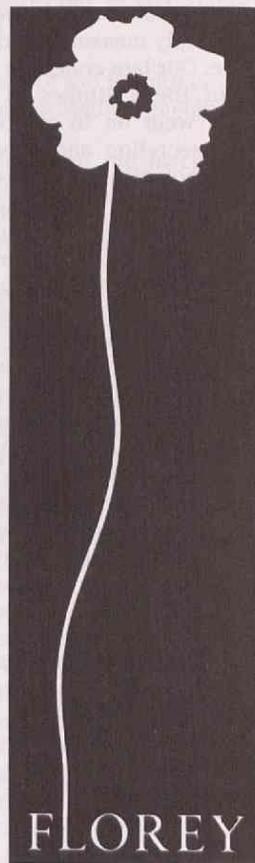
Howard Florey was awarded the Nobel Prize in 1945 for his role in discovering and developing the therapeutic power of penicillin, along with Alexander Fleming who originally discovered and named penicillin, and Ernst Chain, Florey's chemist, who helped to extract and purify the penicillin. Amongst his other achievements, Florey played a crucial part in the development of the Australian National University (ANU) in Canberra and in the creation of its John Curtin School of Medical Research, opened in 1958. Florey also gave his name to the Florey Institute of Experimental Physiology and Medicine in Melbourne.

The first Australian elected to the prestigious position of President of the Royal Society (1960), Florey was knighted in 1944 and accepted the chancellorship of the ANU and a life peerage in 1965, becoming Howard Walter Baron Florey, of Adelaide and Marston. He was provost of Queen's College, Oxford, from 1962 until he died in 1968.

Celebrations and special events will be happening all year, with the central focus during 'Florey Week' (19-26 September 1998) when many events will be held in the Australian cities with which Florey was associated. These include the following scientific symposiums: in Melbourne *The Florey Legacy: Penicillin and the emergence of antibiotic resistance* (Friday 18 September 1998); in Canberra, a symposium on *Helicobacter pylori* (21-22 September 1998), and in Adelaide, a symposium highlighting the work of young researchers (23-24 September 1998).

The 1996 Nobel Prize winner for Medicine and Physiology, Professor Peter Doherty, will be a special guest at these symposiums as well as being the Florey Guest Speaker at the Gala Dinner in Adelaide during which the inaugural Faulding Florey Medal will be awarded by the Prime Minister to 'an Australian or Australians actively working in Australia or overseas for a major biomedical discovery of benefit to human health'. This medal will be awarded biennially.

Please consult the web site for information on all events planned to celebrate Howard Florey, one of our 'tallest poppies' ([www.tallpoppies.net.au/florey](http://www.tallpoppies.net.au/florey)) or telephone 61 2 9810 5642.



## FROM THE DEAN



PROF RICHARD LARKINS

### EDUCATION AND TEACHING

The major focus of activity in this area has been the development of the new curriculum for the Medical School. In what is probably the most major revision at a single time since the commencement of the School, a commitment has been made to an integrated, systems-based curriculum, with extensive (although not exclusive) use of problem-based learning modalities, complemented with computer-based self-directed learning packages.

Over two hundred Faculty staff are actively involved in task-

groups working on aspects of the new curriculum or developing computer-assisted learning packages to support it. One notable feature of this process has been the extent to which it has built bridges between previously separate departments of the Faculty. Another has been the very active and helpful participation of the current students despite the fact that they will not directly benefit from the new curriculum. The process is now being led by Associate Professor Susan Elliott and the other members of the newly constituted Faculty Education Unit, together with Associate Professor Peter Harris, the Assistant Dean, Information Technology.

A second major initiative in education and teaching has been the establishment of the Department of Rural Health to be based in Shepparton. This initiative has been funded by the Commonwealth Department of Health and Family Services, and will be the hub of the Victorian Universities Rural Health Consortium. Recruitment of staff and building of student accommodation and academic facilities will take place this year. The Department will enhance teaching and research in rural and Aboriginal health, and ultimately lead to improvements in the rural health workforce.

### PEOPLE

#### New appointments

- Professor Andrew Kaye - James Stewart Professor of Surgery, Royal Melbourne Hospital
- Professor James McCluskey - Professor of Microbiology, Department of Microbiology and Immunology
- Professor Michael Permezel - Professor of Obstetrics and Gynaecology, Mercy Hospital for Women and Austin and Repatriation Medical Centre
- Professor Peter Smith - Stevenson Professor of Paediatrics, Royal Children's Hospital
- Professor Doris Young - Professor of General Practice, Department of Public Health and Community Medicine
- Associate Professor Warwick Anderson - Director, Centre for the Study of Health and Society
- Associate Professor Susan Elliott - Director, Faculty Education Unit
- Associate Professor Peter Harris - Assistant Dean (Information Technology and Multimedia)
- Professorial Associates with the title of Professor: Glenn Begley, Stephen Cordner, Stephen Davis, Anna Howe, Edward

Janus, Andrew Kemp, Anthony Kinnane, Bill Robinson, Brian Speed

- Professor Len Gray - Professor/Director, Aged Care, Austin & Repatriation Medical Centre

#### New appointments in 1997/98

- Professor John Furness, Associate Dean (Research)
- Professor Bruce Singh, Assistant Dean (North Western Network)
- Professor Peter Smith, Assistant Dean (Women's and Children's Network)
- Professor Neville Yeomans, Associate Dean (Academic Programs)

#### NEW PROGRAMS IN 1998

- Master of Health Sciences (additional specialty streams in transcultural mental health; genetic counselling; drug evaluation & pharmaceutical science)
- Graduate Diploma in Child Health
- Graduate Diploma in Mental Health Sciences (additional specialty streams in young people's mental health; cognitive behavioural therapy; child, adolescent and family mental health)
- Graduate Certificate in General Practice Psychiatry

#### Other academic initiatives

- Creation of Chair of Women's Health
- Creation of Professor/Director position in Rheumatology
- Australian International Health Institute
- Victorian Universities Rural Health Consortium, incorporating the establishment of a new University of Melbourne rural health academic unit in Shepparton, Victoria to be headed by the Foundation Professor of Rural Health

#### PUBLIC PROGRAMS

The 1997 Dean's Lecture Series included ten Dean's Lectures and the medical ethics seminar entitled 'Health Care in a Multicultural Society'. The Series continues to be well attended by students, graduates and members of the public. The Continuing Medical Education program, which had offered high-quality continuing education to medical practitioners since 1979, was discontinued at the end of 1997 as it was felt that the continuing education needs of graduates were being met by the Divisions and the Colleges. Some departments may offer continuing education courses as needs arise.

#### Alumni

A survey of graduates who completed their course between 1979 and 1993 (inclusive) was conducted in February 1997. 1859 graduates, of a total of 2797 resident in Australia, responded to the survey. A report of the survey is published in this issue of *Chiron* (p43). There are 10 000 medical alumni in Australia and around the world. The School of Medicine maintains active contact with 3500 alumni through the University of Melbourne Medical Society, which recently launched a bi-annual newsletter to complement *Chiron*, *The Melbourne PostCard*.

#### RESEARCH

1997 has been an outstanding year for research in the School of Medicine. In the 1997 funding round for 1998 and beyond, the total extent of NHMRC funding to the University increased from

\$12.25m to \$14.81m, by far the largest amount received by any University in Australia. Many staff within the Faculty and the affiliated research institutes received awards for outstanding research, as itemised in the section 'UMMS Congratulates' (p42). The Faculty values its relationships with the affiliated research institutes, and joint research scholarships are planned as a new initiative in 1999. Overall, the research achievements of the

Faculty reflect an enormous level of talent and commitment at all levels, including postgraduate research students and research assistants as well as NHMRC research fellows and the research and teaching staff.

*Richard G Larkins*

*Dean, Faculty of Medicine, Dentistry and Health Sciences  
Head, School of Medicine*

## RENOVATIONS AND EXTENSIONS TO THE MEDICAL SCHOOL BUILDING

**N**O SERIOUS medical scholar, teacher or research scientist could fail to appreciate what the University of Melbourne has done for the School of Medicine in the magnificent extension and refurbishment of the thirty-two year old tri-radiate medical building. The first stage of the extension, costing \$20 million, comprises two new floors, each of three wings, on levels eight and nine, and a refurbishment of areas on level two (ground level) and on level five.

The Department of Pharmacology is now housed on level eight. The east wing is the teaching wing with a seventy-seat practical laboratory and preparation room, three twenty-seat tutorial rooms, separate honours and graduate rooms with carrels and fully networked computer points, the library, and the staff common room and kitchen with a view south to the central business district. The north wing has the tiered seventy-seat Michael J Rand Seminar Room and research laboratories for neuropharmacology, asthma research, cerebrovascular pharmacology and two units; the Anaesthesia Research and Education Unit and the Australian Venom Research Unit. There is also a large open plan flexible laboratory designated for drug discovery where pharmaceutical industry collaborative research programs will be conducted. Administration and teaching staff offices are housed in the west wing, together with core research facilities such as cold room, cell culture suites, radioactivity counting and storage areas, the darkroom, heavy instrumentation rooms for centrifuges and specialised microscopy suites. Research laboratories for neuropharmacology and central control of feeding and blood pressure are also located in the west wing.

Pharmacology also has use of the north wing on level nine where cardiovascular pharmacology research laboratories are housed. Specialist areas have been created in this wing for peptide chemistry and instrumentation and an animal operating theatre.

On the east and west wings of level nine there is a state-of-the-art animal breeding and housing facility for the School. The Pharmacology and Physiology Departments share the east wing facility while the Pathology and Anatomy and Cell Biology Departments share the west wing facility. These areas, approved by the National Health & Medical Research Council Animal Welfare Committee, have ensured that medical research scientists have ready access to the best animal facilities possible.

Previously occupied areas have been refurbished. The old Physiology animal house on level five has been refurbished as tutorial and work rooms for Physiology. The space previously used for Pharmacology's practical class teaching on the ground



Vice-Chancellor Prof Alan Gilbert, Prof Richard Larkins, the Hon Dr David Kemp and Prof James Angus at the opening of the extension to the Medical Building

level (north wing) is now a magnificent fifty-two station high-end computer laboratory and a home for the new Biomedical Multimedia Unit. This initiative of the School of Medicine is central to the self-directed learning aspects of the new medical curriculum and allows for three large tutorial classes with high-end interactive computer-aided learning.

These new and refurbished works have also allowed for the leaving in 'shell' of two wings on level seven for future development. At present, there is an urgent need for

additional space in the building for small group problem based learning rooms and a clinical skills laboratory which will require the development of one wing; the other is being reserved possibly for a future research program in neuroscience.

Other exciting developments are planned for the Medical School. The microbiology building is in urgent need of refurbishment. The University has committed funds to refurbish plant and ex-pharmacology space on levels four and five and to expand the very important Medical Diagnostic Unit under the Woodruff Theatre. Our main lecture theatres, Sunderland and Wright, were totally refurbished and fitted with the latest multimedia equipment over the summer break. As resources allow, the main foyer area on the ground floor will be enlarged towards the Howard Florey Institute to provide outdoor seating and perhaps a coffee shop.

Finally, to the building itself. The architects Castle, Stevenson & Turner have designed a most attractive cap to the late Sir Sydney Sunderland's medical school. The sweeping design along Grattan Street with the 'T piece' feature and red core stem is captured in the lifts, the glass panels and even the laboratory benches in the new levels. This has focused our University colleagues and the surrounding community on the School of Medicine at an important time of change in medical teaching and research. The magnificent quality of the finish owes much to the architects and to the builders Hooker Cockram, who have finished this first stage on time and on budget. The extension was opened officially by The Honourable Dr David Kemp MP, Federal Minister for Employment, Education, Training and Youth Affairs on 22 January, 1998. The investment by the University of Melbourne and the School of Medicine in this extension of the tri-radiate building for research and teaching facilities of the quality we now enjoy, sets a standard and a responsibility for all those who are fortunate to step inside. We are indebted to the former Vice-Chancellor, Professor David Penington, and former Dean, Professor Graeme Ryan, who supported this extension at a critical time.

*Professor James A Angus*

*Head, Department of Pharmacology*

## AUSTRALIAN INTERNATIONAL HEALTH INSTITUTE

THE AUSTRALIAN International Health Institute (AIHI) is being established by the Faculty of Medicine, Dentistry and Health Sciences as the hub of an international health network. The AIHI will be supported by an international board chaired by Professor Emeritus, Sir Gustav Nossal. Members will include:

Professor Chen MinZhang, *Minister for Health from China*; Minister Haryono, *Minister for Population and Chairman of Family Planning Board of Indonesia*; Dr Olive Shishana, *Director-General of Health, South Africa*; Dr Luke Rokovada, *Permanent Secretary Ministry of Health & Social Welfare, Fiji*; Dr Damrong Boonyoen, *Director-General, Department of Health, Thailand*; Mr Jose Fabia, *Chair Philippines Health Insurance Commission*; representatives from the World Bank and the World Health Organization; Professor Emeritus Len Syme, *UCLA Berkeley*; Professor Judith MacKay, *Director, Asian Consultancy on Tobacco Control*; Dr Rob Moodie, *Incoming CEO, Victorian Health Promotion Foundation*; Professor Ian Gust, *Director, Research and Development, CSL Limited*; Professor Richard Larkins, *Dean, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne*; Dr Alok Mukhopadhyay, *Executive Director, Voluntary Health Association of India*; Professor John Bryant, *Emeritus Professor, The Aga Khan University, Pakistan*; Dr Supakorn Buasai, *Health Systems Research Institute, Thailand*; Professor Richard Feacham, *Senior Adviser, Health, Nutrition and Population, World Bank*.

The objective of the AIHI is to develop partnerships with countries, organisations and communities for the development, delivery, and management of health, based on a prevention model.

The importance of disease prevention to development has been outlined by the World Bank, which predicts that non-communicable diseases will overtake infectious disease and malnutrition as the primary causes of mortality and morbidity before the year 2020.

The AIHI will focus on new and emerging health issues including population growth, ageing populations and the increase in chronic diseases, the decline in health status from intense urbanisation and environmental degradation, the emergence of new infectious and tropical diseases, the HIV/AIDS epidemic and the epidemic of non-communicable diseases including injuries and accidents.

To meet these health challenges developing countries require a multi-disciplinary response and the AIHI will link disciplines such as agriculture, veterinary science, environmental sciences, management, economics and public policy development with core medical, nursing and allied health disciplines to provide flexible and tailor-made education and training, the development of joint research projects, consultancy and advice and targeted commercial joint ventures, for the effective management of the health transition.

The AIHI is based on a strategic planning model which focuses on population groups across the life span:

- mother and child health - improving rates of infant and

- maternal mortality and morbidity, infant and maternal service delivery;
- child development within the context of the family, school and community;
- adolescent health - prevention of risk behaviours and the promotion of healthy adolescence;
- adult health - with an emphasis on differential women's and men's health needs and occupational medicine; and
- health of the elderly - health promotion and clinical service delivery through to rehabilitation and palliative care.

The health areas supporting the improvement of health status for population groups include:

- health promotion, particularly as it interfaces with primary health and hospital services;
- development of primary and community health - national policy, provincial, district and local;
- an approach to non-communicable disease prevention and treatment that is integrated, focusing on common risk factors for heart disease, hypertension, diabetes, cancer and muscular skeletal diseases;
- rural health service delivery, health organisation and management, primary health and health promotion;
- an emphasis on the prevention of new and emerging infectious and tropical diseases;
- health systems reform - development of surveillance systems, policy, legislation, regulation, organisation and management within a preventive model;
- hospital management - development, re-engineering, tele-medicine, development of quality assurance systems to promote organisational and patient health;
- health economics, health financing and health management for efficiency and effectiveness;
- medical nursing and allied health specialities;
- injury prevention and safety promotion;
- specialist training and upgrading based on a prevention model;
- early detection, development of treatment guidelines;
- essential drugs development, distribution and quality assurance; and
- mental health - mental health promotion, early detection, mental health service delivery, managed care.

An undergraduate and graduate volunteer program will enable exchanges for a student volunteer contribution to health development as part of accredited education.

The AIHI is a partnership of outstanding organisations combining their enormous knowledge and experience. It will constantly renew itself by attracting excellent people from around the world who are well experienced and understand the very nature of partnership and the building of relationships for facilitation of health development.

The joining of these forces brings together a common belief and capacity about health development based on education and disease prevention.

*Rhonda Galbally*

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## INTERNATIONAL MEDICAL COLLEGE

THE INTERNATIONAL Medical College (IMC) in Kuala Lumpur was established in 1992 with the aim of improving the health care of the people of Malaysia and other countries of the Asia-Pacific region by providing an alternative pathway to medical practice. The College is privately funded and is based on the twinning concept developed by Malaysia with a number of overseas educational institutions, with part of a higher education course being undertaken in Malaysia and part overseas.

The IMC program involves a first phase in Malaysia lasting two and a half years which includes teaching in the basic biomedical sciences in a Malaysian context to internationally

accepted standards and an introduction to clinical medicine. The curriculum uses task-based learning to develop competencies and problem-based learning on simulated and real patient management problems. System courses and topic courses are run in parallel and are taught on an inter-disciplinary basis. The course was developed after wide international consultation and with particular input from Professor Ron Harden of the University of Dundee, and Professor Ian Hart of the University of Toronto. Satisfactory completion of the course results in the award of an Advanced Diploma in Medical Science.

The founding Dean was Professor John Swanson Beck of

Dundee, who has recently been replaced by Professor David Riches. Staff of the IMC are a mixture of local graduates and expatriates and there is part-time involvement of staff from partner medical schools involved in the second phase.

The second phase involves transfer of the students to one of twenty partner schools in the United Kingdom, the Republic of Ireland, Canada, the United States of America, New Zealand and Australia, with the University of Melbourne being the only Australian participant. Melbourne received its first students from IMC in July 1997 (including the gold-medallist), with entry to second semester of year three of the Melbourne MB BS course.

University of Melbourne staff who have participated in the teaching and examination processes at the IMC include Associate Professor Frank Firkin of the Department of Medicine at St Vincent's Hospital and Associate Professor Robert Moulds of the Royal Melbourne Hospital.

The change in curriculum in the School of Medicine of the University of Melbourne in 1999 will lead to even greater compatibility between the early years of the two courses, and the University of Melbourne looks forward to an even stronger association with the IMC in the future.

*Gordon Clunie*



Students from the International Medical College. Photo courtesy of UniNews

## RETIREMENTS

### GORDON JAMES AITKEN CLUNIE MB, ChM, FRCS (Edin), FRACS



GORDON CLUNIE

**G**ORDON JAMES Aitken Clunie graduated in medicine from the University of Edinburgh in 1956. After early training in Scotland he undertook surgical training in Edinburgh before being appointed Reader in Surgery at the University of Queensland and Director of the Dialysis and Renal Transplant Unit at Princess Alexandra Hospital in Brisbane in 1968. In 1973 he was appointed Professor of Surgery at the University of Queensland and in 1978 he was appointed the James Stewart Professor of Surgery at the University of Melbourne.

Professor Clunie has published widely, especially on organ

transplantation, immunology, general surgical research and medical education.

He was appointed Deputy Dean of the Faculty of Medicine in 1986 and continued as Deputy Dean of the Faculty when the Faculty expanded to become the Faculty of Medicine, Dentistry and Health Sciences in 1991. In 1995 he was appointed Dean of the Faculty of Medicine, Dentistry and Health Sciences. In this position he has shown outstanding leadership, and has played a seminal role in the major remodelling of the undergraduate curriculum of the Medical School and in the establishment of the Australian International Health Institute based in the Faculty, as well as in many other initiatives.

In addition to his excellent service to the University of Melbourne, Professor Clunie has held senior positions with many other important bodies. At the Royal Melbourne Hospital he was Chairman of the Division of Surgery and Chairman of the Medical Advisory Committee for many years. He has been a member of the Council of the Royal Australasian College of Surgeons since 1994 and for several years Editor-in-Chief of the Australian and New Zealand Journal of Surgery. He has led important AusAid funded programs for the College of Surgeons, one involving delivery of specialist care to the Pacific Islands and another involving the development of postgraduate training programs at the Fiji School of Medicine. He has also made major contributions to the Anti-Cancer Council of Victoria, the National Health and Medical Research Council, the Australian Medical Council Accreditation Committee and has served on the boards of several medical research institutes.

Gordon Clunie has made outstanding contributions to the discipline of surgery, to medical education and to the University of Melbourne and was admitted to the degree of Doctor of Medicine honoris causa on the 6 December 1997. He retired from the University on 31 December 1997.

### PETER DUHIG PHELAN BSc, MD, FRACP

**P**ETER PHELAN graduated in both science and medicine from the University of Queensland, being the top medical graduate in 1961. He came to Melbourne in 1964 to undertake training as a paediatrician at the Royal Children's Hospital and declared his interest in research by becoming a Fellow in the Clinical Research Unit. He was a Post-doctoral Fellow at the School of Public Health at Harvard University in 1969 and 1970, before he returned to the Royal Children's Hospital in 1971.

His field of specialisation has been respiratory illness in children and he is the author of the standard text in that discipline, which has now reached its fourth edition. He has had substantial support for his research from the NHMRC and from the Victorian Health Promotion Foundation. He has made major contributions to our understanding of respiratory function in children and most particularly to our knowledge of childhood asthma and cystic fibrosis.

He became Chief Thoracic Physician at the Royal Children's Hospital in 1982 and then Stevenson Professor and Head of the University Department of Paediatrics in 1983. He has contributed as an active clinician, teacher and researcher in what is one of the world's leading children's hospitals. In that role he has provided outstanding leadership to his department, to the Faculty as Assistant Dean for Postgraduate Studies and to the profession at both state and national levels. His record as a trainer of academic paediatricians is remarkable. Seven of his trainees hold chairs in Australasia, with others in Canada, Chile and Austria. His achievements have been recognised by the recent award of the Research Medal of the Thoracic Society of Australia and New Zealand and the Gold Medal of the Royal Children's Hospital.

He has held many substantive offices, among them Senior Examiner in Paediatrics and member of the Executive Committee of the Australian Medical Council, member of the Boards of the Murdoch Institute and the Royal Children's Hospital Research Foundation, Councillor of the Royal Australasian College of Surgeons and President of the Australian College of Paediatrics. He has also made major contributions to the broad field of medicine through his roles as Deputy Chairman of the Australian Casemix Clinical Committee and as a

member of the Metropolitan Hospital Review Board, which resulted in a radical alteration in the forms of health care delivery in this city.

He has also been particularly active in encouraging the development of Child Health in South East Asia and has particular liaisons with Indonesia and Thailand. As a result of his activities, trainees come from all over the world to work at the Royal Children's Hospital.

Peter Phelan has made an outstanding contribution, not only to the discipline of Child Health at a local, national and international level, but also to the broad field of medical education and to the methods of health care delivery.

## PROFESSOR GERHARD H SCHREIBER

DrMed, DozBiochem (Freiburg)

**G**ERHARD HANS SCHREIBER graduated in physics from the University of Mainz in 1955, and later in medicine from the Universities of Mainz and Freiburg in 1959. After early clinical training in Germany, he undertook postdoctoral work in biochemistry at the University of Freiburg (1962-63) and subsequently at the McArdle Laboratory for Cancer Research in Madison USA (1965). After an Assistant Lectureship (Medicine) at Columbia University, New York (1966), he served as Lecturer (1967-69) and, subsequently, Senior Lecturer (1970-73) and Managing Director in the Biochemistry Department (1971-73) University of Freiburg. In 1973, he was appointed Chair of Biochemistry (Medical) at the University of Melbourne.

Professor Schreiber has a distinguished record in research in frontier areas of biochemistry, protein chemistry and molecular biology. During his formative years he developed major interests in the fundamental mechanisms and regulation of the synthesis of plasma proteins in the liver, during embryonic and regenerative growth and in response to acute trauma and inflammation. In recent years, his research has concentrated on the synthesis, function and evolution of thyroid hormone transport proteins. He has made numerous important discoveries in these areas, the most important of which are the discovery and molecular characterisation of precursor forms of plasma proteins in the liver and the finding that transthyretin, one of the major thyroid hormone transport proteins synthesised in the liver, is also synthesised in the choroid plexus of the brain in the region of the blood brain barrier. The transthyretin discovery created a major new field of research in which Professor Schreiber is recognised internationally as the leader. This is reflected in the frequent invitations he receives to deliver plenary lectures on transthyretin related research to major international meetings.

Apart from the significance of his discoveries in the context of thyroid hormone transport in blood and across the blood brain barrier, Professor Schreiber's structural characterisation of the transthyretin from a broad range of vertebrates has identified variations in the transthyretin gene between species of considerable evolutionary significance.

In addition to his excellent research, Professor Schreiber has made major contributions to the teaching of undergraduate biochemistry and molecular biology in the Medical and Science degree programs of the University, as well as to the training of BSc Honours and PhD students. He has assumed an active role in the Australian Society of Biochemistry and in 1983 was awarded the prestigious LKB Medal by this Society in recognition of his outstanding contributions to the field of protein chemistry. He has also made important contributions to the assessment of research grant applications in Australia, most recently as a member of a National Health and Medical Research Council Regional Grant Interviewing Committee, and to the wider community as an expert interpreter in the Royal Commission into the Chamberlin Enquiry.

In summary, Gerhard Schreiber has made an outstanding contribution to the discipline of biochemistry and molecular biology, and to science and medical education at the University of Melbourne. He retired from the University on 31 December 1997 after 24 years distinguished service.

## WHAT'S ON IN 1998

### Music Medicine: Expanding Horizons

7th International Music Medicine  
Symposium

12-15 July 1998

Papers will cover the five major areas of research interest: physiological measures of music response; medical problems of performing musicians; music communication and behaviour; music in medical settings and music therapy.

Further information is available from:

Denise Erdonmez, Faculty of Music,

The University of Melbourne,

Tel: (+61 3) 9344 5259, Fax: (+61 3) 9344 5346,

Email: d.erdonmez@music.unimelb.edu.au.

### Medical Ethics Seminar

Too young to know?

Too young to decide?

Consent and confidentiality in  
adolescent health

Convener: Professor Richard Smallwood AO  
Friday 31 July 1998 2-5 pm

Sunderland Lecture Theatre, Ground Floor  
Medical Building, The University of Melbourne

At what age should an adolescent be able to make his or her own health care decisions? Decisions about contraception, whether to accept or refuse medical treatment and so on. Should doctors advise parents of difficult adolescent health matters conveyed in confidence e.g. sexual habits, pregnancy, AIDS, drug abuse?

These and other contentious questions will be discussed by a panel of high-profile speakers at this year's annual ethics seminar.

The afternoon includes a hypothetical led by Assoc Prof Michael Carr-Gregg from the Centre for Adolescent Health.

The seminar is free and open to the public.

### Alumni Association

Breakfast, seminar and privileged viewing of  
New Worlds from Old: U.S. and  
Australian Landscapes in the 19th Century  
8.30 am, Sunday 14 June 1998

Information and bookings on:

Tel: (+61 3) 9344 7469

Fax: (+61 3) 9344 6895

Email: info@alumni.unimelb.edu.au

## AUSTIN AND REPATRIATION MEDICAL CENTRE

**T**O DATE IN 1997, the final year results have been reported and Katrina Dowey was the top student from the Clinical School with a first class honours degree.

In 1997, the programs have remained similar to those of previous years with the emphasis on clinical bedside teaching and the individuality of the student. For the first time, the Clinical School used the units at Preston & Northcote Community Hospital for surgical teaching in final year which gave students a greater breadth of exposure to patients. The student groups were maintained at six students or less.

In the third year 'Introduction to Clinical Medicine', the students were allocated to their clinical school. The 1997 program included a segment on liver transplant in which the transplant team and patients presented many of the issues involved and gave the students an insight into a complex area of medicine. The program also consisted of a series of clinico-pathological correlates and a ward presentation based on the systems undertaken in the pathology demonstration.

The fourth year program was similar to previous years with an emphasis on ward based learning, and a series of formal learning sessions. The counselling service was again made available to the students.

Following an introductory two weeks, the students spent the next four terms attached to medical and surgical wards of the Hospital. An important part of their training is one term spent in the country base hospitals at either Bendigo, Wangaratta or Albury. The first clinical term leading up to Easter is spent at the Austin and Repatriation Medical Centre (ARMC). At the end of term the students have a revision period to assess their grasp of clinical skills.

During the year the students are taught communication skills, clinical skills, presentation, pathology, radiology, emergency medicine and undertake an Advanced Study Unit. Geriatrics is taught using the facilities of the Medical Centre and Bundoora Extended Care.

Fifth Year remains essentially unchanged. During the year Professor Michael Pemezel was appointed Professor of

Obstetrics and Gynaecology at the Mercy Hospital for Women and has demonstrated a great interest in the teaching program there.

In final year, for the first time, surgery teaching was undertaken by two units at PANCH as well as at the ARMC. The medical teaching was undertaken at the Austin Campus of the ARMC. The teaching at PANCH in general surgery was well received by the students with enthusiastic teachers and sufficient patients.

The programs were undertaken in general and specialty units and each student group rotated through a term of emergency medicine, anaesthetics and resuscitation both at the ARMC and PANCH.

Throughout the year the clinical sessions were done in the wards and outpatient departments. The students also had formal teaching in radiology, clinical pathology, ECGs and therapeutics. Core based sessions were undertaken and lecturers were encouraged to use cases to illustrate points in management.

For 1998 the Clinical School is looking forward to using the Northern Hospital for the teaching of both medical and physiotherapy students. This will widen the patient teaching base and allow the current program to continue with small groups of students of six or less in a group. The Clinical School anticipates that teaching will take place mainly at Northern Hospital.

The changes to the public hospital system are having an effect on the teaching programs. The increasing patient load, sicker patients, shorter lengths of stay and bed closures, together with the changing inpatient mix in the major teaching hospitals is making it more difficult for students to see and clerk patients and for the clinical staff to find time for teaching. The Clinical School is looking at other areas for teaching including private hospitals, ambulatory care and pre-admission clinics.

I am grateful to the staff of the hospitals who contribute so much to the clinical training of the students.

*Bernard Sweet*  
Clinical Dean



**Austin and Repatriation Medical Centre - Clinical School Final Year 1997**

**Back Row L-R:** Melanie Bennett, Jiun Y Lai, Ajeet Singh, Selsea Tan, Sarah Healy, Katrina Dowey, Carolyn Bosak, Wendy Teoh, Kylie Petschel, Thanh N Nguyen, Lisa Laidlaw, David Ying, Justin Chee, Gordon Ku, Sheldon Chong, Tom Bowles, Suresh Sivanesan, Rebecca Foxton, Melanie Seale, Melanie Wedd, Veronique Browne, Matthew Labb. **Fourth Row L-R:** Irina Churilov, Kenny C K Chaw, Yau-Feng Chen, Georgia Paxton, Hui-Fu Chen, Hugo Stephenson, Megan Rees. **Third Row L-R:** Jasper Tiong, Gavin Chau, Cheng Ping Lo, Y C Ken Chan, Siu-Kim Yeang, Bao Nguyen, Osman Ozturk, Edward Y K Lee, Sin Hing Mok, Naomi Elliot, Peter Barlis, Teck Hock Toh, Frederick T M Chan, Adam Rehak. **Second Row L-R:** Kok Yang Tan, Jane Tam, Joanne J L Chionh, Nguyen Han, Winnie Ong, Kathryn Law, Suzanne Pearson, Li Ping Chow, Janelle Brennan, Ken-Tze Koh, Cynthia Chen, Lai Mun Looi, Winnie Cheng, Anthony Chiu, Linda H W Chen, Julian Smith, David Ng. **Front Row L-R:** Vu Vu Dang, Chee Keong Chan, Berenika Turchin, Dr Sue Elliott, Professor Colin Johnston, Mrs Rosa Poon, Associate Professor Bernie Sweet, Dr Barbara Goss, Professor Roger Sinclair, Professor Kenneth Hardy, George H-S Ting. **Absent:** Domenic Cincotta, Kenneth H K Lee, Mrs Neale, Shahneen Sandhu, Rabindra Sinnappu, Clare White.

## THE ROYAL MELBOURNE HOSPITAL AND WESTERN HOSPITAL

**T**HE STRUCTURE OF THE COURSE at the RMH/WH Clinical School was similar in 1997 to that in previous years. The fourth year students continued to spend two of their four terms at the Royal Melbourne Hospital, one at Western Hospital and one in the country, at either Ballarat, Wimmera or Wangaratta Hospitals. This use of our clinical resources has worked well over the last few years, and we plan to continue this broad structure of the fourth year program in 1998.

Our sixth year program has also been similar to previous years', with students spending roughly half their time in general medicine and surgery, and half their time in specialist medicine and surgery. The surgery component includes three weeks of anaesthetics and emergency medicine. The specialty terms are spent at the Royal Melbourne Hospital but the general terms are split between Royal Melbourne Hospital, Western Hospital and a few students at a time spending some time doing a general medical term at Ballarat Hospital. Again, this use of our clinical resources seems to work well, and is planned to continue in 1998.

The past year has seen the continued refinement of the use of the microwave link between the main lecture theatres at the Royal Melbourne and Western Hospitals. Lecturers are becoming more adept in its use and most of the teething problems have been ironed out. It enables students at Western

Hospital to remain there for their lectures and not have to travel back and forth between campuses.

The new curriculum plans have been an important activity over the past year. Planning for the pre-clinical years is already in full swing, and the clinical schools are now looking carefully at the implications of continuing to mount the old curriculum at the same time as accommodating the clinical requirements of the students entering the new curriculum in 1999. The new curriculum will also lead to a major rethink of the whole structure of the clinical years which should bring some exciting new developments.

A further development has been the consolidation of the functioning of the Western Health Care Network. The Network structures largely follow those of the Clinical School, and networking has enabled resources, both human and material, to pass backwards and forwards between campuses in much the same way as the students from the Clinical Schools have done for some years. It will also enable the possibility of using Williamstown Hospital in our teaching programs together with the new development at Broadmeadows.

*Robert F W Moulds  
Clinical Dean*



**The Royal Melbourne Hospital and Western Hospital - Final Year 1997**

**Front Row L-R:** Sam Smart, Sarah Meertens, Evan Newnham, Sandra Petty, Suzanne Field, Kate Wheadon, William Renwick, Arvind Sharma, James Gome. **Second Row L-R:** Rathan Subramaniam, Fui Been Teu, Carlos D'Abbrera, Phyllis Fu, Lin-Lin Su, Yong Ming Por, Christina Tan, Sree Appu, David Charlesworth, Sudharshan Karalpillai, Chuong Nguyen, Max Seet. **Third Row L-R:** Kerryn Pastra, Lee Chyi Lam, Chris Angel, Lyn-May Lim, Ruth Lim, Dr Christine Penfold, Lee-Wuen Fua, Jacqueline Gilbert, Victoria Tran, Deepti Srivastava, Asher Hiddlestone, Sia Peng Ong, Phuoc Phu Thi Pham, Tania Meusemann, Li-You Xu, Jane Kho, Rita Furlan. **Fourth Row L-R:** Leon Worth, Robert Tasevski, Leo Rando, Simon Gibbs, William Blake, John Henderson, Michael Hurley, Charlie Baillieu, Marcus Tan, Lean Peng Cheah, Graeme Wright, Kuen Loong Chin, Andrew Cheasley, Daryl Kroschel, Ben Barresi. **Fifth Row L-R:** Associate Professor Rob Moulds, Swee Teng Tan, Cherng Tze Jong, Andrea Chan, Katherine Dawson, Guan Hwee Tay, Eric Hu, Dean Spiliadis, Dennis Lau, Sikenyi Ouna, Anthony Kelman, Stuart Newland, Joe Vetro. **Absent:** Sophie Adams, Claire Hooper, Nesor Houli, Ahsan Hussain, Sharon Tai, Malachy Tarry.

## ST VINCENT'S HOSPITAL AND THE GEELONG HOSPITAL

ONE OF THE KEY ISSUES for medical education at this time is how to adapt to changes in the delivery of health services in Victoria. These changes have resulted in a dramatic decline in the length of stay for inpatients throughout the State. Patients are now admitted on the day of surgery, for example, and discharged at an early stage. Many common, important conditions for which patients were previously hospitalised are now investigated and managed in an ambulatory setting or in the 'hospital in the home'. Advances in technology have also led to a dramatic increase in the proportion of patients whose entire investigation and treatment are now managed in an ambulatory setting. Within the tertiary teaching hospitals, units have become super-specialised and patients frequently have uncommon or very complex conditions. All these changes have taken place over a very short period leaving little opportunity for advanced planning.

We have adapted to these changes in patient care by introducing several initiatives. At the St Vincent's Hospital campus, students attend the pre-admission clinics where they have the opportunity to clerk patients shortly before their admission. Senior students attend the Day Procedure Unit where they review the patient and observe diagnostic and interventional procedures. In order to widen their clinical

exposure small numbers of senior students now attend St Vincent's Private Hospital and there are plans to develop this further in the near future.

Students continue to find their rotation to the Geelong Hospital very valuable in terms of access to patients and appreciate the exposure to the wide variety of cases. The increased use of the video link between our two campuses enables us to provide a more effective and complementary teaching program.

In addressing the issue of short stay and super-specialised units in the city hospitals, we are also fortunate in having excellent country rotations to Warrnambool and Goulburn Valley Base Hospitals. These rotations provide good access to patients and experience in a wide variety of important, common disorders. The clinicians at these hospitals are enthusiastic and effective teachers and many have strong links with St Vincent's Hospital.

Other developments in 1997 have included the implementation of the infectious diseases teaching program at the St Vincent's campus. The program comprises a comprehensive series of lectures given by our infectious diseases physicians and by visiting lecturers, as well as clinical tutorials at St Vincent's Hospital and at the Alfred Hospital (HIV medicine). A further initiative was the introduction of a series of



St Vincent's Hospital and the Geelong Hospital - Final Year Clinical School 1997

**Back Row L-R:** Daniel Croagh, Chee Khoo Liew, Michael Augello, Craig Humphries, Martin Campbell, Nigel Toussaint, Paul Brooks, Simon Jones, Danny Nguyen, Kang Teng Lim, Jasmin Morey, Ray Bruozis. **Fourth Row L-R:** Susannah Leach, Su-Ching Tan, Tzer Hwu Ting, Andrew Lim, Shueh Lin Lim, Bridget Langley, Miriam Koniuszko, Lara Phillips, Genni Newnham, Kate McKenzie, Anthea Greenway, Helen McManus, Mark Page, Alex Thompson, Elvis Ojaimi, Nicola Bryan, Alvin Cham. **Third Row L-R:** Chin Soon Ng, Jacqui Quach, Eng Soon Teo, Thai Quach, Quoc Dinh, Yee Choon Wong, Cheng Kang Ong, Kate Walker, Vicky Tee, Jay Sen Gan, Manuprabha Ratnayake, Michael Jones, Chuk Yin Han, Niranjana Arachchi, Lip Wai Lee. **Second Row L-R:** Emma Pun, Kevin Ong, Amelia Siu, Daniel Wong, Maria Tsanglis, Lee Mei Yap, Claire Short, Colin Chan, David Gilbert, Brad La Ferlita, Alex Kent, Ameera Khan, Karen D'Souza, Chun Wai Yip, Nigel Fang, Genevieve Flannery. **Front Row L-R:** Anne Parsons, David Ho, Kenneth Yap, Dr Jacqueline Walters, Bao Nguyen, Associate Professor Wilma Beswick, David Iser, Brett McGuirk, Ben Burt, Rob Cirtoni, Selene Liew. **Absent:** Shien Ming Tee

multi-disciplinary seminars in oncology given by staff from St Vincent's, Peter MacCallum Cancer Institute and Caritas Christie Hospice.

Our clinical ethics program in fourth year has again been a great success. An increase in our teaching staff enabled us to expand the program to include more formalised introductory sessions and group discussions of ethical issues in a clinical setting. A highlight of the year was the afternoon seminar of group presentations at the end of first term, which was both entertaining and educational. Five groups of students presented vignettes, based upon ethical issues in which they had special interest, to an audience of students and interested members of the medical staff. The program was very well received and found to be most enjoyable and effective. We feel that the ethics program has greatly enhanced students' appreciation of the doctor/patient relationship and inter-cultural diversity between themselves and some of their colleagues, and has stimulated students to expand their knowledge of potential ethical concerns and to develop appropriate responses.

We are delighted to report the continued high achievements of our students in their final examinations. Karen D'Souza was

the top student in medicine and seven other students were awarded first class honours. Daniel Croagh was the top student in surgery, five other students receiving first class honours. Six students were awarded Dean's Honours for excellence in their final year and five students were awarded the MB BS degree with overall first class honours. We congratulate all the 1997 graduates and wish them well in the future.

At the end of 1997 our longstanding affiliation with the PANCH Hospital ceased when its inpatient facilities were transferred to the new Northern Hospital. We have greatly valued the links between our two institutions over many years. Our students and former students are indebted to the highly committed and enthusiastic teaching staff at PANCH. We are particularly grateful to Associate Professors Ewing and Jackson for their excellent teaching and support over the past years.

It is to the great credit of our enthusiastic teaching staff that we are able to maintain our high standard of clinical medical education. Their willingness to teach and their commitment to our students is most highly valued.

*Wilma Beswick*  
Clinical Dean

## HIGHER DEGREES AND DIPLOMAS CONFERRED 1997

### DOCTOR OF PHILOSOPHY

Darunee Amagar DDS, GradDipSIsc *Thailand* - Medicine  
Jennifer Anne Cauchi BSc - Anatomy & Cell Biology  
Robert Ka Ming Chan MB BS - Medicine  
Sheena Wai Yee Chan BDS *Lond* - Medicine  
Denise Patricia Charman MA - Psychiatry  
Robert Mark De Matteo BSc - Physiology  
Miodrag Dodic MB BS *Belgrade* - Physiology  
Noel David Duncan BSc - Physiology  
Hooi Chee Ee - Medicine  
Loke Kit Ee BSc - Pharmacology  
Aude Michelle Fahrer BSc - Microbiology & Immunology  
Amanda Lee Gavin BSc *James Cook* - Surgery  
Neil Murray Gude MSc *Monash*, GradDipOccHazMgt *Ballarat* - Obstetrics & Gynaecology  
Guang-Chi Hiang MB BS *Kunming*, MMed *PRC* - Medicine  
Joanne Mary Hilton BAppSc *GIAE*, BSc *Monash* - Medicine  
SA Reza Hosseini DPS *Tehran* - Medicine  
Susan Jeavons BA *UNSW*, MPhil *Edin* - Psychiatry  
Trisha Anne Jenkins BSc - Medicine  
Stanislaw Jan Kaczmarczyk BSc *La T*, Biotech *Monash* - Medicine  
Michelle Monica Kett BSc - Anatomy & Cell Biology  
Michael Henry Kewshaw BSc - Surgery  
Nicky Konstantopoulos BSc - Medicine  
John Basil Kurek BSc, DipEd *Monash* - Medicine  
Selena Simone Layden BSc - Biochemistry & Molecular Biology  
Jason Derrick Lickliter - Medical Biology  
Graham John Lieschke BMedSc, MB BS - Surgery  
An Truc Lieu BPharm *VCollPharm* - Pharmacology  
Patricia Mary Livingston BSc - Ophthalmology  
Heather Gwen Mack BMedSc, MB BS - Ophthalmology  
Christine Maric BSc - Anatomy & Cell Biology

Geoffrey John McColl BMedSc, MB BS - Medical Biology  
Andrew Murray McLaren BPharm *VCollPharm* - Pharmacology  
Elisabeth Anne Northam MA - Medicine  
Aaron John Oakley BSc *Tas* - Medicine  
Peter Paspaliaris BSc *Monash* - Microbiology & Immunology  
Julienne Radford MSc - Pathology  
Simone Christine Richardson BSc, MSc - Paediatrics  
Andrew Warwick Roberts MB BS *Qld* - Medical Biology  
Mark Andrew Rosenthal MB BS - Surgery  
George Barrett Rudy BA *Yale*, MD *Stan* - Medical Biology  
Mary Catherine Ryan BSc - Medicine  
Bernadette Mary Saunders BSc - Microbiology & Immunology  
Anthony Joseph Slavin BSc - Pathology  
Athina Soulis BSc - Medicine  
Yury Stanislavsky MB BS *Ukraine* - Ophthalmology  
David Morgan Thomas MB BS - Medicine  
Merilyn Anne Thompson MSc *Arizona* - Medicine  
Dimitra Vranes BSc *Monash* - Medicine  
Beverley Joy Warner BSc *ANU* - Medical Biology  
Sarah Louise Whorlow BSc *Monash* - Pharmacology  
Scott Whyte - Pathology  
Elizabeth Deborah Williams BSc - Pharmacology  
Susan Williamson - Anatomy & Cell Biology  
Timothy Gerard Williamson BSc - Pathology  
Timothy Jon Wilson BSc - Biochemistry & Molecular Biology  
Lie Wu BMed *PRC* - Medicine  
Hong Yu - Physiology

### DOCTOR OF MEDICINE

Peter Tuen-Keung Cheung MB BS *HK*  
Chung Wo Chow MB BS *HK*  
Andrew Mark Davis MB BS *Monash*

Michael Andrew Henderson BMedSc, MB BS  
Benno Uwe Ihle MB BS  
Anastase Thomas Christos Kotsimbos MB BS  
Gregory Papworth MB BS  
Richard George Pestell PhD (Medicine)  
Katherine Sylvia Rowe MPubHlth *Monash*, DipEd *Lond*, MB BS  
John Collier Trinca MB BS  
Michael Winston Yung MB BS

#### MASTER OF AUDIOLOGY

Sandra De Vidi BSc, GDipAudiol  
Nina Hogben BSc *Adel&Flin*, GDipAudiol  
Mazwin Omar GradDipAudiol  
Tian Kar Quar GradDipAudiol

#### MASTER OF MEDICINE

Idham Amir BMed *Jakarta*  
Gary Philip Bernard Cohen MB BS *Monash*  
Paul Michael Denborough MB BS  
Mary Claire Murphy BA *Wont*, MD *Tor*  
Helen Elizabeth O'Connell MB BS  
Michael Gerard Plastow MB BS  
Kai Feng Xu BMed *China*

#### MASTER OF MEDICINE

Idham Amir BMed *Jakarta*  
Gary Philip Bernard Cohen MB BS *Monash*  
Paul Michael Denborough MB BS  
Mary Claire Murphy BA *Wont*, MD *Tor*  
Helen Elizabeth O'Connell MB BS  
Michael Gerard Plastow MB BS  
Kai Feng Xu BMed, *China*

#### MASTER OF SURGERY

Walter Peter Chang BMedSc, MB BS  
Jenepher Ann Martin MEd *Tor*, MB BS  
Michael Geoffrey Vaughan BMedSc, MB BS  
Lily Yang BMed, *China*

#### MASTER OF WOMEN'S HEALTH

Nicole German BEd, PgradDipEducSt  
Ruth Pilczyk Goldwasser DipEd *LaT*, BSc, GradDipWomHlth  
Suzanne Marie O'Callaghan GradDiplInfoServ *RMIT*, BA,  
GradDipEd  
Helen Christine Vidler BA *Monash*, BEd (Couns) *LaT*

#### GRADUATE DIPLOMA IN ADOLESCENT HEALTH

Aruna Sree Akkireddi, Judy Margaret Allen, Florence Anne  
Augustine, Sian Bill, Trevor Francis Bourke, Mark Francis  
Boyce, Vicki Bromley, Marueen Ellen Buckley, Peter Charles  
Burchell, Diane Julie Childs, Michele Anne Dean, Mary Gingold  
Patricia Mary Hallinan, Dorothy Joan Henning, Elizabeth  
Holland, Ronald David Jones, Jennifer Mary Osler, Nguyen Thi  
Ngoc-Anh, Alan Arthur Patterson, Eleanor Robinson, Pascal  
Peter Rohan, Louise Eunice Scafidi, Gregory Stephen Stewart,  
Maureen Ward, Anne Christine Rose Wilson, Jill Marie Wilson

#### GRADUATE DIPLOMA IN AUDIOLOGY

Ruth Elizabeth Bennett, Suzana Buden, Eugene Yew Keong  
Chang, Elizabeth Joy Cosson, Natasha Sanchia Cummings,  
Nichola Jane Duffy, Pam Alice Freebairn, Alison Claire Jagger,  
Anna Jaskierniak, Danielle Kosmider, Simone Kate Lawless,  
Viviana Yi Ling Liou, Kylie Luiten, Catherine Marie McMahon,  
David Robert McMaster, Leiana Sharon Morey, Nerissa Anne  
Morgan, Natasha Anne Morrison, Estelle Margaret Peacock,  
Susan Catherine Potter, Susan Elizabeth Potter

#### GRADUATE DIPLOMA IN BIOTECHNOLOGY

Tanya Ann Bashtannyk, Tam Anh Le, Thu Nhat Thi Nguyen,  
Zhao Yan Pu

#### GRADUATE DIPLOMA OF DRUG EVALUATION AND PHARMACEUTICAL SCIENCE

Douglas Gordon Anderson, Karen Moira Bickmore, Susan Gai  
Cairns, Leanne Marie Craigie, Susan Jane Davie, James Anthony  
Dwyer, George Grigoriadis, Dale Francis Hogden, Janet Alison  
Kettels, Edward Vaugh Kilpatrick, Phyllis Min-Yu Lau, Janine  
Maree Raffaele, Kamia Raniga, Elizabeth Jean Wilkinson,  
Bronwyn Gai Williams, David Wong-See

#### GRADUATE DIPLOMA IN EPIDEMIOLOGY AND BIostatISTICS

Harvinder Singh Bedi, Cynthia Helen Benporath, Angela  
Borthwick, Duncan John Campbell, Elizabeth Lynne Conway,  
Michael Allen Henderson, Nola Pearl Kennedy, Robert Jeffrey  
MacInnis, Susan Gaye Poole, Peter Douglas Ritchie, Heather  
Frances Stafford, Janet Elizabeth Strachan, Ratnawati Sundrum,  
Kate Elizabeth Whitehead, Kerry Myra Whyte, Charnisay Susan  
Woodward

#### GRADUATE DIPLOMA IN GENETIC COUNSELLING

Maryanne Aitken, Alison Margaret Boyd, Lisa Gomes, Pamela  
Geraldine Hutchins, Edith Sheffield, Joanne Tilkeridis,  
Catherine Elizabeth Vaux

#### GRADUATE DIPLOMA IN MENTAL HEALTH SCIENCE

(INFANT AND PARENT MENTAL HEALTH)

Julia Maree Cochrane Arthey, Helen Mary Belfrage, Susan  
Margret Breese, Ronald MacDonald Buchan, Christine Ann Hill,  
Doris May James, Kerry Anne Judd, Robyn Margaret Low, Kerry  
Mack, Mary Robinson, Diana Russo, Fiona Catherine Strang

#### GRADUATE DIPLOMA IN WOMAN'S HEALTH

Elizabeth Bulling, Karen Corban, Narine Lee Efe, Mikako Hara,  
Jenny Ho, Rosemary Hogan, Kausar Iqbal, Atya Kahid, Carol  
Leanne Lawson, Stella Tsui Fong Lee, Dianne Joy McMinn,  
Annamarie Perlesz, Robyn Elizabeth Smith, Katsuno Taniguchi,  
Christine Taylor, Caroline Margaret Tyas

# MB BS GRADUATES 1997

Sophia Adams, Christopher Angel, Sreenivas Appu, Niranjan Arachchi, Christos Argyropoulos, Michael Augello, Avram Babovic, Charles Baillieu, Peter Barlis, Sebastian Barresi, Melanie Bennett, William Blake, Carolyn Bosak, Thomas Bowles, Janelle Brennan, Paul Brooks, Veronique Browne, Raymond Bruozis, Nicola Bryan, Benjamin Burt, Martin Campbell, Andrei Catanchin, Alvin Cham, Andrea Chan, Chee Keong Chan, Colin Chun Keng Chan, Frederick Tat Man Chan, Ying Chung Ken Chan, Boon Cheng Chang, David Charlesworth, Gavin Chau, Chee Kien Chaw, Lean Peng Cheah (HI), Andrew Cheasley, Justin Beng Lin Chee, Cynthia Pui Man Chen, Hui-Fu Chen, Hui Wen Linda Chen, Yau Feng Chen, Winnie Cheng, Kuen Loong Chin, Joanne Joo Ling Chionh, Anthony Wai-Ip Chiu, Sheldon Yih Chien Chong, Li Ping Chow, Irina Churilov, Domenic Cincotta, Robert Citroni, Daniel Croagh, Juan D'Abbrera, Vu Vu Dang, Katherine Dawson, Quoc Tuan Dinh, Katrina Dowey, Karen D'Souza, Naomi Elliott, Nigel Fang, Suzanne Field, Genevieve Flannery, Chee Guan David Foo, Rebecca Foxton, Phyllis Yen-Hui Fu, Lee-Wuen Fua, Rita Furlan, Jay Sen Gan, Simon Gibbs, David Gilbert, Jacqueline Gilbert, James Gome, Anthea Greenway, Chuk Yin Han, Nguyen Han, Sarah Healy, John Henderson, Asher Hiddlestone, David Ho, Claire Hooper, Nezor Houli, Yuen Chao Eric Hu, Craig Humphries, Michael Hurley, Ahsan Hussain, David Iser, Michael Jones, Simon Jones, Cherng Tze Jong, Sudharshan Karalapillai, Ameera Khan, Anthony Kelman, Alexandra Kent, Geok Choo Jane Kho, Chee Jian Ko, Ken-Tze Koh, Miriam Koniuszko, Daryl Kroschel, Matthew Labb, Bradley Laferlita, Lisa Laidlaw, Lee Chyi Lam, Bridget Langley, Hui Sung Dennis Lau, Kelvin Hui Kiong Lau, Kathryn Law, Susannah Leach, Kenneth Hee King Lee, Lip Wai Lee, Yuan Kai Lee,

Chee Khoon Liew, Selene Ching Henne Liew, Kang-Teng Lim, Keat Eu Andrew Lim, Lyn-May Lim, Ruth Pec Shiam Lim, Shueh Lin Lim, Cheng Ping Lo, Lai Mun Looi, Gerard John McCaffrey, Brett McGuirk, Kate McKenzie, Helen McManus, Tania Meusemann, Sin Hing Mok, Jasmin Morey, Stuart Newland, Evan Newnham, Genni Newnham, Chin Soon Ng, Choon Sian Ng, David Ng, Jennifer Hwee Kwoon Ng, Bao Chi Nguyen, Bao Quy Nguyen, Chuong Nguyen, Danny-James Nguyen, Thanh Nhut Nguyen, Elvis Ojaimi, Cheng Kang Ong, Kevin Shyong-Tze Ong, Sia Peng Ong, Winnie Peitee Ong, Sikenyi Ouna, Osman Ozturk, Mark Page, Georgia Paxton, Suzanne Pearson, Kylie Petschel, Sandra Petty, David Viet Phan, Phuoc Phu Thi Pham, Lara Phillips, Yong Ming Por, Emma Pun, Jacqueline Quach, Thai Quach, Leo Rando, Manuprabha Ratnayake, Megan Rees, Adam Rehak, William Renwick, Shahneen Kaur Sandhu, Melanie Seale, Pi Ang Seet, Arvind Sharma, Claire Short, Ajeet Singh, Rabindra Nath Sinnappu, Amelia Wink Yun Siu, Suresh Sivanesan, Julian Smith, Kean Hoo Soon, Dean Spiliias, Deepti Srivastava, Hugo Stephenson, Lin-Lin Su, Rathan Subramaniam, Jane Tam, Boon Peng Marcus Tan, Christina Wei-Tze Tan, Kok Yang Tan, Selsea Chih Hee Tan, Su Ching Tan, Swee Teng Tan, Robert Tasevski, Guan Hwee Tay, Shien Ming Tee, Vicky Tee, Eng Soon Teo, Wendy Hui-Ling Teoh, Fui Been Teu, Alexander Thompson, Tzer Hwu Ting, Jasper N. Menn Hoe Tiong, Teck-Hock Toh, Nigel Toussaint, Victoria Nhi Tran, Maria Tsanglis, Berenika Turchin, Joseph Vetro, Katherine Walker, Melanie Wedd, Kate Wheadon, Clare White, Daniel Mun-Yen Wong, Yee Choon Wong, Leon James Worth, Graeme Wright, Li-You Xu, Lee Mei Yap, Seng Keat Yap, Siu-Kim Yeang, David De-Yei Ying, Chun Wai Yip

## DEAN'S HONOURS 1997

### FINAL YEAR

Sreenivas Appu  
Lean Peng Cheah  
Daniel Croagh  
Karen D'Souza  
Anthea Greenway  
Daryl Kroschel  
Susannah Leach  
Mark Page  
Alexander Thompson  
Joseph Vetro

### FIFTH YEAR

Sabina Luigia Ciciriello  
Natalie Harrison  
Brian Le  
Anna Jane Lee  
Paik Yee Ng  
Kenneth Chung-Ren Pang  
Valerie Shiok Hann Tay  
Dominic James Wilkinson

### FOURTH YEAR

Michelle Anne Clonan  
Jason William Galanos  
Saar Gill  
Sue Yen Michelle Goh  
Lynn Pei Er Hong  
Cameron Peter Shaw

### THIRD YEAR

Wai Pheng Alicia Au  
Michael James Desmond  
Heather Marion Francis  
Amy Zigrida Gray  
Eugene Justin Shyong-K Ong  
Shiin-Yun Yvonne Tan  
Eppie Mildred Yiu

### SECOND YEAR

Bruce Charles Vivian Campbell  
Suet-Wan Choy  
Cameron Ian Knott  
Eva Oi Wah Koo  
Sant-Rayn Singh Pasricha  
Lloyd Antony Roberts  
Andrew James Weickhardt  
Benjamin Pak Kwong Wong  
Tricia Wei Chee Wong

### FIRST YEAR

Zenia Yin Chow  
Andrew Adel Guirguis  
Peter Shang-Yu Hsu  
Stephen Chu-Sung Hu  
Christopher Chak-Ming Leung  
Quiang Le  
Philip John Ryan  
Wai Yin Tam

## FINAL YEAR TOP STUDENT 1997



LEAN PENG CHEAH

**L**EAN PENG CHEAH is the School of Medicine Top Student for 1997. Lean Peng was awarded twenty-three prizes throughout his six years in the medical course and placed in the Dean's Honours List in

1993 (the inaugural year), 1994, 1996 and 1997. In addition to prizes awarded by the Faculty in his final year, Lean Peng was awarded the 1997 Stirling Prize in Clinical Surgery and the 1997 Melick Prize in Clinical Medicine from the Royal Melbourne Hospital.

Lean Peng was born in Taiping, Malaysia. His father, formerly an Inspector of Schools, works for Adorna College in Penang which has twinning links with RMIT in Melbourne.

Lean Peng did his secondary schooling at the Klang High School. He finished his STPM, obtaining five As, in 1990 when he was named Klang High School Scholar of the Year and also Top

Student in Malaysia. Lean Peng was then awarded an Equity Scholarship under the Equity and Merit Scholarship Scheme (EMSS) by the Australian Agency for International Development (AUSAID) which enabled him to come to Australia to study medicine. He chose to come to the University of Melbourne because it has the oldest medical school in Australia. Before taking up his scholarship, Lean Peng spent 1991 teaching at the Methodist Girls' Secondary School in Klang.

Although Lean Peng has enjoyed living and studying in Melbourne immensely, there have been some very difficult times for him. His mother died suddenly when Lean Peng was in his first year and, although he has returned to Malaysia to visit every year, leaving his family behind has been hard - his younger siblings (seven and eleven years old when he left for Melbourne) have grown up without him.

President of the Overseas Medical Students Society in 1992-93, Lean Peng was also a member of Toastmasters International and completed his CTM in September 1996. He enjoys Wushu and Tai Chi, surfing the Internet to keep up

with the latest news, and travelling (most recently to New Zealand and the Northern Territory). Lean Peng's main interest outside medicine however, is his girlfriend and best friend Sia Peng, who finished joint tenth in the order of merit list in 1997.

Lean Peng is modest about his success and wishes to acknowledge many people to whom he is very grateful and without whom his success would not have been possible: firstly his parents - his father for his understanding and his mother for her inspiration; Sia Peng, for all her support and prayers; his teachers at the Royal Melbourne, Western and Ballarat Hospitals; and all his friends and the many who have helped him.

Lean Peng aims to pursue a career in surgery - either general surgery or neurosurgery. Due to the number of unmatched positions in Victoria for 1997, Lean Peng has managed to obtain an internship post at Ballarat Base Hospital where he hopes to gain valuable experience in a country setting. The School of Medicine is very proud of Lean Peng's achievements and we wish him well for a bright and happy future.

### UNIVERSITY OF MELBOURNE MEDICAL SOCIETY

**Ordinary Members Reminder to Renew!  
1998 Membership Year**

*If you are a member of UMMS you will have recently received a membership renewal reminder form. If you are not a current member of UMMS you can apply for membership at the UMMS Office address below. Membership will ensure that you receive **Chiron**, **The Melbourne PostCard** and news of reunions, Medical School information, and notices of UMMS and other University events. Members subscriptions also support undergraduate students through sponsorship of the annual UMMS BMedSc Prize and three annual Peter G Jones Elective Essay Prizes.*

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1995 graduates - \$20

1996 & 1997 graduates - \$10

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#### HONORARY MEMBERSHIP

Those who have been Melbourne MB BS graduates for fifty or more years are automatically eligible to become Honorary Members of UMMS.

#### ELIGIBILITY FOR MEMBERSHIP

Besides MB BS (Melb) graduates, those with a substantial association with the School or the University's affiliated institutions, for example past and present academic staff, may become members of UMMS. In addition, legally qualified medical practitioners registered or eligible to be registered in the State of Victoria, who do not qualify for automatic membership of UMMS, may be considered for membership on nomination by two members of the Society.

Members are encouraged to propose membership of eligible people who are interested in being associated with the Society. All that is required is a joint letter together with the consenting signature of the nominated person.

#### UMMS OFFICE

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# PRIZES AND AWARDS 1997

## FINAL YEAR

### Australian Medical Association Prize

Lean Peng Cheah, RMH/WH

### The NOVARTIS Prize

Lean Peng Cheah, RMH/WH

### Rowden White Prize

Lean Peng Cheah, RMH/WH

## MEDICINE

### Robert Gartly Healy Prize in Medicine

Karen D'Souza, SVH/GH

### Keith Levi Memorial Scholarship in Medicine

Alex Thompson, SVH/GH

### Upjohn Award in Clinical Pharmacology and Therapeutics

Janelle Brennan, ARMC

Nicola Bryan, SVH/GH

### Sir Albert Coates Prize in Infectious Diseases

Seng Keat Yap, SVH/GH

## SURGERY

### Beaney Scholarship in Surgery

Daniel Croagh, SVH/GH

### Robert Gartly Healy Prize in Surgery

Daniel Croagh, SVH/GH

### Proxime Accessit Prize in Surgery

Anthea Greenway, SVH/GH

### EH Embley Prize in Anaesthetics

Alex Thompson, SVH/GH

### AOA(Vic) Orthopaedic Prize

Shueh Lin Lim, SVH/GH

## OBSTETRICS & GYNAECOLOGY

### Robert Gartly Healy Prize in Obstetrics

Lean Peng Cheah, RMH/WH

### Prize in Clinical Gynaecology

Jacqueline Gilbert, RMH/WH

### Alfred Edward Rowden White Prize in Clinical Obstetrics

Lean Peng Cheah, RMH/WH

### Edgar & Mabel Coles Prize in Obstetrics

Lean Peng Cheah, RMH/WH

## PSYCHIATRY

### John Cade Memorial Medal in Clinical Psychiatry

Veronique Browne, ARMC

## PAEDIATRICS

### Howard E Williams Prize in Paediatrics

Georgia Paxton, ARMC

### Child Growth & Development Study in Paediatrics

Kate McKenzie, SVH/GH

### Clara Myers Prize in Surgical Paediatrics

Anthea Greenway, SVH/GH

## GENERAL PRACTICE & COMMUNITY MEDICINE

### RACGP Prize in Community Medicine

Anthea Greenway, SVH/GH

## GENERAL CLINICAL

### FIFTH YEAR

### General Practice and Community Medicine Prize

Valerie Shiok Hann Tay

### Crawford Mollison Prize in Forensic Medicine

Natalie Harrison

### The Fulton Scholarship

Ashley Peng Chee Ng

### The Kate Campbell Prize in Neo-Natal Paediatrics

Paik Yee Ng

### The Max Kohane Prize

Anna Lee & Dominic Wilkinson

### Ian Johnston Prize in Reproductive Medicine/Biology

Tim Iseli

### The Vernon Collins Prize in Paediatrics

Sabina Ciciriello

### The John Adey Prize in Psychiatry

Paik Yee Ng

### FOURTH YEAR

### The Harold Attwood Prize in Pathology

Kathryn Field

### Geriatric Medicine Prize

Senen Gonzalez

### Manu Thomas Prize

Sue Yen Michelle Goh

## PRE-CLINICAL

### THIRD YEAR

## PHARMACOLOGY

### Boots Prize

Michael Desmond

## PATHOLOGY

### Walter and Eliza Hall Exhibition

Shiin-Yun Yvonne Tan

## MICROBIOLOGY

### Glaxo Microbiology and Immunology Prize

Shiin-Yun Yvonne Tan

## SECOND YEAR

## ANATOMY

### Dwight Prize

Benjamin Pak Kwong Wong & Subashimi Wijewardena

### Exhibition Prize

Benjamin Pak Kwong Wong & Subashimi Wijewardena

### TF Ryan Prize

Benjamin Pak Kwong Wong & Subashimi Wijewardena

## PHYSIOLOGY

### Glaxo-Wellcome Prize

Eva Oi Wah Koo

## GENERAL BIOCHEMISTRY

### Exhibition

Tricia Wei Chee Wong

## FUNCTIONAL BIOCHEMISTRY

### Exhibition

Susi Fox & Andrew Weickhardt

## NEUROSCIENCE

### Sunderland Prize

Cherry Ee Peck Koh

## PHYSIOLOGY/INTEGRATED BODY FUNCTION

### RD Wright Prize

Andrew Weickhardt

## BEHAVIOURAL SCIENCE

### Novartis Prize

Suet Wan Choy

## FIRST YEAR

## BIOMEDICAL PHYSICS

### GA Syme Exhibition

Andrew Guirguis

### TF Ryan Röntgen Prize

Wai Yin Tam

## INTRODUCTION TO MEDICINE

The Australasian College for Emergency Medicine, Victorian Region, Prize  
Raymond Hu

## MEDICAL BIOLOGY

### WH Swanton Exhibition

Ingrid Homer & Wai Yin Tam

### Baldwin Spencer Prize (for Zoology Practical Work)

Sue Cheng Chew

## MEDICAL CHEMISTRY

### Exhibition

Andrew Adel Guirguis

## ANATOMY

### Mathew W McKenzie Award

Kheman Rajkomar

## 1997 MB BS HONOURS GRADUATES



### 1997 MB BS Honours Graduates

**Back Row L-R:** Lip Wai Lee, Andrea Chan, Joseph Vetro, Paul Brooks, Will Blake, Genni Newnham, David Iser, Nicola Bryan, Simon Jones, Karen D'Souza, Mark Page, Cheng Kang Ong, Lara Phillips, Daryl Kroschel, Colin Chan. **Middle Row L-R:** Siu Kim Yeang, Daniel Croagh, Thanh Nhut Nguyen, Georgia Paxton, Susannah Leach, David Ying, Lisa Laidlaw, Melanie Seale, Janelle Brennan, Alexander Thompson, Anthea Greenway, Helen McManus, Eng Soon Teo, Leon Worth. **Front Row L-R:** Lean Peng Cheah, Sia Peng Ong, Lee Mei Yap, Sree Appu, Sin Hing Mok, Ruth Lim, Shueh Lin Lim, Andrew Lim, Suzanne Pearson, Li Peng Chow, Rita Furlan, Lin-Lin Su, Yong Ming Por, Swee Teng Tan, Katrina Dowey, Chun Wai Yip.

**Absent:** Ahsan Hussain, Pi Ang Seet.

**I**N 1997, FOR THE FIRST TIME at the University of Melbourne, the MB BS degree was awarded with honours to forty-seven of the graduating class in recognition of their consistently excellent performance throughout the course.

Although the proposal to award honours with the MB BS degree had previously been considered and rejected by Faculty, in 1996 it decided that such degrees would be awarded, beginning in 1997. Over recent years all other Australian universities with medical schools have begun to offer their medical degrees with honours which led to University of Melbourne medical graduates being disadvantaged in comparison with their peers from other

medical schools when in competition for postgraduate scholarships. The University of Melbourne system of awarding honours in individual subjects did not seem to be well understood: a number of granting bodies place great emphasis on academic performance in the undergraduate years and it was hard to equate the performance of Melbourne graduates with those of other medical schools in the absence of an overall honours grade. Honours degrees are also an appropriate way for the University to recognise those students whose academic performance over the whole of the medical course has been outstanding.

There are three grades of honours awarded to MB BS graduates:

The Bachelor of Medicine and Bachelor of Surgery (with first class honours) is offered to those who are above the 97.5 percentile in the graduating class provided their overall weighted score is 76 per cent or greater.

The Bachelor of Medicine and Bachelor of Surgery (with second class honours division A) is offered to those who are between 92.5 and 97.5 percentile provided their overall score is 74 per cent or greater.

The Bachelor of Medicine and Bachelor of Surgery (with second class honours division B) is offered to those who graduate between the 85 and the 92.5 percentile provided their overall weighted mark is 72 per cent or greater.

## FROM THE STUDENTS

THIS IS THE FIRST of what I hope will be a regular part of *Chiron*: an update on what students are up to from the students' perspective. The Medical Students' Society (MSS) is not the only organisation providing social functions and educational support for medical students. There are also the hospital student clubs, the Overseas Medical Students' Society (OMSS), Matrix (a group focusing on women's issues in medicine), the Medical Association for the Prevention of War, and Outlook (a group dealing with Aboriginal, rural and Third World health).

No doubt many MSS activities are similar to those of years ago, but they continue to be popular. We began 1997 with O' Week and all the old favourites - O' Week Camp, now held regularly at Mt Eliza; 'Dag Night'; a river cruise with a pirate theme; lunches, a PFA - but there was also a scavenger hunt, a pool night, an Outlook dinner and many other events. Soon after O' Week a combined Melbourne-Monash function, appropriately named 'Anastomose', was held at the Chevron Nightclub. The main event for the year, the 'Med Ball' was the biggest in memory, with nearly a thousand people at the Melbourne Town Hall, all looking suitably 'Lost in Space' - the evening's theme. Another tradition that continues is Medleys - for the last three years held in the Union Theatre. This offers opportunities for medical students to become involved in proper

back-stage activities as well as the traditional acting, singing and writing. 'A Clockwork Cumquat' was performed on three nights, and attracted about a thousand audience members and wide critical acclaim - at least by the cast and crew. Other social events during the year included the medical music concert 'Auscultations, Orchestrations and Ultra-Sounds', barbeques, post-exam parties, Outlook dinners, OMSS events, the list goes on...

Unfortunately, medical students can't spend all their time going to social events and, sooner or later, education gets in the way. With the development of the new medical course for 1999, the Faculty has seen an unprecedented amount of involvement from the student body. There are students sitting on every committee, and their dedication to future students is highly commendable. While the Faculty and the students don't always agree, I'm pleased to say that we are always listened to and our views are carefully considered.

While doing our best to avoid it, the MSS can't help becoming a slightly political organisation. Issues such as provider numbers, registration of medical students, out-station funding and others keep the Society busy, and much of this load is carried by AMSA. In 1997 the AMSA office was just down the road (two of the executive members were Melbourne University students) and did a fantastic job for Australian medical

students. The conference in Tasmania - 'Head Two Tassie' - saw the usual combination of fascinating lectures and a non-stop social program. AMSA is now also a full member of the Asian Medical Students' Association (AsMSA), and sent a delegation to the Philippines in 1997. There were scientific paper presentations and group discussions, as well as technical tours and a cultural night. This year Australia holds the executive of AsMSA, with the Chair, Celia Kemp, and the Secretary for Finance, Q Minh Phan, both Melbourne students.

This is still a time of change for the Medical Students' Society. This year is only the third that the Society has represented all six years of medical students at the University and the first that a committee has been around for two O' Weeks. As with all changes, it hasn't been the smoothest ride, but I hope that it will produce a better Society.

So, lots of new things for the students to be getting up to while, in their spare time, they complete an MB BS. Social stuff, other clubs, education, AMSA, politics - perhaps its not so different from what went on years ago. My thanks go to all the MSS committee members and others for the hard work they put in to making 1997 such an interesting year for medical students. I look forward to reading about how things are going in years to come.

*Ed Giles*  
President, MSS

### THE OVERSEAS MEDICAL STUDENTS' SOCIETY

THE OVERSEAS Medical Students' Society was established in 1984 by an enthusiastic group of overseas medical students and with the generous support of Faculty staff, particularly Professor David Penington, Dr Norm Eizenberg and Professor Graeme Ryan. The OMSS was formed to create an organisation separate from the Medical Students' Society (MSS) to cater for the special needs of overseas students.

Over the years, students have come and gone, and the Society has tried to keep abreast of the changes within the Faculty and the Medical School. Last year was very busy for the Society, as several new events were organised.

We began 1997 with O' week and then the 'Buddy' lunch - a mentoring system open to all first year students - where lunch was provided for the first year students to get together with their older peers. In addition to the 'Buddy' lunch, several free lunches for all the students were held during the year.

A dance party was organised for the July holidays in conjunction with our friends from the Melbourne University

Overseas Commerce, Engineering and Law Students' societies. The party was enjoyed by all who attended and went well on into the night!

We were also glad to welcome five new members from the International Medical College who joined third year at the end of first semester. Being the first students of this kind, it was a new experience for both the Medical School and for the Society. Hopefully there will be many more students in the future choosing to further their study in Melbourne.

On an academic level, an education seminar on communication skills was organised for overseas students in August. The seminar was conducted by Associate Professor Doris Young from the Department of Public Health and Community Medicine and attended by over ninety appreciative students. This was a new event for the OMSS in 1997, and we plan to hold two seminars in 1998.

The annual Melbourne-Monash sports day was held at Monash in 1997. After being beaten in 1996 by a small group of students from the International

Medical Students' Association, our members were eagerly awaiting this encounter. Unfortunately however, our enthusiasm before the matches was not reflected in the results as Monash won all the events.

Finally, the traditional annual dinner was held at Dragon Boat Palace Restaurant. The night was attended by 180 students and lecturers in the post-exam period. Activities such as limbo dancing, a performance of the 'MIB' dance by second year students, and a cameo appearance demonstrating the ballroom ability of Graeme Parslow and his wife were greeted with wild applause, and made the night a most memorable occasion. The annual dinner was a fitting end to 1997 for the Society.

In 1998 the Overseas Medical Students' Society will continue to grow and provide the necessary support for the increasing numbers of overseas students choosing to study medicine at the University of Melbourne.

*Andrew Huang*  
President, OMSS

SCIENCE, SCULPTURE AND SEXUALITY

A research elective in female urogenital anatomy

Megan Rees MB BS 1997

WOMEN'S SEXUALITY and sexual function are a source of much public interest. They feature prominently in many glossy magazines which would have us search for the perfect orgasm as if it were a quest for Nirvana. However, in the past when I have been asked simple questions on this matter by non-medically trained friends, I found it difficult to provide many medical facts. During my 1996-1997 summer vacation I undertook a research elective which was a small component of a larger research project on female pelvic anatomy, with a focus on the urogenital system.

Prominent local comedienne will tell us that although the modern Australian man is aware of the clitoris' existence, finding it is another matter (certainly more difficult than finding the pub). We find this funny because it is outrageous but are we also laughing at a grain of truth?

I began my study with some initial reading and was taken aback at the paucity of information. This watershed area between urology and gynaecology should surely have been avidly explored and explained. However it seems that the precise relations of the clitoris to the vagina and urethra, its innervation and its blood supply (both at rest and during coitus) are not yet known. The comedienne are perhaps not so far from the truth. A Medline search revealed many articles on the clitoris. Almost half were opinions on female circumcision or ritual mutilation, and most others were plastic surgery articles regarding the construction of an artificial clitoris in a



MEGAN REES

male-to-female gender reassignment or sex change. Where was the leading article on the normal clitoral structure and function I was seeking?

So it was, with some excitement, that I approached a new frontier in anatomy. My specific project was to dissect the ligament of the clitoris in detail and progressively photograph the findings from my dissections. This dissection based study would contribute to the broader research which has been conducted at the University of Melbourne Departments of Anatomy and Surgery for the last few years.

Having found no recent articles I pursued descriptions of this anatomy in textbooks from anatomy, embryology, pelvic surgery, gynaecology and urology. I was disappointed with not only the scarcity of information but also with the way in which it was written. Slight turns of phrase in descriptions that should have been objective made transparent the attitudes of the authors or the time they were written. I was left with a sense of unease. As a woman I did not feel this

was how women's bodies should be described and it was the language more than the scientific facts that did this. For example the historical description of the vagina as 'the birth canal' implies redundancy of this structure when it is not actually delivering an infant, which is almost all of a woman's life. It could be further extrapolated that the use of the term 'birth canal' reflects an attitude about the roles of women's bodies and lives. Now there is an awareness that the vagina's role includes coitus, sexual pleasure, menstruation and as an integral part of a woman's self-image. Couple to this our acceptance that women's roles in society extend beyond reproduction and the term 'birth canal' is seen as inaccurate, inappropriate and redundant. Must scientific facts (though aiming to be objective) always be packaged and presented in a social context?

This research has reinforced the experience I had as a preclinical medical student in which the male form was almost always presented first as the normal, and the female subsequently described as the variant. In Grant's anatomy atlas the clitoris is referred to as a 'miniature penis'<sup>1</sup>. The tendency of authors of anatomy texts to regard the male form as normal and the female as variant has actually been quantified<sup>2</sup>. In a study of thirty-one anatomical textbooks, illustrations, vocabulary and syntax primarily depicted male anatomy as the norm or standard against which female structures were compared. This was compounded by the use of pejorative terminology in textbooks: for

FIG 1 DEEP DISECTION OF CLITORIS

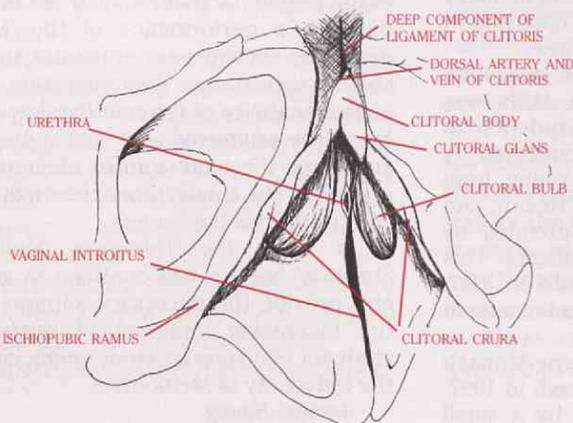
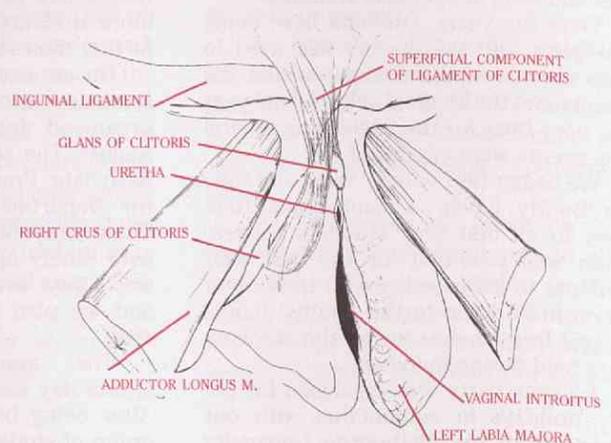


FIG 2 SUPERFICIAL DISECTION OF CLITORIS



example an anatomy text<sup>2</sup> which stated that in the urogenital triangle there is a 'failure in the female of mid-line fusion of the genital folds' (thereby implying pathology), and then referred to urethral glands as 'poorly developed'. The same text completely omitted a description of the clitoris.

On dissection I found that the clitoris is a substantial organ (Fig 1). The clitoral body extends from the easily palpable clitoral glans, superior to the urethra and anteroinferior to the pubic symphysis. It divides into two crura which pass laterally on either side of the urethra and follow the medial surface of the ischiopubic rami posteriorly, closely apposed to the lateral walls of the distal vagina. The amount of erectile tissue present varies somewhat with age and hormonal status. An extensive suspensory ligament (Fig 2) attaches the body of the clitoris to the pubic symphysis. A superficial component of this ligament provides the fibrous connective tissue structure to the mons pubis, it extends into both the aponeurotic layer of the abdominal wall fascia and the fat pads of labia majora.

Dissection can be described as sculpture in the finest medium. Although you cannot create something that is not there, you can reveal structures at your discretion. Michaelangelo described sculpture as essentially removing waste material until the form is released from the matter in which it was imprisoned<sup>4</sup>. What shall we determine to be the waste material? Are not all the structures in the body important? The role of the spleen in haematopoiesis and immunity was once poorly understood and it was always hurriedly resected after traumatic injury. This practice is now being reconsidered. Similarly female pelvic anatomy may

have been neglected because of ignorance. However as our body of knowledge about female sexuality and reproduction expands, this ignorance needs to be redressed. It is not surprising that such an imperative should follow the rise of feminism and the establishment of Women's Health as distinct from Gynaecology as a medical specialty. Again social change influences medical practice and research. The aims of our research will subjectively influence the detail to which we dissect. We keep particular tissues because of their intrinsic value and discard others because they obstruct our view of something we deem more important. At least if we cannot be truly objective we can be aware of the many truths. Perhaps this will be the 'post-modernist's' view of anatomy.

So what is to be achieved by a contemporary study of adult female pelvic anatomy? An accurate, detailed and objective description based on observation of female anatomy independent of the comparable male anatomy. Using good scientific method, dissecting carefully on many specimens and recording observations with objective methods such as photography and magnetic resonance imaging, anatomy may be clarified.

What will a detailed and accurate description of female pelvic anatomy do for medical science and for women in particular? We need to consider the probable outcomes and implications upon which all research projects and their funding are now based. An accurate description is essential for an understanding of female sexual function and sexual dysfunction. There will also be enormous implications for obstetric and gynaecological, urological or other

pelvic procedures and practice: if such detail is currently lacking, surely working somewhat blindly in the area must result in occasional morbidity. For example loss of sexual enjoyment after a difficult birth or pelvic operation may have a mechanical (rather than the commonly designated psychological) basis.

Anatomy is one of the fundamental studies for the science and art of medicine. Our view of component tissues of the body is influenced by contemporary philosophical and social thought; although our bodies may not have evolved greatly in the last few centuries the way we think about them has changed drastically. We must be aware that the way component tissues are described will influence the way the whole body is seen. In the case of our research this determines how women and men will view women's sexual function and hence sexuality.

For such an interesting and enlightening elective I must thank my supervisor, urological surgeon Helen O'Connell, and those who donated their tissues for the advancement of the dynamic and relevant science of anatomy.

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## YO, BALANDA BOY

Gove District Hospital, Nhulunbuy, Northern Territory

December 1996 - January 1997

David Iser, MB BS 1997

THE NIGHT AIR on the tarmac is hot and heavily sweet. It hits me as I duck out from the carefully conditioned environment of the cabin.

'It's the build-up, you go crazy.'

'December. Mmm. Wet season. Be interesting.'

'The heat'll really knock you.'

Advice from experienced travellers. Their snippets have danced around in my head all the way from Tullamarine.

The aeroplane looks alien, bathed in golden light but surrounded by the inky blackness of the scrub stretching off to

Arnhem Bay. Passengers spill out to meet friends, wives and families. Men in light tan uniform, miners I guess, mill around and I am left with my backpack and Akubra which I clutch uneasily. Ken, a weary orderly from the hospital at the end of his day's duty, has been sent to meet me. He does so without a smile and ferries me into town.

'Wow. Looks like a pretty new hospital.'

'Not really.'

I duly note the homely sixties orange brick architecture in the morning light,

but the meal left for me assures me that this place will be okay.

Any anxious thoughts are dispelled as soon as I meet Kip, the medical superintendent.

'G'day, and welcome to Gove!' He greets me with a warm handshake and a twinkling smile.

'See, what I want for my elective students, is to involve you in as much clinical and procedural work as possible. You'll also have plenty of opportunities to visit the communities of East Arnhem Land. You see, Gove is the only major

centre this side of Darwin, serving all of this . . . his hand sweeps over a huge patch of green on the map. 'So anytime we fly out to a community we want you to come along. Well, perhaps not Groote.' Kip has just returned from Groote Eylandt after only one day of an anticipated week-long trip because of unresolvable political wrangling. It seems that this is an unavoidable part of the job.

Time doesn't muck around in Nhulunbuy. My days begin with the morning ward round where we greet the patients and discuss their progress and management.

'Morning, Jacko.'

'Yo.' His face beams from beneath a tuft of tussled black hair. His neurosyphilis recently manifested as acute psychosis and he became 'mad and sick'.

'We're thinking that you might be ready to go back to Elcho soon. How would you feel about that?'

'Yo.' He is still grinning.

Margie, at fifty, is one of the elders at Galiwinku but her heart and lungs must be older.

'Namira (g'day), Margie.'

She is sitting up puffing on an oxygen mask with big swollen ankles.

'Good morning,' she whispers.

'She looks terrible.' Kip is troubled and leans closer to gently feel her ankles. 'The diuretics just aren't touching her, are they?'

'And she's keeping to her fluid restriction?'

'Want to go home now,' Margie whispers. She knows.

Nangula has airways disease and another infection. She smiles shyly at the crowd around her bed and ducks beneath the bright white hospital sheets. There is quite a crowd: six doctors, two nurses, a part-time interpreter and of course, two medical students. Kip and Peter are discussing the logistics of Margie's wish to go home: relatives, afternoon plane flights, any potential for more diuretics. Peter has also been medical superintendent. Very cool, skilled and with a depth of clinical knowledge, he came here as a medical student ten years ago and returned as soon as he could. Andy, Geoff and Susan arrived more recently but all have similar enthusiasm and clinical perspective. They are here with their partners and have many stories from other remote community hospitals.

Gerry has come from further afield; a general practice on the east coast of the United States. He is humble about his many talents including his surgical ability, his sporting and flying interests. He takes the time one afternoon, to teach me the intricacies of surgical hand-ties.

'Not at all. Actually, you know, I was

looking for an excuse to escape from that meeting. So thank you. In fact, if you practise this tonight, I'll get you to drain that abscess tomorrow morning. You know, see one, do one . . .'

The next day he guides me through my first surgical procedure and later, others such as curettages and an appendicectomy.

'You know, I don't think I've ever seen so much pus in all my life' he confesses in his gentle drawl as he releases an abscess in an old man's hand. The apparent abundance of infection is perhaps the result of poor nutrition or hygiene, but it probably also reflects a willingness to endure minor ailments until they become major catastrophes.

While visiting the clinic at Milingimbi we meet Ronald, a young Yolngu man.

'Come on. Show Dr Kip your finger.' His sister has to drag Ronald's hand out from behind his back. Kip gently peels bank the grubby band-aid to reveal an amputated finger.

'How did this happen?'

'Accident.'

'Roll-over' his sister explains. Ronald is unperturbed by the exposed fragment of bone, content to let it heal itself.

'Ronald, we'll have to take you into Nhulunbuy, to hospital, to prevent a serious infection taking hold' explains Kip. Ronald nods, unconvinced.

However, he trusts Kip and accompanies us to the plane with a small bag of belongings and his baseball cap. As we fly over the maze of swamps and rivers on the Arnhem Land coast I realise that Ronald has never been to Nhulunbuy, let alone Darwin. Over the next week Ronald teaches me some simple Yolngu phrases so I don't feel like such an ignorant Balanda (white fella).

Tropical cyclone Phil delivers the long-awaited rains which have an enlivening effect on everyone. Rather than driving people indoors, the welcome relief brings a flurry of social and sporting activity. After spending each afternoon in the Emergency Department suturing wounds, listening to children's chests or plastering limbs I am sent off by Kip to 'get involved in town life'. Fairly quickly I manage to find one of the local football teams (by

following the bright lights of the football oval) and, a couple of broken ribs later, I can say that I kicked a few goals for the Nhulunbuy Cats. I also discover a group of running enthusiasts who meet at the surf club for their weekly physical punishment, a well stocked public library and a golf course where one can play alongside water buffalo and estuarine crocodiles.

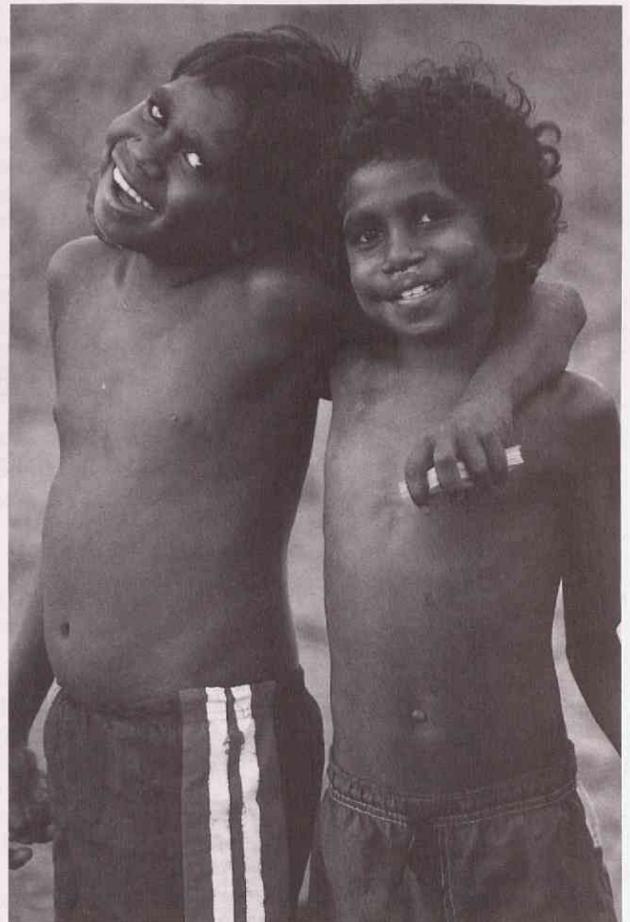
Built principally for an overseas-owned bauxite mine, Nhulunbuy is surrounded by a strong Yolngu population. From Yirrkala, Ski Beach, the Lhanaphuy Homelands and other communities, church leaders, politicians, artists, actors, activists, rock musicians, and sporting personalities have achieved international recognition.

'This one . . . white gull.'

The sun sets over Ski Beach and the mosquitoes settle on the camp dogs. We are sitting on a mat engulfed by the throbbing hum of the yidaki (didgeridoo).

'This one . . . red kangaroo.' Djaralu is the authority on yidaki in these parts. 'Stops. Listens. Scratches. Looking for tucker.'

The pulse is mesmerising and we are plunged into the tepid waters of Arnhem Bay as 'dolphin' dances around our ears . . . dirrup, dirrup, dooot, dooot, dirrup, dirrup. A German psychology student



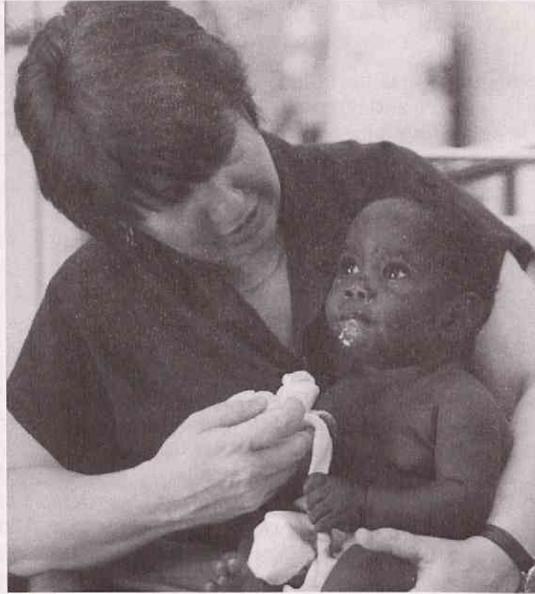
who found Djaralu on the Internet will buy this yidaki.

'I make little one yidaki,' promises Djaralu. 'You can take back on the plane.'

My greatest insight into remote medicine comes with ten days at Ramingining, a community sited shrewdly on a bauxite deposit in the heart of East Arnhem Land. The health centre is run by Betty - wicked smile and weathered face, single, avoiding fifty, and an eight-year veteran of Ramo. She has a sharp sense of humour, takes no humbug from anyone, and happily admits she is a 'little bit loony'. Together with two other nurses and weekly visits from Kip, she provides a twenty-four-hour service to the community and out-stations. No-one's enthusiasm seems dampened by the challenge of managing the epidemic of ear, chest and skin infections, diabetes, heart disease and kidney problems endured by the Yolngu. Well, perhaps when Margaret presents with chest pain and we discover the ECG machine has been soaked by last night's torrential rain I may catch Betty lapse into a bit of gentle blasphemy!

I am wandering south from Ramingining one morning in search of a waterhole when a battered four wheel drive pulls up beside me.

'You walking back to Melbourne



today?' Jilmini grins from under his hat. 'Jump in. I give you a lift.' I squeeze in the back of the troop-carrier with his extended family of four adults and seven children.

'We're going hunting for kangaroo and goanna. You want to come?'

'You bet. How do you hunt goanna?' There is a clamour of voices and the jolting truck skids to a halt. Jilmini's wife slips out clutching a stick, and before I can spot the four feet peeping around the

trunk of a nearby tree, the goanna is lifeless in the red dust. Ah, so that's how.

A little further on Jilmini spots a grey kangaroo bounding through the trees. We stop and he loads his rifle, takes off his hat and shirt and rolls up his jeans. He steals silently into the scrub and beckons me to follow. I struggle to keep pace with his stealthy tread, crashing my way over logs and snapping twigs. He freezes and motions me to crouch down. I perform this perfectly. He inches forward, dancing and weaving, his black back glistening in the sun. Crack. The kangaroo crumples. Jilmini calculates that this one might feed his sister's family. We stop to sip cool water from a rockpool on our way back to his family and Jilmini chuckles.

'Look at this. A blackfella, a Balanda and their bush tucker. We should be on a Coke ad.'

The verdant swamps and winding ribbons below give way to the red and gold of the inland. My taste of life in East Arnhem Land has been an eclectic series of encounters and I am wary of drawing conclusions or generalisations. I am continually grateful that everyone I met was so welcoming. But I feel that I have only glimpsed the complexities of remote and Aboriginal medicine.

## EXCERPT FROM 'ONE ELECTIVE STORY'

Marilla Druiitt

*Unfortunately, space does not allow us to publish all the Peter G Jones prize winning essays. Marilla Druiitt spent her elective in Ho Chi Minh City in Vietnam. In the following excerpt from her essay she describes an experience at the Paediatric Hospital Number One. Marilla is currently finishing her MB BS course having taken a year 'off' to study for a BMedSc in measuring the seriousness of adolescent suicidal behaviour at the Centre for Adolescent Health.*

LB & HA

**I**N OUR SHORT TIME, we saw an infant with hyperkalaemia who arrested and died, due to his underlying chronic renal failure from hydronephrosis. The Emergency Department teemed with people. They tried many drugs, including ATP, but the DC machine was down the hall and up the stairs. I have no experience with which to compare the situation, but even so, organisation may

have saved the day. Perhaps to fail in the long term though, given the lack of treatment options for his renal failure. I returned in the afternoon to find his mum, so composed during the drama, crying at the doorway of the department. Squatting in true Vietnamese fashion, dressed so simply and beautifully, conical hat fallen over one shoulder. Later, she and her husband waited at the side of the bed - the bed in the middle of the row, no curtains. The babe was dressed and snug. They kept on trying to close his eyes.

I learnt a valuable lesson. Parents will grieve for their children as ardently, regardless of race and country. I don't know why I thought that they should have been conditioned by so much death.

Infant in head box in ICU, Paediatric Hospital #1, Hô Chi Minh City, Vietnam





PROF TONY BURGESS

**T**HE LUDWIG Institute for Cancer Research (LICR) was established internationally in 1972 by Daniel K Ludwig, a successful New York businessman who developed supertankers for shipping oil around the globe. Mr Ludwig founded the LICR as a

charitable, non-profit company with cancer research operations in Europe, Canada, South America and Australia. He aimed to bring the best minds to the cancer problem, to provide first class resources for the research and to apply the new information for improving cancer treatment. Today there are ten Branches with expertise in cancer immunology, the proteins which regulate the production of normal and cancer cells, cancer viruses and cancer genetics.

The Melbourne Branch was started in 1980 with ten staff on the Royal Melbourne Hospital campus. Initially, the research focused on one of the growth factors which stimulate blood cell production. The University of Melbourne, The Walter and Eliza Hall Institute of Medical Research (WEHI) and the Royal Melbourne Hospital (RMH) hosted and fostered the activities, encouraging both cell biology and genetics research as well as new anticancer trials. This work led several companies to produce sufficient quantities of these factors to allow their clinical use. Indeed, clinical studies by the LICR, WEHI and RMH scientists/oncologists led to a number of new observations on the physiology of the growth factors which affect blood cell production. In particular, it became clear that when one of these regulators, G-CSF, was administered, not only did neutrophil levels increase but stem cells were released into the blood. These stem cells are now being used instead of bone marrow to help many patients recover after intensive chemotherapy for breast cancer.

The Melbourne Branch currently employs almost 140 staff and twenty students, and work now includes the physiology of the haemopoietic growth factors, the biology of normal and neoplastic colon cancer cells, angiogenesis, the structure and function of cytokines and their receptors, signal transduction studies, analysis of protein structures (in partnership with WEHI) and a clinical, cancer immunology program (in partnership with the Austin and Repatriation Medical Centre). This work has allowed the Branch to contribute understanding of the

molecular pathology of leukaemia, colon cancer and lymphoma, as well as the lung disorder, alveolar proteinosis.

In the laboratories, the Branch scientists have focused on the molecular genetics of growth factors and their receptors. Over the last six years, the Branch has been able to manipulate the mouse genome to alter the expression of transforming growth factor- $\beta$  (TGF- $\beta$ ), the type II and III TGF- $\beta$  receptors, G-CSF, GM-CSF and several of the src-like kinases. LICR scientists have been able to share their experience with embryonal stem cells and gene targeting with many laboratories around Australia.

Scientists and clinicians at the Branch have also formed a direct interest in solid tumours. Work on the epidermal growth factor receptor and epithelial tissues has helped to improve our understanding of intestinal tumours. Indeed, colon cancer has become a major focus of both the laboratory and clinical research programs. Towards the end of 1996 a new molecule (A33) was isolated from the surface of colonic cells. This protein appears to be an important element in cellular interactions in colonic tissue and the restricted expression pattern clearly makes the A33 protein a candidate target for monoclonal antibody therapy. Through the Tumour Targeting and Medical Oncology programs at the Austin and Repatriation Medical Centre the Branch is commencing colon cancer trials with humanised, monoclonal anti-A33 antibodies during 1998.

The Branch is initiating a number of new cancer therapy projects for melanoma, breast cancer and colon cancer using vaccine strategies, antibodies and signalling inhibitors. The mixing of basic research and clinical projects is an important aspect of the Institute's research strategy and the Melbourne Branch has many projects in which we combine both laboratory and clinical skills in an effort to accelerate the development of new anti-cancer agents. More information can be found on the World Wide Web at: <http://ludwig.edu.au>.

## Kerrie Clarke



DR KERRIE CLARKE

**C**ONVENTIONAL radiotherapy and chemotherapy expose both normal and neo-plastic cells to identical doses of cytotoxic agents, relying on the enhanced sensitivity of rapidly dividing cancer cells to achieve preferential killing.

Mono-clonal anti-bodies either unmodified or conjugated to radioisotopes (iodine, yttrium) toxins or drugs can be directed against tumour associated antigens minimising toxicity to normal cells. They have shown promise for both detection and therapy of malignancies.

Breast cancer is the most common malignancy in women with 1/14 Australian women developing breast cancer in their lifetime. Despite advances in the treatment of breast cancer in terms of new chemotherapeutic and hormonal agents the median survival of patients with advanced breast cancer has remained virtually constant. In addition to improving currently available therapies, new treatment strategies are therefore required. The role of monoclonal antibodies in the treatment of breast cancer is yet to be established. Of the recombinant antibodies currently being developed HER-2 which is directed against a growth factor receptor (p185HER2) over expressed in 25-30 per cent of breast cancer patients is among the better known, having entered Phase III clinical studies.

Currently we are investigating the use of a new antibody termed hu3S193 which is directed towards the Lewis Y antigen present on 60-90 per cent of carcinomas of epithelial origin including breast cancer. 3S193 has been humanised, theoretically allowing multiple doses to be delivered safely to patients without inducing immunogenicity as is seen with repeat doses of murine antibodies. Initial preclinical studies have demonstrated that hu3S193 is internalised or taken into cells and can therefore deliver toxins or drugs (including chemotherapeutic agents) directly to the cell surface and the interior of malignant cells where they can inhibit protein synthesis or damage DNA causing cell death. Alternately, unmodified antibody can act directly to kill malignant cells via activating components of the immune system (complement dependent or antibody dependent cellular cytotoxicity). Hu3S193 has also been successfully conjugated to a number of radioisotopes including iodine-131 and indium-111. Breast cancer is a radiation sensitive disease and conjugation of radioisotopes permits radiation to be targeted or localised to tumour cells without usual radiation induced toxicity. Therapeutic studies of radiolabelled antibody in nude mice have produced favourable results and it is planned that the antibody will enter clinical trials in patients with advanced breast cancer in the near future.

## Joan K Heath



DR JOAN HEATH

**O**UR RECENT studies have been principally concerned with characterising of the A33 antigen. This molecule of as yet unknown function interests us because of its exquisite tissue-specific distribution. It is found on the cell surface

lining the small and large intestines but, except for its expression by most colorectal carcinomas, virtually nowhere else. This distribution is highly significant in a clinical context and the A33 antigen has attracted considerable attention as a potential target for immunotherapeutic approaches to colon cancer. However, until recently, the molecule was defined solely by its reactivity with a mouse monoclonal antibody namely A33.

In 1994 a multidisciplinary team from the Melbourne Branch of the Ludwig Institute, along with the participation of colleagues at the New York Branch, embarked on the further characterisation of the A33 antigen. My group (including Sara White and Cameron Johnstone) was able to exploit the N-terminal amino acid sequence obtained by the protein chemists to clone its cDNA. We deduced the molecule

to be a novel transmembrane glycoprotein comprising 298 amino acids with an extracellular region of 213 amino acids, a highly hydrophobic transmembrane domain of 23 amino acids, and a highly polar intracellular tail of 62 amino acids. The extracellular domain is predicted to be folded into two immunoglobulin-like (Ig-like) domains, and we speculate from this general structure that the A33 antigen participates in protein-protein interactions with an hitherto unknown binding partner such as a cell adhesion molecule.

We also isolated several clones containing the human A33 antigen gene. One of these was used by Karen Arden and her colleagues at the San Diego Branch in fluorescent in-situ hybridisation studies to demonstrate the localisation of the A33 antigen gene on human chromosome 1 q22-q24. As yet, neither deletions nor mutations at this locus have been correlated with a predisposition to colon cancer. However, this remains a topic of interest for us because of our observation that in more than 20 paired samples of normal and malignant human colon tissue, A33 antigen mRNA expression was consistently weaker in the tumour tissue compared to the adjacent normal mucosa. We hypothesise that down-regulation of the A33 antigen may play a role in tumourgenesis.

This body of work has established our group in a leading position for future studies aimed at understanding the

function of the A33 antigen and its importance in normal physiology and disease.

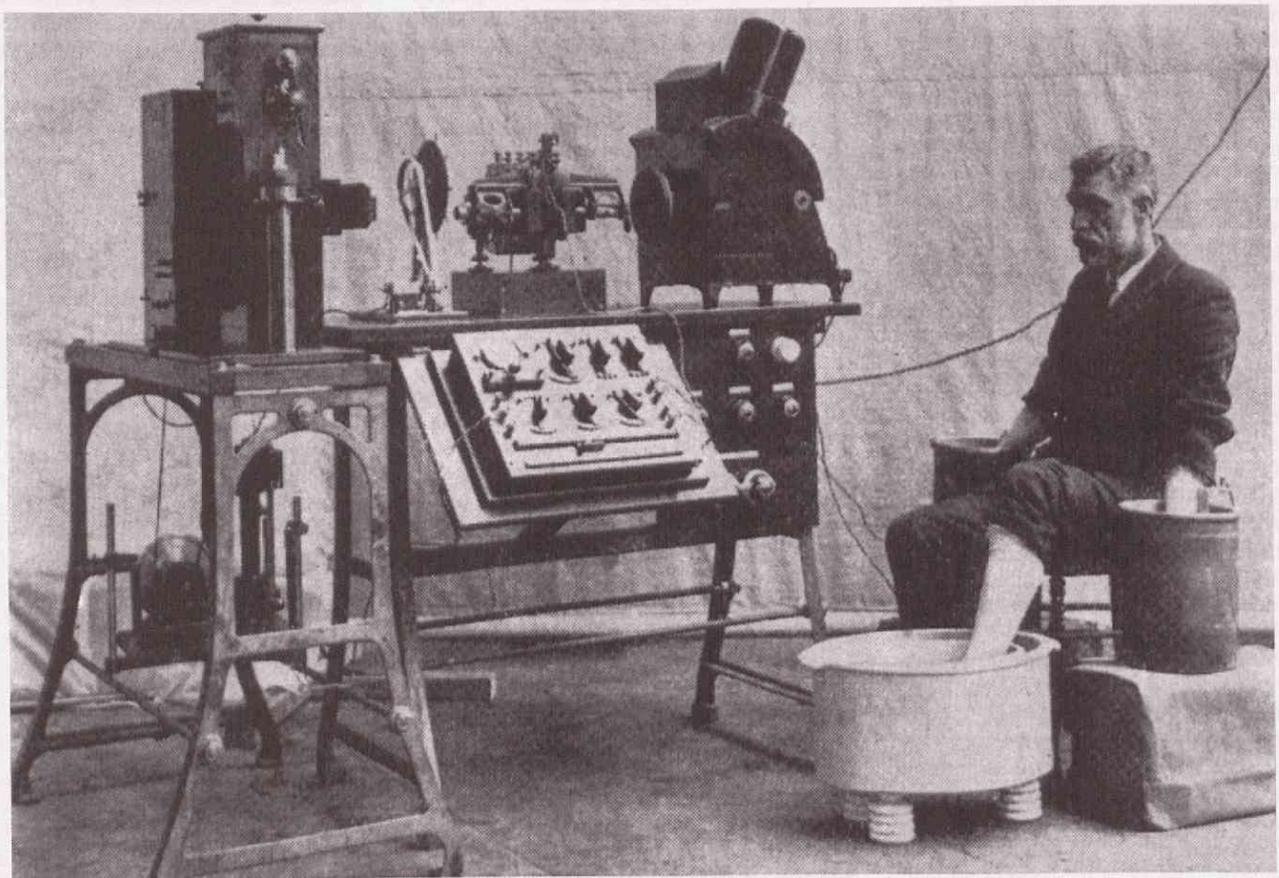
### Publications arising

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EARLY MODEL ELECTROCARDIOGRAPH c1920.

## THE NEW MILLENNIUM IN THE GARDEN OF HIPPOCRATES AND GATES

Professor Richard Larkins

WE ARE LIVING IN A PERIOD of extraordinary change in medical practice and health care delivery. Much of this change has resulted from dramatic advances in medical science, notably those stemming from molecular biology, which have affected many areas of medical practice. Technological discoveries outside medicine have also been important: fibre-optics, magnetic resonance technology, nuclear physics and, most of all, information technology. Superimposed on these advances have been major demographic, sociological and economic changes. Notable among these are the ageing of the population and, in Australia, large scale waves of immigration, from Europe, then the Middle-East and most recently Asia, which have produced a degree of cultural diversity undreamt of in the fifties. Recognition of and collective guilt about the systematic oppression and displacement of Aboriginal people, combined with evidence of the huge disparity between the health status of indigenous and non-indigenous Australians has led to the realisation of the need for especial efforts in this area. The tendency for family structures to break down, the increase in unemployment from the traditional one to two per cent to ten per cent or so, the epidemic of drug abuse and the growing disparity between rich and poor are global trends all of which have had an enormous impact on the environment in which our students will practice.

The traditional respect and deference with which medical practitioners were regarded has been eroded and partially replaced by cynicism, criticism and questioning by the public. This has been fuelled by media attention and increasing litigation often inspired by US-style marketing by some law firms. The availability of information on the internet has led to previously sacrosanct domains of medical knowledge being widely available to sectors of the lay public. The consumer movement has altered attitudes resulting in the expectation of full disclosure of all information and an active role in decision making. What was previously regarded as beneficence by the medical profession is now called paternalism and rejected by many. The relationship between doctor and patient has altered, presumably for ever. Nurses and other health professionals are now no longer content to be subservient to the doctor, but rather expect equal status in the health care team, and, in many cases, expect to assume roles

previously confined to medical practitioners. The community's use of a variety of methods of alternative health practice has risen, driven by many of the factors described above, including multiculturalism. Moreover, political thought has become progressively dominated by economists with emphasis on high growth and low taxes, risk reduction by the privatisation of government enterprises which, by definition, become profit-orientated, and the minimisation of public expenditure on health, welfare and education.

Is it any wonder then, that a system of medical education designed almost a hundred years ago should be beginning to show its age? Those giants of their time, Sir William Osler and Abraham Flexner are mainly responsible for the current structure. In the 1890s and early 1900s Osler combined the bedside teaching of the English school with the scientific base of the German school. In 1903, he observed 'Of medicine, many are of the opinion . . . that the ancients intended to make it a science and failed, and the moderns to make it a trade and have succeeded'. In his seminal report of 1910 Flexner advocated the association of medical schools with universities, and the initial strong foundation in basic sciences followed by study of clinical medicine in an atmosphere of critical thinking. He was very disparaging of private American college medical school education which had little basis in science and little contact with patients. He also found shortcomings in the English system, based largely on bedside teaching by consultants who he described thus:

The English consultants are cultivated, charming and able men, excellent physicians, occasionally distinguished contributors to scientific knowledge, but the system does not seek out, does not reward effort or achievement in a scientific direction. For the consultant scientific distinction is a becoming decoration: it is not the breath of his nostrils.

Of course things have not stood still. There has been steady and progressive evolution of medical education from the model described by Flexner. Community-based experience, general practice units or departments, public health teaching, training in communication skills, molecular biology and computer-assisted learning are firmly entrenched, whereas there has been de-emphasis of physics, chemistry, biology and anatomical dissection. Elective terms,

often overseas, and minor degrees of integration of clinical with preclinical studies have been incorporated. But the basic discipline-based structure, with separation of preclinical and clinical teaching has remained.

With the information explosion, the curriculum has become progressively crowded - each discipline faced with the compulsion to add more and more as knowledge expands. Teaching modalities are mostly didactic and student learning superficial and examination oriented. Of course I am exaggerating: our current course continues to produce excellent graduates who are respected the world over and student questionnaires have, by-and-large, been satisfactory - although they have been far from outstanding: a major stimulus to the decision by the School of Medicine to change.

Nor do we operate in isolation from the world-wide educational environment. Problem-based learning was introduced with the example of pioneering innovation at McMaster University in Canada and, a decade later, Newcastle University in Australia. The basic platform for education in the medical sciences shifted from passive learning in lectures, supplemented by dissection and practical classes, to active learning by small groups of students seeking out knowledge of the underlying basic medical sciences in order to understand a clinical problem. In this way, knowledge is acquired in a clinically relevant context, and the skills of analysing problems and actively seeking knowledge become ingrained.

Recognising the problems identified in the so-called traditional approach to medical education, a variety of accrediting and review bodies around the world produced a series of reports and guidelines with a surprising number of elements in common. Examples of these reports and guidelines included the GPEP report of the Licensing Committee for Medical Education in North America, the GMC report entitled 'Tomorrow's Doctors in the UK', the Doherty Report for the Committee of Inquiry into Medical Education and the Workforce in Australia and the AMC Guidelines for the Accreditation of Medical Schools in Australia and New Zealand. These reports and guidelines all emphasised the need to integrate basic science and clinical medical education; to concentrate on the understanding of principles and concepts rather than a comprehensive compendium of factual information; to encourage self-directed

learning and enquiry, with use of computer technology; and to experience a variety of clinical settings and environments. Opportunities to explore areas in depth through a significant component of optional or elective studies in addition to the core curriculum were also advocated. Around the world, medical schools are revising their curricula with a greater or lesser degree of radicalism. In some, this has been a positive experience, for others a destructive and divisive one, on several occasions leading to the premature end to the academic career of the Dean.

So is this all a passing fad, or does it represent a real advance? Our own evaluations indicate that our students do perceive a problem. Questionnaires conducted by both the Faculty and the students indicate that many students feel the curriculum is overloaded and encourages superficial learning. Teachers' experiences are that despite the length of time spent on the basic sciences students are poorly able to apply them to the clinical scenario. Students feel they have insufficient time to explore areas in depth and too little opportunity to learn about rural health, Aboriginal health, medical ethics, law and medicine and several other areas.

Early in 1996 the School of Medicine commenced a process of review of the curriculum in conjunction with the other schools of the Faculty. A number of Faculty staff visited medical schools around the world, and senior members of the School and the Curriculum Review Committee together with a number of students and recent graduates took part in a weekend retreat. After a vigorous and constructive debate, a consensus was reached which we feel has achieved an exciting combination of the best of the old with the best of the new, and two exciting novel aspects.

The first novel aspect relates to selection. Many will be aware that three Australian medical schools have moved to graduate entry, the system used almost universally in North America. After at least three years of undergraduate study, students are selected on the basis of some combination of three criteria: their grade point average during the last two years of their undergraduate course, performance in a specially designed Graduate Australian Medical Schools Admission Test (GAMSAT) and a structured interview. The students then undertake a four year medical course - each year long and demanding. The three medical schools using this form of admission (Flinders, Sydney and Queensland) have all chosen a curriculum which integrates basic science and clinical teaching, contains a significant component of

problem-based learning and is delivered with a greater or lesser degree of computer-based technology.

The Faculty seriously considered moving to a similar graduate entry system. Clearly, there are considerable advantages. Any educational disadvantage conferred through inequality of secondary education, such as that generally believed to exist between government and private schools and rural and urban schools would be buffered by the university experience. Students would be more mature, better able to choose their vocation, and adjusted to study in the more *laissez-faire* environment of a tertiary institution. But there are also some disadvantages. For many undergraduate students, already committed and motivated to study medicine and with outstanding capability, a forced additional period of three years study with the pressure of competing for selection hanging over their heads would seem an unnecessary imposition, adding slightly to the total period of study and greatly to the period of uncertainty about their future. A packed four year course provides little opportunity for exploring areas in depth, supporting oneself with part-time employment or continuing with interests outside medicine. From the practical point of view, most students given the option of entering medicine directly from school, rather than undertaking another course for three years and then competing for selection, will choose to do so - leading to the loss of some of the brightest and most motivated students to other medical schools. So we recognised merit both in graduate entry and in school leaver entry, and decided to choose two thirds of students as school leavers and one third as graduates. We hope that combining the two will allow the best of both worlds. Moreover, by using similar selection techniques for graduate entry as those used by the three graduate entry schools and retaining VCE rank, but adding a psychometric test for school leaver entry we feel we are greatly diversifying the selection criteria and broadening the base from which students will be selected. We will strengthen the policies encouraging entry to medicine by rural students, students from disadvantaged backgrounds and Aboriginal students.

Despite the advantages of the two selection streams, there were also potential problems. A six year course for graduates would clearly be inequitable and uncompetitive. However, under current resource constraints and in the environment of a partially problem-based learning curriculum, two separate streams would be quite impractical. Fortunately, we had another primary

intention in our new curriculum - the second novel aspect. We wished to give students the opportunity to explore in depth areas of particular interest broadly relevant to medical practice, and to develop the rigours of research methodology, including critical appraisal of information, data retrieval and analysis, clear oral and written communication skills and original and creative thought. We have therefore included, for the school leaver cohort, a year between the fifth and eighth semesters where they will select from a range of options, all including a minimum of one-third research but some incorporating 100 per cent research. Some examples of programs offered in this 'inter-calated' year will include traditional bench-based research, rural health, Aboriginal health, international health, law and medicine, medical ethics, medical history, drug and alcohol studies and many others. All these courses will have clearly defined objectives, most will include course work as well as project work and research, and many will be based away from the University and teaching hospital campuses, for example in rural environments or overseas. We hope to develop opportunities for our international students to study in their own country, making the overall experience during their course more relevant to their home environment.

The students completing the course up to the completion of this year of Advanced Medical Science will receive the degree of Bachelor of Medical Science, allowing a potential exit with a qualification and dignity for those who decide at this point that medicine is not for them.

The graduate entry stream will not be required to complete the Advanced Medical Science Year allowing them to leap-frog from semester five to semester eight. As they will also be allowed, if they choose, to omit the first semester with appropriate bridging material, the total course duration for the graduate entry stream will be four and a half years. We feel it is appropriate for these students to be exempted from the Advanced Medical Science Year in view of the breadth of their experience and study before entry to medical school.

Our objectives when designing the new course were to equip doctors to cope with the recent enormous technological, demographic and sociological changes which will continue over their lifetimes. Factual knowledge will soon become obsolete, but the ability to learn by seeking out and analysing information within a sound conceptual framework using the latest technology will be an enduring skill. Society's expectations may well continue to change, but qualities of compassion,

communication, understanding and integrity will never become obsolete. The current environment requires that we produce doctors with the knowledge and skills to exploit the new world of information technology - popularised by Bill Gates and his colleagues - and yet retain the values and idealism of the Hippocratic tradition with which most students started the course. We also want them to enjoy the course; to be intellectually stimulated and challenged and to emerge from the course imbued with the excitement of living in the era of most rapid development in the history of medicine, rather than dulled and pessimistic as too often happens now.

I don't wish to go into detailed description of the curriculum, but I do want to enunciate some principles. The most important is that the curriculum will be integrated. There will be no subjects known as biochemistry or physiology or anatomy or medicine or surgery. There will be four vertical streams extending throughout the course. These are the scientific basis of medicine, health and society, clinical skills and professional attitudes and development. An introductory semester will provide students with a broad outline of the structure and function of the human body in health and disease, together with an introduction to health and society, the human mind and behaviour, first aid and emergency medicine and the first contact with problem-based learning. The next four semesters cover the body systems, integrating structure and function in health and disease, and use a problem-based format in addition to more traditional teaching methods. The population sciences, behavioural sciences and clinical skills will be taught throughout, integrated wherever possible with the basic sciences. Self-directed learning will receive a much greater focus and much will be computer-based. With the help of funds provided by central University sources, a range of highly innovative, interactive learning programs are being developed. Assessment techniques will be compatible with the teaching modalities and the learning objectives. It should be emphasised that while we are decreasing the factual content and contact hours throughout the course, we do not wish in any way to de-emphasise the understanding of the basic sciences. Rather, we are hoping to increase the degree of understanding and retention of the important concepts by having the students seek them out and learn them in a clinical context.

The years of the course after the Advanced Medical Science Year will have more clinical emphasis than the earlier years, but the basic sciences will

again receive appropriate emphasis by continuing with a problem of the week directed towards integrating basic science concepts into the clinical arena. Sharp distinctions between clinical areas such as medicine and surgery will be lost, just as they are in general practice and as is becoming the norm in hospitals. However, patient-based teaching will remain the central focus. As Thomas Sydenham said: '... you must go to the bedside, it is there alone that you can learn disease'. Emphasis will be given to experience in rural, community and ambulatory environments, and the extent of exposure in specialised tertiary hospitals will be reduced. We aim to produce doctors knowledgeable in science, comfortable and proficient with new technology, and with the human and caring qualities that have always been essential for good medical care. As the famous physician, Francis W Peabody said in 1927: 'The essence of the practice of medicine is that it is an intensely personal matter... the treatment of the disease may be entirely impersonal; the care of the patient must be entirely personal'.

I would like to acknowledge the superb contribution made by many people to the ongoing work of development of the curriculum. Susan Elliott has been appointed as the Director of the Faculty's Education Unit, and together with Ann-Maree Kelly and Jenepher Martin, has played a pivotal role in co-ordinating and leading the work of the very many task groups involving over two hundred Faculty members. Neville Yeomans as Chair of the Curriculum Review Committee, Peter Harris and Dick Wettenhall have all had major roles. The current medical students have made a major contribution even though they will not benefit directly from the new course. The Faculty administrative staff have provided superb support, as has the University's Multimedia Unit and Centre for the Study of Higher Education. In addition Professor Gordon Clunie played a major leadership role in generating and facilitating the environment where these radical changes could be accomplished - changes that many thought the University of Melbourne could not achieve. It has been a real team effort, much remains to be done, but the quality of the effort to date suggests that we will be able to develop a medical course suited to the new millennium - an appropriate blend of the old world of Hippocrates and the new world of Bill Gates.

I think it appropriate to end by giving the last words to the two people who gave their names to this lecture. Bill Gates has recognised the enormous changes occurring in medicine which

requires a new approach to medical education: 'Like software, biotechnology will change the world... I expect to see breathtaking advances in medicine over the next two decades...'. Hippocrates articulated the dilemma of medical education that we have been wrestling with for so long as early as the fifth century BC: 'The life so short, the craft so long to learn'.

## BUILDING THE NEW LEARNING ENVIRONMENT

An exciting new environment is planned to enable students to undertake self-directed learning and develop their clinical skills.

New facilities include twenty-four problem-based learning rooms equipped with the latest computers and a small library, as well as a clinical skills laboratory.

These will be located in the medical building.

We are inviting corporate sponsors to support this development, and welcome interest from individuals who would like to be associated with these new student facilities.

For further information, please

contact myself or

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*Richard Larkins*

*Dean, Medicine, Dentistry and  
Health Sciences*

## NOTICE OF ANNUAL GENERAL MEETING 1998

The Annual General Meeting of the University of Melbourne Medical Society (UMMS) will be held at 6.30 pm on Tuesday 9 June 1998, in the Sunderland Theatre, ground floor of the medical building, The University of Melbourne, Parkville. The meeting will be preceded by the Dean's Lecture in which Professor Michael Permezel, Professor of Obstetrics and Gynaecology, Mercy Hospital for Women and Austin Repatriation Medical Centre, will deliver a lecture entitled *The damaged baby. Who is at fault?*

### Business

1. Minutes of 1997 Annual General Meeting
2. Chairperson's report
3. 1997 Financial Report
4. Election of Committee, 1998-2001  
Nominations are called for the election of six (6) members of the Committee of UMMS for 1998-2001 and close on Tuesday 2 June 1998.

In accordance with section 7.3 of the Constitution, any two members may nominate, in writing, addressed to the Honorary Secretary at least seven days before an Annual General Meeting, any other member or members to fill vacancies on the Committee. The consent of each person so nominated must be submitted in writing.

The following five retiring members of the Committee are eligible and available for reappointment, and under section 7.3 of the Constitution are proposed for re-election:

Dr Lorraine Baker  
 Mr David Westmore  
 Mr Michael Wilson  
 Dr Andrew Rothfield  
 Dr Thomas Kay

If more nominations are received than vacancies available, then an election will be held at the meeting.

5. General business

## MINUTES OF THE ANNUAL GENERAL MEETING 1997

The annual general meeting of the University of Melbourne Medical Society (UMMS) was held at 6.30 pm on Tuesday, 20 May 1997 in the Sunderland Lecture Theatre, Medical Building, the University of Melbourne. The meeting was preceded by the Dean's Lecture entitled *Regulating the intracellular circuitry of cell death*. This was delivered by Professor Suzanne Cory, Director Walter and Eliza Hall Institute of Medical Research.

### 1. Minutes of the Annual General Meeting 1996

The minutes of the 1996 Annual General Meeting, previously published in the 1997 issue of *Chiron* and circulated to UMMS Members, were adopted as a fair record of proceedings.

### 2. Chairperson's Report

The Chairperson congratulated the editorial team of Professor Emeritus Harold Attwood and Ms Liz Brentnall for another excellent edition of *Chiron*. This journal continues to document important aspects in the life of the School of Medicine, the University and our alumni. The Chairperson acknowledged the continued generosity of the Medical Defence Association of Victoria in supporting this journal.

The Editorial in *Chiron* outlines the substantial review of the MB BS program being undertaken by the School of Medicine. It is scheduled for implementation in 1999.

Membership of UMMS at the end of 1996 was 2424.

A survey of medical graduates, who completed their course between 1979 and 1993, was undertaken early this year to find out what professional activities these graduates are now undertaking. 1859 graduates responded to the survey - a 68.5 per cent response rate, and over 1611 graduates claimed a free membership of UMMS, which was offered as an incentive to complete the questionnaire. A report will be published in the next *Chiron*.

The Bachelor of Medical Science Prize for 1995 was awarded to Ashley Ng for his study entitled *NR2, an orphan haemopoietin cytokine receptor: expression pattern and genomic structure*.

One Peter G Jones Elective Essay Prize was awarded for 1996, to Felicity Dent for her essay *Oh, the Places You'll Go!* on her elective in Romania and Zimbabwe.

Alumni activities in 1996 included the University AlumniFest in October, at which we welcomed several medical graduates back to the University, including one from Thailand.

The Annual UMMS Lecture, entitled *The Opium Poppy: Friend or Foe?*, was delivered by Professor Emeritus David Penington, to a large audience including many members of the public with an interest in improving the management of drugs in the community.

The Dean's Lecture Series in 1996 was well attended and concluded with the annual medical ethics seminar, this time entitled *The New Genetics: for Good or Ill?* convened by Professor Richard Smallwood.

Forthcoming events this year include the annual UMMS Lecture and function. Details will be announced and members will receive invitations later this year.

Member's are reminded of the forthcoming Dean's Lectures for this year and the ethics seminar which concludes the Series - *Health Care in a Multicultural Society*.

### 3. Financial Report

The Financial Report, for the twelve months ending 31 December 1996, was circulated and it was noted that the balance at the end of the year was \$74 343. A motion to accept the financial report was carried.

There being no further business the meeting closed at 6.40 pm.

## UMMS 1996 BMEDSC PRIZE

**Rathan M Subramaniam**

for his study entitled

**Tolerance to Model Self Antigens**

To examine the state of tolerance to a secreted extrathymic antigen, mice were generated that expressed ovalbumin (OVA) in the  $\beta$  cells of the pancreas under the control of the rat insulin promoter. These mice did not produce OVA-specific antibody or CD4-dependent OVA specific cytotoxic T cell responses, suggesting that they were tolerant to OVA. After priming with OVA<sub>257-264</sub> peptide in CFA, which can induce CD4-independent cytotoxic T cells in normal mice, a response was detected, suggesting that CD8<sup>+</sup> T cells were not tolerant to this antigen. To confirm this point, RIP-OVA mice were crossed to the OT-I transgenic line, which produces class I-restricted OVA-specific CD8<sup>+</sup> T cells. Analysis of lymphoid organs indicated that there was no thymic or peripheral deletion of OVA-specific CD8<sup>+</sup> T cells in RIP-OVA x OT-I double transgenic mice. In addition, CD8<sup>+</sup> T cells in these mice responded normally to antigen in vitro, indicating that they were not anergic. When RIP-OVA mice were crossed to the DO11.10 transgenic line, which produces OVA-specific CD4<sup>+</sup> T cells, thymic deletion of OVA-specific CD4<sup>+</sup> T cells was observed. This was due at least in part to expression of OVA by a bone marrow derived population.

The role of Fas and tumor necrosis factor receptor-p75 in CD8<sup>+</sup> T cell peripheral deletion in the Met-K<sup>b</sup> was examined. In this system the allogeneic major histocompatibility complex class I molecule H-2K<sup>b</sup> (K<sup>b</sup>), is expressed under the sheep metallothionein promoter (Met-K<sup>b</sup> mice). When K<sup>b</sup> specific T cells (Des-TCR) were injected into the Met-K<sup>b</sup> mice, cells expanded before undergoing deletion. We provide some evidence that CD8<sup>+</sup> Des-TCR T cells are resistant to deletion when TNFR-p75 was blocked by antibody injection. Therefore, the results suggest that TNFR-p75 may play a role in CD8<sup>+</sup> T cell deletion in the Met-K<sup>b</sup> system.

To determine the number of CD8<sup>+</sup> T cells required to reject a class I-disparate skin graft, different doses of K<sup>b</sup> specific CD8<sup>+</sup> T cells from Des.BR TCR transgenic mice were injected into CBA nude mice. Recipients were the grafted collaterally with K<sup>b</sup> bearing skin and syngeneic skin and examined for graft survival. Mice injected with as little as 10 CD8<sup>+</sup> T cells were able to reject their K<sup>b</sup> bearing grafts, indicating that the transfer of very few cells could result in graft rejection. Increasing the number of cells, however, greatly reduced the length of graft survival and increased the proportion of mice that rejected their grafts. This suggested that the number of cells transferred could influence the outcome. Examination of the proportion of transgenic T cells in both grafted and ungrafted mice several weeks after transfer, indicated that injected cells could expand without a specific antigenic stimulus. This was the case even when donor T cells were from a Rag-12-deficient background, which would not allow rearrangement of endogenous TCRs. These results indicate that the transfer of few CD8<sup>+</sup> T cells is required for graft rejection.



## UMMS CONGRATULATES

*Dr Sam Berkovic* (Austin & Repatriation Medical Centre) - the **Selwyn-Smith Medical Research Prize 1997**

*Professor Graeme Clark* (Department of Otolaryngology) - the **Sir William Upjohn Medal**

*Professor Suzanne Cory* (Director, Walter and Eliza Hall Institute of Medical Research) - the **1997 Burnet Medal**

*Professor John Furness* (Anatomy & Cell Biology) - the **Davenport Medal of the American Physiological Society**

*Dr Sandra E S Neil* (PhD(Medicine)) - **President-Elect 1997-98 of the International Council of Psychologists**

*Dr Seong-Sen Tan* (Principal Research Fellow and Head of the Development Biology Laboratory, Howard Florey Institute of Experimental Physiology and Medicine) - the **1997 AMGEN Award**.

### Officers of the Order of Australia (AO)

*Professor John Watson Funder* (BA 1964, MB BS 1965, PhD 1970, MD 1971) - for service to medicine, particularly in the field of endocrinology research, and in the development of a public policy across a range of primary health issues

*Professor Richard Smallwood* (Austin & Repatriation Medical Centre) - for service to medicine, particularly in the field of gastro-enterology, to research through the National Health and Medical Research Council, and to education

### Members of the Order of Australia (AM)

*Dr John Barton Best* (MB BS 1963, MD 1970) - for service to the development of quality assurance in health care in Australia, particularly through the creation of the Peer Review Resource Centre and as foundation editor of the Australian Clinical Review

*Emeritus Professor Hermann Barry Collin* (BSc 1957, MAppSc 1966, PhD Med 1970) - for service to optometric research and education in the Asia-Pacific region

*Dr Harold Robert Elphick* CBE (MB BS 1940) - for service to medicine, particularly thoracic medicine and the management and surveillance of tuberculosis, and as President of the Australian Council of Smoking and Health in Western Australia

*Dr Warren Frederick Johnson* (MB BS 1960) - for service to Australian medicine particularly in the fields of surgery and research, and to professional associations

*Dr Leslie Koadlow* (MB BS 1944) - for service to medicine, particularly as a rheumatologist specialising in musculoskeletal diseases and rehabilitation, and to the Arthritis Foundation of Victoria

*Dr Raymond Francis Martyres* (MMed 1992) - for service to the community through fund-raising for the Bone Marrow Donor Institute and its related laboratories

### Recipients of the Medal of the Order of Australia (OAM)

*Dr Elsie Koadlow* (MB BS 1947) - for service to the medical and allied health professions as a psychotherapist and educator, particularly in the fields of sexual and relationship therapy

*Professor Frank Oberklaid* (Paediatrics) - for service to medicine, particularly in the fields of ambulatory paediatrics and child health

*Dr Joseph Natalino Santamaria* (MB BS 1948, MMed 1987) - for service to community health, particularly in the fields of alcohol and drug addiction

*Dr Allen Peng Yung* (MB BS 1960) - for service to medicine, particularly in the field of infectious diseases

### Recipients of the Public Service Medal (PSM)

*Dr Graham John Rouch* (MB BS 1958) - for outstanding public service as the Chief Health Officer for Victoria

# THE UNIVERSITY OF MELBOURNE MB BS

## A SURVEY OF 1979-1993 GRADUATES

What career paths have our recent graduates been following and where are they practising? These were two of the questions asked in a survey of 2,895 University of Melbourne medical graduates who completed the MB BS course between 1979 and 1993.

The survey, conducted in January 1997, was analysed in three five-year cohorts. The overall response rate was about 70 per cent, which is reasonable considering that some who did not respond were overseas, and there are others, of course, for whom the University no longer has a current address.

In light of recent concerns about the Federal Government's provider number legislation, it is interesting to note that almost every graduate had obtained a provider number from the Health Insurance Commission, but that in the twelve months leading up to the survey, 14 per cent of these graduates had not used their provider number for the provision of services covered by Medicare.

During the fifteen year period from 1979 to 1993 the proportion of our female graduates increased steadily, from 30 per cent in the most distant five year period to 43 per cent in the most recent. Very few graduates were unemployed at the time of the survey (2.2 per cent of women and 0.5 per cent of men) and few (1.5 per cent) had switched to another career outside medicine. Women were slightly less likely (17.6 per cent vs 21.3 per cent) to be practising in a non-metropolitan area.

Figure 1 shows the professional activities of the graduates at the time of the survey. Gender differences were statistically significant, with more female graduates in general practice and less in specialist practice than their male counterparts. Disciplines in which women were very much under-represented include orthopaedic surgery, cardiothoracic surgery and ENT; while areas in which women were substantially (three or more times) over-represented include obstetrics and gynaecology, geriatrics, paediatrics, medical administration, occupational medicine, clinical haematology and clinical pharmacology. Despite earlier stereotypes to the contrary, men and women were much more equally represented in general surgery (8.3 per cent and 4.8 per cent) among the graduates who responded to the survey.

Some information relevant to redressing the rural/urban imbalance also surfaced. It has been assumed that students who come from the country are more likely to end up practising there. This appears to be the case. Of those who came from the country, 57 per cent said that they intended to practice or were already practising there, compared with only 22 per cent of those who grew up in a city.

When asked to reflect on their undergraduate medical education at the University of Melbourne, the graduates were generally complimentary. More recent graduates tended to rank

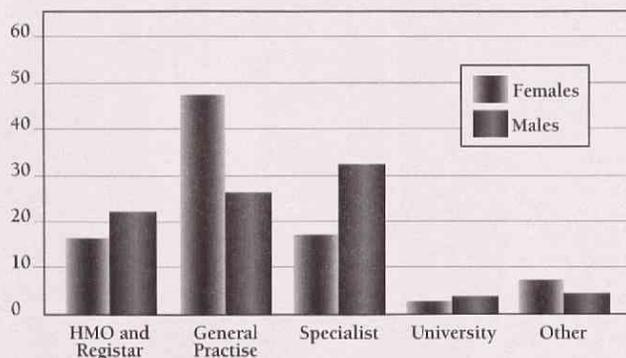


Fig.1

the medical course more highly - which might reflect the School of Medicine's efforts to improve the course over the past fifteen years (or may simply reflect fading memory!).

The academic performance of the graduates during their course bore some relation to their subsequent career path. The group who had ended up in a university or research career were significantly more likely to have ranked in the top 25 per cent of their class, followed by those who chose a specialist career. Of course the fact that intern positions are determined partly by class rank would be likely to have a bearing on opportunities to enter those career paths.

Many graduates put a lot of importance on family commitments when deciding about their length of training and about how and where to practice. Women were significantly more likely to give this more weight, especially when considering the length of their training.

The School of Medicine is grateful to all the graduates who took part in this survey, and to Dr Andrew Rothfield (MB BS 1988) who analysed it.

*Professor Neville Yeomans  
Deputy Head, Department of Medicine  
The Royal Melbourne Hospital and Western Hospital*

### PETER G JONES 1997 ELECTIVE ESSAY PRIZES

The University of Melbourne Medical Society awards up to three prizes each year to sixth year MB BS students. Prizes are awarded for the best essays of up to 1500 words describing the student's elective experience in both professional and personal terms.

Prize-winning essays are also considered for publication in *Chiron*.

The 1997 prize winners were:

Marilla Druitt, *One Elective Story* (excerpt *Chiron* 1998, p35)

David Iser, Yo, Balanda Boy (*Chiron* 1998, p33)

Megan Rees, *Science, Sculpture and Sexuality: A research elective in female urogenital anatomy* (*Chiron* 1998, p32)

# 1997 REUNIONS

## SCHOOL ALBUM



**F**ROM THE MEDICAL HISTORY MUSEUM COLLECTION, a photograph of 1879 and 1880 medical students in the courtyard of the Old Medical Building. In the back row, third from the left, is Thomas Rupert Henry Willis, one of the founding committee members of the Medical Students' Society - the Society's emblem is portrayed by the skull and crossbones.

The Medical History Museum and Collection is now thirty years old and holds a large number of group and individual photographs of students and graduates of University of Melbourne Medical School. To make the photographic collection

as complete as possible photographs from the 1880s to the 1960s are needed.

Graduates, relatives and friends are urged to donate photographs to the Medical History Museum where they will be catalogued and properly conserved. Arrangements can be made to copy particularly precious photographs and the originals returned to the owner.

Your photographs would greatly enrich the collection's historical value. Please contact Lisl Bladin on 9344 5719 if you think the Museum might be interested in your photographs.

### MB BS 1933

#### SIXTY-FOUR YEARS REUNION

**The home of Dr & Mrs Turnbull  
25 September 1997**

*From Spot Turnbull* - The reunion luncheon to celebrate the sixty-fourth anniversary of the 1933 medical graduates of the University of Melbourne was held at our home on Thursday 25 September 1997.

Although there were thirteen of us still alive, only five were able to attend the reunion. They were: Norman Cust, John Hayward, Lorna Lloyd-Green, Dorothy Sinclair and myself. The remaining eight were overseas (1), interstate (2), in nursing homes (3), or in Victoria but unable to attend (2).

We all hope to be present at our sixty-fifth reunion!!



L-R John Hayward, Lorna Loyd-Green, Norman Cust, Spot Turnbull, Dorothy Sinclair

## MB BS 1937 SIXTY YEARS REUNION

Naval and Military Club  
10 October 1997

*From Jim Peters* - A luncheon to mark the sixtieth reunion of the University of Melbourne graduates of 1937 was held at the Naval and Military Club on 10 October 1997. In June 1997 graduates on the UMMS list had been circularised and by checking with University colleges and medical boards etc., four on the 'missing list' were found, two of whom came to the luncheon. Of the eighty-four who graduated in 1937, twenty-four were located as still being with us and a reunion booklet was produced as a memento for those at the luncheon and those unable to attend. Ten graduates and eight guests attended the luncheon.

This reunion, our first in ten years, was a happy and somewhat nostalgic occasion. University days, war service years, and careers since were discussed and remembered. Toasts were made to those present and those unable to come. As one of the ladies said, the 'survivors' of '37 should get together before another ten years!

Apologies and good wishes were sent by: Joy Bell (Frew), Eileen Catarinich (O'Keefe), Dorothy Champion (Fraser) from NSW, Gerard Davies from WA, Llew Davies from NSW, Kiernan Dorney from Qld, Archie Ellis from WA, Betty Flaxman (Bright) from Adelaide, David Jackson from Qld, Maurice Morris, Elizabeth Miller (Coles) and Michael Woodruff from Edinburgh.



**Back Row L-R:** Jim Peters, Jack Gild (from Queensland), Mark O'Brien, Cyrus Jones, Don Oldmedow (from Perth), Victor Brand. **Front Row L-R:** Pat Wellington (Hudson), Jean Hutchings (Plendereith), Lena Drake (Thomas), Clare Abrahams (Jelbart)

## MB BS 1940 FIFTY-SEVEN YEARS REUNION

11 November 1997

*From Norman Wettenhall* - To celebrate our fifty-seventh year of graduation we had lunch together at the Melbourne Club. Thirty-two were present including Emeritus Professor Richard Lovell, who graduated in 1940 in London and was invited to join our group. Bob Elphick, Don Flemming and Lloyd Morgan came from Western Australia and Sam Mecoles came from Queensland. There were seven apologies, mostly because they were not well enough to come. Rachel Meschan (Farrer) was in the USA and Mary Salvaris (Irvine) was in Greece. A few of us are still in practice but most have retired, almost all of us being in our eighties. Bill Rigg, as sprightly as ever, is ninety-three and Roy Phillips, the uncrowned king of Wangaratta, is ninety. Ted Spring and John Cahill were the two youngest but both will have had their eightieth birthday by the time this report is read. It was a nostalgic occasion with much conversation and good will. There were no formal speeches.

Our first reunion was in 1960 and subsequent ones have been held every five years, so this was our ninth. The next one in the year 2000 will be our tenth get-together and our 'diamond jubilee' to celebrate sixty years since graduation.

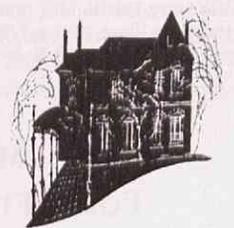
Those present were: John Bignell, Ken Brennan, John Cahill, Basil Conlon, Peter Davis, Ken Davidson, Bob Elphick, John England, Don Fleming, Howard Hoban, Harry Jackson, Sheila Lusted (Barr), Graham McKenzie, John McMahon, Sam Mecoles, Frank Moore, Les Moran, Lloyd Morgan, John Murphy, Norrene Nicholson (Findeisen), Roy Phillips, Albert Piper, Bill Rigg, Bill Rose, Warwick Rosenthal, Edward Ryan, Gladys Simpson

(Morris), Ted Spring, Murray Verso, Norman Wettenhall, Jean White, Richard Lovell (London, 1940).

Apologies were received from: Cornelius Christie, Noel De Garis, Ian Galbraith, Lindsay Irwin, Ken Morris, Peter Sleeman, Elizabeth Turner.

### Organising a Reunion Dinner?

University House, on the campus  
of the University of Melbourne is  
the ideal venue.



The House is able to cater for reunion groups ranging in  
size from 30 to 250 guests.

We offer a variety of competitively priced menu  
packages to suit any occasion.

Please contact Mr Martin Zarb on 9344 5254 for menus,  
costs, a tour of the facilities and further information.

## MB BS JULY 1947 FIFTY YEARS REUNION

University House  
10 July 1997

*From Tom Hurley* - The medical graduates of 7 July 1947 held a reunion at University House to celebrate fifty years since graduation. Of the seventy-seven graduates presented by the then Dean, Professor MacCallum, to the Deputy Chancellor Dr L S Lathan, forty were present to reminisce and recall undergraduate days half a century ago. There were apologies from a further twenty-five and we recalled with sadness the twenty-seven of us who had died.

It was a memorable evening with no formal speeches but several short presentations recalling with gratitude our teachers; especially Syd Sunderland and Pansy Wright who had been present on previous reunions.

Some travelled from distant places to join us including several from interstate and Sam Rose who came from the USA especially for this event.

The graduates from 1947 were a select group and the only year to commence their academic studies by digging slit trenches in the lawns of the University. It was also one of the

shortest courses in recent years, spanning a little over five years from March 1942 to June 1947. Those attached to The Royal Melbourne Hospital were the last year to have been students in the buildings in Lonsdale Street before the hospital moved to Parkville in 1944.

The evening concluded with a unanimous expression of thanks to Ross Webster who had, as on previous occasions, organised our reunion with his usual quiet efficiency.

The evening was attended by: Bruce Bailey, Ric Bouvier, Herbert Bower, John Bradley, Peter Bradley, John Clarebrough, Ralph Clark, Henry Cohen, John Connell, Peter Crooke, Des Dooley, Peter Dow, Harry Eizenberg, Jim Ferris, Greg Forristal, Athel Hockey, Ern Hodder, Yumna Holyoke (Mansour), Tom Hurley, Don King, Elsie Koadlow (Shinberg), Ted Levick, Gerald Manly, Murray Maxwell, Harold McCombe, Peter McMahon, Jack Morris, Frank Mouser, Bernard Neal, Kevin O'Reilly, Noel Ramsey, Peter Robertson, Sam Rose, Ian Rowe, Alex Splatt, Alex Stewart, Harold Story, Ced Vear, Ross Webster, Howard Whitaker.



**Class of 1947 - 50 Years Reunion**

**Back Row L-R:** Peter Dow, Des Dooly, Tom Hurley, Peter Crooke, John Bradley, Ralph Clark, Howard Whitaker, Bruce Bailey, Harold McCombe, Peter McMahon, Harold Story, Ern Hodder, Don King, Harry Eisenberg, Frank Mouser, Peter Robertson. **Second Row L-R:** Alex Stewart, Herbert Bower, Henry Cohen, Murry Maxwell, Ian Rowe, Bernard Neal, Alex Splatt, John Connell, Ross Webster, Ric Bouvier, Jim Ferris **Third Row L-R:** Noel Ramsey, Ced Vear, Sam Rose, Peter Bradley, Greg Forristal. **Seated L-R:** Jack Morris, Ted Levick, Elsie Koadlow (Shinberg), Yumna Holyoake (Mansour), Athel Hockey, Gerald Manley, Kevin O'Reilly, John Clarebrough

## MB BS 1952 FORTY-FIVE YEARS REUNION

8 & 9 November 1997  
Commonwealth Golf Club

*From Hugh Hadley* - Every five years a committee of doctors who graduated in medicine from the University of Melbourne in 1952 organises a reunion dinner and barbeque. This year the dinner was held on 8 November at the Commonwealth Golf Club and the barbeque at my home in Toorak. Both were a great success.

The reunion was attended by: John Aberdeen, Andy Ahern, John Anchen, Dot Bailhache, Neil Barter, George Bearham, Ron

Benson, John Booth, Ken Brearley, Len Champness, Dick Chenoweth, Dick Colahan, Alister Cole, Owen Coltman, Shirley Coombs, Graham Corbet, Peter Cosgriff, Henri Coutanceau, Fred Cox, Alex Davis, John Dodshun, Brendan Dooley, Abe Dorevitch, Nan Ferguson, Ern Finkelstein, David Fone, Peter Forsell, Maurice Gilfedder, John Gorman, Keith Grabau, David Grounds, Hugh Hadley, Bill Hardy, Ross Jagger, Max Kent, Lindsay Knight, Laurie McInnes, David McIntosh, John McKenna, June McKeogh, Scotty Macleish, Alan McPhate, Denis O'Brien, Colin Officer, Bill Orchard, Kevin Owen, Ted Palmer, Harry Pannifex, Jim Pryor, John Riddell, Dick Roberts, Ian Robertson, Patti Rogers, Clyde Scaife, Bill Self, Max Shavitsky, Lionel Sloan, Rod Sutherland, Ian Swain, Bill Taylor, Kath Taylor, Morrie Thwaites, Ken Twiddy, Vern Vivian, Ben Wadham, Brian Walklate, Neville York, Phil Zaccari.

**MB BS 1957**  
**FORTY YEARS REUNION**

**8 November 1997**  
**The Australia Club**

*From Bill Traffon* - We gathered at the Australia Club on 8 November 1997 to celebrate forty years of practice in various forms. In spite of having all passed the magic age of sixty there was a general feeling of smug satisfaction at being able to be there. The statistics (collated by Professor Gabriel Kune) are good. Out of approximately 156 graduates (depending on how you count us) 133 are still alive, contact has been lost with three and twenty have died. Eighty-three per cent replied to a social and health questionnaire; a remarkable compliance rate. Eighty-one graduates were in attendance - over sixty per cent of the 'possibles', with a total attendance including spouses of 140.

Our epidemiology is likewise good. Ninety-five per cent reported themselves in good general health, only six per cent

reported malignancies and the smoking rate has fallen from fourteen per cent ten years ago to three per cent now. Eighty-five per cent are still employed in medical work, sixty-six per cent are currently married and only seventeen per cent have divorced. Twelve members of our year married co-graduates.

The excellent dinner was compered by John Royle, Past President of the Royal Australasian College of Surgeons and our guest speaker was our (so far) only knight, Professor Sir Peter Morris, Nuffield Professor of Surgery at Oxford, who made the trip from the UK with his wife Jocelyn (a co-graduate) to be with us.

Our thanks to Tony Carden and John Buntine for organising a successful gathering, ably assisted by Gabriel Kune's statistics and Nancye Edwards's computer.

**MB BS 1962**  
**THIRTY-FIVE YEARS REUNION**

**21-24 March 1997**  
**The Athenaeum Club**

*From George Santoro* - The reunion consisted of a formal dinner for sixty-six graduates at the Athenaeum Club, Collins Street, Melbourne; a very convivial evening with an excellent menu. The guest speaker was Bob Dickens, President of the Medical Defence Association of Victoria, who gave an excellent speech on medical malpractice using a lap-top computer attached to a projector to illustrate his story. Amongst those present were: Thonueb Uttravichien from Thailand where he is Professor of Surgery at Khon Kaen University; Elizabeth Shaw, who has recently retired, and flew in from London; Alan Ebringer who came with his wife from the UK; Jane Mathews (Ahern) who flew her own plane from Albury; and Gaby Reisner, all the way from Toorak. Nick Diamond drove from Frankston, Col Luth, Paul Maher and Carroll Major also graced us with their presence.

Although the evening started at 6.30 it was hard to get everybody moved out by midnight as we all found the evening so enjoyable.

On Sunday 23 March we met at Ian Rechtman's house with partners for an informal lunch. Luckily the day was sunny and pleasant and some were able to lunch in the garden. Rees McCarthy continues to maintain one of the largest collections of recordings, both vinyl and CD, in private hands in Australia. Wilfred Brook has been unwell and we wish him all the best

for the future. It was noted at both functions that nobody drank as much as they used to. Moderation was the name of the game. Oh! How things have changed!

Many thanks to Bob Dickens for his excellent talk and to Ian Rechtman without whose help all of this would not have been possible.

The reunion was attended by: Ross Adie, Jim Anastasios, R Atkins, Alex Auld, Lois Bell, Richard Bell, J F Cade, David Conron, R W Cowie, Dan Czarny, David Dekretser, Nick Diamond, Robert Dickens, John Doncaster, Geoff Dreher, Mary Dwyer, Alan Ebringer, Norman Edwards, John Egan, Ken Farrell, Adam Fligelman, George Footit, Kay Foster, Bernard Freedman, Geoff Gillam, John Green, John Harrison, Arthur Harrison, Peter Hearne, Gedeon Herschberg, Peter Higgs, George Jerums, Douglas Johnson, Darryl Jones, Henryk Krantz, Jack Leder, Colin Luth, Paul Maher, Carroll Major, Rees McCarthy, Donald McComish, Don McMahon, Jane Mathews, John Maynard, Graeme Minifie, Warner Mooney, Mary Morrissy, Zoltan Okalyi, Robert Padanyi, Ron Palmer, Jeannine Paton, Michael Polke, Ian Rechtman, Gabby Reisner, Peter Renou, Bill Robinson, Elliot Rubinstein, Harry Rundle, Bernard Ryan, Vin Sammartino, James Scott, George Santoro, Elizabeth Shaw, John Sheedy, Neil Sist, John Spensley, Thongueb Uttravichien, Geoff Vaughan, Rex Williams.

**MB BS COMMENCEMENT 1977**  
**TWENTY YEARS REUNION**

**Sheraton Towers Ball Room, Melbourne**  
**21 July 1997**

*From Nicholas Gelber and Jeremy Ryan* - A reunion dinner was held on 21 June 1997 in Melbourne, trying to include all medical course inductees from 1977 and all graduates from 1982. The occasion was the twentieth anniversary of our medical course commencement.

A total of 116 medical course participants attended a highly

successful night. Most of those who attended were from Victoria with many country graduates making a weekend of it in Melbourne. Several interstate participants made the trip, particularly from Sydney.

Although unable to attend, a number of people sent their best wishes from places as distant as Bhutan and Boston.

Our 1977 first year group photograph provided much amusement as did some photocopied pre-clinical exam papers which for many of us were virtually incomprehensible. Three short talks were made after the main course with Dr Ian Cox representing the Austin Clinical School, Dr Michael Rasmussen the St Vincent's group and Dr Matthew Naughton the Royal Melbourne contingent. All three talks were very well received with highlights being Ian's amazing collection of undergraduate memorabilia, Michael's tales of postgraduate training in Ireland and Matthew's stories from life at the Royal Melbourne.

Enthusiasm for a repeat reunion appears to be very high and there is an excellent chance that we will be obliged to organise a similar event in a few years time, perhaps in 2002 to celebrate the twentieth anniversary of our graduation.

Attending were: Ralph Ballard, Alisdair Barnes, Maree Barnes, David Beilby, Nathan Better, Alan Blandthorn, Jennifer Bourke, Rose Brewer, Trevor Brott, Graeme Brown, Jonathan Buckmaster, Peter Callan, Marcus Carey, Anne Cass, Michael Chou, Catherine Coffey, Anthony Cohen, Steven Collins, William Connell, Mark Cooper, Ian Cox, Michael Cox, Jacinta Crimmins, Gary Crosthwaite, Andrea Currie, Robert Danks, Rodger Davies,

Jacob Dessauer, Peter Drysdale, Delwyn Dyal-Smith, Narine Efe, David Ernest, Ginette Falcone, Beverley Ferres, Gregory Fitt, Maureen Fitzgerald, William Fleming, Yaron Flicker, Jane Fox, John Fox, Ronnie Freilich, Charles Gelber, Timothy Godfrey, Michael Gray, Andrew Haines, Phillip Hall, Colin Harper, Jennifer Hayes, Bernadette Hess, Brian Hodgkins, Phillipa Hore, Karl Horsburgh, Sean Howard, Fiona Jane, Ian Jennens, Richard John, Lynette Kiers, Geoffrey Kilminster, Deborah Kipen, Kenneth Knowles, Diana Korevaar, Elizabeth Kotchoff, David Krelle, Mark Langley, Francis Laska, Andrew Little, Charles Loader, Geoffrey Markov, Jenepher Martin, Paul McCrory, Desmond McGlade, Lisa McKay Danks, Jane McKenzie, Stephen McMahon, Jean McMullin, Peter Mitchell, Peter Mitchell, Jacinta Mogg, Arlene Murkies, Matthew Naughton, Prudence Neerhut, Dennis O'Connor, Peter O'Keefe, Richard O'Sullivan, Marie Pirota, Julian Rait, Michael Rasmussen, John Reeves, Simon Reilly, Peter Reiter, Gary Russell, Angela Rutherford, Jeremy Ryan, Simon Scharf, Andrew Smith, Stephen Smith, Anthony Sommer, Mark Stebnyckyj, Wanda Stelmach, Keen Tai, Cheng Teh, Ailsa Walbran, Richard Wardlaw, Roderic Warren, Georgina Webb, Heather Wellington, Peter Wilde, Morris Williams, Owen Williamson, Andrew Woodard.

## REUNION ANNOUNCEMENTS

### THINK AHEAD

When did you graduate? Is next year your fifth or fifty-fifth since graduation? Reunions are best planned well ahead of time. Your classmates who are living overseas or interstate will travel to Melbourne for reunions if they have enough advance notice. Venues also need to be booked well ahead.

Please let UMMS know of your plans - we like to publish information about reunions in *Chiron*. We can obtain, on your behalf, a list of graduates from your year and sets of address labels from the Alumni Office and advise you on alternatives you may wish to explore regarding University venues.

We are also able to help you publish a reunion booklet containing details of graduates' activities since graduation. Reunion booklets give those who attend the reunion something to remind them of the event and those unable to attend some information about their old friends and colleagues.

### MB BS GRADUATE ANNIVERSARIES IN 1999

10th year class of '89	40th year class of '59
15th year class of '83	45th year class of '54
20th year class of '79	50th year class of '49
25th year class of '74	55th year class of '44
30th year class of '69	60th year class of '39
35th year class of '64	65th year class of '34

#### UMMS OFFICE c/- School of Medicine

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Telephone: (+61 3) 9344 5888 Facsimile: (+61 3) 9347 7084  
Email: [umms@medicine.unimelb.edu.au](mailto:umms@medicine.unimelb.edu.au)

### 1998 REUNIONS

#### 10TH YEAR OF 1988

August 1998  
Dr Andrew Tauro  
(+61 3) 9496 2611

#### 20TH YEAR OF 1978

Associate Professor David Ames  
(+61 3) 9344 5511

#### 21ST YEAR OF 1977

25 April 1998  
All Saints Winery  
Dr Carolyn Re  
(+61 2) 6021 8252

#### 30TH YEAR OF 1968

October 1998  
PR Conference Consultants  
Pamela Richards  
(+61 3) 9816 9111

#### 35TH YEAR OF 1963

Professor Sayers  
(+61 3) 5226 7899

#### 45TH YEAR OF 1953

Dr Margaret Brennan  
(+61 3) 5334 6565

#### 53RD YEAR OF 1945

23 April 1998  
Mr Nate A Myers  
bh: (+61 3) 9345 5522  
ah: (+61 3) 9576 2176

#### 55TH YEAR OF 1943

Dr W E Swaney  
(+61 3) 9822 7039

#### 60TH YEAR OF 1938

Dr Horace Tucker  
(+61 3) 9598 4250

#### 65TH YEAR OF 1933

18 September 1998  
Lyceum Club  
Dr Spot Turnbull  
(+61 3) 9822 7727

## MICHAEL RUPERT BARRETT

**MB BS 1953**  
**1928-1997**



MICHAEL BARRETT

**M**ICHAEL BARRETT was born in Nairobi where his Melbourne-based family managed a coffee plantation. He attended school in Nairobi and in his spare time enjoyed the company of local black workers, speaking their native Swahili and hunting with them. Leadership, administrative and survival skills were rapidly developed in this environment. If the Second World War had continued beyond 1945 he could well have become an officer in the King's African Rifles direct from school where, during the last three years, his leadership and maturity were acknowledged.

However, his determination to pursue medicine in his home town overcame matriculation woes (including the loss of exam papers sunk between Africa and the UK) and led to his joining the University of Melbourne in 1947, attending the Mildura Campus and Trinity College. The medical student community at that time was largely composed of local and interstate school leavers whose approach to life in general was enriched by the influx of War service personnel during the three years after the War ended. We were additionally fortunate to have in our number, Michael's calm, mature and self-disciplined attitude, undoubtedly honed by his early life in Kenya.

Following graduation in 1953, he worked for two years at Geelong Hospital and then joined the Belmont practice where he focused on service to the community with a tenacity and integrity that won admiration from the community at large and from his many colleagues and trainees. His high practice standards and good administrative skills quickly established the Belmont Clinic as a landmark in quality care. He and his clinic partners continued involvement with the Geelong Hospital contributing to surgery and obstetrics in the sixties and seventies before specialist appointments reduced their commitment.

Despite his often reserved, self-contained exterior, Michael had a soft and generous heart. He acted as Honorary Medical Officer to a Geelong orphanage and after Cyclone Tracey hit Darwin he worked for many weeks as a volunteer junior resident in the Darwin Hospital. This experience was partly responsible for his great love of the outback - he paid annual exploratory visits to Northern Australia with his wife Diana.

Teaching, encouraging and inspiring family medical trainees was an important part of his professional and his family life and many have expressed their gratitude for the dedicated and wisdom-packed apprenticeship Michael gave them. He was also instrumental in developing clinical meetings at the Geelong Hospital involving both local general practitioners and the developing consulting staff from the Hospital.

Illness plagued him for many years - between 1956 and 1958 recurrent pericarditis caused him to lose much time from work but his patient, calm approach in coping with illness did not dampen his enthusiasm for work once he was able to return to active practice. A long battle over the last ten years of his life, with cancer (which he suspected may have been a legacy to his long exposure to sun in Kenya), only enhanced his enthusiasm for his work and he continued despite constant pain and

impaired mobility. Michael remained calm in an extraordinary accepting and lovable manner, no doubt supported by the unstinting devotion of Diana and their three children. His strength and resolve in overcoming pain and discomfort over these many years was inspirational to his friends and colleagues.

*G S Hale*

## WILLIAM SAMUEL BENWELL

**MB BS 1941**  
**1916-1996**



SAM BENWELL

**S**AM BENWELL was the model of a well-rounded man. He was a dedicated general practitioner; a good listener with a special understanding of the problems of women patients and consequently a considerable interest and practice in obstetrics. He had a strong social conscience on controversial issues and very definite opinions which he was willing to voice. He did much work at the Salvation Army Haven Hospital. A man with a critical appreciation of food and wine, he was author of a book *Journey to Wine in Victoria*, which ran to three editions. All this was woven

into a wonderful family life and a wide, if somewhat disparate, circle of devoted friends.

William Samuel Benwell was born in Essendon and raised in Mentone. He attended Scotch College and graduated in medicine from the University of Melbourne in September. In undergraduate days I remember his great interest in traditional jazz (which enlivened many parties) and also his early interest in wine - a mentor in this field being Professor W A Osborne.

After a residency at Prince Henry's Hospital Sam joined the Australian Imperial Forces (109 Casualty Clearing Station) serving from 1942 to 1946 in Western Australia and New Guinea. He then spent 1946-47 as Resident Medical Officer at the Royal Women's Hospital where he came under the influence of George Bearham and Arthur 'Bung' Hill.

Sam was a partner in a general practice in Clifton Hill and Carlton for nearly forty years, his early partners being Cyrus Jones, John and Gordon Trinca, Peter Sleeman, George Shaw and Dick Gutch. He convinced them that the practice could be run by four people while the fifth had a 'year off' but continued to receive his share of the profits. Sam was the first to benefit from this arrangement and took his artist wife Meg, their two children, his mother and a mothercraft nurse to Italy - living on the island of Elba for eight months and spending three months in Positano. Here his interest in wine expanded; he remained a keen traveller throughout his life, and led a wine tour to Italy in 1983.

Every Tuesday Sam lunched with friends at Jimmy Watson's in Carlton in an upstairs room dubbed 'The House of Lords'. One of his friends, Dudley Phillips of Pitman Publishing suggested he write a book on Victorian vineyards and Sam set about this task with enthusiasm. The immediate reaction of the local vignerons was that he was a spy from other vineyards, but it took only a short time for him to be accepted and appreciated.

The Medical Wine Society, founded by Frank May and Dorothea Church, was nurtured by Sam and later, appropriately, he became its President. In 1995 he received the Distinguished

Service Award from the Victorian Wine Industry Association.

At a Medical Wine Society dinner at the Australia Hotel held on election eve in 1972 when Whitlam swept to power, Sam, Meg, and a few friends were wreathed in smiles in a room largely filled with disbelieving and disappointed Liberals.

Not surprisingly, his politics being to the left, Sam spoke about the nuclear threat and was strongly against Australian involvement in the Vietnam War. Linked with his considerable experience of women with unwanted pregnancies, he pushed for abortion law reform, and was honoured by the Salvation Army 'In Recognition of Exceptional Service' in this field. He was a supporter of legal aid, women's liberation, liquor reform laws, voluntary euthanasia and an active demonstrator to 'Save Albert Park'. He was also a frequent writer to the newspapers, suggesting reform in what he saw as wrong in our society.

Sam Benwell was highly moral, often provocative, whimsical, witty and a great host; at heart a man dedicated to his family, his friends and his patients, with a genuine concern for the world in which they lived.

*James Guest*

## NAN PATON BELL

**MB BS 1949, GDip Psych Med 1957, BSc 1960  
1924-1996**

**N**AN BELL qualified MB BS at Melbourne University in 1949. After a time as an intern studying medicine, surgery and obstetrics, Nan obtained her diploma of psychological medicine at Melbourne University in 1957. She was an SRMO at Mont Park Psychiatric Hospital and worked at the Malvern Clinic for many years.

She married Leighton West and they had one son, Richard. Nan worked as an Honorary at the Queen Victoria Memorial Hospital with the late Dr Una Porter and was known for her commonsense approach to many of the mental problems of those patients. She was loved and respected by all her patients and the staff who worked with her.

Generous with her time in dealing with her patients and her friends, Nan also bravely tackled the problem of bringing up her son after Leighton died when Richard was only six. She learned to ski at a relatively advanced age so that Richard should not be deprived of the opportunity to learn.

Nan is sadly missed by her friends.

*Joyce M Daws*

## CYRIL CHECCHI MBE, CBE

**MB BS 1914  
1892-1997**

**O**N 14 MAY 1997, Dr Cyril Checchi died at the age of 104. At the time of his death he was the oldest medical graduate of the University of Melbourne. He died in the hospital he built in Willaura, about forty kilometres south of Ararat, where he had been town doctor for nearly seventy years. Cyril Checchi's life of devoted professional and community work for Willaura was repaid with the love and admiration of the townspeople. His autobiography, *The Greatest Joy of All*, was published in 1995 and reviewed in *Chiron*, Vol 3, No 4, 1996, p 67.

*HA & LB*

## SIR JOHN CAREW ECCLES AC, KT

**MB BS 1925, MA, DPhil (Oxon), DSc (Cantab), DSc (Oxon,  
Tas, Brit Colombia, Marquette, Gustavus Adolphus, Loyola,  
Yeshiva), Hon LLD 1978, Hon MD (Charles Univ Torino), FRS,  
FRACP, FAA  
1903-1997**

**A** GRADUATE of the University of Melbourne, Eccles was one of Australia's most distinguished scientists. His profound insight into the workings of the mammalian nervous system began as a Rhodes scholar with Sherrington (Oxford 1925-1936)

where he studied the neurophysiology of the flexor reflex. He returned to Australia in 1937, and together with Katz and Kuffler at the Kanematsu Memorial Institute of Pathology, discovered the end-plate potential. Between 1943 and 1951 he held the Chair of Physiology at the University of Otago, where he established the principles of intracellular recordings to distinguish electrical from chemical transmissions between nerve cells. Fortuitously, he met Karl Popper, a German refugee in New Zealand, who later had a major influence in the philosophy of science and upon Eccles's approach to the nervous system. Work in New Zealand began on the intracellular recordings of excitatory and inhibitory post-synaptic potentials of motor neurons, which came to full fruition after he moved back to Australia in 1952 as the Foundation Chair of Physiology at the John Curtin School of Medical Research. The ensuing thirteen years were perhaps the most productive of his scientific career, during which he laid the molecular foundations for the ionic basis of excitatory and inhibitory transmitters in the nervous system. This achievement was appropriately recognised by a Nobel Prize in 1963. Then, at the pinnacle of his career, it appears that he left the Australian National University because he was uncertain of his post-retirement future. Regrettably, this was to be the first of two examples of the ANU losing the presence of a home-grown Nobel laureate.

After a time in Chicago and Buffalo, he finally retired in 1975 at the age of seventy-two. Taking up residence in Switzerland, he returned to the fundamental question of the brain-mind problem and collaborated with Popper to produce some challenging (if not widely accepted) ideas on the dualist nature of the mind. Looking back on his life, one can see the determining influences of Sherrington and Popper, and how from these stem his outstanding discoveries of how the essence of neural communication is formed. Together with Burnet and Doherty, we can place Eccles at the front-line of Australia's contribution to biological science; poof that our research effort has made a significant contribution to the global advancement of science.

*Colin L Masters*

## BRYAN HUDSON AO

**MB BS 1946, MD 1949, PhD 1958, FRACP, FRCP(Hon),  
FACP(Hon), FRCP(Canada)  
1923-1997**

**B**RYAN HUDSON was a giant of Australian medicine: a distinguished physician, researcher, educator and leading endocrinologist. His role in research and training helped lay the foundations of a new era in Australian medical science, elevating the country to world standard and establishing his home town of Melbourne as a centre of excellence in endocrinology.

Hudson was born in 1923, the son of Victorian Supreme Court Judge Sir Edward Hudson. He was educated at Geelong Grammar School and then at the University of Melbourne. A top student who was driven to excel and lead he became a resident medical officer at the Alfred Hospital, Melbourne. He then trained in internal medicine at the North-Western Medical School, Chicago and at St Mary's Hospital in London before returning to Melbourne as a research fellow at the Baker Institute and the Alfred Hospital Clinical Research Unit in 1952.

In 1958, Bryan received further training in steroid hormones at the University of Utah in Salt Lake City. He enjoyed measuring himself against brilliant young investigators from around the world and formed lasting friendships, in particular with the doyens of the international steroid field, Leo Samuels and Kris Eik-Nes. His family had a particularly happy time in the Mormon heartland where Bryan fared very well despite his acknowledged agnosticism, which perhaps reflected more on the Mormons' ability to accommodate than on his to adapt.

He returned as joint Physician-In-Charge (with the late Professor Joe Bornstein) of the Ewen Downie Metabolic Unit at the Alfred Hospital. With other leading figures in endocrinology, Bryan started the monthly endocrine think-tank which became the Victorian Endocrine Group.

In 1962 Bryan was appointed to Monash University's first chair of medicine at Prince Henry's Hospital. He set up and ran a first-class department and contributed to the training of many prominent physicians. He established and initially directed the Medical Research Centre, now the Prince Henry's Institute for Medical Research and recognised internationally for excellence in hormone research.

At this time, with John Coghlan and Marelyn Wintour at the Howard Florey Institute, methods to measure testosterone and other hormones were established which were the basis for a renaissance in androgen physiology in which Bryan was an international authority for many years. The group was the first to demonstrate production of testosterone in sites other than the testes, a principle now central to the understanding of endocrine processes. Bryan's early research into hormone inhibin and male contraception, in which his leading collaborators were David de Kretser and Henry Burger, led to an initiative, funded by the Ford Foundation and World Health Organization, to explore the possibilities of a reversible male steroid contraceptive.

In 1972 he was appointed Senior Principal Research Fellow of the NHMRC at the Howard Florey Institute, where he eventually became Associate Director and Head of Clinical Studies, a position he held until 1983. Thereafter he spent five years as Medical Director at the Royal Southern Memorial Hospital, before retiring from active practice.

Bryan was one of the first modern specialist physicians, having been highly trained locally and overseas. He was an astute diagnostician who delighted in teaching at the bedside. He espoused the scientific approach to the practice of medicine with a passionate insistence and promoted clinical research as a requirement of training of physicians.

A mentor to many people, Bryan exerted a powerful influence on the world of medical science. He had an innovative approach to medical education - one of his initiatives was the introduction of part-time study for women. He was also instrumental in recruiting from overseas several prominent endocrinologists and scientists to posts in Australia.

He received many awards, including Nuffield, Fulbright, Collip and Sims travelling professorships, and there were invitations to lecture around the world. He was President of the Royal Australasian College of Physicians from 1982 to 1984 and appointed as an officer in the Order of Australia in 1985. Monash University awarded him a doctorate of medicine (*honoris causa*) in 1991 and he was an honorary life member of a number of professional societies.

Bryan had a presence that radiated over any gathering - his dramatic personality could not escape attention. He had a particular quizzical way of looking at people with unblinking eyes and head slightly to one side that left no-one in any doubt of his focus of attention. He was a purist; short with stupidity and quick to detect cant and hypocrisy. But this was balanced by a broad-ranging intellect and a willingness to consider the views of others with an open mind.

A man of eclectic tastes from classical music and literature to fine wines, Bryan gloried in the splendours of nature and regularly went fly fishing, particularly to the Howqua River and Lake Eucumbene. He was also a skilled golfer and served as captain and president of the Metropolitan Golf Club and was a prominent member of the Tantangara Hunt Club and Madrigal Society.

A chronic progressive illness, undiagnosed over several years, developed in the last decade of his life. He bore this with dignity despite the disappointment of the unfulfilled desire to lead an active retirement of fishing and golf. The illness put great strain on his wife Norma who bore all selflessly and stoically with great humour.

Bryan is survived by Norma and their son Richard and daughters Mandy and Leigh, and grandchildren Chris, James and Toby.

*Gordon Baker*

*Henry G Burger AO*

*John P Coghlan AO*

## LESLIE ERNEST LE SOUËF OBE

**MB BS 1922, MD 1924, FRCS, FRACS, Hon LLD (WA)  
1900-1996**



LESLIE LE SOUËF

LESLIE LE SOUËF had a long and distinguished medical and surgical career. For many years he was Honorary Surgeon at the Royal Perth Hospital and the Princess Margaret Hospital for Children where he pioneered the Plastic Surgery Units.

A member of the Australian Army Medical Corps before the Second World War he raised the 2/7th Field Ambulance which served the 6th Division, AIF, in the Western Desert Campaign in Egypt and Lybia in 1941 and, later that year, in the Greece and Crete Campaigns where he and most of his unit were captured and

became POWs of the Germans.

As a POW in Germany for almost four years, Le Souëf served as a Senior British Medical Officer for thirteen POW camps and hospitals: he worked tirelessly to improve the lot of the POWs and, whenever possible, invoked the Swiss Protecting Power. In 1980 he published *To War Without a Gun* in which he vividly describes his experience as a POW.

From 1969 to 1974 he was Chairman of the Nurses' Registration Board. In 1978 he was awarded an Hon LLD from the University of Western Australia in recognition of his forty years' membership of the Senate.

A life time member of the BMA and of the AMA he also served as President of the WA Branch.

Leslie Le Souëf is survived by his wife Marjorie, whom he married in 1947.

*Alan King*

## DAME ELLA MACKNIGHT

**MB BS 1928, MD 1931, MD (Hons Monash), FRCOG, FRACOG,  
DGO 1936, FRACS, FAMA  
1904-1997**

TO HER COLLEAGUES and the wider community Ella Macknight was a very dedicated, ethical, talented, highly disciplined, but sometimes very demanding, professional who devoted her working life to her mostly female patients and to the administration of health in the community.

To her family and her many friends Ella was a kind, generous, loving, but above all very humble lady, who despite her very full professional life always had time to help those in need.

Ella Macknight was devoted to her patients - rich or poor, private or public - all of whom she treated equally with great enthusiasm, skill and dedication. She gave generously to charities and dedicated much of her time to teaching.

Although unmarried Ella brought up a very large family. Ella's family consisted of her blood relatives, her adopted nephews and nieces and her many god-children, all of whom she loved and cherished dearly.

During the Second World War Ella often worked more than twelve hours a day with frequent night and weekend calls to desperately ill patients. I remember those years very vividly, when as a four-year-old I often went with Ella in her gas producer car on her regular weekend ward rounds stopping at Epworth, Bethesda, St Andrews and finally the Queen Victoria Hospital. That routine and the smell of ether that constantly emanated from Ella's medical bag was my first experience of hospitals.

Regardless of her enormous workload Ella was always able to find time: time to support and comfort her sisters; time to house, feed and host birthday parties for her nephews and nieces; and time to support her many friends and their particular needs. Ella was the matriarch of the family.

In Ella's handwritten journal 'Recollections of the Macknight Family' is written:

Our governess was a wonderful woman we called Neddy. I was 6 1/2 years old when I started having lessons and I remember being rather bored the year before because my three older sisters were in school, and thinking I would like to be learning too. When I was eight my parents decided I could do without lessons for twelve months and Neddy went to another family for that one year. I loved reading and would read anything I could lay my hands on. In the year Neddy was away and I had no lessons, I went through all Shakespeare's plays (without understanding) and a lot of European history, as well as novels.

One of the great family stories relates to one Sunday during that time when Ella, aged eight, was suffering from the flu and considered too ill to go to church. As the family went out the front door Ella was standing on one leg in the hallway reading Shakespeare. When at last the family returned there was Ella still reading in the very same position, and some say, still standing on the same leg. Such was her ability to concentrate her attention.

Ella never just dabbled but always got deeply engrossed in any endeavour in which she became involved. There is no doubt that Ella's endeavour, strength, resolve and fortitude was an example to us all. She was always able to condense her thoughts down to a few well chosen words rather than enter into a long discourse on a subject. When Ella spoke, we all listened.

At times Ella could appear rigid and unmoving, treating males as equals in a male dominated profession, and not tolerating fools lightly. But beneath that sometimes daunting exterior there was a very emotional, soft-hearted lady who would often reveal deep emotion in her voice and not uncommonly shed a quiet tear or two.

Talented academically; skilled surgically; compassionate; wise in administration; fluent in German and also Russian, which she taught herself so that she could treat her non-English speaking Eastern European patients; cultured in the arts; sportswoman; aviator; loyal and loving - Ella was a remarkable woman.

*Dr Peter N Henderson*

## MAURICE MALCOLM MCKEOWN

MB BS 1941, DDR 1950, MD 1983, FRACR  
1917-1997



MALCOLM MCKEOWN

**M**ALCOLM MCKEOWN was an Associate in Radiology of this University from 1965-80. He will be remembered for the research carried out after his retirement which culminated in the four volume treatise *A History of Radiology in Victoria, 1896-1940*. This well referenced and detailed work involved several years of archival research in Melbourne and provincial centres and is an important record, not only of radiology, but of an aspect of Victorian history. Interestingly, Malcolm passed the Part I MD examination just after the Second

World War (it was a two part examination in those days) and his post-retirement aim was for a dissertation to complete the degree, an avenue which remained at the time, prior to the degree being exclusively by thesis. The major work which resulted far exceeded that requirement and he received the degree in 1983. In all things Malcolm was a private individual and considerable persuasion was required for him to attend the graduation ceremony. Likewise, he was an accomplished artist with a significant art collection, especially etchings, but he resisted invitations to join the AMA arts group and exhibit.

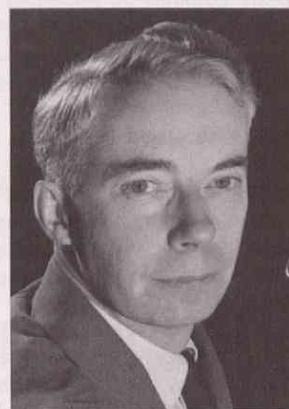
Malcolm was a bachelor with an endearing touch of eccentricity and was well known by his hallmarks. As a staff radiologist at the Royal Melbourne Hospital from 1950-80 he claimed the traditional white coat to be uncomfortable much preferring a patient gown worn in reverse and held together by a red cummerbund used to distinguish technologists in radiology from the other departments. His battered brown 'pork pie' hat and raglan overcoat together with his aged but well cared for black Humber motor car were constant trademarks whilst in transit. In the Hospital Malcolm had a particular interest in the film library and the majority of the unusual and interesting case envelopes in that archive bear his inscription still.

Following graduation in 1948, Malcolm joined the RAAF where he served as a medical officer for the remainder of the Second World War. He was proud of his Scottish ancestry being a life member of the Melbourne Scots, which he joined in 1945, and of the Clan MacKenzie Society of Australia; his mother's maiden name was MacKenzie. Scottish literature made up the bulk of his personal library and it was in Scotland that he spent sabbatical study leave. Until 1976 he lived with his parents, to whom he was devoted, and, with their passing, he moved to his home in Toorak where gardening became another of his interests. Throughout his career he remained attached to his old school, Melbourne Grammar School, for which he reserved his deepest affection and was a major benefactor.

*WSC Hare*

## NEIL CAMERON RAOUL MERRILLEES

MB BS 1942  
1916-1997



NEIL MERRILLEES

**N**EIL MERRILLEES, the only son of C Raoul Merrillees, a well remembered medical specialist in public health, was born in Richmond, Victoria, and educated at Melbourne Grammar School. After matriculating he was accepted into medicine at the University of Melbourne. On graduation he became a resident medical officer at the Alfred Hospital. After the completion of his residency he enlisted in the Second Australian Imperial Force and served with the Australian Army Medical Corps in the South-West Pacific theatre of the Second

World War. After the War he commenced training for plastic surgery at the Repatriation General Hospital, Heidelberg, but after a time decided that he was more interested in the study of the fundamental basis of anatomical structure and function. Accordingly, he relinquished his surgical training and in 1949 became a Research Scholar of the National Health and Medical Research Council within the Anatomy Department of his alma mater; so began an association with this department as a staff member that was to last for the next thirty years. In 1951 he left the NHMRC and accepted a University appointment as Senior Lecturer in Histology and Embryology. In 1966 he was promoted to a Readership in these areas of anatomy. He retired from this position in 1979 and moved to Lorne where he remained until his death.

I first met Neil on a visit to Melbourne from Brisbane early in 1958. He had just returned from leave in the United States of America as a Research Fellow at the Department of Biological Structure of the University of Washington in Seattle. He explained to me that he had gone to this department in order to learn electron-microscopy from Dr H Stanley Bennett, an early exponent in the application of this instrument to the study of biological material. During his time with the NHMRC he had studied muscle spindles in the extrinsic muscles of the eye and,

as a consequence, became interested in neuromuscular mechanisms generally. The investigation of the fine structure and functional anatomy of these mechanisms was to be the main area of his research throughout his academic career.

When I joined Neil in Melbourne the following year he was looking forward to the arrival of an electron-microscope and planning the laboratory in which it was to be housed in the Old Anatomy School, the Berry Building of the University. Eventually, all was in readiness for the installation of the microscope and the excitement was great within the department in 1961 when the microscope was ready to use. The early sixties were heady days in electron-microscopy and Neil is rightfully regarded as a major pioneer of it in Australia. His laboratory became a teaching centre of electron-microscopy and he it taught meticulously. Many senior investigators today acknowledge that their subsequent contributions were underpinned by the thorough way in which he had taught them as postgraduate and honours students.

Neil will be remembered by countless undergraduate students in the medical, science, and dental courses for his exposition of histology and by his students and academic colleagues for his particular quirky sense of humour. He was strongly individualistic, and never afraid to express his opinion on a matter.

As an undergraduate he had displayed his sureness of touch and precision by winning the Empire Universities award for rifles, but in later life it was his love of gardening that came to the fore. His father had been a leading figure in the Camellia Research Society and had passed on his interest in horticulture to Neil. He brought many plants into the Anatomy Department for the gardens of colleagues who by this means have a constant reminder of him. The department remembers him by the Neil Merrillees Award which is won annually by the best second year science student in histology.

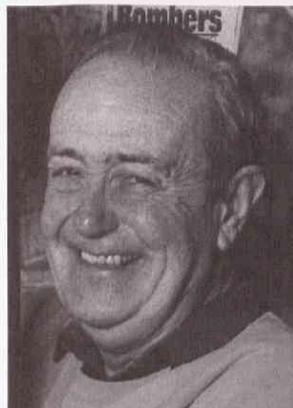
It was inevitable that Neil would acquire the sobriquet 'Meg' as a result of the particular John Keats poem telling of Meg Merrilies. Of 'Meg' I am sure he was pleased and it was a sign of his acceptance of an individual when he called on the telephone 'Meg here'.

Neil is survived by his wife Rosemary who was a staunch companion in his declining years.

*Geoffrey Kenny*

## ALAN FRANCIS LEO NEAL

MB BS 1949, FRACR  
1920-1997



ALAN NEAL

ALAN NEAL died on Good Friday, 1997, aged seventy-six years.

He was the eldest surviving son of Doctor Leo Neal, a solo general practitioner in Preston for many years, who reared his family in the belief that 'the patient comes first' - a principle to which Alan always adhered.

After a happy childhood and education by the Christian Brothers at Parade and St Kevin's, Alan interrupted his medical course to serve as a navigator in the RAAF during the Second World War. He was based mainly in Great Britain and while there he

established strong friendships in Scotland, which he maintained to the end of his life.

Whilst completing his medical course after the War Alan won the University table tennis championship, and, more importantly, fell in love with a charming St Vincent's nurse, Winifred Mary Kellett. They married in January 1949 and Alan graduated in October of the same year. After a year in Sale as an RMO (where he formed more long-lasting friendships), he

entered general practice in Preston with his father, from whom he caught a love of x-rays.

In the next ten years he and Wyn had five fine children - one daughter and four sons. Alan earned an enduring reputation as a hard-working and caring family doctor (although he is reputed to have once advised a rather neurotic patient 'of course you could always try just putting up with it!'). During this period he started to study radiology seriously at St Vincent's. After becoming a Member of the (then) College of Radiologists of Australasia in 1959, he was invited by Dr Pat Cody to join him in the well-known radiology practice at 49 Spring Street (later 20 Collins Street) which had been founded by Dr John O'Sullivan, (the partners were successively: O'Sullivan and Cody, Cody and Neal, Neal and Banting). He also ran the radiology service at the Mercy Private Hospital.

After relatively early 'retirement', he agreed to do some sessions at Mount Royal Hospital. Alan loved working with the old people there and soon set up a very successful full-time service. He was respected as a fine radiologist, but loved as a compassionate man of extraordinary integrity.

Sadly, he developed progressive obstructive lung disease, probably related to his war service. It was typical of Alan that he kept to himself as long as he could the nature and prognosis of the disorder.

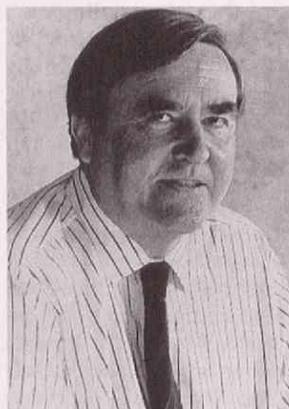
His great love in his last years was tracing the history of his family forebears. Of mainly Irish, but partly English, descent, Alan ascertained the details with great zeal, leading him to travel to and write about Walhalla in country Victoria, Dorset (UK), Thames (NZ), and County Sligo in Ireland, whence he made one last expedition to attend a reunion of the O'Dowds. Even when old and sick he was still fostering friendships in all these places.

At his requiem his parish priest said of Alan 'How can I describe him - he was good, good, good . . .'. Indeed he was.

*Bernard Neal*

## BLAIR CAMPBELL RITCHIE

MB BS 1956, FRACP 1970  
1933-1997



BLAIR RITCHIE

THE DEATH of Blair Ritchie on 27 August 1997 ended a career devoted to medicine, the arts and epicurean pursuits. Blair was born in 1933 in Ballarat and was educated at Ballarat College where he was school captain in his final year and dux of school. He studied medicine at the University of Melbourne graduating MB BS in 1956, and was elected FRACP in 1970. Following initial appointments at the Alfred Hospital and the Royal Melbourne Hospital in Melbourne, Blair gained research experience in Edinburgh, London, and California, before joining Monash

University as Senior Lecturer in the Department of Medicine at Prince Henry's Hospital in 1967. In 1973 he relocated to the Department of Medicine at the Alfred Hospital where he was promoted to Clinical Associate Professor in 1981. He resigned from the University in 1988 before taking up a dual appointment as Honorary Associate Professor in the Monash University Institute of Reproduction and Development and Respiratory Physiologist in the Monash Medical Centre.

Throughout his career, Blair was a dedicated teacher, both of undergraduate medical students and postgraduate research students. His greatest interest in medicine always centred on research, and very early in his career he went overseas to get the best training possible. In 1964 he was appointed Nuffield Fellow at the MRC Respiratory Unit of Kings College Hospital. In 1965 he crossed the Atlantic to join the staff of the Cardiovascular Research Institute in San Francisco where he

came into contact with some of the great names of respiratory physiology including Julius Comroe, John West, Norman Staub and John Severinghaus. During this period Blair was highly productive, publishing major papers on exercise physiology and the pathophysiology of pulmonary oedema. On his return to Australia in 1967 he established a close relationship with John Maloney and Michael Adamson and they became the nucleus of a research group devoted to developmental physiology, a subject which remained his research passion until his death.

Always an innovator and a planner Blair sought to promote excellence in academic and cultural life. His vision for an Institute devoted to developmental physiology and medicine was critical in the founding of the Centre for Early Human Development at Queen Victoria Medical Centre in 1978 in partnership with John Maloney, the founding Director. This Centre was later expanded into the Monash University Institute of Reproduction and Development in 1991. Blair worked tirelessly for the Centre and the Institute, serving as a founding Board member and Trustee of the Research Foundation for Mothers and Babies and the Research Foundation for Reproduction and Development. His associates, whom he convinced to sit on boards and committees of the Institute, have contributed significantly with professional advice and governance. Notably, his contributions also included generous donations to the Institute as well as to Monash University and a number of Melbourne hospitals over many years.

Blair had many personal characteristics that endeared him to his friends and attracted people of influence to his causes. He was generous and loyal. He was persistent and always a man of action, so that matters of importance received his immediate and undivided attention. He used the telephone unremittingly, regardless of the time of day, to ensure that no stone was left unturned in search of solutions. He would phone anybody, from politicians to radio talk-show hosts and University Vice-Chancellors. Memorably, his calls included one to a no doubt astonished Australian cricket captain to discuss the folly of leg-side bowling during a test match in Brisbane.

Blair's greatest pleasures were good company, food and wine. There would be few of his friends, students and registrars who were not entertained at a memorable lunch or dinner at one of the best restaurants in Melbourne, or in any other city he was visiting. As well as his generosity as a host, and his support for medical research, Blair was a patron of the arts, continuing a tradition begun by his father Bill who served for many years as President and Honorary Secretary of the Ballarat Gallery. As the culmination of this family tradition Blair has bequeathed his finest art works to that Gallery, including pieces by Arthur Streeton, Arthur Boyd, Fred Williams, Charles Blackman and Jeffrey Smart. Along with gifts of glassware and sculpture, these will be housed in the Ritchie Collection which will serve as a memorial to his life.

*Philip Berger  
Adrian Walker*

## SUSAN MARY SCOTT

MB BS 1969, FRACP 1977  
1945-1997



SUSAN SCOTT

**F**OR TWENTY YEARS we worked together, managing a busy general medical unit at what was originally known as Footscray and District Hospital. The inpatient numbers were often up to forty or more, while the outpatient lists seemed to stretch on to the crack of doom.

I had started there in 1970, assisted only by a first year graduate, (the regrettable term 'intern' had yet to be imported). In the fullness of time, a registrar became a regular and welcome addition to the team. Sue Scott was one of the first of these, and

immediately impressed me with her sound common sense and devotion to our working class clientele, most of whom spoke rather poor English and many of whom were not literate in their own tongue. She was appointed as Physician not long after obtaining her FRACP.

She was a striking looking woman, with no airs, totally without conceit. She resembled a still pool whose deeper recesses are visible only rarely, and even then are imperfectly glimpsed.

She saw no value in verbosity or self-promotion. I once suggested that success in medicine seemed to depend on the exercise of these very qualities, and that she should change her approach accordingly. She thanked me for this advice but fortunately disregarded it. Indeed, we two were a contrast in so many ways, that it might have surprised some to realise what a compatible team we made.

She had a way with patients that many would (or rather should) envy. Even the most difficult of personalities was quite at home in the presence of this calm, cool confidante. She had a therapeutic persona and, not surprisingly, was an expert hypnotherapist. She also had exceptional dexterity, and for a long period her private practice included intravenous fluid and electrolyte management.

At a time of personal crisis, I thought it best that my closer friends should know that I was to live a single life again. Naturally, Sue was one of these. It was only then that I learnt of her own tragedy, caused by an accident in a far country a year previously. She had coped, a self-sufficient woman with an awesome private strength. The pool had deep recesses indeed.

A further decade passed by, days spent comparing our experiences, ward rounds, clinics; a happy and productive era. Then illness came, mysterious, ominous: eventually diagnosis and treatment, rigours, transfusions, steroids. She worked whenever her condition permitted it, but she was often observed to be exhausted. I feared the worst.

We went to see the Tom Roberts exhibition one Sunday afternoon and shared cakes and wine afterwards. My mood was gloomy, for the 'New Economic Order' had come to the hospital, discarding what had taken years to build. Sue, however, was of the belief that her own story was far from over. We talked of the future in a positive way. There was laughter, and in that brightly lit cafe the shadows were almost banished. I saw, momentarily, that indomitable strength once again, but this time was not surprised.

She passed peacefully away two weeks later. At her funeral, a lifelong friend gave us a glimpse of an unusual, imaginative child, the inventive leader of a 'Famous Five'.

Sue had two sons. In them lives a glimpse of the mother.  
*John Mathew*

## RONESH SINHA

MB BS 1987  
1963-1997



RONESH SINHA

**T**HE TRAGIC and unexpected death of Ronesh Sinha on 18 November 1996 claimed a vibrant young surgeon who balanced his competing loves for medicine, music and the sport of kings. Born in Liverpool, UK he arrived with his family via India in 1966, and was educated at Melbourne Grammar School. His schooling was interrupted frequently by ill health, but despite this, he was able to achieve his ambition to enter medical school. His years as a medical student were memorable for his many friendships across all faculties of the Uni-

versity, facilitated by his residency at Ormond College. He attended the clinical school at the Royal Melbourne Hospital and, following graduation, toured various Melbourne hospitals

while pursuing surgical training. A year was spent at the Anatomy School at Monash University, where he enjoyed teaching undergraduate students. The attendance of several of his former pupils at his funeral attested to his popularity at that time. After completing his FRACS part 1 examinations, Ron settled on a desire to become an orthopaedic surgeon. He completed research and several stints as an unaccredited registrar but failed to gain an accredited training position in orthopaedic surgery. Ronesh had commenced legal proceedings against the College but his sudden and unexpected death occurred prior to the resolution of this situation.

Ron Sinha had an appetite for life which few others ever match. He had a deep love and respect for his family, incorporating them in his many social activities. He was renowned for his ability to meet people and introduce them to others from completely different fields. His generosity was legendary, and many of his friends were surprised by spontaneous gifts or invitations. Always there to support others who were suffering, he never complained about his own health problems. He was a talented pianist, who used the playing of music as his relaxation, as well as to impress at parties. His extensive collection of music showed a wide appreciation for all forms of the art, and he frequently attended concerts and the opera. He was a keen follower of all sports and had a particular love for the Collingwood Football Club. A keen student of horseracing, he often attended the racetracks of Melbourne, meeting many of his orthopaedic colleagues. He had an interest in politics, being an active member of the Liberal Party. He found it difficult to balance all of these pursuits, but made time for his many friends. He lived every day to its fullest, at a pace that many of us could not keep.

Ron was a great friend to many people in many ways. He had a warmth of character which attracted others, and a fierce pride and determination to achieve his goals. His strength of character would have made him a committed and compassionate surgeon who ultimately would have been a credit to the College.

*Chris Holmes*

## IAN MITCHELL TULLOCH

**MB BS 1943  
1920-1997**

**I**AN MITCHELL TULLOCH, the youngest of seven children of a Presbyterian minister from the Shetland Islands, was born in Goulburn, New South Wales, in 1920, but grew up in Perth, Western Australia. He entered Ormond College at the University of Melbourne, as there was no medical school in Perth in those days, and graduated in 1943. Always modest, on graduation he was surprised to have come eighth in his year of 120. He chose the Royal Perth Hospital for residency so as to be close to his family before possible war service, but he was retained at that hospital and at Fremantle Hospital (WA) until 1945.

Ian was attracted to surgery, and after the war he returned to Melbourne. He did not continue with pursuing a higher degree, and in 1948 he married, and joined a general practice in Berwick and subsequently Moreland. As it became less acceptable for general practitioners to do surgical operations and obstetrics and more common to use locum services at weekends, Ian became disenchanted with general practice and in 1979 he joined the Commonwealth Department of Health, as an administrator. As a medical counsellor, he concluded that most doctors were not out to make as much money as possible out of Medicare; real villains were few.

Ian's last appointment (1985-1988) was as personal assistant to the chairman of the original Medical Research Ethics Committee of the National Health and Medical Research Council. He saw this as one of the most interesting periods of his life.

In his later years, almost to the time of his death, Ian gave time to the Royal Australian College of General Practitioners and he was on the Practice Management Committee of the Victorian

Faculty. In the early 1980s, he was Media Editor of *Australian Family Physician*, the College's journal.

The graduates of 1943 looked to him to arrange their fiftieth reunion, a task he much enjoyed. He also developed new-found enthusiasms for lawn bowls and bridge.

Ian died in Melbourne in January 1997. He is survived by his wife Cecily, four sons (one of whom is a doctor) and twelve grandchildren.

*Richard R Lovell, AO*

*Lovell RR. Obituary: Ian Michael Tulloch. MJA 1997; 166: 497.*

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## DAVID HENRY WATERWORTH

**MB BS 1940  
1912-1997**



DAVID WATERWORTH

**D**AVID WAS BORN in 1912 into the most respected Hobart optical family. He was Dux at his primary school and then went, on a bursary, to the Hobart High School. During the years 1929 and 1930 David and his parents lived in London where he obtained the Fellowship of the British Optical Association. He also studied piano under an eminent teacher with such intent that it nearly led him into a career as a professional musician. However, upon his return to Australia he entered the University of Melbourne to study medicine.

David is well remembered by his year group for his ready smile and his willingness to help, in discussion, and his generosity when it came to inspecting his dissections at length.

After graduating MB BS in 1940, he joined the AIF and served abroad as Medical Officer to the 2nd Field Ambulance in the Pacific. He returned to Australia in 1947 and met his future wife, Betty Cook, in Adelaide whilst convalescing from malaria contracted in New Britain. They were married later that year. Theirs was a close and loving family, with daughters Joanna and Helen and later grandsons Timothy and Nicholas (Joanna Williams).

In 1947 David also obtained the Diploma of Ophthalmology of the University of Melbourne. He was admitted to Fellowship of the Royal Australasian College of Surgeons in 1948.

1951-52 saw David in England again and also on the continent doing further postgraduate studies in ophthalmic medicine and surgery before returning to commence practice in Hobart. He was Visiting Ophthalmic Surgeon to the Royal Hobart Hospital for twenty years where he did the first corneal grafts in Tasmania and excelled in children's strabismus surgery. He also worked very hard for the Tasmanian Society for the Blind and Deaf.

David became the National President of the Ophthalmological Society of Australia in 1968 and helped launch the Royal Australian College of Ophthalmologists in 1969. Although he had a fine reputation as an eye surgeon, a public speaker and a writer on professional matters, it was his capacity as a sensitive and capable musician which led him to be acutely aware of the beauty in nature and in the human mind. This was the aspect of his being that friends found held the most profound value in their regard for him.

He had rejected formal religions and was agnostic. He admired Keats' philosophy and wrote:

Are our actions [as humans] dictated by the requirement to survive? Two uniquely human qualities refuse to fit this definition. His noblest emotion - compassion - has nothing to do with survival. Nor has his wonderful and mysterious appreciation of beauty, his ability to create Beauty.

David wrote again of 'finding in music an endless testimony to its rightness' referring to Keats' philosophy. Also 'I have kept and cherished an orchestral setting of the Choral Prelude of JJ Bach - I call upon Thee Lord Jesus - for no less than sixty years'.

He had a most loyal family and a deep mutual attachment with his friends.

*John L Bignell*

**ALICE ELIZABETH (BETTY) WILMOT OBE**

**BSc 1934, Dip Diet 1938, MB BS 1945, DCH Lond Inst Ch Hlth, MPH Uni of California, Berkley, 1967, FACMA 1968 1912 - 1998**

**U** MMS RECORDS with sadness the death of Dr Betty Wilmot OBE. An obituary will appear in the 1999 edition of *Chiron*.

## BEQUESTS

### THE IMPORTANCE OF BEQUESTS

**O**NE OF THE MOST valuable aspects of a bequest is that it is a gift which will benefit generations of students and staff at the University. Very occasionally benefactors request that their bequests be expended in a specified time, but almost all are made in perpetuity with only the income from the capital being used.

Not only students and staff benefit from the foresight of benefactors but the wider community benefits as research conducted at the University extends the boundaries of knowledge and as our graduates go on to contribute to medical science in Australia and overseas, many becoming leaders in their field.

The generosity of bequest benefactors is evident in every area of the University from teaching and research, through buildings and equipment, to student financial aid. The University has been receiving bequests since its foundation in 1853. Many of the scholarships and fellowships awarded today are the legacy of benefactors who died years ago and, similarly, much of the research currently being undertaken is fully or partially funded by income from bequests.

One of the most common applications for bequests in medical science is for research into the causes, treatment and prevention of cancer. These have included legacies from Francis Haley, William Pomeroy Greene, who died in 1934, and Elizabeth Spencer Hebden, who died in 1942. When she died in 1952, Mary Warren specified that her bequest for cancer research be named in memory of her niece, Mollie Hoffmeyer. More recently, bequests for this purpose have been received from Ivan Sookhanoff and Ellen Mavis Leigh, both of whom died in 1991. These exemplify two of the many types of provision which can be made, Mr Sookhanoff's being all his residuary estate and Miss Leigh's representing a quarter of her residuary estate.

Family members often share an interest in a particular area of research. In such cases a permanent fund can be established to which members contribute their bequests through the generations. For example, the Johnston sisters - Jane, Beatrice and Henrietta - each left a bequest for cancer research. When realised, the three legacies were formed into a single fund known as the Johnston Bequests.

The funds from all these bequests support a number of cancer-related research activities in the various departments of the School of Medicine. There are currently two supported by the Sookhanoff bequest in the Department of Surgery at the Austin and Repatriation Medical Centre. In the first, Dr Jane Whitley, a former NHMRC Australian Postdoctoral Fellow, together with her collaborators, Professor Arthur Shulkes and Associate Professor Andrew Giraud (Department of Medicine, Western Hospital), is examining the biological significance of the presence of Gastrin Releasing Peptide (GRP) - formerly thought to be confined to the stomach - in the uterus and breast. Previous funds from the Sookhanoff bequest allowed the researchers to obtain preliminary data which enabled them to put forward a successful NHMRC grant application. Currently the bequest funds are supporting a project which is examining a panel of uterine cancer cell lines for the presence of GRP

receptors and the effect of GRP antagonists on cell growth.

In the second project, Dr Graham Baldwin and Professor Shulkes have demonstrated that particular types of gastrin (progastrin) are made by tumours of the colon and that progastrin has proliferative effects on colon cell lines. Funds from the bequest have allowed the researchers to make human progastrin in bacteria to determine the nature of the receptor that mediates the effect of progastrin. Once the new receptor is characterised, these studies have the potential for novel therapeutic strategies.

Other areas of cancer research to benefit from bequest funds include the Departments of Medicine and Surgery (breast cancer) at St Vincent's, and the Departments of Medicine (colon and prostate cancer) and Surgery at the Royal Melbourne Hospital.

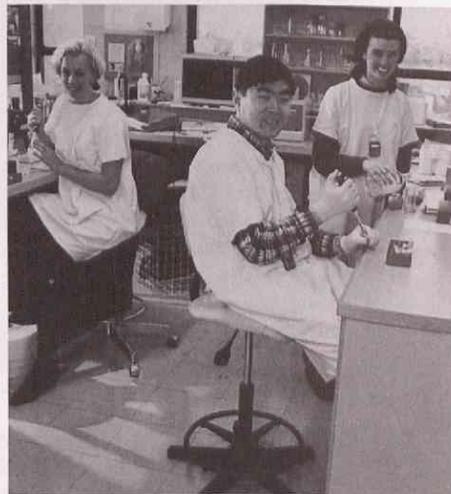
In 1935 there were 3500 students enrolled at the University; by 1975 the student population had reached 15 000 and this figure has now doubled. Although it is anticipated that student numbers will remain for the foreseeable future at around 30 000 - and the numbers of academic and general staff will remain at around 5000 - the costs involved in providing a first-class teaching and research environment continue to rise. This, together with the fact that Government funding continues to decline, makes it imperative that the University seeks sources of funding outside government grants.

A bequest to the University is a permanent gift which enables benefactors and the University to become partners in ensuring that it remains one of the nation's pre-eminent teaching and research institutions, internationally renowned for the quality of its research training. If you would like further information about making a bequest to the University, please contact Ms Elizabeth Douglas, Bequests Manager, Alumni and Development Unit, University of Melbourne, Parkville, Victoria 3052 telephone +61 3 9344 7804, facsimile +61 3 9344 6895. All enquiries are treated in strict confidence.

#### L-R: NHMRC

Australian post-doctoral Fellow Dr Jane Whitley, Research officer Dr Yang Zhiyu and Research Assistant Kristy Rorison, members of the Molecular and Cell Biology Laboratory at the Department of Surgery (Austin campus) take a break from their work examining the regulation of growth factors in normal and neoplastic tissue.

Photo by Roy Larkin



# M A G A Z I N E



MELBOURNE HOSPITAL WARD 18 JANUARY 1895



MELBOURNE HOSPITAL WARD 20 JANUARY 1895

THE COLLECTION of nineteenth century journals in the Brownless Biomedical Library holds a wide range of titles, of which some categories have dropped into total disuse. One such group is a fairly extensive collection of journals and reports from hospitals in the United Kingdom and America detailing the medical cases of interest dealt with during the year. These range from the tabulated format of St George's Hospital (Wimbledon) which include details of all patients treated who died or were discharged, to the single case description often with a blow-by-blow account of treatment, to comparative studies on a particular condition in which an essay approach is used. These journals still have a wide range of research uses and it seems a pity that they are so neglected as a resource.

Their first and most obvious use is in the area of social medical history. In virtually every case, whether a brief description or a long essay, details of the life of the person who was the patient and the social opinions of the doctor leap from the page. A couple of pages from St George's Hospital report for April 1880 demonstrate the interest in even the briefest of reports:-

John H, aged thirty-eight, 'a butler; usual good health; moderately temperate; occasional excesses' was 'thrown downstairs in the course of a brawl and caught his foot in a baluster' - his broken leg healed.

James S was aged forty-two, 'a lamplighter; total abstainer for some years. Health always good; led an active industrious life.' He broke a leg after falling from a ladder while cleaning a lamp. The leg did not heal and was amputated a month after the accident.

George M aged sixty-two was 'a planer; very temperate and abstemious for 40 years. Usual health very good' he had his right forearm 'caught in a planing machine, and crushed against a wall.' Miraculously, he recovered and did not lose the arm.

Even more miraculous was the survival of Charles W aged six who was 'a healthy child' until his left leg was broken by 'the overturning of a truck when about 2 cwt of coal fell on his leg'. He was released from hospital two months later with the limb healing.

Less fortunate was Henry D aged seventy-two, 'a retired major of active temperate habits; accustomed to hard work and much riding' but also 'a rather corpulent man' who succumbed after having his left leg broken by 'a runaway cab'.

Many of the reports include detail regarding the individual - the description of hair, eyes, length of eyelashes, height, colouring were undoubtedly of medical importance but are also evocative scene-setters. MC's case is given at length in Guy's

MEDICAL AND  
RESEARCH REPORTS  
FROM  
NINETEENTH  
CENTURY HOSPITALS



Dorothea Rowse  
Life Sciences Librarian

Hospital Reports for 1851 - *Cases selected from the Ward Books of Petersham Hospital.* Her medical history included eight births. In the case of the first four she was generally pregnant within six months of the previous birth. The longest gap was three years between babies six and seven; she was bedridden and very ill following the birth of the seventh baby but fell pregnant again! She survived a miscarriage, a baby born dead (number nine), and a tumour but was reported to be well and 'cheerful!' The same report includes a number of similar cases. Obstetric and gynaecological cases form regular contributions to the literature and much information on women's health and their social conditions can be gleaned.

How patients themselves saw illness and its causes underscores the information given to doctors and is duly noted in the records. An example is an entertaining article by Dr Donkin entitled *A commentary on one hundred and five cases of chorea* in the Westminster Hospital Reports for 1885. Chorea had been chosen for discussion at the International Medical Congress in London in 1881 and the writer felt that its causes were still open to doubt and discussion. He was very interested in the 'nervous' basis for chorea and his article includes a list of twenty-six possible causes suggested by the parents of patients - fell into the lake at Crystal Palace, found grandmother dead in same bed, clothes caught fire, trod on a cat; much alarmed, saw a 'ghost', his grandmother goes into fits at the same time, threatened with 'gypsies' by a woman, etc. These were all categorised as a 'severe fright!' The writer's moral views can be seen in his account of a ten year old patient with a severe case of chorea who 'was sexually precocious . . . had distinguished herself at school recitations and had danced in public' (p.92).

A desire to publish original research can be seen in all the titles. This is often 'hidden' - an introduction which claims that this is a minor contribution to the topic but . . . In other cases, there was a definite aim to report new findings. Guy's Hospital Report for 1881 included the Astley Cooper Prize Essay for 1850 on *The State of Blood and Blood vessels in Inflammation* by T Wharton Jones. Their Report for 1881 includes an eighty page discussion *Observations on the various forms of superficial dermatitis, particularly erythema, eczema, psoriasis, lichen and pityriasis rubra* by P H Pye-Smith. The article includes tables of cases, details of some of the cases and a discussion on causes. In St Bartholomew's Hospital Reports for 1881, J Wickham Legg gave an extensive update on his research work on haemophilia and added a note on the hereditary descent of colour-blindness. The report includes the pedigrees of families so afflicted (p.300) and case descriptions.

Other areas of potential interest include material for the epidemiology of diseases, an analysis of the lists of subscribers which provide names and addresses of the readers, and the fairly gory criminal forensic articles which discuss in horrifying detail celebrated murders by strangulation, poisoning and other nasty methods. These latter include a wealth of sociological and social detail.

Access to original records and archival resources is the ideal for historical research but these volumes of reports would seem to provide an acceptable partial substitute. Never dull, they provide alternately heartrending and hilarious accounts of life in the nineteenth century.

#### **Titles in the Brownless Biomedical Library**

##### **United Kingdom**

*Clinical lectures and reports* by the Medical and Surgical Staff of the London Hospital. 1864-1867/8

*Edinburgh Hospital Reports.* 1893-1900  
*Guy's Hospital Reports.* 1836-1968  
*King's College Hospital Reports.* 1893/4-1900/01  
*Middlesex Hospital Reports of the Medical, Surgical and Pathological Registrars.* 1887-1903  
*St Bartholomew's Hospital*  
- *Reports* 1871-1884  
- *Journal* 1897/8-1968  
*St George's Hospital Reports.* 1866-1881  
*St Thomas's Reports.* 1835/36; 1870-1911

##### **United States**

*Johns Hopkins Hospital, Baltimore*  
- *Bulletin.* 1894-1966 (irregular)  
- *Reports.* 1891-1906 (irregular)  
*Mt Sinai Hospital Reports.* 1898-1906  
*Philadelphia Hospital Reports.* 1890-1910

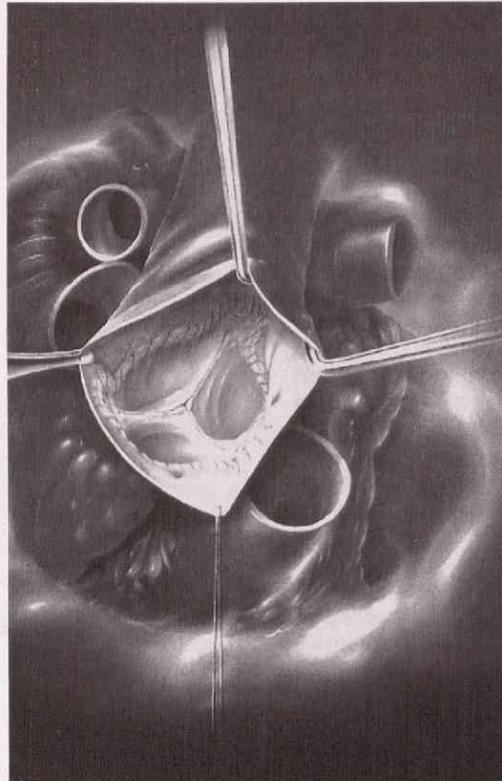
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## THE DONOR TISSUE BANK OF VICTORIA

**I**N THE HOURS AFTER A DEATH has been reported to the Coroner, staff of the Donor Tissue Bank of Victoria contact the deceased's family making them aware of the possibility of donating tissue for transplantation and offering them the opportunity to do so if they wish. The approach to relatives for permission to use tissue for grafting is critical. It involves a transplant coordinator telephoning the family to discuss donation and to offer support and, if the family wishes, visiting them at their home. Although the transplant coordinators try to allow as much time as possible between notification of death and their approach, this is a very stressful time for the family as they may have only known of their loved one's death for a few hours. Often families have no knowledge of tissue transplantation, have not discussed donation and do not know the deceased person's views on the subject. Also, the coordinator must ask questions about the health and lifestyle of the deceased to ensure the tissue will be safe for the recipient. Notwithstanding all of these factors, fifty per cent of families approached give permission for tissue to be retrieved.

The Donor Tissue Bank of Victoria is part of the Victorian Institute of Forensic Medicine (VIFM) and situated at the Coronial Services Centre in Southbank. Established in 1989 to provide a central facility for the acquisition, processing, storage and distribution of tissue for transplantation, it is the only one of its kind in Australia and offers relatives the opportunity to salvage something positive from a death by agreeing to donate tissue for transplantation.

Since its establishment the Bank has made a major contribution to reducing the suffering and improving the quality



of life and self sufficiency of more than 2000 children and adults in Victoria by supplying hospitals with cadaver tissue for transplant purposes. The Tissue Bank has supplied 2318 allografts over the last three years. Since March 1991 the Bank has provided over 360 heart valves for use by cardiac surgeons at the Royal Children's, the Royal Melbourne, the Alfred, Cabrini, Epworth, Austin and Royal Hobart Hospitals. The most urgent need for human heart valves is for transplantation into infants and children with congenital heart disease. Paediatric surgeons at the Royal Children's Hospital literally wait on the Bank for any suitable heart valve that becomes available. On occasion the needs of several patients may be met by the death of one suitable donor. In 1992 the valves and conduit from one teenager were transplanted into four separate children - aged one month, four months, three-and-a-half years and nine years old respectively. These four children are now all leading normal lives. Cadaver heart valves from young people who die accidentally are by far the graft of choice both for function and for longevity in children. In

addition, they do not require life-long anti-coagulant therapy as do artificial prosthetic heart valves.

Criteria that are taken into account for tissue donation are age (for example heart valves are taken from people less than fifty-five years old, whilst for skin and bone the age limit is sixty-five years), time of death (tissue must be taken within twenty-four hours of death), lifestyle (people who have engaged in high risk behaviour such as intravenous drug users or homosexual males are unsuitable as donors) and the presence of infectious diseases or malignancies. The cause of death is also checked.

Once permission is obtained from the deceased's family the tissue is removed and processed, then stored until it can be

transplanted into a suitable recipient. All staff in the Bank are trained for these specialised tasks. The Bank's transplant coordinators, all four of whom have nursing backgrounds, are also experienced in grief support and in dealing with the recently bereaved. The scientists and technicians have been trained by forensic pathologists and specialist surgeons in retrieving tissue for transplantation.

After a suitable donor has been identified and permission to remove tissue for transplantation gained, the tissue is surgically removed under sterile conditions in a clean environment and placed in transport media, usually with antibiotics. Excess tissue is removed and the allograft is trimmed, bathed in antibiotics and packaged. This is carried out in a laminar flow cabinet which supplies sterile air to the working field. Following packaging, the tissue is stored at various appropriate temperatures. Bones are x-rayed and irradiated and placed in a -80°C freezer, and skin and aortic valves are stored in the vapour phase of liquid nitrogen. As the well-being of the recipient is of paramount importance, every care is taken to minimise the risk of transfer of infection and great care is taken with quality control. This involves the microbiological culture of specimens taken during procurement and processing, the testing of donor serum for HIV antigen and antibodies, Hepatitis B and Hepatitis C, HTLV-1 and syphilis. An autopsy report including the results of histological examination of tissues and organs is prepared by the case pathologist. The complete donor file, including all results, is then reviewed by a pathologist and a scientist to confirm that the tissues are suitable for transplantation before being signed out for release. Once tissue is available for release the Tissue Bank can respond to requests for tissue from hospitals.

Allograft bone was first supplied from the Bank to orthopaedic surgeons in Victoria in December 1991. Since then requests for skeletal tissues have rapidly risen. In the year ending August 1997, 449 such allografts were despatched. Some of the procedures using allografts include total hip revisions, spinal fusions, joint reconstructions, repair of un-united fractures and resection of osteosarcoma and other tumours. The rapidly increasing demand for cadaveric bone has required research and development by the Bank in an attempt to keep abreast of the number of requests received. Earlier this year a collaborative program with surgeons to retrieve surgical discard bone from patients undergoing total hip replacement was begun. This program involves fifty-five surgeons at eighteen Victorian hospitals.

Bone allografts have many uses including acetabular and proximal femur support for replacement of failed prosthetic hip joints, packing benign bone cysts, fusing the cervical or lumbar spine to correct disc disease or scoliosis, restoring alveolar bone in periodontal pockets, restructuring maxillofacial defects, and replacing resected bone involved with slow spreading malignancy. While autograft is the most effective material, preserved allografts are also effective substitutes. In fact the clinical outcome of bone allografts approximates results obtained from fresh bone autograft. The advantages of using allograft are the decreased operative morbidity, increased joint mobility, and the option of using composite graft.

The skin banking capacity was made possible by a generous donation from Esso Australia of \$85 000 to underwrite the research and development costs of the service. In December 1994, burns surgeons at the Royal Children's Hospital requested allograft skin for a seriously burned child and the Bank was able to respond for the first time to such a request.

Skin allografts are used for chronic, unhealed wounds, decubitus ulcers, autograft skin donor sites, pedicle flap donor sites and traumatically denuded areas. They are the dressing of choice for deep burn wounds providing temporary coverage, acting as a barrier against loss of water, electrolytes, protein and heat, excluding bacterial infections, and speeding epithelialisation. Skin allografts are replaced periodically until sufficient autograft skin can be obtained.

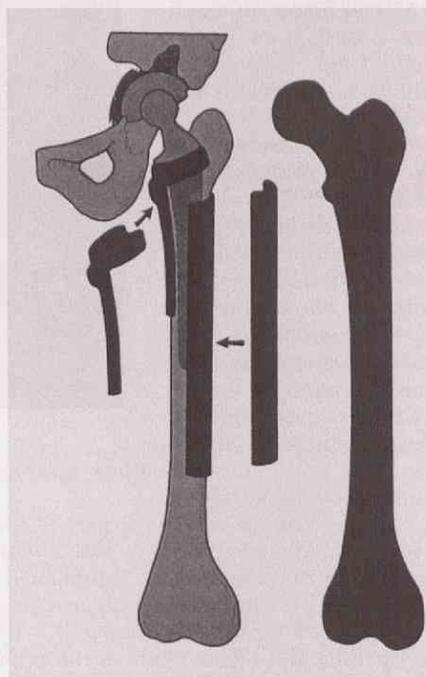
The Donor Tissue Bank of Victoria is self-funding, recouping the costs of retrieval, processing and testing of the tissue by charging a service fee. The tissue itself, like blood, is donated and free although, like blood, there are considerable costs associated with its retrieval and processing. Following discussions with the Commonwealth Department of Health, Housing and Community Services, fees levied by the Donor Tissue Bank of Victoria now appear on the Basic Table for Prostheses. It is important to appreciate that the Donor Tissue Bank of Victoria is a not-for-profit organisation and that the fees charged are based on the reimbursement of costs incurred. These costs include fifteen per cent for research and development.

There are advantages to having a centralised procurement agency at the VIFM. The Institute is responsible for providing forensic pathology and related services and hence performs approximately 2400 autopsies each year. The procedures for access to relatives for permission to use tissues already exist in the Coronial Services Centre. There is no duplication of services, as all skills and resources for the procurement of tissues and their processing are concentrated in one institution. The distribution of tissue is also centralised, facilitating follow-up studies and the monitoring of any adverse reactions or complications as well as clinical outcomes.

The Bank was established by the Council of the VIFM to administer and oversee the provision of tissue for transplantation. The ethical aspects of the Bank's operations are overseen by an Ethics Committee, and The Donor Tissue Bank Advisory Board, which includes representatives from the specialist user groups (e.g. burns, orthopaedic and cardiothoracic surgeons), advises about the management and operations of the Bank.

The organised availability of these tissues has had a beneficial effect on the mortality and morbidity of many Australian adults and children. It is hoped that the provision of this very essential medical service in Victoria will act as an impetus for the establishment of similar services in other capital cities in Australia.

*Lyn Ireland and Stephen Cordner*  
Victorian Institute of Forensic Medicine



REPRODUCED FROM  
'BONE STOCK DEFICIENCY IN TOTAL HIP REPLACEMENT'  
EDITED BY HUGH CHANDLER AND BRAD PENENBERG

# NOT JUST DOCTORS

## EN GUARD

TED CERAOLO MB BS 1956

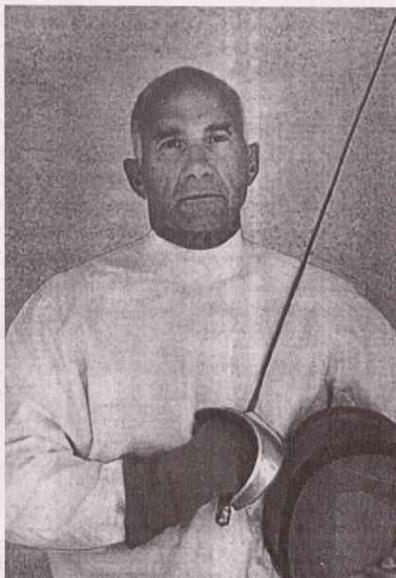
**W**HEN I WAS ELEVEN YEARS OLD, living in New York City, two blocks away from my house was an establishment called The Boys' Club of New York. This Club had been created by wealthy philanthropists, such as the Rockefellers, the Astors, the Vanderbilts and the J P Morgans, to take youngsters off the streets and protect them from trouble. The Club exposed boys to social group activities such as basketball, baseball, swimming, gymnastics, wrestling and boxing as well as providing art classes and a library. This is where I was first exposed to the art of fencing and where I was fortunate to have Mr Robert Farrell, the former national foil champion, as my instructor. As a result I received a sound foundation in the basics of fencing.

There are three fencing weapons: the foil, the épée, and the sabre. The foil is the basic weapon but also the most complicated and the most demanding to master. Touchés are made with the point of the weapon only; there is no cutting edge. The target area in foil is smaller than that in épée and sabre and consists of the chest and torso excluding the head, arms and legs which are off-limits and 'foul'.

Once a fencer learns the use of the foil, he or she can readily learn the sabre and épée. The épée is a development of the duelling sword of the 16th century and touchés again are made only with the point, but the target area encompasses the entire body including head, arms and legs. Finally, in sabre, points are scored with the sword point as well as the cutting edge and the targets are the head, arms, chest and torso all above an imaginary horizontal line passing across both hip joints where they meet the torso.

I continued to fence foil exclusively through secondary school and finally entered New York University in Manhattan as a premedical student in a four year curriculum receiving a Bachelor of Arts degree in 1949.

Fortunately for me, at that time, the University had the most advanced and powerful fencing team in the country and were the undefeated intercollegiate fencing champions. This was due to Maestro Julio Martinez Castello, one of the truly great fencing coaches whom the United States and New York University were fortunate to have acquired. He did not just teach but created



TED CERAOLO

national fencing champions and Olympic winners from raw stock. He was also the United States Olympic fencing coach.

I became his number one sabre fencer but unfortunately, during a competition, I slipped and fell severely, injuring my lumbar spine and sustaining a crushed intervertebral disk. Eventually I underwent a lumbar laminectomy and discectomy with permanent damage to the S1 nerve root on my right. This produced a weakness and muscle atrophy of my right lower leg with a loss of push-off of the right ankle which remains to this day.

My competitive career as a fencer was over. I turned my attention to medical school but did not have sufficient funds to carry me through the entire program. Research into medical schools around the world revealed that Australia had great teaching schools ranked among some of the world's best universities, taught in English rather than in an unfamiliar language, and was affordable.

I contacted the Australian Consulate in New York City, filled out the necessary applications with my qualifications and was subsequently accepted to Sydney, Melbourne and Adelaide. I chose Melbourne since it was considered the premier school with Professor Sir Macfarlane Burnet on the staff.

I graduated MB BS from Melbourne in 1956. After graduating I returned to the United States and did a four year residency in orthopaedic surgery in New York City. I maintained a solo practice in New Jersey for approximately twenty-five years. After retiring in 1986 I moved to the south-west, where the climate is milder, and taught fencing at New Mexico State University until I retired from this too.

Presently, I take only one or two pupils at a time and teach fencing twice a week. The city of Las Cruces where I live borders the city of El Paso, Texas, where annual fencing tournaments are held between Texas and New Mexico. Recently, during one of these tournaments, one of my pupils won a gold medal for first place, and the other a silver medal for second place in sabre.

Fencing has kept me physically active and stimulates me mentally. I shall continue to teach for as long as I am able or until I am totally bedridden.

## A MEDICAL PIANIST ON TOUR

CAMERON ROBERTS

*Cameron Roberts is a third year medical student who is also studying for a Diploma in Music (Practical) at the University of Melbourne Faculty of Music. The Diploma in Music (Practical) comprises a three year study in music which adds one year to the duration of his medical course, and will be awarded on the successful completion of his MB BS. In 1997 Cameron was one of five young soloists who participated in a concert tour of Thailand and Singapore organised by the University of Melbourne Faculty of Music.*

**P**LAYING THE PIANO HAS ALWAYS brought me great enjoyment, and my interest in music has given me some wonderful experiences. In July 1997 I was invited to be part of a music tour of Thailand and Singapore with four other students from the Faculty of Music. Naturally, it was a very exciting venture and I was particularly honoured to be one of the chosen soloists as the other musicians were either final year or masters students.

People often ask how I can study music and medicine. 'I don't know' is invariably my reply and indeed this is partly true.

Certainly my interest in music is more than just a hobby. At times it is a very serious interest. It is however, never a burden or something in which I feel pressure to succeed. I have always studied music at my own pace and with my own love.

My music education started at a young age when my father taught me basic chord patterns on the piano and sang along with me while we played through old jazz-classics albums. My mother and older sister taught me some basics of technique before I had my first formal piano lesson at ten. I had been learning violin from the age of six but my piano interests and skill very quickly took greater form. I was encouraged to be active in music at school and by the time I left in 1994 I had completed AMEB diplomas on violin and piano, and performed concertos by Haydn, Mozart, Saint-Saens, Tchaikovsky and Rachmaninov, the last of which I played on a tour of England, France and Belgium.

I deferred my first year of medicine to focus my attention entirely on music. During this 'year-off' I visited some of the greatest teachers and music conservatories in the world: London, Vienna, Moscow, Manhattan, and the Tanglewood Summer School, Massachusetts. These opportunities were a real treat for me, yet still I chose to study medicine.

Studying for the Diploma of Music alongside my medical studies has allowed me to continue my piano lessons and play violin in the conservatory orchestra. In my first year I was awarded the Pearis Roger Piano Scholarship and in 1997 I won the Mozart Piano Competition. Although the extra commitment of studying music adds hours to my day, the rewards outweigh the load.

The concert tour of Thailand and Singapore, aimed at raising the international profile of the University, was one such reward. The five soloists, comprising myself and another pianist, a cellist, a violinist, and a soprano, were looked after by Margaret Farren-Price, the tour organiser, from the Faculty of Music. We gave ten concerts between 8-20 July 1997 at a variety of venues. Our first concert was at Pattana School, the British International School in Bangkok, Thailand. The following day we were aboard an early flight to Chiangmai for two concerts at university music departments. Back in Bangkok a full evening concert sponsored by Central Trading Company at the Goethe Institute Auditorium

was recorded for television, a snippet of which appeared on the evening's news bulletin. A Sunday afternoon concert and reception hosted by the Australian Embassy and the University of Melbourne Alumni Association Thailand Branch, and performances at Chulalongkorn University and a newly established music department at Rajamangala Institute completed a busy week in Thailand. Our performances in Singapore were at Raffles Junior College, the National University of Singapore and then a concert at the Australian High Commission which coincided with the inaugural 'Alumni Summit' (a meeting of Alumni representatives from the region together with a delegation from the University) ended the busy tour. The tour leaves me with unforgettable memories.

But what of the future? For me, both medicine and music are great 'human' arts. They both require careful practice; teach about yourself and others; encompass the full range of human emotions; demand effective communication and are life-long pursuits. I hope for nothing more than to be able to continue enjoying both for as long as possible.



Cameron Roberts with fellow student musicians before their tour of South - East Asia. L-R: Kenji Fujimura (pianoforte), Clara Schutz (cello), Judith Dodsworth (soprano), Cameron Roberts (pianoforte and violin), Dominique Gallery (violin)

## BOOK REVIEWS

### ABORTION: RU 486

#### Anecdotes of Anguish and Hope

by Dr Rod Bretherton

Rodney Bretherton, 1997  
Sbk, pp 74, illustrated, appendices,  
bibliography  
Available from Rodney Bretherton,  
PO Box 486, Daylesford, Vic, 3460,  
\$22.50 (including postage)

This text, written by a graduate of the University of Melbourne Medical School, traces the use and abuse of abortion in the era when contraception was not as freely available as it is today and when women died of puerperal fever and of complications from backyard abortions. Having been brought up in a home where

abortion, although not openly discussed, was commonly an agenda item for his father, Dr AW Bretherton, he was clearly well aware of the problems confronting young women when an unwanted pregnancy occurred.

Rodney Bretherton graduated in 1944, and following the Second World War decided to practice in the same building as his father, and carry on the 'service' so graciously provided, often at no charge, to those who required it. This continued through the era of the Abortion Trials of the 1960s and included his own arrest in 1969. It was not until the Menhennit ruling in 1969, that abortion became a procedure which could be lawfully offered to women who satisfied the grounds outlined by this judgement.

Since that time, the problem of

backyard abortion has virtually disappeared, and a maternal death due to abortion or its complications for practical purposes now never occurs. This does not mean that all is inactive in this area however, as RU 486 (Mifepristone) offers a treatment for many women, especially early in pregnancy, which would remove the need for an anaesthetic and a surgical procedure and allow safe medical abortion in almost one hundred per cent of cases treated, with RU 486 alone, or in combination with a prostaglandin, before seven to eight weeks of pregnancy. Unfortunately, due to a combination of activities of antagonists of abortion rights, and the attitude of certain political personnel or parties, RU 486 is not available in Australia, despite being freely available in many countries overseas.

This book is a personal account, is truly anecdotal, and traces the availability and techniques of abortion in Victoria from the time Rod Bretherton's father was actively involved, until today. It is not a medical text, but it certainly serves to provide the reader with information concerning the problems associated with abortion, its performance, the complications thereof, and the potential changes which could occur if religious and political persuasion was not allowed to influence the agenda.

Roger Pepperell  
MGO, MD, FRACP, FRCOG, FRACOG  
Professor of Obstetrics & Gynaecology  
(Royal Women's Hospital)  
University of Melbourne

## AN ANNOTATED BIBLIOGRAPHY OF KENNETH FITZPATRICK RUSSELL

by Mary Fogo Russell

M F Russell, 1997  
Hbk pp 111, illustrated, bibliography,  
cited authors and subject indices  
Available from M F Russell,  
PO Box 1060, Caulfield North, 3161,  
\$60 (including postage)

This is a well printed, sturdily bound book produced by a daughter '[t]o the memory of my father who taught me so much'.

It has 265 citations of papers and books published by Ken Russell and, apart from the usual bibliographical information, reviews and citations of particular publications are given. These make the book so much more valuable and demonstrate how widely many of the books and publications have been read.

The last entry is number 266: *A Bibliography of Johann Remmelin the Anatomist*, J F Russell, Melbourne, 1991. The 124 pages were completed and published by J F Russell, Ken's wife, with help from the family, from KFR's draft manuscript.

The book is a fine tribute, and should find a place in any medical library.

HA

## BRICKS OR SPIRIT?

### The Queen Victoria Hospital Melbourne

by Emma Russell

Australian Scholarly Publishing,  
Melbourne, 1997  
Sbk, pp 112, illustrated, appendices,  
bibliography, index  
rrp \$24.95

This plasticised paperback history of the Queen Victoria Hospital, Melbourne begins by telling the story of the early

medical women, of their versatility, determination and vision, and the support of upper class home maker voluntary workers. It describes the social mores of the times and the effects of two world wars. The need for interpreters in hospitals, the birth of babies with fathers at war and the emotional, social, physical and spiritual support given by the medical women to the very lonely, isolated mothers are highlighted, as are the horrors of backyard abortions where desperate women with large numbers of children were faced by the prospect of yet another mouth to feed. The reduced allocation of funds by successive governments caused changes from a stable hospital situation to one where expenses could not be met. The gradual influx of men met the ever increasing staff needs of a growing hospital. Three transfers to buildings of ever increasing size were undertaken, finally leading to a new hospital and medical school in the suburbs, with the loss of identity as a 'Pro Feminis, A Feminis' hospital.

There were many first discoveries as a result of quiet unsupported research projects. Kate Campbell showed that over-oxygenation of the premature baby resulted in blindness due to retrolental fibroplasia. Lorna Lloyd-Green established one of two infertility clinics in Melbourne, stimulated by the motto 'populate or perish'. Lorna Sisely inaugurated the first breast clinic in Victoria in an attempt to eradicate cancer of the breast. Elizabeth McComas set up an orthopaedic unit at the hospital. As Medical Superintendent, Lorna Lloyd-Green appealed to her resident medical officers to discover what women could endure, not what they could accomplish in childbirth.

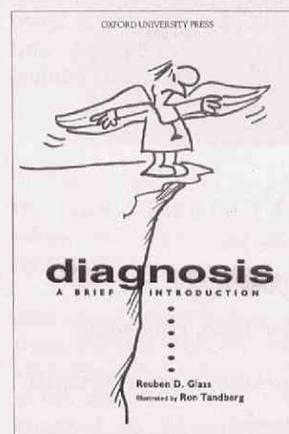
The armed forces required the services of men, so the medical women remaining at home were an essential service and worked long hours caring for the sick in hospitals. The junior doctors earned their keep and a small amount of pocket money, while the seniors were honorary medical officers giving their services to the poor of Melbourne until the late 1940s. Venereal disease was rife and caused many problems with the health of the women. Their diet was often unbalanced and inadequate as well as poor in protein and vitamins - quite often requiring supplementation. The book is enhanced by the use of many excellent black and white photographs. The index relates mainly to references to outstanding medical women, but in addition there is an excellent bibliography which could have been titled references. One appendix contains a chronological record of office-bearers in all sections of the hospital and another records the history of hospital events. The 112 pages are well worth reading.

Lorna Lloyd-Green

## DIAGNOSIS: A BRIEF INTRODUCTION

by Reuben Glass

Oxford University Press 1996  
Sbk, pp 120, illustrated, appendices,  
index rrp \$19.95



It is no wonder that, despite much research, a successful computer algorithm for clinical diagnosis has not yet been developed. Clinical diagnosis is the foundation of medical

diagnosis: it combines problem solving with a huge knowledge base, with techniques to elicit information from a patient and an amount of intuition. Reuben Glass has tried to simplify this process for medical students in his book *Diagnosis: a brief introduction*.

Rarely does a clinical teacher take time out to describe to students why they come to their conclusions about a diagnosis and appropriate treatment regimen. They often resort to phrases such as 'in my clinical experience'. Whilst reasonable and correct this is terribly frustrating for medical students, and less tolerated by newer students who have been schooled in evidence-based medicine.

The author describes a framework for the diagnostic process which usually seems to be an overwhelming task for the early clinical student. Whilst the book describes eliciting a history and clinical signs and how to collate them into a reasonable summary, his focus is on weighting the pieces of information. Dr Glass analyses the decision-making process and the things that influence clinicians, for better or worse, in reaching their conclusions.

The book is clearly directed at establishing a diagnostic framework for a medical student who is just beginning their clinical training, and is written at an appropriate level. The book is illustrated with very pertinent and funny cartoons by Ron Tandberg. Dr Glass uses some neologisms that I found difficult to grasp such as gong values and red and yellow flags. The book is littered with quotes from Sherlock Holmes who is still a relevant if somewhat minor figure in contemporary youth culture. Dr Glass illustrates his theories with examples from his own paediatric practice.

An absence of knowledge regarding the individual paediatric disease should not impede the student from understanding the principle illustrated.

Dr Glass has obviously reflected on the diagnostic process as both a clinician and teacher and distilled his thoughts into this short and simple synopsis of the diagnostic process. Whilst not exposing the art of medicine as a precise science he provides a basic framework and pertinent insights for the early clinical student.

Megan Rees

## NOTHING VENTURE NOTHING WIN

by Sir Michael Woodruff

Scottish Academic Press, Edinburgh,  
1996

Hbk pp 234, illustrated, notes, references,  
index

Available from Keith Woodruff,  
3 Lara Street, Malvern, Vic, 3144 -  
cheques should be made out to Sir  
Michael Woodruff for \$A35, which  
includes postage

'The aim of an autobiography should be to paint for others a picture of what the writer has seen in the course of the strange adventure on which, willy nilly, we all embark when we are born, and to record his reflections on what it all means.'

This is the simply told autobiography of an unusual Melbourne graduate - doubly qualified in medicine and engineering - the son of Harold A Woodruff, Professor of Bacteriology.

A devout Christian, in his last chapter, 'The Faith of a Scientist' Michael explains what his faith means to him. As a student he was taught to play the organ by Dr AE Floyd whose 'biting tongue could occasionally reduce a choirboy to tears'. At one time Michael was College Organist to Queen's.

He was imprisoned in Changi during the Second World War where he did important work in reducing Vitamin B deficiency by producing a 'machine for making grass extract' (fig 11 in the book).

Woodruff's professional life was in Academic Surgery - combining 'the practice of surgery with teaching and research'. After several increasingly-less-junior appointments in a number of countries and the Chair of Surgery at Otago he was appointed Professor of Surgical Science in Edinburgh in 1954. He was remarkably successful with his experiments and, sponsored by Peter Medawar, became a Fellow of the Royal Society in 1968 for studies in the transplantation of tissues and organs. In 1960 he had successfully transplanted a kidney from a twin donor into a 'middle-

aged man with advanced renal failure'.

In 1985, aged seventy-four, his third MRC Project Grant ended and he stopped experimental work '(apart from finishing off work in progress)'. His 'posthumous research as a colleague dubbed it' produced some twenty-five papers and reviews which he set in a broader context in two books.

This is an account of a highly gifted man's long and useful life. It also contains chapters on Mathematics and Sea Fever which deal with two of his 'hobbies'.

HA

## ON THE DUCKBOARDS

Experiences of the other  
side of war

by Gwynedd Hunter-Payne

Allen & Unwin Pty Ltd, 1995  
Sbk pp 220, index, illustrated,  
bibliography rrp \$24.95

This is a brief (1940-1947) hospital history which describes the creation of the Heidelberg Hospital (115th AGH) on the Spira family's large paddock in Heidelberg to care for the casualties of the Second World War. It is an intimate hospital history because records were scarce and it is largely an oral history - created from the personal stories of the men and women involved in all areas of the work.

The paddock, whereon the hospital was built became a small country village with a population of over five hundred people - at one time there were 2921 patients. It even had a village hall, St John Hall, with a capacity of 'seven hundred fixed seats and additional space for bed and wheelchair patients'. 'Stage productions . . . were broadcast live around the hospital via the internal radio network . . .'

The hospital started with many, rapidly built wooden buildings connected by duckboard walks spreading over the paddock. By 1943, these pavilion wards and laboratories were integrated with a 'state of the art' brick hospital with 500 beds. In 1945 there were 'thirty-eight single storey pavilion wards housing over 2000 beds'. This huge hospital was isolated, under military command and much of what was done there was unknown to the staff of other hospitals in Melbourne. This book tells the story graphically and movingly.

Interest is captured immediately by a series of photographs which shows Colour Sergeant Philip Ayton, in uniform, standing outside a tent and, below, the same man in pyjamas asleep following surgery for wounds - the surgery had been done at the 2/7th AGH. The photographs continue for some pages

tracing Ayton's return to Australia, his treatment at the 115th AGH and return to active duty. The most telling photograph in the book, to me, is of Leading Aircraftman Theo van Alkemade (p112) shown standing looking pleasantly at the



THEO VAN ALKEMADE

camera: it is obvious that most of his left arm is missing, but, immediately before the photograph was taken, he had thrown aside his crutches and friends were standing by to catch him if he fell - both legs had also been amputated and his balance was still precarious on new, artificial limbs.

Many photographs show operative procedures to ameliorate horrific facial wounds or reduce limb deformities and improve function. Much of this useful work was hidden from public view as it showed 'the other side of war'. The work of the Facio-maxillary and Plastic Surgery Unit under Benjamin Rank was extremely important and is appropriately recognised here.

Many of the wounded had been treated by the Trueta method, introduced during the Spanish Civil War, where the wound was excised and the limb then encased in plaster. Philip Ayton had such a plaster on for five months and, not surprisingly, the pus escaping from beneath the plaster was foul. When the plaster eventually came off the smell could be very offensive and the stench was long remembered. One nurse treating such a wound impressed an onlooker by her disregard of the smell and the care she took for the patient. The patients were also upset by their wounds being so offensive. Despite the smell the treatment was effective in keeping the wounds free from dangerous infections and the healing was better than might have been expected.

The hospital's first commanding officer was Colonel JAH (Bull) Sherwin, described as 'a sincere, kindly and gentle man', but he was a military man 'and the army had never included women'. Dr Elsie Abrahams, most recently pathologist to the Queen Victoria Hospital, was a staff pathologist and a

gazetted Captain. Elsie and the Colonel had met at the Women's Hospital, where Elsie had shared the medical officers' accommodation, but Sherwin's reference to this was blunt 'You're not at the Women's now!'. Sherwin relegated Elsie to the nursing home and she was not admitted to the officers' 'men's mess'. As her friends know, Elsie is made of stern stuff: she wore an army shirt and skirt, but neither her captain's pips nor hat -thereby she did not have to salute her fellow officers. Eventually Sherwin relented and gave Elsie her rights.

A goodly number of women in the Voluntary Aid Detachment and nurses went overseas to the Middle East and to Singapore. They too could become casualties or be killed. Probably the most infamous incident was that of the *Vyner Brooke* whose survivors were slaughtered when surrendering to the Japanese after she was sunk two days out of Singapore. That tale was told only because Staff Nurse Vivian Bulwinkel, only survivor of the slaughter, lived to tell it. When the Australian Hospital Ship *Centaur* was torpedoed off the Queensland coast 268 of the 332 personnel on board lost their lives including eleven members of the Australian Army Nursing Service. A nurses' memorial garden was created to the south of the formal entrance to the sister's home. I hope this will be remembered in some way no matter what new building is done at the Repatriation Hospital site.

Much of the work done at the 115th AGH was unknown to the community and other hospitals. However when patients arrived from overseas:

Watching ambulance trains make their way out to Heidelberg became a not-to-be-missed activity for children along the route. Children would gather to wave and cheer at the dusty red carriages and khaki uniforms, hoping it would be their turn to catch the sweets that soldiers often threw to them from the windows.

The task of receiving new patients was often formidable. 'Order 1/45, the first such order for 1945, stated that 111 patients would arrive at Spencer Street Station in the city and travel by road to arrive at the 115th between 1900 and 1930 hours . . .' Orders gave details of just how the patients were to be divided into groups so that a steady flow could be maintained by different routes to the appropriate ward. Not surprisingly all staff worked overtime. The registrar, Lieutenant Colonel J R Williams, had the overall responsibility for this and at his farewell it was noted that his position 'demanded the ability to speak on several telephones at once, while arranging for the arrival of a convoy between sentences'. None of the other

hospitals in Victoria could have experienced regular influxes of so many patients in such a short time.

Camaraderie had always existed amongst the wounded patients. When returned POWs were admitted problems arose. The POWs tended to be 'intolerant of authority and ignorant of the conditions then prevailing in Australia'. So accustomed had they become to living with their illnesses they would deny their very real problems-tropical ulcers, dysentery, worm infestations and chronic malnutrition. They needed their fellow POWs and separation was painful. Moreover it was not until after the Vietnam War that the post-traumatic stress disorder was recognised and a proper understanding of these difficulties reached.

This book is enriched by many notes, a good bibliography, a very necessary table of abbreviations and the names of those who have contributed information in a variety of ways.

The Repatriation Hospital has always been well served by its staff. The Hospital has certainly been well served by its chosen historian. Together with her first volume *Proper Care: Heidelberg Repatriation Hospital 1940s - 1960s* (see *Chiron* 1995, p70) Gwynedd Hunter-Payne's *On the Duckboards* gives a comprehensive overview of the history of the Heidelberg Hospital and is an excellent contribution to hospital histories in Australia.

HA

## THE DOCTORS IN VANITY FAIR

**A gallery of Medical Men who appeared in caricature between 1870 and 1914.**

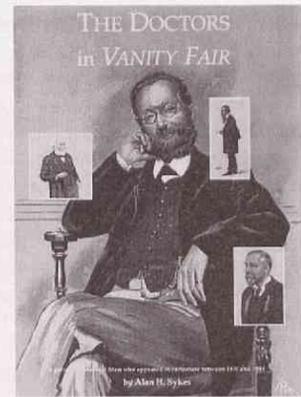
by Alan H Sykes

*Privately published. Printed by Titus Wilson & Son, Kendall, 1995*

*Hbk pp 119, index, ISBN 0 900811 277*

*Available from: Dr Alan H Sykes, Waithwaite How, Chapel Stile, Ambleside, Cumbria, LA22 9JG, UK, £30 (+£2.85 p&p)*

Vanity Fair. First published in 1868, it came to be the most influential 'top people's' magazine in the late nineteenth century. Its appeal stemmed from the quality of its journalism, its mildly satirical and irreverent ethos and its caricatures in colour of people prominent in society, politics, sport and the professions. These have long outlived in popularity the rest of the magazine and have come to be looked upon as a quintessentially English art form much sought after by collectors. Leslie Ward, the most prolific of the artists, worked under the name 'Spy' and collectors often refer to 'Spy prints' as a term for the prints in general.



Each caricature is accompanied by the original pithy text of the magazine editor with additional material supplied by the author.

I have a small collection of the caricatures from Vanity Fair, not all of them medical men, for example there is a very fine one of Darwin - the most genial of his portraits. Not surprisingly, when I chanced on an advertisement for this book, I immediately wrote to Alan H Sykes and was delighted with what I bought for \$103.75 including postage.

Richard Owen and James Paget, who, in England, interviewed candidates for the Chair of Anatomy, Physiology and Pathology in our new medical school and recommended George Britton Halford as 'one of the most distinguished physiologists of the day', are both included. Sir James Paget's caricature is signed 'Spy' but Professor Owen's is not signed. The wonderful caricature of Owen, 'Old Bones' is the first Leslie Ward submitted to Vanity Fair - his signature 'Spy' came later. Professor T H Huxley, the great supporter of Darwin is not always remembered as a medical man; Huxley was caricatured by 'Ape', Carlo Pellegrini, and titled 'A Great Med'icine Man among the Inquiring Redskins'. Why? The 'pithy text' explains.

Professor Huxley favours the movement for the Scientific education for Women. He wants them to be associates of men in the 'feast of reason and the flow of soul,' and would no longer feed them with the fag-ends and scraps of knowledge which they have been accustomed to pick-up. In this respect his practice differs essentially from that of the Uninquiring Redskins, whose squaws are compelled to keep in the background until their lords have dined, and are then admitted to a scramble for the bones and shreds of the repast.

Selection for inclusion in Vanity Fair was obviously an editorial one and largely based on London. However, George Benjamin Clemenceau, the French politician and Rudolf Virchow, the great German pathologist are both included. Surprisingly, among those excluded are Lord Lister, Sir William Osler, Sir James MacKenzie, Sir William Gowers, Arthur Conan Doyle, David

Livingstone and sadly, Elizabeth Garrett Anderson, the first woman doctor.

The cover features Dr Thomas Allison, in one respect the most exceptional of this collection of doctors: he was the only one to have been struck off the Register. He strongly advocated what is now termed 'alternative medicine' and he promoted the wholemeal flour to which he gave his name, but he incurred the displeasure of the General Medical Council over the professional issue of advertising.

Allison adopted the post nominal of 'EX L.R.C.P. Ed' and was the last owner of Vanity Fair.

Alan Sykes' summary cannot be bettered:

There are many other works of reference concerning our subjects but the prime purpose of this collection is not history or biography but enjoyment: the delight of the paintings, the elegance of the texts and the uniqueness of Vanity Fair.

I treasure and delight in this book. So could you by writing to Dr Alan Sykes.

HA

## UNDERSTANDING TROUBLED MINDS

### A Guide to Mental Illness and its Treatment

by Sidney Bloch and Bruce S Singh

Melbourne University Press 1997

Sbk pp 333, illustrated, index

rrp \$17.95

Melbourne University, through its Medical School and more recently the Department of Psychiatry has an excellent history of teaching, care, and research, in relation to the field of psychiatry. This book represents and illustrates that background.

Loosely based on the earlier text *Foundations of Clinical Psychiatry* which was written primarily for medical students, the new text is for the lay reader. It serves as a fine example of how to do the task set themselves by the authors.

It is written in clear, expressive, mainly jargon free English. Many clinical examples serve to illustrate matters under discussion. Numerous references to literature and the arts, both ancient and modern, highlight the perceptive and descriptive ability of such observers and the stability of some clinical pictures over the ages. Lavish use of Leunig cartoons, and pictures painted by sufferers of psychiatric illnesses illuminate many clinical issues and increase the attraction of the text.

It can be read by any reasonably intelligent person without difficulty.

The book, in intention, range and resolution is almost unique if not actually

so. The introduction refers to other texts which can appear skewed, biased and narrowly based. How does it compare with such?

I do not recall a specific reference in it to 'the medical model', a concept held in some disdain in some quarters (usually related to limited information and less understanding on the part of those expressing such views). This book is an admirable demonstration of the proper medical model.

The medical, and in this instance the psychiatric, task is essentially simple but requires sophisticated and complex skills. It can be summarised in the following questions:

What is the problem?

How did it seem to come about?

Who is the person who has the problem and how did he/she become that person?

Can or should anything be done about it?

Overall the authors handle the questions well. Relevant historical background is provided. They range over the whole field of troubled minds, differentiating normal variation and responses to life's difficulties from the more serious major disruptions to normal functioning and frank illness. It would be tedious to give a list of chapter headings and contents to demonstrate this. They use the bio-psychosocial model to great advantage, emphasising what is thought to be known and admitting to uncertainty or frankly not knowing when necessary. They demonstrate an appropriate range of factors which appear to influence or trigger human behaviours and at time illness, including the cultural, social, psychological and biological. The current range of conceptual models and belief systems receive recognition, although some might question the recognition given to some of them. Nevertheless, overall a balanced presentation occurs.

There are a few sins of commission or omission and they are perhaps understandable in a text which attempts to be relatively brief yet comprehensive. A couple of examples will suffice. First of commission or unfortunate association. On page six a descriptive paragraph about various early physical treatments outlines weird and wonderful attempts to treat psychotic disorder. The final sentence begins with the words 'Not one of these so called treatments have the remotest rational basis . . .'. The next paragraph begins 'For example, malaria therapy as a treatment for general paralysis of the insane - syphilis affecting the brain - was introduced in 1917 by the Viennese psychiatrist Julius von Wagner-Jauregg, earning him a Nobel Prize'.

The implication or inference is that malaria therapy was not rational. It was

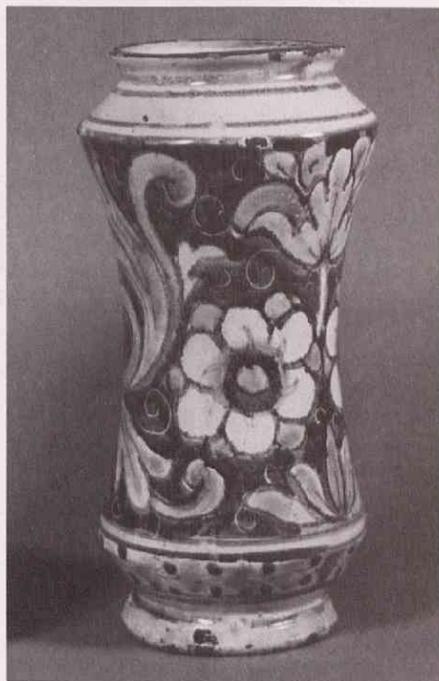
rational and malaria treatment followed much astute observation about the apparent benefits of accidental severe fever on patients with neurosyphilis. Wagner-Jauregg justifiably earned the Nobel medical prize for a treatment which did work, stopping the progress of some major forms of neurosyphilis though unable to heal damage which had already occurred. That treatment remained effective and the one of choice throughout the world for such disorders from 1917 until the arrival of penicillin late in the Second World War.

A minor omission occurs on page 267 with regard to serendipity and the modern tranquillisers. At the time when Chlorpromazine and its value in psychiatry was being discovered, Reserpine, a product of the rauwolfia plant then in use as an early hypotensive drug was also introduced into psychiatry in the west. It had however been used - the plant that is - for psychosis in Indian medicine for several centuries. Unfortunately, though very effective, the severe side effects of the refined form led to its rapid abandonment in favour of Chlorpromazine. (In the 1960s large amounts of that drug were still held in store at the Mont Park Hospital).

Despite such minor nit-picking this is a fine book. It can be read with profit by anyone with an interest in such matters, especially family members of those affected by troubled minds, and it certainly could prove helpful to the affected themselves.

Congratulations to the authors. Buy it.

Richard Ball



One of a pair of Italian Majolica Albarelli. On continuing loan from Graham Roseby to the Medical History Museum

## MEDICAL HISTORY UNIT

### OPENING OF THE DEPARTMENT OF MEDICAL HISTORY

The thirtieth anniversary of the opening of the Department of Medical History was celebrated in 1997. In 1967 funding from the Wellcome Trust enabled the fitting out of a reading room, a rare book room and a museum on the second floor of the Brownless Medical Library creating the first Department of Medical History in Australia. Kenneth Fitzpatrick Russell, Reader in Medical History and Associate Professor of Anatomy had worked long and hard to achieve this and the Department was officially opened on 13 April 1967. Ken Russell was awarded a Litt D in 1968 (the only medical graduate to receive one) and appointed to a personal chair in Anatomy and Medical History in 1969. He retired in 1976, but continued to work in the Department with his wife, Jean Fogo Russell, until 1985. Ken died in 1987.

The Department became the Medical History Unit in 1981 with Professor Harold Attwood as the curator, Edna Bird as secretary and a number of honorary associates.

### THE SAVORY & MOORE PHARMACY

The Savory & Moore Pharmacy opened at 29 Chapel Street London in about 1849 and closed in 1968. The furniture and fittings were presented to the Wellcome Institute of the History of Medicine. Dr FNL Poynter, Director of the Wellcome Institute, who had opened the Department of Medical History, encouraged the Wellcome Trust to offer the Pharmacy furniture and fittings to the University. The generous offer was readily accepted and the furniture and fittings reconstructed according to the dimensional plans of the Chapel Street Pharmacy.

Professor Russell had already obtained bottles and jars from Palmer's Pharmacy in Ballarat, most with their contents of the period 1870-1890. These now appropriately adorn the shelves of the Savory & Moore Pharmacy in the Museum.

### THE MEDICAL HISTORY MUSEUM

Following the successful 1996 series of exhibitions, 1997 started with the exhibition 'Photographs, Memorabilia & Memories: The Queen Victoria Memorial Hospital Centenary Exhibition 1896-1996'. Curated by Ann Southin BA, Honorary Curator, Monash Medical Centre, the exhibition had originally been on display at the Monash Medical Centre and Archivist/Cataloguer Lisl Bladin did a fine job of modifying it for the Museum.

The large number of excellent images created much interest, not only for past staff members, but also for the general public, many of whom had been patients there, had babies there, or had returned there with sick children. Throughout the display of this exhibition small groups of people were regularly seen in the Museum.

In August, a very different exhibition was mounted. Curated by Mr Peter Phillips, a surgeon from Echuca and the author of *Kill or Cure*, a well-illustrated book about medical eccentricity in the 19th and early 20th centuries. The exhibition, 'Quacks, Eccentrics & Alternative Therapies: Tales of Colonial Medicine' included some striking images, many from Peter Phillips' book, and was greatly added to by Lisl Bladin using a number of archival sources.

Provided with a historical background of Victoria in the late 19th century, the

exhibition dealt with quacks and such suspect institutions as the Freeman and Wallace Electro-Medical Surgical Institute with some weird advertisements. Amongst the eccentrics, James George Beaney featured prominently - there was an image of his tomb in Canterbury although he is actually buried in the Melbourne General Cemetery.

Alternative therapists included were Dr James Sam Lee, Bendigo practitioner in Chinese traditional medicine, Johannes Gunst who founded the homeopathic hospital and George Milner Stephen, former Acting Governor of South Australia, who was renowned for his miraculous faith healing. Not surprisingly this exhibition created much interest, even attracting Paul Willis from the ABC Science Show who made recordings of the Curator and Robin Orams in the Museum.

An increased number of requests for tours in 1997 saw visits from: the Siemens Summer School, Korowa Anglican Girls School, the Wellcome Trust, the Monash Sculpture course, the 'English for the Health Industry' course, the Wallaby Club, Staff and Distaff, the Australian Society of Archivists School Archive Special Interest Group, Glaxo Wellcome, and University High School.

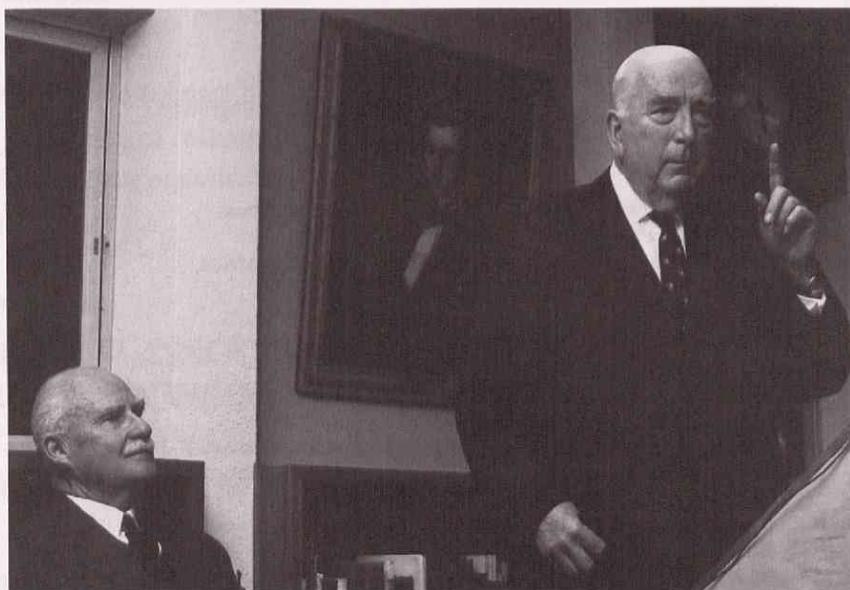
For a visit by Professor Stephen and Dr Donald Cordner I was able to look into the collection and show them photographs of Henry Cordner in the 1909 group, Edward Rae Cordner in the 1919 group and produce the silver tray, donated to the collection by Donald Cordner, which had been presented to him at the 25th reunion dinner of the class of 1945 in gratitude for his arranging all the reunion dinners!

The Fifth Biennial Conference of the Australian Society of the History of Medicine was held in Darwin in July 1997. At the opening ceremony Bryan Gandevia, Geoffrey Kenny and Harold Attwood were presented with certificates of Honorary Life Membership of the Society and at the AGM, very appropriately, Professor John Pearn was also elected an Honorary Life Member.

At the AGM it was decided to go ahead with the publication of a Bulletin with the possible title 'A Bulletin of Health and History in Australia'. The Bulletin's aim is to 'foster the advancement of medical historical research in the Australasian region'.

I retired as Curator at the end of 1997.

*Harold D Attwood*



University Chancellor Sir Robert Menzies, in 'full flight', opening the Savory & Moore Pharmacy 1 June 1971. Professor Ken Russell seated.

## MICROBIOLOGICAL DIAGNOSTIC UNIT 100 Years of Service to Public Health in Victoria

on exhibition to July 1998 at

THE MEDICAL HISTORY MUSEUM  
BROWNLESS MEDICAL LIBRARY

9-5 Weekdays

*With the discovery of gold in 1851 'Marvellous Melbourne' grew rapidly in size and population. The phenomenal growth of the city surpassed the capacity of civic authorities to cope with the disposal of sewage and in some areas sewage and waste water were discharged into open drains which emptied into urban creeks or the Yarra River. The Sydney Bulletin aptly coined the phrase 'Marvellous Smellboom'.*

*The largest and smelliest of these open drains was in the main shopping and business district. In South Melbourne and other low-lying suburbs, some rainfalls resulted in raw sewage seeping from flooded drains into cellars and the ground floors of houses.*

*The incidence of infectious diseases was very high. In 1890 approximately 4000 people contracted typhoid and over 400 died. The city's water supply was thought to be contaminated with typhoid bacteria.*

*To combat these problems the Board of Public Health and the University of Melbourne jointly established the Bacteriological Laboratory in 1897 in the University of Melbourne Department of Pathology. Now the Microbiological Diagnostic Unit, located in the Department of Microbiology and Immunology, it is one of the oldest public laboratories in the world.*

*This exhibition covers the history of the Microbiological Diagnostic Unit: its establishment as a service for the diagnosis of diphtheria, typhoid, tuberculosis and other infectious diseases as well as the examination of the water supply; the high incidence of syphilis and diphtheria through the period between the wars; large outbreaks of typhoid and the beginning of State Government funding after the Second World War; diseases such as cholera and typhoid being imported due to increased air-travel in the sixties and seventies; and the more recent introduction of the National Salmonella Surveillance Scheme.*

*For more information regarding exhibitions at the Medical History Museum telephone +61 3 9344 5719.*

## MEDICINE, DENTISTRY AND HEALTH SCIENCES

### 1998 DEAN'S LECTURE SERIES

*The Dean's Lecture Series is designed to illustrate current research and topics of interest in the fields of Medicine, Dentistry and the Health Sciences. Lectures are held on Tuesdays at 5.30 pm in the Sunderland Lecture Theatre, ground floor, Medical Building, University of Melbourne. Interested graduates and students are invited to attend. For further information contact External Relations, Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne, Parkville, Vic, 3052; telephone 9344 5888; facsimile 9347 7084.*

**3 March**

#### **The bionic ear towards 2000 and beyond**

Professor Graeme Clark, Gibson Professor of Otolaryngology; 1997 Sir William Upjohn Medallist

**17 March**

#### **Child and adolescent health into the new millennium: clinical care, science, public health and politics**

Professor Peter Smith, Stevenson Professor of Paediatrics, Royal Children's Hospital

**24 March**

#### **64th Beattie Smith Lecture**

#### **Mental illness, culture and social change**

Professor Arthur Kleinman, Maude and Lillian Presley Professor of Medical Anthropology; Professor of Psychiatry and Professor of Social Medicine; Chairman of Department of Social Science, Harvard University

**28 April**

#### **Angiosomes: explored, explained, expanded and explanted**

Professor Ian Taylor, Head, Plastic and Reconstructive Surgery Unit, Royal Melbourne Hospital

**12 May**

#### **General practice in Australia: integration or disintegration?**

Professor Doris Young, Professor of General Practice, Department of Public Health and Community Medicine

**26 May**

#### **Mathison Lecture**

#### **Viral persistence and immunity**

Professor Peter Doherty, Nobel Laureate; Chairman, Department of Immunology, St Jude Children's Research Hospital

**9 June**

#### **The damaged baby. Who is at fault?**

Professor Michael Permezel, Professor of Obstetrics and Gynaecology, Mercy Hospital for Women and Austin and Repatriation Medical Centre

**23 June**

#### **Encounters with aliens: the biological basis of infectious diseases**

Professor Roy Robins-Browne, Director of Microbiological Research, Women and Children's Health Care Network

**7 July**

#### **Advances, controversies and future directions in sarcoma management**

Professor Peter Choong, Director of Orthopaedic Surgery, St Vincent's Hospital and Peter MacCallum Cancer Institute

**21 July**

#### **Ageing - an academic octopus**

Professor Anna Howe, Deputy Director, National Ageing Research Institute

#### **DEAN'S LECTURE SERIES MEDICAL ETHICS SEMINAR**

**Too young to know?**

**Too young to decide?**

**Consent and confidentiality in  
adolescent health**

Convener: Professor Richard Smallwood  
Friday 31 July 2.00 pm - 5.00 pm



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