

at X-ray  
in Melbourne  
William Stone  
1880



# CHIRON

JOURNAL OF THE UNIVERSITY OF MELBOURNE MEDICAL SOCIETY

VOL. 3 NO. 4 MAY 1996

# UMMS

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## Acknowledgement

UMMS thanks the  
Medical Defence Association of  
Victoria for their continuing  
generous sponsorship  
of *Chiron*.

# CHIRON

CHIRON THE CENTAUR, TEACHER OF MUSIC, MEDICINE AND HUNTING

Vol. 3 No. 4

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**Acknowledgements:** The Board thanks contributing UMMS members, Faculty staff and the Photography Section, CSHE of The University of Melbourne.

*Chiron* is published annually by the University of Melbourne Medical Society.  
Further copies of *Chiron* may be purchased from the UMMS office  
at \$10 each, plus \$2.50 postage and handling in Australia.

ISSN 0814-3978

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## CHANGE

*Everywhere the old order changes and happy they who can change with it.*

William Osler

**A**S WILLIAM OSLER ADVISES, in the 1895 edition of *Principles and Practice of Medicine*, 'Everywhere the old order changes and happy they who can change with it'. This issue of *Chiron* records a number of changes. Change is part of life and living, but even when from worse to better may not be without inconvenience.

In November 1895 Wilhelm Conrad Röntgen discovered x-rays. Our cover depicts the vast technological changes in the use of x-rays over the ensuing one hundred years. The stark simplicity of the tube made by William Stone in Melbourne in 1896 contrasts sharply with the enormous machine – the scanner – which now encompasses the patient to produce its wondrous images.

Such changes in technology have brought about great improvements in the ability to save and prolong lives. They have also brought about ethical and legal problems which are touched on in the seminar *Caring for the Severely Disabled or Dying Child* (pp4-16).

In the last few years there have been great changes in the hospital system in Victoria. Budgets are now dependent on the case-mix formula which brings with it the rapid discharge of patients and as a consequence, our clinical schools record a reduction in the number of patients available for teaching. Hospital Boards of Management, whose members were not paid, but served with varying distinction, have been replaced by a Health Care Network with salaried personnel and a range of management experiences. Although the benefits of these changes have still to be proved, they have, on occasions, caused worry to staff uncertain of their future.

In the last year, this University has seen the departure of a Vice-Chancellor and the appointment of a new one. David Penington, formerly Professor of Medicine at St Vincent's Hospital and Dean of Medicine from 1978 succeeded David Caro as Vice-Chancellor in 1988. He proved to be a strong administrative head who fought for the rights of this University against strong political forces and budgetary restraints. David presided over amalgamations, changes in administrative structures and championed closer relationships with other universities both in Australia and in Asia. On his retirement the University awarded him an LL *D honoris causa*. In his address to the new graduates about their future, published in this issue (p32), David pleaded with them 'do not abandon your ideals'. He also told of his interest as a schoolboy in Osler's *Aequanimitas*. This oft printed valedictory address given by Osler in 1889 encourages medical students and doctors to develop 'coolness and presence of mind under all circumstances'.

Our new Vice-Chancellor, Alan David Gilbert is a historian with a D Phil from Oxford who has published on Religion and Society in Industrial England and Church and Church Goers. A former Professor of History and Pro Vice-Chancellor in the University of New South Wales he comes to Melbourne after being Vice-Chancellor and Principal at the University of Tasmania since 1991.

Last year too, this Faculty saw the resignation of a Dean and the appointment of another. Graeme Ryan, a Melbourne

medical graduate and an experimental pathologist with an international reputation became Dean of the Faculty in 1986. Graeme presided over the enlargement of the Faculty with the fusion of Dental Science, Physiotherapy and Psychology to form the present Faculty of Medicine, Dentistry and Health Sciences. Graeme was President of the Academic Board (1989-90), and an elected member of the University Council as well as chair of the NHMRC Grants Committee and the Committee of Deans of Australasian Medical Schools. Graeme was also a member of the boards of several hospitals and research institutions and in recognition of his contributions to the community was appointed a Companion of the Order of Australia in 1994.

Graeme is well liked by everyone who worked with him. We were all sorry when he resigned to become the Chief Executive Officer of the Inner Health Care Network in Melbourne but wish him well in this challenging new position. An appreciation of Graeme Ryan can be found in this issue of *Chiron* (p20).

Our new Dean is Professor Gordon Clunie who has been the James Stewart Professor of Surgery at the Royal Melbourne Hospital since 1978 and Deputy Dean of our Faculty since 1986. An Edinburgh graduate, Gordon worked for a time in Edinburgh with Professor Sir Michael Woodruff, a Melbourne graduate who some years ago was the Halford Orator when he talked of his work on transplantation. Gordon had been Professor of Surgery in the University of Queensland from 1973-78 and has major interests in surgical immunology, organ transplantation and surgical education. A member of many committees in the University, in a number of hospitals in Melbourne and of the Royal Australasian College of Surgeons, Gordon was awarded the Louis Barnett Medal of that college in 1994. Gordon is generally well-known, respected and liked. He is married with three children, all of whom are graduates of this University.

The new Vice-Chancellor and the new Dean have very different backgrounds and experiences to their predecessors and, not surprisingly, their viewpoints will be different; they are likely to focus on different areas in the many problems they will have to confront. The changes they are likely to make will be awaited with interest.

During last year, Peter Jones, the founding Editor of *Chiron*, died. Peter was a well-known and well-liked paediatric surgeon and Melbourne personality with an encyclopaedic knowledge and wide range of interests. He is very sadly missed.

In June 1995, Maggie Mackie, originally Assistant Editor and Designer of *Chiron*, retired as Co-Editor. Maggie was largely responsible for the evolution of *Chiron*. She was also the central contact for contributors who were welcomed warmly, helpfully and with rare good humour. Her vitality and wit are missed in the offices of *Chiron* but, thankfully, she remains a consultant. Tributes to Peter Jones and Maggie Mackie are included in this issue.

Previous numbers of *Chiron* have recorded many changes generally accepted in their times. *Chiron* itself, has grown and changed since its first appearance in 1983 as a fifteen-page newsletter. We hope to maintain the high standard of the journal as it bears witness to change in the University, in the School and in medicine.

Harold Attwood & Liz Brentnall

# PETER GRIFFITH JONES

MBBS 1945, MS 1965, FRCS, FRACS, FACS, FAAP

1922-1995

*I had a great day, a three-year old gave me a hug.*

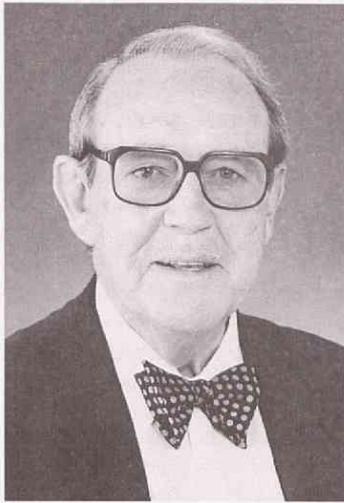
Peter Jones, after a long day at the Royal Children's Hospital

THE UNIVERSITY OF MELBOURNE Medical Society is proud to pay tribute to a distinguished, loyal alumnus and compassionate paediatric surgeon. Peter Griffith Jones personified the Renaissance ideal of wide-ranging learning and culture. Surgeon and teacher, he could hum a Mozart tune, quote French verse, research Spanish archives and manage a yabby farm. He was a proud family man. Tall, good-looking and dressed with sartorial flair, Peter was an entertaining raconteur and much sought after speaker. A wide grin would break over his face as he enjoyed his own erudite wit and the humour of others – he could enjoy a good medical school joke with the best of them. Andrew Jones may have surprised many at Peter's funeral when he suggested there was something of the 'larrikin' in his father.

Peter died at home with his family around him on 15 March, 1995. He was in his seventy-third year. Born in Melbourne in 1922 and educated at Melbourne Grammar, he graduated in medicine from the University of Melbourne gaining honours in all final year subjects in 1945. After completing residency appointments in Australia he was awarded the first Cleveland Fellowship which he held at the University Hospital, Cleveland, Ohio in 1948-49. For further postgraduate training in surgery, particularly paediatric surgery, he went to England and won his FRCS.

It was in England that he won not only his FRCS but also his future wife, Julie, who became a consultant child psychiatrist. They were complementary people – Julie the conceptual thinker and Peter with his astonishing memory for detail. As they pursued their own busy professional lives, the varied, lively careers of their six children – Penelope, Sarah, Deborah, Andrew, Abigail and Caitilin – brought Peter and Julie many delights. (Peter related how when the house was full of small children, he would rock the cradle with one foot as he worked at his desk.) In his last years, he experienced the pleasure of getting to know his three grandchildren, Simon, Isabelle and Francesca.

Peter's academic and professional life earned him many honours and international recognition. In Melbourne he was a renowned teacher of paediatric surgery to generations of students, who also profited from his book *Clinical Paediatric Surgery*. A classic textbook now in its fourth edition (also translated into Spanish and Portuguese), under new editors it has been renamed *Jones' Clinical Paediatric Surgery*. As well as being the first Cleveland Fellow, Peter was one of the first two surgeons to pass the demanding examination of the FRACS in paediatric surgery; the first recipient of the



PETER JONES

Royal Children's Hospital Distinguished Service Award; and the first to be presented with the Gold Medal of the Medical Defence Association of Victoria.

One of Peter's special attributes was an ability to relate well to his small patients and their parents, to all he worked with in the theatres and in the wards, and in the administrative offices of his beloved Royal Children's Hospital. He devoted thirty-five years to the Hospital and his warm, gregarious personality endeared him to many. Nate Myers recalls what a pleasure it was to work with Peter, particularly in the operating theatre – a visitor, commenting on their collaborative effort, remarked that he had never before seen a 'four-handed-surgeon'. In the early days of heart surgery, Peter was one of the team which first operated on children using cardiopulmonary bypass. In 1975 he led the team of surgeons which separated Siamese twins a day after their birth.

He applied his creative energy and intelligence to all facets of the medical profession. In this University he was, in turn, a demonstrator in paediatric surgery, a clinical instructor, and lecturer in the Department of Community Medicine. At seminars and public debates he was a generous contributor and a serious devil's advocate. He became president of many professional societies and colleges and his involvement with the Royal Australasian College of Surgeons was considerable. He was President of the Medico-Legal Society and Vice-President of the Medical Defence Association of Victoria (where he was sought out as a wise counsellor).

Peter was the founding Editor of *Chiron* – he gave it its name and the early editorials sparkled with his erudite wit. Given his nature, it is not surprising that he should

have completed a Certificate of Printing Technology at the Melbourne College of Printing and Graphic Arts. He wrote with a superb command of the English language, publishing over thirty papers and contributing chapters and volumes to the surgical literature in paediatrics. He was the founding editor of *The Australian Paediatric Journal* and of *Defence Update*. He was at one time a Director of Blackwell Scientific Publishing of Australia. It was to honour Peter's literary talent that the UMMS Committee renamed the UMMS Elective Essay Prize, the Peter G Jones Elective Essay Prize.

He envisaged his PhD history thesis *With Men for Pieces – A Documentary Life of Rui Lopez Circa 1520-1594* not only as a mystery book, but also as a film with a splendid cast of his choosing. Sadly, Peter was not to see these two projects to their final stages – with the onset of his last illness his innate skills faltered as he tried and struggled with computer programs, courageously and optimistically keeping his laptop close by as he planned the re-writing of the thesis into a book.

Peter's diverse interests and responsibility required versatility and disciplined thinking. When I was first working with him on the early editions of *Chiron* I would go over to the Royal Children's Hospital so that he could proof-read in between busy operating and consulting sessions. He would walk cheerfully into his office and point to various bits and pieces on his desk – usually about heraldry – give me something to read, sit down and say 'now I will turn my mind to literals' – and would do so until the task was completed in time to warmly greet the next tiny patient. It was Peter who taught me that 'a paragraph should sing'.

He nurtured his special interest in heraldry and derived great pleasure from his contact with the members of the prestigious English College of Heraldry. It was fascinating to listen to him talking about which hospital's coat of arms was 'proper' and which 'improper'. He designed the 'proper' coats of arms for the Royal Children's Hospital, the Australian College of Paediatrics, the Australian Association of Surgeons and the Medical Defence Association of Victoria. He also designed several neckties using these coats of arms which are worn with pride by many practitioners. Peter himself tied his neckties with considerable flair.

In retirement he decided to take on yabby farming and a tree seedling plantation at Mt Blackwood. There he built an award-winning country house, the landscape including a personally designed insect-proof gazebo, complete with desk and lamp, where

he would sit and read in the summer evenings. The delight with which he delivered his first batch of yabbies to a Kyneton restaurant would have been something to behold.

When he was too weak to stay at the farm, Peter returned to the family home in Rockley Road, South Yarra, where in his book-lined study, comfortably rugged up on his couch, a 'soppy' Labrador beside him, he would receive visitors as his family popped in and out keeping an eye on him, his smiling

face occasionally disappearing in a cloud of cigarillo smoke. He loved to philosophise, to discuss the future of medicine and of *Chiron*. He read a little, wrote a little, never complaining, not even to his family, and was always optimistic. It was with great courage that he attended the Fifty Years Reunion of the 1945 graduates at the Melbourne Cricket Club just two weeks before he died.

During these weeks Peter and Julie and the family crafted his funeral service. It was a memorable occasion, the church was

packed and some stood outside in the garden. His peers spoke of him as colleague and friend. With courage, courtesy and generosity, Julie and the family each shared their stories of Peter as husband and Peter the father. They recited their own poetry, they sang together, and as the service ended Peter was carried out to a rousing rendition of the Welsh National Anthem. It was indeed a grand and fitting farewell.

Maggie Mackie  
*Chiron*, 1983-95

## MAGGIE MACKIE *Chiron*, 1983-1995

ON 30 JUNE 1995 Maggie Mackie retired from her position as Co-Editor of *Chiron*. This was a significant departure for the School of Medicine as *Chiron* without Maggie seemed inconceivable.

*Chiron* first appeared as 'The 1983 Newsletter of the Melbourne University Medical Society' [sic] and was a slim fifteen pages. Peter Jones was the Foundation Editor and Maggie Mackie Assistant Editor and Designer. Peter supplied the name *Chiron* – a centaur from Greek mythology, distinguished for his knowledge of plants, medicine and divination, and the tutor of Aesculapius. Peter's explanation was accompanied by an illustration of a centaur – a mythical creature with the head, arms and torso of a man united with the body and legs of a horse. Maggie drew the elegant centaur on the front cover which has become the established emblem of *Chiron*. Over the years *Chiron* became the 'Journal of the University of Melbourne Medical Society' and grew in size, distinction and quality. Much of this development was due to Maggie Mackie.

By 1988 *Chiron* was sixty-four pages in length and carried reports of the 125th Anniversary of the School of Medicine and the Centenary of women entering the medical course. Its importance as an historic record for the School of Medicine and a source of information for medical alumni was well established. Maggie's role in the journal increased as she became Associate Editor and, in 1990, Co-Editor alongside Peter Jones.

Contributors to *Chiron* have been grateful for Maggie's highly professional editorial skills. She brought to *Chiron* a sense of balance and proportion, never losing sight of the whole, even when absorbed in the fine detail of specific articles. Maggie remained sensitive to the importance of the overall tone of a written work, and could even 'cheer things up' if needed with a little skilful editing. Equally important to her was the accuracy of factual information, and many days and weeks were spent checking information supplied.

Maggie's creative skills have been a great asset to the School of Medicine. In addition to the *Chiron* emblem she designed an

emblem for the 125th Anniversary of the School of Medicine, this time representing the portico of the first medical school building. Later on she adapted this image, entwining the sacred snake of Aesculapius around the columns, to produce the emblem of the University of Melbourne Medical Society.

To the office Maggie brought warmth, humour and a concern for those around her. She signed her office notes with a cartoon self-portrait and, at least on one occasion, included a rocket to expedite delivery. She took a lively interest in the contributors to *Chiron*, many of whom she visited to discuss problems or to explain what she hoped to achieve with what they had done. All correspondence was answered personally, often in her own fair hand.

Maggie's working life was structured around the demands of raising three sons and caring for her elderly parents. Her nurturing skills extended to the writers and staff involved in *Chiron*. She also worked closely with photographers, typesetters and printers. Maggie's exceptional commitment to all she does, and her capacity to care for those around her have been evident to her colleagues for whom she has become a good friend.

A talented artist, she has illustrated a number of books including *Yancannia Creek* with Molly Turner Shaw, MUP 1988, *Let Them Dance* with Laurel Martyn, OBE, Dance Books, London 1985, *Berwick – Some Aspects* with John Wells, Shillington Press,



Melbourne 1980 and, in that same year *Islands and Beaches – Discourse on a Silent Land: Marquesas 1774-1880* with Professor Greg Denning, Department of History, University of Melbourne, MUP.

Apart from these publications she has devised, edited and designed many newsletters, reports and bulletins for government authorities and associations including, again with Peter Jones, *Defence Update* (MDAV). She has drafted garden plans for Professor Carrick Chambers and research diagrams, illustrations and teaching material for Professor Ian Darian-Smith. She has been an administrative assistant, an executive officer, a secretary at UNICEF headquarters in Jakarta, Indonesia, and secretary to Professor R M Crawford, Department of History, the University of Melbourne.

Maggie recalls, however, with a far-away look in her eyes, that her most exciting role was as secretary to Edouard Borovansky when she was an aspiring young ballet student in the late 1940s – those *were* the days!

At her farewell party there was a family atmosphere – with members of her own family present as well as her extended 'professional' family.

Maggie set high standards for *Chiron*. She remains as an editorial consultant to the journal, though we all miss her constant involvement.

Although retired from editing *Chiron*, Maggie plans to continue a very active life, spending more time with her grandchildren and pursuing her painting and drawing. We wish her every enjoyment in this and thank her for her major role in establishing *Chiron*.

HA & RO

The success of *Chiron* is due largely to the dedication and dynamism of Maggie Mackie. From the beginning, Maggie was the driving force and energy behind *Chiron*, generating ideas, following up leads, pulling all the loose ends (and slow authors) together, and ensuring that what we produced was of the highest quality. Maggie, thank you for your legacy of excellence. We salute you and wish you well in your retirement!

Graeme Ryan

SEMINAR

28 JULY 1995

CARING FOR THE SEVERELY DISABLED OR DYING CHILD

Convener

Professor Richard Smallwood  
Professor of Medicine, The University of Melbourne  
Austin & Repatriation Medical Centre

DOCTORS' EXPERIENCES

*The New Baby*

Dr Neil Campbell  
Director, Department of Neonatology  
Royal Children's Hospital

*The Older Child*

Professor Frank Shann  
Director, Intensive Care Unit  
Royal Children's Hospital

*The Child with Cancer*

Emeritus Professor Arthur C L Clark  
Foundation Professor of Paediatrics  
Monash University, Chair, Ethics Committee  
Royal Australasian College of Paediatrics

DISCUSSION

THE EXPERIENCES OF OTHERS

*Working with Families*

Mrs Margaret Loughnan  
Haematology/Oncology Social Worker  
Royal Children's Hospital

*A Parent's View*

Mrs Helen Nihill  
Parent

DISCUSSION

ETHICS AND THE LAW

*Can Ethics Guide Us?*

Professor Don Chalmers  
Professor of Law, University of  
Tasmania, Australian Health  
Ethics Committee of the NHMRC

*Should We Change the Law?*

Associate Professor Loane Skene  
Associate Professor, Law School  
The University of Melbourne

DISCUSSION

## CARING FOR THE SEVERELY DISABLED OR DYING CHILD

## INTRODUCTORY REMARKS

PROFESSOR RICHARD SMALLWOOD



PROF RICHARD SMALLWOOD

**W**E LIVE IN A SOCIETY and in an age which has little experience of death and dying in childhood. Many of us have never known a death in the family, or, if we have, it was someone who had reached old age and whose death we eventually accepted as the natural course of things. We are not well prepared, as individuals or as a society, to confront the issues with which a child's terminal illness, or catastrophic injury or disability, presents us.

In Victoria we are very fortunate in the resources and expertise that can be brought to bear in the care of these children. In those with cancer, for example, there are teams of skilled medical and nursing staff to provide clinical care, and social workers and other carers to help support the patient, the parents and family. But even with the best planned management and most devoted clinical teams, desperately hard decisions have often to be made, and the burden on families and carers is sometimes overwhelming.

Questions of life and death are perhaps thrown into sharpest relief in the very young. Medical care for the newborn baby is nowadays a highly skilled and sophisticated exercise, and many lives can now be preserved where previously nothing could be done. But babies do die, and some of those who survive do so with grave handicaps. They may live on for many months or years with such a degree of disability that most of us would conclude that treatment had been harmful. Of those babies who die, many do because a decision has been taken to withdraw treatment.

In recent times there has been a deal of publicity in England about a young boy who had a severe congenital heart defect, and who required heroic surgery just to stay alive. After the surgery it became clear that he had suffered brain damage, was blind and that nothing more could be done. He now faces perhaps months of increasing breathlessness and distress, and his parents have asked if it is not possible, when his distress becomes too great, that something might be done to bring that distress to an end. This poignant story encapsulates some of the most difficult moral, legal and practical questions that we would ever be called upon to answer.

Who should be making these life and death decisions, and should they be supported by the law? Can the ethicist decide the issues for us?

During this seminar we will try to come to grips with some of these questions, to consider what currently happens, and to explore how we might perhaps do things better.

## DOCTORS' EXPERIENCES

## THE NEW BABY

*When care cannot cure: withholding life-sustaining treatment from seriously ill babies*

Dr Neil Campbell



DR NEIL CAMPBELL

**N**EWBORN INTENSIVE CARE is, overall, a joyous and rewarding endeavour. Most babies are admitted with diseases that can kill or maim, and yet most go home, and return to follow-up clinics brimming with life and mischief. A few are not so fortunate. In 1993, 217 Victorian babies (3.4/1000 live births) died before their first birthday from conditions determined at birth. Others survived intensive care, but with serious handicaps – brain damage, mental deficiency, spasticity, deafness or blindness, or life-shortening chronic ill-health.

Increasing skills and new technologies have reduced mortality dramatically in recent decades. New technologies include more sophisticated mechanical ventilation, surfactant and other new drugs, better anaesthesia and surgery, extra-corporeal membrane oxygenation (external heart-lung machines), and total intravenous feeding. For most sick babies, technology is a great blessing. It ensures survival and a reasonable life for those who previously would have died. For a few though, it only delays death for days, weeks, or months, or else ensures survival but with severe handicaps.

Because of these potential harms life-sustaining treatment is from time to time withheld or withdrawn, and babies die. It is hard to know how often this occurs. Practices probably vary from hospital to hospital in arbitrary ways, and people are reluctant to discuss these practices in public since they may be illegal. Nevertheless, we at the

Royal Children's Hospital have reported that seventy-six per cent of deaths in our neonatal unit followed withdrawal of life-sustaining treatment and that most of these babies might have lived if all available treatments had been offered. Another major Victorian centre, managing a patient population different from ours, has reported that sixty-four per cent of deaths in its neonatal unit followed treatment withdrawal, although in about half of these babies death was thought to be imminent anyway. Accurate State-wide figures are not available but it is reasonable to believe that at least sixty babies die each year in Victoria because treatment is withheld or withdrawn, when, with all available treatment, they might have survived.

The legality of withdrawing life-sustaining treatment from babies is unclear. Parents and doctors have a duty to care and no-one has a right established by law to make decisions which result in a baby's death. There is legal opinion that we are not obliged to continue treatment if death is 'inevitable', or if treatment is 'futile' (which presumably means the same thing). But with modern technologies the only situations in which it can be predicted with a degree of certainty that 'death is inevitable' or 'treatment is futile' are extreme immaturity (fetuses born alive at less than twenty-three weeks gestation, more than seventeen weeks early) and a few very rare birth defects. For all other babies who die, that their death was 'inevitable' can only be claimed after death has occurred despite the skilled application of all available technologies. That 'death was inevitable' is a retrospective judgment. It cannot be used with certainty in life as a basis for deciding not to treat.

Thus the criterion which the law appears to accept as a reason for withholding treatment – that 'death is inevitable' – seldom, in reality, exists (except in extreme immaturity and rare birth defects).

For many babies, high technology care can mean days, weeks, or months of arduous treatment. During these weeks or months quality of life can be very poor, with pain, fear, and social and emotional isolation. At the end, some may survive, some may die. Of those who survive, some may have poor quality of life thereafter because of severe handicaps, or chronic ill-health.

It is for these reasons – the prospect of weeks or months of poor quality of life under intensive care with likely (but not certain) death at the end, or else the prospect of survival with a very poor quality of life – that treatment is most often withheld or withdrawn.

The clinical situation in which legal opinion is clearest and virtually unanimous in advising us we have no obligation to treat, is the management of anencephaly – babies born with most of their brain missing, who are without conscious awareness. Why is legal opinion so clear and uniform in this situation? Observers need no special knowledge and little imagination to see such babies are profoundly abnormal. There is no skull above the eyebrows and ears; the top of the head is thus open and the lack of a brain is visible to all. Certainly all such babies die within hours or days. But it cannot be claimed as established fact that their death is 'inevitable'. I have little doubt that if we applied all available technologies, including mechanical ventilation, and surgery to close the head, we could achieve long-term survival in many anencephalic children.

Of course no-one advocates such measures, but this is not because death is inevitable: rather it is because we make judgments about the quality and value of their life should they survive. And yet the law does not appear to sanction decisions to withhold treatment when they are based on judgments concerning the quality or value of a baby's life.

*Rather than needing the law's protection from an uncaring, indifferent society, these babies need legal protection from uncaring, indifferent technology.*

More complex legal and moral dilemmas arise in babies with hydranencephaly. Like babies with anencephaly most of their brain is missing, but unlike anencephalics they have a normal looking face and skull – to the lay observer they are attractive infants. Although never aware, they can live for years. They seldom need high-technology life-support, but most require artificial stomach tube (gavage) feeding because they cannot suck or swallow, at least in the early weeks of life.

Death is not inevitable if tube feeding is provided, but quality of life is no better than that of anencephalics. If we are not obliged legally to provide life-sustaining treatment to anencephalics, surely we are not obliged to provide tube feeding to babies with hydranencephaly?

I have claimed that there is lack of support from the law for decisions frequently made by parents and doctors to withhold life-sustaining treatment from very sick babies when these decisions are based on judgments concerning the likely quality or value of the baby's life.

Over the centuries the law has evolved a strong protective role towards the newborn. This has been because, from time to time, societies have been surprisingly indifferent to infant well-being. But in the last three decades high technology has changed the legal needs of those babies who have little hope of a life with reasonable quality, or who have a high (but never certain) likelihood of dying despite weeks or months of arduous intensive care. Rather than needing the law's protection from an uncaring, indifferent society, these babies need legal protection from uncaring, indifferent technology.

The law, in recognition of these changed circumstances, should be changed. Parents and doctors should be given the legal right to withhold or withdraw life-sustaining treatment when death is very likely despite all care, or when quality of life with survival will be unacceptably poor.

Many will remember that in 1988 St Vincent's Hospital announced that a thirty-nine year old woman, paralysed by motor neurone disease, but conscious and intelligent, had requested that her mechanical ventilator be turned off. Her request was respected and she died. At the same time the Medical Treatment Act passed through parliament formalising the legal right of adults or their agents to refuse life-sustaining treatment.

Similar legal rights are still not available to the newborn. Consider a baby with the neonatal equivalent of motor neurone disease. Such a baby is partially paralysed but fully awake and aware. Placed on a mechanical ventilator after birth because breathing is inadequate, it can take up to six weeks to establish the diagnosis.

Babies with this diagnosis not offered all available technology die quickly. Kept on the ventilator, and offered other technologies such as salivary diversion, a baby with this condition might live one or two years or even longer. We don't know since no-one has tried. If we did try the baby would have periods of happiness and would learn what it is to love and be loved. On the other hand, there would be periods of pain and fear and the baby would express rage and frustration at the things being done.

So with the parents we decide to withdraw treatment. We know the baby could suffer hours of inadequate breathing with panic and fear when the ventilator is stopped. The only way of preventing this in *any* aware baby from whom we are withdrawing treatment is the administration of morphine.

Babies are far more sensitive than adults to one of morphine's side effects – arrest of breathing. In sick babies we know that a dose of morphine sufficient to relieve distress will also stop the baby's breathing as it is given and thus be the direct cause of death, whereas without morphine they will struggle on alive for hours.

When treatment is withdrawn from such babies everyone – parents, doctors, and nurses – hopes fervently the baby will die quickly and without distress. So, with the knowledge that this baby could possibly live a year or more if we continue the ventilator but if we stop he will die soon; in the knowledge that, without morphine, he may struggle for hours before dying, but morphine will cause him to die at the time it is given by stopping his breathing; and with the intense hope that he will die as quickly and painlessly as possible, the morphine is given and the ventilator is switched off.

In what meaningful ways does this differ from active euthanasia? In asking this question I am not advocating active euthanasia. Rather I am trying to indicate how reality differs from theory in the care of sick babies. We do 'kill' this baby, and we 'want' him to die, but analysis is not helped by arguing over notional distinctions between 'active' euthanasia and 'passive' euthanasia, nor 'intention', and 'motive'.

## THE OLDER CHILD

### *Limitation of treatment of children in Victoria*

Professor Frank Shann



PROF FRANK SHANN

and treatment is more likely to be withdrawn in children who have an underlying chronic disease.

Medical treatment may be withheld or withdrawn because death is about to occur anyway (and treatment is just delaying death), or the patients (or their parents) do not want further treatment because, even if the patient did survive, they would have such a severe handicap that life would be intolerable. In both these circumstances, it is not in the patient's best interests that treatment be continued. There is another reason why some treatments are withheld or withdrawn: the benefit from the treatment does not justify the cost. I will briefly discuss these two quite separate, but related, issues.

### **Treatment that is not wanted**

In recent years, the law has given increased emphasis to the rights of the child rather than the rights of parents; in most situations, this is entirely appropriate. However, because of our zeal in protecting the rights of children, we have ended up denying them a most important right – the right not to be kept alive when this would result in intolerable suffering.

*There is an urgent need for more rational public debate in Australia about what medical care we should and should not pay for, so that these decisions are made openly and in a systematic way.*

In the past, when medical treatment was stopped because it resulted in intolerable pain or suffering, the legal position of the patient, the patient's family and the doctor was equivocal. Because this uncertainty was undesirable, the Victorian Medical Treatment Act was passed to give an unequivocal legal right to adults over eighteen years of age and of sound mind to refuse treatment. In Victoria, an adult now has the right to refuse treatment for any reason, including considerations of quality of life.

This right is denied to people who are less than eighteen years old. When the Medical Treatment Act was being developed, children were excluded because young children are not competent to make decisions about refusal of treatment, and because it was not clear who should make such decisions on their behalf. Although adults can refuse treatment because their life would be unbearable, uncertainty persists about the legal situation when the patient is a child.

This is not an abstract academic issue. Recently, legal advice was given that mechanical ventilation could not be withheld from newborn babies with primary alveolar hypoventilation, even if survival were possible only with continuous mechanical ventilation day and night for the rest of the patients' life.

I suggest that parents should legally be able to make a decision on behalf of their child that medical treatment (other than palliative care) should be stopped. The purpose of this is to prevent children suffering unnecessary pain and distress. It would give clear legal sanction to the option, in certain circumstances, of discontinuing burdensome treatment.

Parents should have the legal right to refuse medical treatment on behalf of their child if:

- a) the parents and the treating doctor agree that such a course of action is in the best interests of the child, and
- b) a specialist doctor, who is not involved in the child's care, agrees with the proposed course of action and is satisfied that the parents have been fully informed of the medical facts of the case.

Similarly, in the current discussion about euthanasia, it is important that we do not neglect the needs and rights of children. For example, children are excluded from the provisions of the Northern Territory euthanasia legislation.

### Treatment that is too expensive

Every day in Victoria, and in every country in the world, treatment is rationed because it is too expensive. However, this is not often acknowledged, and there is a widely believed myth that all treatments are available to all Victorians. For example, we do not provide an artificial heart for every child who is dying because he or she has been born with an abnormal heart – this treatment costs about \$4000 a day, and it would only keep the child alive for a few weeks. Rationing is probably even more common in adult practice, where, for example, very few adults have access to an artificial heart.

The marginal benefit from medical treatment becomes infinitely small (and therefore infinitely expensive) before it turns negative – if it confers minimal benefit, even a simple treatment is very expensive in terms of dollars spent per year of life saved. Providing all possible care would result in us spending a million dollars to prolong a patient's life by one day. The issue is not *whether* we should withhold potentially beneficial care, but rather *which* care we should withhold, and *who* should decide where we draw the line.

Our community makes an irrational distinction between preventive treatment and curative treatment. There are strong legal

and social pressures to provide treatment that will keep a patient alive, but it can be very difficult to obtain money to prevent people becoming ill. For example, it costs five to ten million dollars to ventilate one child with high quadriplegia for fifty years (and the patient remains completely paralysed from the neck down), but with five million dollars we could vaccinate every baby born in Victoria over a three year period against hepatitis B (a disease that kills about 1200 Australians each year). Joseph Stalin said, 'A single death is a tragedy; a million deaths is a statistic'.

Unfortunately, debate on this issue is at a very primitive level in Australia. There is general recognition of the need to limit medical costs, but little recognition that there is already widespread rationing of medical care, and that cost is often an important component of decisions to limit treatment. This means that rationing of health care in Australia is haphazard and arbitrary, and it is often clandestine.

In the public hospital system in Victoria, we ration care by limiting the resources available to hospitals, and leave it to individual hospitals and doctors to sort out who gets what. This system has been described as 'muddling through elegantly'. It is preferable to rationing treatment by using the patient's ability to pay for it, as is often the case in the United States, but it would be better if there were public debate about which treatments are to be rationed.

I stress that I do not object to the fact that we have rationing of health care – rationing is necessary and desirable. I am not even objecting (much) to the way we ration care. What does worry me is that we do not admit that there is rationing – we cannot say that a given patient did not get a particular treatment because it would have cost too much.

There is an urgent need for more rational public debate in Australia about what medical care we should and should not pay for, so that these decisions are made openly *and in a systematic way*.

### Conclusion

In Victoria, we adults have given ourselves the right to refuse burdensome medical treatment, but we have not given this right to our children. I suggest that it should be legal to withhold a treatment from a child if the parents and the doctor agree that the treatment is not in the best interests of the child. There also needs to be more informed public debate about how we limit treatment that is too expensive.

### THE CHILD WITH CANCER

**Emeritus Professor Arthur C L Clark AM**

**C**ANCER IS AN EMOTIVE subject. One in five of us die from it; over eight thousand each year in Victoria. In contrast, childhood cancer is uncommon.

### Changing trends



EMER PROF ARTHUR CLARK

My first contact with a child with cancer came in 1950, when as a medical student I saw a boy with leukaemia receiving chemotherapy. At that time, all those children, and most with other forms of cancer, died from their disease. A measurable decline in mortality from most types of childhood cancer commenced between 1960 and 1965, and today more than seventy per cent are cured.

For those who do not survive, there has also been a change in the choice of the place of death. Until the mid-eighties, most families chose death in hospital. In 1995, probably most choose for their child to die at home.

	Australia	Victoria
Annual Incidence	440	120
Annual Mortality	130	30

Table 1 – Children with Cancer.

*. . . even quite young children know when they have had enough.*

### Current experience

The death of a child at home exposes an unfortunate consequence of current management of childhood cancer. Reviewing all children's deaths from cancer in Victoria for the last decade, I note that almost without exception these children have been treated in the paediatric oncology units at the Royal Children's Hospital or Monash Medical Centre. No doubt this is a major factor in the excellent survival figures in this State which rank with any in the world. There is an intention that treatment will be in cooperation with the family doctor, and sometimes with a regional paediatrician. But there are a significant number of children dying of cancer who have no doctor close to their home who is familiar to them and well informed about their management.

When a family doctor has been closely involved and there are local palliative care resources, including nurses familiar with the needs of children, death at home in the care of the family appears to me to be the best outcome. All too often this is not the situation. When it becomes apparent that the hoped-for cure is not to be expected, attempts are made to establish such a team locally, but without a longstanding and trusting relationship between local caregivers and the family, a common outcome is that the child is readmitted to hospital, often after a distressing breakdown of the planned arrangements.

There is clearly a need for better planning, but with the decline in availability of general practitioners around the clock, the growth of locum services and the twenty-four hour clinic, ideal arrangements can be difficult to achieve. Some have seen this as indicating a need for hospice care for children, and plans are in place for such developments in New South Wales and Victoria. For the time being, the oncology units and many regional hospitals are still able to provide hospice-type care for the dying child and the family, but changes in hospital funding arrangements are likely to make this option less available.

### Types of malignancy

New Cases Per Year (Victoria)	
Leukaemia	42
Brain tumours	24
Lymphoma	12
Neuroblastoma	9
Wilms' tumour	7
Soft tissue sarcoma	6
Bone tumours	5

Table 2 - Types of Malignancy.

The commonest childhood cancer is leukaemia in all its forms, with about forty new cases per year in Victoria. Despite an expectation of cure now around seventy per cent, there are still more children dying from leukaemia than from any other cancer. A recent study of experience in the United Kingdom found that survival following a decision to discontinue attempts at curative treatment averaged just over two weeks, and this would accord with local experience. The same would apply to many others of the rapidly growing tumours of childhood, but there are many exceptions where survival may be prolonged for many months, and skill is required in the use of palliative measures, particularly pain control and management of bleeding.

The most difficult group are those children with tumours of the brain. These are second to leukaemia in frequency (about twenty-five new cases per year in Victoria) and many are refractory to treatment. Because such tumours are often slowly growing, the child may be disabled for months or even years by slowly progressive symptoms. This protracted course makes their care more akin to that of children with a number of non-malignant disorders, such as cystic fibrosis, muscular dystrophy and degenerative neurological disorders. The management of children with all these uncommon conditions tends to be on the advice of specialists who become very expert in some aspects of their care, but not necessarily in care of the dying, and the advent of palliative care teams has been of the greatest help in terminal care.

### Conclusion

There are many problems in the care of the dying child which cannot be resolved by any amount of planned management or systems of care. These are the individual judgments that depend on established trust between the child, the family and the medical team. Looking back on my own experience, the bad times have been when there were conflicts between parents over their wish to continue or not to continue treatment, and worse still when the conflict was between parent and child. Fortunately, society in general and the law in particular has shown little interest in intruding into this field, in contrast with the experience of previous speakers.

Asking myself what would I do differently if I were starting again today, I would make greater efforts to respect the autonomy of the child; even quite young children know when they have had enough.

### DISCUSSION



### Doctors' Experiences

A member of the audience stated that he found definitions of euthanasia, as presented in recent public debate, very confusing. Dr Campbell's description of a baby being given an injection of morphine as life support was withdrawn was, he believed, one step back from true active euthanasia. He asked Dr Campbell if he could give a definition of the different forms of euthanasia. Dr Campbell replied that he was not advocating active euthanasia but trying to demonstrate that the area is so grey that clear differences between passive and active euthanasia don't exist in many clinical situations.

Professor Smallwood asked Dr Campbell to comment on parents' difficulties making decisions in these situations. Dr Campbell commented that although parents may be overwhelmed by their baby's illness, they can still be very good decision makers. When dealing with babies where this sort of question may arise, the practice is to introduce the possibility of the need to withdraw treatment early in the course of the baby's illness to give parents time to prepare. Parents are also encouraged to involve as many other people in making a decision, and seek as much support as they think will be helpful.

A member of the audience noted Dr Campbell's estimation that over sixty babies a year die as a result of treatment not being offered or being withdrawn and asked if cost would be a reason for non-treatment. Dr Campbell indicated that cost has not been a

consideration he has needed to use when making a decision whether or not to withhold treatment from a baby. Costs are, however, taken into account in situations where neither research is done nor technology developed to treat illnesses where no-one believes the resultant quality of life would be worth the costs involved. Professor Shann commented that death is inevitable for us all and three variables – cost, length of survival and quality of life – are balanced against each other when deciding what treatment to offer. Cost is never the sole consideration in deciding treatment, particularly in paediatric practice.

A member of the audience proposed that the community, through the Guardianship Board, should be involved in making these decisions. Dr Campbell noted that one of the reasons for speaking in public about these matters is that he and colleagues were asking for help in making these decisions.

## THE EXPERIENCES OF OTHERS

### WORKING WITH FAMILIES

#### Mrs Margaret Loughnan



MRS MARGARET LOUGHNAN

**B**ECOMING A PARENT is a unique experience. Becoming the parent of a dying child is a *painfully* unique experience.

Because of major advances in modern medicine, our society generally expects that death should be synonymous with old age. In fact, there are many young adults today who have never experienced death in their own immediate family circle. So when a child dies, there is often no role model for how to behave, how to act, what to feel, or what to do. In this paper I will emphasise the

professional care we should provide for families during their hospital crisis. That is, care which aims to prevent future grieving responses being unnecessarily prolonged by perceptions of adverse hospital experiences.

Medical problems and complexities surrounding death in children can be highly variable. Imagine the following three scenarios:

- 1) Peter is hit by a truck in front of his home and rushed to intensive care with major head injuries and fixed dilated pupils. Brain death will be diagnosed and a request for organ donation will be made.
- 2) A woman delivers her only child Matthew. He has dysmorphic features, and a diagnosis of trisomy 18 with a lethal cardiac abnormality is made. Physicians discuss with parents the possible need to withdraw intensive support.
- 3) Diagnosed with acute lymphatic leukaemia at four years, and following her second relapse, seven-year-old Sarah has an unsuccessful bone marrow transplant. Death is imminent.

Each of these situations is different in terms of their medical complexities, and certainly the immediate family responses to each situation will vary, depending upon the cause, the timing, or the surrounding circumstances. However all three families have something in common: their child is dying. They will also all experience profound loss in many forms, such as:

- Loss of part of themselves, and their future.
- Loss of a fantasy: 'Peter could have been a ruckman for Collingwood'.
- Loss of esteem: 'I failed as a parent'.

Each will also embark upon a life-style which will become dominated by the peculiarities of individual grief.

### How should we provide crisis support to families?

Any acute admission to hospital is generally associated with fear of the unknown. This can be particularly striking in a busy intensive care environment, where unfamiliar surroundings accompanied by unfamiliar medical language, can enhance anxiety and fear.

*... our smallest action or word  
can create lasting perceptions  
which can influence how a  
family effectively learn to live  
with the death.*

However, in order to appreciate our responsibility to these families in crisis, it is important to note the study of Raphael (1977). This suggested that a family's perception of the level of 'supportiveness versus non-supportiveness' received during their hospital crisis, can lead to adverse effects on future grief. And this would seem to be particularly relevant in cases of sudden, unexpected death, as reported by Nixon and Pearn (1977).

At the Royal Children's Hospital we adopt a team approach to management. The medical needs of the child are correctly the focus of the medical and nursing staff, while the social worker is directed toward the needs of parents and family.

This intervention should not be an intrusion, but rather be a support for:

- Firstly, the *practical needs*. A cup of coffee; a pillow to rest on; assistance to contact family and friends, or perhaps a chaplain; encouragement to bring siblings to the hospital.
- Secondly, the *advocacy needs*. Have they actually heard or understood the seriousness of the information given? Do they need more or repeated information, even though the doctor may believe that he/she has adequately discussed the situation with them several times?
- Thirdly, the *emotional response needs*. The family need to be heard. They need someone to listen as they tell their story of events, often in a desperate attempt to make some sort of sense of their tragedy.

It is also important to *assess risk factors* in family dynamics or individual vulnerabilities, which in themselves could adversely affect future grief. And if these exist, we are alerted to the possible need in the future, for closer bereavement follow up.

### Talking to Parents

Talking about death to parents is never easy. We can see the look of anguish on their faces, and this in turn can cause us, even unconsciously, to have feelings of discomfort. Consequently, our need to 'get it said', may result in us communicating uncertainties or ambiguities by using confusing words such as: 'we lost the battle', 'he fought a good fight', 'we did our best' and so on, without the word *death* ever having been mentioned!

This word *death* does shatter even remote illusions of hope and is usually received like a blow to the stomach. It is not necessary and is often inappropriate, to give complex explanations at this tense time. In fact, it has been stated by Rappaport and Jellinek (1990), that if you have spoken for more than three to five minutes, you have probably said too much.

We need to leave the family alone to cry and cuddle together, to allow private time for even semblances of reality to become apparent. You can always return later when the family are more emotionally prepared to receive information.

The future, normal grief responses can often become frightening, confusing and isolating, because we live in a society where role models for grief rarely exist. Therefore it is useful to 'preview' the normal grief responses which the family may experience in the many months ahead. For example they may:

- see, or hear their child call out to them;
- become unusually attached to toys or articles of clothing;
- possibly experience fleeting, yet unfamiliar suicidal thoughts;
- or they may hear comments and reactions from friends and acquaintances which can be hurtful, unsupportive and certainly unexpected.

## The dying process

From my experience I believe it is beneficial, for the long term well-being of the family, for them to be with their child at the time of death. When families say 'I'd rather remember her the way she was', I believe such comments are, often understandably, related to fear of the unknown. Because if we think about it, the *last* memory of their child may be in intensive care covered with tubes. Or particularly in the case of brain death, their last memory may be of *seeing* the chest movement, *feeling* the body warmth, and *hearing* the heart monitor of their child – all of which are recognisable signs of life. This alone can confuse future grief.

Therefore, words we use are important. To ask a family if they would *like* to be with their dead or dying child would seem to be inappropriate and incomprehensible to me. Yet reality is usually much kinder than fantasy. For example, a future fantasy in grief, can often become a haunting fear such as, 'I can't believe she was really dead' or 'did he need me to be with him?' and so on. Therefore after having the reasons for doing so explained, the family can be asked if they *will* be with their child. From my experience no family has ever regretted having done so.

## The chronically ill child

Time does not permit me to adequately discuss the importance of open communication with the dying child. Suffice it to say, the oncologist Pearson (1991) suggested that twenty years ago it was the exception for a child to know that he or she had cancer; today it is the rule. Although it hasn't as yet become a rule to tell a child he or she is going to die, thankfully this too is becoming increasingly common.

I have noticed that the culture of modern parenting is generally, to communicate far more openly with children than in years gone by. Therefore, perhaps our role should be to help the family maintain this culture of open communication, even at such a difficult time. Certainly, as Pearson believes, the benefits of open communication far outweigh the isolation from silence or denial: parents living with the constant fear of when, how, or if, the child may ask the difficult question, 'Am I going to die?'.

Also, open communication can maintain trust between the whole family, who are then in a position to unite in giving and receiving strength, not only with the child, but also with each other. And importantly, as Mercer (1994) indicated, a better future psychological adjustment in remaining family members is evident where communication has not been impeded.

## Summary

Working with families of dying children is not easy. Even with all the expertise and knowledge we continue to accumulate in this area, we will always have things to learn. But we should remember that our smallest action or word can create lasting perceptions which can influence how a family effectively learn to *live with* the death, for as Pearson suggests, a family should never be expected to 'come to terms with' or be unaffected by the death of their child.

We need to acknowledge, listen to, work with, and continually learn from the families in our care.

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## A PARENT'S VIEW

### *It's a Rough Ride – Hang on Tight*

Mrs Helen Nihill



MRS HELEN NIHILL

**I** WISH TO SHARE with you our experience of caring for a dying child. We were a family of ten and it was Michael, the youngest of our eight children who, at the age of almost six, was diagnosed with Acute Lymphatic Leukaemia.

For twenty years we had lived and worked at various locations in country Victoria. Our home was always open to people. During these years we made many friends and acquaintances. As a family we were actively involved in community, sporting bodies, school and parish

life. We maintained a love and strong bond with each other – had a firm commitment to our family, to our friends and to our faith.

Sudden and emotional changes engulfed us; a life-threatening illness affects not only the sick child but the entire family. Mike was our priority but the needs of his brothers and sisters were also uppermost in our minds. We were adamant that any medical or appropriate information would be conveyed to the family by either my husband Terry, or myself. We were frank with each other, and reassured Mike that, where possible, we would be with him during treatment, medical procedures and hospitalisation. Where practicable he was accompanied individually or by the entire family. On such occasions as these we found the Royal Children's Hospital haematology/oncology unit most professional in their dealings with us. Having been part of this experience we valued their honesty and felt respected as a large family, because we are unique in today's society. When our eldest son wrote 'It's a rough ride – hang on tight' on a note to Mike, we knew that they certainly understood his plight.

*I believe parents know their children better than anyone else.*

Our priorities changed – we learned to take one day at a time. Mike adapted to physical changes, unbalanced weight gain and loss, the loss of hair and the emotional changes brought about by arduous trips to Melbourne, constant medication, treatment and the experience of hospitalisation. Considering each of these, the greatest effect on our son was the separation from his siblings.

The words 'Michael, you can go home' always put a smile on his face and a spring in many a faltering step. Home for him meant returning to a normal, natural environment. Just to be part of the daily happenings of home life – nothing too exotic but where his life-support was – brothers, sisters and his cousin and best friend Sam.

Our extended family rallied and helped maintain and keep the home front afloat. Friends and neighbours were always there for us. Acquaintances became firm friends. We received wonderful support in so many areas, but particularly from our local GPs, school and parish communities and our angel-in-disguise – his visiting teacher.

Rightly or wrongly our emphasis was on living and being positive. I believe parents know their children better than anyone else. The decisions we make for them in life fit their development and personalities, and so it was with Mike, any decisions, and they were numerous, were discussed as family and the input of the children valued. Mike was a positive child, adventurous, and had a great sense of humour – during his illness an almost Jekyll & Hyde personality developed. When hospitalised or experiencing treatment he was often quiet and subdued – brought about perhaps by the fact that when experiencing certain hospital treatment he asked for this to be explained to him, particularly things he could not clearly see. When this was adhered to, he was in control of his emotions, but, if ignored, he became frustrated and upset. At home he was a happy, mature, well adjusted child for his age despite a life-threatening illness.

The duration of illness was twenty months, and at the time this seemed to engulf such a huge portion of his short life. The previous five years seemed to pale into insignificance.

He underwent a bone marrow transplant which entailed a long period of hospitalisation and isolation. He was seriously ill on several other occasions but rarely complained.

Michael's final relapse was just three weeks before death.

We never spoke to Michael about dying. We have no regrets about that aspect of our caring. As family we had, in the twelve months preceding diagnosis, three close family relatives die. My mother and a sister-in-law with cancer and a brother-in-law through road trauma. Death and dying to us and Michael was very real and a part of life. Michael's brothers and sisters were aware of his impending death and normal family dynamics were maintained.

Just forty-eight hours before Michael died he insisted on going to watch his eldest brother play football. He was weak and tired but this was where the family were and he wished to be with us.

Michael died peacefully at home.

His courage was our strength.

His death has left a huge gap in our hearts and family.

The memories we treasure.

The loss we have learned to live through.

It was a rough ride but together we've hung on tight.

## DISCUSSION



### The Experiences of Others

A member of the audience asked how conflict between the wishes of the parent and the wishes of the child can be resolved in these situations. Mrs Loughnan told of an eleven-year-old child who had asked her to speak to her family . . . *because they were acting differently. She told me that she was dying. She knew she was dying but her parents wouldn't accept it. Her father . . . wanted her to have herbal medicine, her mother wanted to buy her lots of toys, her brothers were responding in different ways, and it was very, very sad indeed that she wasn't able to share what she wanted to. And I remember her words so clearly. She said, "Why won't they speak to me? I'm dying and it's no big deal".* Professor Clark commented that the way to manage is by talking, although even then it sometimes doesn't work.

An audience member shared her story of when, as a five-year-old child she supported her seven-year-old sister through leukemia. She noted that the feelings of the child are very much like the feelings of an adult faced with death. Children go through the same sort of grieving process, and being able to control your life is important when dying. She thanked Mrs Nihill for talking about the way her family helped her son deal with his daily life and live as normal a life as possible.

A member of the audience asked Mrs Loughnan to comment on how screening should be used to decide when and how to help families. Mrs Loughnan commented that the risk factors for families dealing badly with grief are probably the same for the death of a child as they are for the death of an adult. Although a family can appear to be well supported they may be experiencing major concurrent life crises such as the parents contemplating divorce, the recent death of another family member or another child in the extended family who is seriously ill. *My own view is . . . pre-warned is pre-armed, and why should we keep certain information to ourselves? Why not share this with the families? I think most people are intelligent enough to be able to understand what we are saying.*

Mrs Nihill was asked if she would recommend that all families are helped in predictable ways or left to their own resources and initiatives. She commented from her own experience: *Very early in Michael's diagnosis it was suggested to us to be honest with our children and we were. There were times when we brought great news home . . . Other times, when things weren't good, we still took that home and discussed it as family, and that certainly has helped us through his death and certainly with the grieving.* Mrs Loughnan noted that it can be a problem when assistance to grieving people is restricted to the professionals. Grief is not an illness but a normal phenomenon that all people go through at some stage. In a lot of situations, it may be the next door neighbour, the parish priest or the hairdresser who is the best counsellor for a family.

A member of the audience commented that medical students are taught to consider the family as well as the child and that it is important to consider the effect a terminally ill child or baby has on its siblings as well as its parents. She also noted that the Royal Children's Hospital has a bereavement group which welcomes parents back to the hospital after the death of their child.

A member of the audience talked about his experience with a death in the family, at a much later time in life, which confirmed Mrs Nihill's comments on the support given by their GP during Mike's illness. *In fact our GP was one of the best supports in every way, and he even came to see me after the funeral, just to make sure I was all right.*

## ETHICS AND THE LAW

### CAN ETHICS GUIDE US?

Professor Don Chalmers



PROF DON CHALMERS

I HAVE BEEN ASKED to make some, inevitably brief comments about whether ethics can guide us through the difficult and indeed depressing issue of caring for the severely disabled or dying child. It is entirely appropriate that we are discussing this issue in Victoria, a State with a distinguished record in the discussion of bioethical issues. It is hard to imagine that it is just over a decade since Professor Louis Waller completed his pioneering reports on artificial conception which were followed by the worlds first legislation in this area: *The Infertility (Medical Procedures) Act 1984*. Victoria has remained at the core of national and international debate in this area with the Monash University Centre for Human Bioethics and a distinguished host of knowledgeable contributors to the bioethics debate.

What we have been involved in is one of the most perplexing bioethical issues. In its strict sense bioethics is:

. . . the disciplined puzzling of people attempting to understand the significance of birth, copulation, illness and death, especially as these are touched on by health care and the biomedical sciences.<sup>1</sup>

However the expression bioethics has tended to develop a wider sense beyond ethical issues relating to birth and death. The term frequently embraces the following:

- informed consent (in the doctor/patient relationship and in the context of those without full capacity such as infants, the aged or the mentally disabled);
- reproduction (including artificial means of conception such as AID, IVF, surrogacy and the control of reproduction by methods such as sterilisation);
- research involving human subjects;
- allocation of resources in health and welfare areas;<sup>2</sup>
- active and passive euthanasia;
- mass screening;
- genetic research and therapy, and
- the ethical responsibilities of health professionals.

*The 'disciplined puzzling' in ethics on the issue . . . will not necessarily provide answers but it may help us to find better ways of dealing with this intensely personal family dilemma.*

May I express a note of caution. The 'disciplined puzzling' in ethics on the issue of caring for the severely disabled or dying child will not necessarily provide answers but it may help us to find better ways of dealing with this intensely personal family dilemma. The difficult thing with ethics is that there are no easy answers. At the Hastings Centre of Bioethical Research there is a plaque which reads: 'For every human problem there is a solution which is simple, neat and wrong'. Unfortunately, bioethics does not give right or wrong answers, conclusions whether something is ethical or unethical. Ethics is not an area for extremists, either 'modernists' (all experimentation must be permitted as knowledge itself will be increased) or 'fundamentalists' banning everything. It is a place where hard questions are asked and debated by those 'moral agnostics'<sup>3</sup> who watch the scientists and listen to religious views and hope to find an answer to it all.

As a community we have advanced by realising that many of the bioethical dilemmas facing the practice of modern medicine are not technical problems but ones which, as Professor Kennedy<sup>4</sup> has noted, involve profound ethical questions. In many ways, medical ethics has brought renewed vigour to the whole area of philosophy in general and ethics in particular.<sup>5</sup>

What are the ways in which the Australian community may debate the ethics in this area? I should like to take this opportunity to discuss the ways in which we, as a community, can address such questions.

### **Australian Health Ethics Committee**

Justice Michael Kirby was an early supporter of some form of permanent institution to tackle questions of bioethics,

otherwise, it will be the judgement of history that the scientists of our generation brought forth most remarkable development of human ingenuity – but the lawyers, philosophers, theologians and law-makers proved incompetent to keep pace.<sup>6</sup>

The Australian Health Ethics Committee was created by a union of the old Medical Research Ethics Committee of the National Health and Medical Research Council (NHMRC) and the National Bioethics Consultative Committee. The Australian Health Ethics Committee is still largely an experimental exercise in national bioethics. As its Chair, I probably have a conflict of interest in making any statement about its future.

The NHMRC having been established by Order-in-Council in 1937 was put under a new statutory framework with the passage of the *National Health and Medical Research Council Act, 1992*.<sup>7</sup> Only two of the principal committees were specifically mentioned within the terms of the Act. By Section 35 of the Act, the Minister must establish principal committees called the Medical Research Committee (MRC) and the Australian Health Ethics Committee (AHEC). During parliamentary debates, particularly those in the Senate, the composition and independence of the AHEC was established. First, AHEC must not have more than one member of the MRC of the NHMRC and its Chair must be a person who is not a member of the MRC.<sup>8</sup> Secondly, the constitution of and appointment of the AHEC was the subject of a specific section under which<sup>9</sup> a nomination system must take place from amongst peak bodies in relation to areas of expertise. The other key aspects of the Australian Health Ethics Committee are:

- the required two stage consultation process (submissions on an inquiry topic with a second round of submissions on any draft guidelines);
- nominated sub-committees with prescribed agendas;
- exclusive jurisdiction over guidelines in relation to medical research ethics;

- references from bodies other than NHMRC.

The AHEC met for the first time at the end of August 1991. Work since that time has included a case study of the legal and ethical implications of HTLV-I, report on the legal liability of institutional ethics committees, ethical considerations relating to health care resource allocation decisions, human gene therapy, workshops for institutional ethics committee members, and consultations on guidelines relating to in-vitro fertilisation and embryo transfer, privacy in medical research, women in clinical trials and the use of patient tissue samples for research.

### **Resource allocation: a case study in ethical debate**

How does AHEC proceed in discussing a matter referred to it? The AHEC work into the ethics of health resource allocation is a useful illustration.

The Working Party on Resource Allocation AHEC 1992-94 conducted a number of open fora which attempted to identify the key ethical issues in the debates about resource allocation. This group produced a paper entitled *Ethical Considerations Relating To Health Care Resource Allocation Decisions*. Rather than reviewing the economic rationale and approaches to resource allocation, a paper was prepared on those ethical considerations which guide the ethical distribution of scarce resources. *Ethical Considerations Relating to Health Care Resource Allocation Decisions*<sup>10</sup> highlights the importance of two ethical issues, namely justice and equity, and autonomy as the primary ethical considerations in respect of resource allocation. The paper notes the subsidiary importance of ethical issues such as:

- respect for human life;
- taking into account quality of human life;
- respecting the integrity of the human body;
- assessing the importance of human disabilities;
- judging the relevance of social worth as being less important.

### **Parliaments, medical practitioners, researchers and professional ethics**

It would be presumptuous to suggest that the Australian Health Ethics Committee is the sole repository of ethical wisdom and advice. Clearly, members of the community as a whole are quite capable of making ethical judgments by themselves. Issues of bioethics have been resolved for centuries without expert committees. Parliaments have been grappling with complex ethical issues in recent years. Most noteworthy has been the way in which the Victorian Parliament has not shied away from legislating in reproductive technology, child care or withdrawal of medical treatment for the terminally ill. Moreover, the medical profession has an ancient code of ethics which guided the profession for centuries before this current spate of bioethical dilemmas. The medical practitioner brings to each individual case not only their technical skills but the accumulated insights of their professional code of ethics. Finally, our researchers operate in a consciously revived ethical culture. There is much debate about ethics and I trust that it is not merely words.

### **The fundamental ethical principle**

In bioethics there is one key principle which transcends all discussion about utilitarianism, deontology and virtues. This principle is *consent*, the ingredients of which are competence, information and voluntariness of decision-making. We have long since revised our views that 'doctor knows best'. The medical profession generally (with a few die hards still in the trenches) has embraced a different relationship with its patients, one based on mutual respect and shared decision-making. Recently our High Court of Australia has followed United States and Canadian decisions and accepted the primacy of the consent principle.<sup>11</sup> Consent has been the fundamental influence in shaping the new doctor/patient relationship.

### **Conclusion**

Consideration of the legal and ethical aspects of health will grow in importance in the future. Institutions such as the NHMRC and I hope, the AHEC, will play vital roles in this development. Of course there are many other organisations contributing to these debates such as the Monash University Centre for Human Bioethics, the Australian Bioethics Association and many university departments. The first conclusion which can be drawn is that ethical debate should be firmly

grounded in community consultation. AHEC is in fact required under the terms of the National Health and Medical Research Council Act 1992 to conduct public consultation in relation to the preparation of guidelines.

Secondly, who is to decide? A balanced approach to this difficult issue must involve a recognition by health practitioners that ethical considerations are crucial in their work, and by the NHMRC that health practitioners and researchers must be an integral part of the development of appropriate guidelines. 'To separate ethical considerations from the practice of health and research is to invite irrelevance rather than independence.'<sup>12</sup> More importantly, as a liberal democracy we value individual autonomy and personal choice. We have to ensure that ethical decisions are made by those most directly affected by the decision.<sup>13</sup> Dr Davis McCaughey, a former Governor of the State of Victoria has expressed this well.

Very few subtle ethical questions are well determined either in the adversarial conditions of parliamentary debate or by bureaucratically drafted ministerial decree. They must be formulated by men and women who understand and who have to live with the consequences of their actions.<sup>14</sup>

Thirdly, in the area of ethics, guidelines are usually superior to rule-making in legislation. Legislation tends to establish minimum standards based upon reasonable norms of practice. On the other hand, ethics is about right conduct and so endeavours for the best standards of practice rather than the acceptable average. In addition, ethics is a dynamic branch of philosophy which if included in legislation may sometimes freeze into immobility, a standard of practice which a later generation may find unacceptable. Simply put, ethical standards may go beyond legislative prescription.

Finally, as we continue to debate this issue, I hope that we can as a community conduct the debate with a little more trust in those involved in making these decisions, principally families and medical practitioners. It is unfashionable to trust in the integrity of individuals, much less professionals, but trust and respect for others are preconditions to constructive ethical debate.

#### Footnotes

- 1 H Tristram *The Foundations of Bioethics* Oxford UP 1986 at p9.
- 2 Ethical principles have been applied to allocation of resources as some decisions can result in consequential bioethical dilemmas.
- 3 *pace* Justice Michael Kirby President of the Court of Appeal NSW.
- 4 See I Kennedy, 'What is a Medical Decision?' Ch. 2 *Treat Me Right*, Oxford University Press 1988.
- 5 See Professor S Toulmin 'How Medicine Saved the Life of Ethics' (1982) 25 *Perspectives in Biology and Medicine*, 736-750; Dr D McCaughey AC 'Facing the Unpredictable Medical-Ethical Considerations on Approaching the 21st Century' (1994) 81 *Federation Bulletin* 123-130.
- 6 The Hon Justice M Kirby *IVF - The Scope and Limitation of Law*, Conference on Bio-ethics and the Law of Human Conception - IVF, London 29-30 September, 1983 at p12.
- 7 No. 225 of 1992.
- 8 Section 35 (6).
- 9 Section 36. Which established the following membership:
  - the Chairperson
  - a person with knowledge of the ethics of medical research
  - a person who has expertise in law
  - a person who has expertise in philosophy
  - a person who has expertise in religion
  - a person who has experience in medical research
  - a person who has experience in public health research
  - a person who has experience in social science research
  - a person who has experience in clinical medical practice
  - a person who has experience in nursing or allied health practices
  - a person with knowledge of the regulation of the medical profession
  - a person with understanding of health consumer issues
  - a person with understanding of the concerns of people with a disability
  - no more than two other persons with expertise relevant to the functions of the Committee
- 10 Published and promulgated by the NHMRC and endorsed at the 116th Session of the NHMRC Canberra - November 1993.
- 11 *Rogers v Whitaker* (1992) 67 ALJR 47; See also D Chalmers and R Schwartz 'Rogers v Whitaker and Informed Consent in Australia' (1993) 1 *Med LR* 139-159.
- 12 Report of an external review of the National Health and Medical Research Council, J Bienenstock, December 93 at 26.
- 13 In the words of Dr Rob Loblay: '... one may well argue that the efficiency of a medical and health system (if it involves medical and bureaucratic paternalism and authoritarianism) runs counter to the ethical value of individual autonomy on which is based the fundamental human right to control one's own life'. Use of routine blood and tissue samples for research, AHEC Discussion Paper 1993.
- 14 Dr Davis McCaughey *op cit* at p126. See also D Rothman, *Strangers at the Bedside*, Basic Books 1991.

## SHOULD WE CHANGE THE LAW?

Associate Professor Loane Skene



ASSOC PROF LOANE SKENE

withholding or withdrawing treatment.

THE LAW on the care of the severely disabled or dying child centres on two issues. First, what treatment, or failure to treat, is *lawful* in the circumstances? And secondly, who is *legally entitled to decide* about proposed treatment, or the withholding or withdrawal of treatment?

This paper suggests that although the law is generally clear, there are two areas in which further clarification is necessary to protect doctors, parents, other health professionals and hospitals in withholding or withdrawing treatment.

### What treatment, or failure to treat, is lawful?

Doctors and other carers may be faced with a range of options when treating a severely disabled or dying child. Some are clearly within the law. Some are in a grey area of uncertain legality. And some are clearly unlawful.

#### No resuscitation after 'death'

The first of the options is the clearest. If a child stops breathing, it is probably lawful not to resuscitate where the prognosis is poor and the very process of artificial ventilation imposes a burden which is not warranted in view of the child's expected quality of life. Thus, in the English case, *Re J (a minor) (wardship: medical treatment)*,<sup>1</sup> three judges of the Court of Appeal unanimously held that it would be lawful to withhold ventilation from a severely brain damaged baby if he stopped breathing. Withholding treatment would be in his best interests because he had severe and permanent brain damage due to shortage of oxygen and impaired blood supply during birth. He was epileptic and was likely to develop serious spastic quadriplegia (paralysis of both arms and legs), to be blind and deaf and unlikely ever to speak or to develop even limited intellectual abilities. His life expectancy was at most into his late teens, yet he would probably experience pain like other babies. The prognosis was clear from his current condition and the proposed medical procedure (reventilation) was itself painful. Thus, if he stopped breathing, it was justifiable not to resuscitate him.

*... there are two areas in which further clarification is necessary to protect doctors, parents, other health professionals and hospitals in withholding or withdrawing treatment.*

#### No extraordinary treatment

The second category of case is where a decision may be made not to offer the full range of available treatment to a critically ill or dying child. 'Extraordinary treatment' here refers principally to surgery and to assisted ventilation. Although it might reasonably include artificial nutrition and hydration, doctors are less willing to withhold this support than ventilation. An example of justifiable withholding of extraordinary treatment was *Re C (a minor) (wardship: medical treatment)*.<sup>2</sup> There, baby C was born with severe, incurable brain damage (in addition to severe hydrocephalus, the brain structure was itself poorly formed). She was paralysed in arms and legs, blind, deaf, unresponsive to her environment and terminally ill. She was given

shunt surgery for hydrocephalus but that was to prevent her head becoming so enlarged that nursing would become impossible. There was no prospect of the surgery improving her overall health as the brain damage before birth was irreparable. The court accepted that the goal of treatment should be to 'ease the suffering of C rather than to achieve a short prolongation of her life'.

### Withdrawal of 'futile' treatment

The third option rests on a similar premise to the second, but instead of not offering all available treatment, treatment is actually *withdrawn*. A common example is the withdrawal of ventilation when it is clear that a patient cannot recover. In the English cases, withdrawal has been justified on the basis that it is not in the patient's 'best interests' to continue the treatment. The question is not whether it is in the patient's best interests to *die*. The question is whether it is in the patient's best interests to have life prolonged by this form of medical treatment or care, which may be painful or intrusive, or upsetting for relatives and carers, when the unconscious or dying patient can gain no benefit from it.

The American cases have often focused on the 'futility' of possible treatment. It is not unlawful to withdraw futile treatment but the meaning of 'futile' is obviously problematic. Can treatment be described as 'futile', for example, if it enables a person to breathe, or it extends a person's life for days, or even hours? In fact, futility has generally been regarded as requiring a longer term perspective. It may be considered futile, for example, to impose treatment when the patient has no prospect of recovering or enjoying an acceptable quality of life, so that it may be legally justifiable to withdraw treatment on those grounds.

English judges have stated that, before withdrawing treatment from adult patients, doctors must apply to a court for a *declaration* and the Official Solicitor has published a Practice Note setting out the procedures to be followed in making an application.<sup>3</sup> It could be argued that similar procedures should be followed when removing treatment from children. In Australia, however, there are no recommended procedures and doctors generally decide, in consultation with parents, when treatment should be withdrawn, without applying for court sanction. If they make the wrong decision, both doctors and parents may face criminal prosecution or a coronial inquiry, despite the fact that they believed they were acting lawfully and in the child's best interests.

### Extra drugs to relieve pain

The fourth option moves from withholding or withdrawing treatment to a positive act – the administration of increasing doses of drugs to relieve pain, knowing that this will accelerate death. This, too, is lawful provided that the primary intention is to relieve pain and not to cause or accelerate death; and the drugs are given because the child is in pain and not because the child's likely quality of life is so poor as to warrant treatment. The cases that serve as authority for this proposition all involve adults (like *R v Dr Bodkin Adams*<sup>4</sup> and *Airedale NHS Trust v Bland*<sup>5</sup>) but there is no reason to believe that the courts would view treatment of children differently in this regard.

### A lethal dose

The fifth option in treating severely disabled or dying patients is unlawful – to administer a lethal dose of a drug, or to do any other act to end life, with the intention of causing or accelerating death, even with the best intentions and at the request of the child or parents. Throughout Australia, this is homicide (even in the Northern Territory as the recently passed<sup>6</sup> *Rights of the Terminally Ill Act 1995* applies only to adults).

### Who decides?

The second legal issue in treating severely disabled or dying children is who has lawful authority to decide about the treatment for a severely disabled or dying child. Is it the parents, or the child if old enough; the doctors or health care team; all together; an ethics committee; or a court? The answer depends in part on the age and medical condition of the child and the general circumstances. The major factor is whether the parties agree or disagree about giving or withdrawing treatment.

### All agree to give treatment



If all parties agree that treatment should be *given*, the parents or an older child can generally consent. Parents are guardians of their child until the child is eighteen (sections 60E(1),(2), 60F Family Law Act 1975 (Cth)) and either parent is entitled to make decisions about any clinically indicated procedure for their child. Thus parents could consent to ventilation, cardio-pulmonary resuscitation if the child stopped breathing, artificial feeding and the like. Similarly,

parents could consent to the administration of increasing doses of analgesia to relieve the child's pain, or sedatives for distress. Normally, parents would be involved in making these decisions, although some hospitals try to spare parents the responsibility of the final decision by making the decision a joint one of the doctors and the parents, rather than the parents alone.

The right of parents to make decisions about their child's treatment, including critically ill newborn infants, was strongly endorsed by the Victorian Deputy State Coroner in 1991, in the widely publicised case of *Baby M*.<sup>7</sup> She said:

A mature community should have confidence in, and lend support to, its members, in these instances. These may include members of the medical profession, parents, and their advisers, guided by the best available information, experience, good judgement, sincerity and common sense, to reach the right decision in a particular case.<sup>8</sup>

The one limitation on the decision making authority of parents is that they must act in the child's best interests. If there is a doubt about whether the decision of a parent (or indeed of a doctor, other health professional or anyone else caring for a child) is in the child's best interests, any person<sup>9</sup> may apply to a court for an order to protect the child's interests. An example was *Re F; F v F*,<sup>10</sup> in 1986, in which a judge of the Supreme Court of Victoria made a newborn spina bifida baby a ward of the court on the application of the child's grandfather and ordered the hospital caring for her to take 'necessary and reasonable steps' and to pursue 'good medical practice' in treating her.

Children over eighteen are entitled to make their own decisions (Age of Majority Act 1977 (Vic)). Before reaching eighteen, an older child who is able to understand about proposed treatment may also consent to it; the age at which this occurs will depend on the child's level of maturity and the seriousness of the treatment (*Gillick v West Norfolk and Wisbech AHA*,<sup>11</sup> *Secretary, Department of Health and Community Services (NT) v JWB and SMB (Marion's case)*).<sup>12</sup>

### All agree to withdraw treatment



If all parties agree that treatment should be *withdrawn*, the position is similar. Provided that the withdrawal is lawful in the circumstances (as outlined above), then the parents or an older child can probably decide; and a doctor who acts on their authority is protected from civil, and probably also criminal, liability (*Baby M*).<sup>13</sup> A cautious doctor could, perhaps, apply for court authority but that is not necessary. However, if an outside party, such as another relative or

a concerned member of the public, believes that the decision to withhold or withdraw treatment is not in the child's best interests, they may apply to a court for an order requiring treatment to be given (as in *Re F* described earlier<sup>14</sup>). Courts have tended to be conservative in these circumstances and a court order overrides the decision of doctors,<sup>15</sup> parents or the older child.

## Disagreements about treatment



By far the most difficult cases are those where there is a disagreement about the treatment. There are a range of different situations.

*Parents refuse treatment that the doctor recommends.* If parents refuse treatment that the doctor believes is necessary to save the child's life, the parents' decision can be overridden in a number of ways. First, there is specific legislation in all States that authorises doctors to give children blood transfusions if that

is necessary to save the child's life (for example, section 24 Human Tissue Act 1982 (Vic)). Secondly, in an emergency it is permissible to do whatever is necessary to save a patient's life or to prevent a serious risk to health, without obtaining consent (*Murray v McMurchy*)<sup>16</sup> Thirdly, as noted earlier, any person may apply to a court for an order to protect a child's interests.

*Older child consents to treatment parents have refused.* A 'mature minor' can consent to treatment even if parents refuse consent. The principle that a mature minor may consent to treatment without her parents' knowledge was established by the House of Lords in *Gillick's case*<sup>17</sup> and approved by the High Court of Australia in *Marion's case*.<sup>18</sup> The same principle would seem to apply if the parents refused.

*Older child refuses treatment that parents and doctors consider appropriate.* Although it might seem logical that a child who is old enough to consent to treatment is also old enough to refuse it, a number of recent English cases suggest that a minor's refusal can be overruled not only by a court order, but also by a parent's consent. Lord Donaldson suggested, in *Re R*,<sup>19</sup> that the parents' authority to consent coexists with that of the child. It would therefore be lawful for a doctor to treat a child who has refused treatment provided that a parent consents.<sup>20</sup> He reaffirmed this view in *Re W*<sup>21</sup> and this appears to be the law in England. However, there is no specific authority on this point in Australia and it is difficult to predict whether an Australian court would allow parental consent to override the refusal of a mature minor. In *Marion's case*,<sup>22</sup> the majority judgments of the High Court of Australia appear to suggest that either a parent or a child can consent, whereas one of the judges (McHugh J) clearly thought that parental power to consent ceases when the child was mature enough to decide. In any event, a doctor who is unsure about whether to proceed on the basis of parental authority alone could apply to a court and it is clear that court orders override the refusal of a child (or parents): *South Glamorgan County Council v W and B*.<sup>23</sup> Courts are likely to be conservative in assessing the competence of a child who refuses treatment recommended by a doctor (*Re E (a minor)*)<sup>24</sup> and if the child is found not to be competent, the parent's decision will prevail.

*Parent or child wants treatment that doctors believe is inappropriate.* Patients are not entitled to be given treatment that doctors do not believe is clinically appropriate and a court will not generally review the doctor's decision in such a case. Thus in the recent English case, *R v Cambridge District Health Authority, ex p B*,<sup>25</sup> the court would not override a health authority's decision not to fund extra chemotherapy and other treatment for a ten-and-a-half-year-old girl with leukemia, because the doctors considered the treatment 'experimental' and said that it had a relatively low chance of success (ten to twenty per cent for each of two stages of treatment). The health authority was not required to prove that granting resources to this patient would deprive other patients of resources.

In contrast, a mother in a recent American case, *Re K*,<sup>26</sup> persuaded a court that she was entitled to ventilator support for her anencephalic baby. Her argument was based partly on her constitutional right under the United States Constitution to practise her religion freely (she was a devout Christian for whom all life was sacred and must be preserved; while the doctors were maintaining her baby's life temporarily, she hoped for a miracle). Other arguments focused on disability legislation, stating that it was unlawful to deny treatment to this baby because of her disability, an argument that would seem to be open

under similar legislation in Australia, though it has not yet been attempted and is probably unlikely to be successful. (In America, commentators since the *Re K* case have been quick to argue that parents should not be entitled to require highly technological treatment for a child who has no chance of gaining or regaining consciousness and courts have not been prepared to require hospitals to provide such treatment for older patients in a persistent vegetative state who are unlikely to regain consciousness.)

*Disagreements between family members.* If either parent consents to treatment for a child, that is sufficient legal authority for treatment to be given, though doctors may decide to apply for a court order. The English High Court recently said that although the views of dissenting relatives are important, they are not determinative; it authorised a hospital to withdraw tube feeding from an adult patient despite his mother's objection because continued treatment was not in his best interests: *Re G*.<sup>27</sup>

*Disagreements between health professionals.* Disagreements between health professionals are generally resolved by institutional policies or procedures; or consultation between all members of the health care team.

## Should the law be changed?

It can be seen from this brief outline of the law, that there are two main areas where legal problems may arise. The first is in defining when it is lawful to withhold or to withdraw treatment from a severely disabled or dying child. If treatment is withheld or withdrawn because it seems futile in achieving more than the immediate maintenance of life, then it is probably lawful to withhold or withdraw treatment. If, on the other hand, treatment is withheld or withdrawn because that seems to be in the best interests of the child based on the child's anticipated quality of life, the law is unclear and doctors or parents who agree to withhold or withdraw treatment may risk criminal prosecution.

*Procedural guidelines* should therefore be developed by a professional body such as the Australian College of Paediatrics to guide doctors and hospitals in decision making and to provide some legal protection. They could be backed by legislation providing that if doctors follow the guidelines and report to an external body such as the Coroner after withdrawing treatment, they are protected from prosecution.

The second area of uncertainty is whether disability legislation could be used by parents in arguing that treatment should not be withheld from their child because of a 'disability'. There is no authority on this issue in Australia and one cannot say with certainty how a court would react.

Nevertheless, it would clearly be desirable for the *disability legislation to be worded so that it is clear that it cannot be used to compel doctors and hospitals to offer treatment that they do not believe is clinically indicated in the circumstances.*

## References

- 1 [1990] All ER 930.
- 2 [1989] 2 All ER 782.
- 3 Practice Note [1994] 2 All ER 413.
- 4 [1957] Crim LR 365.
- 5 (1993) 1 All ER 821.
- 6 But not yet proclaimed.
- 7 Record of Investigation into Death, Case No 3149/89, State Coroner's Office, 1991.
- 8 *Ibid*, pp 25-6.
- 9 The person need not prove any involvement with the case: *Re Michael* (1994) FLC 92-471.
- 10 Unreported, Supreme Court of Victoria, 2 July 1986 (Vincent J).
- 11 [1986] AC 112 (House of Lords). The test is whether the minor has sufficient 'intelligence and understanding to make up his own mind': *id* 187 (Lord Scarman), emphasis added.
- 12 (1992) 175 CLR 218 (High Court of Australia).
- 13 Note 7 above.
- 14 See note 10 and accompanying text.
- 15 Though a court would be reluctant to challenge the advice of doctors about clinical issues.
- 16 [1949] 2 DLR 442 (Supreme Court of British Columbia).
- 17 Note 11 above.
- 18 Note 12 above.
- 19 [1991] 4 All ER 177.

- 20 *Id* p186. In that case, the child was held not to be competent, so these words have no binding force. In any event, the other two judges seemed to believe that the parents' authority ceased when the child became 'Gillick competent'.
- 21 [1992] 4 All ER 627. In this case another judge, Balcombe J, agreed so this was the majority view.
- 22 Note 12 above.
- 23 [1993] 1 FLR 574.
- 24 [1993] 1 FLR 386.
- 25 NLJ reports, 24 March 1995, 415. The case was heard by the Court of Appeal, 10 March 1995 (Sir Thomas Bingham MR, Sir Stephen Brown P, Simon Brown LJ).
- 26 *In the matter of Baby K* 832 F Supp 1002 (ED Va 1993) aff'd 16 F 3d 590 (4th Circuit 1994), cert denied 115 S Ct 91 (1994). The case is described by the baby's mother's lawyer, Ellen J Flannery, 'One Advocate's Viewpoint: Conflicts and Tensions in the Baby K case' (1995) 23 (1) *J of Law, Medicine and Ethics* 7-12. There are six articles on the case in this issue.
- 27 Unreported, English High Court, Family Div, 22 November 1994 (Sir Stephen Brown).

## DISCUSSION



### Ethics and the Law

Asked to enlarge on his comments about care in the hospice context, Professor Clark indicated that he didn't think hospice care provided an answer in terms of a place for children to die. There does however, seem to be a need for some sort of respite care, where children can go with another family member in order to give everybody a break. Mrs Loughnan noted that continuity of care is important and that there are in fact many doctors prepared to spend many hours in the middle of the night with a dying child.

A member of the audience suggested that palliative care should begin when a child is diagnosed with a potentially terminal illness. Continuity of care could be ensured by palliative carers being brought in during the early stages of illness. Professor Clark commented that this presents a dilemma as the treatment of childhood cancer begins with the expectation that the child will be cured and palliative care won't be needed.

It was suggested by a member of the audience that a board of practising doctors should be constituted to decide on questions of terminating the life of a patient dying in agony. A/Prof Skene noted in response, that although it is difficult to require people to go to court to get a declaration that a particular treatment or the withdrawal of a treatment is lawful, the underlying expectation is that the community as a whole, through its judicial officers and the law, should be overseeing these decisions. Although doctors should be involved in decision-making, the community would not be prepared to hand such a decision over to the medical profession without review.

A member of the audience commented that neither guardianship boards, nor a board of doctors should be making these decisions. He believed that the people making the decisions are the correct ones. He noted however, that some speakers were saying that the decision makers – the families and the doctors – would like some support. He also endorsed the suggestion of guidelines for making these decisions, but not a formal decision-making body.

Professor Smallwood asked Dr Campbell and Professor Shann how they felt about guidelines for these sorts of decisions being formulated by the NHMRC, the College of Paediatrics or another constituted body. Dr Campbell indicated that guidelines should be designed not to define the conditions under which treatment might be withdrawn, but to describe the process of decision making in order to guard against inappropriate practices. He noted however, that guidelines can become the norm, the minimum requirement, which may not be enough in some situations. Professor Shann commented that a set of guidelines defining the process of decision making would be useful and would give some protection to children, to their families and treating doctors and other professionals. In the vast majority of cases there are no problems in this area. However, there is potential for problems in some circumstances, which is why both he and Dr Campbell, who deal with a high proportion of the situations likely to be difficult, were saying there is a need for legislation or official guidelines. A/Prof Skene noted that although failure to follow guidelines may lead to prosecution, it would not of itself be conclusive evidence of failure to take appropriate care or failure to act lawfully. Professor Clark noted that although guidelines may be helpful he didn't think that the doctors making these decisions needed guidance; they knew their guidelines. Guidelines would only be effective if there was legislation to back them up and he didn't think that legislation could be effectively devised. Professor Shann commented that if the Victorian Medical Treatment Act was appropriate for adults then it should be appropriate to have similar provision for children.

A member of the audience commented on the situation in which Dr Campbell described the administration of morphine in newborn infants. He noted the situation was a particularly difficult one with a baby whose generalised muscle weakness rendered it particularly susceptible to the problems of respiratory depression due to morphine. In other circumstances doctors would frequently be able to give a baby removed from a ventilator a dose of morphine which adequately relieved its pain but did not directly cause death. Such an infant might live several hours without pain or discomfort and be able to be cuddled and nurtured by its parents. Dr Campbell noted that the great majority of babies from whom treatment is withdrawn are able to be given adequate relief from pain and distress without using morphine or drugs which immediately kill them. The ways of relieving distress can include many drugs which don't directly lead to death and all of the nurturing parents can give a dying baby. He also commented that as soon as a manufacturer comes up with a drug to relieve a baby's consciousness and ensure it is free from distress and which will not depress that baby's breathing, he won't use morphine.

A member of the audience noted his pleasure at hearing A/Prof Skene make the distinction of intention and double-effect. In the case described by Dr Campbell, he believed the intention was very important, as the consequence of the child dying was not the primary reason for administering the drug. Dr Campbell noted that he was trying to make the point that simplistic differentiations which occur in some areas of bioethics are much more complex in practice.

Professor Smallwood asked if the clinicians could say how young the child might be whose wishes should take precedence in such decisions. Professor Clark noted that the mature twelve-year-old makes good decisions about contraception which are upheld by the law. The five-year-old however, has a limited concept of death and is more concerned about being with the family. He suggested that doctors should make the best judgement they can of the maturity of the child between the ages of five and twelve but noted that below the age of about ten, decisions children make are not likely to be actually about death but about whether they want another injection or to be with their mother. Mrs Loughnan noted that the development of children can vary a lot and that one of the main concerns for children is that they are going to be forgotten or left alone. Professor Chalmers suggested that however old we think a child should be to be considered competent to give consent – and even if they are not old enough – their wishes should surely be taken into consideration.

**SEMINAR – THE NEW GENETICS – FOR GOOD OR ILL? – 26 JULY 1996**

## FROM THE DEAN

### HIGHLIGHTS AND ACHIEVEMENTS IN 1995

#### Structure and Function of Faculty Board



Professor Gordon Clunie

During the year Faculty conducted a review of the structure, composition and operations of the Faculty Board and other decision-making structures.

The major changes made arising from the review relate to the size and composition of Faculty Board, and include provision for the new School of Postgraduate Nursing.

The last major review of Faculty Board was conducted in 1988/89 when the amalgamation of the Faculties of Medicine and Dental Science was being finalised with the establishment

of the Schools of Medicine and Dental Science. Since 1989 the Faculty has become a Faculty of Medicine, Dentistry and Health Sciences (with the creation of the Schools of Physiotherapy and Behavioural Science) and the membership of Faculty Board had grown from 115 to more than 150.

While the Board and Faculty committee and school structures were functioning satisfactorily, it was agreed to reduce the Board's size to approximately the level existing pre-1989, primarily by introducing a category of elected membership among the professors and professor/directors in the School of Medicine. The changes made were considered possible without jeopardising the Board's decision-making effectiveness or its role as a major academic forum and communication link into the wider communities outside the University.

The changes included provision for the School of Postgraduate Nursing and took effect from 1 January 1996.

#### Rural Medical Student Initiative

Following a review of School of Medicine special entry programs, and in accord with the Faculty's long-standing commitment to support initiatives aimed at increasing the number of medical graduates wishing to practise in rural areas, Faculty gained approval to replace the current provision for a sub-quota of up to twenty places under the University's Special Admissions Scheme (up to ten places for First Year and up to ten places under the Extended Special Admissions Scheme for Second Year) so that up to twenty places under the Scheme are offered for First Year entry from 1996, including at least ten places for rural students.

#### International Development: Agreement with International Medical College, Malaysia

During 1995 Faculty gained approval to enter into an agreement with the International Medical College, a private medical college in Kuala Lumpur, Malaysia. Under the agreement, phase one of a course is undertaken in Malaysia and phase two in Melbourne. Up to six full-fee paying overseas students will be admitted to the second semester of Third Year MBBS as a bridging program following completion of the three year Advanced Diploma in Medical Science course at the College. Subject to satisfactory completion of the bridging program, the students will be admitted to the MBBS course as Fourth Year students. It is intended that the first intake will occur at the beginning of 1998 following admission to the bridging program in the second semester in July 1997. The College has similar 'twinning' arrangements with up to twenty other universities in the UK, Canada, New Zealand and USA.

#### Teaching Hospital Developments

During 1995 the State Government-appointed Metropolitan Hospitals Planning Board (MHPB) completed two reports with major implications for the Faculty and its role in the health care system. In its Phase One Report, *Developing Melbourne's Hospital Network* (June 1995), MHPB recommended the formation of seven health care networks based upon the existing thirty-five independent public hospitals in Melbourne. Charged with overseeing the gradual transfer of many services from inner Melbourne to the middle and outer suburbs of the city, the networks commenced operation on 1 August 1995 under newly-appointed Boards of Governance. In its Phase Two Report, *Taking Melbourne's Health Care Networks into the 21st Century* (December 1995), recommendations were made on a number of issues, including undergraduate education, postgraduate training, research and development. In recognising that teaching, training, research and development are cornerstones of a high quality health care system and must be safeguarded and promoted in all networks, the MHPB has urged networks, educational institutions and professional colleges responsible for postgraduate training to work together to develop innovative approaches to teaching, training and research across the whole range of health care facilities in the network.

This Faculty is committed to continue to play a major contributing role in meeting the challenges laid down by the MHPB to ensure that high quality, efficient and accessible health care services continue to be available in metropolitan Melbourne into the next century.

#### Reviews of Academic Departments

During 1995 the Departments of Medicine (jointly), the Department of Microbiology and the Department of Paediatrics were each reviewed as part of the University-wide system of external reviews of academic departments which began in 1994. The findings of each review were highly satisfactory and congratulations are recorded to each of the Departments on the outcome.

The Faculty Departments for review in 1996 are Pharmacology and Physiology (jointly), and the Department of Pathology.

#### Medical Centre Extension

A major decision was taken by the University during 1995 to proceed with the construction of two additional floors on the top of the Medical Centre. This project, at an expected cost exceeding \$19m will house the Department of Pharmacology (on relocation from the Microbiology Building), and provides for new animal house facilities and a multimedia unit. The work is anticipated to be completed by September 1997, and is receiving significant funding from Faculty sources [see *Chiron* 1996, p22].

#### Teaching (and Other Academic Developments)

In 1995 the following new programs were introduced: combined MBBS/BSc course; degree of Master of Public Health; graduate diploma in Adolescent Health; graduate diploma in Drug Evaluation and Pharmaceutical Sciences; additional specialty program in postgraduate diploma in Advanced Clinical Nursing (renal nursing).

During 1995 approval was given for the following academic initiatives.

- Creation of Professor/Director positions in the following areas: Critical Care Medicine (Royal Children's Hospital); Haematology and Medical Oncology (Peter MacCallum Cancer Institute); Microbiological Research (Women's and Children's Health Care Network); Young People's Mental Health (Royal Melbourne Hospital).
- New programs in 1996 for the degrees of Master of Audiology and Master of Physiotherapy (by coursework), and graduate diplomas in Genetic Counselling and in Mental Health Sciences (specialty

programs in transcultural mental health, infant and parent mental health).

- Transfer of responsibility for the graduate diploma in Biotechnology from the Faculty of Science to this Faculty for implementation in 1996.
- Amended programs in 1996 for the postgraduate diploma in Psychology (previously titled Adolescent and Child Psychology) and the graduate diploma in Drug Evaluation and Pharmaceutical Sciences.
- Additional specialty programs in 1996 for the graduate diploma in Adolescent Health (early psychosis, youth drug studies) and the postgraduate diploma in Advanced Clinical Nursing (neuroscience, psychiatric nursing, rural critical care).
- Proposal for University consideration for the introduction in 1997 of a three year coursework Doctor of Psychology program to be offered in the specialty streams of Clinical Psychology, Clinical Neuropsychology, and Organisational and Industrial Psychology (replacing current coursework Masters programs).
- Ruling out of a 1995 Dental Auxiliary Workforce Review established by the State Minister of Health, a new two year undergraduate diploma in Oral Health Therapy to be offered in 1996 by the School of Dental Science, comprising two streams of vocational outcome in school dental therapy and dental hygiene.
- Following a visit to China by the Dean as part of a University delegation, an agreement was signed with the Chinese Academy of Medical Sciences and Peking Union Medical College.
- Further to the \$0.82m allocated in 1994 for teaching developments and innovations, additional funding for this purpose was provided in 1995 to the Biomedical Multimedia Unit and to the Departments of Anatomy and Cell Biology, and Biochemistry and Molecular Biology, as well as a successful application for \$0.309m being made to support a telelecturing/teleconferencing link between St Vincent's Hospital and Geelong Hospital from the University's Quality Assurance Grant. Other initiatives in teaching methodology and curriculum development have also been introduced in the Schools of Behavioural Science, Dental Science, and Physiotherapy. Four projects worth approximately \$170,000 were successful in obtaining funding under the Federal Government's 1996 national teaching development grants program.
- The creation of Standing Committees on Ophthalmology and Otolaryngology in the School of Medicine to provide advice on undergraduate education and postgraduate developments in these disciplines.

## Research

The research strengths of the Faculty continue to be demonstrated through the level of research funding attracted, its links with external bodies, including industry, and the demand for higher degree research training. This Faculty was successful again in obtaining the largest allocation of NHMRC funding of any medical/health sciences faculty in Australia. About \$11m of NHMRC funds were obtained to support 120 Project Grants (including thirty-six new projects) and four Program Grants in the Faculty for 1995, as well as approximately \$2m of NHMRC funds awarded to associates of University departments in affiliated teaching hospitals. From all sources outside the University, this Faculty attracted in 1995 a total of approximately \$32m in funding to support research.

Faculty allocated to academic departments a further \$1m in 1995 from its Development Fund for basic infrastructural support, including equipment replacement. This means that \$2.5m of Faculty funds has been distributed to departments during the past three years for this essential purpose.

In principle approval was given during 1995 for the University's administrative responsibility for NHMRC research funding to be transferred from this Faculty to the Office of the Deputy Vice-Chancellor (Research) during 1996/97.

## People

### Key appointments taken up in 1995

- Professor Daine Alcorn, Professor of Anatomy
- Professor Ruth Bishop, Professorial Associate with title of Professor (Paediatrics)

- Professor Graham Brown, Professor/Director of Infectious Diseases and International Health (Royal Melbourne Hospital and Walter and Eliza Hall Institute)
- Professor Lorraine Dennerstein, Personal Chair, Department of Public Health and Community Medicine
- Professor Barbara Cone-Wesson, Beth MacLaren Smallwood Professor of Audiology and Speech Science
- Professor Stephen Harrap, Professor of Physiology
- Professor Robin Marks, Professor/Director of Dermatology (St Vincent's Hospital and Skin and Cancer Foundation)
- Professor Philip Morris, Professor/Director, National Centre for War-Related Post Traumatic Stress Disorder (Austin and Repatriation Medical Centre)
- Professor Lester Peters, Professor/Director of Radiation Oncology (Peter MacCallum Hospital)
- Professor Frank Shann, Professor/Director of Critical Care Medicine (Royal Children's Hospital)
- Professor Robert Williamson, Professor/Director, Murdoch Institute for Research into Birth Defects, and David Danks Research Professor of Medical Genetics (Royal Children's Hospital)

### Key appointments to be taken up in 1996

- Professor Suzanne Cory, Professor of Medical Biology (Director, Walter and Eliza Hall Institute)
- Professor David Kissane, Professor/Director of Palliative Medicine (St Vincent's Hospital/Caritas Christi Hospice/Peter MacCallum Cancer Institute/Mercy Hospice Care)

### Other positions pending appointment

- Chair of Dental Medicine
- Chair of Microbiology
- Chair of Nursing
- Chair of Obstetrics and Gynaecology (Mercy Hospital for Women and Austin and Repatriation Medical Centre)
- Professor/Director of Neonatal Paediatrics (Royal Women's Hospital/Royal Children's Hospital)
- Professor/Director of Orthodontics (Royal Dental Hospital of Melbourne)
- Professor/Director, Young People's Mental Health (Royal Melbourne Hospital)

### Retirements/Resignations

- Professor Norman A Beischer
- Professor David M Danks
- Professor Donald G MacLellan
- Professor Graeme B Ryan (*see also later*)

### Bereavements

- Professor Emeritus Keith C Bradley
- Dr Jack L Evans
- Dr Frank Forster
- Dr Richard H Hammond
- Mr Peter G Jones

### Honours, awards and other appointments during 1995

#### Order of Australia

Dr William Adam, PSM  
Dr Henry Ekert, AM  
Associate Professor John Harcourt, OAM  
Professor Kenneth Hardy, AO

The Australian newspaper *Australian of the Year*  
Professor Sir Gustav Nossal

*Richard Bright Distinguished Lecturer 1995 Award of American Society of Hypertension*  
Professor Colin I Johnston

*College Medal of the Royal Australasian College of Physicians*  
Professor Colin I Johnston

*Morton I Grossman Distinguished Lecturer 1995*  
Professor John B Furness

*Appointment to Board of Governors and Secretary to the Executive of the International Federation for Physical Medicine and Rehabilitation*

Professor Peter B Disler

*Appointment as Secretary of the International Psychogeriatric Association*

Associate Professor Edmond Chiu

*James Barrett Brown Award 1995, American Journal of Plastic and Reconstructive Surgery*

Mr Geoffrey I Taylor

*Scholarship First Prize 1995 of American Society of Plastic Surgery Educational Foundation*

Mr Geoffrey I Taylor

*Honorary Degree of Doctor of Medicine (U of NSW)*

Professor John P Coghlan

*Ramacioti Medal and Prize for Excellence in Biomedical Research 1995 (Inaugural Award)*

Professor John P Coghlan

*International Association for Dental Research (IADR) Awards*

Ms Anne Hendtlass, Ms Christine Jackson, Dr Michael McCullough, Dr Peter Wilson

*Premier's Awards for Medical Research*

Ms Patricia Livingston, Ms Karen McConalogue

*Australian Neuroscience Society Sir Grafton Elliot Smith Award 1995*

Ms Karen McConalogue

*UMMS BMed Sc Prize*

Ms Kirsten Van Haaster, Mr Simon Williams

*Appointments to Royal Australasian College of Physicians*

Professor Richard A Smallwood (President-elect), Professor Richard G Larkins (Vice-President-elect)

*Fellow of Academy of Social Sciences*

Associate Professor Phillipa Pattison

*1996 Sims Travelling Professorship*

Professor Richard G Larkins

*PhD Chancellor's Prize*

Dr Beverley Faulkner-Jones

*Appointments of Professorial Associates*

Professor F Beck (Anatomy and Cell Biology)  
Mr Charles P Clarke (Surgery ARMC)  
Dr John R Zalcborg (Medicine ARMC)

## Students

The Faculty's programs at both undergraduate and postgraduate levels continue to attract outstanding students. At the undergraduate level this is reflected in the receipt of 1995 Premier's VCE Awards and the 1994 Australian Student Prizes. For the MBBS course the 'clearly-in' TER rank (the rank at and above which all VCE applicants were offered a place) was 99.85, with a 'fringe rank' of 98.15 (the rank above which 95 per cent of offers were made) and a 'fringe percentage' of 60 per cent (the percentage of applicants with a TER at or above the 'fringe rank' who were offered places). The corresponding figures for the BSc and BPhysio courses were 99.00, 96.95 and less than 50 per cent (BSc) and 98.70, 94.15 and less than 50 per cent (BPhysio). The 'clearly-in' TER rank for MBBS/BA and MBBS/BSc was 99.95 and 99.90 respectively.

At the higher degree level, strong demand continues for places, particularly by research thesis. In 1995, 791 EFTSU (compared with 704 in 1994 and 669 in 1993) were enrolled, this being 21.2 per cent of the total teaching load of the Faculty. The proportion of Faculty higher degree load to University higher degree load in 1995 is 26.3 per cent (compared with 24.5 per cent in 1994 and 22.7 per cent in 1993).

## Community Relations

The promotion of good relationships with alumni, with related professional groups and the general community, is given high priority in this Faculty.

The University of Melbourne Medical Society (UMMS), established in 1982, provides medical alumni with an opportunity to enjoy active links with the School of Medicine, the University and with fellow alumni. The UMMS journal *Chiron* has an important role in fostering these relationships and in 1995, again achieved the highest standards thanks to the work of Mrs Margaret Mackie. UMMS has maintained a strong membership in 1995 and there has been continued interest in School of Medicine, University of Melbourne and UMMS activities and in medical graduate reunions. Members enjoyed Professor Emeritus WSC Hare's 1995 UMMS Lecture entitled *Röntgen and His New Kind of Rays*. UMMS continues to sponsor an annual prize for the best BMedSc research report submitted by a medical student. UMMS also sponsors up to three prizes (the Peter G Jones Elective Essay Prizes) for essays submitted by final year students in connection with their elective studies – two such prizes were awarded in 1995.

The Society of Alumni and Friends of Dental Science continues to enjoy success under its new constitution and Committee of Management, and provides valuable support to the School of Dental Science. The School of Behavioural Science maintains links with graduates through continuing education programs designed specifically to meet their professional training needs. The University of Melbourne Physiotherapy Alumni Society has been established out of the initial Friends of Physiotherapy group, and the School of Physiotherapy has received support with equipment, a student prize and the graduation function for diplomates.

The Faculty actively promotes high-quality continuing professional education programs. The School of Medicine and the School of Dental Science have well-established continuing professional education programs. Under the leadership of Professor Emeritus Priscilla Kincaid-Smith, the Continuing Education Unit offered eleven medical courses in 1995. These popular courses, mostly for general practitioners, were developed by departments with the support of the Department of Public Health and Community Medicine General Practice Unit and the Continuing Education Unit. In addition, several clinical attachments for overseas doctors from developing countries have been organised as short courses. The School of Physiotherapy continued its Postgraduate Seminar Series, and Bobath and Advanced Bobath courses leading to an internationally recognised certificate have been offered to members of the profession as well as other non-award courses.

The Faculty's annual Dean's Lecture Series continues to offer a valuable public forum for inaugural lectures for new professors/professor-directors as well as for major named lectures.

The 19th Mathison Memorial Lecture, entitled *Gene therapy – expensive dream or exciting reality?* was delivered by Professor Bob Williamson, Director of the Murdoch Institute of Research into Birth Defects as part of the 1995 Dean's Lecture Series. Other speakers in the Series were Professor Frank Oberklaid, Professor Stephen Harrap, Professor Scott Henderson (Beattie Smith Lecture), Professor Margot Prior, Professor Robin Marks, Professor Peter Disler, Professor John Hutson, Professor Eric Reynolds and Professor H Kerr Graham. The 1995 Dean's Lecture Series concluded with the medical ethics seminar *Caring for the Severely Disabled or Dying Child*, convened by Professor Richard Smallwood. The seminar attracted a sizeable audience and considerable media attention.

## Tribute to the Dean: Faculty Management

A major event for the Faculty occurred when the Dean, Professor Graeme Ryan, left the University in November 1995 to take up the challenging position of Chief Executive Officer of the new Inner Health Care Network in Melbourne.

At the last Faculty meeting for 1995 tribute by standing acclamation was paid to Graeme Ryan for his leadership, his outstanding contributions, and for the dedication he has shown in his work for the Faculty, the University and the wider community. In particular, the Faculty expressed its gratitude for the leadership role he played in the Faculty as Deputy Dean (1980-1985) and then as Dean for the past ten years. Before his new appointment, Graeme had been appointed by the University Council during the year as the sole nominee for a further term of office as Dean from 1996.

On the occasion of the above Faculty meeting Professor Ryan as Dean expressed his thanks and appreciation of the support again

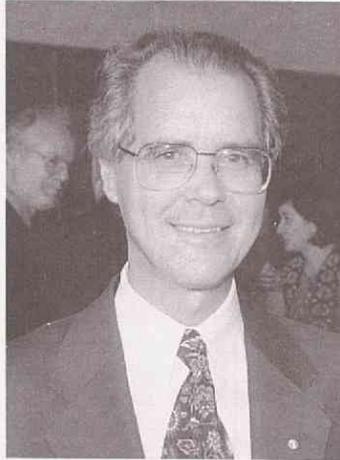
given to him by the Deputy Dean, the Associate Deans, the Clinical Deans in the School of Medicine and the School of Dental Science, the Heads of Departments in the School of Medicine, and to the General Manager and his staff in the Faculty Administration Unit, to the four School Managers and their staff, and to his Administrative Assistant, Mrs Iris Welcome.

Following the vacancy occasioned by Professor Ryan's departure, I was appointed Dean for the period to the end of 1997 and Professor Clive Wright, School of Dental Science, was elected Deputy Dean for the same period.

*Gordon J A Clunie*

Dean, Faculty of Medicine, Dentistry and Health Sciences

## GRAEME BRUCE RYAN, AC



**G**RAEME RYAN RESIGNED from his position as Dean of the Faculty of Medicine, Dentistry and Health Sciences on 17 November 1995 and left the University to take up an appointment as Chief Executive Officer of the Inner Health Care Network in Melbourne. His many friends are genuinely sorry that he has left the University, but sincerely wish him every success with this complex and demanding job.

Graeme Ryan's move from the University inevitably prompts me to reconsider the fifteen or so years during which I have been associated with him both professionally and as a friend. Undoubtedly, the most important aspect of his contribution to the University and to the careers of his more immediate colleagues in the Department of Anatomy and in the Faculty, was that we always knew we were dealing with a genuine, friendly person, who could be trusted to give assistance if that were possible, and whose aspirations for the Department, the Faculty and the University matched ours. This, of course, did not mean that there was always blissful agreement, but it did ensure that one was always confident of being heard out, and of being given the opportunity to explore with him particular problems and their solutions. I greatly appreciated this approach when I moved from Physiology to Anatomy in 1981. The friendliness and calm in Anatomy, and the generous support given the newly arrived, somewhat agitated group from the Brain Research Laboratory, was greatly appreciated, and helped members of that laboratory on their professional way. Similarly, when Graeme became Dean of Medicine in 1986 he established a new sense of security and unity of purpose. This steadying effect provided the foundation for the profound remodelling of the Faculty that would occur in the following decade, and which was effected without spilling blood.

A medical graduate of the University of Melbourne (MBBS 1961, MD 1966), Graeme Ryan quickly moved into a research laboratory, first in the Department of Pathology at Melbourne (1963-1965), then to St. Bartholomew's Hospital, London (1968-1969). He then spent four years in the Department of Pathology, University of Geneva, working

with Professor Majno, and an additional three years at Harvard as a staff member (Associate Professor) working with Morris Karnovsky. By this stage of his career Graeme was a well established experimental investigator of renal structure in health and disease, applying the methods of molecular biology, and with an extensive list of substantial publications.

In 1976 he returned to Melbourne to set up an NHMRC Renal Diseases Research Unit in the Department of Pathology, and in 1978 was appointed Professor and Chairman of the Department of Anatomy. The Renal Unit moved with him to the Department of Anatomy, and quickly attracted excellent co-investigators. These included Daine Alcorn, who not only continues as a singularly active member of this Unit, but who has recently stepped into Graeme's former position of Professor and Chairman of the Department of Anatomy and Cell Biology.

Graeme's period of chairmanship of the Department of Anatomy (1978-1985) was characterised by important changes in the undergraduate teaching courses, and a great expansion of the research in the Department. This transformation was dramatic, with upheavals in the undergraduate teaching of topographic anatomy, cell biology and neuroscience, and with the appointment of new staff. The Renal Research Unit flourished.

In 1986, after a stint as Deputy-Dean, Graeme Ryan was appointed Dean of the Faculty of Medicine, an appointment which redirected his career. While continuing as Head of the Renal Research Unit, Graeme's major commitments were now focused on Faculty and University affairs, which he

tackled enthusiastically. The major Faculty changes which he implemented were (a) the fusion of the Faculties of Medicine and Dental Science, the establishment of a School of Physiotherapy, and the assimilation of all of these along with the University Department of Psychology to form a single Faculty of Medicine, Dentistry and Health Sciences, and (b) the appointment of about twenty new Professor/Directors in the various teaching hospitals of the Faculty. These brave changes in the Faculty have been made against the backdrop of important politically-driven changes that have swept across all Australian universities, including Melbourne, in recent years. We shall have to follow events over the next decade to fully appreciate how this substantial expansion of the Faculty will affect its research and teaching, and its role in the University. What is quite clear, however, is that the impact of these changes will be profound, and that Graeme's deanship will be seen as a watershed in the Faculty's history.

During this later period of his career Graeme has also had an active role in the general University administration, being President of the Academic Board (1989-1990), an elected member of the University Council (1985-1990), and chairman of numerous University committees, including the PhD Committee (1982-1985). He also has had important appointments outside the University of Melbourne, including the chairmanship of the NHMRC Grants Committee (1985-1987) and of the Committee of Deans of Australasian Medical Schools, and as a Governor of the Ian Potter Foundation. Graeme has also been a member of the boards of several hospitals and research institutes associated with the University of Melbourne. In recognition of these many contributions to the community he was appointed Companion of the Order of Australia in 1994.

Graeme Ryan leaves the University of Melbourne with the sincere thanks and good wishes of a very large group of friends. He starts a new, exciting and difficult career, which we shall all follow with interest and with expectation of his considerable success.

*Ian Darian-Smith*

# SCHOOL OF MEDICINE HIGHER DEGREES AND DIPLOMAS CONFERRED 1995

*Unless otherwise stated, degrees awarded by The University of Melbourne*

## DOCTOR OF PHILOSOPHY

Vasso Apostolopoulos, BSc – Surgery  
 Silvio Basile, BSc – Medicine  
 Zdenka Bolcevic, BSc – Microbiology  
 Andrew Sutherland Browning, BA, BSc – Anatomy & Cell Biology  
 Aldona Butkus, MAppSc, DipLabTech (RMIT) – Anatomy & Cell Biology  
 Keith Andrew Byron, BAppSc (RMIT) – Medicine  
 Michael Robert Cancilla, BSc – Biochemistry  
 Marion Cincotta – Medicine  
 Karen Michelle Coates Fryer, BSc – Microbiology  
 Cynthia Rose Davis, MSc – Psychiatry  
 Neil Gregory Della – Ophthalmology  
 Sherif Shafik Farag, MBBS – Medicine  
 Maree Cecily Faux – Medicine  
 Jacqueline McKenzie Goodall – Microbiology  
 Gordon Henry Gotts – Public Health & Community Medicine  
 Jennifer Margaret Gunnerson, BSc (James Cook) – Biochemistry  
 Jane Lavinia Halliday, BSc (Monash) – Public Health & Community Medicine  
 Ailsa Gwendoline Harpur, BSc – Surgery  
 Alan Hayes, BSc – Physiology  
 Souheir Houssami – Medicine  
 Jacqueline Dione Hunt, BSc (Monash) – Microbiology  
 Gary Peter Jamieson, BSc (Qld), MSc – Biochemistry  
 Elizabeth Frances Jones, MBBS (Lond) – Medicine  
 Peter Andrew Jones – Otolaryngology  
 Hariclia Kakouris – Pharmacology  
 Amanda Jane Kay, BA (Tas) – Psychiatry  
 Wen Chen Kendrick, BMed (Shanghai Second Medical Uni) – Medicine  
 Paul Robert King – Medicine  
 Blair Lawley, BSc – Microbiology  
 Shireen Ruth Lamande – Medicine  
 Meredith Jane Layton, BSc (Monash) – Medical Biology  
 Xiaozhou Li, DipMed (Shanxi) – Medicine  
 Zhi Shan Li – Anatomy & Cell Biology  
 Zhanqi Liu, BMed, MSc (Harbin Uni) – Microbiology  
 Roxana Marcela Llanos – Biochemistry  
 Robyn Elizabeth Lukeis, BSc (Monash) – Medicine  
 Carolyn Anne Luscombe, BSc – Microbiology  
 Robyn Louise Malby, BSc (Syd) – Biochemistry  
 Gregory Bruce Mann – Medicine  
 Grant Alan McArthur – Medical Biology  
 Glenn Kevin McConell, BAppSc (W'gong), MSc (Ball State Uni, Indiana) – Physiology  
 Michael Ronald McCoy, BSc, MAppSc (VicUT) – Physiology  
 Andrew Charles McFarlane, BSc – Pharmacology  
 William John McKinstry, BSc (Tas) – Medical Biology  
 Samantha Michaelson – BSc – Pathology

Robert David Moir – Pathology  
 Padma Murthi, MPH, MSc (Madr) – Medicine  
 Robert Oelrichs, BMedSc, MBBS (Qld) – Surgery  
 Ross Desmond O'Shea – Medicine  
 Vasilis Paspaliaris, BSc – Pharmacology  
 Daniel John Peet – Biochemistry  
 Balakumar Pulendran – Medical Biology  
 Linda Jane Richards, BSc – Medical Biology  
 Samantha Jane Richardson, BSc – Biochemistry  
 Mark Allen Read, BAppSc, DipEd (LaT) – Surgery  
 Lorraine Grace Robb – Medical Biology  
 Kevin Gerard Rowley – Medicine  
 Joseph Paul Sarsero, BSc – Microbiology  
 Mark Andrew Schier, BAppSc (Swinburne UT), MSc (Monash) – Psychiatry  
 Anthony Dominic Shafton, MSc, DipEd – Physiology  
 Sansnee Jirojwong Skolnik – Community Medicine  
 Frank Hermann Sotzik, BSc (WAust) – Medical Biology  
 David Ian Stapleton, BSc (LaT) – Medicine  
 Nora Elizabeth Strazincky, BPharm (South Aust IT), DipHospPharm (Syd) – Surgery  
 Hongchen Tao, BSc (Hebei Med Coll) – Physiology  
 Aqa Mohammad Tokhi – Microbiology  
 Kathy Traianedes – Medicine  
 Lerma Ung, MSc (Canada) – Community Medicine  
 Elizabeth Vincan, BSc – Microbiology  
 Xueyong Wang – Medicine  
 Alister Curtis Ward, BSc – Biochemistry  
 Nicholas Raymond Thomas Young, BSc (LaT) – Medicine  
 Weiping Yu – Biochemistry  
 Yanling Zhang – Physiology  
 Yu Zhang, BSc (Nanjing Coll Pharm, China), MSc (China Pharm Uni) – Biochemistry

## DOCTOR OF MEDICINE

Robert Andrew Danks, MBBS  
 Patricia Margaret Davidson, MBChB (Glas)  
 Janice Mary Fletcher, BSc (NSW), MBBS (Syd)  
 Susan Sook-Keng Ho, MBBS (Qld)  
 David William Kissane, MPM (Monash), MBBS  
 Michele Rose Levinson, MBBS  
 Xun Li, MBBS (Jiangxi Med Coll, China), MMSc (Peking Union Med Coll, China)  
 Andrew Ian MacIsaac, MBBS  
 Michael Kenneth Marks, MBBS  
 Wendy Elizabeth Marshman, MBBS  
 Elizabeth Jane McLeod, MBBS  
 Matthew Thomas Naughton, MBBS  
 David Ravine, MBBS (WAust)  
 Susan Margaret Sawyer, MBBS

## MASTER OF MEDICINE

Lisa Helen Amir, MBBS, GradDipWmHealth  
 Sheila Baingana, MBBS (Mak, Uganda)  
 Phyllis May-Ling Chua, MBBS  
 Alexandra Mary Cockram, MBBS (Monash)

Gwenith Ann Matison  
 Kathryn Ann McMahon, MBBS (Monash)  
 Vincenzo Mercuri  
 Marie Vera Pirotta, MBBS  
 Stephen Leonard Stuckey, MBBS

## MASTER OF SURGERY

Constantine Mylonas, MBBS  
 Amanda Jane Robertson, MBBS

## GRADUATE DIPLOMA IN AUDIOLOGY

Melissa Jane Chandler  
 Tina Michelle Dennett  
 Mark Christopher Flynn  
 Belinda Anne Henry  
 Katie Latus  
 Anna Kristen Logan  
 Joanne Lee Mynard  
 Julia Ann Sutcliffe  
 Natalie Patricia Wheeler  
 Nicola Daly  
 Michelle Dwight  
 Natalie Anne Hardie  
 Steven Kargas  
 Andrea Marie Lewis  
 Leasa Maria McVinish  
 Tania Elizabeth Sketcher  
 Jacqueline Ann Tracy  
 Ingrid Joanna Woodger

## GRADUATE DIPLOMA IN EPIDEMIOLOGY

Alan Raymond Blandthorn

## GRADUATE DIPLOMA IN PSYCHOLOGICAL MEDICINE

Peter Charles Farnbach  
 John Joseph Reilly

## GRADUATE DIPLOMA IN WOMEN'S HEALTH

Theresa Anthides  
 Jenny Apostolakos  
 Alison Bailey  
 Gabrielle Bennett  
 Anne Berrett  
 Lynlee Dolman  
 Elizabeth Donohue  
 Jane Duncan  
 Catherine Galbraith  
 Corrine Garamszegi  
 Faye Hector  
 Julia Hopkins  
 Sawako Kino  
 Sylvia Krynski  
 Betty Luders  
 Geraldine McDonald  
 Margaret Morris  
 Shastra Naidu  
 Mary Panjari  
 Kathlyn Pope  
 Elizabeth Wheeler  
 Margaret Wilson

# EXTENSION TO THE MEDICAL SCHOOL BUILDING

**T**HE THIRTY YEAR OLD PROMISE of the University to provide purpose-built teaching and research facilities for the Department of Pharmacology is now a reality. The tri-radiate medical school building is to be completed as originally planned and championed by the late Sir Sydney Sunderland. In March 1996, building will commence to complete floors eight and nine on all three wings with a completion date of September 1997 and at a cost of \$19.8 million.



Architect's model of the completed School of Medicine building.

The modern re-development of the School of Medicine pre-clinical departments from the early buildings in the north-east corner of the University campus began with the recognition that the south-west corner of the campus should be the setting for the medical school – in close proximity to the Royal Melbourne Hospital. The first department to move was Biochemistry; into new facilities in 1961 made possible by the generosity of Sir Russell Grimwade. Next the Howard Florey Institute for Experimental Physiology and Medicine was commissioned in 1963, funded by government, private, and overseas funds in anticipation of the new medical school being built nearby. The pressure was on to clear the old medical buildings to allow a site for an urgently needed physical sciences building. At this time, the Department of Pharmacology was located in the old medical building complex with Physiology. These buildings were in need of demolition with rotten floor boards and laboratories below ground level in 'dungeon-like' conditions. The relocation plans called for a tri-radiate building for the Anatomy, Pathology, Physiology and Pharmacology Departments to facilitate integration of medical training and research, and for Biochemistry and Microbiology to be located in separate buildings nearby.

Early plans were for eight floors in the tri-radiate building with Pharmacology housed in the north wing of the seventh floor sharing animal house facilities with Physiology on the north wing of level eight. However, the building was originally designed for a class of 160 medical students in each year. The government of the day recognised the need for more medical graduates and requested the University to provide for 240 medical students per year. This caused further revision of the plans and a short-fall in funds for accommodating Pharmacology on the seventh floor.

Microbiology at this time was teaching RMIT students. The top two floors of the new microbiology building were planned specifically for these students. By the time the new building was completed in 1965, RMIT had decided to establish its own facility freeing up the top floors of Microbiology. With the difficulties with the medical building the University needed to find space for Pharmacology and also Oriental Studies on a 'temporary' basis. Instead of giving Professor Rubbo the entire microbiology building on his return from overseas, he found Pharmacology in part of the fifth floor shared with Oriental Studies. Pharmacology continued to be split between half of the top floor of the old pathology and microbiology buildings until Oriental Studies moved out in 1972. Pharmacology has occupied the fifth floor and half of the fourth floor with its animal house on the sixth floor of Microbiology ever since. Space has always been at a premium. With the gracious permission of Physiology, Pharmacology has occupied two practical laboratories on the second floor of the tri-radiate building and since 1993 occupied three research laboratories on the sixth floor at the invitation of Pathology. In addition Biochemistry has shared some of its basement space with Pharmacology to allow a synthetic peptide chemistry laboratory to flourish.

With the appointment of Professor Angus to the Chair of Pharmacology in January 1993, the University began planning to complete the tri-radiate medical building. The original architects of the tri-radiate building, Mockridge, Stahle and Mitchell, advised that the structure was still sound enough to allow two additional floors to be constructed and to satisfy the building codes of the 1990s. The original brief was to fit out the north wing of level seven and the whole of level eight but construct level nine to shell with plant rooms and lift motor room on the roof – a brief tentatively costed at \$11 million.

However, the National Health and Medical Research Council and the University Animal Ethics Committee advised that there was an opportunity to bring the existing animal house facilities in the tri-radiate building up to world class standard. In addition, the planning group was keen to see the School of Medicine develop a multimedia centre for student computer interactive learning with networked hardware and the latest in audio-visual CD ROM and video material for all

medical students in the pre-clinical departments. Noting that this was a massive construction program – potentially disruptive over an eighteen month teaching period, the group advised that we should maximise the long term benefit of the work by keeping two wings of the extension in shell for future fitting out as and when needed – the last expansion possible in this building.

## The Plans

In keeping with Sir Sydney Sunderland's original ideal of integration of facilities, the School of Medicine multimedia unit and educational computer facility of over fifty computer stations will be developed in the north wing of the second floor. The existing seventh floor north and west wings (Anatomy animal house) will be completely cleared and shelled for future expansion. The new eighth floor will house Pharmacology on the three wings: in the east wing a teaching facility with laboratories, tutorial rooms and graduate centre; in the west wing teaching staff offices, administration, molecular pharmacology research laboratories and some core research facilities; and in the north wing, toxicology research and the sixty seat Michael J Rand Lecture Theatre. On the ninth floor, the north wing will house cardiovascular research laboratories for Pharmacology. The remaining ninth floor east and west wings will be combined animal house facilities for Anatomy and Pathology (west) and Pharmacology and Physiology (east). On the tenth floor (roof) will be the lift motor rooms and plant.

There will be a complete upgrade of existing lift services and two new lifts in existing shafts with one older shaft left vacant for future use when the seventh floor is completed.

The architects Stephenson and Turner, have developed an exciting plan for the cap on the medical school with a slightly extended wall line on the eighth floor and sweeping roof line that should look quite spectacular from Grattan Street. The advantages of this extensive building program are: to give Pharmacology a state of the art facility after more than forty years in shared/temporary accommodation; to restore space to Microbiology which has been in desperate need to find research laboratories since the original design of the building in 1965; to provide adequate animal house facilities for the medical school consistent with the highest standards for the twenty-first century to ensure that research and teaching standards can be maintained; to develop a multimedia centre for the School of Medicine; and to provide two wings on the seventh floor for future expansion.

The School of Medicine is most grateful to the University Property and Buildings department, especially Mr Don Ewart, and to the architects Mr Richard Cameron and Mr David Roberts from Stephenson and Turner for their expert assistance in the project to date. The Faculty of Medicine, Dentistry and Health Sciences and central funds from the University of Melbourne have provided the capital.

We all look forward to the completion of the tri-radiate medical school – to provide an environment for research and teaching in pre-clinical medical science that is second-to-none in Australia and which will take us well into the twenty-first century.

The promise of providing these first class facilities owes much to the consistent support and unwavering optimism of our recently retired Dean, Professor Graeme Ryan.

*Professor James A Angus*  
Head, Department of Pharmacology

## Reference

S Sunderland (1968), University of Melbourne Gazette 24:2-3.

## CLINICAL SCHOOLS

### AUSTIN AND REPATRIATION MEDICAL CENTRE

I WOULD PARTICULARLY like to touch on changes that have occurred to the programs within the Clinical School during 1995. In previous editions of *Chiron* the clinical teaching programs have been fairly well covered.

The major changes have occurred in our fourth year programs, with firstly the introduction of a mentor scheme for fourth year students from the beginning of their clinical terms. This was done at the suggestion of previous years' students to help students adjust to the clinical situation. The scheme was set up under Dr Jerry Gelb. The aim was to establish a group of counsellors, who were independent from the Clinical School and to whom the students could turn with any problems. At the start of the year, Dr Gelb spoke to the students about potential difficulties and arranged meetings between counsellors and students. The informal feedback to date from students is that the system has worked well.

The second major change, is that the Clinical School has set up the four terms with two of medicine and two of surgery instead of splitting the terms as done previously into five and four week periods. This has allowed for more time with students within one unit and also means that each student undertakes either medicine or surgery during their country rotation but need not do both. The students now undertake either a seven or nine week term within the medical or surgical units. Again, the feedback has been positive from both students and tutors in that it allows for better interaction and a longer time for them to become acquainted.

The fourth year teaching began with an introductory three week period in which there was again an emphasis on introducing students to the hospital scene. During that time students spent at least half a day with the interns of a medical or surgical unit and a day with the nurses on a ward. This is done to ease the students into the ward situation and to give them an understanding of how hospitals work. The emphasis throughout the fourth year is on acquiring clinical skill, as well as making sure that students learn how to communicate and

understand ethical issues. Pathology, radiology and geriatrics are also taught in formal fashion during the fourth year.

The fifth year remains essentially unchanged with teaching undertaken in the various specialist areas of paediatrics, obstetrics and gynaecology, psychiatry and community medicine.

Examination results from fourth year had all the students passing with three of the six students in the Dean's Honours List from the Clinical School. David Ying was our top student and was awarded the Lorna King Medallion. In fifth year, the Clinical School again received more than its share of places in the Dean's Honours List (three out of seven). Guy Bylsma was our top fifth year student.

The final year again commenced with students undertaking electives, many of which were overseas. Lisa Jarvis and Lee K W Fong were awarded the UMMS elective essay prize. The final two semesters consist of medicine/surgery with half the time spent in general and half the time in special units. The programs were similar to previous years.

The greatest change has been the amalgamation of the Austin and Repatriation Hospitals to form the Austin and Repatriation Medical Centre and then the establishment of the North-East Health Care Network.

The significant cuts in beds has reduced the students' exposure to clinical material. The use of ambulatory care and day surgery facilities is occurring but there are difficulties caused by the policy on discharge of patients required by hospital efficiency considerations. However, the Clinical School is looking towards a regional network involvement with PANCH and the new Epping Hospital expanding once more the clinical experience for students. These changes have increased the workload on the medical staff and the Clinical School is extremely grateful for the way in which they have still given their time and energy to the teaching of the undergraduate students.

*Associate Professor Bernard Sweet*  
Clinical Dean



#### Austin and Repatriation Medical Centre - Final Year Clinical School 1995

**Back row L-R:** K Lim, T Wagner, A Tsui, J Cotroneo, T Quach, G Harrison, A Cidoni, J Leatherland, M Smart, C Wong, L Waldrip, J Ooi, J Tan. **Fourth row L-R:** D Van Bavel, M Teoh, N Connelly, S Williams, C Reid, S McConnell. **Third Row L-R:** E Jarvis, L Fong, S Seevanayagam, M Richardson, R Aziz, D Arhangelschi, B Chan, B Greenall, G Ramanathan, G Anasson, K Chuah, N Rabbidge. **Second row L-R:** V Yap, Y Kaya, S-W Lee, J Wong, M Yeo, S Lontos, S Malekzadeh, D Grgic, R Macbeth, A Gavralas, L Gualano, K Kartsogiannis, M Raftopoulos, K Van Haaster. **Front row L-R:** C Cornwallis, J Perret, Y Lim, H Ma, Mrs M Neale, Prof G Burrows, Prof K Hardy, A/Prof B Sweet, Prof D MacLellan, Dr B Goss, Mrs R Poon, L Tran, D Dinh, C Lin. **Absent:** K Galatis, T Kee, W Van Gaal.

## THE ROYAL MELBOURNE HOSPITAL AND WESTERN HOSPITAL

**T**HE THIRD YEAR INTRODUCTORY course in clinical medicine was conducted over nine weeks on Wednesday afternoons in the same manner as previous years. An hour-long pathology demonstration was followed by a ward tutorial, and most tutors chose to demonstrate the taking of a history and the performance of a physical examination of a patient. All students attended one session at Western Hospital which was very successful. However student attendance again tended to fall towards the end of the course, and some tutors continue to question the objective of the course.

As in previous years, fourth year was divided into two surgical and two medical terms, each of eight or nine weeks duration, and the core of clinical instruction occurred within general medical and general surgical units.

All students were either at the Royal Melbourne Hospital or Western Hospital during term one. During the other three terms all students spent one term at either Ballarat Base Hospital, Wangaratta District Base Hospital or Wimmera Base Hospital. Each student group also spent two of the four terms at the Royal Melbourne Hospital and one of the four terms at Western Hospital.

The three week introductory period at the commencement of term one consisted of a broad range of introductory lectures, and 'examination days' in which the students saw a video tape or a demonstration of the examination of a particular system, then undertook self-examination under the supervision of tutors, and finally had a ward tutorial demonstrating the examination on a patient. These included the examination of the cardiovascular system, the central nervous system, the abdomen, the respiratory system and the musculoskeletal system.

There were two innovations to the introductory period in 1995, both of which were very successful. The first was the introduction of a 'familiarisation' day for which each student was allocated to a senior member of the medical staff of either the Royal Melbourne Hospital or Western Hospital and followed that staff member during all their daily activities. The second was the incorporation of 'clinical skills' and 'CPR' sessions during which all students rotated through stations

on cardiopulmonary resuscitation, ENT and ophthalmology examination, ECG recording, blood glucose monitoring and IV insertion.

Radiology teaching again consisted of three lectures per week during first term, and two lectures per week thereafter. These were replicated at Western Hospital and the country hospitals.

Advanced Study Units (ASUs) were again undertaken in fourth year, during either second or third terms, at the Royal Melbourne Hospital or Western Hospital. Each ASU consisted of either a verbal and/or a written presentation about a single topic at the end of the term.

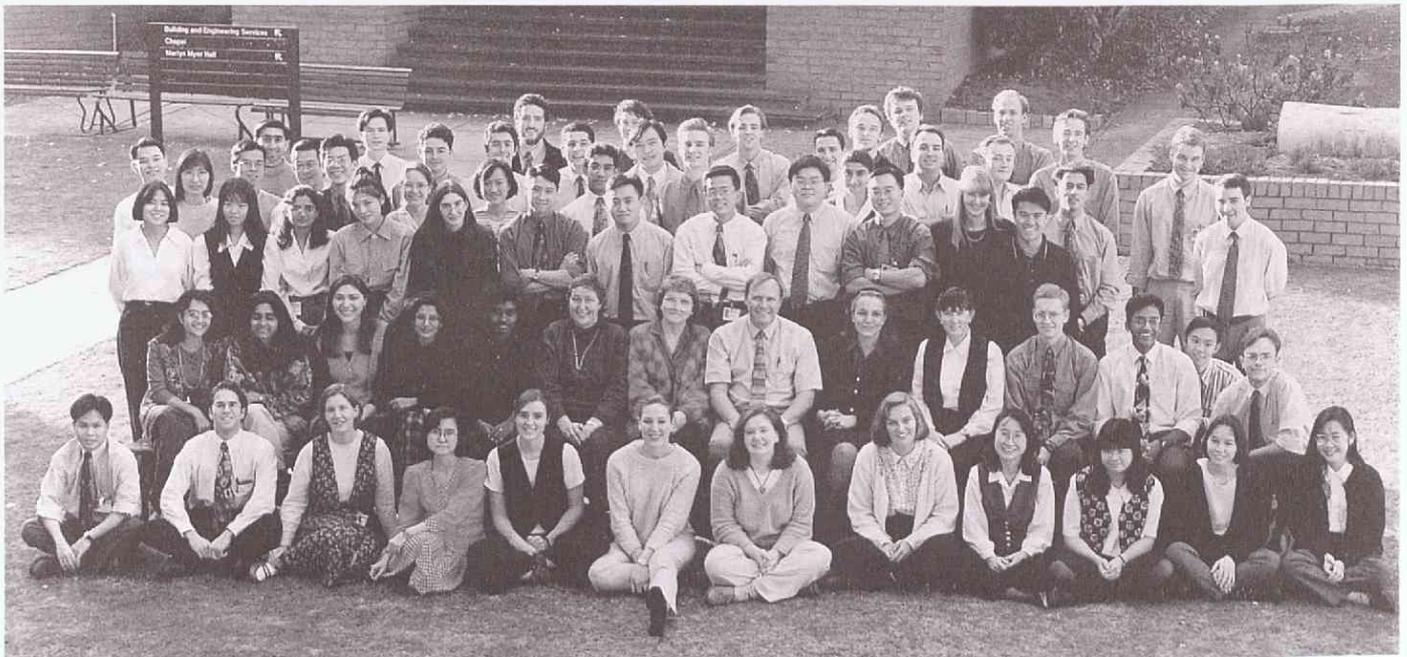
A 'revision week' was introduced in 1994 in which all students return to either Royal Melbourne Hospital or Western Hospital at the end of fourth year to practise clinical presentations. This was held again in 1995 but consisted only of trial long cases. A trial 'OSCE' test in the middle of the year was held to give the students feedback on their progress to that time, as well as a trial written paper towards the end of the year.

No significant changes relevant to the Clinical School have occurred to fifth year subjects in 1995.

Sixth year again consisted of an eight week elective period, finishing in early March, followed by blocks in each of general medicine, special medicine, general surgery and special surgery.

Overseas options were undertaken by students in the following countries: United Kingdom (13), United States of America/Canada (14), New Zealand (10), France (2), Greece (3), Africa (4), India/Nepal/Sri Lanka (7), South East Asia (18), Pacific/Indian Oceans (7), Australia (41) and others (6).

General surgery and general medicine consisted of six and seven week blocks respectively and in each case comprised a 'student internship' in a general medical or surgical ward at the Royal Melbourne Hospital or Western Hospital. In addition, student internships also occurred in general medicine at Ballarat Base Hospital, consisting of three or four weeks at Ballarat Base Hospital coupled to three or four weeks at the Royal Melbourne Hospital.



### Royal Melbourne Hospital and Western Hospital – Final Year Clinical School 1995

**Front row L-R:** Tri Duc Phan, Hendrik Zimmel, Kim Sleeman, Elysa Widjaja, Bronwyn Fitzgerald, Tanya Farrell, Margi Gould, Elizabeth Kyle, Melinda Wong, Annie Leong, Alissa Lim, Carol Lee. **Second row L-R:** Preethi Srikanthan, Dharsh Cugadasan, Helen Psihogios, Rashmi Pandey, Nachu Ramasamy, Miss Dorothy Bugg, Mrs Bette McCarrison, Professor Robert Moulds, Dr Christine Penfold, Dr Anne-Maree Kelly, Ruari Orme, Gehan Roberts, Ian Gan (deferred), David Rolls. **Third row L-R:** Caroline Tan, Linda Chow, Nalini Ben, Fiona Chow, Claude Fahrer, Jason Tye Din, Edward Tsui, Andre Chong, Patrick Chan, Kwong Soon Yeang, Madeleine Howard, Richard Mar, Ross Jennens. **Fourth row L-R:** Mark Hew, Rosana Choy, Hang Wi Tang, Sukhvinder Singh, Tung Nguyen, Gim Tan, Michael Zhang, Melinda Tee, Nick Stragalinos, Jim Tryfonopoulos, Sian-Ling Tan, Sal Rametta, Spiros Furlanos, Parin Patel, Joanne Brown, Irvin Heng, Geoffrey Tymms, Darrin Goodall-Wilson, Josh Kausman, Mandana Nikpour, Arun Rakkar, Julian Castro, David Chorowski, Tom Reade, Andrew Brett, Subodh Joshi, Matthew Taylor, Alex Meakin. **Absent:** Denes Borsos, Swee Ying Cham, Chow Huat Chan, Hang T Chau, Seng Cheong Loke, Keng Loong Ong, Peter Schuller, Sagarika Sirisena, Ing Ping Tiong.

Special medicine and special surgery consisted of blocks of seven and five weeks respectively. In addition each student attended three weeks of anaesthetics and emergency as part of the surgical rotation at either the Royal Melbourne Hospital, Western Hospital or Ballarat Base Hospital. During the special medical and surgical terms students rotated through a wide variety of specialities, and were taught in outpatient clinics, at the bedside or in a seminar format depending on the requirements of the particular specialty involved.

Daily case discussions were presented through the year by the senior medical and surgical staff. These consisted of interactive discussions of cases selected by the staff to illustrate points of diagnosis

or management. Each case discussion was preceded by a trial short answer question.

As in previous years each student group had a medical and a surgical 'mentor', with whom they met regularly during the year.

During 1994, 496 applications for elective placements were received, and 53 elective students were placed, in 1995, in various general and specialist Departments and Units at The Royal Melbourne Hospital and Western Hospital. These students came from the United Kingdom (16), Ireland (3), United States of America/Canada (14), Fiji (4), Germany (7), New Zealand (2), Australia (4), and other countries (3).

*Associate Professor Robert F W Moulds*  
Clinical Dean

## ST VINCENT'S HOSPITAL & THE GEELONG HOSPITAL

**I**N THE HISTORY OF St Vincent's Hospital 1995 was a most significant year. In mid-September the impressive new inpatient facility was opened by the Premier of Victoria and blessed by the Archbishop of Melbourne, Sir Frank Little. The new building provides state of the art facilities and has many innovative features which will greatly enhance the education and training opportunities for our students.

During 1995, there were 213 students in the Clinical School with 70 in final year, 73 in the fifth year and 70 in the fourth year.

The formal teaching program began in early March and was preceded by the eight week elective term which students found both enjoyable and valuable. Options in South-East Asia have become increasingly popular in recent years, not only with students who have family ties in this region, but also as a result of closer relationships which have developed between the Asian Universities and hospitals and those of Melbourne.

The medical rotations were similar to previous years with students spending four weeks attached to a general medical unit at St Vincent's Hospital or The Geelong Hospital and ten weeks rotating through the various sub-specialties.

Students undertook their general surgical rotations at The Geelong Hospital or at PANCH and their surgical specialty teaching in the units at St Vincent's Hospital. This year teaching in trauma and resuscitation was consolidated into an intensive course and the infectious diseases teaching at Fairfield was combined with the anaesthetics program which was held at various inner Melbourne hospitals.

The 1995 final year students achieved outstanding success in their examinations and are to be congratulated upon their enthusiasm and dedication throughout their clinical studies. Kirsty Busing was the top student in the course and also won several awards for achieving first place in medicine. The top student in surgery was Zoë McCallum, and James King distinguished himself as the only student in the course to gain first class honours in both final year subjects. As well as Kirsty and James, Robin Cassumbhoy, Marnie Buckwell, Terence Ong and Melanie McCann achieved the honour of inclusion in the Dean's Honours List. We congratulate all the 1995 graduates, and wish them well in their future careers.

There were no significant changes to the fifth year curriculum during the year. As usual, students found their country practice experience most stimulating and also enjoyed mixing with colleagues from other hospitals.



### St Vincent's Hospital and The Geelong Hospital – Final Year Clinical School 1995

**Back Row L-R:** Kah-Seong Loke, James King, Martin Williams, Kris Cvach, Kim Connelly, Marno Ryan, Anthony Hull, Miles Sparrow, Boyd Yim, Lindsay Chow, Lee Min Yap, P K Kong, Kenneth Koo. **Fourth Row L-R:** Paul Mezzavia, Teck Loh, Kim New, Margie Danchin, Andrew Bradbeer, Klaus, Adrian Ward, Zoë McCallum, Tak Yue Kwok, Milenka Juric, Richard MacIsaac. **Third Row L-R:** Julie Chu, T S Low, Nelson Yap, Chern Yap, Craig McCutcheon, Peter Charalabidis, Andrew Wake, Marcus McMahon, Kate Hamilton, Shannon Reid, Sal Martino, J C Lee, Thuya Nguyen, Swee-San Loo. **Second Row L-R:** Anne Parsons, Gregory Kam, Joseph Chooi, Cybele Tran, Melanie McCann, Kirsty Busing, Andrew Lovett, Rohan Essex, Terrence Ong, Daniela Zantomio, Sally James, Mei Pang, Graham Wong, Lyn-Li Lim, Quee Li Chiam, Terry Wu. **Front Row L-R:** Thushi Cugadasan, Marnie Buckwell, Meredith Lewis, Claire Campbell, Diana Tran, Bridget Clancy, Su-Mien Yeoh, Dr J Walters, Edmund Poliness, Louise Creati, Assoc Prof Wilma Beswick, Sonia Fullerton, Kritika Chaiwatanatorn, Michele Hua, Helen Vu, Elgene Lim. **On Ground:** Pat Charles. **Absent:** Robin Cassumbhoy, Arthur Rallis, Jenny Daniel, Mark Michail.

The fourth year program began with an intensive three week introductory course in clinical method, which emphasised the essential elements of history taking and clinical examination technique. As part of the course, students undertook a series of lectures on communication skills and interview assignments to prepare them for patient clerking. During the introductory course, students were introduced to transcultural issues in medical practice and also to psychiatric problems which may affect the medical practitioner. A patient-centred seminar on reaction to chronic illness was also held, with the participation of medical, nursing and paramedical staff.

Students were then rotated through two medical and two surgical terms which included tuition in sub-specialty areas.

The core lecture program was delivered in term one when all students were based in Melbourne. This has led to some imbalance in the teaching program with 'lecture overload' in the early part of the year. It is expected that the installation of a video link between St Vincent's and The Geelong Hospital will enable the lectures to be more evenly dispersed throughout the year.

The teaching of communication skills using student-patient video interviews took place throughout term one under the supervision of experienced clinicians.

The ethics program of group tutorials and class presentations was once again a highlight of the fourth year. Ethics teaching was undertaken at either St Vincent's Hospital or The Geelong Hospital under the supervision of a dedicated tutor. Students greatly appreciate the opportunity to discuss ethical issues which they encounter at an early stage of their training.

All fourth year students rotated to The Geelong Hospital for one term and they also had the opportunity to undertake a rural rotation at either the Goulburn Valley Base Hospital or the Warrnambool and

District Base Hospital. These rotations are very valuable and most popular with students because of excellent patient access and enthusiastic teaching staff.

Rotations to PANCH continued to form an essential part of our teaching with well established programs in medicine and surgery as well as in pathology and radiology. The strong links between St Vincent's Hospital and PANCH have developed over many years and we have an excellent complementary program, which is greatly facilitated by the rapport between staff at both institutions.

The Introductory Course in Clinical Medicine for third year students was conducted in a similar manner to previous years. Students enjoyed their time at the Clinical School and were enthusiastic about their contact with clinical hospital practice. Some students had the opportunity to see patients with allied health practitioners and this was a very successful inclusion into the program.

Physiotherapy clinical education continues to grow and develop within the St Vincent's Hospital and Geelong Hospital Clinical School.

In 1995, a record number of students have completed clinical placements within the Clinical School. At undergraduate level, 18 first year students, 18 second year students, 19 third year students and 12 fourth year students have been accommodated. At a postgraduate level there has also been considerable activity within the department, with the establishment of clinical placements for postgraduate students and members of staff undertaking advanced studies.

Increased undergraduate student numbers will extend to fourth year for the first time in 1996 which will present a major challenge.

We are most grateful to the hard working and dedicated teachers associated with our clinical school during 1995. Their willingness to teach and commitment to our students is greatly appreciated.

*Associate Professor Wilma M Beswick*  
Clinical Dean

## MBBS GRADUATES 1995

George Anasson, Dan Iurii Arhanghelschi, Rodney Aziz, Nalini Ben, Denes Csaba Borsos, Andrew Grant Bradbeer, Andrew James Brett, Joanne Carolyn Brown, Marnie Buckwell, Kirsty Lee Buising, Claire Belinda Campbell, Robin Cassumbhoy, Julian Michael Castro, Kritika Chaiwatanatorn, Swee Ying Cham, Chow Huat Chan, Wai Hon Chan, Peter Charalabidis, Patrick Pendrill Charles, Hang Thanh Chau, Louise Quee Li Chiam, Andre Kheng Ho Chong, Weng Kong Chooi, David Michael Chorowski, Fiona Yim Fung Chow, Ling Hsi Chow, Linda Cheng-Jing Chow, Rosana Choy, Julie Chu, Kenneth Chye-Yuen Chuah, Anthony Cidoni, Bridget Maria Clancy, Nathan John Connelly, Kim Alexander Connelly, Caroline Meredith Cornwallis, John Cotroneo, Louise Marie Creati, Theivadharsini Cugadasan, Thushyanthie Cugadasan, Kristina Gwen Cvach, Margaret Helen Danchin, Jennifer Alison Daniel, Quoc Hung Dinh, Rohan William Essex, Claude Nicole Fahrer, Tanya Rochelle Farrell, Bronwyn Marie Fitzgerald, Lee Kwong Shui Fong, Spiros Furlanos, Sonia Louise Fullerton, Korina Galatis, Avvangelia Gavralas, Darrin Niel Goodall-Wilson, Margaret Jane Gould, Brenda Jenny Greenall, Darija Grgic, Linda Gualano, Katherine Rae Hamilton, Glenn Robert Harrison, Irvin Chai Min Heng, Mark Ji-Liang Hew, Madeleine Ann Howard, Michele Wen-Chien Hua, Anthony John Hull,

Sally Liang James, Elisa Nicole Jarvis, Ross Ralph Jennens, Subodh Balkrishna Joshi, Shyan Chin Kam, Katerina Kartsogiannis, Joshua Yehuda Kausman, Yelda Kaya, Huai K'Ng Kee, James Alexander King, Poi Keong Kong, Jenn Hian Koo, Tak Yue Kwok, Elizabeth Anna Kyle, Joanna Tracey Leatherland, Carol Hsu-Ling Lee, Sze Wey Lee, Joon Chong Lee, Annie En Nie Leong, Meredith Elizabeth Lewis, Alissa Yam Sian Lim, Elgene Lim, Kang Lim, Lyn-Li Lim, Yik Nyok Lim, Christine Lin, Teck Hiong Loh, Kah-Seong Loke, Seng Cheong Loke, Steve Lontos, Swee-San Loo, Andrew William Lovett, Teck Siew Low, Henry Hin Kui Ma, Robyn Anne Macbeth, Richard James MacIsaac, Shiva Malekzadeh, Richard Wah-Chung Mar, Salvatore Donato Martino, Zoë McCallum, Melanie Joy McCann, Stephen Russell McConnell, Craig Andrew McCutcheon, Marcus Anthony McMahan, Alexius Paul Meakin, Paul Mario Mezzavia, Mark Michail, Kim Min New, Thuya Nguyen, Tung Ngoc Thanh Nguyen, Mandana Nikpour, Keng Loong Ong, Terrence Jong Yeong Ong, Jason Ooi, Ruari Mor Orme, Rashmi Pandey, Mei Kuan Pang, Parin Mahendra Patel, Jennifer Louise Perret, Tri Duc Phan, Edmund James Poliness, Helen Psihogios, Dung Trung Quach, Natasha Caroline Rabbidge, Maria Raftopoulos, Arun Rakkar, Arthur Rallis, Vijaya Gowri Ramanathan,

Nachammai Ramasamy, Salvatore Joseph Rametta, Thomas Harley Reade, Christopher John Reid, John Shannon Reid, Matthew Graham Richardson, Gehan Prebakaren Roberts, David Christopher Rolls, Marno Celeste Ryan, Peter John Schuller, Sathi Sathiyendran Seevanayagam, Sukhvinder Singh, Sagarika K.K.S. Sirisena, Kimberley Jane Sleeman, Marcia Rachel Smart, Miles Patrick Sparrow, Preethi Srikanthan, Nikandros Stragalinos, Caroline Cheng Suan Tan, Sian-Ling Tan, Teck Jack Tan, Gim Kok Tan, Hangwi Tang, Matthew Francis Taylor, Melinda Mary Tee, Mark Wui Tee Teoh, Ing Ping Tiong, Linh Tran, Cybéle Tran, Diana Tran, Jim Tryfonopoulos, Alpha Emmanuel Tsui, Edward Kai Man Tsui, Jason Allan Tye Din, Geoffrey Mortimer Tymms, Dirk John Van Bavel, William Joseph Van Gaal, Kirsten Van Haaster, Helen Boi-Quynh Vu, Timothy Paul Wagner, Andrew Philip Wake, Luke Marvin Waldrip, Adrian Francis Ward, Elysa Widjaja, Martin Emrys Beatty Williams, Simon Reginald Williams, Corinne Pui-Foong Wong, Graham Kenneth Wong, Melinda Wong, Janice Miu Tsz Wong, Terry Tai-I Wu, Yan Tatt Vincent Yap, Chern Jiang Yap, Lee Min Yap, Nelson Chie Chong Yap, Kwong Soon Yeang, Myra Siu Luan Yeo, Su Mien Yeoh, Boyd Yim, Daniela Zantomio, Michael Zhang, Hendrik Simon Zimmet.

## FINAL YEAR TOP STUDENT 1995



KIRSTY BUISING

**Kirsty Lee Buising** was the top student in 1995, when she also gained first class honours in Medicine and was awarded the Australian Medical Association Prize,

the CIBA-GEIGY Prize and the Rowden White Prize, and was included in the Deans Honours List. She also won the Keith Levi Memorial Scholarship in Medicine, the Robert Gartly Healy Prize in Medicine, the Clara Myers Prize in Surgical Paediatrics, the Margaret Ryan Scholarship in Medicine (SVH), the Sister Christine Welsford Prize in Haematology (SVH), and the Institute of Medical Research Prize in Medicine (SVH).

Kirsty is a Melbournian who was brought up in Dingley and educated by the Brigidine Sisters at Killester College in Springvale. In 1990, she entered the MBBS course at Melbourne University, alma mater of her late grandfather, where she distinguished herself throughout the course and was awarded several University prizes. During her clinical studies at St Vincent's Hospital and Geelong Hospital Clinical School, Kirsty spent an elective period in English hospitals at Cambridge and Winchester, and also took the opportunity to backpack through Europe with friends.

The initial inspiration to pursue a medical career may well have come from Kirsty's mother, Pauline, who qualified in nursing, or her maternal grandfather, the late Dr John Ladbrooke, who was a family doctor. Kirsty's family is, however, distinguished in diverse

fields, as her father John, is a business executive, while her younger sister, Emma, is artistically gifted with a special interest in screen printing and design.

For a person of such awesome ability and achievement, Kirsty is exceptionally modest. The family artistic talent is seen in her love of the ballet, in which field she has already passed her student Intermediate Teaching Examinations – so she would have little problem changing career paths if she wants to spread her wings. Her other current interests are in aerobics and swimming, and her love of hiking has led not only to backpacking around a wintry Europe in 1994, but to trekking in Nepal in 1992.

Kirsty will take up an internship in St Vincent's Hospital, and plans to pursue a career in Internal Medicine.

## PRIZES & AWARDS 1995

### FINAL YEAR

#### **Australian Medical Association Prize**

Kirsty Buising, SVH/GH

#### **The CIBA-GEIGY Prize**

Kirsty Buising, SVH/GH

#### **Rowden White Prize**

Kirsty Buising, SVH/GH

### MEDICINE

#### **Keith Levi Memorial Scholarship in Medicine**

Kirsty Buising, SVH/GH

#### **The Robert Gartly Healy Prize in Medicine**

Kirsty Buising, SVH/GH

#### **Jamieson Prize in Clinical Medicine**

Mandana Nikpour, RMH/WH

#### **Upjohn Award in Clinical Pharmacology and Therapeutics**

Preethi Srikanthan, RMH/WH

### SURGERY

#### **Beane Scholarship in Surgery**

Zoe McCallum, SVH/GH

#### **The Robert Gartly Healy Prize in Surgery**

Zoe McCallum, SVH/GH

#### **Proxime Accessit Prize in Surgery**

Bridget Clancy, SVH/GH

#### **EH Embley Prize in Anaesthetics**

Kim Min New, SVH/GH

#### **AOA (Vic) Orthopaedic Prize**

Andrew Lovett, SVH/GH

### OBSTETRICS & GYNAECOLOGY

#### **The Robert Gartly Healy Prize in Obstetrics**

James King, SVH/GH

#### **Prize in Clinical Gynaecology**

Mark (Ji-Liang) Hew, RMH/WH

#### **Alfred Edward Rowden White Prize in Clinical Obstetrics**

Peter Charalabidis, SVH/GH

#### **Edgar & Mabel Coles Prize in Obstetrics**

James King, SVH/GH

### PAEDIATRICS

#### **Howard E Williams Prize in Paediatrics**

Alex Meakin, RMH/WH

#### **Child Growth & Development Study in Paediatrics**

Brenda Greenall, ARMC

#### **Clara Myers Prize in Surgical Paediatrics**

Kirsty Buising, SVH/GH

### PSYCHIATRY

#### **John Cade Memorial Medal in Clinical Psychiatry**

Mandana Nikpour, RMH/WH

### COMMUNITY MEDICINE

#### **RACGP Prize in Community Medicine**

Mandana Nikpour, RMH/WH

### INFECTIOUS DISEASES

#### **Sir Albert Coates Prize in Infectious Diseases**

Robin Cassumbhoy, SVH/GH

### GENERAL CLINICAL

#### **Edgar Rouse Prize in Occupational Medicine**

Julian Castro, RMH/WH

Lean Peng Cheah, RMH/WH

#### **Royal Australian College of Ophthalmologists Prize**

Rohan Essex, SVH/GH

#### **Hedley F Summons Prize in Otolaryngology**

Hendrick Zimmet, RMH/WH

#### **Herman Lawrence Prize in Clinical Dermatology**

Lean Peng Cheah

### FOURTH & FIFTH YEARS

#### FIFTH YEAR

##### **Community Medicine Prize**

Guy Bylsma

##### **Crawford Mollison Prize in Forensic Medicine**

Pending

##### **Medical Officers of Health Section of AMA**

Yee Ping Teoh

##### **The Fulton Scholarship**

Guy Bylsma

**The Kate Campbell Prize in Neo-Natal Paediatrics**  
Guy Bylsma

**The Max Kohane Prize**  
Guy Bylsma

**The Vernon Collins Prize**  
Michael Acton

**The John Adey Prize**  
Heidi Baker  
Garth Weston

#### FOURTH YEAR

**The Harold Attwood Prize in Pathology**  
Claire Short

**Geriatric Medicine Prize**  
Sebastian Barresi

**Manu Thomas Prize**  
Cheng Kang Ong

### PRE-CLINICAL

#### THIRD YEAR

##### Pharmacology

**Boots Prize**  
Constantine Tam

##### Pathology

**Walter and Eliza Hall Exhibition**  
Constantine Tam



THE UNIVERSITY  
OF MELBOURNE

#### Postera Crescam Laude

*I shall grow  
in the esteem  
of future  
generations*

Over the years thoughtful donations and bequests have played a significant role in building the medical school we have today. In an era of declining government funding and rising costs of teaching and research, the need for philanthropic support is now stronger than ever. You may wish to consider planning a personal contribution to support the School of Medicine's research, teaching and students with the designation of a donation or a bequest to the University.

If you would like more information, or a copy of the University Bequest Booklet, please contact Robin Orams of the School of Medicine on (03) 9344 5889 or Elizabeth Douglas, University Bequests Officer on (03) 9344 7804.

#### Microbiology

**Glaxo Prize**  
David Alexander

#### SECOND YEAR

##### Anatomy

**Dwight Prize**  
Kathryn Field

**Exhibition Prize**  
Kathryn Field

**TF Ryan Prize**  
Kathryn Field

##### Physiology

**Wellcome Prize**  
Choon Chieh Tan

##### General Biochemistry

**Exhibition**  
Celia Kemp

##### Functional Biochemistry

**Exhibition**  
Kathryn Field

##### Neuroscience

**Sunderland Prize**  
Alex Yu Hong Tan

##### Physiology/Integrated Body Function

**RD Wright Prize**  
Weng Toon Ng

##### Behavioural Science

**CIBA-GEIGY Prize**  
Sing Shing Jonathan Ting

#### FIRST YEAR

##### Medical Physics

**GA Syme Exhibition**  
Mark Steven

**TF Ryan Roentgen Prize**  
Tawfique Chowdhury

##### Introduction to Medicine

**The Australasian College for Emergency  
Medicine, Victorian Region, Prize**  
Valerie Sung  
Carol Pei-Wei Chong  
Wai Pheng Alicia Au

##### Medical Biology

**WH Swanton Exhibition**  
Shiin-Yun Yvonne Tan

**Baldwin Spencer Prize  
(for Zoology Practical Work)**  
Randal Leung

##### Chemistry

**Exhibition**  
Wai Pheng Alicia Au

##### Anatomy

**Mathew W McKenzie Award**  
Wai Pheng Alicia Au

## DEAN'S HONOURS 1995

In 1993 Faculty established a Dean's Honours List to give formal recognition to the achievements of its most outstanding students. The list comprises a small number of students of high distinction at each year level of the MBBS course based on the weighted average performance obtained in each year level for years 1-5, and the weighted average performance across the years 2-6 for final year.

#### FINAL YEAR

Marnie Buckwell, Kirsty Buising, Robin Cassumbhoy, Mark Hew, Joshua Kausman, James King, Melanie McCann, Alexius Meakin, Terrence (Jong Yeong) Ong.

#### FIFTH YEAR

Heidi Baker, Guy Bylsma, Trudy Clark, Megan Di Quinzio, Pallav Garg, James Thomas, Gareth Weston.

#### FOURTH YEAR

Andrew Burns, Sarah Healy, Thanh Nhut Nguyen, Cheng Kang Ong, Swee Teng Tan, David De-Wei Ying.

#### THIRD YEAR

Haris Haqqani, Anna Lee, Jonathan Ruddle, Toby Syme, Constantine Tam, Sin Kuan Tan.

#### SECOND YEAR

Kyra Yu Lin Chua, Yu Jo Chua, Kathryn Field, Catherine Francis, Saman Gardiya Punchedi, Celia Kemp, Weng Toon Ng, Justine Nielsen, Choon Chieh Tan.

#### FIRST YEAR

Wai Pheng Alicia Au, Richard Bignell, Carol Chaivachirasak, Sue Comerford, Peng-Yun Angela Huang, Randal Leung, Beng Liam Lim, Samuel Norden, Eugene Shyong-K Ong, Mark Steven, Shiin-Yu Yvonne Tan, Sze Chih Jason Tan, Limin Wijaya.

## PAK 'N SAVE – A SURGICAL ELECTIVE

Lee Kwong Shui Fong, MBBS 1995

*Feet pounded up the hallway. Fists hammered on doors. 'Where's Lee? Where's Lee?'*

*It was my first weekend on-call in New Zealand. I was lying on my bed in the nurses' home, enjoying the novelty (and inflated self-importance) of having my very own beeper. Michelle, the other trainee intern, had assured me that one was rarely called upon when on-call.*

*'I'm here!' I jumped off the bed and flung the door open. It was Tracey, one of the on-call theatre nurses. 'What's happening?'*

*'Crash Caesar! RUN!' I ran.*



Lee Fong with operating theatre staff of Kaitaia Hospital.

**WHERE'S KAITAIA?** When I first looked it up in an atlas, I saw (after half an hour of searching) that it was the last major town at the northern tip of New Zealand. Perhaps not surprisingly, I found the most common response to my saying 'Kaitaia' was 'Where's that?'. A more geographically enlightened uncle simply declared, 'You'll be bored within a week'. A diplomatic Kiwi cousin went so far as to comment, 'That's an interesting place to want to go'. The 'Lonely Planet' travellers' guide indicated that the most noteworthy feature of Kaitaia was the 'PAK 'N SAVE', a monstrously huge supermarket.

Well, I wasn't planning on crossing the Tasman to buy a cheap box of Coco Pops.

I'd found out about the hospital there from another medical student (now doctor) at my church. After spending an elective in surgery there, she'd said it was a great little hospital, the staff were fantastic, and she was given heaps of responsibility.

True, the place was isolated, with the bus trip from Auckland taking a tedious eight hours. It hardly had the appeal of a holiday-cum-elective in Europe. Even within the New Zealand context, Kaitaia was hardly a mecca for tourists, but it had what I wanted. I had decided that there was little point doing an elective overseas unless I was offered the opportunity to experience something different from the run-of-the-mill Australian medical student routine. With the 'trainee intern' position, Kaitaia offered that. And in the isolated solitude of the north end of New Zealand, I hoped to have some time to meditate about God, my life and how the two fit together. Besides, I couldn't afford a trip to Europe.

*I was huffing and puffing as we dashed across to the hospital. Two thoughts struggled into my hypoxic brain; 'This is*

*pretty exciting' and 'I gotta start jogging again.'*

As far as responsibility went, I got even more than I'd bargained for. When I arrived, due to a glitch in the timetable and a surprise transfer, there weren't any junior medical staff for the first two weeks. That left just me, one other trainee intern and two consultant surgeons, which meant that I was first on-call one day in three and one weekend in three.

It was all very new to me. Suddenly I was getting called in the middle of the night to assess someone who had rolled a car. 'Uh, sure' I'd say, grab my stethoscope, and dash out the door on my Oxford Handbook and a prayer. Surprisingly, the nurses really expected me to know things, and were actually asking me questions about so-and-so's fluid balance, medication, rising temperature etc. It put me in a situation of considerable responsibility (but with the consultant just a phone-call and five minutes away) which was a bit daunting at first, but meant that I learnt FAST!

And that was just a fraction of the work. On the ward I was doing most of the things an intern would do: clerking patients, doing discharge summaries, updating the notes after ward rounds, filling in new lab results, doing Doppler studies, re-siting cannulas. There was always more than enough to do, and it gave me a gentle introduction to internship. In one sense I was the intern, but in another I was still a medical student, so it was taken for granted I'd be a bit thick. The nursing staff would do no more than exchange knowing glances when I emerged from a room, with any of a range of familiar apologies. 'Ah, sorry, missed the IV again.' 'Ah, sorry, I got the IV in but I spilt a bit of blood.' 'Um, not having much luck with the

Doppler today.' 'Well, I guess I might have been conservative when I called it a bit of blood.'

With the patient good-will of the staff, things gradually got easier. Before long, even I noticed that my clerking efficiency had improved quite remarkably. When the whole operating theatre was at a stand-still, waiting for me to clerk someone I'd forgotten to do the night before, I suddenly discovered that I could do it a lot faster.

*'Forty-one weeks, transverse lie, ruptured membranes and foetal distress. A helicopter transfer to Whangarei would take at least a couple of hours.' The consultant general surgeon paused his scrubbing, and turned*

*to me. 'Have you assisted with Caesar's before?'*

*'Three or four, but I've only been first assistant at one.'*

*'That's OK, I've only assisted at one myself.'*

*'Pardon?'*

Besides assessing acutes, I was also first assistant in theatre for a very wide range of cases, including amputations, laparotomies, laparoscopic procedures, carpal tunnel releases and skin grafts. Thanks mainly to isolation, Kaitaia hospital had a range of surgery I wouldn't have had a hope of seeing in any one Melbourne metropolitan unit. Theatre had the added bonus of being staffed by friendly anaesthetists, who were more than happy for me to try my hand at intubation.

The vast majority of the patients – especially the long-term ones I got to know well – were super friendly. Before long I'd established something of a reputation amongst the staff as an epicure. Once the patients found that out, I was showered with food – freshly smoked snapper and kingfish, grouper fillets, scones with home-made jam and a bottle of wine as well as the standard chocolates. One of the patients' relatives even invited me out so I could catch my own fish.

When on-call for the night, I made a personal practice of doing a quick evening whip-around, just to see how everyone was, and on weekends I'd drop in at least once (on the way to the cafeteria). I had a couple of reasons for doing this. The first was that it made eminently good sense to know first-hand what each patient's condition was, as a reference point should something happen during the night. The second stemmed from

something I remembered from my first clinical year. There was a patient I'd clerked who had rhapsodised about his specialist; a doctor who cared about him so much that he'd drop in on weekends (on the way to golf) just to see how he was doing. I was mightily impressed by that, and made a mental note: that was the kind of doctor I wanted to be. Here was a chance to put it into practice, to see if I could make the grade in part of what I perceived a 'good' doctor to be. I figured that if I couldn't do it with the luxury of time Kaitaia's small patient numbers afforded me, I never would.

It also had the pleasant (and incidental) side-effect of yielding more food.

*For a tricky first Caesar, the consultant did a sterling job. In we went, and out came the baby, with smiles and hand-shakes all round.*

While it's probably true that there's more to see in the south island, I found there was no lack of things to do up north. While Kaitaia itself isn't much to look at, it is in the middle of some fabulous beaches. One thing that stood out were the times Josh, DeVilliers (the new medical officers), and I hired four-wheel drive motorcycles and went blasting around the sand-dunes at ninety mile beach. Incredible, exhilarating fun. And thank God for roll-cages.

The medical officers who arrived after week two of my tenure at Kaitaia deserve a special mention. They taught me a lot about clinical medicine, as well as being all-round top blokes. Even if they did have a death-wish ('You're not on this weekend, Lee? Good, let's go parachuting . . .'). I ended up spending a lot of time at Josh's flat, sharing food ('half of my hospital slop for half of your genuine Indian curry') and exploring the meaning of life. DeVilliers' culinary talents didn't extend quite as far ('half of my hospital slop for half of your . . . er . . . is that Continental instant pasta?') but he was just as much fun to hang around with. Between the two of them and being on call, I found that I didn't have much time for meditation.

Josh and DeVilliers gave me plenty of support during trying times. Something happened at Kaitaia that I knew would happen sooner or later in my professional life: one

of my patients died. It was not entirely unexpected, but when it happened, it was still a shock. Guilt is probably inescapable in such a situation – there always seems to be more that could have been done. And somehow, when the family isn't angry with you, it makes it worse, because you feel they should be, and without their 'punishment' you are left to punish yourself.

I went to Kaitaia hoping to experience 'real' medicine. In some ways, I got more than I bargained for – everything from the highs to the lows. But I've found that the more poignant moments lend a bitter-sweet edge to the highs, enhancing their reality. Medicine has suddenly taken on a meaning that it never really had before. Patients have

become people with personalities, with their own lives, and families that care for them.

On my final day in Kaitaia I was surprised to realise that I was going to miss the place – a lot. It may have taken five years, but I'd truly discovered my vocation.

*The mother and baby were fine. The mother had just been wheeled out of the theatre when I looked at the operating table, and realised we'd forgotten to protect it with a plastic sheet. Blood was dripping from all of its innumerable (and mostly inaccessible) nooks and crannies. I looked around for the surgeon. He'd already left the scene of the crime.*

*'Uh, sorry, looks like we spilt a bit of blood . . .'*



**Postscript:** During my stay at Kaitaia, the services at the hospital were overshadowed by threatened downgrading or closure. The issues of greatest government concern were the ever-tightening health dollar and the desire to centralise surgical services. However, the health authorities gravely underestimated the force of local opinion. The local populace was not amused at the potential loss of the only hospital providing elective and emergency surgery for miles around, and, at short notice, ten thousand people marched to the hospital in a spectacular display of unity. Almost all the local businesses (including the PAK 'N SAVE) closed to allow their employees to attend, and people came in by the bus load from all over the north end. The march made first story on all the news broadcasts that night, and was front page news in all the broadsheets next morning. It was more than enough to catch the attention of the politicians, who backpeddled furiously on the matter (of course, we had all misunderstood them). Last word I heard was that the services provided by the hospital would probably be maintained, and possibly even upgraded – but the struggle continues.



## DONATIONS TO THE UNIVERSITY OF MELBOURNE MEDICAL SOCIETY

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 Society. These donations support two 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. Two UMMS BMedSc Prizes were awarded for 1994: to Kirsten van Haaster and to Simon Williams. Citations describing their research are published 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 1995 prize-winners were Lee Fong and Elisa Jarvis and their essays are published in this issue of *Chiron*, pp29-32.

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

## 1995 Peter G Jones Essay Prizes

In 1993 the University of Melbourne Medical Society established the UMMS Elective Essay Prize for sixth year MBBS students.

In 1996 the prize was renamed the Peter G Jones Elective Essay Prize in honour of the late Peter Jones, founding editor of *Chiron*. Prizes of \$100 are offered annually for the best essays of up to 1500 words describing the elective experience in both professional and personal terms.

Prize-winning essays are also considered for publication in *Chiron*. The 1995 winning essays, by Lee Kwong Shui Fong and Elisa Jarvis, are published on these pages.

# LES PETITS ENFANTS

Elisa Jarvis, MBBS 1995

*With a child's wisdom, she seemed to sense something as I first walked into the house. She knew I was different; somehow displaced. Generously, she offered a faint smile and lingered momentarily in the hallway before scampering in amongst the decorations, leaving the shadow of her smile reflected in the golden baubles. The first words I spoke met with a puzzled stare, her dark chestnut eyes searching for an explanation. She would not answer, intent on keen observation to unravel the mystery. There was no hostility, just a mild tension.*

*Aude fascinated me too. I wanted to be accepted by her almost more than by the others. To truly befriend a young child is a challenge, but ultimately there are great rewards. Some believe that children are free of the social and psychological restraints of adult life. Their eyes are open to the world, perhaps explaining the amazing potential for learning and development.*

*Within the hour, Aude had taken me by the hand, establishing herself as chaperone and instructor in the new festive customs. By evening, a special rapport had developed between us. It was to be a Christmas full of magic and one which I shall never forget.*

**T**HE STILLNESS WAS EERIE as I peered through the shutters. The sky, a crimson-violet haze, was backdrop for falling snowflakes. Opening the window fully, I could see the grounds. Low-standing buildings with tiled roofs, half-buried under the snow were dotted amidst leafless oak trees and carefully tended pathways. An odd man or two could be seen scuttling between the buildings, like field mice from story books. One could be forgiven for believing this was a small village rather than a large, tertiary referral hospital in France. From the outside, there was little evidence of the highly structured medical environment within.

I showered and dressed in my 'whites', overlaying them with woollen pullover, scarf, coat and, finally, snow boots. Opening the door and leaving the warmth of the residents' quarters, I began another day working in the Paediatric Department of Lyon's Hôpital Edouard Herriot.

It was definitely not easy at first. Having arrived at 2 am after a thirty-seven hour journey from Melbourne, I started work at 7 am in the neonatal nursery. My schoolgirl French was fine for a social chat, but somewhat deficient for the purposes of taking antenatal, peri- and postnatal histories from some extremely distraught mums. Within a week, however, I was sharing the 'babyload' with my intern Catherine: full clinical evaluations, procedural work and presenting cases to our supervisors. Soon I had the satisfaction of seeing my babies gradually improve – as they gained weight, recovered from neonatal surgery or overcame problems associated with prematurity – and return home to their families.



Elisa Jarvis with Alexis in the playroom on Ward S3.

Fresh from fifth year examinations at the Royal Children's Hospital, I was to catch a further glimpse of the diversity of paediatrics. In addition to the principles of general medicine and surgery, one must also consider the enormous growth and development in the early years of life, and the profound effect of family dynamics and environment on a child's health. It appears a boundless specialty.

My first month was spent in the neonatal nursery, an efficiently organised twenty-five bed department. Babies were admitted either from the maternity wards downstairs, the adjacent neonatal intensive care, or elsewhere in the Rhône-Alpes region. Almost two-thirds were premature, some as young as twenty-seven or twenty-eight weeks gestation – tiny, lanugo covered creatures with minuscule hands and feet and, often, very distinct facial features. Learning to examine these infants proved to be an art form. Warm hands and stethoscope were

prerequisites, as was careful handling with correct postural support. Apart from vital signs, often the most helpful findings were on neurological examination – is this baby excessively floppy? does he/she conform to expected gestational age?

The department, headed by Professeur Salle, was dedicated to providing as near to sterile an environment as practicable. I was shocked on my first day to be shown how I was to scrub and gown each time I entered the nursery. Parents were also expected to wear sterile gowns and shoes over 'street' attire and toys for the babies were sterilised before being allowed entry. Surprisingly, the environment was not cold and clinical; the colourful decor and lively nursing staff made sure of that.

Many aspects of running the nursery were foreign to those I had experienced in Melbourne. Visiting hours for parents, from 2.30 to 4.30 pm, were timed to fit in with nursing schedules and exceptions rarely made. Bottle feeding with infant formula was the norm. During my stay only two mothers expressed milk for feeding and only one insisted she try to breastfeed. Even amongst healthy mums and babies, the breastfeeding rate at three months was remarkably low (1 in 5 or 6, I was told).

The morning I looked after baby Sara was one of the most frightening I can recall. A three-week-old term baby, rosy pink and chubby compared with the other infants under my care. I was examining her after a referral from outpatients for 'respiratory' distress. She seemed well, apart from a



View of the Hôpital Edouard Herriot.

temperature of 38°C and generalised decreased tone. I turned my head for less than ten seconds and when I looked back the colour had drained from her face, she became a mottled blue-grey, she was not breathing. Instinctively, I shook her – slowly she started breathing and her colour returned – but in less than a minute it happened again. I yelled for Sophie, our Registrar: what followed was half an hour of having to continually stimulate Sara to stop her respiratory pauses. Our department head was reluctant to admit any babies with the highly infectious Respiratory Syncytial Virus. I assisted in intubation and mechanical ventilation for most of the morning. Two weeks later Sara was discharged home to very grateful parents.

Paediatrics is wonderfully rewarding when medicine can cure or at least substantially benefit little children, yet it must be one of the saddest areas when we, as health-care providers, feel redundant. Twice, I have been in the delivery room of women in labour with a foetal death-in-utero. At the Mercy Hospital in Melbourne, I managed to control my feelings in the presence of the family, but once out of the room, burst into tears. For hours I cried uncontrollably in my boyfriend's arms. During the week that followed I was to have difficulty concentrating; I wondered if I still wanted to be a doctor. I knew for that woman it must have been one of the most distressing times in her life and

realised that I would have to face many equally emotional situations in my career.

After Christmas I was fortunate enough to spend time on the maternity and delivery wards. One afternoon I found myself confronted with a similarly awful situation. Ann-Sophie, the pregnant woman, was moved from delivery to a dingy back room and I was told to just 'disappear' if I found the situation too distressing. I decided to stay with this young woman because, if I could comfort her in any small way, I wanted to. Needless to say the experience was upsetting, however, I feel I made the right decision.

*I spent a wonderful traditional French Christmas with one of the neonatal paediatricians and his young family. They subsequently took me skiing in the Alpes and invited me for several Sunday dinners. My spoken French improved, as did my confidence in presenting patients, talking with parents and truly feeling like a member of a therapeutic team.*

The second part of my elective was equally challenging and fulfilling. I worked in general medicine with children aged six months to six years, many with acute respiratory illnesses. During this period I made another special friend, Alexis, two-and-a-half years old, with snowy blonde hair and magical blue eyes. He did not say much more than 'mum-mum', but his laugh and facial expressions provided adequate positive

feedback. His gait was rather wobbly, attracting odd looks from other parents. Alexis has Foetal Alcohol Syndrome and was with us for all of January because his mother was still having difficulties with alcohol and benzodiazepines. I wanted to bring him back to Australia. I hope that, with help, his family life will someday be a happy one.

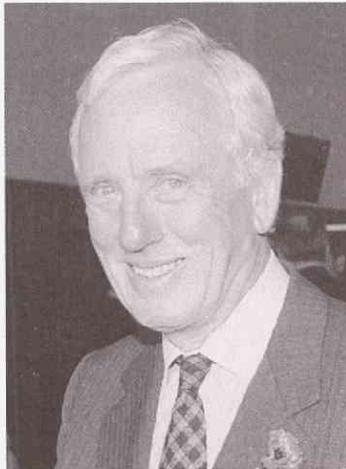
Professeur Salle invited me to participate in a Lyon-Rhône-Alpes regional paediatric conference. This was a great honour and a wonderful learning experience. The research work seemed meticulous with many exciting new developments. However, I detected little input from non-French-speaking regions of the western world. Subsequently in Melbourne, I have had this confirmed – a regrettable situation where, because of a language barrier, potential sharing of knowledge is not occurring.

I could write much more on my two month elective and indeed on my five years of medical studies. Medicine is a prime example of the more one learns, the less one knows, and it is easy to become overwhelmed. I learnt an enormous amount during my elective – about medicine, about babies and children, about myself (oh, and of course, about France). Yet I realise that this is one experience onto which I shall build many more. From this privileged position I would like to say, 'Thank-you Lyon and thank-you Melbourne'.

## DAVID GEOFFREY PENINGTON, AC, LLD

### *Graduation Address on the Occasion of Receiving an Honorary Degree from the University of Melbourne*

*David Penington began his association with the University of Melbourne when he entered Medicine in 1948. In 1950 he transferred his studies to Magdalen College, Oxford where he completed his medical degree. He gained postgraduate medical experience at Oxford and in London at the Royal Postgraduate Medical School and London Hospital. After a year as a Research Fellow in Boston, Massachusetts and a period as a consultant physician at the London Hospital and in private practice, he returned to Melbourne in 1968 as First Assistant in the Department of Medicine at St Vincent's Hospital. In 1970 he was appointed Professor of Medicine, and in 1978, Dean of the Faculty of Medicine. David Penington took up his appointment as Vice-Chancellor of the University of Melbourne in 1988. At the end of 1995 he retired from the Vice-Chancellorship. He was awarded an Honorary Degree at the graduation ceremony on 9 December 1995 where he made the following address.*



effort and is an important milestone in your careers.

Support from our families and friends, both material and moral, is always important. It helps us to know there are those who believe in us and trust in what we are trying to achieve. This is especially important when the going gets rough or when we go through difficult patches, as happens to us all from time to time. Friends and families here today

have every reason to share fully in the sense of pride which we all feel. On behalf of all my fellow graduates, our thanks to you.

It is nearly forty-eight years since I enrolled as a first year medical student in this University. I was to become a 'drop-out' in my third year, as you have heard, but this afternoon I successfully complete my first degree from the University of Melbourne. Some of us are late developers! I did graduate in Medicine in Oxford. I can still remember the feeling I had when I discovered that I had passed. There was such a weight off my shoulders that somehow my feet barely needed to touch the ground for a week! It was wonderful. Enjoy the feeling. But somehow I guess you are now already thinking about what the future has in store for you.

Every graduation, whether as Bachelor, as Master, as PhD or a Doctorate like mine is simply a stepping stone to the next stage in life. For all of us, at every age, life is full of uncertainties and further challenges. The formal charge of our ceremony refers to the 'responsibilities of the degrees'. 'Responsibilities' is a somewhat sombre word – I like to turn it around to think of these as exciting opportunities, for indeed they are!

Most of you here today are about to embark on a career as a 'professional'. What

does that imply? Well, it means different things to different people. To many it means those words 'rank and privileges' which you heard earlier. The respect and status commonly accorded to the 'learned' professions relates to both their commitment to knowledge and wisdom and to their commitment to serve the community. However, before we feel too good about all this, let me remind you of a few home truths.

Professions are often under attack as having a specially privileged position from the knowledge and skills they hold. Attacks on the professions are not new. Bernard Shaw in *The Doctor's Dilemma* wrote 'all professions are conspiracies against the laity'. Margaret Pelling, in Wilfred Prest's *The Professions in Early Modern England* wrote that, in the sixteenth century, 'Contemporary critics saw a symmetry of exploitation in which the clergy monopolised the soul, physicians the body and lawyers, property'. When the medical profession withdraws its services in 'strike action' as a lever to gain additional payments from government, it is trampling underfoot that great tradition of service on which centuries-old respect has been built. However, let me point out that few if any doctors, in reality, withhold their services from the sick or suffering.

The great majority of doctors in the community and in our public hospitals give their best to every patient, and to their hospital, far and beyond what they have a contractual obligation to provide, and quite regardless of the question of remuneration. I was a member of the Lochtenberg Committee on medical remuneration and I am satisfied that not only was it right that Victorian specialists should not be disadvantaged compared with those across Australia – they well deserve that reward – but I am satisfied that the Government is doing the right thing, following negotiations, in enabling the Metropolitan Hospital Network Boards to deliver incomes comparable with other States.

Yes, as professionals we will all be criticised from time to time – sometimes rightly for our failings, often unfairly for being unable to achieve the impossible. What matters is that we are sure of ourselves, our values and know that we are doing the best of which we are capable. Far from having 'arrived' this afternoon, you are setting out on a great journey of discovery, not only about the life of a professional, but also about yourselves, a journey on which you will be discovering new things about yourself in every year of your life. I am certainly still busy discovering as I contemplate my fifth career!

What are some of the salient features of being a professional? I have summarised them under five headings:

- a commitment to provide service to the patient or client of the highest possible order by applying the body of knowledge or skills shared within the profession;
- a commitment to respect the accepted standards of the profession – especially ethical standards – and accept that exclusion from the profession is appropriate if this is not the case;

- a commitment to pass on to others who follow, the knowledge, skills and ethical commitments of the profession through teaching (a corollary to this is respect for knowledge, for teachers and for teaching);
- a commitment to develop that body of knowledge and skills through practice, scholarship and research; and
- a right to a good standard of living for the professional and his or her family if the above principles are honoured, as the life is demanding and unforgiving.

Those young people who enter our universities, who it has been my pleasure to know over some generations now, arrive with high ideals. The world is to be changed to become a better place. By the time they leave a long course such as Medicine, many are wondering more about how to find a deposit for a house, to pay for a car and so on. All too soon they will be asked by others to worry about industrial negotiations. Is there no longer room for ideals?

I plead with you, *do not abandon ideals*. You live only once. What matters most in life is what you have done with it – the real satisfaction it can bring is through the interactions you have with people, the relationships you develop, the real joy and confidence that achieving the almost impossible brings, especially when shared with others. For those of you who become academics or research workers, the thrill of establishing new knowledge is immensely satisfying. A professional life offers wonderful opportunities year after year in many ways as your career evolves.

Who are some of the heroes of medicine for me, who influenced my choice of career and my views? When I was still a schoolboy I found on the shelves of my father's study a book called *Aequanimitas and other Essays* by Sir William Osler, a Canadian who became one of the fathers of modern scientific medicine at Johns Hopkins Hospital in Baltimore near the turn of the century, and was later Regius Professor in Oxford. I was impressed both by his profound belief in the importance of understanding disease processes through science, and his passionate interest in human nature and human relationships. It was this very combination which attracted me to medicine.

Another book on the same bookshelves was *The Beloved Physician*, a biography of Sir James McKenzie, a Scot who practised for more than a quarter of a century as a general practitioner in Burnley, Lancashire. He never lost his curiosity. Whilst a GP, he developed a 'polygraph' to record arterial and venous pulses, to analyse disturbance of heart rhythm in tachycardias of various kinds. He loved dealing with people and their families, but always wanted to know more so he could help patients better. He later became famous for his discoveries and was appointed Physician to the London Hospital. He rescued many people consigned to bed or to sheltered lives when he recognised benign cardiac flow murmurs and the harmless nature of extra-systoles. He ended his career back in country general practice, which he found more satisfying than the rarefied life of a teaching hospital or Harley Street.

Another great name for me as a young man was Dr Edward Wilson, who died with Scott in that tragic trek back from the South Pole. Two biographies which stick in my mind are *Wilson of the Antarctic* and *Edward Wilson, Nature Lover*. Wilson was a deeply religious man and a painter of beautiful water colours of nature. He had his student career seriously interrupted by pulmonary tuberculosis, with several years in a Swiss sanatorium. Perhaps, as a severe childhood asthmatic, I found great empathy with him. I found his self doubts as a young doctor in the wards reassuring when I later experienced them, and greatly respected his set of values and confidence in going ahead with what he believed was right even when others dismissed his views. He was a person who grew through adversity, as indeed we all do in our careers.

What are some of the joys and satisfactions ahead of you? You will each find your own. Three of the following six points are particularly applicable in medicine, the others in all careers.

- Your greatest satisfactions will almost certainly come from the great privilege of being welcomed to enter the innermost thoughts of people who are facing real crises in their lives, and who will turn to you for help. The privilege is to be able to help them as people, not just assist correcting a disorder of their bodies. You will find people in such circumstances will want to share their fears with you in order to gain the confidence to face their crisis and hopefully to overcome it. The attitude of a grateful patient can be very precious at times. I carry with me many such memories which still warm my heart.
- You will have a wonderful opportunity in a life long search for greater understanding of human nature, seeing it in many conditions of joy and anguish. You will gain strength yourself from some of these experiences as well as being able to contribute to them.
- As a doctor, you will have entry to and acceptance into many walks of life and have wonderful opportunities to understand the huge diversity of human society. You will come to respect the ethics of people of many different religions and of many who profess no religion.
- You will have unparalleled opportunities to discover what can be achieved by working in teams with people who bring different backgrounds of knowledge, skills and experience.
- Above all you will have a wonderful opportunity to go on learning new and exciting things throughout your career. It is said that nine-tenths of what we now know has been learned in the past forty years. The pace of discovery is increasing, not slowing and much of what we have taught you will be proved wrong and replaced with new knowledge within the next ten to twenty years.
- Lastly, let me comment on the teaching of Dr William Evans, a small, rotund Cardiologist, a former student of Sir James McKenzie's and one of the most charismatic teachers of the London Hospital when I was a junior lecturer there in the 1950s. He used to make his students take vows on certain

critical matters. One was 'I vow that I will be a slender doctor so that I may chastise my obese patients' – sometimes necessary when patients have serious heart disease. He always added, 'Nobody taught me that when I was young!'

My advice to you is that throughout your careers, whatever the challenges you are tackling, do not neglect to find time to share with your partners, your children as they grow up, and to pursue broader cultural interests. Always remember – life is about people and about relationships above all else, and it is these in the long run where you can contribute the most and gain the greatest satisfaction. As my wife and children hear these words, I fear that I must recall the words of Willy Evans and thank them for their forbearance and support during the times I have had so many opportunities to be engaged in exciting and rewarding challenges.

In conclusion, my sincere thanks to the University for the honour it has bestowed on me, for the privilege of being a member of its staff for nearly twenty-eight years, of experiencing the excitement of research, the fulfilment of teaching very able students over the years, of working with wonderful colleagues and of leading it through eight exciting and rewarding years. It is a great institution and I wish it well as it moves to join company with the great universities of the world.

## ROBERT SIMPSON MEMORIAL FUND

In 1994, friends and colleagues of the late Robert Simpson, BA, MBBS (Melb), MPA (Harv), FRACS, FRACMA, AFCHSE, FAFPHM (1952-1994), initiated a limited appeal to support the establishment of a Robert Simpson Memorial Fund with the University of Melbourne School of Medicine. The Fund was established to support the education of undergraduate and postgraduate medical students, particularly in the field of public health.

It is a great tribute to Rob that funds exceeding \$25 000 have now been received. It has been agreed, commencing in 1996, to make one or more awards up to the value of \$500 each to support undergraduate medical students undertaking a period of elective study in public health. A memorial lecture in the field of public health is also being considered.

The School of Medicine and friends of Rob who initiated the Fund, thank those whose generous contributions have assisted in the successful establishment of this Fund.

## University of Melbourne Medical Society and University Alumni Association Membership

### ORDINARY MEMBERS

#### *Reminder to Renew!* 1996 Membership Year

If you are a member of UMMS you will recently have received your membership renewal 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* 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. Membership of UMMS includes membership of the University Alumni Association.

### MEMBERSHIP SUBSCRIPTIONS

#### Ordinary Members

Annual subscription – \$40  
Post Graduate Students (Melb) – \$20

#### Recent MBBS (Melb) Graduates

1992 graduates – \$30  
1993 graduates – \$20  
1994 & 1995 graduates – \$10

The UMMS office can accept your membership payment through Bankcard, Mastercard or Visa. Cheques should be made payable to The University of Melbourne.

### HONORARY MEMBERSHIP

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

### ELIGIBILITY FOR MEMBERSHIP

Besides MBBS (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.

For information on the benefits available to members of UMMS and the Alumni Association please contact either UMMS or the Alumni Association or access the Alumni Homepage on the World Wide Web address: <http://www.unimelb.edu.au/ExtRels/Alumni/ADU.htm>

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# DEPARTMENT OF PSYCHIATRY

## PAST, PRESENT AND FUTURE

Prepared by Professor Bruce S Singh  
with the assistance of Mrs Rita Costas

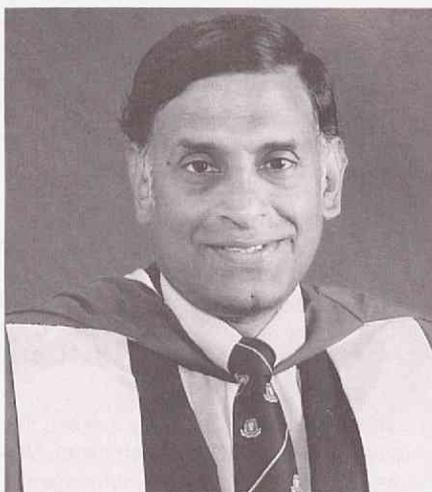
**S**TUDENTS HAVE BEEN TAUGHT psychiatry at the University of Melbourne since the establishment of the Faculty of Medicine in 1876. Initially this consisted of a series of lectures and demonstrations at the main psychiatric hospitals of the time, firstly Yarra Bend Asylum, and then Royal Park Receiving House, and Kew Asylum, where Dr Beattie Smith lectured to medical students. Psychiatry has existed as a medical specialty at the two main teaching hospitals of the University, Royal Melbourne Hospital and St Vincent's Hospital, since pre-Second World War days. In particular, Dr Alex Sinclair headed a unit at the Royal Melbourne Hospital and Dr Eric Seale a unit at St Vincent's Hospital.

The Department, however, was formally established with the creation of the Cato Chair of Psychiatry in 1963, and the appointment of Professor Brian Davies, Foundation Professor, who took up his appointment in 1964. The main driving forces in the establishment of the Chair were Professor Sydney Sunderland, then Dean, together with Dr Eric Cunningham Dax, Dr Una Porter and the psychiatric community, the most prominent of whose advocates were the Victorian Council for Mental Hygiene, especially Drs Hal Maudsley and John Williams.

The University of Sydney established a chair of psychiatry in 1922, and perhaps this provided the impetus for Melbourne to follow, although the history of clinical chairs in all the clinical disciplines has been a relatively recent phenomenon in Australian medical academic life.

Advocates for the establishment of the Chair persuaded Dr Una Porter, a psychiatrist, and her brother Mr Alec Cato, children of prominent philanthropist Mr Frederick John Cato, to donate an endowment from the estate of their late father to establish a Chair in his memory, thus creating 'The Cato Chair of Psychiatry'. This was part of a general strategy set in train by Dr Cunningham Dax to upgrade psychiatric services, the teaching of psychiatry and the education of doctors in psychiatric principles, in the wake of the Kennedy Report which had highlighted atrocious conditions in Victorian psychiatric services in the 1950s.

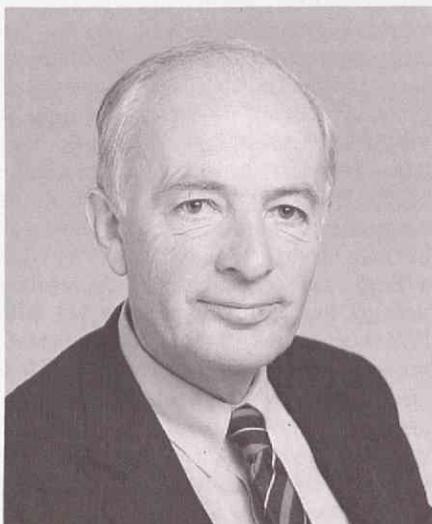
The first appointee was Professor Brian Davies (pictured), a young psychiatrist from the Maudsley Hospital, who arrived in 1964 to a clinical base at the Royal Melbourne Hospital and the Parkville Psychiatric Centre, although his academic base awaited the building of the seventh floor of the



PROF BRUCE SINGH

Clinical Sciences Building on the Royal Melbourne Hospital campus. Professor Davies rapidly went about establishing a vibrant and active Department. He first recruited a behavioural scientist, Dr Mowbray, because of his strong commitment to teaching behavioural science in the pre-clinical years, who in turn recruited a young David Horne (who recently completed twenty-five years in the Department). In addition he established First Assistant positions at the three clinical schools and appointed Dr Graham Burrows, Dr Ivor Jones and Dr Russell Meares (all of whom moved on to Chairs) at Royal Melbourne, St Vincent's and Austin Hospitals respectively, and established the position of academic psychotherapist for Dr Reg Hook.

Professor Davies established an active teaching program for undergraduates based



PROF BRIAN DAVIES

on clinical clerking and revamped the Diploma of Psychological Medicine, the first six diplomas having been awarded in 1944. He also recruited as Associates and Senior Associates some of the most senior and distinguished psychiatrists in Victoria at the time, including Drs Richard Ball, John Cade, John Cone, Herbert Bower, John Grigor, Graeme Mellsop, Bill McLeod, Ed Chiu and numerous others. An active program of research was established primarily in the field of depression and affective disorders and their treatment, and students were recruited for MScs, PhDs and MDs. Many of these went on to active roles in the department and a significant number to chairs both in Australia and overseas. These include (in addition to those mentioned above) Professors John Mann, Bernie Carroll, David Jarrett, Tom Horvath and Lorraine Dennerstein.

A particular development, supported by Dr Dax at the time, was the establishment of the Parkville Psychiatric Unit as a teaching unit of the University of Melbourne, under the leadership of Dr Richard Ball. As psychiatry expanded and the work of the department developed further, the need for professorial leadership at the various Clinical Schools became apparent. In response to this, Professor David Penington, then Dean, encouraged the development of Professorial Associates with the title Professor, to direct services at the Clinical Schools. In 1978, Professor Richard Ball was appointed to such a position at the St Vincent's School and in 1983 Professor Graham Burrows to the Austin and Larundel School.

In 1985, following restructuring of the leadership of the Child and Family Psychiatry Service at the Royal Children's Hospital, which Dr Winston Rickards had led with distinction for many decades, Professor Robert Adler was appointed to the Professor/Director position there, which while primarily located in the Department of Paediatrics, had a strong link to the Department of Psychiatry.

Professor Davies produced a textbook of psychiatry *An Introduction to Clinical Psychiatry*, which went through four editions during his period as Head of department. In addition, a wide variety of other books and scientific articles were published during his period as Chairman, and a large number of Masters, PhD and MD students graduated (MSc 14, PhD 13, MD 15, BMedSc 12), as well as those continuing to take the DPM.

In 1990, after heading the Department for twenty-six years, Professor Davies retired and was succeeded by Professor Bruce Singh, who had previously held a Chair of Psychological Medicine at Monash University. Under Professor Singh considerable expansion of the department in various sub-specialty areas, which had commenced in the second half of the 1980s, was accelerated with a series of externally funded positions throughout the psychiatric hospital system. These included Associate Professors/Senior Lecturers in Geriatric Psychiatry at Royal Park and Mont Park, and appointments in Child and Adolescent Psychiatry, Forensic Psychiatry, Transcultural Psychiatry and General Psychiatry. This funding offered the opportunity for the department to expand its areas of interest in a more formal way into the psychiatric hospital system to support the funding provided by the University for the academic positions in its general hospital units.

In the undergraduate area, the curriculum was revised and the students now spent their nine weeks divided equally between a general hospital psychiatric unit and a psychiatric hospital service. A new undergraduate textbook was produced, edited jointly by Professor Singh and Associate Professor Bloch and involving academics from both the University of Melbourne Department of Psychiatry and the Department of Psychological Medicine at Monash University. An undergraduate education committee was set up and the examination process revamped, including the introduction of a formal clinical examination and more active training of both teachers and examiners. The department joined enthusiastically in the quality assurance and student feedback processes set up by the University as part of its commitment to quality.

The years of the mid-1970s through the 1980s saw a continued growth in the teaching of psychology in the behavioural sciences course by Associate Professor and Reader in Medical Psychology Dr David Horne in the pre-clinical years of the medical course. The Medical Psychology Unit of the department also developed courses in psychology for both the Dental and Physiotherapy Schools. In 1993 the Medical Psychology Unit staff became full members of the School of Behavioural Science when the Department of Psychology moved into the Faculty of Medicine, Dentistry and Health Sciences. The relationship between psychiatry and psychology in this University is quite unique in Australia and holds great potential for innovations in all areas of clinical training, teaching and research.

In the postgraduate area, with the recognition of Fellowship of the Royal Australian and New Zealand College of Psychiatrists as the specialist qualification in psychiatry, the department terminated the DPM from 1995. Instead, the department became actively involved with the Monash Department of

Psychological Medicine in the establishment of a joint MMed/MPM Program, which has proved to be most successful and in which approximately one hundred psychiatric trainees are enrolled, half of them in the University of Melbourne MMed in Psychiatry. The department has also developed a Diploma of Mental Health Sciences which it is offering in a number of areas, in particular Transcultural Psychiatry and Infant and Parent Mental Health in 1996.

The department continues to have an active research program although its foci have broadened considerably to involve the full spectrum of psychiatric disorders. Long-standing interest in areas such as Huntington's Disease (Chiu) and Mood Disorders (Burrows & Tiller) continue but are complemented now with new areas such as Schizophrenia (Singh & McGorry), Psychiatric Epidemiology (Herrman & Patton), Aboriginal Mental Health (McKendrick) and Transcultural Psychiatry (Minas). It is actively recruiting students for its Masters and PhD programs.

The biological laboratory (where the original work on the Dexamethasone Suppression Test was conducted) subsequently developed a particular focus on psychopharmacology whilst at the RMH, and has now been relocated completely to the section of the department at Austin Repatriation Medical Centre (headed by Dr Trevor Norman), and a new molecular biology laboratory, headed by Dr Alexander Kouzmenko, has been established at the RMH site and is building close links with the Mental Health Research Institute (MHRI) of Victoria.

As a result of the development of a private hospital at the Royal Melbourne Hospital the department moved from the seventh floor of the Clinical Sciences Building in August of 1994 and is now well established, with additional space, on the seventh floor of the Charles Connibere Building. It will be joined in mid-1996 by the Medical Psychology Unit which is moving to the ninth floor.

The department has continued to expand with new academic positions funded by its associated hospitals and by the Department of Health and Community Services. Professor Helen Herrman replaced Professor Ball on his retirement from St Vincent's Hospital, and three new Professor/Directorships were established in the 1990s. Dr David Copolov, Head of the restructured Mental Health Research Institute of Victoria since 1987, which has a close association with the department through the co-directorship he has with Professor Singh of the NHMRC Schizophrenia Research Unit was appointed to a chair in acknowledgement of his scientific leadership of the MHRI. The MHRI has completed an affiliation agreement with the RMH. The Department of Veteran's Affairs has provided funds to create a Centre for War Related Post Traumatic Stress Disorder

at the Austin and Repatriation Medical Centre headed by Professor Philip Morris. In addition, a Professor/Director position has been established to head the Centre for Young People's Mental Health at Royal Melbourne Hospital. A Centre for Cultural Studies in Health is proposed for establishment in 1996 located in the Department of Psychiatry as a component of the Faculty's Strategic Plan for the current triennium and as part of the Faculty and Department commitment to internationalisation. New positions in Psychiatry of Intellectual Disability, Geriatric Psychiatry and General Psychiatry have also been created. These include the establishment of an Associate Professorship in a section of the department established at the Melbourne Clinic and filled by Associate Professor Isaac Schweitzer since early 1995.

The department has been very successful in gaining a number of large research awards – the NHMRC Schizophrenia Unit Grant and program grants from the Victorian Health Promotion Foundation for the Early Psychosis Program headed by Associate Professor Pat McGorry, and the Caregiving in the Community Program headed by Professor Helen Herrman. Total grants to the department in 1994 amounted to approximately \$2.5m, from all sources including pharmaceutical companies.

The department has also, as a result of its size, been successful in strengthening its administrative functions with the creation of a Budgets and Personnel Officer, and a Student Administration Officer, both funded by the Faculty, as well as being able to provide additional administrative support at its clinical schools. Mrs Elizabeth Horton who has been with the department for more than thirty years and has been awarded a University Long Service Medal, fills the Student Administrative Officer position and Mr Warrick Jackson was appointed to the Budgets and Personnel position in 1994. The department has also established four major committees to co-ordinate its undergraduate, postgraduate, continuing and public education, research and internationalisation programs, as well as working groups co-ordinating its psychopharmacology research and its initiatives in distance education.

Strong collaboration has been developed with the Department of Paediatrics, through the Centre for Adolescent Health, as well as other departments within the University, particularly the Department of Pathology, with links through Professor Colin Masters.

## The Future

Three main themes determine the department's approach to the future. They are all based on the philosophy espoused by the Chairman of the need for the department to have a high profile in the delivery of psychiatric services, as well as in its involvement with the community as a whole,

both locally and internationally. Firstly, the department is actively involved in the changing environment of psychiatric services as a result of mainstreaming the major psychiatric services into the general hospital system. Leadership of this process falls on the leaders of the three clinical schools, namely Professors Singh, Burrows and Herrman, who are also Clinical Directors of Psychiatry at their respective hospitals. These services will form strong components of the new networks being created in the metropolitan health system in Victoria, and thus give the University department a major opportunity to influence these services.

Second is the major commitment of the department to public, continuing education and general postgraduate education. New proposals are under discussion, the department having funded a half-time Developmental Officer to work on the establishment of a series of new courses, short courses, continuing education programs, Graduate Diplomas and Masters.

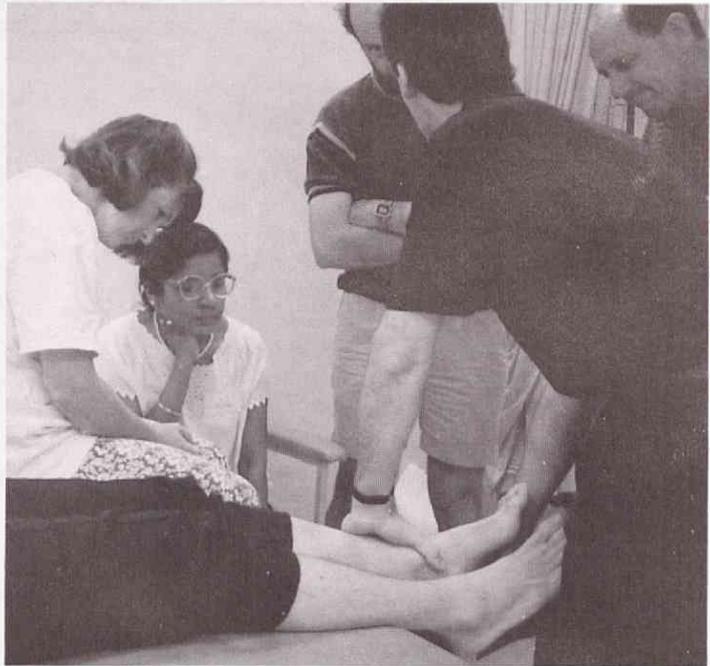
The department sponsors a series of public lectures throughout the year. The first of these was delivered by Professor Myrna Weissman from Harvard University, who lectured on the current understanding of depression in association with the Australian Society for Psychiatric Research Meeting in December 1995.

The third major theme for the department will be its internationalisation program. The department is exploring a strategic plan to become actively involved in internationalising its curriculum and programs, as well as working with countries in the South-East Asian and Western Pacific regions to offer teaching, training and support for the development of psychiatric services in these areas.

Discussions have involved the WHO Division of Mental Health, as well as the World Psychiatric Association. The department will be one component of the WHO Australian Multisite Collaborating Centre in Mental Health expected to be established in 1996.

In addition the department intends to continue its very active research program attempting to consolidate various sites as well as co-ordinate its activities better. Initiatives in the area of distance education are underway, and a secretariat to co-ordinate psychopharmacological studies is under consideration. The department is also continuing to review its undergraduate and postgraduate coursework curriculum to utilise more modern methods of teaching including multi-media and interactive computer learning.

In summary, the department looks with confidence to a widening horizon in which it will continue its contribution to psychiatry as an academic discipline in this city, as well as nationally and internationally.



Participants at the course *Sports Medicine Problems in General Practice* examine the patient.

## CONTINUING MEDICAL EDUCATION

### *Sports Medicine Problems in General Practice*

With the Olympic Games in Atlanta this year and then in Sydney in the year 2000 the popularity of competitive sports in schools and clubs is bound to rise, and with it, the number of sports-related injuries.

The practical management of patients with sports injuries and musculoskeletal problems was the topic of the first course offered for 1996 in the School of Medicine Continuing Education Program. Dr Karim Khan, a sports medicine expert with a background in general practice, directed the course in collaboration with Drs Teng Liaw and Bill Leadston of the University Department of Public Health and Community Medicine General Practice Unit. Participants enjoyed the combination of an intensive lecture program followed by a practical 'hands-on' workshop.

All courses in the continuing education program have a strong practical emphasis with 'hands-on' workshops, visits to hospital clinical departments, small group sessions and case studies. Details of the full 1996 program are on the back cover of this issue of *Chiron*.

If you would like more information, please telephone Tamara Humphries or Robin Orams on (03) 9344 5888.

# CME

ENQUIRIES

(+61 3) 9344 5888



## NOTICE OF ANNUAL GENERAL MEETING 1996

The Annual General Meeting of the University of Melbourne Medical Society (UMMS) will be held at 6.30 pm on Tuesday 21 May 1996, 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 David Kissane, Director of Palliative Medicine, St Vincent's Hospital, Caritas Christi Hospice, Peter MacCallum Cancer Institute and Mercy Hospice Care, will deliver a lecture entitled *Caring for the family in the setting of terminal illness*.

### Business

1. Minutes of 1995 Annual General Meeting
2. Chairperson's Report
3. 1995 Financial Report
4. Amendment of Constitution

When the University of Melbourne Medical Society was originally formed, the constitution was drawn up with references to 'donations' in the belief that membership contributions to UMMS would be claimable as tax deductible donations to the University.

In 1990 the Australian Taxation Office ruled that annual membership of UMMS could not be claimed as a tax deductible donation to the University. Accordingly, the following resolution to amend the constitution is proposed:

That where the word 'donation' appears it is changed to 'membership fee' and where the word 'donors' appears it is changed to 'members'.

In 1995 UMMS changed its financial reporting from a report based on the UMMS membership year, of March to April, to a calendar year report, in line with the University accounting system. It is now proposed that the UMMS membership year be changed to a calendar year in line with the proposed membership year for the University Alumni Association. The following resolution is proposed:

That item 4.3 of the constitution be changed to read 'Membership fees are payable in January each year in respect of a year running from 1 January to 31 December of that year. A member who does not pay the due membership fee by the end of January of the following year is deemed to be unfinancial and is ineligible to vote at any meeting of the Society or its Committee.'

5. General Business

## MINUTES OF ANNUAL GENERAL MEETING 1995

The annual general meeting of the University of Melbourne Medical Society (UMMS) was held at 6.30 pm on Tuesday 16 May 1995 in the Sunderland Lecture Theatre, Medical Building, The University of Melbourne. The meeting was preceded by the Dean's Lecture entitled *What Maketh the Man? Genital anomalies provide clues for understanding embryology of sexual development*. This was delivered by Professor John Hutson, Director of Paediatric Surgery, Royal Children's Hospital.

### 1. Minutes of the Annual General Meeting 1994

The minutes of the 1994 Annual General Meeting, previously published in the 1995 issue of *Chiron* and circulated to UMMS Members, were adopted as a fair record of proceedings.

### 2. Chairperson's Report

- The 1995 issue of *Chiron* was published in April and the Chairperson noted the generous sponsorship of \$25 000 from the Medical Defence Association of Victoria (MDAV). This

sponsorship is an important factor contributing to the excellence of the Journal and the Society is immensely grateful to the MDAV for their support. He congratulated Mrs Mackie on an outstanding issue. Although Mrs Mackie had been persuaded to stay on last year, she had indicated that it was now her intention to resign from the editorship of the Journal although she would be available to act as consultant to the editorial team. The Chairperson noted with sadness the death of Co-Editor Mr Peter Jones, shortly before publication of the current issue of *Chiron*. The Chairperson was pleased to confirm that Professor Emeritus Harold Attwood had agreed to take over as Editor of *Chiron*.

- Membership of UMMS at 11 May 1995 was 2266, compared with 2209 at a similar time in 1994.
- The Bachelor of Medical Science Prize for 1993 was awarded to Mr Andrew Lovett for his study entitled *A survey of the health status of homeless young people in Victoria*.
- UMMS Elective Essay Prizes of \$100 were awarded to Sonia Davidson, Glenn Guest and Chris Oh for essays describing their elective experiences. The essays, *The Maldives - Paradise or Paradox* by Sonia Davidson and *Evolution in the Cradle of Mankind* by Glenn Guest, were published in the 1995 issue of *Chiron*.
- Medical Society activities in 1994 included the UMMS lecture and function, held on 22 November, at which Professor Sir Gustav Nossal delivered a brilliant and inspiring lecture entitled *Medical Science and Human Goals - A Struggling Pilgrim's Progress*. The lecture attracted a large crowd and a shortened version was published in the editorial of *Chiron*. UMMS members enjoyed drinks and light refreshments in the Pathology Museum prior to the lecture.
- The 1994 Dean's Lecture Series was well attended and ended in the medical ethics seminar, *A Better Death*, convened by Professor Richard Smallwood. The seminar was very successful and attracted such a large audience that a second lecture theatre was used with an audio link to the Sunderland Theatre.
- Reunions of medical graduates continue to flourish as can be seen by the reports in *Chiron* each year. A list of reunions currently being planned is also published in *Chiron*.
- Members' attention was drawn to the remainder of the Dean's Lecture Series, in particular, the forthcoming ethics seminar *Caring for the Severely Disabled or Dying Child*.

### 3. 1994 Financial Report

At the last meeting of the Executive Committee in August 1994, it was decided that UMMS change its financial reporting from a report based on the UMMS membership year, of March to April, to a calendar year report, in line with the University accounting system. It was noted that there was a budget balance of \$35 222 at the end of 1994 and that this was a satisfactory result. A motion to accept the financial report was carried.

### 4. Election of Committee 1995-1998

Nominations for the election of six members of the Committee of UMMS closed on Tuesday 9 May 1995. The five elected members of the UMMS Committee were eligible and available for reappointment and under section 7.3 of the constitution were proposed for re-election. They were: Dr Lorraine Baker, Dr Thomas Kay, Dr Andrew Rothfield, Dr David Westmore and Mr Michael Wilson. A nomination for Mr James Guest to be elected to the Committee had been received. As there were no more nominations than places available, it was not necessary that an election be held and all nominated members were declared duly elected.

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

## UMMS 1994 BMEDSC PRIZE

Kirsten van Haaster  
for her study entitled

### Mammary gland development during pregnancy and lactation in *waved-2* mice

This study was the first detailed examination of mammary gland development in the *waved-2* mouse. The findings led to a greater understanding of lactation in mice, as well as the roles that hormones play in the initiation, maintenance and cessation of lactation.

The phenotype of a spontaneous mouse mutant, *waved-2* mice, was identified in 1994 as being due to a point mutation in the gene which codes for the epidermal growth factor receptor (EGFR). During the course of this research it was noticed that the *waved-2* breeding colony had a high pup mortality rate. Investigations suggested that the newborn mice were dying of malnutrition secondary to impaired maternal milk production.

Mammary tissues were examined from proven poor lactating *waved-2* pregnant and lactating mice with matched controls, at day 8, 14 and 18 of pregnancy and at day 1.5 of lactation. The histological features of the pregnant and lactating *waved-2* mice differed to that observed in the *waved-2* control mice, however there was no difference in PTHrP or EGF staining patterns. It was concluded that *waved-2* mouse mammary glands undergo involution at day 14 blocking normal milk production. Preliminary radioimmunoassays show much lower circulating levels of prolactin in the lactating *waved-2* mice than in normal mice. Prolactin is important in the initiation and maintenance of lactation but only to day 14 of pregnancy when placental lactogen is responsible for the maintenance of lactation.

This work has provided crucial ideas and hypotheses for future research on the pregnancy and lactation of *waved-2* mice. The research has made significant advances in the elucidation of the effects of a defective EGF-R and the resultant poor lactation and failure to thrive. This could have important implications in other situations where humans, and other animals, have lactation problems, low litter numbers and a high mortality rate.

Simon Williams  
for his study entitled

### Aspects of folate metabolism in families affected by neural tube defects

An increase in maternal periconceptional folate intake has been shown to reduce the risk of neural tube defects such as spina bifida in offspring, and current evidence suggests that there is an underlying defect in the metabolism of folate in those mothers who have an affected pregnancy. So far, studies have investigated folate metabolism only in women who have had an affected infant. Folate metabolism in other family members, including affected children, has not been studied.

This project addressed this issue by studying the *in vivo* metabolism of folate in children with spina bifida, their parent(s) and sibling(s), compared with families with no history of a neural tube defect. Measures of folate metabolism included vitamin status (folate, cobalamin and pyridoxal), and homocysteine levels, before and after a methionine load. It was designed as a pilot study to assess the feasibility of conducting a larger, definitive study.

The results demonstrated that such a study was feasible, and identified a number of issues relating to the design and conduct of the study which should be addressed in any future study. While the pilot study was too small to detect differences in folate metabolism with confidence, the results suggested a defect in folate metabolism in the affected child which can be measured with baseline homocysteine levels, and which may have been active at the time of neurulation. Indirect evidence also suggested a defect in folate metabolism in the mother.

The importance of this pilot study, the first to examine folate metabolism in children affected with spina bifida, lies in the demonstration of the feasibility of conducting a full scale investigation of folate metabolism in affected children and their families. Such an investigation should now be undertaken.

## WHAT'S ON IN 1996

### UMMS Annual General Meeting

Tuesday 21 May 1996, 6.30pm  
Sunderland Lecture Theatre, Medical Building  
The University of Melbourne

### Seminar

#### The New Genetics – for Good or Ill?

Friday 26 July 1996, 2-5pm  
Convener: Professor Richard Smallwood

### Speakers

Emeritus Professor Max Charlesworth,  
Ms Rhonda Galbally, Dr Eric Haan,  
Dr John McKeand,  
Associate Professor Loane Skene,  
Professor Bob Williamson

### UMMS 1996 Lecture & Function

Thursday 24 October 1996  
Speaker  
Professor Emeritus David G Penington

### Dean's Lecture Series

#### Continuing Medical Education

Details on the back cover of this issue  
Enquiries welcome on (03) 9344 5888

### Alumni Association

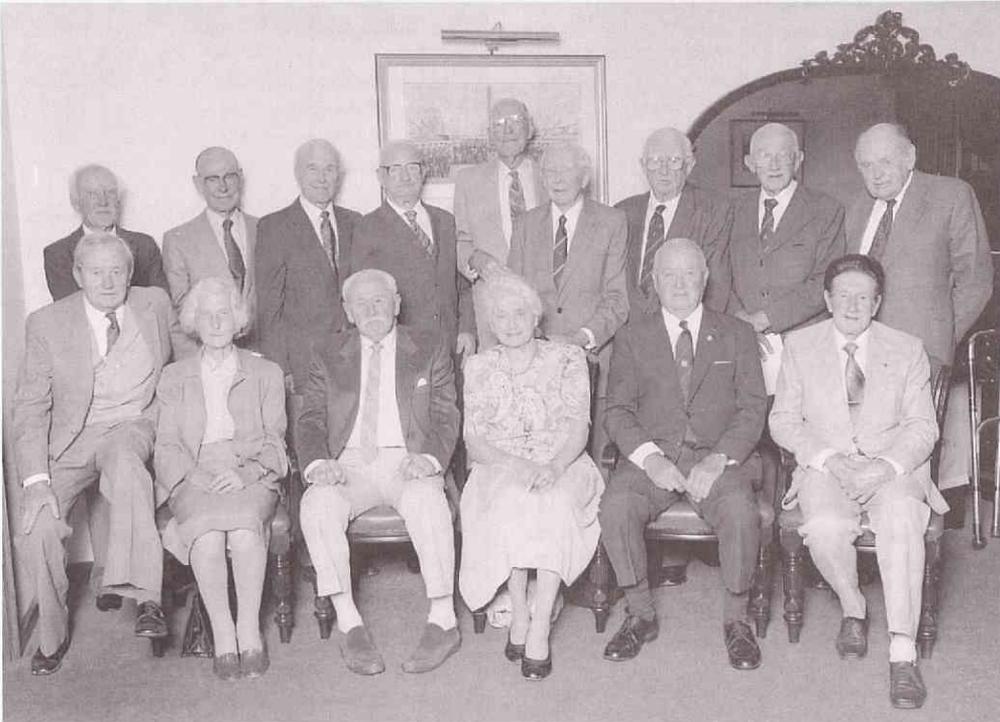
#### AlumniFest

25-27 October 1996  
Three days of academic, cultural and reunion activities to celebrate 140 years of graduates. Details are available from the Alumni & Development Unit on (03) 9344 7469.



THE UNIVERSITY  
OF MELBOURNE

## 1995 REUNIONS



**Class of 1935 – 60 Years Reunion**

**Back row, L-R:** T.H. Steel, H.E. Williams, D.J.M. Dunn, G.R. Kurrle, N.V. Youngman, A.V. Jackson, W.R. Grayton, J. Smibert, R.J. Salts.

**Front row, L-R:** R.J. Riddell, N. Lewis, C.P. Juttner, F.E. Plarre, A.J. King, B.I. Taft.

### **MBBS 1933 Sixty-Two Years Reunion** Alcoston House 19 September 1995

*From Spot Turnbull* – The sixty-second reunion of the 1933 Medical Graduates of the University of Melbourne was celebrated by a luncheon held at the Alcoston House restaurant on Spring Street, Melbourne, on Tuesday 19 September 1995. There were six graduates present – Norman Cust, Lorna Lloyd-Green, John Hayward, Dorothy Sinclair (nee Gepp), Harry Sinn and Spot Turnbull.

Nine other graduates were unable to attend, owing to distance and/or family problems. So, there remain alive a total of fifteen of the fifty-eight medical students who graduated in 1933 – one of the smallest groups of finalists for some time.

We all hope to be present at the sixty-third anniversary to be held in 1996.

### **MBBS 1935 Sixty Years Reunion** Naval and Military Club 1 December 1995

*From James Smibert* – The largest gathering of MBBS 1935 graduates since 1990 came together for luncheon at the Naval and Military Club to celebrate their Diamond Jubilee. (See *Chiron*, Vol 1, No 4, 1988 pp27-29, for a memoir of the MBBS class of '35).

The luncheon was attended by: *DJM Dunn, WR Gayton, AV Jackson, CP Juttner, AJ King, GR Kurrle, N Lewis, FE Plarre, RJ Riddell, RJ Salts, J Smibert, TH Steel, BI Taft, HE Williams and NV Youngman*. In absentia were: *TRB Courtney, L Langmore, AD Matheson and CR Trood*.

### **MBBS 1940 Fifty-Five Years Reunion** Melbourne Club 16 November 1995

*From Norman Wettenhall* – Since 1960 we have had a reunion every five years, so this was the eighth time we have come together. We have usually had a dinner at night, but on this occasion we had lunch with time for talk before and after and no hassle with travel after dark. There were thirty of us able to attend and twelve apologies out of a possible forty-nine whose addresses we had – and that included three with overseas addresses.

Those who attended were: *John Bignell, Alastair Campbell, Basil Conlon, Peter Davis, Ken Davidson, Bob Elphick, John England, Don Fleming, Howard Hoban, Harry Jackson, Shiela Lusted (Barr), Graham McKenzie, John McMahon, Frank Moore, Les Moran, Lloyd Morgan, Norrene Nicholson (Findeisen), Roy Phillips, Albert Piper, Bill Rigg, Bill Rose, Edward Ryan, Gladys Simpson (Morris), Ted Spring, Elizabeth Turner, Murray Verso, Lesley Vincent (Waters), Norman Wettenhall, Jean White, Ian Wilson*. Apologies were received from: *Ken Brennan, Arthur Burton, John Cahill, Cornelius Christie, Noel de Garis, Ian Galbraith, Lindsay Irwin, Sam Mecoles, Ken Morris, Fred Rose, Warwick Rosenthal, David Waterworth*.

The reunion was held at the Melbourne Club where we lunched in the library and had a very pleasant meal. There were no special guests and no formal speeches, but conversation certainly did not flag. Naturally all were looking older, but the general standard of health appeared pretty good and there was plenty of good cheer. It was especially pleasing to have four from Western Australia – Lesley Waters, Bob Elphick, Don Fleming and Lloyd Morgan.

At the end it was agreed to hold our next reunion in two years rather than wait for the next millenium!



**Class of 1945 – 50 Years Reunion**

**L-R, Back Row:** D. Hurley, I. Torode, J. Critchley, W. Lowen, G. Pestell, D. Hewson, A. Bignell, W. Moon, G. Trinca, E. Taft, J. Troup, J. Keipert, R. Hayes, C. Piercy, L. Murphy, J. Little, T. Antonie. **Middle Row:** K. Schwarz, H. Grinblat, I. Leber, P. Jones, S. Francis, J. Gardiner, B. Wilmot, J. Gardiner, C. Anderson, R. Kingston, P. Jeffery, J. de Crespigny. **Front Row:** J. Marsden, P. Rowan, D. Prentice, D. Rush, I. Mackay, D. Cordner, P. Barrett, D. Foster, N. Myers, H. Cumming.

### **MBBS June 1942 Fifty-Three Years Reunion Royal South Yarra Lawn Tennis Club 3 June 1995**

*From John Tucker* – The medical graduates of 1 June 1942 held a reunion dinner at the Royal South Yarra Lawn Tennis Club on 3 June 1995, to celebrate fifty-three years since graduation. Of course, we were accompanied by our wives, husbands etc. which we feel is essential for a proper reunion. I sent out sixty-one invitations and thirty-one members accepted which is not bad considering we are now scattered all over the world and some addresses could have been wrong. Forty-nine people attended. One hundred and ten graduated in our year.

We did not have a guest speaker but members were encouraged to speak. Colin Richards gave a very interesting report on The Garnett Passe and Rodney Williams Memorial Trust which has left nineteen million American dollars for the advancement of the specialty of Otorhinolaryngology and related fields [see Colin Richards' obituary p51]. Colin was the Chairman of the trust which involved a great deal of time and responsibility. We were all greatly saddened by Colin's sudden death. He was a very popular and highly respected member of our year.

Ruth (Farrer) and Ian Chenoweth, both graduates of our year, have attended every reunion we have held, travelling down from Mackay and latterly Mcleay Island, Queensland, to be with us, with which we are very flattered. Ian told us that at last he has retired (this we doubt) and they will settle at The Gap, Brisbane.

John Craig came all the way from Perth and gave us news of the members in Western Australia.

It was suggested that a luncheon gathering should be arranged for 1996. Alan Williams kindly offered to help me and true to his word wrote a letter to all members giving alternative dates and venues. I think practically everyone replied and then to our horror, Alan passed away. This marvellous person will be missed terribly by everyone who was lucky enough to know him but 'The Alan Williams Luncheon' will be held, probably on the first Sunday in June 1996.

The evening was attended by: *Graham Brooke accompanied by Eve Esnough, Norman and Phyllis Chamberlain, Ruth and Ian Chenoweth, Ann and Ted Cordner, John Craig, Rae (Cochran) and Roy Davies, Betty and Lloyd Dixon, Patricia and Rob Fleming, John*

*Gardiner, Peg and John Gooch, Shirley and Malcolm Leembrugen, Bray Lewis, Austin Ley, Joyce and John Monk, Barbara and Douglas Pearce, Colin Richards, Rita and Len Satchell, Dorothy and Arthur Schweiger, John Shelton, Lorna Sisely, Mrs Joan Bell and Jim Sinclair, Helen and Harold Roberts-Thomson, Margaret and John Tucker, Pat and Quin Whitehead, Timmy Williams and daughter Nicole Pizer, Dorothy and Alan Williams, Percy Zerman, June Zwar.*

### **MBBS March 1945 Fifty Years Reunion Melbourne Cricket Club 24 February 1995**

*From Nate Myers* – The class of 1945 held a dinner to celebrate the fiftieth anniversary of their graduation which took place in March 1945. The dinner was held in the Committee Room of the Melbourne Cricket Club, this delightful room being made available through the auspices of one of our number, Don Cordner. In all, seventy attended the dinner, comprising forty-three of the original graduates and twenty-seven who accompanied them (twenty-six wives and one daughter). Although the majority of those attending lived in metropolitan Melbourne, there were several from farther afield including country Victoria, Western Australia, New South Wales and Queensland. We had hoped that Mary Levinson (nee Bennett) who lives in the United Kingdom would be attending but unfortunately she was unable to be with us; in a similar vein John Farrar who also lives in the United Kingdom tendered an apology.

The evening was an extremely happy occasion – it was clear that this was so from the many favourable comments made at the time and subsequently by letter to Nate Myers who had organised the event. All previous reunions had been organised by Don Cordner so this was indeed a great responsibility.

Pre-dinner drinks were followed by the photograph which was taken in the Long Room. A seating plan was arranged for dinner but the meal progressed with considerable activity and movement around the room and from table to table, enabling friendships to be renewed and conversation to progress: all-in-all there was a tremendous spirit of camaraderie.

There were no formal speeches as such, but Des Hurley took the opportunity to pay a tribute to Peter Jones which was well received. It was almost as if Des was able to predict the future because little more than two weeks later Peter Jones died – our reunion was, in fact, the last social event he attended. An obituary on Peter is published in this issue of *Chiron* (see page 2).

The theme of the evening was one of happiness and it was generally agreed that we should meet again, probably towards the end of 1997.

The evening was attended by: *Charlo Anderson, Tom Antonie, Paddy Barrett, Allan Bignell, Don Cordner, John Critchley, Harry Cumming, Jim de Crespigny, Derm Foster, Shirley Francis, Jim Gardiner, Jenny Gardiner, Harold Grinblat, Ross Hayes, Don Hewson, Des Hurley, Paul Jeffery, Peter Jones, Jim Keipert, Ron Kingston, Iris Leber, Jack Little, Walter Lowen, Ian Mackay, Joan Marsden, Bertram McCloskey, Walter Moon, Luke Murphy, Nate Myers, George Pestell, Chan Piercy, Des Prentice, Paul Rowan, Don Rush, Kurt Schwarz, Michael Shoobridge, Jack Swann, Eric Taft, Ian Torode, Gordon Trinca, Sam Troski, James Troup, Betty Wilmot.*

### **MBBS 1955 Forty Years Reunion The Melbourne Club 3 November 1995**

*From John O'Brien* – Sixty-seven graduates met at The Melbourne Club for their forty year reunion.

Many came from interstate: Max Kirwin, Frank Webb, Max Whisson and Lesley Dougan from Western Australia. Max West from Yorkeys Knob, Cairns. Helene Nasser (Sherlock), George Freeman and David Gordon from Queensland. Rosemary Nicholls and John Hood from Sydney and Boyne Russell, John Brennan and Dane Sutton from Tasmania.

Female graduates were well represented. Helene Nasser came for the first time in forty years. Other graduates were Kath Thompson, Boyne Russell, Lesley Dougan, Barbara Stuart, Heather Bartram, Mary Grogan, Phil Joshua, Ursula McKenna and Rosemary Nicholls.

Helene Nasser told organisers John O'Brien and Graham Syme that she was petrified she wouldn't recognise anyone after forty years. However, later in the evening Helene was heard to say that she needn't have worried, nobody had changed, a little older perhaps but personalities don't change.

Such is the medical course, six years seemed to be such a short time after forty years graduation.

### **MBBS 1965 Thirty Years Reunion Ripponlea 1 December 1995**

*From Peter Habersberger* – On Friday 1 December 1995, seventy-eight graduates who had their degrees conferred on 18 December 1965, sat down for dinner thirty years on. Many looked the same, and many have changed appearance in one way or another over those thirty years. The graduates of 1965 are now scattered world-wide and throughout every state in Australia, and although none from overseas could join us on this occasion, graduates came from Western Australia, New South Wales and Queensland.

It was a beautiful balmy summer evening and drinks were served around the pool at Ripponlea, followed by dinner in the ballroom and entertainment by 'Pot Pourri'. Reflecting on the last thirty years, it was difficult to believe that so much time had passed. A review of the conferral program for the 18 December 1965 showed that the graduation ceremony in Wilson Hall was presided over by the Chancellor, the Hon Sir Arthur Dean, and in attendance were the Visitor to the University, his Excellency the Governor of Victoria, Major General Sir Rohan Delacombe, and the Premier of the day, the Hon H E Bolte.

This was the fourth reunion that the graduation class of 1965 have held and each has been an outstanding success. It was resolved that another reunion would be held in a further five years.

### **MBBS 1975 Twenty Years Reunion Dallas Brooks Convention Centre Sheraton Towers, Southgate Botanic Gardens 7 & 8 October 1995**

*From Chris Hogan* – We started with a series of lectures at Dallas Brooks Convention Centre on the theme of 'Medicine, Our Patients & Ourselves'. Peter Turner spoke on his experiences in China, Peter Mortensen spoke on controversies in prostrate disease, Alice Murkies spoke to a survey she had issued to our year on our health and lifestyle behaviour which was most informative and entertaining. Chris Hogan spoke on 'Who doctors doctors and the role of GPs'. There followed a lively panel discussion.

That evening we had a formal dinner at Sheraton Towers Southgate, a long time was spent circulating with pre-dinner drinks no-one wanted to go in! The notice boards, with letters from many of our year giving short résumés of their last ten years, received a lot of attention.

We were treated to a presentation by that multimedia personality and colleague Dr Andrew Pattison on 'Medicine and the Media'. The dinner continued until the early hours and was then adjourned to spontaneous groups in various locations throughout Southgate.

The family day at the Botanic Gardens was held in splendid weather with many participants amazed that midday could come along so quickly!

John Santamaria is in the process of preparing a reunion booklet containing as many photos and résumés of our colleagues that were delivered or otherwise obtained. Also included will be the text of the talks and copies of a poem written by Ron Elisha and one of mine.

I would like to thank my practice manager Marcia Carter for her major effort in capably dealing with all the organisational details of this event. She would like to thank those of my colleagues who tried to offer her a job with less demanding employers.

The reunion was attended by: *Stephen Ackland, Colin Barnes, Jacob Boon, Adam Bradshaw, Graham Bromwich, Pia Brous, Anthony Brown, Elizabeth Brumer, Paul Burns, Patrick Casey, Vivienne Cheary, Peter Clifton, Neville Collins, Maxwell Collins, Klara Coppel, Ross Coppel, John Cullen, Lynne Cunningham, Douglas Czarnecki, Pamela Dagley, Gary Davison, Tony Dunin, Brian Dunne, Geoff Edwards, David Ellis, Roger Fagan, Joanna Flynn, David Fonda, Susan Fraser, Barbara Gallagher, Vin Gallichio, Andrew Gordon, Jim Griffiths, Wendy Hayes, Chris Hogan, John Holmes, Jo Horwood, Anne Howard, Laurie Howes, Neil Jacobs, Mark Jallano, Miranda Jelbart, Ian T. Jones, Josef Juhasz, Lawrence Lau, Anne Lewis, Marion Lustig, Alan McCleary, Colin McDonald, Larry McGrath, Peter Millington, Michael Minogue, Gregory Mitchell, Peter Mortensen, Leigh Munro, Alice Murkies, Richard O'Brien, Diane Palmer, Frank Parker, Andrew Pattison, Justin Peters, Stephen Rogers-Wilson, Alexander Rosalion, Jean Rothero, John Santamaria, Rowan Sawers, Chris Scown, Danny Silver, Wayne Spring, John Taft, Peter Turner, Euahna Vargos, Joseph Virgona, Julie Walker, Rosemary Walker, David Warburton, John C White, Robin Wilson, Mark Zagorski, John Zalberg, Sol Zalstein.*

### **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 Ken French or Mr Philip Taylor-Bartels on 9344 5254 for menus, costs, a tour of the facilities and further information.*

# 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 beforehand.

Please let the UMMS office 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. We can also advise you on alternatives you may wish to explore regarding venues and speakers.

Many reunion organisers produce a booklet containing details of graduate activities since graduation. A small curriculum vitae needs to be requested from each graduate early in the planning stages, and these, sometimes together with recent and old photographs, are compiled into a booklet. Those who attend the reunion take home something to remind them of the event, and those unable to attend enjoy reading about their old friends. We have a small stock of past reunion booklets at the UMMS office and would be very grateful to receive one from your reunion.

## MBBS Graduate Anniversaries in 1997

5th Year Class of '92  
10th Year Class of '87  
15th Year Class of '82  
20th Year Class of '77  
25th Year Class of '72  
30th Year Class of '67  
35th Year Class of '62  
40th Year Class of '57  
45th Year Class of '52  
50th Year Class of '47  
55th Year Class of '42  
60th Year Class of '37

## 1996 REUNIONS

### 15TH YEAR OF 1981

Dr Tony Sellars  
bh: (03) 9459 7497

### 20TH YEAR OF 1976

16 November 1996  
Sheraton Towers, Melbourne  
Dr Tony Kostos  
bh: (03) 9417 7337

### 25TH YEAR OF 1971

Dr Elizabeth Dax  
bh: (03) 9280 2402

### 30TH YEAR OF 1966

8 & 9 November 1996  
Regent Hotel and  
The Melbourne Club  
Dr Stan O'Loughlin  
(03) 9792 1791  
Dr Robert Nave  
(03) 9650 3115  
Dr Viv Peterson  
(03) 9435 1531  
Dr Maria Breen (Vice)  
(03) 9285 2342

### 40TH YEAR OF 1956

23 November 1996  
The University of Melbourne  
Professor Henry Burger  
bh: (03) 9950 4397

### 55TH YEAR OF 1941

20 September 1996  
University House,  
The University of Melbourne  
Mr James Guest  
ph/fax: (03) 9347 3852

## UMMS Office

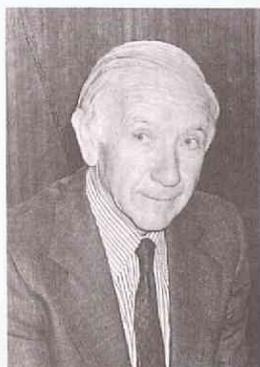
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## OBITUARIES

### KEITH CAMPBELL BRADLEY

BCE 1934, MBBS 1941, FRACS, FRACR (Hon), FRACO (Hon)  
1911-1995



KEITH BRADLEY

KEITH BRADLEY was a likeable person. We met when we were second year medical students and remained firm friends until his recent death. Dux of Melbourne High School in 1929, Keith had graduated in civil engineering before commencing medicine. He carried the precision of this earlier training into his medical career.

He graduated MBBS (Melb) in 1941, the first year the medical course had been shortened as a result of the Second World War. On graduation he enlisted in the RAN and was appointed to the Royal Melbourne Hospital as a junior resident medical officer. He was house surgeon

to Mr Henry Searby, and house physician to Dr F Blois Lawton. As a result of the sinking of the HMAS *Sydney* in late 1941 and HMAS *Perth* in March 1942, naval call up was slow so he also worked for some months as assistant clinical pathologist (to Dr Hilda Gardener) before being called up for full-time naval service.

During this period he and I worked with Dr Julian Smith Snr on aspects of direct blood transfusion, and we carried out some one hundred transfusions with the Julian Smith pump.

Keith Bradley's sea service was in HMAS *Shropshire*; he was in the ship during the Battle of Leyte Gulf and other operations leading to the liberation of the Philippines. Demobilised in September 1946 he started training in obstetrics and gynaecology, but soon transferred to the Anatomy School, commencing a long association with that Department.

Sydney Sunderland was Professor of Anatomy and he indicated that he had positions for Bradley and myself for 1947, but it was not for some months (having not received any salary cheques) that we realised we were working in an honorary capacity! Keith was working as a surgical assistant to J B Turner at the Royal Melbourne Hospital at this time, and by mid year he obtained an assistant neurosurgical post (to Mr Hugh Trumble) at the Alfred. This was the start of a long and fruitful partnership.

It was early days in Melbourne for the speciality of neurosurgery. Dr Leonard Cox had started a neurology clinic at the Alfred Hospital in 1934 and Trumble (a skilled general surgeon) developed the neurological side. Sunderland was busy in anatomical and clinical neurology and they were a very strong team. In fact, Melbourne in the post-War years was well served with neurosurgeons of distinction. Frank Morgan was at St Vincent's, Reginald Hooper and John Curtis at the Royal Melbourne.

Bradley gained his FRACS in 1948 and in 1951 was appointed Research Fellow to the Australian Canteen Services Trust with the aim of studying problems of causalgia and phantom limb phenomena in ex-servicemen. He studied in England, France and the USA in 1952-53 producing an important monograph 'Sequelae of Amputations' published in 1955.

During this time, in England, he renewed acquaintance with Professor Frederic Wood Jones, then Professor of Human and Comparative Anatomy at the Royal College of Surgeons of England.

Keith Bradley succeeded Hugh Trumble as Head of the Neurosurgical Unit at the Alfred in 1955. His stature as a neurosurgeon grew both nationally and internationally, but he maintained a presence in the Anatomy Department.

In 1961, in appreciation of the skills of John Game and Keith Bradley, Louis Roet made a large bequest to set up the Van Cleef Foundation for research in neuroscience. Keith was a founding trustee and was chairman at the time of his death.

He was consulting neurosurgeon to the Royal Australian Navy, and set up a neurosurgical unit at Mont Park to help with problems in the mentally ill. He was secretary-general of the Asia and Australian Society of Neurosurgery and a past president of the Neurosurgical Society of Australasia.

Keith had maintained a constant and increasing interest in anatomy and his chance came in 1966 when he was appointed to a second chair of anatomy at the University of Melbourne. He was popular with staff because he was generous with his knowledge and time, and he was popular with students because of his excellent teaching. He taught in the Wood Jones-Sunderland tradition; a clear exposition, excellent diagrams, and anecdotes to enliven his lectures. He made a large series of video recordings dealing with major neuroanatomical topics.

He taught not only medical and dental students, but a wide range of postgraduates and he was recognised for this work by being made an Honorary Fellow of the Royal Australasian College of Radiologists and the Royal Australian College of Ophthalmologists.

In the early days of CT scans he started teaching cross sectional anatomy and he wrote a number of articles on neurosurgical and neuroanatomical topics. In collaboration with Geoffrey Kenny he did some interesting work on the pineal gland.

His opinion was often sought on medico-legal matters and I know from mutual friends in the legal profession how highly his reports were regarded and the manner in which he gave evidence in court. He was called as an expert witness on one of the most celebrated trials of recent times, that of Lindy Chamberlain.

A man with a great capacity for friendship, he could be relied on when one was in need. In addition to his support for his friends, he helped many people in a quiet and unobtrusive way, never seeking recognition.

His marriage to Iris was a long and happy one. They enjoyed travel, music and conversation and with his son Paul he developed a Poll Hereford stud.

Keith Bradley was a sound engineer, a skilled neurosurgeon, a doctor who never gave up on the patients under his care, but I think he was at his best and happiest as an anatomist. He loved the history of the subject, the eponymous nomenclature, the close contact with students and the research projects which exercised his enquiring mind.

He enjoyed life, lived it to the full and is a man to be remembered.

*James Guest*

### BERESFORD WILLIAM BUTTERY

MBBS 1965, FRACOG  
1939-1995



BERESFORD BUTTERY

IT IS DIFFICULT to accept that Beresford has died. One does not expect death to come to somebody who looked so youthful and had such enthusiasm for life. He has been an important part of our lives but he died suddenly in China on 6 August 1995 – a sad loss to many people. Beresford was a generous, loyal and true friend to many of us. He had a bright optimistic approach to life and an infectious, impish smile.

Beresford was born in 1939 – one of non-identical twin boys. It was appropriate that they were born at St George's Melbourne, a hospital with which Beresford was to become closely

associated, and a hospital he dearly loved.

Educated at Scotch College, Beresford graduated MBBS from Melbourne University in 1965. He later trained at the Alfred Hospital, the Royal Women's, the Austin and the Mercy Maternity Hospitals. He gained his MRCOG in 1971 and then set off for the United Kingdom. He was one of the first Obstetricians to take a serious interest in ultrasound and spent a year in Glasgow with Ian Donald. While in Scotland, Beresford gained his Edinburgh Surgical Fellowship. He returned to Australia in obstetrical and gynaecological practice and showed great vision in establishing a private obstetric ultrasound practice at a time when ultrasound was only beginning to be used in public hospitals.

**ALASTAIR HERIOT CAMPBELL**  
MBBS 1940, MD 1961, FRACP  
1917-1996

Beresford gave much of his life contributing to medicine in the broadest sense. He was Honorary Secretary of the State Committee of the Royal College of Obstetrics for three years and Honorary Treasurer of the State Committee of the Royal Australian College of Obstetricians and Gynaecologists for three years. During his later term, he was Treasurer of the organising committee of the large Asian and Oceanic Federation for Obstetrics and Gynaecology Congress in Melbourne in 1981. This meeting of 2000 delegates from twenty-one nations was the focus of Beresford's life for three years but as with all his commitments, always carried out with good grace, he fulfilled his duties to the limit.

His second great professional commitment was to St George's Hospital. Beresford was appointed Obstetrician from 1976 to 1993. Not only did he perform his duties with distinction but in typical Beresford fashion he gave tremendous support to every aspect of hospital life – medical and social. He regarded St George's as his spiritual home and the hospital was proud to claim him as one of their own.

Beresford's third and probably greatest professional commitment was to the Australasian Society for Ultrasound in Medicine (ASUM) throughout most of his professional life. He was a councillor from 1977 to 1989 and again from 1994 to 1995, and President in 1988. He made many vital contributions to ASUM, including the establishment of the Standards of Practice Committee which he then chaired for its first ten years. He ran innumerable annual scientific meetings. His selfless commitment to the organisation was epitomised by the fact that he took on the Honorary Secretarial position in 1994 when the Society desperately needed his expertise. He was appointed to the Council of the World Federation for Ultrasound in Medicine in 1994 and was attending his first meeting as a councillor in China at the time of his death.

Although not well recognised, Beresford had a strong academic record. He had a keen and inquiring mind. He published nineteen articles in refereed journals, several of which were milestone articles; in particular the obstetric management of the ovarian cyst in pregnancy and the first description of the myometrial contraction in pregnancy – 'the lump of Buttery'. In 1993 he was the first to describe ultrasonic hystero-graphy which only recently has been taken up seriously by other workers.

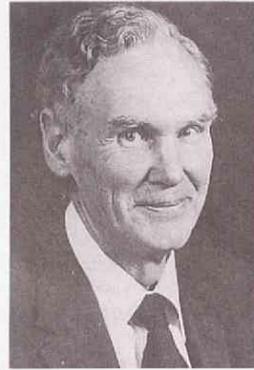
Outside medicine Beresford had wide-ranging interests. He had an excellent tenor voice. His 'musical premiere' was probably in 1964 when, with a group of fellow fifth year medical students, he sang in the Med Medleys Revue. The Barber Shop Quartet comprised Beresford, Neil Roy, Roger Pepperell and Russell Conway. *The Embryos* as they were known were billed as the only clean act on the program and were a great success. Not wanting to suffer from over exposure they performed again in 1981, seventeen years later, and for some years after that as the highly acclaimed *Prolapsed Chords* at the Royal Women's Hospital revues.

Beresford was generous both to his friends and in his support of charity. He was a founding member of the ECHO Foundation in 1978 – a fine organisation which funds and provides holidays for elderly citizens. He remained an active member and was a past vice-president. A proficient if somewhat foolhardy skier he believed the shortest route down the mountain was the best, and apparently showed great reluctance to upgrade his ski apparel. He enjoyed cooking and surprised even his friends when one year he quietly entered a plum pudding at the Royal Melbourne Show and received a highly commended award.

Beresford was a keen traveller, and twelve months before his death he went to Sweden for one day to surprise a friend for a fiftieth birthday celebration. This trip also demonstrated his extraordinary stoicism – as he boarded the plane he knew he had a bowel obstruction secondary to his diverticular disease. Three days later, having drunk and eaten little and travelled to Sweden and back, he returned to Melbourne and drove himself to hospital where his obstruction was treated!

Beresford's company will be sadly missed by his many friends and there are many important organisations that will be the poorer for his passing. He will be particularly mourned by Barbara, Andrew, Michael, Robert and Marian.

*Lachlan de Crespigny, Keith Layton & Peter Heath*



ALASTAIR CAMPBELL

**T**HE SPEED at which Alastair Campbell walked up the Banksia Street hill slowed over the years, but the sense of purpose in his stride remained to the end. Alastair and Wilma Campbell made their home within walking distance of the Repatriation General Hospital (Heidelberg), in which Campbell was to base his medical career. It was in the basement of this home that we clambered together – amongst the results of his years of 'hoarding' – in search of his first 'machine' a device made to his design in the hospital's workshops from a gas meter and an anaesthetic balloon, providing the first

objective measurement of respiratory function in Australia. Campbell was a pioneer of respiratory function testing in Australia, and the first specialist to have a full-time appointment in respiratory medicine in Victoria. Born into a family with Presbyterian traditions, Campbell inherited the protestant work ethic, but not the faith. Together with his wife, Alastair Campbell was an active socialist and for many years a member of the Australian Communist Party, with a continuing commitment to social justice for all.

Graduating MBBS from the University of Melbourne during the Second World War (1940), Campbell joined the RAAF in 1942. He had hoped for overseas service; instead he was placed in successive appointments within Australia which involved establishing new medical services. This early experience in medical administration convinced him of the efficiency of a nationalised system of health care in which the need for payment did not intrude between patient and doctor. His exposure to medical administration in the Services proved a model for his subsequent service with the Repatriation Commission. Campbell was born into a family with a tradition of tertiary education, which continues through his own children and grandchildren. His great-grandfather, Alexander Campbell, arrived in Melbourne in 1859, a university-educated Presbyterian minister who was instrumental in the formation of Geelong College, the Ecclesiastical Hall and Ormond College, and in the promotion of the Working Men's College (later RMIT). Campbell's father had obtained a Doctorate of Science from the University of Melbourne, and so it was with some determination that he commenced reading towards his MD whilst in the RAAF. Having successfully sat the first examination prior to discharge, he accepted a full-time position at the Greenvale Sanatorium for one year, during which time he passed his Membership, but failed the MD final examination. This he finally obtained some years later by thesis, although he recalled, with lingering regret, that it came after the death of his own father.

His interest in tuberculosis led him into the Repatriation General Hospital (Heidelberg) in 1947, as a full-time medical officer. Within fifteen months he was himself admitted as a patient to the Chest Division. Reflecting on his period of hospitalisation with tuberculosis, he recognised that it had provided him with an opportunity to expand his knowledge, for he spent this time reading Shakespeare, the great poets, some philosophy, and cultivating an interest in classical music – his single-minded devotion to medicine had been broken! During his prolonged convalescence, Campbell was offered a part-time research position in the Chest Division at the Repatriation General Hospital. This was unusual for two reasons: the Department did not employ part-time medical officers, and the Repatriation Commission had no commitment to research since its responsibilities, as defined in the respective Acts, were for the provision of treatment and compensation only. The research was to determine if there was a direct link between prolonged courses of a relatively new drug used in the treatment of tuberculosis (para-amino-salicylate, or PAS) and reports of muscle weakness and cardiac abnormalities in patients. This he demonstrated and, as a result, was awarded one of the early Wunderley Travelling Scholarships to study tuberculosis and other respiratory diseases in England, Canada and America. He resumed work with the Department as a junior specialist on his return, with responsibility for the Chest Clinic at RGH (Caulfield), a full-time position created for him. It was there that he first developed his

'machine'. His leadership within the field of respiratory medicine is well documented elsewhere. That he established a large research-based respiratory service within the Repatriation Department was extraordinary. Alastair Campbell had a commitment to, and a vision of what could be achieved in, a nationalised health-care system. He described himself as 'a conniving sort of person', but others recall his strong leadership and determination, together with an intimate knowledge of the Department. He was the first physician to carve out a full-time career in a single specialised area, excluding those within University departments. His commitment to teaching was recognised in the wide attendance at his regular chest meetings which became an accepted part of postgraduate training for graduates preparing for their Membership examinations. He achieved a position of considerable authority in the Repatriation system, being appointed as the Department's first national Consultant (Chest Diseases), an appointment he held from 1964 until his retirement from full-time practice in 1979.

The Repatriation Department sent Campbell to Queensland as a specialist in chest diseases during the late 1950s. It was there that he developed his interest in social anthropology. He joined the Queensland Branch of the United Nations Association, aware of the plight of the Queensland Aboriginal population who, at that time, were denied both the status of citizenship and a good education. Together with other members of the Association, Campbell produced his first work on aboriginal culture during this period, highlighting the difficulties the Queensland Act placed on its indigenous population. Returning to Victoria in 1959, Campbell became a member of the Federal Council for the Advancement of Aborigines. After the granting of full citizenship to the aboriginal population, Campbell withdrew from the Committee but maintained his involvement in aboriginal affairs by way of the study of social anthropology. He subsequently published papers on tooth avulsion, elementary food production, traditional 'pharmacy' and the culture and prehistory of the aboriginal peoples of Victoria. After his retirement from full-time medicine, Campbell spent one day a week in the Victorian Museum, to which he had been appointed as an honorary associate in 1983. He also prepared the papers of John Bulmer, the first superintendent of the Lake Tyers Aboriginal Reserve, for publication by the Museum and, in 1987, published *John Batman and the Aborigines*, (Kibble Books).

Alastair Campbell maintained his involvement in respiratory medicine as an honorary consultant in thoracic medicine at the Repatriation General Hospital until 1987. He then continued to attend the weekly thoracic clinical meetings when in town.

He was a devoted husband, father and grandfather. He nursed his wife through her final illness, pleased that after fifty years of marriage he was able to reciprocate for the care she had given him during his convalescence with tuberculosis. After her death, he completed a biography of his great-grandfather, which was launched at his home in December 1995. (*Campbell 1815-1909*, Spectrum Books, 1995)

Alastair Campbell was a physician of high repute. He was also a gentleman, a political activist, and a scholar. In many fields he will be sadly missed.

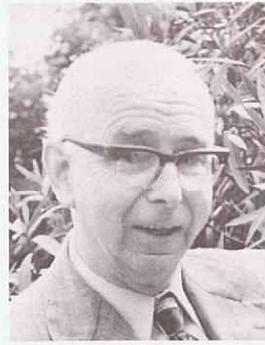
Gwynedd Hunter-Payne

<sup>1</sup> Alastair Campbell's personal account of his period in hospital with tuberculosis appears in *In the Company of Strangers*, p133-42. See Chiron, 1996, Books section p66. Ed.

**JAMES ERIC CLARKE, ED**  
**MBBS 1934, MD 1937, FRCP, FRACP**  
**1911-1995**

**J**ERIC AS HE WAS KNOWN best in medical circles, died in the Epworth Hospital surrounded by his six children in April 1995 shortly after suffering a severe stroke. He was a remarkable and godly man whose life touched many people in unforgettable ways: his family, friends, colleagues, students and patients. Intellectual and professional leadership, wisdom, integrity, humility, love, compassion, warmth, discipline, humour and a strong commitment to God were some of the attributes of this 'gentle man'.

Eric was born in Kuling, a remote part of central China in 1911, the second of three surviving sons of missionary parents. Together with his older brother Murray, and at the age of eleven, he came to Melbourne for schooling. He became a boarder at Caulfield Grammar School and later at Scotch College, spending school holidays with cousins. In many ways they were harsh years. He used to tell about his



JERIC CLARKE

first day at boarding school when, not having the requisite pens for class, he strapped a nib to a pencil with string. He was duly taken off to the Principal's office and caned. Despite hardships and the distance from his parents he successfully negotiated these school years with determination and a great sense of purpose, his goal of studying Medicine always before him. He distinguished himself academically, gaining the necessary scholarships to see him through University and Ormond College.

He revelled in University life during the 1930s, achieving many distinctions through his course and coming equal top in final year surgery. He was a keen and talented tennis player for both Scotch College and Ormond College. At a recent Ormond College dinner he stood in front of team photographs and accurately recalled the scores of the finals matches between Ormond and Queens Colleges held sixty years ago. During his university years he was also actively involved in the Christian Union and gave his time generously to various Christian youth activities.

He completed his residency at Royal Melbourne Hospital and then went as Registrar to Fairfield Hospital. In the late 1930s he sailed to England to study for his FRCP, as the ship's doctor on a Swedish cargo vessel. Evening news reports were anxiously awaited each day because in the event of the outbreak of war this ship would have made for the nearest German port! He did reach England safely and the war began during his time at Brompton Chest Hospital. There followed postings to the Middle East and New Guinea, and distinguished service mainly in 2nd/7th AGH. Most of his many decorations remained unclaimed because of his lack of interest in seeking recognition for the things he did. His involvement with the Army continued through the post-war years and he finally attained the rank of Colonel.

On return from the war Eric was appointed Honorary Physician at the Alfred Hospital where he remained until 1971. This position was without salary but gave him great experience. Eric also became visiting medical officer to the Repatriation Hospital (1948-76) which did provide some remuneration, but, in general, consulting physicians were relatively poorly paid. Eric also had a private practice in Collins Street.

While in London Eric had worked at the Brompton Hospital and he maintained a special interest in tuberculosis and other lung diseases. He made many contributions to the National Thoracic Society of Australia and was President from 1970-72.

Eric had clinical expertise, teaching and administrative abilities so that, not surprisingly, his opinion on clinical problems was often sought and his ward rounds well attended. He became Clinical Dean of the Medical School from 1961-64. Eric was a councillor of the Royal Australasian College of Physicians for many years, Vice-President from 1961-68 and had the difficult task of being Chief Censor for ten years.

A measure of the regard held for Eric was that, when Richard Lovell was appointed to the first Chair of Medicine in the University of Melbourne at the Royal Melbourne Hospital, Eric was asked to take leave from the Alfred Hospital to help Richard Lovell establish himself and his unit in Melbourne. Eric did this in his usual quiet way and it was much appreciated.

In 1940 Eric married the love of his life, Beth Kinross. Following the war he and Beth set up their home in Kew creating a remarkable family environment in which to raise their six children. Despite his demanding work and voluntary commitments Eric found ways in which to be involved 'hands-on' in loving and caring for the family. It was he who woke everyone with a hot drink each morning and then cooked a two course breakfast of porridge and eggs. In keeping with his disciplined approach to life, he summoned all to the table with a gong at 7.30 am, and then left for work at 7.50 am. His commitment to family was such that in the evening he arrived home at exactly 6.30 pm for tea. He was so reliable in this that dinner could be served in absolute confidence that he would be there by the time the meals reached the table, even if he would be gone again by 7 pm.

He was very proud of his children and followed their academic and sporting progress keenly. In school holidays he would set up circuit training programs, and encourage tennis, football, netball and even swimming coaching at 5.30 am. Weekends began after Saturday

morning Outpatients at the Alfred Hospital and were special for family, with gardening and football and the beloved Hawks. Sunday school (of which he was superintendent) and church filled Sunday mornings, and Sunday afternoons were for hospitality. He proudly oversaw afternoon teas cooked and presented by the children.

Eric was wise and generous in sharing a little about his work life with his children. If he had to visit a hospital or his rooms on weekends he often took them with him, giving them some knowledge of the nature and context of his work and an important identification with those places. All the children carry an enduring and significant memory of singing with the Alfred Hospital Nurses Choir each Christmas Eve. Sunday evenings were very special. That was the one time of the week when children were allowed to venture into his study. Piles of paper, x-rays, journals and books were moved aside, the fire lit, and following hair washes all round he would read stories.

Eric's wife Beth died after a short illness in 1974 – a terrible sadness in his life. In the years that followed he assumed the role which Beth had occupied in relation to the children. He provided a home base as they established themselves as adults. He continued the practice of providing Sunday lunch, and would serve up elaborate meals for a large number of people. He proudly tried new dishes attributing them to staff at the Alfred who passed on to him their 'prescriptions'.

Eric married Helen Evans in 1980 and subsequently cared for her through a long illness. She died in 1994. He was a remarkable father (and grandfather to his fifteen grandchildren) continuing to be an enormous source of affirmation, encouragement and strength as he became more frail over recent years.

He will be missed by all of us who were his family, friends, colleagues, patients and students. *Marjorie Quinn & HA*

### DAVID FRANCIS COSSAR MBBS 1946, DLO, FRCS, FRACS 1922-1995



DAVID COSSAR

DAVID COSSAR, who died on 26 February 1995, was a fellow undergraduate and post-graduate student with me at this University and a dear and valued friend for many years. David came from a long-established pharmaceutical business and his mother urged him to study medicine as there were more than enough pharmacists in the family. We graduated at the end of the Second World War, in 1946, having done the usual six year course in a little

over five years – the course being condensed because of the war. There was some time for extracurricular activities, but not much! David, having played football for his school, won a University football blue. Later in life he developed the hallmark of a keen footballer – a crook knee!

In 1948 David and I became fellow residents at the then (now Royal) Victorian Eye and Ear Hospital. Gaining his DLO, David then served as a demonstrator in Anatomy.

We met again in London, when he was a resident at the world renowned Gray's Inn Hospital for diseases of the ear, nose and throat. I was at the Institute of Ophthalmology and our paths crossed frequently through functions organised by his hospital and the then Empire Medical Advisory Bureau for overseas postgraduates. David went to the Radcliffe Infirmary, Oxford, gained his FRCS and, in 1954, returned to Australia and obtained the FRACS.

He began private practice with the well known surgeon George Swinburne and became Honorary Otolaryngologist to the Royal Melbourne, the Royal Women's and Box Hill Hospitals.

Despite a busy consulting practice he had an exchange involvement in teaching his specialty with colleagues in Singapore. He made close friends with several Singaporeans – not all medical – and there were regular visits between Victoria and Singapore.

David had many friends and outside interests. From a small bush block in West Gippsland he developed a thousand acre property with dairy and later beef cattle. I have fond memories of some of the honey he produced from his beehives and tastings at a wine and food society. He was also a keen bird watcher.

Above all these interests was his joy in working with wood. Much of his leisure time and energy went to being a woodcraftsman and he produced many magnificent pieces for himself, his children and his grandchildren.

Dave had a keen sense of humour and laughed with people not at them. A good story teller, I well remember when we were residents, his account of his previous night's reading of a well known book on the comparative anatomy of the larynx with a detailed rendering of the strange noises emitted by different animals under various circumstances.

David is survived by his wife Joan (nee Towns) two married daughters and grandchildren. Joan, a fellow graduate with us was a demonstrator in Histology for over thirty years.

David will be mourned by many and will be specially remembered at the proposed fifty years reunion of the 1946 graduates in 1996.

*Geoffrey Serpell*

### BRIAN SANGSTER FARAGHER MBBS 1952, FRACP, FRCPA 1927-1995



BRIAN FARAGHER

BRIAN FARAGHER'S graduation, delayed by a year on account of a suspicious radiological shadow, was followed by happy years as an RMO at the Bairnsdale and the Royal Children's Hospitals and afterwards with Registrar appointments at the Royal Children's Hospital and the Alfred Hospital. He earned membership of the Royal Australasian College of Physicians in 1960.

Having spent two years in the Alfred's Clinical Pathology Department Brian was appointed Assistant Clinical Pathologist there in 1961. In 1964 he was appointed Deputy Director of the

Alfred's newly created Haematology Department and held this position until 1989 when he retired at the age of sixty-two years.

It was my great fortune to have Brian as my close colleague for twenty-four years from 1961. No-one could have asked for a more amiable, competent, wise and devoted co-worker than Brian. Our compatibility made our long time together professionally productive, but each was able to follow his particular bents without reproach or disagreement. He developed a great skill in morphological haematology and a devotion for teaching laboratory haematology. Over the years his easy manner, his knowledge and his teaching ability gained for him the greatest respect of his medical colleagues in Australia and the world.

My own views about his personal qualities have been echoed in the letters of condolence sent to his wife by both medical and scientific colleagues. Expressions used in some of them give an idea of the very high regard in which he was held . . . *honesty and forthrightness; an intelligent and meticulous scientist; totally supportive and caring of co-workers; sound advice on haematological and medico-political issues; cheerful member of Melbourne's haematological community; greatly loved by medical and scientific colleagues alike.*

On his retirement from the Alfred Hospital in 1989 he was awarded a medallion by the Victorian Branch of the Australian Institute of Medical Laboratory Scientists in recognition of his great contribution to the education of medical scientists through his teaching of haematology.

In addition to these activities, he played significant roles in the Australasian and international societies of haematology and of blood transfusion in both administrative and scientific capacities; as visiting consultant in laboratory haematology at Fairfield Infectious Diseases Hospital; and as a Clinical Assistant in the Department of Medicine, Monash University. His expertise was also used for the improvement in and the assessment of haematology laboratory standards in Australia and in developing countries.

He had always wanted to take early retirement and when this became opportune in 1989 he was able to fulfill his wish to spend more time with his wife, Dr Pam Dickenson, whom he had met at the Royal Children's Hospital, married in 1955 and who later presented him with a son and three daughters.

In 1990 he was honoured for his services to the Alfred Hospital by the life-time appointment as Honorary Consultant Haematologist.

After two years of full retirement he resumed working two sessions a week as Visiting Haematologist at the Heidelberg Repatriation Hospital. He was most generous in promoting and aiding the medical discipline of haematology which he loved.

Brian had many outside interests: the scouting movement; his family (of whom he was very proud); and later the collection of antique maps of Australia and its colonies, photography and exploring the outback of Australia.

It was on one such trip, shortly before he died, that his health suddenly deteriorated. The rewards of his early retirement were that he and Pam were able to share the enjoyment of their common interests over six years and that the ill-health he suffered was brief.

*Ronald Sawers*

## YRSA ELIZABETH FITTS (NÉE OSBORNE)

MBBS 1936

1913-1995



YRSA FITTS

YRSA FITTS GREW UP in the third of the five houses of Professors' Row in the University of Melbourne. The Baillieu Library now occupies the site. Her father, WA Osborne came at the age of thirty to the Chair of Physiology and Histology which he held from 1903 to 1938. His wife Ethel, completed her MSc after their arrival, and gave birth to two children in their first house which was in the west wing of the Quadrangle. Yrsa was the third child. She was named after a queen in the Norse sagas, which were read and enjoyed by her linguist father. Charis, the third daughter, was born just after

Ethel finished her medical degree in 1920.

Yrsa was a member of a family where high achievement was the norm. There was the expectation that whatever her brothers and sisters, father and mother could do, so too could she. Her father threw his young daughter into the Yarra attached to a rope, and it was a case of sink or swim. She developed into a fine swimmer and athlete, and was a good shot.

By the age of fifteen, she had qualified for entrance to university, but her failure to pass Latin, a prerequisite for Medicine, kept her at Merton Hall for two more years. A scholarship took her to Janet Clarke Hall for the five years of her course, and she was later to spend many years on the council of the College. She excelled in her studies and in sport. First class honours peppered her university record and, in her third year, she was one of the 'Apostles' – the top twelve students in her father's Honours Physiology class. This group would meet with Professor Osborne on Wednesday afternoon to discuss current physiological problems over afternoon tea! In her final year she won the EH Embley Memorial Medal in Anaesthetics and the Douglas Stephens Prize for diseases of children. As well, she was awarded the JT Ryan Scholarship for Surgery by the Royal Melbourne Hospital.

She loved skiing, and became the first Australian women's downhill champion in 1932. During this event she was going so fast she jumped a corner rather than rounding it. One severe winter, when Mount Hotham was inaccessible except by foot, she trudged in nineteen miles with her week's supplies on her back. She gained a University Blue in hockey, and represented Australia in hockey and skiing. A contemporary, Douglas Stephens, described her as '... very popular, handsome... pretty'. She inherited her father's wit and humour, but was less acerbic. Her speaking voice reflected her Anglo-Irish origins.

In 1938 Yrsa sailed to England earning her passage as ship's surgeon aboard a freighter – not only was she the doctor, she was the only woman on board. Her equestrian skills, honed on the cattle musters in her beloved Snowy high plains, stood her in good stead in 1938 when she was given a large horse in Haworth, Yorkshire, as her means of transport for visiting her patients. Her reception as the new locum, so young and female to boot, had been chilly, but she was not disturbed by this snub. She possessed a beautiful madrigal voice which she put to good effect when working in a sanatorium in Montana, Switzerland,

in 1939, where, in her free time, she skied and yodelled. She would later embarrass her children by singing the descant part in carols.

When she left for England she was engaged to a tutor from Trinity College, Clive Fitts, whose medical course had been prolonged by his being a member of the Davis Cup squad. They married on Yrsa's return in October 1939 in the chapel of Trinity College, and had three daughters and two sons, none of whom studied medicine.

Yrsa did not practise medicine after her marriage, but found outlets for her lively intellect while rearing her children in reading, cooking, and in the creation of two superb gardens, one in Hawthorn and the other at Main Ridge where she and Clive lived from 1976. Small talk was not of interest to her. She enjoyed discussion and argument, and expressed her forthright opinions succinctly. Gatherings in the Fitts' house in Kooyong Koot Road were always spirited for their friends came from all walks of life. Dry fly fishing was a hobby that she and Clive loved, and they spent many holidays with friends at Waterfall Farm, Khancoban, at Bibbenluke and on the Howqua.

Yrsa had enjoyed smoking cigarettes for most of her life and died in August 1995 at the age of eighty-two from a smoking-related disease.

*Vanessa Griffith (née Fitts)*

<sup>1</sup> The Victorian Historical Magazine, 150th issue, Vol 38, No 4, Nov 1967, p 236. The Late Emeritus Professor William Alexander Osborne: An Appreciation by Dr Colin Macdonald.

## FRANK MENZIES CAMERON FORSTER

MBBS 1948, FRCOG, FRACOG

1923-1995



FRANK FORSTER

FRANK FORSTER was an outstanding obstetrician and gynaecologist who made significant contributions in several areas of his specialty. His clinical and research contributions were numerous and their influence profound. Frank was one of the 'golden three', including Pat Maplestone and Glyn White, who made their mark on obstetrics, obstetrical analgesia and neonatal paediatrics in Melbourne.

Frank Forster was born in Sydney. His father, Cameron McDougall Forster,

was a medical practitioner and Medical Superintendent of a paediatric hospital. His mother was Jean Catherine Officer, formerly of Melbourne. Frank's early education was at Ashfield Grammar School, NSW, but in 1934 the family returned to Melbourne. Frank won a scholarship to Melbourne Grammar, where, intending to follow his Uncle Keith into the diplomatic service, he concentrated on the classics. However, uncles Keith and Hugh – later Brigadier Hugh Officer – persuaded him to make the wise choice of medicine.

Without knowledge of chemistry or physics Frank entered the Medical School of the University of Melbourne. His undergraduate career was interrupted when, in second year, he developed paraplegia from a spinal tumour which proved to be benign. Frank left the medical course and, as it was war-time, began to work at CSIRO. It was Pansy Wright who went to see him there and induced him to complete his medical studies. First on crutches he regained his ability to walk and graduated MBBS in 1948 with honours in both surgery and obstetrics and gynaecology.

After two years of general surgery at the Royal Melbourne Hospital, Frank began work at the Royal Women's Hospital Melbourne where he was RMO, Assistant Pathologist and Registrar in Obstetrics and Gynaecology. During a term in London he worked at the Soho Hospital for Women, and in 1953, gained his membership of the Royal College of Obstetricians and Gynaecologists. Returning to Melbourne the following year he became Second and then First Assistant to Professor Lance Townsend at the Royal Women's Hospital. Leaving his university post he established a private practice and, in 1959, became Honorary Obstetrician to Outpatients, a position he held at the Royal Women's Hospital until 1965.

In 1956 he became the Consultant Obstetrician and Gynaecologist to Fairfield Hospital and made regular visits there until 1984. At Fairfield he spent much time coping with difficult obstetrical problems

in women with a variety of severe infections. During the 1960s he became a world expert on liver disease in pregnancy and managed more women with such problems than anyone else in Australia. His work gained the respect of the staff and the confidence of the women.

Frank was an honest, intelligent and forthright man and emphatic in his views. He was neither a choreographer of power nor a seeker of such. He was compassionate to others and was not critical of his fellow practitioners. Meticulous in his care of women in all aspects of obstetrics and gynaecology Frank enjoyed the complete confidence and affection of his patients. Not surprisingly, he delivered the children of a generation of young medical practitioners in Melbourne.

Frank respected the abilities and achievements of women; they felt safe in his care for they knew he always put their welfare first. He regarded midwives as professional colleagues who played a vital role in the management of labour.

Frank was unique in running his own antenatal and postnatal classes. 'All babies must be bathed, clothed and put in the pram and put outside by 9am. No matter what the weather!'

Frank's enduring passion was medical history. He was President of the Section of Medical History (AMA Victorian Branch) 1966-68 and 1980-82, President of the Medico-Legal Society of Victoria 1979-80 and the first Tracy Memorial Orator at the Royal Women's Hospital in 1964.

Frank made substantial contributions as a medical historian and was known and respected in the obstetrical and gynaecological societies of the United Kingdom, Europe and America. Frank made obstetrical and gynaecological history live for those fortunate enough to listen to him tell of what he had gleaned from the original texts of previous masters. No one else in Australia could speak with such authority on any of these facets of history.

From his student days Frank built up a fine collection of books and pamphlets which reflected social and cultural changes in birth control and obstetrics. Frank, who received the President's Medal in 1990 for the many ways in which he had served the Royal Australian College of Obstetricians and Gynaecologists, donated his books and pamphlets to the library there, where it forms the only specialist reference library of its type in the southern hemisphere. Sadly, Frank was climbing the stairs to this library for its naming – the Frank Forster Library – when he died.

It is singularly fitting that this library, in the college for which Frank did so much in so many roles, should be named after him. However it is not only there you will find his monument, but in the hearts of his many patients, colleagues and friends.

Frank Forster was a family man, dedicated to his wife Prue, his children and grandchildren. Prue especially, was supportive of all his efforts despite the interruptions to family life inevitable in a busy obstetrical practice.

*G J Bishop & HA*

### **GEORGE EDWARD GARRATT**

**MBBS 1950  
1917-1995**

**G**EOERGE GARRATT was a resident at Trinity College and, after graduation, became a general practitioner in Armadale. A quiet, cultured man he was also an unusually kind doctor and is known, on occasions, to have personally delivered lunch to some of his older patients.

George was also a very generous man and presented a number of works of art to the Graduate Union.

Quite a few years ago George and Norman Long came to many of the meetings of the Section of Medical History AMA (Victorian Branch). George, like many others, was a great admirer of Professor Ken Russell. In 1977 George commissioned Dora McRae to paint a portrait of Ken and presented this to the Section. The portrait now hangs in the Medical History Reading Room of the Brownless Medical Library. George insisted on his gift being anonymous, but I wish to record this now as another example of his generosity to the University of Melbourne.

George never married, but is fondly remembered by a brother, a nephew, many friends and grateful patients.

*HA*

### **JEAN GITTINS 1908-1995**



JEAN GITTINS

**A** MAJOR REASON for the success and well-being of many of the departments of the Melbourne University Medical School has been the ability and devotion of their administrative and secretarial staff. One of the most prominent and best known members of this important group was Jean Gittins who died on 11th August 1995, aged 87.

Born in Hong Kong, the eighth of ten children of the prominent businessman and philanthropist, Sir Robert Ho Tung, Jean married a British engineer, had two children and seemed assured of a happy life in Hong Kong until the outbreak of the Pacific War in late 1941. Both she and her husband were interned. He died in captivity and on her release in late 1945 Jean immigrated to Australia to begin a new life with her children, Elizabeth and John, who had spent the war years in Melbourne.

Soon after her arrival she obtained a temporary position as assistant to Sir Peter MacCallum's secretary in the Department of Pathology. A few weeks later Sir Peter told her that he was to marry his secretary and invited Jean to succeed her in the department. She accepted and remained in the department for the next twenty-four years as secretary to Peter MacCallum (1945-1950), Edgar King (1951-1966) and George Christie from 1967 until her retirement in 1968. By her own account she was at first diffident and anxious about her new duties. However she rapidly gained confidence and became a major force in all aspects of the affairs of the department.

She established a strict, almost dictatorial, rule over the office staff, demanding the highest standards in all their work. She had a highly developed sense of propriety and woe betide any member of the academic staff who attempted to have his work typed before its due turn. In her prime she was an almost frightening figure to newly appointed junior staff. However her formidable facade concealed a genuine desire for their welfare. If properly approached she would do all in her power to help them, especially with her highly developed skills in scientific writing, spelling, punctuation and proofreading. There was however one overriding priority – nothing could be done if it might diminish the welfare or reputation of either the department or the professor.

She was a painstaking and meticulous administrator who thought it her duty to be fully familiar with all departmental activities. She used her talents to great effect when Edgar King decided to prepare a departmental history. She collected and collated detailed records of all who had worked in the department since its foundation. Not content with this, she proofread the entire work and oversaw its publication by Melbourne University Press in 1962. Her contribution was a major reason for the success of the *Melbourne School of Pathology* which became recognised as a model of its type.

After her retirement in 1968 Jean needed a new outlet for her energy and literary talents. She found these in writing and became the successful author of five books—four are accounts of different aspects of her life in Hong Kong and Melbourne and the fifth the story of the Chinese on the Australian goldfields. As if this were not sufficient, she accepted the position of secretary to the Society of Authors, PEN, and ran their affairs for several years with her usual precision and efficiency.

All who had the pleasure of working with Jean Gittins know how much she contributed to the success of the Pathology Department. Whilst some may smile about her idiosyncrasies her very many colleagues remember her with respect and affection and mourn the passing of an old friend.

*John Hurley*

### **ROBERT FREDERICK FITZGERALD HARBISON**

**MBBS 1950, FRACGP, FRCGP  
1920-1995**

**M**ANY DOCTORS take an active part in the life of their community. Such a one was Robert Harbison, who died on 30 March 1995.

Rob Harbison's parents were both surgeons [see *Chiron*, 1988, p56, obituary of JM Hickford] and many of their forebears had also been

in the medical profession so that it seemed foreordained for him to enter medical studies at the University of Melbourne in 1938. In that same year, Rob had enlisted in the Royal Australian Naval Volunteer Reserve for part time duty. Realising that if he passed his first year examinations he would be deferred from service until he had qualified, he deliberately failed two of his subjects and enlisted for full-time duty. Sent to Britain he attended the Royal Navy's first wartime radar course. He topped that course and joined the British frigate HMS *Alisma* as a radar officer; he later held a similar posting in the Australian destroyer HMAS *Warramunga*.

On his return to Melbourne he re-entered the medical course and graduated at the age of thirty. After residency at the Alfred Hospital, he went to Corryong as a General Practitioner because he foresaw the range of experience that might come to him there when construction started on the Snowy Mountains Hydro-Electric Scheme. Rob stayed in Corryong until 1967 and during that time he and a friend, Jock Berry, head of the Victorian Ambulance Service, got the Corryong Council to improve the airstrip so that an air ambulance could use it. From this small beginning, these two men developed a Victoria wide air ambulance service.

In 1967 he left Corryong and became a Postgraduate Fellow of the Victorian Branch of the Royal Australian College of General Practitioners; later he was appointed Chairman and then Director of the Family Medical Programme of that college. In 1977, he was honoured by the Rose Hunt Award of the Royal College of General Practitioners (London) 'for service to general practice in medicine'. From 1978-1989, Rob returned to general practice in Mt Macedon where he again became heavily involved in community affairs. After the bushfires in 1983, Rob joined the local council which he served for eleven years. He was Shire President in 1989-90. It was his initiative which led to the Macedon Ranges Cultural Heritage and Landscape Study and the development of the aged people's hostel in Gisborne, where he was chairman of The Gisborne and District Community Health Centre. A keen member of the RSL he also lobbied, successfully, to re-establish the Mt Macedon memorial cross.

In all his endeavours, Robert Harbison was strongly supported by his wife, Chubby, and their four children.

*Compiled from a number of sources by HA*

**DAVID PATRICK HJORTH**  
MBBS 1974, FRACS (Ortho)  
1952-1995

**D**AVID HJORTH, Orthopaedic Surgeon, died in November 1995. His death was a tragic loss for colleagues and friends; gone from our lives was a man who cared for all, especially his patients.

Educated at St Patrick's College, Ballarat, David commenced his medical course at the University of Melbourne in 1968. As a student he had a reputation for meticulous note taking and subsequent compilation of each subject into notebooks. The prized facts were referred to as 'the juice' and were in great demand with his student friends less oriented to study.

This approach to study was lifelong. The benefits were passed on in his teaching of medical students and orthopaedic registrars.

His introduction to the practice of medicine came in 1975 with his internship at Preston and Northcote Community Hospital where he had his first taste of orthopaedic surgery in Brendan Dooley's unit. As a student he had vowed to become a surgeon – the branch of surgery was now decided. Four resident years were spent gaining general medical experience and realising his goal to become an orthopaedic surgeon.

In 1984 he commenced the orthopaedic training program in Melbourne with four years spent gaining knowledge and expertise in the surgery of 'bones and joints' at the Austin, Alfred, St Vincent's and Royal Children's Hospitals. Then, as is customary in this specialty, he went to England to gain further experience in life and orthopaedic surgery, especially spinal surgery.

On his return to Melbourne, David's expertise was clearly in demand. He held consultant appointments in orthopaedic surgery at the Austin Hospital and at Preston and Northcote Community Hospital. As a consultant, his enthusiasm was infectious and his capacity for hard work exemplary. In private practice and hospital practice, he delighted in treating patients, sometimes anguishing over decisions of treatment, but relishing his ability to help and care for

people. The business side of private practice was of no interest to him, nor the material trappings of life. Caring for people, in particular his patients, was foremost.

As a full-time Orthopaedic Surgeon at the Austin Hospital his talent for teaching became manifest.

Academically, David was logical and had an excellent knowledge of orthopaedics which he readily shared with students and peers alike. The only time David might appear somewhat intolerant was when his colleagues failed to allow their woolly thinking to be unravelled.

David was generous in giving his time for his patients, their relatives and his students. Frequently however, he was not very conscious of real time, a minor irritation to both colleagues and friends. There is no doubt that this was part of his true gentle and kind nature. His giving was quite remarkable and was accepted by all, with little given in return. He was so aware of others' sensitivity, he undoubtedly buried his own for his friend's sake.

Although he obviously loved and was devoted to his work, including teaching, this did not entirely consume his life. David was a deep thinker who read profusely on many subjects – he had an extensive library. He had a dry sense of humour and a 'laid-back' attitude to gambling which involved him in various forays into ownership of thoroughbred racehorses – not without some success.

His talents as a caring friend, teacher and surgeon were recognised by the large gathering at his requiem mass and funeral.

*John O'Brien*

**CHI HUNG MOK**  
MBBS 1958, MAdmin(Monash), FRACMA,  
DCH(Glasgow), ACHSE  
1930-1994



CHI HUNG MOK

**C**HI HUNG MOK, 'Mokkie', died on 28 December 1994 after a long illness borne with great dignity. For much of his illness he had been cared for by old colleagues and friends at St Vincent's, his former clinical school where he had been Deputy Director of Medical Services from 1983 to 1992.

Chi Hung was born in Canton, China, in 1930 – a time of political unrest. His father was a pharmacist. In 1938 the Japanese invaded China and overran Canton. The Mok family fled, first to Macau and then to Hong Kong. Chi Hung's little padded jacket bore much of the family's money sewn into the lining. Having settled in Hong Kong the family sent Chi Hung back to Canton to be educated at a Presbyterian boarding school and then to Lingnam University for pre-med studies.

Towards the end of 1952 the Communists reached Canton and began to purge the 'bourgeoisie'. Chi Hung and a cousin were brought before the cadres and asked why they could afford to wear shoes. That evening, both very wisely took the train back to Hong Kong and did not return.

Despite a preference to study Engineering at the Massachusetts Institute of Technology, Chi Hung, like any good Chinese son of that era, obeyed his father's wishes that he study Medicine at the University of Melbourne. Enrolment was easy; he and two friends just went along to the Registrar and signed on. Studying and communicating in English were much more difficult, but many of his classmates generously shared their notes and tutorials. Clinical years at St Vincent's were most enjoyable and he graduated in 1958.

After residencies at the Royal Hobart Hospital and the Royal Children's Hospital, Chi Hung returned to Tasmania, where as Registrar at the Launceston General Hospital, he met and married a nurse, Joan Stewart. At first he wanted to specialise in Paediatrics and

held registrar posts in that specialty at the Royal Children's Hospital and the Austin Hospital in Melbourne. After eighteen months in Scotland he gained his diploma in Child Health and returned to the Queen Victoria Hospital as a Clinical Teaching Fellow in the recently established Monash University Department of Paediatrics.

Chi Hung then decided to change course and pursue a career in Medical Administration, gaining the Master of Administration from Monash University and, later, his Fellowship of the Royal Australian College of Medical Administrators. Assistant Medical Superintendent at the Austin Hospital from 1972-1983, Chi Hung then returned to his old medical school, St Vincent's, as Deputy Director of Medical Services.

Chi Hung was never an impersonal administrator. The arrangement of rosters is a tedious task and often done mechanically. Chi Hung, with personal knowledge of his staff and their needs was always fair, but meticulous in making sure that those about to sit examinations were not overburdened.

Following his retirement from St Vincent's in 1992, he worked happily at the Broadmeadows Community Health Centre for fifteen months until the ravages of chemotherapy forced him to take sick leave.

Chi Hung was a founding and highly respected member of the Chinese Medical Association, in which he held a number of offices. He pursued interests in classical Chinese history, art and literature and exercised his recognised skill as a calligrapher.

Like most he had his foibles. He could never resist buying the 'specials' in supermarkets and was reluctant to accept the fact that he might be wrong. Not surprisingly, these made him all the more likeable.

His family was the centre of Chi Hung's life. Proud of his parents and grateful for their care, he delighted in his wife and children. Musically gifted, he played both Chinese and Western wind instruments and he and his family loved singing. Towards the end of a very moving thanksgiving service in a crowded Deepdene Uniting Church his children, David, Jennifer (MBBS, BMedSc 1991), Duncan and Catherine and his daughter-in-law Emily, rose and faced the congregation. David said 'Recently we have not been able to sing, but we can sing now'. They sang unaccompanied, beautifully and joyfully. There could be no greater thanksgiving.

*HA with thanks to Joan Mok*

## J ROSS MORRIS

MBBS 1940  
1917-1995

UMMS RECORDS WITH SADNESS the end of the life of 'old Doc Morris' of Greenberg's wartime cartoon (see *Chiron* 1995, Vol 3 No 3 p65). Ross Morris not only served his country with courage, he and his wife Gladys (née Simpson, MBBS 1940) also served the town and district of Wentworth from 1947 until the unkindly onset of Parkinson's disease forced his retirement in 1970. By that time he had offered himself to the medical profession as a guinea-pig and had undergone pioneering surgery and levodopa treatment. During their working lives, Ross and Gladys, already busy with their practice, the hospital and bringing up four children, also devoted themselves to civic affairs - Ross served on Wentworth Council for twelve years and was Mayor during 1955 and 1956. The RSL and, of course, cricket were two of his special interests. The contribution made by Ross and Gladys Morris was honoured in 1979 by the placing of a plaque on the new wing of the Wentworth Hospital. Ross Morris died in Melbourne, in loving care at Mont Calm Nursing Home, Canterbury. *MM*

## COLIN SERGEANT RICHARDS

MBBS 1942, DLO (Melb) 1948, FRACS 1950  
1920-1995

COLIN RICHARDS was a quiet, modest man who achieved many things through patience and tact. He became a medical student when he was only sixteen and graduated aged twenty-one with honours in surgery.

After internship and residency at Prince Henry's Hospital he became a Surgeon-Lieutenant in the Royal Australian Navy Reserve and did active service in minesweepers and as a medical officer in charge of the naval wing at the 110 Perth Military Hospital. Until 1958 he was visiting otolaryngologist to the navy.

In 1950 he had become a specialist in otorhinolaryngology and was appointed honorary ENT surgeon to Prince Henry's Hospital. In 1963

he became head of the ENT unit and, following his retirement in 1985, consultant otolaryngologist.

Colin did much work in postgraduate education and, for many years, was an examiner for the Royal Australasian College of Surgeons. A founding member of the Australian Society of Otolaryngology Head and Neck Surgery he went on to become Treasurer (1952-1959) and President (1965-1967) of that Society. A member of many professional boards and committees, Colin joined the council of the Medical Defence Association of Victoria in 1969 and served that important body as treasurer for fifteen years (1977-1992).

Fond of music and enjoying golf, Colin was also a happy family man with five children and eight grandchildren. He was devoted to his wife Joan, who died in 1994 after a protracted illness.

This quiet, unassuming man was largely responsible for ensuring that the Garnett Passe and Rodney Williams Memorial Foundation came entirely to Australia rather than being divided between this country and the United States. The Foundation holds funds which go into seven figures: the Trust deed specifies that the fund is 'to be dedicated in perpetuity exclusively for charitable, scientific and educational purposes including the advancement in Australia and other countries of the specialty of Otorhinolaryngology and the related medical, surgical and paramedical fields'.

This Foundation was created by Barbara Williams, a South African, to honour her two husbands, Garnett Passe and Rodney Williams. Garnett Passe was a dental graduate from the University of Melbourne who became a successful ENT surgeon in London where he specialised in the surgery of otosclerosis. Rodney Williams was a New York stockbroker.

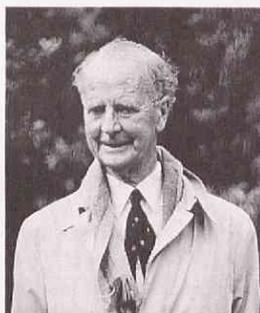
Garnett Passe died in 1952, and Barbara, from the early 1960s, wished to leave the major part of her estate to perpetuate his memory. Negotiations were protracted. Colin Richards became involved in direct negotiations with Barbara in 1968, the year she married Rodney Williams. Peter Freeman joined Colin in negotiations in 1976. Barbara died in 1991 and it was through her will, which had been challenged and changed on a number of occasions, that the Foundation was eventually established. Colin had been a major player in the negotiations that ensured the Foundation came to Australia.

Colin Richards died suddenly while speaking on the telephone, discussing with a colleague and friend the awarding of grants from the Foundation. *HA*

I Freeman, Peter and Richards, *Colin Aust J Otolaryng* Jan 1993, 1, /3, 260-8. See *Chiron*, 1995, pp75-79, for Colin Richards' article about the lives of Clifford Scantlebury, Raymond Hennessy and Frank Stone: 'Three Long-Living Victorian Otolaryngologists'. Eds.

## JOHN FRANCIS RUTTER

MBBS 1940, DPH (Syd), MRACGP, VRD  
1911-1995



JACK RUTTER

JOHN FRANCIS RUTTER died after a long, varied and useful life helping people. John died in Caritas Christi Hospice to which he had been a visiting doctor between 1976-1986. At his funeral service a succinct curriculum vitae was handed out and the only speaker was his wife Margaret; she spoke movingly about John as a very caring man.

John or 'Jack' Rutter was born in Melbourne the son of John Hemphill Rutter, MBBS 1907, and Maud Rutter (née Dodgson) MBBS 1907, and grandson of Joseph Rutter, MD London 1862. Like his father he was to become a well-loved general practitioner.

Jack Rutter graduated from the University of Melbourne in 1940 with the Stirling Prize in Surgery. As an undergraduate he came under the spell of the charismatic 'Freddy' Wood Jones, Professor of Anatomy, of whom he often spoke late in his own life.

After residency posts at the Alfred and Women's Hospitals he became, in 1941, a Surgeon Lieutenant in the Royal Australian Naval Reserve and served in an armed merchant cruiser and two destroyers. On discharge, in 1946, he was a Surgeon Lieutenant Commander and

was later awarded a VRD. In the early part of the war (12 December 1941) he married Margaret Wilson, a daughter of Dr Arthur Wilson.

Discharged from the services he spent brief periods at the Women's Hospital and as an assistant in general practice in Prahran, with Dr Mathew Patrick before he went to become the sole medical practitioner for the Nagambie-Avenel district. He and his wife served the community right well from 1947 to 1963 and were affectionately remembered; indeed a notice from the Nagambie Hospital appeared in *The Age* on his death thirty years later.

Six years (1964-1970) were spent with the Commonwealth Health Department carrying out medical examinations for invalid pensions, workers' compensation, overseas travel or entry to the public service with added quarantine duties and the surveillance of nursing homes for good measure. During these years Jack also managed to squeeze in locums at Cocos Keeling, Manus and Norfolk Islands and visits to New Guinea with the Royal Australian Navy.

In 1968, when in his fifties, he gained, by examination, the Diploma in Public Health from the University of Sydney and Membership of the Royal Australian College of General Practitioners. A year later he was on editorial boards and an examiner for the RACGP.

In 1970, Jack joined the Victorian State Health Department and became Medical Superintendent of the Prison Services. With Dr W Keane and the help of the ombudsman, Mr Dillon, a hospital was established at Pentridge and a closed ward at St Vincent's.

Retiring in 1976 he immediately became visiting medical officer to Caritas Christi Hospice and, in 1980, added to these duties attendances at Moran House where the Sisters of the Disciples of the Divine Master care for retired priests. Constrained by physical disabilities, Jack finally retired in 1986.

As a man, John Rutter was tall, quietly spoken, gentle in manner and smoked a pipe in a meditative, sometimes forgetful manner. He had a beloved dog. Although he had gone sailing with Wood Jones and had served in the navy he never took up sailing as a hobby. Nevertheless these experiences would seem to have had some effect as his daughter recalled that he often sang sea shanties while driving his car. He will certainly live on in the memories of his families, his friends, his colleagues and the many, many people he looked after as a caring doctor.

He is survived by his wife Margaret, a son John, a daughter Elizabeth, a granddaughter, three grandsons, all of whom are in their twenties, plus an extended family of nieces, nephews and in-laws.

*Margaret Rutter & HA*

**PETER STONE**  
MBBS 1957, FRACGP  
1930-1995

**I** FIRST MET Peter Stone in the early 1950s. We were both in our pre-clinical years and were working with the then Victorian Civil Ambulance Service. Even then he had an impressive character, with a broad range of interests, and a whimsical sense of humour.

Peter did many things during his medical course. Keen on sport, he was an enthusiastic rugby player, and had a great interest in Jazz. His involvement with the Army Reserve led to much interest and activity with security during the Olympic Games in 1956.

Following a resident year at Benalla and a short time in general practice in that town, he bought a solo practice in Orbost in Eastern Victoria, where he spent the next eight years. He developed a particular skill in dealing with injuries from local sawmills in the area and his expertise in the care of hand injuries was well known.

In 1967 he returned to Melbourne to a group practice in Essendon and two important things occurred. He came to know Dr Kent-Hughes, whom I have no doubt influenced him in his subsequent Royal Australian College of General Practitioner days. He also met John McEnroe, who became his partner in a two-man practice in Hawthorn from 1970 for the rest of his working life. Peter was fortunate that John was similarly dedicated to the RACGP, for without John's help in the practice, Peter would not have been able to achieve what he did in his College activities. Peter was aware of this and appreciative.

His type of practice necessarily changed when he returned to Melbourne. He became very interested in medical education and of course carried this on through his activities in the RACGP. He was also interested in counselling, psychological medicine and hypnosis. Through his interest in medical education in general practice,

he became involved in the maintenance of standards within general practice, and this became a major feature of his work within the College over the years. He remained, however, the family doctor to many East Gippsland families who made the journey to Hawthorn for visits until the day of his death.

On numerous College committees, Peter had the ability to sort out the useful from the useless and under his chairmanship meetings went well. He was a great ambassador for the RACGP amongst other learned colleges in the medical world.

President of the Royal Australian College of General Practitioners from 1992-1994, Peter was Medical Director of the Victorian Medical Post-Graduate Foundation at the time of his death. Peter published many articles and teaching materials about medical education, counselling, psychological medicine and hypnosis.

*Arthur J Day*

**DIANA MAY SUTHERLAND**  
MBBS 1953  
1930-1995



DIANA SUTHERLAND

**D**IANA SUTHERLAND DIED on 28 December 1995, following an illness of three-and-a-half years. In her typical, indomitable manner she ignored the knowledge of her fatal disease and continued working until a few weeks before she died.

The eldest of four children, Diana spent her early years in Bendigo where her father was a bank manager. Schooled at Girton and probably influenced by her uncle, Dr Charles Sutherland, an early allergist, she enrolled in Medicine at the University of Melbourne in 1948. At that time a university education was still something of a privilege for women.

And so it was that we were among 237 hopeful medical students who set off by special train together with numbers of dental, engineering and science students to Mildura.

At that time, the University of Melbourne, the only university in the State was strained to the limit by the sudden increase in the student population. Ex-service students had grasped the opportunity for tertiary education, while there was no restriction on the entry of qualified school leavers. At that time, fees charged were the main barrier to university entrance and many parents made considerable financial sacrifices to enable their children to get a tertiary education. A branch of the University had been established at Mildura to cope with the additional numbers [see *Chiron* 1989, p61-63 for Bill Lawrence's article]. Close friendships were often formed at the Mildura Branch and it was there that our lasting relationship with Diana began.

After a year at Mildura we returned to the main campus where Diana became a resident at Janet Clarke Hall. At graduation, Diana topped her year. She became a JRMO at the Royal Melbourne Hospital and then a locum in the Brisbane practice of Lady Cilento. She then went to London and worked at St Mary's Hospital where she had some training in the treatment of allergy. In London she met and married her husband Dr Brian Wilbur-Ham (MBBS 1949) an ophthalmologist. On returning to Melbourne three children were born and in the custom of that time, while the children were young, Diana virtually retired from practice.

In the early 1970s Diana took a refresher course and joined the staff of the newly formed Family Medicine Programme. This programme did much to help women medical graduates return to practice and Diana both helped them to get positions in General Practice and gave counsel to those subjected to the unaccustomed stresses. It was Diana who arranged the courses to fit in with the women's family responsibilities - scheduled from 10 am to 3 pm and never during school holidays. She also realised that when marital breakdown occurred the women were often considerably financially disadvantaged. The changes she sought were not just confined to women - she wanted to make retraining as attractive as possible to all.

Diana's apparent sweet, soft appearance belied a steel will and determination to achieve her aims. She was a matriarch to her family with a store of practical hints and advice. She always carried a large

handbag from which she would extract miniature bottles which she had refilled with Scotch. 'Here have an Irish Coffee' she would say as we shared coffee. This large bag was also known to contain biscuits, cough drops and headache tablets for colleagues.

She and her husband Brian had a great sense of humour and could make an instant pithy comment about someone or something; at times she could be quite disarming, leaving one speechless. She stuck to her principles when she saw these were right and could be quite unforgiving to those who disagreed with her.

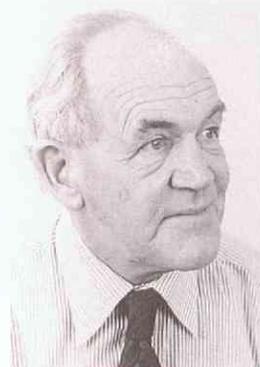
Diana belonged to many organisations and often represented groups on committees where she took an active part in debate and often held executive positions. She was Honorary Secretary to UMMS (1989-93) and three times held the presidency of the Victorian Medical Women's Society. In 1984 she joined the AMA Victorian Branch Council representing the VMWS. She never refused appointments to Branch committees and was an enthusiastic and valuable Branch representative to outside organisations such as the Victorian Council of Professions and the Federal President's Advisory Committee on Women. She was State Vice President (1987-88) and Honorary Secretary (1988-89) of the AMA. In fact, the State Presidency seemed within her grasp, but her work as a member of the Commonwealth Administrative Appeals Tribunal, to which she was appointed in 1985, and her husband's fatal illness, ended this ambition.

At her memorial service Brian Forrest, Deputy President of the Administrative Appeals Tribunal, told how Diana was a great fan of Leunig's cartoons and often used these in her presentations at conferences and seminars. 'She had a genuine concern for the human face of the Tribunal and the way it responded to the hopes and fears of persons who came to the Tribunal, whether a war widow seeking a pension or a worker seeking compensation for an injury.'

Diana leaves two sons and a daughter, three grandchildren and her brother and sister.

*Compiled from notes by Heather Peden & Malcolm McKenzie*

**ALAN LLEWELYN WILLIAMS**  
MBBS 1942, MD 1959, FRCPA  
1919-1996



ALAN WILLIAMS

**A**LAN WILLIAMS was a man of honour, integrity and humanity – one of the most considerate and civic-minded people I have known. He had the gift of inspiring loyalty and enthusiasm in others; he was a great man and his greatness lay in his humility.

Educated at Box Hill High School and Wesley College, he excelled at sport and was involved in all scholastic and social activities. While studying medicine at the University of Melbourne he gained a blue for boxing. He graduated in 1942 and after a two year Residency at Prince Henry's Hospital, he served as a Captain in the Australian

Army Medical Corps. While working at Heidelberg Repatriation Hospital he met Major John Perry and Sergeant Betty Wilson. After the Second World War, these three became the complementary triumvirate responsible for the extraordinary post-War development of pathology in the Children's Hospital in Melbourne.

In 1948 John Perry took over as pathologist from Reginald Webster. Alan was appointed to the newly created position of Assistant Pathologist in 1950 while Betty Wilson took charge of haematology and technician training. This team inspired their co-workers. Alan's main focus was anatomical pathology: when paediatric autopsy pathology was developing Alan performed most of the postmortem examinations on almost all children who died at the hospital – some three hundred a year. At the time this made him one of the most experienced and knowledgeable paediatric pathologists in the world.

Until the move to the new Parkville site in 1963, the Pathology Department in Drummond Street occupied the original purpose-built laboratory together with two adjacent tenement buildings with offices and laboratories reached by external stairs and board walks. The tea room was central in that rabbit-warren complex and there all staff met

to exchange ideas and gossip. Alan and John Perry were always ready to chat to staff members and created the unique *esprit de corps* of that department.

Although geographically separate, the pathology department was an integral part of the hospital. Alan was often in the wards where he enjoyed visiting sick children, a measure of his concern for and interest in the welfare of children. Meetings of medical staff were an important part of hospital life. All the staff – medical, surgical and pathology – would attend the so-called 'death' meeting, at which the cases of children who had died the previous month would be discussed. These were the days when everyone was learning and mistakes were mercilessly exposed by the presentation of postmortem findings and the lively, challenging discussion. The young pathologists and registrars learned quickly to present facts clearly and succinctly. To Alan Williams' credit all presentations were meticulously prepared and rehearsed before the big night. No one questioned the late hour or the length of those meetings.

I came to the department early in 1958 and for the next eighteen months Alan was in Cincinnati as research fellow at the Children's Hospital Medical Research Foundation on a Fulbright Scholarship. On his return, plans were developing that would result in the move to the new hospital in Parkville. In 1960 John Perry became Medical Director of the Hospital and Alan was appointed Director of Pathology.

As Director, he soon placed his stamp on the position with enthusiasm and vision. He nurtured a sense of unity in the department and all staff from the 1970s will remember the Christmas parties held in the leafy back garden at the Williams' home in Monomeath Avenue.

Recognising the enormous developments in pathology in the 1960s and 70s he introduced the new disciplines of cytogenetics, immunology and isotopes to anatomical pathology, microbiology, haematology and clinical chemistry. In 1963 his thorough planning and single-mindedness made the move to the new Hospital in Parkville extremely smooth. He had recognised that the various sections needed their own directors and arranged for several sections to become departments, each with its own director. The directors were encouraged to run their own areas with minimal interference. All benefited from this typical Alan Williams approach.

Space rapidly became inadequate and two new floors were planned. The co-ordination and planning for these was under Alan's overall control through the department heads.

In the late 1970s and early 80s Alan complained that the department ran so smoothly that he had not enough to do. In 1974 he turned his attention to investigating the Sudden Infant Death Syndrome. Twenty years earlier he had been concerned that the parents of children dying suddenly and unexpectedly received no satisfactory explanation of the reason for their child's death. He discussed the problem with the government pathologist Dr Keith Bowden and began performing autopsies on these babies in the old Coroner's Court (now the site of the World Trade Centre) in a small room under appalling conditions and without running water. His meticulous studies produced data which led to several publications. Moreover, the parents of these children were no longer left without help or support. Alan began the now accepted procedure of interviewing them after the death of their child. He did this with great gentleness and sensitivity and his interview with one parent led indirectly to the establishment of the Sudden Infant Death Research Foundation, an organisation that in its early years owed much to his personal involvement and support.

Alan Williams was characterised by honesty, frankness, tenacity, self discipline, energy, stubbornness, loyalty and a genuine love and concern for others, especially children.

Alan could never abide part-truths, let alone lies, and seemed to have an instinct for detecting prevarication in others. 'Like Hume he was a man utterly incapable of falsehood.' Though frank in expressing his views he was never threatening or overbearing: his remonstrances were meant to help and support, not undermine and hurt.

His tenacity was formidable. He decided to write a thesis for an MD at Melbourne University to be completed before he left with his family to Cincinnati. Coming to work quite early I would find Alan at his desk, having been there for an hour or more, determined to finish the job before he had to leave for America.

Stubborn and difficult to shift from an opinion or idea, he was a determined advocate of his strongly held beliefs: a formidable adversary he was equally a very stout ally.

In 1984 on his retirement a Festschrift was given in his honour. Papers covering anatomical pathology, bacteriology, biochemistry, cytogenetics, laboratory haematology, immunology, muscle pathology and virology were evidence of the respect and honour in which he was held. Freed from the responsibility of running a large and complex laboratory, he turned his full energies to his involvement with SIDS and the general welfare of children. He was a passionate advocate for the establishment of play therapy in the wards and fought a long battle for the liberalisation of visiting hours for parents and relatives.

Even when Director his outside interests and involvements were extraordinary – the Paediatric Society of Victoria, Australian Rotary Health Research Fund, Children's Welfare Association, Children's Bureau of Australia, and the Sudden Infant Death Research Foundation to name a few. In all of these he served at times as Chairman and was an active, involved, sensible and practical adviser. In 1956 he was the first secretary of the newly formed Victorian Branch of the College of Pathologists of Australasia and for many years was an important member of the Consultative Council on Maternal and Infant Morbidity and Mortality and gained the extension of the Committee's brief to include children up to age fourteen.

Alan was the instigator of the College of Pathologists country meetings – an annual get-together of city and country pathologists and their families, in which many friendships were made that might otherwise never have blossomed.

Family always came first with Alan, and his wife Dorothy and children Megan, Michael, Peter and Simon were the central focus of his life. The tragic loss of Peter, who after recovering from a fifteen month coma in 1952, died whilst climbing Cape Schanck in 1968, may have given him the sensitivity and insight that characterised his pioneering involvement helping and counselling parents of SIDS infants.

In retirement he enjoyed more than ten years with his wife Dorothy at their beloved Fairhaven and became fully involved in local activities. His great joy was his grandchildren. At the thanksgiving service on 11 January 1996, one could marvel at the continuity of life and ideas in the eager faces of his ten grandchildren. Life does continue.

Alan Williams lived life to the full, because he lived for others – his family, his hospital, his profession and his friends. All owe him much.

*Peter Campbell*

*UMMS records with regret the passing of*

Florence Marjorie Belz (Hughes), MBBS 1922  
 Richard James Bottcher, MBBS 1942  
 Peter Frederick Russell Brown, MBBS 1928  
 Lloyd Wallis Bryant, MBBS 1941  
 Edward Pruen Cordner, MBBS 1942  
 William Frederick Crick, MBBS 1936  
 Arthur Ewins Dickmann, MBBS 1924  
 Margaret Mary Dixon (Lancaster), MBBS 1941  
 Ralph Joseph Farnbach, MBBS 1928  
 Arthur Russell Hughes, MBBS 1937  
 John Malcolm Piercey, MBBS 1945  
 Clive Francis Henry Pyman, MBBS 1947  
 David Seward, MBBS 1936  
 Mary Margaret Westcott, MBBS 1974  
 Freda Alyson Wraight, MBBS 1954

## THE MEDICAL HISTORY MUSEUM

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# 1996 EXHIBITION

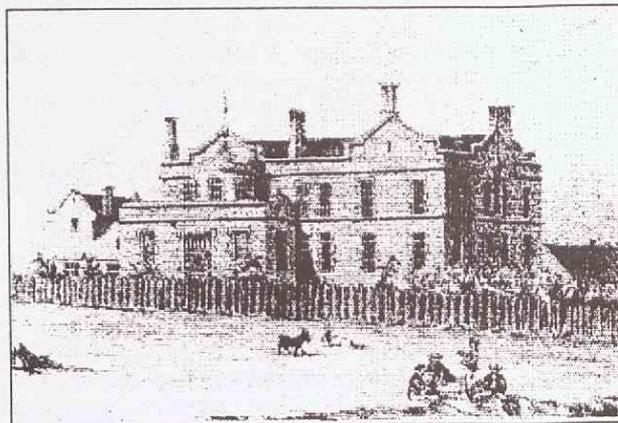
Curated by

Gabriele Haveaux

Archivist, The Royal Melbourne Hospital

## AN ICON OF CARE

150 Years of The Royal Melbourne Hospital



*An exhibition to commemorate the  
150th anniversary of the foundation  
of Melbourne's oldest hospital*

Title Display

THE BUILDING

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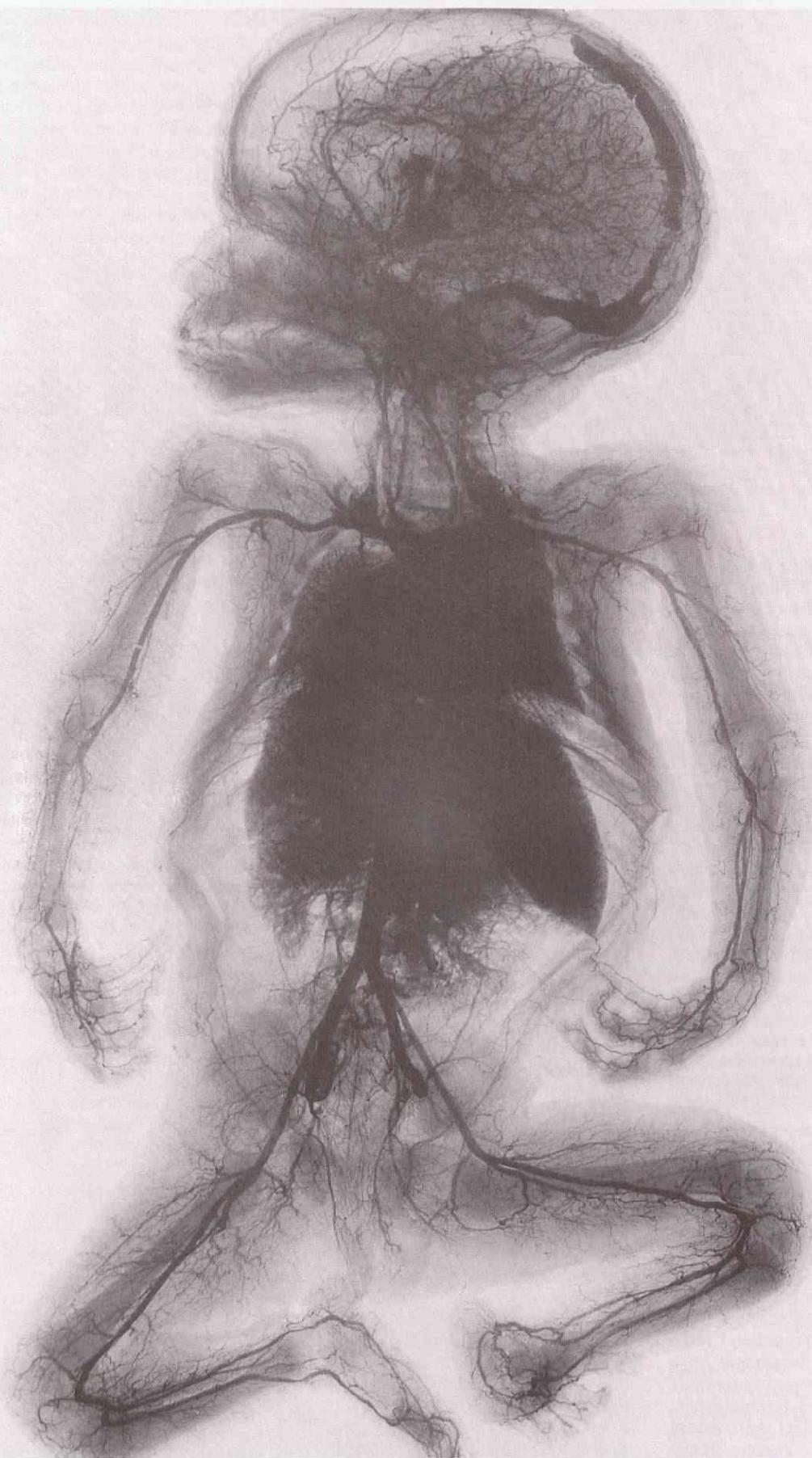
THE PUBLIC

STUDENTS, RESEARCH AND WAR

*For further information contact*

*Gabriele Haveaux*

*Telephone (03) 9342 8532*



One print of a pair of stereo skiagrams of a fetus with the vascular system injected, created by AG Fryett in the University of Melbourne Anatomy Department in about 1903. Röntgen discovered x-rays in 1895. The print demonstrated skills in injection procedures, radiography and photography. Fryett died in 1931 from 'carcinoma of the axilla and lung; epithelioma of hands; X-Ray burns of fingers and hands during the war'<sup>1</sup>

<sup>1</sup> McKeown, Malcolm, MD thesis, *A History of Radiology in Victoria, 1896-1916*, 1983 Vol 1, p219.

# THOSE NAUGHTY, NAUGHTY RÖNTGEN RAYS

## CENTENARY REFLECTIONS

by Professor Emeritus W S C Hare, AO

*The 1995 UMMS Lecture was delivered on 14 November 1995 by Professor Emeritus W S C Hare, in celebration of the centenary of the discovery of x-rays by Professor W C Röntgen in Germany on 8 November 1895. This is an edited version of Bill Hare's Lecture.*



**F**ear that privacy might be invaded was the initial outcry of the community to the news of Röntgen's discovery of x-rays.

I'm full of Daze, Shock and Amaze  
For nowadays I hear they'll Gaze  
Thro' Cloak and Gown – and even Stays!  
These naughty, naughty Röntgen rays

commented a London editorial, whilst in Canada 'Buckskin garments, impervious to rain, wind and x-rays' were advertised. In New Jersey, Assemblyman Reed caused amusement when he introduced a Bill in the House prohibiting the use of x-rays in opera glasses. But for some, it was all good news, particularly the temperance cause which claimed 'by this means, drunkards and cigarette smokers can be shown the steady deterioration of their systems, which follows the practice. And seeing is believing.' A religious publication recorded

... this discovery corroborates, so far as any material experiment can Paul's doctrine of the spiritual body as now existing in man. It proves, as far as any experiment can prove, that a truer body resides within us and awaits the moment of its unclenching, which we call death, to set it free.

All this aside, there is no doubt that on 8 November 1895, Professor Wilhelm Conrad Röntgen of Würzburg, Germany, opened a whole new world for scientists and changed the course of medical history to the benefit of mankind. There are fascinating aspects to the discovery itself, the man who made it, and the scientific environment of the times.

Legend has it that Röntgen accidentally discovered x-rays when he noticed some platino-cyanide crystals fluorescing on a bench whilst passing a current through an evacuated cathode ray tube, a common item in physics laboratories of the time. Because Röntgen's interests had been in acoustics and optics until some weeks before his discovery and because he departed the field of x-ray research soon after, there has been a tendency to dismiss his discovery, albeit momentous, as a chance finding. There are

aspects of the discovery, however, which contradict this and suggest it was an example of Louis Pasteur's statement that 'in the field of observation, chance favours the prepared mind'.

First, the cathode ray tube was not freestanding – Röntgen had placed it in a black cardboard box ensuring that visible and ultraviolet light would not emerge. Secondly, we might ask why Röntgen changed direction to begin experimenting with cathode rays. In the only press interview he gave, he admitted to having followed the work of scientists in the field for a long time, hoping to get the time to do some experiments of his own. Cathode ray research began about 1850 when scientists began to study electrical discharges in partially evacuated glass tubes and it is relevant to summarise developments up to the time of Röntgen. In retrospect it is clear that scientists working with x-ray tubes were producing x-rays but were unaware of it.

Today, we know that x-rays are produced when a rapidly moving stream of electrons, those tiny negatively charged particles, are abruptly brought to a halt. Also, we know that the x-rays are not particulate but are best considered a wave form and part of the electromagnetic spectrum, along with such things as ultraviolet light, visible light, radar and radio waves. This understanding of the nature of cathode rays was acquired painstakingly over the latter fifty years of last century by the contribution of many scientists. With greater evacuation of the tubes, the cathode rays, or electrons as we now know them, increased in velocity and on hitting the end of the tube, the glass was seen to fluoresce and x-rays were undoubtedly produced.

Sir William Crookes, a British physicist, on more than one occasion returned photographic materials stored in cupboards in his department to the supplier with the castigating remark that he had been sold partly fogged material, entirely missing the reason for the deterioration. In 1890, Professor Goodspeed, in Philadelphia, was doing similar work with the help of his assistant, a Mr William Jennings, reputed to be a meticulous person who always prepared for things well in advance. On one particular afternoon, Jennings was heading for the doorway to take the tramcar home when Goodspeed called him back to steady a piece of cathode ray apparatus. Jennings, with his fare already in hand, placed the coins on a nearby bench resting on an unexposed photographic plate. Some days later, when

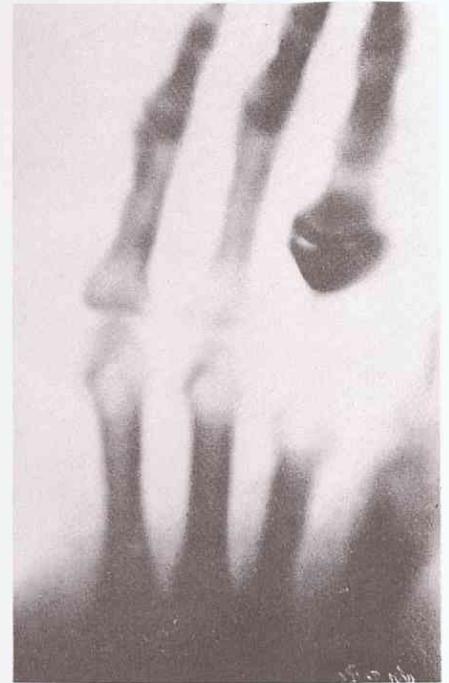


Figure 1. Röntgen's first human radiograph, said to be of his wife but unconfirmed.

developed after another experiment, the plate revealed the outline of the coins. In 1901, some six years after Röntgen's discovery, Goodspeed came across this plate and published it claiming it to be the first industrial radiograph recorded, but he claimed no honour as he stated that the manner in which the images were produced had completely escaped him.

Prior to 1893, the cathode rays could only be studied within the confines of the evacuated tube, and controversy continued as to their nature; the German school favouring a non-particulate wave form whilst the British, correctly, considered them particulate, a point proven by JJ Thomson in 1899 when he measured the mass of the electron. In 1893 Philip Lenard in Heidelberg, later to become a detractor of Röntgen's work, developed a tube with a thin aluminium window allowing the cathode rays (electrons) to pass a short distance in free air, and he made photographic images and saw crystals placed nearby fluorescing. In 1895, Röntgen was aware of this work and his entry to the field might well have been to solve some unanswered questions in his mind. This may have been why he enclosed the cathode ray tube within a black cardboard box. On seeing the crystals glow some distance away from the apparatus, he knew

immediately that the cathode rays, with their very limited range in air, could not be responsible, and that he was dealing with some new form of invisible light.

Röntgen was so stimulated by his finding that he fervently set about confirming his observation and learning more of the nature of this new type of radiation. He moved his bed to the laboratory from the floor above and became very much a recluse, telling no one of his discovery and causing concern to his wife as to his state of mind.

On 28 December 1895, he delivered his paper entitled 'Eine neue Art von Strahlen' (A New Form of Rays) to the Würzburg Physical-Medical Society in which he described some seventeen elegant experiments confirming his discovery and describing many of the fundamental characteristics of x-rays as we know them today. His paper was hand written and only ten pages long, and the fifty days of intensive research had extended across the Christmas season – not the most productive time for most research workers!

The paper was published immediately and on 23 January 1896, Röntgen delivered his one and only formal lecture to an eminent gathering of German scientists demonstrating his experimental findings including the first radiograph of a human hand (Figures 1 & 2). Surprisingly, Röntgen made only two further contributions to the literature on the subject, the final in 1897 in which he described further experiments clarifying the nature of the new radiation. After almost fifty years of cathode ray research, we see Röntgen's meteoric arrival on the scene; making the crucial observation and then describing most of the characteristics of these hitherto unrecognised rays, which he designated x-rays.

Röntgen was born in the small village of Lennep in Germany. As a very young boy his family moved to the Netherlands where he took his secondary education in Utrecht. Through a peculiar circumstance, science almost lost him. In his last year at the

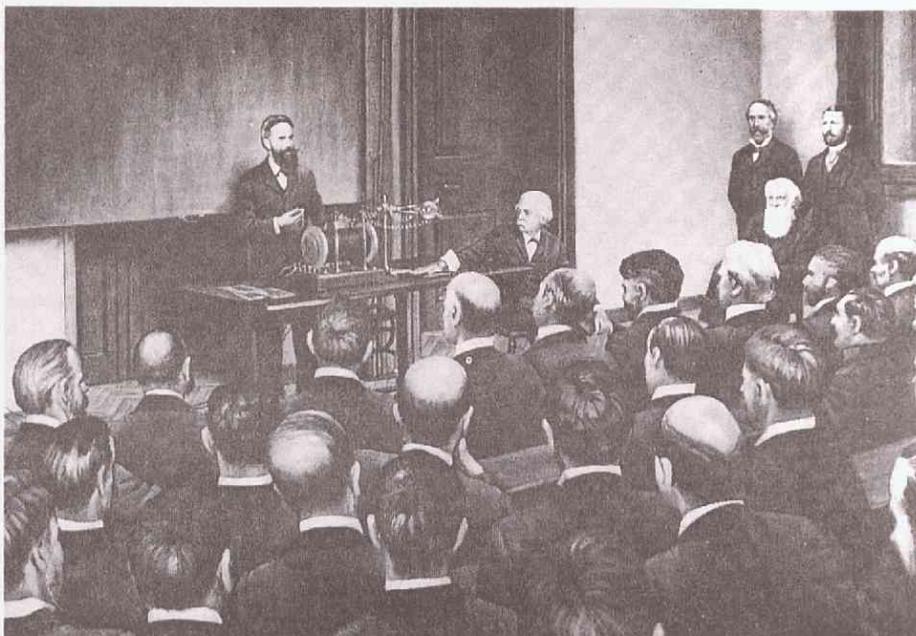


Figure 2. Artist's impression of Röntgen announcing his discovery to a gathering of scientists on 23 January 1896. The Chairman, Albert von Kölliker, the famous anatomist, is having his hand x-rayed.

Technikon School, he was unjustifiably accused of drawing a caricature of the headmaster on the blackboard. Refusing to name the real villain, he was expelled and refused entry to the University Entrance Examination or *Abitur*. Fortunately, a family friend confided that the Polytechnic in Zurich, Switzerland, would admit him and he proceeded there to obtain a diploma in mechanical engineering. Undecided on his future, he was influenced by Professor August Kundt to try Physics, becoming his assistant. Röntgen developed a profound love of the Swiss countryside which remained with him throughout his lifetime. The Swiss have reciprocated by claiming, whenever the opportunity arises, a goodly share of the honour associated with Röntgen's discovery!

He followed Kundt, as his assistant, to several Chairs in Germany before obtaining his own appointment as Professor of Physics at Würzburg University in 1888 and Director of the Institute of Physical Sciences.

Röntgen was a meticulous experimenter and an enthusiast, whose hair was said to 'stand up from his forehead as though permanently electrified'. At the same time he was shy, quietly spoken, rather austere, and critical of much of the entrepreneurial promotion of x-rays in the aftermath of his announcement. He continued to receive accolades and was the first recipient of the Nobel Prize in 1901. He demonstrated his discovery to the Kaiser, but refused the invitation to join the nobility and be known as 'von Röntgen'. He did however, at the Kaiser's request, pose for a sculpture which was placed on the Potsdam Bridge. He refused to take out patents on any aspect of his discovery and found the thought of obtaining financial advantages abhorrent. Kölliker, the anatomist, whose hand was x-rayed during Röntgen's inaugural lecture, promoted 'Röntgen Rays' as appropriate for the new radiation, but Röntgen himself was opposed to it, preferring his own designation of 'x-rays'. In recent years, the unit of radiation dose was changed from Röntgen to Gray, perhaps providing further comfort, posthumously, for Röntgen who rejected any form of personal aggrandisement.

He suffered considerable deprivation during the First World War when, in keeping with his character, he melted down his medals for the good of the Fatherland, just as he had donated his Nobel Prize money to the University for scientific purposes. Röntgen moved to Munich in 1900 and continued to experiment, but in other fields, right up until his death in 1923 from carcinoma of the bowel, probably not related to his work with x-rays.

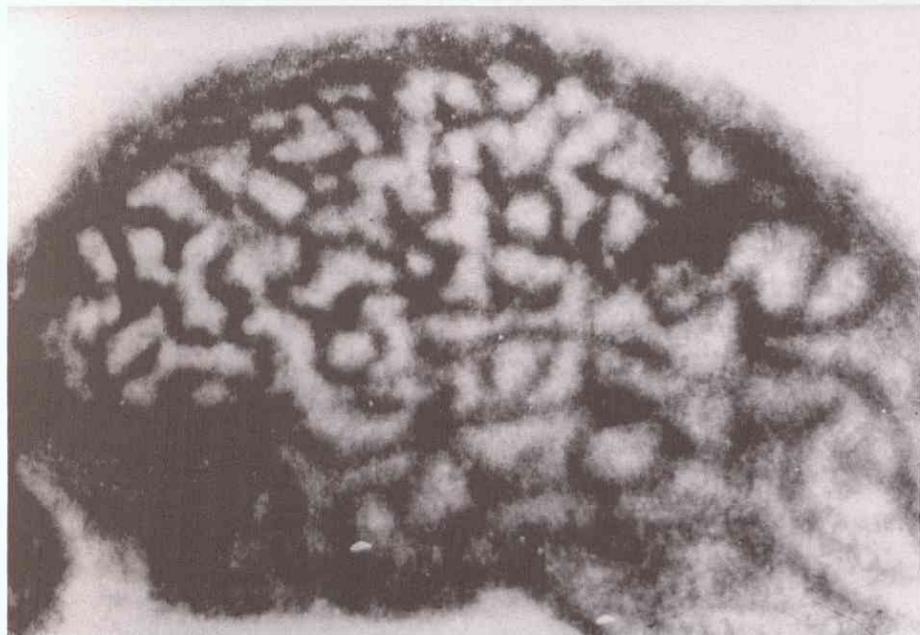


Figure 3. Radiograph, claimed to be of the brain, made by HA Falk of the 'XRay Shadowgraph Co.' of New Orleans in May 1896. Later shown to be of cat's intestines.



Figure 4. Sir Thomas Rankin Lyle (1860-1940), Professor of Natural Philosophy at the University of Melbourne (1889-1915). Acknowledged as the first Australian to produce a human radiograph (*Argus*, Melbourne, 4 March 1896).

Over the years Lenard continually criticised Röntgen claiming, incorrectly, that Röntgen used his modified tube and, again incorrectly, that x-rays were merely a higher frequency form of cathode ray. Lenard had been actively promoted for the first Nobel Prize in 1901 and both names went forward from the Committee but the Board of the Academy, recognising Nobel's wish for a singular appointment, selected Röntgen.

Lenard was successful in 1905. Years later, with the coming of the Third Reich, Lenard continued this criticism in his role as a scientific adviser. In his register of significant German physicists, it is of interest that neither Röntgen, nor Einstein were included, although, no doubt, for different reasons. Sadly the Potsdam bridge sculpture of Röntgen was melted down at this time, supposedly to support the war effort.

Because the necessary apparatus was freely available in physics laboratories, it is understandable that within weeks of Röntgen's discovery, radiographs were produced in most developed countries. Such was the volume of publication, that the first journal devoted to clinical skiagraphy was published in London in May 1896. About the same time, x-rays were used in Naples to examine soldiers injured in the Ethiopian War, and studios, often owned by photographers, sprang up offering x-ray photographs for clients. Even the Tsar and Tsarina had framed x-ray photographs of their hands. Many extravagant claims were made. In the USA a quack named Dr Falk distributed what he claimed to be an x-ray photograph of the human brain at a time when all others had failed because of the density of the surrounding skull bones. When revealed, the truth was that Falk had x-rayed some cats' intestines which he had placed in an appropriately shaped radiolucent container (Figure 3). For a time, apparatus was sold almost as a toy and watching one's moving parts with a fluoroscope was available to the public virtually as a parlour game. All this ended with the realisation that x-rays were injurious leading particularly to skin cancer

– there were many x-ray martyrs amongst the early practitioners.

The news of Röntgen's discovery reached Australia on the 31 January 1896. Professor Thomas Rankin Lyle of this University was accredited with the first human radiograph, as reported in the Melbourne *Argus* of the time (Figure 4). It is said he called Professor Orme Masson of the Chemistry Department into his laboratory who became the first person x-rayed by Lyle. Since that time the University of Melbourne has been the leading academic institution in the country in the promotion of radiology. The first lecturer in radiology was appointed in 1915, the Diplomata were established in 1936 and the first Chair and Department of Radiology in Australia was established in 1965. The subject has been actively promoted to the present day.



Commemorative Medal – Paris Mint.

## Pre-Twentieth Century Journals IN THE BROWNLESS MEDICAL LIBRARY

Dorothea Rowse  
Life Sciences Librarian

**T**HE PRE-TWENTIETH CENTURY journals are one of the treasures of the Brownless Medical Library. The collection has been formed in a number of ways – the determined policies of early academics, the rather ill-defined collections created by the activities of Anne Harrison and the Central Medical Library Organisation, and the dispersion of old collections formed at the Australian Medical Association and the Parliamentary Library. The journals are housed on the second floor of the library, one of the last such collections in Australia not consigned to storage. There are over three hundred titles of which seventy-five are in German and twenty-nine in French.

A number of extremely early periodical titles start off the collection. The change

from the rather anecdotal and quaint quality of some of the eighteenth century texts to a more scientific and analytic approach in the nineteenth century is striking. A periodical publication, appearing at irregular intervals, *Medical Communications* was published by the Society for Promoting Medical Knowledge and included detailed, illustrated case histories. We have Volume One of 1784. *Medical Essays and Observations*, published by a society in Edinburgh, was probably not conceived as a periodical in modern terms but we have five volumes which appeared over a number of years from 1747. These

contain a wealth of case histories from doctors in Scottish centres ranging in size from Edinburgh to the little town of Cupar in Fife. The presentation of medical facts is old-fashioned and the bizarre was always of most interest.

A later title which considered itself to be 'the leading Medical Journal in Europe' (1821) was *The Monthly Gazette of Health*, edited by Richard Reece. It aimed its coverage at the family physician and lay readers and had a mission to eliminate quackery. A feature of which the editor was particularly proud was a series of biographical studies of well-known physicians designed to inspire and instruct 'young practitioners'. The quality of the articles is variable. The same could not be said of the contents of *The Medical and*

*Physical Journal* containing the earliest information on subjects of medicine, surgery, pharmacy, chemistry and natural history. It was edited by T Bradley and A F M Willich and started to appear in March/July 1799. Its philosophy has a very modern ring to it.

The first and preliminary consideration was that of rendering it a respectable vehicle for those discoveries, improvements, and medical cases, which either required it to be speedily laid before the Public or, which, not being sufficient importance to be published separately, might without such an opportunity be consigned to oblivion.

It also sought to publicise 'hints and improvements which are constantly rising from the presses of Europe and America! Articles from such people as Charles and John Bell were included. Dr Bradley wrote on cow-pox, while Matthew Baillie's retirement was cause for comment.

A further twenty-nine journals which commenced before 1850 are to be found in the collection. The oldest is the *Edinburgh Medical Surgical Journal* (Constable) for which we have a run from 1805 to 1855 – a wonderful resource for medical practice in Britain at the time. The *Medico-Chirurgical Transactions* (Longman) also provides an excellent survey of medicine in Victorian Britain, with a collection spanning the period 1813 to 1906/7. *Guy's Hospital Reports* for 1836 to 1968 contain an extraordinary collection of case reports, the earliest ones in a measured and somewhat pompous literary style, spanning a period of over a century, and contributing a superb overview of changing medical and surgical conditions in London. Two American titles contribute excellent surveys of developments in medical science on that continent – *American Journal of Insanity* (Bennett, Backus and Howley) 1844/5 to 1920/1 and *American Journal of the Medical Sciences* published in Philadelphia (Carey, Lea and Carey) 1827 to 1968.

In 1893 Professor Allen, then Chairman of the Medical School Library Committee, compiled 'with assistance of the librarians', a *Tabular list of Medical Periodicals in Melbourne Libraries*. This appeared as a separate publication and also as an article in the *Australian Medical Journal*, 15 February 1893, pp 97-112. He noted that some duplication of subscriptions was occurring in the Melbourne area and that

by correspondence and mutual agreement, it might be possible to obtain, with little or no additional outlay, a nearer approach to a completely representative set.

It's a dream that still eludes us!

At that time, the libraries taking medical journals included the Public Library, the Medical Society of Victoria and the Library of the Medical School. The Parliamentary Library also took some relevant titles but these were not included in the survey. Over the years, the periodical collections in the Public Library, now the State Library, the Medical Society of Victoria and the Parliamentary Library have migrated to what is now the Brownless Medical Library. A quick check of the forty-two titles on the first two pages of the survey shows that we now have all but three of the titles, in runs which match

## THE INQUIRER, NO. III.

“Is there any certainty in medical science?”

THE uncertainty and inutility of physic is the favourite cant among men who are alive and hearty, among incurable patients, and among no small part of the fraternity, who rejoice in having such a convenient means of escape in their frequent approach to the halter. Is a medical practitioner *ipso facto* a quack? or (what is seldom the case) will it be discovered, after inquiry, that professional men are really better than they call themselves? Let us examine the twofold grounds of impeachment brought against the most honourable faculty. We are unable to guard the body against the accession of disease, and to devise proper means of cure for all those which do exist. The prevention of diseases, it must be recollected, is generally left to each individual, as far as his own person is concerned; he may be taught, by the same experience which teaches all physicians, what is likely to hurt or to benefit him: in spite, however, of his knowledge and of his self-love, he chooses often to run the hazard of future contingencies, rather than sacrifice a momentary gratification; it is not, therefore, his domestic medicine that is in fault, but the accidental bent of his passions. He eats an hearty dinner, feasts on certain fruits, and drinks particular wines, because the whole flatters his palate, although he has never eaten so much, nor tasted such fruit and wine, without suffering afterwards: “*Quæ nocere sequar, fugiam quæ profere credam;*” he is as sure of the consequences of those sensual gratifications, as he must be of the scalding property of boiling water poured upon his hand or his foot. Hence the adage so true in itself, when the faculties are not disordered and impaired by irregular habits or by disease, that *every man must be his own physician*. Disease, however, is brought on by inexperience, thoughtlessness, and by various uncontrollable circumstances; the mind becomes agitated and disturbed, the patient thinks himself worse than he really is, and he wants somebody whose appearance he conceives to be the precursor of health and comfort. The physician becomes acquainted with the most prominent sensations of his patient; he feels his pulse and his skin, looks at his tongue, and examines the expression of his countenance. Not a word is said respecting those circumstances which exclusively belong to this particular patient, by which he is distinguished from all other men, in

Page 425 from 'The Inquirer' section of the *Edinburgh Medical and Surgical Journal*, 1 January 1805.

fairly closely to those listed. In 1893, only fourteen of the titles were credited to the Medical School Library. In some ways Professor Allen's wish has been fulfilled.

The pre-twentieth century journals collection is used steadily. For the earliest titles, no photocopying is permitted and they are housed in closed storage. They may only be used a volume at a time under supervision. For the later titles, i.e. those closer to the turn of the century, photocopying is permitted if the volume is robust enough to cope. Conservation is the greatest problem. Many of the volumes need to be rebound to give them greater protection, while the

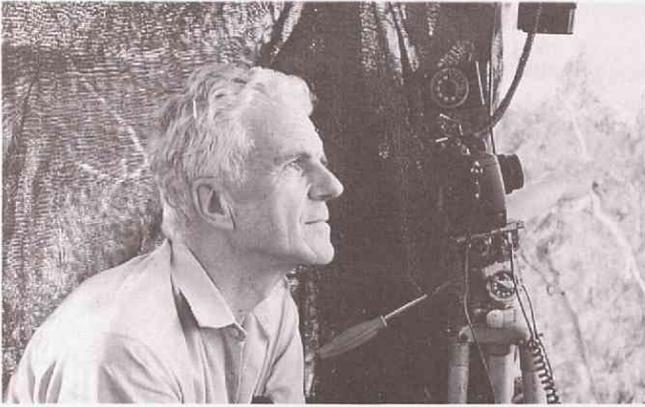
whole question of paper acidity in publications of that period is beyond managing. The air-conditioned storage, and the lack of central heating found in overseas libraries, do seem to have slowed down the deterioration reported from North America and Europe.

From time to time, donations provide volumes to fill gaps in the collection and such gifts are most gratefully received.

Further information about this collection can be obtained from the writer, at the Brownless Medical Library, telephone (03) 9344 5717.

## BIRD PHOTOGRAPHY

David Hollands, MBChB 1956, FRACGP



David Hollands and camera.

*In the 1995 issue of Chiron, Norman Wettenhall wrote an article on birdwatching doctors which was illustrated with two photographs of birds – one a White-bellied Sea Eagle about to strike, the other a Lesser Sooty Owl. The photographs were by David Hollands, a graduate of Birmingham, England (MBChB 1956) who is now in general practice in Orbost, Victoria and gained his FRACGP in 1972. The editorial board were so impressed by David's photography that we decided to seek an article on how he achieved such fine results.*

IT ALL BEGAN with a visit to a bookshop nearly fifty years ago. On the shelves I found a book by Eric Hosking, pioneer and legend among wildlife photographers. *The Art of Bird Photography* was a tiny book by modern standards, printed on wartime paper that nowadays would be more likely to find use with the packaging industry, but it would be both inspiration and bible to me for many years to come.

I had already tried my hand at photographing birds with the Zeiss equivalent of

a Box Brownie. The resultant specks in a vast landscape indicated that there was much to learn.

These were the days of black and white film and cameras with cloth bellows, polished wooden bodies and brass focusing knobs. They took pictures on 5 x 4 inch glass plates and focusing was onto a ground glass screen, made brighter by shutting out the surrounding light with a dark cloth over the photographer's head. The fastest shutter speed was about 1/25 second and, even for a big bird,

the maximum distance to obtain an acceptable picture was about six feet. I had holders for eight plates and, once they were used, it was time to pack up and go home.

It all sounds very primitive today, but it was a method which could produce wonderful results and out of it grew a passion for birds of prey and owls which was to prove lifelong.

Then came medical school, resident jobs, the army, the move from England to Australia, raising a family and running a practice. I had little time for birds but they were never entirely forgotten. There was a memorable trip to the Victorian Sunset Country with Norman Wettenhall, and in the beautiful surroundings of East Gippsland only a blind man could fail to be aware of the wildlife.

By the 1970s I was starting to photograph again and decided to turn my love of birds of prey into a book. Much had changed in twenty-five years. There were precision 35 mm cameras, superb long lenses and fine grain colour film. Nevertheless, there remained the problem that many birds of prey nest at a great height and, that to portray them, I needed to be up there too.

It was then that I met Jack Cupper – one time soldier, rabbit trapper, fisherman, truck operator, land developer and farmer – a man without formal qualifications but with huge drive, imagination and belief in himself.

Late in life he too had become interested in birds of prey, and, lying at night in bed, had conjured up the design for a telescopic aluminium tower, capable of reaching to all but the highest of nests and able to be transported on top of a vehicle. He built four of them for himself and one for me, and with it, I was able to put myself in the tree-tops with the birds. It was an uneasy experience at first, sitting on top of twenty metres of tapering aluminium, held up only by a series of thin ropes: not a place to sit out a gale, but otherwise, a remarkably stable platform.

Loaded on top of my four-wheel-drive, the tower makes a strange sight and has been mistaken variously for an oil drilling rig and



Black Falcon. Female at nest. Birdsville Track 1976.



Barn Owl with young. Photographed in the loft of an old barn. England 1961. Taken with  $\frac{1}{4}$  plate Sanderson camera using flash bulbs.

a portable lighthouse. Portable it certainly is: it came with me across much of eastern Australia and into such remote places as the Simpson Desert and the Strzelecki Track. It was the key to success, and after many rolls of film and even more tanks of petrol, *Eagles, Hawks and Falcons of Australia* was the result.

Perhaps I should have stopped there but wildlife photography is an addictive condition and by now, I was a chronic sufferer. Owls had to be the next project.

Owls have always fascinated me but to find all nine Australian species seemed an impossible task. They are abroad in the darkness, they are secretive, many are rare and over half of them live in big forest.

I could not have managed it without help but I had many able allies, notable among them being John Young, a remarkable Queensland naturalist who has been passionate about owls since childhood. Not only is he an expert at finding owls and their nests but he also climbs like a monkey and has the almost unique ability to construct hides in the tree tops using only hessian, nails and poles which are cut on-site. This was a priceless asset for many of the nests were far from roads and in steep country where it would have been impossible to take the aluminium tower.

The ascent to the hide is made by flexible steel rope ladder and I shall not forget my first attempt to climb one. As I set foot on the



Barking Owl. Aggressive attitude of male which had newly fledged young. Queensland 1985.

ladder, my legs shot forwards, my body tipped back and I found myself gyrating uncontrollably to and fro, parallel to the ground. Further progress seemed impossible.

Fortunately, there is a technique which can be acquired but it was a daunting sight to look up that ladder before the very first twenty-five metre climb. With John's help, I managed it and this was the start of many fascinating sessions in the dark, sometimes staying all night so as to be there for action which might take place only at dusk and dawn.

Not every owl accepted having its privacy invaded and the descent of the ladder could be a hair-raising experience. Rufous Owls are particularly aggressive and would sail out of the darkness to rake me repeatedly with their talons as I came down. Eric Hosking lost an eye to an owl in the night and helmet and goggles are essential.

Fortunately, I survived the onslaughts and was able to complete *Birds of the Night* covering all the owls and other nocturnal birds of Australia.

I would have had no hope of completing either of these projects without a loving wife and understanding medical partners, and fortunately, I have both. They have been nothing but supportive of my often sudden

disappearances and I would never have got past the first chapter without them.

Now the addiction has me working on two projects at once: Australian Kingfishers and a selection of Owls around the world. Only time will tell if I can succeed.

**Publications**

**EAGLES, HAWKS AND FALCONS OF AUSTRALIA**

by David Hollands  
Thomas Nelson, Melbourne 1984  
Currently out of print

**BIRDS OF THE NIGHT**

**Owls, Frogmouths and Nightjars of Australia**

by David Hollands  
Reed Books, Sydney 1991  
Now available through Tower Books, 9/19  
Rodborough Road, French's Forest, NSW 2086,  
through booksellers, rrp \$25, or through David  
Hollands, Box 125, Orbost, Vic, 3888.



White-tailed Kingfisher. Male approaching nest in termite mound. Queensland 1993.

**COMEDY**

Rob Sitch, MBBS 1987



Mike Moore (Rob Sitch) - front man for *Frontline*.

**I**T'S NOT AN UNUSUAL STEP to go from medicine to some form of the performing arts. Dr George Miller, film director and Dr Johnathan Miller, actor, writer and director are just a couple to have done it a lot better than I!

In my case it was more a hobby that got out of hand. Having performed in a couple of University revues that ended up being reasonably successful, we fooled ourselves into thinking we could write a new one and tour it. Most people say you should think things through before you commit but naivety proved quite a strength. In most instances over the next few years we had no idea how foolish our decisions were. We made them work out of a survival instinct rather than by grand design.

In the midst of my fifth year the ABC asked us to do a television series of our comedy. Now those two commitments didn't go together and wouldn't have except for Dr Roger Melick who was Dean of the Royal Melbourne Hospital Clinical School at the time. Having already encouraged me to tour the original show he canvassed the support of the relevant professors and fashioned my fifth year around the television commitments. If not for that I would not have taken it further. Most medical subjects require more than a few essays to be handed in and so without the support of the Faculty and hospitals it would have ground to a halt there.

In fact the senior medical staff and clinical school staff went out of their way to give me support over the following years.

And so it went, squeezing in a few television shows here and there until I'd finished my internship. At that point I decided to take another break and it's one that hasn't stopped. We've bounced from a breakfast radio show to four series of *The Late Show* to a couple of series of *Frontline*. In the meantime we've put out three albums, a video clip, three books and six videos, using the maxim of volume over quality! In addition I've experienced all the best that Australian TV has to offer: I've been a judge on *Red Faces*, hosted *Countdown*, drunk too

much at the Logies, met Don Lane . . . truly things to be proud of.

Along the way I've wondered what those who gave me so much support have thought of our various shows and endeavours. No doubt at times they've regretted they didn't put a stop to it when they had the chance . . . but no-one's let on.

Outside work I've kept up some of the traditions of the medical profession. Fly-fishing is now my major pastime. One of the nice things about flyfishing is that if you're injured, trout streams have the highest concentration of medical staff outside of a hospital. There is only one drawback: flyfishing is based on insect cycles, and insects are named using Latin terminology. Somehow Latin seems to follow me. I've made a pact with fishing buddies that we're only allowed to describe insects by colour and the terms 'big' or 'small'!

The biggest shock of being out of the profession is running into old student friends who are now consultants, but as my body continues its rapid aging process that is becoming quite a blessing. In the not too distant future my body will take over from my mind in making my friends laugh. I guess that's the thing I like most about comedy: as your body gets older your mind gets younger (technically more immature). It's rather like being an adolescent with plastic hips.

## THE FIGURE SKATING JUDGE

Elizabeth Ryan, MBBS 1989

IT'S CHRISTMAS EVE 1995 and I've just returned to Australia after a brief visit to Israel as the Australian judge for the international figure skating competition *Skate Israel*. The long trip from Metulla, a small border town, situated in the mountainous far north of Israel, to Melbourne, has taken forty-two hours. Although we all enjoyed the competition, the skaters, our team leader and myself are relieved that our long journey home is concluding. We part, congratulating and thanking each other for all the hard work at a rather successful event, with good wishes for future competitions at home and abroad.

Thoughts of meetings with strangers on my trip run through my head. People are always surprised and interested to meet Australian ice skaters travelling to international events. I guess it is rather unusual. Most Australians play tennis or swim. Few Australians ice skate, even fewer competitively figure skate and the number of Australian international judges with qualifications in singles, pairs and ice dancing, as myself, can be counted on one hand.

Although I love it, judging figure skating is not a straight-forward job. It's not as simple as deciding who is first over the line or which skater is the best dressed, has done the most jumps or is the most entertaining (which is often how the audience 'judge' it). There are many factors and rules involved in any judging decision. The difficulty and quality of the performance must be evaluated carefully. A judge must give each competitor marks, such that all the competitors are ranked from first to last place on the judge's protocol. Some events can have up to thirty skaters, each of whom must be 'ranked', requiring a lot of concentration. The places, rather than actual marks, from all of the judges are then clerked, looking for a majority of places, to determine the result.

People often ask how I became a figure skating judge. Initially, I started as a figure skater myself. I can still recall learning 'tricks' early on, such as three turns, bunny hops and cherry flips, and recounting to my school friends, with my fingers pinched together, about my ability to balance on a blade 'this thin'. Ice skating was something I loved to do,



Elizabeth Ryan

far more than any of the other hobbies that I tried.

As a teenager I started figure skating tuition and training in earnest. Despite my commitment to do well at school, my involvement in a youth concert band and a casual job, I fitted in five to six training sessions of two to four hours per week at the rink. This was not possible at university making it hard to be competitive, so I retired from skating during my third year of medicine having collected a few medals from state competitions and having passed my silver tests in figures, free skating and ice dancing.

I was introduced to judging around the age of fifteen while I was still competing. With my plans to attend university and my average ability as a skater, I was realistic and had no aspirations to make a living from skating by coaching or becoming a professional skater with my name in 'big lights'. Alternatively, I found the task of judging interesting and challenging. I started judging at local club competitions and worked my way up by trial judging higher levels. I judged my first national championship in 1985 and

am now a national referee and senior judge for singles, pairs, ice dancing and precision. Hence, I am usually on twelve or more events during an eight day national championships – a fun way to spend a holiday! Since 1985, the only national championships I have missed was the 1989 championships, held in Perth, during my final year of medicine. The time commitment, expense of the trip and an airline strike made it impractical to attend.

In 1993 I was nominated to the international judging panels and attended my first junior world championships as the Australian Team Leader in Colorado Springs. This opened a new phase of my involvement in ice skating and gave me the honour and privilege of representing my country overseas. To date I have been sent to judge competitions in Germany, Switzerland and Israel. Also, medicine has enabled me to be accredited as the (honorary) Australian Team Doctor for world championships, which I am not yet qualified to judge, so I can be a part of the team at these prestigious and exciting events.

In addition, I have taken on a position on the Council of the Victorian Ice Skating Association to assist in the management of the sport and training of junior judges. This is an extra time burden on top of my physician advanced training and other interests, such as ballroom dancing, but I enjoy it and want to help the sport. Fortunately the Austin and Repatriation Medical Centre has been supportive and understanding by allowing me to slot in my annual leave at times of competitions for my second 'career'. Something for which I am truly grateful.

Although I still enjoy going for a 'bit of a skate', being rink side, judging, is where I quite happily find myself nowadays when I am not working at the hospital or studying. I hope always to be a fair and competent judge to do justice to the hard work of the skaters whom I adjudicate, be they tiny tots in Bendigo or world champions in an Olympic arena. Who knows, one day I may be rink side, with a front row seat, judging an Olympics, witness to a performance worthy of a perfect 6.0! Now *that* would be something!

### The University of Melbourne Community Access Program

The University of Melbourne Community Access Program allows members of the public to study single subjects offered by some of the Faculties of the University. For example, the Faculty of Arts offers a diverse range of subjects across fifteen departments from Philosophy to Italian, from Fine Arts to Criminology. Most subjects are available through the Community Access Program.

If you are interested in studying an Arts Faculty subject through the Community Access Program please contact Sheridan Clarke on (03) 9344 8844.

## OLD NORSE

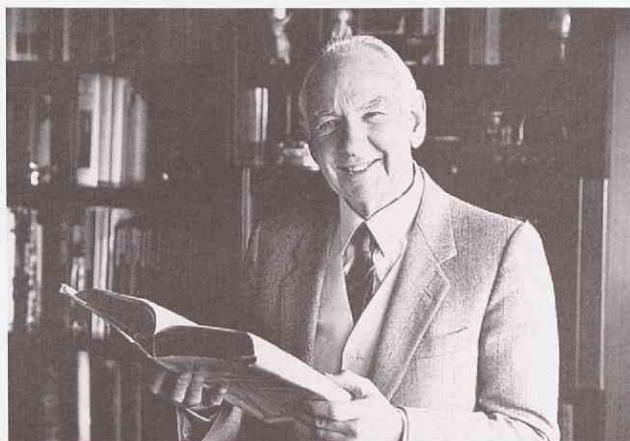
Andrew Newell, MBBS 1944, MD, MA, FRACP

MY INTEREST IN LANGUAGES started early with French at Box Hill High School. I found an affinity for that cultivated language with its elisions, nasal vowels and compounded syllables which challenge the Anglo-Saxon ear and tongue. My interest flourished when I moved to Melbourne High School where language teaching was second only to that of the private convent schools. The Latin teacher was German, Johann Rucker, known as 'the vor'. French teaching in year twelve was in the hands of an exchange professor from Toulon. The German teacher was an Australian who had worked in an exchange post in Germany, and spoke fluent German. He had a limp, which in retrospect was probably the result of an arthrodesed tuberculous knee, but which with schoolboy insensitivity earned him the nickname 'Hopalong'. At his instigation, students would occasionally visit the Lutheran Church in East Melbourne, where the pastor – a kindly man with a sonorous voice, who was later interned when a radio transmitter was found concealed in the vestry – gave the service in German once a month.

In 1939 I enrolled at the University of Melbourne and graduated MBBS in February 1944, the course having been truncated to five years by the wartime demands for medical manpower. My use of languages in the years following graduation was restricted to the occasional need for French and German in consultations with migrants. My fluency was maintained by reading novels: *Clochmerle*, *Le Pont sur la Rivière Kwai* and translations into German of Hemingway and Graham Greene.

After moving to Geelong I began studying Italian which proved valuable in my medical practice. Many Italian patients, particularly older people, many of whom were denied basic education during the war years, had difficulty in mastering English, a language totally foreign to them. A knowledge of language, even one's own, permits greater communication between doctor and patient and nothing is more important in medical practice than that. A common language has also allowed me to forge friendships with overseas graduates and students which are often maintained by return visits.

The year 1972 was a turning point in my progress from RAAF medical officer, rural GP and provincial city physician, with an appointment to the Austin Hospital. The Austin appointment brought me back to Melbourne, which enabled me to enrol in the University of Melbourne Arts Faculty for a combined honours degree in Germanic Studies and Italian. In that year the late 'Dinny' O'Hearn was sub-dean of Arts which had eighteen medical graduates enrolled. With this enrolment and the Austin



Andrew Newell. Picture courtesy Herald-Sun.

appointment I became a student and a staff member of my university of graduation.

After completing half of Italian III in the combined honours course, I transferred to pure honours in Germanic Studies. My special interest was the Middle Ages and my MA thesis was a study of the King Hákon translations of epic poems from French to Old Norse. These translations were carried out between 1210 and 1260 by Anglo-Norman monks at a monastery outside Trondheim, Hákon's royal residence.

One must never overlook the part played by the twelfth century epic poem – referred to as *romans courtois* or *chansons de geste*. The first was the *Chanson de Roland*, written by an Anglo-Norman monk and the later poems of Chrétien de Troyes – Érec, Cligés, *Le chevalier de la Charette* (Lancelot), *Le chevalier au Lion* (Yvain) and *Le conte du graal* (Percival), were all based on Arthurian legends. Written in the last decade of the twelfth century, they represented a new wave of classical literature. They took the place of religious tracts and the lives of the saints, written in Latin, and pre-dated by one hundred years the first 'Italian' literature – that of Dante (1265-1361) and Petrarca (1304-1374). They found their way into the Middle High German literature of the early thirteenth century and later Middle English adaptations.

Apart from frequent use of Italian and Greek (German and French are rarely required), an interest in linguistics has had other benefits for my medical practice. First, it is intellectual exercise, an escape from the day-to-day involvement with people and their problems. Of secondary value has been translation, more particularly from German but also from French. I translated a phrenological study of the skull of the exhumed Beethoven, published in Vienna soon after his death in 1827. During my honours year in German (1984) Harold Attwood displayed Robert Koch's monumental article *Die Aetiologie der Tuberkulose* in the Medical History Museum to mark the one hundredth

anniversary of its publication. I took this article as the basis of an essay on German stylistics. Koch was a civil servant who wrote logically and with great clarity. His observations were recorded with obsessional accuracy. He used litter mates as controls in an age when statistical method was hardly known and eighty years before it was commonplace in German scientific writing. His experiments with rabbits and guinea pigs would not have passed the ethics committees of today but this was an age when cruelty to humans was equally widespread. More recently, my translation of Michael Földi's handbook *Das Lymphödem* was completed and published by the Lymphoedema Society of Victoria and my occasional translations from French, on behalf of Australian Red Cross, of medical reports have justified ten years time and effort.

Study of a foreign language can intrigue and fascinate, but it is much more than a set of words. Language instruction at the University of Melbourne is literature orientated, and is used as a means to that end. It enables the student to read and understand what Dante and Petrarca, Machiavelli, Tasso and Ariosto have to tell us. To read in the original the plays of Goethe, Schiller, and Pirandello; the poetry of Heine; the philosophy of Kant, Marx and Freud; novels by Thomas Mann, Heinrich Böll and Günther Grass – that is the pleasurable reward which awaits the language student.

Why is Old Norse taught and studied so widely in Western society? The ninth international saga conference was held last year in Akureyri, Iceland's second city, situated on a fjord close to the Arctic Circle. There were three hundred registrants from almost every European country, North and South America, Australia, Japan, and of course Iceland. All had read the ancient texts and many spoke fluent Icelandic. Old Norse has been taught in Australia since 1942, when it was introduced to Melbourne by Professor Augustin Lodewyckx. After his retirement in 1947 Ian Maxwell continued the teaching in

the English Department and from 1981 it has been taught in the Department of Germanic Studies by John Stanley Martin. Old Norse has been studied in departments of English in the United Kingdom and North America and in departments of Nordic language and literature in many European universities.

Old Norse, also called Old Icelandic, is known to linguists as the stem north Germanic language and to historians as the language of the vikings. Viking incursions commenced in northern France during the ninth century. For two hundred years young Norwegian warriors harried England, Scotland, Ireland, and ultimately Iceland as they penetrated westward robbing, burning, pillaging, and ultimately, settling. Swedish vikings sailed down the great rivers of Russia to reach the Byzantine cities. Danish vikings harried East Anglia, the coastal towns of the English Channel and southern Ireland. In all these areas vestiges of the viking language have remained as place names or have influenced the regional language. Normandy was the most durable settlement, but the viking influence remained in Scotland and Ireland for 150 years. In the battle of Clontarf, Brian Boru (926-1014) defeated the Danish invaders and Macbeth (d. 1058) defeated the Norwegians under Thorfinn, earl of Orkney and Caithness, who earlier had defeated Duncan.

The movement of vikings was not a migration. Young men sailed the longboats, and those who married often chose Celtic brides. The children of these unions,

educated by the mother in her own tongue, may never have spoken Old Norse. The exception was Iceland, where the viking language was preserved with little change for one thousand years. The Normans who invaded England in 1066 spoke 'valska' – the French spoken in Normandy which varied only by inflection and spelling from Parisian French. Anglo-Norman remained the language of the English court for three hundred years.

As Gunnlaug said (Gunnlaugs saga, chap. 7):

Ein var þá tunga á Englandi sem í Nóregi ok í Danmörku. En þá skiptusk tungur í Englandi, er Vilhjálmr bastarðr vann Englandi; gekk þaðan af í Englandi valska, er hann var þaðan ættaðr.

(At that time the same tongue was spoken in England as in Norway and Denmark, but the idiom changed as soon as William the Bastard conquered England. From then on French was spoken, for he was of that race.)

The impact of the viking language was greatest in the North of Britain, as seen in many place names, family names and in the use of Norse loan words in relation to farming, housing and seafaring. For example, the Lancashire town Kirby Lonsdale – the kirk by Lon's dale – lies in the valley of the river Lon. Yorkshire is divided into three 'ridings' (*priding*) and is famed for its fells and dales (*fjáll ok dalir*). Common Norse words in English are booth, loft, thresh, thatch, geld, scathe (unscathed), hew, cleave/cloven; the

adjectives grim, glad and little; and nautical terms such as thwart, aloft, shipshape, boatswain, deal (planking) and billow. Phrases such as 'a pig in a poke (sack)' and Scots terms like bairn, byre, neat (ox), canny and spier reflect 150 years of Norse occupation. From the Anglo-Saxon south, terms have survived which are similar, even identical to other Germanic languages: words denoting parts of the body, and many relating to farming and habitation. In my medical student days we were enjoined by Sir Alan Newton to use the monosyllabic Anglo-Saxon or Old Norse words in medical communication. 'Wind', he would say, 'not flatulence, stays not corsets.'

We study Old Norse because of its significant contribution to our language and we study its literature because it gives us an insight into four centuries of human existence covering a wide geographical and cultural area. Is that not a good enough reason?

I am currently studying Swedish: it seemed illogical to read and understand the ancient Nordic tongue without exploring a related modern language. Eight million people speak Swedish and over a million migrated to the United States, where Swedish is now widely taught. So far, I have never needed to use it, or modern Icelandic, in medical practice.

For the last fifty-six years, the University of Melbourne has played a major part in my life giving me the opportunity to satisfy consuming interests in both internal medicine and European language and literature.

## BOOKS

### EPILEPSY – I CAN LIVE WITH THAT!

Edited by Sue Goss

Epilepsy Foundation of Victoria 1995

Sbk pp 112, illustrated

rrp \$10

This slim book is immediately attractive and arresting. Attractive, because of the lovely cover depicting seashells which are also used in black and white to introduce each essay. Arresting, because of the title *Epilepsy – I can live with that!*

The book contains twenty essays by ordinary people who have epilepsy. Each tells a different story of their experiences, some of which are quite startling. Here are a few of the titles:

- *The day I jumped off the roof*
- *I can cope with me*
- *Experiences in and out of court*
- *I saw eternity*
- *Am I going crazy?*

On page 44 there are three statements by children, who recount, simply, some terrifying experiences of seeing a parent having a seizure – one of which summarises

the situation: 'I still love my mum even though she frightens me when she has fits.'

I thought I knew a great deal about epilepsy. This book has shown me just how ignorant I have been. I had never realised how numerous and varied the seizures could be. I had no idea how ill-understood the first seizure could be, by the person and by their family. Moreover, the after-effects of a seizure can be much longer and upsetting than I had ever imagined. I did know of the difficulties changing medication. These are often mentioned.

All tales are told with the determination to live as abundantly as possible. Humour and courage are the major ingredients of these tales. Libbie Minifie, who has Jacksonian epilepsy and can watch the effect of her attack on others, entitles her story *A sense of humour* – and what a sense of humour!

My daughter's dog has always appreciated being present any time I have an episode as he always likes his back scratched, and manages to get a good scratch going under my left leg, [which jerks] watched by my five year-old granddaughter almost hysterical with laughter!

Libby graphically describes the misunderstanding and lack of compassion which may accompany an attack in public. Dressed in window cleaning clothes Libby felt an attack coming on and, sitting down, propped herself against a fence.

Soon my left side was away, at its most furious jumping. I looked up and saw a male crotch stepping over me. How interesting, I thought, I guess he thinks I'm drunk.

An informative introduction and a useful glossary enhance this slim book.

I hope this book will be read by many people from all walks of life for it gives much information about a poorly understood group of disorders. It is also a good read spiced with honesty, humour and courage.

I was delighted to learn that these tales have already been translated into several languages for the disorders are not confined to any group.

At \$10 it is too cheap. You could not get a better bargain. Write to: Epilepsy Foundation of Victoria, 818 Burke Road, Camberwell, Vic, 3124. HA

## AN APPLE A DAY Common Consultations

by Andrew Pattison  
Harper Health, an imprint of HarperCollins-  
Publishers (Australia) Pty Ltd, 1995  
Sbk pp 241, index  
rrp \$17.95

It's a tricky business writing medical reference books and/or dictionaries for the general public. Either the language is too technical, thus failing to engage the reader, or they contain so much detail that they tempt the dangerous practice of self-diagnosis. The recent publication however, *An Apple a Day*, is refreshingly different, in that it manages to achieve a balance of clarity, interest and useful information.

The author, Dr Andrew Pattison, a general practitioner for approximately eighteen years, is well known for his medical segments on radio, and more recently, for his weekly medical column in *The Age* newspaper. This publication follows his earlier, highly successful children's series the Doctor Toby Books. *An Apple a Day* is a collection of eighty-one essays written for adult readers which aim to enhance understanding of common medical problems. They also serve to highlight the importance of the doctor-patient relationship.

The essays are grouped in three sections, titled 'Symptoms', 'Common Medical Problems' and 'General Health Issues'. A broad range of medical problems is thus covered in clear, easy-to-read language which keeps the use of technical medical terminology to a minimum. The essays are short, generally three to four pages in length, and each one covers a separate medical problem. Each essay begins with an explanation of the purpose of that particular function of the body, and then gives a brief description of common problems that sometimes occur. Any tests to assist diagnosis are explained. This is followed by a brief discussion of possible treatments. The emphasis throughout is to give the reader knowledge of how the body works, and what can be done to correct any problems that arise. For instance on 'Cholesterol' we are told:

Cholesterol is a white, waxy substance that is produced by animals and is present in foods like brains, egg yolks and meats like kidney and paté. Most people take in about one gram of cholesterol every day. The body also makes its own cholesterol; it forms an important part of cell structure and is necessary for the production of various hormones. (p195)

The tone in every essay is conversational and positive, and combines with the information given to stress the message that we can do a lot to preserve a healthy life. But in every case, Dr Pattison clearly and firmly indicates when a person needs to seek medical advice. The voice is clear in the segment on 'Fever' for example:

A fever that occurs with abdominal pain, urinary symptoms, breathing difficulties, neck pain or sensitivity to light, all require urgent medical assessment. (p15)

Each essay concludes with a box section headed 'Health Tip', which gives concise, sensible advice. For example, the essay on 'Sexually Transmitted Diseases' gives the following health tip:

If you choose to have sex, make sure it is safe sex. Even the remotest possibility of getting an STD is a very good reason to use condoms.

The feature that gives greatest interest to this work, and distinguishes it from many others, is the inclusion of a brief case study that precedes most segments. Most people are fascinated by the diagnostic process – how a doctor decides on what is wrong with a patient, when often there are not many symptoms to go on. These case studies certainly raise the reader's awareness of the importance of the doctor having a full medical history. They highlight the need for the doctor not only to ask the right questions, but also to observe the patient for other, seemingly incidental clues, which may be vital to a correct diagnosis. Simultaneously, the patient's responsibility in this process is also revealed. The patient must disclose all symptoms fully and frankly to the doctor.

Dr Pattison writes from the premise that if people understand how their bodies work, and what their bodies need to function well, they will be encouraged to pursue a healthy diet and a healthy lifestyle. This book conveys just enough information to promote such understanding. However, it stops short of giving too much detail which may tempt some to 'play doctor'. As such, *An Apple a Day* merits addition to the family library.

Mariana Kakos\*

\*Mariana Kakos is a BA and DipEd graduate of the University of Melbourne, a VCE English teacher at Balwyn High School, a mother and a medical consumer.

## IN THE COMPANY OF STRANGERS Former patients of Australian tuberculosis sanatoria share their experiences and insights

by Janet M Brown 1994

Pbk pp 251, illustrated, index  
Available for \$18 plus \$5 postage and  
handling from Janet M Brown, PO Box 448,  
Werribee Mail Delivery Centre, Werribee,  
Vic 3030

This is a compilation of the experiences of patients with tuberculosis who were treated in sanatoria in Victoria over the years 1930-1963. The stories are told simply and graphically and give an insight into experiences that were rarely talked about, previously unsolicited and, nowadays, most people would find difficult to believe.

In the 1930s the only treatment for patients with tuberculosis was rest, good nutrition and fresh air in sanatoria where they might stay in isolation from their families for several years. Many died in hospital and those who survived were accustomed to have nights broken by other patients' coughing. The isolation produced boredom and depression for many and the

## 'Pansy' Wright Biography

Professor Peter McPhee of the University of Melbourne Department of History has commenced work on a biography of Roy Douglas 'Pansy' Wright. He would be very grateful for written recollections of 'Pansy' from former students and colleagues. His address is c/- Department of History, The University of Melbourne, Parkville, Victoria, Australia, 3052. Alternatively, he may be telephoned on (03) 9344 5961.

survivors found it difficult to relate to their children whom they had not seen for several years. Having been discharged from the sanatorium they could also be shunned by neighbours who might cross the street rather than meet them – there was always the chance of recurrence.

In the late 1930s and early 40s there were a variety of surgical attempts to close the cavities in the lung – air introduced into the pleural cavity or into the peritoneum with crushing of the phrenic nerve. The more drastic operation of thoracoplasty in which one side of the chest was collapsed by removal of the ribs is also mentioned and curiously the people say little of any problems. These treatments could be effective, but recurrence could still occur.

After the discovery of streptomycin by Waksman and Schatz in 1943 drug treatment with cure could be achieved. The stories told bridge these different periods and record fewer deaths and changes in social attitudes.

In 1939, Gwen Smith tells of a haemoptysis, a spitting up of blood from the lung, which was so severe that 'As I tried to talk it was spurring from my mouth'. (p12)

In 1942 Betty tells that 'There were a lot of young girls on the verandah, who were very, very ill and subsequently died. They were mostly rosy cheeked, beautiful girls – it was very sad'. (p30)

In 1943 David tells 'I was too bad for a pneumothorax. I was too bad to be operated on. So all I had was rest. For nearly twelve months my temperature every night was 100 degrees (F) or more'. (p45) David survived and was followed up by the Health Department until he was seventy-nine years old!

This book records personal encounters with pulmonary tuberculosis as it was, as it still is in many parts of the world and as it may be again if drug resistant organisms flourish. This book should be read by all who have the privilege of looking after ill people.

HA

'With 2.7 million fatalities a year, tuberculosis remains the world's leading cause of death from infectious disease.' World Health Organization. Bridging the gap. Geneva: WHO 1995.

## THE GREATEST JOY OF ALL



**The Story of Dr. Cyril Checchi**

Paul McLoughlin

### THE GREATEST JOY OF ALL The Story of Dr Cyril Checchi

by Paul McLoughlin

Bob Meredith, Willaura, 1995

Pbk pp 130

rrp \$20

This unusual autobiography comprises selected recollections of a respected country doctor whose words have been adapted by Paul McLoughlin from transcribed and edited tape-recordings made when Dr Checchi was in his nineties.

The first chapter deals mainly with the doctor's army career in the Great War of 1914-18, first in the RAMC, serving at Cape Helles, and then in the AAMC, serving at Passchendaele. His distaste for rigid military discipline, his frustrations with the British establishment and his arraignment for defying orders on medical grounds are similar to what other spirited Australians have experienced. Dr Checchi's remarkable memory has given us another vivid account of an MO's experiences in that war.

Although Cyril Checchi's memory is generally very sound, he has occasional lapses with detail, e.g. the *Orontes* in which Checchi travelled with twenty members of 'Kitchener's Hundred' left Melbourne on 15 April 1915 (not January 1915) and their military training in England started in June (not April) 1915. (See *Chiron* 1991, pp 57-63).

In the remaining fourteen chapters the 'Doc' describes his activities and experiences in the town of Willaura and tells many anecdotes of medical and civil life there during the course of sixty-seven years. His memories of Willaura are indeed 'a reflection on the times when community values were greater than those of the individual'.

As a solo medical practitioner in a somewhat remote country town Dr Checchi had to overcome many difficulties and was required to act at times in various capacities - dentist, veterinarian, pharmacist, coroner. His 'greatest joy of all' was the first cry of a

baby after a delivery. Tamie Fraser was one of his 2000 obstetrical patients. His activities included the establishment of the Bush Nursing Hospital, commissioner of the Water Trust and president of the local football club. Largely through Checchi's efforts, reticulated water and sewerage were brought to Willaura. For his community services Cyril Checchi was twice honoured by the Queen.

Not all of Dr Checchi's recollections have been transcribed from his tape-recordings and there may be others that he did not record, such as the following story, as told to the reviewer, of how his surgical ambitions were thwarted by Anatomy Professor Berry:

After the 1914-18 war, Cyril Checchi took up a position in the University of Melbourne's Anatomy School under Professor Berry. In due course he sat for the first part MS, but Berry failed all the candidates in Anatomy except one, namely Leslie ('Treacle') Hurley. Berry told Checchi that Hurley's results were so outstanding that no other candidate was worth passing. Checchi, having done well in Physiology and presumably in Anatomy, vigorously disputed Berry's decision, but to no avail and he left the University in high dudgeon.

The editors have performed a difficult task exceptionally well, only one medical term is misspelt, viz. verecella for varicella, and no typographical errors have been spotted. This interesting autobiography of a well-loved physician should appeal to the general reader as well as to the historian.

John C Trinca

### JAMES COOK AND THE CONQUEST OF SCURVY

by Francis E Cuppage

Greenwood Press, Westport Connecticut, London 1994

Hbk pp 163, illustrated, bibliography

rrp \$76.95

There is no shortage of authors attempting a reappraisal of James Cook. I have just read a biography (by Richard Hough) published in 1994, and now this book on Cook and his role in the conquest of scurvy.

The author is Professor of Pathology at the University of Kansas Medical Center, Kansas City. He links enthusiasm for nautical medical history with reading the Hornblower novels by C S Forester and the Bolitho series by Alexander Kent, and he built a model of the *Endeavour* before embarking on this book.

Cook's voyages and the history of scurvy are extremely well documented and this volume, while not producing any new material, does add a new dimension.

Dr Cuppage has visited sites in New Zealand, Australia and Honolulu associated with Cook's voyages and the book contains a number of black and white photographs taken by the author. He records the anchorage in Queen Charlotte Sound, the landing at Botany Bay, the site in Queensland (now Cooktown) where *Endeavour* was

beached for repairs, and finally the place where Cook was murdered at Kealakekua Bay. There are also photographs of various plants growing in New Zealand and Australia which were used by Cook to prevent scurvy. It is unfortunate that these original photographs do not add to our knowledge of Cook or of scurvy. In particular the plant photographs lack any useful detail, comparing unfavourably with illustrations reproduced from Banks' *Florilegium* and contemporary sketches.

The book is well researched and has an extensive bibliography. In the preface the author pays tribute to a number of New Zealanders and Australians who assisted him with subject matter or provided hospitality. There is no doubt that Dr Cuppage enjoyed writing this book - his enthusiasm shines through.

The tables and appendices bring together useful and interesting information which is less readily available elsewhere. Indigenous plants used as presumed antiscorbutics are listed together with their present day Vitamin C analyses. The ascorbic acid content of supposed antiscorbutics supplied by the Admiralty is listed and it should be noted that there was no antiscorbutic activity in malt wort which was recommended by Cook after his First Voyage.

Cook certainly avoided scurvy during his three great voyages. He started off with carefully selected, fit men. He kept his ship and men dry and clean and the latter as comfortable as possible. The level of victualling was generous and as he had an unshakeable belief that health at sea was linked with fresh provisions and fresh water, he never let pass an opportunity of replenishing supplies. Importantly, he also saw that the fresh fruits, vegetables and grasses that were collected were presented in a reasonably palatable form and were consumed by his crew.

Cook had been supplied with a wide range of alleged antiscorbutics but they were used haphazardly and often in combination so that the effectiveness of these suggested remedies, unknown at the start of the First Voyage, remained so at the end of the Second Voyage. While one might agree with Cuppage that '... Cook finally broke the back of scurvy' he did not clarify for the Admiralty which of the supposed antiscorbutics they should be issuing to ships.

Cuppage is incorrect when he states: '... many famous scientists began their career as ship's surgeon including Charles Darwin...' Darwin was invited to join HMS *Beagle* as a naturalist and companion to Captain Fitzroy. Robert MacCormick was surgeon and his assistant was Benjamin Bynoe.

This is a brief, well researched account of James Cook and his times, and of the hazards, and some of the solutions, relating to the health of sailors.

Published in America, this book is expensive for Australian buyers.

James Guest

**THE WESTERN MEDICAL TRADITION  
800 BC TO AD 1800**

by Lawrence I Conrad, Michael Neve, Vivian Nutton, Roy Porter, Andrew Wear  
Cambridge University Press 1995  
Pbk pp 556, illustrated, bibliography, index  
rrp \$44

The scope of this journal does not permit a full review of this important book, but it should be brought to the attention of readers who are encouraged to buy it and benefit from it.

This attractive book is another interesting, scholarly work from the Wellcome Institute for the History of Medicine in London. The decision to stop this survey at 1800 is understandable as the changes since then could well justify another book of similar size or larger.

The seven chapters each have a chronological table which links medical and scientific writers with contemporary events and there is both a general bibliography and a bibliography for each chapter. This is a book to read with enjoyment, to study and to use as a source of reference.

This book deals with the western medical tradition and deliberately excludes 'the medical theories of ancient Egypt and Babylonia, and likewise of India, China, America and the other civilisations with whom the Europeans later came into contact' because of their scant effect on 'the main European tradition of medicine, [and not as] a judgement on their efficacy, rationality, or historical importance'. Neither does this book 'confine the Western medical tradition to a series of 'great names' or as the title might suggest, to a tradition of medical ideas alone'.

The chapters follow a well trod path – the Greek world, Roman medicine, late antiquity and the early middle ages, the Arab-Islamic medicine, medieval western Europe, modern Europe 1500-1700 and the eighteenth century. The concluding chapter by Michael Neve provides an excellent summary of the philosophy behind the book.

The breadth of vision is sometimes startling, e.g. Vivian Nutton in a small section *Christianity and medicine* in chapter three has the following sentence:

Bishop Caesarius of Arles (c. AD 470-542, p. 84), St. Bernard of Clairvaux (1090-1153), the monastic reformer, and Mary Baker Eddy (1821-1910), the founder of Christian Science, are but three who set the medicine of faith and prayer above the corrupt worldly material of the body.

The whole trend of this book is away from hero worship, but there is a succinct biography of William Harvey included in Andrew Wear's excellent review of the background to his work which emphasises how much Harvey depended on Aristotle and of course on his own observations. 'For Harvey nature was much more trustworthy than writers . . .'

In Roy Porter's chapter on the eighteenth century, I, as a pathologist, was delighted that both Morgagni and Matthew Baillie

were mentioned. My delight turned to dismay when I realised that the details for Matthew Baillie's works were quoted from the gospel of secondary sources. That the sources were reputable is not sufficient excuse when the author and his research workers are sited in an institution where primary sources are readily available. I quote and then comment:

In 1793, Matthew Baillie (1761-1823) . . . published his *Morbid Anatomy* (1793). Illustrated with superb copper-plates by William Clift (1775-1849) – it depicted, amongst other things, the emphysema of Samuel Johnson's lungs – Baillie's work was more of a textbook than Morgagni's; . . .

The first part of this statement is almost a direct quote from Garrison and Morton's citation 2281 for the 1793 book by Baillie. Unfortunately the citation is wrong – very wrong. Neither Baillie's 1793 first edition or his 1797 second edition were illustrated. Moreover, William Clift was not an engraver, but did the drawings from which the three engravers produced the illustrations for Baillie's atlas published to illustrate and complement his unillustrated texts. The 'atlas' was published in ten fascicules between 1799 and 1802 and entitled:

*A SERIES OF ENGRAVINGS accompanied with EXPLANATIONS which are intended to illustrate THE MORBID ANATOMY of some of the most important parts of the HUMAN BODY.*

On the preceding page of the book being reviewed, as Fig. 54, one of the engravings is reproduced. The caption 'Here kidney stones and polycystic kidney disease are displayed' was never written by Baillie for no stones are illustrated. Fig. 54 is Fascicule VI Plate VII which Baillie describes as: ' . . . the formation of hydatids in the kidney'.

Figs 3 & 4 of the engraving are smaller hydatids and not stones. Baillie uses 'hydatids' to mean fluid filled cysts. Earlier Baillie illustrated and correctly interpreted the parasitic hydatid in the liver.

The statement about Samuel Johnson's lung dates back to 1849 and the illustration (Fasc 2 Pl 6 Fig 1) was used in Singer's *A Short History of Medicine* and by Major in *Classic Descriptions of Disease*. Baillie never used the term 'emphysema', but 'air cells of the lungs enlarged'. Few modern pathologists would accept Baillie's illustration as emphysema and the idea that the specimen came from Dr Johnson is not based on facts – see *Lancet* 1985: 11: 1411-1413.

Flaws in this area of the book do not detract from the solid value of the book as a whole.

The last chapter, *Conclusion* by Michael Neve, is a gem for it summarises the book and the philosophy behind it. Several quotes are given to encourage you to read this book.

. . . current writers of medical papers often appeal to this idea of greatness, thereby misconstruing the historical record and producing a series of historical icons instead of a historical context. (p477)

Even something as apparently simple and fatal as the Black Death has a complex social history. (p483)

In this historical work, removed from the heroic ideas and images of other medical histories, public health is the issue; public health conceived as a relationship between human beings and their social environment, rather than a relationship between human beings and their doctors. (p485)

and prophetically

Cholera and tuberculosis – and even bubonic plague – are as likely to reappear, perhaps even in strengthened forms in the late twentieth century, as to disappear. (p489)

It is possible that with the recent rise in incidence of drug resistant strains of the tubercle bacillus in New York and elsewhere that we are already seeing the beginning of this.

This book is highly recommended. HA

**KEY CENTRE FOR WOMEN'S HEALTH  
MONOGRAPH SERIES**

**Shifting latitudes, changing attitudes: immigrant women's health experiences, attitudes, knowledge and beliefs**

by Martha Macintyre and Lorraine Dennerstein  
Pbk pp 106, bibliography  
Key Centre for Women's Health, 1995

**The unfolding chrysalis**

by Susan Feldman  
Pbk pp 42, bibliography  
Key Centre for Women's Health, 1995

\$15 each (includes postage) from Key Centre for Women's Health Publications, The University of Melbourne, 211 Grattan Street, Carlton, 3052.

These two small volumes are the first in a monograph series from the Key Centre for Women's Health. Both are beautifully presented and both tackle subjects of major importance in women's health: immigrant women's health experiences and women and ageing.

*Shifting latitudes, changing attitudes* describes the findings of a community based research project involving interviews with approximately twenty women from each of seven non-English speaking backgrounds: Lebanese, Vietnamese, Chinese Vietnamese, Salvadorean, Chilean, Russian and Ukrainian. The study also encompassed focus group discussions with groups from each community involving interpreters, ethnic health workers, women with experiences of working in health care services in both their country of origin and in Australia and women who had experienced hospital care overseas and in Australia.

Focusing on the specific health beliefs, expectations and practices of the groups studied, the authors consider their effects on women's experiences of different life phases and evaluate the relevance of present health services delivery for women from these backgrounds. As the authors themselves acknowledge, the findings of the study cannot be considered to represent the views

of all women from these backgrounds, the samples from each group being small. Rather, the aim of the publication is to present an exploration of the range and diversity of views expressed by the women interviewed. With this in mind, *Shifting latitudes, changing attitudes* makes a fascinating introduction to the women's views on issues ranging from menstruation, abortion, pregnancy, birth, infertility, contraception and menopause to their preference for sex of doctor and issues of access and communication in using health services in Australia.

Some women, particularly those from non-Christian backgrounds (Lebanese and Vietnamese) reported that their use of hospital services was often made more difficult by a lack of sensitivity for their religious commitments, particularly in relation to dietary observances and dress codes – the latter being a particular reference to the scant nature of hospital gowns. Preference for female doctors was not uncommon, with all the Lebanese women interviewed and close to half of the Salvadorean and Chinese Vietnamese women preferring a female doctor. The other groups were less likely to state a preference for female doctors perhaps reflecting a combination of preference above all for competence over gender, as well as the women's pragmatism given that few are likely to be given a choice.

Insensitivity to traditional birth and confinement practices concerning the need for maternal rest and recuperation after birth was an area of concern for various of the groups of women interviewed, particularly for Vietnamese, Chinese Vietnamese and Lebanese women. Current hospital practices emphasising early maternal ambulation and mobility after birth and active care of the infant by the mother were seen as unsympathetic to the mothers' needs for rest and recovery – needs which would have been met by female relatives in the women's countries of origin.

The study uncovered a range of possible variations in the way different life phases are construed among the ethnic groups studied, as well as many common themes. Experiences of symptoms surrounding menstruation appeared to vary between, as well as within the groups. Vietnamese, Chilean and Salvadorean women seemed to experience fewer psychological and/or physical changes which they associated with menstruation compared to women from Lebanon or the former USSR. Positive views of the menopause were more common in the women from Vietnam and Lebanon where for some women this time was viewed as heralding 'a new level of physical, spiritual and emotional maturity'. Vietnamese women also quite commonly expressed the view that if women had many interests, they would not be bothered by the menopause. Further studies of larger and representative samples are needed to determine whether there are indeed culturally determined differences in

these and other health experiences among immigrant women.

Although women were asked in the interviews about their knowledge, use of and preferences regarding interpreter services, there is no discussion of this part of the analysis in this volume. This is a shame as women's views on this topic would have added some useful background to the, albeit important, exhortation that health workers need to be encouraged to use interpreting services more often and to be trained in ways of assessing need.

In summary, this book makes a useful contribution to the small, but growing literature on the diversity of immigrant women's health beliefs and experiences. It is to be hoped that numbered among those who read it will be the health professionals who care for immigrant women in Australian hospitals. A companion volume: *Immigrant women's health project. Hospital based research report* by Rafaela Lopez and Lella Fazzalori and published by the Mercy Hospital for Women (1995) documents the issues and challenges to be faced at the hospital level in relation to policies and practices in order to achieve more culturally sensitive health care for women.

The focus of *The unfolding chrysalis* is quite different. Rather than describing research undertaken, this volume offers to analyse current research on women and ageing and to provide a set of priorities for future research. As an introduction to some important issues that need to be considered – for example, that the views of older women themselves need to be a major focus of research; that the diversity of women's experiences of ageing needs to be taken into account; that ageing needs to be seen as another stage of development in the human life cycle and not simply as the decline of youth; that future research on ageing needs to explore more fully the interrelationship between social context and health and well-being – *The unfolding chrysalis* serves a useful purpose.

On the level of literature review, as a critical guide to the findings of current research in the field, it is ultimately less than satisfactory however. There is more here about a range of different commentators' views on the research on women and ageing than there is about the research itself. Clearly in a field where there are many gaps and an unsatisfactory coverage of the important issues, there needs to be a strong focus on what is missing, but more attention could productively have been paid to providing an overview of current research knowledge. Some examples from the section on health might serve to illustrate my point. It is noted that women experience a higher degree of chronic disease and report more doctor visits than men (p12), yet there are no further revelations about what sorts of chronic diseases women experience as they age. Such research has been done and ought reasonably to have been documented.

Frequently there are interesting statements made, such as: 'While women do have a longer life expectancy than men their health status has a greater negative impact on daily life' (p12), followed by no reference to the research study or studies from which it presumably arose. For readers wanting to go beyond this review and follow up particular studies, this lack of attention to detailed referencing is quite frustrating.

The coverage of topics as they relate to women and ageing is wide ranging, including sexuality, socioeconomic issues, physical and mental health, lesbian older women, cultural and ethnic issues, older women as carers, concerns for rural women, housing and transport. This breadth means that as an issues paper, *The unfolding chrysalis* raises many important aspects of older women's lives which need to be on the research agenda.

*The unfolding chrysalis* is thus a provocative, but somewhat incomplete, critical overview of the research on women and ageing.

Rhonda Small, Research Fellow,  
Centre for the Study of Mothers' and  
Children's Health, La Trobe University.

## THE 1995 SPECULUM

Eds Jason Chuen and Susan Shedda

This *Speculum* is unique for it is the first edition to be distributed to students at the Melbourne and the Monash Medical Schools – a representation of '25% of Australia's future doctors'. The front cover is also unusual – black with mainly orange lettering and a seated, deified Hippocrates holding open a book, the pages of which show an old University of Melbourne insignia and the letters 'MELB UNI MSS'. In white there are the insignia of the three sponsors – Victorian Medical Insurance Agency, Bongiorno & Associates and the Medical Defence Association of Victoria.

As usual there is a wide range of articles giving varied points of view on different topics. Jason Chuen and Tony Chan have bravely reported an interview with the formidable Marie Tehan. Their conclusion is excellent, but I won't steal their thunder!

Dr Andrea Bendrups writes quietly and succinctly about the problems women still face in achieving specialist qualifications and subsequent recognition. She ends the article with her belief that such problems will disappear 'as the emphasis shifts to the achievement of excellence and job satisfaction, regardless of gender'.

Two articles, 'Matters of the Heart' and 'Bagel Breakfasts and Bodybags' by Jacqueline Brown and Chris Oh, give vivid summaries of elective periods in the Cardiac Service at the Massachusetts General Hospital and in a MedSTAR (Shock, Trauma, Acute Resuscitation) Unit in 'North West DC away from the prestigious Georgetown and George Washington University Medical Centres'. Days started early – 4.30 am – and

periods of surgery could extend for ten hours with emergencies at any time. Both were impressed by the American system and the readiness with which each was accepted as a member of the team with responsibilities much greater than would have been contemplated here. Jacqueline's descriptions of some of the surgeons' tantrums showed that these manifestations cross all boundaries.

Clinical teachers should read these articles as there are invidious comparisons made between methods in the US and here. However the American system is essentially a postgraduate course which makes the apportioning of responsibility easier.

Sophie Adams writes about the AMSA Convention '93 which included a question-and-answer session with three HIV positive people – a 'sobering moment in the middle of a week of indulgence'. On the following page there is a photograph of a group of stalwarts caught with their pants down and handkerchiefs tied on their heads. The caption is masterly – 'Friends made at an AMSA Convention are friends for life – and boy are you going to regret it!'

In sharp contrast, Kylie Mason writes of her personal experience in living with Acute Lymphoblastic Leukaemia and the importance of the self-help group CanTeen – the Australian Teenage Cancer Patients' Society. This group was created by teenagers with cancer and guided by teenagers living with cancer. The aims are simple – 'supporting, developing and empowering teenagers living with cancer and their teenage brothers and sisters'. Kylie is now in her second year as the Victorian President. Everyone can benefit from this article.

Dr Daniel Silver writes on Castlemaine's medical services, David Topchian on what an intern does and Alex Pitman, a former editor of *Speculum* writes an acerbic article on the resident.

*Spicula's* are largely an original guide to medical terms which include 'Rectum – Damn nearly killed him' and a very novel one – 'Impotent – Distinguished, well known'.

Ilona Di Bella has written a well researched article 'To Speculate on Specula' in which she doubts that the original editor of *The Speculum* meant 'Speculum' to mean

anything other than a vaginal speculum. It is true that amongst the originators there was one student who 'strongly objected because he could not lay a journal of that name on his sister's table. However, his scruples were overcome.'<sup>1</sup>

The original idea was taken from Terence, a Roman playwright's *The Brothers*, and the translation of the relevant poem is given as 'In a word I tell you to look into the lives of all men as into a glass (mirror) and thence to take example'. The original motto *Si Speculum Placet, Inspice* is a play on these words.

I suppose it is possible that, with the inclusion of the Monash students in the distribution of this number, a new journal may arise to represent the '25% of Australia's future doctors' and a new title have to be found. If so, I hope that those given the task of creating a new title take as much care as did those in 1884.

This *Speculum* has the usual goodly mix and to all concerned, congratulations. HA

1. Gandevia, Brian The Melbourne Medical Students 1862-1942 MMSS 1948 p39-40.

## MODELS FOR REMNANT A New Dissection – Sixty Years On

ONE OF THE FINEST SPOOFS in *Speculum* is 'The Anatomy Lesson (Remnant)' which appeared in 1935 and was based on *The Anatomy Lesson of Dr Tulp*, 1632, by Rembrandt.

The Rembrandt has often been used as a template for other groups – even the Labor government with Bob Hawke as Dr Tulp redrawn by Horner – few have been accomplished with the wit and accuracy of that in *Speculum*.

I have been fascinated by it for many years and have been guilty of misinterpreting the caption. I believed, quite wrongly, that the cadaver was Peter Parsons. In the caption only eight names are given, but there are nine faces. The cadaver was *never* named.

Two of the students depicted in 1935 are still alive – Bill Refshauge, and Peter Parsons. Thereby hang these tales.

Peter Parsons corrected the naming in the caption (Figures 1 & 2) and told me that 'It was singularly appropriate that the cadaver was Merry'.

*Master Nicholas Wood-Pulp (of no fixed abode)* was the then Professor of Anatomy – the much revered Frederic Wood Jones, who rarely spent more than seven years in any post.

*Raphael Refshauge (of Rotterdam)* is now Major General Sir William Dudley Refshauge.

Bill Refshauge graduated MBBS in 1938 and following residency at the Alfred Hospital, served in the AIF becoming a Lt. Col. in the Australian Army Medical

Corps. He was mentioned in dispatches four times and was awarded the OBE in 1944.

Returning to Australia he was RMO and then Medical Superintendent at the Royal Women's Hospital. Bill has at one time or another been Director General Army Medical Services, Commonwealth Director General of Health and Honorary Surgeon to Queen Elizabeth. Bill has also been Secretary General of the World Medical Association and President of the World Health Assembly. He was made a Knight in the British Honours list of 1966 and became an AC in 1980. When he gets time for hobbies Bill indulges in 'gardening, bowls and rug making'. Truly a rounded man.

*Piccolominus Pete Parsons (of Pisa)* is Peter Parsons who was born, as he says, 'at a very early age' and educated at Geelong Grammar then at the University of Melbourne where he graduated BSc in 1937 and MBBS in 1938.

During the Second World War he served in the AIF in the Middle East, Syria, and New Guinea and was mentioned in dispatches. He developed an abiding interest in gastroenterology after working with Avery Jones at the Central Middlesex Hospital in London. Peter was President of the Gastroenterological Association from 1967-69. He has been Honorary Physician and Consultant to the Alfred Hospital for many years and was at one time Vice President of the Royal Australasian College of Physicians. Now

retired, he is a delightful raconteur with a good memory.

*Vincentius Agina Bristo (of Bologna)* was Vincent George Bristow (MBBS 1938, MD 1954). Vincent did residencies at St Vincent's and the Austin Hospitals in 1939 and 1940.

He was a member of the University of Melbourne Regiment for six years. In 1941, he was appointed to a commission in the Second AIF and served with the First Australian Independent Company – a commando group – in New Ireland and was mentioned in dispatches. Captured by the Japanese in 1942 he was interned in a number of places, finally at Hakodate in Japan. On his return to Australia in 1945 he weighed a mere forty-five kilos.

Vin was Medical Superintendent at the Austin Hospital from 1946-1953, but because of his own hay fever became increasingly interested in allergies. From 1955-1974 he was physician in charge of the allergy clinic at the Alfred hospital. Vin was an original member of the Asthma Foundation of Victoria and medical vice president from 1974-1984.

Vin died in 1986 and is remembered as 'a happy, jocular person who shone as a raconteur. He was generous, unselfish, fair-minded, modest and a master of understatement.' (Roll of the RACP Vol. 2 p36-7). He had a happy marriage and family life.

*Eustachius Johannes Connell (of Copenhagen)* was John Fletcher Connell, MBBS



THE ANATOMY LESSON (Remnant).

Among the celebrated anatomists in the picture may be seen: Piccolominus Pete Parsons (of Pisa), The Cadaver, a condemned and censored criminal, Vincentius Angina Bristo (of Bologna), Johannes Ambrose Parry (of Paris), William His Knight (of Folkestone, Kent), Fallopius Fitz-Jackson (of Amsterdam), Raphael Refshauge (of Rotterdam), Eustachius Johannes Connell (of Copenhagen). The whole production staged by Master Nicholas Wood-Pulp (of no fixed abode), who may be seen wearing his old-school hat and saying, "Of course, this is all wrong!"

Several absent faeces may be noticed in the picture, including those of Andrew Snape, Vesalius and Jack Hunter. Professor Os-orne, when shown the picture, remarked, "It is entirely without physiological significance. It is a mere Remnant, and depicts nothing but a lot of anatomist ruff-necks."



1. Frederic Wood Jones.
2. William Dudley Refshauge.
3. Peter James Parsons.
4. Vincent George Bristow.
5. John Fletcher Connell.
6. Alan Dove Jackson.
7. Victor Ernest Knight.
8. John William Hugh Merry.
9. John Russell Parry.

1938, who won a blue for swimming during his university career. John served in the Australian Army Medical Corps with the 2/1 Infantry Battalion and the 2/8 Field Ambulance and was awarded the Military Cross 'immediately' - which means on the battlefield. He became an in-patient surgeon at Kyneton Hospital, but later went to South Australia where he worked in Victor Harbour. John Connell died in 1989, but I have not found an obituary in the *MJA*.

*Fallopius Fitz-Jackson (of Amsterdam)* was Alan Dove Jackson who took a Diploma of Pharmacy in 1923 and started Medicine in 1933. Alan had a bumpy course almost certainly because he was also working in his Pharmacy at 198, Canterbury Road, Canterbury. He left the medical course in 1937 and continued as a pharmacist in Victoria for a number of years before moving to Prospect, South Australia. As he was born in 1901, I assume that he is dead.

*William His Knight (of Folkestone, Kent)* was Victor Ernest Knight, MBBS 1939, who had served in the Australian Flying Corps in

the First World War. Peter Parsons remembers Victor giving the advice that if the plane caught fire the best thing to do was to put it into a dive - surprisingly enough, dependent on the speed obtained, this can douse such a fire.

The *Medical Journal of Australia* (1/1967 p464-5) carries a wonderful tribute to Victor Knight by Dr Gordon Grant. In the First World War, Victor served as a stretcher bearer, but, with the start of air warfare, transferred to the Australian Flying Corps as a pilot with commissioned rank. Among his cobbers in No. 2 Squadron there were Harry Cobby and Hudson Fysh. All three served again during the Second

World War! Despite these records, Victor was not a belligerent man.

As well as an officer, he was truly a gentle man, who loved the quieter things of life. To him, Christianity, love of family, music (choir and instrumental) were the major factors in life. (His sense of humour was kind. He scored off no man.) He sought his spiritual refreshment from his very exacting medical duties at his weekend house amongst birds and the trees at Mount Nebo.

At his funeral an Air Force sword was carried before the coffin.

The significance of the sword was that he had honourable service as an officer. The real symbolism lay in the fact that the sword was sheathed.

*The Cadaver - a condemned and censored criminal* was John William Hugh Merry (MA 1930, MBBS 1939), who had been an English master at Geelong Grammar and later at Scotch College before entering medicine. After residency at the Royal Hobart Hospital he served with the

Australian Army Medical Corps from 1940-46 in Lebanon, the Northern Territory, Bougainville, and Papua New Guinea. John spent 1946-47 in Japan with the British Commonwealth Occupational Forces. Later, he became a Major in the AAMC Reserve.

John Merry was Assistant Clinical Tuberculosis officer with the Central TB Bureau. A volunteer medical officer at the Olympic Village in 1956 he worked as a School's Medical Officer from 1968 to 1972. It is likely that he is dead although I have not been able to find a Victorian death certificate to 1980.

To my great delight Peter Parsons told me that the originator of the spoof was John Russell Parry - *Johannes Ambrose Parry (of Paris)*.

John Parry, educated at Xavier College and a devout catholic, was older than most medical students, having completed a Diploma in Architecture in 1929. In 1927, as an architectural student he won a bronze medallion from the Royal Victorian Institute of Architects for a measured drawing of the Swanston Street stone facade of the National Gallery and Public Library. The drawing was so good that the examiners asked that it be kept, framed and put on display as a model for future contenders. John was a draftsman which explains the very careful setting out of the faces which, in position and attitude, are so like the Rembrandt. John had red hair receding from his forehead, and a red moustache. The burgher in the same position in the Rembrandt has red hair, moustache and beard!

Peter Parsons remembers that John, who drove an A model Ford coupe when most students could not afford a car, was a delight to be with and very popular. He had been President of the Students' Representative Council, played the piano well, sang, wrote plays and contributed articles, drawings and cartoons to the *Speculum*, *Melbourne University Magazine*, the *Age*, the *Argus*, *Australian Home Beautiful* and *Table Talk*. John was one of the scribes who did some of the calligraphy for the Honours Roll of the Fallen in the Shrine.

In 1938, he became a medical officer of the Mental Hygiene Department and a house surgeon to Dr Hugh Ryan at St Vincent's. Hugh Ryan remembers when John, while at St Vincent's, developed the first sign of progressive muscular atrophy - his hand could not keep hold of a razor while shaving. John died from his disease in October 1940 at the age of thirty-four. A year earlier he married a nurse, Eileen McGrath, who cared for him in their home.

Many death notices and tributes appeared in newspapers and journals in Melbourne and Sydney, but no obituary appears in the *MJA*. A fine tribute to John is in his former school's journal, *The Xaverian*, (p100-102, 1941) by Basil Buller Murphy. John Parry 'was a man of remarkable versatility and many accomplishments - architect, doctor, musician, literateur, actor, raconteur connoisseur. Grand company, he could always be counted on to set the table in a roar.'

Of the eight students who were the models for Remnant in 1935 only two are alive sixty years later. One of the students, a pharmacist, left the medical course. Like so

many young men of that time six students served in the Second World War; unlike many others, all survived.

Three of the six were mentioned in dispatches and one got a Military Cross on the battlefield. One served in both world wars. One became a Major General and was knighted.

John Russell Parry, the real Remnant, was a greatly talented man who died of a dreadful disease at the age of thirty-four. One relative said to me 'John died young and achieved little'. His widow, Eileen, does not agree with this and neither do I. I never had the privilege of meeting him, but, in talking to those who did, everyone has become

incandescent as they vividly recount an impression or a story about John Parry. Such vivid memories quickly recalled fifty-five years after John died are surely great achievements. The Anatomy of Remnant is one monument to his memory. HA\*

\*With thanks to John Parry's widow – now Eileen Macintyre – for much willing assistance.

## MEDICAL HISTORY UNIT

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Curator Prof Emer H D Attwood

Enquiries 9344 5884

**T**HE MUSEUM is now open from 9am-5pm weekdays without seeking entry at the Information Desk in the Brownless Medical Library. An audit of the collection had shown that a small number of items had been stolen from the Savory and Moore Pharmacy. A security system has now been installed to cover the pharmacy area and its efficacy demonstrated. Simple methods to reduce the level of UV light on precious documents have also been installed. Lis Bladin, our archivist and cataloguer, has made major contributions to these improvements and, using material from the AMA collection, has mounted a number of small exhibitions. A goodly number of students can now be found in the museum. *The VD Story* curated by Dr Di Tibbits has been the major exhibition during the year and is probably the most socially relevant exhibition to be mounted in our museum. Changes in social attitudes, general knowledge about the sexually transmitted disease, attitudes during the war and the range of treatments from the chemically and physically ineffective to the antibiotic curative era have all been graphically displayed. This exhibition has not had the attention it deserved, but this is due to the sequestered position of the museum. It did get an excellent write-up in the Newsletter of the Prostitutes Collective of Victoria.

Guided tours by the Curator can be arranged and, in recent years, these start in January as part of the Siemens' Summer School, when groups of school children are shown round. The museum is always open on Discovery Day with the Curator in attendance.

Late in the year, a request for a tour of the Pharmacy from the Speaker of Victoria's Legislative Assembly, Mr John Delzoppo, puzzled the curator. The Speaker and Mr George Cox, MLC for Nunawading came and the puzzlement quickly disappeared. John Delzoppo, a pharmacist by profession, quickly showed his ability to interpret many of the Latin names on the drawers in the pharmacy. Mr Cox has a special interest in cabinet making and, some years ago had been given a set of heavily painted drawers similar to those in a pharmacy. Mr Cox carefully removed the paint not only to show fine wood underneath but to reveal gold labels which John Delzoppo immediately recognised as old familiar pharmaceutical labels. George Cox brought with him photographs of his loving restoration of the

set of drawers and they are every bit as handsome as those in the Savory and Moore Pharmacy. As the Curator is also interested in wood carving, following the tour of the pharmacy, we crossed to admire the beauties of the 1880 tall display cases (*Chiron* 1994, p71) accompanied by a bemused photographer and Christina Buckridge, media liaison officer for the University.

### Medical History Conference on Norfolk Island

This International Conference of the Australian Society of the History of Medicine – Mutiny and Medicine – was appropriately set on Norfolk Island and was a great success. Over four hundred registrants came, not only from all states and territories of Australia and New Zealand, but from Canada, the USA, the UK, Sweden and Austria; our conference increased the population of the island by fifty per cent!

Over one hundred papers were presented and given in three venues which could mean a brisk walk from one to the other or a short, hasty car drive. The conference proceedings will be published and should provide much of interest even to those who attended as it was impossible to hear every paper. I was particularly impressed by two senior colleagues, Eric Dax and James Smibert, who gave papers which had been well prepared, were well presented and the questions well fielded.

The social events were well organised, always of interest and included several dramatic presentations of the vile treatment of the convicts on Norfolk Island. Many of us

took part in 'A Night as a Convict' during which we all dressed in convict 'overalls', some were subjected to simulated floggings and order kept at table by harsh voiced soldiers. As the evening went on and the food and drink were good and plentiful all became convivial with dancing and singing. James Smibert, somehow or other changed his convict tunic for one of an officer, and, thus resplendent, danced and sang the night away.

Dr Warwick Anderson, Lecturer in the History of Medicine at the University of Melbourne, told me that the number attending the conference on Norfolk Island was greater than the usual attendance at an annual meeting of the American Association of the History of Medicine. The Australian Society for the History of Medicine was formed in 1986, after which the Medical History Unit acted as secretariat for several years. The Society proved its maturity on Norfolk Island. The success of the conference was due to the far-sighted preparation done by the Brisbane group headed by Dr John Thearle and Professor John Pearn. John Pearn took over from Dr Geoff Kenny as our new President.

Dr Geoff Kenny had done an enormous amount of work for the conference and, in Melbourne with the help of the Medical History Society of Victoria, stage-managed the voting for the incorporation of the Society before the conference began. Geoff presided over the conference as only Geoff can – with great knowledge, an infinity of good manners and a gently persuasive, good humour.



Visiting the Savory and Moore Pharmacy (from left) Mr John Delzoppo, Mr George Cox and the Curator.



## THE MEDICAL DEFENCE ASSOCIATION OF VICTORIA

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## CONTINUING MEDICAL EDUCATION

*These continuing professional education courses are designed for medical practitioners. They may also be of interest to those working in associated health science professions. Enquiries should be directed to: Continuing Education and External Relations, Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne, Parkville, Vic, 3052.*

### **Sports Medicine Problems in General Practice**

Friday & Saturday 1-2 March, The Royal Melbourne Hospital & Essendon & District Memorial Hospital  
Directors: Drs K Khan & T Liaw

### **Psychiatry for Non-Psychiatrists: Crises and Difficult Management Problems in General Practice**

Friday & Saturday 22-23 March, Austin & Repatriation Medical Centre, Austin Campus  
Directors: Associate Professor F Judd & Professor G Burrows

### **ENT Problems and Procedures in General Practice**

Friday & Saturday 10-11 May, Royal Victorian Eye & Ear Hospital  
Directors: Associate Professor B Pyman, Dr A Cass & Dr W Leadston

### **Refresher Course and Update in Ophthalmology**

Friday & Saturday 17-18 May, Royal Victorian Eye and Ear Hospital  
Director: Professor H Maclean

### **Radiography for General Practitioners**

Wednesday to Friday 29-31 May, Essendon & District Memorial Hospital  
Director: Professor Emeritus WSC Hare

### **Paediatrics for General Practitioners**

Tuesday to Thursday 11-13 June (Clinical Program), Friday & Saturday 14-15 June (Lecture Program), Royal Children's Hospital  
Directors: Professor P Phelan & Dr H Van Doorn

### **Keeping Up To Date With Medical Information**

Saturday, 22 June or 31 August, Brownless Medical Library, The University of Melbourne  
Directors: Ms D Rowse & Ms H Newton

### **Red Scaly Rashes**

Friday & Saturday 19-20 July, Skin & Cancer Foundation of Victoria, Carlton  
Director: Professor R Marks

### **Update on Obstetrics and Gynaecology for General Practitioners**

Friday & Saturday 26-27 July, Royal Women's Hospital  
Directors: Associate Professor D Young & Professor R Pepperell

### **The Design and Conduct of Clinical Trials**

Thursday & Friday 22-23 August, The Royal Melbourne Hospital  
Directors: Drs R Basser & M Green

### **Update in Internal Medicine for General Practitioners**

Friday & Saturday 11-12 October, Western Hospital, Footscray  
Director: Professor N Yeomans

## 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 of the medical building, the University of Melbourne. Students, graduates and members of the public are welcome. The lectures are free. For further information contact Continuing Education and External Relations, Faculty of Medicine, Dentistry and Health Sciences, the University of Melbourne Parkville, 3052.*

### **Development and Disability of the Auditory Nervous System: Electrophysiologic Evidence**

5 March – Professor Barbara Cone-Wesson, The Beth MacLaren Smallwood Professor of Audiology and Speech Science

### **62nd Beattie Smith Lecture**

#### **Psychiatry: an Impossible Profession?**

19 March – Associate Professor Sidney Bloch, Associate Professor and Reader, Department of Psychiatry

### **The State of the World's Children:**

#### **How Can Mortality be Reduced?**

2 April – Professor Frank Shann, Director of Critical Care Medicine, Royal Children's Hospital

### **Malaria: Pathology and Prospect for Vaccine**

23 April – Professor Graham Brown, Director of Infectious Diseases and International Health, The Royal Melbourne Hospital and the Walter and Eliza Hall Institute

### **War-Related Post Traumatic Stress Disorder:**

#### **Cause and Cure**

7 May – Professor Philip Morris, Director, National Centre for War-Related Post Traumatic Stress Disorder, Austin and Repatriation Medical Centre

### **Caring for the Family in the Setting of Terminal Illness**

21 May – Professor David Kissane, Director of Palliative Medicine, St Vincent's Hospital/Caritas Christi Hospice/Peter MacCallum Cancer Institute/Mercy Hospice Care

*This will be followed at 6.30 pm by the 1996 Annual General Meeting of the University of Melbourne Medical Society*

### **Radiation: Risks and Benefits**

4 June – Professor Lester Peters, Director of Radiation Oncology, Peter MacCallum Cancer Institute

### **The Kidney: New Perspectives on Development**

18 June – Professor Daine Alcorn, Professor of Anatomy

### **Women's Health: Women's Business?**

2 July – Professor Lorraine Dennerstein, Director, Key Centre for Women's Health in Society

## **DEAN'S LECTURE SERIES SEMINAR THE NEW GENETICS – FOR GOOD OR ILL?**

Convener – Professor Richard Smallwood

**Friday 26 July 1996 – 2.00 pm to 5.00 pm**