



THE UNIVERSITY OF
MELBOURNE

MELBOURNE MEDICAL SCHOOL



2009





This view of the University of Melbourne was taken in the 1960s during the construction of the Medical Building. Many changes to the University landscape can be seen when compared to a similar photo, taken in 1942 (see page 25) and the one on our back cover, which was taken earlier this year.

CONTENTS

1

THE VALUES OF A MEDICAL EDUCATION

James Best

2

A PLACE FOR ETHICS

Graham Brown, Richard Smallwood, Loane Skene, Lynn Gillam, Jeffrey D Zajac, Paul Stewart, Jim Black, Dave Carmody, Aaron Wagen

10

MELBOURNE MEDICAL SCHOOL

Appointments and Departures

12

MEDICAL TEACHING AND LEARNING IN THE 21ST CENTURY

Jenny Hayes, Geoff McColl, Sarah Wonseelashote, Chance T Pistoll, Christine Mandrawa

17

ALUMNI STORIES

Nick and Hannah Mason, Charles Mullany, Richard Pestell

21

MELBOURNE MEDICINE: 150 YEARS

22

REUNIONS

1941, 1944, 1949, 1958, 1978
2012 Reunions and Medical School memories

24

MEDICAL MEMORIES

James Guest and Jenny Hayes

26

OBITUARIES

33

FROM OUR COLLECTION

A monument is uncovered, Brownless Biomedical Library redevelopment

35

IN BRIEF

Congratulations, Student Prizes and Awards, 2008 Dean's Honours List, Participants needed, Books

COVER

FRONT:

Anatomy students in a 'body painting' class run by senior lecturer Jenny Hayes. Haylee Walsh learns about the nerves and vessels of the head and neck by painting them on fellow student Baotuti Sebolao.

BACK:

This recent photo shows the Melbourne Medical School building, the Howard Florey and Microbiology and Immunology buildings and the building site of the Parkville Neuroscience Facility. The old Dental Hospital (bottom right-hand corner) is currently under demolition and will become the site of the Parkville Comprehensive Cancer Centre.

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THE VALUES OF A MEDICAL EDUCATION

JAMES BEST



James Best

Chiron the centaur was a great healer, famous for his knowledge and skill with medicine. Highly revered as a teacher and tutor he is described as being intelligent, civilised and kind. Among his many famous pupils was the god of medicine, Asclepius, whose staff with serpent entwined is one of medicine's most recognised symbols. Appropriately, medical education is the key theme for our 2009 edition of *Chiron*, with an emphasis on its effect on the lives of our pupils.

Geoff McColl's article draws our focus onto the attributes or qualities we wish for in our medical graduates. These include a capacity for self reflection, the ability to deal with complexity and uncertainty, qualities of leadership, and a strong sense of the ethics and responsibilities that must underpin the practice of medicine. Several articles in this issue describe our ethics seminars which address issues we now expect our medical students to contemplate and discuss.

While developing these qualities has always been part of both the official and unofficial curricula, the new graduate course to begin in 2011 will recognise and seek to develop these attributes more explicitly. These are not skills to be learnt online or from textbooks as part of the

'competency based training' some seek to impose on universities and their medical schools.

Another of our erudite alumni, recently retired vice chancellor of Monash University, Richard Larkins, addressed these issues more broadly in his University of Melbourne 2009 Menzies Oration, entitled Universities: the Foundation of Civil and Successful Societies. He warns of the risk of reproducing 'the errors of the recent past where the things that can be easily measured rather than the things that really matter become the determinants of both evaluation and behaviour'.*

In Franz Kafka's short story, *A Country Doctor*, he writes: 'To write prescriptions is easy, but to come to an understanding with people is hard'. Outstanding examples of both the capacity for self reflection and an understanding of people are provided by the medical student elective essays and by reports from Nick and Hannah Mason and Charles Mullany.

I worked with Charles as an intern when he was a surgical registrar at St Vincent's Hospital and was surprised to receive a letter from him earlier this year describing his career change after 22 years as a leading cardiac surgeon at the Mayo Clinic. Correctional health must be one of the most challenging areas of medical practice and, although he does not mention it, Charles was prompted by a desire to 'give back' to society. His move between two such radically different areas of medical practice was made possible by the sound knowledge base in his medical education. We are committed to maintaining this flexibility in our students through outstanding teaching in the scientific basis of medicine as well as in its clinical practice.

We have worked closely with our medical students' society this year and I hope to extend the interaction over coming years. Christine Mandrawa and her fellow students have contributed selflessly to many medical school committees and workshops, including those supporting development of the new medical course.

The poignant article on Canute Henry Clowes reminds us to value each one of our students and we are very grateful to those who choose to contribute for the benefit of future students.

I congratulate those who are graduating this year and hope that you will maintain close links with your medical school. I am sure we can do more to engage you with your alma mater and hope in particular, that you will become involved in some of our celebratory activities leading up to and during the Melbourne Medical School's 150th anniversary in 2012.

To a significant extent we are considered one of the world's great medical schools because of our alumni, whose achievements and contributions are so prominent and numerous. Exceptional lives and medical careers are recorded in this issue, several tragically shortened by accident and natural disaster. What a remarkable range of individuals have come through medicine over the years and how well their lives embellish the ethos of Australian medicine.

Because of our deserved reputation we attract outstanding professorial appointees, nationally and internationally, but diminishing resources make it increasingly difficult to maintain excellence. If we are to be highly regarded internationally we must be competitive at the international level in our ability to support academic staff, particularly when they take up chairs with the responsibility of leading a department. The support of our alumni is greatly valued and we will seek to provide more specific opportunities to engage your support in this area over the next year.

I hope you enjoy reading this edition of *Chiron* and that it informs you well about our medical school. I wish all of you fulfilment and success in the coming year.

Professor James Best is Head of the Melbourne Medical School

* Richard Larkins' Menzies Oration can be found online at: <http://www.trinity.unimelb.edu.au/news/2009/assets09/20091027-1>



A PLACE FOR ETHICS

ON ALL GREAT SUBJECTS MUCH REMAINS TO BE SAID. *John Stuart Mill*

GRAHAM BROWN AND RICHARD SMALLWOOD AO

The annual medical ethics seminar, held in the Sunderland Lecture Theatre, attracts large audiences from the medical and associated professions.

In 1985 the then Faculty of Medicine at the University of Melbourne ran a seminar entitled 'AIDS (Acquired Immune Deficiency Syndrome) and Its Implications for Medical Practice'. The seminar, chaired by Professor Graeme Ryan, heard from Professor David Penington (then Dean of the Faculty and Chairman of the National AIDS Task Force) and Dr Ian Gust (then Director of the Virology Laboratory at Fairfield Hospital). The following year, another seminar, 'Ethics at the Growing Edge of Medicine' was held as part of that year's Dean's Lecture Series. Convened again by Graeme Ryan, then Dean of the Faculty, the seminar heard from Professor Emeritus Richard Lovell and Dr Davis McCaughey, then Governor of Victoria.

From these events was launched a series of seminars exploring ethical themes and issues pertinent to the study, practice and research of medicine, which have since formed part of each year's series of dean's lectures. As we move towards the 150th anniversary of the Melbourne Medical School in 2012, we take this opportunity to ask past and current seminar contributors and current staff and students to reflect on some of the issues considered in these seminars over the years, beginning with the thoughts of two past seminar conveners; Richard Smallwood and Graham Brown.

Before entering into this reflection, however, we might allow the closing comments of Davis McCaughey's ethics seminar address in 1986, to presage the discussion:

A good ethical discussion will range over a wide series of considerations. Old wisdom and new demands will cast light one upon another until there emerges that consensus on which formulated conventions depend. It is not necessary for medical scientists to be dragged screaming through every page of Aristotle or Kant, any more than it is necessary for lay members of an ethics committee to understand every scientific process involved in the experiment. It is necessary, if conventions are to be formulated, that men and women of different backgrounds and skills should be willing to sit down and talk and listen. And when we have done that, we shall still remember the dictum of John Stuart Mill: 'On all great subjects much remains to be said'. (Chiron, 1987, p.10)

A university environment provides an ideal place to discuss issues of contemporary ethics, separated from politics and the law, where opinions can be expressed, debated and reconsidered by an audience of professionals and informed lay people.

Over the 23 years that the seminars have run, the burning ethical issues have evolved, in part due to advances in medical science and technology. For example, the revolution in molecular biology has enabled genetic testing and creation of

genetically modified organisms. The increased accessibility of information through electronic communication and data storage has brought problems of privacy and confidentiality. New situations have emerged to revive old debates about rights of individuals in a liberal society, and the intrusion into medical research and practice by government, advertising agencies, the pharmaceutical industry, or others who choose to support medical research.

In 1982, the National Health and Medical Research Council (NHMRC) set up a working party on ethics in medical research, which was chaired by Professor Richard Lovell, and which subsequently became the Medical Research Ethics Committee (MREC) of the NHMRC. Stimulated by the work of MREC, Professor Lovell, with Professor Graeme Ryan, the then Dean, decided in 1986 to establish an ethics forum in the University of Melbourne in which contemporary ethical issues, particularly those that were to appear before the law or other regulatory bodies, could be debated freely by experts in the field. He saw the advantage of bringing together experts from disciplines of medical research, medical practice, the law, and ethics, so they could inform, amongst others, the lay community, particularly people who

may be asked to sit on ethics committees of medical institutions or research bodies. The ethics seminars have become a point of great interest for Australians involved in contemporary ethics, and it is timely to reflect on the topics that have been discussed, decisions made, and outcomes or advances that were predicted in these symposia.

In the first group of symposia Professors Ryan and Lovell convened panels composed of experts and community members and considered contemporary issues in medical ethics, examining the first of recurring themes of privacy in medicine, resource constraints in the practice of medicine, and issues in transplantation.

Professor Smallwood's era considered the ethics related to 'end of life' decisions and caring for severely disabled or dying children. Two seminars dealt with questions that arose with the revolution in genetics, both as a general proposition, and with particular implications for genetic testing and the right to know or not to know the results of individual testing that may be of relevance to others. The 'hypothetical' format, where an expert panel was quizzed by a moderator, was first used when issues of consent and confidentiality in adolescent health were debated.

Professor Brown further developed the hypothetical format, including on one occasion using a hypothetical ethics committee to discuss issues of ownership of tissue, the ethics of embryonic stem cell research, and whether Australia needed a moratorium on this work. One seminar was devoted to the ethics of the interaction between medical practitioners, medical researchers and the pharmaceutical industry, with particular emphasis on the potential risks of 'conflict of interest' in research and medical practice. A further topic concerned research in cross-cultural settings at home and abroad, in particular the ownership of data and implications of outcomes for different cultures. The questions of 'designer babies', 'advanced care directives', and 'end of life' decisions were also raised again.

In the series now being convened by Professor Zajac, the ethics of organ transplantation and the ongoing issue of rationing of health care have been considered, particularly in the context of

the rights of citizens to equitable outcomes in health care.

Revisiting the topics covered in these ethics seminars is a reminder that the conflict between the rights of the individual and a utilitarian approach to the needs of society will always provide dilemmas for those in authority or those needing to make decisions to achieve the greater good.

Many themes are recurrent, but new issues will arise as medical science advances and community attitudes and expectations change, so the debates will go on. We should all pay tribute to Professors Ryan and Lovell for their foresight in establishing this landmark calendar event of the Dean's Lecture Series.

Richard Smallwood, AO, Professor of Medicine at the Austin and Repatriation Medical Centre (1990-99), convened the Dean's Lecture Series Ethics Seminars from 1993 to 1999 and was Chief Medical Officer for the Commonwealth of Australia (1999-2003). He is currently Professor Emeritus of Medicine at the University of Melbourne.

Graham Brown, James Stewart Professor of Medicine and Head of the Department of Medicine at Royal Melbourne and Western Hospitals (1999-2007), convened the Dean's Lecture Series Ethics Seminars from 2000 to 2006. He has been Foundation Director of the Nossal Institute for Global Health since its establishment in 2006.

DEVELOPMENTS IN GENETIC AND STEM CELL RESEARCH IN THE LAST 25 YEARS

LOANE SKENE

In 1984, the state of Victoria became the first jurisdiction in the world to legislate on IVF after a series of careful reports by the Waller Committee canvassing community opinion. Many were wary—even openly critical—of the new technology. Today, IVF is routine and thousands of babies have been born from IVF around the world.

There have been similar fears and ethical concerns about human stem cell research especially where stem cells are derived from human embryos. In 2002, federal legislation was enacted to permit donated human embryos to be used in research if people undergoing fertility treatment no longer needed them. Some states, like Victoria, allowed donated human embryos to be used in research much earlier. However, many people objected to embryo research, believing that human life starts at conception. Embryos that are not needed for fertility treatment, they say, should be allowed to 'succumb'—to die naturally.

Ethical objections to embryo research became more intense when scientists were able to create embryos by *somatic cell nuclear transfer* (SCNT, the 'Dolly technique'). Scientists removed the nucleus of a donated human egg, replaced it with the nucleus of a person's body cell (such as a skin cell) and stimulated it to

develop. The stem cells produced from that entity would be almost a perfect 'match' for the person whose body cell was used. The cells should not be rejected by the person's immune system if they were transplanted back to the person in treatment and the person could avoid a lifetime of the immunosuppressive drugs that are needed after transplants of cells derived from donated tissue. However, SCNT involves the deliberate creation of a human embryo in order to destroy it, which many people condemn even more than the use of donated embryos for research.

A later advance in stem cell research avoids the ethical issues of creating or using human embryos in research. In 2006, Professor Shinya Yamanaka of Kyoto University converted adult mouse cells into *induced pluripotent stem (IPS) cells* without creating an embryo and he and other scientists (including Australian scientists) have since derived human IPS cells from human skin cells for research. At present, embryonic stem cells are believed to have greater flexibility and potential than IPS cells but that could change as research progresses.

Over the last two years, pluripotent stem cells derived from embryos and from body cells have been *differentiated* into other types of cells that may be needed to

repair particular types of tissue, such as neural precursor cells, cardiomyocytes and haematopoietic (blood forming) precursor cells; and Professor Doug Melton from Harvard University reported last year that he had been able to 'short-circuit' the process of re-programming an adult cell into a differentiated cell of another kind in mice through a process he termed 'lineage reprogramming'.

In time, it is hoped that stem cell research will lead to treatments for a range of human conditions, such as spinal cord injury, heart disease, diabetes, vision disorders, Parkinson's and Alzheimer's diseases. Critics who question whether such treatments will come—or should be permitted—should remember that the concept of treating patients by transplanting healthy stem cells to stimulate the repair of diseased tissue has been established for more than 40 years in treatment for leukemia (stem cells from donated bone marrow).

Successful stem cell *treatments with a patient's own cells* are starting to be reported in people as well as in animals. In various trials, stem cells are being injected into patients' tissue after heart and other surgery to aid repair. Stem cells from a patient's eye were recently grown artificially and 'transplanted' on a contact lens to treat corneal disease in the other eye. In the United States, the first clinical trial of *embryonic* stem cell therapy planned by the pharmaceutical company Geron for acute spinal cord injury has been approved by the Food and Drug Administration and is due to start shortly, though it has been deferred for further safety studies in animals.

The realisation that the long-standing treatment for leukemia is a form of stem cell therapy, and the developments in these new stem cell therapies, is changing the discourse about stem cell research, even when the stem cells are derived from embryos (as in the proposed Geron trial). If safe and effective treatments are developed from this research, it will be hard to argue against the technology when so many people have serious conditions that might be treated with stem cells. In recent presentations, I have found less opposition to stem cell research than previously, despite canvassing not only the use of embryonic stem cells, but also the possibility that women might be paid

for donating their eggs for research; or that animal eggs might be used to gestate human material to derive human stem cells for research (both currently unlawful in Australia, but lawful in the US and the UK respectively). Next year, three years after the Lockhart Committee's recommendations were implemented in amendments to the federal legislation, the Australian legislation on human cloning and stem cell research will be

reviewed again by a federal committee (yet to be appointed). The law may then be further amended in the light of scientific developments and changing community attitudes.

Loane Skene LL.D (Melb), LL.M (Mon), Professor of Law, Melbourne Law School, and Adjunct Professor, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne, was Deputy Chair of the Lockhart Committee on Human Cloning and Embryo Research, 2005.

AUTONOMY AND CONSENT: THE PERENNIALS OF ETHICS

LYNN GILLAM

Medical ethics covers a great range of topics: from end-of-life decision-making to privacy for adolescents seeking contraception; from organ transplantation to respect for cultural difference; from resource allocation to human embryo research. But amongst this apparent diversity there are some relatively constant themes. One notable theme is informed consent and its underlying principle of respect for autonomy.

The idea of informed consent is a relatively new one in the history of medical ethics. It is certainly not an idea that Hippocrates would recognise as central to medical practice; indeed, he may well take exception to it in no uncertain terms! It is also a radical idea, especially when interpreted as an expression of the fundamental ethical value of personal autonomy. Autonomy says that people have a right to make their own choices about their own lives. This may sound perfectly reasonable and innocuous. In the health care setting, however, it can have far-reaching consequences. This is because the choices some patients make may be seen by health professionals as foolish, short-sighted, ill-considered, risky, and even dangerous. And yet, provided the patient has sufficient mental capacity and has been adequately informed, the principle of respect for autonomy protects all these choices. So patients' choices may put them at avoidable risk, cause them to recover more slowly, or less fully than they could have, experience unnecessary pain, suffering and disability—and even die, when this could have been prevented, at least in the short term.



Lynn Gillam, photo courtesy Educational Resource Centre, Royal Children's Hospital, Melbourne

It can be hard for health professionals when patients refuse treatment altogether, or opt for a sub-optimal alternative: if they are to respect autonomy, they must stand back and refrain from interfering, once they are sure the patient is well-informed and has made a free choice. Perhaps even harder, though, are situations where patients want doctors to provide them with treatment which doctors consider would at best be futile, and at worst do more harm than good.

The on-going debate over end-of-life decision-making shows these sorts of considerations playing out in an arena where the stakes are of the highest possible magnitude. In the 1970s and 80s, the focus was on the right of competent patients to refuse medical treatment, even when death would be the outcome. In Victoria, the issues were very publicly aired in relation to John McEwen, a young man rendered quadriplegic in a water-skiing accident. John McEwen did not

want to continue with the mechanical ventilation that was keeping him alive, because he found life as a quadriplegic distressing and meaningless. The reaction from his doctors was first to treat him for depression, and when he didn't change his mind, then simply to say that ventilation could not be stopped, despite his wishes. John McEwen's situation was the catalyst for a parliamentary inquiry, which resulted in a law called the *Medical Treatment Act*, which affirmed the right of competent adults to refuse medical treatment even when death would be the outcome, and gave clear legal protection to doctors who respected these wishes.

Since that time, the idea that continued medical treatment for people with terminal or incurable conditions might not always be the best thing, has become quite widespread in the community and the health professions. Indeed, the debate has changed significantly to now focus on patients who do want continued active treatment, when doctors think it will do no good, and only extend suffering. Patients may want more chemotherapy, or ventilation, or CPR, when doctors believe this would not be in their best interests. So the ethical question is whether doctors have an obligation to respect the patient's autonomy by doing what the patient has chosen, even though they believe it will do no good, or indeed will cause harm. In some of these situations, the issue of scarce resources also comes into play—intensive care beds are limited, and some argue they should not be allocated to patients who are expected to die soon anyway.

Consent and autonomy are also central issues in the medical care of children, but in an even more complicated way. Parents are recognised by our community and its laws as decision-makers for their children in all aspects of their lives, including health care. In health ethics, we therefore sometimes speak of respect for parental autonomy, and focus on making sure that parents are given information about their child's condition and get a say in decisions about what is done to their child. However, this concept of parental autonomy is a dangerous one, as it suggests that parents can make whatever decision they want about their child's health care, just as an adult can make any decision she wants about her own health care. But this is not so—neither in ethics nor law.

Parents have an obligation to protect and promote their child's interests. If they make decisions about medical treatment that fail to do this, and expose their child to harm or loss of opportunity to regain health, then that decision can, and arguably should, be overridden. So in paediatrics, the central ethical question often relates to whether parents' wishes would cause enough harm or detriment to the child, to require efforts to change the parents' mind, or circumvent them altogether (a legal process which is distressing to all parties involved). Things get even more complicated when children reach adolescence, and begin to develop significant capacity to understand their situation and make decisions for themselves. It can happen that young people have views about their medical treatment that are quite contrary to those

of their parents, and their treating doctors. The question of whether the wishes of the young person should be respected is often very vexed, especially where the young person is refusing treatment which may prolong or save their life.

Recognition of the ethical principle of respect for autonomy has in many ways made medical practice much more difficult, but has also, arguably, made it more humane.

Lynn Gillam is Academic Director and Clinical Ethicist at the Children's Bioethics Centre, Royal Children's Hospital and Murdoch Children's Research Institute and Associate Professor in Health Ethics in the School of Population Health's Centre for Health and Society.

For more information about the Children's Bioethics Centre see: <http://www.rch.org.au/bioethics/index.cfm>

THE ETHICS OF RATIONING MEDICAL CARE

JEFFREY D ZAJAC

Implantable cardiac defibrillators can save lives. In patients with cardiac arrhythmias, common in ageing hearts, the onset of ventricular fibrillation is almost inevitably fatal. When treated in hospital with electrical defibrillation, survival rates are significant and patients can go on to live long healthy lives. When ventricular fibrillation occurs outside a hospital setting, it is sometimes preceded by serious but non-fatal arrhythmias. Implantable cardiac defibrillators can revert potentially fatal arrhythmias to normal—a relatively

straightforward process, which is life-saving if the arrhythmia is ventricular fibrillation. Access to these devices through the public hospital system is limited because of their expense. Thus, there are people who would benefit from such devices but in whom they are not implanted and it is likely some of them will die.

Rationing of healthcare resources is occasionally obvious and transparent as in the example above: more frequently it is subtle or hidden. New pharmaceutical



Jeffrey Zajac (centre) with students at the Austin Hospital

agents, almost inevitably more expensive than older drugs, offer improvements in therapy for cancer, neurological disease and diabetes. Subsidised access, however, is controlled (rationed?) by the Pharmaceutical Benefits Scheme (PBS). In most cases when these drugs are introduced to the market they are licensed for use but not subsidised by the PBS. Issues of cost and benefit are assessed during the decisions to list these drugs for general use for those who cannot afford to pay the unsubsidised prices. Such limitation of access always generates media controversy. Similarly, admission to hospital for elective surgery is heavily regulated (rationed?) by waiting times and access to outpatients.

What ethical basis should be used for rationing healthcare? On the one hand, it seems relatively straightforward at first. There is limited amount of money available for healthcare and thus there must be restrictions on what can be provided. On the other hand, for a doctor treating a patient, or a relative of a patient seeking medical therapy, the expense of a particular procedure seems the least important consideration and is frequently not a consideration at all. Our society has been particularly poor at reconciling these two viewpoints.

Politicians, and those charged with running healthcare within the Commonwealth and State Governments rarely admit that healthcare rationing occurs. There is little community discussion of how choices are made and who makes them. Rationing can be financial (those unable to pay for expensive new therapy are more likely to be affected than the wealthy) or involve other considerations such as the availability of organs for transplant. In Australia, one would hope the financial status of the transplant patient would not be an issue.

It is clear that rationing needs to occur. For example, new drugs are regularly developed for treating diabetes. Each offers some incremental advantage and is usually added to pre-existing medication. Many cost between \$100 to \$200 a month and two or three or more of these agents, if unsubsidised by the PBS, can result in considerable expense to the patient. Cancer drugs are even more expensive and the issue even more controversial. New agents with small effects on tumour

size, resulting in very slight increases in average survival, can cost \$50,000 to \$100,000 for a course. Who decides when they should be used?

These decisions are often focused on the elderly. How are judgements made? Would the same decision be made for an elderly person as for a child or teenager? Should we be spending more to treat younger people? Should the person's contribution to society be taken into account? If this were the case, decisions would favour older individuals with a history of community service. Most medical expenditure is spent in the last six to twelve months of a person's life and, while not futile, the benefits of many therapies when measured against the cost can be limited. Examples include dialysis in ageing patients; the use of intensive care units for people in the terminal stages of disease; and major surgery for advanced tumours.

Considered apart from individual patients, it seems clear: this is not the best way to spend money for health care. However, when the focus shifts to the individual—yourself, your spouse, your child or your parent—the approach is almost inevitably reversed. Most of us want the best available healthcare for our friends, relatives and ourselves: any benefit, however slight, is considered worthwhile. The response when a physician suggests a particular life-saving therapy is too expensive and should therefore not be used is likely to be anger. The media is particularly good at forcing new therapies onto the market and when individual instances are highlighted by the media, therapy almost always results. This is especially true in younger patients.

As with many ethical quandaries there is no easy solution. It is clear that medicine is becoming more expensive and that there is an increase in care towards the end of life. Rationing is inevitable and yet acknowledgement, admission and discussion about it remain, in most cases, non-existent. No doubt we will continue to address this among many other perennial issues in the Dean's Lecture Series Ethics Seminars.

Jeffery Zajac is Professor in the University Department of Medicine at Austin Health/ Northern Health and currently convenes the Dean's Lecture Series Ethics Seminars.

THE HISTORICAL DEVELOPMENTS IN ABORIGINAL & TORRES STRAIT ISLANDER HEALTH RESEARCH ETHICS

PAUL STEWART

[For researchers to] engage with this history, they may begin to overcome Indigenous distrust by demonstrating that they have learned not to repeat the more oppressive practices of the past. *Thomas 2004*

To understand the 'wrong doings' as well as the 'right doings' in Aboriginal and Torres Strait Islander health research it is important to acknowledge the history and role of research ethics. By engaging and consulting with Communities from the outset, researchers can dilute some of the discouraging phrases associated with Aboriginal and Torres Strait Islander research.

The easiest way to understand the developments in Aboriginal and Torres Strait Islander health ethics is through a timeline that outlines the key developments that have taken place on a national level. Much of this work has been done by Onemda VicHealth Koori Health Unit, which has had a significant role to play in bringing researchers and communities together.

Copies of Onemda publications about conducting research with Aboriginal Communities, some of which are pictured here, can be downloaded from the Onemda website.

Paul Stewart, a Taungurong man from Central Victoria has been Research & Community Development Officer with Onemda since 2002. Paul's research focuses on health research methodologies and ethics in Aboriginal Communities. He has been a principal investigator on the following projects: 'Victorian Aboriginal Health Ethics Project', 'Promoting Ethical Research with Indigenous Communities', and 'We can like research ... in Koori hands'.

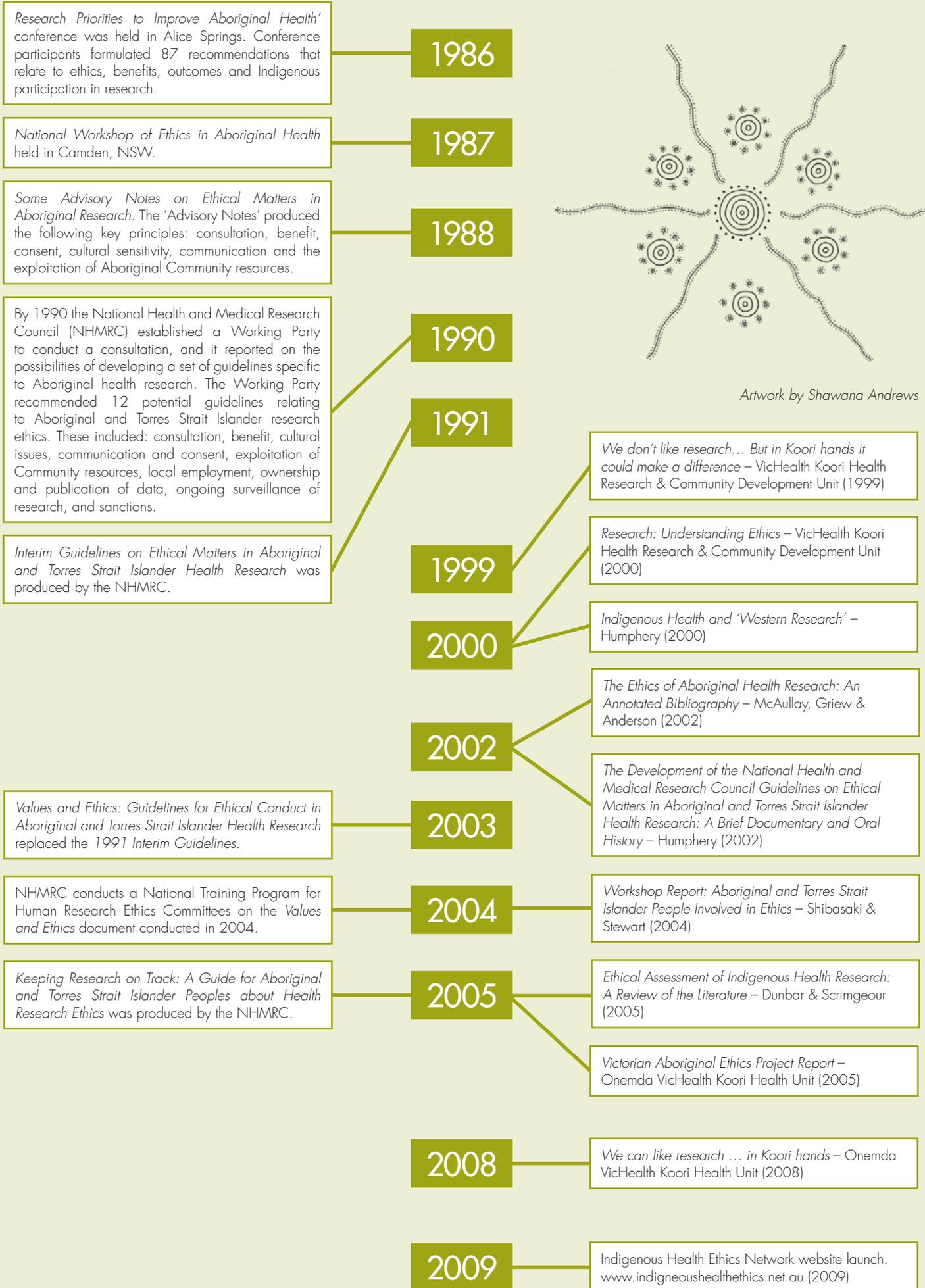
Useful websites:

www.onemda.unimelb.edu.au

www.indigenoushealthethics.net.au

NATIONAL DEVELOPMENTS

ONEMDA VICHEALTH KOORI HEALTH UNIT



QUESTIONS OF ETHICS IN GLOBAL HEALTH

GRAHAM BROWN AND JIM BLACK



Graham Brown (centre) with staff of the Nossal Institute for Global Health

Global Health is a relatively new discipline that now appears in the curricula of many medical schools, subject lists, and publications of politicians and aid agencies. Whereas international health refers to implications for health between nations, and tropical medicine focuses on biomedical aspects of disease, global health is generally concerned with multiple issues in many countries, particularly the poorest countries of the world. A recent definition suggests that global health is:

an area for study, research and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasizes transnational health issues, determinants and solutions; involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration; and is a synthesis of population-based prevention with individual-level clinical care. (Koplan et al 2009).

The working definition described above is a useful way of differentiating global health from other disciplines, and immediately highlights equity and inclusive multi-disciplinary approaches that need to be considered in relation to the ethics of global health.

Although ethics principles formally adopted by many countries are likely to be the same, based on landmark documents such as the 1964 Declaration of Helsinki and the United Nations Universal

Declaration of Human Rights 1948, their interpretation for an individual or for a community may be different in different circumstances. In particular, the focus of western societies on individual rights and patient autonomy may be inadequate to account for ethical responsibilities to contribute to well-being or capacity building in the communities in which these people live, and may be at odds with a society in which communal decision making is normal practice. Community input is important in determining whether particular clinical practices or clinical research should be undertaken, but it is hard for an outsider to decide whether community consent is in fact present, or whether vested interests of powerful personalities are being met, and whether individual consent is also being obtained.

Special questions arise when considering what research should be done in resource-poor settings, remembering that only ten per cent of the world's research resources are spent on health problems that account for 90 per cent of the global burden of disease. What should be the role of an Australian university dedicated to being a 'great public university' in such a global context? What should our research priorities be? How can we best tackle injustice? What are our local and international capacity-building roles? What knowledge do we exchange and with whom?

Is it ethical to perform studies if the major risks will be borne by people in developing countries but the major benefits will accrue to people in affluent societies? Can anyone really make an 'informed decision' to participate in the trial of a new drug if the trial is their only hope of getting treatment of any kind? When does appropriate compensation for participants become undue inducement to participate when communities are extremely poor or vulnerable in other ways? What do researchers owe to other community members who are equally in need of treatment but happen not to be enrolled in the study, such as family members or neighbours of HIV-positive participants in a study? How do you obtain informed consent in communities that have little or no concept of 'research' or 'consent'?

A good general principle for clinical research in developing countries is that there should be 'no research without service, and no service without research'. It is important to consider the benefits that may be gained by participating in research, to ensure that they are not inducements to participate, and that existing health services are strengthened to ensure adequate treatment and care for the community where research is being conducted. Debate continues as to whether subjects in trials should receive 'gold standard international treatment' that may not be present, or sustainable in the country, or whether individuals should receive the optimal standard of care outlined in national guidelines. If we insist on a high international standard we risk impeding valuable research that might benefit local people, but if we allow 'the best which would otherwise be available' we risk exploiting impoverished communities. It is important to consider the need for ongoing care at the conclusion of any research study, for example in treatment or vaccine trials. Lifelong access to the study drug should be made available if it is effective, even if the drug would not otherwise become easily available locally, and lifelong health care should be provided if subjects are injured through their participation in a trial.

There are many important ethical issues for students and staff who choose to work in developing countries where standards of medical care are inferior to

those we receive in Australia. An ethical dilemma is presented for the clinician with access to personal therapy, for example if an injury is sustained with a needle contaminated with HIV infected blood, whereas such intervention is not available for fellow colleagues or students. The personal dilemmas in such encounters are set against a background of working in extremely poor environments, with under-resourced healthcare systems where students can gain an understanding of their responsibility to use the lessons to make a difference in reducing health inequities through good care, and through carefully scrutinised ethical medical research for the benefit of those in need.

Global health also highlights the inequity of medical services, and the loss of workforce from developing countries to well-endowed countries, popularly referred to as the 'brain drain'. Richer countries preparing workforce plans should bear in mind their ethical obligations to ensure that their plans do not exacerbate the situation in countries where the need for a trained medical workforce is far greater, and the numbers of trained workers are already relatively insufficient to meet local needs.

There are various ways of doing our best to attempt to avoid unethical behaviour and colonial approaches to working in poor countries. When reflecting on a given health-related decision from an ethical perspective, we need to understand the advantages and limitations of, on the one hand, utilitarianism (manifesting as 'the greatest good for the greatest number' or via health economics as 'getting the most value for money' even if that means some people miss out on basic services) and, on the other hand, deontology (most often seen as 'doing what is right'). Working with partners, ensuring community participation in research and practice, putting the centre of gravity of activities in the developing countries, and adhering to national guidelines and ethical review at home and abroad should assist in achieving ethical standards that stand the test of time for all involved.

Graham V Brown and Jim F Black, Nossal Institute for Global Health

Reference

Koplan JP et al (2009). Towards a common definition of global health. *Lancet* 373: 1993-1995

PHARMA PHACTS

DAVE CARMODY AND AARON WAGEN

The 'modern' medical curriculum endeavours to produce ethical graduates almost as much as it does knowledgeable and capable ones. Medical courses therefore broach topics such as confidentiality, patient autonomy, and life and death directly. Pharma Phacts is a student initiative established to fill a perceived hole in medical education, and to varying extent, in the medical profession as a whole.

Medications have been effective in decreasing morbidity and mortality for millions of people and, despite the push to preventive medicine and lifestyle interventions, are still the staple of much medical practice. Unfortunately, pharmaceuticals today are often mistakenly equated with a mere supply of pens, pads, and other clinical tools. Medical students of today are entering a largely ambivalent professional landscape with regards to pharmaceutical sponsorship, with the very real danger that the next generation of doctors will be ill-equipped to interact positively with pharmaceutical companies and make objective prescribing choices.

In an attempt to raise awareness about the issue of pharmaceutical advertising and its potential effects on students, a group of medical students from each of the 19 Australian medical schools have formed a group called Pharma Phacts. Inspired by the efforts of similar student run organisations overseas and by the work of groups of doctors such as Healthy Skepticism here in Australia, Pharma Phacts campaigns to encourage students to consider the effects that advertising can have on them and what they can do to remain as objective as possible.

One way Pharma Phacts does this is to encourage students to recognise that it is normal to be affected by advertising, as students often see this suggestion as an affront to their intelligence or professionalism. In addition, Pharma Phacts tries to educate students about the evidence which suggests that even seemingly innocuous items such as the ubiquitous drug pen do have an effect on attitudes to certain medications or products and can therefore affect clinical judgment. Pharma Phacts also campaigns for universities to include this issue in medical courses to better prepare students for interactions with the industry. On the Pharma Phacts website, students can also elect to sign a pledge to avoid accepting gifts from pharma companies and to always seek out unbiased sources of prescribing information.

With over 600 members so far on the social networking site Facebook, Pharma Phacts seems to have struck a chord with many medical students across Australia. This is extremely positive, and shows that there certainly is a movement amongst medical students to challenge some of the accepted practices in the medical community and make the appropriate steps to take their ethical practice of medicine into their own hands.

If you are interested in Pharma Phacts or would like to join the group, please visit our website or simply search 'Pharma Phacts' on Facebook. The website features information about the group, details of the evidence on the issue of pharmaceutical advertising and discussion boards, where visitors are encouraged to voice their own opinions on this important issue.

Dave Carmody and Aaron Wagen are entering their final year of Medicine/Arts at Melbourne.

The Pharma Phacts website can be found at: www.healthyskepticism.org/pharmaphacts/



Medical students and Pharma Phacts members Aaron Wagen, Dave Carmody and Elise Williams. Photo Jason South, The Age.

MELBOURNE MEDICAL SCHOOL

APPOINTMENTS AND DEPARTURES

Professor Ian Overall recently took up his new appointment as Cato Chair of Psychiatry, based at Melbourne Health.

After medical training at Leicester University School of Medicine, Ian trained in psychiatry at the Bethlem Royal and Maudsley hospitals in South London. The focus of much of his research has been investigating the cellular and molecular neuropathology of disorders relevant to psychiatry. He has investigated the neuropathological changes associated with schizophrenia, major depression and bipolar disorder and identified that HIV infection of the brain resulted in neuronal death.

Recent appointments include running an HIV liaison psychiatry service at the Maudsley Hospital and a position as Professor of Experimental Neuropathology and Psychiatry at King's College, London. Ian now comes to us from the University of California, San Diego (UCSD) where he has been Professor of Psychiatry since 2004. In work with colleagues at the HIV Neurobehavioural Research Centre, UCSD, Ian correlated the pathological changes with neurocognitive impairment. More recent work has seen him investigating avenues for neuroprotection and assessing how well various antiretroviral agents suppress viral replication in the human brain.

Ian's clinical focus is in liaison psychiatry for individuals with ongoing medical disorders, including HIV, and the assessment and treatment of affective disorders.

In 2006, Professor Jonathan Crowston was appointed to the only specialty glaucoma chair in Australia when he became Professor of Glaucoma in our Department of Ophthalmology. Jonathan has now taken up appointments as the Ringland Anderson Chair of Ophthalmology and Managing Director of the Centre for Eye Research Australia (CERA).

With science (immunology) and medical degrees from the Royal Free Hospital Medical School in London, Jonathan also undertook his specialist training in

ophthalmology (Moorfields Eye Hospital) and a PhD (University College) in London.

Two Glaucoma Fellowships took him, firstly, to Westmead Hospital, Sydney, then to the University of California, San Diego. His 2003 Pfizer Award for Excellence in Glaucoma Research was ranked first in the USA for this award.

Tackling glaucoma, the leading cause of irreversible blindness world-wide, is a pressing cause. In ageing populations like Australia, the incidence of glaucoma is set to double in the next 20 years costing billions in health services, support payments and lost productivity, to say nothing of the human cost to patients and their families.

In response to this urgent need for more research, Jonathan assembled an outstanding team in the newly-established basic science glaucoma laboratory in the Department of Ophthalmology and at CERA. The department and centre jointly employ some 100 researchers and are considered the leading ophthalmology research group in Australia today. Jonathan continues to teach and was recognised with the Excellence in Teaching award from the RANZCO last year.



Jonathan Crowston

Professor Wayne Morrison, AO stepped down this year from the Hugh Devine Chair of Surgery at St Vincent's Hospital.

Wayne's pioneering work in reconstructive microsurgery and prodigious record of publications in the fields of plastic surgery, microsurgery, the ischaemia-reperfusion phenomenon, angiogenesis and tissue engineering have been very important for the department, as has his record of continuous NHMRC funding for his

research. The first specialist surgeon to be appointed to a chair of surgery at this university, many of Wayne's 17 years as chair of the department corresponded with his directorship of the Bernard O'Brien Institute of Microsurgery.

Succeeding Wayne Morrison to the Hugh Devine Chair of Surgery is Melbourne medical graduate (1984), Professor Peter Choon who is internationally recognised for his expertise and research in surgical oncology, in particular bone and soft tissue cancer.

While undertaking his advanced surgical training, some years ago, at St Vincent's Hospital, Peter also began a three-year basic science MD under the supervision of Professor TJ (Jack) Martin. A succession of international fellowships, focusing on musculoskeletal oncology, followed, including appointments at the University Hospital in Lund, Sweden and at Mayo Clinic, Rochester, USA.

Since Peter's return to Melbourne and St Vincent's in 1996, he has held a number of key clinical leadership roles in addition to his role as Professor/Director of Orthopaedics and as chair of the RACS board of orthopaedic surgery.

The Hugh Devine Chair of Surgery is named for Sir Hugh Berchmans Devine (1878-1959), in recognition of important contributions he made to the University, St Vincent's Hospital and the discipline of surgery. These included a period as dean of the clinical school and founding roles in the development of the Royal Australasian College of Surgeons (RACS), St Vincent's Institute of Medical Research and the Anti-Cancer Council of Victoria.

Coming from a position as Professor of Gynaecology at the University of Western Australia, Martha Hickey has been appointed to a new chair of gynaecology based at the Royal Women's Hospital.

Martha entered the study of medicine from psychology, training in the United Kingdom and in Australia. With a Doctor of Medicine from Bristol University, she was awarded the RCOG/RANZCOG Young Investigator of the Year Award in 2002.

During 2006-7, Martha was Visiting Professor ObGyn at Yale University. Her interest in the endometrium and uterine bleeding problems has led to several research grants in this area in addition to research on young women and breast cancer.

Honorary professorial associate at the Department of Medicine, Austin and Northern Health since 2007, Geoffrey Donnan commenced as Director of the Florey Neurosciences Institutes at the beginning of this year.

Geoffrey's major interests in neuroimaging and clinical trials have involved him in founding roles with the National Stroke Research Institute, the Australian Stroke Trials Network and Neurosciences Trials Australia and leadership roles with the Stroke Society of Australasia, the Australian Association of Neurologists and the World Stroke Organization. He is author of over 400 papers in peer reviewed journals, over 60 book chapters, and has edited four books.

International acknowledgement of Geoffrey's leadership in the field of neurology has led to numerous visiting lecturer and professorial appointments across the world and the bestowal of important awards such as: the American Stroke Association William Feinberg award for excellence in clinical stroke research; the MJ Eadie Award for Career Achievement in Neuroscience Research at the Australian and New Zealand Association of Neurologists; and the Bethlehem Griffiths Research Foundation medal for outstanding contribution to international stroke research. In 2007 he delivered the Priscilla Kincaid Smith Oration for the Royal Australasian College of Physicians.



Geoffrey Donnan

At the end of June this year, Professor George Jerums stepped down from his position as Director of Endocrinology at Austin Health although he continues in his clinical and academic roles. Two of his seven current graduate students highlight his achievements and celebrate his remarkable career as follows:

George Jerums and his family arrived in Australia from Latvia in 1944. In 1962 George completed his medical training at the University of Melbourne, and he was awarded an MD in 1970 for investigating mechanisms of hypertension under the supervision of Professor Austin Doyle. After post-graduate work in Cleveland, Ohio and Hammersmith and St Bartholomew's Hospital in London, George returned to the Austin Hospital in 1976 as senior endocrinologist.

His inaugural directorship of endocrinology at Austin Health in 1991 has seen the department flourish to become one of the largest in Australia. Every week, approximately 350 patients attend the Endocrine Centre and over 30 medical staff, from professors and specialist consultants to endocrine trainees, work in the department. In addition, George has assembled a dedicated team of research nurses, specialist diabetes nurse educators and dietitians.

He has also played a significant role in the development of research in diabetes in Australia. George's rigorously conducted research in the field of diabetes complications, in particular diabetic nephropathy, is reflected in his over 260 papers published in leading endocrinology and diabetes journals and in competitive funding received during his 47-year career. The Australian Diabetes Society 2002 Kellion Award went to George for his achievements in teaching, scientific and clinical research in the field of diabetes and diabetes-related kidney disease.

George's skills as a clinician exceed even his administrative and academic prowess. He ensures that every effort is made to provide the best clinical care for each patient, bringing care and compassion to each consultation. In particular, he really strives to understand his patients and respects their choices. His clinical acumen is excellent and there have been many instances when he has made the correct diagnosis in difficult clinical settings.

To this day, many clinicians ask for George's opinion on their challenging patients.

Finally, George is an outstanding teacher. He has always kept to the 'open door policy', literally keeping his door open at all times, being available to answer questions. Over the years he has taught many medical students, residents, registrars, colleagues, nursing staff and the public. His energy and enthusiasm are contagious and he inspires the passion for learning and striving for excellences, this being reflected in the success of his former students. Many of his former students now head their own research groups and have leading roles in medicine. Some of his previous mentees include Mark Cooper and Terri Allen (Baker IDI), Leon Bach (Monash University), Richard Gilbert (University of Toronto), Ashim Sinha (James Cook University), and Albert Frauman, Richard MacIsaac and Richard O'Brien (University of Melbourne).

Importantly, George has also created a friendly, productive working environment for all his staff and students, showing the importance of mutual respect to work together despite differences. There is a sense of integrity and honour working alongside Professor George Jerums and we are very fortunate to have the opportunity to work with him.

Elif Ekinci (MBBS, FRACP) & Scott Baker (MBBS, BMed Sci, FRACP)



George Jerums



MEDICAL TEACHING AND LEARNING IN THE 21ST CENTURY

ANATOMY CLASSES – PAINTING AND LAYERING

JENNY HAYES

Anatomy students Zhi Liang Tan & Friih Footit explore the difference between dermatomes and cutaneous peripheral nerve distribution by painting on Erika Tomlinson's arms.

Was I participating in the halcyon days of anatomy when I took my seat in the Sunderland Lecture theatre for an anatomy lecture in the late 1970s? A total of 600 contact hours with single topic lectures, small group tutorials in the Padua rooms on level five and weekly dissection with six students per cadaver seems an embarrassment of riches compared with today's total of 124 contact hours. Yet my cohort also raised the ire of elder statesmen: 'Don't you know any anatomy?'

Anatomy in the current problem based learning (PBL) curriculum is taught via 58 lectures and 66 hours of practical classes delivered to a mixed cohort of undergraduates and graduates. In accordance with PBL philosophy the curriculum is 'hidden' but lectures and practical classes are closely aligned with the body system being studied and the weekly PBL tutorials.

By contrast the new generation MD will have a clearly defined anatomy curriculum and, although the contact hours will remain roughly the same, all students will already have studied anatomy to a pre-requisite level.

And so, how to 'dream large' with 124 contact hours?

I have planned an anatomy curriculum that will move through anatomical regions in a way that roughly aligns with the systems-based curriculum. The weekly lectures will each revise basic principles and basic regional anatomy but will mostly emphasise clinically important anatomy and clinical applications. Dedicated radiological anatomy lectures will be placed at the end of each study unit.

Some practical classes will be in the form of workshops with student groups rotating through osteology, radiology and wet-specimen stations guided by a worksheet that promotes individual study. Over the last two years I have piloted body painting to encourage the study of surface anatomy and this has proved hugely popular and successful. Any initial reluctance to participate on the students' part has been replaced by unabashed enthusiasm as they come to appreciate the advantage of a 'draw or be-drawn-on' philosophy! So body painting will continue as an interactive station in practical classes.

We are privileged at Melbourne University to have the only body donor program in Victoria. The willed bodies are nearly always co-morbid in several

systems and we have a policy to procure any radiographs available. I want to use the wealth of learning opportunities that each cadaver has to offer. Over the last two years Duncan Macgregor (who sat in that same anatomy lecture theatre as I in the 70s) from the Pathology Department, has provided wonderful impromptu pathology tutorials during dissection as students uncover diseased tissue. It's a fabulous lesson for the students to approach dissection as a mini post-mortem examination and compare their findings with those listed on the de-identified death certificates available to them. The arrival of scales in the dissection room has allowed better appreciation of normal variation as individual viscera are weighed and the results tabulated. If, in the future, we have the radiographs available for similar impromptu radiology tutorials as the imaged tissue is uncovered, we will take the educational experience to another level again.

As students of the current program have progressed through the clinical years and graduated, it is rewarding to be contacted by a number who want to return and teach in the program. Instead of only the traditional surgical trainees, I currently

have a flexible list of demonstrators drawn from final year medical students, interns and surgical trainees and am happy to cater for irregular availability in return for the wonderful collegial atmosphere generated in the practical classes.

Peer teaching or co-operative learning has been used in classrooms for many centuries and my experience is very much that those who teach learn, and that the more layers available in the expertise, the more energy and enthusiasm in the teaching and learning process. In the new MD we will have a mix of anatomical experience in the student cohort as well, as some will have just the basic pre-requisite knowledge whilst others with an anatomy major will be able to assume informal responsibility for teaching their less experienced peers around the cadaver.

My dream is an even greater sharing of expertise in the dissection sessions. We all share the provenance of the medical anatomy program. It is a wonderful opportunity to create a vibrant interface between consultants, trainees and students in the fields of surgery, radiology and pathology (and beyond?) I look forward to hearing from anyone who shares an interest and enthusiasm for the process.

Jenny Hayes graduated MBBS from Melbourne in 1982 and is now a senior lecturer in the Department of Anatomy. Alumni interested in participating in Jenny's anatomy classes please contact her on: j.hayes@unimelb.edu.au



Drawing on the abdominal viscera has really helped the current cohort understand what they are palpating for in clinical examination of the abdomen. Pictured around Anton Musiienko are (L-R) Zhi Liang Tan, Sarah Grigg, Haylee Walsh, Jenny Hayes and Heath Tibballs



Haylee Walsh paints the nerves and vessels of the head and neck on fellow student Baotuti Sebolao.



Pictured around Anton Musiienko are (L-R): Zhi Liang Tan, Sarah Grigg, Baotuti Sebolao, Jenny Hayes, Haylee Walsh and Venkataganesen Ponnalagu

GRADUATE ATTRIBUTES FOR OUR NEW COURSE

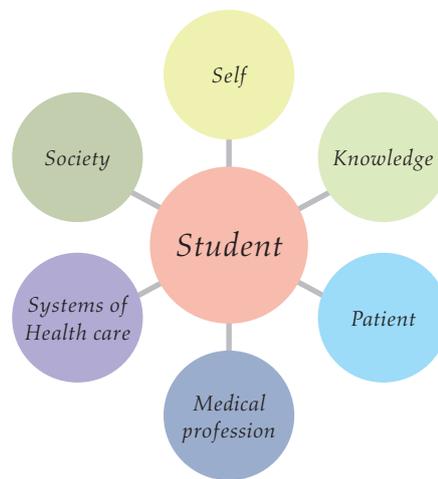
GEOFF MCCOLL

In February 2011 a group of 330 students will begin the new MD program at the University of Melbourne. They will be in the vanguard of a new medical program developed from the ground up to meet the needs of the students and their future roles in the health care environment. At the very centre of this program will be 67 graduate attributes which define the characteristics of those who will graduate from this new course.

The Melbourne MD graduate attributes are the result of a rigorous process of development, alignment and refinement. We began with the premise that desirable attributes for graduates of our new program would depend on the perspective of the individuals viewing those attributes. In other words, what a student or patient or doctor or community member might think about the ideal characteristics of a doctor may well be different (although they may overlap). To account for this notion of perspective we chose to employ a technique called concept-mapping to develop our graduate attributes. In this process seven small groups (8-10 people) were asked to define the ideal characteristics of a medical graduate from our University in 2025. The groups included current medical students, patients, bio-scientists, doctors, allied health professionals, public health professionals/health administrators and faculty members.

Concept mapping is a technique that allows a group to collate and map their responses to a particular question. At the end of the sessions over 400 statements were assigned to concept maps. These were then examined by a reference group which found considerable overlap between the maps and some differences, related mainly to emphasis. The reference group found that the majority of statements could be placed into six domains—self, knowledge, the patient, the medical profession, society and systems of health care.

The six domain map and its graduate attributes were then benchmarked against key local and international graduate attribute frameworks including those from the Australian Medical Council, General Medical Council (UK), Tuning



project (European Union), Association of American Medical Colleges (USA), CanMEDS (Canada), Cambridge University, University of Sydney and Stanford University. We ended up with 67 statements mapped into the six domains. This aligned map was then taken to a faculty workshop for further refinement. The final product is a 'living document' which will continue to be reviewed and refined during the development and implementation of the Melbourne MD.

So why are the Melbourne MD graduate attributes different to those of other medical schools? First, they were derived using a broad group of informants and applying a rigorous methodology. Second, as a result of the breadth of the informants, the graduate attribute statements set a new educational agenda for our medical school. Traditional graduate attribute statements for medical programs focus on knowledge and the patient. The Melbourne MD graduate attributes will bring the educational program to focus on additional areas including self, the medical profession, systems of health care and society. Third, the graduate attributes will be used to scaffold the curriculum, so students will be aware of building their knowledge, skills and attitudes in all six domains over the course. Finally, the Melbourne MD graduate attributes will be used to develop evaluation tools to test that we have achieved our aims. This will include matching assessment to the attributes but also looking at the performance of our graduates in the longer term in a proposed longitudinal study.

To emphasise the importance of this framework of attributes the Melbourne MD will begin with a week in which the educational goals of the program will be laid out in the context of the six domains.

It is intended that on each day of the first week of the course the students will examine their learning goals in the context of self, knowledge, the patient and systems of health care, the medical profession and society. This will set the agenda for their learning which will be reinforced in each phase of the course. By the end of the course the successful achievement of the graduate attributes will be ensured in each student through a combination of assessment and self reflection. In this way we believe that the graduates of the Melbourne MD will demonstrate a new benchmark in medical education.

Geoff McColl is Director of the Medical Education Unit and Professor of Medical Education and Training.

MELBOURNE MD GRADUATE ATTRIBUTES

EXAMPLES

Self: an understanding of the principles of reflective practice, the ability to apply them, and recognition of their importance in health care.

Knowledge: an understanding of the aetiology, pathology, symptoms and signs, natural history and prognosis of important physical and mental illnesses in all stages of life.

Patients: the ability to communicate with patients from diverse backgrounds including the ability to listen to, respond to, inform and understand the patient's perspective.

Medical Profession: an understanding of organisational governance, the ability to be an active participant in professional organisations, and an appreciation of the benefits of this participation.

Systems of Healthcare: an understanding of the roles, responsibilities and expertise of all health professionals, and how they work in teams to deliver health care.

Society: an understanding of the health of Indigenous Australians including their history, cultural development and the impact of colonisation and the ongoing health disparities of indigenous peoples in this country and globally.

More on the Web: www.meu.medicine.unimelb.edu.au/md/

ON THE BORDER OF TWO WORLDS

SARAH WONGSEELASHOTE

Dr Cynthia Maung, a Karen refugee, fled across the Burmese/Thai border in 1989 after the military had seized power in her homeland the previous year. In the border town of Mae Sot she established the Mae Tao Clinic to help treat the thousands of ethnic Burmese fleeing into Thailand. Many were students being persecuted for their involvement in pro-democracy activities. Dr Cynthia believed the situation would soon resolve and that they would be able to return home but, sadly, the internal conflict continues. The Mae Tao Clinic comprises several small buildings and treats some 400 patients every day. Its team of medics are themselves refugees and receive training, food and shelter at the clinic.

There are no signs to mark the entrance. We are told to look for the blue telephone box and the blue gate. The Thai government tolerates the clinic but does not officially recognise it, as nearly all of the staff and the patients are considered illegal immigrants who would be deported immediately if the clinic was raided by Thai police. Some patients have travelled for days to reach it, often by foot through jungles strewn with landmines. In the adult inpatient department a 22-year-old trainee medic, Kyawni-Soe, takes me on ward rounds each morning. The ward is crowded with rows of wooden benches with no mattresses. We stop by

each patient and try to make a diagnosis or to work out the best treatment, in the absence of nearly all investigations besides urine dipstick and blood films for malaria. Even the need for a plain chest x-ray must be rigorously discussed and agreed to by the senior medic, as sending the patient to Mae Sot hospital consumes precious funds needed for medications and food for the other patients. It is clear that no test should be ordered which will not affect the patient's management. Very often, the reason that the test will not affect the patient's management is not because the patient's condition is untreatable, but because neither the patient nor the clinic would have enough money to pay for the treatment.

In the children's inpatient department I work with another trainee medic, Aung Myint Pin (or Ha-Aung) who is 24. The ward round is done kneeling down on the floor beside the children, where they lie on rugs or blankets. Those along the window side have malnutrition. The two in the far corner writhe constantly, eyes shut, brains damaged from tuberculous meningitis. Ha-Aung is gentle and softly-spoken. He helps me to examine the children and adjusts their treatment. He came to the clinic when he was 21. I ask him if he will stay here much longer. He says, if democracy comes to Burma, he would like to go home and see his family. If it doesn't, maybe in a year's time he will enter a refugee camp to wait, for an indeterminate period of time, to be resettled in a third country. Suddenly a child in the corner starts seizing. Ha-Aung

quickly removes the child's clothing and cools him down with wet towels. Within minutes he has inserted a drip and has given him diazepam and IV artesunate as presumptive treatment for cerebral malaria. He reassures the child's mother and father in Karen.

I look on in awe of his swift thinking and skill. I imagine him waiting in the camp for a foreign nation to accept him and feel like crying. We are the same age, both medical students of sorts, but we live lives so vastly different that it is virtually impossible to comprehend. My time at the clinic showed me how difficult it is to practice medicine in a resource-poor environment. It made me realise that everything comes at a cost to somebody and, in practical terms, to think carefully about the patient's clinical picture before turning to investigations. It was also the most humbling experience I have ever had: to be around young people working with so much skill, dedication and courage, in the face of tremendous hardship. I learnt about the ways in which Burma's internal conflict has affected the health of her people, both directly and indirectly, through the abysmal poverty it has brought. It made me almost painfully aware of the plethora of opportunities I have and gave me a greater awareness of the people of this region, whose struggles are largely hidden from view.

Sarah Wongseelashote is a final year medical student. This is an edited version of her winning Peter G Jones Elective Essay. Other winning essays this year were by Alyson Kelly and Chance T Pistoll.



Kyawni-Soe (on left) and two friends. The boy in the corner has malaria for the twelfth time, due to having to sleep in the jungle each time soldiers come to ransack his village.

AN INFLEXIBLE MIND

CHANCE T PISTOLL

'Medicine is nothing if not multi-tudinous... defined in the broadest sense, as organized health practices and decisive therapeutic choices...it is fundamentally human in experience amid the vast diversity of cultural worlds.' – Arthur Kleinman, Medical Anthropologist

Sometimes you set out on a project with such determination you forget to look sideways. I had always been interested in public health and when time came for the medical elective, Cuba, I thought, would be the obvious choice. I dreamed about academic discussions regarding healthcare delivery in a socialist and financially embattled context. I devoured Cuba's history and envisaged drawing together macro-level models into a discrete review of public health theory. I was determined. The people I met in Cuba challenged my perseverance: they taught me to look sideways, and when I did, I began to see another variable at work in the Cuban health system, one I did not come across in my reading.

THE SETTING

*Hospital Pediátrico Centro La Habana
Stray dogs lazing in the long grass
The lingering smell of cigarette smoke
wafting from open doors
Pre-revolutionary blue paint flaking
from porous concrete walls*

Professor Ramon was director of the diarrhoeal ward and quite possibly the shortest fully grown man I had ever seen. He toiled tirelessly, lumbering around the ward directing interns, weighing newborns in archaic looking contraptions, and meticulously washing his hands at the solitary basin with the solitary bar of soap. His brow, contorted by a heavy burden, reflected the never ceasing demands of his patients. One day I watched him discharge a patient: he instructed the infant's young mother how to prepare oral rehydration formula and supplied her with a few packets of the stuff and a kitchen kettle. Then, before she left, he rose from his chair, turned and disappeared into the closet opposite his desk. Several rustling moments later, Dr Ramon emerged clutching an old bottle full of a viscous green concoction. As he poured it into



Peeling paint on Cuban buildings

a plastic bag, the mother recited her directions aloud:

'So, I should apply it two times.'

'Yes, that is correct' came the reply.

My mind roamed. What was this foreign substance the doctor had prescribed? Silently, I performed a review of the management of dehydration in infants. No green solution surfaced. Was this some groundbreaking treatment the Cubans had kept secret from the west? After the mother and baby left, Dr Ramon asked:

'Any questions?'

'Yes. What was the medicine in the bottle, Dr Ramon?'

He let out a hearty chuckle and turned to me.

'That medicine was paint! She is repainting her living room and can't afford to finish the job.'

'I had some left over from my house.' He continued casually.

At that moment, I became acutely aware of something. But, why this interaction affected me specifically, I cannot put into words.

I met a young patient during my time at the nephrology service. Carmelo, a 16-year-old boy had presented two weeks prior with fasciculations and headaches. After a battery of investigations, it was declared his kidneys had begun failing—the aetiology unknown. I remember observing the boy from the end of the bed. His muscular physique and preoccupation

with the television belied the severity of his illness. Carmelo was on the waiting list for a kidney transplant, citing 'irreversible end stage disease'. He lay in bed connected to a haemodialysis unit, the odd air bubble disrupting the constant flow of red. Sitting in the chair next to him was a young woman. She was slouched lazily, eating a canteen ham and cheese sandwich. I introduced myself to Carmelo and asked how he was doing.

'Fine' came the reply, without averting his gaze.

Turning my attention to the woman, 'You must be Carmelo's mother?'

An outburst of laughter:

'I'm the registrar! I'm on my lunch break! Carmelo's mother couldn't make it for dialysis today. We are hanging out.' The giggling continued. 'Is there anything you want to know about Carmelo?'

In my final week, Gabriela, a Cuban student, approached me to ask a favour. Her cousin had moved to Australia a few months ago, and had developed an illness prior to leaving. He spontaneously married an Australian tourist and had to depart the country quite suddenly, before the results of his investigations were available. Because neither the hospital nor his family could afford to contact him, Gabriela asked if I would carry the results of his investigations and a course of treatment to him in Australia. Her cousin would contact me in Melbourne after I had arrived. I thought this to be

a highly unorthodox request but after making enquiries with my indemnity organisation and customs I accepted her appeal and packed my bags for my return to Melbourne.

On a grey afternoon in late February, the doorbell rang. I answered and saw a young Cuban man.

'Hi' he said sheepishly, 'my name is Juan. My cousin is Gabriela, I think you met her in Cuba.'

As I handed him the letter and prescription, we began to talk. He told me how he left Cuba, about his new wife and life in Melbourne. He was enjoying the

West, although it was a whole new world for him. I broached the topic of his illness. He told me how he had been suffering for the last three months. He had not seen a doctor in Australia due to finances. After a lengthy discussion, he left with instructions on applying for Medicare, details of bulk billing, how emergency departments work and how to contact a general practitioner. I told him, if he ever needed anything he has my number. With that he walked away and I haven't heard from him since.

In Cuba, I anticipated learning about the politics and economics of healthcare

delivery. Instead I learned that a health system is more than just governmental decisions and the availability of resources. It is made up of individuals and the relationships they forge. In this sense Arthur Kleinman was right: there is something fundamentally human about the experience of medicine. Gabriela's trust has shown me this, and in a small way I feel I have become a part of the Cuban health system.

* All names have been changed.

Chance Pistoll is a final year medical student. This is an edited version of his winning Peter G Jones Elective Essay.

UNIVERSITY OF MELBOURNE MEDICAL STUDENTS SOCIETY: CONTRIBUTING NOW FOR OUR FUTURE MEMBERS

CHRISTINE MANDRAWA

You're clearly doing something right when students say: 'I wish I was doing the new medical course' ... and that's exactly what those students who have been involved in the MD curriculum development workshops are saying!

This is an exciting time for the University of Melbourne Medical Students' Society (UMMSS) and the Melbourne Medical School. With the incoming *Melbourne Model* currently being implemented and a revamp of many courses at the University of Melbourne, the medical course is also turning over a new leaf to become a masters level entry MD course.

To the advantage of our future students (and therefore future members of UMMSS), our student society has a unique and strong relationship with the medical school. As a result, we have been involved in curriculum development for the new course since its conception through a variety of forums, including the curriculum development workshops run by Geoff McColl.

As students, we have been looked upon to provide valuable feedback regarding the 'on-the-ground' experience of medical schooling, to give realistic views about how educational programs are received and suggest innovative ideas around how medical teaching could be better delivered. Our involvement has been well received and greatly valued.

UMMSS believes that the new medical course will incorporate current best evidence-based teaching practices, be intellectually stimulating and challenging and continue to produce the excellent, caring and competent doctors for which the Melbourne Medical School is renowned. The new medical course will not only be focused on teaching knowledge but also on equipping its graduates with skills in communication, research, professional and personal development and leadership.

Being heard by Faculty has meant that more students are willing to voice their opinions on the current course and new ideas for change. So, whilst not all interested students can be involved directly in forums such as the workshops, opinions and feedback are regularly procured through a pool of students within the UMMSS education subcommittee. Through this subcommittee, we are able to provide greater representation of the student cohort and stimulate greater interest in medical education. This subcommittee has been involved in providing feedback on the current course with selected student ideas lately implemented with the view to carrying these through into the new course.

Our members are also involved in pilot programs such as peer-to-peer teaching which encourages students to get involved in informal teaching of their peers. This is recognised as a positive step



Christine Mandrawa

by UMMSS, as we face an increasing number of medical student enrolments in Victoria and therefore an increasing need for clinical teachers.

The student contribution to the development of the new course has ensured student advocacy needs are met from the very beginning. UMMSS would like to thank the Melbourne Medical School and the Medical Education Unit for the opportunity to be involved in the course development process during this exciting time. We look forward to continuing to work together to make the new Melbourne graduate MD course an outstanding medical degree.

Christine Mandrawa is 2009 President of the UMMSS



ALUMNI STORIES

Nick and Hannah at the Apam Hospital in rural Ghana. This photo was taken by Nick's father, John Mason, when he visited them in Ghana during their time there.

OUR YEAR IN GHANA

NICK AND HANNAH MASON

From October 2008 to August 2009 we worked as medical officers in rural Ghana. Apam Hospital is a district hospital in a town of 20,000 serving a population of about 200,000. It has approximately 150 inpatient beds and sees about 300 outpatients a day. At the time we visited, there were two other doctors and two medical assistants providing the medical care with good pharmacy, x-ray and lab facilities on site. About 75 percent of the population subscribes to the national health insurance scheme, which provides basic in- and out-patient care for about A\$15 annually per person.

Overwhelmingly, the main health issue in the district is malaria. Mainly due to HIV/AIDS, TB is again increasing as a public health problem. In Ghana, HIV prevalence is about three percent—quite low compared with the rest of Africa. Also common are nutritional disorders, gastrointestinal and respiratory infections. What surprised us, however, was the impact of chronic disease throughout the population: hypertension and type 2 diabetes formed a large proportion of outpatient reviews.

Dealing with chronic diseases, especially diabetes, highlighted some of the cross-cultural and language barriers

we encountered. Ideally, chronic disease like diabetes is managed with good patient understanding, lifestyle changes, dietary adjustment, allied health co-operation and medical optimisation. So, how to achieve this in a five minute consultation with a poorly trained nursing assistant translating for an elderly Twi-speaking Ghanaian? How do you explain to this person that their condition, unlike malaria or pneumonia, will not be cured by taking tablets for a week, and needs long term treatment and follow up? What sort of doctor gives medicines that probably won't make you feel better in the next few days?

Another challenging case involved a newly diagnosed type 1 diabetic boy. It was very difficult to treat this boy and educate him and his family in a busy, understaffed and under-resourced hospital. Nursing staff (who would also translate for us) often had very limited training and understanding of conditions such as diabetes themselves. Initially, few health staff understood that there were different types of insulin, and many nurses believed that insulin was administered intramuscularly. In a paternalistic medical culture like in Apam, many health practitioners are unused to ideas such as

teaching patients to monitor and manage their own conditions. Most families' main concerns are financial and a prolonged admission, not to mention costly diabetic equipment such as glucometers and glucose testing strips (if available), cause huge financial stress on a family, even with health insurance.

In this case the boy's family were subsistence farmers in a village about an hour's drive from Apam. The boy's father, who is illiterate and cannot speak English, was taught to record blood sugars, administer subcutaneous insulin at appropriate times and doses, and to recognise and manage dangerously low blood sugars. The family benefited from supplies including a reliable insulin supply, glucometer and test strips donated from an Australian organisation Insulin for Life. Despite this, the family's level of understanding of his illness, the resources available, and the boy's blood sugar levels are still far from optimal. It appears that the co-ordinated, time- and labour-intensive approach needed to properly address chronic disease is still some way off for the people of rural Ghana.

Nick and Hannah graduated MBBS from Melbourne University in 2005, Hannah, as Hannah Magree

FROM THE MAYO CLINIC TO BEHIND BARS: A SURGEON'S ODYSSEY

CHARLES MULLANY

The last 18 months have been some of the most challenging and rewarding of my medical career. After a professional lifetime in surgery, including 22 years as a consultant and professor in cardiothoracic surgery at the Mayo Clinic, Rochester Minnesota, it was time for a new direction. My nights are now spent treating society's marginalised and forgotten—the inmates of the Maricopa County Jail, which serves the greater Phoenix area in Arizona. The jail houses 10,000 inmates and books over 300 inmates each day.

At any one time, more than two million individuals in the United States are behind bars (one percent of the adult population) and an even greater number are either on parole or probation. Jail populations of the major cities are staggering: the Los Angeles County jail houses 20,000 inmates, New York City 14,000 and Cook County (Chicago) 10,000. Most prisoners are minorities (39% Black, 16% Hispanic) and 13% are female, many of whom are pregnant and will deliver while incarcerated. The per capita incarceration rate in the USA is the highest in the world (six times that of Australia) and comes at enormous social and economic costs. Over the last 20 years, spending on corrections has increased 127%, while at the same time spending on higher education has increased only 21%.

Since many inmates come from a background of poverty, dysfunctional homes, poor education, sub-standard housing and inadequate or often no health care, their medical problems tend to be extensive and severe. In addition, the 'enlightened' closure of state run mental hospitals in the 1960s has led to criminalisation of the mentally ill. It is estimated that 15-20% of incarcerated individuals have serious psychiatric disorders, with the consequence that prisons and jails have become the major de-facto facilities caring for the mentally ill. The Maricopa County Jail has a 240 bed psychiatric ward and employs eight psychiatrists, making it the largest psychiatric facility in the State of Arizona. Psychotropic medication accounts for 40% of all pharmaceutical expenses for the jail.



The 4th Avenue Maricopa Jail receives over 300 inmates a day.



Charles Mullany in his Arizona desert garden.

Being physician to the jail's intake area is equivalent to working in a busy inner city casualty. On arrival, all inmates undergo a medical assessment, including recording vital signs (pulse, BP, respiratory rate, oxygen saturation, and, where appropriate, blood glucose and pregnancy testing). They are questioned regarding serious medical problems, prescription medications and psychiatric disorders and

assessed for risk of self harm or suicide. Suicide is a major cause of death in both prisons and jails and every effort is made to identify and manage those at risk. All inmates with a psychiatric history are assessed by a mental health worker and suicidal individuals are placed in safe cells with constant observation. Alcohol abuse and intoxication, as well as addiction to heroin and other opiates, is widespread and

a serious cause of morbidity within the jail. Monitoring these individuals, as well as preventing and treating of withdrawal symptoms, is a major function of the intake area. Uncontrolled hypertension (BP > 220/120), diabetes (blood glucoses are often >33.3 meq/l), asthma, epilepsy, chest pain, lacerations, fractures and abscesses are seen many times a day and are routinely treated. Serious infectious disease is also widespread. HIV infection among inmates (1.0-2.0%) is estimated to be four to five times that of the general population while Hepatitis C is estimated to be present in 17-41%, depending on geographical location. In 1997 it was estimated that one quarter of all individuals infected with HIV in the USA and one third of those with Hepatitis C passed through a correctional facility during the year.

Having been a surgeon all my life, I approached my new 'career' with both trepidation and excitement. Touring the jail at the time of my interview convinced me that this was something that I had to do. Nothing in my entire professional life had prepared me for what I saw behind bars. Here I saw a minority marginalised population that desperately needed basic care, yet I felt totally inadequate to deal with these problems: it was 39 years since I had been a resident. Moreover, I would be working within the confines of a jail.

My fears could not have been more unfounded. To my surprise, the transition has been easy, stimulating and rewarding. Reflecting on why this should be so, I believe that the outstanding medical education I received at Melbourne University and St Vincent's Hospital prepared me well. The emphasis on mastering the basics of anatomy, physiology and pathology and the clinical skills of history taking,

physical examination and diagnosis were the highlights of my medical education and have stood the test of time. My mentors were master clinicians. Furthermore, my experience as a surgeon has brought invaluable skills to the jail intake area. Clinical actions need to be decisive and rapid, particularly with the large volume of inmates passing through the area. Minor trauma can be handled easily. I feel renewed, as if I had returned to my roots in the casualty department of St Vincent's Hospital, Fitzroy! Finally, I could not have done this without the overwhelming love and support of my wife, Anne, and our seven children. Thanks to you all.

Charles Mullany graduated MBBS in 1969 and MS in 1982. His email address for alumni interested in contacting him is: cmullany@mayo.edu

A SHARED JOURNEY

RICHARD PESTELL

Early experiences often play a formative role in the development of a person's career. For Richard Pestell, son of an academic surgeon, the deaths from cancer of a number of friends and family, the first when Richard was six years old, kindled in him a desire to make a difference by working in cancer research.

Richard's Western Australian childhood was enriched by immersion in science and scholarship through family and friends: science magazines around the house, a father who discussed his work with his son, and early involvement in the life of a university. His path in cancer research, begun in childhood, has taken him through a medical degree at the University of Western Australia, a PhD (Howard Florey Institute) and MD at Melbourne University and a wide range of clinical and academic appointments.

For the past four years now, Richard has been Director of the Kimmel Cancer Centre in Philadelphia, PA, and Director of the Delaware Valley Institute for Clinical and Translational Research (a five state, four university clinical and research institute). His research focuses primarily

on new discoveries in the area of cell cycle/control and the interface of the cell cycle with hormone signalling.

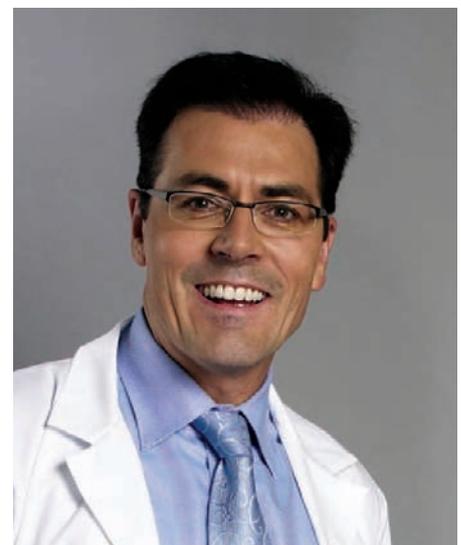
With a string of awards to his name already, Richard's overriding sense of his career so far, is of a journey he is sharing with friends, mentors and colleagues—people who share many understandings: of the value of developing enabling technologies; the barriers to translational research; growing health care delivery inequity; the inertia of scientific dogma; apparently stunning serendipity in discoveries; the perversity of the scientific review process; the importance of targeted therapies; the value of team science; the changing perception that the diagnosis of cancer is now a journey 'not a destination'; a growing interest in quality of life values; and the value of truly transformational discovery in driving real cures for cancer.

Richard's hopes that his own research translates readily into therapeutics for cancer patients are matched by his hopes that initiatives in his and other laboratories and the growing international collaboration in cancer research—a renaissance in which fundamental

discoveries are being made as a collective intelligence—will be a real legacy of the current generation of cancer biologists.

This article was compiled from information in Richard Pestell's article 'Remembering Team Science is for the Patients', published in Cancer Biology and Therapy, 5:4, April 2006. Ed.

Discover more from the Delaware Valley Institute for Clinical and Translational Research website: www.dvicts.org/aboutus/



Richard Pestell



MELBOURNE MEDICINE: 150 YEARS

Anatomy Class, 1916

In 2012 the Melbourne School of Medicine will be 150 years old. As a way of marking and celebrating this milestone we are commissioning a history of the school to be researched and written by Drs Janet McCalman and James Bradley of the Centre for Health and Society in the School of Population Health.

Our history encompasses the full history of modern medicine: the story of medicine at Melbourne is also the story of the rise of biomedicine over the past 150 years, beginning with the role of the clinic in medical training, anaesthesia, the impact of the laboratory, anatomy and concluding with the evidence-based, research-driven medicine of the 21st century. A literary, well-synthesised history is planned, which focuses on the making of doctors—on the medicine they were taught and the manner in which they learned it—contextualised by discussion of the nature, potential and limits of modern medicine and its practice in Australia.

The planned history will look in detail at the cohorts of students and settings for their learning—clinical schools, laboratories, class rooms, home births and casualty departments—and maintain an underlying narrative of how scientific and clinical discovery has changed understandings and practice.

Commemorating 150 years of Medicine at Melbourne will focus on the past, present and future experiences of medical students as they become doctors and we are interested in collecting the memories and memorabilia of medical

student days: photographs, video or film footage, documents and stories. Medical graduates interested in contributing to or becoming involved in this project are invited to contact Liz Brentnall at: eabren@unimelb.edu.au.



The third year medical students hockey team in 1976, the day they played the second year team - and lost! Pictured are (L-R), in the back row: Julie Knight, Lorraine Baker, Helen Banting, Judy McNaughton, Kate Davey, Mary Parkin, and in the front row: Barb Goss, Marguerite Skeehan and Jo McCubbin. Team members missing from the photo were Lovella Crawford and Heather Cleland. Lorraine Baker remembers the umpires for that day were Joe McKendrick and Tom Kay and says: 'We women were rather tired of watching inter-year football and had demanded a girls' contest'.

REUNIONS



MBBS 1941

The MBBS graduates of 1941 on 18 September 2009, celebrating 68 years since their graduation. Pictured L-R are: (standing) Brian Costello, Peter Bird, James Guest and Frank De Crespigny; (seated) Clarice Hetherington, Alexe Gale, Mary Wheeler. Ida Seward was present at the luncheon but not for the photograph.

James Guest



MBBS 1944

Six of the surviving MBBS graduates of 1944 met for lunch at the Kew Golf Club on Wednesday 18 March 2009. Those attending were, as pictured: Back, L-R—Howell Hosking, Charles Wilson, Peter Blaubaum; Front, L-R—John Floyd, June Howqua, Andrew Newell.

Mary Abrahams (Hoy), Bell Matthews (Broderick), Nancy Cowling (McNeill), Percy Cowan and John Williams were unable to attend and sent their apologies.

Andrew Newell & Howell Hosking



MBBS 1949

The 1949 medical graduates celebrated their sixtieth year since graduation with a luncheon at Graduate House on Tuesday 20 October. We were particularly pleased to welcome Rae Williams (Lee) from Perth, John Pawsey from Queensland and John Brine from Canberra, author of several books (the latest on medical aspects of Shakespeare's plays) who joined us for the first time.

An informal occasion, apologies and greetings from those absent, followed lunch. Most of those attending looked pretty fit despite the years and, although many reported minor problems with arthritis, hearing and vision, there was widespread agreement that the alternative to advanced age, even with some disability, is a poor option.

An interesting feature of reminiscences was the lasting effect of those who worked as groups during anatomy dissection in second and third years, perhaps reflecting the impact of this very unusual and demanding activity on people just reaching maturity. Certainly the long medical course and shared experiences have led to ongoing, close associations. Conversation inevitably reflected changes in medicine and practice since we graduated, and concern that the enjoyment of practising medicine might be at risk. On the other hand, advances in medicine during the second half of the twentieth century were clearly to our advantage—artificial hips and knees, cataract replacements and coronary stents as well as developments in surgery, anaesthesia and therapeutics.

The recent deaths of ten members were noted with sadness, and there was widespread agreement that we should meet annually from now on!

Noel Cass (for the conveners)



MBBS 1958

After 50 years since graduating MBBS at Melbourne University in 1959, 57 of the original 109 who graduated gathered on 8 November 2008 at the RACV Club to renew friendships and compare notes. The venue was highly suitable, and the camaraderie, if measured by the conversation noise level, was excellent. Several comments have been made, saying what a great experience it has been to catch up with colleagues again and exchange details of activities since last seen.

It was particularly pleasing to have two international and seven interstate graduates attend. After toasting ourselves as the Class of 1958, MC Barrie Morley proposed a toast to absent friends—two of whom have died since our last gathering, and those who were unable to attend. A page of messages from 18 of those who sent apologies was displayed.

Assembling the graduates for the traditional photograph appeared to interfere with the social aspect of the evening, and the process resembled

the futility of herding not only cats, but seagulls!

Mr Robert Marshall gave an enjoyable talk about success and about many of his memories of surgical practice over the 60 years since he graduated. Some of the stories were quite disturbing and he exhorted us to do all possible to continue improvements in medical practice and medical ethics to enrich our noble profession.

Ralph Lewis



MBBS 1978

One hundred & fifty four people attended the 30 year reunion of MBBS 1978 on 22 November 2008 in the Jim Stynes room at the MCG. The venue was magnificent, looking over the floodlit oval. Prior to dinner we had the opportunity to spend time in the wonderful National Sports Museum. The highlight of the evening was a rendition of the Neuro-anatomical Aria, led by Elsdon Storey (photo).

Robert Brack

2012 REUNIONS AND MEDICAL STUDENT MEMORIES

As Noel Cass has noted, in his report of the 1949 graduates' sixty years reunion (facing page), the long medical course and shared experience—such as anatomy dissection classes and first clinical encounters with birth and death—on people just reaching maturity, led to ongoing, close associations. With the Melbourne Medical School about to turn 150 in a few years, we are interested in determining how medical

students' experiences have changed over the time and in identifying and tracing the common threads which run through all those years.

Accordingly, we would like to tap into our medical graduates' memories of their student days in any way we can. If you are organising a reunion between now and 2012 and are interested in gathering and recording memories from your student days, please contact us.

MBBS graduate cohorts with anniversaries in 2012 may also be interested in combining their reunion with

a return to Melbourne and organising a celebration in coordination with the Medical School's anniversary activities. If your group is planning a reunion for 2012, please let us know.

CONTACT DETAILS:

Liz Brentnall

Advancement and Communications
Faculty of Medicine, Dentistry and Health Sciences

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The University of Melbourne

Email: eabren@unimelb.edu.au

MEDICAL MEMORIES

The approach of our 150th anniversary has prompted the Melbourne Medical School to reflect on our students' changing experience of becoming doctors over the past one-and-a-half centuries. With this in mind we have begun a program designed to document and record the memories of past students. The first of our 'Medical Memories' interviews involves two alumni, James Guest AO, CBE and Jenny Hayes in conversation.

Jenny graduated MBBS from Melbourne in 1982 and her memories of student anatomy classes include lectures from James Guest. She is currently a senior lecturer in the Anatomy Department and writes about her experience of teaching anatomy in this issue of *Chiron* (p.12).

During the interview James talks about his experience as a student of science, then medicine, during the 1930s and '40s. His first year at University coincided with

the first year of the Vice-Chancellorship of Raymond Priestly—the first salaried Vice-Chancellor of the University. James' memories of one effect this change to University administration had, are that 'Priestly pushed the student point of view' and insisted on the construction of the student union building. This had a great impact upon the day-to-day lives of students, providing a central place for them to gather and socialise. Prior to that, students had to bring sandwiches from home or find food at a nearby shop, unless they were lucky enough to be able to return to a college residence for lunch.

Some of James' fondest memories of his student days are of life at Trinity College. During his first year at University he lived off campus but 'worked hard' and gained a scholarship to Trinity. He remembers that his time at Trinity 'altered [his] whole life'. His life's experience of schooling

at Mildura High, then as a boarder at Geelong Grammar, was quickly eclipsed by the liberating experience of college life. Enjoying the opportunities to fraternise with women and become involved with sports and societies he threw himself into college life. Involved in many activities, in particular rowing and the dialectic and theatrical societies, James reflects that, although he participated perhaps too much, he doesn't regret it at all.

Other compelling memories of James' student days involve the teaching of Frederic Wood Jones and membership of the McCoy Society under Wood Jones' leadership. Wood Jones, easily the most inspirational teacher of the course in his day, led groups of students and staff (including, on at least one occasion, the Vice-Chancellor) on annual field expeditions. The McCoy Society motto: 'For field investigation and research' describes the opportunity offered by the society for students from a wide range of science-based disciplines to participate in hands-on research in the field. Working and living side-by-side with experts and students from a range of related disciplines was an obviously inspirational experience for a young man, as was the eclectic, wide-ranging approach to education taken by the somewhat rakish-looking, intellectual and practical adventurer, Wood Jones.

The interview was filmed and edited excerpts will be finished in early 2010 and posted on the Melbourne Medical School website.



'The camp established'. This photograph from a McCoy Society expedition is reproduced courtesy of the University of Melbourne Archives.

For more on the Web: http://www.mdhs.unimelb.edu.au/knowledge_transfer/podcasts/medical_memories



James Guest talks with Jenny Hayes about his memories of Medicine at Melbourne University.

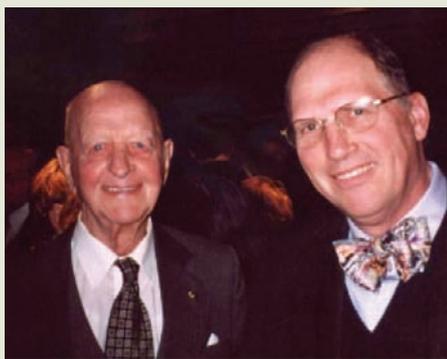
This aerial photograph (facing page), from the Melbourne University Archives, was taken by the Royal Australian Air Force in (1942). Other photos from the series show the RAAF barracks on nearby Royal Park, where James Guest remembers them being stationed during the war. The photograph clearly shows the layout of the University soon after James' graduation. The bottom left hand corner, the site of the current medical building, microbiology and immunology, the Howard Florey and the Neurosciences building site, is still a playing field and the row of professors' houses are still standing. The Vice-Chancellor's residence, built during James Guest's student days is next to them. The newly built Student Union Building is in place at the centre of the campus but the Baillieu and Brownless libraries are still yet to be imagined.



OBITUARIES

RECORDED WITH REGRET, THE PASSING OF:

- Jack Acheson (MBBS 1956)
- Clement W Ahern (MBBS 1943)
- Patricia M Bale-Hirst, AM (MBBS 1955)
- Nicholas R Bare (MBBS 1964)
- Harley K Baxter (MBBS 1969)
- Michael S Benson (MBBS 1941)
- Stanley C Berger (MBBS 1954)
- Marcus K Benjamin (MBBS 1955)
- Alexander L Bennett (MBBS 1951)
- Noel M Bennett (MBBS 1954)
- Stanley C Berger (MBBS 1954)
- Benjamin W Bergman (MBBS 1963)
- Nishal K Bhullar (MBBS/BMedSc 2006)
- John T Breen (MBBS 1953)
- Kenneth F Brennan (MBBS 1940)
- Margaret F Bridge (MBBS 1971)
- Leon R Bryan (MBBS 1952)
- Frank H Buchanan (MBBS 1951, GradDip Psych Med 1968)
- Barry L Butler (MBBS 1946)
- Roger Bullen (MBBS 1953)
- Barbara G Burbury (MBBS 1938)
- Heather Carmichael (MBBS 1972)
- Anne J Caro (MBBS 1954)
- Norman J Chamberlain (MBBS 1942)
- David M Conroy (MBBS 1957)
- Russell G Cole (MBBS 1944)
- John L Connell, AO (MBBS 1947, MS 1951)
- Desmond A Cooper (MBBS 1949)
- Donald P Cordner (MBBS 1945)
- Leo J Cussen (MBBS 1954)
- Robert E Davies (MBBS 1953)
- Eric C Dax, AO (MD 1984)
- Bryan Egan (MBBS 1949, BA 1974, MA 1982)
- Bill Etheridge (BDS 1940, MBBS 1945)
- Austen S Ferguson, AM (MBBS 1943)
- Dermot C Foster OAM (MBBS 1945)
- Andrew Fraser (MBBS 1939)
- Bryan H Gandevia, AM (MBBS 1948, MD 1953)
- Alan Gilchrist (MBBS 1944)
- John M Grant (MBBS 1948)
- Harry Green (MBBS 1956)
- Philip H Griffin (MBBS 1966)
- Maxwell L Hankin (MBBS 1958)
- Keith E Harrison (MBBS 1941)
- Cleve Hodge (MBBS 1956)
- Henry Horne (MBBS 1958)
- June L Howqua (MBBS 1944, MD 1947)
- Kenneth G Howsam (MBBS 1943, GDip Ophth 1948)
- Ronald W Hoyling (MBBS 1941)
- Shirley M Huntsman (MBBS 1950)
- Helen G Irinyi (MBBS 1964)
- Lindsay F Irwin (MBBS 1940)
- Paul E Jeffery (MBBS 1945, DipO&G 1952)
- Richard A Joske, AM (MBBS 1948, MD 1952)
- Donald F King (MBBS 1947, MD 1953)
- Julie C Knight (MBBS 1979)
- Walter H Koschade (MBBS 1954)
- Ivan W Laurich (MBBS 1963)
- Bill Lawrence (MBBS 1953)
- John H Leyden (MBBS 1951)
- Charles R Lucas (MBBS 1956)
- Helen Mackenzie MBE (MBBS 1938)
- Gerald A Manley (MBBS 1947)
- Dennis W Maginn (MBBS 1946, MD 1952, BSc 1963, GDipPsych 1963)
- F Ian R Martin, AM (MBBS 1953, MD1957)
- Douglas N McCulloch (MBBS 1953)
- Douglas McCutcheon (MBBS 1950, MD 1959)
- Brian D McKie (MBBS 1962)
- Ian G McPherson (MBBS 1966)
- Ian L McVey (MBBS 1949)
- Samuel D Mecoles (MBBS 1940)
- Peter F Meehan (MBBS 1968)
- Camille Michener (MBBS 2003)
- Helen M Moran (MBBS 1969)
- Alan B Ng (MBBS 1958)
- Hazel Y Noble, AM (MBBS 1949)
- Ian M North (MBBS 1964, GDip Ophth 1970)
- Francis J O'Rourke (MBBS 1955)
- Robert J Pierce (MBBS 1970, MD1980)
- Murray C Piercy (MBBS 1945, GDip Anaes 1983)
- Patricia M Preston (MBBS 1942)
- Jack Ptasznik (MBBS 1972)
- Ronald P Quirk (MBBS 1959)
- Noel M Ramsey, OAM KSJ (MBBS 1947)
- William Refshauge, AC, KT cr CBE (MBBS 1938)
- Charles R Richardson (MBBS 1962)
- Hendrik D Ritman (BAGSc 1958, MBBS 1965)
- Douglas M Ritchie (MBBS 1954)
- Hendrick D Ritman (BAGSc 1958, MBBS 1965)
- Pamela D Roberts (MBBS 1965)
- Neville J Rothfield (MBBS 1946)
- Shaw Rudzki (MBBS 1961)
- Leonard B Satchell (MBBS 1942)
- Ron Saunders (MBBS 1951)
- Simon A Schnall (MBBS 1976)
- Daniel Shortall (MBBS 1990)
- James L Sinclair (MBBS 1942)
- Keys Smith, OBE (MBBS 1940, BA 1983)
- Colin A Speck (MBBS 1948)
- John C Spensley (MBBS 1962)
- Henry Stonnington (MBBS 1950)
- Harold F Story (MBBS 1947)
- Brian Thomas (MBBS 1965)
- Robert V Thompson (MBBS 1994)
- Chris Towie (MBBS 1982)
- Gordon W Trinca, AO, OBE (MBBS 1945)
- Chester A Troy (MBBS 1955)
- Clifford E Warmbrunn (MBBS 1959)
- William F Wilson (MBBS 1966)
- Peter F Williams, AO (MBBS 1946)
- Susie Woodward (MBBS 1970, GDipEpidemiol 1996)

ERIC CUNNINGHAM DAX AO**1908—2008**

Eric Cunningham Dax is pictured here with his son-in-law Hugh R Taylor (Harold Mitchell Chair of Indigenous Eye Health).

Eric Cunningham Dax died in his hundredth year. Recruited from Britain by the Victorian Government in 1951, 'Dr Dax' became a household name which still resonates with many. As Chair of Victoria's Mental Hygiene Authority he presided over an all-encompassing reform of facilities. His many contributions centred on reforming care facilities and seeking social acceptance for mental illness: innovations which form a continuing legacy of scholarship and understanding of mental health.

Born in Eastwood, Nottinghamshire in 1908, Eric attended Perse School, Cambridge, excelling academically and in sport, and achieved a London University Matriculation First Class. Having checked the results of the entry examination he wired home that he had failed: he hadn't looked at the distinctions list!

In 1933 he graduated in medicine with honours—scholarship prevailed throughout his professional life—and soon after met, courted and married a nurse, Kathleen Aimee (Katie) Thompson. Their marriage lasted 62½ years until her death in 1998. Several house jobs in psychiatry led to his appointment as Deputy Superintendent at Netherne Hospital, Surrey in 1939—only twelve years after he had left school—and promotion by 1942 to Medical Superintendent. When he left Netherne to immigrate to Australia, the hospital was what would now be called 'a best-practice organisation' for the care of the mentally ill. His pioneering work included editing a handbook for psychiatric nursing; introducing different types of care for different mental illnesses; introducing general anaesthetics for electroconvulsive therapy; advancing psychosurgery; music

therapy and; particularly, art therapy—indeed, he has been called 'the father of art therapy'.

Chair of the Victorian Mental Hygiene Authority until 1969, Eric described his work in many publications—the Victorian work in *Asylum to Community* where he wrote that when he came to Victoria, 'mental hospitals were in a deplorable state of neglect and disrepair'. Staff 'frustrated and disillusioned' and patients leading 'an asylum-like existence, often unoccupied, locked up, sleeping on straw mattresses and badly clothed'. The book's preface observed: 'With imagination and dynamic energy Dr Dax and his colleagues stimulated the staff by giving them new purpose, initiative and opportunity.' Dilapidated buildings and bedlam-like wards were repaired and refurbished, new hospitals were acquired or constructed, new research and methods of treatment undertaken. (It should not be forgotten that therapies for the mentally ill at that time were limited.)

He separated the intellectually disabled from those who were ill, developed occupational therapy services, professionalised psychiatric nursing and expanded other professionally associated groups, developed in-prison psychiatric services and instituted day hospitals. He introduced the first telephone crisis line in Australia. Communicating this innovative work to the public helped abolish much of the prevailing stigma of 'madness'.

Eric was able to make these changes because he fostered extraordinarily good relationships with the press, with politicians, and later with business, particularly through the Lions Clubs of Victoria. Although he spent much effort improving mental hospitals, he believed in progressively moving care of mentally ill people into the community and involving community in that movement. At one point there were 1500 volunteers supporting mental health services in Victoria. The State's services became an international show-piece and his family entertained visitors from all over the world. His reputation led to several World Health Organization consultancies and a prominent role in the Royal Australia and New Zealand College of Psychiatrists.

In 1969 Eric took the position of Tasmanian Coordinator Community Health establishing a new Department

of Psychiatric Research from where he coordinated research still used by Tasmanian services. Here, too, he led the expansion of voluntary services to the mentally ill or disabled. In 1978 (aged 70!) he started his first private practice which he continued upon returning to Victoria in 1984.

From 1984 until his final retirement in 2002 Eric worked two days a week cataloguing and writing commentaries for the artworks he had gathered since 1947. These works were donated to the University in 1985-6 and now form the basis of an expanding collection of over 12,000 works fashioned by people experiencing mental illness or psychological trauma: one of the largest such collections in the world. Named for him by the University, the 'Cunningham Dax Collection' is based in Parkville and runs a regular program of exhibitions. In 2012, the collection is due to move to the University's Parkville Neuroscience Facility where it will present the 'human face' of basic scientific research on brain function. The collection constitutes a remarkable and under-recognised legacy to the nation which, as a centrepiece of the future Cunningham Dax Centre, will offer education about mental illness with the aims of promoting mental health through the use of art.

Eric remained in good health until shortly before his death. Well-respected for professional achievements, he was also held in deep affection by many. He is survived by his four children, his daughter-in-law, and son-in-law, his nine grandchildren, their partners and ten great grandchildren.

Elizabeth M Dax, AM

BRYAN EGAN**1922—2008**

Bryan Egan graduated in medicine from Melbourne University in 1949. Much of his time as a medical student was spent at St Vincent's Hospital, as a clinical student and as a long-term patient following a bout of pulmonary tuberculosis. He spent much of his career at Box Hill Hospital where he was Medical Superintendent (1958-73) before returning to St Vincent's as Assistant, then Deputy, then Medical Superintendent of the Hospital. His early retirement in 1981 enabled him to

pursue his interest in historical studies for which he obtained a PhD from Monash University.

In 1988 Bryan was commissioned to write a history of St Vincent's to commemorate the Hospital's centenary and his book *Ways of a hospital: St Vincent's Melbourne 1890s—1990s* established his unparalleled knowledge of the hospital. Retaining an active and passionate interest in preserving and documenting the history of St Vincent's Hospital until his death, Bryan was a driving force in the hospital's Archives and Museum Committee. He was generous with his knowledge and modest about his own accomplishments.

LB from material kindly supplied by St Vincent's Hospital

CHARLES RONALD LUCAS

1932—2009



For a person legendary for his long silences and frugal use of words, Ron Lucas answered to an unusually long list of names. Known as 'Ronny' to his school friends and 'Ron' to his medical colleagues, he was known as 'Lagubes' (lugubrious) at University, 'Rowdy' to his cricket mates and, perhaps most appropriately to the members of the Melbourne University Cricket Club team, which he toured England with aged 60, as 'Gunsynd'... the galloping grey.

Ron attended Ballarat Grammar School when it was led by the legendary educator and playwright GF 'Jack' Dart. With only 200 students in the school and very small matriculation classes, Dart took a particular interest in senior students and

passed on his love of learning, his ability to see both sides of an argument and his love and respect for nature.

It must have been a remarkable experience as the school turned out a Rhodes Scholar and several academics including George Seddon, Geoff Tunbridge, Jim Pittard and Ron: all outstanding teachers and mentors, imbued with a love for nature and the environment, all committed to public service.

Ron was a resident at Trinity College while he studied medicine. His great passion was cricket and, an accomplished left handed batsman, he represented both the University and, later, Richmond Cricket Club with distinction.

After graduating Ron spent a brief period at Horsham Base Hospital before he was recruited by John Forbes to Fairfield Hospital for Communicable Diseases in 1964, where he remained until his retirement in the early 1990s. Ron was an outstanding physician: calm, thoughtful and thorough. Inspired by John Forbes' view that medicine could only advance if it were illuminated by insights from clinical research, Ron worked closely with the hospital's laboratory team—the sympathetic administration and close relationship between clinical and laboratory staff were an ideal research environment. While primarily a clinician, Ron saw his role to challenge existing paradigms, create hypotheses and help others sort out the answers. With the advent of diagnostic tests for hepatitis B and later hepatitis A, he worked closely with the virology team, laying the building blocks for our current knowledge of the natural history of those diseases as he did later with hepatitis C.

During the 1970s, fulminant hepatitis B infection was a relatively common cause for admission to Fairfield Hospital. Ron pioneered a number of techniques in Australia for patients with no other clinical options, and was thrilled when a vaccine was developed and the disease largely disappeared. He played a critical role in the development of the hepatitis A vaccine as the physician who cared for the large family from whom HM175, the strain which became the basis of the world's first licensed vaccine, was isolated.

During the notorious dispute at Fairfield Hospital in the 1970s, when Ron and Ian Gust, unofficial spokesmen for

the medical staff, were threatened with dismissal, Ron was a tower of strength, with a clear view of the principles at stake and a firm resolve to avoid compromise. His integrity and the huge respect in which he was held by his peers, were significant factors in the resignation of most of the medical staff and the threatened resignation of the scientific team—forcing the State Government to intervene and replace the medical superintendent and the board. Not long after, Ron was appointed to the inaugural board of the new hospital research centre, now the Burnet Institute, and played a key role in its success.

In the 1980s, as AIDS appeared in the community, Fairfield managed most Victorian patients with the disease. Before much was known about the disease there was a great deal of anxiety, but Ron's calm, sensible, pragmatic, non-judgmental approach and honesty endeared him to his patients and earned him great respect in HIV affected communities. He facilitated the establishment of dedicated HIV clinics and acted as a guide and role model for an entire generation of infectious diseases physicians and physician scientists.

Ron's founding membership of the Australian Society for Infectious Diseases was a significant contribution to the field of infectious diseases. He also taught medical students from both Monash and Melbourne for approximately 30 years. Graduates will recall their three weeks of infectious diseases teaching at Fairfield Hospital (and also the scones with lashings of jam and cream provided for morning tea around the fireplace).

After Ron's first marriage ended in divorce he married Jo Cornish. They built a wonderful mud brick home on a hill overlooking the Yarra River at Eltham which became a haven for the many friends they entertained with Ron's well stocked wine cellar and Jo's superb cooking. Following his retirement, Ron helped Sandy Milne roll out a regional hepatitis B immunisation program in New Zealand, before settling down to his other passions: woodwork and gardening. His finely turned tables, chairs, boxes and trays, made from jarrah fence posts recovered from Fairfield Hospital's grounds, and his special twig chairs were highly sought after, as was his company.

As Ron began to develop signs of the debilitating neurological disease which

was to claim his life, he was forced to give up most of the pleasures which sustained him and became increasingly immobile and confined to his favourite chair where in the loving presence of Jo and his daughter Kate and his sons Eric, Michael and David, he received a stream of visitors, with calm dignity to the end. Ron was a physician's physician—the person you would want caring for you if you were ill.

Ian Gust, Suzanne Crowe & Edwina Wright

FIR (SKIP) MARTIN, AM
1929—2008



Skip Martin was an extraordinary and wonderful man.

Extraordinary because he was one of a kind: totally unconventional in manner and style. At first impression he was disorganised and awkward; at second impression he was a person of razor sharp intellect, perpetual curiosity, enthusiasm for everything he did with a passionate interest in his fellow human beings.

Wonderful because of his generosity of spirit and the inspirational effect he had on those around him.

Born in 1929, Skip was in the University of Melbourne cohort who studied at Mildura after the Second World War. He undertook research at Case Western Reserve University in Cleveland, on the exchange program started after the occupation of the Royal Melbourne Hospital by the US 4th Army from Cleveland, and returned to succeed Pincus Taft as physician-in-charge of endocrinology in 1964, a position he occupied for 25 years.

Although his appointment was part-time, Skip established an active research program. In the grandly-named Endocrine

Laboratory—an alcove-sized room in the Department of Medicine—he established bioassays for gonadotrophins and one of the few bioassays for the Long Acting Thyroid Stimulator, later known as thyroid stimulating immunoglobulins. Immunoassays for insulin and growth hormone were soon followed by several others. Important papers were published in international journals, including seminal work done with Alan Stocks on the association of resistance to the action of insulin and the complications of diabetes. This interest in insulin resistance and its adverse associations predated the description of syndrome X or metabolic syndrome by a couple of decades. Another seminal work related to the different expression of diabetes in Papua New Guinea with an early description of J-type diabetes.

Skip's perpetual curiosity and genuine desire to find answers to the clinical problems he saw in his patients inspired my interest in research. He had a powerful influence on the direction of my career, as on many others who now occupy leadership positions in hospitals and universities throughout the country and the world. Shortly after I started with Skip, I learnt he was the author of, to that point, 112 scientific papers. As I struggled to publish my first two or three, the magnitude of this achievement for someone with a huge clinical load quickly became apparent.

What I remember most about Skip Martin is his interest in the lives of his patients and the respect he held for them. Fascinated by their range of interests, their backgrounds and the way they handled their illnesses, he had a particular affinity for migrants, especially from the Mediterranean region, and the prevalence of diabetes in different ethnic and national groups. His affection for his patients was reciprocated: an exemplar of the best kind of doctor, he cared for his patients in every sense. The travails of the long-term sufferer of diabetes and its complications require just this sensitivity.

Skip occupied many leadership positions at the Royal Melbourne Hospital and in the Australian Diabetes Society. His selfless contributions to medicine and to medical research, the training of a generation of endocrinologists and his leadership and support of the Australian Diabetes Society were recognised in 1995

by Membership of the Order of Australia.

More recently, Skip's passion found yet another outlet—medical history. His book *The History of Diabetes in Australia*, commissioned to celebrate the 25th anniversary of the Australian Diabetes Society, was a scholarly treatise and fascinating to read. He focused on the characters involved—including the first patients to receive insulin—the researchers and the early practitioners. As always he was interested in the quirky, including the first attempt at pancreas transplantation by an imaginative maverick in Tasmania in 1911. Skip was an active member of the Australian and New Zealand Society of the History of Medicine after retiring from active hospital practice.

Devoted to his family, Skip Martin is survived by his wife Megan, their five children and an increasing number of grandchildren. Every person who knew Skip has been enriched by the experience. We give thanks for his life and mourn his passing.

Richard Larkins, AO

IAN LUMSDEN MCVEY
1927—2008

Born in Brisbane, Ian's early years were in Queensland before the family moved to Melbourne where he finished his schooling at Wesley College.

Ian studied medicine at Melbourne University, graduating in 1949 and going on to resident, registrar and associate surgeon positions at the Alfred Hospital, while also working as demonstrator in the Anatomy Department. He won the Sir Gordon Taylor Prize for Excellence in the Primary Fellowship Examination in 1953.

Travelling to England to further his studies, Ian worked at St Bartholomew's Hospital (with Sir James Patterson Ross), obtaining his FRCS in 1955 and finishing his training as registrar at the West Middlesex Hospital.

He returned to Melbourne and the Alfred Hospital where he was duly appointed senior inpatient surgeon and proved himself a skilful, often conservative and thoughtful surgeon. His main area of clinical interest was in diseases of the breast and he strived long for the development of a multidisciplinary breast clinic. His lectures to students and nurses were always clear and, given his command

of language and caring approach, always popular. He was examiner in surgery at Melbourne and also, more latterly, at Monash.

In 1983 Ian was nominated to directorship of the Road Trauma Service, a position he held until 1996. The service benefited from his ability to organise and obtain a desired result. As the revolutionary helipad structure of the trauma centre and its organisation and reception of casualties became a reality, the Alfred Hospital became the prime centre for management of road trauma in Victoria. His work on the consultative council on emergency and critical care was pivotal in the development of trauma services in Victoria and the Road Trauma Centre at the Alfred Hospital remains a monument to him.

His career was studded with committee work: for the hospital, the AMA, the Medical Practitioners Board, the Medical Defence Association of Victoria, the Medical Benefits Schedule Advisory Committee, the Anti-Cancer Council of Victoria, the Victoria Medical Insurance Agency and the Professional Indemnity Insurance Company of Australia. A master of organisation with an ability to think on his feet, he could often influence a meeting and had a strong and clear vision for the profession.

A most generous host, Ian and his wife, Norma, developed a property raising Murray Grey cattle on the Mornington Peninsula, selling it at the turn of the century to build a residence at Mornington where Norma still resides.

Cas McInnes. An abridged version of the obituary originally published in the Alfred Hospital Residents and Graduates Association Newsletter.

CAMILLE MICHENER

1979—2009

It is with great sadness that we farewell a dear friend and colleague, Camille Michener.

Born on 4 February 1979 and raised in country Victoria, Camille graduated in medicine from the University of Melbourne in 2003. She had deferred her training for a year during her course in order to travel and work as a volunteer at the 2000 Sydney Olympics.

After finishing medical school Camille moved to Perth for the lifestyle

and the beaches—especially her beloved Cottesloe—and completed her internship at Freemantle Hospital. After initially considering a career as a rural GP, Camille fell in love with, and trained in, obstetrics and gynaecology: she received the RANZCOG Award for Outstanding Achievement for the DRANZCOG exam in 2005.

Continuing her training in Western Australia, Camille spent time at many hospitals including Joondalup, Osborne Park, Princess Margaret, Albany and King Edward Memorial hospitals. She became involved in junior doctor advocacy from her first meeting as an intern and was an active member of many professional groups, committees and forums.

Despite her heavy workload and professional commitments, Camille still found time to volunteer for LifeLine as a counsellor, the Red Cross Family Support Program and to Banda Aceh following the 2004 Tsunami.

In 2007, Camille became Chair of the AMA (WA) Doctors in Training Committee and WA representative to the AMA Council of Doctors in Training. A passionate advocate for junior doctors, her dedication, energy and resilience were respected by all who worked with her. She was particularly interested in junior doctor training and doctors' health and her enormous contribution to work in these areas must be applauded. She remained an active member on the committee after the completion of her term as chair, and was always happy to help.

Vivacious, bubbly, generous and modest, Camille always had a smile on her face, especially if the conversation involved anything to do with her favourite foxy team, Collingwood. She loved sports and the outdoors, especially running, swimming and surfing. Even when away at AMA meetings, she would ensure she went for a run and was a wonderful role model for us all.

Camille adored her friends and family (parents Helen and Norm and sister, Sarah) and worked hard to stay in touch with those in the east and west.

Her tragic accident on 24 July this year devastated all who knew her and the wider medical community. She was farewellled at a beautiful memorial service on Cottesloe Beach by her family, friends and colleagues.

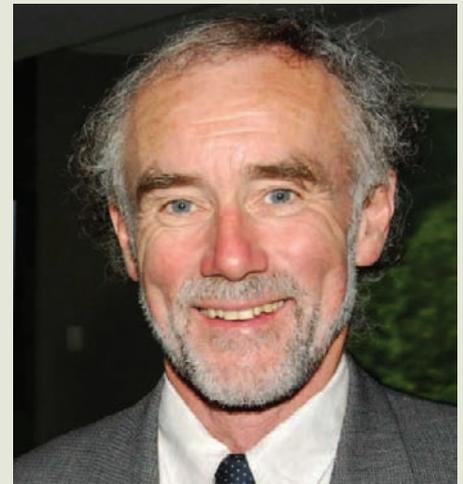
Camille, your legacy will live on in our hearts and our work. We thank you.

Alex Markwell and Ruth Blackham

This is an edited version of the obituary which was published first in AusMed

ROB PIERCE

1947—2009



Robert John Pierce died tragically on 7 February 2009 whilst defending his home at St Andrews, Victoria against the Black Saturday firestorm. Rob graduated in medicine from Melbourne University in 1970 and completed his house officer years at St Vincent's Hospital. Inspired to enter the field of respiratory medicine by the late Doug Gauld at the Repatriation General Hospital, Heidelberg, he completed his training at the Royal Brompton Hospital.

An excellent clinician and teacher, Rob's inquiring and incisive mind and capacity for hard work led to research publications in the fields of pulmonary physiology, asthma, chronic obstructive pulmonary disease, lung cancer, and more recently, sleep and upper airway mechanics.

Rob used the amalgamation of the Austin and Heidelberg Repatriation respiratory units as an opportunity to establish the Victorian Respiratory Support Service which now supports the needs of patients requiring chronic ventilation throughout Victoria. He was well known and highly respected throughout national and international sleep and respiratory communities, forging strong collaborations and enduring friendships with colleagues in many different parts of the world.

He founded the Institute for Breathing and Sleep to promote research, education

and public advocacy in respiratory and sleep medicine and was integral to the development of the Australian Sleep Trials Network.

Rob was loved by his patients, many of whom became friends. His abiding interest in respiratory and sleep health in Indigenous Australians was deepened during a sabbatical spent travelling and working in northern Australia where he saw many unmet needs in the understanding and treatment of common respiratory and sleep health problems in remote Aboriginal communities.

Rob loved living, walking and camping in the bush. He enjoyed music, art and sailing in his yacht *Terra Nova* out of Williamstown. He regularly served as medical officer on tall ships such as the *James Craig* and *Alma Doepel*.

An extremely humble person, Rob's door was unfailingly open to patients, students, colleagues and friends. His sphere of influence was wide and stories attesting to his laid-back but hands-on attitude to work and life abound. Always down-to-earth, he had a laconic sense of humour and a lifelong desire to minimise red tape and get the task done.

He inspired research students, scientists and registrars, many of whom are now in senior positions—all of whom would be proud to have considered him their friend. Rob leaves his wife Jan, their children Chris, Lucy, Nick and Tristan, and his grandchildren. Taken from us all so suddenly—he is sadly missed.

Abridged from the obituary by Christine McDonald and Peter Holmes published in 'Medicine, Dentistry and Health Sciences' earlier this year.

NOEL MCHUGH RAMSEY OAM 1925—2009



Born on 6 March 1925 at Caulfield, Noel was the adored only child of Merle and Roy Ramsey. His 'onlyness' was quintessential to his character: an independent thinker, self contained and often single minded in his ambitions, he also actively sought to engage with others, and his great capacity for friendship saw him always at the centre of a wide social circle.

He attended school at Auburn South Primary, then his father's alma mater, Scotch College. A good cricketer, he held his own at footy, but excelled at school work and matriculated aged 15 before going up to 'the shop' as Melbourne's only university was then known, to graduate MBBS in 1947.

After a residency at Prince Henry's, Noel's interest in paediatrics took him to the Royal Children's Hospital. His marriage and children to Diana Harrison, the young theatre sister he met over an operating table, led to a reassessment of his ambition and kindled a new passion in primary care and family medicine, which became the hallmarks of his general practice.

In 1951 he and Stan Kay purchased a general practice in Box Hill where Noel remained for 52 years, providing exceptional family medical care, often for five generations in one family, and delivering over 4000 babies.

From the early 1960s Noel and John Gates, a Cessna pilot, would spend a week or two each year flying all over Australia and later New Guinea—Noel navigating and John flying. Each trip became more daring, until, in 1978, they flew with their wives to London and back in a single engine Cessna 210. The trip took four months as the intrepid foursome flew from one refuel stop to the next across South-East Asia, through Burma, Afghanistan and the Middle East, and on to Europe. After a short stop in London they returned to the confines of the plane's cabin to do it all again flying home.

Noel's medical career extended far past his general practice. He provided honorary service at the Royal Children's and Prince Henry's hospitals and, his move to Box Hill coinciding with the emergence of the Box Hill Hospital, had a long involvement with the hospital which included a range of clinical and leadership roles. He also served a number of hospital and health services throughout Melbourne's east.

Noel played an important role in improving the standards of general practice though the RACGP and with the FMP. In 1979, when required to sit the inaugural exam for the Diploma in Obstetrics and Gynaecology, to continue practising obstetrics, he topped the course.

As his clinical work wound back he took on teaching roles: as senior clinical lecturer for the Monash University and as clinical tutor and lecturer in the Department of Community Medicine at Melbourne University where he also sat on Faculty. His interest here led to his election to the Committee of Convocation (1994—2007).

In the last two decades of his career his services as an expert witness were sought by the major medical defence solicitors and by the Commonwealth Government as a member of the Professional Services Review Tribunal.

Noel's active professional and recreational life did not keep him from his family. His children each shared one or other of his passions: golf, skiing, surfing, cricket, fishing or tennis. They revelled in his attention, enjoying family camping and fishing holidays and was proud to see them through university. His greatest trial came in 1993 when his youngest child, Rosie, died from cancer at the age of 36. He cared for her with the patience, tolerance and understanding that were the hallmarks of his practice, in the face of the overwhelming grief he must have felt as her illness dissembled her immense creative and academic talents.

Noel and Diana travelled extensively visiting isolated places in a wide variety of vessels and vehicles and often in the company of close friends. In 2003, after the fabulous celebrations of Diana's 70th and their golden wedding anniversary, he was again faced with loss when Diana died. His own health had not been without its problems but, as with his own struggle with cancer since 2004, he bore them with amazing stoicism, retaining his gentle humour, charm and unflagging interest in others until his final days. He is survived by his children Andrew, Malcolm and Jill and five grandchildren.

Andrew and Jill Ramsey

CHRIS TOWIE 1955—2009

Chris Towie, a 1982 MBBS graduate of the Melbourne Medical School, died in the devastating fires which swept through much of Victoria on Saturday 7 February this year. Barely three weeks later, the Broadmeadows Town Hall filled to capacity with Chris' friends, patients and family who came together to remember a remarkable man. The many tributes from friends and family during the memorial service paint a picture of someone whose legacy was perhaps already well-written long before he died.

Born in Alberta, Canada, Chris migrated with his family to Australia when he was eleven. Long-time friends of Chris remembered him as the kind of child who loved maths quizzes and reading the encyclopaedia and took delight in confounding his teachers by learning to read upside down.

Many words were used to describe Chris as a person: eccentric and very clever; wildly unconventional and fiercely intelligent; physically powerful; controversial; unshakable, unmistakable and irreplaceable. Other stories of Chris told about his drug and alcohol-free, vegetarian lifestyle, his twice-daily meditation and a legendary kindness to animals which saw his Broadmeadows general practice—a converted bank building—often full of rescued animals.

With such character traits it comes as no surprise to learn Chris deliberately chose to work in areas of disadvantage because that was where he felt he could make the most difference. A strong campaigner for social justice, Chris would challenge orthodoxy and injustice wherever he found them and often took on the role of advocate for his patients.

His intuitive ability to assist with healing and make people feel comfortable was matched by his generosity, often paying for patients' prescriptions himself when he knew they couldn't afford to.

Chris sought refuge in the bush—retreating like a monk to draw strength from the pure, peaceful environment—and spent the last few weeks of his life there considering new challenges and horizons.

Towards the end of the memorial service Chris's brother, Rod, quoted him

as saying: 'The trouble with living is that you only get one body to live in, one life to live, when a million wouldn't be enough.'

Chris Towie was obviously an extraordinary person: someone who saw what was wrong in the world and sought to change it by changing himself. Perhaps the best legacy he could leave would be, as Chris' brother, Rod, suggested at the memorial, to take his example and live as he did.

Liz Brentnall from a DVD recording of the memorial service for Chris Towie

GORDON WALGRAVE TRINCA AO, OBE 1921—2009



Gordon Trinca, son of notable pioneer Melbourne surgeon and pathologist Alfred John Trinca, was educated at Melbourne Grammar School and the University of Melbourne. He went from general practice at Clifton Hill to a surgical career holding various posts before becoming head of a surgical unit at the Preston and Northcote Community Hospital.

In the 1960s, aware of the increasing volume of casualties from road accidents and concerned at how cases were handled as they came into the hospital, Gordon started collecting statistics. Under his direction surgeons were soon no longer 'on call' at home, but at the hospital ready to make the all-important first assessment of an accident case. Gordon himself set the example by spending long hours at the hospital during peak crash times. Later research showed conclusively how important early treatment was for the recovery of trauma victims.

While surgeons were only one group to fight for road safety measures to reduce

road trauma, they were an influential group—and among this group Gordon stood out as an incessant and successful campaigner. He chaired the Royal Australasian College of Surgeons (RACS) road trauma committee 1971-93 and NSW surgeon Jim McGrath noted that he was: 'the dominant force in the College road trauma work. His tremendous enthusiasm and drive inspired all of us.'

In December 1970 Victoria passed compulsory seat belt legislation—a world first. Much more was to follow: stricter seat belt legislation, helmets for cyclists, blood alcohol tests, speed limits, improved vehicle design, safety equipment, road improvement and vitally, education. Statistics quickly showed the enormity of the achievement. Overall road fatalities for Australia from 1960 to 1994 declined by 49 percent. There was a similar diminution of serious injuries from road crashes.

His international reputation for work in road trauma led to Gordon's establishment of the Global Traffic Safety Trust in 1985: a group of eight people in the field from different parts of the world. Informally known as 'Trinca's Thinkas', the group looked at the traffic injury issue globally, estimating that fifteen million people world-wide were injured annually in traffic accidents, and published a book, *Reducing Traffic Injury - A Global Challenge*, which received the prestigious 1988 international Volvo Traffic Safety Prize.

From 1939 Gordon was also active in the Lord Somers Camp and Power House. He held many posts and was involved in a wide range of activities with this organisation and its clubs for the welfare of young people.

The contribution of Gordon Trinca to combating road trauma cannot be overemphasised. The Gordon Trinca Medal of the RACS honours him as does the annual Gordon Trinca Lecture of the Australasian Trauma Society. A keen sportsman and poet, he was happily married to Elizabeth (Beth) Robertson, who died in 2004. He is survived by two sons and a daughter, three grandchildren and one great grandchild.

From Alan Gregory, author of Blood Belts Booze and Bikes, a history of the response of the Royal Australasian College of Surgeons to the epidemic of road trauma

FROM OUR COLLECTION

A MONUMENT IS UNCOVERED

RITA HARDIMAN

In late 2005 a plaque was discovered in the triradiate medical building during a refurbishment. It was made in the early 1900s to commemorate and express gratitude to a student of the University. The plaque reads:

IN MEMORY
OF
CANUTE HENRY CLOWES
A STUDENT OF THIS UNIVERSITY
1903-1910
HE DIED ON 27TH NOVEMBER 1910
IMMEDIATELY AFTER COMPLETING
HIS MEDICAL COURSE.
THIS TABLET HAS BEEN ERECTED BY
HIS FELLOW STUDENTS
IN REMEMBRANCE OF HIS
MANLINESS OF CHARACTER AND
KINDNESS OF HEART AND TO
COMMEMORATE THE SERVICES
THAT HE RENDERED TO STUDENT
LIFE IN THE UNIVERSITY.

To say that this plaque kindled some interest in the mystery that was Canute Henry Clowes would be an understatement. The plaque testifies to a student who made a large contribution to the University and its students. It was compelling: a mystery engraved in brass, waiting to be solved after many years. Who was Canute Clowes? What did he do that was so appreciated by his fellow students—enough for them to take it upon themselves to erect a plaque in his honour? For the following months, various members of staff and students passed through the curator's office of the Harry Brookes Allen Museum of Anatomy and Pathology and offered theories as to what might have happened to Canute Clowes and what had been so special about him.

No degree exists to acknowledge Canute Henry Clowes' graduation from the medical course. His passing occurred soon after the final exams for the year in 1910 and even sooner after his return home to Tylden in central Victoria. He died at home on 27 December (not November as stated on the plaque). As such, his name is not recorded with his

contemporaries who moved up into the medical profession: he had one more exam to pass, held in March 1911.

The only written clues to his participation in the medical course were two hand-written entries in anatomy examination results books of 1906 and 1908, the latter signed by Richard Berry, professor of anatomy at the time.

A PRODUCTIVE LIFE CUT SHORT

Canute Clowes was a widower at the time of his death. Details on his death certificate reveal that he had been married. His wife's name was Minnie. The death certificate also tragically revealed that Minnie had died in 1903, seven years before Canute. Canute and Minnie were married in April 1902, and Minnie died of 'heart failure' after a haemorrhage in a fallopian tube. So Minnie had presumably been pregnant with what would have been the Clowes' first child when she died. The pregnancy was ectopic and the result was the death of Canute's new wife. At this point it is significant to note that in modern times, most probably neither Minnie's nor Canute's medical conditions would have been fatal. One wonders whether Minnie's tragic death was the driving force behind Canute's choice of medicine as a career.



According to the death certificate, Canute Henry Clowes died in his home of a peri-tonsillar abscess, after a brief illness, at the age of 32 years. An obituary in the local district newspaper stated that he died of septic pneumonia, contracted from a poor patient he treated in Melbourne. According to the obituary, CH Clowes was attended to in his final days by his close friend from medical school, Dr Colquhoun.

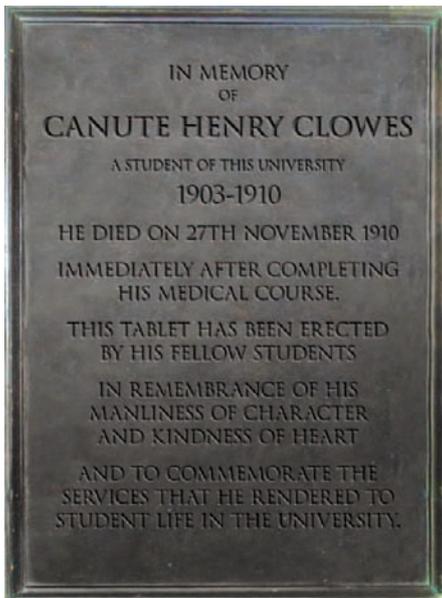
YOURS FAITHFULLY, W BALDWIN SPENCER

Baldwin Spencer, at the time Secretary of the Sports Union, wrote in a letter to Canute Clowes' father that Mr CH Clowes death 'is a loss to the University as a whole'.

Spencer later sent another handwritten letter together with some photographs of the 'memorial tablet' that had been erected in Canute's honour by students of the



Canute Henry Clowes' family gravestone



The plaque found during refurbishments.

University. This is the tablet discovered in 2005. Baldwin Spencer wrote in a second letter to Canute's father that he trusted the plaque would be 'of some gratification' to the Clowes family because in this way 'his memory will be perpetuated amongst future generations of students'. The University community will only be enriched by this story—by the fact that good deeds and a community spirit are both remembered and appreciated by your peers, and then by those in the future when they learn the story.

THE KYNETON CONNECTION

The Clowes family is still present in Kyneton and surrounds today. Indeed, there is even a Clowes Street in Kyneton. Through a member of the Medical History Society of Victoria I was invited to speak at the annual weekend conference in 2008, held in Kyneton.

There I met the Clowes family's GP, and other locals who knew or knew of the family. All were pleased to know of the existence and 'resurrection' of the commemorative plaque.

Soon after, I was sent photographs of the Clowes grave. This brought the story of Canute Henry Clowes to an end, at least in my mind. I found I had unearthed all the information I could from what was, in the beginning, the suggestion of a great life engraved in brass. Today, the plaque is awaiting restoration and a suitable location to be displayed with this story.

Rita Hardiman is curator of the Harry Brookes Allen Museum of Anatomy and Pathology

BROWNLESS BIOMEDICAL LIBRARY REDEVELOPMENT

In June this year the Brownless Biomedical Library was closed to allow construction work to begin on a significant redevelopment of the library building. The library, which has served medical students and other health and science students since the 1960s, is being substantially redesigned to offer an expanded range of services including: access to books, journals and online resources; improved self-service facilities; improved information technology and study environments for students; displays from the Medical History Museum; dedicated quiet study

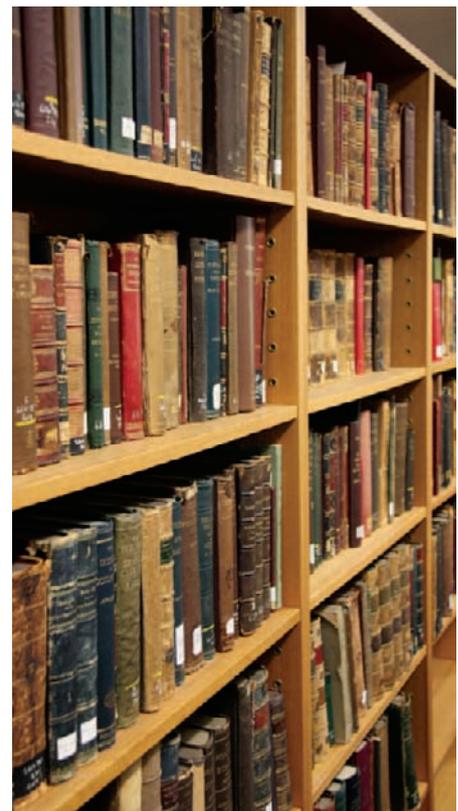
space for research higher degree and honours students; the Faculty Graduate Centre (Faculty delivered enrichment and administrative support services for students) and a café. The construction work is on schedule to be finished in December with staff and services available to students from February 2010.

These photographs were taken as library materials were removed to other sites for the duration of the renovations.

More on the web: www.lib.unimelb.edu.au/collections/medicine/



Moving the journals collection



The rare books collection

IN BRIEF

CONGRATULATIONS TO ALUMNI, FRIENDS, STAFF AND STUDENTS

Thomas F Acheson (BSc 1954, MBBS 1957)—OAM for service to medicine as a general practitioner, through administrative roles with aged-care organisations, and to the community.

Associate Professor John W Agar (Staff)—OAM for service to renal medicine, and to the community of Geelong.

James D Best (MBBS 1972, MD 1989, Head, School of Medicine)—reappointment as Chair, NHMRC Research Committee.

Samuel Berkovic (Medicine, Austin/Northern Hospitals, Epilepsy Research Centre)—2009 Bethlehem Griffiths Research Foundation Medal.

John A Carnie (MMed 1989)—PSM for outstanding public service in leading the advancement and protection of the health and well-being of all Victorians.

Lawrence A Carroll (MBBS 1963)—OAM for service to medicine in the field of ophthalmology, particularly through the provision of surgery and training in developing countries.

Jennifer Conn, Margo Collins, Agnes Dodds and Ruth Sutherland (Medical Education Unit)—Australian Learning and Teaching Council Citation for Outstanding Contributions to Student Learning and Award for Programs that Enhance Learning for Innovation in Curricula, Learning and Teaching for their program 'Beyond Serendipity: Structuring early Clinical Skills Learning for Medical Students'.

Alan K Eade (GDipEpid&Biostat 2004)—ASM for outstanding contribution to the development and provision of ambulance services in Victoria.

Elizabeth A Farrell (Obstetrics and Gynaecology)—AM for service to medicine in the field of women's health, particularly obstetrics and gynaecology through research, clinical practice, education and administrative roles, and as a contributor to a range of professional organisations.

Sandra Hacker AO (MBBS 1969, GradDipPsych 1974)—appointment as Chair, NHMRC Australian Health Ethics Committee.

Liz Hartland (Coordinator, Infection and Immunity Research Domain, Microbiology and Immunology)—2010 Australian Society for Microbiology Frank Fenner Award.

David J Hill—AO for service to public health, particularly through leadership roles in the promotion of cancer awareness and prevention programs.

James Hillis, Brendan Jones and Ewan Chan (medical students)—2009 Dreamlarge Knowledge Transfer Student Project Grant for their part in their development of 'Teach the Teacher: Sexual Health Activities Booklet'. The booklet has been produced through collaboration between medical and education students at the University of Melbourne and the Australian Medical Association of Victorian Doctors in Training and is aimed part of a project aimed at helping future teachers feel comfortable when dealing with sexual issues in the classroom. For more information see: http://www.mdhs.unimelb.edu.au/knowledge_transfer/podcasts/teach_the_teacher

Michael R Jones, PSM (MBBS 1963)—AM for service to medicine in the areas of health services management, accreditation and patient care, particularly with the Australian Council on Healthcare Standards and the World Health Organisation.

Michael R Kidd (MBBS 1983)—AM for service to medicine and education in the areas of general practice and primary health care and through a range of professional organisations.

Geoffrey L Klug (MBBS 1959)—OAM for service to medicine, particularly in the field of paediatric neurosurgery, as a clinician and mentor to professional organisations, and to the community.

Liyen Loh (PhD candidate, Microbiology and Immunology)—high commendation in the 2009 Premier's Awards in Medical Research for her work towards understanding how HIV-infected people respond to the virus and how this plays a role in successful vaccine design.

Kylie Mason (WEHI)—Premier's Award for Public Health and Medical Research in recognition of her ground-breaking work in the treatment of blood cancers and discoveries about the life-span of blood clotting cells.

William D McKellar (MBBS 1962)—OAM for service to medicine as a paediatrician, and to the community of Barwon.

Brian A McNamee (MBBS 1979)—AO for service to business and commerce through innovative leadership in the expansion and growth of the Australian bioscience industry, and to the community.

Alan B P Ng (MBBS 1958)—OAM (Posthumous) for service to medicine, particularly in the field of pathology.

Stephen O'Leary (William Gibson Chair of Otolaryngology, RVEEH)—Royal Australasian College of Surgeons' John Mitchell Crouch Fellowship.

Anna Proietto (WEHI)—high commendation in the 2009 Premier's Awards in Medical Research for her research into the development and functions of dendritic cells and their role in regulating the immune system to prevent autoimmune disease.

David J Scrimgeour (MBBS 1974, BMedSc 1974)—AM for service to medicine through the development and delivery of services and programs in remote Indigenous communities, and to public health research.

Micheil F Sweet (MBBS 1958)—OAM for service to medicine as a general practitioner, and to the community of the Derwent Valley.

Melissa Wake (Paediatrics, RCH & Murdoch Children's Research Institute)—2009 Federal Health Minister's Award for Excellence in Health and Medical Research.

STUDENT PRIZES AND AWARDS

2008 UNDERGRADUATE MEDICAL STUDENT PRIZES AND AWARDS

GA Syme Exhibition—*Tsui Nam Trier Lau*

Australian Medical Association Prize—*Hannah Skrzypek*

Clara Myers Prize in Surgical Paediatrics—*Xueling Tan*

David Danks Essay Prize for Human Genetics—*Emily Margret Geraghty*

Dr Kate Campbell Prize—*Ankit Garg*

Dwight's Prize in Integrated Clinical Studies—*George Heriot*

ESJ King Prize—*Julia Lai Kwon*

Edgar and Mabel Coles Prize—*Kate Hodgson*

Edgar Rouse Prize—*Hannah Skrzypek*

Fulton Prize—*Lucy Ralston*

Geoffrey Royal Prize in Clinical

Surgery—*Jasana Aleksova*
 Geriatric Medicine (Aged Care) Prize—*Lucy Ralston*
 GlaxoSmithKline Semester 5 Prize—*Julia Lai Kwon*
 Harold Attwood Prize in Pathology—*George Heriot*
 Hedley F Summons Prize (for Otolaryngology)—*Halina Lisnichuk*
 Herbert Bower Memorial Prize—*Danielle Clucas*
 Herman Lawrence Prize in Clinical Dermatology—*Bonnie Swan*
 Howard E Williams Prize—*Scott Schemer*
 Ian Johnston Prize in Reproductive Medicine/Biology—*Scott Schemer*
 James Stewart Bequest—*Julia Lai Swon, Vivien Li & John William Guinane*
 Jamieson Prize—*Sidharth Vermuri*
 John Adey Prize in Psychiatry—*Jonathan Epstein*
 John Cade Memorial Medal in Clinical Psychiatry—*Scott Schemer & Lucy Ralston*
 Katharine Woodruff Memorial Prize – Palliative Medicine—*Rehana Ratnatunga*
 Keith Levi Prize—*Sidharth Vermuri*
 Max Kohane Prize—*Lucy Ralston*
 Neil Johnston Prize—*Nathan Wong*
 Peter G Jones Elective Essay Prize (UMMS Elective Essay Prize)—*Jennifer Jamison, Cameron McPherson, Jonathan Epstein & Daniel Mason*
 Prize in Clinical Gynaecology—*Jyoti Blencowe*
 RACGP Victoria Faculty Prize—*Jessica Day*
 RANZCOG Women's Health Award—*Rehana Ratnatunga*
 Rehabilitation Medicine Prize—*Danielle Clucas*
 RL Simpson Memorial Fund—*Christine Mandrawa, Sudha Palit, Chance Pistoll, Joshua Crace & Sarah Good*
 Robert Gartly Healy Prize in Medicine—*Sidharth Vermuri*
 Robert Gartly Healy Prize in Obstetrics—*Francene Bond*
 Robert Gartly Healy Prize in Surgery—*George Heriot, Sidharth Vermuri, Francene Bond*
 Robert Yee Prize in Medicine—*Sarah Good*
 Royal Australian and New Zealand College of Ophthalmologists' Prize—*Michael Jamieson*
 Royal Children's Hospital Paediatric

Handbook Award—*Paxton Loke*
 Sir Albert Coates Prize—*Asma Sohail*
 Smith and Nephew Prize—*Lucy Ralston*
 The Ilana Rischin Award for Outstanding Achievement by an International Student in Medicine (2007)—*Shuli Cheng*
 Therapeutic Guidelines Award—*Ajay Iyengar*
 Thomas and Elizabeth Ross Scholarship—*Nicole Tham*
 Vernon Collins Prize in Paediatrics—*Stephanie Chen*
 Victorian Metropolitan Alliance Prize in General Practice—*Joe Rotellai*.

2008 DEAN'S HONOURS LIST

Semester 12

Francene Christie Woodse Bond, Sook Chuei Cheong, Kathryn Nicole Cugley, Katherine Dorothy Cummins, Jonathan Epstein, Lawrence Evatt Gray, Khai Lin Huang, Hieu Minh Lam, Heath Andrew Liddell, Katherine Moors, Lucy Victoria Anastas Ralston, Erin Frances Sharwood, Scott Andrew Shemer, Candice Simpson, Hannah Judith Michel Skrzypek, Victoria Mary Snowball, Xueling Tan, Jessie Huey Teng, Sidharth Vermuri.

PARTICIPANTS NEEDED FOR UNIVERSITY OF MELBOURNE TRIALS

OSTEO-CISE: STRONG BONES FOR LIFE

This study, being run by the Department of Medicine at Western Hospital combines health education, behavioural modification strategies and high velocity power training with the aim of improving bone strength and reducing the incidence of falls and fractures in older Australians. The study group are looking for more than 80 participants to participate in the second stage of the study.

Participants will need to attend a gym for twelve months training three times a week, under supervision of a qualified exercise trainer once a week. In addition to the exercise program, development of personal strategies to improve lifestyle behaviours is included. Participants will also need to attend quarterly educational seminars to improve their knowledge and awareness of bone health.

Bone density testing, muscle strength and function testing is conducted every six months.

If you have patients interested in participating in the study (Melbourne only), contact program coordinator Dr Christine Bailey on: 8345 7164.

FITNESS FOR THE AGEING BRAIN STUDY II

This study has been designed to test whether physical activity can improve the memory and wellbeing of sufferers of Alzheimer's Disease (AD). The main hypothesis is that participants with mild to moderate AD who participate in 24 weeks of physical activity will experience significantly less memory loss by the end of the program than participants who undertook usual exercise activity.

The study, led by Professor Nicola Lautenschlager, Chair of Old Age Psychiatry and Director of St Vincent's Aged Psychiatry Service, is being coordinated across the University of Melbourne, the National Ageing Research Institute, the University of Western Australia and the University of Queensland with the support of Alzheimer's Australia and is funded by the NHMRC.

The study needs both participants living at home with mild to moderate AD, and their carers, from metropolitan areas in Melbourne, Brisbane and Perth. The program prescribes a range of physical activity for up to 150 minutes per week. Participants will have personalised training programs and be assessed on their activity using a pedometer, their ability to walk distances, how quickly they can get out a chair, and their ability to grip objects.

Commenting on the study Nicola Lautenschlager says, 'the evidence is mounting that regular exercise is good for brain function, even in older age. Whilst promising progress has been made in drug development research, there is an urgent need to progress research on non-pharmacological treatment for AD and one of the most promising strategies is physical activity.'

People from Melbourne, Brisbane or Perth who are interested in participating should contact Dr Elizabeth Cyarto on 03 8387 2332.

More information is available on: www.mednwh.unimelb.edu.au

BOOKS

A Century of Influence The Australian Student Christian Movement 1896-1996

by Renate Howe, UNSW Press, 2009,
paperback, pp480, rrp \$69.95

This is an account of a remarkable history begun during a meeting at Ormond College in June 1896, led by John R Mott, the first General Secretary of the World Student Christian Federation (WSCF). Renate Howe has done a remarkable job—not only sifting through mountains of documents, but also undertaking lengthy and telling verbal histories from many key players.

The book gives a fascinating insight into changing Christian views and attitudes over the century, as adopted and adapted by successive generations of young people embarking on careers in universities. Not only did the movement contribute to shaping the lives of individuals, it had a powerful international influence in many ways.

The Australian Student Christian Union, as initially titled, mixed young men and women and frequently provided the only outlet for the growing number of young women on campuses around Australia to participate in situations where ideas could be explored and they could hold office as much as men.

In the late 1800s, its work was seen as 'the evangelisation of the world in this generation' and many young graduates did commit their lives to missionary work in hospitals, schools and parishes in India, Africa and China. Before the First World War, however, awareness was growing that better understanding

of other cultures was needed to bring real change in the world; not imposing our beliefs on them. Following the war, a commitment to international peace was seen as more appropriate than traditional evangelising missions. Amongst other things, the Student Christian Movement (SCM) urged action to abandon the White Australia policy. Many within it urged dropping commitment to formal religious doctrine and examining growing interest in social reform, including the politics of such movements as founding of this University's Labour Club. The Evangelical Union split off, distressed at the move away from traditional religious endeavours.

The years following the Second World War were, in many ways, the blossoming of the SCM. Still struggling with many issues, still led by students, it was supported by older members who did their best to hold it together at difficult times. Traditional beliefs were being questioned and tested and membership longer depended on formal Christian tenets.

The remarkable contribution of Herb Feith, from the Melbourne SCM, working in the public service of the new Sukarno Indonesia after graduating from Melbourne in political science, was followed by Operation 20 Plus, in 1954, when a significant number of members, including medical graduates, committed to work in Indonesia. Ken Inglis, a former SCM leader, became founding Vice-Chancellor of the University of Papua new Guinea. My medical contemporary, Ian Maddocks, founded the Papua Medical College, and later the Faculty of Medicine of the university. Vern Bailey made a remarkable contribution to improved nutrition and health in Indonesia then spent many years,

doing similar imaginative and productive work in this field through the World Health Organisation.

Perhaps, as Renate's title suggests, the biggest contribution of SCM has been in the way it has influenced the development and attitudes of generations of young people as their careers evolved. The list of notables touched by it included the first president of the United Nations, a notable prime minister, a deputy prime minister, many high achieving state ministers, the heads of many government departments, professors and vice-chancellors and leaders in many professions. *A Century of Influence* is worthy of celebration!

David Penington

Psychiatric Ethics Fourth edition

by Sidney Bloch and Stephen Green,
Oxford University Press, 2009,
paperback, rrp\$59.95

Ethical issues are pivotal to the practice of psychiatry. Anyone involved in psychiatric practice and mental healthcare has to be aware of the range of ethical issues relevant to their profession. An increased professional commitment to accountability, in parallel with a growing 'consumer' movement has paved the way for a creative engagement with the ethical movement.

The bestselling *Psychiatric Ethics* has carved out a niche for itself as the major comprehensive text and core reference in the field, covering a range of complex ethical dilemmas which face clinicians and researchers in their everyday practice. This new edition takes a fresh look at recent trends and developments at the interface between ethics and psychiatric practice.

Coming ten years after the third edition, the editors have observed several emerging aspects of psychiatric practice and as a result, five new chapters have been added, including cutting edge and controversial topics—such as neuroethics, trauma/PTSD, and the relationship between psychiatry and the pharmaceutical industry. All other chapters have been fully revised and updated.

The book will continue to be essential reading for psychiatrists, psychologists, other mental health professionals, and bioethicists, as well as of interest to policy makers, managers and lawyers.



WSCF Conference, Agape, Italy, 1952. ASCM delegates (L-R) in back row: Harry Wardlaw (1st), David Penington (2nd), 'Bill' Strugnell (4th) and Frances Paton (5th). ASCM Centennial History Collection.



 **CHIRON**

2009