



# CHIRON

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# UMMS

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Medical Society  
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# CHIRON

Vol. 2 No. 5

Contents

April 1992

1 Guest Editorial – UMMS and the Medical School . . . . *Graeme B. Ryan*

### Dean's Lecture Series

2 • Seminar – Issues in Transplantation: Aspects of Supply  
*Prof. Emer. Richard Lovell, Prof. Gordon Clunie,  
Prof. Priscilla Kincaid-Smith, Mr Robert Jones,  
Prof. Richard Smallwood, Dr Frank Shann,  
Dr Tom Mandel, Prof. Stephen Cordner, Mr Russell Scott*

15 • The 1991 Mathison Lecture – Endocrinology in the  
Molecular Age . . . . . *John P. Coghlan*

17 • The 57th Beattie Smith Lecture – The University,  
Psychiatry and the Care of the Mentally Ill . . . . . *Bruce S. Singh*

### Faculty of Medicine, Dentistry & Health Sciences

24 • From the Dean . . . . . *Graeme B. Ryan*

27 • Retirements

28 • Reports from Clinical Schools  
Austin Hospital & Repatriation General Hospital . . . *Bernard Sweet*  
Royal Melbourne Hospital & Western Hospital . *Robert FW. Moulds*  
St Vincent's Hospital & Geelong Hospital . . . . . *Wilma M. Beswick*

29 • Final Year MBBS 1991

• Top Final Student, Graduate List

30 • Prizes and Awards

32 • The Austin Hospital Clinical School – Twenty-five  
Years of Patient Care, Teaching and Research, 1966-1991

### University of Melbourne Medical Society

41 • Notice of Annual General Meeting 1992  
• Minutes of Annual General Meeting 1991  
• UMMS B.Med.Sc. Prize 1990

43 • Reunions

45 • UMMS 1990 Lecture – The Melbourne Medical School and  
Some of its Characters, 1931-1975 . . . . . *Sir Sydney Sunderland*

53 Is there a Doctor in the House?  
Medical Women's Centenary Celebrations 1891-1991

59 Books . . . . . *Harold D. Attwood*

61 News

63 Obituaries

68 UMMS Membership List

72 Medical History Unit . . . . . *Harold D. Attwood*

**Front Cover:** Aerial view, Austin Hospital.

**Back Cover:** Dates to Remember – Continuing Medical  
Education, Dean's Lecture Series, 1992.

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### UMMS AND THE MEDICAL SCHOOL

CLOSELY FOLLOWING TWO IMPORTANT ANNIVERSARIES in 1991 – the centenary of the graduation of the Medical School's first women doctors and the twenty-fifth birthday of the Austin Hospital Clinical School – this year we celebrate the 130th anniversary of the founding of the Medical School and the tenth birthday of the University of Melbourne Medical Society (UMMS). UMMS was founded at an inaugural meeting of graduates on 19 April 1982. The Constitution of the Society was adopted at its second meeting on 13 September 1982. Ten years on, what has happened to the Medical School and the Society?

First, the Faculty of Medicine has become the Faculty of Medicine, Dentistry and Health Sciences, comprising the Schools of Medicine, Dental Science (formerly the Faculty of Dental Science which amalgamated with Medicine in 1989), Physiotherapy (a new School established in 1991) and Behavioural Science (formerly the University's Department of Psychology which transferred from the Faculty of Arts in 1992). The structure of the new 'super-Faculty' provides opportunities for more effective interactions between the four major health-related disciplines in the University, whilst promoting the academic independence of the individual schools and encouraging their more active involvement with the appropriate graduate communities and professional groups outside the University.

The Dean of the Faculty of Medicine in 1982 was Professor David Penington. At the end of 1985, after eight years as Dean, Professor Penington stepped aside from that position to allow himself more time to deal with his major responsibilities as Chairman of the National AIDS Task Force and Chief Advisor on Health Policy and Programs to the Health Department Victoria as well as his Chairmanship of the University Department of Medicine at St Vincent's Hospital. In 1988, he was appointed Vice-Chancellor of The University of Melbourne, a position that he has filled with characteristic energy and distinction, particularly reflecting his long standing commitment to promoting excellence and accountability in University teaching and research.

The Faculty has continued the process of curriculum reform initiated by David Penington. The Curriculum Review Committee actively monitors the success of the teaching program in meeting the agreed course objectives through consultation with students and staff and the extensive use of student questionnaires. There has been a substantial increase in clinically related teaching in the preclinical years of the course. Advanced Study Units have proved to be a useful innovation in providing students with opportunities for elective independent study in particular areas. There has been an expansion in general practice experience and all students spend significant periods of time in country hospital rotations. In recent years, we have been particularly fortunate in obtaining affiliation agreements with Western Hospital and The Geelong Hospital, both of which add further strength to our already excellent network of teaching hospitals.

We have seen a burgeoning of important academic developments in the Medical School, not only through the establishment of new Chairs (for example, Orthopaedic Surgery in the Department of Paediatrics and, fully funded from hospital sources, Chairs of Medicine and Surgery at Western Hospital and The Geelong Hospital) but also through the development of a number of Professor/Director appointments in collaboration with teaching hospitals (for example, in Psychiatry, Anatomical Pathology, Clinical Haematology and Medical Oncology, Rehabilitation Medicine, Gerontology and Geriatric Medicine, Medical Imaging, Adolescent Health, Cardiac Surgery, Perinatal Medicine, Anaesthesia, Nephrology.)

The research activities of the Medical School continue to thrive. We easily maintain our leadership position in research, attracting

far more competitive external research funding than any other medical school in Australia. The past decade has also been a period of massive increase in postgraduate research student enrolments for the Medical School, more than compensating in total student numbers for the 20 per cent reduction in medical undergraduate intakes that have occurred in the School in response to medical workforce considerations.

The Medical School has needed to survive the substantial budget cuts that all the older universities have suffered in recent years, particularly in association with the 'reforms' imposed on the Higher Education sector by the Commonwealth Department of Employment, Education and Training under Minister John Dawkins. Our students now pay fees (the Higher Education Contribution Scheme charge) incurred as an accumulating tax liability against future earnings at a rate of about \$2,000 per year. The subsidised overseas student scheme has been replaced by the full-fee overseas student scheme under which non-resident students currently pay \$24,000 per year to enrol in the medical course. This year, more than 40 such students will enter the medical course here – about half receive government scholarships that pay the fees but not living expenses.

The student population continues to change. Half of those now entering the medical course are women. For the past four years the top student in Final Year has been a woman. More than half of our students have a migrant background with either themselves or one or both of their parents being born overseas. There is still very heavy demand for entry to the course, causing the VCE cut-off score to escalate astronomically. For 1992, students needed a VCE score of at least 379 to gain entry to the course, the highest cut-off score of any University course in the State. Not surprisingly, our students are extraordinarily smart and hard-working, with very few failing years or otherwise falling by the wayside. We encourage and enjoy their participation on the Faculty Board and in the Curriculum Review Committee where they play a particularly important role in assisting us in evaluating and upgrading the course.

And what of the Medical Society? Published with this issue of *Chiron* you will find the list of current membership by years of graduation. It's not bad, but we need to do better in encouraging more of our colleagues to show their involvement and commitment to their *alma mater*. Please help us in increasing the participation of your class mates.

We have had some changes in the UMMS Executive Committee over the years, most notably the appointment of Professor Emeritus Sir Sydney Sunderland as President of the Society, in succession to the late Professor Emeritus Sir Douglas Wright. The Dean's Lecture Series, Professor Emeritus Richard Lovell's Ethics Seminars, and the Annual UMMS Functions continue to be well attended and provide a useful focus for interaction between the Medical School and our graduates. The assistance that Robin Orams and her staff in the UMMS office give to the organisers of Class Reunions has been very valuable. And our journal, *Chiron*, has had ten years of going from strength to strength under the inspired editorship of Maggie Mackie and Peter Jones. On behalf of all members, I congratulate them for their marvellous work. I also thank the Medical Defence Association of Victoria for their continuing generous sponsorship of *Chiron*.

In closing, I wish to bring to the attention of all UMMS members that the University has agreed to run an appeal during 1992 to establish the R. Douglas Wright Fellowship in memory of 'Pansy' Wright, Professor of Physiology, Dean of Medicine, Chancellor of the University, a member of UMMS and an extraordinary, much quoted and loved character! When you receive notice of the appeal, please give generously!

Graeme B. Ryan, Dean

SEMINAR

# ISSUES IN TRANSPLANTATION ASPECTS OF SUPPLY

Dean's Lecture Series  
School of Medicine  
The University of Melbourne  
2 August 1991



The martyred twin physicians Cosmos and Damien  
(Detail from a 16th century painting attributed to Fernando Del Rincon,  
in the Prado, Madrid.)

Convener

**Professor Emeritus Richard Lovell, AO**

Professor of Medicine, 1955-83

Former Chairman NHMRC Medical Research Ethics Committee

## ISSUES IN TRANSPLANTATION ASPECTS OF SUPPLY

### PROGRAM

#### Introduction

Professor Richard Lovell

#### HISTORY

Professor Gordon Clunie  
James Stewart Professor of Surgery;  
Deputy Dean, Faculty of Medicine, Dentistry and  
Health Sciences

#### WHAT HAPPENS IN PRACTICE

##### Experiences of a physician

Professor Priscilla Kincaid-Smith, AC, CBE  
Professor of Medicine; Director of Nephrology,  
The Royal Melbourne Hospital

##### Experiences of a surgeon

Mr Robert Jones  
Director, Liver Transplant Unit,  
Austin Hospital

### DISCUSSION

#### ASPECTS OF SUPPLY – PRESENT AND FUTURE

##### Organs from adults

Professor Richard Smallwood  
Professor of Medicine; Head of Gastroenterology,  
Austin and Repatriation General Hospitals

##### Organs from children

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

##### Unconventional sources of tissue – fetal and xenogeneic

Dr Tom Mandel  
Head, Transplantation Unit, Walter and Eliza Hall  
Institute of Medical Research

##### Tissue banks

Professor Stephen Cordner  
Professor of Forensic Medicine, Monash University;  
Director, Victorian Institute of Forensic Pathology

##### International aspects

Mr Russell Scott  
Consultant to Mallesons Stephen Jaques, Solicitors;  
Member NHMRC Medical Research Ethics Committee,  
1982-1990; Adviser WHO/CIOMS Project on  
Organ Transplantation

### DISCUSSION

## INTRODUCTION



Prof. Richard Lovell

**I**T MUST BE about twenty years ago that I spoke at a Friday lunchtime seminar at The Royal Melbourne Hospital immediately on returning from the first international conference on human organ transplantation in Paris. I remember trying to convey the sense of excitement for the future that I felt. I have something of the same feeling today. What we shall do this afternoon, is first to set the scene by looking at today's practice and then focus on the key questions of

supply and demand. In doing this we will look not only at the growing edge of transplantation endeavours, but we will also try to see beyond, at what the future may hold. And, in line with the policy we have developed in previous seminars in this series, we are glad to be conducting not just a medical occasion but a gathering involving interested people from the broader community. This topic potentially touches all of us.

## HISTORY OF TRANSPLANTATION

### Professor Gordon Clunie



Prof. Gordon Clunie

**S**INCE THE BEGINNING of recorded history, surgeons have been engaged in an amputative specialty, their technical skills being displayed largely in the precision and the speed of the amputative procedure. However beneficial such operations may have been in the control of disease and in the management of injury, surgeons have always dreamed of restoration of function and form rather than simple destruction of tissue.

Early writings tell of such restorations, most clearly illustrated in the perhaps miraculous, perhaps apocryphal surgery of St Cosmos and St Damien, who replaced the gangrenous leg of the sacristan of the former Roman Basilica, with the healthy limb of an Ethiopian gladiator, retrieved from his burial place on the Hill of St Peter – the first recorded cadaver transplant.

Centuries later, the first great surgical researcher, John Hunter, claimed success with the transfer of parts of chickens from their normal site to elsewhere in the body – which we would now call autotransplantation – and even with a transfer between members of the same species – allotransplantation – such as the transfer of a cock's testis to a hen, although he also records that the hen's nature was unchanged. Indeed, Hunter claimed that there was 'a disposition in all living substances to unite when brought into contact with each other', happily true within an individual's body, but as we now know, not the case when the tissues are foreign to each other. The capacity of the body to accept the transfer of tissues from one part to another had been recognised by surgeons long before Hunter's time, with the once common battle or domestic injury of loss of the nose being treated by Indian surgeons by the rotation of a flap from the forehead or by the great Renaissance war surgeon, Ambroise Paré, by a flap from the upper limb.

As surgical techniques and instruments improved and as the development of anaesthesia allowed greater time for the conduct of more precise surgery in the latter part of the nineteenth and in the early years of the twentieth century, a large number of surgical researchers undertook the transfer of tissues and organs between experimental animals, with varying degrees of success. Among the

most effective of such researchers were Guthrie and Carrel, who perfected the technique of vascular anastomosis, leading to the development of vascular surgery. The transfer of tissue from one part of the body to another has reached its zenith with the progress of microsurgery, pioneered in this centre by Ian Taylor and Bernard O'Brien and their colleagues, which allows the reconstruction and salvage of digits and limbs which would have been sacrificed only a few short years ago. What Carrel and his colleagues had failed to recognise was that the ultimate failure of many of the tissues and organs exchanged between animals and later between humans was due to the process of recognition and destruction of foreign tissue by the host's immune system. Some tissues such as the cornea appear to be privileged and less susceptible to (although not immune to) rejection than vascularised organs, and the transplantation of cornea to restore sight is one of the success stories of twentieth century surgery. Early experiments involving kidney transplants from cadavers or even from animals to patients suffering from renal failure, although justified in the context of the times when little else could be offered, were doomed to failure. The signal exception was in the case of monozygotic or identical twins, where the twins' tissues are identical, the immune system is not involved, and rejection does not occur. The first successful kidney transplant between twins was performed by Murray, Merrill and Harrison in Boston in December 1954, not only establishing the feasibility of the procedure but also acting as a stimulus for the development of forms of immunosuppression which would allow the wider application of the technique to allotransplants between non-identical individuals.

Let us pause for a moment to consider the ethical and moral issues posed by this operation and some of the unsuccessful earlier attempts to carry out live donor related kidney grafts. For the first time, individuals as potential donors were being asked to undergo a major surgical procedure not for their own benefit or their own health, but for the welfare of another. Living donor transplantation of non-regenerative tissue remains a unique process and one which can only be justified if the chances of success are high for the recipient and the risks of morbidity or mortality low for the donor.

The surgical and clinical success of the first Boston transplant was followed by largely unsuccessful attempts in both the USA and in Europe to control the process of rejection of allotransplants by total body irradiation. The development of the immunosuppressive drug azathioprine, and the successive utilisation of steroids, antilymphocyte globulin and more recently cyclosporin, monoclonal antibodies and FK506 have brought organ transplantation, particularly of the kidney, the heart and liver, from an experimental process to a well established and highly successful form of therapy in a period of less than thirty years. The problems which still restrict the wider application of the procedures relate to the difficulties of tissue preservation, to the persistent side-effects of immunosuppressive drugs, but most particularly to the question of organ supply. The only potential sources of organs are live or cadaver human donors or animals, each with their particular problems in terms of compatibility, community attitudes, ethics and morals, and we shall hear more on each of these issues during the seminar. The achievements of the last thirty years have been so great that I have no doubt that the problems can be solved, thus establishing surgery in its new minimally destructive and highly reconstructive role.

*... surgeons have always dreamed of restoration of function and form rather than simple destruction of tissue.*

## WHAT HAPPENS IN PRACTICE

### EXPERIENCES OF A PHYSICIAN

Professor Priscilla Kincaid-Smith



Prof. Kincaid-Smith

OVER THE THIRTY years since the renal transplant program commenced at The Royal Melbourne Hospital attitudes within the profession have altered. The following quotation from a recent editorial expresses the current attitude to transplantation in the profession and seeks the support of the profession in achieving adequate supply:

It is clear that organ and tissue transplantation is one of the major therapeutic advances of

our time, the benefits of which can be realised to the full only with generous community understanding and support. How to achieve that support in a setting of tragedy and its attendant grief is a challenge for all members of our society. The medical profession as a whole needs to assess the part that it can best play in ensuring that that challenge is met.<sup>1</sup>

Transplantation was not always regarded as 'one of the major therapeutic advances of our time', nor did it always have the support of the profession. In the early days of transplantation we sometimes faced vigorous opposition from some of our medical and nursing colleagues as well as strident criticism for subjecting patients to the 'experimental procedure' of transplantation.

The first issue which I should like to discuss in relation to supply of donor kidneys is the question of adverse publicity, particularly adverse publicity based on biased and incorrect statements. Let me give you two examples of the disinformation which related to well-known medical figures and which had serious effects on supply of donor kidneys at that time: Sir Macfarlane Burnet, one of Australia's greatest scientists, appeared on the front page of *The Age* with headlines 'Transplantation in man can never work'. The problem was that he made this statement several years after our program started and at a time when we were justly proud of our 80 per cent 1 year graft (and patient) survival – you can imagine what an impact that statement had on our patients and their relatives, on our medical and nursing colleagues and particularly those who found the whole question of transplantation distasteful and who were looking for reasons to oppose continuation of the transplantation program. You will not be surprised that this statement also had a major impact on availability of donor organs.

Another incident which had less impact in Australia than in the United Kingdom occurred as late as 1974. A prominent nephrologist and Professor of Medicine in London claimed in a letter in the *London Times* that transplantation was so unlikely to succeed that the medical profession should reject it as an unethical experiment. Although this statement was clearly untrue and reflected a personal and individual bias, it was nonetheless very harmful to the planning of transplantation facilities in the United Kingdom at that time and had some impact in Australia because it was picked up by the media here.

Repeatedly since that time we have suffered from adverse publicity which was often ill-informed, but which created sufficient media interest to lead to a significant, sometimes substantial, reduction in the supply of cadaver organs donation. A 'Panorama' program in Britain some years ago was so strongly slanted against transplantation that it affected donor organ supply around the world, including Australia – the 'Couchman Show' last year also had adverse effects in this country.

Returning to the early days of transplantation, our results in the first 24 patients transplanted were recorded in *The Lancet* in 1967, 80 per cent 1 year graft (and patient) survival<sup>2</sup>. At that time we had only one machine and 2 places for patients on dialysis. They needed 12 hours overnight dialysis on alternate nights. On the positive side the waiting time for patients was short – from 2 weeks

to 3 months. We didn't have to fuss with tissue typing in those days, only red blood cell typing was done and it was therefore quick and easy to find a compatible kidney.

Our enthusiasm for cadaveric transplantation was almost unique in 1967 because Murray, in a review of world results in that year, showed that one year patient survival in small units (such as ours) was 21 per cent and in large units 39 per cent. With these poor results most units in the United Kingdom or United States of America opted for maintenance dialysis or living donor transplantation rather than cadaver transplantation. History – I am glad to say – proved that we were right.

We have continued with a major emphasis on cadaveric transplantation. Our original aim was to give every patient with renal failure a functioning transplant. As the age of people commencing dialysis increased, we were forced to make an arbitrary cut-off point at 60 years as the upper age limit for renal transplantation. This is because the results in older patients are less good. In making such rules the physician faces an ethical conflict between his duty to his patient to give each individual the best available treatment and his duty to society to ensure the optimum use of a scarce resource. This is the second issue which I should like to address today.

I thought that I would try to let you see how recipients of kidney transplants perceive our dialysis-transplant program and particularly how they react to issues relating to the shortage of cadaver kidneys and their allocation.

I wish first to introduce Mr M., who might have been sentenced to permanent dialysis because of a policy we had relating to older transplant recipients who can be shown statistically to fare less well than younger patients. We had a policy of doing coronary angiograms on patients over 55 and excluding those with significant disease. Mr M. fell into the latter category and his name was removed from the transplant list. He would still be on dialysis now if he had not challenged our policy. Mr M., who has had a transplant, is here today to give us briefly what might be termed the 'consumer's perspective'. [Mr M. then spoke about what he saw as an inequitable initial decision and the process that he followed to have his name restored to the list of patients eligible for a transplant.]

Secondly, I would like to introduce Mr E., referred to me for a transplant by a urologist in 1967. Luckily – thanks to medical management of his cysteine stones and his outstanding compliance – he didn't require dialysis for almost twenty years. He waited for a very long time on dialysis as another victim of our rules, this time relating to tissue typing. I've never been a strong advocate of tissue typing because our early transplant program was so successful without tissue typing and on the international scene, it is of interest that there has recently been a call to abandon tissue typing because of excellent results since cyclosporin was introduced. Mr E. had a very long wait for a transplant because of his tissue typing and I'd like to ask him, given that there is a small statistical benefit to be gained from tissue typing, would he rather have say a 3-5 per cent better chance of a successful transplant and a long wait on dialysis, or would he rather opt for a system which gave more weight to 'first come first serve' and less to optimum tissue typing. [Mr E. then indicated that, in the light of his experience, he would opt for the shorter wait.]

*In making such rules the physician faces an ethical conflict between his duty to his patient to give each individual the best available treatment and his duty to society to ensure the optimum use of a scarce resource.*

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## EXPERIENCES OF A SURGEON

### Mr Robert Jones



Mr Robert Jones

**T**WENTY YEARS AGO when I was a medical student, medicine could offer little hope to the following people with liver failure: A 24-year-old admitted to hospital with acute liver failure from viral hepatitis. Death came quickly. An 8-year-old born with a missing liver enzyme,  $\alpha$ 1-antitrypsin, that had made her liver cirrhotic. She had been facing death since birth. A 36-year-old mother of three whose liver had been destroyed by her own misguided

immune system. Her future beyond two years was uncertain.

These patients were all dying of liver disease. Their bodies would waste from malnutrition, becoming intensely yellow, with continual itching, and their abdomen would distend with fluid. Death would come slowly through decay, starvation and coma, if not before by sudden violent haemorrhage or infection. We could prolong life by continuous hospitalisation, blood tests, injections, blood and blood product transfusions, investigations and countless other procedures. Unlike kidney failure, there was and still is no machine to keep alive people dying from liver failure.

Today, I would hope to discharge those patients to a fairly normal life. What has happened in twenty years? The answer is of course solid organ transplantation. Not only will that 8-year-old child with the enzyme deficiency be cured of liver failure, her new liver will have the enzyme she lacked. Although still bearing the same gene, she will no longer have the disease she was born with.

It is not only these few selected patients who have benefited from the scientific advances of transplantation. Transplantation has stimulated research that has been central to the development of our understanding of immunology. Patients with autoimmune diseases, cancer, and viral and parasitic infections are all being treated more successfully because of this knowledge.

Along with many others in clinical transplantation I have had the privilege of working in a field filled with optimism about treating diseases which until recently were fatal. Today, I have the luxury of talking about something that I feel is important.

This afternoon we will hear of some controversial sources of human tissue and of the implications of this tissue donation. As you listen I would like you to bear in mind my perspective. As a transplant surgeon I see both sides. I deal with the person waiting for the new organ and the person who is the donor. The sudden death, family chaos and disaster at one end contrast with the hope and optimism of the recipient and his or her family embarking on what is commonly felt to be a new life, a second chance.

My talk is biased by my experience – liver transplantation, but my comments are applicable to other solid organ transplants. I will discuss some of the issues which I feel are important to the aspects of organ supply.

Although many areas of transplantation are surrounded by controversy and complex ethical problems, I would like to remind you and stress that most organ donation is straightforward and widely accepted by the community. It does not lie at the fringes of community acceptance. Most donors have died from trauma or cerebral haemorrhage.

I would like to raise the issue of brain death. The concept of death of the brain while the heart is still beating is widely

understood but not universally accepted. The issue of brain death has nothing whatever to do with organ donation or transplantation. Yet the two have become intermixed. Transplantation has and had nothing to do with the setting up and establishment of brain death criteria. The demand for the definition of brain death arose with the creation of the intensive care unit and the ability to prolong life beyond a point of no return. Transplant surgeons have nothing to do with certifying brain death; this belongs entirely to the treating doctors. If all organ transplantation in Australia stopped today, the same number of people would continue to be certified brain dead.

This leads me to the media. The public attitude to transplantation has arisen from an altruism that is delicately poised and easily disrupted. None of us easily contemplates our own death. The media concentrate on the controversial or sensationalised aspects of organ donation; this reporting lacks balance and has a negative impact which spills over to the community's perception of all transplants. The mainstream becomes buried by the marginal. For example, media reports of today's seminar will most probably centre on tissue donation from the newborn or animals.

It would be surprising if there were not many problems accompanying such an emotionally charged issue as organ donation. What is surprising is that the problems with mainstream organ donation are so few. Yet these problems are reported sensationally, without proportion or any sense of responsibility. The media forget that for most donor families the trauma is the sudden death and unexpected loss not the organ donation.

My third point involves the community's apathy. I see patients and families looking for treatment of end-stage liver disease and find that this is the first time that they have ever considered organ donation. Most people are willing to receive but fewer are willing to donate. We are all in a giant game of chance. If some of us will need to be recipients, some will need to be donors. Fate decides. The system will only work if people enter into it willingly and are prepared to take either role. It is a giant game of Lotto that should appeal to most Australians.

If you do not like to think of organ giving, why not concentrate on organ getting. For example, why use donor cards? Why not ask people if they wish to carry a recipient card. If a person does not wish to donate then should he expect to receive?

My fourth point relates to the presentation of the cost of transplantation. Liver transplantation has become a benchmark of 'high tech' medicine, meaning expensive medicine. Liver transplantation is expensive but no more so than many other available treatments where there is currently little public debate and the outcome less optimistic. For example, we spend a large proportion of our personal health care dollars during the last year of our life. In Victoria each year, eighty or so new spinal injuries occur. Cardiac surgery is concentrated in the elderly. The cost of these services far exceeds that of liver transplantation. Patients in liver failure should have equal access to treatment for their disease. It is often overlooked that the demand for treatment comes from patients and their families, as well as from the medical staff who are aware that there is no alternative.

Dying of liver disease is expensive. The patient's loss of earning during his prolonged sickness and the ongoing cost to the State for financial support of the family after death, should be offset against the cost of transplantation.

*The issue of brain death has nothing whatever to do with organ donation or transplantation.*

The impression is given that liver transplantation could soak up endless funds. This is not so. Liver transplantation is limited by both demand and supply. In Victoria approximately 160 people die each year from liver disease; 60-70 will be referred for consideration for transplantation. Of these, 25 will be accepted onto the waiting list and another third rejected; 10 per cent will die before an organ becomes available. The remainder will be deferred for later consideration.

With a Victorian population of about 4.3 million, only 24-26 people will need and be suitable for liver transplantation each year. These people will range from children – through all age groups. They will have one of more than 50 liver diseases. At any one time there will be 4-8 people actively waiting for a new liver. Some will have many months to live, others only days, depending on the severity of their liver disease.

Even if there were an endless demand for liver transplantation, organ supply places a cap on activity. In Victoria the number of donors is finite and would limit liver transplantation to about 30 people per year.

How many donors are needed to supply 24 recipients in any year? The answer is about double. This is because organ donation and recipient need do not coincide in time. We match the donor and recipient by blood group, size and crossmatching. Your new liver may turn up tomorrow or in six months time – it will be unfortunate if you have only three months to live. This risk of death of the waiting recipient and on the other hand the waste of donor organs is minimised by exchanging livers throughout Australia. Donated organs are a national resource. As of today, 43 Victorians have received a liver transplant in Victoria; 36 are alive. Nearly all have returned to work, school or full-time home duties. These 36 people now live reasonably normal lives.

The Dean's Lecture Series has examined publicly some of the issues that continue to surround organ donation for transplantation. Your decision regarding organ donation should bear in mind the consequences. If we as a community wish to have this treatment available for ourselves and our family, then we must be prepared to donate. Your decision will not be theoretical – it may determine whether you will live or die.

## ASPECTS OF SUPPLY – PRESENT AND FUTURE

### ORGANS FROM ADULTS Professor Richard Smallwood



Prof. Richard Smallwood

LET ME BEGIN by saying that I am going to take as my basic premise the principle that transplantation is a 'good' thing, that its benefits outweigh its costs, and that we should therefore be striving to ensure that the full benefits of transplantation are realised. In the context of my brief (aspects of supply – organs from adults) this means primarily that those who need a transplant should be able to receive it at the appropriate time. Patients in renal failure should not have to wait for years on a dialysis program before being offered a kidney; those with end-stage liver disease or heart disease should not be dying for want of an available liver or heart.

What is the current state of affairs concerning the supply of cadaver organs, which form the vast majority of organs transplanted? It would seem that, worldwide, the perception is that demand is outstripping supply. In the United States of America there are over 175,000 patients with end stage renal disease on haemodialysis. About one-third of these (> 50,000) would benefit from transplantation, but at present there are only 7,000 cadaver donor kidneys transplanted per year, and the number is falling.

Increasing numbers of patients are waiting three years or more for a kidney, and in some regions they may have to wait as long as five years.

In Australia, there are some 1,500 patients awaiting a kidney, the average length of wait now being over two years, and that period is increasing. The number of deaths occurring amongst those patients accepted for liver or heart transplantation amounts to 15-20 per cent of the total, largely due to the months of waiting for an organ to become available.

There is a worrying drop off in the number of cadaveric donors in the last year or two. In Victoria, for example, the number has dropped from 14 donors per million of the population in 1989, to 9.5 in 1990, and that downward trend seems to be persisting this year. The overall Australian figure was 11.5 (down from 13.5), and this compares with 16 in the USA, and 40 in Austria (or at least in Vienna, where they are actually now seeing *reduced* waiting lists for kidney transplants).

*What is the explanation for the diminishing number of cadaver donors in Victoria?* Motor car accident victims make up around 40 per cent of cadaver donors, and the number of MCAs is decreasing. In 1990, the Victorian road toll fell by 30 per cent from the previous year, but the donor rate from motor car accidents fell much more – by 50 per cent. So it has not apparently been just a question of a diminishing supply of suitable donors.

*Why are we so far behind Vienna, and getting further behind, in the procurement of organs for transplantation?* Do we have an ill-informed or misinformed community? Are there widespread, entrenched religious or cultural beliefs that would outlaw the transplanting of cadaver organs? Are the procedures and structure that have been set in place cumbersome and inefficient, so that a proportion of would-be donor organs is lost? Are doctors and other health professionals, for example in intensive care units, failing to identify potential donors, or failing to discuss with relatives the possibility of donation? Is there a tyranny of distance, making it more difficult to ensure that the organ reaches the appropriate recipient?

As far as structure and procedures are concerned, it seems to me that there is little room for refinement. For example, in Victoria there are three donor co-ordinators, one at Austin, one at RMH, and one at Monash, who provide a 24-hour on call service. When the intensive care staff contact the co-ordinator about a possible donor, she (or he) swings into action. The co-ordinator is often involved with discussions with relatives, in conjunction with the ICU staff. When consent is obtained, for livers and hearts at least, the appropriate unit is contacted, with pertinent details about the potential donor such as age, size, blood group, cause of death, or whether there has been protracted hypotension or sepsis.

Meanwhile blood is sent to RMH for tissue typing and cross-matching against potential recipients. If the auguries are good, the transplant team sends surgeons out to retrieve the liver (let us say), the recipient is called in, and if the liver proves on inspection and frozen section to be satisfactory, the transplant goes ahead. If there is no suitable recipient in Victoria for a Victorian donor, then the organ will be offered interstate. The procedure for kidneys is a little different, since more emphasis is put on tissue typing and cross-matching, but for all three organs – liver, heart, and kidney – the mechanics of getting the right organ to the right recipient by and

large work well. I would add that this process has been considerably helped by the enactment some years ago of comparable legislation in the different States concerning organ procurement.

Even distance does not seem to be too great a problem. You will probably all have seen the recent publicity concerning a donor in Western Australia who provided liver, heart and kidneys for recipients in Queensland, Victoria, and I think, South Australia.

*What about religious or cultural scruples?* In a leading article in *The Medical Journal of Australia* of a month or two ago, Graeme Schofield, who has been instrumental in setting in place the current *Australian Code of Practice for Transplantation of Cadaveric Organs*, pointed out that all the major religions regard organ donation as a gift of life, and none would object to the receiving of a transplant. None the less, in a 1987 survey by the Kidney Foundation, a substantial number of people listed religious grounds as the reason for objecting to organ donation, so perhaps there is a problem here. Moreover, the donation rate from the various ethnic minorities in our community appears to be appreciably lower than that from caucasian Australians, which may in part reflect cultural attitudes rather than simply lack of knowledge or understanding.

*Is it likely that health professionals are missing potential donors?* The first phase of a study in New South Wales examining the records of patients dying in several hospitals has suggested that there ought to be 2-3 times as many donors as are presently being identified. Phase 2 of this study provides for an educational campaign for hospital doctors, part of which, I understand, includes the assessment of each death soon after it has occurred, with a view to discussing with the treating doctor, in appropriate cases, whether organ donation was considered. After increasing doctors' awareness, it is planned in Phase 3 to explore the various attitudes of doctors and other staff to organ donation. In Victoria and other states, similar studies are beginning under the auspices of ACCORD (The Australian Co-ordinating Committee on Organ Registries and Donation) to try to estimate how many potential donors are being missed. It seems, then, that there may well be a block at the level of the treating doctor (or other staff), although the extent of this is not yet clear.

*Is the failure properly to inform the community about transplantation in general, and organ donation in particular, an important cause of our low and declining donation rate?* The answer must be yes. People in Victoria will mostly be aware of transplantation, particularly since liver and heart transplantation began in Melbourne. But how much do they really know about the process, and have they had any information given to them beyond the 'medical breakthrough, gift of life' type stories which have been appearing in the media at regular intervals over the last couple of years? These types of articles, while generally very supportive of transplantation and gratifying to the transplant team, provide little of the sort of information which people need to have.

Perhaps the most reasonable attempt I have seen to provide information in an accessible form has come from the Health Issues Centre. While those of us involved in transplant units may disagree with the way some of the issues have been put in the Health Issues Centre paper on Organ Transplants, we would have to agree that it is not polemical, and it is informative. Perhaps NHMRC should complement its *Code of Practice* document with one that is better designed to give ordinary people an understanding of what transplantation entails.

There seems little intuitive reason to doubt the value of having a well-informed community, and there is evidence to show that better informed about transplantation means better disposed toward it. A recent study amongst high school students is very informative. A series of videos and other teaching material on tissue transplantation, designed for years 10, 11 and 12 was piloted in 15 schools, mainly in Victoria between July 1989 and May 1990, and pre- and post-program evaluations were obtained from approximately 600 students. The percentage who felt positive about transplantation increased from 25 per cent to 75 per cent. Of those students from non-English speaking groups, only six per cent were pro-transplantation initially. This figure rose to 60 per cent after the teaching program. It is intended that the teaching kit become widely available to schools throughout Australia, and I believe that this is an excellent initiative. However, the program

*I am going to take as my basic premise the principle that transplantation is 'a good thing', that its benefits outweigh its costs . . .*

## ORGANS FROM CHILDREN

Dr Frank Shann

*. . . the best tool we have to remedy this is education, skilfully and repeatedly applied.*

is stalling for want of money, despite the realisation that there is a lot more to be done to inform and educate the community about organ transplantation.

It is instructive to learn why the Viennese think they have achieved such high rates of organ donation (that is, four times our rate). They emphasise particularly the need for repeated information campaigns at a local level – for example, in potential donor hospitals – and the importance of feedback to these hospitals. By contrast, in the USA, expensive, impersonal national campaigns, and large organ procurement organisations (OPOs) which cover 80-90 million people, seem to have achieved very little. The evidence from the USA points to the value of the small OPOs, with local retrieval areas, and intensive personal, door-to-door campaigns. So if we are to mount education campaigns, I hope ACCORD will heed the lessons from overseas and keep those campaigns local and personal. I note that ACCORD has recently appointed a Public Awareness Co-ordinator, which is certainly an important step in the right direction.

One area that I think needs special attention in educating the community concerns the diagnosis of death. The definition of death in the NHMRC *Australian Code of Practice* is clear to doctors, and the criteria and procedures are generally accepted and leave no margin for error. However, some of the distress that surrounds the request for organ donation derives from the lack of understanding of brain death in the community, and hence the difficulty that distraught relatives have in understanding that a loved one has died, even though they still appear to be breathing and have a measurable pulse and blood pressure. Perhaps this aspect of organ donation has been over-emphasised, but I can see nothing but benefit in a wider community understanding of how death is diagnosed.

Two other aspects of organ donation deserve comment. It has been said that counselling services for donor families are inadequate, and I think that we would acknowledge that more could be done. Some hospitals have marvellous counselling services; others, in these straightened times, have had to put resources elsewhere. Transplant co-ordinators maintain contact after the donation, they do let families know what has become of the donated organ, and families can receive information about the progress of the recipient if they wish. Those who seek longer term support and grief counselling may be assigned a trained volunteer for up to two years under the After Care Bereavement Program. However, grief support services still have a way to go before an optimal service is in place.

And then, of course, there are the staff involved in organ retrieval. Some theatre staff have found the procedure upsetting, particularly after the major surgical activity is finished and the body has to be prepared for the mortuary. Staff debriefing services have been established to minimise the adverse effects on staff morale, and these appear to have been very helpful.

There has been public criticism, on occasion, from ethicists and others, of the process of cadaver organ donation, and some of this criticism has been couched in highly emotive language. While the negative impact of such criticism on donor rates may have been exaggerated by those of us involved with transplant units, I don't think our concern has been entirely misplaced. We need to respond in two ways: first, by doing our best to ensure that cadaver organ donation is not de-humanising, and I think we are doing just that; and second, by ensuring that the community is well-informed, so that ill-informed criticism gains no credence.

To sum up, we do have a present problem with organ donation rates, particularly in this state, and I think the best tool we have to remedy this is education, skilfully and repeatedly applied.



Dr Frank Shann

THERE ARE NOT nearly enough organs available for transplantation in Australia. Because of this, many children die. I would like first to consider which children need transplanted organs. The first group consists of children in whom transplantation is usually urgent and a size-matched donor is needed. Most children in this category have congenital heart disease, and I estimate that there are some 20 or 30 such cases per year in Victoria. The second

group usually has a less urgent need for transplantation, although the degree of urgency varies and they still need a size-matched donor. Most children in this group have cardiomyopathy, renal failure or corneal disease; in renal failure and corneal disease, transplantation can usually be done on a semi-elective basis. In the third and last group, the urgency of the need for transplantation varies, but adult organs can usually be used. This group includes liver failure, where the need for transplant may be very urgent, cystic fibrosis, and possibly diaphragmatic hernia if it proves possible to transplant adult right middle lobes into newborn babies as a new left lung.

*What is the supply of organs in Victoria?* Over 600 children die in Victoria every year but, in the four years from 1987 to 1990, Victoria averaged only six child organ donors per year. So, despite 600 deaths per year, there are only six children per year who are able to donate organs. Why do so few children donate organs? Why is there such a gross discrepancy between the number of deaths and the number of organs available?

Let us consider the children who died in the Intensive Care Unit at the Royal Children's Hospital in the two-year period 1988 and 1989:

Table: 211 deaths  
Royal Children's Hospital  
Intensive Care Unit 1988-1989

<i>Unsuitable for organ donation</i>		
- Brain died with or after other organs	165	(78%)
<i>Brain died before other organs</i>		
- Permission not requested	22	(11%)
- Permission refused	7	(3%)
- No suitable recipients	2	(1%)
- Donation took place	15	(7%)
	<u>211</u>	<u>(100%)</u>

It is important to realise that these deaths represent almost the entire pool of child organs available for donation in Victoria; almost all the child deaths where organ donation is a possibility occur in the Intensive Care Unit at the Royal Children's Hospital.

Of the 211 deaths, almost 80 per cent were unsuitable for organ donation because the brain died after the other organs or at the same time as the other organs; there was no possibility of organ donation. In about 20 per cent of cases, the brain died before the other organs; this is the group in which there is the potential for organ donation. In about half of those (10 per cent of the total), permission was not requested for organ donation; most of these children had a contraindication to organ donation, usually a medical contraindication such as severe sepsis, but no request was made in some because of social, legal or ethical considerations. In the other half of the potential organ donors, permission was requested; about one-third of families refused permission for donation and two-thirds granted permission. There were two who granted permission but for whom there were no suitable recipients for the organs, and there were 15 in whom organ donation took place (making seven-and-a-half actual donors per year in that two-year period).

## The definition of death

The way we define death in Victoria partly explains why there are not enough organs available for transplantation in children, and I would like to consider the definition of death in some detail. Some of the issues involved are complicated and it is very difficult to discuss this topic in a balanced way in six or seven minutes, but I will do my best.

*What is the legal definition of death in Victoria?* Well, first, there is the old definition, 'Irreversible cessation of circulation of the blood', but, fairly recently, there's been added to that the second definition, 'Irreversible cessation of all function of the brain'. It is this second part of the definition that I would like to discuss.

*Why was this second definition, brain death, added?* There were two quite distinct reasons for adding the definition. First, the new definition allows intensive care units to stop treating patients with dead brains – patients with a dead brain who still have circulation of the blood. The second and quite distinct reason is that it allows organ donation by patients who have a dead brain but adequate function of other organs.

The medical Royal Colleges of the United Kingdom and of Australia have stated that 'brain-stem death' is evidence of death because such patients have no chance of even partial recovery of functional capacity. There are two problems with this definition of death. The first is a practical one: many adults have brain-stem death but adequate function of other organs; these are the patients who are potential organ donors. However, although many adults come into that category, very few children have brain-stem death with adequate function of other organs; this is part of the explanation for the extreme lack of organs for donation in children. There is a group of children, perhaps 5 to 15 a year, who have cortical death but still have some function of the brainstem; for example children with encephalitis, or children with near-miss sudden infant death syndrome. However, these patients are not legally dead so, although they all become legally dead within a few days, they die without being able to donate organs.

The second problem is a legal one: *brain-stem death is not evidence of death of the whole brain, as required by law.* There are now numerous examples of persistent endocrine function or persistent EEG activity in patients with a dead brain stem. Furthermore, brain-stem death is not inevitably followed by death of the whole body within a few days, as was claimed by the Royal Colleges. With modern intensive care, survival for many months is now possible in brain-stem dead patients; possible, but not, of course, desirable.

It is important to make a clear distinction between, first, the legal definition of death (irreversible cessation of all function of the brain), and, second, the medical way of saying that the legal definition has been fulfilled (the medical Royal Colleges have suggested that that should be 'brain-stem death'). As I have said, there is a problem. Brain-stem death is *not* evidence of loss of all function of the brain; it is certainly evidence of loss of many functions of the brain, but *not all* functions.

Therefore, we must either change the medical procedures that we use to demonstrate death, or change the definition of death. To change the medical procedures used so that they did demonstrate irreversible loss of function of the whole brain, would be technically

*... despite 600 deaths per year, there are only six children per year who are able to donate organs, in Victoria.*

difficult and would stop most, if not all, dying patients from donating organs. It would probably be the end of transplantation. The alternative is to change the law. I suggest that a radical change that should be considered is that *irreversible loss of consciousness should be accepted as evidence of death.* I want to stress that my main reason for suggesting this change is *not* the need for organs for transplantation, but the logical and legal problems with the present brain-stem definition of death.

Let us briefly consider irreversible loss of consciousness as a definition of death. To have a personality requires consciousness, or at least the potential for consciousness. If consciousness is irreversibly lost, the person is dead even if their body is still alive. I suggest that the way we have changed the definition of death with changing technology supports the view that this is, in fact, the definition of death that most people intuitively accept as being the overriding one. Before mechanical ventilators were available, it was held that you were dead when you stopped breathing. After mechanical ventilation became available, death was believed to occur when the heart stopped beating. Once external cardiac massage and DC cardioversion became available, loss of all functions of the brain-stem was introduced as a definition of death. Now we know that we can keep 'brain-stem dead' patients alive for long periods of time, so we need to re-think our definition again. Intensive care, as I say, can now provide all the vegetative functions of the brain stem – but it will never be able to provide consciousness. I accept that it will take years of discussion and thought before irreversible loss of consciousness becomes an acceptable definition of death. However, the present situation just cannot go on; it is illogical and it is illegal, because 'brain-stem death' does not demonstrate death of the whole brain.

In conclusion, many Victorian children die because of a lack of organs to transplant. About 600 children die in Victoria each year, but there is an average of only 6 child organ donors per year. 'Brain-stem death' is not evidence of irreversible cessation of all function of the brain as is required by law; so we need to change the way we diagnose loss of all functions of the brain, or we need to change the legal definition of death. I suggest that irreversible loss of consciousness should be taken as evidence of death. If there is irreversible loss of consciousness the person is dead, even if their body is still alive.

**Further reading:** Rethinking Brain Death. Robert D Truog in: Sanders K, Moore B, eds. Anencephalics, infants and brain death. Melbourne, Law Reform Commission of Victoria, 1991: 62-74.

## UNCONVENTIONAL SOURCES OF TISSUE: FETAL AND XENOGENEIC

Dr Tom Mandel



Dr Tom Mandel

**T**HE REPLACEMENT OF defective tissues and organs by transplantation is now an accepted and widely used treatment in an increasing range of diseases. Over the past thirty or so years transplantation has become safer and more effective and is now the treatment of choice for many diseases. With its increasing use, however, the discrepancy between the numbers of patients that require treatment and the supply of suitable organs for transplantation from 'conventional' sources, that is, primarily from human cadavers and to a much lesser extent from living donors, is becoming progressively greater. Even with kidney transplantation where each cadaver donor generally yields two organs, and living donors can provide a single graft without apparent detriment to their long-term health, the gap between the numbers of patients in end-stage renal failure who require a kidney transplant and the availability of donors is ever widening. In most other instances of organ failure, living donors cannot be used and there is a critical shortage of suitable cadaver donors so that many patients die

before a suitable graft can be obtained. For example, in neonatal heart transplantation there is a severe shortage of suitable cadaver donors, and in pancreatic islet transplantation, if this is to become acceptable therapy for diabetes early in the course of the disease, there will be a vast discrepancy between the numbers of potential patients and the supply of cadaver human donors. Therefore, other 'unconventional' sources of donor tissue will have to be considered; these will include human fetal tissue and the organs and tissues of non-human species.

The use of 'unconventional' tissue and organ donors raises a number of ethical and biological issues that are not always pertinent to the use of grafts from either adult human cadavers or from living human donors. I will address some of these novel issues briefly since time will not allow a discussion in depth.

## Fetal tissues

The use of fetal tissues has been frequently considered and has indeed been tested in some circumstances. Fetal tissue has some attributes that may be unique. In particular, with tissues such as central nervous system cells, and pancreatic islet cells, the fetal tissue has a capacity for proliferation which may either be absent or greatly restricted in adult cells of the corresponding tissues. For example, fetal pancreatic islet cells have an enormous capacity for growth so that, in experiments in mice at least, a small graft of fetal islet cells can produce a large amount of functional insulin-secreting tissue, and a graft from less than one fetal donor is adequate to reverse diabetes in each recipient. In contrast, adult islets have little if any capacity for proliferation, and generally multiple donors are required to provide enough tissue to treat each recipient. This now seems to be true in some clinical trials of isolated islet transplantation where more pancreas is required when isolated islets are used than when vascularized pancreas grafts are performed. In a situation where there is already a huge discrepancy between the number of potential recipients and the availability of tissue, the suboptimal use of tissue, where multiple donors may be needed to treat each recipient, only aggravates this problem. Similarly, in transplants of neural tissue from fetal brain the properties of the fetal graft are quite different from those of corresponding parts of the adult organ, and some experimental data suggest that there are marked advantages in the use of fetal tissue. In addition, there are at least theoretical and perhaps even practical advantages of fetal tissue in other situations such as the use of fetal liver cells in the treatment of metabolic diseases, and the absence of mature immune cells in fetal organ grafts that may make the fetal tissue less able to mount a graft-versus-host response or to stimulate a rejection response in the recipient. Many of these attributes of fetal over adult tissue are only quantitative, and in most instances where fetal tissue has been seen to have advantages these have been demonstrated in experimental rather than clinical situations, at least so far. However, if these advantages are real, they should also be applicable to clinical situations but in most cases this has not been adequately tested.

The problems with the use of human fetal tissue are its limited availability in a suitable state, and the ethical problems of using tissue that has, in the vast majority of instances, come from aborted fetal donors. The availability of viable fetal tissue depends on the organ that is to be used. In contrast to adult organs where the entire

organ is generally surgically implanted in a recipient, in probably all instances fetal grafts are used as free transplants of isolated cells or as organ fragments that develop a blood supply from the host by an ingrowth of vessels rather than as whole organs which require a vascular anastomosis. Thus, fetal transplants resemble bone marrow grafts rather than conventional organ grafts. The identification of the organ that will be the source of the transplanted fetal tissue and the isolation of cells from that tissue are crucial. Most medical abortions are performed in the early stages of pregnancy by methods that physically destroy the fetus so that even if the cells that are required are viable, they may not be identified in the curettings obtained, or may not even be present at the time the termination is performed in very early pregnancy. For example, the pancreas of very early fetuses may be so small and poorly differentiated that it is impossible to identify it in the mass of tissue removed piecemeal during a termination. In contrast, the pancreas is readily identified when a termination is performed in the mid-trimester, that is, after the 12th week of gestation, but when this is done using prostaglandin induction, as is the usual practice here, there is often fetal death *in utero*, and the prolonged warm ischemia results in cell death, making the tissue quite unsuitable for transplantation.

The ethical problems of the use of tissue from induced abortions are often raised, and there are some in the community who strongly object to the use of tissue from such sources. These ethical problems have been widely debated and the NHMRC has developed precise guidelines for the use of fetal tissue which address these objections. I believe that linking abortion with the subsequent use of fetal tissue is spurious and there are in place mechanisms that can prevent the abuse of fetal tissue. In broad terms the link generally suggested between abortion and the use of fetal tissue is that if fetal tissue has a use this will encourage the performance of abortions, and may even lead to terminations being performed in order to obtain tissue. The strict guidelines that have been promulgated can readily prevent such abuse. My main concern with the use of human fetal tissue is therefore not primarily ethical, it is rather practical in that suitable tissue is, in fact, difficult to obtain in any quantity, at least in this community. There are also some immunological disadvantages with the use of allogeneic tissue, but these are probably true for all allogeneic tissue and can to a large extent be overcome with the immunosuppressive therapies already available. Thus, while fetal tissue grafts have some unique advantages over adult tissue grafts in some circumstances, I do not believe that human fetal tissue grafts will have a major place in transplantation except in some well-defined and quite restricted circumstances. Nevertheless, even if the circumstances are limited there will probably be some role for fetal tissue allografts and this source should not be neglected.

## Non-human tissues

The second and potentially much more extensive 'unconventional' source of organs and tissues is from non-human species. Transplants across species barriers are referred to as xenografts and were explored quite widely but with very little success in the early days of transplantation. Although the vast majority of xenografts failed, mostly very rapidly and often within minutes after transplantation, there were some instances of prolonged function. It must be remembered that these early xenografts were performed mostly in the very early days of transplantation when allografts also had poor success, due largely to the limited immunosuppression then available. However, as the success of allografts steadily improved there was a great diminution of effort with xenotransplantation and few further reports of clinical trials appeared. At present, however, allografts are largely successful and with most organs there is a much greater than 80 per cent graft survival at one year post-transplant. The pressure is therefore now on an adequate supply of organs and the gap between supply and demand is rapidly increasing. The concept of an alternative source, that is, xenografts, is again becoming attractive. Xenografts do, however, face a number of obstacles that need to be solved before they have a place in treatment.

One major problem is the appropriate source of organs. Intuitively one may think that closely related species such as primates and humans, or rats and mice, might be the most appropriate

*The use of 'unconventional' tissue and organ donors raises a number of ethical and biological issues that are not always pertinent to the use of grafts . . .*

donor-recipient combinations, but there is evidence which suggests that less closely related species may generate a less vigorous immune response against one another. I will deal with this in more detail below. In clinical transplantation, however, primates and particularly higher primates such as the apes, would not be available, both because of their very limited numbers and because ethically their use as organ donors would, in all probability, be quite unacceptable. The use of organs from species that are already being bred and used commercially as a source of food would be far less controversial, and in my view using such animals as organ donors would pose no more of an ethical problem than in their current use as a source of food. There may of course be a need to raise such animals under more stringently controlled conditions than are currently used in normal production.

Assuming that there are no insuperable ethical problems with the use of xenogeneic donors, what other problems would need to be solved? Clearly the major problem is the immune response generated against a transplant. The control of anti-graft immune responses is the major problem in most transplantation at present where the graft is of allogeneic origin, but there are some additional problems when xenografts are considered. These are mainly concerned with hyperacute rejection that is due to the presence of natural antibodies in the recipient which react with the endothelial cells of the blood vessels of the transplanted organ and result in graft loss, due to infarction of the transplanted organ. These antibodies have been the major problem with vascularized xenografts such as the heart and kidney, but despite this, in a few instances, xenografts have functioned for prolonged periods though mostly when concordant (that is, closely related) species have been used as donors. The mechanism of graft loss in these circumstances seems to be the activation of the complement system by molecules present on the endothelial cells lining the blood vessels of the transplanted organ. If complement activation can be prevented, this activation may not occur and a variety of ways are being studied in attempts to overcome this problem. These include the pretransplant elimination from the recipient of preformed natural antibodies and treatment to prevent their reappearance, as well as treatment of the graft to prevent the activation of complement. These latter approaches include the construction by genetic engineering of transgenic animals that are made to express on the surface of their endothelial cells human type molecules which inactivate the complement cascade, as occurs naturally in the vascular system of one's own organs. All the above methods of coping with hyperacute rejection are still in their infancy and much more work will be required before their role, if any, can be evaluated.

If, however, one assumes that hyperacute rejection can be prevented, what then of the other immune responses which can be generated against a xenograft. Are these different, qualitatively or quantitatively, from those provoked by an allograft, and can they be controlled with the agents presently available? Anti-allograft immunity is mediated by T-cells which react against histocompatibility antigens present on the cell surfaces of the transplanted cells. The immune response generated against an allograft is complex and involves a variety of cell types. These anti-allograft responses are amongst the most vigorous immune responses known, and are indeed so strong that they tend to escape some of the constraints that normally apply to T-cell mediated immunity which is generated against, for example virus infected cells; the 'normal' targets of a T-cell mediated immune response. Thus, the normal constraint that operates in the latter response, 'Major Histocompatibility Complex (MHC) restriction', that is, the need for the responding T-cell to recognize self-MHC antigens before it can be activated, does not operate in allograft responses and a strong polyclonal immune response is generated. There is some evidence that when the immune system responds via its T-cells to a xenograft, a less vigorous response is generated than the response seen when a graft of allogeneic origin is encountered. While the precise nature of the anti-xenograft response is still incompletely understood, most of the evidence available suggests that it is at worst no greater than that generated against an allograft and may indeed be significantly less vigorous. If this is indeed the case and hyperacute antibody-mediated rejection can be overcome, then xenografts may have an increasing role in clinical transplantation.

Clearly it is still too early to define the final role of xenografts in therapy, but the notion that foreign species may have an important place in organ replacement cannot be dismissed. Formidable problems remain to be solved, but there were equally formidable problems present when allotransplantation had its beginnings only a little more than thirty years ago. There has been significant progress in organ replacement over this time so that transplantation is an accepted treatment modality and the problems now are more of organ supply than of transplantation success. With this in mind it is necessary to consider 'unconventional' sources of organs and tissues, and fetal, and to a potentially very much greater extent, xenogeneic tissues will need to be more carefully evaluated.

## TISSUE BANKS

Professor Stephen Cordner



Prof. Stephen Cordner

THE DONOR TISSUE BANK of Victoria is part of the Victorian Institute of Forensic Pathology. The Institute is a statutory body which is part of Monash University and affiliated with The University of Melbourne and has responsibilities to provide forensic pathology and related services for Victoria. Since the provision of tissues for grafting is part of the fundamental benefit of the performance of autopsies, the establishment of a Tissue Bank is a service which is clearly related to forensic pathology. I take the view that if an autopsy is to be performed then the Institute has a moral responsibility to ensure that, within the law and subject to ethical considerations, the maximum possible benefit is derived from that autopsy.

As most in the audience would be aware, Victoria is fortunate to have a facility upon which such an activity as Tissue Banking can readily be grafted. No Tissue Bank such as that which is now developing at the Institute exists elsewhere in Australia, although it is a standard phenomenon in most major cities of the United States of America and in Europe (but not in the United Kingdom). Indeed the Donor Tissue Bank of Victoria is modelled on its counterpart in Dallas, Texas, which is part of the South Western Institute of Forensic Science, an organization with functions very similar to the VIFP.

It is important to realize that the Donor Tissue Bank of Victoria has nothing to do with the removal of organs for transplantation from brain dead/beating heart donors. The Bank is concerned with cadaver donors in the traditional sense, and in the main with the following tissues: Aortic valves, bone, corneas (in association with the newly established Lions Eye Bank under the direction of Professor Hugh Taylor), and skin.

*... an adequate supply of cadaveric organs requires a primary commitment and orientation towards the interests of the donor and support for the donor's relatives.*

## The advantages of the centralized procurement of tissues

1. The VIFP as part of its service responsibilities is responsible for 3,500 autopsies per year. A significant percentage of these deceased persons are suitable as donors of tissue for grafting. Procedures for access to relatives for permission to use tissues have been developed under the scrutiny of the Donor Tissue Bank of Victoria Advisory Committee which is constituted under NHMRC guidelines governing Institutional Ethics Committees. This means that the best possible control is exercised over the approach to relatives. The Donor Tissue Bank of Victoria is the only organization in Australia whose procedures for approaches to relatives have been developed in consultation with an Ethics Committee. 60 per cent of relatives approached by the Donor Tissue Bank have agreed to some form of organ or tissue donation. Interestingly, this is the same as the American experience.

2. There are ethical considerations making it preferable that those approaching relatives and procuring the tissue from donors be separate and independent of the users. These considerations are analogous to the legal requirements which prevent a member of the transplant team being one of the medical practitioners making the diagnosis of brain death in a prospective donor. The importance of this consideration is emphasized by the American Association of Tissue Banks in its definition of a Tissue Bank:

A tissue bank is deemed to exist when any of the following criteria are satisfied: 1) viable or non-viable tissues are collected, processed, stored, and distributed to clinicians who are not involved in the collection process; 2) tissues are collected, processed, and stored in one institution; and made available to clinicians in other institutions; 3) collection, processing, and storage of tissues are performed for individual depositors and released to clinicians at the depositor's request; and 4) regenerative tissue is donated by a living donor and is processed and stored for future distribution to unrelated recipients.

3. The centralized procurement of all tissue in one institution minimizes the risks of public confusion which could occur if different banks for different tissues were to be established in different places. In addition, the skills and resources for the procurement of tissues and their processing, are centralized, thus avoiding duplication.

4. The Institute, as part of its every day operations is screening all bodies undergoing post mortem examination for HIV and Hepatitis B & C. Other contraindications to the use of tissues for grafting will usually be evident following the post mortem examination, if not before.

5. The distribution of organs and tissues can be centralized. Follow-up studies of the use of tissues will be facilitated, including the monitoring of clinical outcomes and complications.

## Legal and ethical aspects

### 1. The Donor Tissue Bank of Victoria Advisory Committee

This committee was established by the VIFP Council in March 1989 and has the following responsibilities to the Council:

- Matters of policy concerning the objects and functions of the Donor Tissue Bank.
- The ethical implications of the Donor Tissue Bank's objects and functions and the acceptability of these objects and functions on ethical grounds.
- The surveillance of the Donor Tissue Bank's functions ensuring that they conform with approved ethical standards.

The membership of the Committee follows the guidelines established by the National Health and Research Council for Institutional Ethics Committees. Its members are:

Professor Graeme Schofield – Chairman  
His Honor, Mr John Barnett (Judge of the County Court of Victoria.  
Nominee of the Attorney-General on the VIFP Council)  
Professor Stephen Cordner (Director, VIFP)  
Dr Douglas Fullerton (Clergyman)  
Mr Hal Hallenstein (State Coroner)

Professor Vernon Plueckhahn (Associate Professor of Legal Medicine, Monash University)

Professor Graeme Ryan (Dean, Faculty of Medicine, Melbourne University)

Mrs Diana Sher (Social Worker)

Mr Robert Taylor (Retired senior Public Servant)

Dr Gad Trevaaks (Medical Director, Montefiore Homes for the Aged.  
Nominee of the Minister for Health on the VIFP Council)

### 2. Human Tissue Act (1982) and Health (General Amendment) Act 1988

Part IV of the Human Tissue Act concerns 'Donations of Tissue after Death', Part V concerns post mortem examinations, and Part VIII concerns 'Prohibition of Trading in Tissue'.

Section 133 of the Health (General Amendment) Act relates to Tissue Donation and the responsibilities which need to be carried out to ensure immunity against any civil liability for the transmission of HIV infection by tissue transplantation. In essence, the blood of the deceased must be tested, the result must be negative and reasonable enquiries must be made about the deceased donor to find out whether that person was at high risk of being infected with HIV.

All the relevant sections of both Acts are complied with by the Donor Tissue Bank of Victoria.

### 3. Funding of the Donor Tissue Bank of Victoria

- No charge is made for tissues.
- Page 15 of the American Association of Tissue Banks' *Standard for Tissue Banking* (1984) states: 'Retrieval, processing and storage of tissues are labour intensive and capital intensive operations. Service fees may be levied to cover these costs . . .' The VIFP Donor Tissue Bank currently levies such service fees to cover some of:
  - The salaries of staff to approach relatives for permission.
  - The salaries and some of the technical costs associated with removal, storage and transport of tissues.
  - Administrative costs.
- It is a fundamental principle of the Donor Tissue Bank that no charges, other than passing on necessary service costs, be raised by institutions or medical practitioners for tissue received by them for transplantation or any other purpose.

What this means in essence is that the tissue is a donation, but its collection, preparation, storage and distribution generates costs which are passed on by the Donor Tissue Bank to the user. The situation is exactly analogous to the Red Cross Blood Bank, the only difference being that all its costs are met by the Government or by Red Cross on behalf of the users.

### 4. The essence of the Bank's ethical position is exemplified in its name: The Donor Tissue Bank of Victoria.

We ally ourselves to the Donor. The opportunity to donate is offered to relatives as an opportunity to make a positive gesture at a time of tragedy and despair. This is in the belief that such a gesture freely made will be of assistance in the subsequent grieving process. The bank is independent of the users of the tissue, both physically and administratively. (Technical aspects of the Bank's operations are vetted and agreed to by representatives of the users, for example, cardiothoracic surgeons, orthopaedic surgeons).

### Grant from the William Buckland Foundation

The Institute has received a very generous grant towards the construction of an extension to its facility to house the operations of the Donor Tissue Bank of Victoria. The detailed plans for the Buckland Wing are now being drawn and I am hopeful that the Buckland Wing will be operational by the middle of 1992.

### Conclusion

Victoria is at the threshold of an exciting development which will improve the life expectancy and quality of life of hundreds of people every year for relatively small cost. This seminar is about the supply of organs and tissues for transplantation. It is my view that an adequate supply of cadaveric organs requires a primary commitment and orientation towards the interests of the donor and support for the donor's relatives. When this is established, agreement to donate is much more likely to occur and to be of assistance at a critical time of distress for the deceased's family.

## INTERNATIONAL ASPECTS

Mr Russell Scott



Mr Russell Scott

**I**N THE WESTERN WORLD, parliaments began to regulate the acquisition of organs and tissues from human cadavers for therapeutic purposes shortly after the Second World War. Laws permitting cadaver donation appeared in the United States of America and France as early as 1947. The three following decades saw the appearance of legislation regulating transplantation throughout the West, as well as in Russia and Eastern Europe.

As the 1970s progressed, imperatives for lawmaking began to emerge. These included consideration of the relative merits of the notions of 'opting in' and 'opting out'. Lawmakers also had to decide whether to introduce into legal systems acceptance of the concept of brain death as a determinant of human death, and protection of living donors, including minors and others who lack legal capacity. There was also the significant distinction between tissues that will regenerate and those that will not. Looming over all of it was acute scarcity of organs and the possibility of trade and commerce.

The 1980s saw a great increase in traffic in human organs and body parts. Evidence of this commerce came to the World Health Organisation from all parts of the world – Asia, the Middle East, Europe and the Americas. The first formal response was a resolution of the World Health Assembly in May 1987 expressing concern 'at the trade for profit in human organs among living human beings' and declaring the trade to be an affront to 'the most basic human values' and a contravention of 'the Universal Declaration of Human Rights and the spirit of the WHO Constitution'.

Not even the most developed and prosperous of nations was innocent. Newspaper advertisements were appearing in the USA press in the late 1960s offering to sell organs, eyes and other body parts. The USA has a long history of lawful commerce in regenerative and cadaver tissues.

In Britain, a major transplant scandal erupted in 1989. The purchase of kidneys for wealthy patients of a London hospital at prices up to \$US3,000 from poor Turks who were brought to London by middlemen, resulted in the deregistration and disciplining of prominent British medical practitioners and the enactment of legislation in 1989 whereby commercial dealings in human organs were prohibited and organ transplantation between living persons severely limited.

In 1989 an international symposium on organ transplantation was called by the Canadian government and others in Ottawa. Extensive evidence of traffic in human body parts, and even in women and children, was produced in relation to Brazil, Guatemala, Honduras, Paraguay and Mexico, as well as the Middle East. It has been known for some time that a well-organised system of marketing the organs of living persons has operated in India. A prominent Indian journal has traced the live kidney trade to its beginnings in 1983, suggesting that in the succeeding seven years the trade multiplied forty fold and is related to hospitals in 'every major metropolis' in India.

However, despite widespread disapproval, reflected in the legislation of more than forty countries, this trade continually increases. In the USA, the federal National Organ Transplant Act of 1984 addressed it and outlawed the giving and receiving of 'valuable consideration' for any human organ for use in transplantation.

In May 1989 the World Health Assembly, comprising 166 nations meeting annually, returned to its concerns about the commercial exploitation of human distress, particularly in children and other vulnerable groups. The Assembly called for completion of a code of international Guiding Principles envisaged by its earlier resolutions. Immediately WHO began to assemble an international task force of advisers. Members were drawn from North and

South America, Britain, Europe, the Middle East, Asia, Africa and Australia. I was invited to serve as chairman and moderator of the meetings which were held during 1990. The task was not easy. For a start, notions of morality differ widely. Such fundamental principles (at least to developed western societies) as personal autonomy and individual consent to the removal of organs and to medical treatment are neither understood nor acceptable in some societies, as we were reminded by an African delegate.

The use of bodies of deceased persons as a principle source of organs gives pause to many. For example, the Japanese appear to have major cultural reservations about the use of human cadavers for therapeutic purposes. Late last year I was visited in Sydney by a Japanese government commission enquiring into the feasibility of incorporating the concept of brain death into Japanese law.

The WHO group attempted to identify acceptable ethical principles as a basis for all national legislation. First we decided that it could not be said that the WHA resolutions, or the international declarations, *of themselves*, constitute ethical principles. Further, some people claim that trade in human organs is ethically acceptable. One Indian medical expert said recently, 'I'm not purchasing a kidney. I'm giving someone the gift of life. Tell me, what's so ethically objectionable about that?'

We also considered the principle of Kantian ethics that holds every human being to be an 'end', never to be used as a means to an end. However, this principle appears to encounter difficulty with organ transplantation because of its clash with other ethical principles used in medical practice and human research, for example, the principle of autonomy and the notion of altruism. The Kantian principle would, presumably, prevent the altruistic, loving donation of a kidney by an adult child to a dying parent. This leads to more difficulties, because some human body parts will regenerate and there are historical precedents for the sale of regenerative human tissues, for example the traditional trade in human hair for wig making. But what about the liver with its remarkable capacity for regeneration?

The WHO task force identified two ethical principles. The first proceeds from the belief, based on evidence before the WHO, that such trade will inevitably lead to exploitation of the weakest members of society: the poor, those without capacity, and those in dependent relationships, including children. This may be seen as an aspect of the ethical principle of autonomy and related to the ethical duty of medical practitioners to act with beneficence. On this basis it was held that the human body and its parts cannot ethically be the subject of commercial transactions.

The other rule is the principle of distributive justice and equity which requires that donated organs be made available to sick patients on the basis of medical need and not on the basis of financial or any other consideration.

The result was the completion of draft guiding principles by the end of 1990. On Monday 13 May 1991 they received formal approval in the following words:

The Forty-Fourth World Health Assembly . . . recommends that Member States take account of the Guiding Principles in the formulation of their own policies on human organ transplantation.

Some doubt the capacity of an international resolution to restrain the growing trade in human body parts. However many believe

*Australian transplant laws may be inadequate if there is an offshore commercial element in the relationship between donor and donee.*

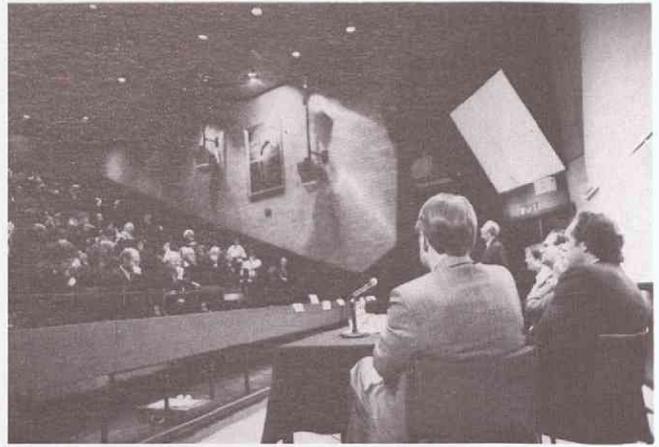
that the reputation of WHO is particularly high in undeveloped countries where much of its field work is done. The considered recommendation of the 166 nations comprising the Assembly is thought to have the potential to be persuasive in many legislatures. The Guiding Principles themselves are brief and simply expressed. There are nine in all and five address the human organ trade.

I will conclude by returning to Australia where all states and territories have accepted, with minor variations, the code of legislation on transplantation prepared by the Australian Law Reform Commission in 1977. The Australian laws prohibit trade and commerce in human tissues under criminal sanctions. The question arises whether the Australian legislation remains adequate to deal with problems of trade or commerce that may arise in the future. On the face of it, it would appear so. However there are current developments in this country which could give rise to ethical and legal concerns:

- It is not uncommon for patients from nearby countries to come to Australia for medical treatment, including patients with terminal kidney disease who are not eligible for the overcrowded Australian waiting lists for organs.
- Some are advised that they will not survive if they are unable to obtain treatment by dialysis or to find a donor. Further, not all communities have dialysis equipment and facilities for transplantation.
- Some patients have apparently returned to Australia with a 'living, willing donor' in circumstances that may or may not contain a commercial element.
- In late 1990 the federal Treasurer referred to the Industry Commission the question of the export of Australian health services for inquiry and report by 31 December 1991. The Terms of Reference indicate that the Australian Government may encourage patronage of Australian health services by overseas patients. This suggests that transplantation activities may increase.
- Australian transplant laws may be inadequate if there is an offshore commercial element in the relationship between donor and donee. In addition there could arise an ethical dilemma and a potential conflict with the WHA Guiding Principles. One of the Guiding Principles directs that physicians and other health professionals should be prohibited from carrying out organ transplantation if they have reason to believe that the organ has been the subject of commerce or profit making.
- These could become matters of real concern for Australia and Australian transplant practitioners.

## SUMMARY OF DISCUSSION

1. It was observed that transplantation was not an open-ended commitment for health services. The number of kidneys, liver and heart transplants needed each year can be estimated. (R. Jones)
2. The trend away from the use of traditionally dead donors (cadaver donors) for kidney transplantation was noted. (S. Cordner) The emphasis nowadays was on multi-organ donors, donors with beating hearts, from whom not only the kidneys but also the liver and heart could be used. (P. Kincaid-Smith)
3. Related to the use of cadaver donors was the question of tissue typing. Apart from major blood groups, tissue typing had always been questioned in Melbourne. (P. Kincaid-Smith) Detailed tissue typing could lead to delays in matching. The question of the need for typing was again being raised now that cyclosporin was available. (P. Kincaid-Smith)
4. It is said that in the USA one quarter of the kidneys obtained for transplantation were not used because there was a gap between the transplant surgeons and nephrologists running dialysis programs in North America. (R. Smallwood) There is no such wastage in Australia, where fortunately a joint program has always existed. (P. Kincaid-Smith)
5. In the early days of renal transplantation, placing recipients on a priority list was a major problem. (R. Lovell) It continued to be a problem, but with liver transplants the pool was relatively



small and patients were ranked by their clinical outlook. Those with the shortest life expectation rose to the top of the list. (R. Jones)

6. Because of the shortage of donor organs, it was suggested that the medical profession had an obligation to use the media to increase knowledge about tissue transplantation, and even perhaps to publish tissue donor forms in newspapers. It was also proposed that a registry should be created of people who wished to donate their organs after they die. (L. Skene)

7. Regarding the definition of death, it was observed that it is always a mistake to define something to mean something that it does not mean in popular parlance. Many people have a problem with the idea that a beating heart donor is dead. It would be better, instead of defining death, to say what can be done in certain circumstances. In tissue transplant legislation, the need is to try to say when it is permissible to remove organs from donors. (L. Skene)

8. Regarding Dr Frank Shann's proposal, it was asked how irreversible loss of consciousness could be accepted as evidence of death? How could irreversible loss of consciousness be diagnosed? (L. Skene) In reply several criteria were enumerated which might be considered, including the present 'brain-stem death' criteria, anencephaly, and demonstrated absence of blood flow to the cerebral cortex. (F. Shann)

9. It was said that Australian law was not intended to define death but to be a recognition of the circumstances where death had occurred, leaving the criteria for the medical profession. One provision was that death occurs when there is a cessation of all functions of the brain. A second provision was that death occurred when there is cessation of circulation of the blood. It was left to the medical profession to state when all brain function had ceased. There had been medical unanimity on what constituted certainty that all brain function had ceased. If this was to be altered, complete unanimity in the medical profession would again be necessary. (R. Scott)

10. A plea was made that this discussion should not end without recognising that, whatever the arguments for change, there was at present a proper process being applied properly by responsible people. (B. Clark)

11. The question of contact between donor and recipient families was raised. What would be the effect on a child recipient if a donor family had the option of continuing contact with the recipient family? (Anon) In reply it was said that the Australian Law Reform Commission, which had produced the basis of the laws bearing on transplantation, held hearings in every capital and there was overwhelming evidence that donor family and recipient family contacts were undesirable. (R. Scott) In further discussion emphasis was placed on the need to improve counselling for donor families.

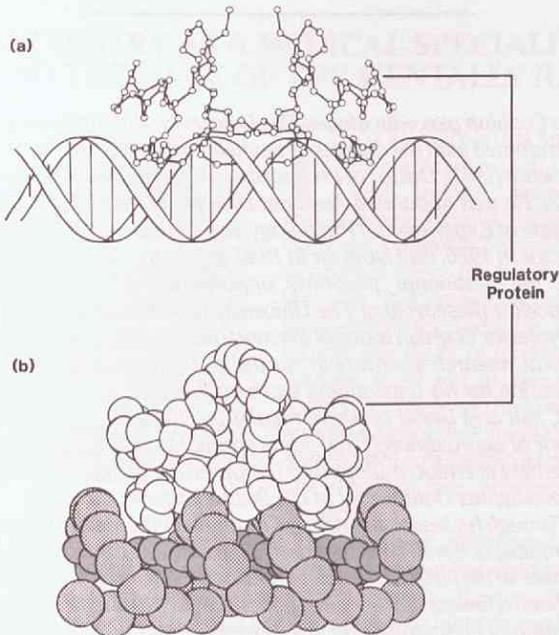
12. Mrs R, who identified herself as a mother who had given permission for a son to be used as an organ donor (which she described as an extremely traumatic experience), said she wanted to thank Professor Lovell and all concerned for the opportunity to be present, and for the encouragement of public debate.

13. The Dean, in closing the meeting, observed that to have attracted the more than 300 people present was a tribute to the organisers of the seminar and the contributors. □

The 1991 Mathison Lecture  
**ENDOCRINOLOGY IN THE MOLECULAR AGE**

Professor John P. Coghlan  
 Director, Howard Florey Institute of Experimental Physiology and Medicine

Dean's Lecture Series  
 The University of Melbourne  
 2 July 1991



**Fig. 1:** This figure illustrates how a well characterized regulatory protein binds to DNA. The formation of specific protein-DNA complex is an essential step in the regulation of expression of particular genes. (a) is a wire model in which the backbone of the regulatory protein is shown bound to a schematic DNA helix. (b) space fitted model of the protein-DNA complex demonstrates how the protein 'fits' to the sequential turns of the genetic material. It should be noted in relation to what follows that the triple helix would be created by a short piece of synthetic oligonucleotide winding into the large groove of the DNA.



Prof. John Coghlan

**S**INCE THE CONCEPTUAL breakthrough which led Watson and Crick to announce the double helix in 1953, not even the most remote and isolated niche of biological science has remained unaffected. Older biological scientists like myself have had to pump intellectual iron to become bilingual and converse fluently in the molecular idiom. In the long run, however, our long exposure to biological science gives us an edge, as molecular studies become more applied. Our

wealth of biological information and understanding cannot be picked up overnight by even the most energetic and entrepreneurial molecular biologist.

Only a few years ago, whether a cliché or not, the cell was essentially a black box. Now we know how things get into cells, how cells excrete and secrete material, how protein and peptides and other chemicals are synthesized, how these materials are packaged for export, how information from outside the cell is transduced, how genes and their expression orchestrate cell function, and even determine what type of cell it is (differentiation). Thus it is fair to say that when we lift the lid on the black box we can now see the wheels

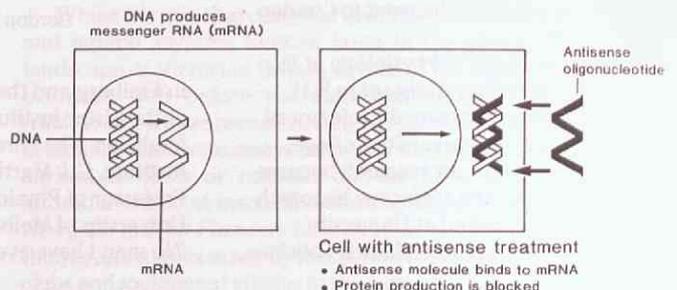
turning; however, we are still very far from a full set of emerging discoveries engineering drawings and instructions for operating the plant.

Much is known about how genes are coded and expressed, that ribonuclease has an attachment site to DNA near a so-called start site. But other sites in the DNA remote from this can be recognized as regulatory or transcriptional activator sites. The group of these assembled near the start site is called the promoter region; binding sites beyond this are called enhancer sites. These special sites usually bind proteins produced from expression of other genes. The special small proteins which bind to these DNA sites are transcription or cis factors. Of these factors, many regulate the rate at which mRNA, and thus protein, is produced; their action can be positive or negative (Fig. 1). The properties of these factors are complex and diverse but they are the vectors by which environmental, hormonal or other changes outside the cell membrane are linked to gene expression or inhibitors of expression. Of course, internal cellular information can also influence their actions.

Enhancer sites may be many thousand of bases away from the promoter site and can even be in the coding region or down stream, although the most common placement is upstream. A great deal of energy has gone into understanding how transcription factors act from remote sites. Transcription factors often link to form homodimers or heterodimers even though they may be separated along the gene (leucine zippers). Other configurations involving other proteins have been found to occur, and a general description for these more complicated arrays is protein transcriptional complexes.

Several hundred different transcription factors have been described and a large number of these can be fitted into a taxonomy based on their molecular structure: zinc fingers, leucine zippers, helix turns helix and helix loop helix. How transcription complexes work in concert is not yet clear but herein may be part of the answer to tissue specific gene expression.

When mRNA is produced, and this may be the result of the inappropriate influence of a virus or a cancer causing gene, it could be blocked by introducing a short piece of RNA or DNA complementary to the mRNA in question. This is called an antisense strand. This antisense strand would, because of its intrinsic chemical properties, hybridize to the mRNA and block its translation. Parallel developments in oligonucleotide (oligos) synthesis, synthetic DNA or RNA production have made the manufacture of synthetic antisense oligos a relatively simple task so that they are readily available. Another approach is to use synthetic oligos to block upstream transacting sites by forming a triple helix, thus inhibiting expression of the gene. Blocking gene expression either by use of antisense oligos or formation of a triple helix is likely to be a basis for the most exciting pharmacological developments in the near future (Fig. 2).



**Fig. 2:** Diagnostic representation of antisense inhibition of translation by binding to mRNA.

One formidable problem is that the properties of cell membranes are such that foreign material, especially polar hydrophilic compounds like oligos, do not get into cells through cell membranes easily and special strategies have to be adopted to achieve this. Many approaches are being used in different laboratories throughout the world as the potential of antisense and the manipulation of expression of specific genes have been recognized widely.

The Howard Florey Institute has evolved a very exciting and novel approach. Because we recognized the value of antisense at a very early stage we decided to examine options for getting suitable 'oligos' into cells. Our approach was to conceive of a hybrid molecule which was protein-DNA or in fact peptide-oligo (or oligo-peptide). Our chemists, Professor Geoff Tregear and Dr J. Haralambidis were able to achieve brilliantly the chemical synthesis of these compounds.

Obviously the peptide could be an epitope of an agonist for a receptor which is internalized, thus 'pulling' the oligo into the cell. Other approaches beside receptor mediated endocytosis immediately come to mind. Early experiments using AIDS infected cells with the Fairfield group have been very encouraging.

A major tangential benefit has also accrued because the peptide 'handle' on the oligo can be used to advantage to develop non-radioactive labelling methods which are urgently needed, especially in the diagnostic field.

The Howard Florey Institute is fully equipped to be right in the front line of the application of 'new' pharmacology, especially in the fight against viruses and cancer. Endocrinology for the 1990s and beyond will not address blockade of receptors by hormonal antagonists or replacement of hormones, but will go straight to the heart of the matter and aim to switch appropriate genes on and off.

**Acknowledgement:** This work was supported by an Institute Block Grant from the National Health and Medical Research Council of Australia.

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*John Coghlan was educated at The University of Melbourne where he graduated with the degrees of Bachelor of Science (1958), Master of Science (1961), Doctor of Philosophy (1964) and Doctor of Science (1972). He was appointed Assistant Director of the Howard Florey Institute of Experimental Physiology and Medicine in 1971, Deputy Director in 1976, and Director in 1990. Between 1987 and 1989, he held the additional part-time appointment of Deputy Vice-Chancellor (Research) of The University of Melbourne.*

*Professor Coghlan is one of the most distinguished and influential medical research scientists in Australia. He has an international reputation for his outstanding work on the hormones involved in fluid, salt and blood pressure regulation. He is the author or co-author of approximately 400 publications. His pioneering research in the field of endocrinology was honoured in 1988 by the award of the prestigious Dale Medal of the British Endocrine Society.*

*Through his leadership role as Chairman of the Medical Research Committee of the NHMRC between 1988 and 1990 and as a Council Member of the NHMRC between 1982 and 1990, Professor Coghlan has been a tireless worker and spokesman for the medical research community in Australia. He has played a major part in upgrading the level of government support for medical research in this country over the past decade. (GBR)*

## GORDON CLUNES MCKAY MATHISON, MBBS 1906, MD 1911 1884-1915

**G**ORDON MATHISON was one of the many gifted young men whose lives were wasted on Gallipoli. Mathison's death was a loss to medical science in general and to The Walter and Eliza Hall Institute of Medical Research in particular.

'Mathie' or 'Mattie' as he was known to his friends was small, 'chubby', modest and likeable. He was also brilliant - graduating with first class honours in every subject. After appointments at The Melbourne Hospital, in the Physiology Department and as Medical Tutor at Ormond College he went to London in 1908.

As Lecturer in Physiology at St Mary's and then Assistant to E.H. Starling, the renowned Professor of Physiology at University College, Mathison's flair for research became obvious. As Beit Memorial Research Fellow he worked at University College, London, the Medical Policlinic



Gordon Mathison

in Freiburg and then again in London at the Lister Institute of Preventive Medicine. The Director of the Institute, C.J. Martin, formerly Acting Professor of Physiology at The University of Melbourne, said of him, 'No man I have ever known possesses

the genius for research so highly as Mathison. He always seems to know by instinct the essential difficulties of a problem and how to tackle them.'

In 1912 he gained the DSC (London) and in 1913 'Mattie' returned to Melbourne as Sub-Director of Pathology and Sub-Dean of the Clinical School at The Melbourne Hospital. At the outbreak of war he enlisted and while on active service he was to be offered the Directorship of the Walter and Eliza Hall Institute of Medical Research. With the AIF he went to Gallipoli. On 18 May 1915, after a night and day treating wounded, he was sitting outside his dugout when a 'spent' bullet wounded him fatally in the head.

Mattie's friends subscribed to the endowment of a triennial lecture to be called the 'Mathison Lectures', the first of which was given by W.A. Osborne in 1923. (HDA)

The 57th Beattie Smith Lecture  
**THE UNIVERSITY, PSYCHIATRY AND THE CARE  
OF THE MENTALLY ILL**

**Professor Bruce S. Singh**  
Cato Professor and Head, Department of Psychiatry

Dean's Lecture Series  
The University of Melbourne  
25 March 1991

**PSYCHIATRY AS A MEDICAL SPECIALITY  
AND THE CARE OF THE MENTALLY ILL**



Prof. Bruce Singh

**P**SYCHIATRY is that branch of medicine which deals with mental disorders, that is, diseases whose manifestations are primarily behavioural or psychological. But psychiatry was the last speciality to be incorporated into medicine. Even though the study of human behaviour is as old as recorded history, it is only in the last two hundred years that mental disorders have established a secure place within the province of medicine<sup>1</sup>.

The care and treatment of the mentally disordered has undergone many radical changes in the last two hundred years. It is, nonetheless, possible to detect certain themes in its development which provide continuity, and to identify conflicts and contradictions which have exerted an important influence throughout the period. In major respects the late eighteenth and early nineteenth centuries were the formative years of the modern mental health system, fixing its most fundamental characteristics and establishing the basis for the struggles which were to shape its future. This period was seminal for modern social thought and practices. Michel Foucault<sup>2</sup> treats the transformation as being so profound as to constitute an epistemological break in the history of Western culture. Geoffrey Pearson<sup>3</sup> defines the nature of this break in the following terms:

At this precise point, not before and not later, the modern controversies announce themselves. There was crime, deviance and madness before this point, of course, but it is then that men begin to relate to it, and see it, in a different way. Social thought and practice undergo a convulsion, and out of it emerge the institutions of the police, the penal system, psychiatry, education and welfare; and also new conceptions of life, family and work.

Some time in the first half of the eighteenth century, in England, the idea began to develop that there was a group of people who needed special protection because of their mental condition. The idea grew under its own momentum. Influential men in the larger cities compared notes, discovered a state of quite appalling misery, and began to plan reforms. In time, the attention of members of Parliament led to revelations which brought home to the general public the plight of a group of helpless people: chained, beaten and half-starved, they lived in cellars and garrets, in prisons and workhouses.

The tide of industrial change brought an intensification of social distress of many kinds. The social problems of small rural communities became acute in the dirt-ridden and disease-ridden life of the towns; but industrialisation, whilst increasing social distress, also provided the means of dealing with it. A new social conscience emerged and a desire to tackle the problems of poverty, sickness and ignorance which had been taken for granted. Money was available; the growth of the middle and artisan classes provided the staff; and ease of communication by road and rail made it possible to establish national standards.

The late eighteenth and early nineteenth centuries witnessed a gradual shift in the structure of social discipline from the paternalism and localism – characteristic of pre-industrial England under the government of the landed gentry – toward more mechanistic, centralised and specialised systems for the management of poverty, crime and madness, which were appropriate to an urban, industrial society and a rapidly advancing capitalist mode of production thriving upon rational calculation. For the mentally disordered, the consequent reorganisation entailed a dramatic escalation in the rate of their consignment to institutions, their substantial segregation from other classes of the deviant and the destitute, and the emergence of the medical profession as the pre-eminent therapeutic power in the new system of asylums.<sup>4</sup>

**The impact of the asylum<sup>5</sup>**

Institutionalisation may be treated as the most important of these changes, in that the others flowed from it. In the eighteenth century the experience of confining the mentally disordered in general mixed workhouses, gaols and houses of correction was unfortunate proving to be disruptive and troublesome, both to other inmates and the authorities.

The advent of an institutional system designed exclusively for the accommodation of the mentally disordered created the need for professional and bureaucratic apparatuses of management, that is, a site for the development of psychiatry as a speciality of medicine and a domain in which the medical profession could claim the foremost right to control the organisation and the patients' existence, as against others – magistrates, Poor Law officials, lawyers, and relatives who also had claims to participate.

The process of institutionalisation of the mentally disordered was not new. What was exceptional in the late eighteenth century was the expansion of the realm of the institution. In London and the major cities, where the pressures for institutionalisation were greatest, the construction of public asylums marked the first initiative by the central State to promote special institutional provision for the insane. It is important to realise that the asylum system in Britain was a State initiated development, unlike the growth of general hospitals, which were more often funded by benevolent and religious orders.

The Lunatic Asylums Act of 1845 made the establishment of asylums mandatory. This necessity to resort to compulsion in the relationship between government and local authorities is a feature of the history of early nineteenth-century State intervention. In the movement toward the institutionalisation of the deviant and unproductive, it paralleled the imposition of duties to build workhouses (1834) and prisons (1835), and the establishment of county police forces (1856).

Whilst it is true that custodial institutions, workhouses, prisons and lunatic asylums loomed large in the physical and social landscape of Victorian Britain, critics of the institutions were in evidence well before the twentieth century. Daniel Defoe (1660-1729), whose breadth of interest extended to the treatment of lunatics – he wrote essays calling for the construction of a public asylum for 'fools' or 'naturals' and for public madhouses – was himself a victim of institutionalisation being held as a debtor in Newgate. In *Moll Flanders* he took his revenge: 'There are more thieves and rogues made by that prison of Newgate, than by all the clubs and societies of villains in the nation.'<sup>6</sup> The ironic contention that the apparatus of social control can in a variety of ways actually generate deviance also has a long history. Charles Dickens was

## The Beattie Smith Lectures

*Beattie Smith was a bachelor when a guinea was worth 21 shillings, and the Commissioner of Taxation was only a boy, so he was both willing and able to make a handsome bequest for annual lectures on the early treatment of insanity.*



William Beattie Smith

Dr William Beattie Smith of Collins Street, Melbourne, Fellow of the Royal College of Surgeons of Edinburgh and Licentiate of the Royal College of Physicians of Edinburgh, played an important role in the development of academic psychiatry in Melbourne. In his Last Will and Testament, he gave The University of Melbourne one thousand pounds and directed that the interest be used to establish 'a few annual lectures' on the early treatment of insanity, 'as I consider the practitioner and the public are in need of much education in regard to this subject'.

The first of the annual Beattie Smith Lectures was given in 1928 by R.S. Ellery on 'The problem of neurosyphilis and its treatment'. He has been followed by a series of distinguished local and international speakers, including John Cade, Henry Maudsley, Oscar Oeser, Eric Cunningham Dax, Henry Bower, James Anthony, Ainslie Meares and Sir Martin Roth. In 1992, Professor Beverley Raphael, AM (the first woman Beattie Smith Lecturer), gave the 58th lecture entitled 'The violent society and mental health'.

Beattie Smith, a native of Northumberland, arrived in Victoria in 1882 and took up the post of Medical Officer at Ararat Asylum, becoming Superintendent within a few years. He sought to improve the standard of nursing in institutions and advocated the boarding-out system of patient care – an early example of community psychiatry. In 1899 he was appointed Superintendent of the asylum in Kew (later Willsmere Hospital) and began to give a course of lectures on mental diseases to medical students at The University of Melbourne.

He was said to be an arrogant and dictatorial man. In a dispute with a pathologist colleague, he was reported in the press as saying 'the man's post mortems were without scientific value'. He also criticised the administration of a fellow superintendent (a tendency not unknown today). In 1902 he had a disagreement with the Chief Secretary, submitted his resignation and went into private practice (again, not an unknown tendency in the public system today).

The reason for his emphasis on the early treatment of insanity is clear: in 1905 he complained that relatives too often delayed seeking early treatment for a mentally ill person because of the stigma associated with insanity and the asylum. At the time that the bequest was made, a revolution was occurring that would take psychiatry out of the asylum and into the community, into a new therapeutic role and into contact with a broader cross-section of the mentally ill, which until then had little to offer. With the development of psychoanalysis by Freud, psychiatry improved its image and its therapeutic techniques and changed its focus from mental illness to mental health.

The transition of psychiatry from an asylum-based specialty to a one with broader perspectives and concerns was embraced enthusiastically by members of the profession, who hoped thereby to overcome the stigma associated with their patients and the settings in which they were treated.

Bruce S. Singh

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another who was personally acquainted with the effects of institutionalisation (his father and the rest of his family having been detained in the Marshalsea Debtors' Prison), and gave the subject extensive treatment in his novels, being concerned with the phenomenon of constraint and its effect on both psychological and physical health.

This perception of the institution as positively harmful to its inmates was applied in the Victorian period to the asylum as well as to the prison. The Victorian recognition of the pathological potential of the asylum foreshadows that to be elaborated in Russell Barton's *Institutional Neurosis* published in 1959<sup>7</sup>. This anti-institutional attitude led, in both the nineteenth and twentieth centuries, to movements in favour of deinstitutionalization.

Disciplinary institutions, as houses of destitution, criminality and madness, became stigmatised partly because of their authoritarian, detentionary and penal aspects, and partly because of the anti-social reputation of their populations. In the mind of the public insanity was still perceived as 'part of a gothic landscape of doom and terror, synonymous with bestiality' forming 'a configuration of which confinement (was) a necessary part'<sup>8</sup>.

Under these conditions, panic regarding the dangers of sane people being locked up in asylums was readily generated, especially in periods of therapeutic pessimism, as in the late nineteenth century, when the custodial functions of the asylums seemed to be their only role.

Popular concern has not been concentrated solely upon the fate of the sane, however. The argument has also been about the legitimate boundaries of medical power in the lunacy reform campaigns. Throughout the years two themes recur – whether the sane should through mistake or conspiracy be confined with the insane, and whether the medical definition of insanity should expand to embrace mere eccentricity.

## The medical and bureaucratic management of the asylum system in Britain

The new asylum system being established in the early nineteenth century furnished the main institutional basis for the development of psychiatry as an exclusive province of a branch of the medical profession, and provided the rationale for bureaucratic supervision and control. The deepening involvement of doctors in the treatment of the insane during the nineteenth century has been characterised by its critics as an instance of medical imperialism and an example of the medical profession striving to establish hegemonic control over wider areas of the community's experience. Scull<sup>9</sup>, for example, portrays the rise of the psychiatric profession as medical men occupied in the treatment of the insane engaged in a vigorous struggle to fight off the challenges of rival therapists such as the Moral Managers, and to repel interference by laymen, especially the local magistrates – who until 1889 were the managers of the public asylums.

The process of medical dominance of psychiatry was indeed a complex one. It certainly did not flow from the scientific mastery of insanity by medical men. In the early nineteenth century the scientific status of medical knowledge of insanity, in relation to most other conditions, was very primitive and unsystematised. Until the Medical Registration Act 1858, there was no basis for a unitary medical profession<sup>10</sup>. Although their hold was being relaxed as the market system eroded traditional guild control, medical practice was still divided into three professional orders ranked by social class: the physicians, providing medical services for the rich and usually themselves drawn from the upper classes; the middle-class surgeons; and the relatively humble lower middle-class apothecaries. Certain medical men from all three orders were engaged in the private madhouse trade in the eighteenth century, and it was from this base that they claimed expertise in the care and treatment of the insane against clerical and lay groups. Institutionalisation and classification posited a need for the development of a psychiatric profession which doctors were well fitted to fulfil.

The development of medical control was initially hampered, however, by the temporary popularity of a therapeutic method which did not require recognised medical skills. This was moral treatment, developed both in theory and practice by the Tuke family at *The Retreat*, the Quaker asylum near York, from the last

years of the eighteenth century. This therapeutic philosophy, because of its emphasis on humane treatment and optimistic, curative orientation, represented a decisive rejection of the eighteenth century concept of insanity as a species of bestiality, responsive only to crude physical confinement and restraint. Moral treatment rested on the belief that orderly behaviour could be cultivated in the insane by communicating with their remaining humanity through a calculated system of rewards and deprivations. In other words, appropriate environmental conditions could catalyse recovery. The advocates of moral treatment expressly denied the efficacy of medical treatments, but their non-medical practices failed in the end to generate an occupational group of lay therapists with the capacity to rival the medical profession. In this debate, one finds the origins of the inter-professional rivalries which are very much a part of the modern mental health system.

Statutory requirements for medical visitation and superintendence of asylums dating from the 1828 Madhouses Act, legally reinforced the view that the treatment of insanity *should be the prerogative* of the medical profession.

By the middle of the nineteenth century, asylum doctors had organised themselves and were producing regular journals to foster psychiatric knowledge and to provide a forum for exchanges and debates. A sense of professional community, identity and interest was generated. In 1841, the Association of Medical Officers of Asylums and Hospitals was founded. This became the Medico-Psychological Association of 1865 and acquired the title Royal Medico-Psychological Association in 1925, eventually becoming the Royal College of Psychiatrists. In a similar way the change in title of the association's journal, from the *Asylum Journal* (1853), to the *Asylum Journal of Mental Science* in 1854, and thence to the *Journal of Mental Science* in 1859, and finally to the *British Journal of Psychiatry* in 1962, reflects the attempt to dissociate psychiatry from its asylum origins.

Unity between 'alienists', the term that came to be applied to asylum doctors, and the rest of the medical profession, was a long time coming. Medical treatment of the insane was of low status within the profession, the psychiatrists suffering from the vicarious stigma of the custodial rather than curative orientation of their work.

It was in their capacity as arbiters of civil commitment, routinely deciding who was and who was not a fit person to be maintained at public expense as a pauper lunatic, that doctors could determine the practical limits of medical discretion. It was in relation to this question that psychiatry became engaged in its most bitter external conflict in the civil sphere of its practice, namely with the legal system. The claims of the medical profession to be able to determine questions affecting individual liberty, could be seen as threatening to displace the traditional trial model for the ascription of guilt, with which lawyers were intimately familiar, by a therapeutic model for the diagnosis of illness. From a legal point of view this could be perceived as placing decision-making power over vital questions of civil liberty in the hands of experts guided by esoteric knowledge rather than judicial authorities whose reasoning notionally incorporated commonly accepted behavioural standards.

This discursive collision could only be resolved politically and it was the might of the legal profession which, in the late nineteenth

*Even though the study of human behaviour is as old as recorded history, it is only in the last two hundred years that mental disorders have established a secure place within the province of medicine.*

century, drove their side of the argument in to the statute book under the momentum of their superior political power, in the Mental Health Act of 1890.

Asylums could only take certified patients; and patients could not be certified until the illness had reached a stage where it was obvious to a lay authority, the Justice of the Peace. This made it impossible for asylums to deal with early diagnosis and the treatment of most mild or acute cases. They were thus confirmed in their largely custodial role.

The difficulties did not end there. Because certification was a necessary preliminary, many doctors tried to avoid sending patients to asylums except as a last resort, and sought other means of treatment; and doctors who wished to specialise in psychiatry often avoided a sphere where most of the work was routine, and where there was little opportunity for improvement of professional techniques. These conflicts between the legal and lay systems and psychiatry are still manifest today as lawyers and the community continue to demand the right to have an overview of the role of psychiatry in the care of the mentally ill. This right to review is asserted through Mental Health Acts, community visitors programs and recurrent inquiries such as the current one being conducted by Mr Burdekin on behalf of the Human Rights Commission in Australia.

## The asylums post-Second World War

When new theories of the aetiology of mental illness developed and new techniques for treatment were formulated, they at first bypassed the asylums completely. The treatment of neurosis developed in the consulting rooms and outpatient clinics of the 1920s and 1930s. It was stimulated considerably by the large number of psychiatric casualties of war and by the growth of the child guidance movement offering, as it did, the prospect for early intervention.

In the early 1950s, three new trends developed which foreshadowed the end of the asylums as they had been: new drugs, first developed in France, were used in the treatment of mental illness; mental hospitals began the 'open-door' movement which was in time to reduce their numbers and to bring their work closer to those of the community service; and politicians decided that mental hospitals were no longer appropriate.

Enoch Powell, delivering what has become known as the 'water tower' speech at the annual conference for the National Association of Mental Health in Britain in 1961, stated that he hoped most of the patients receiving hospital treatment in fifteen years' time would not be in 'great isolated' institutions or 'clumps of institutions', but in wards or wings of general hospitals. The mental hospital was to go.

Now look and see what are the implications of these bold words.

They imply nothing less than the elimination of by far the greater part of this country's mental hospitals as they stand today. This is a colossal undertaking, not so much in the physical provision which it involves as in the sheer inertia of mind and matter which it requires to be overcome. There they stand, isolated, majestic, imperious, brooded over by the gigantic water-tower and chimney combined, rising unmistakably and daunting out of the countryside the asylums which our forefathers built with such immense solidity.

This theme of closure of mental hospitals and what is to replace them has dominated us for the past three decades – general hospitals versus psychiatric hospitals, institutional versus community care, mainstreaming versus isolation – all are seen as solutions to an age-old dilemma; 'what are we to do with the mentally ill?'

## PSYCHIATRY IN VICTORIA

I HAVE HIGHLIGHTED some of the issues regarding the practice of psychiatry in Britain as it had considerable influence on psychiatry in Australia. The imperial connection meant that leadership of the state psychiatric services in Australia – the centre of the practice of psychiatry for a long time – was in the hands of British psychiatrists until well into the twentieth century. The State of Victoria retained this tradition into the 1950s when Eric Cunningham Dax was appointed to carry out the reorganisation of Victorian psychiatric services.



Administrative building, Kew Asylum (from *Early Victorian Psychiatry 1835-1905* by C.R.D. Brothers).

This is how Ellery<sup>11</sup> described it in the post-Second World War years:

The Victorian Lunacy Department of other days changed its name but not its methods when it became the Department of Mental Hygiene. It was still a one horse show, the patients in the asylum were in rags, there was overcrowding everywhere, many of the institutions were seriously understaffed . . . No doubt Hercules would have had to alter the course of the River Yarra in order to cleanse the Augean stables of the Victorian Lunacy Department – but the Government chose the less mythical figure of E.C. Dax to do the Herculean task in a less spectacular manner.

The legacy of Dax and those who followed him was a streamlining of the large institutions into modern smaller facilities, and the treatment and maintenance of patients, where appropriate, in the community.

The early activities in Victoria were detailed by Brothers<sup>12 & 13</sup> in his Beattie Smith lectures in 1956: The first major development consisted of the building of a new asylum at Yarra Bend in 1848. By 1852 there had been set up the first of the Select Committees of Inquiry into the Lunacy Department, that were repeatedly held throughout the remainder of the nineteenth century and into the twentieth century. As a result of this inquiry the entire staff of the Asylum was dismissed. In the period 1867 to 1872 one city and two country asylums (Kew, Ararat and Beechworth) were opened.

In the Lunacy Statute of 1867 we see the effect of the creation of the asylums on the isolation of psychiatry from medicine: provision was made for the transfer of all ‘imbeciles, idiots, feeble-minded persons and harmless seniles from their previous places of abode, such as benevolent asylums and general hospitals, into asylums for the insane’. Criminal lunatics and alcoholics were also admitted, despite the protest of the superintendent, who claimed they had a damaging effect on the prospects of cure of the mentally ill.

In 1871, for a brief period, general hospital units commenced – a lunacy ward attached to Castlemaine Hospital was established, then at Bendigo and Geelong, but all were closed in favour of the larger asylums. Thus until the 1970s, when a number of psychiatric units were built alongside, but separate from, general hospitals (for example, Dandenong, Geelong and in Footscray) we continued to have a system of psychiatric apartheid in Victoria – small general teaching hospital psychiatric units and developing private hospitals on the one hand and large psychiatric hospitals on the other.

It is interesting to note the recommendations by Dr Ian McCreery, Inspector of the Lunacy Department, in 1898. Anticipating that after Federation the care of the insane would remain

with the states, he recommended the appointment by the Federal Government of a Commissioner in Lunacy to visit, inspect and report on all asylums in which mental patients were detained, thus developing a uniform system of care and treatment for the insane throughout the Commonwealth. This recommendation was virtually identical to that made in the Stoller Report of 1955<sup>14</sup>, and being made today in an attempt to achieve a National Mental Health Policy – an issue to which I will return.

## THE MODERN MENTAL HEALTH SYSTEM

WHEN CIVILISATION grew in the western world it grew behind walls – in castles and monasteries and small crowded cities, and the outcasts – madmen and idiots, lepers and escaped slaves, outlaws, felons, some victims and some predators – moved in the forests. The wall, the gate and the drawbridge were signs of safety because freedom was dangerous. Then the position was reversed. The forests were felled and the victims and the predators were in their turn confined behind walls in hospitals and asylums, in poorhouses and workhouses and gaols. Sometimes it was done out of kindness and sometimes out of fear, but as society grew harsh with industrialisation, the result was much the same – an institutional system which held a population captive despite the efforts of many to make it more humane. In the second half of this century the walls started to be breached: social scientists advocated the abolition of the institution; politicians and civil servants promoted community care because they hoped it would be better and thought it could be cheaper<sup>15</sup>.

And when Randle McMurphy lies dead as a result of his challenge to Nurse Ratched in the film *One Flew Over the Cuckoo's Nest*, his death stimulates Chief Broom to escape from the hospital in a memorable final sequence, to the accompaniment of cheers from the audience, and, once free, implicitly lives happily ever after. Anyone who visits San Francisco, Los Angeles and New York can see the Chief Brooms who no longer need to escape from hospital – there are few beds to admit them, and their happiness is not apparent. While the failings of the large institutions are well known, the failings of the places to which these patients are being discharged are becoming better publicised. Fuller Torrey<sup>16</sup> in his book *Nowhere To Go* has detailed the tragic odyssey of the homeless mentally ill in the USA. Closer to home, in large headlines *The Sydney Morning Herald*, early in January 1991, reported Mr Justice Slattery's findings in regard to mentally ill patients in the community as part of his second term of reference for the Chelmsford Royal Commission<sup>17</sup>: 'Judge blasts mental care rorts',

'Boarding houses rife with abuse', 'Judge urges psychiatric shakeup', were accompanied by an editorial entitled 'Some other Chelmsfords'<sup>19</sup> detailing the abuse of patients in the community, particularly in private boarding houses. 'His inquiry was informed of cases in which boarding house residents have been effectively sold to the proprietor of other boarding houses'. The 'trade in lunacy' continues now in the community.

The care of the mentally ill, whether in hospital or in the community, needs to take into account the following factors which are accepted by most experts in the field<sup>19</sup>.

- Patients with chronic mental illness are continually vulnerable to mild or moderate stresses which can exacerbate symptoms and precipitate episodes of acute illness.
- Such patients find daily living a struggle and are deficient in the basic social skills necessary to accomplish this.
- Thus, in addition to optimal medical treatment for their mental illness (which sometimes needs to be pre-emptive and assertive) they require continuing comprehensive and at times intensive help with crises, activities of daily living, housing, employment, financial management, medical care of physical illness and support and guidelines in social and recreational activities, all of which used to be provided to a greater or in most cases lesser extent in the total institution.
- Community treatment will need to take account of the needs of the family and other carers both in terms of education and support.
- Mental health services need to be involved in assisting those who provide the accommodation for those who cannot or will not live with families.

If these facts are indeed the case, and I believe they are, then as an academic in psychiatry who is teaching both undergraduates and postgraduates about optimal care of this group of patients, it behoves me to take an interest in health services research and the way health care services are being planned and developed, particularly as they involve my patients.

One of the curious features of human behaviour is that whenever we encounter an apparently intractable problem, judgement is likely to be replaced by enthusiasm. Psychiatry has provided its fair share of examples. The head of the Department of Psychology, University of Queensland, Professor Steven Schwartz wrote to the Royal Commission<sup>17</sup> in May 1990:

Despite numerous advances (tranquillisers, antidepressants, antipsychotics) much of psychiatric practice remains largely empirical. As in the medicine of the past anything that can be dreamed up will be given a try. Putting people to sleep, playing soft music, exercise, bright light, group and individual therapy, shock treatment, art therapy and so on all have their advocates. There are few standard treatments and even fewer attempts to provide scientifically acceptable evidence for treatment effectiveness. Almost anything goes.

Early this century the mental hygienists held sway with their programs of prevention moving us from the concept of mental illness to mental health, a view parodied by Torrey as from 'the suffering sick to the worried well'. They were succeeded by an era of 'anything that held out hope should be tried' leading to what has been described as a period of 'great and desperate cures' – psycho-surgery, malarial therapy, insulin therapy and deep sleep therapy (which has returned to haunt us). Since then, as Ellard<sup>20</sup> observes, there are the champions of day hospitals, therapeutic communities, community psychiatry, biological psychiatry, psychopharmacology, etc, each promising much and in the end delivering a small but useful contribution to the totality of what has to be done. It is an error to believe that the disabilities of severely impaired chronic schizophrenics – alienation, isolation, purposelessness – will be remedied by abandoning our hospitals and allowing them to wander neglected in the doubtful care provided in unsupervised boarding houses or other shelters.

The psychiatric hospital – the asylum – was psychiatry's first 'enthusiasm' to all our problems. Like others it is now trying to find its proper role within a balance of services.

This task of planning and delivering care for the mentally ill used to be exclusively a task for the State. With the advent of systems such as Medicare, stigma has been reduced and many patients can now be managed by private practitioners in the community. The task of caring for the severely mentally ill will, however, continue to occupy the attention of the State acting in two major roles: First, is the paternalistic role which now drives it, in all modern Western countries, to become involved in health, welfare, education and transport, etc; and second, because in the mental health area there is a second duty to protect citizens from being a danger to themselves and to others<sup>21</sup>.

As such, mental health is and always has been both a public health issue and a political issue, and therefore is inevitably caught up in many of the current political economic debates about public health. If all cannot be provided with everything then who will be provided with what?<sup>22</sup>

The task of caring for the mentally ill is one that is subject to ideological swings according to prevailing whims of society, often articulated by committed and influential individuals. It is important to realise that such swings in policy cause tremendous disruption and loss of morale in systems of care that are already stigmatised. It is incumbent on us, therefore, to work towards common, sensible, achievable goals, accepting that the care of the mentally ill requires:

- i) an integrated service which involves acute inpatient care, as well as some medium and longer stay units;
- ii) community mental health facilities including day hospitals and crisis and out-reach services, working with the private sector (both GPs and psychiatrists), and with non-Government organisations;
- iii) that such services need to be located closer to the population they serve;
- iv) that where appropriate the acute services should be delivered in association with other medical care, that is, from general hospital psychiatry units;
- v) that the profile of services depends on the needs of the populations of be served (for example, the inner south in Melbourne has very different needs from the outer east)
- vi) and that an administration structure needs to be set up to co-ordinate the services.

Such a plan is both sensible and practical and if carried through allows us to work towards some commonly agreed goals. Some of us have detailed these views in a working paper for the NHMRC<sup>23</sup>.

## The Universities

What should be the role of universities in all of this? We in the universities have been challenged in recent years to play our part in contributing to the future of the country in probably the most radical upheaval in higher education since Federation. In a report by the Higher Education Council<sup>24</sup> entitled 'The Challenges Ahead' we read:

The higher education system must continue to play its part in contributing to the vision of a cultured and competitive Australia. To fulfil the role, the higher education sector will have to help to shape the agenda for the future and to participate in moulding the hopes and aspirations of the Australian community. This will require the higher education system to be part of the community as a whole not an asset confined primarily to particular groups. It will need to be seen as a community resource, accessible but uncompromising in its education standards, flexible but unashamedly pursuing quality in both teaching and research, critical but objective in its role as community conscience.

Obviously, neither the Minister for Employment Education & Training, [then] Mr Dawkins, nor the National Board had psychiatry in mind when these words were penned, but they apply particularly to those of us in the clinical disciplines in medical schools. Australia has world-class medicine because of our academic and research endeavours. We in the clinical disciplines, more clearly than most, need to exercise our skills in the real world, whilst not compromising our standards – we have to be 'in the world but not of the world'. The days of the ivory tower for the clinical disciplines, if they ever existed, are over.

The other point I would make is that the university is wherever we, its academics are. Whilst The University of Melbourne is in Parkville and Monash University is in Clayton, we the clinical academics are scattered throughout the city. Through us the university is interested, involved and contributes to the big issues in our society, without allowing us the luxury of sitting back and being armchair critics. Not that I am against being critical – we must be constantly critical of ourselves as well as of others but, criticism based on front-line soldiering, not back-room boffinry.

Whenever there are tasks to be done we should be helping to do them; whenever there are issues to debate, we should be debating them; whenever there are deficiencies we should be highlighting and helping to correct them. That is my view of the role of the clinical academic discipline in today's world.

Whenever there is ideology out of control we should be challenging it, and we should be researching in the important areas, asking and trying to answer the vital questions. Some years ago, when we were appointing a new director of the Mental Health Research Institute of Victoria, both applicants who were interested in schizophrenia research, were asked the question, 'Why march on Moscow?' I would answer because in the end, even though one may be less likely to succeed, it may be more important than liberating the Falklands.

The clinical academic in medicine must, by the very nature of his task, take an interest in the setting within which he works and the quality of the service in which he functions. If he is to teach good patient care then he must deliver good patient care, and must be interested in the broader context and organisational aspects of the way that care is to be delivered. In mental health as in most of medicine, the system is complex, as aptly described by Sax<sup>25</sup>, 'in which a strife of interests' prevails.

I have pointed out earlier in this talk that the beginning of academic psychiatry in both New South Wales and Victoria, as well as in several of the other states, arose as a result of the wish of these states to upgrade their mental health services, which had by virtue of their origins, continued to be the responsibility of the State. The agreement of the profession that this was appropriate and necessary, combined with the willingness of the universities through their faculties of medicine to establish these Chairs of Psychiatry, gave us the beginnings of a system which, directly and indirectly, could influence both the quality and the system of care for the mentally ill as we enter the 1990s.

I now have a broader view of the way the university should be interacting with mental health services than when I gave my inaugural lecture at Royal Park seven years ago. I believe now, that wherever there are significant developments in services, academic psychiatry should be associated with them – to provide clinical leadership, to assist in raising standards of care, to teach and to conduct research. We cannot afford to have 'private affluence and

public squalor', no more in psychiatry than in the other areas of our life as a society.

At the present time there are a number of academic initiatives taking place or in the process of discussion. I should point out that these are not my initiatives, but those of a number of people, too numerous to mention. They are the result of a deliberate strategy by Health Department Victoria to work with the universities to upgrade services. In addition to university academics working at this micro level, there is a need for us to be contributing to debate in this country about health services at the state level and about relationships between the Commonwealth and the States, for example, the National Health Strategy review<sup>22</sup> and the attempts to achieve a national mental health policy for the community.

## Research initiatives

I wish to make a few points about research initiatives in psychiatry in Victoria. Although mental illness accounts for approximately 10 per cent of health care costs, psychiatric research captures only 3 per cent of the medical research budget, a situation which is quite different in heart disease and cancer medicine.

The most important recent development in research in Victoria is the restructuring and refocussing of the Mental Health Research Institute of Victoria (MHRI). Building on a strong tradition, as a centre for epidemiological psychiatric research, the Mental Health Research Institute has, under the leadership of Dr David Copolov, become incorporated as an independent institute with its own Board of Management. It has also changed its focus to a predominantly biological approach to two major disorders – schizophrenia and Alzheimer's Disease. Its early success in both these endeavours has been recognised by the award of large grants from the Victorian Health Promotion Foundation to set up the Alzheimer's program under Professor Colin Masters' leadership, and a grant to establish the NHMRC Schizophrenia Research Unit together with Monash University. This is one of only six SRU research units in Australia and the only one located in Victoria. Although sited in temporary premises, the MHRI's recent success in being awarded a grant of \$1 million from the Federal Government in competition for capital funding with other medical research institutes (subject to matching funding from the State Government), make it likely that within the next five years it will be firmly established in new premises at Royal Park.

## Conclusion

I wish to conclude with a painting by Aubert Fleury which illustrates one of the great moments in the history of medicine and possibly the greatest in the history of psychiatry. The painting captures the moment when Philippe Pinel released the chains from the mentally ill in the Bicêtre in Paris. Rousseau said 'man is born free but is everywhere in chains'. Despite Pinel's actions, the chains



Philippe Pinel, the founder of modern psychiatry, liberating *des aliénés* at the *Hôpital de la Salpêtrière*, Paris, in 1795. From the painting by Aubert Fleury.



Philippe Pinel (1745-1826).

*. . . conflicts between the legal and lay systems and psychiatry are still manifest today as lawyers and the community continue to demand the right to have an overview of the role of psychiatry in the care of the mentally ill.*

that bind the mentally ill still exist; but they are different now – our lack of knowledge about the severe mental disorders, the inadequacies of our treatments, the discrimination against the mentally ill and the fragmented system of care we provide for them.

Ladies and gentlemen I have traversed a very broad field in this lecture. I have given you a view of the care of the mentally ill and also highlighted my views about academic psychiatry's role in this task. I have detailed some initiatives currently in train and require support before they can be brought to fruition. Let me quote from T.S. Eliot's poem of 1925, *The Hollow Men*.<sup>26</sup>

Between the idea  
And the reality  
Between the motion  
And the act  
Falls the shadow . . .

Between the conception  
And the creation  
Between the emotion  
And the response  
Falls the shadow . . .

In every period there exists the opportunity for individuals to lighten those shadows; in my discipline, to work towards removing the symbolic chains that continue to bind the mentally ill. There are many sitting in this audience who have already and will continue to contribute to that task in different ways. We in the university, in medicine and in psychiatry have a special opportunity and a special responsibility to accept a role in the attempts to improve health care. There are and continue to be opportunities in teaching, research, clinical work and administration. I am also aware that history sometimes judges harshly those who have had the temerity to attempt to influence the ways in which we care for the mentally ill. The ground is littered with more corpses than statues. But I, for one, shall try to avoid being remembered in the words of another stanza from *The Hollow Men*.<sup>26</sup>

Shape without form, shade without colour,  
Paralysed force, gesture without motion;

Those who have crossed  
With direct eyes, to death's other Kingdom  
Remember us – if at all – not as lost  
Violent souls, but only  
As the hollow men  
The stuffed men.

Thank you ladies and gentlemen.

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*Bruce Singh, MBBS(Syd 1968), PhD(Newc 1982), MRACP(1972), MRANZCP(1975), FRACP(1978), FRANZCP(1979), came to Melbourne in 1984 to take up the Foundation Chair of Psychological Medicine, Monash University at Royal Park and Alfred Hospitals. In 1991 he succeeded Professor Brian Davies as the second Cato Professor of Psychiatry and Director of Psychiatric Services at The Royal Melbourne Hospital.*

*Professor Singh's research activities have been in the area of schizophrenia and his major achievement, together with Associate Professor David Copolov, Director of the Mental Health Research Unit of Victoria, has been the establishment of the NHMRC Schizophrenia Research Unit, Royal Park Hospital of which he is Co-director. Other areas of research include psychiatric rehabilitation, psychiatric aspects of disasters, rehabilitation in physical illness and caregiving in the community.*

*He has been Consultant to the Commonwealth Government of Health, Canberra, for Evaluation of New Drugs since 1982, and Chief Policy Adviser, Office of Psychiatric Services, Health Department of Victoria since 1988. He has been Chairman of the Fellowships Board and Committee for examinations of the RANZCP since 1988. He is a member of the NHMRC Grants Committee.*

## From the Dean

**I**N 1991 the Faculty emerged with a significantly broader role in the University and in the community. Towards the end of 1989, the Faculties of Medicine and Dental Science amalgamated to form the Faculty of Medicine and Dentistry, comprising the School of Medicine and the School of Dental Science. At the beginning of 1991, with the establishment of the new School of Physiotherapy, the name of the Faculty changed again to the Faculty of Medicine, Dentistry and Health Sciences. Most recently, towards the end of 1991, it was agreed that the Department of Psychology would transfer in 1992 from the Faculty of Arts to become the School of Behavioural Science in the Faculty of Medicine, Dentistry and Health Sciences. These major changes to the structure and composition of the Faculty provide exciting opportunities to interact more effectively in promoting the highest quality undergraduate and postgraduate education and research in medicine, dentistry, biomedical science, physiotherapy and behavioural science.

A highlight of 1991 was the establishment of the School of Physiotherapy, marked by a number of milestones: provisional approval of the proposed undergraduate physiotherapy course by the Physiotherapists' Registration Board of Victoria; the welcoming of the Foundation Class of 40 students to the University in February; the formal opening in July by the State Minister of Health, the Honourable Ms Maureen Lyster, of the School's handsome new accommodation at 200 Berkeley Street; and the very generous and enthusiastic support from the Victorian physiotherapy profession and the departments of physiotherapy in our clinical schools for this important new development. Professor Joan McMeeken accepted appointment to the Foundation Chair of Physiotherapy and as Associate Dean (Physiotherapy), ensuring strong leadership for the School in the development of its undergraduate and postgraduate physiotherapy programs, its research activities and its links with the physiotherapy profession. The Faculty looks forward to building on the success of this first year and the emergence of the School as the leading School of Physiotherapy in Australia.

## Research

Again in 1991, the Faculty was successful in obtaining the largest allocation of NHMRC funding of any medical faculty in Australia. Approximately \$10.6 million of NHMRC funds were obtained to support 111 Project Grants and 8 Program Grants in the Faculty, as well as approximately \$1.5 million of NHMRC funds awarded to associates of University departments in affiliated teaching hospitals. From all sources outside the University, the Faculty attracted a total of approximately \$22.5 million in funding to support research.

It is particularly pleasing to note the extent to which research in the Faculty has developed major links with industry. A good example is the work of Dr Eric Reynolds and his co-workers in the School of Dental Science who have been awarded a major Government Industry Research Development (GIRD) grant to work on new approaches to dental caries prevention in collaboration with colleagues in the Department of Chemical Engineering, Bonlac Foods Ltd and the Victorian Dairy Industry Association. A major GIRD grant has also been awarded to a research team in the Department of Biochemistry, headed by Professor Richard Wettenhall, to work on food preservation systems with the Food Research Institute of the Victorian Department of Agriculture, the CSIRO Division of Food Processing, and Burns Philp and Co Ltd. Congratulations are also due to our two winners of Cooperative Research Centres in 1991: 'The Australian Growth Factors Cooperative Research Centre' involving the Walter and Eliza Hall

Institute of Medical Research (the School of Medicine's Department of Medical Biology), the Ludwig Institute for Cancer Research, the CSIRO Division of Biomolecular Engineering, the Biomolecular Research Institute, and Amrad Corporation Ltd; and 'The Cochlear Implant, Speech and Hearing Research Centre' to be directed by Professor Graeme Clark and involving our Department of Otolaryngology at the Royal Victorian Eye and Ear Hospital, the Australian Bionic Ear and Hearing Research Institute, the National Acoustic Laboratories, and Cochlear Pty Ltd, a biomedical subsidiary of Pacific Dunlop.

## Staff

There is little doubt that the very strong research performance of the Faculty is an important factor in helping us to attract and retain staff of high quality. During 1991, the Faculty continued to make excellent appointments at all levels of seniority. As well as the appointment of Professor Joan McMeeken to the Chair of Physiotherapy, other important chair appointments in 1991 were those of Professor Bruce Singh to the Cato Chair of Psychiatry, Professor Donald MacLellan to the Chair of Surgery at the Repatriation Hospital Heidelberg, and Professor Geoff Nicholson to the Foundation Chair of Medicine at the Geelong Hospital. Professor Wayne Morrison took up his appointment to the Chair of Surgery at St Vincent's Hospital early in 1992. In addition, Professor Bill Sawyer's appointment in 1991 to a Personal Chair in the Department of Biochemistry is noted with pleasure.

Notable retirements at the end of 1991 included Professor Priscilla Kincaid-Smith from her Personal Chair in the Department of Medicine at The Royal Melbourne Hospital, Professor Richard Ball as Professor/Director of Psychiatry at St Vincent's Hospital, and Professor Hugh Burry as Professor/Director of Rehabilitation Medicine at The Royal Melbourne Hospital. Professor Kincaid-Smith has been appointed Professor Emeritus and was awarded the Honorary Degree of Doctor of Laws of The University of Melbourne at the 'medical' degree conferring ceremony in December 1991. She has agreed to accept appointment as Convenor of Continuing Education for the School of Medicine in 1992, taking over from Professor Emeritus Richard Lovell who has filled this important position with great distinction since his retirement as Stewart Professor of Medicine in 1983.

Notable honours awarded during 1991 to those associated with the Faculty included the appointments in the Order of Australia of Mr Bernard McC O'Brien, CMG, as Companion, Dr Elizabeth Turner and Mr E Durham-Smith as Officers, and Drs Evelyn and John Billings, Dr Maurice Cauchi and Dr Graeme Sloman as Members. Professor Jim Pittard was awarded the 1991 Lemberg Medal of the Australian Society for Biochemistry and Molecular Biology. Professor Bill Cole received the Arthur Huene Memorial Award of the Pediatric Orthopedic Society of North America. Dr John Bateman received the Andre Lichwitz Prize. Dr Richard Cotton was awarded the 1991 Selwyn-Smith Medical Research Prize. It has also been announced that Professor Jack Martin will be awarded the 1992 Dale Medal of the British Endocrine Society.

1992 Australia Day honours were awarded to Professor David Curtis (AC), Professor David White (AO), Professor Richard Bennett (AM), Mr John Clarebrough, OBE (AM), Professor Arthur Clark (AM). Mr Bernard O'Brien, AC, CMG, was named Victorian of the Year.

## Students

The Faculty continues to be successful in attracting outstanding students. For the medical course, the VCE selection score was a record high of 366 in 1991 for the 169 quota places for non-overseas students; of this number, 49 per cent were women. The first year

quota included 10 students with social and/or educational disadvantage admitted under the University's Special Admissions Scheme. The second year quota of 192 included 5 Lateral Entry Scheme students and 9 Extended Special Admissions Scheme students (including a student considered under the University's selection policies for Aboriginal students), who gained admission after the satisfactory completion of two years of Science to prescribed standards. There were 41 full-fee overseas students admitted to first year outside the above quota; 31 such students were undertaking the course in 1991, one of whom graduated at the end of the year.

For the dental science course, the first year quota for non-overseas students remained at 45. The VCE selection score for first year entry was 355. The first year quota included two Special Admissions Scheme students and 11 students who transferred from other tertiary courses. Of the total first year quota, 46 per cent were women. Three full-fee overseas students were admitted to first year outside the above quota. Three Lateral Entry Scheme students were admitted to the second year of the course, and one foreign-trained dentist was admitted to third year. An important initiative approved late in 1991 was a program to allow a small number of Master of Dental Science candidates admission to the medical course with advanced standing, following a special bridging course, to encourage and facilitate their training in oral and maxillofacial surgery at an internationally competitive level.

The Faculty was very pleased with the extraordinarily high level of demand for places in the new undergraduate physiotherapy course. For the first year quota of 40 students, the VCE selection score was 358, one of the highest of any course in the State. The entry included 22 women and 18 men. Within the quota were two Special Admissions Scheme students.

There is still strong demand for places in higher degree programs of the Faculty. In 1991, a total of 405 EFTSU (Equivalent Full-time Student Unit) were enrolled as higher degree students in the Faculty. This is approximately 17 per cent of the total teaching load of the faculty, compared with a figure of 9 per cent in 1980. Some growth remains likely in future years, particularly with the development of postgraduate programs in physiotherapy.

## Quality of education

In contributing to the University's Strategic Plan for 1991-1993, the Faculty re-affirmed its commitment to monitoring continually and enhancing further the quality of all of its educational programs for undergraduate, postgraduate and continuing education students.

Since 1978, the faculty has had as a major policy the process of curriculum reform and development for the undergraduate medical course. Key steps in the implementation of this policy have been the following: (1) establishment of the Curriculum Review Committee, including active student membership; (2) formulation of agreed educational objectives; (3) restructuring of the curriculum aimed to achieve these educational objectives; (4) monitoring of the effectiveness of the curriculum in achieving these objectives through feedback from departments, regular meetings with representative groups of students, and extensive use of detailed student questionnaires with results going to the Curriculum Review Committee, departments and students; (5) review and modification of the curriculum as appropriate to take account of the monitoring process and emerging needs. The Faculty believes that the work of the Curriculum Review Committee has been, and continues to be, a creative force in generating constructive and responsive approaches to curriculum development and in promoting the Faculty's commitment to quality in education as well as excellence in research.

## Information technology

The Faculty recognises the importance of well-targeted Information Technology developments in complementing its teaching programs. In the past year, approximately \$1 million has been invested in the establishment of major computer laboratories for physiology/pharmacology practical classes. In addition, there has been substantial upgrading of computer-aided instruction facilities and specialist staffing in several departments. The Faculty is also exploring the use of multi-media teaching technology in a number of areas.

## New academic developments

Significant new academic developments have occurred during 1991 in collaboration with the teaching hospitals with the appointment of Professor Oliver Hennessy as Professor/Director of Medical Imaging at the Austin Hospital, Professor Glen Bowes as Professor/Director of Adolescent Health at the Royal Children's Hospital, and Professor Brian Buxton as Professor/Director of Cardiac Surgery at the Austin Hospital. Taking up their appointments early in 1992 will be Professor Shaun Brennecke as Professor/Director of Perinatal Medicine at the Royal Women's Hospital, Professor Gavin Becker as Professor/Director of Nephrology at the Royal Melbourne Hospital, and Professor Duncan Blake as Professor/Director of Anaesthesia at The Royal Melbourne Hospital.

There have also been substantial academic developments in collaboration between the Department of Psychiatry and the Office of Psychiatric Services of the Health Department Victoria, leading to a number of new Senior Lecturer/Associate Professor appointments in specialty areas of psychiatry funded by the State Government. The Department of Community Medicine has also been successful in obtaining State Government funding to support important academic developments in the fields of intellectual disability and drug and alcohol studies. Community Medicine has also established an Occupational and Environmental Health Unit with industry funding, and a Rural Medicine Unit in Ballarat with the support of Ballarat Base Hospital.

## Graduate and Community Relations

The Faculty continues to place a high priority on promoting good relationships with its graduates and with related professional groups in the community.

**UMMS:** The University of Melbourne Medical Society has over 2000 members, many of whom attended the Annual UMMS Lecture in November in which Professor Emeritus Harold Attwood, Curator of the Medical History Museum, gave a most enjoyable presentation entitled 'The Oldest Medical School in Australia' in which we were reminded of the 130th Anniversary of the Medical School in 1992.

Many UMMS members also attended a seminar in October entitled 'Is There a Doctor in the House? Medical Women's Centenary Seminar' to mark the centenary of the graduation of the first women doctors from this University in 1891. This seminar, which was convened by the Director of the Key Centre for Women's Health in Society, Associate Professor Lorraine Dennerstein, was a great success. In the evening, the Key Centre hosted an excellent, well-attended dinner at Ormond College.

The joint editors of the UMMS journal *Chiron*, Mr Peter Jones and Mrs Maggie Mackie, again produced an outstanding, widely acclaimed issue in 1991.

**SAFODS:** During 1991, the Society and Friends of Dental Science continued their activities in support of the School of Dental Science.

**Physiotherapy:** The physiotherapy profession has rallied enthusiastically to support the new School of Physiotherapy with a proposal to establish a 'Friends of Physiotherapy - University of Melbourne'. It is anticipated that this will be a very useful vehicle to promote interaction and mutual support between the School of Physiotherapy and the physiotherapy profession.

**Continuing Education:** The Faculty was again active in planning and promoting Continuing Education programs for graduates. Professor Emeritus Richard Lovell was very ably supported by Ms Robin Orams in developing nine Continuing Medical Education courses during the year, particularly designed to suit the needs of general practitioners. Associate Professor John Harcourt, with the assistance of Ms Judith Campbell, developed 16 Continuing Dental Education courses. These courses continue to attract considerable interest and good attendances.

**Dean's Lecture Series:** Another excellent series of Dean's Lectures was presented during 1991, providing a valuable forum for

inaugural orations and other special lectures. Speakers included Professor Bruce Singh who gave the Beattie Smith Lecture, Professor John Furness, Dr Eric Reynolds, Professor Donald MacLellan, Dr Ruth Bishop, Professor Hugh Taylor, Professor Geoff Nicholson, and Professor John Coghlan who gave the 1991 Mathison Memorial Lecture. To close the series, Professor Emeritus Richard Lovell once again convened a major seminar on an important ethical topic; for 1991, this was 'Issues in Transplantation - Aspects of Supply' which attracted an audience that filled the Sunderland Theatre.

## Faculty Office

Finally, it is most fitting to pay special tribute to the outstanding support given to the faculty by the Faculty Office staff under the excellent leadership of the Assistant Registrar (Medicine, Dentistry and Health Sciences), Mr Darrell Mead, with the assistance of his staff: Mr Peter O'Keefe and, later in the year, Ms Joan Reese, as Executive Officer (Dentistry); Ms Tina Adams as Executive Officer (Physiotherapy); Ms Deborah Rogers and, later in the year, Mr Cyril Yardin taking special responsibility for budgetary and NHMRC matters, assisted by Ms Joan Forrest; Ms Anne Szadura, assisted by Ms Claire Stevenson, Ms Lorna Botham and Ms Judith Hillier, in dealing with undergraduate and postgraduate coursework student matters; Ms Robin Orams, assisted by Ms Elizabeth Brentnall, in overseeing the Continuing Medical Education and Community Relations activities of the Faculty; Ms Judith Campbell assisting with Continuing Dental Education; and Mrs Iris Welcome for continuing to run the Dean's Office with great efficiency.

*Graeme B. Ryan*  
Head, School of Medicine  
Dean, Faculty of Medicine,  
Dentistry & Health Sciences

## Professor Lovell Retires as Academic Convener of Continuing Medical Education

AT THE END OF 1991, Professor Emeritus Richard Lovell, AO, retired from his appointment as Academic Convener of Continuing Medical Education for the Faculty. He held this appointment on a part-time basis since his earlier retirement in 1983 as the Foundation James Stewart Professor of Medicine at The Royal Melbourne Hospital. During his eight years in the position, he did a marvellous job (in collaboration with Ms Robin Orams of the Faculty's Continuing Medical Education and Graduate and Community Relations Office) in encouraging and assisting academic staff in the development and presentation of a broad range of Continuing Medical Education courses, with an emphasis on courses of special interest to general practitioners. Under his wise guidance and leadership, the Continuing Medical Education program of the Faculty has become a very important forum of interaction between the Faculty and the medical profession. The program is in great shape to pass now to the leadership of Professor Emeritus Priscilla Kincaid-Smith who takes on this role in 1992.

It is appropriate to take this opportunity to pay tribute to Professor Lovell's continuing convenership of our annual series of Medical Ethics Seminars. The proceedings of these excellent seminars have been reported each year in *Chiron*. He will chair the 1992 seminar, entitled 'Looking After Ethics - A Decade of Change' on Friday 17 July 1992, again bringing together an array of very eminent, well-informed speakers. The 1992 seminar will review the current status of medical ethics in research, ten years after the establishment of the Medical Research Ethics Committee (MREC) of the National Health and Medical Research Council (NHMRC). Professor Lovell was the Foundation Chairman of this Committee for seven critically important years between 1982 and 1988. During this period, Professor Lovell gave outstanding leadership in guiding the NHMRC, Australian research institutions, researchers and the wider community in the development of sensible and sensitive approaches to a wide range of medical ethics issues. (GBR)

## 1992 Highlights

### Seminar

#### Looking after ethics - a decade of change

*Convener: Professor Emeritus Richard Lovell*

**Friday 17 July, 2.00 p.m. to 5.00 p.m.**  
Sunderland Theatre, Medical Building  
The University of Melbourne

### Birthday Celebration and UMMS 1992 Lecture

**130th Anniversary of the Founding of  
the Medical School and the  
10th Birthday of the University of  
Melbourne Medical Society  
(details to be advised)**

### UMMS AGM

**Tuesday 26 May, 6.30 p.m.**  
Sunderland Theatre, Medical Building

### Dean's Lecture Series

### Continuing Medical Education Courses

General enquiries: (+61 3) 344 5888

### Alumni Association

#### Gala Recital

Leading Australian Concert Pianist  
Stephen McIntyre  
21 August  
Melba Hall, The University of Melbourne

Enquiries: Kathryn Clarke, Alumni Office,  
The University of Melbourne, Parkville, 3052,  
telephone (+61 3) 344 7469.

## Retirements

### Professor Richard Ball

**J**AMES RICHARD BALDWIN BALL graduated from the University of Durham in 1951. In 1965 he gained the MD by thesis in the same University. In 1958 he obtained the Diploma in Psychological Medicine and in 1963 became a Member of the Royal Australian and New Zealand College of Psychiatrists and a Fellow in 1970. His initial psychiatric training was in teaching hospitals in Newcastle-on-Tyne and later at King's College Hospital and Maudsley Hospital in London. He spent a year in Canada and completed his training in 1961 as a Senior Registrar at the University Department of Psychological Medicine at Newcastle-on-Tyne. For three years (1952-55) he served as a Medical Officer in the Royal Air Force – part of the time in Egypt. He came to Australia in 1962 and held a number of positions in the Mental Hygiene Authority in Victoria, including an appointment as Director of the Institute of Mental Health Research and Postgraduate Training. He served for a number of years as Censor-in-Chief of the Royal Australian and New Zealand College of Psychiatrists.

In 1975 he was appointed as a Professorial Associate of the University of Melbourne and in 1977 he accepted appointment as Professor/Director of Psychiatry at St Vincent's Hospital. For more than fourteen years in this position, until his 'retirement' early in 1992, Professor Ball provided outstanding leadership for the discipline of psychiatry and for the Faculty. He developed a very strong unit of the University Department of Psychiatry at St Vincent's Hospital and promoted valuable links with major psychiatric hospitals affiliated with the University. He played an important role in upgrading the teaching and research activities of the Department as well as having a major input into the committees of the Faculty. The Faculty is very pleased that Professor Ball will continue to participate in the work of the Department of Psychiatry during 1992 through a half-time appointment in Forensic Psychiatry.

### Professor Hugh Burry

**A**FTER COMPLETING his undergraduate medical qualifications in New Zealand in 1954, Hugh Cameron Burry went into general practice for seven years. In 1966 he joined Guy's Hospital, London and was appointed Director of the Department of Rheumatology in 1968 and Director of the Hume Kendall Rehabilitation Unit. On his return to New Zealand in 1976, he was appointed Consultant Rheumatologist and Adviser on Rehabilitation to the Wellington Hospital Board and in 1978 was appointed Associate Professor of Medicine (Rheum-

atology) at the Wellington Clinical School. In 1982, he was appointed the Chief Health Adviser and Rehabilitation Controller of the Accident Compensation Corporation in New Zealand.

In 1988, Professor Burry accepted the appointment as Professor/Director of Rehabilitation Medicine at The Royal Melbourne/Essendon and District Memorial Hospital and in the Department of Medicine (Royal Melbourne Hospital/Western Hospital), a position that he filled with great energy and distinction until his retirement at the end of 1991. During this period, he played an important leadership role in promoting the discipline of rehabilitation medicine in undergraduate teaching and in total patient care. He was a driving force in the development of the excellent rehabilitation facilities at the Essendon campus of the amalgamated hospitals. With the support of the Victorian Accident Rehabilitation Council, he inaugurated a number of substantial research programs in areas of special significance in rehabilitation medicine. The Faculty looks forward to building on the outstanding foundations established by Professor Burry for the further development of rehabilitation medicine as an academic discipline.

### Professor Priscilla Kincaid-Smith

**P**RISCILLA SHEATH KINCAID-SMITH was born in Johannesburg, South Africa. After obtaining qualifications in science and medicine at Witwatersrand University followed by hospital experience in Johannesburg, she moved to London where she trained in clinical pathology and then internal medicine at the Royal Postgraduate Medical School and Hammer-smith Hospital. While in London, in 1958, she met and married a young Australian physician, Dr Ken Fairley, whom we can thank for bringing Priscilla to Melbourne at the end of 1959. After a period of two years as a Research Fellow at the Baker Institute and Alfred Hospital, she was appointed an NHMRC Senior Research Fellow and Senior Associate in The University of Melbourne Department of Medicine at The Royal Melbourne Hospital. She was appointed Honorary Physician at The Royal Melbourne Hospital in 1966, First Assistant in the Department of Medicine in 1967 and Reader in Medicine in 1969. In 1975 she was appointed to a Personal Chair in the Department of Medicine, the first female Professor of this University, a position that she has filled with outstanding distinction.

Professor Kincaid-Smith is internationally acclaimed for her many contributions to the understanding, treatment and prevention of kidney disease. She showed that the excessive use of common, over-the-counter pain-killing drugs resulted in a form of kidney damage that was the leading cause of kidney failure in Australia at that time. She played a major role in the efforts that

led to legislation limiting the availability of such drugs and the eventual prevention of this important health problem. Her pioneering work on new approaches to the treatment of severe forms of nephritis, depending upon an understanding of disease mechanisms, provides the basis for the current clinical management of these conditions. Her work on high blood pressure, pregnancy-associated kidney disease and kidney scarring is at the forefront of knowledge in these fields. She has published more than 500 articles in scientific journals or chapters in books. She is the author or editor of 10 books on kidney disease.

She has received many awards, honours and fellowships around the world, including the Sussman Prize of the Royal Australasian College of Physicians, the David Hume Award of the National Kidney Foundation of New York, the Leon Chesley Award of the International Society for the Study of Hypertension in Pregnancy. She has served as President of the International Society of Nephrology, President of the Asian Pacific Society of Nephrology, President of the Australian Society of Nephrology, Member of the Australian Science and Technology Council (ASTEC), Member of the Australian Marine Science and Technologies Advisory Committee (AMSTAC) and many other important national and international bodies. At The Royal Melbourne Hospital she has played a major leadership role as Chairman of the Division of Medicine and Chairman of the Medical Advisory Committee. From 1986 to 1988 she was President of the Royal Australasian College of Physicians.

At the end of 1991, she retired as Professor of Medicine and Director of Nephrology at The Royal Melbourne Hospital. In addition to these positions, she has held a remarkable array of appointments, including Assistant Dean (Postgraduate Studies) of the Faculty of Medicine, Dentistry and Health Sciences, Member of the Health Care Committee of NHMRC, President of the Association of University Clinical Professors of Australia, President of the Australasian Society for the Study of Hypertension in Pregnancy, Chairman of the Victorian AIDS Advisory Committee, Member of the Victorian Branch Council and Chairman of the Federal Council of the Australian Medical Association, Member of the Board of the Commonwealth Serum Laboratories, Member of the Board of Fairfield Hospital, Chairman of Board of Directors of the Australian Medical Publishing Company and many others.

Professor Kincaid-Smith's career is one of extraordinary energy, dedication, achievement and public service. In 1975, she was appointed Commander of the Order of the British Empire. In 1989, she was appointed Companion of the Order of Australia for her contributions to medicine and the community. At the end of 1991, she was awarded the Honorary Degree of Doctor of Laws of The University of Melbourne. In 1992, Professor Kincaid-Smith will continue her association with the Faculty in the part-time role of Convener of Continuing Medical Education.

### Austin Hospital & Repatriation General Hospital

In 1991 we celebrated twenty-five years association between the Austin Hospital and The University of Melbourne School of Medicine, the first professors being appointed at the Austin Hospital in 1966. It was also the Repatriation General Hospital's 50th birthday.

The number of students at the Clinical School in 1991 was 182, an increase of 28 from the previous year. The teaching program reflected the introduction of the new curriculum for all clinical years, with final year consisting of two 14-week terms commencing in the second week of March. It now includes casualty and anaesthetics, which are undertaken at the Austin, Repatriation General and Preston & Northcote Community Hospitals.

Fourth year commenced at the end of January and for eight weeks in the last three terms students were rotated to country hospitals for experience in medicine and surgery. These country rotations are extremely popular with students. They 'live-in' and become closely involved with the hospital and see a broad range of conditions. It is hoped that some will be attracted to country practice as a result of this experience.

In final year, all but one of the 65 students passed outright. Andrea Kattula was the top student of the Clinical School, also coming second in the year with first class honours in medicine and surgery.

Both the Austin Hospital and the Repatriation General Hospital have agreed to accept students from the School of Physiotherapy for clinical training. In 1991 first year physiotherapy students attended the Austin Hospital for clinical training.

The Clinical School continues to be affected by funding problems within the Public Hospitals – bed closures, changes in case mix and average bed stays falling. These factors mean that students have less opportunity to get to know their patients and to follow them through their illnesses.

During 1991, Mr Ken Millar, Senior Surgeon at the Repatriation General Hospital, retired after being with the Clinical School since its inception.

The longer clinical years in fourth and final years have put an increased teaching load on the clinical staff of the Hospitals. I am dependent on them and I thank them all for their willingness to undertake undergraduate teaching.

*Bernard Sweet*  
Clinical Dean

### Royal Melbourne Hospital & Western Hospital

The introductory course in clinical medicine in third year, conducted over eight weeks on Wednesday afternoons, consisted of an hour pathology demonstration followed by clinical demonstrations in the wards. The students appeared to be enthusiastic, and attendance was very high for all of the eight weeks. At this stage it is our intention that this course will be the same in 1992 as in 1991.

As in previous years, fourth year was divided into four terms – two surgical and two medical – and all students were either at The Royal Melbourne Hospital or Western Hospital during term 1. For the other 3 terms, there were always some students away at Ballarat Base Hospital, Wangaratta District Base Hospital and Wimmera Base Hospital.

Ward teaching in medicine and surgery continued as before. Students attended Wimmera Base Hospital for the first time for a surgical rotation in 1991. This appears to have been a very successful rotation, and students have been very enthusiastic about the teaching and experience there. We are therefore extremely pleased that this Hospital has been added to the other country hospitals which so successfully provide rotations for our students.

During the medical and surgical terms, students had special teaching in geriatrics, vascular surgery, orthopaedic surgery, clinical

pharmacology, rehabilitation, emergency medicine, and dermatology. The geriatric medicine teaching consisted of a two-week block at the end of one of the medical terms and was very successful. Clinical pharmacology teaching consisted of one clinical session per week in one of the medical terms. Teaching in emergency medicine consisted of attendance for either one or two weeks at the Emergency Departments of The Royal Melbourne Hospital or Western Hospital and in the country hospitals. Advanced Study Units were also undertaken in fourth year, during either 2nd or 3rd terms, at The Royal Melbourne Hospital or Western Hospital.

The introduction of the fifth year subjects as terminating subjects has led to a welcomed clarification of the place of these subjects in sixth year. In the past, students have been confused as to how much of their time in final year should be devoted to fifth year subjects, since there were still some marks to be earned in those subjects. The longer sixth year has in general been successful. The year consisted of seven-week blocks in each of general medicine, special medicine, general surgery and special surgery. However, a three-week anaesthetic and emergency period was taken out of the special surgery term.

For the first time in 1991 the general surgical term, in addition to the general medical term, comprised a 'student internship'. In general, this has been a successful move, and it is anticipated that student internships will again occur in both the general medical and the general surgical terms in 1992. It is also planned to utilize Ballarat Hospital in 1992 for student internships in general medicine and surgery to ensure that there are always two student interns attached to a unit.

Anaesthetics and emergency medicine teaching comprised a three-week block, during the special surgery term. This shortened the special surgery term to only 4 weeks. For 1992 it is planned to shorten the general surgery term to 6 weeks and lengthen the special surgery term to 5 weeks. This will make the timetabling a little more difficult, but will give a better balance between special surgery and general surgery.

In 1992 it is also planned to lengthen the introductory period at the commencement of term 1 in fourth year from two weeks to three weeks. This will allow more introductory lectures, and further use of video tapes and other teaching methods, including supervised student examination of themselves, to introduce the techniques of physical examination. Communication skills will also be more formally taught by a series of introductory lectures during the introductory term, together with the recording and commenting on video tapes of patient interviews by students undertaken during medical terms.

*Robert Moulds*  
Clinical Dean

### St Vincent's Hospital & Geelong Hospital

The Clinical School had a particularly busy year in 1991, with a substantial increase in the complement of fourth year students and a 40 per cent increase in the length of the teaching year for sixth year students.

Following the amalgamation with Geelong Hospital in 1990, clinical students are now taught in rotation throughout the academic year at Geelong. A comprehensive teaching program was organized by Dr Doug Hocking, Clinical Sub-Dean and all our students were most enthusiastic about their experiences at Geelong.

The elective program for sixth year students was reduced to eight weeks and many students expressed disappointment at this change. The majority of students undertook work experience overseas with a substantial number electing to work in underdeveloped countries. Students gained benefit from the elective program both in terms of clinical experience and personal development. The new curriculum was introduced into the sixth year in 1991 thereby expanding the teaching year from 20 to 28 weeks. Students found the lengthened teaching year quite taxing.

Our final year students worked very hard during the year and were well rewarded with creditable performances in their examinations. Our top students were Gaylene Heard and Kristen Pearson who gained equal third place in the course aggregate. We congratulate all the 1991 graduates and wish them well in their future careers.

Students in fifth year spent very little time at their present clinical school during the year. They enjoyed their rotations to other institutions and appreciated the opportunity to mix with students from the other clinical schools. We look forward to their return as senior students in 1992.

Fourth year students were kept busy with a very full curriculum. In addition to terms at St Vincent's Hospital, Geelong and PANCH, all students had the opportunity to rotate to a country hospital for a 5 to 7-week period. Medical rotations were offered at Goulburn Valley Base Hospital and at Warrnambool and District Hospital and a surgical term at Wangaratta and District Hospital. These country rotations again proved to be very popular with students who appreciated the opportunity to clerk a large number of patients in a 'student friendly' environment.

Unfortunately, there have been ongoing difficulties in the co-ordination of pathology teaching between clinical schools and their country affiliations. These problems have necessitated a rearrangement of country rotations from 1992 and we will rotate a group of surgical students to Goulburn Valley in addition to our established medical rotation. This will replace the surgical rotation at Wangaratta which will be taken over by the Austin Hospital and Repatriation General Hospital Clinical School. We thank the surgical staff of Wangaratta and in particular Dr Kate Davey (Clinical Supervisor) for their high standard of teaching during the time of our association.

We are most grateful to all the dedicated and hard-working teachers associated with our clinical school during 1991. The standard of tuition is high and our students have many opportunities to experience a variety of clinical practice.

*Wilma Beswick*  
Clinical Dean

## Final Year MBBS 1991

### Top Final Year Student 1991



Dr Karen McKertich

Karen Mary Frances McKertich topped Final Year 1991 and was awarded the following prizes: Australian Medical Association Prize, The CIBA-GEIGY Prize, Rowden White Faculty Prize, Keith Levi Memorial Scholarship in Medicine, Robert Gartly Healy Prize in Medicine, Jamieson Prize in Clinical Medicine, T.F. Ryan (RMH) Scholarship in Medicine, Beaney Scholarship in Surgery, Robert Gartly Healy Prize in Surgery, Geoffrey Royal Prize in General Surgery, Howard E. Williams Prize in Paediatrics, Clara Myers Prize in Surgical Paediatrics, RACGP Prize in Community Medicine, Sir Albert Coates Prize in Infectious Disease, The Royal Melbourne Hospital Robert Andrew Stirling Prize in Clinical Surgery.

Karen also received many awards and prizes in the earlier years of her course: second year, Prosector; third year, the Walter and Eliza Hall Exhibition in Pathology; fourth year, the Royal Melbourne Hospital Moody Prize, awarded to a student who, in the opinion of teachers, most shows 'skill, kindness and human understanding' to patients. She also received the Ken Grice Prize to the top Royal Melbourne Hospital student. In fifth year, she was awarded the Fulton Scholarship in Obstetrics & Gynaecology, and the Vernon Collins Prize in Paediatrics.

Karen was born in India, the elder of two children, arriving in Australia when she was one year old. Her primary education was at Holy Eucharist, Chadstone, and her secondary education was completed at Sacre Coeur in Glen Iris, where she obtained an HSC score of 405.

Karen's interests are in old movies starring Cary Grant, and listening to music, particularly jazz. Eating chocolate and visiting Acland Street for her weekly ration of cakes, she believes, saw her through the course.

Karen chose to complete part of her elective studies in the Emergency Department of Western Hospital, and at Timaru Hospital, New Zealand. In 1992 she has an internship at The Royal Melbourne Hospital, and is particularly interested in graduate studies in surgery.

## Graduate List 1991

### Bachelor of Medicine and Bachelor of Surgery

Joel Aizenstros, Phillip Nicholas Antippa, Narin Bak, Amanda Baric, Bruce Hilton Bartley, Daniel Bergman, Michael Paul Bethune, Paul Edgar Beyer, Kirsten Black, Laura Genevieve Breedon, Ann Louise Brennan, Rachel Lauren Brown, Dac Thong Bui, Leo Kelvin Cantwell, Damian John Castanelli, Kueh Kong Chai, Cassandra Richelle Chan, Raymond Tsz Tong Chan, Thomas Chan Chun Kuang, Louis Che Shuan Chang, Yau Wei Chen, Chiu Suk Ching Doris, Min-Hin Chong, Mui Hun Chong, Andrew James Chow, David Kenneth Clarke, Dominique Elizabeth Coleman, Michael John Coman, Laura Marie Cooney, Rosalind Louise Coulson, BMedSc, Bernard John Creati, David Cunningham, Sarah Louise Dahlenburg, BMedSc, David William Daniels, Tanya Elisabeth Davies, Albina Teresa Della Bruna, Leanne Douglas, Ann-Marie Elliot, BAppSc (RMIT), Wilson Eu Tieng Juoh, Stella Fabrikant, Stephen Gerard Farrell, Stephen Peter Fitzgerald, BSc, John Ronald Forsyth, BSc, Darren John Fox, Wei Ping Fung, Martin Gerard Gallagher, Philip Seng Lim Gan, Katherine May Garran, Merilyn April Gates, Robert Norman Gelder, David Vincent Gill, Sanjeev Singh Gill, John Gioulekas, John Milton Greer, Richard John Grills, Dishan Herath Mudiyansele Danasiri Bandara Gunawardana, Karoline Liesel Gunn, Andrew Juen-Fai Ha, Rosemary Anne Harrup, Gaylene Claire Heard, Andrew Alistair Cromie Heggie, MDSc, Robert Heng Cheng-Chung, Patrick Scott Hosking, Elizabeth Bing Hu, Christopher Owen Jackson, Simon John Jones, Majo Xavier Joseph, Andrea Mary Kattula, Anthony Charles Keeble, Julian James Kelly, Anthony James Kemp, BSc, Susan Mary Kermond, Jonathan Charles Knott, Christos Michael Kondogiannis, Arete Kouteris, Ross Charles Lamplugh, Eu-Meng Law, Lee Wai Kit, Andrew Peter Letcher, Vicki Levidiotis, BSc, Martin Yong Jong Lew, Ernest Kah-Seong Lim, Steven Heong-Tong Lim, Lim Wye-Leng, Lara Rachel Lipton, Anthony Lo Soo Keong, Fabio Vincent Lo Giudice, Jacqueline Loh Swee Yim, Robert Leslie Love, Benjamin Lui, Gavin Christopher Mackie, Cleve Anthony Magree, Michael Harold Maher, Renee Louise Manser, Bruno Anthony Matthew Martin, Craig David McColl, Andrew Glenn McDonald, Helen Maria McKenzie, Karen Mary Frances McKertich, Maria Milone, Jennifer Yee Ping Mok, BMedSc, Amber-Jane Moore, Melissa Louise Morgan, Rosalind Anne Morrow, Christopher Daniel Mow, Parmanand Sirkari Naidoo, Lynda Janette Newman, Ross Martin Nolan, Alan William Nugent, Simon Ooi Oon-Teong, Richard Brian O'Regan, Lisa Michelle Orme, Sylvia Palanca, Greta Mary Palmer, Stathis Papaioannou,

Kristen Jane Pearson, Marc Pellegrini, BSc, Pham Huynh-Hung, Pham Trung Hoai Nguyen, Hugh Charles Richard Platt, Franklin Hong Kiu Pond, Christopher Chi Hao Poon, Michael John Porter, Dimitra Psarianos, Rosalind Jane Reid, Joylene Lois Rentsch, Leisha Joy Riddington, Jeffrey Bruce Robinson, Maria Eugenia Rodopoulos, Dimitrios Romas, Stephen Lewis Rosen, Monique Marie Germaine Ryan, Justin John Scarlett, Lisa Annette Scurrah, James Alexander Shaw, Penelope Marie Sheehan, Julia Esther Sher, David McNaughton Smallwood, Joanne Michelle Smart, BSc, Malcolm Charles Aldridge Steel, Raymond Geoffrey Steele, Christopher Bryce Steer, Damien Luke Stella, Andrew Hector Strickland, Suen Kwok Chu, Michael Fraser Sutherland, Antony Swingler, Peter Panagiotis Tagkalidis, Fiona Yee-Ming Tai, Raymond Bow-Kwong Tam, Tan Gim Aik, Kenneth Tan Hark Hong, Andrew John Taylor, Mary Thomas, That Lu Ton, Andrew Bartholomew Tosolini, Danielle Tran, Ngoc Quang Tran, Tung Kai Cheong, Paul David Turner, Elizabeth Maria Varrenti, Anne Katrine Ward, David George Maxwell Welsh, Philip John Michael Westmore, Anita Jane White, Michelle Wielicki, MD (Wroclaw), Megan Louise Willaton, Victoria McKinley Wilson, Suzanne Victoria Wintle, Meredith Louise Wolfe, Aaron Wong Sung Lung, Wong Bee Choo, Karen Wong, Simon Wai-Lun Wong, Theresa Fung Mei Yee, Michael John Yeoh, Steven Zebic.

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## PRIZES AND AWARDS 1991

### **Australian Medical Association Prize**

McKertich, Karen (RMH/WH)

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

McKertich, Karen (RMH/WH)

### **Rowden White Prize**

McKertich, Karen (RMH/WH)

## **Medicine**

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

McKertich, Karen (RMH/WH)

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

McKertich, Karen (RMH/WH)

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

McKertich, Karen (RMH/WH)

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

Gelder, Robert (RMH/WH)

## **Paediatrics**

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

McKertich, Karen (RMH/WH)

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

McKertich, Karen (RMH/WH)

### **Child Growth and Development Study Prize**

Willaton, Megan (AH/RGH)

## **Psychiatry**

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

Brown, Rachel (AH/RGH) and Willaton, Megan (AH/RGH)

## **Surgery**

### **Beaney Scholarship in Surgery**

McKertich, Karen (RMH/WH)

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

McKertich, Karen (RMH/WH)

### **Ryan Prizes in Surgery (RACS) (RMH/WH, SVH/GH)**

Orme, Lisa (RMH/WH) and Westmore, Phillip (SVH/GH)

### **Smith and Nephew Prize in Surgery (AH/RGH)**

Kattula, Andrea (AH/RGH) and Wolfe, Meredith (AH/RGH)

### **E.H. Embley Prize in Anaesthetics**

Kattula, Andrea (AH/RGH)

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

Kattula, Andrea (AH/RGH)

### **Neil Bromberger Prize in Orthopaedics (AH/RGH)**

Nugent, Alan (AH/RGH)

### **Geoffrey Royal Prize in General Surgery**

McKertich, Karen (RMH/WH)

## **Obstetrics and Gynaecology**

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

Kattula, Andrea (AH/RGH)

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

Kattula, Andrea (AH/RGH)

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

Antippa, Phillip (RMH/WH)

### **Prize in Clinical Gynaecology**

Kattula, Andrea (AH/RGH) and Pearson, Kristen (SVH/GH)

## **Community Medicine**

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

McKertich, Karen (RMH/WH)

## **Infectious Diseases**

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

McKertich, Karen (RMH/WH)

## General Clinical Prizes 1991

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

1st Prize – Elliot, Ann-Marie (RMH/WH)

2nd Prize – Mackie, Gavin (RMH/WH)

### **Hedley F. Summons Prize**

Gioulekas, John (RMH/WH)

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

Kemp, Anthony (RMH/WH)

### **Australasian College of Occupational Medicine Prize**

Pirpiris, Marinis (RMH/WH)

## Fourth and Fifth Year Prizes 1991

### **Fourth Year**

#### **The Ramsay Prize in Clinical Microbiology**

Provenzano, Elena (SVH/GH)

#### **The Harold Attwood Prize in Pathology**

Hii, Melinda (RMH/WH)

#### **Geriatric Medicine Prize**

Heath, John (SVH/GH)

#### **Manu Thomas Prize**

Heath, John (SVH/GH)

## **Fifth Year**

### **Community Medicine Prize**

Pirpiris, Marinis (RMH/WH)

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

Gruen, Russell (AH/RGH)

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

Pirpiris, Marinis (RMH/WH)

### **The Fulton Scholarship**

Larkins, Sarah (RMH/WH) and  
Morgan, Susan (SVH/GH)

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

Larkins, Sarah (RMH/WH)

### **The Max Kohane Prize**

Lau, Wing Fai Eddie (AH/RGH)

### **The Vernon Collins Prize**

Morgan, Susan (SVH/GH)

### **The John Adey Prize**

Amor, David (SVH/GH)

## **Physiology 2**

### **Wellcome Prize**

Buising, Kirsty

## **General Biochemistry**

### **Exhibition**

Ong, Terrence Jong Yeong

## **Neuroscience**

### **Sunderland Prize**

Buising, Kirsty

## **Functional Biochemistry**

### **Exhibition**

Ong, Terrence Jong Yeong

## **Physiology 2**

### **R.D. Wright Prize**

Din, Jason Tye

## **Behavioural Science**

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

Buising, Kirsty

## **Pre-Clinical Prizes 1991**

### **First Year**

#### **Medical Physics**

##### **G.A. Syme Exhibition**

Bylsma, Guy

#### **Medical Physics**

##### **T.F. Ryan Roentgen Prize**

No Prize

#### **Introduction to Medicine**

##### **The Australasian College for Emergency Medicine, Victorian Region, Prize**

Hargrove, Joshua

#### **Medical Biology 1**

##### **W.H. Swanton Exhibition**

Lye, Chien Boon

#### **Medical Biology 1**

##### **Baldwin Spencer Prize**

Choong, Wui Chun

#### **Chemistry**

##### **Exhibition**

Bylsma, Guy

#### **Anatomy 1**

##### **Mathew W. McKenzie Award**

Lye, Chien Boon

### **Second Year**

#### **Anatomy 2**

##### **Dwight Prize**

##### **Exhibition**

##### **T.F. Ryan Prize**

Hew, Mark

### **Third Year**

#### **Pharmacology**

##### **Boots Prize**

Wilkinson, David

#### **Pathology**

##### **The Walter & Eliza Hall Exhibition**

Buckwell, Marnie

#### **Microbiology, including Immunology**

##### **Ramsay Prize (Third Year)**

Charles, Patrick

### *Organising a Reunion Dinner?*

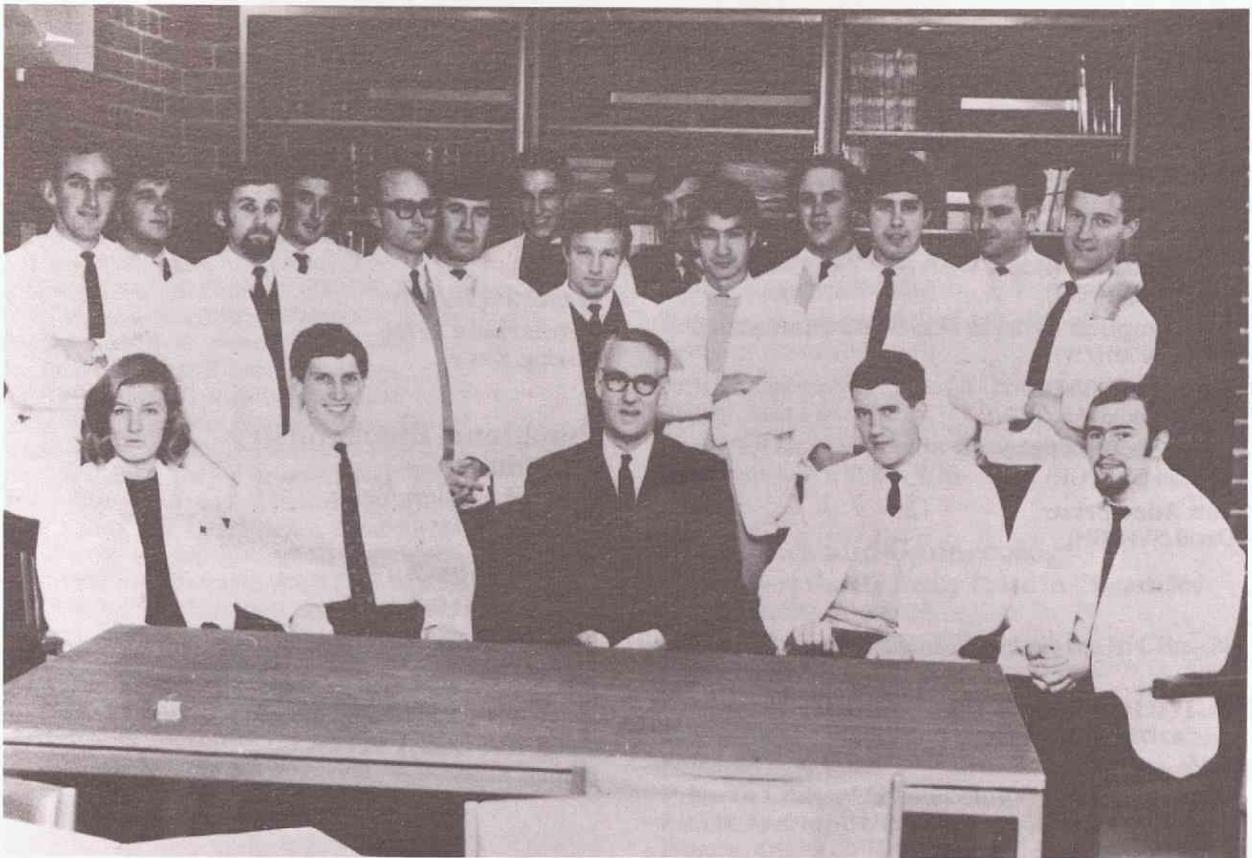
*University House, on the  
campus of The University  
of Melbourne, is an ideal  
venue to host such  
an occasion.*

*The House is able to cater for reunion groups, ranging in  
size from 30 to 200 guests. There is a variety of  
competitively priced menu packages to suit any occasion.*

*For further information contact Mr Joe Borg or  
Mr Stan Bracchi on 344 5254.*

*Menus and costs are available on request.*





1967 – the first seventeen students. Front row L-R: Meryl H. Griffiths, Hugh Ringland Taylor, Professor Lance Townsend, Dr Christopher Targett (Clinical Supervisor), Ian R. Pryor. Back row L-R: Graeme A. Thompson, Uldis E. Eglitis, David R. Duncan, John G. Easton, Barry J. Stevens, Paul J. Pelligrine, Howard W. Stevens, Guisepppe M. Giarrusso, David C.A. Francis, Sunya S. Virvaitya, Brian A. Brigham, Peter A. Sinclair, Ian J. Skelton, Andrew T. Forsyth.

## THE AUSTIN HOSPITAL CLINICAL SCHOOL

### TWENTY-FIVE YEARS OF PATIENT CARE, TEACHING AND RESEARCH

### 1966-1991

**GENESIS**  
**Professor Emeritus**  
**Sir Sydney Sunderland, CMG**

**T**HOUGH TWENTY-FIVE YEARS have passed since the Austin Hospital Clinical School was established, I still have a vivid recollection of those times and of the events leading up to its establishment. This is largely because I was closely involved with the project as Dean of Medicine at the time, as a member of the Finance and Buildings Committees of the University Council and also as a member of the Australian Universities Commission.

Just prior to the Commission's triennial visit in 1963, the State Government was pressing the University to increase admissions to Medicine from 160 to 240. It was, however, impossible to accede to this request because of gross deficiencies in the facilities available, particularly in the clinical years of the course. However the Australian Universities Commission supported the proposal to increase medical admissions and to give effect to this they took into consideration the additional space facilities and staff that would be required to provide for an increased enrolment. At the same time it was agreed by all parties that this plan would necessitate the creation of a third clinical school for Medicine.

In the event, the Australian Universities Commission's recommendations for capital grants for The University of

Melbourne in the 1964-66 triennium, included one for more than 3.1 million pounds to complete, in one 'hit', the move of an enlarged medical school to the south-western corner of the campus. Biochemistry and microbiology were already accommodated on that site, but some additions to their facilities were necessary to cover the anticipated increased enrolments. This was the origin of the triradiate building on the corner of Grattan Street and Royal Parade, now an admired feature of the campus.

However this was not the end of the Faculty's problems. The decision to increase enrolments necessitated the creation of a new, third Clinical School. This required both capital and recurrent funding and, importantly, the selection of a suitable hospital to accommodate a Clinical School. These matters involved not only the University but also the Australian Universities Commission and State instrumentalities, in particular the State Hospitals Commission. Speedy decisions were necessary, but these are always difficult to obtain in Government circles with the result that some delays in planning were inevitable.

Several hospitals were investigated by the Faculty in collaboration with the Hospitals Commission and a list finally reduced to two – the Austin Hospital and the Queen Victoria Hospital. The Commission favoured the Queen Victoria and Faculty the Austin Hospital. After strenuous opposition, the Hospitals Commission finally accepted the University's decision to site the new Clinical School at the Austin Hospital. The Commission also agreed to provide the additional beds and

related facilities necessary for the conversion of the Hospital into a teaching institution. With this agreement the next move was to determine a capital works program for the Australian Universities Commission along with recurrent estimates.

At the last moment the Hospitals Commission reneged on its undertaking by presenting Faculty with a time-scale for the development of the hospital component that was totally unacceptable. There was a decision of considerable concern, not only to the University, but also to the Australian Universities Commission. I recall in great detail two particular meetings, one in the State Cabinet Room attended by Dr Lindell, Sir Ernest Coates, State Director of Finance at the time, the Vice-Chancellor (Professor George Paton) and myself; and another in the Vice-Chancellor's room attended by Sir Leslie Martin, the Chairman of the Australian Universities Commission, Sir Ernest Coates and Dr Lindell. As a result of these meetings the Hospitals Commission finally agreed to proceed with the original plan. Too much was at stake to entertain any thought of failure.

With the building plans and medical base of the project and associated finances finalised and approved, this completed my direct involvement but not my continued interest in the Austin Hospital Clinical School project. From that point onwards the directorial activities of the project were transferred into the capable hands of Professor Lance Townsend (later Sir Lance), the Deputy Dean, who carried on the work with great distinction. All are indebted to him for the splendid service he gave over many years to the Clinical School and it is a pleasure to see his outstanding contribution recognised by attaching his name to the Clinical School building.

At no stage did I entertain any doubts about the decision to select the Austin Hospital, or a successful outcome for the venture. At the outset Faculty was fortunate in securing the services of first class Foundation Professors and sub-professorial staff who, in a remarkably short period of time, created a clinical school with an innovative program of clinical instruction and research activities of a very high order.

**EARLY STUDENT DAYS**  
**Peter A. Sinclair, MBBS (1970), FACD**

Some twenty-five years ago, seventeen third year medical students made an historic decision to leave the protected confines of Melbourne University, where they had completed the first three years of their medical course, and headed north-east to the Austin Hospital, Heidelberg, to begin their clinical years. It had no record of success compared with the traditional Melbourne University Hospitals (The Royal Melbourne and St Vincent's) and consequently the choice – and it was a choice for these students – was one which involved charting and exploring of new territory.

*'We are all equal here my boy.'*  
*This typified the attitude of*  
*the medical staff.*

Among the group, the reasons for choosing the Austin were quite varied. Some chose for geographical reasons, with the hospital being relatively close to their homes. Others wished to make a break from tradition; but uppermost in everyone's mind was the powerful feeling that the new clinical school would be keen to obtain a high success rate in its first years of operation and to develop a reputation as a centre for teaching and excellent medical care. Time was to prove this belief

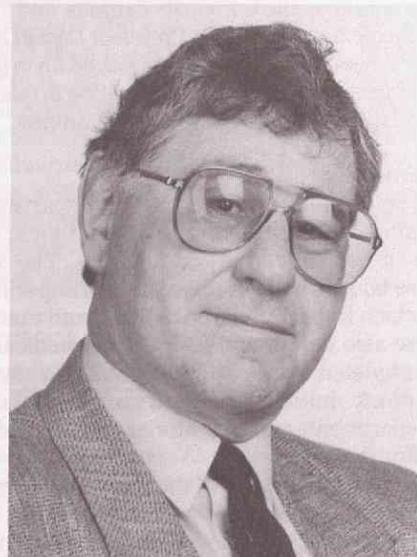
correct; all seventeen students successfully negotiated final year MBBS, along the way earning a few honours – not bad for a group which had not exactly decorated itself with honours in the pre-clinical years.

The students had not known one another closely in their pre-clinical years, and friendships developed, many of which have remained over the ensuing years. There was a close family feeling at the Austin Hospital between staff members, medical and non-medical – the whole hospital structure seemed to have embraced the idea of developing into a fully-fledged teaching hospital. One occasion remains vividly in my mind. Mr John Clarebrough (probably Melbourne's most respected chest surgeon at the time) stood back when I opened the door to allow him through, saying, 'We are all equal here my boy.' This typified the attitude of the medical staff. Lectures were given in the 'Leslie Jenner' nurses lecture theatre. The original students' quarters were in the little house at the bottom of the hill which has subsequently become the crèche. I can well remember the rabbit warrens that constituted the out-patients and casualty areas where much of our clinical teaching occurred. Post-mortems were held in the old pathology building.

Social life in the early years was also quite active, and these functions continued to foster relationships which developed between staff and students. Inter-hospital football was always popular, and the Austin in those early days was quite a force.

Above all, the friendly family nature of the Austin Hospital is probably the strongest memory that remains.

**OVERVIEW**  
**Associate Professor Bernard Sweet,**  
**Clinical Dean**



Assoc. Prof. Bernard Sweet

In 1966 the first University professors were appointed to the Austin Hospital. In November of the following year, the first intake of seventeen students was accepted. In 1991 there were 182 students and the Hospital together with the Clinical School celebrated twenty-five years as a Clinical School of The University of Melbourne School of Medicine.

The Austin Hospital was opened in 1882 with a donation from Mrs Elizabeth Austin to found the 'Austin Hospital for Incurables'. In 1926 it was gazetted as 'Austin Hospital for Incurable and Chronic Diseases' – a change that converted the hospital from the 'ante-room to the grave' to a place of hope. In 1927 the name was again changed to 'Austin Hospital for Chronic Diseases', at a time when Rupert Willis became Medical

Superintendent of the Hospital. He introduced thorough laboratory investigation and did some of its early research into cancer there. He later became Professor of Pathology at the University of Leeds. In 1948 the name was changed to 'Austin Hospital Heidelberg', and in 1975 it became simply 'Austin Hospital'.

In the 1950s the hospital undertook responsibility for patients with spinal injuries and medical students attended the spinal injuries wards. In fact, for twenty years or more before it became a Clinical School in its own right, the Austin Hospital medical staff and patients had participated in undergraduate teaching.

The 1960s saw an unprecedented increase in the number of universities and medical schools in Australia. During that decade eleven new universities and six new medical schools were created. The State Government was pressing the Melbourne Medical School to increase admissions from 160 to 240. Because of the lack of facilities, especially in the clinical years, it was agreed that this plan would require the creation of a third clinical school. After many meetings and discussions, the Austin Hospital was chosen.

The University and the Hospital entered into an agreement in 1965 to establish the Austin Hospital Clinical School. It differed from agreements with other Clinical Schools in that the professors in the various disciplines would be chairmen of the appropriate hospital departments. This led to integration of the Hospital and University, with a close link in both research and clinical activity.

The first intake of students in 1967 underwent training in pathology and microbiology, and clinical pharmacology occurred during fourth year. In order that the Austin Hospital Clinical School remain a freestanding initiative, in fourth year all subjects were taught by the University departments of the Austin Hospital.

The curriculum changed in 1976 – pathology and microbiology were taught on the University campus, and fourth year consisted of medicine and surgery. Professor David Gray retired in 1975, but Professor Harold Attwood stayed on in pathology, running the Hospital division and participating in teaching both at the Austin Hospital and the University campus.

### Physical facilities

The Clinical School offices for the various departments were above the Spinal Injuries Unit in the Davies Block, with their laboratories in the converted old kitchens. The seventeen students were housed in the former Medical Superintendent's cottage, in which Rupert Willis once lived, and many of their tutorials were also held there. In 1968 the medical students block was completed as a freestanding building south-east of the Davies Block. Initially the top two storeys housed the University departments and laboratories and the students used the ground floor.

In 1971 the Stage 1 Building of the Hospital was completed and the University departments were able to move out of the students block, which became extremely pleasant student quarters. There were eighteen bedrooms that the students could use when on call, as well as pleasant common rooms and lounge rooms. By November 1971, there were 139 students so the quarters became necessary as a place for the students to congregate.

Because of increasing student numbers, more teaching beds became necessary. Initially the problem was overcome by using the Repatriation General Hospital for teaching and two members of the RGH staff, Ken Hardy and Trefor Morgan, were appointed to the University. In 1972 the University signed an agreement to include the Repatriation General Hospital as part of the Clinical School which became the 'Austin Hospital and Repatriation General Hospital Clinical School' with a Joint Academic Board as its executive arm. In 1976 Gabriel Kune and Jack Martin were appointed Foundation Professors of Surgery and Medicine.

In the mid-seventies, with first year intake of medical students at The University of Melbourne running at 230-240, the Clinical School was asked if it could take 80 students. Professor Eddey held discussions with Box Hill Hospital and from 1974 the Clinical School's students attended Box Hill for casualty training and by 1976 Box Hill Hospital had become associated with the Clinical School and undertook teaching in medicine, surgery and casualty. This ended in 1988 when there was a reshuffling of hospital affiliations between Melbourne and Monash University. In 1989, Bernard Sweet, the Associate Dean (Clinical), negotiated undergraduate training at Bendigo and Northern District Base Hospital and increasing numbers of students have attended Bendigo Hospital during their fourth year.

### Personalities

A number of people were closely involved with the creation and development of the Clinical School. Without them the School would not have been established at the Austin Hospital nor would it have been so successful.

*Professor Sir Sydney Sunderland* was Dean of the Faculty of Medicine in the 1960s and supported the creation of a third Clinical School at the Austin Hospital against opposition from some government quarters. He was ably supported by the University and the Austin Hospital Board and he is especially grateful for the help given him by Sir Harold Stokes, Chairman of the Board of the Hospital and Mr G. Winwood of the Building Committee.

*Professor Lance Townsend* (later Sir Lance), took over as the Associate Dean (Clinical) and became the driving force in the development of the Austin Hospital Clinical School. He served on the major University/Hospital committees as well as on the Board of Management of the Austin Hospital. He chaired the



Excavation work, Stage 1 Building.

Project Committee which oversaw the development of the Clinical School and the Stage 1 Building. In August 1971 he became Dean of the Faculty and was followed by Professor Howard Eddey as Associate Dean (Clinical). Sir Lance continued on the Board of Management of the Austin Hospital and played an important role in the rapid growth of the Clinical School in the 1970s. He was President of the Board of Management of the Hospital from October 1979 until his untimely death in March 1983.

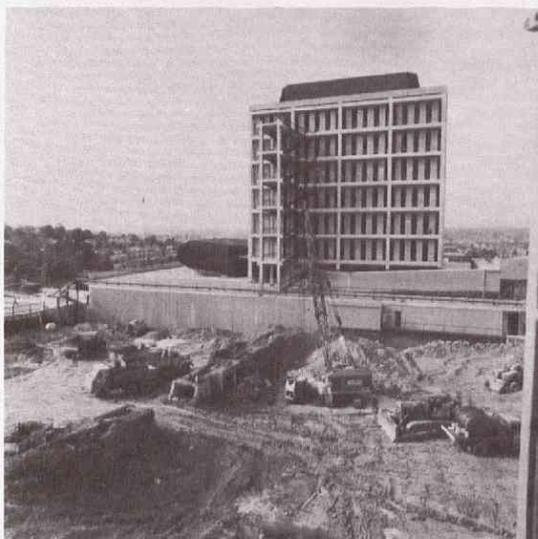
*Professor Austin Doyle* was the first of the four Foundation Professors appointed to the Clinical School. He had a strong background in clinical and academic medicine and was world renowned for his work in the field of hypertension. He came

to The University of Melbourne in 1956 as First Assistant to Professor Richard Lovell and soon established himself as an excellent lecturer, researcher and clinician. He was appointed Professor of Medicine at the Austin Hospital in March 1966 and was very involved in the early development of the Clinical School, as a member of the University/Hospital committees. He had a sharp intellect and was forceful in committees. He saw the need to develop research facilities for the University departments and to increase the number of teaching beds. He was a hard worker and determined fighter for the School and his department. He saw the value of hospital/university integration and, most importantly, he was able to attract a group of excellent young clinician/researchers around him. He had the ability to pick good people and support them in their work and very quickly built up a department which attracted more money than any other clinical department in Australia. He retired from his Chair in 1985 and has remained active in the field of hypertension since then.

#### UNITY AND PRIDE

Professor Emeritus Austin E. Doyle, AO,  
MD(Lon.), FRCP, FRACP

*I was appointed to the newly created Chair of Medicine at the Austin Hospital in March 1966, and although I did not actually move to the Austin until about October of that year, Harold Attwood and I made a number of visits to the Hospital in the intervening months. A number of quite major problems were apparent, particularly the provision of adequate accommodation for offices and laboratory space for the University Departments of Medicine and Surgery. A second major problem was the paucity of in-patient facilities available for teaching purposes. In 1966 the Austin was in a*



Stage 1 Building in progress.

*transitional state, with very few acute beds for medicine and general surgery.*

*Nevertheless, the early days of the Austin Hospital Clinical School were exciting and rewarding. The challenge of developing a new and integrated undergraduate course, the establishment of research as a major endeavour in the University departments, the development of specialty areas within the Hospital, the detailed planning of the new buildings, and the successful integration of the Hospital and University staff, all contributed to a feeling that the Austin was on the threshold of great developments. This resulted in a remarkable sense of unity and pride in the*

*Hospital, and a determination to press ahead, which has persisted to the present day. Although there was often disagreement about the pace and direction of the changes occurring, there was an overriding consensus of the need to develop.*

*There is no doubt in my mind that the success of the Austin as a teaching and research institution stems mainly from the close integration between the Hospital and the University and from the fact that the staff have been not only excellent in patient care but also distinguished in research and academic medicine. An important factor in the ability to recruit first class people was the virtual absence of any pre-existing structure in the medical and surgical subspecialties, the result being that the Hospital was in a position, as it developed, to attract young, enthusiastic and able individuals – the backbone of its pre-eminence. The fact that so many of these people have gained appointments to University Chairs underlines their distinction, and has incidentally created vacancies, which has allowed the process to continue.*

*William (Bill) Louis came to the hospital with Austin Doyle in 1967, and was appointed Professor of Clinical Pharmacology and Therapeutics in the Department of Medicine.*

*Ian McKenzie came back from overseas in the early 1970s as Second Assistant and was awarded a Personal Chair in Medicine. He is now Professor/Director of the Austin Research Institute.*

*Professor Harold Attwood was appointed Professor of Pathology in 1966, with the task of preparing a comprehensive pathology course, including slides and specimens for the practical classes. His original office was the cottage subsequently converted as the Department of Pathology and the post-mortem room. He involved the Hospital pathologists in his teaching program and was held in the highest regard for his integrity and ability as a lecturer. In 1968, he was joined by Dr Chris Louis, and by Dr Josh Xipell who later became Director of Anatomical Pathology. Following the curriculum changes of 1976, Professor Attwood taught at both the Hospital and the University campus. In 1980 he moved to the campus department, and in addition to his teaching commitments did a great deal of work upgrading the Pathology Museum. In 1981 he was appointed Curator of the Medical History Unit at The University of Melbourne.*

#### BUILDINGS AND BODIES

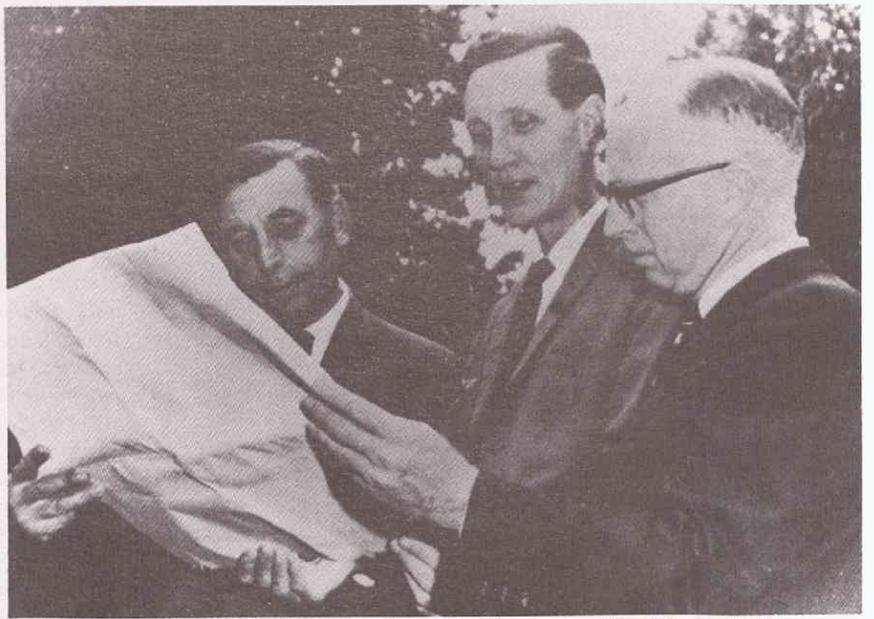
Professor Emeritus Harold D. Attwood  
MD, FRCPA, FRCPath., FRACP

*Appointed to the Austin Hospital in October 1966, I had a small office in a bungalow adjacent on one side to the Nurses Home and, on the other, the excavation site for the Stage 1 Building. The old brick mortuary and post-mortem room still stood on the opposite edge of the excavation site. Jim Riddell, the Anatomical Pathologist, had an office close to mine and it was Jim who had overseen the addition of a laboratory, mortuary and post-mortem room to the bungalow. The routine anatomical pathology for the Hospital was done in these makeshift quarters until the opening of the Stage 2 Building in 1984.*

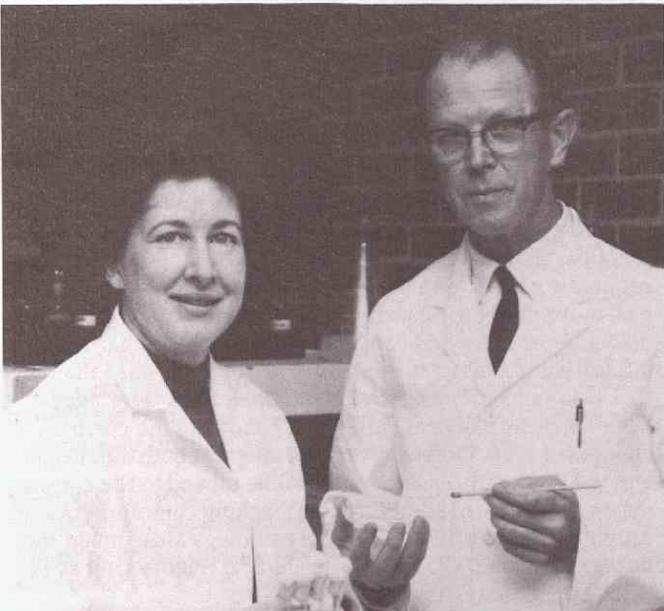
*The post-mortem room was poorly insulated and ventilated. In summer conditions were hot, unpleasant and the concentration of formalin vapour unacceptably high by present standards or common sense. Joe Kingdon, the Mortuary Attendant and a natural anatomist, was of enormous assistance to me in preparing specimens for the museum from anything that came to hand. We had no other teaching material.*



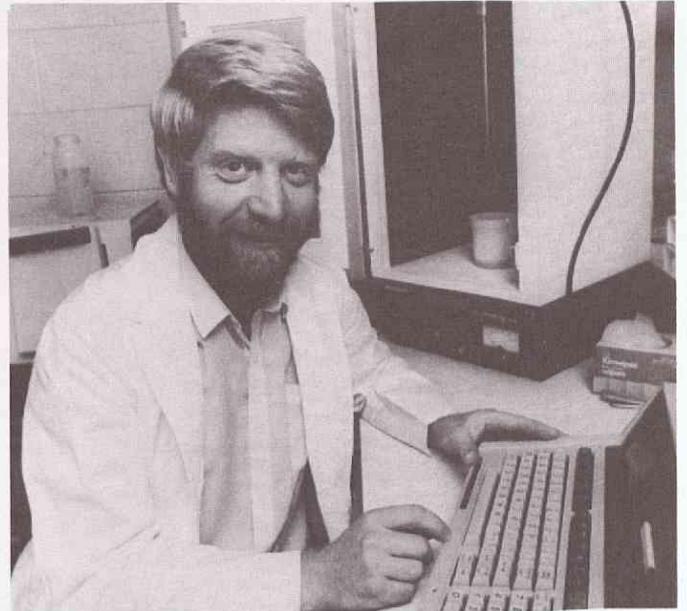
Mrs Elizabeth Austin



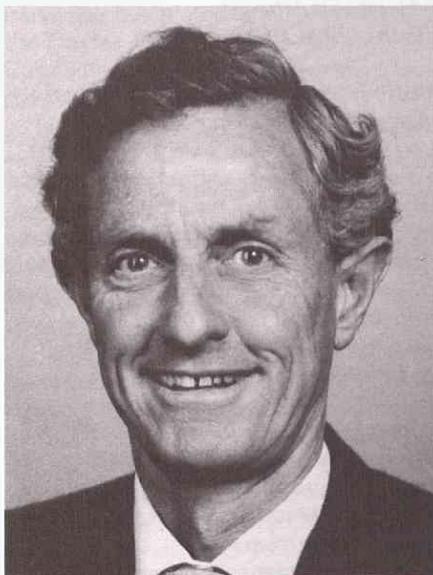
Professors Doyle, Attwood and Eddey study plans for the new teaching building, 1967.



Dr Joan Schiavone and Professor David Gray



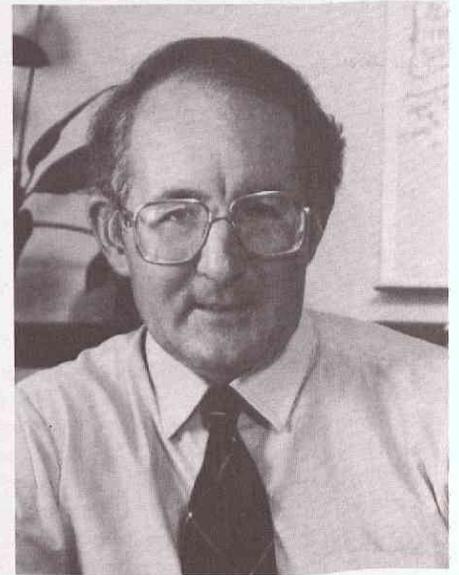
Professor Fred Mendelsohn



Professor Ken Hardy



Professor Colin Johnston



Professor Ian McKenzie

One hot day Graeme Ryan, the present Dean and then Lecturer in Pathology, who had already done good work in experimental pathology, came to assist me by doing post-mortems. After that experience I believe he was convinced that experimental pathology was much more attractive than anatomical pathology.

It soon became obvious that a demonstration room was needed so a hut was built close to the post-mortem room. In this hut, using a crudely built football stand, post-mortem demonstrations were eventually held. In this hut too, the first meetings of the Town and Country Pathologists were held – cushions of foam rubber covered by ticking were placed on the football stand to provide tiered seating. The T & C Club held its 23rd Annual Dinner in November 1991.

Austin Doyle and I wrote a narrative for the Stage 1 Building and then settled down to prepare for the entry of seventeen students in November 1967. It was hard, often frustrating work, but greatly lightened by what might eventually be achieved – a new teaching hospital in the oldest medical school in Australia.

Professor Howard Eddey came to the Austin Hospital as Foundation Professor of Surgery in 1967. He had been on the staff of The Royal Melbourne Hospital and, besides his excellent surgical skills, had a reputation as a brilliant teacher. He was highly respected in the Melbourne medical scene. His initial months at the Hospital were spent in obtaining sufficient teaching beds and in forming an integrated Department of Surgery with the visiting surgeons of the Hospital. He attracted good young surgeons to his staff, including Ken Hardy who later succeeded him as Professor of Surgery, and John Royle and Peter Hart both of whom joined the senior staff of the Hospital.

During his nine years as Professor of Surgery, Howard Eddey served on the Board of Management of the Hospital from 1972-1977 representing The University of Melbourne, and was Associate Dean (Clinical) from 1972-1975, following Professor Townsend. He retired at the end of 1975.

#### HIGHLIGHTS 1967-75

Professor Emeritus Howard H. Eddey, CMG  
BSc, MBBS, FRCS, FRACS, FACS

I was appointed Foundation Professor of Surgery at the Austin Hospital by the Council of The University of Melbourne in December 1966 and commenced clinical duties in April 1967. I remained on the staff of The Royal Melbourne Hospital until June 1967 and spent the first few months of 1967 in negotiation with the Board of Management of the Austin to establish a site for a professorial unit. Finally it was agreed that I take over the twenty-five beds on the top floor of the private hospital, Heidelberg House, which meant that the surgeons of the Hospital did not lose control of any beds. This had been a major concern to them because the agreement between the University and the Board of Management of the Hospital made the professor head of all surgical services in the Hospital.

Further surgical beds were made available in the 3KZ Block following the transfer of children with tuberculosis to other institutions. The two orthopaedic units were moved into that block. Closure of the cancer unit, in which terminal cancer patients from other Victorian hospitals were treated, released beds for general use. These changes provided enough surgical beds for teaching by members of the professorial unit and by the staff surgeons of the Hospital.

Further development of the professorial unit occurred with the establishment of a unit at the Repatriation General Hospital when that Hospital was integrated as part of the Austin School. The head of that unit, appointed by the Council of the University, was Ken Hardy, a member of my unit at the Austin.

I participated in the planning of the Lance Townsend and Harold Stokes buildings and was responsible for the planning of ten operating theatres in the Harold Stokes block, including two specially large theatres with laminar flow ventilation for transplantation, and open heart operations and extensive orthopaedic procedures. A ceremony was held by the Board of Management in 1984 to commemorate naming this suite the 'Howard Eddey Operating Theatre Suite'.

My association with the students as Associate Dean (Clinical) 1972-75, and participation in the development of the Clinical School was quite exciting. The increasing number of students and the prizes won by many of them were rewarding. The incorporation of the Box Hill Hospital in 1972 for teaching surgery and teaching arrangements with the Peter MacCallum Clinic were an essential part of the exposure of students to a wider range of surgical conditions.

Professor David Gray was appointed Professor of Medical Microbiology in 1967 after a successful academic career in the Department of Microbiology at The University of Melbourne. He developed a course in medical microbiology for the fourth year students assisted by Dr Joan Schiavone who was Senior Lecturer.

Professor Gray retired in 1975 and changes in the curriculum in 1976 left little microbiology teaching at the Hospital. Dr Schiavone stayed on, continued teaching and research and became very involved with the Stage 2 Building. She died in 1980 before she could see the completion of her work.

Professor Norman Beischer, appointed in 1968, was the last of the four Foundation Professors. He still holds the Chair of Obstetrics and Gynaecology although the department is mainly situated at the Mercy Hospital for Women. He is the only one of the Foundation Professors still at the Clinical School.

#### OBSTETRICS TEACHING

Professor Norman A. Beischer, MD, BS,  
MGO, FRCSE, FRACS, FRCOG, FRACOG

My involvement with the Austin Hospital began in 1963 when I returned from overseas to Lance Townsend's department as his second First Assistant. I became the gynaecologist and together with Harold Hattam shared the gynaecological clinical duties. Sir Lance, as he became later, was the senior gynaecologist and he had a lasting love of the Austin – I think I am right in saying that Lance's first public hospital appointment was as gynaecologist to the Austin Hospital. His most longstanding academic interest was in pelvic tuberculosis, a subject in which he probably first became interested because of the Hospital's involvement with tuberculosis.

Some years later, Harold Hattam retired and after Eric McKay was appointed to the Foundation Chair of Obstetrics and Gynaecology in Brisbane I became the only gynaecologist seeing patients. I was appointed to the Chair of Obstetrics and Gynaecology at the Mercy and Austin Hospitals in April 1968, and became the senior gynaecologist at the Austin Hospital by virtue of my University position. Sir Lance notionally retired from the Austin at that time, but continued seeing patients with pelvic tuberculosis when they presented.



Department of Medicine, 1972



1990, Final Year students, Austin Hospital and Repatriation General Hospital Clinical School.

*I had many contacts with Sir Sydney Sunderland as Dean of the Medical Faculty and he was absolutely marvellous in the way he encouraged me to set up my department, including the appointment of staff and the proper equipping of the laboratories. It was a wonderful thing to be able to go and see the Dean and meet a man who was interested in helping you with your problems and who never mentioned for a moment that he had problems of his own.*

*The Chair of Obstetrics and Gynaecology in our Medical School was properly termed 'Mercy and Austin Hospitals'. The Chair required an affiliation with a general hospital, partly because the Mercy Maternity Hospital, as it was then called, had practice limitations due to its Catholic philosophy.*

Mrs Jean Bright joined the Clinical School as administrative secretary in 1967, having previously worked in the chest unit. She was recruited by Professor Townsend and remained in the position till she retired in 1988. Mrs Bright looked after three Associate Deans – Lance Townsend, Howard Eddey and Bernard Sweet – but more importantly she 'mothered' many students through their clinical years. Professor Hugh Taylor, one of the original graduates of the Clinical School, describes her major contribution to the success of the Clinical School: 'She was unimaginatively known as the 'Bright Missus'. It was her onerous task to unravel the tangles of our day-to-day program, to get us where we should be, and to sort out all our other problems.'

### **The next generation**

The Foundation Professors all established strong departments within the Hospital, forged bonds between the University and Hospital and attracted people of excellence to their departments and divisions. The Department of Microbiology laboratories became those of the Department of Clinical Pharmacology under the direction of Professor Bill Louis. The Department of Pathology remained and continued to teach and undertake research. When Professor Attwood moved back to the main campus, Dr Chris Louis remained in charge. Finally, Professor Roger Sinclair was appointed Professor/Director of the Department of Anatomical Pathology. He had previously worked at the Alfred Hospital and did his early research in renal medicine.

In the Department of Medicine, Professor Austin Doyle retired in 1985 leaving a large and vibrant department renowned for both its research and teaching. A previous first assistant, Colin Johnston, who had gone to Monash as Professor of Medicine, was to return as Professor of Medicine at the Clinical School. His research interests are in hypertension and he has continued the development of the department, maintaining the high standards set. The department acquired a third professor, Professor Fred Mendelsohn, who was appointed to a Personal Chair for his research into hypertension and neuropeptides. In 1990, Richard Smallwood moved from the Austin Hospital to become Professor of Medicine at the Repatriation General Hospital.

In the Department of Surgery, Professor Ken Hardy followed Professor Eddey in 1976. He had been First Assistant in the Department of Surgery at the Repatriation General Hospital and is an outstanding undergraduate teacher. He quickly developed basic research in his department and has overseen the development of cardiac surgery and liver transplantation at the Hospital. In 1991, Professor Brian Buxton, a senior member of the department, became the first Professor/Director of Cardiac Surgery in Australia. In the same year Professor Donald McLellan became Professor of Surgery at the Repatriation General Hospital.

Dr Russell Meares was originally appointed as First Assistant in Psychiatry within the Department of Medicine and remained until 1981. In 1983, Graham Burrows was appointed Professor/

Director of Psychiatry and has built up a large unit with many research interests.

With the retirement of Professor Eddey as Associate Dean in 1975, Dr Bernard (Bernie) Sweet was appointed to that position. He had previously been a Second Assistant in the Department of Medicine and involved in the early days of the Clinical School. He oversaw the expansion of the Clinical School and the more recent involvement of country hospitals such as Bendigo and Northern District Base Hospital, Albury Base Hospital and Wangaratta Base Hospital in 1992.

In 1991 the Hospital and University appointed a Professor/Director of Radiology, Professor Oliver Hennessy. He had been Director of Radiology at the Repatriation General Hospital and had undertaken a lot of his initial graduate training in the United Kingdom. He brought to the position a wealth of knowledge and very strong management skills.

### **Relationship with the Repatriation General Hospital, Heidelberg**

With the early popularity of the Clinical School and the increasing number of students, it became obvious that more patients were needed for teaching. The Repatriation General Hospital had a long reputation for teaching since its founding in 1941. Many undergraduates had been taught there by clinicians who held appointments at other hospitals. In the early 1970s students from the Clinical School went to the Repatriation General Hospital as part of the clinical rotation. It then became associated with the Austin clinically and finally became a partner in the Clinical School.

In 1976 the first Professors were appointed in Surgery and Medicine (Gabriel Kune and Jack Martin). They developed important departmental units at the Repatriation General Hospital and were succeeded by Professor Richard Smallwood in Medicine and Professor Donald McLellan in Surgery. The teaching is integrated between the two campuses; so are the University departments, and the Clinical School looks forward to a close relationship between the two hospitals.

*The Austin Hospital has always cared for its patients. It has always led in specialised areas in which it has excelled . . . The Clinical School has always depended on its staff for its strength . . .*

### **The staff**

The Clinical School has always depended on its staff for its strength and many professors have been appointed from its members: Colin Johnston, Peter Castaldi, Jack Martin, Ian McKenzie, Bill Louis, Graeme Boyd, Richard Larkins, John McNeil, Nick Christophidis, Ken Hardy, Donald McLellan, Richard Smallwood, Brian Buxton, Trefor Morgan, Fred Mendelsohn, Russell Meares, Bruce Tonge, Neville Yeomans, John Horowitz.

The relationship between the University and the Hospital allowed surgeons such as John Royle, Peter Hart, Malcolm Douglas and Andrew McLeish to move from the University Department of Surgery to the visiting staff of the Hospital. George Jerums, Bill Adam and Jim Wiley were attracted back to the Hospital after working in the University Department of Medicine.

Others such as Andrew Tonkin and Geoff Donnan were also attracted to the Hospital because of its close University affiliation. Richard Smallwood moved from Director of Gastroenterology to become Professor of Medicine at Repatriation General Hospital. This free exchange between the Hospitals and University, encouraged by the close integration of the two organisations, has allowed the Clinical School to attract clinicians interested in teaching, research and in developing a first class School in a short space of time.

### The future

The Austin Hospital has always cared for its patients. It has provided general services to the community but has always led in specialised areas in which it has excelled, such as its cancer services and spinal injuries unit. It has undergone tremendous changes since 1966 when it became a major teaching hospital. It has expanded into many areas especially of a highly technical and tertiary referral nature. It has amalgamated with the Royal Talbot Rehabilitation Centre, it has developed the Austin Research Institute on the campus, and it has acquired one of two Positron Emission Tomography units in Australia. The Austin looks forward to a closer association with the Repatriation General Hospital, and to the combined development of a major centre.

In 1982, on its centenary, a history of the Austin Hospital (by Edward Gault and Alan Lucas) was published, entitled *A Century of Compassion* and I see this as an important strength of the hospital. I would like to quote Professor Austin Doyle:

*There is no doubt that the Austin has undergone a metamorphosis in the past twenty-five years. In 1966 its great strengths were compassion and dedication to the welfare of the sick. I hope and believe that these qualities have not disappeared since they remain as important in the era of scientific medicine as they have ever been.*

## PRESENT DAY STUDENTS Leanne Douglas (MBBS 1991)

Although I was a part of the Austin Clinical School for only three years, as a final year medical student I saw a number of changes indicative of the Clinical School's continuing development and improvement. In 1989 students were sent for the first time on country rotations to Bendigo Base Hospital. This proved to be not only an extremely enjoyable term, but also an invaluable clinical experience, and set a precedent for associations with other country hospitals in the future.

The Austin Clinical School is comparatively young, but it has certainly developed an excellent reputation for teaching and is no longer considered to be just the 'country cousin' of its city counterparts. Over the past few years the Austin has become increasingly popular with students, both for its friendly atmosphere and increasing academic success.

However, one aspect of the Clinical School that has definitely not changed is the continuing support and encouragement given to students. The Clinical School office is easily accessible to students to discuss any problems or suggestions for change, which are willingly acknowledged and often implemented to improve the teaching course. The high standard of teaching and the eagerness of staff to help is undoubtedly reflected in the results achieved by students each year.

On the social side, the tradition of lively Austin PFA's continues and staff-student dinners are always occasions to look forward to.

With so much to offer and so much potential, the Austin Hospital Clinical School will undoubtedly continue to flourish, as it has done over the last twenty-five years.

*The Board thanks Assoc. Prof. Bernard Sweet (Clinical Dean) and Ms Eva Lomski (Public Relations Officer, Austin Hospital) for their generous assistance in preparing this anniversary article.*



1991, Final Year students, Austin Hospital and Repatriation General Hospital Clinical School.

## Notice of Annual General Meeting 1992

The Annual General Meeting of the University of Melbourne Medical Society (UMMS) will be held at 6.30 p.m. in the Sunderland Theatre, ground level, Medical Building, The University of Melbourne, Grattan Street, Parkville, on Tuesday, 26 May 1992. This meeting is preceded by the Dean's Lecture in which Professor Wayne Morrison, Department of Surgery, St Vincent's Hospital, will deliver a lecture entitled 'The development of plastic reconstructive and hand surgery and the Australasian connection'.

### Business

1. Minutes of 1991 Annual General Meeting.
2. Chairman's Report.
3. Financial Report, 1991-1992.
4. Election of Committee 1992-1994.

Nominations are called for the election of six (6) members of the Committee of UMMS for 1992-1994 and close on 19 May 1992.

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

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

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

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

5. General Business

presented a marvellous lecture entitled 'The Melbourne Medical School and some of its characters 1931-1975'. Prior to the lecture refreshments were served in the Pathology Museum. Details of the 1991 UMMS lecture and function will be announced later in the year.

- A special feature of the Dean's Lecture Series in 1990 was the seminar entitled 'Privacy in Medicine: Issues Old and New'. The proceedings of this seminar will be published in *Chiron* 1991. A similar seminar entitled 'Issues in Transplantation - Aspects of Supply' will be held on Friday 2 August 1991 at 2.00 p.m. in the Sunderland Lecture Theatre. This seminar will also be convened by Professor Emeritus Richard Lovell.

- There were a number of successful medical graduate reunions held in 1990. Details of those being planned are available from the UMMS office and will be published in *Chiron*.

- 1991 is the Centenary of the graduation of the first women doctors from this medical school. To celebrate this occasion, a dinner, organised by the Key Centre for Women's Health in Society, and a seminar, will be held later in the year.

### 3. Financial Report 1990/91

In the absence of the Treasurer, Dr Diana Sutherland, Honorary Secretary, moved that the financial report be accepted. The motion was carried.

### 4. General Business

Members were made aware of the recent ruling by the Australian Taxation Office that membership of UMMS may no longer be claimed as a tax deductible donation to the University. The Chairperson noted that the situation may be different with regard to claiming membership of a professional association and that members may wish to consult their tax advisers.

The meeting closed at 6.45 p.m.

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## Minutes of Annual General Meeting 1991

The Annual General Meeting of the University of Melbourne Medical Society (UMMS) was held at 6.30 p.m. on Tuesday 7 May 1991, in the Sunderland Theatre, Medical Building, The University of Melbourne. The meeting was preceded by the Dean's Lecture entitled 'Stress ulceration of the stomach - the enigma continues'. This was delivered by Professor Donald MacLellan, University Department of Surgery, Repatriation General Hospital.

### 1. Minutes of the Annual General Meeting 1990

The minutes of the 1990 Annual General Meeting, previously circulated, were accepted as an accurate record of the proceedings.

### 2. Chairperson's Report

- The Chairperson acknowledged and thanked the Medical Defence Association of Victoria for its continued generous sponsorship of *Chiron*. He advised that the publication date for *Chiron* 1991 had been deferred until the middle of the year owing to Co-Editor, Mrs Margaret Mackie, being on sick leave.

- The Chairperson noted the current membership of the society was over 2,000.

- The UMMS B.Med.Sc. Prize for 1989 was awarded to Ms Sarah Larkins for her study entitled 'The role of the genitofemoral nerve in testicular descent'. A report on this award will be published in the 1991 issue of *Chiron*.

- Activities during 1990 included the highly successful UMMS Lecture and function. Professor Emeritus Sir Sydney Sunderland

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## UMMS B.Med.Sc. Prize 1990

### Marinis Pirpiris

for her study entitled

### Steroids and pressor responsiveness in man

Marinis Pirpiris assessed several aspects relating to the mechanisms of steroid-induced high blood pressure in humans. A range of experimental procedures were used to demonstrate that:

1. hypertension caused by the administration of cortisol (a glucocorticoid) is not dependent on any initial change in cardiac output;
2. hypertension caused by the administration of fludrocortisone (a mineralocorticoid) is associated with decreased activity of the sympathetic nervous system, at least when assessed by the spillover of noradrenaline into the circulation; and
3. in hypertension caused by both mineralocorticoids and glucocorticoids, the blood vessels in the forearm show increased responses to other agents or stimuli which constrict blood vessels.

These three observations add significantly to our knowledge of steroid hypertension in humans, and the mechanism(s) by which blood pressure is elevated and/or modulated.

This work was carried out under the supervision of Professor Judith Whitworth in the Department of Nephrology at the Royal Melbourne Hospital, the Howard Florey Institute of Experimental Physiology and Medicine, the Clinical Research Unit at the Alfred Hospital and the Baker Medical Research Institute.

## Reunions — Think Ahead

*When did you graduate? Is next year your 5th, 10th, 15th, 20th, 25th, 30th, 35th, 40th, 45th or 50th since graduation? It is best to plan your reunion well ahead of time. Some of your class mates will be overseas and some interstate. Overseas and interstate graduates do travel to Melbourne for reunions if they have enough advance notice.*

*Venues also need to be booked well in advance.*

*Please let the UMMS office know of your plans — we would like to include information in Chiron. We can obtain, on your behalf, a list of graduates from your year and a set of address labels from the Alumni Office. We will also advise you on the alternatives you may wish to explore and give any assistance we can regarding venues and speakers.*

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### 1992 Reunions

#### 20th Year Class of '72

Date: 14 November 1992  
Venue: Melbourne Cricket Club (Dinner at Hyatt on Collins)  
Contact: Lachlan de Crespigny  
(03) 417 6788

#### 25th Year Class of '67

Date: 17 October 1992  
Venue: The University of Melbourne  
Contact: Phillip Harris  
(03) 890 0648  
Deanne Wilson  
(03) 895 7642  
Andrew Tonkin  
(03) 450 5934

#### 30th Year Class of '62

Date: 3 and 5 April 1992  
Venue: The University of Melbourne (academic program)  
Contact: Ian Rechtman  
(03) 509 3322  
George Santoro  
(03) 428 4494

#### 40th Year Class of '52

Date: 7-8 November 1992  
Venue: Lake Side Reception Centre (Melbourne Zoo)  
Contact: Hugh Hadley  
(03) 866 1777

#### 45th Year Class of '47

A reunion function is likely  
Date: Latter part of year  
Venue: To be advised  
If you are interested please contact:  
Ross Webster (03) 344 6592  
(via answering machine)

#### 50th Year Class of '42

Date: 29 May 1992  
Venue: Royal South Yarra Tennis Club  
Contact: John Tucker  
(052) 51 3468  
John Zwar  
(059) 74 1397

### MBBS Graduate Anniversaries in 1993

5th Year Class of '88  
10th Year Class of '83  
15th Year Class of '78  
20th Year Class of '73  
25th Year Class of '68  
30th Year Class of '63  
35th Year Class of '58  
40th Year Class of '53  
45th Year Class of '48  
50th Year Class of '43

### UMMS OFFICE

Graduate and Community Relations  
School of Medicine  
The University of Melbourne  
Parkville 3052  
Telephone (+61 3) 344 5888  
Facsimile (+61 3) 344 5998

## Reunions



**Class of '41 – 50th Reunion**

**Back row:** Lach Hardy-Wilson, Mick Connaughton, Alan Worcester, Joe Robinson, Alf Steel, Mervyn Barrett, Peter Bird, Brian Costello, Edward (Scotty) McDonald, Tom Walpole. **2nd row:** Ian McConchie, Nairne Elder, Frank Burke, Sam Benwell, Bill Sloss, Stewart Moroney, Doug Atkinson, Knox Jamieson, John Simpson, Michael Benson, David Pitt, Frank de Crespigny, Tom Griffiths, John Trembath, John Hede, Clarice Arendsen (Hetherington). **3rd row:** Alex Gale (Elder), Sheila Clifton (Clerehan), Ida Seward (Benson), Marcia Jack (Blackburn), Margaret Lancaster (Dixon), Sue Wheildon, Mary Wheeler, Roxie Abbey (Inder), Elizabeth Kenny, Winifred Champion. **Front row:** Arthur Parkin, Keith Bradley, Ian Stahle, Beric Glanville Hicks, James Guest.

### **MBBS 1941 Fifty Years Reunion The University of Melbourne 4 October 1991**

Of the 101 graduates of 1941, 67 were traced and 42 dined at University House, writes James Guest. It was an excellent evening and much enjoyed by everyone. A 'class' photograph was taken and copies sent to all participants, and to a number of those who unfortunately could not be present.

This group graduated in September 1941 instead of in December of that year. It was the first group whose course was shortened as a result of the Second World War. Over a period the medical course was reduced from six to five years.

A biographical booklet was prepared for all those present – what had happened to these graduates over half a century provided very interesting reading.

### **MBBS 1938 *A letter from Horace F. Tucker***

The 1938 group of graduates have held regular reunions since their 25th year – 1963, 1973, 1983, 1988, 1990. All of these have been held at the Naval and Military Club and have been well attended, particularly the 50th in 1988. It was then agreed that owing to our increasing age, the dinner would be held every two years, and that spouses would be invited to the 1990 reunion.

At all of these meetings, except in November 1990, Professor Sir Douglas Wright (Pansy) was Guest of Honour. He became, as

it were, our patron. There was no Guest of Honour at the 1990 dinner – each member (listed) was invited to speak for a few minutes on what he or she thought of retirement activities (if any), which proved to be an interesting exercise. It is planned to hold our next meeting late in 1992.

Barbara G. Burbury (Stenhouse), Margaret M. Henderson, M.H. Leslie Williams, Fay M. Kinross (Morris), Ian C. Heinz, Robert K. Edwards, Helen P. Mackenzie, Henry D. Steward, Sol Rose, Robert W. Waddell, John C.C. Mullany, Donald G. Duffy, Thomas E.G. Robertson, Peter J. Parsons, R. Rainy Macdonald, Allen J. Christophers, Horace F. Tucker, Henry B. Kay.

### **MBBS 1951 Forty Years Reunion The Regent 26 October 1991**

Brian Entwisle reports that the formal dinner was beautifully presented by the Regent; the wines were generously donated by John Middleton from his Mt Mary vineyard. Professor Arthur Clark delivered the Occasional Address and John Middleton spoke of his transformation from general practitioner to vigneron. Eighty-seven graduates (listed) and partners voted the reunion a great success:

Jean Allison, Bill Armstrong, Vivian Balmer, Peter Banting, Cliff Barnes, Alex Bennett, Jim Birrell, Lois Bishop (Janes), Frank Bishop, Peter Breidahl, Geoff Briggs, Peter Broughton, Frank Buchanan, Bill Chanen, Arthur Clark, Ron Cleary, Phil Cohen, Geoff Cornish, Bruce Cornwell, Pauline

Cowderoy (Bradley), Rex Davis, Michael de Laine de la Tycki, Pam Dickinson (Faragher), Maurice Dowell, Brian Entwisle, Ken Fairley, Peter Fay, David Fearon, Ian Ferguson, Jan Finney (Altmann), Peter Frajman, Ian Fraser, Margaret Garson, Ian Gault, Keith Goulston, Ian Goy, Peter Graham, Jim Griffin, Bill Hare, Arthur Hargrave, David Hawkins, Ron Henry, Judy Henzell, Ian Hewitt, Gaby Hornstein, John Hunn, Stewart Johnston, Sandy Jones, Gordon Kelley, Mark Kenrick, Peter Kirby, Allen Lapin, Ken Leversha, Bill Littlejohn, John McArthur, John McCubbin, Ian McLachlan, Jean McLeod (Dunn), Jim Martin, Paul Matthews, Rae Matthews, Hugh Melville, Kingsley Mills, Jim Milne, Brian Minto, John Niall, John Officer, Grant Pattison, John Pennington, Peter Pitt, Charles Proctor, Alan Riseborough, Ron Saunders, Bill Sewell, Nonie Shuter (Sewell), Pam Sheil (George), Charlie Shugg, Tesse Spatt, John Stoney, Bob Summers, Max Swan, John Taylor, Bert Vanrenen, Bill Walsh, Geoff Wicks, Alex Wood, Dick Wyatt

**MBBS 1961  
Medical Women Graduates  
Thirty Years Reunion  
University House  
The University of Melbourne  
23 August 1991**

Terry Rush writes: During dinner we were able to catch up with some of the more dramatic events in our lives, as well as enjoy some quiet conversation. It was interesting to hear that not only had most of us forged ahead with our medical careers and achievements, but two of us had graduated in Arts. Anne Shanahan had done Law, was called to the bar in 1991 and was now sitting on the Commonwealth Administrative Appeals Tribunal.

Unfortunately, not all could attend: Fiona Proper (Weir) was doing a locum at Atherton in Queensland, Anne Quay (D'Arcy) was walking in Western Australia, Judy McKenzie was listening to opera in London and Rosemary Crowley (Willis) was making government policy in Canberra. We were all very sad to hear that Lee Chan had died two years ago.

Present were Eve Addis (Yuer), Rosalie Cooper (Alexander), Jan Garland (Peeler), Evelyn Lipton (White), Anna Loeders (Steiniger), Louise Pearce (Roberts), Anne Shanahan, Joan Symington (Cornwell), Terry Rush (Vice), Kris Whan (Bredikis).

It was a most enjoyable evening and we hope to meet again in 1996.

**MBBS 1961  
Thirty Years Reunion  
University House  
The University of Melbourne  
23 November 1991**

The celebration dinner was attended by 69 graduates (listed) and 60 partners. Graeme Ryan reports that 'a good night was had by all . . . I can recommend University House as an excellent venue for a class reunion, modestly priced, with attentive staff and providing the opportunity for graduates to return to the University campus - commonly for the first time since graduation.'

R.P. Barkman, J.K. Barnes, K. Bredikis, R.W. Brown, S.P. Brumley, L.G. Buckle (Roberts), R.C. Buckle, D.W. Buntine, J.A. Burgess, B.L. Butler, R. Carey, K.C. Chee, J.K.C. Chew, A.A. Coates, O.R. Cole, R.M. Cooper (Alexander), J.A. Corrie, W. Crombie, B.G. Cutter, A.F. D'Arcy, P.J.J. Davies, G. Dennerstein, M.C. Douglas, R. Dupuche, J.E. Field, R.L. Fink, A.J. Franks, G.N. Gibney, J.R. Giltinan, J.A. Hart, W.F. Heale, M. Holsman, R.E. Hooper, R.N. Hope, A. Isaacs, J. Jagoda, C.W. Jones, R.G. King, M. Korman, L. Lewi, H.B. Liszukiewicz, J. Long, A. Lopata, P.B. Malcolm, T. Mandel, D.W. Newell, R.W. Parker, R. Pattinson, D.A. Phillips, B.M. Rigg, R.G. Robinson, D.S. Rosengarten, J.H. Rush, T. Rush (Vice), G.B. Ryan, L.M. Ryan, C.E. Seabridge, K. Shannon, B. Singh, J.L. Smyth, R. Southby, D.C. Sowden, A.M. Steiniger, J.R. Stockigt, I.K. Ting, N.W. Trezise, N. Warhaft, B. Woodward, B.R. Zimmet.

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Society and University Alumni  
Association Membership**

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**Membership year  
1 April 1992 - 31 March 1993**

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**Foundation Life Membership**

*Foundation Life Membership carries with it lifelong membership of UMMS and the Alumni Association. New members will be admitted to Foundation Life Membership only until the end of 1993.*

**Honorary Membership**

*Those who have been Melbourne MBBS graduates for 50 or more years are eligible to become Honorary Members of UMMS and may request such membership by contacting the UMMS Secretariat.*

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• Annual subscription \$40

**Recent Graduates 1989, 1990, 1991**

• Annual subscription \$10

**Foundation Life Membership**

• \$1000, or \$500 in each of two years

**Honorary Membership**

• no cost

**Donations**

*UMMS would like to thank members who generously made donations to the University. Donations to the University of \$2 and over are tax deductible.*

**Who is eligible to join UMMS?**

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

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

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# The Melbourne Medical School and some of its 'characters'

1931-1975

Sir Sydney Sunderland, CMG

*On 20 November 1990 Sir Sydney Sunderland delivered the 1990 UIMMS Lecture in the lecture theatre that bears his name. He has since remarked that it was 'really more of a talk – a conversation'. Chiron is proud to publish this modestly edited transcript of his 'off the cuff' reminiscences, told without notes to an appreciative and responsive audience.*

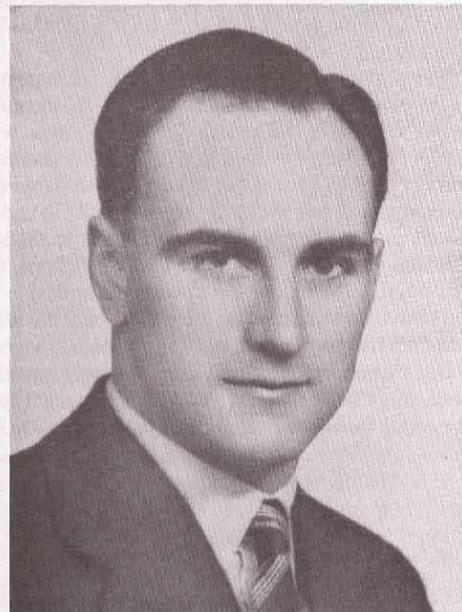
**M**r Chancellor, Lady Woodward, Vice-Chancellor, Dean, and so many friends. Let me say first that I want to extend to the Dean my very warm thanks for a more than generous introduction. The occasion does bring to mind that very elderly professor who was invited back to his old medical school to give a talk such as the one listed this evening. The function of the Chairman, of course, was to introduce him, and he did so by saying what a great pleasure it was to welcome back to the school their revered and venerated professor. That's what he intended to say, that's what he thought he said. But in fact there was some short circuiting in the synaptic circuits. What emerged was: 'It is a great pleasure to welcome back to this medical school our venerated and renovated professor.' I think by chance I've just missed that.

I was also going to say what a great pleasure it is to see so many old faces here, and then I thought, no, I can't say that. There are so many faces of very old friends and I thank them for coming along on this romp through the past, so to speak.

The invitation from the Dean to give this talk this evening was by way of a long distance telephone call across the Pacific which provided no opportunity to enter into discussion of detail. However, the all-embracing title does allow scope for some change and manipulation and I intend to avail myself of that opportunity. I certainly propose to talk about the Melbourne Medical School. But I have decided to reduce the period to the 1930s. These were the most interesting and significant years to a young man coming from a remote country town to Melbourne, to what in those days was regarded as a very famous medical school. On reflection I also had difficulty with the term 'character'. In a country such as this, which is dominated by a Ned Kelly mentality and where cult heroes are often the undisciplined, the permissive and the outrageous, the term 'character' has taken on a very dubious connotation. Those are not the characters I have in mind or propose to talk about. Clearly the selection must be a matter of personal choice and this inevitably introduces an element of personal bias – for which I make no apology.

I suppose it all commenced for me on an early February beautiful sunny morning in 1931. I'd arrived from Brisbane a week before to enrol in 2nd year Medicine, settled into my digs in East Melbourne, and decided that I would walk across to the University and make a reconnaissance. I did so and the first department I entered was the old anatomy school. For those who remember it, there was a long corridor leading down to two branch corridors and double doors, which in those days opened into the old museum. It was a dimly lit corridor, but the doors of the museum were wide open and a shaft of sunlight had come through from the skylight above falling on a robed figure against the black background. I thought for a moment that it was a living person examining some objects on a table. At one hundred paces it looked magnificent. But as I approached it turned out, of course, to be an individual, a portrait of that gentleman who is looking down on you from the

right. I didn't know at that time that it was Richard Berry, the first Professor of Anatomy in this medical school. I studied it very carefully and the prevailing thought was the sort of mischief that an artist can do to his subject – the body form was acceptable but the face seemed to be very strange. I was to learn later, much later, when I did meet Berry, that in fact it didn't do him justice.



The young Dr Sydney Sunderland, 1937.

I also remember a famous painting I saw at Johns Hopkins University, many years later when I was there as a visiting professor to study the local atmosphere. It was a study of the four foundation clinical professors. Johns Hopkins Hospital, of course, was built towards the end of the nineteenth century, ahead of the creation of the actual medical school. The money for Johns Hopkins came from shares in the Baltimore and Ohio Railroad Company which had fallen on difficult times. The funds had run out and several years had to pass before the Medical School was established. But the four foundation clinical professors were appointed and they were, of course, Halsted, that famous, distinguished American surgeon, Osler, Welch and Kelly. Amongst other things, Halsted introduced the surgical glove to operative surgery – not as any gesture to asepsis, but to protect the delicate hands of his theatre sister from the strong antiseptics which were used at that period. There's no secret that the theatre sister was Halsted's mistress. Osler had just published his very famous textbook of medicine, *The Principles and Practice of Medicine*, which has become a watershed

in the history of medical publications. It's a classic. Welch was Professor of Pathology and Bacteriology, and Kelly, the Professor of Obstetrics and Gynaecology. There was something about that portrait that intrigued me because Kelly wasn't quite the same as the others. With time, the story revealed itself.

The founding fathers of Hopkins decided that these four foundation professors should be painted as a group portrait. By the time they'd got around to making a decision, Osler had left to become Regius Professor of Medicine at Oxford. So it was clear that the painting would be executed in England with the other professors coming over from time to time. The artist commissioned was John Sargeant.

(John Sargeant himself had a very interesting career. He was born in Florence of American parents who moved to France, while he was still young, and entered him into a school of art there. He moved on from there with great distinction and was clearly going to become one of the distinguished portrait painters of the day. He settled in England and was ultimately elected a Royal Academician.)

It appeared that Sargeant had struck up a friendship with Osler. The portrait of the group, following the Dutch school, was apparently magnificent. It received rave reviews in London, New York and Philadelphia on its way to Baltimore. But after a time, it was noticed that Kelly was fading from the picture. There came a time when you could barely detect that there was a fourth figure there. It transpired that Sargeant had developed an extreme dislike of Kelly, and Kelly had developed an extreme dislike of Sargeant. But of course Sargeant was the master of the situation and he said 'Master Kelly, you're not going down to posterity.' He painted Kelly in poor pigments and of course they faded. Ultimately, there had to be a restoration, which of course nowhere matched the work of Sargeant. That's why, if you ever go to Hopkins, I recommend that you take a look at that famous painting and you will see that Kelly by no means matches the others.

To return to Berry and the School of Medicine in Melbourne. At that time the University was in dire financial straits. The accountant had embezzled something of the order of 25,000 pounds, which was a lot of money in those days, and had not only depleted the financial pockets of the University, but of course it destroyed the community's confidence in the ability of the University to conduct its business affairs prudently. So funds were in short supply. If history tells you that all was well with the Medical School, don't believe it. It was dead in the water and about to founder!

Halford, who had done a magnificent job establishing the school, had grown old and frail and could no longer carry the burden of the headship of the Department of Physiology. The University solved that problem by appointing Charles Martin as Acting Professor. Charles Martin was a very distinguished physiologist who had already been awarded the Fellowship of the Royal Society of London for his work. Year after year he had to function as an acting professor, which must have been extremely frustrating. Finally, he became so dissatisfied that he up anchored and left for England to take over the first directorship of the Lister Institute in London.

So there was the Chair of Physiology vacant and Halford unable to participate in any way at all. The University decided it was necessary to proceed to the appointment of a professor of physiology. But were they going to have two professors of physiology, because Halford was the professor with a contract? Halford, learning of these developments, finally said, 'Look, if you will give me a pension of 500 pounds for the rest of my life I'll resign.' And that he did. Whereupon the University advertised the Chair of Physiology at 900 pounds a year. Osborne was appointed. It was said at the time that he was an applicant for three chairs in the University of Melbourne – history, English literature and physiology. I don't know whether that's true or not, but he was certainly a very fine scholar. The University decided on physiology.

When he arrived Osborne found that the University had deleted 200 pounds from his salary as an amount towards Halford's 500 pounds. That didn't make him very happy, but as a true Irishman he took it on the chin and accepted it. Mind you, in those days a salary of 900 pounds was not unreasonable; on that income you could afford a cook, a maid, a governess and a gardener. And the University houses had been designed to provide accommodation for that size domestic staff.

At that time Harry Allen was the Professor of Pathology and Anatomy, but he was a pathologist at heart and had very little interest in anatomy. The major centre of his interest was, of course, the creation and development of his museum, which became one of the finest in the world. Anatomy had fallen into decay – reduced to perfunctory sort of anatomy demonstrations on post-mortem material and it was clear that something had to be done.

The University decided to advertise the Chair of Anatomy. Richard Berry applied. He was at that time Lecturer in Anatomy in the Medical School of the Royal Colleges in Edinburgh, and a very fine anatomist. He arrived and found that the University was attempting to reduce his salary – but by 100 pounds only as a special concession. The University wasn't as successful with Berry as they had been with Osborne. He remained on his 900 pounds; he was very determined about that, but it was grounds for conflict in the future.

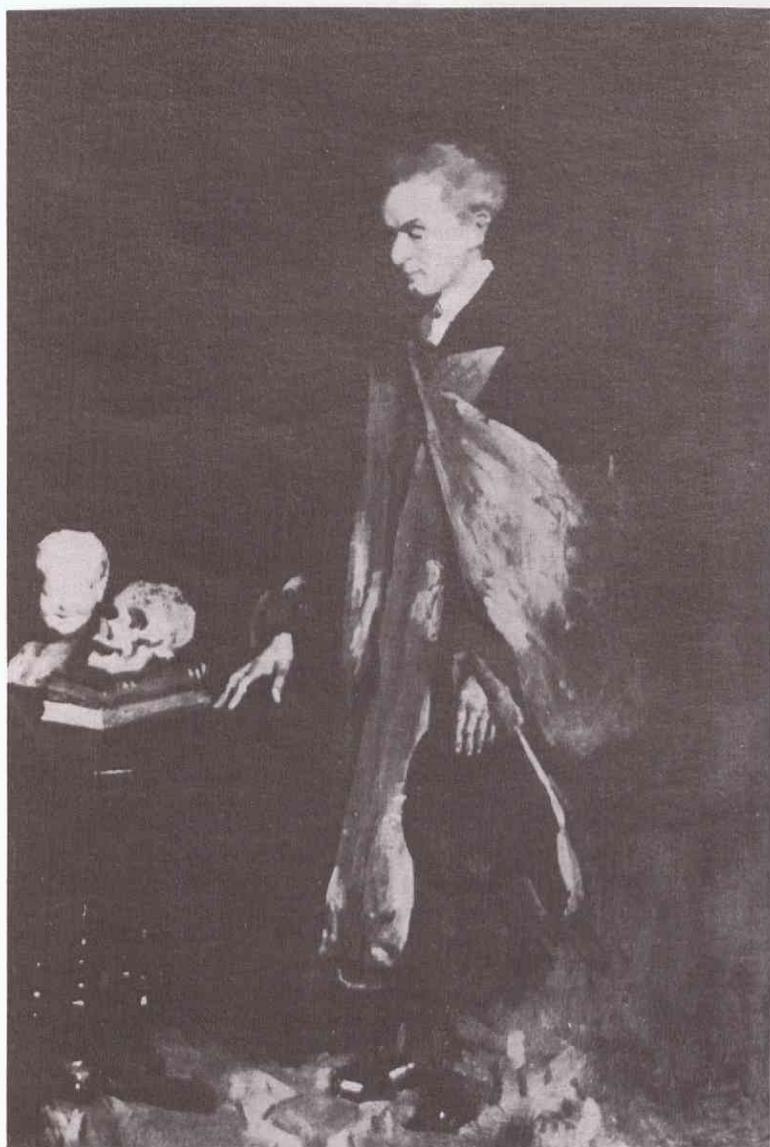
Berry never saw eye to eye with the administration of the University. He was appalled at what he found in Melbourne. When I met him years later in Bristol, he said he was so disheartened that if there had been a boat available, he would have turned around and gone back to Scotland. But the next boat was three months away, so he knuckled down, went through that department like a fireball and quite quickly established three objectives: to restore anatomy to its rightful place in the curriculum as the fundamental basis of the healing art; to get a new anatomy school; and to bring the Medical School and the Melbourne Hospital into juxtaposition, side by side.

He set to, first, on anatomy, organised a superb course – if you think only in terms of the didactic instruction on the subject. But at that time he had three extraordinary students – Newton, Hurley and Upjohn. They were remarkable in every sense of the term. Berry introduced the title of 'prosector' which he gave to the top four or five students at the end of second year. Newton, Hurley and Upjohn were the first prosectors. You can see their names on the board outside, which is a fantastic record of the history of this school. One of the duties of the prosectors was to prepare dissections for the museum and over the years, Berry did build up a superb museum of anatomy. I suppose the centrepiece of it was his complete transverse and sagittal sections of the entire body which really made history at the time. Incidentally, I should mention (and I will be mentioning him again in a little more detail) those sections were prepared by Preston, his Senior Technical Assistant. The museum gradually grew, but of course it was largely in storage because the facilities were appalling.

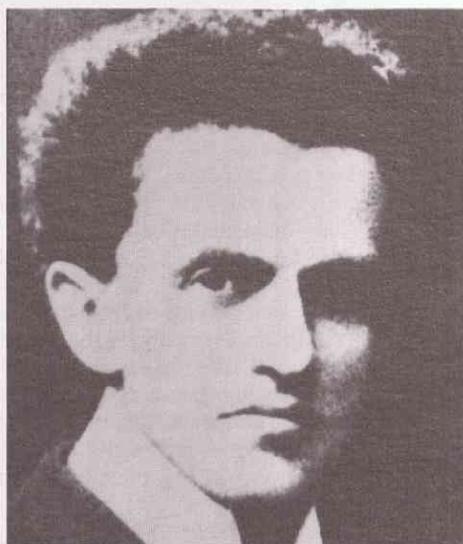
We can skip some years. Berry had to tolerate those conditions for quite a long time. Finally in the 1920s it was clear that the University wasn't going to do anything about the problem. He was becoming quite an influential person outside at that time. He approached the local government of the day and had a parliamentary committee appointed to come up and look at the conditions in the dissecting room. He gave a pep talk to the students and said he wanted them all there on that afternoon and to bring their friends from other faculties. The place was just packed and Preston told me that you could tell who the friends were. They were either rushing outside to be violently ill or they'd taken on an ashen grey or olive green colour – you could take your pick. This unquestionably worked the trick and Berry got his anatomy department.

So you see, with perseverance he succeeded, but not without difficulty because he was now in open conflict with one who was regarded as a 'tyrant' in the medical profession and also in the University – James Barrett, the ophthalmologist. James Barrett was determined to negate every idea and suggestion Berry advanced. Even when Berry obtained the money for the department, and it was being planned, Barrett engineered to have it reduced in size. It was a very sad business, in a way, because everything that Berry attempted to do regarding the development of the Medical School, Barrett thwarted in one way or another.

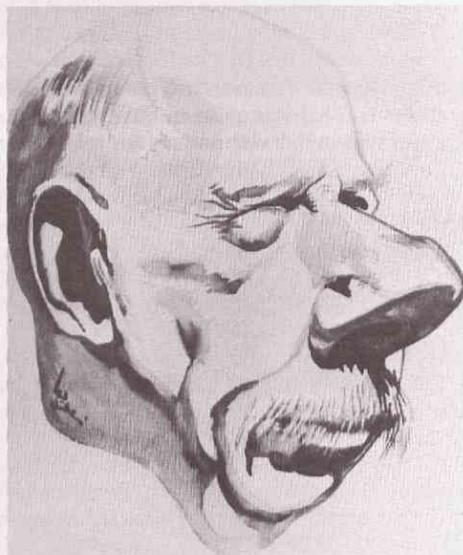
I remember Henry Searby telling me that one day when he was acting for Berry, who was confined to his bed over in the professor's house at the time (he had the job of collecting the mail and taking over the morning paper), as he entered Berry said, 'Sit there.' He wasn't interested in the mail. He took the paper, looked through it quickly and threw it down on the floor. This went on for a week. Finally Henry said he couldn't contain himself any longer,



Professor Richard Berry, painted by Justus Jorgensen, c.1927.



The young 'Dicky' Berry.



James William Barrett. Drawing by Syd Miller for *Smith's Weekly*, 1938.

'Professor,' he asked, 'what is the trouble? Is there anything special you're looking for?' Berry said, 'Yes, I'm looking for the death notice of that so and so Barrett and it's never there.'

So the feelings ran very, very high in those days. It was the same with Berry's plans to bring the Medical School and the Melbourne Hospital together. The idea was first advanced back in 1914, when Berry was planning to take the Medical School down to Russell Street, opposite the Hospital. But St Vincent's was opposed to that and, in any event, with the outbreak of war the whole plan was scrapped. After the war, Berry tried again. The plan now was to bring the Melbourne Hospital up to the Carlton area. Berry believed there was no point in doing so unless it was alongside the Medical School. Everyone was talking about the [then] pig market site over on the western side of the campus. History creates the impression that Berry was in favour of that – in fact he was not. As he told me later, he was opposed to a move to that site because it would lead to a situation in which the entire University campus would be interposed between the Medical School and the Hospital, and they wouldn't be much better off.

What Berry wanted was to build the hospital to the southern side of the anatomy department in what was then a tremendous vacant lot. You'll all remember that the entrance to the anatomy department was on the southern side when the other medical buildings were to the north. He was pretty smart. At that time he was thinking the Melbourne was going to go there and students would walk out of the anatomy school and just across a little road into the hospital.

He wasn't getting very far with the University, so he opened negotiations with the Rockefeller Foundation in 1925 and 1926. The Rockefeller Foundation was very impressed with Berry's submission to build new departments of pathology and bacteriology alongside anatomy, with physiology. In other words, a new pre-clinical and para-clinical setup with the Melbourne to come up to the site on the south-eastern corner of the University. This was fine. They invited him to New York. He went with Sir Stanley Argyle, who at that time was the Chief Secretary. Berry came back with 250,000 American dollars, which were worth a lot of money in those days. But now the nub. What about the Melbourne Hospital? The condition that the Rockefeller Foundation set on the grant was that this could only go ahead if the Hospital shifted to the site that Berry said was ideal for the future development of the Medical School. Of course, this the authorities were unwilling to do. Sadly, the money went to Sydney, who built their departments of pathology and bacteriology, medicine and surgery, at the back of the Royal Prince Alfred Hospital.

By this time, Berry – he'd gone to the States in 1927 – was discouraged and disheartened. He was sixty and it was clear that the University was not going to give him the extension of five years that was customary. He was still very active, and they did extend it to 1928, but largely because of the discussions relating to the Rockefeller grant. By this time, he could see the writing on the wall, and in 1929 he resigned. He'd received a very favourable offer of the directorship of the Stoke Park Colony for Mental Defectives just outside of Bristol. He upanchored and left.

They tell me that his last lecture was a real riot. Norman Cust, who I understand is still alive, had his jazz band there. They were singing University songs, Berry was taking part in them. He was always very, very popular with the students. When he sailed they hired a bus, put on their white coats and all went down to say farewell. I think that was just magnificent. Years later, Berry had the fondest memories of those incidents.

Here's Berry [slide], the man who's portrait is up there to your right. A mop of dark, upstanding hair, firm face. In a way I suppose a small tyrant because he wasn't a tall man, but a first class anatomist who, because of the interest he developed between surgeons and the department, developed graduates who put the seal of excellence on Melbourne surgery for the next fifty years. Not only Melbourne surgery but Australian surgery.

Next the principal offender: James Barrett was an extraordinary person. He wanted to run everything. He was president of almost all the outside societies in the city and some in the country. His name was up on every public lavatory wall in Melbourne, when the old VD notices you remember were there, and at the bottom, 'JW Barrett, President'. It was always said that, when Barrett died and went to heaven, God would have to move down to the vice-presidency. He was very ambitious, a determined person, was most anxious to become Chancellor, but he was thwarted in his passage to that post and was not elected until 1935.

Barrett as Chancellor, of course, conferred the MB BS on me and my fellow students. That was quite an afternoon. There was no great function in Wilson Hall with parents and relatives and friends and speeches. We were marched in in groups of fifteen. I remember the day, December the 10th, 1935. We were marched in and Barrett got up and said, 'By virtue of etc., etc. I admit you to the degrees of MB BS: Bingo, out! Next group of fifteen came in. And so it was all over in a matter of well under an hour. That's why I have very vivid recollections of Barrett. Maybe I'll have an opportunity to say more about him when we come to physiology.

The next [slide] is the anatomy school when it was opened in 1923. You'll notice the entrance to the south. That was slightly changed for climatic reasons because the prevailing winds and weather came in from the south, and they built a little sort of annexe there to protect that entrance. But you'll notice the vast vacant allotment to the south which Berry always believed should have been the site for the Melbourne Hospital, just across the way from the Women's.

Well, that was the Berry era. He accomplished a great deal, far more, I believe, than he's given credit for. I met him years later in Bristol. I'd gone across to visit the Burdon Neurological Institute, which had recently been opened, and the director was Gray Walters whom I knew was interested in the electrical activity in the cerebral cortex. During a luncheon, somebody commented that there was a very strange professor from Australia there, and of course it was Berry. A meeting was arranged.

I knocked on the door, it was opened and here was this – you know, I'm not tall, but I appeared to be a giant – here was this little fellow. He was stooped by then because he was in his eighties and wizened, still with his shock of hair which was now peppered with grey. And he was so pleased to see me. He was bouncing around just like a rubber ball. I got the impression that I was the first and only Australian who ever called on him after he'd left this country. Into the sitting room I followed him. I suddenly found I couldn't see him. I thought he'd fallen over between the sideboard and the table. I rushed around to help him and he brushed me aside. What was the old boy up to? Of course, his eyesight was failing by that time – he was fooling around in the cupboard for a decanter and a couple of glasses. So out came the Scotch and we sat down. He wanted to know all about Melbourne. He wanted to know if Barrett was still alive. I said Barrett died four years ago. That really pleased him! It pleased him that he'd outlived Barrett. He remained very resentful of the administration, but had the fondest memories and affection for students and the medical staff of the school and the hospital. The administration, no. He said he was the only professor up until that time, in the history of the University, who'd not had his term of office extended from 60 to 65 years; he was the only professor who, after a devoted period of service from 1906 to 1929, had not been made a professor emeritus. He added that 'There's the odd plus too.' The Samuel Gillott Provident Fund had been

established in 1923, but only became operational in about 1924 – maybe it might have been 1925. So he subscribed to it for about four or five years. He said that they'd been paying him a pension ever since. When he was in his eighties he said he'd made a very handsome profit out of them. He lived until ninety-five. So all was not lost.

By that time I'd missed two trains back to Oxford. He would have had me stay on for dinner he was so pleased. When I returned to Australia, I floated the idea of awarding Berry a professor emeritus title, but nobody was particularly interested. Maybe the administration at that time still had unhappy memories of Berry's term here. When Sir William Upjohn became an influential figure on the Council and subsequently Chancellor, and I became Dean, I raised this proposition again and Berry became Professor Emeritus of Anatomy. He wrote a delightful letter back, thanking the University most sincerely for this 'almost posthumous honour'. He had a good sense of humour.

The next person [slide] is one that would go on any list: William Preston, the senior technical assistant in anatomy. And why do we have a technical assistant in this group? Well, he was an extraordinary man. He was a great man. He came out from Kent as a boy, landed in Melbourne in 1887 at 17 years of age, and immediately obtained an appointment as a dresser at the Melbourne Hospital. He was a dresser until 1891 when he was elevated to the position of theatre dresser. In 1893, Harry Allen brought him up to the University as a laboratory assistant in pathology.

In those days Preston worked with Bull who was in charge of bacteriology. Preston was full of worldly wisdom. He was the students' friend. He was intensely loyal to the Medical School and all who served it. Now remember, when Berry arrived he took to Preston straight away and Harry Allen had to release him to become the senior technical assistant in anatomy. So he was with Berry right through Berry's period of professorship, and subsequently of Wood Jones'. Unfortunately, he died in 1941. He was a great loss to the department. He kept the accounts, he did all the ordering, he was the embalmer. He handled all the undertakers in an extraordinary way. The rapport which he established with others was remarkable. And remember, most of the students who became distinguished clinicians had gone through his hands in the anatomy department, and he'd been a good friend to them.

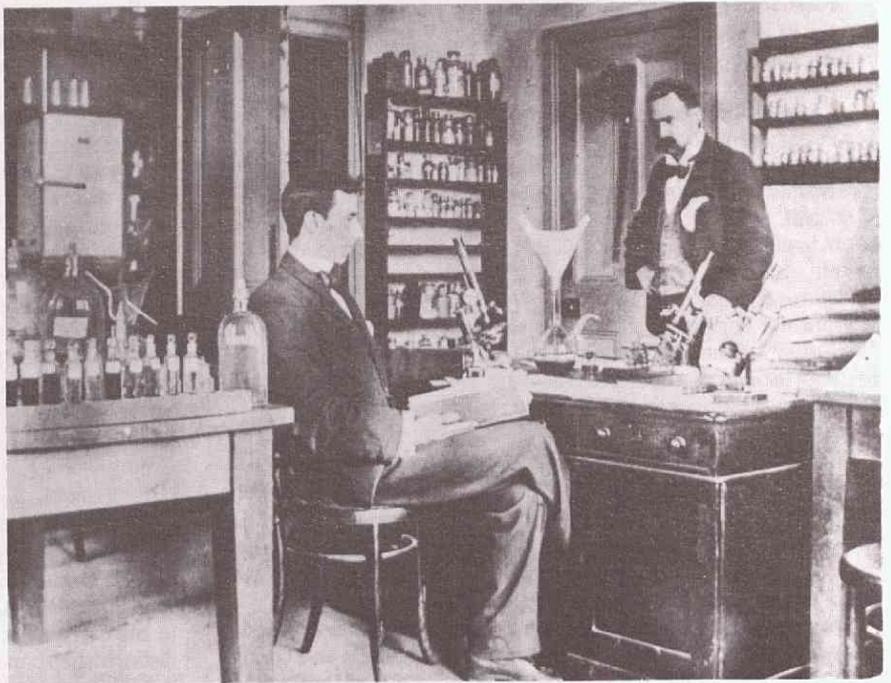
Preston had immediate access to the senior practising members of the profession like Alan Newton, Upjohn, Hurley and so on. They had great confidence in him so that, for example, when the Royal Australasian College of Surgeons was established, who should carry the College mace? Preston. And he did it with great distinction. He was very proud of being given that post. He was a remarkable man and, as I say, he was the students' friend. It was well known that at the operative surgery section of the MS examination, Preston would always advise the candidates on what surgical procedures should be made and so on. He knew the game by heart, you see. Kilvington, who was one of the distinguished surgeons of that period and always ready for a joke, told his co-examiner – Kilvington told me this story later – that they knew what was going on, but thought they'd have Preston on. That day they mentioned some outlandish surgical procedure to the candidate. Preston went over to the body and in a quite audible voice said 'Blimey doctor, I've never heard of it, you're on your own.'

That's why everyone loved him. He was a remarkable figure. A bell ringer at St Paul's and St James', when his funeral cortege moved up Swanston Street it was a very, very long collection of cars. I don't know how many would have been there, but it would have been literally hundreds. As the funeral procession moved past St Paul's there was a muffled peal of the bells. I was privileged to be a pallbearer at the funeral and I was very honoured. He was an extraordinary person and we should not forget him.

The next [slide], of course, is the most charismatic character of that period, Frederick Wood Jones. He was a great naturalist. What was the magic about this person that made him a legendary figure wherever he travelled? His insatiable curiosity took him to many strange places, including, fortunately, Melbourne. The interesting thing is that he never remained long in any one centre; but whenever he left, he left behind him respect, admiration and great affection. I think the spirit of high adventure which surrounded and dominated his life is reflected in the list of his appointments and in the diversity of his writings.



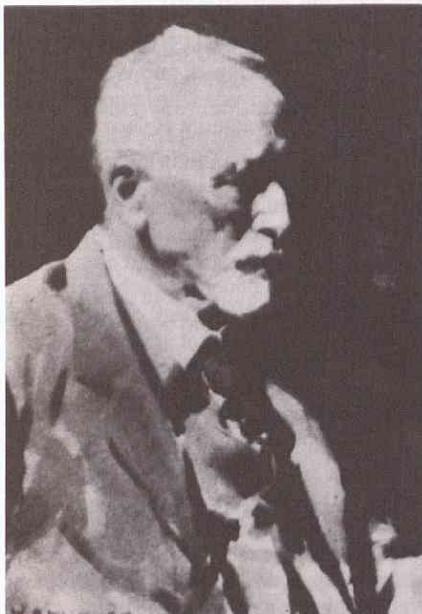
The young 'Freddy' Wood Jones.



Richard Bull (Bacteriology) and 'Mister' Preston, 1898.



Wood Jones, the adventurer.



Archibald Watson, Elder Professor of Anatomy, University of Adelaide, painting by W.B. McInnes.



William Henry Preston carries the Royal Australasian College of Surgeons mace.

Wood Jones graduated in medicine from the University of London in 1904. He had already completed a Bachelor of Science degree from the University of London. He took a position in the outpatient department of the London Hospital, but you'll note that in 1905 and 1906 he decided to move to the Cocos-Keeling Islands. The Far Eastern Extension Telegraph Australasia China Company Limited had advertised for a doctor for the cable station there, he applied and was appointed, also as ship's surgeon on the cable ship *SS Portral*. You might well ask, whatever possessed this person to go out to an isolated spot in the Indian Ocean. I asked him that and he said, 'Sheer adventure.' That was a period, of course, when adventure stood for something.

His chief during his student days was Arthur Keith, later Sir Arthur Keith, who took a personal interest in him. Sir Arthur had been out in Siam as a doctor on the Siam goldfields. He did that to study the anthropoid apes in the area. In any event, Wood Jones was a born naturalist.

It was in the Cocos-Keeling Islands that two important developments took place. He met and later married Gertrude Clunies Ross and they were a wonderful combination. She was a remarkable woman, educated in England and France and a wonderful help to Wood Jones. He dedicated every book he wrote to her and only his death in 1954 separated them.

He was also interested in insects and birds, but he developed some important new ideas on the formation of corals and coral atolls. The interesting fact is that it was clear to him at that point that Darwin was up the wrong creek about evolution. Darwin had also written on corals and coral atolls. When Wood Jones arrived back in England he committed all of his records to a book called *Coral and Coral Atolls* and gave many lectures at the Zoological Society of London. So all knew about his work. This book was submitted for the Doctorate of Science degree at the University of London, but it was rejected. It was rejected, of course, because of his criticism of Darwin. The old story: you must not criticise authority, it isn't done. Later it was re-submitted and passed.

Wood Jones also travelled widely on the cable ship, down to Sydney several times and on the way there and back he would drop off to conduct short studies on the barrier reef, and they were very important ones.

In 1907 he was off again. Grafton Elliot Smith had gone down to Cairo as the Professor of Anatomy. At that time the Aswan dam had just been built and the Upper Nile flooded. This destroyed hundreds, perhaps thousands, of burial grounds, representing a considerable archaeological loss. There was a plan to increase the height of the dam and the Egyptian government said before that was undertaken, a study should be made of the remaining burial grounds in the area – they set up the Nubian Archaeological Survey. Grafton Elliot Smith sent a message to Sir Arthur Keith asking for a first class anatomist – Wood Jones arrived on the scene.

That was a particularly interesting period. He measured over two thousand skeletons in a very short space of time – it was necessary for the elevation of the Aswan dam to go ahead and time was limited. Elliot Smith did little work in the field, but one of his assistants, Dr Derry, towards the end, did. However, most of the work was done by Wood Jones and the archaeological side of the study was conducted by Dr Reisner from Harvard University.

There Wood Jones made one interesting observation – among many, of course: in one burial ground, all the occupants had been put to death either by the sword or by hanging. And he noticed in those who'd been hanged that there was a curious dislocation of the upper cervical region in which the dens, a bony prominence on the second cervical vertebra, had been forced backwards into the spinal cord. He put that observation aside.

Back in London, where he became demonstrator in anatomy at St Thomas' Hospital, he became interested in the anatomy of hanging. There was the case of the butcher's boy. You know the old basket with the handle over it. The butcher's boy, having made his delivery, put the basket over his head with the handle under his chin, and dashed out through what turned out to be a very low doorway. As a result, the top of the basket caught and his head was jerked violently backwards in extension. Death was immediate. The post-mortem revealed dislocation of the second cervical vertebra with the dens forced back into the spinal cord. So Wood Jones immediately said, 'We'd better take a look at this.'

Parsons was the head of the department. Wood Jones and Parsons, at dead of night, took to dropping bodies down the lift well at St Thomas' Hospital. This had to be done carefully. There'd been a lot of work done on hanging: it was a question of the weight of the body, the length of the drop and so on. But the custom was to put the knot under the left ear. Wood Jones showed conclusively that that was a pretty horrible way of disposing of a person because death was rarely instantaneous, it fractured the base, it led to all sorts of injuries. Very often the victim died from strangulation perhaps an hour or two later. He thought this was a subject worth looking into. He wasn't opposed to capital punishment, but he was opposed to the way in which it was being done in the United Kingdom at that time.

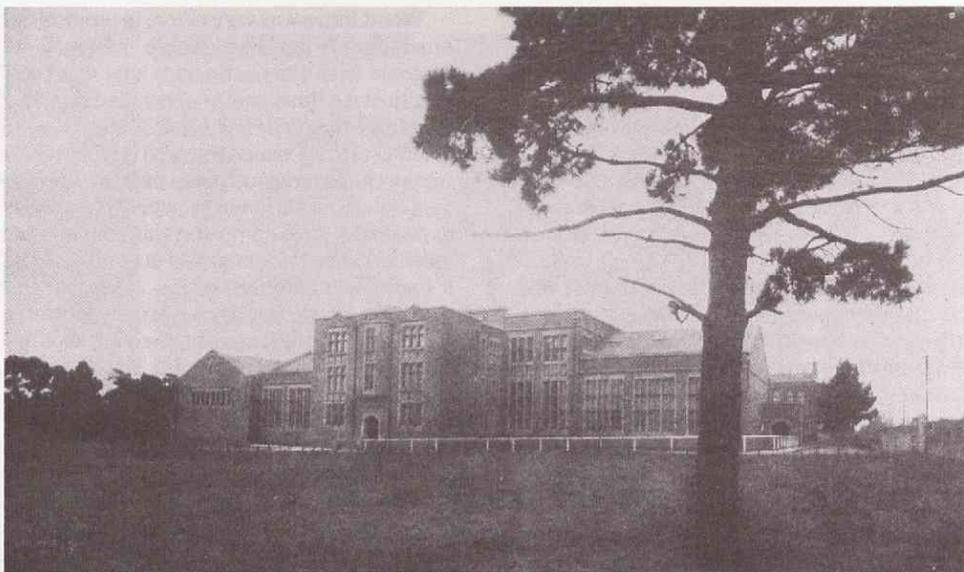
What did he do? He put the knot under the chin, dropped the body, and sure enough, the second cervical vertebra dislocated the dens back into the spinal cord. The attention of the authorities was drawn to this observation, but no notice was ever taken of it. That work became the basis of a celebrated lecture on the anatomy of hanging, which he gave several times in Melbourne.

Wood Jones later went up to Manchester where Elliot Smith was Professor and Head of Department. The two became very close indeed. Grafton Elliot Smith, named after the town of Grafton in New South Wales, was a very distinguished Australian who, even in his early days, immediately after his medical course, wrote distinguished papers on the morphology of the brain. He was taken by Wilson, who was the head of the department at that time, to Cambridge with him. Elliot Smith became a very distinguished figure in British science.

Towards the end of his career – he was the author, incidentally, of many books – Jonathan Cape, the publishers, approached Elliot Smith to write his memoirs, an autobiography. Elliot Smith agreed and received a considerable advance royalty. So every night, immediately he'd finished dinner – his wife had been a well-known violinist and fond of entertaining the Londoners – he was in the habit of excusing himself, saying that he had to go to his study to work on his autobiography. This went on for quite some considerable time. Then, unfortunately, Sir Grafton died, and the publishers asked Lady Elliot Smith for what he had written and been so well paid for. In the study they found nothing, the old boy had not put pen to paper! What he'd been doing was to escape from the guests, put his feet up and have a good zizz! The publishers threatened to sue the estate and Lady Elliot Smith. At that point all Elliot Smith's old friends, Wood Jones and others, decided that they'd better come to the rescue and all contributed to a biography, dedicated to Lady Elliot Smith. Wood Jones wrote on the period in Egypt and Nubia; the Manchester period was written by J.S.B. Stopford, who was originally Professor of Anatomy, became Vice-Chancellor and subsequently Lord Stopford in the House of Lords. There is also a contribution from Lord Rutherford of Cambridge. A very distinguished group and a very, very interesting collection of papers. It was the Manchester connection, which had established the very close friendship between Elliot Smith and Wood Jones.

During the war period Wood Jones moved to the London School of Medicine for Women as Professor of Anatomy. He was a captain in the Royal Army Medical Corps, assigned under Sir Henry Head, the great neurologist, to be in charge of peripheral nerve injuries. It was largely that work which led to the writing of one of the classics of anatomy, *The Principles of Anatomy As Seen in the Hand* – a wonderful book. He had also, at that stage, published another on 'arboreal man' in which he examined the influence of arboreal life on the emancipation of the forelimb, and the effect it had on the development of the brain and the development of manual dexterity.

Toward the end of that period, Adelaide was looking for a Professor of Anatomy, so Henry Newlands, as he was then, offered the post to Wood Jones, who accepted and in 1919 moved out to Adelaide. He immediately commenced very active research programs into South Australian mammals, into the Australian aborigine, and into the birth of the kangaroo as a representative of the Australian marsupial. As you'll remember, the old bushmen said that the kangaroo was born and developed on the nipple – it was quite unlike the normal way of development. Wood Jones quickly proved conclusively that it was a normal birth process with this tiny embryo making its way up to the pouch and attaching itself to the nipple. He also became particularly interested in the



The Anatomy School, 1923.

Australian aborigine and in their plight, with particular interest in the study of the metrical and non-metrical features of the Aboriginal skull.

The person that I do want to speak about in connection with Wood Jones' term at Adelaide is Archibald Watson. Archibald Watson was the only real eccentric in that group. He was a very strange fellow, the *enfant terrible* of the Adelaide medical scene. I first met him as a school boy when I used to walk home across the Brisbane River from Brisbane High School. I had occasion to board one of the vessels of the Burke Line – a small shipping line that plied up the Queensland coast, round Cape York, and into the Gulf of Carpentaria. The plush liners of the day were of course all Howard Smith and Australian Union Steam Navigation Company boats. Down on the stern was a figure fishing off the end. I had fished many a night in the Brisbane River and the only thing I ever caught was the proverbial cold, but I thought I'd go down and talk to this fellow. I didn't get a friendly welcome. He was obviously not going to engage in conversation. I went back to a deckhand and said, 'Who is the crusty old boy up on the stern?' and he said, 'Oh that's the mad professor from Adelaide. He's got almost a permanent berth on this boat; he just spends his time travelling up and down fishing.' It was not until many years later that I learned fishing was his great hobby. All his fish notes, and they were considerable, as he'd fished right round the Australian coast, and around the world as far away as the Amazon, are now in the National Library in Canberra.

My information on Archibald Watson comes from Wood Jones, Preston, the Murray Black family of Tarwin Meadows, and my own brief contact with him. It appeared that he came from a very wealthy pastoral family in the Upper Murray and as a boy went to work on boats in the Pacific. He became involved with the slave traders who were running Melanesians illegally into the Queensland cane fields. They were caught, tried and were sentenced in Fiji. I understand the sentences were very severe. So severe that a group of the local white colony engineered their escape back to Australia. Archibald Watson was sent off by the family to Europe immediately. He studied medicine in Germany, France and later in London. He became a demonstrator in anatomy at Charing Cross Hospital. He was a good choice for the professorship in Adelaide because he was a first class anatomist. But he was a very strange person and stories abound about him.

He was in the habit of riding his motorbike into the dissecting room and around the tables. Students loved it. He was asked to go to the Registrar to discuss a matter of departmental importance:

*'Now, Professor Watson, I understand that you are in the habit of putting the examination paper in an envelope and sending it across to the office by your attendant.'*

*'Yes, that's correct.'*

*'Professor, I also understand that you don't seal the envelope.'*

*'No, no, I never bother sealing the envelope.'*

*'But, Professor, would it surprise you to know that on the way across to the office, for a consideration that attendant allows students to see the contents?'*

*'Well, he'd be a fool if he didn't.'*

*'Look, Professor Watson, what is the purpose of the paper? How do you get on about marking them under these conditions?'*

*'Well, I never look at the papers. I know my students. I know who should pass and who should fail.'*

And that was the end of it. He was known to commence a post-mortem operation at the Adelaide Hospital by saying 'Well gentlemen, let us now look at the latest case of murder from the Adelaide Hospital.' So you can realise that he was a very strange person.

Here's another story. Invited up to one of the country residences for a weekend, he arrived on his motorbike – he never had a car, but was very fond of motorbikes – and the lady of the house met him as he arrived:

*'Professor Watson, where is your luggage?'*

*'Oh, I haven't got any luggage.'*

*'But Professor Watson, the invitation said that we were dressing for dinner tonight.'*

*'No worries, I've got my dinner suit under this one.'*

*'But the invitation also indicated that it was a weekend.'*

*'Oh yes, no problem, my pyjamas are on underneath. I have my toothbrush in my inside pocket.'*

He was indeed a strange customer.

Preston tells the story that when he was a theatre dresser Archibald Watson came to Melbourne. He was well known in medical circles around the country. At the Melbourne Hospital there was a clinical discussion on the localisation of a cerebral tumour in a patient. The local surgeon was convinced – I don't know whether he said right or left, but Archibald Watson said the opposite side. There was quite an argument but, since it was the surgeon's patient, his opinion prevailed and the patient went into the theatre. The skull was opened on that side and the local surgeon was wrong, the tumour was on the other side. So at the top of his voice Archibald Watson said, 'Well Jerry, don't you wish you were double jointed so you could kick yourself in the backside.'

They were the characters that were about in those times. Wood Jones was remarkable for many reasons. He was a brilliant and inspiring teacher, a fluent lecturer with an engaging style. He believed in the creative use of knowledge rather than the accumulation of facts. He believed in unifying ideas and guiding principles. In other words, to him education was lighting a lamp and not filling a bucket. And believe me, that was a very novel and

refreshing approach in those days. He established remarkable rapport with younger students, as well as with senior medical personnel. He had open house on a Wednesday evening for his prosectors which were wonderful occasions. I never missed one, and there were many others. I met artists – I ultimately met there Jorgensen of the Meldrum School who'd painted Berry. (I didn't have the courage to ask him about Berry's portrait for there had been quite a row over it.) I met musicians, writers, Percy Leason – the great cartoonist who went to New York and established fame and fortune.

Wood Jones established the McCoy Society for undergraduates and he delighted in taking them away on naturalist expeditions during the vacations. One group went to the Lady Julia Percy Island off Port Fairy, the next group went to the Joseph Banks group off Port Lincoln. And there are members here this evening who were in those expeditionary groups and have the fondest memories of them.

As an orator, Wood Jones was unsurpassed. He stood head and shoulders above all his contemporaries. Wherever he spoke and whatever subject he spoke on, the auditorium was packed to capacity. No standing room left and the corridors outside packed as well. Who could ever forget *The Anatomy of Hanging, Disease and Individuality*, and *The Changing Point of View*. And his valedictory address when he left at the end of 1937 on *Universities in Life* was given in the Melbourne Town Hall, which was packed out. The oration was broadcast. It was a superb delivery on that particular evening.

He was a prolific writer, published more than twenty books and over three hundred articles. He wrote with great authority on human anatomy, comparative anatomy, archaeology, anthropology, the marsupials, mammals, fishes, birds, medical research and even the plight of the medical student, for whom he had a very soft spot. And, of course, very extensive writings on the Australian aborigine.

It was a remarkable period for those who were exposed to Wood Jones and I regard it as the greatest treat of my life. He left Melbourne in 1937. I left a few weeks later. He went to Manchester, I went to Oxford. That's another story. But I remained in contact with him throughout his life.

Wood Jones was very active in promoting medical research in Australia. He had remarkable influence on people. He was a personal friend of Cumpston, who was the Director General of Health at the time, and he persuaded him, along with Kellaway, to establish a National Health and Medical Research Council. The first meeting of that Council was held in Hobart in February 1937. Wood Jones represented Australian universities with medical schools on the Council, and delivered a paper on problems of medical research in Australia. And no person thinking of undertaking a career in medical research or engaged in one should fail to read that paper. It's an absolute masterpiece.

It's time to say goodbye. I've only got half-way through because there are the physiologists, the pathologists, there are all of the clinicians, a magnificent group. The clinicians were great teachers but very few of them were innovators. It was clear that they were going to leave surgery and medicine as they'd entered it. The key individuals who were the innovators, and there were very few of them in those early days: Edgar King, Bert Coates, Hugh Trumble, Leonard Cox and Rupert Willis. They were the great ones and fortunately I became closely associated with all of them. But the others were great teachers, splendid surgeons and clinicians. Unfortunately in those days there were no professors of surgery or medicine. There was only a Professor of Obstetrics who did his best without professorial support at a clinical level.

It was a great period. The period of the 1930s was one of the greatest up to date in the history of this school. I remember it with great affection and I know that there are many in this room who think likewise.

I'd like to finish by reading just a small quotation. I'm going to quote the words that Thucydides put in the lips of Pericles in his famous funeral oration over the Athenian dead:

*The whole earth is the tomb of great men. Nor is their name graven only on stone which covers their clay, but abideth everywhere without visible symbol, wrought in the stuff of other men's lives.*

All honour to those who go before, even if those who come later go further.



Sir Sydney Sunderland and the Dean, Professor Graeme Ryan, at the conclusion of the UMMS 1990 Lecture.

Thank you very much for inviting me to give this lecture. My thanks to you also for attending. Old friendships unquestionably twist arms, but I've enjoyed the evening and I hope you have as well. Thank you very much for your patience.



## IS THERE A DOCTOR IN THE HOUSE? MEDICAL WOMEN'S CENTENARY CELEBRATIONS 1891-1991

School of Medicine  
The University of Melbourne  
18 October 1991

'WELCOME TO OUR BIRTHDAY PARTY!' And so the Dean, Professor Graeme Ryan, greeted a 'full house' as he opened a day of celebrations for women graduates of The University of Melbourne School of Medicine, the oldest medical school in Australia. The celebrations – a seminar in the Sunderland Theatre, followed by dinner in the historic Ormond College dining hall were organised by the Key Centre for Women's Health in Society and the Friends of the Key Centre, together with the School of Medicine.

One hundred red balloons decorated the Medical Centre foyer where graduates – from 1928 to 1990 – greeted friends and colleagues, sharing experiences and discussing issues that influence their professional and personal lives. They were joined by a few brave males, medical students and guests from other professions. The women doctors had come from far and wide – Jean Allison from Hong Kong, Lesley Winter/Waters from Western Australia, Heather Bartram and Hilary Joyce from New South Wales and many from Victorian country centres. Two brought their young babies, and most carried 'bleepers'.

In his introduction, Professor Ryan noted that in 1987, four years earlier, the School of Medicine had celebrated the

entry of the first women into the course, and that in 1988 the Key Centre for Women's Health in Society had been established. He congratulated Associate Professor Lorraine Dennerstein, the founder and Director, and her colleagues, on their achievements during the Centre's foundation years.

### THE SEMINAR Sunderland Theatre



Assoc. Prof. Dennerstein

Professor Dennerstein, Convener, before introducing the speakers, spoke of the struggles and achievements of the first two

women to graduate and to register in medicine in Australia – Margaret Whyte who topped the final year of her course, and Clara Stone who was not far behind. This was not the end of the battle for acceptance, she continued, neither woman was offered an internship at The Melbourne Hospital, where places were traditionally reserved for top students. Resistance to postgraduate training for women was finally overcome in 1896 with the founding of the Queen Victoria Hospital, its motto: *Pro feminis a feminis* – for women by women. Professor Dennerstein said that one century later this seminar honoured the achievements of these early medical women, adding that there are still many barriers to overcome if women are to reach their full potential.

The seminar program was designed to address two major concerns: how to combine a career with personal and family life, and how to enter the professional medical bodies. Professor Dennerstein pointed out that a 1987 survey of Melbourne women graduates showed the most important factor limiting success was not gender, but having to consider a family when making career decisions. (Dennerstein, L. et al. Roles and achievements factors affecting career success of medical graduates. *J Psychosom Obstet Gynaecol* 1989; 10:89-102.)

## Part One HOME, FAMILY AND PROFESSIONAL DEVELOPMENT

### HAVING CHILDREN DURING TRAINING Dr Sharon Keeling MBBS 1989



**Dr Sharon Keeling**

*Our children are a source of endless joy and comfort and keep our working lives in perspective . . .*

Dr Keeling trained as a nursing sister at the Royal Children's Hospital, later working at The Royal Melbourne Hospital and The Royal Hospital for Sick Children in Edinburgh. She determined to become a doctor, returned to Australia and repeated her HSC, gaining a higher score and a place in the medical course at Melbourne. In her undergraduate years, Dr Keeling not only achieved many prizes, she also married a fellow student and had two children. On two occasions she took a year's leave of absence, her husband took one year, and she finally completed her degree topping final year with eight prizes and awards. She is now a Resident Medical Officer at both the Royal Children's Hospital and The Royal Melbourne Hospital.

DR KEELING began her talk by explaining that as a mature-age student she chose to have children while studying; the alternative was having them at the end of her course, when she would be in her late thirties. Consideration had to be given to hours of work, flexibility and lack of income during undergraduate years, as well as to the ease with which one can deal with exams and assessments. The most overriding aspect of having children during a medical course is that you have small children in your junior hospital years. Medical school, she commented, is essentially office hours, and easy compared to postgraduate life.

Intern work was particularly difficult under the old award: until August 1990, the Resident Medical Officers Award meant an 80-hour week, including overnights with 36-hour shifts. Under the new Hospital Medical Officers Award an intern or resident does not work more than 16 hours in

a row. Rosters now average 50-60 hours per week in the wards, with as little as 40 hours per week in accident and emergency. Dr Keeling observed that she had to work out her junior hospital rotations carefully to achieve both medical experience and time with her children: 'I have learnt from bitter experience to do the homework, and to discuss with my predecessors not only what is to be learnt, but how busy it is.'

The issue of gender politics, or who remembers to buy the toilet paper is central to the topic of women in medicine. 'I do not know of any marriage where child care and home duties are equally shared.' Women are almost always the default child-care givers. This results in the famous 'double-shift'. 'You are on duty at the hospital and you are on duty at home. If husbands shared the work at home - the vigilance, the shopping, the cooking and linen changing and one hundred other considerations that are necessary in running a home - then combining children and a career would become everyone's problem instead of our problem. The question of quality time with children is everyone's problem but the double-shift applies to women.'

Dr Keeling concluded: 'Our children are a source of endless joy and comfort and keep our working lives in perspective. Nothing ventured - nothing gained.'

### POSTGRADUATE TRAINING IN A RURAL SETTING Dr Helen O'Connell MBBS 1985



**Dr Helen O'Connell**

*'Miss Prostate'*

Dr O'Connell is the first woman in the Urology Training Program of The Royal Australasian College of Surgeons. She is working for twelve months in a clinic in the Albury area, 300 k from her spouse: 'The bloke, well, he is very supportive, but unfortunately he is still very much in Melbourne. Too seldom do women marry men who are truly portable.'

Dr O'Connell described her current practice as being in one of Australia's most beautiful settings - the Ovens and Murray Valleys, and highlighted her talk with slides of the landscape, including the local wineries. The clinic covers a big area and is very

busy providing a comprehensive urological service. There is a large volume of work, and the training is mainstream ('pardon the pun') rather than esoteric.

Dr O'Connell said that increased exposure of trainees to rural practice is an important strategy in addressing the issue of maldistribution. She commented that rural women specialists are an exceptionally small group and that women doctors should be aiming to provide a service to rural as well as to urban women. One important factor holding women back from establishing rural practices, she suggested, is consideration of a partner's career. However, in its favour, child care and home help are reputedly more readily available.

Surgical training in a rural community is excellent - there is no shortage of operations and far less red tape (few computers, whilst still providing sophisticated clinical services). 'We all carry our little beepers around as if they are grafted on and when one is called, at whatever hour, it is to be heeded - and immediately.'

Dr O'Connell made several observations regarding the differences between the rural and urban registrar's life. For example, rural patients seem to take more personal responsibility for their illnesses, work and their families. It is also rare to treat someone who does not have a supporting family network. She described the overall training as comprehensive and intellectually rich.

The local community have been warm and encouraging and she has received support from the nursing staff, general practitioners, consultants and their families. She has been able to structure her week to enable her to travel to Melbourne on Friday afternoons for registrar tutorials. However, being the first urology registrar in the area has its moments. When giving a talk to the local obstetricians, Dr O'Connell was introduced as 'the woman who injects fear into the hearts of men'. In another incident, introducing herself to a consultant he barely touched her hand, remarking, 'Oh. You're Miss Prostate.' [Later, a member of the audience was heard to ask: 'If a female urologist is called Miss Prostate, what do you call a male gynaecologist?']

Dr O'Connell concluded remarking that postgraduate training in a rural setting is a rewarding and useful experience - that for the future of this country, it is mandatory. But remember, you need a reliable car!

### THE IDEAL HUSBAND Dr Bernadette White MBBS 1976

Dr White, Director of the Family Birthing Centre at the Mercy Hospital for Women, graduated with honours in medicine, surgery, obstetrics and gynaecology; she gained membership of the Royal Australasian College of Obstetricians and Gynaecologists in 1984 and became a Fellow in 1987. Married when she was twenty and a fourth year student, Dr White now has two children, aged four and two years. When their first baby was three

months old, her husband gave up his psychiatry training to be the 'person at home'. He now works three or four sessions a week and is still the primary care-giver at home.

Dr White began her talk with historical and literary references to woman's role: 'Wives submit yourselves unto your own husbands as it is fit in the Lord.' (St Paul), and quoted from Shakespeare and George Eliot - woman is seen as an appendage to her husband, supporting and sharing his ambitions and achievements, but dependent on him for her happiness. She remarked that Margaret Whyte and Clara Stone would have had very different requirements of prospective husbands other than they be 'counsellors and providers.'



**Dr Bernadette White**

*For some couples a complete role reversal may be the solution . . .*

The roots of feminism, however, go a long way back. In 1792, in *A Vindication of the Rights of Women*, Mary Wollstonecraft wrote: 'The divine right of husbands, like the divine right of Kings, may, it is hoped, in this enlightened age be contested without danger. I do not wish women to have power over men but over themselves.' Nonetheless, it is only recently that the concepts of feminism have become a practical reality for the majority of women, at least in Western society. Dr White cited *The Feminine Mystique*, one of the important feminist books of the 1960s, in which Betty Friedan averred that it is essential to her happiness for a woman to have a life and career outside of marriage and home.

Dr White referred to Professor Ailsa Burns' recently published study of the views of highly educated women regarding their criteria for the ideal partner. The qualities that were universally stressed were 'egalitarian, supportive and able to look after himself both physically and emotionally'. For a woman making a career in medicine, these are the qualities the ideal husband would have to possess. He would see marriage or a relationship as involving two equal people, each with their own ambitions to be fulfilled, each supportive of the other, but also each responsible for themselves. Such a 'modern' relationship cannot be achieved easily: what will happen to a previously egalitarian relationship

when children arrive, with a new set of responsibilities to be shared, perhaps to the detriment of one partner's career? How does the man cope with the fact that his wife earns more than him, or has a more prestigious job, or is more successful in her career than him?

Concluding, Dr White said, 'I can't really tell you what the man is like who would make the ideal husband; but if the freezer looks like something left over from the ice age, he won't automatically assume that it's your responsibility to defrost it . . . if at the end of a long day you're both relaxing in front of the TV with your cups of coffee, and your three year old is sick all over her bed, he'll at least help you to clean it up.'

## Part One DISCUSSION

The discussion ranged over questions of paid help, the need to accept the fact that some things have to be postponed in order to achieve career goals, and the pros and cons of job-sharing and part-time training.

A first year mature-age student with two children asked for tips on how she might specialise when, five years down the track, her children would be approaching adolescence. A doctor with a family of six children remarked that most women want to be perfect in everything, and that they should not feel guilty when it is not possible.

It was observed that because of her gender a medical woman is expected to be the person with whom one can talk, that you will spend more time with them, be more caring, more patient . . . 15-minute appointments pose an interesting challenge to the woman medical practitioner.

It was generally agreed that it is important to be generous with household help; to preserve quality time with a spouse and children; to 'short-list' a possible husband with household skills, who respects his mother; and to investigate job-sharing and part-time or sessional work.

## Part Two WOMEN'S CONTRIBUTION TO PROFESSIONAL LIFE WHY AREN'T THERE MORE?

In introducing the second session, Professor Dennerstein explained that she had been motivated to choose this aspect of women's medical careers by the findings of the 1987 survey: although women continue to practise medicine as often as men, they are significantly less likely to take on activities that influence medical practice; they are less likely to teach medical practitioners, to be involved in research, to publish and, most importantly, they are less likely to be elected to committees of medical organisations.

## THE AUSTRALIAN MEDICAL ASSOCIATION AND THE COLLEGES

**Professor Priscilla Kincaid-Smith, AC, CBE**



**Professor Priscilla Kincaid-Smith**

*Don't give up altogether,  
keep your finger in the pie!*

Professor Kincaid-Smith retired at the end of 1991 as Professor of Medicine, The University of Melbourne, and Director of Nephrology, The Royal Melbourne Hospital. She is Chairman of the Australian Medical Association, and in 1992 became Convener of Continuing Medical Education at the University. Born in South Africa, she graduated in Johannesburg and moved to London for further training in clinical pathology and internal medicine. She came to Melbourne in 1959 and in 1975, after senior positions at the Baker Institute, the Queen Victoria Hospital and The University of Melbourne School of Medicine, was appointed to a Personal Chair in the Department of Medicine, becoming the first woman professor at this University. She has three children.

Professor Kincaid-Smith admitted that she was inclined to begin by saying 'Ladies' as she had always been addressed as 'Gentlemen'. Instead, she chose 'Friends and colleagues' and commented that she could see many familiar faces in the audience, particularly those from the Queen Victoria Hospital who welcomed her in her early years in Melbourne. It was then she discovered women were not often appointed to teaching hospitals and that they were not necessarily all that welcome in them.

She stressed, especially to the medical students in the audience, that medicine offered an extremely rewarding career and that women must not feel put upon by their male colleagues. She strongly encouraged women to participate in College and AMA affairs. The only way women will be included in the decision-making processes that affect professional lives and the future of medicine in Australia, she said, is to be involved in these bodies.

Not being a supporter of affirmative action, Professor Kincaid-Smith said that medical women should always be prepared to compete on an equal footing with male

and female colleagues. Women should not think of themselves as 'lady doctors', a term which clearly implies an attitude towards women in medicine that should be opposed.

Community attitudes have affected women participating fully in the Colleges, she said, as well as the attitudes of husbands and families and friends to all those years training instead of rearing a family. If women do not enter specialty training programs, then they cannot participate in College affairs and decision-making processes.

Professor Kincaid-Smith remarked that the percentage of women in some of the specialties was pitifully small. In internal medicine, she said, women are making some progress, with five currently on the Council of The Royal Australasian College of Physicians. She applauded Dr Helen O'Connell as a trail-blazer in the field of urology and reminded the audience of the extraordinary accomplishments of women such as Lorna Sisely, a Fellow of The Royal Australasian College of Surgeons and a Member of the Urological Society of Australia of many years standing. Although only two per cent of Fellows of the Royal Australasian College of Surgeons are women, currently 15 per cent of trainees are women representing a dramatic increase in a traditionally male-dominated area.

The reasons why women have been reluctant to enter specialty training were self evident: six or seven years specialist training after six years of intense and demanding study as undergraduates and a year of internship; competition for training posts; and limited availability of part-time training. She suggested that women do their training first and have their families later, saying that it was much easier to arrange for part-time or at least less demanding work after completing training. 'Don't give up altogether,' she urged, 'keep your finger in the pie!'

As women enter the Colleges in increasing numbers – and she believes they will – she emphasised that it is important they stand for election to councils and for other offices. 'We cannot afford to stand back from politics,' she stressed, 'given the enormous problems faced by the medical profession – general practice is under threat, and the hospital scene is in an even bigger mess! The AMA is the logical umbrella organisation for all members of the profession, she said, adding that she would like to see more women support it.

The solution to the question 'Why aren't there more?' she said, is in our hands. 'Let us take up the challenge!'

## THE DIAMOND CEILING

### Professor Beverley Raphael, AM

Professor Raphael is Head of the Department of Psychiatry, University of Queensland; Director, Psychiatric Services, Royal Brisbane Hospital; Director, National Centre for HIV Social Research. One of her particular interests is women's mental health. She has one daughter.



**Prof. Beverley Raphael**

*Role strain and conflict are one of the biggest sources of stress for women doctors.*

Professor Raphael entitled her address 'The diamond ceiling', symbolising the difficulties preventing many women rising to senior positions in medicine – academic, clinical and administrative. Rather than the glass ceiling commonly spoken of as blocking the upward path of women executives – a subtle and unseen barrier, the ceiling blocking the path of medical women is as hard as diamonds – not subtle, but still unrecognised. The factors that contribute to this ceiling are multiple and include women's and society's attitudes to woman's role, and the subtle discriminations revealed in the Dennerstein 1987 survey – women earn less, reach less senior positions, and at least until recently, have found it more difficult to fit in with the post-graduate specialised training or post-graduate research careers. Professor Raphael reminded the audience of the longevity of women and that they can have very long careers; but full access to the upper echelons is not yet available to them.

After a brief history of women in medicine, Professor Raphael identified some of the processes which still stand in their way. For the individual they involve the dynamics of personal family life and the values of society. Young women do not see themselves as authority figures, having been conditioned to more 'feminine' roles, lowering their expectations of academic achievement and often turning to nursing rather than medicine: the scientific side of caring is seen to belong to men, while its soft, empathic components are more the province of women. It is certainly the case that empathy has not traditionally been valued as much as scientific input in medicine – although this is starting to change, and the contributions of women may become important here.

Many studies show that women usually support a husband's career and consequently make changes to their own expectations. Domestic tasks are still not shared equally: 'help' is hired rather than the husband taking equal responsibility in the home. Professor Raphael called this 'triple jeopardy' – the juggling of career, family and assisting the husband's career.

Professor Raphael talked about intrapsychic issues: low self-esteem, success

being attributed to luck or some fortuitous circumstance, discomfort with the 'pushy' aspects of leadership. Sexuality may be seen as difficult: as a female medical student, boyfriends think you know all about sex, that you are mechanistic in performance and as detached as they might be. Response is seen in terms of anatomical and physiological knowledge rather than in terms of personal feelings.

She commented on the fear of the biological clock, how to fit babies into career paths, and the fact that if you are competitive you're seen as aggressive; and that in situations where they feel discriminated against, women tend to limit their behaviour and become apologetic. The emotional costs for women physicians may be substantial – high levels of stress, depression and even heightened suicide rates.

Professor Raphael referred to the lack of mentors, sponsors and role models for women doctors. Women now comprise more than 40 per cent of medical students, but, at the last count, there were only twelve women full professors (nine medically trained) in Australian medical schools. Men are taught how to get jobs and grants and informed sponsorship – in the 'boys club', the locker room and elsewhere. There is no supportive network for women – although there should be.

Professor Raphael concluded by advocating a policy of affirmative action. Women should be sought actively for any position, and if there are two equal applicants there should be a strong possibility that the woman will be chosen. Maternity leave, child care and training opportunities are critical. 'We need to be flexible, to support our colleagues and to be affirmative in our actions to promote women into senior positions.'

## BARRIERS: STRATEGIES TO OVERCOME THEM

Mrs Fay Marles, AM



**Mrs Fay Marles**

*Medical women must support each other, act as catalysts, be part of female support networks and become involved in medical administration and politics.*

Mrs Marles is Deputy Chancellor of The University of Melbourne; Chairperson, Management Committee, Key Centre for Women's Health in Society; and Vice-President, Alfred Group of Hospitals. She returned to studies in her forties, lectured in Social Work, and in 1977 was appointed Victoria's first Commissioner for Equal Opportunity. In 1978 she spent nine months chairing the Study of Professional Issues in Nursing. She has four children.

Mrs Marles described herself as having acquired a new identity – whilst chairing the nursing study she became a 'non-nurse' and 'Today, I feel very much a non-doctor . . . my remarks are being made specifically from the vantage point of an observer of the health care scene and a consumer of its services.'

It is crucial for women to increase their participation in all areas and at all levels of medicine, she said. Many women prefer doctors of their own sex – they are more understanding and, as carers, have particularly valuable attributes. Society and the profession cannot afford the systematic under-utilisation of women doctors.

Societal structures impede the progress of women in medicine – they must become superwomen, attempting to perform traditional social as well as professional roles. Most successful women have a supportive spouse, have chosen not to have a spouse or, increasingly, have been through the Family Court!

Attitudes change slowly, she commented, referring to a recent study of students in two single-sex private schools which showed that boys still have the sex role expectations of the 1950s, while girls express independence and assume gender equity.

Mrs Marles observed that women have a high participation rate in the medical profession, but it is often part-time or intermittent. The pattern of professional progression makes little allowance for this. In particular, the structure of postgraduate medical education presupposes no family ties until the practitioner's mid-thirties; or dedicated family support and the freedom to pursue a career without substantial

responsibilities. The Key Centre for Women's Health in Society's Graduate Diploma of Women's Health, and other courses, are beginning to redress this problem.

The medical profession has a very well-established culture, and in common with similar cultures has powerful ways of achieving conformity, excluding others, perpetuating itself and regulating change. The entry of women into the profession created unease and resentment as language modes, topics of conversation, networks and interests of close-knit male teams were threatened.

Sex roles have been identified as having an essential and, until recently, a mutually satisfying place through the doctor/nurse relationship:

*'The nurse is to be bold, show initiative and be responsible for making significant recommendations, while at the same time she must appear passive. This must be done so as to make her recommendations appear to be initiated by the physician.'*  
(Leonard Stein, 1975)

The entry of the female doctor has been one of the many destructive influences on this symbiotic relationship.

It has been said that a close-knit group can withstand the entry of outsiders up to about 15 per cent of its number before its own characteristics begin to be modified. Medical women have breached that barrier in some areas, but not in others. The increased female undergraduate intake will bring different work priorities, needs, interests, values, language forms, networks, uniform and dress – colleague relationships and customary sex roles will have to mesh.

Mrs Marles remarked that in Victoria both the Minister and the Shadow Minister for Health are women and that this must represent some progress!

How will the medical profession change? Traditionally women have been socialised not to rock the boat, and it is best that changes occur without adding to the recent assaults on medicine and without loss of morale. Education and socialisation of undergraduates is clearly important, she said, so that they in turn will contribute to the process of cultural change.

Medical women must support each other, act as catalysts, be part of female support networks and become involved in medical administration and politics. Affirmative action is not to remove competition, Mrs Marles stressed, it is to educate and establish mentors for women and enable them to become competitive for the higher positions.

## Part Two DISCUSSION

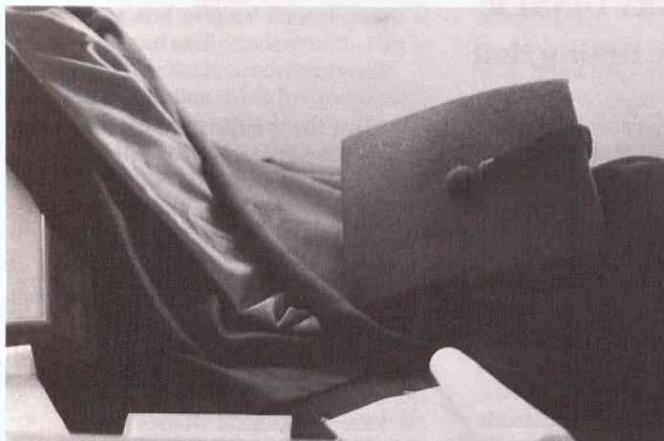
In the concluding discussion some examples of discrimination were cited, particularly relating to partnership offers. Several women asked what they should do when questions about their private lives were raised during interviews. It was commented that discrimination certainly exists in the upper echelons of psychiatry in the United Kingdom and the USA.

An anaesthetist remarked that she had found little discrimination in her work. She agreed with Professor Kincaid-Smith that it is best to complete training before having a family, but that job-sharing made it difficult to gain experience.

It was generally agreed that the sharing of experience is very important – several professional bodies have formed discussion/support groups, for example, women gynaecologists and obstetricians, and the Royal Australian and New Zealand College of Psychiatrists.

## CONCLUSION

The seminar proceedings concluded with the Convener, Professor Dennerstein, reminding the audience that they have chosen a wonderful profession and that they must continue to work together to achieve personal and professional goals. Professor Ryan followed paying tribute to the staff of the Key Centre for Women's Health in Society, the Victorian Medical Women's Society, the audience, and the staff of the School of Medicine for a highly successful seminar.



Display case and board in the Medical Centre foyer illustrating 100 years of women in medicine.



Dame Ella Macknight, graduates and friends in the Ormond College dining hall.

## THE CENTENARY DINNER Ormond College Dining Hall

Professor Dennerstein warmly welcomed His Excellency the Governor, Dr Davis McCaughey and Mrs McCaughey, the Chancellor, Sir Edward Woodward and Lady Woodward, the Vice-Chancellor, Professor David Penington and Mrs Penington, the Dean, Professor Graeme Ryan and Mrs Ryan, and the two hundred guests, friends and partners to the candle-lit celebratory dinner.

The Guest Speaker, Dame Ella Macknight (MBBS 1928), a slim, dignified figure in her eighty-eighth year and doyenne of Melbourne medical women, carefully recounted

women's struggle for acceptance and equality in the medical profession. The major part of her life had been deeply involved in these history-making events and the audience listened with admiration and respect. She concluded her address with the words: 'One must hope and trust that the best traditions of service, developed from the roots put down by those who have gone before, will continue to flourish.'

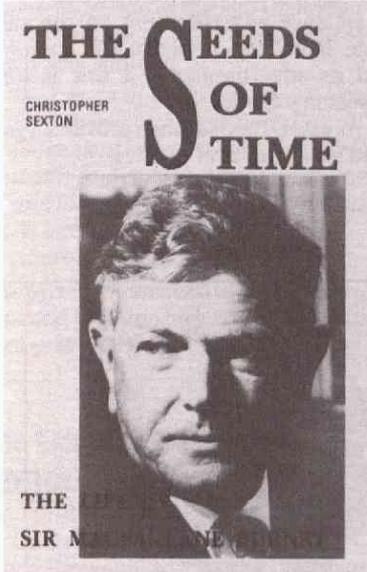
Professor Penington responded, thanking Dame Ella on behalf of the University and all those present. Professor Dennerstein

added her thanks, also paying tribute to the staff of the Key Centre, the Friends of the Key Centre and the staff of the Medical School, for the success of the Centenary celebrations.

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*The Editorial Board wishes to thank Ms Robin Orams, Co-Ordinator of Continuing Medical Education and Graduate and Community Relations, and Dr Diana Sutherland, Honorary Secretary UMMS and Secretary of the Victorian Medical Women's Society, for their generous assistance in preparing this report.*

**The Seeds of Time. The Life of Sir Macfarlane Burnet**

by Christopher Sexton  
Oxford University Press, 1991  
Hardback, pp.301, appendices, illustrated  
Rrp A\$39.95



Christopher Sexton, a young barrister and tutor in law at Trinity College, The University of Melbourne, was appointed official biographer by Mac Burnet himself and, like so many things that Mac did, he chose well. This is a well-written biography – a pastiche of narrative linking Mac Burnet's diary extracts, letters and interviews together with comments from or interviews with colleagues and friends. The result is a readable and frank account of one of this century's greatest medical scientists and original thinkers. Mac Burnet was a reticent man who originally refused to have a biography. We must all be glad he agreed to permit this biography to be written and that he chose Christopher Sexton to write it.

The sequence of parentage, childhood, education and accomplishments is standard, but the information flows easily and always interestingly. The analysis of Mac Burnet's discoveries and original contributions is simply told and easily understood – this in itself is a remarkable accomplishment.

The contribution made by Linda, Mac's first wife, is rightly recorded, for she assured his freedom to work as he pleased and eased social interchanges in which he was, for much of his life, ill at ease. In her last illness he gave her devoted care.

Numerical references in the narrative are easily found, there is a useful glossary of terms and no less than five appendices which list all Mac Burnet's professional accomplishments and give details of all his writings.

Proof-reading and editing is of high standard. However, the account of Berry and Osborne on p28 is flawed. There is an

unsupported legend that Osborne – not Berry – applied for the Chair of English as well as Physiology. Berry was never a 'second-rate physiologist' but always a superb anatomist. Interestingly enough it appears that Mac Burnet himself slipped a little in a letter to his wife (p103) in which he seems to imply that Paul de Kruif and not Sinclair Lewis was the author of *Martin Arrowsmith*. Paul de Kruif did provide background materials for Sinclair Lewis.

Mac Burnet's enormous accomplishments are to my mind delightfully summed up by Niels K. Jerne whose natural selection theory preceded Mac Burnet's clonal selection theory. Jerne commented: 'I hit the nail, but Burnet hit the nail on the head.'

This book should be in every library, public, scientific or private. Once started it will be read right through.

**Ethics, Legal Medicine and Forensic Pathology, 2nd edn**

by Vernon D. Plueckhahn & Stephen M. Cordner  
MUP, Melbourne, 1991  
Hardback, pp.371, appendices & index  
Rrp A\$85.00

In 1865 Dr James Edward Neild was appointed Lecturer in Forensic Medicine in the recently established Medical School of The University of Melbourne. Since then lectures in that subject were given by a series of incumbents, Crawford Mollison, Redford Wright-Smith, Keith Macrae Bowden, Norman MacCallum and Vernon Plueckhahn. Lecture notes for the students were produced by Mollison, Bowden, MacCallum and Plueckhahn. The latter steadily increased the scope and richness of these until in 1983 he produced the first edition of the book under review. The first edition was a fine piece of work.

In collaboration with Stephen Cordner, Foundation Professor of Forensic Medicine, Monash University and Director of the Victorian Institute of Forensic Pathology, Vern Plueckhahn, a major force in the realisation of the institute, has produced a second edition which will readily stand comparison with any other internationally known texts.

The range of subjects is appropriately wide, the writing easily understood and the colour photographs, diagrams and cartoons – Tandberg included – are all clear and relevant. Of the four appendices three illustrate the increasing complexity of problems that have to be addressed in medicine's links with the law – Human Experimentation, AMA Limited Code of Ethics, and the NH&MRC – Australian Code of Practice for Transplantation of Cadaveric Organs and Tissues 1990. The last appendix lists abbreviations of medical journals and law reports.

The book, of the high standard usually associated with MUP, is rich with references and has an excellent index. The authors are

to be congratulated. The torch of Forensic Medicine has passed from The University of Melbourne to Monash University, but it burns brightly and lightens a formerly dark area.

**Hugh Cairns**

by G.J. Fraenkl  
Oxford University Press, 1991  
Appendix, index, references, bibliography,  
Hardback, pp.296, illustrated  
Rrp A\$85.00

The biography of Hugh Cairns, the first Nuffield Professor of Surgery at the University of Oxford, is written by a former student and surgical assistant who later became Foundation Chairman and Dean of the School of Medicine at Flinders University, South Australia. It is not, however, merely a junior's tribute to a well-beloved teacher and colleague. It is a carefully researched historical document which sets a great Australian neurosurgeon into the various scenes in which he worked and gives perspective by using letters and diaries.

Hugh Cairns, of Scottish ancestry, won scholarships which took him to Adelaide High School and the Adelaide Medical School which he, aged fifteen and a half years, entered in 1912. In May 1915, he took leave of absence and enlisted as a private in the AAMC. After serving in Lemnos he returned in 1916 and despite his interrupted studies passed his examination with first class honours. In 1919 a Rhodes scholarship took him to Oxford, but in the interval he again served in the AAMC – this time as a captain.

The major part of the book tells of Cairns' training and eventual mastery of neurosurgery, greatly benefitted by associations with Sherrington, Souttar, Cushing and Russell Brain. What may be less well known is his early advocacy (1941) of crash helmets for motor cyclists. The co-operation between Florey and Cairns in using the relatively impure penicillin in treating war wounds in Africa and Sicily is well documented.

W.R. Morris, Viscount Nuffield's, generosity are recorded and an interesting event provides differing views on the relative importance of things. At a meeting of the Master of Arts working in the University of Oxford called to accept Nuffield's gift of 1.25 million pounds Nuffield rose to speak. This constituted a 'disorderly interruption' for that body as, although Nuffield was a DCL *honoris causa*, he was not an MA and not a member. No censure was expressed for he announced an increase in his grant to two million pounds! To avoid future embarrassment he was, by decree, made an MA.

At the end there is a useful index, references and a bibliography. An appendix, which is really a treasure, gives descriptions of places and succinct biographical sketches of people linked with Cairns. This frees the

narrative and enhances the value and interest of the book. Descriptions of hospitals, Oxford, Balliol College and Banbergh include information of the people who worked and lived there. As might be expected, biographical notes of Osler, Cushing, Sherrington and Eisenhardt are given, but vignettes of Australians James Barrett, Harold Dew, Charles Kellaway and Hugh Trumble also appear.

Snippets of information which might come in handy at dinner parties or games of Trivial Pursuit abound: for example, the explanation of stars tattooed on the shoulders of Le Gros Clark or the nature of Unity Mitford's suicidal gun-shot injuries, their relationship to Hitler and to her death some ten years later.

The book is well produced and the illustrations generally clear and appropriate. The price, \$85, is high, but a discount is advertised. Moreover, the price is about a third of many standard medical texts much less interesting to read. Buy the book for the pleasure it can give and for its importance in medical history.

### Malignant Mesothelioma

Eds. DW Henderson, KB Shilkin, SLeP Langlois, D Whitaker  
Hemisphere Pub.Corp., NY, 1992  
Hardback, pp.383, illustrated

Mesothelioma is a malignancy closely linked with exposure to asbestos and it is likely that Australia now has the highest incidence in the world of this asbestos related tumour.

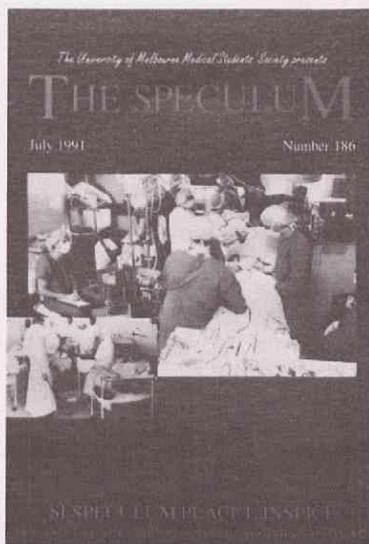
The reasons for drawing the attention of readers of *Chiron* to *Malignant Mesothelioma* are that this is an Australian book, published in America, that incorporates an excellent historical perspective and particular emphasis on Wittenoom and the blue asbestos mine there. The pathology is well surveyed, but the book is unusual in that the last section (IV) is given over to 'Social-Historical, Medicolegal, and Ethical Aspects' including the 'Bioethics of Industrial Activity and Disasters'.

I believe this book is an historically important documentation of an industrial disaster with grave human and sociological consequences. It should, of course, be in all medical libraries but it should be read by caring doctors, industrial workers and those, including some unionists, who have grossly over-reacted.

### The Speculum 1991

This *Speculum* has a modern surgically oriented cover in keeping with the sponsorship by the Medical Defence Association of Victoria. Inside there are useful topical reprintings of former *Speculum* articles on Syd Sunderland and Pansy Wright on their appointments to their chairs. Set in sepia tones there is also a well-collated tribute to Pansy by the editor Malachy Tarpey.

This seriousness continues in a review of the psychological impact of 'the first dissection experience' but is quickly lightened by accounts of 'Med Medleys' and



the annual report from President Simon Williams of the MSS.

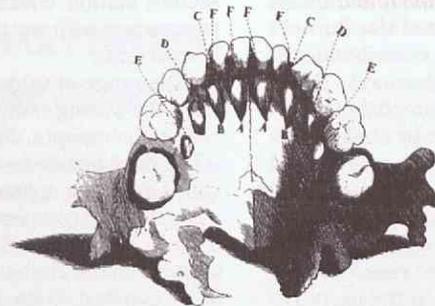
Two excellent articles on electives in Micronesia and India are provided by Chris Jackson and Martin Gallagher with appropriate and sometimes moving photographs. The article 'The road not taken' – based on Robert Frost's poem which is reprinted – is unusual in that the writer is a Queensland graduate and the substance is the advantages of the Defence Force Undergraduate scheme. Any reader interested can immediately apply to join up as there is a Department of Defence advertisement on the same page. In my experience of *The Speculum* and its advertisements, a first is for a Vasectomy Clinic.

As usual, *The Speculum* provides a good read for a variety of readers.



## A CENTURY OF DENTISTRY NOW ON SHOW

This first exhibition for 1992  
has been prepared by  
Professor Henry Atkinson  
Professor Emeritus of Dental Prosthetics  
and traces the history of  
institutions, teaching, training and techniques  
over the last hundred years  
in Victoria



The Medical History Museum  
2nd Floor, Brownless Medical Library  
Enquire at desk for entry.

## Geoffrey Royal Prize in Clinical Surgery

The Medical Staff Group at the Geelong Hospital have established the Geoffrey Royal Prize in Clinical Surgery in commemoration of the late Geoffrey Royal's contribution to the teaching and practice of surgery.

*He was an outstanding surgeon and his surgical technique and clinical judgement were exceptional . . . He was a source of great encouragement and inspiration to medical students. As a teacher he was unsurpassed. (Chiron 1991, Vol.2:4, pp.70-71.)*

The prize commenced in 1991 and was awarded to Karen McKertich, 1991 top final year MBBS student.

## Mr David Brownbill honoured

On 14 February 1992, HE The Governor, Dr Davis McCaughey, presented Mr David Brownbill with the 1991 Advance Australia Award for Medicine. Mr Brownbill has been head of Neurosurgery at The Royal Melbourne Hospital since 1974. The citation reads:

*It is through the vision and perseverance of Mr Brownbill, giving an example to Australians to support and encourage talents within this country, that the Stroke Research Foundation was established in the late 1970s. Later, in 1988, at The Royal Melbourne Hospital through the Stroke Research Foundation, The Higginbotham Neurosciences Research Institute, of which Mr Brownbill has been appointed Founding Director, was formed. This Institute now provides the facilities for wide ranges of research into diseases of the nervous system, including tumours and stroke, and into the basic science and mechanisms of brain function which must be understood fully for the causes of disease and malfunction to be found and treated . . . The dedicated contribution by Mr Brownbill in establishing this research facility and his continued energy and commitment to the organisation and funding of the Foundation and the Institute have been outstanding.*

## Plastic surgeon Victorian of the Year

Mr Bernard McCarthy O'Brien, AC, CMG, was named Victorian of the Year. Founder and Director of the

Microsurgery Research Centre and Plastic Surgeon, St Vincent's Hospital since 1975, Mr O'Brien was appointed Companion of the Order of Australia in 1991. In the same year, the Melbourne Rotary Club honoured his work with the 1991 Vocational Service Award. Mr O'Brien is Consulting Plastic Surgeon to the Mercy Hospital for Women, Geelong, Dandenong and Williamstown Hospitals, and to the RAAF.

## Bob Bennett retires as Honorary Secretary/Treasurer of the AMA Arts Group (Victorian Branch)

*. . . nominations are invited for this rewarding position. Maybe the next incumbent will not wish to remain in the position for thirty-two years!*

Thus Dr W.R.C. (Bob) Bennett announced his retirement from these positions at the opening of the Group's 32nd Annual Exhibition at the Victorian Artists Society, East Melbourne on Sunday 22 September 1991. Bob has held both offices, as well as being President for some years, since the Group's inception in 1959, when Morris Davis was its enthusiastic first President. With a particular interest in watercolour portraiture, Bob has also exhibited in every successive annual show.



As Director of Radiology at the Preston & Northcote Community Hospital, Bob runs a 'state of the art' department. He is pictured here with his sculpture, a bust of his friend and colleague, the late John Bernard Fethers (MBBS 1949), Senior Consultant Surgeon at PANCH. The sculpture, entitled 'Between patients', was later cast in bronze and has pride of place at the entrance to the surgical ward of the Hospital.

Bob's more recent contribution to the Art Group's activities was a lecture, *Influences, images and imaging*, a two-screen presentation of some 160 images exploring talents and influences, and examining the arguments about the effects of genes and the environment.

## Professor T.J. (Jack) Martin awarded Dale Medal for 1992

The Dale Medal is the highest accolade bestowed by the Society for Endocrinology and is awarded annually to a member of the scientific community in recognition of outstanding studies which have changed the understanding of endocrinology in a fundamental way.

Professor Martin is Professor of Medicine, St Vincent's Hospital and Director, St Vincent's Institute of Medical Research. In March of this year he delivered the Dale Lecture to the Eleventh Joint Meeting of the British Endocrine Societies, held in Harrogate, England. He was also awarded an Hon.MD from the University of Sheffield.

## A Reunion of Hospitals The Melbourne-Cleveland 1992 Reunion Symposium 25-27 March 1992

1992 marks the 50th anniversary of the occupation of The Royal Melbourne Hospital by the Fourth General Hospital of the United States Army.

The occupation of an entire hospital is unique in Australia's history. Following the bombing of Pearl Harbour in 1941, the US Surgeon-General invited the Fourth General Hospital to set up the first United States Armed Forces General Hospital overseas, as it had done in the First World War. On 26 February 1942 the unit, staffed with physicians, nurses and five hundred enlisted men, arrived in Melbourne to care for American and allied troops. After temporarily camping in Royal Park (Camp Pell) the Hospital moved into the partially completed new Royal Melbourne Hospital in April, initially occupying the Nurses Home and then, on 12 May, took over the main building.

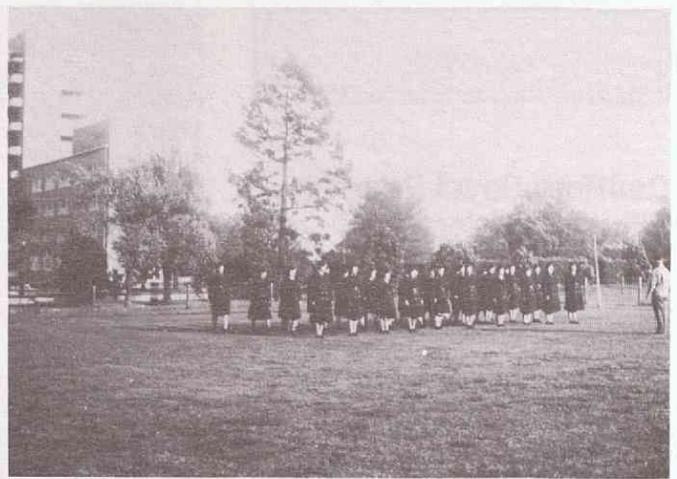
For two years the hospital was stationed in Melbourne as the major United States Base Hospital for the South Pacific. It received casualties from Guadalcanal, New Guinea and other islands. For months over two hundred patients were admitted each day and, at any one time, there were up to two thousand in-patients in the hospital and in tents on the surrounding University High School grounds.

The medical nursing staff of the hospital was recruited from Cleveland, Ohio, with the majority coming from the University Hospitals of Cleveland, and was supplemented by Australian physiotherapists and secretaries. The medical staff also helped teach students as The University of Melbourne Medical Faculty was depleted by war service.

When the medical staff returned to Cleveland they established a scholarship to enable graduates of The Royal



Cow & Pig Market gate, 1942.



American nurses parading — site of future Medical School, 1942.



RMH, building in progress, 1941.

Melbourne Hospital medical school to receive further training at the University Hospitals of Cleveland. Since 1948, twenty-two graduates – the first of whom was Peter G. Jones (now MDAV Councillor and Co-Editor of *Chiron*) – have received postgraduate experience in Cleveland. A reciprocal scheme in Melbourne has also been established.

To commemorate this anniversary The Royal Melbourne Hospital and associated institutes, The Walter & Eliza Hall Institute of Medical Research and The University of Melbourne, hosted a special medical symposium for three days in March 1992. The symposium focussed on the challenges of the future – the role of university hospitals, the finances and politics of the delivery of health care, the best utilisation of new developments in medicine, and medical ethics. In addition concurrent workshops discussed more specialised areas in detail.

The Symposium was opened by HE The Governor, Dr Davis McCaughey, who was followed by two octogenarian veterans, Dr Elden Weckesser, Emeritus Professor of Surgery in Cleveland and Sir Sydney Sunderland, Professor Emeritus of Anatomy in Melbourne, who gave entertaining and informative accounts of Melbourne and The Fourth General Hospital fifty years ago. Symposia

speakers from Australia included Sir Gustav Nossal, Professor Emeritus Richard Lovell, Professor Stephen Leeder, Dr Diana Horvath, Dr Nigel Gray, Mr Stephen Duckett and Mr Peter G. Jones. Some fifty-six Australian and twenty-nine American graduates took part in the concurrent workshops.

The social program – The Australian-American Association Welcome Reception, The Royal Melbourne Hospital Great Reunion Concert featuring the remaining members of the Glenn Miller orchestra, and the 40s Nostalgia Dinner (both held at the Victorian Arts Centre) – was attended by over 200 participants and friends

including three of the seven Melbourne graduate physiotherapists who worked in the otherwise all-American hospital – Mrs Joan Gabb (nee Hallam), Mrs Shirley Martin (nee Vines) and Mrs Mary Wood (nee Walman).

An historical exhibition of the history and building of the Hospital at Parkville, its occupation by the US Army Fourth General Hospital and the continuing association with exchange Fellowships between The Royal Melbourne and University Hospitals of Cleveland, provided interest to all, with both photographs and video presentations highlighting the days of the Second World War.



L-R: Shirley Martin, Mary Wood, Joan Gabb and Dr Elden Weckesser, 1992.

## Harry William Garlick, AM, MBBS 1941 1917-1991



HARRY GARLICK

FOR AN EXEMPLAR of a post-Second World War general physician, one need look no further than Harry Garlick. It would be difficult to identify what he was and what he did in any pithy statement of this all-rounder; fine physician, excellent teacher, effective committeeman, staunch friend; he was all of these – and more.

After a distinguished medical course in which he gained honours in most subjects, and graduating with honours in medicine and surgery, he joined the RAAMC, AIF and was posted to New Guinea with the 13th Field Regiment RAA. His experiences there were mainly as a tiro surgeon which seemed likely to be his future career; but circumstances determined otherwise. He would indeed have become a notable 'operating physician'.

The six years which separated our graduation meant that our paths did not cross until some time after the war. Sir Alan Newton, then Stewart Lecturer in Surgery at Melbourne University (1947-48) – the 'Clayton's professor' as it were – with his usual perspicacity had chosen Harry to be one of the first student supervisors at The Royal Melbourne Hospital (1949-50). He proceeded MD and then went overseas for his MRCP (Lond) and enjoyed a rich clinical experience at the London Hospital (1950-51). Melbourne teaching hospitals, the AMA, and the Royal Colleges provided a friendly medical milieu in post-war Melbourne with strong academic connections. Although we worked in different hospitals, I got to know Harry well as a man clearly marked for success and influence.

By 1952 he had been appointed as an outpatient physician at Prince Henry's Hospital, a connection which continued as inpatient physician, and later Board member, until 1982. This Hospital from its humble homeopathic beginnings, had converted only from the mid-1930s to a standard general hospital, to become a teaching hospital in the Melbourne Medical School (1952), Harry's first year on the visiting staff. This revolutionary sea-change saw Harry on the bridge as one of the principal officers to set a course of great promise.

With the establishment of the Monash Medical School in 1960, and its need for clinical teaching, with generosity The University of Melbourne agreed to the affiliation of Prince Henry's and the Alfred Hospital to the new University. Harry was Dean of the clinical school at Prince Henry's (1965-68) when the first Monash students were coming on the clinical line, and the development of the University professorial Department of Medicine, chaired by Bryan Hudson was becoming established. As Foundation Dean of the Monash Medical School, with difficulties as much human as financial and logistical, I was to discover in my old friend rare qualities of sense and sensibility. He and his close friend, Bryan Hudson, were crucial in establishing a fine clinical school of high reputation at Prince Henry's; between them, they were the vital elements that established the bridge between

gown and town without which we would have floundered.

His medical career has been fully covered by Bryan in his contribution to Vol III of the *RACP Roll* to be published in the next year or two. Bryan has generously allowed me to see this entry about Harry which follows his distinguished career in detail – his membership of the Medical Board of Victoria; President of the AMA Victorian Branch, and member of Federal Council; member of the medical faculty (Monash) and part-time professor, a breakthrough as the proper recognition of the vital contribution by top visiting staff clinicians to teaching.

I remember Harry especially in our membership (and then when he was chairman) of the Hospital Accreditation Committee. I journeyed with him into what was *terra incognita*, very unsure if the natives would be indifferent or cannibalistic, to country and metropolitan hospitals that had applied to our committee for accreditation. We were usually regarded with profound suspicion but Harry, with his quick wit, searching competence and friendliness, soon disarmed both medical staff and administrators. He gave the impression, with his red-haired stocky frame, of being more of the rover than the ruck man, darting into the fray without inhibitions, with great courage and enviable effectiveness. And at dinner when the inspection concluded all went merrily with Harry's conviviality, even if at times we had to conceal the Black Cap.

On many other occasions when we sat together – AMA, postgraduate committees, faculty and so on, I was invariably impressed, and sometimes humbled, not only by his determination to find out the facts, but also by his rational conclusions and pragmatic summaries. One was aware of the understanding behind his sometimes acerbic comments made without malice: 'Now Rod,' he would pull me up, 'that is all airy fairy bullshit' – to be accepted usually as fair comment.

He was among the very best of his peer group as a bed-side teacher – knowledgeable, widely read, firmly rooted in basic studies. Not a researcher primarily, he gained insights into research from his brief experience at the RMH Clinical Research Unit under Sir Ian Wood, who had the highest regard for him. As a clinician he was the last and best of the all-rounders before the demands of hyper-specialization made it impossible to bat and bowl and field, as he did, occasionally taking the gloves. Thus he became inevitably the doctor's doctor to so many of his colleagues, and the model of one-to-one continuing education with the GPs who referred cases to him.

His hobbies were pursued with skill and gusto – lacrosse at the University (A grade); later golf and then woodwork, which in its design and accomplishment went far beyond a desultory diletantism. My abiding impression of Harry, shared by his many friends, was of his infectious enthusiasm for any cause he judged to be sensible and attainable – the art and practice of the possible.

He was twice married – first to Dr Winifred Champion, a Melbourne University graduate (1941) and they had three daughters. In 1976 he married Suzanne Gunn to enjoy 15 years of great happiness. With devotion and sensitivity she saw him through his last few years of terminal painful illness. I know it is standard lore, in

writing of one's friends, that they bore with great courage a battle with their terminal illness. In Harry's case with very painful secondary carcinomatosis from a prostatic primary, this could not be said with greater truth of him – good cheer and courageousness characterised his whole life.

Rod Andrew

## Alister A. Hinchley, MBE, MBBS 1929 1904-1991



ALISTER HINCHLEY

worked tirelessly for thirty-seven years until his retirement in 1976. Catherine wrote:

*He used to grumble occasionally, but never failed to attend any kind of call. Living in the bush meant everything from a premature baby born on a riverbank somewhere, to trips to flooded farms, problems amongst the Aboriginal community, the occasional brawl or accident – the ambulance was the back seat of his car. In the early days, surgery was performed at night when the neighbouring town doctor (usually Mark O'Brien of Jeparit) could give the anaesthetic.*

Alister Ashworth Hinchley was born in 1904 at Wangaratta, where he went to school. At The University of Melbourne his undergraduate career was active and rewarding: he was a member of the University Rifles and won a Blue; he was one of Osborne's 'apostles'. A fellow graduand was 'Pansy' Wright. 'Al' Hinchley wrote to Pansy in 1989 saying that a proposed 60-year reunion was the only sort of thing that would get him, aged eighty-five, out of 'the ease and comfort of Dimboola'.

After residencies at the Melbourne and Adelaide Hospitals, he spent two years in Meekatharra, Western Australia, before going to England. In 1932 he and Maud Arnott of Benalla were married – a marriage that lasted happily for fifty-seven years, and from it came two children, Catherine and Peter. Sadly, Peter (MBBS 1960) died in 1976. Peter had four children and Catherine (Thomson) three.

He loved the people and the countryside – each patient was made to feel important, and the way he healed people 'was not limited to the physical'. Catherine explains:

*He was a gentle man and enquiring – there were many things that made people warm to him. One seemed to learn something whether it was about humility – every baby he delivered was a miracle of life – or about scholarship or how things worked. Amongst his papers and books I found everything from the art of China (and everywhere*

*else!) to the method of embalming a body, to The Poacher's Handbook. Until his death he was discussing complex medical developments that had occurred long after his retirement.*

Alister Hinchley had given lectures to ambulance first aid classes for twenty years. He was an active member of the Rotary Club and the AMA Arts Group – his watercolours, sketches and linocut prints adorn the walls of many homes in Dimboola. He convinced the community to look after the elderly locally and in 1972 The Dr Alister Hinchley Nursing Home Wing of the Dimboola Hospital was opened by Dr John Lindell, Chairman of the Hospital and Charities Commission. In 1974 he was honoured by the Queen with the Most Venerable Order of the Hospital of St John of Jerusalem, in 1976 he was made a Life Governor of the Hospital, and in 1979 his career was highlighted when he was awarded the MBE.

Despite his 'disorders probably inseparable from old age' and compounded by myasthenia gravis, he was always admirably independent. At eighty-five he continued to four-wheel drive the Little Desert, canoe the Wimmera River, and there was his beloved bush and his watercolours. He was always generously supportive of medical colleagues – John Pickering, the present Dimboola GP, has been heard to refer to himself as 'the sorcerer's apprentice' – a great compliment to an old man. Bearded as he was in later life, Alister Hinchley could well have posed as the beloved physician in the well-known portrait 'The Doctor' by Sir Luke Fildes. St Peter's Church, Dimboola, could not hold all the mourners at his funeral service, where the hospital staff formed a guard of honour for their dearly loved colleague and wise friend.

*We thank Catherine Thomson for her letters and Harold Attwood who compiled this obituary.*

## Ann Harrison 1923-1992

THE SCHOOL OF MEDICINE records with sadness the death of Ann Harrison, Medical Librarian at the University of Melbourne from 1949 to 1983, on Thursday 13 February 1992. She joined the University of Melbourne Library Service in 1948 as Assistant Medical Librarian and was promoted the following year. Some of the highlights of her career were the establishment of the Central Medical Library Organisation (CMLO) in 1953, the opening of the new Brownless Medical Library in 1967, with its History of Medicine collection and Audio-Visual Unit, and her involvement in the establishment of a Health Libraries Section of the Australian Libraries and Information Association (ALIA). CMLO provided support for some of the smaller health libraries in Victoria, especially via a union catalogue of books and journals, and a published audio visual catalogue (1986), and attempted to centralise the collection of older books and journals in the Brownless Medical Library, the main benefit of which has been the superb collection of nineteenth and early twentieth century journals which has become a national resource. The History of Medicine collection was established with the help of Professor K. Russell and continues to be a valued resource for the study of the history of medicine, and science generally.

Miss Harrison played an important role in the management team for The University of Melbourne

Library System, and will be remembered with gratitude by many graduates as a tireless worker whose work was her whole life. Her contribution to Australian librarianship has been commemorated in the Ann Harrison Award which is given for excellence in research activities.

*Dorothea Rouse*

## **Reginald Smythe Hooper, MBBS 1933** **1909-1991**



REG HOOPER

'BOB, WOULD YOU CONSIDER taking me on as a radiology registrar?' At the age of sixty-five, the renowned neurosurgeon had decided to train in a new specialty. It was an almost unbelievable proposition, but Reg Hooper – surgeon, painter, photographer, filmmaker – a latter-day Renaissance man, was a truly remarkable human being.

He was tall, handsome and distinguished, but humility and gentleness were his strengths. Reg served with the British Army in North Africa, India and Burma, and with the 8th Army in Italy. Working close to the front-lines in the new mobile neurosurgical units, he would not have suffered gladly any obstruction from the 'top brass' – seemingly never angry, in his well-considered precise way he would quietly get results.

Whilst in military service his myriad talents developed alongside his surgical ability – he produced a teaching film on the setting up of a mobile surgical unit; he illustrated his Burma diaries with line drawings and watercolours. A number of Yugoslav partisans came under his care during this period (three later held key positions in Tito's early government) and the Yugoslav Army awarded him the 'Titolek' for his services.

Reg Hooper was born in Melbourne in 1909, the youngest of six children, all of whom died before him. His distinguished career began at Scotch College, where he was a prefect, a member of the Second Eight Rowing Crew and was awarded a scholarship to The University of Melbourne. Throughout his medical course, he achieved many honours – an Ormond Resident Scholarship, the Baldwin Spencer Prize in Zoology, Prosector in Anatomy, and he was one of the top graduates in his year. He kept up his interest in rowing and was a member of the Ormond crew that won the Intercollegiate Head of the River in 1931.

Following residency at the (then) Melbourne Hospital and gaining his MS, he was in general practice in Colac and completed the First Part of his surgical Fellowship. In 1936 Reg and Elwyn Masters (of Castlemaine) were married. Their son, Robin Edward, is an ENT Consultant

at the Alfred Hospital, and their daughter Elisabeth Mary (Krien), is a journalist.

In London before the Second World War, Reg worked at Queen's Square and then in Oxford at the Radcliffe with the great Australian neurosurgeon, Hugh Cairns. On completing his surgical Fellowship, Reg took charge of one of Cairns' mobile neurosurgical units. In 1962 he showed his affection for Sir Hugh, 'his own neurosurgical father', when he delivered the Cairns Lecture in Adelaide.

At the end of the war, Reg returned to The Royal Melbourne Hospital and, with Dr Graeme Robertson, developed a Department of Neurology and Neurosurgery. The sole neurosurgeon at The Royal Melbourne and Royal Children's Hospitals, he also accepted responsibilities for his specialty in other major hospitals in Melbourne, as well as taking calls from doctors and hospitals throughout Victoria.

Local and international recognition came, including Membership of the American Association of Neurological Surgeons, Blackfan Lecturer at Harvard, and the Jamieson Medal. A former registrar remembers his 'paternal eye', his 'flexibility of thought, a freshness of imagination, a capacity for invention and a breadth of vision'. He was the author of two successful texts – *Patterns of Acute Head Injury*, which he illustrated with his own line drawings, and *Neurosurgical Nursing*, now a collectors' item and quite the best on the subject.

After retiring from neurosurgery, Preston and Northcote Community Hospital (PANCH) did 'take him on' and Reg trained in radiology gaining the DDR (Melb) in 1978, and his MD on the basis of published works. He worked at PANCH and the Royal Children's Hospital as a sessional radiologist until in his late-seventies, when ill health deprived his colleagues of his smile, gentleness and intellectual stimulation.

The autumn of Reginald Smythe Hooper's life was full of colour, like his brilliant photographs of that season. He would have dreaded the winter of his life, which a cerebro vascular accident in December 1991 could well have led to – but he was spared that.

Elwyn, Robin and Elisabeth and his four grandchildren survive him, and they, his colleagues and friends and grateful patients will long remember this gifted, humble gentle man.

*W.R.C. (Bob) Bennett*

## **Ian Haig McConchie, AM, MBBS 1941** **1917-1991**



IAN McCONCHIE

ST HILARY'S CHURCH, Kew, could not comfortably accommodate the people who attended Ian's Memorial Service on 31 December 1991. A warm and moving address was given by John Hayward, his mentor in thoracic surgery and long-time friend.

Recently, Ian and over forty 1941 medical graduates of The University of Melbourne celebrated their 50th Reunion with a dinner, which was a most happy occasion. Ian had been the star

of that year, gaining first class honours and all three Exhibitions in the final examinations. He is remembered not only as an excellent student, but also more importantly, as a careful and compassionate surgeon, and a man with considerable skills as a physician in the chest field, dedicated to the well-being of his patients.

Because of the outbreak of war in 1939, Melbourne University shortened the medical course; the 1941 year was the first to be affected by this change. The period of hospital residency was curtailed also.

After some months at The Royal Melbourne Hospital, Ian married Marjory Sutcliffe and within weeks he was off to the war, serving in the Australian Army Medical Corps until 1946. On discharge from the Army he did his postgraduate surgical training, adding MS to his Melbourne medical degree and becoming FRACS. Later, his work was honoured in America when he was made a Fellow of the College of Chest Physicians. He had a long, happy and successful career in thoracic surgery, learning from John Hayward, a pioneer of this specialty in Melbourne. For twenty years they worked together at The Royal Melbourne Hospital, Austin Hospital and the Repatriation General Hospital at Heidelberg.

In 1966 Ian took over as thoracic surgeon at The Royal Melbourne Hospital and became mentor to six cardiothoracic surgeons. He was a great teacher as well as an outstanding clinician; students and patients remember him with affection and gratitude.

Ian was a private sort of person who never complained, and many were unaware of his personal medical problems. He suffered from severe arterial disease, requiring grafts to his aorta and lower limb arteries. Much of the time he was in great discomfort, he could not hurry, and constantly needed to be near skilled medical attention. He kept his problems very much to himself.

After retiring from the staff of The Royal Melbourne Hospital he put together his original papers and submitted them to The University of Melbourne. This gained him an MD which gave him much satisfaction; it was a distinction that recognised his broad understanding of chest disease.

John Hayward described him as '... the bravest, kindest and most generous person I have ever known.' Those of us who knew Ian would support that view of a notable doctor and noble man.

James Guest

## Henry Devenish Steward, MBBS 1938 1912-1991

*We thank Peter Ryan for his kindness in permitting the Editors to reproduce this article, which was first published in The Age Extra, p.2, 28 September 1991, with the title 'Death of a physician.'*

A GREAT AUSTRALIAN died last week. His name was Henry Devenish Steward, though everybody (including himself) called him 'Blue'. Yes, he was a redhead, or at any rate he was until he went bald. I noticed no media mention of his passing. Had he been some swindling millionaire, some cretinous goal-kicker, some pissant politician, we would undoubtedly have been favoured with a sketch of his career. Such are the values of today's Australians, and the media serve them faithfully.



'BLUE' STEWARD

War II began, when he was a young doctor just through his residency at the old Royal Melbourne Hospital (now the 'Queen Vic' hulk at the corner of Swanston Street and Lonsdale). In 1940 he sailed for the Middle East in the grand old *Mauretania*, and saw active service against the Vichy French in Syria.

Army doctors were given commissions immediately on enlistment, but to become an officer created no social distinctions for 'Blue'. He combined, like many redheads, kind heart and hot temper. On leave in Alexandria, he insisted on taking a friend, a lowly gunner, into a British club reserved for officers. A certain fame followed hard upon unwise attempts to remove him, as one British military policeman after another sank to the floor under flailing Steward fists. Court-martialled, he narrowly escaped return to Australia in disgrace.

Now he will not see next year and the 50th anniversary of the Kokoda track campaign but, enduring as stone or bronze, his book *Recollections of a Regimental Medical Officer* will remain a memorial to what happened there in 1942. His distinguished medical colleague, T.H. Ackland, calls the book the 'testimony of a man of courage, ingenuity, great professional ability and immense compassion'. It was written to pay a humble tribute to the Australian infantryman, for what he did, and what he suffered.

In the freezing rain and mud, in the days before penicillin, young Captain Steward, still in his twenties, had to cope with ghastly sucking chest wounds and limbs blown away. He had to treat malaria, dysentery and the consequences of starvation. Surgery went on under fire. 'I'll finish your job lying down,' said Steward to one wounded man, as Japanese bullets whizzed through the canvas shelter above. 'Mad if you don't, Doc,' replied the stoic patient. Steward laid his life on the line to save the lives of others.

His stories show that he never lost his sense of humour. One man, given calamine lotion for his tropical itch, returned next day to request alternative treatment: 'Every time I take that stuff I throw up.' To a man with an injured knee he gave no choice, but sent him instantly out of battle. Two of the man's brothers had recently been killed in action. 'I didn't give a damn if the Army disapproved... that man's parents were not going to lose three sons in a row.'

Under relentless Japanese pressure he had suddenly to get all his wounded back, along frightful mountain tracks. Military writing contains no more moving description than that of Steward's silent passage in the dark, through the hut where all his patients lay upon the ground, no man complaining the merciful last injection of morphine for three hopeless cases. 'The hardest thing in the world is not to flinch from the gaze of a man you know is going to die.'

'Blue' Steward's later decades of civilian practice were dedicated likewise to the compassionate exercise of his immense skill for the welfare of his patients. Ask any of them.

A couple of months ago, in a city restaurant, I had my last meal with him. Weak and in pain, this tall and still powerful-looking man needed help to rise from the table. But he didn't whinge.

God rest him!

Peter Ryan

*Henry Devenish Steward, MBBS 1938, MRACP 1947, MRCP(Lond) 1951, Hon.FRACP 1972, was born in Eaglehawk and educated at Bendigo High and Geelong Grammar Schools. In peacetime he continued to dedicate himself to the welfare of the victims of war: SMO Australian Military Mission (Berlin) 1948; Consultant, Rehabilitation of Disabled/Displaced Persons (Germany) 1949-50; CMO, Intergovernmental Committee for European Migration (Greece and Italy) 1954-56; he was the first non-European doctor appointed Medico-in-Charge of ships with Italian crews; he worked at the Out-patient Clinic of the Repatriation Department, sat on the committee determining TPI pensions, and was Director of the Royal Talbot Rehabilitation Centre, Kew 1966-1975. Between these activities and civilian practice, he lectured in pathology at The University of Melbourne 1953-54, 1957-59.*

## Rowan George Webb, MBBS 1945 1922-1991

*Life is mostly froth and bubble,  
Two things stand like stone,  
Kindness in another's trouble,  
Courage in your own.*

Adam Lindsay Gordon



ROWAN AND ANNE WEBB

put forward the view that he died of a broken heart, and no less an immunologist than Ian Mackay has conceded that this could be a factor.

It is difficult to know if the University improved him, for he enrolled in 1940 from Carey Baptist Grammar School with a record which would be well nigh impossible

WHEN Rowan Webb's death was announced, many thought that he had died from a sudden illness. On the contrary, he had bravely and carefully concealed a progressive illness which had its onset almost three years earlier shortly after the death of his wife Anne, with whom he constituted the perfect match. No less a biologist than Donald Corder has

to surpass. At Carey, he was not only Captain and Dux of the School, but also represented the school in the first team in every sport, being vice-captain of tennis, open athletic champion, captain of football and captain of cricket. Certainly it did him no harm, for in his medical course, he gained first class honours in every year and topped final year in 1945, more than justifying the senior government scholarship, and the major resident scholarship at Ormond College, which saw him through the University. Far from being an academic recluse, he entered enthusiastically into extra-curricular activities. He was known as the most generous of friends, but the meanest of full-backs. He re-created the *Ormond Song Book* into a robust and spicy anthology, and was known for his *sotto voce* witticisms and repartee throughout the course.

His professional surgical career centred round The Royal Melbourne Hospital. He was the first to be retained as a resident for five years. Though he absorbed much from many distinguished clinicians, he bore the stamp of the Coates/Ackland stable in which he had much of his surgical upbringing. He became MS(Melb) in 1949, FRCS (Eng) in 1950, and FRACS in 1952. After overseas experience at the Birmingham Accident Hospital, he served as Major (RAAMC) with the British Commonwealth Forces during the Korean Campaign. Late in 1951, he began as a consultant surgeon in Melbourne, a career which was to span forty years, and to earn him a reputation for the soundness of his judgement, the safety of his technique, and the sincerity and sympathy with which he treated his patients. So, too, was he known for the clarity and wit of his teaching and his special expertise with the diabetic limb.

Rowan took his work and obligations very seriously – himself hardly seriously at all. He was utterly devoid of ostentation. He had known sorrow and was acquainted with grief. Yet his fun-loving nature was one of his most outstanding characteristics. Equally at home with the finery of Flemington or the camaraderie of a picnic country race meeting, he was one of the most sought after postprandial speakers in town – so much so that Robert Menzies tried to interest him in a political career. He had a prodigious memory for the interests and activities of all his patients and friends. Few would be aware of the kindness he showed and help he (and Anne) gave to many sick and aged relatives, and to others to whom he had no special obligation.

The official record will show that he was an Honorary Surgeon to The Royal Melbourne Hospital from 1958 to 1972. It will not show how skillfully he acted as scribe to the RMH Graduate Society. His Newsletters reflected his deep knowledge of all his colleagues, and were models of topical interest and impish humour. He died in harness as President of that Society.

Extending Gordon's metaphor just a little – no 'Wearie Wayfarer' was Rowan Webb. What a pure liquid refreshing ale he proved himself to be!

D.G. 'Scotty' Macleish

## University of Melbourne Graduates (MBBS)

## Honorary Members

**1914:** C Cecchi

**1921:** R L Fulton, E J Hone

**1922:** F M Belz, E Kirsner, L E Le Souef, R D McKellar-Hall, I J Parer

**1923:** G B Bearham, S Finkelstein, D I Fitzpatrick, M I Ireland, E R Killmier, A D Mune, E Stevens, G A Waterhouse

**1924:** E M Ashton, J E Blewett, F E Browne, D L Camm, G A Cook, A E Dickmann, C W Farrow, R E Street

**1925:** R L Almond, B A Baker, F H Baker, B P Cass, E H Deane, P Goodman, L S Horton, G C Jago, C J McTeigue

**1926:** V Baron-Hay, J M Bonwick, H C Callagher, E L Davey, W Davis, E J Day, T Giblin, H J Ham, G M Haydon, R J Long, J A McLean, F C Middleton, M L Powell, H E Robinson, J B Simpson-Silbereisen, R E Skinner, T A Travers

**1927:** J S Bothroyd, C N Cantor, H J Ennis, E J Grieve, R H Hadley, B O Jones, B K Laverty, M Mushin, R K Scott

**1928:** T G Allen, H K Bailey, P F Brown, R J Farnbach, A Fryberg, J R Heath, R N Howard, E A Macknight, A T Park, E Sandner, D L Thomas, I O Thorburn, J Thorn, E W Turner, W E Williams, N P Wilson

**1929:** T W Carroll, T M Gilbert, T J Lee, R Munro, R H Natrass, L A Osborn, J C Reed, G H Van Nooten

**1930:** A W Baker, J H Gowland, J P Horan, R A Lewis, A A Patrick, D P Schafer, N T Schafer

**1931:** P Bartak, R J Cato, R B Charlton, K S Crouch, F J Hayden, R Hemsley, T G Hogg, N C Joel, J G Johnson, J W Johnstone-Need, A A Merritt, M M Perl, L E Rothstadt, P C Thomas

**1932:** T H Ackland, P G Dowling, K I Graham, E E Green, T E Lowe, G B Murphy, C I Williams

**1933:** K M Bowden, F Cavanagh, N A Cust, H D Drury, C A Duncan, D M Gepp, E J Green, J I Hayward, W G Holdsworth, J Jackson-Richmond, A R Kelly, L Lloyd-Green, R A Macdougall, A H McGregor, S R Peters, A J Sinclair, H J Sinn, M Starke, R A Stewart, R J Turnbull, E C Wallace, G G Watters, J C Whitehead

**1934:** E L Abrahams, W T Agar, B J Butcher, A J Carroll, I W Charles, J E Clarke, M G Cormack, E E Dunlop, H H Eddey, M Goldenberg, M M Green, A F Griffiths, M J Heseltine, C M Hopkins, J J Kenny, H V Peake, E S Peters, B K Rank, A W Richards, R M Rome, M H Troup, R Wallace

**1935:** R R Andrew, G Brosnan, T R Courtney, D J Dunn, K M Franklin, E J Gallagher, W R Gayton, A V Jackson, C P Juttner, A J King, G R Kurrle, L Langmore, N Lewis, A D Matheson, R J McAllister, W H Milroy, F J Mulcahy, F E Plarre, R J Riddell, W H Rolph, R J Salts, R Shatin, J Smibert, T H Steel, S Sunderland, B I Taft, C R Trood, H E Williams, A M Wright, N V Youngman

**1936:** T J Beresford, L L Bevan, H L Catchlove, C K Churches, F W Connaughton, T J Constance, W F Crick, K J Eager, A A Ferris, R D Ferris, Y E Fitts, M Gilchrist, L N Gollan, H W Hannah, J D Hicks, J F Hughes, T W Jenkins, C D Jermyn, H H Johnson, J F Kaw, C A Kuhlmann, L A Langley, R A Lewis, N P Long, F J McCoy, F J Moss, A J Nicholson, W H Phillips, M Pratt, M H Ryan, D N Seward, H R Smith, W E Spring, F D Stephens, F G Turner, K N Uhd, P S Woodruff

**1937:** C B Abrahams, V Brand, A G Davies, L S Davies, K J Dorney, J M Downing, A S Ellis, E Forward, J M Frew, J L Guild, W B Gray, P G Hayes, E M Hill, A R Hughes, J A Hutchings, D C Jackson, P N Jenkins, C H Johnston, C A Jones, E N Kurrle,

S G Lauricella, D R Leslie, R S Marshman, J A McAuliffe, G McEwen, E C Miller, L J Murphy, M M O'Brien, E M O'Keefe, D J Oldmeadow, N F Pescott, J S Peters, C F Pyman, H A Retallick, E P Roberts, E W Seward, K F Sweetman, L A Thomas, A F Walsh, P F Wellington, G C Wilson, M F Woodruff

**1938:** J D Bishop, B G Burbury, A J Christophers, D G Duffy, R K Edwards, C Georgeff, H B Hattam, I C Heinz, M M Henderson, J A James, H B Kay, F M Kinross, J O Lavarack, H P Mackenzie, R E Maclean, M Morris, J C Mullany, P J Parsons, W D Refshauge, A H Robertson, S Rose, B P Ryan, M Ryan, V E Sampson, R A Stanton, H D Steward, H F Tucker, R W Waddell, M H Williams

**1939:** D A Alexander, W J Alexander, A J Barnett, E V Borbidge, H R Clegg, C L Coghlan, C R Copland, R A Douglas, A N Fraser, D R Gauld, M M Gooley, V E Hollyock, H W Illingworth, K Keely, C R Laing, R F Lowe, D L Mercer, M E Meredith, H K Millikan, W R Moloney, A J Nelson, U O'Day, H C Pope, R F Read, J J Refshauge, T E Robertson, M Rohan, N Rose, D M Ross, G F Salter, W A Sanguinetti, J R Sherwin, W H Smith, E G Strahan, R F Strang, A L Thom, S D Watsford, G M Whight, B Widmer, R C Willis

**1940:** J L Bignell, K F Brennan, A W Burton, J T Cahill, A H Campbell, C H Chambers, B M Conlon, P H Davis, C N De Garis, H R Elphick, J R England, R M Farrer-Meschan, D W Fleming, A C Foley, B L Hughes, L F Irwin, S M Lusted, J G McMahan, S D Mecoles, F M Moore, L T Moran, L O Morgan, J R Morris, K N Morris, J S Murphy, N M Nicholson, F R Phillips, A E Piper, W R Rigg, F T Rose, W M Rose, J F Rutter, E D Ryan, M C Salvaris, G W Simpson, R L Sleeman, A T Smith, G K Smith, E E Spring, E K Turner, M L Verso, L Waters, D H Waterworth, H N Wettenhall, I A Wilson

**1941:** W M Barrett, T O Beatty, A C Bell, M S Benson, R P Boyle, P H Cody, J R Eley, I C Galbraith, A H Gale, B T Glanville-Hicks, L T Griffiths, J S Guest\*, L Hardy-Wilson, H Hoban, H H Jackson, E M Kenny, M M McKeown, H S Moroney, E I Morrison, A R Parkin, D M Peace, D B Pitt, D Pope, W Rosenthal, I M Seward, W L Sloss, I O Stahle, T V Walpole, I J White, M B Wheeler, A Worcester, M Zilko

## Ordinary Members

**1942:** R Chenoweth, E P Corder, D M Downing, R J Fleming, J M Gooch, G Hewitt, R A Hill, C S Richards, L V Selsey, J C Trinca, P Zerman, J C Zwar

**1943:** A Bardsley, G E Bennett, P R Brett, F P Callaghan, R M Charters, T M Cockbill, D C Cowling, O O Logan, I T Macgowan, D G Rayment, W S Rickards, A O Rosenhain, H M Shaw, M M Sussex, W E Swaney, I M Tulloch

**1944:** E L Beavis, S Brand, I B Brodrick, C J Craig, R K Doig, G A Donald, R T Galbally, A R Gilchrist, J L Howqua, J V Hurley, W J Jamieson, L L Morgenstern\*, A C Newell, R M Porter, E L Ryan, G P Ryan, A H Toyne, J F Williams

**1945:** T E Antonie, J W Barrett, A G Bignell, B E Christophers, W N Etheridge, D C Foster, R A Hayes, P E Jeffery, P G Jones, B P McCloskey, G G McCloskey, J M Piercey, T P Rowan, R D Rush, G W Trinca

**1946:** N H Colyer, W G Doig, J K Fullagar, L J Fullagar, J K Henderson, S W Hyland, D W Maginn, M J Marshall, N J Rothfield, S Troski, B Ungar, P F Williams

**1947:** J K Clarebrough, J L Connell, T H Hurley, G A Manly, J J McCarthy, J P Morris, B W Neal, P M Robertson, C D Rosengarten, K Semmens, H F Story, R W Webster, E Wong

**1948:** I H Anderson, H D Breidahl, G L Christie, G W Cooper, M E Davey\*, D C Forster, L J Hartman, J R Kelly, K B Layton,

J O Maxwell, P J Ryan, J N Santamaria, C W Wilson

**1949:** W R Atkinson, N P Bell, A G Bond, N M Cass, C Douglas-Smith, J B Egan, J R Fraser, D A Gammon, G J Groves, J D Gunter, J A Horton, J A Kelly, W H Kitchen, C F Macdonald, A D Maclean, I L McVey, A F Neal, C J Pawsey

**1950:** R M Aitchison, W R Bennett, E B Collins, T W Farrell, M T Fish, R Fowler, F J Grant, R F Harbison, H D Irish, J L James, A Liston, B E Mackay, P M McConnachie, A D McCutcheon, M H Morland, H C Newman, B M O'Brien, H D O'Brien, D W Renton, L I Taft, A R Waterhouse

**1951:** V G Balmer, L A Bishop, G W Briggs, F H Buchanan, I K Buckley, A C Clark, P R Cowderoy, M De Laine, M K Deerton, K F Fairley, D N Fearon, O M Garson, A Goldman, J J Griffin, W S C Hare, A F Hargrave, J M Henzell, S C Johnston, G E Kelley, M J Kenrick, W E Littlejohn, J H Martin, R N Matthews, J Q McCubbin, H K McLachlan, J M McLeod, J W Middleton, J E Milne, G Pattison, C R Proctor, J G Refshauge, A Salvaris, R H Saunders, P Sheil, T F Spring\*, J N Taylor, B S Vanrenen, R C Webb, G R Wigley

**1952:** J M Armour, L I Baird, P F Cosgriff, P Forsell, D J Hewat, F H Hocking, O Lipson, D G Macleish, K J McColl, B H Murphy, C B Officer, K J Owen, H M Pannifex, I A Swain\*, N K Taylor, K M Twiddy, B M Wadham, N G York, F Zaccari

**1953:** R F Bullen, P E Campbell, J D Cannon, O M Coltman, J M Court, K S Crowley\*, A M Cuthbertson, L A Fennessy, E M Franklin, J A Fuller, G S Hale, J S Hamilton, W C Heath, J W Hill, W C Lawrence, A Marshall, F I Martin, N J McCarthy, H E McKenzie, M A McKenzie, R N Mellor\*, D M O'Sullivan, M J Sanders, M Schnapp, J G Sloman, V K Spowart, D M Sutherland, G Trigg, J W Upjohn, J B Webb

**1954:** P Z Adrian, M C Canning, A J Caro, E M Craig, D M Danks\*, D P Gale, G W Harley, W H Huffam, W H Koschade, J F Macdonald, J McMullin\*, K D Muirden, C G Price, R Rosanove, P R Scott, L Simpson, B Sutherland, F A Wraight, J S Yeatman

**1955:** G L Buckwell, R G Cameron, S H Chani, N T Cheshire, W E Fabb, J E K Galbraith, D M Gee, R D Glass, R L Goffrey, K J Green, R P Gunter, L Hemingway, R W Hill, J A Horgan, P Joshua, M Kirwan, G J Little, A K Lowe, N K Mackey, J H Mitchell\*, A Owies, P Pierotti, I K Robinson, A Ross, J F Russo, B P Sawyer, G O Smith, M J West, M E Whisson

**1956:** J E Aldred, W Chin, R M Compton, J F Connelly, G A Danielson, J R Downie, J C Doyle, P R Eisen, G Freed, E R Gillies, P F Hart, D C Hodge, A D Hore, R W Howard\*, J Igra, F C Jones\*, E J Keogh, H A Larwill, J Levin, G D Lewin, R U Meyer, S F Phillips, H Reisler

**1957:** T F Acheson\*, J A Buntine, G H Capp, C I Childs, D M Conroy, J G Gibb, B S Gilligan, G M Greenbaum, I J Hopkins, T J Horgan, M A Kidson, G A Kune, J F Mainland, J J McTeigue, S Moraitis, G J Mushin, M H Ng, J G Nicholson, V N Niteckis, J E O'Donovan, J G Ogilvy, G H Rayner, J P Royle, L Slonim, W B Southwell, J H Stevenson, W G Straffon\*, B Sweet, H S Symons, G H Tippet, J R York

**1958:** F A Billson, A S Bodey\*, B G Clarke, C P Clarke, W M Donoghue, K J Hardy, J B Heinze, R B King, S W Kwong\*, E W Leake, H J McMahon, J S Robinson, P A Valentine, R Valentine, C M Williams, I E Wluka, J C Woods

**1959:** D M Bourke, R B Brown, P J Duggan, W B Essex, J D Fitzpatrick, P D Hall, G L Lipton, J Y Mathew, A C McBain, J M McNamara, G Medley, K A Rickard, I E Robertson, P S Rogers, W J Spicer

**1960:** R E Abud, C S Bennetts, J S Biggs, A M Borten, J E Breheny\*, D C Burke, P J Champion, E R Dammary, P H Francis, M G James, W A Kemp, Y C Liu, T M Long, A M Macleod, R J O'Bryan, F B Phillips, M A Pickles, J Wright-Smith, S L Yong

**1961:** R P Barkman, R C Bennett\*, R W Brown, J A Burgess, J K Chew, O R Cole, J A Corrie, P J Davies, M C Douglas, J F Garland, J C Grimwade, J R Grove, J A Hart, W F Heale, R E Hooper, R G King\*, E R Lipton, J Long, A M Lueders, G B Matthews, I F McKenzie, R W Pattinson, F M Proper,

W E Renton-Power, G L Richardson, B M Rigg, R G Robinson, J H Rush, T Rush, A L Ryan, G B Ryan\*, S Sethbhakdi\*, M Shenfield, R M Southby, J R Stockigt, N W Trezise

**1962:** R M Adie, D L Bell, R G Bell, D S B Brownbill, J F Cade, D M De Kretser, N C Diamond, K M Foster, G L Gillam, A W Harrison, V D Hunt, A Isaacs, D G Johnson, H Kranz, S K Loh, C N Luth, J M Matthews, J H Maynard, R A McCarthy, R Padanyi, J W Paton, H Pragier, I Rechtman, C R Richardson, A M Sandland\*, M E Schramm, J E Scott, E J Shaw\*, H R Shilkin, B W Smith, M M Stannard, J O Wilson

**1963:** D C Cade, D P Crankshaw, G E Duigan, P Dumbrell, I B Faris, I F Gunn, A M Jenkins, C Kibel, P A Lowe, D J Macintosh, B N Margetts, D N Mushin, D H Nye, W J Rogers, C J Smith, H G Standish, D I Stewart, J A Streeton, R A Ward, R A Weaver

**1964:** F P Alford, B P Batagol, I W Black, B J Cairns, B B Davis, J T Dowling, I D Gust, E B Heffernan, J C Holm, S Imecs, J F King, F E Mair, N L Nicholas, D J O'Donnell, B E Petersen, M R Redpath, J M Ross, G J Royal, R L Sutcliffe, E A Tomlinson, A G Tymms, R W Wade

**1965:** D A Abell, W R Adam, J C Burford, S Ceber, W G Cole, B J Dowty, M E Doyle, B G Elliott, P G Habersberger, J E Hammond, P E Harrison, M G Korman, L I Landau, P H Lee, W Leung, H M Manning, M J Martin, K M McBeth, F A Mendelsohn, D P Mitchell, J F O'Brien, R J Pepperell, N J Radford, L Rose, K W Sleeman, J F Stickland, T H Thia, G B Thomas, R J Thomas, V H Thomas, A M Van Der Knijff, K W Waldron, N D Yeomans, V Zachariah

**1966:** G J Baker, M R Brown, M F Brown, A R Clifford, C J Cox, J C Davey, L Fail, R E Farnbach, P A Faull, K J Fraser, G P Gay, T L Hee, J O King, R G Larkins, W H Leadston, J R Nave, S J O'Loughlin, L M Parr, G M Patience, A K Roberts, G C Shardey, J H Silver, A P Weldon, U Wilson

**1967:** J M Anderson, R J Bartlett, G K Blanks, J B Brennan, D G Buist, Y H Chin, B J Dawson, R W Denisenko, P C Dobson, J C Duggan, R L Eyres, D H Feiglin, P Fox, R D Gaunson, R W Gee, D M Giltinan, J W Glover, J H Iser, T Jones, E M Kermod, P M Loewy, M D Lush, J A McLeish, M E Meldrum, L Mendel, E J Miglic, G M Moran, P M Motteram, G C Mullins, E A Nash, J F Oldham, A G Ostor, M J Power, S M Ray, A M Tonkin, B M Tress, B Weiss, S J Williams, D M Wilson

**1968:** D J Andrew, A J Basham, M J Best, D M Birks, K P Birks, J M Brown, J G Buls, A J Cass, L K Cleeve, P J Collier, A M De Clifford, F P Denton, D D Elder, P J Harris, R F Haskett, S D Hogg, P W Johanson\*, M E Kemp, G D Kerr, M E Kidd, L Markman, P R Mayall, L M McBride, R F Moulds, L J Murton, R G Newnham, L J Norton, J O'Day, K Oppenheimer, J N Rattray, G D Richardson, R M Rome, F A Shann, B R Speed, D W Stoney, V Szymis, C G Tan, C P Thelander, Y M Wu, A Zimmerman

**1969:** R J Bond, N A Brinkley, P F Burke, C W Butcher, P R English, G Fell, H C Foster\*, P Grossberg, L M Harewood, R W Harper, K A Jackson, D J Kidman, R J Kuhn, N M Ludbey, M R Luxton, G D Miller, I C Mitchell, C A Morgan, D I Moss, A M Pape, H M Parker, A J Portelli, R B Rattray, L J Reeves\*, P M Rosenberg, A W Ross, F J Ryan, S M Scott\*, D Steiner, M J Sullivan, R D Ulman, D D Westmore, J M Wettenhall, R J Whiting, R Yee, G P Young, R A Young

**1970:** D A Barbaro, E A Carew-Reid, D N Chamberlain, L Dennerstein, G C Fabinyi, J Federman, R I Fitzpatrick, M E Griggs, J E Grogan, R S Grogan, Z W Gruba, P J Hammond, R T Judson, R W King, P L Leslie, M J Macdonald, G Mendelson, P Y Milne, J A Pedrotti, R C Peterson, R B Reid, A B Rossiter, J J Scally, J P Sherman, J W Stocker, G A Thompson, H L Weaver, D J Wohlfahrt, K V Woollard, R L Yewers, R W Ziffer

**1971:** A I Anderson, K E Anderson, J F Bacon, D J Butterfield, C Calandra, A H Crosthwaite, D M Gawler, J S Goldbaum, E L Green, A D Hibberd, B U Ihle, B Korman, M Lichtenstein, M J Liddell, B J Main, A F Mariani, J T Patten, R R Ragazzon, E Rothstadt, N Salanitri, J L Sanderson, G C Stribley, G J Taggart, J E Taylor, K Tiedemann, H W Tom, G A Varigos, J M Weiner, R N Westh, M J Wilson

**1972:** S N Bell, W M Beswick, J M Butler, N Christophidis\*, L E Clemens, A J Costello, M G Dobson, G A Donnan, R M Drummond, P Fineberg, J Freeman, B H Hong, A M Kalys, P A Kelly, T H Landy, J R Lazdins, G P Leilt, G J Lockrey, S E Martin, C J Meehan, Z J Minas, W E Orgill, J J Pattison, A M Perlesz, G J Pribaz, A A Rigioni, J M Russell, S Sandrasegaram, M G Soccio, R G Stillwell, I K Symington, I S Verso, M W Verso, B H Wakefield, R H White, A D Winter, M J Wisdom, A G Wise, L I Woodgate

**1973:** P M Ashton, L E Bolitho, S R Clifforth, M E Dalziel, N P Downes, H P Ewing, C K Goh, D M Hookham, R F Hunt, S B Kay, A H Kaye\*, S W Laurie, G E Littlejohn, S K Lowe, P N McDougall, P D Meese, W H Miles, J G Mullett, J Nowatka, J G Plenderleith, S Punyanyitya, P Roberts-Thompson, M R Salzberg, I Schweitzer, R J Stawell, R F Terry, F A Walker, B J Williamson, P I Wong

**1974:** M G Aizen, R C Allen, J C Beaumont, R B Brink, W F Christophersen, C M Clark, D L Copolov, J F De Campo, B R De Morton, M P Esser, R N Gibson, B S Gilbert, W J Hare\*, M I Haskett, A W Heinz, G J Hill, L Y Ho, R I Holmes, I E Humphrey, A M Lavoipierre, D A North, V Novelli, M S Skinner, J H Taylor, R M Voselis, J A Wark\*, D R Webb, H G Williamson\*, L A Woollard

**1975:** S B Baker, G J Bromwich, W B Buckley, C Cyngler, D B Czarnecki, P D Danne, G A Easton, J M Flynn, J F Gill, A Gordon, C D Hogan, J L Holmes, A K Horwood, R J Kearney\*, S W Lau, R F Lim, P F Millington, M V Minogue, A D Pattison, A C Richards, A Rosalion, E Varigos, D J Warburton, J E Woinarski

**1976:** N R Atkinson, I S Beasley, R Colahan, W G Cowell, R Fagan, A B Glover, I Goater, W J Howson, N D Johnson, T M Kostos, A S Lew, P V Lockie, A E McCleary, M Medownick, G J Mitchell, I N Olver, C S Reeves, S J Rodgers-Wilson, K C Rose, J V Rosenfeld, D Rosner, D F Schifter, S A Schnall, R J Southwell, M D Spillane, P W Tribe, D G Vivian, P D Ward, A M Zagorski

**1977:** C M Bayly, S F Berkovic, A M Brooks\*, P D Brukner, I A Campbell, L J Campbell, W D Capell, P L Champness, A J Chong, M L Christie, S M Cordner, S A Costello, M J Cotter, S M Davey, D M Dobriansky, N S Gordon\*, H J Grossman, G K Hart, J T Heywood, J S Hoare, V A Hurley, W J Kelly, B J Lichtblau, D A Lindsay, P C Lugg, M Martakis, R Mestrovic, A J Monk, J H Olver, D R Phillips, A H Ramsay, J R Salkeld, D Shan, W P Sheridan, R L Simpson, M Sovers, A J Storti, J H Tan, W R Twycross, K J Watson, A T Weerasiri, B S Workman

**1978:** D J Ames, R A Ayton, N R Bergman, E F Boyd, M G Carty, M T Chapman, A D Cochrane\*, M J Dawkins, D F Eckel\*, N A Fisher, L E Grigg, R Herrmann, T J Hodson, H F Joyce, F K Judd, P J Keppel, E M Langenegger, I D Mathieson, D W McKenzie, B F Murphy, J M Pyman, M A Rees, S D Robertson, R J Simmie, E Storey, Y Torii, A B Waterhouse, M A Watson, R F Weller, F S Wong

**1979:** L Baker, G K Barker, R E Beavis, M R Buckland, G D Campbell\*, A G Frauman, G L Leber, D P Lowenstern, A A McNab, R Oei, J J Pinkstone, R M Puy, H A Royston, R J Searle, J W Serpell, D M Ungar, A G Walpole, S G Warmington, C R Welsford, S Zalstein

**1980:** J M Adams, G P Bearham, R A Cuthbertson, T A Dillon, A L Fisher, J M Fitz-Gerald, J E Gooley, H D Goonatillake, J S Gordon, J J Hatfield, B F Kay, C J McHardy, V L Mieziis, M H Rowe, G W Self, N F Strathmore, A C Street, G E Taylor

**1981:** S W Banting, A Bendrups, R Black, D G Bolzonello, J H Briedis, R J Briggs, M F Cole-Sinclair, M J Dodd, J E Elder, D A Ellis, M C Fitzgerald, I E Gartley, J M Goddard, I D Grant, R A Hampton, R M Hemphill, D A Infeld, R A Kwiatek, H K Lou, B M Lyons, G M McInerney, C J O'Donnell, G F Opie, R M Ryan, A J Sellars, R Sheen, J A Smith, L J Smith, M J Stewart, S A Tobin, B R Tulloh, R L Wall, C L Wilson

**1982:** J M Barlow, R M Brewer, A D Cass, M F Coffey, M Coppersmith, G L Crosthwaite, R P Davies, D J Dyall-Smith, D Ernest, G M Falcone, W R Fleming, J G Fox, M I Garwood,

T R Godfrey, P H Goonetilleke, E J Green, M H Heyning\*, T J Kilpatrick, A J Landgren, A P Lawrence, M W Lawry, A F Little, I Mackay, C A McConnell, R B McCoy, H A McPherson, M T Naughton, P K Neerhut, G M Russell, J P Ryan, K H Tai, A M Walbran, G R White, O D Williamson

**1983:** M Barnes, P L Barnett, R L Basser, A Buchanan, A H Bui, C S Choong, I M Davidson, R G Doig, J R Dyer, E Fabris, R J Ferguson, P A Francis, A P Garnham, W Hardikar, A Kelly, S C Lau, M K Law, A I MacIsaac, A H Marceglla, C J Nolan, P Palasanthiran, M V Pirota, H P Rehfish, M A Rosenthal, C A Silagy, J M Tobin, K J Wade, P Wein

**1984:** C Baldi, J L Bodycomb, R J Bonwick, R M Chan, M A Daly, L M Danvers, G Garra, R P Gerraty, L Kritharides, H G Mack, A E Malatt, K C Miran-Khan, J L Newstead, M R Patrick, M A Payne, J P Russo, M J Walland, C J Worsnop, M M Worsnop, A G Yapanis

**1985:** A J Baker, D M Bolton, A G Cain, R M Fethers, V Fourlanos, C R Grant, G S Hebbard, C J Hogan, K W Horsburgh, M R Hurley, R Jacobs, J C Jamieson, O Kefaladelis, G B Mann, G J Morgan, A S Narita, H E O'Connell, J M Opie, A P Porter, A J Robertson, D Shnier, J A Silberberg, J Tsaltas, M G Veitch, S L Wallace

**1986:** F Alberico, M J Benson, R W Bills, R S Breadmore, S Chung, D G Clarke, V Cocotis, M J Fitzpatrick, J Gardiner, A B Golemo, P D Hebbard, M K Hocking, D W Keating, P W Larsen-Disney, J M Lee, J L Leong, C F Liow, R V Liubinas, S A Locarnini, A W Lowe, M J Lynch, P Mainland, W E Marshman, R P McNair, T E Merriman, J M Negri, S G Radford, M D Richardson, E Romas, V R Ross, J A Sutherland, J Swieca, S G Troupakis, M A Viney, K Wing Shing

**1987:** M C Anderson, C Andronis, J M Ayton, M F Bennett, G N Boag, F G Brown, C P Burren, G R Casper, K Chao, M L Chong, M E Colson, J P Cooney, M Cranswick, N E Cranswick, A J Davidson, J G Dezordi, F K Dickinson, G T Ellis, J Erlich, D I Fenn, A M Ferruccio, A S Gray, P A Hancock, M Hatzis, S E Hauser, C J Holmes, J L Jenkins, M Keady, M L Kelly, A D Kerwin, S M Knights, C S Lee, M N Lee, M J Leung, J Y Ma, C J Mandel, V P Mercuri, A D Merritt, J A Mullins, R M Nash, C L Ong, M A Pearl, G A Pitson, A N Purcell, B F Raleigh, J Risteviski, C L Royse, C F Royse, G A Russell, U J Russell, A J Ryan, H F Savoia, W R Seager, J F Seymour, R D Sinclair, R K Sinha, R I Sitch, J M Smith, K G Smith, A M Staughton, M Stavropoulou, C J Stern, T A Tran, C R Underhill, T M Vaughan, I Vrazas, D A Westerman, L P Williams, J K Wong, N W Woodford

**1988:** T L Alexander, D Azaredo, S M Bartle, S E Battaglia, P R Bishop, A C Chan, M J Clarke, J J Conn, J A Conway, A T Crawford, R K Dawborn, C M De Poi, F Devincintis, C P Fong, C M Fong, C J French, D J Gillatt, V J Hayes, D E Herbst, G R Hocking, A P Howard, D K Huppert, R J Ingamells, C L Johnson, B E Jones, A G Kambourakis, I H Katz, M C Killen, J A Kimmins, J L Leong, R Y Leong, H H Liem, I Lindsey, E W Lo, G R Macaulay, C M McKenzie, L Papadopoulos, H L Parker, A J Patrick, C R Pearson, C V Pham, T H Pham, J Proimos, L K Rasmussen, A P Rothfield, A B Shepherd, I J Skinner, W J Smit, P B Sparks, L J Squires, S P Stafrace, M Starr, D P Stephens, N D Stitt, C S Su, A F Tan, P Vafiadis, S W Walker, M A Watt, P T Whiting, G M Wright

**1989:** L Acevedo, C M Adami, R E Adams, P K Anderson, P D Archer, R B Auwardt, D Badov, M J Bardsley, T L Batten, E K Bekhit, F Blaher, G M Bourke, P A Carter, P S Chan, W P Chang, S M Chapman, Y M Cheong, R H Chin, G K Chopra, S N Chow, M E Craig, D J Daly, A R Davies, M D De Kretser, D E De La Harpe, J A Deague, K Denison, A J Dowling, K S Drew, T D Duke, L C Eastaugh, S G Eaton, S L Elliott, D B Fahroedin, G Fenn, P B Fitzgerald, V M Fitzgerald, J A Gall, L R Geron, D Giannakopoulos, B F Glassenbury, B B Goh, C L Goh, P J Guiney, R Guneva, B D Gunn, A L Hamilton, R H Haslam, I R Hogarth, J Horvat, R G Howard, S S Huang, K L Jones, A D Jowett, M A Kainer, J Katsoris, J Katsoulis, S L Keeling, S M Kennedy, S Khoo, P T King, A Kipouridis, R M Knafelc, Z Koutsogiannis, C S Lai, H C Lai, H C Lau, C R Lawson,

T A Lazzaro, T T Le, S C Lim, P V Mackey, J C Mather, F L Maughan, R J McMahon, J Melick, A J Mikkelsen, F N Milne, D J Mitchell, R Mocellin, S M Moore, G W Moritz, P C Morris, C H Ng, A E Nicholson, S Nuon, K E O'Leary, E A Oakley, J W Orchard, S C Parnham, D R Patrick, C J Payne, J J Pereira, H L Peters, T S Phang, M G Plastow, L B Poon, M C Poon, K M Prince, S I Proper, E Rapoport, C Rassias, M L Rawson, K O Read, D J Richardson, A Roscioli, E W Ryan, G M Salvador, J M Sandbach, L M Schachter, S Sewak, A C Silvester, S R Skinner, N R Smith, B Sofield, J M Stewart, J C Su, M Tam, M P Tassone, A J Tauro, A P Thomas, B M Thorn, A E Tobin, J J Torr, S J Trethewie, F M Tso, I Tumewa, A L Vance, A G Waldron, C M Ward, C L Wells, E B Whan, P G Wolf, C Xenos, A Zahirovic

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Who knows these icecream eaters? The year is 1925 and they've just finished the physiology exam. The place is Luna Park, the pilot is 'Pansy' and Alister Hinchley is third from the left – who are the others? The Faculty thanks Dr John Pickering of Dimboola, who kindly sent this gem to add to our collection.



Poachers?



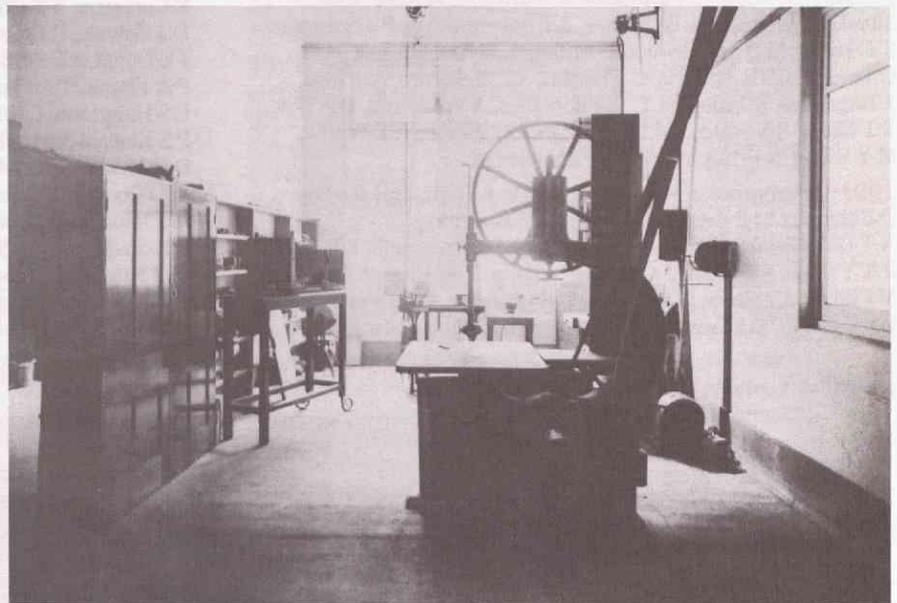
The Professor of Anatomy Retiring Room.

## From Our Collection

A photograph album is of most interest to its owner. If the owner is dead it may remain sterile unless something about the owner is known. Similarly, a single photograph may take on great significance when a story can be told about the recorded situation. A photograph album and a photograph of two men are recent acquisitions to the Medical History Unit collection.

The album was transferred from the Anatomy Department and has a 1909 plan of The University of Melbourne as its frontispiece – it almost certainly belonged to 'Dicky' Berry and the photographs most probably were done by Mr Preston. Among the contents is a set of small proofs of illustrations for Berry's *Clinical Atlas of Sectional and Topographical Anatomy*, published in 1911.

A photograph of the 'Professor of Anatomy Retiring Room' has, on its wall, a photograph of George Britton Halford and, over the fireplace, a photograph, probably of Sir William Turner, Professor of Anatomy in Edinburgh (1867-1903) with whom Berry had worked. Turner had done anthropological work on skeletons and skulls from the 'Challenger' expedition and may well have influenced Berry in the work he was to do in Melbourne. The 'Retiring Room' looks staid and quiet. Yet the peace must have been frequently shattered by Berry's expostulation 'That bugger Barrett!'



The Workshop.

Turning the page, there is the 'Workshop', in sepia tones. The major feature is a huge band-saw which must have been used to cut the large sections of cadavers from which the sectional atlas was created, depicting what now can be seen more readily and gently by the CAT scan. It is also recorded that during a demonstration something went awry with the saw and produced a different but probably equally vehement expostulation from Berry.

The single photograph of two men gazing admiringly at a goodly catch of fine fish spread out on a lawn, was presented to the collection by Dr John C. Trinca. The two men are Cyril Croke and Peter MacCallum – the fish are trout and the

year is 1930. So what? The fish had been poached! Using skills learnt in dealing with barbed wire entanglements in the 14-18 war, entrance was easily gained to a reservoir. Croke and MacCallum and the photographer, Alfred John Trinca, fished happily and successfully during the night and, not surprisingly, recorded in the morning their fine catch. Other similarly obtained catches went unrecorded. For another reference to 'activities . . . of a questionable nature, such as clandestine midnight excursions into forbidden waters', see *Chiron* Vol.1, No.5, 1987, in The Trinca Family section of 'Medical Genes', p.24.



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# Dates to Remember 1992

## Continuing Medical Education

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### Friday and Saturday 13-14 March

*Psychiatry for non-psychiatrists: mood and anxiety disorders*  
Venue: Austin Hospital  
Directors: Professor Graham Burrows and Associate Professor Fiona Judd

### Wednesday to Friday 29 April – 1 May (Course 1)

### Wednesday to Friday 28-30 October (Course 2)

*Radiography for general practitioners*  
Venue: Essendon and District Memorial Hospital  
Director: Professor Emeritus Bill Hare

### Friday and Saturday 15-16 May

*GP refresher course in ophthalmology*  
Venue: Royal Victorian Eye and Ear Hospital  
Director: Associate Professor Hector Maclean

### Friday and Saturday 26-27 June

*Common problems in neurology for the general practitioner*  
Venue: Austin Hospital  
Director: Dr Sam Berkovic

### Friday 31 July

*Common problems in the elderly – new treatment options for general practitioners*  
Venue: The Royal Melbourne Hospital  
Directors: Dr Leon Flicker and Dr Jenny Schwarz

### Friday 14 August

*Management and diagnostic dilemmas in gastroenterology*  
Venue: St Vincent's Hospital  
Directors: Professor Neville Yeomans and Associate Professor Chris Martin

### Wednesday and Thursday 26-27 August (Optional intensive course)

### Friday and Saturday 28-29 August (Lecture program)

*Common problems in paediatrics for general practitioners*  
Venue: Royal Children's Hospital  
Directors: Professor Peter Phelan and Dr Max Robinson

### Friday and Saturday 4-5 September

*Update on surgical procedures in general practice*  
Venue: The Royal Melbourne Hospital  
Directors: Mr Rodney Judson and Associate Professor Doris Young

### Friday 23 October

*Molecular biology – an update for clinicians*  
Venue: St Vincent's Hospital  
Directors: Dr Matthew Gillespie, Dr David Findlay and Professor Jack Martin (Patron)

## Dean's Lecture Series

**Tuesdays at 5.30 p.m.**  
**Sunderland Theatre**  
**Ground Floor, Medical Building**  
**The University of Melbourne**

*The Dean's Lecture Series is designed to illustrate current research and topics of interest in the fields of Medicine, Dentistry and Health Sciences. Interested students and graduates are invited to attend.*

### 17 March

*Physiotherapy – movement for life*  
Professor Joan McMeeken, Head, School of Physiotherapy.

### 31 March – 58th Beattie Smith Lecture

*The violent society and mental health*  
Professor Beverley Raphael, Professor of Psychiatry, University of Queensland, and Director of Psychiatric Services, Royal Brisbane Hospital.

### 14 April

*Cancer research, cell surface receptors and cytoskeletons – a photophysicist's delight*  
Professor Bill Sawyer, Department of Biochemistry.

### 28 April

*Forensic odontology: planning for the unimaginable disaster*  
Dr John Clement, School of Dental Science.

### 12 May

*Recent advances in interventional radiology*  
Professor Oliver Hennessy, Director of Medical Imaging, Austin Hospital.

### 26 May

*The development of plastic reconstructive and hand surgery and the Australasian connection*  
Professor Wayne Morrison, Department of Surgery, St Vincent's Hospital.

*This will be followed at 6.30 p.m. by the 1992 Annual General Meeting of the University of Melbourne Medical Society.*

### 9 June

*Birth – miraculous, mysterious or mechanistic?*  
Professor Shaun Brennecke, Director of Perinatal Medicine, Royal Women's Hospital.

### 23 June

*Contemporary threats to adolescent health*  
Professor Glenn Bowes, Director of Adolescent Health, Royal Children's Hospital.

### 7 July

*The future of cardiac surgery – was William Harvey correct?*  
Professor Brian Buxton, Director of Cardiac Surgery, Austin Hospital.

**Seminar: Dean's Lecture Series**  
**Friday 17 July – 2.00 p.m. to 5.00 p.m.**  
**Looking after ethics – a decade of change**