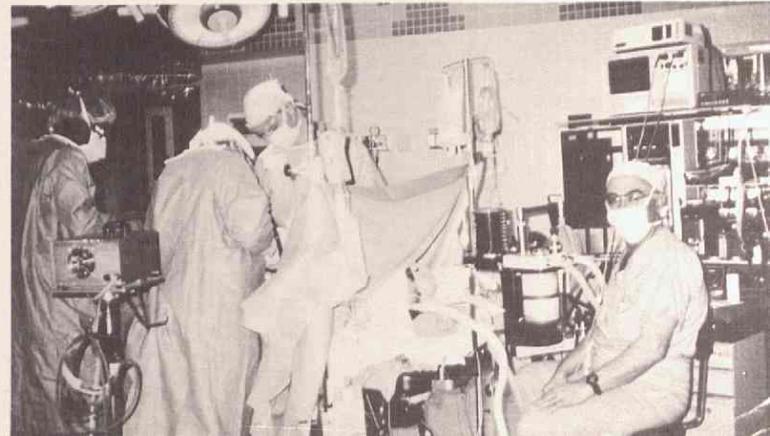


CHIRON

JOURNAL OF THE UNIVERSITY OF MELBOURNE MEDICAL SOCIETY VOL. 3 NO. 1 APRIL 1993



UMMS

University of Melbourne
Medical Society
As at 1 March 1993

President

Prof. Emer. Sir Sydney Sunderland

Executive Committee

Chairperson

Professor Gordon Clunie

Deputy Chairperson

Professor Graeme Ryan

Honorary Secretary

Dr Diana Sutherland

Honorary Treasurer

Mr David Westmore

Dr Lorraine Baker
Dr Andrew Rothfield
Mr Michael Wilson

Chiron

Editors

Mr Peter Jones
Mrs Maggie Mackie

Editorial Board

Prof. Emer. Harold Attwood
Mr Darrell Mead
Ms Robin Orams
Professor Graeme Ryan

Design

Mrs Maggie Mackie

Editorial Assistant

Ms Liz Brentnall

Typesetting

Fingers Typesetting, Box Hill

Printing

Capitol Press Pty Ltd, Box Hill

Enquiries

University of Melbourne
Medical Society
School of Medicine
The University of Melbourne
Parkville 3052

Telephone (+61 3) 344 5888

Facsimile (+61 3) 344 5998

Acknowledgement

UMMS is grateful for the continuing generous support of the Medical Defence Association of Victoria in sponsoring *Chiron*.

CHIRON

Vol. 3 No. 1

Contents

April 1993

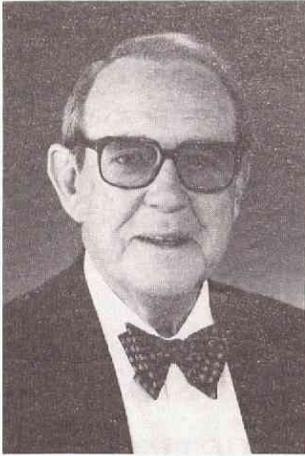
- 1 Editorial *Peter G Jones*
- Dean's Lecture Series**
- 2 • Seminar - Looking After Ethics - A Decade of Change
*Prof. Emer. Richard Lovell,
Prof. Ross Kalucy, Mrs Jean McCaughey,
Rev. Dr Norman Ford, Mrs Loane Skene,
Dr Paul McNeill, Prof. Richard Smallwood,
Ms Robyn Layton*
- 18 • Contemporary Threats to Adolescent Health *Prof. Glenn Bowes*
- 20 • The Development of Plastic Reconstructive and Hand Surgery
and the Australasian Connection *Prof. Wayne Morrison*
- Faculty of Medicine, Dentistry & Health Sciences**
- 23 • From the Dean *Prof. Graeme Ryan*
- 26 • Clinical Schools
Austin Hospital & Repatriation General
Hospital *Assoc. Prof. Bernard Sweet*
The Royal Melbourne Hospital & Western
Hospital *Assoc. Prof. Robert Moulds*
St Vincent's Hospital & The Geelong
Hospital *Assoc. Prof. Wilma Beswick*
- 27 • Final Year MBBS 1992 - Top Student
- 28 • Prizes & Awards 1992
- 29 • Graduate List 1992
- Retirements
- 32 • Electives
Leprosy in Vietnam *Russell Gruen*
- 35 • Perspective Pursuit *Alexander Pitman*
- 40 • Department of Public Health &
Community Medicine *Prof. Hedley Peach*
- 43 Books *Prof. Harold Attwood*
- University of Melbourne Medical Society**
- 47 • Notice of Annual General Meeting 1993
- Minutes of Annual General Meeting 1992
- 48 • Reunions
- 52 • Obituaries
- 58 • Reunion Announcements
- Magazine**
- 59 • Medical Genes - Then and Now *Maggie Mackie*
- Not Just Doctors!
- 60 • Artists Galore - The AMA Arts Group *Bob Bennett*
- 62 • Just Jazz *Noel Cass*
- 63 • Harold Fabrikant - A Harmony of Interests *George Szmukler*
- 64 • Medical History Unit *Prof. Harold Attwood*

Acknowledgements: The Board thanks all contributing UMMS members and Faculty staff who assisted with production; the Photography Section, CSHE of The University of Melbourne; and Drs David Amor (Rabaul Hospital, PNG), Nadine Eazard (Bolivia), Russell Gruen (Vietnam), Sue Morgan (Prem Sewa Hospital, India), Alexander Pitman (USA), and Peter Roberts (Kapura Hospital, PNG) who generously provided electives photos for the front cover.

Further copies of *Chiron* may be purchased from the Faculty Office at \$10 each, plus \$2.50 postage and handling in Australia.

ISSN 0814-3978 Copyright © 1993

EDITORIAL



Mr Peter Jones

THERE HAS BEEN some discussion recently about the 'internationalisation' of The University of Melbourne. One of the most basic expressions of this phenomenon, for anyone who graduated before 1950, has been the emergence of a multicultural Australia and the integration of overseas-born students into the life of the University. At the forefront is the School

of Medicine, with its substantial numbers of overseas-born undergraduate and postgraduate students and its outstanding international reputation in research.

During the past fifteen or so years, there has been a very significant change in the profile of students entering the medical course – approximately 60 per cent were either born overseas or have one or two migrant parents; and for about 20 per cent of students, a language other than English is spoken at home. The School is proud of the achievements of its refugee students – commonly having survived amazing deprivation and hardship – who had completed or nearly completed medical studies in other countries and have been admitted part-way through the course under the University's Special Admissions Scheme. A full-fee paying program accepting an average of 30 students a year has replaced the recently phased out government subsidy for overseas students.

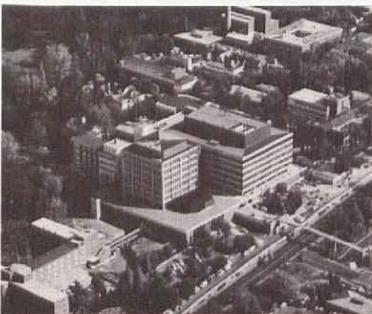
The Medical School has a flourishing Overseas Medical Students Society (OMSS – membership is open to all medical students), which publishes *The Alternative*, a lively journal comparable to *The Speculum*. Their office sits alongside the Medical Students Society in recently refurbished rooms in the lower ground floor of the main Medical School building. Students for whom English is a second language, are encouraged to attend the bridging ELICOS courses (English Language Intensive Courses for Overseas Students) at the Horwood Language Centre, which was established on campus some twenty years ago.

There are several strands in the process of internationalisation, which is, desirably, a two-way street. The School has an electives policy that encourages final year students to pursue both career and cultural interests in accredited overseas hospitals or other health-related settings. The choice has led to a much broader awareness of the world at large – a 'global' village we are told – and our students have emphasised that point in village communities, as well as in major cities, in Africa, Europe and Asia. In this issue *Chiron* publishes two electives reports – Dr Russell Gruen on 'Leprosy in Vietnam' and Dr Alex Pitman's 'Perspective Pursuit', a critical essay on being a student, intern and resident in the United Kingdom, Canada and the United States. Beginning in 1993, three UMMS Electives Essay Prizes are being offered and the prize-winning essays will be considered for publication in *Chiron*.

So what do Melbourne students learn from an elective abroad? The answers are as numerous as the people and places, but a central core of experience seems to include an increased self-reliance and self-discipline, especially in adverse circumstances, a sharpened awareness of criticisms of Australia and Australians, a broader perspective of health, disease and the economics of health care, and the fact that medicine is and always has been at its best when conceptualised and practised *sans frontiers*.

Despite our predominantly European origins, Australia is undeniably South-East Asian in geographic terms, but regionality is as much a cultural, historical and emotional matter as it is topographical. Australian medical schools have always had the advantage of opportunities for postgraduate experience in the UK and the USA, although this is becoming more difficult with the development of restrictions in immigration, quotas of medical graduates and approved training posts, and recognition of time spent in training. It is no bad thing that just when postgraduate posts abroad are becoming limited, there is an increasing number of opportunities opening up for undergraduate experience in other countries. The University as a whole is particularly interested in its international position in higher education and the Medical School is playing its part in encouraging students to take advantage of overseas experience and in providing excellent programs in Melbourne for overseas undergraduate and postgraduate students.

Peter G Jones



Mea culpa?

Full marks to those (Austin Hospital staff excluded) who noticed that the *Chiron* gremlin, *G. malevolens parkvillii*, var. *inversio*, had flipped last year's front cover, turning the Austin Hospital in an amazing direction. Not satisfied, inside the covers, watches were mysteriously moved to righthand wrists!

An elephant stamp to the correspondent who addressed his letter to 'Mrs WACKIE'.

Maggie Mackie

This is the *real* Austin Hospital.

SEMINAR 17 July 1992

LOOKING AFTER ETHICS - A DECADE OF CHANGE

Convener

Professor Emeritus Richard Lovell, AO

Professor of Medicine, 1955-83

Former Chairman NHMRC Medical Research Ethics Committee

PROGRAM

AT THE CENTRE

Developing a national approach:

The Medical Research Ethics Committee of NHMRC, 1982-1991

Professor Richard Lovell.

The preparation of guidelines

Professor Ross Kalucy. Professor/Director, Psychiatry, Flinders University; Deputy Chairman, Australian Health Ethics Committee of NHMRC.

WHERE DECISIONS ARE MADE

Being on an Institutional Ethics Committee:

A lay person

Mrs Jean McCaughey. Research Fellow, Institute of Applied Economic & Social Research, The University of Melbourne (1967-77); Research Fellow, Australian Institute of Family Studies (1981-1985, 1990-1991); Member of the Board of Management (1971-1986) and Member of the Ethics Committee on Research (1975-1988) The Royal Melbourne Hospital.

A minister of religion

Rev Dr Norman Ford, SDB. Lecturer in Bioethics, Catholic Theological College; President, Melbourne College of Divinity.

A lawyer

Mrs Loane Skene. Principal Research Officer, Law Reform Commission of Victoria; Member, Fairfield Hospital Research & Ethics Committee; Member, Animal Welfare Committee of the NHMRC

A view from outside: Surveying ethics committees

Dr Paul M McNeill. Senior Lecturer, School of Community Medicine, University of NSW; Chairman, Faculty of Medicine Ethics Committee, University of NSW

THE FUTURE

New roles for hospital ethics committees

Professor Richard Smallwood. Professor of Medicine, Heidelberg Repatriation Hospital; Chairman, NHMRC Health Care Committee and Working Party on Informed Consent

The Australian Health Ethics Committee:

Role and function

Ms Robyn Layton. Chairperson, Australian Health Ethics Committee

DISCUSSION

INTRODUCTION

Professor Richard Lovell

IN SUGGESTING THE TOPIC for this year's seminar I had it in mind that the regulatory system operating today was set up ten years ago to cope with practical problems arising from medical research. That regulatory system has come to occupy time given generously by many, literally hundreds, of busy people and it costs money. For these reasons alone it is worth discussing from time to time.

As we talk about 'Looking After Ethics', the actual process of regulation will figure prominently. Process is the easiest aspect to discuss because it can be described in terms of measurable things like numbers of committees set up, documents written, meetings attended, projects considered and so on. But processes are not ends in themselves. The question to be asked at the end of the day is whether the outcomes for which the processes were set up are being achieved; specifically, in relation to research, are reasonable decisions being made on ethical aspects reasonably effectively, and reasonably efficiently? Ten years ago, did we set off on a good track?

The regulatory system for ethics in medical research that we have evolved has two components, central and peripheral. We shall consider both these and then look into the future, recognising that ideas in this field should not be set in concrete and must be amenable to change in the light of experience.

It also seemed timely to have today's discussion for a second quite different reason. Our regulatory system, having been designed specifically for medical research, has been under pressure to broaden its sphere of interest to include questions of ethics in medical practice and the philosophy of resource constraints in public health policy. Such pressures must have important implications for an organisation set up to perform much more precise, limited and above all practical functions. What are these implications? Will these broader functions be best performed by being grafted onto a regulatory system that was designed to cope, and is coping, with practical and immediate questions from day to day of research. This will be in the background of our thinking in the second half of the seminar.

AT THE CENTRE

DEVELOPING A NATIONAL APPROACH: THE MEDICAL RESEARCH ETHICS COMMITTEE OF NHMRC, 1982-1991

Professor Richard Lovell



Prof. Richard Lovell

IN THIS OPENING PAPER, my task is to outline the national approach as it developed at the centre from 1982 to 1991. By way of background, let me remind you that, for many years, ethical codes governing medical practice seemed adequate for research. Things should not be done to people without their consent, there was a duty of confidence, and there was a duty to exercise reasonable skill. This made sense. It often was and still is impossible to draw a line and say where medical practice ends and where

medical research begins.

But for various reasons there was a growing belief in the 1960s that some specifically research orientated code of ethics was needed. In Australia the initiative came (as Paul McNeill has observed) largely from the research community itself through the National Health and Medical Research Council (NHMRC). The first *NHMRC Statement of Human Experimentation* was made in 1966. It was prepared by a group of medical academics, assisted by a Queen's Council, and it consisted of ten clauses covering half a page. The Statement was amended from time to time by ad hoc committees (notably in 1973 by one that included among non-medical members Professor Zelman Cowan and Dr Davis McCaughey). But by 1981 it was clear that many issues needed more detailed attention, and the Council's Medical Research Advisory Committee, chaired by Professor Robert Porter, set up a Working Party on Ethics in Medical Research.

The 1982 Working Party

The Working Party, which I was invited to chair, was given terms of reference that at the time looked astonishing and in retrospect impossible. We were to review the existing NHMRC Statement, we were to consider a regulatory system, ethics committees, research on children, therapeutic trials, *in vitro* fertilisation, transplantation of foetal tissue, epidemiological research – and for full measure research on contraception, sterilisation and abortion were tacked on. The whole shopping list that NHMRC had accumulated over the previous few years was passed to us, and we were required to report within a year. Under most headings we did.

I was given a splendid team and it is right that their names should be written into the record: Professor Arthur Clark, Sir John Frew, Mrs Elizabeth Grant, Professor Brian Hudson, Dr Robert Jansen, Mrs Yolanda Klempfner, The Reverend Dr Davis McCaughey, Mr Russell Scott, Professor Rodney Shearman. Committee members had to do their own homework, and draft the material that we later brought forward. We had no supporting research assistants, just one loyal and fully-extended secretary, Paul Van Belkom, who was supplied from the secretariat in Canberra. I think he would tell you that we were totally intolerant of any threats of administrative delay. We met almost once a month, a frequency which seemed unheard of in the Health Department. And by the end of the year 1982 we presented a report which was adopted by NHMRC and which determined the shape of the regulatory system that we now have.

Briefly, it was agreed the NHMRC should set up a national committee called the Medical Research Ethics Committee (MREC). The MREC was charged with recommending ethical principles that should be observed in human experimentation, facilitating the work of institutional ethics committees, responding to questions referred to it by NHMRC, ministers and other bodies, and with establishing dialogue with the standing ministerial committees on health and law.

At the periphery every institution in which medical research was undertaken was to have a committee to consider ethical implications of all proposed research projects, and these committees were to have a specified core membership including a laywoman, a layman,

a minister of religion, a lawyer and a medical graduate with research experience.

We did not invent ethics committees. With peer review in mind they had been recommended by NHMRC in the 1970s for clearing NHMRC research grant applications. Some institutions had indeed appointed ethics committees with varying functions and constitutions much earlier. We elaborated and codified an idea that was already there.

The Medical Research Ethics Committee

At the end of 1982, the members of the original Working Party were constituted as the new Medical Research Ethics Committee for the remaining two years of that NHMRC triennium (to the end of 1984). There was a turnover in membership in the next two triennia (1985-1987, 1988-1990). When I passed on the chairmanship to Professor Ross Kalucy in 1989 there were four medical or scientific members and six non-medical members. By this time I also had a personal assistant, Dr Ian Tulloch, all the more valuable as an addition to the team because the bureaucracy in Canberra contrived to change the secretary of MREC every few months. I am sorry I have no photograph of the original team but the photograph from the archives shows members in the middle years.



Medical Research Ethics Committee of NHMRC, 9 December 1986.

L to R: Mr Russell Scott, Mrs Elizabeth Grant, Prof. Emer. Richard Lovell, Ms Lee Simmons (Secretary), Mrs Yolanda Klempfner, Dr Robert Jansen, Dr Ian Tulloch (Assist. to Chairman), HE Dr Davis McCaughey, Mr Phillip Bates. Absent: Dr Elspeth McLaughlin, Dr Leonard Harrison. (Photo Bob Ivison).

Picking out some highlights from the activities of MREC, firstly we worked up ethical guidelines on the subjects left over by the Working Party, and others that were nominated. Guidelines were published as *Supplementary Notes* to a revised *Statement of Human Experimentation*. When the 1982 Working Party produced the first four Notes with its report to the Council, only one had a background paper and that was brief. Subsequent *Supplementary Notes* were all submitted to Council, and published, with substantial background papers.

The *Supplementary Note* I personally found most complicated to prepare was the one on epidemiological research. It turned out to be critically important because of the impact that it made on the final form of the Commonwealth Privacy Legislation, as a consequence of which NHMRC was specified as the official body to be involved in adjudication on privacy issues in medical research.

We took very seriously the task, with which we were charged, of facilitating the work of institutional ethics committees. We tried, by meeting at intervals with them across Australia, to discover things that they were concerned about. We hoped they were helped at least by talking. We were certainly helped to modify *Supplementary Notes* in the light of feedback on real life situations from these meetings. I believe the newsletter started by Dr Tulloch also made a significant contribution.

Other activities included arranging interdisciplinary round table conferences, presenting information to the Senate Select Committee on Embryo Experimentation and preparing advice to NHMRC on various specific topics.

We asserted at the outset that NHMRC had no obvious teeth. It was an advisory body with no apparent power to ensure that what it said

should be done was done. Somewhat to my surprise, as things evolved, we found that NHMRC had a good deal of clout. There were real sanctions that could be applied to backsliders, if any, and this reinforced our conviction, based on other grounds, that there was no good case for introducing a legislative model of regulation that was advocated by some. In this regard it is interesting to note how, in some special areas, NHMRC has now had quasi-legal authority thrust upon it through the Australian privacy legislation and in relation to some aspects of clinical trials.

In doing an audit of institutions involved in IVF we found that institutions were, as we had anticipated, willing to provide the Medical Research Ethics Committee with access to their records and to discuss the proceedings of their ethics committees with us.

Throughout this period we resisted all requests from IECs to make judgments on individual research protocols. We maintained that such judgments must be made peripherally, in the institutions in which the research was to be done.

Expanding the agenda

In 1990, the Report of a Review of the NHMRC commented that the Council's ethical guidelines were accepted nationally and highly regarded internationally, where Australia was seen as a world leader in this field. It applauded the combination of guidelines and local IEC review as a unique system. The review also observed that the community had increasingly turned to NHMRC for advice on ethical issues extending beyond research, into medical practice and public health, and it concluded that there was need for NHMRC to cover these areas as well as research. The result was the creation in 1991 of a new body within NHMRC called the Australian Health Ethics Committee (AHEC), to carry out not only the functions of the original MREC, but these new ones as well. Ms Robyn Layton, who chairs AHEC, will pick up that story later in the afternoon.

To complete a 'view from the centre', we have asked Professor Kalucy, who is now deputy chairman of the new AHEC, to say something more about the preparation of guidelines.

THE PREPARATION OF GUIDELINES

Professor Ross Kalucy



Prof. Ross Kalucy

SOME HALF-A-DOZEN principles can be recognised as lying behind the decision to approach ethical matters in Australian health research by the formation of widely dispersed institutional ethics committees and the use of guidelines as a method of assisting in arriving at ethical conclusions. These include:

1. The fact that we live in a pluralist society. From the outset of the deliberations of MREC, it was recognised that there was no possibility in Australia of arriving at conclusions which would have community-wide support. Australia has many distinctive communities and strata within it; and these include communities whose views are shaped by their culture, by their race, by their age, by their social class and by their religion. The central ethical issue was to establish our approach so that diversity could be catered for, and so that changes in the dynamics of this state could be accommodated.

2. It was seen that ethical deliberation is different from moral deliberation. There is no view within ethical deliberation that one is arriving at a final and binding conclusion. Most usually it is a method of resolving a conflict between competing goods. An ethical conclusion is always a relative conclusion. Competing goods might include weighing up risk to subject versus gain to the community in a particular research protocol.

3. It was seen that the scientific and ethical demands of each project must be considered on a case-by-case basis, since all could raise issues specific to themselves.

4. It was thought that individual hospitals and research institutions and communities would differ significantly in what they believed could or could not be done, what they believed should be included in consent forms, and the degree of sophistication of the community in terms of the way in which consent would need to be given.

5. From the beginning it was seen that new ways of thinking and new technologies were emerging as a result of endeavours of Australian health research workers. These raised new ethical questions and there was a considerable need to ensure that health research institutions, health research workers and clinicians, and the community, had a chance to understand that these new ethical problems existed and to take part in deliberating upon them.

6. By nature, the early committee members who wrote guidelines or who were involved in hospital ethics committees saw great value in community discussion and in representation by the community when ethical matters were being considered about research. All those involved in the evolution of ethical debate believed strongly that a decentralised rather than a centralised system was a key strategy.

With these views in mind, it was natural to encourage the development of institutional ethics committees in all institutions conducting health research.

Turning now to the writing of guidelines: this, too, seemed to flow naturally from our background beliefs and views. Guidelines are a complementary strategy to the establishment of institutional ethics committees. Guidelines provide, at least as they have developed, two kinds of information: one kind relates to the subject matter, for example, explaining what is meant by gene therapy, and the other provides a series of statements which allow orderly debate to occur. Quite obviously, guidelines do not contain definitive solutions or regulations.

I experienced the decade as a developmental or maturation process. It seemed that the Medical Research Ethics Committee (MREC) and then the Australian Health Ethics Committee (AHEC) of the National Health and Medical Research Council and the Institutional Ethics Committee (IEC) learnt a great deal and became much more aware of the complexities of our task as the decade progressed. At times, this maturation process occurred very slowly and other complexities arose out of the difficult process of writing guidelines. It cannot be emphasised too greatly that this is a slow and tortuous process, both within the committee and within the consultation process. It was not uncommon for sets of guidelines to develop over several years. At other times, there were major challenges, even crises, which changed things a lot or tested the robustness of the system significantly and resulted in important redefinition of our tasks.

This paper identifies some of these 'defining' moments; and attempts to crystallise aspects of how they had important meanings for development; and how they threw up new questions. I will comment on nine such issues.

1. The development of Supplementary Notes 1 and 2

This was the earliest work of the MREC. These notes laid out a composition for IECs and emphasised a limitation on medical membership. Basic rules of how to conduct business were laid out. Most importantly, an approach to 'consent' was defined and particular ethical issues in relationship to a consent, for example, where the subjects of research were dependent or psychiatrically ill or unconscious, were highlighted. It is hard to appreciate now quite how substantial that first step was. Whilst there were ethics committees in major hospitals around the country by that time, the linking of the presence and status of IECs to research funding in all institutions was a major step forward and a unique strategy. This anticipated international approaches by a good number of years, and indeed, even then constituted a different direction, since most other countries had a more centralised system, at least in some areas such as reproductive technology.

This approach has its critics. There are those who still advocate a much more centralised approach and who are concerned by what is perceived as the 'control of ethical behaviour in health research' being in the hands of 'amateurs'. The formation of IECs in this way and the distribution of guidelines has proved successful, although it has been a great strain on the committees and the health system. It is a huge amount to ask of volunteers.

It could be that MREC and AHEC have been a little too reluctant to provide some degree of central authority. For example, we have always argued that IECs should develop their own operational methods, whereas *some* IECs would prefer to have stricter guidelines on how they should solve problems. In particular, there is and has been concern about how the question of scientific merit should be settled as distinct from other ethical matters such as consent and confidentiality. Some hospitals chose to consider scientific merit along with other ethical matters in the same committee and some have separate research and ethics committees. We have been content up until now to allow IECs to work out their own solutions to these problems. It may be that this will not be able to continue.

2. The epidemiology guidelines

This was a very good experience for the MREC. It was the first attempt to address ethics in the area of public health science and practice. In retrospect it was probably overdue, but the fact is that at the time of writing the guidelines there was little available to help us either identify the major ethical issues or to address them.

There is no view within ethical deliberation that one is arriving at a final and binding conclusion. Most usually it is a method of resolving a conflict between competing goods.

Perhaps the most difficult issue and the most critical one was identifying the circumstances under which confidential information about people could be used in public health research in general, and epidemiological studies in particular, without obtaining individual consent from subjects. This, of course, is absolutely essential in epidemiological studies since answering major questions about health involves the use of large amounts of data obtained from many different sources; and this information was often gathered for quite different purposes to the research project in question. The fact that epidemiological sciences emphasise the aggregation of data and have little use for individual data does help in overcoming the issue of personal privacy. On the other hand it means that great emphasis on mechanisms of maintaining confidentiality must apply. We were helped in this matter by the fact that there had never been a crisis or a scandal or even an accidental mistake emanating from public health groups, whether they be in health commissions and departments of health, or in hospitals or research institutions. The advent of computerised data bases adds a burden to those carrying a duty of confidentiality and this may need to be addressed in the next decade.

3. The new technologies

The MREC members and many specialist societies throughout Australia recognised in the early 1980s that the advent of new technologies, such as reproductive technologies and those relating to gene manipulation, would throw up new ethical questions and require a new kind of debate. This gave IECs and MREC new insights. We recognised when we considered these areas that IECs would need clear, well and simply written information, so that they could understand the technology and hence its implications. That was a very time consuming piece of work and all of us were grateful to the lay members of our committees who maintained a constant pressure for simplicity of language.

The experience in writing these guidelines brought us into dialogue with sections of society which had not previously been heavily involved in our debates. These were groups who had very powerfully held views about, for example, the use of reproductive technology. Some saw any obstruction to their use as discriminating against women or against the orderly processes of science, whilst

others saw their development as a fundamental intrusion into the most basic questions of life and death. This, at least, speaking personally, was a very different kind of experience and a different kind of challenge. For me, the lesson learnt was that one must concentrate very hard on the task at hand, viz., informing institutional ethics committees, and not allowing oneself to be distracted by those who hoped to see no progress made. There were, of course, many people with strong views who were helpful in the evolution of guidelines. Strong views it seems are not the same as rigid views.

Australia is definitely not homogeneous in relation to ethical matters. It was about this time that we ran our first 'round Australia' workshop. This meant that we went from one city to another, meeting with institutional ethics committees. On the matter of reproductive technology, the IECs of Melbourne were completely preoccupied, whereas it was hardly mentioned in any other state – each other state having its own preoccupation.

4. Privacy

In the late 1980s a major political thrust occurred in the area of the privacy of personal information. An Act was envisaged which would cover this issue. Many of us recognised that if the Act came into being in its draft form it could be applied to public health activity, whether clinical or research, or indeed, the ordinary activities of a public health department within, say, a health commission, and that many of these activities could be constrained to the point where there would be a real threat to public health. Much lobbying ensued, and a section was included in the Act which enabled the NHMRC to write guidelines that would address the Federal Privacy Act, and which, if approved by the Commissioner, would allow research to continue 'in breach of the Act'.

This was the first occasion in which the MREC had a formal link with a Federal Act and the first occasion in which IECs found themselves having to address issues within a legal framework. Some lessons were learnt here. For example:

- a) We were all very impressed with the enormous amount of effort that goes in to trying to make ourselves intelligible to the legal world, and conversely, that must be put in by commissioners, etc., to making themselves intelligible to us.
- b) The drafting of guidelines to satisfy a Federal Act is not entirely compatible with the drafting of guidelines to satisfy IECs – and the language used was often in the end frightening or confusing. Ordinary citizens on an institutional ethics committee do not like phrases like 'when you wish to do a project which is in breach of the Act, you must ...'

Despite many attempts on our part to write these guidelines and background information in simple lay English, we were in the end, unsuccessful – and this was partly because the Commissioner was anxious not to allow confusion and ambiguity to arise from a legal point of view. Thus in addressing his responsibilities, there was a conflict with our own.

- c) If we were to go through this process again, and this may of course arise with the various states of Australia, it would be my view that the best thing to do would be to simply apply for an exemption within the Act for public health research. I doubt if that would have worked four years ago, but the experiences of the past few years have made it a more acceptable outcome.

- d) Sadly, the introduction of the Act has had an adverse effect on public health research. There is a strong impression that people are now reluctant to work with federal agencies in this area, and indeed there is a strong feeling that federal agencies are inhibited in co-operating with research workers. Much work needs to be done here.

5. Genetic registers

This was a very difficult piece of work. The problem is that genetic registers are a clinical tool. All geneticists have such registers and use them on a day-to-day basis to advise and help patients. The issue of course is that as in any other clinical setting there is a lot of information on these registers about people who did not give permission for that information to be collected; for example, a careful family history. The practice of clinical genetics could not occur without such information, and I imagine they would be seen as blessed by convention to collect family histories. This becomes an issue when we turn from ordinary clinical practice to research. Here, either the keeper of the register or outside research workers wish to make use of the information for a purpose for which the original informants would not have been aware

or could not have foreseen. It is impossible to obtain individual consent from all those on a register. The real aim of the guidelines was to ensure that those who could not give consent could not have the confidentiality of the situation betrayed. Again it is reassuring that such registers have existed for a long time without any such betrayal.

This is an example of a growing problem for AHEC and, in the past, MREC. There is a clear overlap between clinical activities and clinical research and basic research activities. It is often difficult to decide when something is a research activity or when it is an audit or an evaluation or a pure clinical intervention. Definitions of these matters prove to be very difficult.

6. Aboriginal health ethics

The writing of guidelines for the conduct of health research which involves Aboriginal people was a first encounter between writing guidelines and the social health sector. The need for the guidelines was made clear at a large meeting in Alice Springs organised by the Menzies Foundation and the NHMRC. Most of those who attended were Aboriginal people. The purpose of the meeting was to attempt to identify research priorities for Aboriginal people. The need for an ethical framework for research emerged as a top priority. The issues that arose during the experience of writing these guidelines were as follows:

- i) Is it a good idea or not to be writing guidelines for a particular groups of, in this case, disadvantaged, people? If it is, should we extend those guidelines to all cases of disadvantaged groups, whether they are ethnically defined or defined for us by their employment status? Alternatively, is this simply a task in ensuring informed consent – that is, that the nature of informed consent takes into account in a more refined manner the difficulties of the disadvantaged in understanding a research program?
- ii) This was a case, and the only case in the experience of the MREC, where in the end there were problems which simply could not be solved. For example, the issue of who owns the data and who has a right to its use – is it the community or the scientist or both? – was not resolved. Nevertheless, interim guidelines and then final guidelines were written, which have proved to be useful.
- iii) On a personal level I found this experience very enlightening. Much of the work was done in large groups by people who were angry, worried and uncertain. I would not have thought, had I not been through the experience, that one could have achieved so much in such improbable surroundings. In the end, I thought that it was an enormous credit both to the Aboriginal people and to the NHMRC that such a difficult task could be taken so far.

7. Clinical trials

We are all familiar with the changes in the conduct of clinical trials and the changes in central administration. The relatively diminishing role of the TGA and the emphasis on a CTN and CTX scheme has been a very destabilising experience for many institutional ethics committees. This was our first experience with IECs being incorporated into a major change in government policy and government strategy. In addition, the whole process unfolded rapidly and it was very difficult for IECs to see what their new responsibilities were. What is certain is that some IECs coped very well, and these were mainly in large experienced hospitals, with large research budgets; others coped less well or refused to take part.

The introduction of the CTN scheme focused on several new issues and the most important of these were:

- i) The problems of conducting research in several institutions – in this case, clinical trials. A lot of work will need to be done to find ways for institutional committees to feel comfortable with multi-centre studies.
- ii) With the advent of changed responsibilities of IECs – in this case, their responsibility in judging safety of a trial – the issue of the legal liability of IECs and IEC members comes into sharp focus. Much work will need to be done in this area before people feel safe.
- iii) The whole issue of how an IEC gains information which it can feel to be independent, expert and presented in a readily understandable manner, needs further work as a result of this exercise.

8. The Triennial Review

By the time the last Triennial Review had come into being, MREC was aware that IECs could no longer function solely as bodies

considering medical research. At least at the level of the NHMRC, it was necessary to have a committee which could look at the work of MREC, but also consider new ethical issues in clinical practice, public health practice, and at the level of government policy. The Australian Health Ethics Committee came into being as a result of those insights.

This will mean that institutions will have to find new ways of functioning. It is inconceivable that IECs alone can handle matters of clinical ethics, administrative ethics, research ethics, and judge the quality of science. New committees will need to be formed, and this is already happening. In some of the larger teaching hospitals there are research committees, clinical trials committees, clinical ethics committees and institutional ethics committees. This is an expensive and time consuming answer to the new way of looking at ethical responsibility.

9. The MREC workshops

MREC has conducted two series of workshops, separated by four years, in the last decade. In these we visited each capital city and spent a considerable amount of time with groups representing the IECs of that city. In these workshops:

- i) It was obvious that there had been tremendous movement over four years. The first workshop was mainly concerned with process and interpretation of responsibilities, whilst the second workshop was mainly concerned with issues.
- ii) Most importantly, it became clear that each state has different problems which arise partly because of the nature of the research and clinical work that goes on in each state, and partly because there are different advocacy groups in each state, and because of differences in the management of the health system at a state level.

There is obviously a need for greater co-ordination of institutional ethics committees' activities through guidelines at a national level.

There was a time in the middle of the last decade when some imagined that the work of a committee like the MREC would simply disappear because there would be no more need for guidelines. This is clearly not the case. There is much work to be done, and much of this is thrown up by new experiences and new ways of organising our society. Equally, it is likely that new discoveries will throw up new ethical questions, and perhaps the most obvious of these would arise from the public health sector and from the work in molecular biology.

In conclusion, I would just say that it has been a great privilege to live through this decade and to work with so many people who have given a lot of time, very selflessly, to what I would see as a 'noble endeavour'.

WHERE DECISIONS ARE MADE

BEING ON AN INSTITUTIONAL ETHICS COMMITTEE

A lay person – Mrs Jean McCaughey



Mrs Jean McCaughey

IT IS AN HONOUR and a pleasure, if a somewhat daunting one, to be invited to speak at this seminar. It seems a long time since I was invited to join the Ethics Committee on Medical Research of The Royal Melbourne Hospital. It was an interesting and lively committee and my recollections of it are still vivid, though I cannot claim that my memory of its history is one hundred per cent accurate. As in W.H. Auden's poem I am not a Camera, 'Flash backs falsify the past: they forget the remembering present'. Fortunately,

my 'remembering present' was supplemented by two documents which have survived a purge of my medical ethics file: the *NHMRC Statement on Human Experimentation and Supplementary Notes*, and a paper by John Yeatman and Len Swindon on the *Ethics Committee and Board of Medical Research at The Royal Melbourne Hospital*.

The Royal Melbourne Hospital ethics committee predates the decade we are particularly concerned with this afternoon. In the mid-seventies the Board of Management of the hospital set up two

committees, the Board of Medical Research and the Ethics Committee on Research. The latter was concerned with developing ethical policy, especially in research, the former with the registration and approval of all research projects within the hospital.

The terms of reference for the Ethics Committee were:

- a) To consider and advise the Board of Management and the Board of Medical Research on all ethical matters arising from research activity which require determination.

The committee is required to have particular regard to the importance of obtaining the informed consent of patients and volunteers and especially to the maintenance of the best interests of patients.

- b) The Ethics Committee shall be appointed by the Board of Management and in making such appointments regard will be had to the selection of people with a good understanding of the moral, legal and ethical considerations of medical research and of community attitudes in this area.

The membership of the Ethics Committee was given careful consideration by the Board and the seniority of the those selected established the importance of the committee. It comprised nine persons:

- Two were non-medical members of the Board of Management; one of whom was Senior Vice-President and Chairman of the hospital's Law Committee.
- Two were representatives of the general community. One of these was a minister of religion and the other a medical officer of consultant status who held no active position on the medical establishment of the hospital.
- Two were representatives of the administration, that is, the Director of Medical Services and the Executive Director.
- One representative of The University of Melbourne.
- One representative of The Walter and Eliza Hall Institute of Medical Research to provide an independent research opinion.
- The Chairman of the Board of Medical Research also attended the meetings.

All were people of outstanding ability and experience. They were also extremely busy people, so we met over a coffee and sandwich lunch and dealt with our business with commendable expedition.

In the next few years the committee addressed many important questions. First in 1975 a statement on ethics and research was drawn up for the hospital in line with the Declaration of Helsinki. This statement defined hospital policy and provided a yardstick for the Board of Medical Research in assessing ethical aspects of all research projects.

The committee also worked on the question of the meaning of informed consent and how this could best be safeguarded in a dependent population such as hospital patients and volunteers. A standard consent form was designed which must be used by all researchers conducting research involving patients and healthy volunteers.

Other topics dealt with by the committee included the ethical difficulties in determining how to evaluate the worth of a project to the community as a whole, against the risk to the individual patient or volunteer involved; the use of human tissues and the difficulties of access to them for transplants. In addition to considering specific ethical problems referred by the Board of Medical Research, the committee regularly reviewed selected projects to make sure that the guidelines laid down were being followed.

The Board of Medical Research and the Ethics Committee were seen as complementing each other in a two-tier system – the Board dealing totally with a large number of project applications within the guidelines laid down by the ethics committee, the ethics committee serving as a referral body for especially complex ethical issues and also monitoring the system to ensure the effectiveness of the guidelines.

This comfortable arrangement was radically changed in 1982 when the Ethics Committee of the NHMRC issued its *Statement on Human Experimentation and Supplementary Notes* for all researchers and administrators of institutions in which research on humans is undertaken in Australia. This statement declared that all such institutions should have an ethics committee and specified the functions and composition of such committees. The composition of our committee was acceptable but the functions differed from our

It is sometimes said that ethics committees are not an effective way to control medical research, that they have no authority, and are dominated by the doctors and researchers.

ways of working at the RMH in one radical respect: the ethics committee was to consider ethical implications of *all* proposed research projects and 'to determine whether or not they are acceptable on ethical grounds'. Applications for NHMRC grants would only be considered if they were certified by the ethics committee of the institution concerned.

Our ethics committee was immediately confronted by the prospect of examining the protocols of all the research projects undertaken in the hospital. This meant a heavy load especially for the non-medicals who had to labour through unfamiliar and sometimes almost incomprehensible jargon. We asked the researchers to supply a statement in plain English describing the purpose and methods of the research, any possible side effects and any special ethical problems involved. We also asked them to supply an account of the actual words they would use when describing the project to the patient in securing his or her assent.

To begin with we had problems. Committee members found it difficult to get through all the protocols, and researchers found the delays imposed on the project frustrating, but gradually we evolved more efficient ways of working, speeding up the process of approval for the many projects which raised few or no ethical problems, and learning to define our questions and reservations more precisely.

In cases where there was considerable doubt, we usually asked the researcher to come to the meeting and discuss the protocol with us and this was very helpful for both parties. Almost always modifications were willingly made to comply with the committee's requests and the researchers were prepared to endure some delay to improve the protocol and gain our approval. I only remember one or perhaps two occasions when the project was knocked back. The NHMRC Guidelines were our basic reference and always lay on the table at meetings. Often they helped to resolve differences in opinion.

What was it like to be a lay member of the RMH Committee on Ethics in Medical Research? It was a lot of hard work going through all the protocols, but it gradually became easier or at least less time consuming. But it was good to have to think hard about these complex ethical questions which are of great concern to our society, and to think with a group of outstandingly able people who were so well equipped to do so. We learned to listen to each other and to change our own positions and sometimes our prejudices in response to better ways of thinking. And that is the best justification for the time spent in committee meetings.

We were also fortunate to have an outstanding chairman whose meticulous care and penetrating scrutiny of the protocols raised the standard of the whole committee and forbade any slipshod slackness. He also listened to all points of view and encouraged the process of consensus mentioned above. And we usually had one conservative member, often a doctor, whose contrariness enlivened the whole proceedings!

In committees as in many other things, nothing succeeds like success. Because our committee had an important job, and because it was always lively and stimulating, the members attended very regularly and so built up good rapport.

It is sometimes said that ethics committees are not an effective way to control medical research, that they have no authority, and are dominated by the doctors and researchers. No doubt they are not perfect and some will work better than others; but this criticism was certainly not true of our committee. The non-medical members were

people of sufficient ability and standing to make their own contributions and we never felt that we were overborne by doctors and researchers or the power of the institution. We were all committed to 'respect the personality, rights, wishes, beliefs, consent and freedom of the individual subject', and always to have in mind the best interests of the patient.

A minister of religion – Rev. Dr Norman Ford



Rev. Dr Norman Ford

I THOUGHT BEING ON AN institutional ethics committee would be similar to my usual work of lecturing in philosophy and ethics: I found it different in that I had to listen more and work much harder if I wanted to get my own way and the last word. On reflection, this is how it should be when a multi-disciplinary group of dedicated professionals meet to discuss hospital ethical issues.

Legislation is indeed necessary, but it alone is insufficient to protect the community from harm and to

promote the common good. Consider business, finance, industry, the media, the military, human reproductive technology, sport, politics, the law, government and even the Church itself. Over the last decade has not the community painfully learnt the lesson that being ethical and acting in accord with some ethical standards is essential for every profession and the good of society as a whole? The health care professions are no exception. During the eighties, while public discussions on bioethics and medical ethics boomed, institutional ethics committees mushroomed all over the country to join ranks with medical research ethics committees. This is how I accepted an invitation to join the foundation ethics committee of Cabrini Hospital – a large private Catholic Hospital.

We were aware that the hospital's health care services had to conform to professional standards and community values enshrined in legislation. We were also aware that the hospital's policy and practices had to accord, and not conflict, with Catholic moral principles based on Christian revelation and respect for the absolute value and dignity of each human being. Advances in science and technology had revolutionised and benefited the practice of medicine. At the same time it was necessary to be on guard against the creeping in of any depersonalising factors in the provision of health care from people's conception throughout life until death.

Moral respect is owed to a human person because one is an individual subject of a rational nature, 'created male and female in the image and likeness of God', and not because of one's future choices. Personal acts, experiencing pleasure and enjoying our subjectivity are indeed precious, but they derive their value from the nature of the individual who is a human person and for whom they are a value. It is the person who is the primordial and self-justifying value as well as the source and foundation of value for our personal experiences. Unconscious human individuals are persons of inviolable value.

Ethical imperatives refer to what we must unconditionally do or avoid to be true to ourselves as human beings. Whatever is opposed to the objective nature of the human person and of human acts cannot be truly good, appearances notwithstanding. We agree on some moral issues but not on all. Usually moral differences boil down to different views on the nature of the human person. A mastery of the concept of the human person and its complex web of essential relations is necessary if we are to respond adequately to the new moral challenges encountered in today's hospitals.

My experience is not of a research ethics committee. The proper role of a hospital ethics committee, in my view, is only advisory to the hospital's Governing Board, which is really responsible for making binding decisions on policy and permissible procedures. It is important for an ethics committee to avoid giving grounds for any perception of undue threat by the medical staff to the free and responsible exercise of their professional judgement in caring for their patients. They should practise to the best of their ability subject only to hospital policy and decisions of the Governing Board.

The members of a hospital ethics committee should be experienced and chosen from persons who are willing to support the hospital's ethos. Since it has to offer advice on the whole range of health care services provided by the hospital its composition should be broad enough to enable it to cope with all the ethical issues that are likely to arise. Ours works well and its membership comprises five men and six women, including the hospital administrator, the hospital's medical director, a doctor from another hospital, the charge nurse of the intensive care unit, the director of nursing, two members from the pastoral care team, a lawyer, a religious sister and two Catholic priests trained in ethics and theology. Liaison with the Governing Board is facilitated by having several Board members serve on the ethics committee. The minutes of meetings are confidential and distributed only to members of the committee and of the Board.

The ethics committee often serves as a forum where ethical issues raised by its members are discussed for mutual benefit. The results of these discussions are communicated to the departments or persons concerned. One day it's a matter of allaying some staff's groundless fears about certain procedures involving the withdrawal of medical treatment for the dying. At other times the pastoral care members raise issues touching on how communication could be improved between staff, nurses, the patients or their families in delicate cases or situations. Topics discussed have included: the annual review of the structure and function of the ethics committee, ethical issues in the intensive care unit especially DNR orders, brain death, problems regarding artificial nutrition and hydration for permanently comatose patients, responsibility for decisions and the decision making process, staff education on ethics and ethos, bio-ethical publications, the Medical Treatment Act and the difference between euthanasia and withdrawing unwarranted medical treatment, the distinction between *direct* and *indirect* abortion, problems arising in the management of pregnancies with anencephalic fetuses or premature rupture of the membranes before 26 weeks, organ donation, reports on bioethics conferences attended by members, hypnotherapy, ante-natal diagnosis and amniocentesis, AIDS, various Bioethical Discussion Papers, informed consent, conscientious objections and professional confidentiality etc.

We do not discuss individual cases. Our objective is to establish and clarify the relevant ethical principles that are applicable to each type of case. Medicine is not an exact science: at times there may be more than one ethical way of proceeding. We must realise doctors have to use their discretion in making a morally responsible professional judgement in each clinical situation. This accords with Catholic teaching when, referring to lay people, it says:

... it is their task to cultivate a properly informed conscience and to impress the divine law on the affairs of the earthly city. For guidance and spiritual strength let them turn to the clergy; but let them realise that their pastors will not always be so expert as to have a ready (the latin text adds concretam, concrete) answer to every problem (even every grave problem) that arises; this is not the role of the clergy; it is rather up to the laymen to shoulder their responsibilities under the guidance of Christian wisdom and with eager attention to the teaching authority of the Church.¹

It is becoming increasingly clear that there is a need for members of ethics committees and health care professionals to receive some basic ethical information to ensure decisions are made with an informed conscience. Feelings and guesswork are not reliable guides to discover an ethical solution in complex cases. It is not good enough to be highly educated in medical disciplines without attempting to achieve comparable standards in basic ethics. Hopefully this might prevent undue encroaching by the law and the courts in the exercise of the medical profession in Australia. This would also help one to understand the reasons for, and the validity of, one's own institutional ethical stand and to appreciate the reasons why other institutions in our pluralist society think differently.

Reference

1. See *Gaudium et Spes* n. 43 in Vatican Council II, ed. A Flannery, Dominican Publications, Dublin 1975.



Mrs Loane Skene

LIABILITY OF INSTITUTIONS for IECs' decisions: Institutions may be liable in negligence for their IECs' decisions. An action might be brought by a subject who has been injured in a clinical trial that was negligently approved by the IEC. This is illustrated by the following case.¹ It is also conceivable that a researcher might sue in negligence if an IEC failed to take reasonable care in considering a research protocol submitted by the researcher.

In 1989, a Canadian court held a hospital liable in negligence because its research and ethics committee failed to take reasonable care in reviewing the protocol for a clinical trial and in approving the consent form. The case was *Weiss v Solomon*.²

Mr Weiss, a 62-year-old man undergoing cataract surgery, was asked by his surgeon to take part in a trial of some eyedrops to see if they would reduce retinal edema after cataract surgery. The surgeon, Dr Solomon, explained that Weiss himself would not benefit from this test. Part of the test involved injecting a dye and doing an angiogram immediately after the drops were inserted. Weiss agreed and signed the consent form. Unfortunately, seconds after being injected with the dye for the angiogram, he had a cardiac arrest and died.

The hospital's research committee had reviewed the consent form and the protocol describing the administration of the drops and any associated side effects. The form included the words: 'Some patients may develop a minor allergic reaction to this injection, but the majority of patients have no side effects'. The patient acknowledged in signing the form: 'I have been told of the possible side effects and unfavourable reactions that can happen and what my alternatives are. I have had a chance to ask questions to the doctor and have received acceptable answers'.

His relatives sued Dr Solomon who had suggested that he join the study, the physician who conducted the study and the hospital. They alleged that Weiss should have been excluded from the study because he had a long (but asymptomatic) history of hypertrophic cardiomyopathy and that he should have been warned of the rare risk of cardiac arrest resulting from a fluorescein dye injection. There had been only two reported cases of cardiac arrest in these circumstances but one member of the research and ethics committee was aware of those cases. The physician who conducted the study and the hospital were found liable (but not the recruiting physician) and the plaintiffs were awarded CDN\$118,800.

In relation to the responsibilities of the research and ethics committee, the court said that the risk should have been disclosed in the consent form (even though there had been only two reported cases) and that the knowledge of one member of the committee was the knowledge of the committee. The court did not consider the extent of the committee's obligation to inform itself if none of its members had the relevant knowledge. Nor did it consider what discretion the committee should leave to the principal investigator in making clinical decisions during the trial.³

Liability of IECs and their members

The liability of particular IECs depends on their relationship with their institution. If an IEC is legally part of an institution,⁴ that institution will generally be responsible or vicariously responsible for claims arising from the conduct of the IEC. As suggested earlier, this would apply to people who have been injured while participating in a trial approved by the IEC, and also to researchers adversely affected by the procedures or decisions of the IEC.⁵ If, on the other hand, the role of the IEC is not purely to advise the institution but to make decisions about projects itself, it may be directly liable for its decisions.⁶

It has also been suggested that individual members of IECs may be liable in negligence to people who suffer harm as a result of the members' failure to take reasonable care in making decisions.⁷ Whether liability arises will depend on the circumstances. An IEC member who is also a member of the Board of the institution will probably be protected from personal liability by section 39 of the

Health Services Act 1988 (Vic). Other IEC members who are not members of the Board may be personally liable. The institution would no doubt indemnify them for any monetary compensation that they may be ordered to pay. And they would probably fall within the hospital's insurance cover because they are people for whose conduct the hospital is liable at law. Nevertheless liability would rest upon the individuals themselves. They may be subjected to the stress of preparing for trial, attending court hearings and so on.

In any event, IEC members would be well advised to clarify the relationship between their IEC and the institution and to make sure that they are covered by the institution's insurance policy in respect of their decisions.

Situations where trial subjects' legal rights must be protected and where legal liability may arise

1. Disclosure of risks

Participants in non-therapeutic trials should be fully warned about potential risks, even more than patients facing other medical procedures. This was suggested by the Supreme Court of Saskatchewan in 1956, in the case of *Halushka v University of Saskatchewan*.⁸

The plaintiff in that case was a young university student who had been paid \$50 for participating in a trial of a new anaesthetic drug. He was not told that the new drug was an anaesthetic about which the doctor had no previous knowledge, nor that a catheter would be advanced to and through his heart. He suffered a cardiac arrest and recovered damages from the doctors performing the test and from the university. The court said that the duty to inform is at least as great, if not greater, when people offer themselves as subjects in experimental research, as there is no discretion to withhold information in the interests of the patient's peace of mind.

This accords with the general Australian law on 'informed consent' stated in cases such as *F v R*.^{9*} King CJ said in that case that doctors must discuss 'material' risks with patients before they agree to a medical procedure. A material risk is one that 'might influence the decisions of a reasonable person in the situation of the patient'.¹⁰ The word 'reasonable' in this context indicates that the test is objective; the question is not whether the particular person would have considered the risk significant, but whether an ordinary person in that position would have considered it significant. If people are asked to participate in a research procedure from which they will obtain no benefit, the prospect of such a serious risk as a cardiac arrest, however rarely it occurs, is surely a factor that might influence their decision whether to participate!

2. Potential breaches of confidentiality

A second area of responsibility of IECs that involves safeguarding people's rights and may result in liability is the approval of a protocol for research that might involve a breach of confidentiality. This might arise in a number of ways.

Common law. Ethical codes commonly include a requirement that personal information about a patient acquired by a doctor or other health professional during consultations or treatment must be kept confidential.¹¹ Although the codes are not themselves 'law', they are evidence of accepted practice. A breach of confidentiality might be regarded as failure to take reasonable care for the purposes of a negligence action, or a breach of an implied term of a contract for health services. A person who has suffered injury or financial loss may then be able to sue for negligence or for breach of contract.¹² There are numerous exceptions to the general obligation to maintain confidentiality¹³ but medical research is not one of them.¹⁴

Victorian legislation. In Victoria, section 141 of the *Health Services Act 1988* makes it a criminal offence for hospitals and hospital employees to give anyone outside the hospital confidential information about a patient from which the patient could be identified, except in certain circumstances.¹⁵ A penalty of 50 penalty units (which means a fine of up to \$5000) may be imposed. Section 140A of the Victorian *Mental Health Act 1986* contains a similar provision in relation to psychiatric hospitals and hospital employees. There is, however, an exception where an IEC has approved the use to which the information will be put and the research methodology. The IEC is responsible for checking research protocols to ensure that the proposed methodology is sound and for ensuring that the information obtained is used only for medical research.

Federal Privacy Act. The federal *Privacy Act* 1988 requires federal agencies to observe the Information Privacy Principles set out in the Act in collecting, storing, using and releasing personal information.¹⁶ People may complain to the Privacy Commissioner if an agency breaches these principles (section 36). Section 95 (4) states that an act done in the course of medical research and in accordance with the NHMRC Privacy Guidelines (see below) is not a breach of the Act. If a complaint concerns a breach of privacy that is not covered by the NHMRC guidelines, the Commissioner has power to investigate it (section 40), to declare that it must not be repeated (section 52 (1)(i)(A)) and to declare that the respondent (in this case the institution) 'should perform any reasonable act or course of conduct to redress any loss or damage suffered by the complainant' (section 52 (1)(ii)). This may involve the payment of compensation.

NHMRC guidelines. The NHMRC has published *Guidelines for the Protection of Privacy in the Conduct of Medical Research*¹⁷ and the guidelines have been approved by the Privacy Commissioner under section 95 of the *Privacy Act*. The Act deals only with the use of information held by federal agencies (para 2.1), though they do not apply where the federal agency itself undertakes the research (para 2.3).¹⁸ One writer has suggested that the guidelines are intended to be observed by state agencies as well, when 'the public interest in privacy and the public advancement of medical knowledge will conflict'.¹⁹ This interpretation appears to be beyond the literal meaning of the guidelines in their present form. If the NHMRC intends the guidelines to apply to state agencies as well as federal ones (as was apparently the case in an earlier draft of the guidelines),²⁰ then that should be made clear by an amendment to the guidelines.

As IECs are responsible for an increasing number of 'legal' rather than 'ethical' matters, there is a greater risk that they will be open to civil proceedings or even to criminal prosecution.

If the guidelines apply to a particular project, and the proposed research involves using personal information about someone without their consent for a purpose other than that for which it was collected, the IEC has particular responsibilities in protecting the privacy of the information. If there is a possibility that one of the Information Privacy Principles may be breached in proposed research, the IEC must identify the Principle that may be breached (para 3.6) and then determine whether the public interest in the proposed research outweighs to a substantial degree the public interest in the protection of privacy (para 3.9). The guidelines explain the factors that should be considered in making this assessment (para 3.9). The decision and the reasons for it must be recorded in writing (paras 3.10-3.11). The guidelines also require greater monitoring of research to ensure that it is conducted in accordance with the approved protocol (para 3.13). If an IEC or a researcher fails to comply with the guidelines, the NHMRC may name the offender in its annual report, advise the agency from which the information was obtained and report the breach to the Privacy Commissioner (para 3.17).

3. Supply of drugs on a CTX or CTN basis

A third area that may present legal problems for IECs is the approval of the supply of drugs that have not been fully assessed and approved by the Therapeutic Goods Administration (TGA) in Canberra. Until recently, the TGA assessed the safety information provided by the sponsors of new drugs. TGA experts then confirmed the validity of the information provided to IECs by the sponsors. The TGA's advice on safety did not address the specific protocol submitted to the IEC. That remained the responsibility of the IEC. This option is still available to IECs under the CTX (Clinical Trials Exemption) scheme.²¹

Late last year, however, a new system was introduced by the federal government following its acceptance of the recommendations in the Baume report on drug evaluation in Australia (1991). The new scheme extends the authority of IECs to make experimental drugs available before they have been fully tested in Australia. Now, IECs may authorise the use of new drugs under the fast track CTN (Clinical Trials Notification) scheme.²² This enables IECs themselves to authorise the use of drugs in clinical trials after notifying the TGA. The TGA does not conduct any review of the safety of the drug or of any aspect of the proposed trial.

This option may put pressure on IECs to approve experimental drugs for patients. There have been rapid developments recently with drugs for AIDS and cancer. Patients suffering from these terminal conditions are often keen to try experimental drugs before they reach the market. This may pose a dilemma for ethics committees. On the one hand, patients' autonomy should be respected: people are entitled to decide for themselves what risks they are prepared to take. On the other hand, however, people may need to be 'protected from themselves' by agreeing too readily to be guinea pigs in testing potentially dangerous drugs.

Whether a drug is supplied on a CTX or a CTN basis, IECs are responsible for examining the particular protocol and deciding whether the drug is sufficiently 'safe' to be taken by the patients for whom it is proposed.²³ But with CTN approval, IECs' responsibilities are even greater. They must make their own inquiries about the drug itself as well as consider its use in the particular trial. They can no longer rely on an assessment by a government agency.

Whether the drug should be approved on a CTN basis will depend on a number of factors. The first is the nature of the drug. As the Australian Health Ethics Committee (AHEC) has advised IECs,²⁴ if the drug in question is an established drug that has been approved by an independent approval body²⁵ for one use, then the IEC may need only to obtain certified, up to date information about it from the sponsor before approving it for a new use. The IEC's main role will be to check that the trial is good research and that the consent form is adequate.

If the drug in question is a drug that has been used for other conditions, however, 'the principal role of the IEC is to ensure that the information is comprehensively reviewed by experts in toxicology, pharmacology and clinical trials'.²⁶ AHEC advises that most IECs will not have direct access to this expertise and Phase 1 and Phase 2 studies should always be assessed by the TGA (Phase 1 and phase 2 studies are preliminary studies to test tolerance and dose response to new drugs on a small number of subjects, as compared with phase 3 and phase 4 studies that test the efficacy of a new drug on a large number of subjects).²⁷ AHEC advises IECs to require the drug company supplying a test drug to provide indemnity for the institution and the particular trial²⁸ but that will not prevent the institution being held liable itself.

IECs have special responsibilities in ensuring that participants in CTN trials are adequately informed. In addition to the information that would ordinarily be necessary for the patient to make an informed decision whether to participate in the trial (especially any foreseeable risks or side effects), the participants should probably be warned that the drug has not been assessed by the TGA. They should also be told what provision there is for insurance or compensation if there are unforeseen problems, and the use to which the trial records will be put.

4. Monitoring of projects

A fourth area in which IECs should be particularly careful is in monitoring research projects after they have commenced. The *NHMRC Statement on Human Experimentation* states that one function of IECs is 'to provide for surveillance of research projects until completion so that the committee may be satisfied that they continue to conform with ethical standards'.

The need for effective monitoring is evident from the notorious carcinoma-in-situ research at the National Women's Hospital in Auckland, New Zealand²⁹ which led to the establishment of IECs. The research involved 948 women with abnormal cytology and a diagnosis of carcinoma-in-situ between 1955 and 1976. These women, who believed that they were being treated at the hospital, were in fact given no treatment or only minimal treatment, so that they could be observed to see if invasive cancer of the cervix or vaginal vault developed (Dr Herbert Green, the principal researcher, believed that carcinoma in situ was not pre-malignant and wanted to prove it).

A number of the women died. Two researchers learnt what was happening during the trial from seeing the women's test results and tried to have the women's cases reviewed by the hospital. The Hospital Medical Committee conducted an internal inquiry, found that the initial procedure for having the project approved had been followed and did not recommend that the research should be terminated or that the management of the patients should be reviewed. Later, an inquiry by Justice Cartwright found that the concerns of the two researchers had been well founded.

All IEC members should consider whether, if a similar situation arose at their institution, there would be appropriate procedures to deal with it.³⁰ The IEC should not only require standard reports on completion of a project or annually. It should also provide for a 'whistleblowing' mechanism to enable researchers, staff, participants in trials and others to tell the IEC about any research or ethical problems that arise during a trial.³¹

Conclusion

As IECs are responsible for an increasing number of 'legal', rather than 'ethical' matters, there is a greater risk that they will be open to civil proceedings or even to criminal prosecution. This paper has drawn attention to some of the areas in which liability might arise. They include negligence in reviewing research protocols to ensure that subjects in clinical trials are adequately warned of potential risks or side-effects; disclosure of personal information from patients' records without their consent or appropriate statutory authority; the supply of experimental drugs without making proper inquiries to see whether they are safe and to ensure that the people who receive them are adequately warned of risks, and without obtaining an indemnity from the drug sponsors; and failure to monitor research projects after they have commenced. If a subject in a clinical trial suffers injury as a result of an IEC's decision on matters such as these, it is possible that the IEC's institution, the IEC itself and even the individual members of the IEC may be legally liable to compensate the injured person. It is also conceivable that they may be liable to compensate a researcher whose research protocol has been negligently approved. Who is liable depends primarily on the relationship between the IEC and the institution. If the IEC's role is advisory, the institution and not the IEC will probably be liable. If the IEC itself decides, it may be liable, and also any members of the IEC who are not also Board members. In any event, IEC members should clarify the relationship between the IEC and the institution and ensure that they are covered by its insurance policy.

Footnotes

1. It should be emphasised that this case is described as an illustration. It was decided by a Quebec court, and it is by no means certain that it would be followed in Australia, particularly in relation to the ruling that the knowledge of one member of a committee may be taken as the knowledge of other members as well. In the United Kingdom, the Department of Health has issued a Circular advising that its legal advice is that 'there is little prospect of a successful claim against an LREC [local ethics research committee] member for a mishap arising from research approved as ethical by the LREC. Any such claim would lie principally against the researcher concerned and against the NHS body under the auspices of which the research took place. . . . [and they] should seek to have any claim against an LREC member struck out'. Nevertheless, the Circular acknowledges the possibility of personal liability on the part of ethics committee members and suggests a form of indemnity that members might seek from the District Health Authority to cover them if they are sued. Professor Ian Kennedy says that '[F]ailure on the part of a Committee member to satisfy himself . . . [on any of the matters that should be considered when approving a research protocol] may render him liable to a legal claim in negligence at the suit of a research subject if the research subject suffers harm as a consequence. . . . [T]he obligation [on committee members] is to behave reasonably. Clearly, the expertise of the member may limit what he can do, but the law is likely to require that any reasonable member finding a matter on which he is unsure, should seek advice. . . . and may not simply remain in a state of ignorance' (*Manual for Research Ethics Committees*, Centre of Medical Law and Ethics, Kings College, London, April 1992). On that reasoning, ethics committee members in a case like *Weiss v Solomon* might be found negligent not because they are imputed to have the knowledge of one member of the committee about potential risks, but rather because they did not inquire sufficiently as to what those risks might be. Professor Kennedy suggests that liability might be imposed on ethics committee members who did not satisfy themselves that proper arrangements exist for compensation if research subjects are injured; members are not expected to be specialists in insurance or finance, he says, but they are expected to make reasonable inquiries about the provision for compensation (*Ibid.*).

2. [1989] R.I.Q. 731; discussed by Benjamin Freedman and Kathleen Cranley Glass, 'Weiss v. Solomon: A Case-Study in Institutional Responsibility for Clinical Research', *Law, Medicine and Health Care*, 18, 4, Winter 1990, 395.

3. See Freedman and Glass (note 2).

4. Paul McNeill, Catherine Berglund and Ian Webster found that 'All committees except one reported to the governing body within their institution. This finding simply reflects the fact that the research review committees operate as part of the institutional structure, as do those in the United States': *Medical J of Australia* 152, Mar 19, 1990, 289-296 at p 292.

5. Letter from Professor Ross Kalucy, Chairman, NHMRC Medical Research Ethics Committee, to Chairperson, all institutional ethics committees, 12 Dec 1990.

6. *Ibid.*

7. Ian Kennedy (Note 1).

8. (1965) 53 D.L.R. (2d) 436.

9. (1983) 33 SASR 189. The development of the Australian law is described in *Informed Decisions about Medical Procedures*, a report of the Victorian, Australian and New South Wales Law Reform Commissions, June 1989.

10. *Ibid.* p 192 (King C.J.).

11. For example, the Declaration of Geneva adopted by the World Medical Association; the International Code of Medical Ethics; the Australian Medical Association's Code of Ethics; and the Code of Ethics of the Medical Records Association of Australia.

12. See Loane Skene, *You, Your Doctor and the Law*, OUP, Melb, 1990, pp 146-7.

13. *Id.* pp 130-8.

14. Paul Bravender Coyle, 'The law relating to confidentiality of data acquired by researchers in the biomedical and social sciences', *University of Tasmania Law Review* 9, 1987, p 337. There have been a number of proposals to change the law. In March 1989, the Western Australian Law Reform Commission acknowledged in its discussion paper *Confidentiality of medical records and medical research*, Project No 65 Pt II, that 'the nature and methodology of much epidemiological research seems incompatible with a total ban on the use of name-identified patient information in the absence of patient consent' and asked whether the law should not be amended to authorise this practice: paras 40 and 41. The Australian Institute of Health is seeking increased access to health-related information: Margaret Lane, 'Privacy protection: implications for public health researchers', *Medical J of Australia*, 155 (Dec 2/16 1991), 831-833, at p 832.

15. Other jurisdictions have similar legislation: *Health Administration Act* 1982 (NSW) s 23 (1); *Health Act* 1937 (Qld) s 154M; *Health Act* 1976 (SA) s 64 d (1) (1987 amendment).

16. The Privacy Commissioner has approved a plain English form of the Information Privacy Principles. It is reproduced in an article by Josephine Cooper, which explains how the NHMRC guidelines (that were developed under section 95 of the Privacy Act) operate in practice: 'Balancing the scales of public interest: medical research and privacy', *Medical J of Australia*, 1991, vol 155, p 557.

17. *Commonwealth of Australia Gazette* No P19, 1 July 1991.

18. In that case, the agency must comply with the Information Privacy Principles in the Privacy Act, a Public Interest Determination, or the NHMRC Privacy Guidelines: para 2.3.

19. Cooper (note 16) pp. 557-8. The words quoted appear in the Foreword to the Guidelines.

20. *Ibid.*

21. The legal basis for the CTX scheme is section 19 of the *Therapeutic Goods Act* 1989 (Cth).

22. Section 18 and Schedule 5A of the *Therapeutic Goods Act* 1989 (Cth).

23. The Australian Pharmaceutical Manufacturers Association Inc has published guidelines on the documentation to be submitted to IECs in relation to CTX and CTN applications.

24. Letter addressed to the Secretary, all institutional ethics committees, dated 7 November 1991.

25. Such as the Therapeutic Goods Administration in Australia, the Food and Drug Administration in the United States, or similar authorities in the United Kingdom, Canada or Northern Europe.

26. See note 24.

27. *Ibid.*

28. *Ibid.*

29. The study is described by Charlotte Paul, 'The implications of the cervical cancer inquiry for ethics committees. Could it happen again?', in conference proceedings, 'Can ethics be done by committee?', Monash Centre for Human Bioethics, Nov 1988, pp. 26-49.

30. Many IECs apparently do not monitor projects adequately. Paul McNeill *et al* found in their study of IECs in 1990 that 26% 'never', 18% 'usually', 16% 'sometimes', 21% 'rarely' and 16% 'never' undertook a review of research in progress: note 4 above, at p 292.

31. For other methods of monitoring, see NHMRC Medical Research Ethics Committee, *Report on Workshops on the constitution and functions of institutional ethics committees in Australia 1988-90*, para 3.5.

* This paper was presented before the High Court of Australia decided the case of *Rogers v Whitaker* (Nov 1992). That case endorsed the principles stated in *F v R*.

A VIEW FROM OUTSIDE: SURVEYING ETHICS COMMITTEES

Dr Paul McNeill



Dr Paul McNeill

FROM 1988 through to the end of 1990 my colleagues and I had an NHMRC grant to investigate and describe institutional ethics committees. As well as conducting empirical studies of ethics committees in Australia, I have also made a study of ethics committees in the United States, Canada, New Zealand, Britain and a number of countries on the continent. Much of this material is included in a book entitled the *Ethics and Politics of Human Experimentation* which is to be published by Cambridge University Press early in 1993. In this paper I propose to describe some of our research into the functioning of committees in Australia and to indicate some of the suggestions for change to committees that have been included in my book.

Most of the developed countries in the world now rely on review by committee to ensure that research conducted on human subjects is ethical. As previous speakers have indicated, in this country the NHMRC guidelines require that Australian institutional ethics committees (IECs) include a minister of religion, lawyer, layman, laywoman, and a medical graduate with research experience.

History

Most of the developed countries in the world now rely on review by committee to ensure that research conducted on human subjects is ethical. As previous speakers have indicated, in this country the NHMRC guidelines require that Australian institutional ethics committees (IECs) include a minister of religion, lawyer, layman, laywoman, and a medical graduate with research experience.

Studies of committees

Our research has shown that on average committees have the following members – see Table 1: You will note that there are many more doctors, researchers, and institutional members than are required, but only the one lawyer, one minister of religion and two lay members. On average there are eleven members.

Table 1
Average Numbers Members of Australian IECs

4 medical graduates
1 medical administrator
2 or 3 other professionals
nurses
psychologists
non-medical researchers
2 lay members
1 lawyer
1 minister of religion
Total 11 members

That information is drawn from answers to a questionnaire survey we conducted of all IECs in 1988. We identified 101 committees and of these 89 completed our questionnaire. There are many more committees now. Our best estimate, based on another study we are conducting on ethical issues in hospitals, indicates that there are approximately 170 IECs. We have found that the majority of committee members are in the 40 to 54 age bracket although there is a reasonable spread of ages on either side.

Table 2
Ages of Members

< 25	26-39	40-54	55-69	> 70 Years
6%	20%	52%	26%	12%

We found that the average number of research proposals considered in the previous year by committees was 40.5, although the median was 30 and the standard deviation 45. That means that the data was skewed by some committees considering a large number of studies.

Ten per cent of committees considered over 100 research proposals in the previous year and the highest number considered by any one committee was 272. As you can see from Table 3, almost 80 per cent of research then considered by committees was medical or health related research.

Table 3

Types of Studies	%
Medical	
Medical Science	65
Health Services	8
Population/Epidemiological	6
Total	79
Social/Psychological	
Behavioural Studies	15
Social Science	5
Other	1
Total	21

We looked at how many proposals were passed on first consideration by the committee, and what action the committee took in relation to other studies. Of all proposals considered, 95 per cent were passed either on first consideration or after clarification or modification. These findings were reported in more detail in *The Medical Journal of Australia* in 1990.

Table 4

Action Taken	%
Approved	
On first Consideration	63
After Clarification	15
After Modification	17
Total	95
Not Approved	
Rejected	3
Lapsed	2
Total	5

There are some glaring examples of unethical experimentation on human subjects within the armed forces in this country. However, apart from military research, we are not aware of any studies in Australia, approved by ethics committees, in which harm has been inflicted on the human subjects. We consider that committees in Australia function well by world-wide standards.

There is evidence of abuse of subjects in medical research overseas. A great deal of unethical experimentation was revealed in the United States in the 1960s and 1970s. The New Zealand cervical cancer case at the National Women's Hospital in Auckland (which came to public attention in 1987) also illustrated what can happen when ethics committees do not function effectively.

Although there is no evidence of harm to subjects in reviewed studies, we had some concerns about the functioning of committees in Australia. There is little active monitoring of research once it is approved by a committee. That is true of committees internationally. A few committees met infrequently or not at all. Of all 101 committees, 12 per cent met twice a year or less. Two committees did not meet in person but conducted their business by telephone and mail. We were also concerned about the independence of lay members. Lay members are supposed to be 'not associated with the institution'. However most committees consider appointing new members from people whom they know. Consequently many lay members are neighbours of committee members. Some lay members had closer affiliations. For example, one laywoman I interviewed from a committee in a major hospital was the wife of one of the senior consultants. Others are ex-administrators or ex-Directors of Nursing. These members are not independent of the institution in the way in which the NHMRC intended. This finding raises questions therefore about the adequacy of committee processes in appointing lay members. I note that one committee (Greenslopes in Brisbane) now advertises for lay members and interviews them according to criteria laid down by the committee. I believe that is a preferable method of appointment. We found that

53 per cent of members whose proposal was before a committee stayed in the committee while their proposal was discussed. In our view their presence constitutes a bias even when they do not actually take part in the discussion.

Study of researchers

We also conducted a study in 1989 and 1990 based on both questionnaires and interviews with researchers. A survey questionnaire was completed by 449 researchers and we subsequently interviewed 92 respondents. The major finding was that researchers are supportive of the present system of review. Researchers agree that the committee makes them more aware of ethical issues in research, and even though the majority found the system time-consuming, and some thought it impeded research, basically they are in favour of the review process. Surprisingly, the few researchers who actually had their work rejected by a committee were significantly more inclined to say that the review process was effective in making researchers more ethical.

Researchers were also in favour of more active monitoring by ethics committees of research in progress. The comments offered were that monitoring would 'prevent people from deviating from their research if they knew it was possible that they would be monitored'. One researcher said monitoring was 'a big stick that makes you think'. At the same time researchers are concerned, as indeed are committee members, that the IECs may not have sufficient resources to properly monitor research. This concern should encourage IECs to work more actively towards the monitoring of research, and particularly encourage those IEC members who are fearful of intruding on researchers and inhibiting research. These findings will be published in the *Social Science and Medicine* journal this year. [1992]

There were concerns arising from that study. A consistent pattern emerged that respondents believe Australian researchers do not always abide by NHMRC and IEC directives. It appears that some research proposals may not be submitted to IECs for review; this was supported by occasional statements volunteered by researchers in interview. One researcher said, 'As I walk around the hospital, I find out that research is going on that should have gone to the committee but didn't'. It also appears that some researchers change their research plans without seeking the view of the IEC which initially approved the proposal. This is similar to earlier findings in the United States and Britain. Of the researchers we interviewed, 13 volunteered that they deviated from their research proposals, as is shown in Table 5.

Table 5

Deviations from Research Process

Deviations from Research Proposal Without Consent

- Increasing Number of Drugs Compared
- Expanding Age Range Beyond the Criteria
- Taking Additional Biopsy
- Doing Additional Whole Body CT Scan

In interview, researchers most commonly described the reason for deviations in research as stemming from the need to plan research a long time ahead, and of unpredictable needs to change the proposal once instituted. Researchers explained that the direction of research can only be 'surmised' in a proposal, and that the actual research evolves as it is conducted. They stressed that 'research is not a linear inquiry', that it leads in unexpected directions, and therefore the researcher has to be flexible. However, in a strict sense, any research proposal which deviates from that approved by an IEC could be viewed as unethical, because it has not been approved and does not conform to the accepted system of review of the ethics of research. This would not be of concern if the deviations were small but not all reported deviations could be viewed as minor. Some of the self-reported deviations demonstrated conscious decisions by some researchers to perform significant procedures on research subjects without the proper approval of an IEC. One researcher explained that his usual practice was to submit a proposal for committee review (and to seek

funding), after having already conducted the research described in the proposal. There is some concern, therefore, about whether or not researchers actually abide by NHMRC and IEC directives.

Lay members, ministers of religion and lawyers

The question which interests me particularly is whether the inclusion of lay members, lawyers and ministers of religion on committees makes an effective difference. A United States study showed that non-institutional and non-scientific committee members did not have much influence. This suggests that their committees are effectively peer review committees rather than more broadly based ethics review committees.

In Australia we have had similar results from our studies of committee members' participation. In interviews we conducted in 1988 and 1989, we asked committee members to rate other members (and themselves) on two scales: one, on their activity in meetings, and two, on the importance of each member in contributing to committee decisions. What we found was that the most influential members are the medical graduates and administrators. Lay members were seen as significantly less active and less important. The only non-medical or institutional member seen as important was the lawyer. When we put these findings together with committee members' comments about their roles, we learn that lay members and ministers of religion do not see themselves, nor are they seen by others, as influential.

Suggestions for change

Taking this into account I have suggested a number of changes in the composition and functioning of research ethics committees. One suggestion is that IECs be composed of an equal number of researchers (that is representatives of research and the research institution) and equal numbers of representatives of subjects. Along with those two groups, I have suggested including an administrator and a lawyer or 'ethicist'. This recognises the importance of an administrator on committees. I also believe, based on our research in Australia, that lawyers are effective advocates for human subjects in experiments; and they are useful on committees for their understanding of consent and the law. However, I accept that someone trained in philosophy or ethics may perform this role equally as well.

I also advocate explicit and different role descriptions for the research representatives and representatives of research subjects. This suggestion is based on the observation that many of the lay members and ministers of religion we interviewed did not have clear idea of their role. I believe that committees should be much smaller. To accomplish this committees would need to rely much more on expert advice on questions relating to the scientific validity of studies.

Training

I advocate training for committee members. If there are to be minimum standards for all committees there needs to be a training program to establish those standards. In addition there is a need for training in a consensual style of decision-making that encourages all members to express their differences of opinion. This is not a consensus based on with-holding views so as to avoid 'rocking the boat' but a consensus based on a discussion of all views (including opposing views) and continued debate to arrive at an outcome that gives appropriate weight to all expressed concerns. This suggestion is intended to overcome the tendency for some lay members to keep quiet when they hold contrary views. It is also intended to provide constructive techniques for dealing with differences of opinion.

Summary

In summary, I see institutional ethics committees in Australia as being an expression of concern for the well-being of subjects in medical and other research. They have been effective in changing attitudes and making researchers more aware of ethical issues in research on human subjects. Whilst there is little evidence of subjects being harmed in research in this country there is some evidence that committees are predominantly influenced by members from research institutes. I have made some suggestions on changing the formation of committees in order to make better use of the non-research and non-institutional members and to clarify their roles. I have also expressed some concerns about studies conducted without review and have suggested that there is a need for more effective monitoring of research after approval.



Afternoon tea in the foyer.

THE FUTURE

NEW ROLES FOR HOSPITAL ETHICS COMMITTEES

Professor Richard Smallwood



Prof. Richard Smallwood

INSTITUTIONAL ETHICS COMMITTEES (IECs) have done a sometimes difficult job well. The NHMRC's former Medical Research Ethics Committee and its IECs have set high standards without blocking or unduly impeding important and worthwhile research. The vast majority of researchers strongly support the present system, despite some irritation engendered by the increased paperwork or occasional delay in starting a particular study. IECs are perceived to be conscientious, hard-working and helpful, not

capricious, self-righteous, intrusive or obstructive. They have probably done a lot to ensure that the scandals of the past in clinical research will not occur again.

Well, what are the new directions in which IECs are moving? I would like to spend a little time on clinical trials and the new responsibilities of IECs, then say something about privacy and confidentiality, which, although not a new issue in general, is a potentially new issue for IECs not associated with Commonwealth institutions. Finally, I want to speculate a little about the future.

Before 1987, any proposal for the clinical trial of a drug had to undergo detailed scrutiny by the Therapeutic Goods Administration (TGA). TGA evaluated all safety and efficacy data available, examined the trial protocol (from an ethical as well as a scientific standpoint), and finally met with the sponsor and investigators before deciding that the trial might go ahead. This came to be seen as a tedious and unwieldy procedure, so that the Clinical Trials Exemption (CTX) scheme was introduced in 1987 to speed things up. Under this scheme the sponsor submitted a package of material to TGA, including toxicity and safety data; if no objection was notified within three months, the trial could go ahead, subject always to IEC approval. TGA did not examine the scientific worth or ethical acceptability of the trial, both these responsibilities falling to the IEC. This scheme in turn came to be viewed as sluggish, so that the Federal Government (some said in a fit of pique) passed the buck entirely to the IECs and introduced the Clinical Trials Notification (CTN) scheme twelve months ago. Under this scheme the TGA simply has to be notified of a proposed trial. It takes no responsibility for scrutinising any information about the trial drug; it takes no responsibility for assessing safety or toxicity. The IEC has to do the lot, and I have had estimates of increased workload for IECs from 30 to 50 per cent.

This may pose no problem for what are called phase 3 or phase 4 trials, where the drug will already have been evaluated by accepted

regulatory authorities (e.g., FDA). But for phase 1 or 2 trials, where, for example, a new drug is being administered to small groups of volunteers to determine its pharmacological behaviour and its side effects, often there will have been no prior assessment by any acceptable regulatory authority. How does the IEC cope then? How do the laywoman and layman, minister of religion, lawyer and medical graduate with research experience evaluate, for example, toxicity data, which is a highly technical exercise, in order to come to a view about the safety of the new drug?

They are clearly going to need to take advice, which may be available from individual experts in the same institution, or from a drug or clinical trials committee. More likely, the IEC will have to seek external advice from such people as toxicologists or pharmaceutical chemists. This will take time and money and may prove, for these early phase studies, to be more cumbersome than the original CTX scheme.

What if the IEC gets it wrong? What happens if a catastrophe occurs, and the IEC is found, in retrospect, to have assessed the toxicity and safety data inadequately? The whole question of who is liable, who needs to be indemnified, and how this is to be effected, needs to be thought through carefully if early phase trials are to be carried out under the CTN scheme.

There is another option. The CTX scheme is still extant, in modified form, as recommended in the Baume report. I suspect that most IECs will require early phase trials to be carried out under this ongoing CTX scheme, where TGA will still be responsible for evaluating safety and toxicity data.

I note that the Australian Health Ethics Committee (AHEC) has set up a Clinical Trials Working Party to try, amongst other things, to sort out ways of providing expert assistance to IECs when they need it. This may minimise any reluctance of IECs to embrace the CTN scheme. It seems to me that at the moment IECs are still feeling their way.

The Commonwealth's *Privacy Act* 1988 looked, at one stage, as though it might stop medical research in its tracks – particularly epidemiological research. The major stumbling block was privacy of information. The Act contains eleven information privacy principles (IPPs), the most pertinent being the prohibition of the use of personal data, for example, for research purposes, unless the individuals concerned were aware of those purposes at the time the data were collected, or unless they subsequently gave their consent. The IPPs only apply to personal information held by a Commonwealth agency, so most IECs do not have to consider them. After representations from various quarters, the Privacy Commissioner accepted that medical research might be exempted from the *Privacy Act* provided that guidelines developed by NHMRC were followed. Thus the guidelines apply only when a research project is considered likely to be in breach of an IPP.

Where does the IEC come in? First it has to decide whether the research is in breach of an IPP. Where the problem is – as it usually is – that consent has not been given for personal information to be put to a particular use, the IEC has to satisfy itself that it is not reasonable to seek that consent. The IEC then has to take into account how the personal information is to be used, whether the research is in the public interest, and whether 'the public interest in the proposed research outweighs, or does not outweigh, to a substantial degree the public interest in the protection of privacy'. If the IEC decides that the importance of the research does substantially outweigh privacy concerns, then the research is not regarded as being in breach of an

Is there a danger that the pendulum is about to swing too far, that IECs are about to become too assertive and intrusive, that regulation will become too rigorous and that important research will be blocked?

IPP. In coming to this decision, the IEC has twenty or more points to consider – a potentially Herculean task. For example, the IEC has to take into account:

- The weight that was given by the community and by relevant areas of expertise to similar previous studies;
- whether the research design cannot be satisfied in any other way; and
- the degree of intrusiveness of the questions to be asked or the procedures to be employed.

These are just three of the twenty-odd items to be explored to give you the flavour of what is required.

The Commonwealth is the pacesetter, but the states will in all likelihood have produced similar guidelines before much longer, and privacy considerations may soon prove to be a major issue in all protocols coming to IECs. The privacy guidelines add a new dimension to the work of the IEC. It has to adjudicate not just on ethical standards, safety issues, and scientific merit. It has to decide public benefit, or what the public interest is. I believe this is a proper function, and a readily achievable one, if 'public benefit' is to be assessed in broad terms. But I do confess to some unease when I read through these detailed instructions to IECs about how they should decide the public interest.

And this brings me to my final theme: Is there a danger that the pendulum is about to swing too far, that IECs are about to become too assertive and intrusive, that regulation will become too rigorous and that important research will be blocked?

Philip Pettit, in a lecture to the Academy of Social Sciences in November 1991, developed this theme in some detail. He drew on an interesting model developed by Oliver MacDonagh which traced the dramatic growth in regulatory legislation and in regulatory agencies in Victorian England. The model traces the growth of administrative government in this way:

1. An evil is exposed, there is public outrage, and this provokes a legislative response.
2. Some time later it is discovered that the original evil is going on undisturbed, when there is a further scandal, and then there is an administrative response – experts look into the problem.
3. The experts recommend tightening of the legislation and officers are appointed to gather data and monitor the problem.
4. Further down the track still, it becomes apparent that the new legislation and monitoring have not rectified the original problem.
5. The final response is to set in place a regulatory bureaucracy with powers not only to monitor and review, but to intervene.

So here we have public policy being formed in reaction to a perceived evil.

As Pettit points out, this model can be readily applied to the development of ethical regulation of medical research in this and other countries. There is no doubt that there has been scandalous conduct by research workers in the past. It is interesting that Nazi doctors at the Nuremberg trials attempted to mount a defence of their experiments on the inmates of concentration camps by quoting published accounts of earlier human research utilising similar experiments. As recently as the 1960s a researcher in New York injected elderly patients with cancer cells without their knowledge or consent. However, it may reasonably be averred that we have now evolved to the point where ethical standards in medical research in this country are high, regulatory and review mechanisms are in place. So where do we go from here?

The concern is that IECs, in a sense to justify their presence and to be seen as other than rubber stamps, will start to become unreasonably intrusive and inhibit rather than facilitate good research. Privacy regulations, a likely growth area for IEC activity, have already caused some tension. You may recall that Norman Swan in his 1988 Peter MacCallum Lecture told the story of how epidemiologists in Perth had important research blocked by the University's ethics committee – I gather because a lawyer on the committee was adamant that the study was in breach of privacy laws. Looking at the current privacy guidelines, you might well come to the view that there is considerable scope for IECs to exert their authority unnecessarily or in an unbalanced way.

Well, do I share this somewhat bleak view of the future activities of IECs? No, I don't. As I said at the beginning, I believe IECs have done their job well, and will continue to do it well. They have been

reasonable, sensible, helpful and appropriately assertive. I don't see why they won't continue to be just that. My principal worry is that their increasing workload will outstrip their resources by so much that their performance will fall away. I hope that Robyn Layton will see as one of the principal roles of her committee, AHEC, to nurture and assist the IECs, not just to 'monitor' them, to ensure that their present excellent work continues.

THE AUSTRALIAN HEALTH ETHICS COMMITTEE: ROLE AND FUNCTION

Ms Robyn Layton



Ms Robyn Layton

IT IS TIMELY TO REFLECT on the present and future role of the Australian Health Ethics Committee which is now one year old. Institutional Ethics Committees (IECs) are older. In 1973, the NHMRC, prompted by developments particularly in the United States and the amendment to the declaration of Helsinki, recommended that 'Institutions undertaking medical research should have a medical ethics review committee'. In 1976 these amendments were incorporated in the revised *NHMRC Statement on Human Experimentation*. This Statement has provided the basis for the present constitutions and functions of IECs. The NHMRC recommendations for review of research have been mandatory only since 1985.

Over the decade, the number of IECs has grown to approximately 140 in 1992. Also over the decade, important changes and advances have occurred which have had significant impact on the work being undertaken by the dedicated and hard-working persons who comprise these committees. These changes include:

- technological advances
- changes to the drug evaluation processes in Australia
- greater refinement of ethical issues surrounding autonomy of research subjects
- development of privacy requirements which are compulsory in certain research
- increasing areas of research including more sociological and qualitative research
- potential legal liability in a litigious environment.

All of these concerns impact on the volume of work and the nervousness with which some IECs approach their functions.

There is an advantage in the new AHEC taking over the previous function performed by the Medical Research Ethics Committee of NHMRC, providing a fresh approach to the current roles and functions of the IECs. This must be done, however, in a context which ensures that persons with historical knowledge of the origins and gradual development of current IEC functions, have significant input in order to avoid historical pitfalls and ensure that good features are not eroded in endeavours for improvement. AHEC also has the advantage of being able to build on a system which has been proven to be successful and it is a matter of further developing and refining the structures.

The IECs have identified a number of issues of concern, as have the researchers. There will always be some tension between researchers and IECs. The aim of AHEC is to try and produce an appropriate meeting point in a spirit of co-operation, understanding and respect for the roles which each of them have towards the end goal of quality research.

AHEC has identified its function in relation to IECs as that of 'monitoring and supporting' and is still developing how best to perform that role. The beginning process has been the setting up of a sub-committee of AHEC which is dedicated to the task. Some of the issues being looked at as potential topics for consideration by the committee include:

- composition of IECs
- problems of multicentre trials
- an appeal system for researchers

- evaluation of scientific merit
- monitoring of research
- legal liabilities of IEC members
- CTN drug trials.

IEC composition

Debate is occurring in a number of forums and constituencies about the preferred composition of IECs. A variety of reasons have given rise to this debate:

- Concern about the relevant expertise of members to assess qualitative research protocols.
- Concern about the variety of research proposals and the limited expertise available on IECs to cope with the technical aspects of such research protocols.
- Added burdens placed on IECs by the new Clinical Trials Notification (CTN) scheme.
- Increasing use of IECs to advise on ethical issues arising in clinical practice.
- The increasing availability of persons with appropriate training in ethics to sit on such committees.

Some suggestions for the future composition of IECs include:

- Instead of the only choice being a medical graduate, there should be flexibility to reflect the nature of the search protocols usually considered by the institution. For example, an institution which has a preponderance of sociological search protocols could include a member with graduate research experience in sociology; similarly, an IEC which mainly considers protocols from nursing graduates and students, could have a member with appropriate expertise in nursing.
- Maintaining a distinction between assessment of scientific merit and the ethical aspects of the implementation of the protocol. A study undertaken by McNeill, Bergland & Webster published in *The Medical Journal of Australia* Vol. 152 March 1990, indicated that at the time of the survey of the 133 IECs in July 1988, only 36 per cent used another committee to assess the scientific merits of the application. This left a possible inference that the remainder of the IECs were themselves judging the scientific merit without necessarily having appropriate skills.
- Appointment of an ethicist or person with expertise in ethics instead of a minister of religion.
- Having an open method of selection of members. The McNeill study mentioned above indicated that almost all non-lay members were appointed on the basis of recommendations from within the committee (54 per cent) or the institution (82 per cent). The lay persons were also appointed largely on the basis of suggestions from within the committee (52 per cent) or the institution (56 per cent).

The composition of IECs is linked with the issue of assessment of scientific merit and validity of protocols. Several methods of potentially dealing with that problem have emerged including:

- Retaining the present IEC structure but recommending that the IEC seek an assessment from a hinged or selected panel to advise on that aspect of their ethical assessment.
- Expanding the composition of IECs to appropriately reflect the need for IECs to themselves undertake that assessment as part of their ethical evaluation.
- Formally separating the assessment of scientific validity and ethical evaluation, so that the IECs confine themselves to ethical concerns and not scientific evaluation of validity or merit. Such evaluation could be left to a Scientific Evaluation or Advisory Group specifically constituted to reflect a peer review system. Such a group could evaluate the scientific aspects and then report to the IEC which would then take that into account in the overall assessment; and
- Other variations or combinations of the above potential models.

The new CTN scheme, which requires an IEC to evaluate safety and efficacy of proposed drug trials, has also raised the angst of some IECs. AHEC has responded by recently issuing interim guidelines for the consideration and use of IECs, and also circulating them for public comment with a view to having settled guidelines published for use by the end of this year.

In considering the composition of IECs it is important to find the right balance between a too prescriptive approach to composition which does not take into account particular needs of the institution,

and a minimum standard upon which all IECs should be based. It is also essential to bear in mind that ethical issues, and similarly the function of IECs, will always be in a state of flux, that is the nature of the beast. What may appear to be an ideal solution now, may change in the future with further advancement. The aim of AHEC assisting IECs, must therefore be to continue to be vigilant and monitor changing needs as they arise.

Multicentre research

Researchers in particular are expressing concern about difficulties and delays associated with multicentre research. Problems include:

- Delays while each of the institutions considers the proposals when there may be a time restriction in which research funds are to be expended.
- Individual requirements before consent to research is granted by institutions which differ between institutions. These differences are not only irritating and can increase expenses of protocols if different forms are required, but more importantly may adversely affect the integrity and uniformity of the application of the research protocol itself; and
- Dissipation of energy of researchers in trying to satisfy the diverse requirements of different institutions at the same time.

The frustration of researchers can be understood easily. Again this must in some way be juxtaposed against the need for institutions to take individual responsibility for the acceptance of research protocol being performed within their institution. The problem is not new and in England the Local Research Ethics Committees (LREC) have recommended that:

Each LREC is free to arrive at its own decision when considering a proposal which is planned to take place in more than one area. It would, however, obviously be sensible – in the interests of eliminating unnecessary delay and ensuring that similar criteria are used to consider a proposal – that committees should arrive at a voluntary arrangement under which LREC is nominated to consider the issue on behalf of them all. Health authorities should positively encourage networks for neighbouring LRECs so that such co-operation is more easily achieved.

However, this statement also occurs in a context in which the LRECs are advised by the Department of Health:

Legal advice available to the Department of Health is that there is little prospect of a successful claim against an LREC member for a mishap arising from research approved as ethical by the LREC.

Further:

... The DHA will take full responsibility for all your actions in the course of the performance of your duties as a member of the LREC other than those involving bad faith, wilful default or gross negligence. . . .

The situation of legal liability in Australia and the means of indemnity may not be so clear cut and certainly there would appear to be no backup by government. Work is presently being undertaken by AHEC through its sub-committee on the topics of legal liability as well as multicentre research with the aim of producing a report or guidelines at the end of the year on both of these important issues.

Appeal system for researchers

Suggestions have been made by a number of people including Professor Philip Pettit in the Academy of Social Sciences Annual Lecture in November 1991, strongly recommending an appeal system for researchers. Such an appeal system could deal with rejections or proposed modifications by IECs to protocol, to which the researchers object. Again, any such system would have to take into account problems of legal liability for a rejecting institution, and in particular the problems of an institution being required to accept what it regards as unacceptable research protocol. The resolution of the problem is therefore not simple.

Other related issues to appeal systems are methods by which records may be kept as precedents for use by IECs if similar research concerns arise. Such stored data may be of assistance in recording how a matter was dealt with previously. This may also lead to a greater consistency of approach and also provide future guidance to both researchers and IECs.

Evaluating scientific merit

This was briefly dealt with under the heading of 'IEC Composition'. There have undoubtedly been considerable advances in the type of research which comes before IECs, with increasing technological complexity. There is also an increase in the number of research

protocols involving sociological or qualitative research which, it is argued, are not appropriately catered for as the IECs require a graduate in medical research. It is also suggested that researchers are unhappy about persons without relevant expertise making assessment on protocol validity or merit. A further concern expressed by IECs themselves was a potential risk that as a consequence of focus on scientific merit, there was potential for basing a decision to approve a protocol solely on scientific validity and not the ethical issues. Further, concern has been expressed by IECs about research which has little scientific merit, for example, market research, and how that should be assessed. These are matters which will require future detailed debate by AHEC in consultation with IECs.

Monitoring research

AHEC is presently drafting guidelines for the monitoring of research by IECs. The reasoning behind such guidelines is to ensure that protocols accepted by IECs are in fact implemented in accordance with the protocol. Issues arise about the extent to which there should be obligatory monitoring, the nature and extent, and by whom. It is hoped that AHEC monitoring guidelines may also be available for comment shortly, with a view to again having more settled guidelines by the end of this year.

Legal liabilities of IECs and their members

This has previously been touched on and again a draft report is being considered by AHEC for the purpose of distribution to IECs on this issue and the related issue of what indemnity IEC members should seek as a condition for the approval of research work being conducted in an institution.

CTN drug trials

AHEC has responded urgently to the need for IECs to have guidelines on the new system of assessing drug trials. This has, as previously mentioned, been sent out to IECs and the public for response.

Apart from these specific issues, the challenge for AHEC and the IECs for the next decade is to:

- improve the processes for IECs to reduce or spread their workload;
- provide communication between IECs and with AHEC to support their work;
- balance the needs of researchers and the functions of IECs so that there is a co-operative spirit; and
- provide information and backup for IECs to enable the professional approach to their work to continue developing.

AHEC welcomes this challenge and the composition of the committee and secretariat augurs well for its successful implementation.

DISCUSSION



Questions and answers.

1993 WHAT'S ON

Seminar

THE DEAD DO TELL TALES

DECLINING AUTOPSY RATES AND
THE QUALITY OF HEALTH CARE

Convener: Professor Richard Smallwood

Friday 23 July, 2.00 to 5.00 p.m.
Sunderland Theatre, Medical Building
The University of Melbourne

UMMS 1993 Function

*Watch for
announcement*

UMMS Annual General Meeting

Tuesday 18 May, 6.30 p.m.
Sunderland Theatre, Medical Building
The University of Melbourne

Dean's Lecture Series Continuing Medical Education

Details on the back cover of this issue
General enquiries: (03) 344 5888

Alumni Association

Gala Concert

Stephen McIntyre (piano)
and
Phillip Green (cello)

7.30 p.m., Friday 14 May
Melba Hall, The University of Melbourne

Enquiries:
Kathryn Clarke, Alumni Office
The University of Melbourne, Parkville, 3052
Telephone (03) 344 7469

CONTEMPORARY THREATS TO ADOLESCENT HEALTH

Professor Glenn Bowes

Director, Victorian Health Promotion Foundation Centre for Adolescent Health
Royal Children's Hospital



Prof. Glenn Bowes

THE HEALTH OF YOUNG people is a major issue for today as well as being critically important to the future success of our society. Current social and economic circumstances have contrived to place young people at particular risk of disadvantage. During such times, their rights to have access to health services and to be able to pursue their lives in a healthy environment need to be carefully protected. In addition, it is self evident that the future productivity of our society is linked to the

health status of today's young people and their ability to contribute towards the maintenance and development of our community.

Defining adolescence

Adolescence is that time of life between childhood and adulthood. Most of all it is a period of change, transition and development. Chronological classifications of adolescence are of limited value as they may not truly represent the progress through developmental stages. However, the following chronological categories have general acceptance: adolescent 10 to 19 years; youth 15 to 24 years; and young person 10 to 24 years of age.

Young people between 10 and 24 years of age make up 23.4 per cent of Australia's total population. Thus, notwithstanding the 'greying' of the Australian community, young people constitute a major population group. Moreover, it is a population group of great diversity and heterogeneity. Young people do not form a cohesive advocacy group within the community due to their variety of developmental stages, and the fact that the majority are unable to vote in the normal democratic process. The voice of young people is seldom heard in the context of health policy discussions and initiatives.

Adolescent development has been characterised as occurring within biological, cognitive and psychosocial domains. These domains do not occur in phase, with physical growth and physiological maturation having been completed before psychological and sociological development has run its course. Such a phase lag represents a challenge to health providers, who must take time to observe more subtle markers of cognitive and psychosocial development as part of their general developmental assessment of the young people to whom they are delivering services.

An important part of cognitive development during adolescence involves the acquisition of formal thought processes. This brings with it the ability to think in an abstract manner and thereby a sense of future perspective. This cognitive process also enables young people to understand the consequences of their actions and to consider the deferral of acts of immediate gratification in favour of the pursuit of goals that will bring long term success in the future. Awareness of this cognitive development process is important for health providers in their attempts to engender compliance with treatment regimens and health promoting behaviours in young people.

From the perspective of a young person the process of adolescent development may be seen as a number of tasks that have to be achieved in order that passage into adulthood is successfully negotiated. The psychosocial tasks which need to be achieved include body self-integrity, sexual self-concept, autonomy and independence,

mastery and control, the ability to develop more mature and intimate peer relationships and a pursuit of educational and vocational goals. The pursuit of adolescent goals by young people may at times appear to conflict with more narrowly focused treatment priorities of health providers.

Adolescence may also be viewed as a social construct. This perspective sees adolescence as a long period of time constructed largely in response to economic and social changes. The duration of adolescence therefore can be seen as resulting not so much from internal, biological and developmental 'clocks', but rather from external factors that have influenced the role of an adolescent in society. This view also places adolescence in the historical context, contrasting the brief initiation periods of 'rights of passage' that formed an integral part of primitive societies with the long period of dependence that has evolved for young people in developed societies.

Irrespective of the approach taken to defining adolescence, it is clear that the timing and pattern of adolescent development varies widely between and within individuals. Adolescents universally exhibit rapidly changing behaviour. There is frequently a waxing and waning of the process of development. This lack of a defined and regular schedule poses a challenge to health care professionals. The inconsistent performance of young people is often seen in a judgemental manner by the health care providers and this of itself constitutes a major disincentive to good compliance. Variation in behaviour should be expected. Non health promoting behaviours should not be condoned but the focus should be on the provision of rewards when young people make good decisions with regard to their health management.

Experimentation is also a common part of adolescent behaviour. Although there is no question that adolescents do take risks, the term 'risk-taking behaviour' does little to improve understanding between adolescents and adults. Whilst research into the risk-taking behaviours of young people is an important area of academic pursuit, the judgemental and pejorative nature of the term 'risk-taking behaviour' means that it would be beneficial for health providers to remove it from their lexicon.

Defining health

The health of young people needs to be viewed in the broadest context. It needs to be recognised that health is not merely the absence of disease but constitutes a state of complete physical, mental and social wellbeing. Health should be a resource for everyday life.

Adolescence is usually characterised as being the healthiest period of life. When viewed from a strict medical viewpoint, adolescence is clearly the most disease free period of life.

Traditional mortality statistics are now recognised as being an incomplete way of judging the health of a population. Nonetheless, mortality statistics remain influential in the development of health policy. Young people in particular are disadvantaged by the use of mortality statistics in driving policy. The major causes of death of young people in Australia do not result from disease, but rather from accidents (including motor vehicle accidents), suicide and other causes of a more social and behavioural aetiology.

With the exception of asthma, all chronic diseases increase in prevalence with age. Asthma therefore constitutes the major chronic illness of adolescence. A small number of young people with severe life threatening childhood illnesses are now surviving into adult life and represent a special group requiring tertiary and high technology services. The health system is being challenged by the need to develop

appropriate services for these survivors of the tertiary paediatric institutions.

The estimation of disease morbidity as a means of gaining a broader view of the health of the community is a challenge being embraced by the public health and epidemiological communities. Valid measurement instruments need to be developed and gain wide acceptance. Nowhere is the importance of such developments more evident than in the adolescent health arena.

Markers of adolescent health

Although there has been a lack of systematic data collection that accurately reflects the health of young people in Australia, there is a range of studies which indicate the extent to which the health of young people is compromised. These studies show disturbingly high use of drugs, failure to practice safe sex behaviours, depression with attempted suicide, and a range of disorders related to body image and eating behaviour especially in young women. There is a clear need for state and national surveillance of adolescent health using appropriate health indicators relevant to young people.

Key issues in adolescent health

Access to health services is a key issue for young people. A range of barriers exist that prevent young people accessing good quality health services. Such barriers include cost, transport, cultural differences, moral attitudes and knowledge. In general, young people lack the skills that enable them to interface easily with health care professionals.

Adolescents are also concerned about confidentiality issues when they access health services. Common concerns include the possibility that general practitioners and other health providers will communicate with parents, thereby breaking confidentiality. Health practitioners and services need to be explicit in their commitment to preserve confidentiality when dealing with young people. The absence of this sense of trust between a young person and their health provider can constitute of itself a significant barrier to health care.

Equity is also a major issue in adolescent health. The resource distribution of the health care dollar to young people is inadequate. There is particularly a problem with young people who are disadvantaged. Disadvantage may result from social factors that lead to homelessness or poverty or may result as a consequence of chronic illness or disability. The health of socially disadvantaged young people currently represents a major challenge to our health system.

Adolescent health – solutions

There are no easy solutions to the health care problems of adolescents. However, the major factors that pose threats to young people's health are structural, social and political in nature. Authoritarian systems all too frequently place blame on young people for their health problems by making the 'risk-taking behaviour' of young people a major focus. It is vital that appropriate amounts of resource are put into the adolescent health sector to enable the development of appropriate health services that are accessible, welcoming and ensure confidentiality. The health system needs to provide a variety of opportunities for young people to gain health services, both through specialised young people's health programs as well as appropriately targeted services within the main stream agencies.

The strategies used to address young people's health issues need to be diverse and to be focused on designing health services around them. In this regard, there needs to be a systematic intersectoral approach taken with educational and youth sectors operating in a co-ordinated manner with the health sector. In addition, medical, health planning and community development approaches also need to be incorporated into an overall adolescent health strategy.

Conclusion

The health needs of young people are not being adequately dealt with by the existing systems of health service delivery and health promotion. Social and economic circumstances in our contemporary society have led to young people being placed at relative disadvantage with regard to health and health services. Structural changes combined with targeted, developmentally appropriate health programs are required to ensure that young people are able to draw upon health as a true resource for their everyday life and productivity. Furthermore, the health system needs to develop innovative strategies for dealing with the special health needs of young people disadvantaged by social circumstance or chronic illness and disability. □



CME staff, Mr Paul Geyer and Mr Bob Hannam, with registrants at the Psychiatry for Non-psychiatrists course, Austin Hospital, March 1993.

CONTINUING MEDICAL EDUCATION ARE YOU UP-TO-DATE?

Most medical graduates are keenly aware of the extraordinary rate of progress in medicine, and advances in all aspects of investigation and treatment since they graduated. The Medical School of The University of Melbourne, recognising the needs of its graduates and the profession, established over ten years ago the Continuing Medical Education Unit which each year arranges a number of courses in a wide range of subjects. The topics of such courses are mostly designed for general practitioners.

Recertification involving a commitment to continuing education has been approved in principle by most Colleges. The equivalent in general practice is the continuing education requirement for Vocational Registration. The Faculty is examining ways of working with the Colleges in designing appropriate continuing education activities.

Of the many ways in which general practitioners can update their knowledge – journals, lectures, group meetings – one of the most popular are continuing medical education courses, which provide direct interaction with specialists, and with colleagues. In preparing general medical updates, it is important to consider the perspective of the general practitioner: the demands on their time, the difficulty and expense of obtaining locums (particularly in rural areas), the wide range of appropriate topics, the importance of practical information and the need for a 'take-home' booklet summarising the main points covered. From the specialist-lecturer's perspective, the University is an ideal vehicle for continuing medical education with its research links and hospital clinical schools, where the courses are held.

In 1992, Professor Emeritus Priscilla Kincaid-Smith followed Professor Emeritus Richard Lovell as Convener of Continuing Medical Education. The program for 1993 covers areas of special importance for general practice, with emphasis on discussion and practical clinical information. There are eleven courses of varying length – from one-day to four-day programs which include an update in general medicine, psychiatry for non-psychiatrists, radiography, ENT problems, paediatrics, diabetes, dermatology and other topics. The complete list is printed on the back cover of this journal.

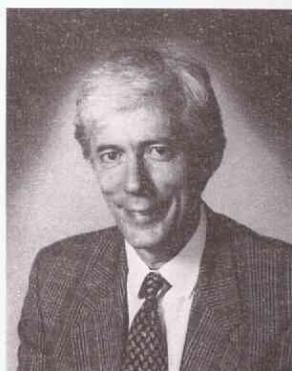
A brochure giving details of courses including topics to be covered, has been widely circulated to all graduates of the Melbourne Medical School and is available from:

Continuing Medical Education
School of Medicine
The University of Melbourne
Parkville, Vic 3052.
Telephone (03) 344 5888
Facsimile (03) 344 5998

The CME Unit welcomes comments and suggestions
for future programs.

THE DEVELOPMENT OF PLASTIC RECONSTRUCTIVE AND HAND SURGERY AND THE AUSTRALASIAN CONNECTION

Professor Wayne A Morrison
Department of Surgery, St Vincent's Hospital



Prof. Wayne Morrison

A LIMITED REPERTOIRE of operations which are now acceptably within the fold of plastic surgery have been performed sporadically for centuries, the most notable being nose reconstructions by Sushruta (circa AD 200) and Tagliacozzi (16th century). Dieffenbach was responsible for many advances in reconstructive procedures and some of these were described with the suffix 'plasty', as in nasenplastik (1845). Pinch skin grafting was first reported by Reverdin in France in 1872 and

larger split skin graft sheets by Ollier (France) and by Thiersch (Germany) some years later. Full thickness grafting was claimed by the Hungarian ophthalmologist Wolfe (1875) who practised in Glasgow but its originality was hotly disputed in letters to the *Lancet* of the time by another ophthalmologist, Simpson, in London.

In 1885 William (Gerry) Moore graduated in medicine at Melbourne University with the highest honours. He received the first Master of Surgery ever awarded from this University and was fluent in French, Italian and German medical literature. He was appointed to The [Royal] Melbourne Hospital in 1887 and a few years later to St Vincent's Hospital. His chief at The Melbourne Hospital was the notorious Diamond Jim Beane who epitomised the medical system of the day. Beane allegedly earned more than two million pounds during his surgical career, wore giant diamonds in his lapel and tie and, as was typical of the period, owned his own hospital which is still standing on the south-east corner of Collins and Russell Streets, now renovated as the Westpac Bank. Beane shunned the newly described Listerian principles of cleanliness and espoused the laudable pus, operating in frock coat and with a large audience. He was charged with murder on two occasions, one involving the removal of an enormous bladder stone which he proudly had displayed in a shop window tagged 'The largest stone ever removed; by Dr J Beane, Collins Street, Melbourne'. The inevitable death of the patient was not highlighted in his advertisement. During this second murder trial the body was exhumed and conviction would have meant hanging. Buoyed by his eventual exoneration he hired an elephant from a travelling circus to advertise his medical contributions to Melbourne citizens during a campaign to muster votes for re-election to his post as Surgeon to The Melbourne Hospital. The process of election involved public voting akin to the current city council elections. The system was lampooned in the *Bulletin* of the day and attracted widespread public scepticism. The opium-ridden denizens of Chinatown in Little Bourke Street were a ready source of votes for contenders. Only those who were subscribers to the hospital were eligible to vote, so by a direct payment of one pound to residents of Little Bourke Street, votes were easily secured, as can be seen from the voting record of the day which read like a Chinese telephone book.

Moore was chief advocate for reform. By introducing Listerian techniques he reduced the mortality of abdominal surgery from 80 per cent to 10 per cent at The Melbourne Hospital. He was able, after many years of acrimonious exchange, to replace the voting process with the Electoral College system that we currently enjoy today.

Of greatest relevance to us was the direction of Moore's surgical interest. In 1899 he published a small book which he entitled 'Plastic

Surgery' - probably the first book ever published on plastic surgery in the English language; its chapters range widely from nose reconstruction to flaps and grafts. Moore soon established a large practice and as befits a budding plastic surgeon, moved into a palatial home-cum-hospital, Alcaston House, now replaced by a 1930s version on the north-west corner of Spring and Collins Streets.

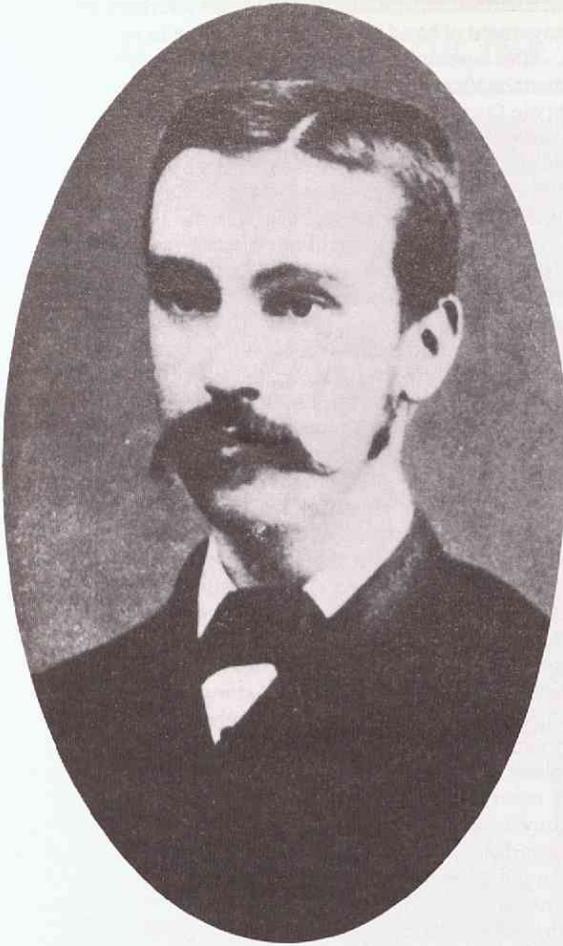
Between 1895 and 1901 Wolfe of Wolfe graft fame practised in Melbourne, renting rooms in Moore's very building. He had been enticed to Melbourne by his wife who was eager to visit relatives. From correspondence it is clear that Moore communicated personally with Wolfe and no doubt discussed his skin grafting technique which Moore described in detail in his book.

Strangely, Moore has been given little recognition among the pantheon of Melbourne surgeons of that era, his subsequent career being marred by a protracted and bitter court case involving a fellow medical practitioner. It centred on a trivial dispute over the ethics of his visiting a patient of another doctor, the latter poisonously pursuing the issue through the Medical Board, BMA and the courts over several years.

Plastic surgery with an Australasian connection next appeared in England during the First World War. Harold Gillies [1882-1960] was born in Dunedin, New Zealand and was sent to Cambridge for his medical studies, pursuing a career in ear, nose and throat surgery. At the outbreak of war he was posted briefly to France where he was greatly influenced by the extraordinary maxillo-facial reconstructive procedures which he saw being done by Valadier. This French-American self-acclaimed dentist of dubious training and repute ran his practice from a chauffeured Rolls Royce equipped as a gipsy dental caravan. Maxillo-facial reconstruction was now in great demand because of the horrific 'trench jaw' injuries of the war. While in Paris Gillies was first welcomed by the eccentric genius Hippolyte Morestin, an unpredictable creole from Martinique, who was rumoured to be performing remarkable reconstructive feats. On a subsequent visit Morestin locked his doors to Gillies.

Major Gillies was appointed to set up a hospital at Aldershot for the treatment of facio-maxillary injuries and this centre became a Commonwealth hospital with the New Zealander Gillies as its chief and medical appointees nominated from Australia, Canada and South Africa. Henry Simpson Newland [later Sir] returned from Gallipoli to take command of the Australian casualty clearances in London and was seconded to Gillies and placed in charge of the Australian section of the new plastic surgery unit. Newland was the first Australian to learn and practise the newly developed plastic surgical techniques and returned to South Australia in 1919 where he became the doyen surgeon of his era. He maintained his interest in plastic surgery throughout his career but practised mostly general surgery.

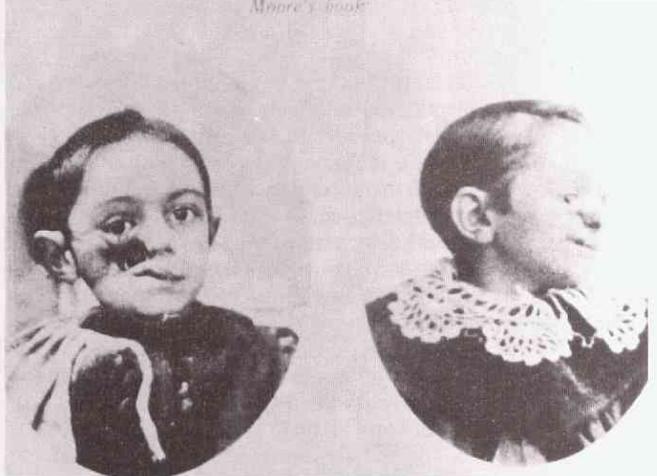
Newland was instrumental in enticing a young Fred Wood Jones to the Chair of Anatomy in Adelaide. Wood Jones had already written books entitled *Arboreal Man* and *Anatomy as Applied to the Hand*. He studied the formation of coral reefs in the Cocos Islands where he married Governor Clunies-Ross's daughter, Gertrude. He explored Nubian tombs in Egypt, wrote a treatise on how best to tie the hangman's knot and remained a lifelong anti-Darwinian. After eight years in Adelaide and a brief sojourn in Hawaii as the Rockefeller Professor he took up the Chair of Anatomy at Melbourne University in 1930. He returned to England in 1937 and in his retirement became curator of the Hunterian Collection at The Royal College of Surgeons of London. His strong interest in hand surgery influenced the surgical direction of his Melbourne pupils Rank and Wakefield.



'Gerry' Moore at graduation.



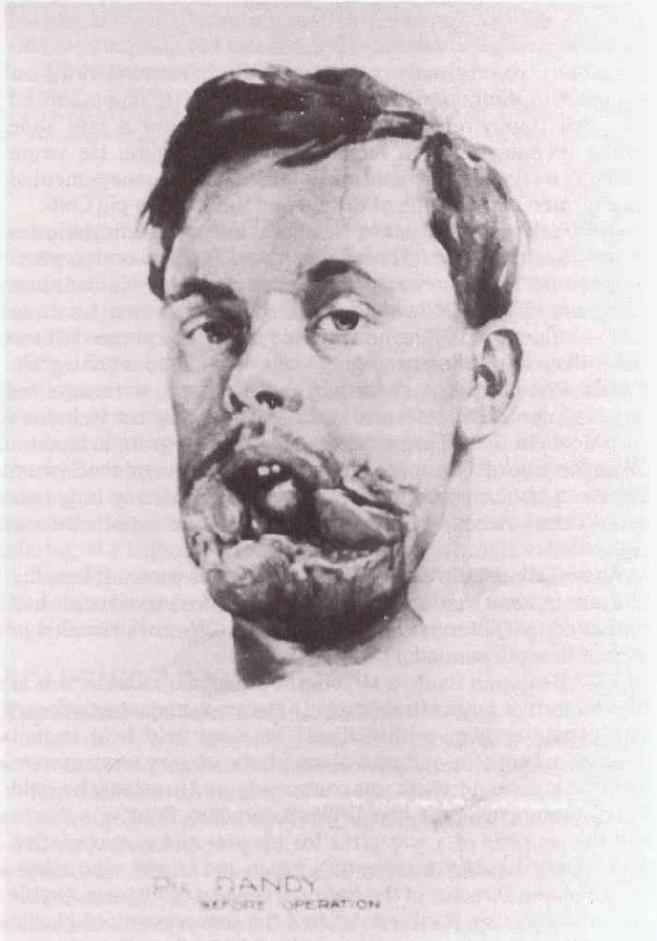
Illustrative cases before and after facial reconstruction: from Moore's book



Facial deformity corrected by flaps – illustration from Moore's book *Plastic Surgery*, 1899.



Harold Gillies, World War I.



Pre-operative watercolour of B K Rank's patient, World War II, by Daryl Lindsay.

Rumour has it that Dame Nellie Melba, whose vocal cords had been treated by Gillies in London, died at St Vincent's Hospital in Sydney from septicaemia following a facelift.

Meanwhile, Gillies's fame grew and he continued his plastic and reconstructive surgical interests exclusively. There is little dispute that Gillies founded the modern specialty of plastic surgery at least in the English-speaking world. He introduced the technique of the tube pedicle skin transfer which involved a staged migration of skin and fat by training the tissue to tolerate controlled ischaemic insults which eventually permitted its safe detachment from one site and its transfer to another. This revolutionised reconstruction of regions such as the head and neck. Inevitably with any advance of this magnitude, its originality was claimed by others including the Russian Filatov, the Frenchman Morestin, and a South African trainee of Gillies.

In 1931 Archibald McIndoe arrived in London with the expectation of taking up a promising post with university prospects. Lord Moynihan had made the 'offer' during a visit to the Mayo Clinic where the young New Zealander, who had had a brilliant undergraduate career in Dunedin, was making a name for himself in hepatic surgery. On arrival in London with wife and newborn child, and penniless, the promised job did not exist and Moynihan recalled nothing of the offer. In desperation McIndoe contacted his distant cousin Gillies, who offered him a position which was readily accepted and he rapidly adapted his career to one of reconstructive surgery which he performed with great distinction. He went on to establish his own unit. He repopularised surgery for Dupuytren's contracture by describing a safe wide exposure technique which included Z-plasty closure. He wrote extensively on the burned hand and is famed for his management of burned airmen in the Battle of Britain and the 'Guinea-pig Club'.

Rainsford Mowlem, another New Zealander, was finishing his general surgery training at Hammersmith Hospital in London when the registrar (Millard) who was to replace him choked on his Christmas pudding and expired. Mowlem was asked to stay, where he came under the influence of Gillies and plastic surgery and pursued this as a career. His contribution to surgery was the cancellous bone graft. Ironically, when McIndoe chose him as his surgeon to remove his Dupuytren's contracture it is said that he accidentally cut McIndoe's nerves. Mowlem retired prematurely to an orange grove in Spain.

From the time of its foundation by Gillies to the end of the Second World War, plastic surgery in Britain was represented by only four surgeons, three of whom were New Zealanders. Their anaesthetist was an Australian.

In Australia in 1931 plastic surgery techniques were not keeping pace. Rumour has it that Dame Nellie Melba, whose vocal cords had been treated by Gillies in London, died at St Vincent's Hospital in Sydney from septicaemia following a facelift.

In 1937 Benjamin Rank, a Melbourne Hospital graduate, was in London for further surgical training and a chance locum rotation found him in plastic surgery with Gillies. This new field held instant fascination and with the outbreak of war plastic surgery services were again in great demand. Rank was commandeered to establish a field unit at El Kantara in Egypt. Like Gillies before him, Rank was able to recruit the services of a war artist for his pre- and post-operative records – Daryl Lindsay, brother of Norman and Lionel, who subsequently became Director of the National Gallery of Victoria. On his return to Melbourne, Rank established the first recognised plastic surgery and hand surgery unit in Australia at Heidelberg Repatriation

Hospital, Victoria. With Allan Wakefield he wrote a classic book on the management of hand injuries *Surgery of repair as applied to hand injuries*. After appointments to The Royal Melbourne Hospital he established the Victorian Plastic Surgery Unit associated with Preston & Northcote Community Hospital, a purpose-built centre for plastic surgery postgraduate training.

John (Black Jack) Hueston, also a Melbourne Hospital graduate, joined the group and quickly demonstrated his technical skills and prodigious intellectual potential. He was the first to describe the concept of the myocutaneous flap (skin with sterno-mastoid) and became the international authority on Dupuytren's contracture with his classic monograph. Always a Francophile, he recently retired to Provence.

A forgotten and unheralded contributor to hand surgery was an Australian orthopaedic surgeon, Arthur 'Ben' Murray, a graduate of Tasmania, who as a child had lost a leg in an explosion and sustained an ulnar nerve paralysis from another accident. He established the famous Leith Hand Surgery Service at Princess Margaret Hospital in Edinburgh during the War, where he performed the first true pollicization of an index finger to make a thumb, designed and inserted the first artificial stainless steel joint prosthesis for finger joint replacement, and transferred a ring finger from one hand to the other. After the war, medical jobs were allocated preferentially to returned servicemen. Murray had been ineligible for war service because of his physical disabilities and so he returned to Australia where he established an orthopaedic hand practice in Brisbane. Unfortunately he was shot dead by a crazed patient, along with two colleagues.

A further character to pass across the plastic surgical stage was an Englishman, Graham Humby. He was still a medical student when he invented the Humby skin graft knife, a modification of the primitive barber's razor, to control the thickness of the graft. He was an understudy to Fred Astaire, represented Britain in international yachting and obtained the first certificate for gliding in England. He trained in plastic surgery and during the War joined the naval air command, achieving high distinction. His Australian connection began after alleged dubious dealings as well as the contraction of TB, led him to seek warmer climates, initially in Barbados and eventually to Melbourne where he set up practice as a cosmetic surgeon. Rank branded him a 'lipstick salesman' and 'threw him out of town', whereupon Humby became superintendent of a regional hospital in Sydney and continued plastic surgical practice until his death in 1970.

The golden era of plastic surgery began in the late sixties and early seventies with the advent of microsurgical transfer of tissues, which revolutionised reconstruction. At the forefront of this were Bernard O'Brien of St Vincent's Hospital and Ian Taylor of The Royal Melbourne Hospital. O'Brien established the internationally renowned Microsurgery Research Centre at St Vincent's which has attracted researchers from around the world to train in microsurgery. Many have returned to their own countries to establish the specialty and become leaders in their field. The unit has produced a prodigious output of scientific and clinical contributions over a broad range of microsurgical and hand surgical subjects.

Ian Taylor has also made many contributions to the field of microsurgery and microsurgical anatomy especially with respect to skin and bone transfers and continuing research into the vascular anatomy of skin, muscle and nerves.

Microsurgical repair in hand injuries led to renewed interest in the microanatomy and topography of peripheral nerves. The classic work in this field *Nerve injuries and their repair – A critical appraisal*, by Sir Sydney Sunderland, Professor Emeritus of Anatomy at The University of Melbourne, was reappraised by surgeons and his contributions are now recognised as invaluable to peripheral nerve surgery.

Australasian surgeons have mapped and continue to map the course of the illustrious pathway of plastic and hand surgery. The field is ever broadening and there are many milestones to plot. Australians have never been afraid to go out on a limb because that's where the fruit is – long may the pickings continue.

References

- Rank BK. Gerry Moore and some of his contemporaries. The Hawthorn Press, Melbourne, 1975.
- Rank BK. Heads and hands – an era of plastic surgery. Gower Medical Publishing, London, 1987.
- Taylor BW. 'Foundations of Australasian plastic surgery and Fred Wood Jones'. *Annals of the Royal College of Surgeons of England*, 15: 335-339.

FACULTY OF MEDICINE, DENTISTRY & HEALTH SCIENCES



Staff of the Faculty of Medicine, Dentistry & Health Sciences and School of Medicine

Back row L to R: Darrell Mead, Cyril Yardin, Maggie Mackie, Ashleigh Carr, Shiva Mandri, Liz Brentnall, Toni Langley. **Centre row** L to R: Joan Forrest, Judith Hillier, Claire Stevenson, Colleen Bermingham, Julianne Munro, Dana Angove. **Front row** L to R: Bob Hannam, Karen Cremona, Iris Welcome, Graeme Ryan, Robin Orams, Paul Geyer, Geraldine D'Costa. **Absent:** Kaye Lincoln, Anne Szadura.

FROM THE DEAN

HIGHLIGHTS AND ACHIEVEMENTS

A major event on 1 January 1992 was the transfer from the Faculty of Arts of the Department of Psychology to become the School of Behavioural Science in the Faculty of Medicine, Dentistry and Health Sciences. Professor Roger Wales was appointed Head of the School and Associate Dean (Behavioural Science). Links at Faculty level with the psychology profession were established formally through membership on Faculty Board of a nominee of Australian Psychological Society. During the year approval was given to introduce a Master of Psychology post-Masters coursework degree program in Clinical Psychology in 1993. A course in child psychology will commence in 1993 and a proposal for a course in medical psychology is under consideration for 1994. Agreement also has been reached for five academic staff who are currently members of the Medical Psychology Unit in the Department of Psychiatry at The Royal Melbourne Hospital to become members of the School of Behavioural Science in 1993. The Unit will remain at The Royal Melbourne Hospital and staff will hold appropriate adjunct appointments in the Department of Psychiatry.

Faculty endorsed proposals developed by two departments within the School of Medicine to change their names to reflect their academic activities and future directions. The Department of Community Medicine was renamed 'Public Health and Community Medicine' during 1992, and the Department of Anatomy will be re-titled 'Anatomy and Cell Biology' from 1993. The Chair of Community Medicine has also been re-styled as the 'Chair of Public Health and Community Medicine'.

In conjunction with the release of the Vice-Chancellor's paper 'Challenges in Education for The University of Melbourne', consideration is being given in consultation with the Faculties of Arts and Science for combined MBBS/BA and MBBS/BSc courses for possible commencement in 1994.

The School of Physiotherapy is continuing its growth and development under the leadership of Professor Joan McMeeken. Features of its second year of operations include more than five new academic staff appointments, mounting of year 2 of the BPhysio course, development and approval of the year 3 program for 1993, offering of a new postgraduate diploma program in four specialist areas of study, development of research programs and links, and offering of a higher degree MPhysio research program.

The School of Dental Science has continued to consolidate teaching and research activities with the further development of The Royal Dental Hospital of Melbourne as a major teaching hospital.

ACADEMIC APPOINTMENTS

Appointments taken up in 1992

- Professor Wayne Morrison, Chair of Surgery (St Vincent's Hospital)
- Professor Gavin Becker, Professor/Director of Nephrology (The Royal Melbourne Hospital)
- Professor Duncan Blake, Professor/Director of Anaesthesia (The Royal Melbourne Hospital)
- Professor Shaun Brennecke, Professor/Director of Perinatal Medicine (Royal Women's Hospital)
- Professor Andrew Kaye, Professor/Director of Neurosurgery (The Royal Melbourne Hospital)

- Professor Edward Byrne, Professor/Director of Clinical Neurosciences (St Vincent's Hospital)
- Professor Helen Herrman, Professor/Director of Psychiatry (St Vincent's Hospital)
- Professor Irwin Faris, Chair of Surgery (Geelong Hospital)
- Professor Robert Thomas, Chair of Surgery (Western Hospital)
- Professor John Mills, Professor/Director, Macfarlane Burnet Centre for Medical Research.

Appointments to be taken up in 1993

- Professor Jim Angus, Chair of Pharmacology
- Professor John Furness, Chair of Anatomy (transfer from Chair of Physiology)
- Professor Greg Whelan, Professor/Director of Drug & Alcohol Studies (St Vincent's Hospital)
- Professor David Copolov, Director, Mental Health Research Institute
- Professor Bruce Kemp, Deputy Director, St Vincent's Institute for Medical Research.

NEW POSITIONS APPROVED

- Professor/Director of Neurology (Austin Hospital/Heidelberg Repatriation Hospital)
- Professor/Director of Infectious Diseases (Fairfield Hospital/Austin Hospital)
- Professor/Director of the Murdoch Institute for Research into Birth Defects (Royal Children's Hospital)
- Professor/Director of Cardiology (The Royal Melbourne Hospital).
- Professor/Director of Orthodontics (The Royal Dental Hospital of Melbourne).

STAFF RETIREMENTS

- Professor Ian Darian-Smith (Anatomy)
- Professor Michael Rand (Pharmacology)
- Professor Peter Reade (Dental Medicine and Surgery)
- Professor William Cole (Orthopaedic Surgery, Paediatrics) (Resignation).

1992 HONOURS AND AWARDS

- *Sir William Upjohn Medal*: Professor Priscilla Kincaid-Smith
- *Order of Australia*: Professor D R Curtis AC, Professor P A Castaldi AO, Dr J F Gardner AO, Professor I D Gust AO, Professor D O White AO, Dr T M Long AM, Professor Emeritus R C Bennett AM, Professor A C L Clark AM, Mr J K Clarebrough AM.
- *NHMRC Sir John Eccles Award*: Professor H R Taylor
- *Clunies Ross National Science and Technology Award 1992* (One of 5 recipients): Professor G M Clark
- *Royal Society of NSW James Cook Medal*: Professor G M Clark, for role in development of bionic ear for profoundly deaf people
- *1992 Dale Medal of the British Endocrine Society*: Professor T J Martin
- *Commonwealth Senior Medical Fellowship*: Professor G J A Clunie
- *Sims Travelling Professorship* for 1993 awarded by Royal College of Surgeons: Mr G I Taylor
- *Silver Medal* to Professor K J Hardy for services to Biliary Surgery at Fourth World Congress of Hepato-Pancreatic-Biliary Surgery, and invited to give Keynote Address on behalf of Australia at Third World Congress of Endoscopic Surgery
- Professor R Smallwood elected as Fellow of Royal College of Physicians
- Professor C L Masters (and Professor Konrad Beyreuther) awarded the Max Planck Research Award from Alexander Von Humboldt Foundation
- Mr David Brownbill awarded 1991 Advance Australia Award for Medicine.
- *1993 Australia Day Honours*: Dr W H Kitchen AM, Professor Graham F Mitchell AO, Dr John M Court AM, Dr Peter F Bladin AO.

RESEARCH

In 1992, as in previous years, Faculty was awarded the largest allocation of NHMRC funding of any medical faculty in Australia. Approximately \$10.3 million of NHMRC funds were obtained to support 106 Project Grants and 7 Program Grants in the Faculty, as well as approximately \$2.0 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 \$27.1 million in funding to support research.

The Faculty continues to maintain and develop major links with industry. The Faculty is connected with two Co-operative Research Centres approved in 1991: 'The Australian Growth Factors Co-operative 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 Biomedical Engineering, the Biomolecular Research Institute and Amrad Corporation Ltd; and 'The Cochlear Implant, Speech and Hearing Research Centre' under the directorship of Professor Graeme Clark and involving the 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.

The recently-announced successful bid for the CRC for Vaccine Technology involves Dr David Jackson of the Department of Microbiology as the leader of one of three major programs in a co-operative venture aimed at improving the efficacy of current vaccines and to assist in the design and construction of the next generation of vaccines. The other core participants are the Queensland Institute of Medical Research, CSIRO, The Walter and Eliza Hall Institute of Medical Research, CSL Ltd and Biotech Australia Pty Ltd.

STUDENTS

Medicine

The Faculty continues to attract outstanding students. For the medical course, the VCE selection score was a record high of 377 for the 169 quota places for non-overseas students; of this number, 45 per cent were women. The first year quota included ten students with social and/or educational disadvantage admitted under the University's Special Admissions Scheme and one student admitted under the University's selection policies for Aboriginal students. The second year quota of 182 included six Lateral Entry Scheme students and eight Extended Special Admissions Scheme students, who gained admission after the satisfactory completion of two years of Science to prescribed standards. Within the upper limit of 220 places available in first year, 51 full-fee overseas students were admitted, 39 such students were enrolled in second year, 32 in third year, and two in fourth year. There are likely to be significant reductions in admission of full-fee overseas students to first year in future in view of decreases in Government scholarships and numbers of students studying at VCE level. Two refugee students admitted previously were undertaking studies in later years of the course in 1992.

Dental Science

The first year quota for non-overseas students of 43 was filled with a VCE selection score of 355. This quota included two Special Admissions Scheme students. Of the total first year quota, 50 per cent were women. In 1992 six full-fee overseas students were enrolled in years 2 to 4 of the course. For the first time in 1992, two students were admitted to the combined MDSc/MBBS program in oral and maxillo-facial surgery, completing a medical bridging program in 1992/93 before admission to fourth year MBBS in 1994. No places were available for lateral entrants at second year level but three students were admitted to third year.

Physiotherapy

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 374, one of the highest of any course in the State. Of this quota, 63 per cent were women. Within the quota were two Special Admissions Scheme students. Four students with appropriate tertiary studies were admitted as lateral entrants to the second year following completion of a bridging program before the commencement of classes. Two full-fee overseas students were admitted to first year outside the above quota. From 1993 there will be 80 places available for local students in the first year quota.

Other programs

There is still strong demand for places in higher degree programs of the Faculty including those offered by the new School of

Behavioural Science (Department of Psychology). In 1992, a total of 584 EFTSU (Equivalent Full-time Student Unit) were enrolled as higher degree students in the Faculty. This is approximately 18 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 and psychology.

Continuing strong demand exists for the Faculty's graduate diploma programs in adolescent and child psychology, audiology, epidemiology, clinical dentistry, forensic odontology, women's health, and the new diploma in physiotherapy which attracted 32 applications in its first year to the four specialist areas under offer.

GRADUATE AND COMMUNITY RELATIONS

Our well-established medical society, the University of Melbourne Medical Society (UMMS), now has over 2,000 members. At the annual UMMS lecture in October 1992, Professor Emeritus Priscilla Kincaid-Smith, Convener of Continuing Medical Education for the Faculty, gave a fascinating account of her medical life through three countries over fifty years, entitled *Half a Century of Medicine - a Personal View*. The tenth anniversary issue of the UMMS journal *Chiron* was produced by its joint editors, Mr Peter Jones and Mrs Maggie Mackie. This excellent issue marked ten years of the publication's growth from a newsletter to an outstanding and widely-acclaimed journal. For a number of years UMMS has sponsored an annual prize for the best BMedSc Research Report submitted by a medical student. In further support of medical undergraduate education, UMMS has agreed to award up to three prizes each year to final year students for essays submitted in connection with their elective studies.

During 1992, the Society and Friends of Dental Science (SAFODS) continued their activities in providing valuable support for the School of Dental Science.

The School of Physiotherapy has successfully launched 'Friends of Physiotherapy - University of Melbourne' providing a vehicle through which interaction and mutual support between the School of Physiotherapy and the physiotherapy profession can be promoted.

The School of Behavioural Science has surveyed its graduates seeking information to assist in developing continuing education and professional interaction with graduates.

Continuing Education programs have been actively promoted in the Faculty. Professor Emeritus Priscilla Kincaid-Smith, supported by the Continuing Medical Education Unit, developed nine Continuing Medical Education courses particularly designed to meet the needs of general practitioners. Associate Professor John Harcourt, assisted

by the Continuing Dental Education office, developed 17 Continuing Dental Education courses. These courses continue to attract considerable interest. In addition, the School of Dental Science ran a series of research seminars throughout the year for School and Hospital research staff. The School of Behavioural Science continues to offer summer schools for clinical psychologists as part of the University's Summer School program. Occasional seminars for members of the physiotherapy profession were offered by the School of Physiotherapy.

In 1992 a well-attended Dean's Lecture Series covered a wide range of subjects, providing a valuable forum for inaugural orations and other special lectures. Speakers were Professor Joan McMeeken, Professor Beverley Raphael (who gave the Beattie Smith Lecture), Professor Bill Sawyer, Dr John Clement, Professor Oliver Hennessy, Professor Wayne Morrison, Professor Shaun Brennecke, Professor Glenn Bowes and Professor Brian Buxton. The series closed, once again, with a major seminar on an important ethical topic: *Looking After Ethics - A Decade of Change*, convened by Professor Emeritus Richard Lovell, and attracted a large audience representing those involved in the development of medical ethics over the last decade.

FACULTY ADMINISTRATION

Finally, it is again most fitting to pay special tribute to the outstanding support given to the Faculty by the staff of the Faculty Administration under the excellent leadership of the Assistant Registrar (Medicine, Dentistry and Health Sciences), Mr Darrell Mead, with the assistance of his staff: Ms Joan Reese, as Executive Officer (Dentistry); Ms Helen Revell, Executive Officer (Behavioural Science); from March, Ms Glenda Nicol as Executive Officer (Physiotherapy); Mr Cyril Yardin taking special responsibility for budgetary, finance and research including NHMRC matters, assisted by Ms Joan Forrest; Ms Anne Szadura, assisted by Ms Claire Stevenson and Ms Judith Hillier, in dealing with School of Medicine student matters; Ms Robin Orams, assisted by Ms Elizabeth Brentnall, in overseeing the Continuing Medical Education and Graduate 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 and Health Sciences



R DOUGLAS WRIGHT FELLOWSHIP APPEAL

The response to the R Douglas Wright Fellowship Appeal from alumni and friends has demonstrated both generosity and a sincere appreciation for the work of Sir

Douglas. Clearly 'Pansy' touched the lives of many as an intellectual role model and is remembered also for his personal kindness. We would like to thank donors for their kind support of this memorial to Sir Douglas' achievements.

The R Douglas Wright Fellowships will be open to candidates carrying out post-doctoral research in the fields of Physiology, History and Philosophy of Science or Medicine, and Justice, Equity or Ethics in Society. They will be awarded on the basis of the academic merit of candidates and their proposed research program.

If you have not had an opportunity to support this Appeal and would like further information, please write or send your donation to:

R Douglas Wright Fellowship Appeal
The University of Melbourne Alumni Office
216 Leicester Street
Carlton Vic 3053

Enquiries: Ms Robin Orams, telephone (03) 344 5889



THE UNIVERSITY
OF MELBOURNE

CARING FOR THE UNIVERSITY

THE UNIVERSITY
FUND AND BEQUESTS

On behalf of staff and students I extend our sincere thanks to alumni and friends who have continued to support the University and the School of Medicine through the University Fund.

Over the years thoughtful bequests have also played a significant role in building the University and the School of Medicine we have today. You may wish to consider planning a personal contribution to support the Medical School's research, teaching and students with the designation of a bequest to your alma mater. If you would like more information or a copy of our bequest booklet, please contact me at the School of Medicine, The University of Melbourne, Parkville, Victoria 3052. The telephone number is (03) 344 5894.

Graeme B Ryan
Dean, Faculty of Medicine,
Dentistry and Health Sciences

AUSTIN HOSPITAL & HEIDELBERG REPATRIATION HOSPITAL

In last year's edition of *Chiron*, there was an article on the twenty-fifth anniversary of the Clinical School. The Clinical School continues to make rapid advances, its hospitals combining high technology – positron emission tomography and liver transplantation – with the clinical care of patients, local and Australia-wide.

The increasing demands for high technology medicine mean that there is a continuing need to emphasise the teaching of basic clinical skills and to ensure that students see the more common clinical conditions. In fourth year, to help achieve this, students rotate to two country hospitals, Bendigo and Northern Districts Base Hospital and either Albury Base Hospital or Wangaratta Base Hospital.

In 1992 there were 176 students at the Clinical School, but we are looking at an increased number, approximately 198, in 1993. In 1993, for the first time, third year physiotherapy students will also be attached to the Clinical School Hospitals for training.

I would like to highlight some of our approaches. The Clinical School divides the students into 12 groups, the size of each group depending on student numbers but generally with no more than six in a group. In fourth year, after an introductory two weeks, there follows two terms, each of five weeks, in medicine and surgery. For the last three 9-week terms students spend two in medical wards and one in the surgical wards.

The Clinical School undertakes a comprehensive program in communication skills and assesses the effect of the program on the student's ability and patient satisfaction. Both parameters are improved by the training received. We have demonstrated that students can obtain more appropriate information and show improved diagnostic skills with this program. In addition, in fourth year, students are introduced to ethical problems in medicine, emergency medicine, and geriatrics. In pathology, they have formal lectures on special pathology, and demonstrations attended by a clinician, a pathologist and an imaging physician where appropriate, the cases being carefully selected and worked up before presentation.

In final year the Clinical School is still looking at the best way to continue the program initiated several years ago for student interns. The aim is to involve the students, in pairs, during their general terms. The problem is to balance the need to give students the free time to be on the wards with the need to have some formal sessions (lectures and tutorials) to prepare them for their examinations. The difficulty is to bring students and consultants together so that students can perform their intern role to best effect.

During the year, Laurie Howes left to take up an appointment as Professor of Clinical Pharmacology and Therapeutics at St Georges Hospital, Sydney; and Dr Peter Stanley shifted across to St Vincent's Hospital as a physician in Infectious Diseases.

I am grateful to all the clinical teachers for the effort and skill they put into their teaching. The students appreciate the amount of time that tutors give, much of it unrostered, in helping them acquire a broad knowledge of medicine.

Associate Professor Bernard Sweet
Clinical Dean

THE ROYAL MELBOURNE HOSPITAL & WESTERN HOSPITAL

During 1992, the Clinical School office was relocated to the 1st floor of the Charles Connibere Building. The new accommodation is considerably more spacious than the old cramped offices, and we are grateful to Faculty for providing the funds for refurbishment.

The introductory course in clinical medicine during the second semester of third year was conducted over eight weeks on Wednesday afternoons as in previous years. A one-hour pathology demonstration was followed by a ward tutorial, and most tutors chose to demonstrate the taking of a history and the performance of a physical examination of a patient. The course again appeared to be well accepted by the

students, and at this stage we intend to mount the same course in 1993. However, preliminary discussions have been held with the School's Department of Public Health and Community Medicine with the aim of better integration of the teaching of communication skills in third year with the introductory course to clinical medicine. If this proves feasible, the Introduction to Clinical Medicine course may change.

As in previous years, fourth year was divided into two surgical and two medical terms, each of eight or nine weeks duration. All students were either at The Royal Melbourne Hospital or Western Hospital during the first term. During the other three terms all students spent one term at either Ballarat Base Hospital, Wangaratta District Base Hospital or Wimmera Base Hospital. Each student group also had at least two of the four terms at The Royal Melbourne Hospital.

In 1992, the introductory program at the commencement of fourth year was lengthened from two to three weeks and considerably altered: a broader range of lectures was provided, the students visited Western Hospital for a full morning, and a 'cardio-vascular examination day' was programmed with the students initially seeing a video tape on the examination of the cardio-vascular system, then undertaking self-examination under the supervision of tutors, and finally having a ward tutorial demonstrating the cardio-vascular examination on a patient. This introduction to one aspect of physical examination proved extremely successful, and it is planned to develop this process further for the examination of other systems during the 1993 introductory period.

Another major innovation in fourth year in 1992 was a formal course in the teaching of communication skills. Three lectures on this topic were given during the introductory period in addition to the usual lectures given by the Professors of Medicine and Surgery on history taking. During first term each student group then participated in four tutorials with members of the Department of Psychiatry where individual students were observed taking a short history from a patient, and then given feedback on their communication skills. Lastly, during second or third term a 10-minute videotape was taken of each student during a patient interview; their communication skills were then discussed in a group tutorial conducted by a senior clinician from that particular unit. This new program of teaching communication skills seems to have been successful, although we are awaiting the results of the student questionnaire before deciding on modifications in 1993.

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

Sixth year consisted of an eight-week elective period, finishing in early March, followed by blocks in each of general medicine, special medicine, general surgery and special surgery. Students varied their electives, most travelling overseas, mainly to the United Kingdom, USA/Canada and South-East Asia with some students venturing to Greece, Vanuatu, France, Thailand and even Bolivia, Kenya and Vietnam. The general consensus was that all students enjoyed this elective experience and returned to RMH keen to complete final year.

General surgery and general medicine consisted of six or seven-week blocks respectively and in each case comprised a 'student internship' in a general medical or surgical ward at The Royal Melbourne Hospital or Western Hospital. For the first time, student internships took place in general medicine and surgery at Ballarat Base Hospital, consisting of three or four weeks at the Hospital coupled with three or four weeks at The Royal Melbourne Hospital.

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

It is not intended to make any significant changes to the final year format in 1993, but further consideration will be given to the student

internships at Ballarat Base Hospital, depending on the feedback from the students in the final year questionnaire.

Initiatives for 1993 include:

1. It is planned to continue the introductory program as three weeks at the commencement of first term of fourth year, but to compress the lecture timetable during this time, and also to provide extra demonstrations and self-examination periods to introduce the students to the physical examination of the different systems.
2. Teaching of communication skills in fourth year will be further refined depending on the feedback from the fourth year student questionnaire. It is not planned to make any major changes to what seems to have been a successful format in 1992, but the use of videotapes will probably be expanded.
3. It is planned to include a week 'swot-vac' at the end of fourth term in fourth year, in particular to enable the students to have practice on long cases. At the present time the examinations commence the week after the students finish, and this has caused some anxiety, particularly with the students who have a country rotation right up to the week before the examinations commence. All students will come back to The Royal Melbourne Hospital for the 'swot-vac' and have long cases arranged at either The Royal Melbourne Hospital or Western Hospital.
4. With the welcome appointment of the Professor of Surgery at Western Hospital (Professor Robert J Thomas) and the increased number of students in final year requiring student internships, it is planned that all groups of students in fourth year will spend one of the four terms at Western Hospital.

Associate Professor Robert F W Moulds
Clinical Dean

ST VINCENT'S HOSPITAL & THE GEELONG HOSPITAL

This was a particularly busy year. In July, the Clinical School was relocated to new premises on the hospital campus to make way for a major redevelopment of the hospital, and now comprises a single storey educational block with excellent facilities for teaching and student amenities. The residential accommodation for students is located in two terrace houses which have been extensively renovated and refurbished. The transfer of premises was carried out with minimal disruption to students who are now well at home in their new surroundings.

During 1992 the Clinical School had a complement of 178 students with 50 students in final year, 69 in fifth year and 59 in the fourth year class. This year has seen Bruce Jackson take up his appointment as Associate Professor (Clinical) in Medicine at PANCH, where he has participated fully in the teaching program throughout the academic year, and in August, Professor Irwin Faris took up his appointment as professor of Surgery at the Geelong Hospital.

Final year students commenced the year with an eight-week elective term which saw many undertaking elective attachments overseas. A number chose more adventurous electives in Asia, outback Australia, Africa and New Guinea, and gained significant benefit in terms of clinical experience and personal development.

Sixth year students spent most of their time at St Vincent's Hospital with some having the opportunity to rotate to the Geelong Hospital for a 4-week medicine term or to PANCH for a 5-week block in general surgery. Students found these rotations a valuable opportunity to experience a wide variety of clinical practice.

This was also a highly successful year with all 50 final year students passing their examinations well. All students worked very hard during the year and were well rewarded for their efforts. Many received honours and a number distinguished themselves by winning various prizes and scholarships. Dux of final year was David Amor, who achieved consistently high results over the six years of the course and was awarded several prizes for his performance in final year. Susan Morgan, who was placed third in the year, also distinguished herself by obtaining first class honours in the two final year subjects of medicine and surgery. Our congratulations go to David and Susan and to all the 1992 graduates and we wish them well in their future careers.

The fifth year curriculum was similar to that in 1991, with students spending the major part of the year away from their parent clinical school. Students enjoyed this time away and appreciated the opportunity to mix with students from the other clinical schools.

Fourth year students found the year quite taxing with the demands of a very full curriculum. During the year there was a strong emphasis on the teaching of communication skills as well as clinical examination technique. Country rotations were again very popular, and considered invaluable because of the excellent patient access. This year a surgical rotation was offered at the Goulburn Valley Base Hospital in addition to the existing medical term. This surgical rotation was highly regarded by our students who valued the excellent tuition and interest shown by the surgical teaching staff at Shepparton.

The challenge for Clinical Schools in the future is to maintain the current high standard of undergraduate training. The increasing use of day facilities, shortened length of hospital stay and financial constraints placed on the hospitals resulting in bed-closures, will all affect student teaching. In addition, the increased numbers of clinical students from 1993 will fully stretch clinical school facilities, teaching and patient-resources. There is a need to develop alternative methods of teaching to supplement the traditional patient-related bedside sessions.

We are most grateful for the tuition given by all the dedicated and hard-working teachers associated with our Clinical School during 1992. Their willingness to teach and their commitment to undergraduate education is most gratefully acknowledged.

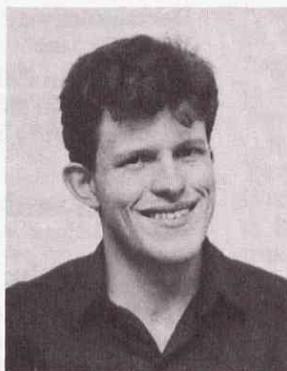
Associate Professor Wilma M Beswick
Clinical Dean

UMMS ELECTIVE ESSAY PRIZE

The University of Melbourne Medical Society has established an elective essay prize for sixth year MBBS students. Three prizes of \$100 will be offered annually for the best essays of up to 1500 words describing the student's elective period and what was gained from it, both professionally and in terms of personal development. Prize winning essays will also be considered for publication in *Chiron*.

FINAL YEAR MBBS 1992

Top Student



Dr David Amor

DAVID JOHN AMOR was the top student in the medical course in 1992 and was awarded the following prizes: Australian Medical Association Prize, The CIBA-GEIGY Prize, Rowden White Prize, Proxime Accessit Prize in Surgery and the Division of Surgery Prize (SVH). He achieved consistently high results throughout his pre-clinical years and excelled in all branches of his clinical studies. He is modest about his achievements and is a very popular member of his class with staff and students alike.

David was educated at Glen Iris Primary School and won an entrance scholarship to Melbourne Grammar School. He entered the Melbourne University Medical Course in 1987, following in the footsteps of his sister Katie who was then a third year medical student. He chose to do his elective term at Nonga Base Hospital, Raboul, Papua New Guinea where he gained valuable practical experience in rural medicine in the tropics.

He has been actively involved in the scouting movement for the last eighteen years and is a Queen's Scout. He is an accomplished photographer and his other interests include music, racquet sports and outdoor activities.

After his intern year at St Vincent's Hospital in 1993 David plans to pursue a career in a medical speciality.

PRIZES & AWARDS 1992

Final Year

Australian Medical Association Prize

Amor, David (SVH/GH)

The CIBA-GEIGY Prize

Amor, David (SVH/GH)

Rowden White Prize

Amor, David (SVH/GH)

Medicine

Keith Levi Memorial Scholarship in Medicine

Sapozhnikov, Alexander (RMH/WH)

The Robert Gartly Healy Prize in Medicine

Sapozhnikov, Alexander (RMH/WH)

Jamieson Prize in Clinical Medicine

Chen, Robert (SVH/GH)

Upjohn Award in Clinical Pharmacology and Therapeutics

Morton, Joseph (AH/HRH)

Paediatrics

Howard E Williams Prize in Paediatrics

Kennedy, Richard (SVH/GH)

Clara Myers Prize in Surgical Paediatrics

Roberts, Peter (SVH/GH)

Child Growth and Development Study in Paediatrics Prize

Pirpiris, Marinis (RMH/WH)

Psychiatry

John Cade Memorial Medal in Clinical Psychiatry

Marks, Carolynne (SVH/GH)

Surgery

Beaney Scholarship in Surgery

Croxford, Matthew (RMH/WH)

The Robert Gartly Healy Prize in Surgery

Croxford, Matthew (RMH/WH)

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

Croxford, Matthew (RMH/WH)

Garoni, Elizabeth (RMH/WH)

Chew, Derek (SVH/GH)

Morgan, Susan (SVH/GH)

Smith and Nephew Prize in Surgery (AH/HRH)

Aly, Ahmed (AH/HRH)

Poon, Anthony (AH/HRH)

EH Embley Prize in Anaesthetics

Lawton, Paul (SVH/GH)

Proxime Accessit Prize in Surgery

Amor, David (SVH/GH)

Neil Bromberger Prize in Orthopaedics (AH/HRH)

Lau, Eddie (AH/HRH)

Geoffrey Royal Prize in Clinical Surgery

Chew, Derek (SVH/GH)

Obstetrics and Gynaecology

The Robert Gartly Healy Prize in Obstetrics

Lau, Eddie (AH/HRH)

Cheshire, Lisa (RMH/WH)

Alfred Edward Rowden White Prize in Clinical Obstetrics

Cherry, Catherine (AH/HRH)

Edgar and Mabel Coles Prize in Obstetrics (RMH/WH, SVH/GH)

Cheshire, Lisa (RMH/WH)

Prize in Clinical Gynaecology

Brodthmann, Amy (AH/HRH)

Community Medicine

RACGP Prize in Community Medicine

Green, Alison (RMH/WH)

Infectious Diseases

Sir Albert Coates Prize in Infectious Diseases

Green, Alison (RMH/WH)

General Clinical

Edgar Rouse Prize in Occupational Medicine

1st Prize – Tan, Wee Jin

2nd Prize – Pirpiris, Marinis

Royal Australian College of Ophthalmologists Prize

Tan, Wee Jin

Hedley F Summons Prize in Otolaryngology

Hew, Ruth

Herman Lawrence Prize in Clinical Dermatology

Young, Richard

Australasian College of Occupational Medicine Prize

No prize awarded in 1992

Fourth and Fifth Year

Fourth Year

The Harold Attwood Prize in Pathology

Buckwell, Marnie (SVH/GH) and Nguyen, Peter (RMH/WH)

Peter (RMH/WH)

Geriatric Medicine Prize

Fuller, David (SVH/GH)

Manu Thomas Prize

Hennel, Sabine (SVH/GH)

Fifth Year

Community Medicine Prize

O'Donnell, David (AH/HRH)

Crawford Mollison Prize in Forensic Medicine

To be announced

Medical Officers of Health Section of AMA

O'Donnell, David (AH/HRH)

The Fulton Scholarship

O'Donnell, David (AH/HRH)

The Kate Campbell Prize in Neonatal Paediatrics

Brown, Steven (SVH/GH)

The Max Kohane Prize

O'Donnell, David (AH/HRH)

The Vernon Collins Prize

Tores, Delia (RMH/WH)

The John Adey Prize

Akikusa, Jonathan (RMH/WH)

Pre-Clinical

First Year

Medical Physics

GA Syme Exhibition

Gan, Jay Sen

Micut, Samuel

Por, Yong Ming

Medical Physics

TF Ryan Roentgen Prize

Thomas, Elizabeth

Introduction to Medicine

The Australasian College for Emergency Medicine, Victorian Region, Prize

Chan, Colin Chun Keng

Cheah, Lean Peng

Por, Yong Ming

Medical Biology 1

WH Swanton Exhibition

Nadesapillai, Subanesan

Medical Biology 1

Baldwin Spencer Prize (for Zoology Practical Work)

Chaw, Chee Kien

Chemistry

Exhibition

Nadesapillai, Subanesan

Anatomy 1

Mathew W McKenzie

Award Chea, Lean Peng

Second Year

Anatomy 2

Dwight Prize

Exhibition Prize

TF Ryan Prize

Lye, Chien Boon

Physiology 2

Wellcome Prize

Lye, Chien Boon

General Biochemistry

Exhibition

Lye, Chien Boon

Neuroscience

Sunderland Prize

Shiu, Tin Ming

Functional Biochemistry

Exhibition

Jayathillake, Anuradha

Physiology 2 Integrated Body Function

RD Wright Prize

Lye, Chien Boon

Behavioural Science

The CIBA-GEIGY Prize

Lim, Lyndell Lee Ping

Third Year

Pharmacology

Boots Prize

Buising, Kirsty

Pathology

The Walter & Eliza Hall Exhibition

Hew, Mark

Microbiology Prize

Din, Jason Tye

RETIREMENTS

PROFESSOR WILLIAM COLE

WILLIAM GEOFFREY COLE, who resigned in October 1992, graduated from the Medical School of The University of Melbourne in 1965. After resident appointments at The Royal Melbourne Hospital he was a senior demonstrator in the Department of Anatomy of the University in 1968. He continued his surgical and orthopaedic training at The Royal Melbourne Hospital, St Vincent's Hospital and Royal Children's Hospital. He was appointed Senior Orthopaedic Resident at Montreal Children's Hospital and Shriners Hospital for Crippled Children and McGill University, Montreal, Canada in 1974. The following year he became a research fellow in the Genetics Unit of the Department of Experimental Surgery, McGill University. He returned to the Royal Children's Hospital in 1978 as a Senior Research Fellow in the Department of Orthopaedics and in 1989 was appointed a First Assistant in the Department of Paediatrics and an Orthopaedic Surgeon in the Department of Orthopaedics, becoming Deputy Director of that Department in 1981. In 1988 he was appointed Foundation Professor of Orthopaedics (Royal Children's Hospital) of the University. He was awarded his Fellowship of the Royal Australasian College of Surgeons in 1971, obtained the degree of Master of Science from McGill University in 1976 and was awarded the degree of Doctor of Philosophy from Melbourne University in 1975.

During his training he was a recipient of many prizes including the Stirling Prize in Surgery from the Royal Melbourne Hospital, the J P Ryan Scholarship in Surgery of the Royal Australasian College of Surgeons, the Sir Gordon Taylor Prize, the Sir Thomas Naghton Fitzgerald Scholarship in Surgery of the University, the ABC North American Travelling Fellowship of the Australian Orthopaedic Association and the Uncle Bob's Travelling Fellowship of the Royal Children's Hospital.

Professor Cole has an outstanding international reputation for his research related to the molecular biology of collagen and connective tissue. He and his group have identified the biochemical defect in a number of heritable connective tissue disorders. His research has been very strongly supported by grants from the National Health & Medical Research Council. As well as research into the molecular biology of collagen, he has also made major contributions in clinical research in aspects of orthopaedics in children. Many of his studies have led to significant changes in management. He attracted many overseas Fellows to work with him both in his clinical and basic research and in orthopaedic training.

He played a major role within the University Department of Paediatrics and the School of Medicine generally, within the

GRADUATE LIST 1992

Bachelor of Medicine & Bachelor of Surgery

Anne E Adams, Alex Alperovich,
Ahmad Aly, David J Amor, Chwee G Ang,
Jayne A Bambit, Robert A Barger,
Heather L Barry, Rowena S Beck,
Bobby H-S Bedi, Robert H Blum,
Alex Boussioutas, Shona M Breward,
Rowena L Bristow, Amy G Brodtmann,
Gregor J Brown, Helmut Butzkueven,
Robert Y M Chen, Jeanie L Y Cheong,
Catherine L Cherry, Lisa A Cheshire,
Derek P B Chew, Wai K Daniel Chiu,
Heng T Victor Chong, Sak E Chua,
Susan L L Chua, Stephen A Cole,
Justin J Coleman, Margaret A Coleman,
Dean A Cowie, Genevieve A Cowie,
Matthew A Croxford, John R Daffy,
Amanda C Dawson, Daiva Dawson,
Julian H J Elliott, Jacqueline El-Masry,
Andrew V H Evans, Matthew C Evans,
Nadine N Ezard, Laura J Farrow,
Sing Z Fong, Thomas J Fong, John Fotakis,
Eleanora Fridman, Elizabeth M Garoni,
Hamish M Gawne, Russell J Goudge,
Alison L Green, Marisa Grossi,
Antonio Grossi, Russell L Gruen,
Marion T Harris, Gregory D Harvey,
Raphael CY Hau, Andrew J Haughton,
Ruth L S Hew, Keith Ho, Mei Ling Ho,
Christine A Houlihan, Kirsten S Hoyle,
Andrew C Y Hui, Julian J Hunt-Smith,
Sally E Hyden, Lee R Jackson,
Michael J Johnston, Miriam A Johnston,
Patti Johnston, Francisco Jong,
Harin A Karunajeewa, Jamie A Kearsley,
Richard J Kennedy, Arthur Kokkinias,
Yuri Kontrobarsky, Gideon M Korman,
John Koutsogiannis, Yew M Kuan,
Eddie W F Lau, Lee S Lau, Paul D Lawton,
Carl T Le, Jimmy K L Lee,
P W Cecilia Ling, Lance Lui,
Paris B Lovett, Jik Hua Loy,

Andrea S-L Lung, Alvaro Manovel,
Carolynne J Marks, Elizabeth A Martin,
Sonia T Masciantonio, Ross A McAlpine,
Brendan C McCann, Andrew J McDonald,
Sally A McIlroy, Jared J Mee,
Robin A Meusemann, Susan J Morgan,
Vanessa A Morgan, Joseph B Morton,
Carol-Anne E Moulton, Louise M Murdoch,
Nimalan Nadarajah, Carmel L Nelson,
Christina V T Ng, Chin S Ong,
Gerard M O'Reilly, George Osianlis,
Stephen J Parnis, Rhys D Parry,
Louisa Patrikios, Michael H Pech,
Maree E Pekin, Vlado Perkovic,
Claire E Phillips, Marinis Pirpiris,
Anthony B Poon, Aurora M T Poon,
Elizabeth K Prentice, Carolyn Quan,
Manonmani N Rao, Janet M Reid,
Edwina K Rice, Peter A Roberts,
Andrew W E Robinson, Libby M Rochstein,
Alexander Sapozhnikov, Duncan Savery,
Christopher W Scarff, Katherine L Scott,
Philip O Sewell, Mark J Shackleton,
Joanne M Sharpley, Rosemarie J Shea,
Peter Shortall, Simon A Shute,
Timothy J Slattery, Piyush M Srivastava,
James D Stoney, Alexander J Swain,
John A Sycamias, Alwin Tan, Syan J Tan,
Wee Jin Tan, Christine L Taylor, Jason Teh,
Benjamin N Thomson, Joanne M-S Tingt,
Manuela G Toledo, Hoang M Tran,
Maria Triglia, Stephen H Tudge,
Gabrielle L Van Essen, Rhys B Vaughan,
Rebecca J Wade, Michael P Waechter,
Liam D Walsh, Matthew G Ward,
William R Watson, Tamara G Weerasinghe,
Nayleen J Whitehead, Malcolm J Wiley,
Michelle C Williams, Jacqueline L Wood,
Phillip D Wood, Amanda E Wright,
Dominic J Yong, Richard G Young,
Kathy Zebic.

Royal Children's Hospital and also in the wider medical and scientific community. He was Chairman of the Research Subcommittee of the Australian Orthopaedic Association, Executive Secretary, Research Advisory Committee of the Royal Australian College of Surgeons Foundation. He was a member of the British editorial board of the *Journal of Bone and Joint Surgery*.

In 1992 he accepted the invitation to become Chief of Orthopaedic Surgery, Hospital for Sick Children, Toronto and Professor of Orthopaedic Surgery within the Department of Surgery of the University of Toronto.

Professor Cole is a great loss to the University and in particular to the Department of Paediatrics. The Hospital for Sick Children, Toronto is the largest children's hospital in the English-speaking world and the clinical and research opportunities there are extensive. Its research budget is in excess of \$40 million Canadian. Undoubtedly he will continue to play a major role in clinical orthopaedic surgery and in basic research in disorders of collagen.

PROFESSOR IAN DARIAN-SMITH

IAN DARIAN-SMITH graduated in medicine at the University of Adelaide in 1950. Following periods of residency training at the Royal Adelaide Hospital and Adelaide Children's Hospital, he was appointed in 1953 as an NHMRC Fellow at the Kanematsu Memorial Institute of Pathology, Sydney Hospital. He was awarded the MD degree of the University of Adelaide in 1956. Between 1956 and 1958, he was an NHMRC C J Martin Fellow at the National Institute for Medical Research, Mill Hill, London, and in 1959-1960, NHMRC Senior Research Fellow in the Department of Physiology, University of Sydney. In 1961, he was appointed Associate Professor of Physiology at the University of New South Wales and then to a Personal Chair in the same University in 1965. During 1966, he was Visiting Research Fellow in the Department of Physiology at Johns Hopkins University School of Medicine in Baltimore where he worked in close association with Dr Vernon Mountcastle. In 1968, he resigned his Chair at the University of New South Wales and took up a position as Visiting Research Fellow in the Department of Physiology at the John Curtin School for Medical Research at the Australian National University in Canberra. He then accepted an appointment in 1969 as Associate Professor of Physiology at Johns Hopkins University School of Medicine. He returned to Australia in 1973 to become Professor of Physiology at The University of Melbourne. He was appointed Professor of Anatomy in 1982.

Professor Darian-Smith is one of Australia's outstanding medical research scientists. He is a neuroscientist with a special interest in sensory processes, particularly those related to the sense of touch. His pioneering work and discoveries relating to the organisation and function of the brain pathways involving sensory perception are internationally acclaimed. He was President

of the Australian Neuroscience Society, 1988-1989. He has inspired many PhD students and post-doctoral Fellows, at least six of whom are now in Chairs of Physiology or Neurosciences in Australia, Canada, the United States of America, and Japan. As well as through his achievements in research, Professor Darian-Smith has contributed in a major way to the University through his leadership roles in the School of Medicine over twenty years. He was Chairman of the Department of Physiology from 1973 to 1981, and has been Head of the Department of Anatomy since 1986. He has served on most major committees of the Faculty and was Deputy Dean from 1978 to 1980.

He has played a key role in ensuring that the University leads by example in the implementation of high quality ethical processes for the monitoring of animal experimentation. Although not especially noted for his tolerance of formal bureaucratic processes, he is unswervingly committed to fostering an academic environment that promotes teaching and research programs of the highest quality. In the medical curriculum, his legacy of excellence in teaching includes an innovative and challenging integrated neuroscience program. His Brain Research Unit in the Department of Anatomy has become established as one of the world's leading centres in the field of sensory perception. Following his 'retirement' from his University position, Professor Darian-Smith will continue his research program in the Howard Florey Institute. All who know him well are confident that his work will continue to flourish.

PROFESSOR MICHAEL RAND

MICHAEL JOHN RAND was born in 1927 in Suffolk, England. He migrated to Australia in 1941 and completed his schooling at Ivanhoe Grammar School. He graduated Bachelor of Science at this University in 1949 and then went on to complete a Master of Science degree. Subsequently, he undertook PhD studies at The University of Sydney, graduating in 1957. He returned to England to undertake postdoctoral training with one of the most eminent pharmacologists of the time, Professor J H Burn, in the Department of Pharmacology at the University of Oxford. The three-year collaboration between Rand and Burn resulted in a number of important discoveries in the field of autonomic pharmacology. After a brief period as a visiting scientist in the Department of Pharmacology at the University of Vermont, USA, Michael Rand returned to Australia as a Senior Research Fellow in the Department of Pharmacology, University of Sydney, a post he occupied until 1960. On being awarded a Wellcome Medical Research Fellowship he returned to the United Kingdom to work in the Department of Pharmacology of the School of Pharmacy, University of London. After one year, he was appointed Lecturer in the School of Pharmacy, a position he held until 1965.

He was appointed Professor of Pharmacology at The University of Melbourne in

1965. Within a brief period he developed a department with great strengths in undergraduate and postgraduate teaching and in research. Throughout his twenty-seven years in the Chair, he had a major influence on the development of the discipline of pharmacology in Australia. He continually attracted substantial research funding and made numerous seminal discoveries in pharmacology. His work has been acknowledged internationally. His major research interests have been in mechanisms of nervous transmission and their relationship to high blood pressure, heart disease, asthma, and psychiatric disorders. His research has resulted in more than 300 research papers in international journals.

In 1968, together with Professor W C Bowman, he published the *Textbook of Pharmacology*. This work, which underwent major revision in 1980, is considered internationally as a major textbook of pharmacology. He has been a member of the Editorial Board of many international journals of pharmacology. He was the founding Editor and Editor-in-Chief of the *Journal of Clinical and Experimental Pharmacology and Physiology*, a publication which quickly developed into a major international journal for the discipline of pharmacology.

He has worked with indefatigable energy to strengthen the disciplines of pharmacology, clinical pharmacology and toxicology in Australia, and in other countries of the South-East Asian, Western Pacific region. In 1967, he was instrumental in setting up the Australasian Society of Clinical and Experimental Pharmacology and Toxicology, the major professional society for its constituent disciplines within Australasia. He has served as President of the Society on two occasions. He has been instrumental in organising numerous conferences in Australia and the South-East Asian region. He was Chairperson of the National Organising Committee of the 10th International Congress of Pharmacology, which was held in Sydney in 1987. This Congress represents the major scientific meeting for the discipline of pharmacology internationally and, for the 1987 Congress, he was appointed President.

Professor Rand's pre-eminence in pharmacology and toxicology has been recognised by his appointment to many consultative positions and extra-mural committees. He has served on several committees of the Departments of Health of the Victorian and Australian Governments. Of particular significance is his continuing service since 1971 as a member of the Victorian Government's Poisons Advisory Committee. At an international level, he has been a member of the World Health Organisation Expert Advisory Panel on Food Additives and Contaminants since 1968 and he has served as Chairperson of the Joint Expert Committees' meetings on several occasions. He was recently appointed a Commissioner on the National Food Authority, a statutory authority of the Australian Government whose task is to establish uniform food standards throughout Australia.

As Professor of Pharmacology of this University, Michael Rand has been the focus of

a stimulating academic research environment. His enthusiasm and skills have provided inspiration for undergraduate and postgraduate students and the academic staff of the Department. Many of his students have established themselves in prestigious appointments in research, academic institutions and government organisations, nationally and internationally.

PROFESSOR PETER READE

PETER CLARENCE READE was born in Adelaide, South Australia, in 1930 and gained his Bachelor of Dental Surgery degree from the University of Adelaide in 1952. Following a brief period in general dental practice he took up a position with the Eastman Dental Hospital, University of London, where he completed the FDSRCS. In 1958 he returned to Adelaide as Lecturer in Periodontia at the University of Adelaide Dental School. He held several positions at the University of Adelaide including a Nuffield Scholarship in the Department of Microbiology and later a Research Fellowship with the NHMRC. He received his MDS degree from the University of Adelaide in 1961 and his PhD in 1964. In 1966 he took up an appointment as Research Associate in the Department of Bacteriology and Immunology at Harvard University in Massachusetts.

Professor Reade returned to Australia in 1968 to take up the Chair of Dental Medicine and Surgery at The University of Melbourne. He brought to this position the highest ideals in biological science investigation and encouragement for the pursuit of these ideals in dental graduates. He developed an exemplary department for oro-biological research and oral and maxillofacial surgery. He has supervised many PhD and MDSc students who have become international leaders in their fields. He has pursued a wide range of research in experimental oral pathology, including work on auto transplantation of teeth, oral carcinoma and the temporomandibular joint pain-dysfunction syndrome.

Professor Reade's teaching and research activities in oral health sciences have led to many national and international fellowships and awards, including the Leverhulme Visiting Fellowship to the Tokyo Medical and Dental university in 1974; election as a Fellow of the Royal College of Pathologists of England in 1980; and the Alice and George Edwards Research Award of the Anti-Cancer Council of Victoria in 1988. He has served as President of the ANZ Division of the International Association for Dental Research, Chairman of the Graduate Union of The University of Melbourne, and as Chairman of the nominating Committee of the International Association for Dental Research. He will now be able to pursue in a more leisurely fashion his interests in motor cars, farming and photography.

University of Melbourne Medical Society and University Alumni Association Membership

Ordinary Members Reminder to Renew!

**Membership year
1 April 1993–31 March 1994**

If you are an UMMS member your renewal form will be enclosed with this issue of Chiron. If you are not a current member of UMMS, you can obtain an application for membership from the UMMS office at the address below. Membership will ensure that you continue to receive Chiron and news of reunions, Medical School information and notices of UMMS and University events. Members' subscriptions also support undergraduate students through sponsorship of the annual UMMS BMedSc Prize and three UMMS Elective Essay Prizes.

Foundation Life Membership

Foundation Life Membership carries with it lifelong membership of UMMS and the Alumni Association. 1993 is the last year that members will be admitted to the category of Foundation Life Member.

Honorary Membership

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

Membership Fees

Ordinary Members

- Annual subscription \$40
- Recent Graduates
- 1989 graduates \$30
- 1990 graduates \$20
- 1991 & 1992 graduates \$10

Foundation Life Members

- \$1,000, or \$500 in each of two years

Honorary Membership

- No cost

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

Who is eligible to join UMMS?

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

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

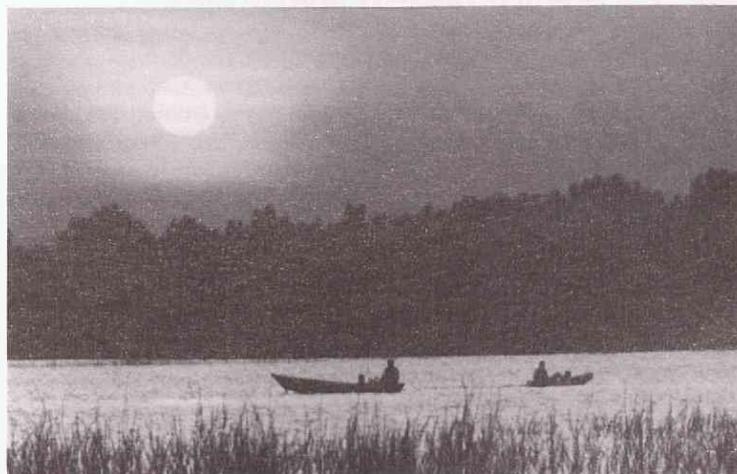
UMMS Office

Ms Liz Brentnall
School of Medicine
The University of Melbourne
Parkville 3052

Telephone (+61 3) 344 5888 Facsimile (+61 3) 344 5998

LEPROSY IN VIETNAM

February–March 1992

Russell L Gruen, MBBS 1992

A view near the Health Centre, Dong Nai Province, Vietnam.

This article is an abridged version of a report prepared for The Leprosy Mission. The research was conducted to determine the extent to which leprosy is a health problem in Vietnam, to look at the Vietnamese solutions and ways of assisting them to achieve their goals. This followed eight weeks at The Leprosy Mission's Anandaban Leprosy Hospital in Nepal, where Dr Gruen took part in the training and operation of leprosy control programs as well as clinical leprosy work involving medical and surgical treatment and rehabilitation. He spent four weeks in Vietnam, in a Primary Health Care project in Dong Nai province, and in Ho Chi Minh City, Hue, Hanoi and Nam Dinh. Most of the leprosy research was conducted in Hanoi.

The full report formed part of a successful submission to the Australian International Development Aid Bureau (AIDAB) by The Leprosy Mission. A bilateral agreement with the Vietnamese Government has since been created, to assist the leprosy eradication program in three provinces over three years, with AIDAB funding in excess of a quarter of a million dollars.

Some background

War and isolation have been major contributing factors to Vietnam becoming one of the world's poorest nations. It is unnaturally so. It has a sound agricultural industry, particularly rice, and an ideal location as a seaport. Its people are well educated and hardworking, and its government highly structured.

Following the Nationalists' success in the Vietnam War, North and South Vietnam were

reunited into one nation in 1975. Since then Vietnam has endured a diplomatic and trade embargo imposed by the United States, being denied political, trade and financial interactions with most developed nations. Its closest diplomatic ties were with the Soviet Union, Eastern Europe and with its neighbour, Laos. China and Cambodia have often been unfriendly, the Chinese most recently threatening the northern border in 1979.

Hundreds of thousands of Vietnamese fled the country in the late 1970s and early 1980s, and many more endured years in re-education camps. Significant changes to government policy occurred in the late 1980s: private enterprise and interaction with foreigners was tolerated, and relations with overseas governments and businesses increased. The decline of the Soviet Union was the loss of a significant ally, and in the last year the Hanoi and Beijing governments have gone to great lengths to restore friendships.

The total population of Vietnam in 1989 was 64.4 million, of whom 19 per cent were urban. Population densities per square kilometre vary from 1000 in Hanoi and Ho Chi Minh City and 500 in the Red and Mekong River delta areas, to fewer than 50 in the mountainous regions of the central highlands and northern border provinces. Uneven population distribution has been of concern to the Hanoi government, which has encouraged movement through their 'New Economic Zones' policy.

Development in Vietnam is now progressing at a rapid pace as foreign businesses and aid organisations are establishing themselves.

Many Vietnamese, particularly those in Ho Chi Minh City, are beginning to learn English to make the most of an impending tourist and industrial boom. The Saigonese boast of using Bangkok as a model for the future. The increasing exposure of the Vietnamese people and government officials to the West is fuelling their hunger for development.

Large amounts of foreign aid and investment will flow to Vietnam in the coming years. Whether the government infrastructure with its corruption and eroded social services will put it to best use, remains to be seen. Other problems that may arise in the near future have to do with equity and the widening gap between rich and poor in an economic society that is becoming more 'user pays'. Issues of migration and the environment will arise and AIDS is becoming a growing concern. Political instability may become a significant problem, particularly in the South where few people feel entirely comfortable under the Hanoi government.

Leprosy in Vietnam

Despite an established national program, leprosy is still a major health problem in many parts of Vietnam. Its prevalence is estimated at 1 per 1000 population in the North and 1.5-1.8 per 1000 in the South. In the central highlands, where old cases congregate and access is difficult, there are areas with prevalence of up to 50 per 1000. Incidence data would be more useful but none was available.

'Mass surveys', organised centrally and being conducted province by province, are currently being carried out to establish more reliable statistical data. They involve the training of provincial and district personnel to organise workers at the primary level to visit every household. It takes approximately one year to conduct such a survey in each province, and during 1991-2 three provinces were completed (Nam Ninh, Binh Luc and Hua Lu). So far, less than half of all provinces have been surveyed, most of these being in the north.

Leprosy has suffered the same stigma in Vietnam as elsewhere. It is said that only thirty years ago it was common for victims to be buried alive. Coordinated health education programs were initiated in 1959, when segregation of patients was the rule. In 1978 the policy of segregation was officially abolished. There are still 22 leprosaria in Vietnam, varying in size from 100 to 500 beds. They predominantly house long-term destitute patients – every attempt, it seems, is made to manage new patients in their home environment.

The National Leprosy Program

The National Leprosy Program is organised by the National Institute of Dermatology and Venereology (NIDV) in Hanoi, which also has the responsibility of addressing sexually transmitted diseases. It has its own inpatient ward which focuses on training, research and close patient follow-up. However, for all projects on a national basis, its major responsibility lies with its Section of Directives. In addition, there are two specialist leprosy surgeons in Vietnam, both trained in Kirigiri,

India. One is now based in Hanoi and one in Ho Chi Minh City.

At the provincial level specialist staff work in the specialist units – the Dispensary of Dermatology in charge of leprosy control, a Clinic of Dermatology in each general provincial hospital and, in some provinces, a specialist inpatient treatment centre. In Hanoi and Ho Chi Minh City inpatient and outpatient facilities are combined and co-ordinated through a specialised dermatological hospital.

It would appear that provincial general hospitals are still often unprepared to accommodate simple surgical cases of leprosy and severely disabled patients, and are referring them to the specialised treatment centres. It is hoped that such centres will eventually become unnecessary and obsolete.

At a district level specialist staff trained by the province work in more general units such as the District Centre for Preventive Medicine, and the District Hospital. Drug therapy is usually dispensed at this level.

Other than the 'mass surveys' being conducted, the national program aims to achieve early detection of cases by education of the public, particularly through the schools. In some provinces, leprosy has been included in annual teacher training and, usually, is subsequently incorporated into school curricula. It is a provincial responsibility and Thai Binh was the first and model province, its school program beginning in 1985. The main messages are what leprosy is and its cause, its low infectivity, the cardinal signs and what to do about it. The program aims to increase the rate of detection and reduce the stigma associated with the disease. Media used include the distribution of class timetables with printed poems and messages about leprosy. Funding comes from both the national program and the People's Committees. It is hoped the children will become the main detectors of the classical skin lesions.

Treatment

Treatment of established leprosy consists of a prolonged course of drug therapy to eliminate the mycobacteria, physiotherapy and the use of prosthetics, patient education, treatment of contacts, and surgical management of ulcers and reconstruction to overcome paralysed muscle groups.

All treatment, including inpatient treatment, is theoretically free of charge to leprosy patients. It is uncertain whether or not this is true in practice.

Multi-drug therapy is used and comes from a variety of sources, often through Non-Government Organisations (NGOs). Poor compliance is a problem, but is less of a problem than illnesses for which patients pay for treatment.

Prevention of deformity

Minor septic surgery is conducted in provincial centres. Major reconstructive surgery is performed by two leprosy surgeons, one in the North and one in the South.

Physiotherapists are trained in Vietnam but have not been extensively employed in leprosy work. Outside Hanoi there are very few physiotherapists involved.

Among other places, prostheses are made at a specialised centre near Thanh Hoa, but budgetary constraints have made them a luxury beyond the reach of most needy patients.

Special footwear is an important part of the management of neuropathic feet. No significant footwear industry has been developed – only the NIDV has the capacity to order and issue orthopaedic sandals.

The Vietnamese Health Care System

The government's commitment to equitable health services and the primary health care approach has been seriously impeded by its inability to decentralise, by the inaccessibility of population groups, inadequate wages and materials, and inefficiency.

The major causes of mortality and morbidity in 1986 were malaria, tuberculosis and diarrhoeal disease. In fact, the ten leading causes of mortality and morbidity were all communicable diseases, most of them preventable, thus emphasising the need for basic public health initiatives.



Drs Des Soares and Russell Gruen. Reconstructive surgery to restore a paralysed hand, Anandaban Leprosy Hospital, Nepal.

Over 50 per cent of the population was under 15 years of age in 1984. Like many of its Asian neighbours, with the exception of Thailand, there is little antenatal or postnatal care and Vietnam's rates of maternal mortality and low birth-weight infants are high.

The Ministry of Health has identified seven 'social diseases' that are of major public health concern: malaria, tuberculosis, leprosy, sexually transmitted diseases, trachoma, endemic goitre, and psychiatric disorders.

Other stated major current health strategies, initiated in the 1986-1990 period include:

- Prevention and control of other infectious diseases
- strengthening and developing the basic health services network, particularly at a grassroots level
- reduction in the population growth rate
- development of the pharmaceutical industry

- promotion and integration of traditional medicine, and
- improvement of environmental health.

At the primary level, a 'health station' manages simple preventive, curative, promotive and educative aspects of health care in each village. The main emphasis at this level, as far as leprosy is concerned, is recognition of new cases and follow-up of current, treated and discharged patients. Usually there are a few beds, one or two assistant doctors and some medicines. Supplies and training are the responsibility of the Ministry of Health, whereas the buildings are provided by the local People's Committee. The government pays the salaries of three staff per station, additional staff must be paid by the village. Thus adequate staffing and training are ongoing difficulties.

Both the Central Government and the Provincial Governments contribute to the National Health Budget. It is estimated that they contribute approximately US\$100 million per year in 1990 financial terms, which is equal to 3.7 per cent of the gross

domestic product and approximately US\$2 per capita. These contributions can meet no more than 40 per cent of that required to maintain the health services and, as a result, fees for service were introduced in 1989, hospitals have appealed for donations, and health workers are often underpaid.

Sections of the system have been necessarily privatised, particularly some hospital wards, and many health workers have opened a private consulting practice and a private dispensary. Others rely on a second job of a different nature. Privatisation has only been officially condoned since 1988-9. In addition, a substantial proportion of the drug supply is sent by overseas expatriot Vietnamese back to their families in Vietnam to sell.

Non-monetary exchange of services and the contributions of local communities also go to making up the difference in health expenditure. Foreign support through NGOs and United Nations agencies amounted to



Outside Nhat Dinh Dispensary (Benh Phong means leprosy).

US\$19 million in 1987 and US\$23-25 million in 1990, representing about 13 per cent of the resources available to the health sector.

Health personnel

Health personnel are not in short supply. Five major medical schools annually graduate about 2,000 doctors of six years' training, and 330 pharmacists. Each province has a secondary medical school that trains assistant doctors over a three-year period, as well as nurses, midwives and medical technicians. Training is also provided for traditional medicine assistant doctors. Two undergraduate colleges of public health exist, but little postgraduate training in public health is available.

There was one medical graduate or assistant doctor for every 960 in 1987, who were relatively evenly distributed across the country, being posted to hospitals at central, provincial and district level, and to intercommunal polyclinics. In 1990 the government discontinued its scheme of compulsory appointments and there was a large influx of

medical staff to the major cities, particularly Ho Chi Minh City. Today the rural areas of the country are undersupplied with doctors, while there are many graduates unemployed or working in other employment in Ho Chi Minh City and Hanoi.

The doctors' levels of competence are variable. Most of those observed appeared capable, confident, dedicated and diligent. In recent times the government has sent some for specialist training overseas. Some notable flaws in the management of basic childhood illnesses were observed by the author during his limited exposure. In addition, many patients consult traditional doctors or pharmacists about health problems before they visit a doctor, and hence late presentation is a problem.

Non-Government Organisations

In December 1990 there were 61 NGOs operating in Vietnam. Since then many more have begun projects, mainly in humanitarian aid, health and agriculture. The government still insists that each must establish its first

office in Hanoi. They have used a variety of strategies, most being directed through centralised bodies in Hanoi. As an example, The Save the Children Fund (UK) has found working within the education system in Vietnam to be a very difficult approach.

So far the Hanoi government has not permitted NGOs to work in most mountainous and ethnic minority areas. There are many reasons for this, including the traditionally anti-communist sentiments, sensitive border relations and the remaining re-education camps. NGOs should be able to use their particular skills and experience – focusing especially on a community and training basis – to address the issues with sustainable programs where they will have the most impact. It seems that this is often not the case due to government policies in Vietnam.

Conclusions

Undoubtedly the Ministry of Health's claims for financial support of its National Leprosy Program are valid, and government-controlled native Vietnamese-staffed execution of the program is a positive step for their health care in the long term. However, it is felt that they may be denying themselves some of the expertise that specialist NGOs can offer.

A real need is for both the National Leprosy Program and NGOs to address leprosy in the harder-to-reach mountainous and ethnic minority areas. The state of roads and communications in Vietnam is such that direction from and interaction with bodies in Hanoi and Ho Chi Minh City is not currently feasible. They are politically sensitive regions, and it may be some time before access is granted.

Despite large centralised programs, difficulties in equitable allocation of resources, and political uncertainty, Vietnam's attempts at leprosy control will particularly benefit from the level of education of the population and of indigenous health professionals, its community groups, a health system that is capable of being revitalised, and the promise of a better economic future.

Acknowledgements

- United Nations Development Program 'Report on the Economy of Vietnam', UNDP December 1990.
- Miss Ingrid Schraner, representing *Association Aide aux Lepreux au Vietnam*, Zurich, Switzerland.
- Professor Le Kinh Due, (Director), and Mrs Do Kim Dung, (Project Officer), National Leprosy Program, National Institute of Dermatology & Venereology, Hanoi, Vietnam.
- Dr Ainh vau Voi, (Deputy Chief), and Dr Trinh vau Chinh, (Leprosy Control Specialist) at Nam Dinh Dispensary for Dermatology and Venereology, Nam Dinh Province, Vietnam.
- Ms Linda Hiebert and Miss Mary Takeda, The Save the Children Fund (UK), Hanoi.
- The Ministry of Health in Hanoi for permission to conduct the research; those who helped with translation, organisation, and preparation of the manuscript.
- Generous financial support from The Leprosy Mission, The Medical Defence Union and the Douglas Hill Memorial Foundation.



Drs Des Soares and Russell Gruen, Anandaban Leprosy Hospital, Nepal.

PERSPECTIVE PURSUIT

November 1991–March 1992

Alexander Pitman (*Sapozhnikov*), MBBS 1992

*They sought it with thimbles, they sought it with care;
They pursued it with forks and hope;
They threatened its life with a railway share;
They charmed it with smiles and soap.*

Lewis Carroll,
The Hunting of the Snark



Dr Alexander Pitman

IN MY allotted fourteen weeks of electives I tried to examine three issues: how the practice of medicine *per se* in the United States, Canada and Britain compares with ours; the teaching of the practice of medicine (the clinical years) in those countries; and whether it would be easy for an Australian graduate to return to the country of his/her elective to work or study for a while (irrespective of whether or not one would want to).

Between November 1991 and March 1992 I spent six weeks on a neurosurgical unit in Boston (not Massachusetts General Hospital – it is not representative of the United States), four weeks on a cardiovascular surgery unit in Canada (eastern seaboard), and four weeks in a large regional general hospital in London (general surgery). By far the worst to organise was the US rotation, mostly because I had to obtain professional malpractice insurance.

THE STUDENT

The aim [of student intern rotations] is to make the students' experience more akin to that of interns, to give them more responsibility and practical experience. (Clinical School)

THE US and Canadian MD is a four-year, postgraduate course. There are some prerequisites for the undergraduate curriculum, but the reality is that the medical student has to be retaught most of the theory in the first two years. This leaves the last two years to tramp the wards.

United States

The clinical medical student in the States is older than the British or the Australian counterpart, frequently married, occasionally with a job. Because medicine does not

come cheap (at some US\$20,000-25,000 per year), maturity comes fast. The majority is still male, although change towards an equal number of females is definitely in the works.

There is very little formal teaching in the clinical years; instead, it is the student's lot to do as the intern does. Students are within their rights in many institutions to order just about any test (and then chase the results) and to prescribe with the resident counter-signing. They are also expected to do admissions, and the student's internal assessment is directly related to the number and the quality of admissions performed. Physical signs recorded are not double-checked by anyone – it is your insurance, buddy! Patient checkups and progress notes also commonly fall to the student.

The keen are very welcome to assist in the OR – this frees up the resident. Those procedures within the student's competence are available for the take – drips for example. Those requiring supervision such as lumbar punctures are as hard to organise as anywhere else. The admissions, the post-op checkups, the chasing of results are all heaped indiscriminately on the student until no more can be tolerated. The definition for this activity is 'scut work' (a term unfortunately absent in Australia and hence replaced by colloquialisms), and by inference the medical student is termed the 'scut monkey'. 'Presentation' or the art of delivering your medical ideas in a monotonous whine is thankfully absent. If you can't put it into points in the notes or talk about it sensibly with the resident, you are useless.

The US system is marvellous for learning the practical things – fast. If you do not question and just follow the routine, you are guaranteed a smooth transition to doctorship after a couple of hectic years. I have never yet met a better inducement for learning than responsibility, and the amount of responsibility heaped on the student is limitless.

The obvious downside of the US system is the direct result of the amount of time sunk into work. Both the theoretical and the practical knowledge base of the typical US student is rather lacking, through little time spent on thinking about medicine, reading about medicine, and plain seeing enough medicine. The imperative goal is to survive – a laudable aim, but little knowledge processing and rethinking occurs. It is also very difficult to acquire an overview in four short years.

The Australian clinical years are geared towards a history and examination graduate. There is nothing which teaches management or ward work, and there are few opportunities to jump in the deep end to learn for yourself. Conversely, the US clinical years teach but little of history and examination, and there is palpably less skill in this area compared with the Australian in the early years.

So, in the States you emerge at the other end bitter and disillusioned, capable of ward work, with a finely honed bullshit detector, a fair few thousand dollars in debt and a lot yet to learn.

Britain

In Britain, the MBBS is a five-year undergraduate degree that bestows on you the honorary title of 'Doctor'. Steeped in tradition, socialism and unending red tape, the NHS serves as the backdrop for the struggles of the average 20-odd year old who goes through the course more for social reasons than out of a keen desire to make money.

Compared with his/her American counterpart the British medical student is impotent in all respects (except accumulation of theory), a fine young man (still most common) who is whiling away time just like a century ago in a definite vocational niche. The student is taught formally quite well, taken on teaching rounds and presentations, given tutes and time. All of that (dispensed with in the Americas) constitutes the definitive medical education.

Nothing practical is expected of the British student, not even drips. For legal reasons (if you are a student, you are by definition not medically qualified) many places prohibit student admission or progress notes in patient histories. In any case, the resident is obliged to double-check your signs. Active participation in wards day-to-day is officially expected, and effectively discouraged. The student is frowned on if chasing investigation results, while ordering routine tests is out of the question. Needless to say, students are not let anywhere near the drug chart. In theatre, the student is expected to attend and not to interfere. This inevitably implies being stuck behind a few backs and getting to see two people sweating over a deep hole.

When I challenged one or two of my peers about their attitude to the essentially passive role bestowed on them by the system, a couple pointed out legal concerns, while most gave a philosophical shrug and an expectation to catch on 'real fast' once they are the intern.

Herein lies an interesting difference: the States, the land of the lawsuit, allows the student to take on virtually anything he/she can cope with – granted, student professional indemnity is an absolute prerequisite. In Britain, where litigation is (comparatively) unheard of, the concern over 'who is legally capable of doing what' is paralysing. Certainly one's skills and knowledge are the same a week after graduation as a week before!

The strong points of British undergraduate medical education can really all be

extrapolated from what we see in Australia: a firm grounding in signs and symptoms and reasonably thorough, albeit basic, theoretical groundwork.

So, in Britain you pass into the intern year knowing a fair amount about medicine, and very little medicine. Although you know what to expect, nobody has ever let you do it before, and your sense of worth rates somewhere just above domestic help.

Canada

The Canadian student is somewhere between Australia and the States on the British-Australian-United States continuum. The proud owner of a 'student physician' badge, he or she has a definite role to play on the unit but is not under the inhuman pressure allocated to their US counterpart.

Typically, the student gets to do the admissions and to write up the initial medications (countersigned by the senior resident). From the admission on, the student has a marginally hovering presence as far as patients are concerned. Writing progress notes, following through investigations and minor on-the-spot patient management decisions are certainly welcome.

In the OR the student can have a go at most simple things (simple intubations and lines, occasional skin suture). The situation is very dependent on the resident's need for experience. However, there are more concerns in Canada about whether it is appropriate for a student to hold responsibility than there are in the States.

Theoretical teaching is integrated into the course to much the same extent as in Australia in terms of time and type. There is also much more time to do reading and personal study, unlike the States, and most take every opportunity to do so. The same problems are present in Canada as in the States: getting an overview, a knowledge base and enough history/examination variety in four years.

THE RESIDENT

"I follow a terrible profession. In the old days it was reasonable. I put the lamp out in the morning, and in the evening I lighted it again. I had the rest of the day for relaxation and the rest of the night for sleep."

"And the orders have been changed since that time?"

"The orders have not been changed," said the lamplighter. "That is the tragedy! From year to year the planet has turned more rapidly and the orders have not been changed!"

Antoine de Saint-Exupery,
The Little Prince

United States

In all the places I have seen (including Australia) nobody enjoys residency for residency's sake. It is at best a stepping stone towards greater things and at worst just whiling away time. This is most obvious in the States, where residency pursuit is a deadly serious game, with money and lifestyle by far and away the main driving forces.

Residency programs are offered on the base of universities/teaching hospital

networks, which differ greatly both in prestige and in quality and quantity of experience. The intern year postgraduate Year 1 (PGY1) is most commonly organised through the National Resident Matching Program (NRMP) in Chicago. The success rate of the NRMP (defined as providing first choice for applicants) is good.

Subsequent to that, specialist training commences in the second postgraduate year. 'Family medicine' is essentially a speciality in its own right and does not claim the majority of residents. Its only substantial difference from other specialty training is its shorter duration and its primary care setting. There are twenty-odd specialty Boards in the States, which register practitioners in their branch of medicine. Just like Australian College Fellowships, in theory there is nothing stopping any MD from doing anything, but for practical purposes consultant type practice (even if it be in family medicine) can only be undertaken once registered. The Boards certify training programs offered by the various hospital groups. The principal feature of the programs is their definitiveness: outcome is virtually guaranteed provided you have been accepted and can satisfy progression criteria. The duration of most programs is from five to seven years.

Opportunities to practice are very much determined by the base where you had your residency. Acceptance back to the same hospital system is easier, but you are limited to its features, and cross-acceptance depends on both performance and the prestige of the residency.

The major heave in PGY1 and PGY2 therefore, is to be accepted into a residency of choice. Surgical residencies are in most demand for purely remuneration reasons, even though the issue of litigation is very real and work conditions both during the residency and after graduation are much tougher. The specialties that appear to be most in demand are ophthalmology (clean, money), neurosurgery (prestige, mystique, money), ENT (lifestyle, money) and cardiac surgery (money, money, money). Of the medical specialties neurology is probably the winner (clean, stimulating, money). Ophthalmology, neurosurgery, ENT and neurology run their own matching programs, and you have to apply at the end of third year of medical school and tailor the rest of your medicine accordingly to stand a chance.

In order to make a convincing and possibly successful bid to enter a specialty (unless it is something of non-existent demand) one has to start planning in the second and third years of medical school. Clerkships taken and electives done (with references and CVs) have some relevance to subsequent acceptance. Academic performance is important, as is internal assessment.

I gave a talk to a group of US medical students finishing their third year (and, hence, planning their elective). I told them how important it is to go to places different from home and how vital it is to avoid the routine. I told them about Australia and offered to help. Of forty or so people present three stayed behind – to discuss with the Dean how to organise their US electives in

order to ensure getting into ophthalmology, anaesthetics and dermatology respectively!

Residency in the States is an intense experience. Unlike the British system which we have inherited, many units 'receive' every day. That is especially the case with units dealing with elective patients – at least there one has a weekly draft admissions plan. Typically, the unit/department for the day does a seven a.m. ward round on everyone's patients, and then the resident is left to run the ward and to assist in the OR.

The staff-patient ratios are not at all generous to the resident, and are marginally worse than in Australia. The standard of care, however, dictates that far greater levels of minutiae and fine points be observed. This puts you under quite some stress (*The House of God*, Dr Potts) and often corners that are not obviously above water are the ones that get cut.

One of the great axioms of Western medicine is that the degree of nursing initiative and involvement is inversely proportional to the degree of medical sophistication. If I were to draw a continuum, it would look like this: (most) Britain-Australia-Canada-US (least). In the States, the nurses are caring, competent and intelligent to the same degree as anywhere else. However, the system is such that most of what would squarely fall into nursing responsibilities in Australia (nursing care plans, collation of regular non-vital signs, bedsores, determining the fate of dressings, catheters, etc) falls to the resident. Although this ensures that nothing is missed, it creates a lot of extra work for the resident.

The North American system for specifying a doctor's orders is noteworthy and quite unlike the British system inherited here. All orders are placed in the orders section of the chart. These include: drugs with levels, IV fluids specified in cc/hr (for the infusion pumps), diet, nursing orders (that is, nursing care plan), frequency and nature of obs, nature and handling of tubes and monitors, referrals, and the lab analyses required. In the better-run institutions these orders are then scrupulously carried out and crossed off. This offers the doctor the welcome opportunity to have the entire patient management plan (including fairly basic stuff) on the one single page. It also makes you think of the whole patient as you go through the checklists. There is certainly no fractionation of the orders as occurs in the British system (drugs to end-of-the-bed broadsheet, diet on head-of-bed card, nursing care instructions to sister, biochemistry slips to biochem (no record), undated IV fluid orders in a pile in one end of the ward). The disadvantages of the North American system are two: one, you have to think of everything yourself (see above re nursing responsibility); two, there is no way known to find out what drugs the patient is on *now* as you shuffle through orders from days ago trying to work out how the initial dilantin dose came to be altered with time. There is certainly no broadsheet at the end of the bed!

Once you get to the end of the day, one of you stays on call. It is up to you to organise who does. Medical admin does not go in for luxuries such as night cover. It also does not

go for overtime, because being in a training program you are not salaried; rather, you are receiving a stipend (fixed for the year) and cheap health insurance. In 1991 a typical stipend was US\$25,000-30,000 – enough for basic existence.

US higher qualifications are essentially not recognised in Australia for the purpose of obtaining equivalent standing (say, getting FRACS). The same is absolutely and emphatically true for Australian qualifications in the States. The bureaucrats certainly will not let you claim credit for a year or two years of residency in one country towards qualification in the other. The most common pattern for Australians going to the States is to do a year or two in the position of Fellow usually just after Part II. This works reasonably smoothly – at least it has for the most recent crop of consultants.

In order for an Australian national (no green card, no special privileges, no time spent in US medical schools) to work in the US hospital system one had to pass, until very recently, FMGEMS from ECFMG (Part I and Part II) before applying for a residency/fellowship of choice. Currently, medical graduation assessment is changing in the States (as it does there on quite a regular basis). The previous parallel systems of FLEX and National Board of Medical Examiners are being abolished and replaced by a single USMLE to be 'administered' to all US medical graduates and to all foreign medical graduates (that is, us) from 1994. USMLE comes in three parts: Part I (basic sciences), Part II (clinical knowledge enough for supervised medical practice) and Part III sat after PGY1 (knowledge for unsupervised practice of medicine). The USMLE is essentially a battery (as in assault and battery) of MCQs lasting some two days for each Part. The USMLE is currently available in Australia through ECFMG. It looks like those among us who have already sat FMGEMS will eventually have to sit USMLE anyway.

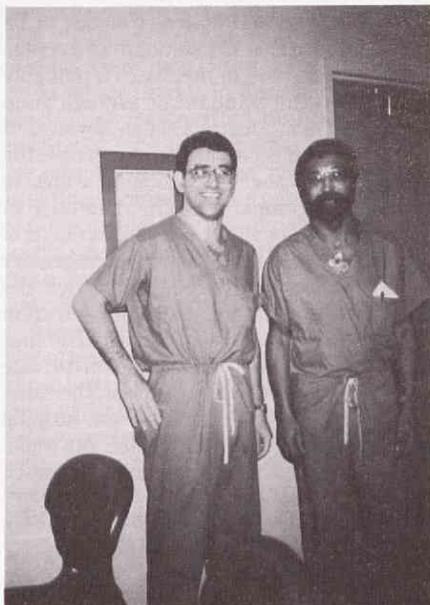
Canada

In Canada, the content of residencies (ward work, record keeping, responsibilities) is quite similar to that in the States, and I shall not go into detail there.

After graduation from medical school graduates sit the Medical Council of Canada Qualifying Exams (MCCQE) Part I. This is followed by internship, and most hospitals participate in the Canadian Intern Matching Service. The internship is followed by either entry into categorical training programs, or completion of the internship to two years. A categorical training program at such an early stage usually means the Family Medicine Program of the College of Family Physicians of Canada (a newly-hatched body, designed to plug the rural gap). All specialty certification is handled by the omnipresent Royal College of Physicians and Surgeons (Canada), which is the traditional umbrella organisation. After one or two years internship the doctor sits MCCQE Part II. On successful completion of all this the Medical Council of Canada issues its Licence (LMCC) to the doctor. Following this, he or she becomes eligible to be fully registered to practice medicine, and such registration is

granted by Provincial Medical Boards of the various Canadian provinces. Parts I and II and the LMCC are portable throughout Canada.

Unlike the States, with its bewildering heterogeneity of various training programs, the training programs in Canada are much more uniform. They are under government control, and at least in specialties the number of positions is being cut (all else being equal, this is also saving money). Competition is quite intense. The total number of programs is also small, and comparable to the situation in Australia. Universities offer various posts through their affiliated hospitals. As family medicine is being pushed more and more by government bodies, three streams are becoming apparent: the FMP intern, destined for FMP, the straight specialty intern, destined for 'greater things', and the rotating intern, on the bottom of the heap, who could not get into any program. The rotating internship will probably be eliminated with time. The RCPS(C) is the main player here.



Author with US neurosurgeon, operating rooms' tea room. The pyjamas are blue, not green, the gowns and drapes are disposable.

Examples of Canadian programs: paediatrics takes a straight intern, and lasts for a minimum of four years to RCPS(C) certification. The market is tight, especially in the cities. The programs are recognised in the US. Obstetrics and gynaecology takes a straight intern, and lasts four years. There is a significant rural demand. Internal medicine includes one year of straight internship, followed by two more general years, and then two years of specialisation. General surgery takes a minimum of five years post intern, with the first two post-intern years being 'core'. Demand for positions is high, and hopefuls are advised to take electives in surgery, get references from surgeons, undertake surgical research and extracurricular activities! Family medicine is a two-year dedicated program (the FMP stream).

The attitude to foreign medical graduates in Canada is close to glacial. The vestiges of the British Commonwealth ensure that the Australian internship is recognised as an acceptable alternative to the first year of

Canadian residency, but beyond that there are no formal mechanisms of recognition. In order to be able to sit MCCQE Part I the foreign graduate has to first pass the Medical Council of Canada Evaluating Examination (CDN\$575 in 1992). That is a MCQE hurdle that generates money. The pamphlet sternly warns about lack of opportunities in Canada. The closest place where the MCCQE can be sat is Hong Kong (it is of note that the other places outside Canada are London, Paris, Riyadh and Bogota).

Residency programs accept only those eligible for MCCQE Part I. However, many universities have a policy of accepting only those applicants who reside and intend to practice in Canada. There is a small number of openings for sponsored foreign graduates (like the ECFMG sponsored graduates in the US). The foreign graduate also has to apply to the Canadian Intern Matching Service. Temporary registration by Canadian Provincial Medical Boards follows acceptance into a residency. It is of interest that US graduates are not considered 'foreign', and have much the same advantage as Canadians. The situation with temporary or locum work in general practice in less fashionable Canadian provinces might well be less gloomy than the situation with training programs; however, MCCQE might still have to be passed.

Britain

The British residency is an institution. Following the familiar internship required for full qualification by the General Medical Council one is faced with an Australian-style scatter of advertised resident positions, which need to be fitted into the planned post-graduate education. The resident is called the HMO, and practises almost exclusively within the NHS. The junior 2-3 years after internship comprise pre-registration training, like in Australia, and in effect are paperwork.

Specialist training is run by the Colleges, with training posts scattered in various hospitals. In order to be accepted into the training program one needs to pass Part I (like here), and have had the relevant junior experience. Historical forces ensure that there are four Colleges of Surgeons in Britain and Ireland, with the subsequent resulting confusion. Senior HMO and registrar posts are where all the training for the specialty is meant to be done. In reality, however, British training programs are overlong, with Part II candidates not yet adequately trained. There are many reasons for this, but the Colleges are in the process of instituting Part III exams to follow on higher specialist training, which is currently an accepted *de facto* standard for improving the quality of Part II graduates.

The intern in Britain is powerless, harried, and not allowed anything. Although the workloads are generally lighter than in Australia, the paycheck is boredom and frustration. In the theatre, your job is to hang onto the retractor in position number three and try not to fall asleep. On the ward, the progress notes fall to you, as you run behind the consultant, while initiative is the province of the registrar and the senior HMO. Procedures more complicated than drips are essentially out of your reach. Overtime is

paid at 50 per cent normal rate. The mechanics of the job are very similar to the Australian system, but are simply more antiquated, and I shall not go into any detail there.

Traditionally Britain has been a favourite place for Australian graduates looking either for a year or two of work in a different place, or going for post Part II fellowships. This is facilitated by simple registration procedures. To obtain registration Australian graduates simply apply to the General Medical Council attaching every conceivably relevant scrap of paper. 'Provisional registration' and 'full registration' can be applied for. Most posts require registration, and also personal presence in the country for interviews. I have come across a very significant number of Australians in Britain, either temporarily or permanently, on various levels of the health ladder. One trend is that registrar positions are eventually going to be two track: career registrar and overseas registrar. This will stop 'overseas' registrars hogging higher specialist training.

However, what I see as a relevant issue with residencies in Britain is not how to get there – but why to go there? There is very little the 'average' British hospital has to offer the 'average' Australian resident in the way of stimulating work or advanced education. It takes longer in Britain to reach the same standard, and so most applicants going 'straight across' are likely to be bored. The overall standard of British medicine is not ideal, but there are towering (as in Guy's Hospital tower) centres of excellence sprinkled around the landscape. The situation is not dissimilar to the position the Royal Children's has in Melbourne: the hospitals with poorer funding can only lick their chops. British research is still holding its own – thanks to the centres of excellence and to the large population. So, one should carefully choose a hospital with a good reputation – not only for the sake of having the name on your CV, but also to avoid frustration.

THE SYSTEM

The Parliament shall have power to make laws with respect to the provision of sickness and hospital benefits, medical and dental services. (Australian Constitution, Part V, 51 xiiiA)

Benchmark: *In Australia, health expenditure has been kept between 7 and 8 per cent for the period 1975-76 to 1989-90 (7.1 per cent in 1987).*

United States

In the States, the medical system is self-affirmatorily private. Hospitals like Boston City Hospital, which is a state-run state-funded institution, are rarities. The hospital charges you incur are passed directly on to your medical insurance company, with you contributing a lesser or greater amount. Medicare and Medicaid, the two government schemes for the poor and the elderly, however, comprise a surprising part of the budget of an average tertiary hospital.

The economics of health insurance are blatantly simple the world over: unless you

generate enough income during your lifetime to pay for your own geriatric care (and any emergencies that happen on the way) someone else will have to pay extra. While in Australia this uncomfortable fact is hidden behind rosy political rhetoric, in the States the loop between payer, fund reservoir and point of care is much more direct. Multi-pooling is strong; whether you are selected and the premiums you pay often reflect how healthy you are in the first place. There are also complex rules governing what happens to you in the senium of life, when the amount of money which is going to be spent on you will increase.

The average, working US adult can still afford health insurance – as long as he or she is working. Once out of a job and with no savings the regular premiums become an impossibility. However, the government is already reeling under the numbers in its safety net, and the net sits low: the criteria are very stringent. The pinch is thus very much on the middle-income earner.

The second matter which needs to be appreciated is that the standard of average good medical care in the States is palpably better than the standard of average good medical care in Australia. That, however, is very much subject to the ten-ninety rule: the advantage of the US standard is low, in proportion, compared to the difference in GNP spent on health (USA: 11.2 per cent in 1987). The much-talked about heterogeneity of care in the States (the best for the rich, the worst for the poor) does exist, but at least in my experience is not critical. Not dissimilar to the public Australian hospital/private Australian hospital arrangement, the same attendings work both in a private hospital and in a public hospital. Unlike Australia, however, the nursing care standard is much worse in the public hospital.

For doctors, working in the US private system is, at its best, eminently satisfying. Waiting lists are unacceptable. There is also no such thing in a good hospital as unavailability of a major diagnostic service: such a hospital would simply go under because of its competition. Elective operations do not get cancelled. Patients generate income, rather than drain precious resources. Of the countries I visited the ratio of doctors to domestics is best in the States. The medical profession still has a great deal of autonomy and power over its own destiny and less administrative interference in patient management.

At its worst, however, hospital practice in the States is the same as everywhere else: loss of autonomy in the name of cost constraints, imposition of rigid guidelines, loss of esteem and community standing. What the government does to Australian doctors and patients with Medicare, Health Maintenance Organizations (HMOs) do in the States in the private sector. These are large health insurance companies, which compete with each other for your health insurance dollar. They sign up specific hospitals to carry out services on their own subscribers for predetermined fees, or with predetermined guidelines, and they employ physicians in general practice or outpatient clinics. If you belong to an HMO

as a patient, you can only be treated in its contracted hospitals, not elsewhere. If you work in a hospital signed up with an HMO, you are constrained by the HMO's guidelines as to what you are allowed to do and to spend. And, in an ugly reminder, it is to bureaucrats that you, the medico, often have to account for your budget.

And the States, of course, is the place where you go to get sued. Subway ads glare at you: 'Injured at work? car accident? malpractice? No fee until we win!' A down-to-earth orthopedist told me outright: if you do not get sued at least once a year, this means your practice is not busy enough.

Canada

Canada, meanwhile, goes its own way. Canadian Medicare is about twenty years old now, and few remember anything else. It is remarkable for its severity: no medicine is allowed outside the socialised, bureaucratized system. Needless to say, it is not a money-generating enterprise. It shares many features with our Medicare, being the direct inspiration for it. The medical system is funded by taxation, with facilities planned and built by committees and subcommittees, with politics (like in Australia) often as important as patient care. GPs bill Medicare for patient services, and are, essentially, employed. Hospital specialists also bill Medicare. Direct billing is allowed only for items not covered by Medicare. This leads to some memorable rorts. For example, injection sclerotherapy of spider veins (not varicose veins, but still unsightly) is a cosmetic procedure not covered by Medicare. Because of litigation pressures, this procedure is normally practised by vascular surgeons. Completely outside the realm of Medicare, the fees charged are in the hundreds of dollars for a handful of short visits. The practitioner doing this has a completely controlled lifestyle and a higher income than the vascular surgeon doing AAAs on call under Medicare! There is no shortage of demand.

Waiting lists in Canada are something of a permanent fixture. CABG and valve waiting lists are some six months to a year; many patients manage to have another heart attack in that time. Other waiting lists are comparable. And yet, this appears to be better than the situation in Australia. The Canadian health expenditure (what the government is willing to admit to) is some 9 per cent of the GNP (8.6 per cent in 1987). The overall level of patient care is comparable to Australia – it is beefier, however, being North American, and there is less historically ingrained fear of major procedures and high technology. Still, the relatively high technology level is at the complete mercy of the government. The number of domestics in Canadian hospitals is lower than in Australia or Britain, and higher than in the States.

As a cost containing measure, the Canadian government has long played with the concept of salary capping for doctors (and for no other profession).

What is interesting is that most of the medical profession and most of the patient population have been brainwashed to accept

the concept 'it might be a wastebucket we are sitting in, but at least it is ours and all of us are in it together'. Those who prefer better care or professionally free practice go south, while the rest point at the unfair, unmanageable, litigious United States as an excellent reason to continue to sit in mediocrity.

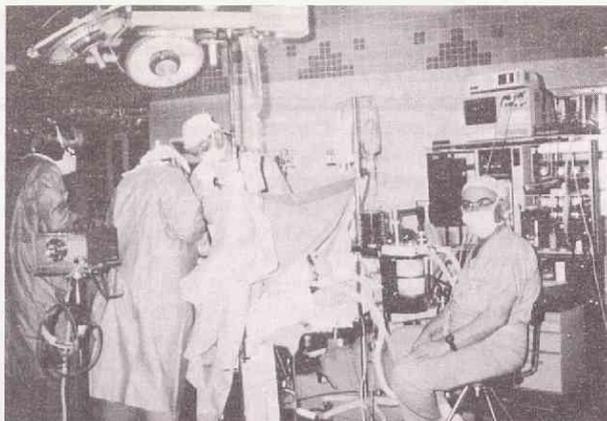
Britain

If Canada can be mediocre, Britain can be farcical. The current state of the NHS, complete with politics, dilapidation, unions, and Euro-integration has to be experienced to be believed. (NB: private medicine exists and thrives in Britain, but is not for the majority.) The GNP percentage spent by Britain on health care is around 6 per cent (6.1 per cent in 1987), and has been for a long time. If in Australia facilities are reasonable and the government attempts to save money by cutting down services, the British NHS tries to save on facilities.

Under the NHS, patients 'belong' to GPs, who must maintain a register. If a patient wants to change GPs, he or she needs to be struck off one GP's register and entered into another's. At least in the recent past, GPs were paid based on the number of patients on their register. This pattern continues through to regional hospitals: you get to go to your catchment hospital. The GPs are forced to act as gatekeepers. One of the more recent attempts by the government to trim the flab from the NHS was the creation of Regional Health Authorities, and the attempt to run hospitals on a quasi-private basis, 'contracting out' patients and services to hospitals in an attempt to increase efficiency. So far this has made few inroads into Unionland.

A part of this 'brand new NHS' drive has been the production of the most incredible document it was my privilege to see in Britain: the NHS Patient Charter. It gives the fortunate citizen of the United Kingdom certain new rights from 1 April (!) 1992: 'to be guaranteed admission for virtually all treatments by a specific date no later than two years from the day when your consultant places you on a waiting list' and 'to have any complaint about NHS services investigated, and to receive a full and prompt written reply from the chief executive of your health authority or general manager of your hospital'. Consider the real length of the waiting lists if two years is seen as a carrot by the general population! Among the standards proposed for the NHS are: ambulance arriving within 14 minutes of call, no more than 30 minutes waiting time in outpatients, and no more than two cancellations for elective operations. Needless to say, the standards are completely unrealistic. The Patient Charter is a slick exercise in desktop publishing and political goodwill. However, these unilaterally imposed rights are trumpeted without any extra money being poured into the system – and it is doctors who are being held accountable for failing to come up to the politicians' promises!

In the meanwhile, those UK hospitals not funded specially for political reasons continue their decline. Britain is below Australia on the international standards of care continuum, and it is exceptionally



Neurosurgery US-style, author taking photo: attending resident, back to us, neuroanaesthesiologist, sitting.

fortunate that litigation is still embryonic in Britain. Equipment and facilities are of a poorer standard than in Australia. Well run, complex diagnostics are rare to non-existent, while routine high-intensity ward care is something done by the nurses. The ICU in Britain has a mystique all of its own: there are so few ICU beds that only the initiated could possibly know how to run them.

As we are used to in Australia, there is a shortage of theatre time, and most of the elective list is taken up by emergencies, with the disgruntled electives sent home time after time. I came across a patient who only had his inguinal hernia repaired after his psychiatrist wrote to say that the patient's most recent suicide attempt had been directly caused by the hernia!

Morale in the present day NHS is low, and a lot of people stay in it through sheer apathy. Those who make it to consultantdom are the kings of the heap – in a fashion. In Britain the double pressure of a worsening public attitude and bureaucratic control over a traditionally medical domain is increasing like everywhere else. Although the image of the doctor is still the old fashioned one (fits in with low litigation levels) it is in practice only a shell of its former (relative) glory.

THE HOMECOMING

Then came the Age of Bronze, and dispositions took on aggressive instincts, quick to arm, yet not entirely evil. And last of all The Iron Age succeeded.

Ovid, *Metamorphoses Book I* (translated by Rolfe Humphries).

IT WAS with a feeling of relief that I saw gum trees again. The outcome of the comparison is that Australia is no worse or better – it is simply different. We get excellent value from the money we put into health care, but if we are to improve clinical care and academic medicine, we should be learning from the Americans.

Undergraduate medical education in Australia came through well, but we badly need more practical learning and more responsibility in the senior years. The student internships have made an attempt at this, but much more work still needs to be done. Electives to other countries are most definitely recommended.

Residency in Australia leans much more towards the Brits than the Yanks, but escapes

most of the troubles ailing the NHS. What I would really like to see is involvement of private medicine and the private sector in medical postgraduate (and undergraduate) education. This should do both a lot of good.

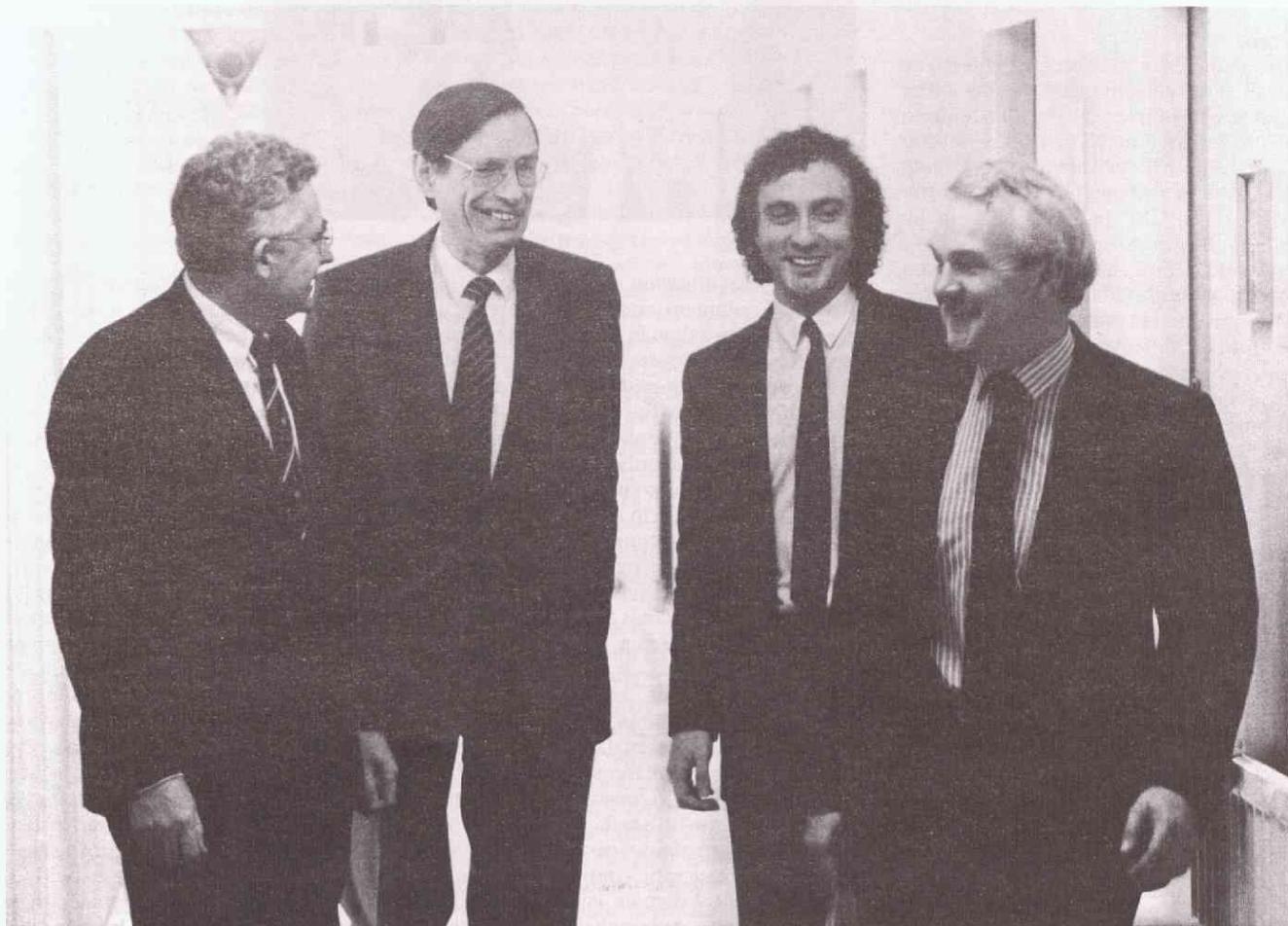
To date, socialised medicine in Australia has retained some degree of freedom, although we are already beginning to slide in the long run. Ideally, responsible and well-run private medicine could play a much bigger and better role in Australia – although that is an unlikely outcome.

What I see happening in Australia and the world over is large-scale bureaucratized medicine replacing 'cottage industry' medicine. The agent bringing about the change is private or public, depending on the history of the country, but the effect is the same. Engineers at the turn of the century tended to be private consultants or headed their own small businesses. With the rise of multinational manufacturers and increasing government control the profession has degenerated into employees with little identity or influence. Doctors are also being regulated from without in ever-increasing financial distribution systems that dictate their own rules which are politically or economically determined. The striving for uniformity and the laudable vigorous attempts at cost control leave individual patient care behind. This is, in a way, a consequence of the profession's own success: a lot is possible now, but only a very small part of it is critically dependent on the doctor's skills and knowledge. Most of the success and the cost resides in the impersonal 'facilities', which no doctor (a cottage industry of one) can ever effectively control.

These are trends yet, but they are remarkably the same all over the world: the era of the doctor as an autonomous professional, guided by his or her conscience and professional commonsense, may be coming to an end.

References.

1. BMJ 1992;304:496-9. (22 Feb 92). Rationing.
2. MJA 1992;156, 592-594. (4 May 92). Health Expenditure in Australia.
3. The Patients Charter. Department of Health, Freepost London SE99 7XU.
4. The House of God.
5. Clinician's Pocket Reference (The Scut Monkey's Manual).
6. Glaxo Pathway Evaluation Program (Glaxo 1988).



Prof. Peach (third from left), with Mr E Macauley (Chief Executive Officer), Prof. D Woolley (Board President) and Dr C Davis (Director of Medical Services), Ballarat Base Hospital, at the opening of the Ballarat Rural Health Unit in 1992.

EARLY IN 1992, the University Council approved a proposal to change the name of the Department and the Chair from 'Community Medicine' to 'Public Health and Community Medicine', recognising the fact that the scope of the Department's activities has broadened considerably over the last two-and-a-half years. This wider and exciting role for the Department was heralded in July 1990 by the University choosing to appoint a Public Health Physician (Hedley G Peach) to the Chair of Community Medicine.

In the United Kingdom the terms 'community medicine' and 'public health' are used synonymously but in Australia they are quite different. University Departments of Community Medicine or Community Health were established in Australia in the mid-1970s with earmarked funds from the Commonwealth Government. The purpose was to ensure that medical students, and other health professionals for that matter, were trained in delivering health care outside hospitals. As such, the terms 'community medicine' and 'community health' include general practice but they are not limited to it. Community medicine embraces, for example, aspects of geriatric medicine, rehabilitation and psychiatry, drug and alcohol counselling and maternal and child welfare services. It was intended that these new Departments of Community Medicine would have a close association with Community Health Centres. It was hoped that such departments would become a focus for general practitioners and other health professionals to work together as a team, to collect epidemiological data from the local community and to plan local health promotion campaigns and other initiatives.

In recent years there has been something of a public health Renaissance in Australia. The last seven years has seen the establishment of multi-disciplinary postgraduate training programs in certain tertiary institutions, such as at Monash University, and the emergence of new University Departments of Public Health (for example at the University of Western Australia) as well as the development of new Schools of Public Health (for example at Queensland University of Technology).

Public health has always had a much broader brief than community medicine, which, as outlined above, is concerned only with the health care of communities outside hospitals. The 'old' public health was concerned largely with housing conditions and the safety of food, air and water. The 'new' public health has emerged to meet an additional set of challenges which have arisen at both the national and international level because of factors such as increasing longevity and over-population, industrialisation and industrial decline, health inequalities in affluent societies, environmental damage and ecological imbalance.

Countries differ in their perception of the need for a medically qualified public health expert, perhaps because of a shortage of medically qualified specialists, inadequate training resources or simply because the value of a medical qualification in the context of public health is not appreciated. In England, medical graduates have been given a key role in public health. The medically qualified expert in public health is seen as best able to monitor the health of the population; to analyse patterns of illness in relation to its causes and

evaluate services; interpret the value of new developments in health care in the light of what is known about the natural history of disease; challenge clinical specialists on their own ground in relation to funding priorities; advocate and explain health issues to the public at large and challenge vested interests. However, the doctor is seen as only one member of a team of professionals involved in public health, which includes nursing, those involved in health promotion and health education, environmental health specialists, experts in education, town and country planners, architects and engineers. For that reason the incorporation of University Departments of Public Health Medicine within multi-disciplinary Schools of Public Health have been advocated. The United Kingdom is far ahead of Australia in conceptualising a role for the medical graduate in public health, in the provision of postgraduate training programs in Public Health Medicine and in the establishment of a career structure for Public Health Physicians.

It is only in the last few years that the Royal Australasian College of Physicians established a Faculty of Public Health Medicine to ensure that interested medical graduates are properly trained for a professional role in the 'new' public health. Medical schools must ensure that undergraduates, too, become familiar with modern concepts of public health whether or not they intend to become public health professionals. This will mean that as doctors they can have an informed voice in government decisions which may have profound implications for the health of the population and the resources of Australia. In Europe, doctors have been criticised by some for being less vocal than they should on public health matters and health professionals may even find themselves deliberately excluded altogether from the newly formed European Public Health Alliance. It was to ensure that its medical undergraduates did become familiar with modern concepts of public health that The University of Melbourne appointed a Public Health Physician to the Chair of Community Medicine and later approved a proposal to change the name of the Department and the Chair from 'Community Medicine' to 'Public Health and Community Medicine'.

The new Department of Public Health and Community Medicine now comprises six Units and two Centres. The Units are focused on General Practice, Epidemiology and Biostatistics, Occupational Medicine and Environmental Health, Drug and Alcohol Studies, Intellectual Disability and Rural Health. The two Centres are the NHMRC National Centre for Health Program Evaluation and the Key Centre for Women's Health in Society.

A number of commentators have argued in the medical press for the establishment of separate Departments of General Practice. Such arguments have centred around issues of prestige and resource allocation within universities. However, in addition to providing care of the acute and chronically sick, general practitioners are playing an expanding role in the prevention of illness and the promotion of health, thus having an increasingly important role in translating national public health policy into practice at the small area level. Examples of this include immunisation, screening, risk reduction and women's health. Both General Practice and Public Health Medicine have much to gain from close interactions and collaboration in teaching, research and practice. The creation of a Unit of General Practice within the Department of Public Health and Community Medicine ensures a close interaction with other aspects of community medicine as well as public health whilst preserving the identity of general practice within The University of Melbourne. All Units and Centres of the Department contribute to the teaching of public health in fifth year. Drugs and alcohol misuse, occupational and environmental health, intellectual disability, women's health, nutrition, Aboriginal health, communicable and sexually transmitted diseases and health economics are among some of the varied topics now studied by students during their fifth year public health course.

General Practice

The Unit of General Practice is headed by Associate Professor Doris Young. The senior staff of the Unit comprise the Associate Professor and 1.3 FTE (full-time equivalent) senior lecturers. The Unit is responsible for teaching emergency medicine and the nature of medical practice to first year students; counselling skills, sub-groups of the population with special problems (for example the elderly and Aborigines), the family and the community to third year students; and general practice to fifth year students. An important part of the fifth

year teaching in general practice is the placement of students with a metropolitan general practitioner for two weeks and a rural general practitioner for a further two weeks.

In addition to teaching, the Unit has now developed an active research program. Earlier this year the Unit won a \$200,000 tender from the Commonwealth Department of Health, Housing and Community Services to support those general practitioners in Victoria who had themselves been awarded grants to enhance aspects of their practice. Other research areas in general practice include detection of the problem drinker, the quality of care given to diabetics, sore throat, referrals to Hospital Emergency Departments and an evaluation of the hospital component of the Family Medicine Program. The Unit includes a number of persons studying for higher degrees and is responsible for training two Victorian Academy of General Practice Fellows.

Epidemiology and Biostatistics

The Epidemiology and Biostatistics Unit is headed by Ms Ellen Herlihy from Yale University in the United States. This Unit comprises a 0.5 FTE Associate Professor and two lecturers. It is responsible for teaching epidemiology, biostatistics and health promotion to third year students and co-ordinates the teaching of public health to fifth year students.

The research interests of the Unit include drug related mortality in Victoria, the health effects of electromagnetic fields and toxic effects of blue-green algae. The Unit is responsible for co-ordinating a Graduate Diploma in Epidemiology and Biostatistics which can be taken on a part-time basis over two years.

Drug and Alcohol Studies

The Drug and Alcohol Studies Unit is headed by Associate Professor Margaret Hamilton. Professor Hamilton's position is a new venture being a joint appointment with Drug Services Victoria where she is responsible for providing leadership in drug and alcohol research and training throughout Victoria. The new Professor/Director of Drug and Alcohol Studies at St Vincent's Hospital, Professor Greg Whelan, is a Professorial Associate in the Unit. The other staff of the Unit include a research fellow and a Public Health Research and Development Committee (PHR&DC) NHMRC research fellow. The Unit is responsible for teaching drug and alcohol misuse during the fifth year public health course and has a heavy research program. Evaluation of drug treatment programs, women and alcohol misuse, alcohol and drug use by Out of School Youth, the role of self-help groups in drug treatment, the impact of alcohol regulation and legislation and evaluation of Victoria's drug and alcohol withdrawal services are among the many varied and exciting topics being studied in this Unit.

Occupational Medicine and Environmental Health

The Occupational Medicine and Environmental Health Unit is headed by Associate Professor John Bisby. The Unit's staff includes a lecturer in epidemiology and biostatistics and a computer programmer. The Unit teaches occupational medicine and environmental health to fifth year students during their public health course but its main activity is monitoring the health of national cohorts of workers from the member companies of the Australian Institute of Petroleum. This is the largest and longest running study of cohorts of workers in any industry anywhere in the world. The project is funded by the Australian Institute of Petroleum.

Intellectual Disability

The Intellectual Disability Unit is headed by Dr Judith Hammond. Funded by Community Services Victoria the Unit is an exciting new initiative to provide leadership in the education of medical students and general practitioners about the health problems of intellectually disabled people, in the medical care of intellectually disabled adults in the community, and in research in this field. The Unit currently comprises one other lecturer but more positions including training appointments are to be funded in 1993. The Unit teaches intellectual disablement to fifth year medical students and provides clinical services through Lalor and The Western Region Community Health Centres and at the Royal Children's Hospital's Centre for Adolescent Health.

Rural Health

Twelve months ago, the Department established a Rural Health Unit at the Ballarat Base Hospital. The Unit has an epidemiological focus and is interested, although not exclusively, in the health problems of country Victoria. The Professor of Public Health and Community Medicine heads this particular Unit on a part-time basis. The Unit is located in modern accommodation provided by the Ballarat Base Hospital and is supported by its Administrative and Pathology Departments. It works closely with the hospital's physicians and surgeons. The Unit is undertaking research into diet, plasma lipids and blood clotting; the aetiology of varicose veins; health promotion in country Victoria and sport and exercise. The Professor is also working on a number of Queensland based projects including evaluation of a project to train Aboriginal people to be nutrition workers.

National Centre for Health Program Evaluation

The National Centre for Health Program Evaluation is a joint initiative of The University of Melbourne and Monash University, funded jointly by the PHR&DC of NHMRC and the Victorian Health Promotion Foundation. The Centre seeks to provide leadership in health program evaluation and health economics in Australia and the South-East Asia Region. The Centre is directed by Associate Professor David Dunt from The University of Melbourne and by Professors Christopher Selby-Smith and Jeffrey Richardson from Monash University. The University of Melbourne's staff at the Centre comprise the Associate Professor, a senior research fellow and several research fellows, and has major responsibility for the evaluation of a diverse range of important health programs. These include the Victorian Health Promotion Foundation sponsored Healthy Localities Program (essentially a wide variety of initiatives to make a selection of communities in some way healthier places to live); a National Heart Foundation sponsored community-wide multifaceted health promotion program; and a high profile drug and alcohol education program for young people. The Centre as a whole is developing exciting new educational initiatives in health economics and health program evaluation.



Prof. Peach at a presentation of certificates to newly qualified Aboriginal Community Nutrition Workers. Prof. Peach is assisting the Queensland Government to evaluate its program to train Aboriginal and Torres Strait Islander people to become Community Nutrition Workers.

Key Centre for Women's Health in Society

The Key Centre for Women's Health in Society, funded primarily through the Australian Research Council, aims to increase knowledge and awareness of women's health with a perspective that considers cultural, social, psychological and biological influences on health and sickness. The Centre is under the direction of Associate Professor Lorraine Dennerstein. The Centre's staff includes, besides the Associate Professor, a senior lecturer and several research fellows. The Centre participates in the teaching of women's health to medical students and is responsible for running the highly successful Graduate Diploma of Women's Health and an annual short course for overseas health personnel.

The Centre has an active research program into women's health in the mid-life years, pre-menstrual syndrome, post-natal depression, ethnic women's health, gender differences in health, mental health and substance abuse and rehabilitation. The Centre has a large number of research students undertaking Masters degrees and Doctorates by research.

Administration

These academic Units and Centres are supported by a very able administrative unit which is headed by Mrs Sandra Turner and comprises the Head of Department's administrative assistant, Mrs Leanne Fisher, and a third administrative assistant. The unit has responsibility for managing departmental funds, all personnel matters, and time-tabling of lectures and other classes. In this support role the unit is assisted by administrative staff employed within the Occupational Medicine and Environmental Health Unit and the two Centres. This greatly expanded Department of Public Health and Community Medicine is managed by the Professor of Public Health and Community Medicine assisted by an executive committee comprising the heads of the various Units and Centres. Chairpersons of the Postgraduate Research Students' Sub-Committee and Computer Sub-Committee are also members of the Executive Committee.

The teaching and research being undertaken by the many different Units and Centres which now make up the Department of Public Health and Community Medicine are just a part – albeit an important part – of the ever-expanding research and teaching activities of the University as a whole. The University of Melbourne does not yet have any postgraduate courses which are designated 'public health' but a number of Departments across the University are offering courses at postgraduate level which are directly relevant to the 'new' public health. Within the Faculty of Architecture and Planning, these include a Master of Environmental Studies, Town and Regional Planning, and Urban Planning. Within the Faculty of Engineering these include a Graduate Diploma in Geographic Information Systems, a Master of Environmental Engineering, and particularly relevant to Public Health in developing countries, a Postgraduate Diploma and a Masters Degree in Developmental Technologies, and a Postgraduate Diploma in Irrigation Engineering Management. Within the Faculty of Medicine, Dentistry and Health Sciences these include the Graduate Diplomas in Women's Health and in Epidemiology and Biostatistics offered by the Department of Public Health and Community Medicine.

There is enormous potential for the Faculty of Medicine, Dentistry and Health Sciences to contribute teaching in Public Health Medicine to a range of postgraduate courses across the University which are directly relevant to the 'new' public health. Similarly, many Faculties and Departments could contribute to the teaching of public health in the Faculty of Medicine, Dentistry and Health Sciences. Indeed, there is scope to explore the feasibility of introducing public health degrees in The University of Melbourne to which all Faculties might contribute.

The new Department of Public Health and Community Medicine is testimony that The University of Melbourne recognises medical graduates have a key role in the 'new' public health and that it wishes to support the development of teaching, research and training in public health and public health medicine in Australia.

Hedley G Peach

Professor of Public Health
and Community Medicine

Bibliography

- Anonymous. What's New in Public Health? *Lancet* 1991; 337:1381-83.
- Committee of Inquiry into the Future Development of the Public Health Function. *Public Health in England*. HMSO, London, 1988.
- Murrell T. Developments in Primary Health Care in Australia. In Holland W & Detels R (Editors) *Oxford Textbook of Public Health*, Volume 2, Oxford University Press, United Kingdom, 1984, pp 77-93.
- National Centre for Epidemiology and Population Health. *The Role of Primary Health Care in Health Promotion in Australia*. NCHPE, Canberra, 1991.
- Scott-Samuel A. A Public Health Alliance for Europe. *BMJ* 1991; 303:737-8.
- Townsend L. New Curriculum for Medical Course. *Med J Aust* 1974, 1:624.
- Webster R & Christie D. Community Health in The University of Melbourne. *Med J Aust* 1977; 2:128-30.

THE MECHANISM OF HUMAN FACIAL EXPRESSION

by G-B Duchenne de Boulogne
Ed & trans by R Andrew Cuthbertson
Cambridge University Press 1990
Editions de la Maison des Sciences de l'Homme
Hardback, pp 287, illustrated
rrp A\$110.00

In 1978 Andrew Cuthbertson (MBBS 1980), 'guided by Kenneth Russell', completed an excellent BMedSc on Duchenne de Boulogne. This book arose out of his BMedSc report, but is very much more. It is a very valuable addition to texts on the history of medicine in general, and the history of neurophysiology and plastic surgery in particular.

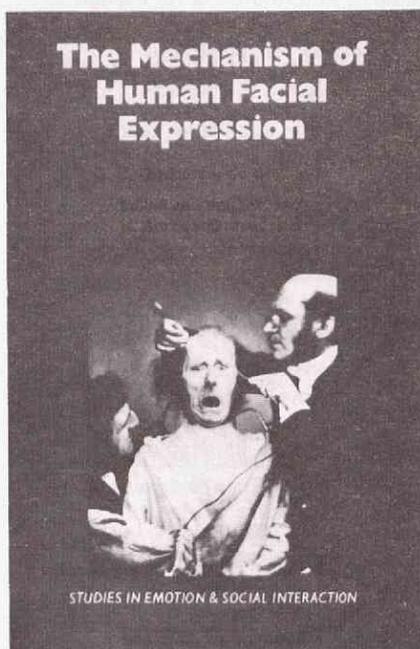
The dust jacket is arresting. Duchenne is shown 'applying the electrodes with great concentration and delicacy to the face' of an old man. 'Delicacy' is not the major impression as the old man looks horrified although he probably did not experience pain.

Duchenne has no less than nine listings in Garrison & Morton's *Medical Bibliography*. Most are related to his work with faradic stimulation of muscle which he began in 1830. His better known description of Duchenne's pseudohypertrophic muscular dystrophy (1852) is illustrated in this book in an evocative photograph taken in the mid-1850s.

The translation of Duchenne's work on facial expression is in itself a valuable contribution and the reproduction of the plates makes the whole thing a treasure. It is true that these are 'single frames from a moving picture', but they will remain in memories for a very long time.

Duchenne was not only a 'professional scientist', but also an 'amateur aesthetician'. Chapter 16 is a critical study of some classical sculpture. The criticism arose out of Duchenne's experiments and he proceeded to remodel several sculptures according to what he believed they should have shown. Chapters 17 and 18 on 'Aesthetic electrophysiological studies' include photographs depicting a nun praying, but also recreations of expressions that Lady Macbeth might have depicted in some of her more difficult or aggressive scenes.

The book is further enriched by four commentary chapters. Andrew Cuthbertson writes of 'The highly original Dr Duchenne', Jean-Francois Debord tells of the Duchenne Collection in the Department of Morphology, *L'Ecole Nationale Supérieure des Beaux Arts* which includes Duchenne's personal photograph album. Several plates are missing and two of these correspond with engravings which appeared in Charles Darwin's *The expressions of the emotions in man and animals* (1872). Cuthbertson records that Duchenne gave Darwin permission to use some of his photographs, without asking for remuneration, stating that 'questions of



money should not arise between men of science.' That he should have broken his collection of originals to give them seems over-generous.

John Hueston (MBBS 1948) has contributed a chapter which tells of the debt that modern plastic surgeons owe to Duchenne's work and experimental psychologist Paul Ekman's final chapter deals with 'Duchenne and facial expression of emotion'.

This is a small book of 287 pages and is reasonably expensive. It is a very important compendium which greatly enriches the texts on the history of medicine and links the past with the present. It should be in all medical libraries and will delight medical historians, neurologists, surgeons and anyone interested in the nature of things. We owe a debt to Andrew Cuthbertson.

Curiously enough, Duchenne would probably have been disappointed that his scientific work is now given more importance than his efforts to influence aesthetics.

A HISTORY OF MEDICINE

by Lois N Magner
Marcel Dekker Inc, New York 1992
Hardback, pp 393, illustrated
rrp US\$55.00

Lois Magner is an Associate Professor of History in Purdue University, West Lafayette, Indiana, and has already published *A History of the Life Sciences* (1979). Her book is very welcome. Most well-known texts were published many years ago and most are out of print. Philip Rhodes' *An Outline History of Medicine* (1985) is an exception.

Lois Magner's book is put forward as a 'perfect' text for a one-semester course. It would certainly provide for an exciting semester's work and with its numerous easily

attainable references could broaden the perspective and deepen the knowledge of any student interested in the history of medicine. The illustrations are appropriate but, because of the method of production, are not quite as sharp as those in earlier texts. The style and lack of jargon more than make up for this. It is printed on acid free paper.

The approach to the problems and style remind me of the writings of Henry Sigerist. As a student I remember vividly after reading Sigerist's first volume how I feared he would never complete the proposed seven further volumes. He had not quite completed Volume 2 when he died.

Lois Magner's style and thoughtfulness are apparent even in the preface:

The most important aspect of teaching the history of medicine is to allow students to discover for themselves a feeling of kinship with patients and practitioners past and present, a sense of humility with respect to disease and nature, and a critical approach to our present medical problems... In essence, the history of medicine can be seen as the study of the encounter between patient and practitioner, but this must inevitably be broadened to include all the relationships in society that intersect at the point where the sick person meets the healer.

The thirteen chapters can be divided into four groups:

- I) 1 – *Paleopathology and Paleomedicine*. 2 – *Medicine in Ancient Civilizations: Mesopotamia and Egypt*. 3 – *The Great Medical Traditions of India and China*. 4 – *Greco-Roman Medicine*.

These cover the periods which Sigerist wrote about in his two volumes. However for the first time I realised that despite the Western emphasis on anatomical dissection as a prerequisite for surgery, Indian medicine developed a strong surgical tradition without this.

- II) 5 – *The Middle Ages*. 6 – *Islamic Medicine*. 7 – *Medicine and the Renaissance*. 8 – *The Scientific Revolution and the Circulation of the Blood*.

Admirable accounts of syphilis and leprosy are given in the section on the Renaissance and AIDS is mentioned many times throughout the book.

In discussing the revolutionary effects of Harvey's description of a closed circulation the paradox is revealed that this in no way stemmed the activity of the phlebotomists. Indeed the era of bleeding and leeching extended for several centuries after Harvey with some benefits and much harm. Nowadays leeches are sometimes used by the plastic surgeon and scientists in 1990 gathered together to present papers on the 'Biomedical Horizons of the Leech'!

In this section, too, there is a graphic account of the discovery of the pulmonary circulation with a fine pen portrait of Michael Servetus 'burned in effigy by the Catholics and in the flesh by the Protestants'. Indeed,

despite the fact that the proper penalty for his crimes should have been banishment, he was condemned to burn 'without mercy'. 'Mercy' implied that strangulation preceded the burning!

III) 9 - *Selected Aspects of Clinical and Preventive Medicine: From Sydenham to Smallpox.* 10 - *Childbed Fever, Midwifery and Obstetrics.* 11 - *The Art and Science of Surgery.* 12 - *The Germ Theory of Disease: Medical Microbiology.*

These are broad topics and are dealt with appropriately. Because of a personal interest in puerperal fever I read this section with interest and knowledge. It is well done. The contributions of Alexander Gordon, Charles White, Oliver Wendell Holmes and Ignaz Semmelweis are succinctly given and then meditated upon:

Although Semmelweis had provided a practical system of antiseptics that could have prevented both puerperal fever and postsurgical infection, it would be wrong to assume that his discovery changed medical practice. Just as the term 'classic' is generally applied to a book that nobody reads, the term 'landmark' is applied to an insight that was largely ignored.

IV) 13 - *Diagnostics and Therapeutics.*

This chapter goes from 'Laennec's cylinder' to 'nuclear magnetic resonance' and from 'serum therapy' to 'molecular biology'. Throughout there are cautionary tales:

Moreover, if we look at the history of medicine from the point of view of the diseased and distressed person, it seems likely that in terms of dealing with the patients experience, suffering, hope, despair, expectations of help from the physician, and tendency to disobey medical orders and resort to self-medication, Hippocrates and Galen might well have valuable advice for the modern physician. Indeed, their emphasis on the prevention of disease, the individuality of the patient, the interplay between patients and their environment, the notion of treating the patient as a whole, and the role of the physician in prescribing a life-long, health promoting regimen would enjoy a powerful resonance with public hopes and expectations.

Excellent accounts are given of salvarsan, the sulphonamides, penicillin and the increasing sophistication of therapeutics.

The book ends with:

But as always, there are no remedies without risk; therefore, the words of the wise doctors of Salerno still provide an appropriate conclusion to any considerations of the history of medicine:

*And here I cease to write,
but will not cease
To wish you live in health,
and die in peace;
And ye our Physicke rules
that friendly read,
God grant that Physicke
you may never need.*

I bought the book because I thought I had to do so and started to read it with a mite of condescension that was very quickly dissipated. The book is well written, easy to read and has much food for thought.

IN THEIR DAY. MEMOIRS OF ALUMNI. THE BAKER MEDICAL RESEARCH INSTITUTE

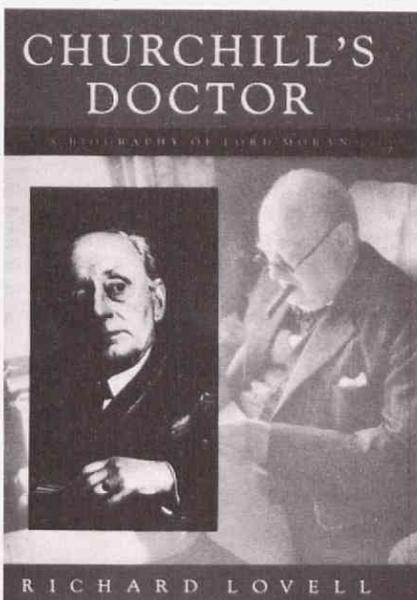
edited by Rod Andrew & Alf Barnett
Hyland House 1992
Hardback, pp 188, illustrated
\$29.95 + \$3.00 postage from the Baker

This book is enjoyable reading about interesting people who tell of their joys and sorrows while working at the Baker Institute. Throughout there is a fondness for having been there. Proceeds from sales go to help future research.

CHURCHILL'S DOCTOR. A BIOGRAPHY OF LORD MORAN

by Richard Lovell
MUP 1993
Hardback, pp 457, illustrated
rrp A\$59.95

An advanced copy of Dick Lovell's long-awaited biography of Lord Moran has just arrived. A full review will be published in the next *Chiron*, however even a cursory inspection reveals a well-written, interestingly illustrated biography of a great doctor. Dick's travail has been long, but the product is worthy of the writer - what better recommendation could I give. UMMS members have the privilege of purchasing this book at a discounted price - enquire at the UMMS office.



DARWIN

by Adrian Desmond & James Moore
Penguin 1992
pp 808, illustrated
rrp US\$55.00

This great biography has been written by two authors but the style is seamless and the narrative flows easily from first to last page. Well illustrated and enriched by an abundance of notes it is one of the most readable biographies I have encountered. Buy it now and enjoy it.

GALLIPOLI - THE MEDICAL WAR

Michael B Tyquin
UNSW Press 1993

It is rash to write about a book 'in press'. However, a foretaste of the book-to-be is available in *War and Society* (Vol 10 No 2 pp 57-72 October 1992). The journal which may not be well known to some of our readers is published by The University of New South Wales.

The article 'Medical evacuation during the Gallipoli campaign - An Australian perspective' gives a graphic account of the tragic muddles due to lack of preparation, tortuous lines of communication and a complete blindness to the likely number of casualties in relationship to the siting of medical officers.

The book, which is based on Dr Tyquin's PhD thesis (Department of History, The University of Melbourne, 1992), will be of interest to many readers and, on publication, will be reviewed.

MELBOURNE UNIVERSITY PRESS AND THE MELBOURNE MEDICAL SCHOOL



FOR SIXTY OF ITS SEVENTY YEARS Melbourne University Press has been active in the field of medical publishing. Ten years after its foundation J S Rogers' *Physics for Medical Students* was published

and went through numerous subsequent editions. A captive audience ensured firm sales, and the practice of photocopying was still blissfully in the future.

After 1933 there was a lapse until 1950 when there appeared *Studies in Pathology presented to Peter MacCallum*. In those days collections of papers were popular, and probably more marketable. The idea was used again in 1957 with *The Collected Papers of Hugh Trumble*, published in association with the Alfred Hospital. The following year K S Inglis produced *Hospital and Community: A History of The Royal Melbourne Hospital*. This was not only an institutional history but also a social and historical perspective of the growth of Melbourne during a century of change. The Melbourne medical scene was well and truly on the publishing map.

The 1960s saw many textbooks from the Melbourne Medical School. These were aimed at specific students and courses and proved very popular. [Sir] Lance Townsend cleverly used Professor Marshall Allan's notes and turned them into two landmark student textbooks on gynaecology and obstetrics. No self-respecting medical student of the sixties would have admitted to not owning a copy of each of them. These were followed by another classic textbook, R V S Thompson's *Primary repair of soft tissue injuries, with special reference to the head and extremities* (1969), which filled a gap in the teaching at the time. In 1971 appeared Brian Davies' *An introduction to clinical psychiatry*, which went to four editions and was produced in a

small format suitable for students' and resident medical officers' coat pockets.

Cliff Judge in 1975 published *Retarded Australians*, a book so full of humanity and compassionate understanding that lay people and students alike benefited from the knowledge within. His interest in the ethical, personal and social problems surrounding mental retardation provided new insights into the subject and the book was hailed both here and overseas.

Kenneth Russell's association with the Press began in 1963 when he produced a signed limited edition, *British Anatomy 1525-1800*, a bibliography which became a standard reference work and has appeared as a second edition. In 1977 his centenary history, *The Melbourne Medical School 1862-1962*, was an excellent collaborative effort between the School and the Press. This book rightly documents the high standards set and maintained by Anthony Colling Brownless who was the undoubted founder of the oldest medical school in Australia.

The 1970s were also notable for the publication of [Sir] Macfarlane Burnet's *Endurance of Life*, in which the author used his wide experience as a medical scientist to examine the phenomenon of old age. Earlier, in 1969, the Press published his *Cellular*

Immunology, Books One and Two, followed by *Walter and Eliza Hall Institute 1915-1965* (1971) and *Credo and Comment: A Scientist Reflects* (1979). Lorraine Dennerstein et al's *Gynaecology, Sex and Psyche* was published in 1978, and in the same year appeared Tony Moore's *The Missing Medical Text: Humane Patient Care*, which gave medical students the chance to examine the philosophical side of medical care through discussion of extracts from novels, poems and short stories.

The next decade saw the publication of 'Blue' Steward's *Recollections of a Regimental Medical Officer* with its terrible story of the Kokoda Trail. Steward painted a picture of rare courage and endurance, but through it all flashes the humour of the Australian soldier – that sense of the absurd which saved the sanity of men pushed beyond the ordinary limits.

When heavy rains flooded the medical library in 1953, Ken Russell rescued from the basement several old medical texts. Amongst these he recognised a copy of Matthew Baillie's *Atlas of Morbid Anatomy* which was unique in that 48 of the 73 engravings had been replaced by the original drawings prepared by William Clift for the engravers. The copy had belonged to William Clift.

It was known that the Royal College of Physicians held another 24 such drawings. In the 1980s Harold Attwood obtained permission to photograph the London set and, with an almost complete set of drawings for an atlas produced between 1799 and 1802, the Press was persuaded to produce the beautiful facsimile printed locally in 1985. In a separate essay Harold Attwood provided documentation of the book, a description of each drawing and a modern interpretation of each disease illustrated. (He also proved untenable the belief, held since 1849, that one of the specimens of lung illustrated had come from Dr Samuel Johnson.)

The happy association between the Melbourne Medical School and Melbourne University Press continues in the nineties with the publication of *An Introduction to Medical Rehabilitation* by Graeme Penington and Hugh Burry, and Richard Lovell's *Churchill's Doctor – A Biography of Lord Moran*, co-published with the Royal Society of Medicine Service Limited, London. No doubt there will be many more books in future decades.

Wendy Sutherland
Melbourne University Press



HAZARDS!

To paraphrase, the price of child safety is eternal vigilance. But it is more than that – it begins with the collection of data on childhood injuries, followed by careful analysis of various categories to distil into advice and educational materials for the community at large, government departments, research organisations, specialist medical practitioners, consumer groups, manufacturers, insurers and so on.

These activities have been coordinated since 1988 by the Victorian Injury Surveillance System – VISS. VISS collects data from five participating hospitals, the Coronial Services, a group of participating clinicians, and ward staff. The results are published not just as raw data, but also in specialised reports, and in the series, HAZARD, each edition being devoted to a particular area of safety, for example burns prevention, sports injuries, horse riding injuries, school injuries, poison control, dog bites, and drownings. Some editions apply to all ages and include updates on previously published information. This information is important to parents, municipalities, child welfare centres, school teachers and sports coaches, as well as to legislators and product control managers.

VISS is a project of the Monash University Accident Research Centre in association with the Royal Children's Hospital, and until recently was housed at the Hospital, with The University of Melbourne's Department of Paediatrics providing office facilities, secretarial and infrastructure support. VISS is funded by the National Better Health Program, and has been able to recruit a number of generous sponsors, including Hewlett Packard who donated computing equipment to manage the database and to assist in the production of HAZARD.

HAZARD is a well-designed and delightfully illustrated series with clearly presented statistical information – Numbers 1 to 12 have been produced with the artistic and graphics assistance of the Education Resource Centre of the Royal Children's Hospital. The data can be drawn upon for general information, teaching materials, research and prevention strategies. If you would like to have more information contact the VISS Coordinator or the Director at PO Box 197, Caulfield East, 3145. Telephone 573 2880, facsimile 573 2882.



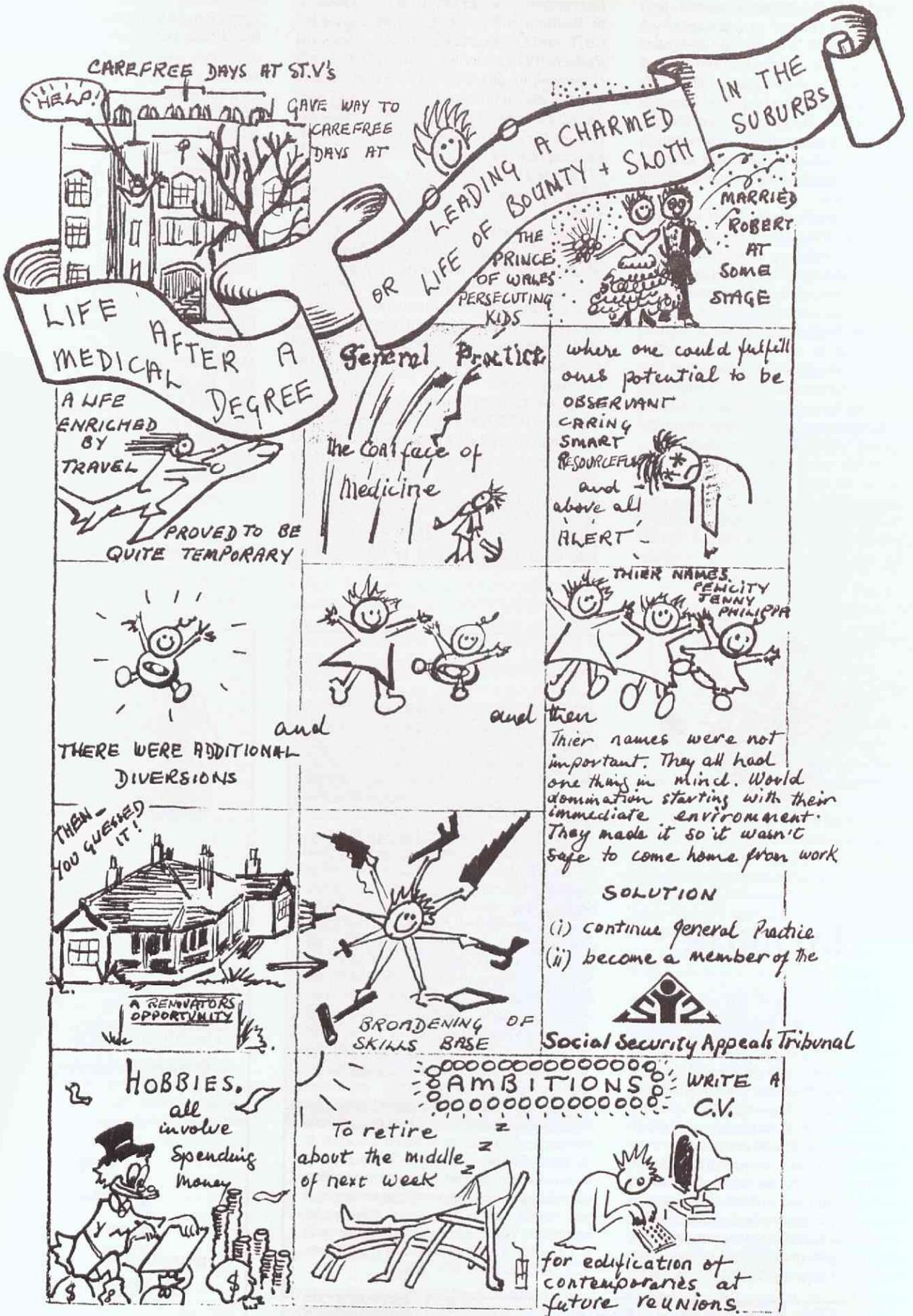

EPILEPSY

History and Treatment

The Medical History Museum
Brownless Medical Library

1993
Exhibition
developed by
neurologist & epileptologist
Dr Peter Bladin, AO

Enquire at desk for entry.



by P. D. Fricker.

Patricia D Fricker, MBBS 1972



NOTICE OF ANNUAL GENERAL MEETING 1993

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, 18 May 1993. This meeting is preceded by the Dean's Lecture in which Professor Andrew Kaye, Director of Neurosurgery, The Royal Melbourne Hospital, will deliver a lecture entitled 'Brain tumour surgery beyond 2000 – shining a light on the future'.

Business

1. Minutes of 1992 Annual General Meeting
2. Chairperson's Report
3. Financial Report 1992-1993
4. General Business.

MINUTES OF ANNUAL GENERAL MEETING 1992

The Annual General Meeting of the University of Melbourne Medical Society (UMMS) was held at 6.30 p.m. on Tuesday 26 May 1992, in the Sunderland Theatre, Medical Building, The University of Melbourne. The meeting was preceded by the Dean's Lecture entitled 'The development of plastic reconstructive and hand surgery and the Australasian connection'. This was delivered by Professor Wayne Morrison, Department of Surgery, St Vincent's Hospital.

1. Minutes of the Annual General Meeting 1991

The minutes of the 1991 Annual General Meeting, previously circulated, were accepted as an accurate record of the proceedings.

2. Chairperson's Report

- This year we celebrate the 130th anniversary of the founding of the Medical School and the 10th anniversary of the University of Melbourne Medical Society.
- The 10th issue of *Chiron* was published in May and Professor Ryan commended the editors, Mr Peter Jones and Mrs Margaret Mackie, for yet another 'best ever' issue. He thanked the Medical Defence Association of Victoria for their continued generous sponsorship of *Chiron* in 1992.
- The University of Melbourne Medical Society continues to thrive with a current membership of 2,327.
- The UMMS B.Med.Sc. Prize for 1990 was awarded to Mr Marinis Pirpiris for his study entitled 'Steroids and pressor responsiveness in man'. A report on this award was published in the 1992 issue of *Chiron*.
- Activities in 1991 included the annual UMMS Lecture in which Professor Emeritus Harold Attwood gave a most enjoyable presentation entitled 'The Oldest Medical School in Australia'. 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. The seminar was convened by Associate Professor Lorraine Dennerstein. In the evening, the Key Centre for Women's Health in Society hosted an excellent, well-attended dinner at Ormond College.
- The Dean's Lecture Series continues to attract good audiences and in 1991 it was completed splendidly by another seminar on medical ethics convened by Professor Emeritus Richard Lovell entitled 'Issues in Transplantation – Aspects of Supply'.
- In 1991 medical graduates held a number of very successful reunions and details of those being planned for 1992 are published in the recent *Chiron*.
- Professor Ryan reminded those present of forthcoming events including the remainder of the Dean's Lecture Series lectures and the Continuing Medical Education Program. In particular

he drew attention to the sixth medical ethics seminar in the series, 'Looking After Ethics – a Decade of Change', which will complete the 1992 Dean's Lectures. It will be held on Friday 17 July 1992 in the Sunderland Theatre, and will be convened by Professor Emeritus Richard Lovell.

- The 1992 UMMS Lecture and function will be announced later this year.

3. Financial Report 1991-92

The Chairperson noted that the UMMS financial statement was comparable to the previous year and that finances were in reasonable shape. In the absence of the Treasurer, Dr Diana Sutherland, Honorary Secretary, moved that the financial report be accepted. The motion was carried.

4. Election of Committee 1992-94

Six retiring members of the Committee were eligible and available for reappointment:

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

No other nominations were received and they were duly elected.

5. There being no further business the meeting closed at 6.45 p.m.

UMMS BMedSc PRIZE 1991

Elizabeth Uren

for her study entitled

Antiviral strategies in chronic hepatitis B virus infection: use of amplitgen alone and in combination

The thesis submitted by Elizabeth Uren for the degree of Bachelor of Medical Science reports on a study in which an animal model for chronic hepatitis B virus (HBV) infection in man, the duck hepatitis B virus, was used to investigate the potential application of new therapeutic regimes. The importance of therapy is emphasised by the fact that chronic hepatitis B infection occurs in over 300 million people worldwide and current therapy is efficacious in only ten percent.

Treatment for chronic hepatitis B has had limited success and alternative strategies are clearly needed. For example, more than one drug may be necessary to disrupt the complicated replicative cycle of HBV. Also, there is good evidence that chronically infected individuals have impairments in their immune system, in particular their interferon responses. Therefore, combining both antiviral and immunomodulatory regimes could provide more rational and efficacious therapy.

Elizabeth Uren's work tested this premise using duck hepatitis B virus infection in domestic ducks. Her study examined the effect on replication markers of duck HBV of amplitgen, a known inducer of interferon, alone and in combination with two other antiviral agents. The first was ganciclovir, a nucleoside analogue, and the second, nalidixic acid, a known inhibitor of DNA gyrase, an enzyme important in the replicative cycle of the hepatitis B virus.

It was concluded that, by combining antiviral and immunomodulating therapies that act at different levels in the animal and targets in the replicative cycle of the virus, a synergistic effect can be achieved. Longer term studies are now clearly indicated, and to achieve this Elizabeth Uren also developed a novel liver biopsy technique in ducks.

Ms Uren has made a significant contribution to our knowledge on the pathogenesis and possible therapeutic intervention for one of the most common and serious viral infections of man, hepatitis B.

WE WERE WRONG: The 1990 UMMS BMedSc Prize winner, Marinis Pirpiris, is a 'he', not a 'her'.

Apologies from the reporter.

REUNIONS

MBBS 1933 Fifty-Nine Years Reunion The Lyceum Club 18 September 1992

From Lorna Lloyd-Green – Enthusiasm for keeping in contact and a sense of humour remain apparent in everyone, despite being octogenarians of senior citizen status with a few disabilities. Those who attended the annual reunion luncheon on the anniversary of our day of graduation, voted it to be a very happy occasion. Graduates present were: *Norman Cust (Geelong), John Hayward, Lorna Lloyd-Green (Convener), Alec McGregor (Geelong), Sheila Peters (Queensland), Dorothy Sinclair (nee Gepp), Henry Sinn (and wife, Wilma), George Watters (and daughter Rosemary).*

All members of the group were contacted, those in Australia by telephone and the one overseas by air mail. All who were unable to attend sent details of their health and hobbies, and these reports were well received.

Reginald (Spot) Turnbull unfortunately slipped on the golf course earlier in the day, and whilst we partook of a delectable meal he was under anaesthesia for the reduction of a Pott's fracture.

Deepest regret was expressed on the death of Reginald Hooper in December 1991, with reminiscence on student days together and his medical achievements; earlier as a neuro-surgeon and later as a radiologist. We look forward to celebrating our 60th reunion in 1993.

MBBS 1939 Fifty-Three Years Reunion University House The University of Melbourne 6 November 1992

From Alf Barnett – Seventy-five persons graduated from our year. Of these we believe about forty are still alive – several overseas or interstate. Twenty-four attended the dinner, which had been organised by Roy Clegg, and we spent a very pleasant time renewing acquaintances and reminiscing on the 'old days'. The party included three members from interstate. In spite of our age, several are still in practice.

MBBS 1942 Fifty Years Reunion Royal South Yarra Tennis Club 29 May 1992

Received from John Zwar shortly before he died – Our class of '42 (May 1942 – another class of '42 graduated later that year), had their fifty year reunion at Royal South Yarra Tennis Club on 29 May 1992. Sixty-four attended the dinner, 37 graduates (listed below) and 27 spouses. A most enjoyable evening, full of reminiscences and 'what happened to?' was had by all.

Guests were welcomed by John Tucker and John Zwar. There was no guest speaker but a toast to our spouses was given by Mossy Hain and responded to by Anne Cordner. Brian Clerehan proposed a toast to 'The Year of 42' and Ted Cordner proposed a vote of thanks to the organisers and made a presentation to them.

It is hoped a further reunion dinner will be held in two or three years. Present were: *Jim Bottcher, Graham Brooke, Norman Chamberlain, Ian Chenoweth, Brian Clerehan, Rae Cochrane (Davies), William Cooper, Ted Cordner, Ron Davies, David Downing, Ruth Farrer (Chenoweth), Robert Fleming, John Gardiner, John Gooch, Mossy Hain, Gwen Hewitt (Frearson), Rothwell Hill, Malcolm Leembruggen, Austin Ley, John Monk, Heather Morris (Gibson), Douglas Pearce, Herbert Purton, Colin Richards, Alan Rosenhain, Len Satchell, Arthur Schwieger, James Sinclair, Lorna Sisely, Lyn Thomas*

(Billings), Harold Robert Thomson, John Trinca, John Tucker, Quin Whitehead, Ina Williams, Alan Williams, John Zwar.

MBBS 1947 Forty-Five Years Reunion University House The University of Melbourne 22 October 1992

From Ross Webster – In relative terms this was the best attended reunion to date. (Previous reunions have been held at ten year intervals, this being the first after only five years). It was a happy occasion and there were a few present who had not seen some others for 45 years! Three graduates came especially from Perth, and one each from Adelaide, Albury and Ballarat.

Reunion organisers should not be discouraged if initial interest is less than enthusiastic. It builds up once a firm date and venue are fixed! This was the first reunion we have held at University House and the assembled gathering was more than pleased with the food, the service and the modest price.

Present were: *Ric Bouvier, Herb Bower, John Bradley, Philippa Carter, Ralph Clark, Henry Cohen, Trevor Currie, Hugh Denehy, Harry Eizenberg, Greg Forristal, Allen Green, Bill Hare, Athel Hockey, Tom Hurley, Bill Jenkins, Don King, Elsie Koadlow (Shinberg), Theodore Levick, Gerald Manly, Murray Maxwell, Harold McComb, Ian McDonald, Peter McMahon, Jack Morris, Noel Ramsey, Frank Raynor, Peter Robertson, Ian Rowe, Alex Stewart, Harold Story, Maxwell Stubbs, Ced Vear, Ross Webster, Howard Whitaker, Elaine Wong (Chong). Bernard Neal and John Clarebrough were present for pre-dinner drinks only. Dick Denton returned from overseas the day of the reunion and could not attend.*

MBBS 1962 Thirty Years Reunion University House The University of Melbourne 3-5 April 1992

From George Santoro – This year's reunion was a weekend festivity. It commenced with lunch at University House on Friday 3 April, after which we walked to the Sunderland Lecture Theatre for an afternoon of talks by members of our year: Brian Buxton 'Update in Cardiac Surgery', Mary Stannard 'What's New in Medical Administration', Bob Atkins 'Brights Disease Revisited', Bob Hjorth 'Updating Neurology', Henry Rundle 'Sleep Disorders', Gabby Reisner 'Updating Male Impotence' (very appropriate at a thirty year reunion – they didn't teach anything like this in 1962), Alex Auldish 'Paediatric Surgery Update', Elizabeth Shaw 'An Expatriate in London for 22 Years'. (Elizabeth came from London for the reunion.)

With the lecture series completed, an organised walk through the University grounds demonstrated the enormous structural changes that have occurred in the last thirty years. Many of us nearly lost our way. Dinner at night at University House was over all too quickly. It was not a very formal affair. Eighty graduates attended.

On Sunday there was an informal lunch, with partners, at George Santoro's house, which was enjoyed by all despite inclement weather. The two-day format with lunch, dinner and an afternoon clinical meeting gave members considerable opportunity to meet up with old friends.

Others who travelled from afar were Sylvia Topor from Honolulu, Hawaii, John Rolph from Vanuatu, Mary Schramm from Fiji and Jack Taylor from Perth. Regrettably, since our last reunion, Ludwig Engel has passed away. The 1962 reunion demonstrated its respect for the work he has done by giving a donation to the Ludwig Engel Fund for Respiratory Medicine.



Class of '39 - 53 Years Reunion

L to R, back row: Hedley Millikan, Bill Hamilton Smith, Bob Douglas, Winston Kiel, Norman Rose, Blair Widmer, Ron Lowe, Bill Ferguson, Graeme Salter, Frank Kenny, Gordon Keys Smith, Maurice Gooye, Doug Gauld. *Centre row:* Alf Barnett, Gladys Saunders, Una Shergold, Mary Meredith, Rod Strang, Roy Clegg. *Front row:* David Alexander, Vernon Hollyock, Colin Laing, Andy Fraser, Alan Nelson.



Class of '42 - 50 Years Reunion



Class of '67 - 25 Years Reunion

L to R, back row: Wayne Morrison, Peter Canty, James Rowe, John Harris, Andrew Tonkin, Brian Tress, Trevor Jones, Kevin Collins, Barry Dawson, John Bartlett, John Duggan. *2nd row:* Phillip Mein, Victor Syrmis, John Vance, Peter Dobson, John Brennan, Kathy Anderson, John Anderson, Brian Pyman, Dominic Vellar, Keith Elsner. *3rd row:* Les Sedel, Phil Harris, Robin Dunne, Andrew Michaelides, Ben Weiss, Simon Williams, Peter McCann, Murray Esler, Graham Kitchen, Arnold Singer. *4th row:* Gail Pyman, John Mackay, Margaret Lush, Libby Smibert, John Sullivan, Mary Meldrum, Bernadette Kelly, Val Hewitt, Heather Munro, Harvey Turner. *Front row:* Elizabeth Nash, Barbara Knothe, Miron Goldwasser, Diane Wilson, Margaret Smithers, Maija Rinks (Sullivan), Rosemary McConchie, Katie Lubbe, Richard Ng.



Class of '71 - 20 Years Reunion

We wish to offer our thanks to the Medical School and Professor Graeme Ryan for his co-operation and especially to Robin Orams of the Medical School staff for her assistance.

Many thanks to Bob Dickens, Mary Dwyer, Jack Leder and especially Ian Rechtman.

MBBS 1972
Twenty Years Reunion
Melbourne Cricket Ground
Hyatt Hotel
14 November 1992

From Lachlan Ch de Crespigny – A scientific program and lunch for graduates was held at the Melbourne Cricket Ground with some interesting scientific presentations. The main function was for the graduates and their spouses at the Hyatt in the evening. It was a wonderfully successful evening with highlights including an after-dinner speech by Dr John McBain and cartoonist Weg drawing caricatures of registrants during the evening.

This was our second reunion; both have been well attended and appear to have been thoroughly enjoyed by graduates. There was support during the evening for running another function in five years so a twenty-five year reunion is in the pipeline.

A reunion booklet of activities since graduation was produced, with contributions from: *Andrew Ball, Simon Bell, Jim Best, Wilma Beswick, Alex Blau, Carl M Blecher, Ruth Borenstein, Alan D Bradshaw, J W Brooksbank, Lexia Bryant, Christopher Buckley, Jim Butler, Lynne Cade, Richard Cade, Kenneth J Carlile, Heather Carmichael, John Clifford, Tony Costello, Raymond J Crowe, Anthony L Cunningham, Stephen Davis, Lachlan De Crespigny, Mario De Luise, Peter Deutschman, Michael Dobson, Geoffrey A Donnan, Lex W Doyle, Roslyn Drummond, Isaac M Eisenbruch, Paul Fineberg, Peter Fox, Jack Freeman, P D Fricker, Jeremy Frost, Allan S Garfield, Nicki Goldwasser, Abe Granek, David L Hare, Judith W Heale, Boon H Hong, Andrew Jamieson, Paul Jenkinson, Allan Kalus, Peter Kamen, John Kavanagh, Paul A Kelly, Ian J Kronborg, James La Nauze, Gerald Lawson, Samuel Leung, Greg Lockrey, Mark Lowen, Sylvia E Martin, Leon L Massage, Julian Mazzetti, John McLennan, Don McRae, C J Meehan, Stanley J Menzies, Adrian Neath, Bill Orgill, John Pattison, Annamarie Perlesz, Marion Peters, David Piekarski, Vera Polgar, A N Prendergast, Julian J Pribaz, Jack Ptaszniak, Leslie L Reti, Marcello A Rigoni, Dave Rivett, Donald Robertson, A Rotstein, Doug Roydhouse, John McRae Russell, Segar Sandrasegar, Richard John Gilmour-Smith, Robert L Spokes, Ross G Stillwell, Joan Sutherland, Ian Symington, Irene Szymanski, Margaret Roberts-Thompson, James Tatoulis, Chong-Tin Tan, R F Ventura, Murray N Verso, Bruce Wakefield, Rowan G Walker, John Walters, Gordon A White, Roger H White, Richard Bruce Williams, Abraham Winter, Doris Young, Margaret Zacharin, Abe Zelwer, Ralph A Zito.*

MBBS 1967
Twenty-Five Years Reunion
Union House
The University of Melbourne
17 October 1992

'... make each day a work of art.'

From Phil Harris – Our year has developed an impressive range of talents, in and out of medicine, and with no modesty at all, we claim to be a peak year in the history of The University of Melbourne Medical School. Some demonstration of this is the range of speakers at our Reunion Seminar.

The anatomy of the day was a seminar format in the Sunderland Theatre, from 10.00 a.m. to 4.00 p.m., followed by a dinner in Union House; the physiology was based on a self-selecting sample of our graduates to deliver summaries of their interests. Starting with a re-accreditation test from 1962-67 exams, which we all failed (what are plant auxins?), John Vance led us through the current ideas on Sudden Infant Death Syndrome: cause, consequences and some management.

Murray Esler then amazed us with his work on the cerebral-cardiology responses to noradrenaline, can this level of research be happening in Australia? Chris Hazzard relived his student times to explain his diversion into creative art, via Bali, sculpture and wondrous breadth of vision. He showed slides of his works and explained his philosophy that one should try to 'make each day a work of art'.

After morning tea, we returned to the mainstream, Andrew McLeish enumerated the total bowel actions our year should have produced since graduation, and summarised progress in colorectal surgery, rejoicing in the long-term existence of haemorrhoidal diseases. He was followed (aseptically) by John Bartlett discussing knees – what else? – amid jokes and vignettes of AFL, osteoarthritis and olden days. Wayne Morrison led us to lunch with a history of plastic surgery, especially the role of Australia in the major advances.

The afternoon produced a range of revelations; John Anderson of card game fame spoke convincingly of the role of faith in medicine, and totally confused his old image. Brian Tress showed some examples of the growth in radiology, including interventional techniques. If that was not clever enough, Brian Pyman then amazed us with the techniques of cochlear implantation, including the benefits of proper communication for otherwise 'lost cases'. While we were weak from these doses of knowledge, Andrew Tonkin gave a masterly summary of topical cardiology, raising the anxiety levels of the surgeons about cholesterol and BP levels. Les Sedel then told us more about Multiple Sclerosis in 30 minutes than most had known for the last 25 years, including the odd presentations, the horrific effects on families involved, and the great strengths of the Australian style of community support systems, taken for granted here and unknown overseas. The tone was then suitably lowered by a session of reminiscence about student days.

Physiology continued by alimentation in the evening; 120 graduates and partners were greeted by music, food and libations. Professor Austin Doyle said several nice things about 1967, and exhorted us to remain as Community Role Models, resist changes which denigrate Medicine in particular and Society in general, and anticipate even more advances in medicine in the next twenty-five years.

Biochemistry, of course, is self-generating, many exothermic reactions were generated during the day. Substrates were added by Vic Syrmis from New York where he runs a chocolate factory, Richard Ng from Singapore where he is in general practice, Kevin Matar from Queensland, Harvey Turner from Fremantle, Val Hewitt from Tasmania, Phil Mein and Simon Williams from Sale, Keith Blanks from the (we sold the farm) Western District, John Higginbotham from Sydney and lots more. Unfortunately Julie Cliff could not come from Mozambique or Kingsly Gee from somewhere in the Pacific.

Some pathology is unhappily present, we are missing Ian Galbraith and Kerin Gittus-Stubbs since last reunion. Happily Ian McMaster is back at work after his stroke. No pathology is seen between our members, luckily we are all more worldly, milder, more tolerant of diverse views and bonhomie was apparent amongst all, including those who previously felt little in common with each other. A small segment of atrophy is apparent in those who declined to meet their classmates or even acknowledge a reunion invitation, but we will try them again in 1997 and hope the extra time eases their angst.

Higher functions have been tested, all our lady graduates are in the work force, in well-women clinics, general practice, as pathologists, haematologists, anaesthetists, nephrologists, cardiologists, etc. Academics abound: 1967 has produced professorial level physicians, anaesthetists, cardiologists, general surgeons, obstetricians, orthopaedic and plastic surgeons, radiologists, nuclear medicine and research fellows. We have developed highly regarded city, suburban and provincial GPs, some very talented creative artists and at least one prize winning author. No 1967 graduate has been de-registered or gaoled to our knowledge, or has stood for parliament.

Prognosis for the graduates is very optimistic, we are at the height of our careers, with a marvellous diversity of ideas and interests, some of which we cross-pollinated on October 22, and we are a perceptibly closer group now than twenty-five years ago, when competition for jobs and status distracted some. We will individually often, and as a group in 1997, enjoy each others company and maybe even do a few good works.

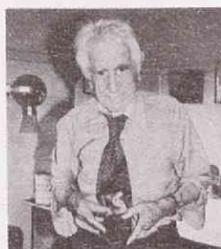
MBBS 1971
Twenty Years Reunion
The University of Melbourne
30 November 1991

Michael Wilson's report of a very successful reunion in 1991 vanished in the mailroom, and to soften his disappointment the editors agreed to publish it in this issue. We congratulate the group on the production of an excellent 20-year reunion booklet.

From Michael Wilson – The occasion of our reunion was marked by a luncheon in the Pathology Museum, which was attended by graduates only. Sixty-two graduates attended and Professor Harold Attwood was guest speaker.

The evening function was a dinner at University house on the same evening and on that occasion 68 graduates and their partners attended. Although the evening was meant to finish at 11.00 p.m. there were still groups of people chatting on well after 1.00 a.m.

Present were: *Adrienne Anderson, Kaye Anderson, Grant Barham, Douglas Barkley, Royce Baxter, Peter Bevez, Kok Yong Boon, Doug Bristow, Mary Burbidge, Jonathan Burdon, David Butterfield, Claude Calandra, Alasdair Cameron, Geoff Clarke, Stephen Clarke, Alan Crosthwaite, Rosemary Cummins, Sabrina Dawson, Elizabeth Dax, Roy Dorner, David Gawler, George Gescheit, Josef Goldbaum, Jacob Goldstein, Afif Hadj, Roslyn Hall, Adrian Hibberd, Benno Ihle, Gerald Irvine, Albert Kaplan, Dianne Keenan, Maurice Kohn, Ben Korman, Ann Kupa, Mier Lichtenstein, Margaret Lythgo, Barbara Main, Anthony Mariani, Katherine McGrath, Frances Minson, Guilio Notini, Gerard O'Brien, Robert Pianta, Virgil Pierini, Leon Piterman, Ralph Ragazzon, Robert Ramsay, David Ross, Les Rothbart, Elizabeth Rothstadt, Jill Sewell, Richard Sewell, Bruce Sterling, Greg Stribley, Roger Sutherland, Greg Taggart, Llew Testro, Robert Thomas, Karin Tiedmann, Helen Tom, Michael Tomaszewaski, George Varigos, John Wark, Sue Wark, Jill Watt, John Weiner, Kaye Weiner, George Werther, Roger Westh, Michael Wilson.*



Greetings and congratulations to our oldest graduate **Dr Cyril Checchi**, MBBS 1914 who celebrated his 100th birthday on 24 July 1992

*Organising a
 Reunion
 Dinner?*

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



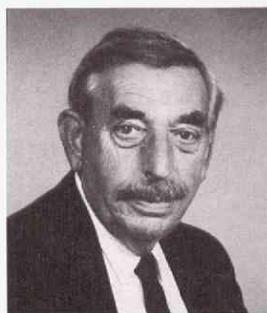
The House is able to cater for reunion groups, ranging in size from 30 to 200 guests. There is a variety of competitively priced menu packages to suit any occasion.

For further information contact Mr Ken French or Mr Stan Bracchi on 344 5254.

Menus and costs are available on request.

OBITUARIES

**AUSTIN DOYLE, AO, MD (Lon), FRCP, FRACP
 1923-1993**



AUSTIN DOYLE

AUSTIN ERIC DOYLE died suddenly in Auckland on Monday 22nd February 1993, on his way home from an overseas meeting. His outstanding academic contributions and influence continued until the time he died.

Austin was born in Yorkshire in August 1923. After graduating in medicine in London and a period of three years as Surgeon Lieutenant in the Royal Navy, he completed house jobs in the UK and then spent two very productive years in New Zealand working on hypertension with Sir Horace Smerk, before returning to the Hammersmith Hospital and Postgraduate Medical School. There he began to establish the reputation in hypertension research which was to be enhanced so greatly over subsequent years.

In the days when good men were sent to the colonies, Austin was appointed in 1959 as First Assistant and subsequently as Reader in the new University Department of Medicine at The Royal Melbourne Hospital, with Dick Lovell as Head of Department and Priscilla Kincaid-Smith,

Roger Melick and Bob Fraser as colleagues. He gave his clinical work high priority, was an astute physician, and was sought after enthusiastically as a teacher of students and of graduates preparing for the MRACP examination. This enthusiasm remained undimmed despite the criticism he handed out to students at all levels, with a capacity to identify deficiencies or obfuscation, and to expose them with what was often a devastating wit. The latter was not reserved for students, but was also used in more exalted company, sometimes to Austin's personal disadvantage – not something which ever worried him especially. He was particularly effective in dealing with any form of pomposity, and officialdom and bureaucracy were often on the receiving end. His critical insights were nevertheless highly productive, and this is nowhere illustrated better than in his research career, and in those of the individuals he trained or who worked in his department. Austin became a world leader in the study of hypertension, a position which he held until the day he died, and many of his students and Fellows have followed him in leadership status in this area.

His outstanding contributions were undoubtedly made during his time as Foundation Professor of Medicine at the Austin Hospital. He took up this position in 1966 and retired in 1985. Few could have contemplated how remarkably successful the Austin Hospital development would be, and this success owes more to Austin Doyle than to any other individual. He began with very primitive facilities and space in a hospital with no tradition as a teaching hospital,

attracted people to work there almost by the sheer force of his personality, chose these people well, and gave them liberal rein. He inspired the changes in the hospital which led to it becoming in a very few years one of the outstanding teaching hospitals of Australia, and housing what was arguably the best department of academic medicine in Australia. None has spawned so many professors and heads of other academic departments. He developed and fostered basic research to complement the excellent clinical research he promoted, and his support for research was eclectic. Indeed, Austin himself was a highly perceptive critic of research in almost any area. There were many occasions during departmental seminars by visitors, or others, with the audience rendered speechless either by the depth of science or lack of it, when Austin would come to the rescue with a penetrating question or trenchant and relevant criticism.

The Department expanded in its scope and success, and included the developments from the early 1970s at the Repatriation General Hospital which he so energetically supported. At the height of its success he decided in 1985 to take early retirement, leaving behind him a monumental achievement. The retirement was in name only because he remained active and influential in many areas. He took on the supervision of postgraduate medical education at the Repatriation General Hospital, a role he greatly enjoyed, which provided great stimulation in that institution. As Emeritus Professor he spent the last five years based in the Department of Medicine at St Vincent's Hospital, was active in research in hypertension and diabetes and in promotion of basic research, besides contributing very actively to work of the Hypertension Unit at that hospital. He continued also his editorial roles and in being a highly respected international figure in the hypertension world. He had been President of the International Society of Hypertension, 1982-1984, and remained active in its affairs, having extensive overseas speaking commitments planned at the time of his death, and a major role planned also in organising the next conference of the International Society of Hypertension in Melbourne in 1994.

For his outstanding contributions to medicine, Austin Doyle was awarded the Order of Australia in 1986. His achievements and his influence on Australian academic medicine have been remarkable. They have given this University and Faculty a great legacy, and we are grateful for his many wonderful contributions and for the times that we had with him.

Austin is survived by his wife Jill and family, Simon, Michael, Patrick and Susan, to whom we extend our deepest sympathy.

T J (Jack) Martin

EILEEN GREEN, MBBS 1932 1902-1992

EIILEEN EVA HAMILL GREEN was born in 1902 into a gifted family. Her brothers John and Arthur were also distinguished doctors in their fields. John was an Ormond man, Eileen an extern student of Ormond tutorials.

Eileen was awarded a Freemasons Scholarship at the age of thirteen, which enabled her to attend the Presbyterian Ladies College. Her keenness for knowledge blossomed early and she was noted as a distinguished pupil and a prominent and effective leader. She held the position of Vice Captain in her final year, as well as Editor of the school's magazine *Patchwork*.

She graduated BSc in 1925 and MSc with honours in biochemistry in 1926. From 1926 to 1930 she was a lecturer



EILEEN GREEN

and demonstrator in biochemistry at The University of Melbourne. During this time Eileen also taught honours physiology to final year students at her old school, PLC.

With these meagre earnings and some money borrowed from her older brother, Eileen embarked on her medical course. In 1932 she graduated MBBS, with

honours in surgery.

Eileen had hoped to carry out her residency at the Alfred Hospital but history will relate that the hospital was not, at that time, accepting women candidates. She accepted a position at Prince Henry's Hospital where she was acknowledged as an 'excellent anaesthetist, and with pathological and bacteriological work far in advance of the average resident'.

Following her residency, Eileen was keen to proceed with her MD, and had been asked to take up the position of Superintendent at Prince Henry's Hospital. However, in the mores of the time, her brothers felt that she was needed in their general practice in Moonee Ponds and, with no further consideration for her personal career, there she went.

She was a fine physician and much loved throughout the area. She also cherished the two children of her older brother, John, devoting many weekends to them after their mother died. During the war years she maintained the general practice whilst John concentrated on O & G and Arthur went overseas with the Army.

After retiring from general practice Eileen undertook a course in psychiatry and accepted the position of physician to Willsmere Mental Hospital (Kew), where she worked until her retirement in 1972. She restored many a uraemic patient to healthy independent living; the nurses were at her feet.

Dr Eileen Green was always an enthusiastic supporter of others and their endeavours, taking particular interest in Melbourne University graduates and the activities of the Lyceum Club. Sadly her own deteriorating health in later years prevented her from actively pursuing these interests.

Throughout her life, Eileen balanced the rigours of her medical career with an equally consuming devotion to gardening, inheriting a special passion for roses from her father. She was always thrilled to know that gardening continued as a strong family trait. Eileen also derived a lot of comfort and solace from her religion.

Right up until her death at the age of ninety, Eileen delighted in her relatives, always displaying a lively interest in their growing up, herself maintaining a young-at-heart spirit, full of spontaneous warmth.

As someone whose first thoughts were always for others, and the last of her generation in the Green family, she is sadly missed by her peers and her devoted family.

From the family.

JOHN HORAN, MBBS 1930 1907-1993

FACULTY records with sadness the death of 'The Latin Scholar', John Patrick Horan, KCSG, MD, FRCP, FRACP, memorable for his immaculate wardrobe and fund of Tobruk memories. His elegant pin-striped suit was only slightly marred by a creased, worn right-hand pocket - he was never without his beloved *Odes* of Horace, and if not in his pocket a volume would be kept handy in the glovebox of his car. A full obituary will appear in the next issue of *Chiron*.

DAVID FRANCIS GRAY
1912-1993

PROFESSOR Emeritus David Gray was appointed from the Department of Microbiology at The University of Melbourne to the Foundation Chair of Medical Microbiology at the Austin Hospital Clinical School in 1967. He was an experienced, versatile and gifted teacher of microbiology with a particular interest in the immunology of tuberculosis. He was the author of a successful textbook, *Immunology*, which went to three editions and was translated into Japanese, Romanian and Spanish. His pioneering studies on experimental tuberculosis in guinea pigs and mice spanned a number of years and provided one of the first clear animal models of the influence of genetics on resistance to tuberculosis (*J.Hyg.*, 1960, 58:215). In the course of these studies he developed the now widely used footpad swelling test for delayed hypersensitivity in mice (*Am.Rev.Tuberc.*, 1958, 78:226). He was a master of technique with all animals and laboratory procedures. Together with the late Dr Joan Schiavone, he shaped the course in medical microbiology for fourth year medical students at the Austin Hospital. He retired in 1975.

Professor Gray had a long and brilliant career as a microbiologist, veterinarian and teacher. He is survived by his wife Betty and two sons, Tony and John.

*Prepared by Professor David White
from the obituary published
in the Aust.Vet.Journal.*

VERA KRIEGER, DSc
1901-1992



VERA KRIEGER

VERA ISABELLA KRIEGER died on 25 June 1992 in her ninety-first year. Vera was not medically qualified. She was a Doctor of Science of The University of Melbourne and as such served the patients and medical staff of the Royal Women's Hospital for some forty years.

Born on 28 October 1901 in South Yarra, Vera was the daughter of Marion Estella

Chapman and her husband Louis Krieger, a member of the Stock Exchange. She was educated at Girton Private School and the Presbyterian Ladies' College, entering The University of Melbourne in 1921, graduating BSc in 1925 and MSc in 1927. In 1938 The University of Melbourne accepted her published work for conferring on her the prestigious degree of DSc.

In 1926 Vera was appointed Research Biochemist and assistant to Dr Robert Marshall Allan, Director of Obstetrical Research, who became Professor of Obstetrics in 1929. In 1928 she was the first biochemist to the Royal Women's Hospital, all her work being carried out in the Biochemistry Department at the University by agreement with W J Young, Associate Professor of Biochemistry and W A Osborne, Professor of Physiology. Vera often talked with delight about these three men.

In the early years much straightforward biochemical work was done, particularly in blood urea estimations in patients with pregnancy toxaeias and/or nephritis. However, between 1934 and 1947 Vera and her limited staff prepared the solutions for intravenous use in treating

patients with oliguria or anuria from pregnancy toxaeias. The initial estimate of nine pints of fluid per month was soon exceeded. Production increased from 500 units (1934-35) to 15,000 in 1946. The methods of distilling and achieving sterility were cumbersome and, until 1939, the finished product still had to be carried across from the University to the hospital. This quiet service must have saved many lives. Quietness, reticence and a tendency to remain in the background were characteristics of Vera Krieger.

Vera's work with Dr Bill Rawlings on pregnanediol levels in repeated abortion was well researched, carefully carried out and equal to anything being done at that time. This work has been underrated. Pregnanediol levels were good measures of placental function but did not always predict when the fetus might be rejected. Oestriol levels were better predictors of impending fetal loss but methods for measurement were not then available.

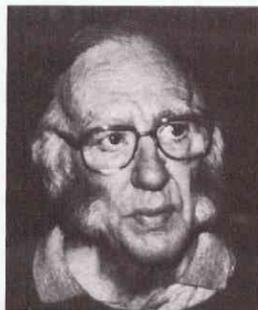
In 1941 Hans Bettinger quickly appreciated the importance of the discovery of the rhesus factor and asked Vera to take on this new challenge. Within a year all women attending the hospital were routinely screened for this factor. Vera combined biochemistry and serology until 1957 when, officially, she became Serologist. By that time Vera, through her publications, had acquired international recognition in that specialty.

In 1964, while in America she was asked by Dr J G Gorman to take part in assessing the efficacy of anti D gamma globulin in preventing rhesus immunisation. After her retirement in 1968 she continued this work with Dr Geoff Bishop to give serological proof of how effective this treatment could be. Deaths of babies due to rhesus immunisation are now rare all over the world due to many such workers.

Vera left the services of the Royal Women's Hospital in 1968. In retirement she made several jaunts overseas but increasingly lived quietly at home with her cat, and was regularly visited by relatives, friends and many former colleagues. A small woman, she became increasingly stooped with the years, but managed, with help, to look after herself until she was ninety. Once this was achieved she did not strive as much and became increasingly confined to bed. Her intellect was largely unclouded and I shall always remember an occasion, shortly before her death, when, awakening briefly, she saw a camellia pinpointed by a shaft of sunlight. 'How lovely!' she said. Her smile was as delightful as ever.

H.A.

EUAN MACLEAN, MBBS 1938
1915-1992



EUAN MACLEAN

IT IS a severe test of character and resilience to go through life in the shadow of an unrelenting illness which, little by little, saps the physical strength and constricts the movements until life itself can no longer be supported. This was the lot of Roderick Euan George MacLean. He never was heard to complain of it. He pursued his professional life with success in spite of it. He confidently believed in the mystery of God and derived comfort and strength from contemplation of it. Throughout his long illness he enjoyed the sympathy and support of Nancy, his wife of fifty years, and together their equanimity and peaceful presence was the admiration and

inspiration of their many friends and acquaintances.

Euan was the only son of a senior officer of the Victorian State Public Service. After primary education at local state schools he entered Scotch College. He matriculated and entered the Medical School of The University of Melbourne in 1933. At the age of thirteen the diagnosis of primary muscular dystrophy of limb girdle type had been made. During his medical course there was exacerbation of his weakness to the point when he feared that he might not be able to complete the course, but a timely remission allowed him to continue and graduate in 1938, and to complete a residency at Geelong Hospital.

In 1940 Euan entered the then Mental Hygiene Branch of the State Health Department as Medical Officer at the Royal Park Receiving House (now the Royal Park Psychiatric Hospital). He was subsequently transferred to Beechworth Mental Hospital and to Mont Park Mental Hospital. During this last appointment he became a student in the first course given by The University of Melbourne for the DPM. Although this diploma had been available for some years, the requisite number of six students had never applied to activate the course, until a Sydney graduate (Dr F W Graham) collected a team for that purpose. Euan obtained the diploma in 1946.

This was a period of great professional activity in a time of relative quiescence of his illness. He was a part-time university tutor, an assistant at the clinic for child psychiatry and an activist in marriage guidance. He was the chairman of the provisional council and in 1949 became the first chairman of the subsequently established Marriage Guidance Council. This period culminated in Euan's appointment as Superintendent of a new clinic established in the buildings of the former State Observatory in the Domain in South Yarra, a position he held for twenty-two years. This Observatory Clinic was to develop into a large and active out-patient centre for adult and child psychiatry, as well as a centre for education in psychology for psychologists in training, and for lay groups such as police cadets and school teachers. The few surviving colleagues from that time remember the Clinic with affection and Euan as warm and sympathetic to patients and staff. In 1955 he was appointed Honorary Consulting Psychiatrist to the Queen Victoria Hospital, a position which he held until 1969. In 1963 he became a foundation member of the Royal Australian and New Zealand College of Psychiatrists.

The muscular dystrophy which haunted him gradually deprived Euan of strength and mobility, first requiring the use of walking aids and later, increasing use of a wheelchair. In 1971 he could no longer carry out his duties as he wished and asked to be retired. Still undaunted, though immobilised, he commenced a private practice at his home and continued until the week before his death.

Euan MacLean had always been interested in music. In early days he played trombone and French horn, both of which he had to abandon, but he continued to play recorder until his death. In his home he had a beautiful small chamber organ on which he played every day. For twenty years his home was the centre of regular gatherings of recorder players and less frequent meetings of string and assorted wind players, and for twenty years Nancy and Euan played a central part in the organisation of the Victorian Recorder Guild.

In the last ten years Euan became completely chair-bound and latterly a tiresome additional discomfort kept him housebound. Calm, courteous and courageous he departed this world on March 5th, 1992, after a long and fruitful life.

He is survived by his noble wife Nancy, and their only son Alastair.

A Tait Smith

WILLIAM KNOX PEACOCK, MBBS 1925 1898-1992

We thank the Australian Society of Anaesthetists for their permission to reproduce this obituary, which was first published in Anaesthesia and Intensive Care 1992, 20: 387.



BILL PEACOCK

BILL PEACOCK, a pioneer anaesthetist in Western Australia, died on 5 March 1992 at the age of ninety-four. Born in Victoria in 1898, Bill was the youngest of four children and attended Geelong College and Melbourne Grammar School. He commenced his medical studies at The University of Melbourne in 1917 but these were interrupted by Bill's service as a

trooper with the 3rd Australia Light Horse Regiment in the Great War. He saw service in Palestine and Egypt and on his return recommenced his studies, graduating MBBS in 1925.

Bill did his internship in Victoria first at the Alfred Hospital (1926) and then at the Women's Hospital (1927). In 1928 he arranged a three-month locum tenens in Albany, Western Australia, where he met a young nurse, Julia Rodda. They were married in 1929. Their first child, Jean, died in infancy; Bill is survived by his two sons, Peter and John, and six grandchildren.

Bill set up general practice in Victoria Park, first as a junior partner to Sir Thomas Meagher and later on his own. He had a very large obstetric practice extending to Armadale and became increasingly busy giving anaesthetics.

Eventually giving up general practice and obstetrics to specialise in anaesthesia, Bill became an Honorary Anaesthetist to Royal Perth Hospital in 1932, being one of the first appointees – others included Drs Troup, Beech, Bennett and Godfrey. The only general anaesthetic agents available were ethyl chloride, ether, chloroform and nitrous oxide and oxygen. The only gas machine available was unreliable and difficult to use. Bill was the first Honorary Anaesthetist at King Edward Memorial Hospital and held appointments at the Princess Margaret Children's Hospital and the Repatriation Hospital. He retired from Royal Perth Hospital in 1953 and became an Emeritus Consultant Anaesthetist there until his retirement from private practice in 1974.

In 1952 Bill became a foundation member of the Faculty of Anaesthesia, Royal Australasian College of Surgeons and in 1966 he was elected as a Fellow of the Society.

Like others of his profession, Bill worked very long hours, particularly during the period of the Second World War. He is remembered with great affection by many of his patients; one of the sons he delivered, at no charge to the mother, was able to repay this kindness in later years by acting as his chauffeur once Bill was unable to drive. He was a very keen golfer and was a member of Royal Perth Golf Club for over sixty years. He had the unique distinction of winning, on two occasions, the Veteran's Cup (limited to players over the age of fifty-five years) – these two victories were separated by a period of twenty-five years!

An event which caused him considerable amusement was the publication by the Faculty of Anaesthetists of his premature death some five years ago. He enjoyed immensely being alluded to as 'The Ghost'. Bill Peacock was in no way a ghost in anaesthetic history in Western Australia. He made a major contribution to the community, both as an anaesthetist and as a general practitioner and we extend our deepest condolences to his family on their bereavement.

D H Alltree

**PINCUS TAFT, MD, FRACP
1920-1993**

Hyman Pincus Taft was the epitome of Osler's Physician – a clear head and a kind heart – a cheery word with sound advice for those in need.

PINCUS TAFT graduated MBBS in 1942 from The University of Melbourne and after a year's residency at The Royal Melbourne Hospital served in the Royal Australian Army Medical Corps. He returned to the Melbourne as a Registrar and in 1949 was appointed the second Cleveland Fellow. At a time when specialisation in medicine was not regarded with favour he elected to train in diabetes and endocrinology both in Cleveland and London. In 1950 he was appointed Honorary Medical Officer for Diabetes to The Royal Melbourne Hospital and in 1952 with Ronald Rome established the first Diabetic Ante Natal Clinic in Australia at The Royal Women's Hospital. In 1963 he accepted the positions of Director of the Diabetic and Metabolic Unit at the Alfred Hospital and Associate Professor in Medicine and Biochemistry at Monash University. From 1964 to 1970 he was both Physician for Diabetes and Endocrinologist at The Royal Women's Hospital. After his resignation from the Alfred Hospital in 1981 he served as Visiting Endocrinologist at St Vincent's Hospital until 1986. His association with four of the original teaching hospitals is probably unique.

These bare bones do not give an adequate picture of Pincus Taft's contribution to endocrinology and medical practice in Melbourne and Australia. He was one of the founders of the specialties of endocrinology and diabetes in Australia and his guidance and wisdom supported the research endeavours of young physicians and scientists for many years. He was President of both the Endocrine Society of Australia and the Australian Diabetes Society, having been a founding member of both. He was an innovative and inspiring clinical teacher who is warmly remembered by generations of students and residents of both medical schools in Melbourne. He was in consultant practice for over forty years and his reputation for integrity and devotion to care became deservedly legendary. His opinion was sought as an ultimate consultant by many, but most of his time was spent in the continuing care of patients, mainly with diabetes. His innate ability to treat all as equal with compassion, wisdom and humour ensured that patients became his friends and mourn his passing as do his medical and nursing colleagues. Medicine and his family were his life and both are infinitely poorer for his death.

FIR (Skip) Martin

**BERTA UNGAR, MBBS 1946
1923-1992**

THE death of Dr Berta Ungar brings to Melbourne and The Royal Melbourne Hospital the loss of a unique character and Consultant Haematologist. She identified with the Hospital and contributed to it in many ways.

Berta was born in Vienna in 1923. After secondary schooling in Switzerland she attended the University of Grenoble for a year, topping her class in French. Her family managed to escape from the dark days in Europe, and Australia was a random but fortunate choice for them. A year at Taylor's College brought matriculation to enter medicine at Melbourne University and Berta did a brilliant course, overcoming cultural and language changes.

Apart from a year as an RMO at the Royal Children's Hospital her whole medical life was at The Royal Melbourne



BERTA UNGAR

Hospital in the depression years and stayed on to become a hospital identity.

After John Lindell's appointment to the Hospitals and Charities Commission, Berta spent a term as Acting Medical Superintendent. She then joined me in Clinical Pathology and became an outstanding deputy. She developed a keen interest in the autoimmune aspects of pernicious anaemia.

Berta was a great reader. Her mother started a Continental Book Shop in Melbourne and Berta was well read in continental as well as English literature. In her earlier years she was interested in the theatre and was a great Olivier fan. As a girl she had been a keen horse rider, paying her way at Miss Irving's Riding School by 'mucking out' the stables. She was always strong physically.

Berta suffered from Hodgkins disease, but continued to attend the Hospital after retirement. She died suddenly in bed, a way she would have approved of.

Berta Ungar was known to generations of young doctors and regarded with respect. She taught many budding young specialists and piercing wit and penetrating comments were her hallmark. She loved her family and, to an extent, this included everyone at the Hospital. She will live on in many hearts and minds.

David Cowling

**JAMES McBRIDE WHITE
1916-1992**



JIM McBRIDE WHITE

JAMES McBRIDE WHITE graduated from the Sydney Medical School soon after the beginning of the Second World War. His background was not dissimilar to some of Melbourne's own greats.

A country boy, he was born on 26 June 1916 in Narrandera in New South Wales, where his father was the City Engineer. A Scots Collegian (Sydney), he distinguished himself as a first class cricketer. From a fledgling pharmacist, like Weary Dunlop, he switched to medicine and on graduation spent four years on Active Service with the AIF in the South Western Pacific. He was to maintain a life-long association with the Army, becoming Colonel Consultant to the Director-General of Medical Services.

At the end of the War, on discharge from the Army, Jim joined the Royal Victorian Eye and Ear Hospital. He took

The University of Melbourne Diploma of Ophthalmology and from then on devoted the next forty-three years of his professional life to the advancement of the Hospital and to both its specialties.

Jim was recognised as a skilful surgeon who flourished under the tutelage of the late Mark Gardiner. He established a network of grateful patients and friends from all walks of life – political leaders, industrialists, stockbrokers and medical colleagues. At the height of his energies he not only conducted a busy hospital clinic, private practice and attended to various boards assiduously as a member or chairman, he also found time to pursue his farming interests, first at Holbrook and later in the Yarra Valley.

Jim's contributions to the Committees of the Royal Victorian Eye and Ear Hospital and of the Royal Australian College of Ophthalmologists were recognised by his peers when he was elected unanimously to Chair important bodies – the Public Relations Committee, the Research and Ethics Committee, and the Federal Council of the Royal Australian College of Ophthalmologists (as its President). In all of these activities he acted from the highest altruistic principles. When approbation came he was unaffected, accepting it with grace and dignity.

Although Jim was spared the ravages of a long illness he was no stranger to pangs of severe arthritis, nor the anguish of a cerebro vascular incident. His courage and tenacity were seen at their best as he fought his way back to a remarkable recovery. He died suddenly on the 18th May 1992. At the time of his death, he was still Chairman of the Bionic Ear Research Institute and of the Public Relations and Fund Raising Committee.

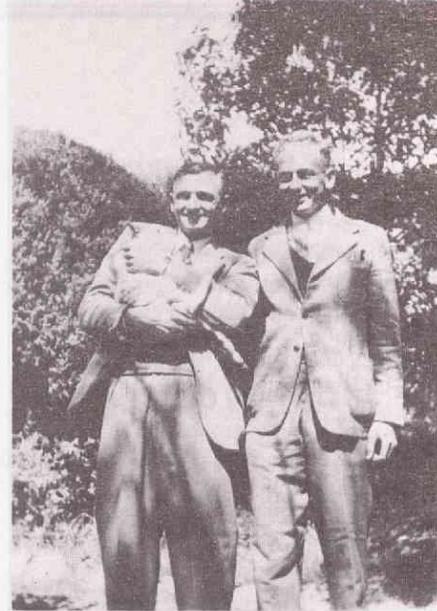
Gerard W Crock

JOHN CRAIG ZWAR, MBBS 1942 1918-1993

A Memoir

ALTHOUGH I had not seen a great deal of John Zwar since undergraduate days, our paths were to cross several times in recent years. Through his generosity in lending me a book from his library I was made aware of his terminal illness. John's cheerful optimism in the face of a devastating diagnosis was typical of the friend I remember as a schoolboy and undergraduate. We travelled on the same tram route to school and were in the same House. As medical students we shared many curricular and recreational activities.

John commenced his medical course at The University of Melbourne in 1937 together with fifteen other Melbourne Grammar boys, nine of whom shared with him the distinction of having medical genes in their system. When the Second World War broke out we were in the third year of our medical course. Being medical students we were exempted from military service, but most of our year joined the medical wing of the Melbourne University Rifles – in the picture on the front cover of *Chiron* (1991) John Zwar is in the left-hand column, second from the front. However, when the war situation became grim after the defeat of France, John, along with several other medical students, decided to defy the authorities and try to enlist in the services, and thus emulate the patriotic medical students of a previous generation. We were then in fourth year, but Peter Macallum, Professor of Pathology and Dean of the Faculty of Medicine,



John Trinca (with Trixie) and John Zwar, Rosebud, January 1940.

became aware of these activities and gave us all a blasting and told us to get on with our studies.

In those days few students drove motor cars but John was one of the privileged – his little red Standard was often used to transport students to various venues. He was a keen tennis player and I have many pleasant memories of the mixed doubles played on the Essington Lewis court near his home in Hamilton Road, Malvern. Another happy memory is the holiday we spent at Apollo Bay camping beside the Barham River with fellow medical students, Colin Richards and John Tucker and future medical graduates, John Lane and Peter Birrell (MBBS 1946 and 1944 respectively) and Peter's younger brother John. The latter was a very good cricketer who later played District Cricket for St Kilda and I well remember the agony and frustration which John Zwar and I suffered as we bowled over after over in the vain attempt to get John Birrell out.

Our course was continually being foreshortened until eventually we ended up with practically no final year. We sat for our exams in April/May 1942, faced orals on a Saturday afternoon and a Sunday morning, before graduating on 1 June 1942. The fiftieth anniversary of our graduation was celebrated last year with a happy reunion dinner at the Royal South Yarra Tennis Club organised by John Zwar and his fellow enthusiast, John Tucker. The occasion was another opportunity to renew my acquaintance with the jovial and generous John Zwar.

In sport John was a popular member of the Peninsula and Frankston Golf Clubs and an active tennis player until his last illness. He was a keen photographer and a writer of novels and short stories for adults and children. John never lost contact with his old school, Melbourne Grammar, and was given the honour of reading one of the lessons at the Chapel Service preceding the Old Boy reunion held on 14 November 1991. He was a regular contributor to *Chiron* and told the story of his 'medical genes', his community activities and his career in the 1988 edition of the journal.

John Zwar was devoted to his wife and family. They must be proud of his many achievements and a life dedicated to the betterment of mankind as remembered in John Tucker's eulogy at the memorial service held at the Uniting Church, Mount Martha on 21 January 1993.

John C Trinca

REUNIONS

1993 REUNIONS

20TH YEAR CLASS OF '73

Date: 13/14 November 1993
Venue: Sheraton Towers Southgate
Contact: Professor Hamish Ewing
(03) 285 2542

25TH YEAR CLASS OF '68

Date: 13/14 November 1993
Venue: ANZ Pavilion, Melbourne Arts Centre
Contact: Dr John Stuckey
(03) 579 2711

35TH YEAR CLASS OF '58

Contact: Dr Ralph Lewis
bh: (03) 284 3680 or
ah: (03) 836 1559

40TH YEAR CLASS OF '53

Date: 27 November 1993
Venue: University House
Contact: Dr Neville McCarthy, AO
(03) 817 1085 or
(057) 80 2259

48TH YEAR CLASS OF '40

Date: 19 February 1993
Venue: Melbourne Cricket Club
Contact: Dr Donald Cordner
(052) 52 2373

50TH YEAR CLASS OF '43

Date: 15 March 1993
Venue: South Yarra Tennis Club
Contact: Dr Ian Tulloch
(03) 817 3275

60TH YEAR CLASS OF '33

Date: 13 September 1993
Venue: Naval & Military Club
Contact: Dr Reginald 'Spot' Turnbull
(03) 822 7727

THINK AHEAD

When did you graduate? Is next year your 5th or 55th since graduation? It is best to plan your reunion well ahead of time. Some of your classmates 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 like to include information about reunions 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 alternatives you may wish to explore and give any assistance we can regarding venues and speakers.

Many reunion organisers produce a booklet containing details of class members' activities since graduation. A small curriculum vitae needs to be requested from graduates early in the planning stages, and these, sometimes together with recent and old photographs, are compiled into a booklet. Those who attend the reunion will take home something to remind them of the event, and those unable to attend will enjoy reading about their old friends. Requests for information for reunion booklets sometimes elicit serendipitous responses, such as the cartoon drawn by Patricia Fricker in response to a request for a curriculum vitae for the 20th year reunion booklet of 1972. At the UMMS office we are always interested and grateful to receive copies of reunion booklets – they contain valuable archival material of the sort not available elsewhere.

MBBS Graduate Anniversaries in 1994

5th Year Class of '89	30th Year Class of '64
10th Year Class of '84	35th Year Class of '59
15th Year Class of '79	40th Year Class of '54
20th Year Class of '74	45th Year Class of '49
25th Year Class of '69	50th Year Class of '44

MBBS 1941 Fifty Years Reunion Donation 4 October 1991

The Society wishes to acknowledge with thanks, the generous donation of \$219 received last year from the class of '41 reunion funds. This is a positive and painless way for graduates to contribute to the funds of their alma mater. As James Guest wrote in last year's *Chiron*, 'It was an excellent evening and much enjoyed by everyone'.

UMMS OFFICE
Ms Liz Brentnall
School of Medicine
The University of Melbourne
Parkville 3052
Telephone (+61 3) 344 5888
Facsimile (+61 3) 344 5998

MEDICAL GENES

THEN AND NOW



(L to R) Drs Debbie, Ruth and Eva Kipen.

A FEATURE of *Chiron* since 1987 has been the histories of Victorian medical families, some dating back more than a century. The branches of their family trees bear the 'lateral genes' – sisters and brothers and cousins practising medicine.

In recent decades, new variations of 'medical genes' have emerged. In 1991 *Chiron* published the history of the School's famous brothers, the country surgeons David and Sam Fitzpatrick, who between them have produced five medical graduates. In the same year Mrs Christina Westmore wrote that five of Gerald (Gerry) Westmore's eleven children had graduated MBBS (Gerry graduated in 1945) which is certainly noteworthy, and at the time of her writing, four had specialist degrees. *Chiron* has yet to publish the history of the Spring family, and the twin sons of Priscilla Kincaid-Smith and Kenneth Fairley, Stephen and Christopher who graduated MBBS in 1983, provide a new theme with a family history of three generations of distinguished 'medico-lateral genes'.

Three consultants, three sisters

Prompted by the 1991 Medical Women's Centenary festivities, Dr Ruth Kipen wrote about the three Kipen sisters. Theirs are not 'medical genes' but their story is a celebration of changing conventions and family attitudes to women pursuing professions. In an enlightened era, they are combining medical careers with marriage and parenthood.

The Kipen family's association with The University of Melbourne began in 1954, with the meeting of Felicia, a science student, and Les, an economics student. Both were immigrants from Poland. They married in 1955. Les is a director of an industrial chemical manufacturing company.

Debbie was born in January 1959, Ruth in October 1960, and Eva in May 1962, so there is less than three and a half years

between the eldest and youngest. They were educated at Mount Scopus Memorial College and matriculated in 1976, 1977 and 1979 respectively. Eva was school captain of her year, while Debbie and Ruth were vice-captains. Debbie was Dux of her school year and Ruth was second Dux of hers. Their parents were always strong supporters of tertiary education for women and encouraged them to make the best use of their potential in pursuing careers.

Debbie commenced her medical course in 1977. She had been particularly interested in medical sciences such as microbiology since secondary school and in later school years became increasingly attracted to the human side of medicine. During her course, she won several honours, including Prosector in Anatomy, an Exhibition in Biochemistry, and the Jacobs Prize in Gynaecology. She attended The Royal Melbourne Hospital Clinical School and returned there for her intern year in 1983. Thereafter, Debbie trained in Paediatric Medicine at the Royal Children's Hospital and became a Fellow of the Royal Australian College of Physicians in 1990. Debbie has worked at the Royal Children's Hospital and in private practice and is currently working part time in postgraduate teaching. She has a particular interest in clinical nutrition and intends to undertake further research in this field in the future. She married Jeffrey Rosenfeld in 1988 and they have a daughter, Hannah aged two, and a newborn son, Alexander. Jeffrey, who is also a graduate of The University of Melbourne, is director of Neurosurgery at the Monash Medical Centre, and a consultant at the Royal Children's Hospital.

Ruth commenced her medical course in 1978. She was interested in working with people and had contemplated specialising in paediatrics. During her course, she won several honours, including an Exhibition in Community Medicine, and the John Adey prize in Psychiatry. Ruth attended the Royal Melbourne

Hospital Clinical School and spent her intern and junior resident years there. Since fifth year, she had become very interested in psychiatry, so in 1986 she commenced psychiatric training based at Mont Park Hospital, Melbourne. Ruth became a Fellow of the Royal Australian and New Zealand College of Psychiatrists in October 1990. She has been a lecturer in the Psychiatry of Old Age, The University of Melbourne, during 1990 and 1991. In January 1992, she commenced working as a Consultant Psychiatrist to the Inner East Geriatric Psychiatry Service, located at the Wildara Centre, Hawthorn. Her interests are in General Psychiatry and the Psychiatry of Old Age. Ruth is married to Mark Cherny, and has a son, Daniel, aged two, and a four month old daughter, Tamara. Mark is completing his ophthalmology training and is doing research with the excimer laser for refractive and corneal diseases in The University of Melbourne Department of Ophthalmology.

Eva entered the medical course in 1980. She had also been attracted to working with people but was slightly reticent about following in her sisters' footsteps. She graduated in 1985, gaining honours in all her final year subjects. She commenced her resident medical officer training at The Royal Melbourne Hospital in 1986, and continued her basic physician training there. In 1992 she became a Fellow of the Royal Australasian College of Physicians, having completed her advanced training in the field of Geriatric Medicine. Eva is currently working at Mount Royal Hospital, and is interested in dementia and osteoporosis. She married Leslie Aldor in 1990. Leslie is a graduate of the Monash University Economics and Law Faculties, has a masters in Law from both Monash University and the Columbia Law School, and is a member of the New York Bar Association.

General practice, two brothers and a sister

How different were family conventions of sixty years ago. Eileen Green (1902-1992), sister of medical graduates John (1917) and Arthur (1924), graduated MBBS with honours in surgery in 1932, having already gained a BSc and MSc with honours in biochemistry. Following residency she was asked to take up the position of Superintendent of the Prince Henry's Hospital. 'However, in the mores of her time, her brothers felt that she was needed in their general practice in Moonee Ponds and, with no further consideration for her personal career, there she went.' Eileen Green led a full and fruitful life alongside her brothers and their families, though it was many years, in fact not until after her retirement from general practice, before she was able to pursue her interest in psychiatry. The story of her life is told by her family in the obituary they wrote together for publication in this journal.

Maggie Mackie

NOT JUST DOCTORS!



Sir Benjamin Rank on a 'paint-out'.

ARTISTS GALORE THE AMA ARTS GROUP

W.R.C. Bennett

TOWARDS the end of 1959 a notice appeared in the *Monthly News* of the Victorian Branch of the British Medical Association:

A meeting of interested members called for the purpose of establishing a Medical Art Group will be held in the Council Room, Medical Society Hall, Albert Street, East Melbourne on Monday, 26th October.

At this meeting, initiated by Morris Davis, were Doctors Gladys Hallows, Eric Beveridge, Morris Davis, John McLean, Harry Friedman, Michel Brous, Cecil Colville, Byron Stanton, Donald Hossack, Robert Trauer, Hugh Ryan, Kurt Petzold, Harry Shannon and Robert Bennett. Cecil Colville (later Sir Cecil and the first Federal President of the Australian Medical Association) proposed that a group be formed and it was decided that it should be named 'The BMA Arts Group' (the name was changed to The AMA Arts Group at the time of the 1962 Annual Exhibition). Morris Davis, then Honorary Physician to the Alfred Hospital and a prime mover in establishing the Department of Visual Aids there, was elected President, and Bob Bennett Honorary Secretary/Treasurer. The Minutes read:

It was generally agreed that although some aspects of the activities of such a group could have a practical application in the field of medicine, this was not the purpose of forming such a group.

Dr Colville said that it was essential, as William Dargie had pointed out, to have a place to meet and work together and that many groups formed in the past had foundered for want of a hub

for group activity. This, however, applies largely to practical painters and does not include those that take a less practical but nevertheless intense interest in art.

The first meeting of the Arts Group was held one month later on November 26th, when Mr Des Norman, art teacher at Melbourne Grammar School, gave a fascinating demonstration of screen printing. He became a friend of the group from that time onwards.

On 21 April 1960 the group's first exhibition was held in the Tasmanian Tourist Bureau Galleries in Collins Street, and was opened by Dr Leonard Cox, eminent neurologist and sometime Chairman of the Trustees of the National Gallery of Victoria. The catalogues were run off in Morris Davis's rooms and the covers individually illuminated by his nurse/secretary, Miss Joyce Pepperel, a long-time loyal supporter of the group. Exhibitors in this first show were Robert Bennett, Eric Beveridge, Michel Brous, Donald Cheek, Cecil Colville, Morris Davis, Eric Gutteridge, William Hare, Reginald Hooper, John McLean, Sydney Pern, Ethel Robinson, Hugh Ryan, Byron Stanton, Douglas Smith, Ian Thomas and Robert Trauer. Two paintings by Douglas Thomas were included – he was a great friend of Arthur Streeton, who was believed to have said that Thomas could have been as successful an artist as he was a medical practitioner. Sydney Pern's oil painting of Lake Wendouree, which hangs in the Medical Society rooms, was painted when he was over eighty years old. Hugh Ryan and Robert Bennett have exhibited in every exhibition since that time and are the only Foundation Members exhibiting today.

In 1961 the second exhibition also included photographs by Harry Friedman, Douglas Pearce and renowned neurologist Graeme Robertson, who showed one of his famous studies of 'Como'. At one of the earliest meetings he gave a memorable address on 'Cast Iron'. Edwin 'Bunny' Cato, a friend of artists whose name is commemorated by the Cato Gallery at the Victorian Artists' Society, also exhibited.

The third exhibition was held in 1962 at the Victorian Artists' Society Galleries in East Melbourne, as have all exhibitions since. It was opened by Major General Sir Kingsley Norris who contributed a fine watercolour, 'The Squall'. In the meantime the group sent paintings to the 5th Benger's Doctors' Hobbies Exhibition in London, and in May 1962 contributed paintings to the exhibition of Doctors' Hobbies at the 1st Australian Medical Congress in Adelaide. In response to a notice in *The Medical Journal of Australia* proposing an exhibition of doctors' art to be held in Japan, fourteen members exhibited with the Japan Doctors' Art Society in Tokyo and subsequently in Osaka.

About that time John McLean (of direct blood transfusion fame) published an article on the Victorian Branch Arts Group in *The Medical Journal of Australia*. This article was illustrated with the first black-and-white reproductions of members' work, a feature which continued in the 'Peripatetic' section for many years. Colour reproductions of paintings by Reginald Hooper and Brian Fleming also appeared on the front cover of the Journal.

Following the publication of John McLean's article interest was engendered in New South Wales, where an art group was formed. The NSW group contributed work to the Victorian Branch's 5th Annual Exhibition, which was opened by Sir Daryl Lindsay – he purchased two oil paintings from the show, 'Banksia' by Brian Fleming and 'South Morang' by Douglas Pearce, for the Commonwealth National Collection. The National Gallery of Victoria lent sculpture by Dr Clive Stephen, who 'when the majority of Australian sculptors were looking to The Royal Academy for their direction, . . . was one of the few artists to respond sensitively to the developments which had taken place in European sculpture since the turn of the century' (Graeme Sturgeon, *The Development of Australian Sculpture 1788-1975* (1978)). Meanwhile, in 1965 six paintings were sent to the Medical Art Society's 23rd Exhibition in London (a society which was founded in 1935 under the leadership of Sir Leonard Hill and Sir Harold Gillies).

A number of women medicos have exhibited over the years: Ethel Robinson worked for some time at the Santa Theresa Aboriginal Mission where, as well as being the mission doctor she taught art, and it is hardly surprising that in many subsequent shows she depicted Central Australia. Gweneth Wisewould, renowned Trentham GP, not only drove down from Trentham for meetings, but also exhibited

fine pencil sketches. In 1971 her book *Outpost – A Doctor on the Divide*, was launched in Trentham by Professor Harry Garlick, who was at that time President of the Victorian Branch of the AMA. (In 1968 Dr Wisewould endowed 'The Truganini Scholarships' for Aboriginal students at Melbourne University.) For many years Ruth Walker has provided some contrast with delightful wood sculpture, as did John Fethers, using driftwood found on remote beaches as the basis of his work. A bronze portrait bust of the late John Bernard Fethers was created by his friend and colleague Bob Bennett, and is displayed in the surgical foyer at Preston and Northcote Community Hospital. Mary Long exhibited in the early days and Dorothy Bignell, Janet Fitzpatrick and Joan Bradley have contributed in more recent times.

Exhibitions have included ceramics by Morris Davis, Ian Nunn, Dorothy Bignell and Alan Wise; and for some years very professional watercolours of the Western District by its renowned resident Sam Fitzpatrick (pioneer of hydatid surgery who died in 1991 at the age of ninety-eight). Many members have held solo exhibitions – Morris Davis, Cliff Judge, Ethel Robinson, Donald Cheek, Sir Benjamin Rank (in aid of Interplast) and Des O'Shaughnessy (the author of *Music and Medicine*, 1984).

Picnics and *plein air* painting, demonstrations and addresses by members and professional artists and visits to regional galleries are part of the yearly program, but the important appointment each year is the Annual Exhibition. Spouses have been



Cliff Judge, *Gum Blossom*, oils, 106.5 x 91.5 cm.

encouraged to participate and some are artists. The group is pleased that many keep in touch after the loss of their partner, by becoming honorary members. In 1972, the 13th Annual Exhibition was opened by Dr James Champion de Crespigny, the then President of the Victorian Branch of the AMA, and since then it has become the custom for the current President of the Branch to open the Annual Show.



Bob Bennett, *Portrait of John Fethers*, bronze.



Sir Cecil Colville with Bob Bennett at the Annual Exhibition.

Many well-known artists have been a great support, including Laurie Pendlebury and his wife Nornie Gude, Des Norman and Alan Sumner, a former Director of the National Gallery Art School. On several occasions members have been guests in the studio of Harold Freedman (State Artist). His son David, a surgeon practising in Swan Hill, has participated in exhibitions and held several successful one-man shows.

The 33rd Annual Exhibition was opened by Dr Stephen Clark on 18 October 1992 and 60 exhibits were contributed by John Barnes, Robert Bennett, Andrew Blecher, Paul Clarke, Janet Fitzpatrick, Joe Friedin, Edmund Himmelreich, Ivan Horacek, Cliff Judge, John Mathew, Malcolm Menelaus, Desmond O'Shaughnessy, Benjamin Rank, Hugh Ryan, Douglas Stephens, Richard Strangward and Ruth Walker.

It has been the custom to wind up the year's activities with a garden party or dinner at which current works of members are displayed. At the annual dinner in 1980 Morris Davis, Foundation President, suggested that after twenty years as president it was time for him to retire. He was a great innovator who tried most media with success and continued to



Arts Group Garden Party. L to R: Doris Sumner, Alan Sumner, Dorothy Baker and Laurie Pendlebury.



Des O'Shaughnessy with Ming Mackay, at the opening of his exhibition in the Cato Gallery.



Gwenth Wisewould and Harry Garlick at the launching of her book, *A Doctor on the Divide*.

contribute to Annual Exhibitions until his death in 1987. Bob Bennett, Secretary/Treasurer, became the next President, but as there were 'no takers' for his former role, the President fulfilled all three roles for the next twelve years! In 1991 at the opening of the 32nd Annual Exhibition, Bob announced that after thirty-two years he was retiring from his 'rewarding' role as Secretary/Treasurer, and hoped that somebody would come forward to take over.

In 1992 a grateful Bob Bennett was 'let off the hook' by Ivan Horacek, who is the new Secretary/Treasurer, and the AMA Arts Group looks to the future with renewed enthusiasm. They invite medicos who enjoy artistic pursuits and good company to join the Group by contacting

Dr Ivan Horacek
Secretary/Treasurer, AMA Arts Group
7 Cantala Drive
Doncaster 3108
Telephone (03) 848 5347

or

Dr Bob Bennett
President, AMA Arts Group
50 Victoria Crescent
Mont Albert 3127
Telephone (03) 890 4521



Just Jazz by Noel Cass



At Dame Elisabeth Murdoch's 'Cruden Farm'. Noel Cass (piano), Norm Follett (banjo), David Patton (trumpet), Fred Sommerville (clarinet), Rod Neal (trombone), Alan Stott (sousaphone).

NEW ORLEANS JAZZ has had a continuing influence on the dance floors since the '20s – *Alexander's Ragtime Band*, *Darktime Strutters Ball* and *When The Saints Go Marching In* never fail to stir an audience.

I had the conventional piano lessons for four years and enjoyed them greatly. By a stroke of luck one of the seniors at school (Pat Markham at Wesley College, in Perth) showed me some chords and I started playing by ear – my sight reading

had been abysmal. Playing popular dance tunes (almost all in the key of C) was a relaxing interlude in the round of education, but two decades were to pass before the chance to play in a group came along, in 1965.

At a medical conference in Hobart an impromptu trio played at a party, and next day Bryan Keon-Cohen (a Melbourne graduate and leading orthopaedic surgeon who had himself played piano in a dance band) suggested that I enlist Max Wearne (a trumpet playing orthopaedic surgeon

originally from Dunedin) and some other friends and form a band. Subsequently Bill Swaney (yet another orthopaedic surgeon) and his wife Marie (both Melbourne medical graduates) invited us to their home, and the band was formed – John Andrews (a London graduate and a nuclear medicine specialist) on drums, Gray Woolley (an Adelaide graduate and a physiologist) on clarinet, myself on piano and two non-medical members, Doug Lampard (banjo) was Professor of Electrical Engineering at Monash and a Sydney graduate, and David Patton (trumpet) a senior lecturer in Engineering at RMIT.

For some years we played regularly at each other's homes, and invitations came to play for weddings, birthday parties, charity functions and medical groups. We adopted the name 'Doctors' Jazz', after the ever-green tune *Doctor Jazz*. Over the years geographic and other constraints reduced the medical component of the group and the name was dropped. Anonymity produced some curious alternatives, such as the 'Rinkly Rockers', and in self-defence we adopted the name 'Anonymous'.

For twenty-seven years the band has played regularly, and the music has taken us far and wide, to nearly all the Hotels and City Clubs in Melbourne, the Polly Woodside, Puffing Billy, many sporting clubs and homes, and even Government House (for the Red Cross). We have also played in a number of country halls and woolsheds, and of course the Australian Jazz Convention, but have not entered any competitions or been actively promoted.

The jazz community is an egalitarian group, and players are delighted to be invited to join a band which lacks a member on occasion – we have met many talented musicians in this way. The band has evolved over the years and among regular members are a retired headmaster, Fred Sommerville (clarinet), a retired engineer, Peter Law (clarinet), a political scientist, David Goldsworthy (trumpet), a retired businessman, Norm Follett (banjo), a civil engineer, Rod Neal (trombone), and a dental technician, Alan Liversidge (string bass), as well as some of the original group.

The band plays almost entirely by ear, with some assistance from hand-written chord-books (whose scruffy appearance evokes great interest from the audience at times). This approach to music precludes the need for rehearsal as the standard format is simple: the whole band plays the tune through twice, then the front line (clarinet, trumpet and trombone) take solos accompanied by the rhythm section (drums, banjo, bass and piano), and then the whole group join for the finish. Often a solo is also taken by a member of the rhythm section when the front line is caught unawares.

As a relaxation from medicine, jazz is very therapeutic. Perhaps it could be seen as the antithesis of my area of medicine, anaesthesia. □



Harold Fabrikant — A Harmony of Interests

By George Szmukler

A FORTUNATE, small group of aficionados of the keyboard pay regular Sunday morning visits to a house in Caulfield. In the room on the right, occupying it entirely, there stands a beautiful instrument made by Australia's foremost organ builder, Knud Smenge. In the room on the left stands a Hubbard harpsichord from Boston completed by McAllister. The adjacent room is dominated by a splendid Seiler grand piano. The owner and master of these instruments is Harold Fabrikant, a graduate in medicine in 1966 and now a radiologist at The Royal Melbourne Hospital.

There was no history of music in Harold's family – his grandfather, about to emigrate from Russia to New York in 1892, was instead shanghaied aboard a boat, but managed to jump ship in Melbourne, and his father studied metallurgy and mining at Melbourne University. No-one played a musical instrument until Harold's older brother began to learn the piano.

Harold started on the piano at the age of five and his most significant early teacher was Lillian Carter. Soon after, he was afflicted with an inexplicable craving for the sound of the organ, and was fortunate in attending Wesley College where he was able to commence lessons with James Wastell. From the age of twelve he studied piano with Waldemar Seidel, who decided that Harold should train as a concert pianist. Meanwhile it was demonstrated that this gifted musician

was no academic laggard – he gained three Exhibitions in his matriculation. When he decided that prudence favoured medicine rather than an uncertain future on the concert platform, Dr A E Floyd, the revered organist at St Paul's Cathedral, wrote to him sympathising with the difficult choice he had made and congratulating him on his wisdom. As a medical student, Harold still managed to astonish Mr Seidel with his performances of taxing works such as the Chopin Etudes.

At this time Harold decided that justice to keyboard works in the baroque style required proficiency on the harpsichord, and studied this instrument with Mancell Kirby, doyen of the harpsichord in Australia since the 1920s. In 1972, the great organist, Lionel Rogg, visited Australia, and after hearing Harold at a masterclass, invited him to take lessons in Geneva. Having embarked on training in radiology at Prince Henry's Hospital, Harold combined these lessons, together with those for harpsichord, with Gustav Leonhardt in Amsterdam, and a Visiting Fellowship in Radiology in Milwaukee, into an intensive overseas experience. The secrets of radiology and of the techniques of enhancing expressiveness through phrasing and articulation on the harpsichord were revealed.

After being Deputy Director of Radiology at Prince Henry's until 1984, Harold moved to The Royal Melbourne Hospital. His greatest enthusiasm is for neuroimaging, but he showed little

excitement about a suggestion that he might have a PET scan while playing the organ to show us what happens to his brain during a JS Bach six-part fugue, four voices shared by the two hands, and two pedalled by the feet; an explanatory verbal commentary on which voice is presenting the theme in inversion and which in augmentation may accompany the performance! Harold's playing has one marvelling at the extent of human capacities.

Harold gives many public performances, and is in particular demand as an organist – relatively structured working hours in radiology permit this. Many performances have been broadcast on the ABC, and he gives recitals around Australia at various music festivals. In 1989 he was invited to perform at Westminster, Coventry and St Paul's Cathedrals in England. Some fine recordings are also available. The Sunday morning recitals are at present covering all of Beethoven's music for keyboard up till 1800. As if the volume of works is not already large enough, Harold also presented a world premier – his own transcription of Six Minuets for Two Violins and Bass (WoO 9) for organ.

Does he regret the choice of medicine rather than music? 'Not really. As an amateur I can play on all of my instruments without needing to specialise in any one. Anyway, I probably couldn't have afforded to buy them if I were a professional musician.' □

FROM OUR COLLECTION

IT IS RARE for a General Practitioner to refer a 'patient' to me. This patient came with two pieces of family memorabilia which gave me much delight.

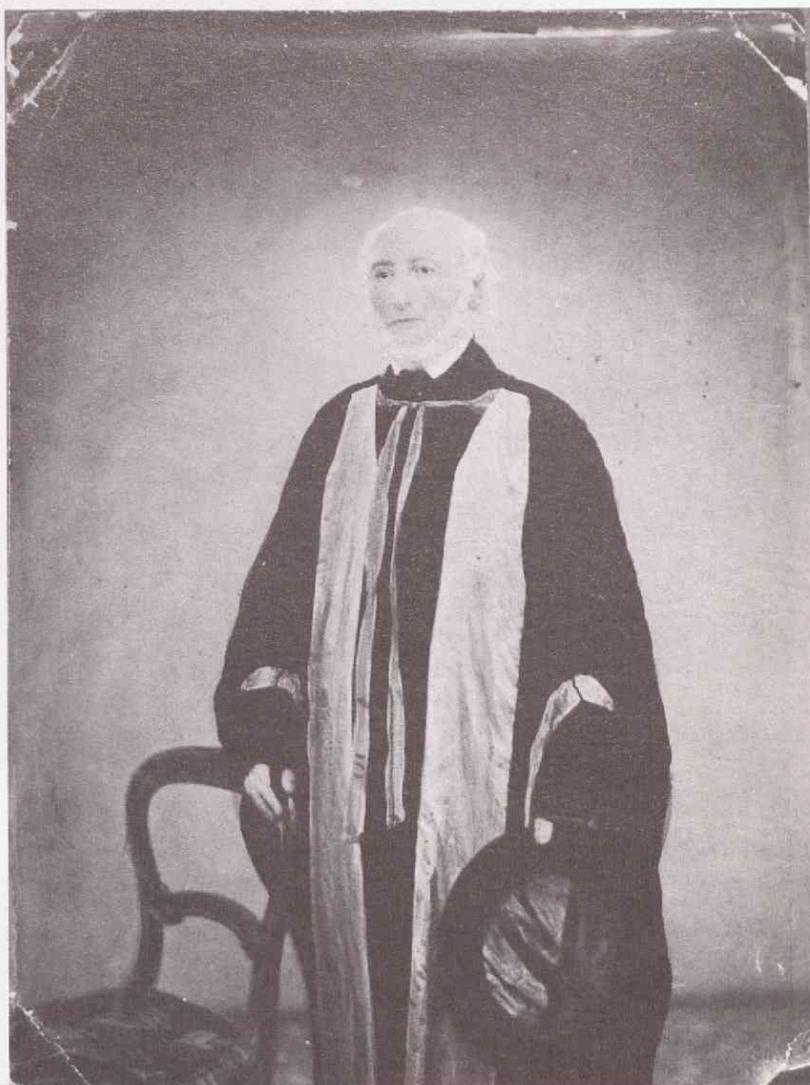
First a somewhat haunting colour photograph of William Jameson Sherwin (1804-1874) in doctor's gown and bonnet. This man, born in Parramatta was apprenticed to William Bland in 1817 but held an MRCS London – the first Australian youth to do so. His pamphlet (1844) 'On the primum mobile of the blood in the lungs at birth: its complete vitalization or animalization; and its subsequent circulation' explains changes in the fetal circulation at birth. It is the first medical publication by a native-born Australian.

On his return to Australia Dr Sherwin served as assistant surgeon to the Melville Island Settlement in Northern Australia. In 1829 he established the first private practice in Parramatta and moved to Sydney in 1840. Although he qualified as FRCS in 1862, on his return to Australia he practised homeopathy and published two pamphlets in support of that specialty. Married in 1839 to a Harriett Rowe he died without issue in 1874. He is not listed in the *Australian Dictionary of Biography*, but is listed in standard medical bibliographies. The photograph was immediately interesting.

The second treasure, a document on vellum measuring 355 x 300 mm (irregular), appeared at first to be a diploma from the Blenheim School of Medicine. It was dated 1836. Diplomas of that date are not common, but this proved to be something much more rare – a testimonial to a Mr Alfred Huntley. Moreover, despite the high praise given to his personal characteristics it explains why a diploma was not given – Mr Huntley was too young. He was only 19. Because of the very unusual nature of the document and its language it is reproduced in full:

Blenheim Street School of Medicine

This is to certify that Mr Alfred Huntley has assiduously attended two courses of my Lectures on Anatomy, Physiology and Morbid Anatomy, and one course of my Lectures on Surgery during the sessions of 1835 and 1836; and that he has diligently dissected without interruption during the last six months. In his dissections and in practising the operations of Surgery on the dead subjects he displayed great manual dexterity. He has also assisted me most efficiently and successfully in practice by



Dr William Sherwin, the first Australian born MD (1804-74).

attending several of my patients whose cases required great care and skill. I feel it incumbent on me to state, after considerable opportunities of estimating Mr Huntley's professional and private character, that his mind is of the highest order. His talents, prudence, industry, integrity and inflexible determination to do his duty on all occasions are such as I have seldom seen equalled. These and his amiable and obliging disposition, mild and gentlemanly manners and kindness of heart justify my belief that there are few stations in society, however elevated, which he would not fill with honour. His conduct, as I have had occasion to witness, under trying circumstances, proves him to possess presence of mind and sagacity which I believe will enable him to cope with great difficulties.

I deem him highly qualified to practise as a Surgeon or Physician, and regret that

the regulations with regard to the age of Practitioners do not admit him to examination at our Colleges, and that he should be deprived of a Diploma, to which I consider him well entitled, merely on account of his youth.

*W. King
6 Maddox Street
Hanover Square
May 4, 1836*

Alfred Reynolds Huntley came to Australia and in 1838 married Eleanor, a sister of Dr Sherwin. Strange to relate he did not make his name in medicine. He became a successful business man in Sydney. Truly he had 'presence of mind and sagacity' which enabled him 'to cope with great difficulties'.

The 'patient' referred to me was Con MacGillcuddy, the great great-grandson of Dr Robert Huntley.

THE MEDICAL DEFENCE ASSOCIATION OF VICTORIA

A.C.N. 004 046 379

PELHAM HOUSE, 165 BOUVERIE STREET, CARLTON VICTORIA 3053



MDAV was founded in 1895 by Victorian doctors to provide medical indemnity for medical practitioners in Victoria. Now in its 98th year, it is one of the oldest and largest State indemnity organisations in Australia.

By arrangement with the Faculty of Medicine, Dentistry and Health Sciences of The University of Melbourne, MDAV extended indemnity to

all medical students of the Faculty throughout their undergraduate years and while working outside of a recognised teaching hospital, for example, in a general practice. It also extends to cover electives throughout Australia and overseas, with the exception of USA and Canada – in many cases, MDAV can negotiate cover in those two countries, given sufficient notice of a student's intentions.

Become a student member of MDAV (at no cost) and as well as other benefits, MDAV will mail you the Association's quarterly newsletter, *Defence Update*.

Contact

Therese Carroll (03) 347 3900

All enquiries (24 hours)
(03) 347 3900

Facsimile
(03) 347 3439

THE MEDICAL DEFENCE ASSOCIATION OF VICTORIA
IS THE PROUD SPONSOR OF CHIRON
THE JOURNAL OF THE UNIVERSITY OF MELBOURNE MEDICAL SOCIETY

DATES TO REMEMBER 1993

MEDICINE, DENTISTRY & HEALTH SCIENCES

CONTINUING MEDICAL EDUCATION

These continuing professional education courses are designed for medical practitioners. They may also be of interest to those working in associated health professions and others concerned with health care. The School also offers a continuing medical education program in Diagnostic Radiology. Enquiries to: Continuing Medical Education, School of Medicine, The University of Melbourne, Parkville Vic 3052.

Telephone (+61 3) 344 5888, Facsimile (+61 3) 344 5998

Friday and Saturday 5-6 March

Psychiatry for non-psychiatrists: common psychiatric problems and their management

Venue: Austin Hospital

Directors: Associate Professor Fiona Judd and Professor Graham Burrows

Wednesday to Friday 28-30 April (Course 1)

Wednesday to Friday 10-12 November (Course 2)

Radiography for general practitioners

Venue: Essendon and District Memorial Hospital

Director: Professor Emeritus Bill Hare

Friday and Saturday 7-8 May

ENT problems and procedures for general practitioners

Venue: Royal Victorian Eye and Ear Hospital

Director: Dr Brian Pyman

Friday and Saturday 28-29 May

GP refresher course in ophthalmology – basic ophthalmology

Venue: Royal Victorian Eye and Ear Hospital

Director: Associate Professor Hector Maclean

Friday and Saturday 25-26 June

An update in office gynaecology for general practitioners

Venue: The Royal Women's Hospital

Director: Associate Professor Doris Young (in association with the Royal Australian College of General Practitioners and the Department of Obstetrics and Gynaecology, The Royal Women's Hospital)

Friday 30 July

Spots and itches – update in dermatology for the family physician

Venue: The Royal Melbourne Hospital

Director: Dr George Varigos

Wednesday and Thursday 18-19 August (optional intensive course)

Friday and Saturday 20-21 August

 (lecture program)

Paediatrics for general practitioners

Venue: Royal Children's Hospital

Directors: Dr Max Robinson and Professor Peter Phelan

Friday and Saturday 3-4 September

Diabetes, hypertension and the eye

Venue: Royal Victorian Eye and Ear Hospital

Directors: Professor Hugh Taylor, Associate Professor Hector Maclean and Dr Justin O'Day

Friday and Saturday 8-9 October

Update in general medicine for general practitioners

Venue: Austin Hospital

Director: Dr Paddy Phillips

Friday and Saturday 5-6 November

Recent advances in diabetes and its management

Venue: The Royal Melbourne Hospital

Directors: Dr Joe Proietto and Professor Richard Larkins

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.

23 February

Strategies for the treatment of viral infections

Professor John Mills, Director, Macfarlane Burnet Centre for Medical Research

9 March

Molecules, mechanisms and methods: vascular pharmacology in hypertension, atherosclerosis and angiogenesis

Professor Jim Angus, Department of Pharmacology

23 March – 59th Beattie Smith Lecture

From psychosomatic medicine to consultation-liaison psychiatry

Professor Graeme Smith, Chairperson, Department of Psychological Medicine, Monash Medical Centre

6 April

The role of the twenty-fifth chromosome in neurological disease – an evolving story

Professor Edward Byrne, Director of Clinical Neurosciences, St Vincent's Hospital

20 April

How cellular enzymes are regulated: the past, present and future

Professor Bruce Kemp, Deputy Director, St Vincent's Institute of Medical Research

4 May

Training medical practitioners for the twenty-first century

Professor Irwin Faris, Department of Surgery, The Geelong Hospital

18 May

Brain tumour surgery beyond 2000 – shining a light on the future

Professor Andrew Kaye, Director of Neurosurgery, The Royal Melbourne Hospital

This will be followed at 6.30 p.m. by the 1993 Annual General Meeting of the University of Melbourne Medical Society.

1 June – 34th Halford Oration

Muscular contraction – the first steps

Richard Adrian, Baron Adrian of Cambridge, MD, FRCP, FRS, Formerly Professor of Cell Physiology, Master of Pembroke College, and Vice-Chancellor, University of Cambridge

15 June

Adhesive dentistry – a sticky problem

Associate Professor Martin Tyas, Reader, School of Dental Science

29 June

Anaesthesia – does better science improve outcome?

Professor Duncan Blake, Director of Anaesthesia, The Royal Melbourne Hospital

SEMINAR: DEAN'S LECTURE SERIES

Friday 23 July 1993 – 2.00 p.m. to 5.00 p.m.

THE DEAD DO TELL TALES

DECLINING AUTOPSY RATES AND THE QUALITY OF HEALTH CARE