

MBBS 1994



# CHIRON

JOURNAL OF THE UNIVERSITY OF MELBOURNE MEDICAL SOCIETY

VOL. 3 NO. 3 APRIL 1995



# UMMS

**University of Melbourne  
Medical Society**  
As at 1 March 1995

## President

Professor David Penington AC

## Executive Committee

### Chairperson

Professor Gordon Clunie

### Deputy Chairperson

Professor Graeme Ryan AC

### Honorary Secretary

Dr Andrew Rothfield

### Honorary Treasurer

Mr David Westmore

Dr Lorraine Baker

Dr Thomas Kay

Mr Michael Wilson

## Chiron

### Editors

Mr Peter Jones

Mrs Maggie Mackie

### Editorial Board

Prof Emer Harold Attwood

Ms Liz Brentnall

Mr Darrell Mead

Ms Robin Orams

Prof Graeme Ryan AC

### Associate Editor

Mr Paul Richiardi

### Design

Mrs Maggie Mackie

Miss Jan Goddard

### Typesetting

Fingers Typesetting, Box Hill

### Printing

Capitol Press Pty Ltd, Box Hill

### Enquiries & Correspondence

University of Melbourne

Medical Society

School of Medicine

The University of Melbourne

Parkville 3052

**Telephone (+61 3) 9344 5888**

**Facsimile (+61 3) 9347 7084**

## Acknowledgment

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

# CHIRON

CHIRON THE CENTAUR, TEACHER OF MUSIC, MEDICINE AND HUNTING

**Vol. 3 No. 3**

**Contents**

**April 1995**

- 1 Editorial** ..... *Sir Gustav Nossal*
- Dean's Lecture Series**
- 3** • Seminar: A Better Death ..... *Convener: Prof Richard Smallwood*  
*Rev Dr Davis McCaughey, Rev Dr John Morgan, Dr Ruth Redpath,*  
*Ms Sanchia Aranda, Prof David Lanham, Mrs Loane Skene*
- 18** • Mental Illness: The Public Health Crisis  
of Our Time ..... *Prof Helen Herrman*
- 25** • Acute Stroke: A New Era ..... *Prof Geoffrey Donnan*
- Faculty of Medicine, Dentistry and Health Sciences**
- 28** • From the Dean ..... *Prof Graeme Ryan*
- 31** • Medical Education Programs – Dean's Visits to  
Singapore, Bangkok and Jakarta
- 32** • Retirement – Prof David White AO
- 33** • School of Medicine Higher Degrees and Diplomas Conferred 1994
- 34** • Postgraduate Life at The University of Melbourne ..... *Erkadius*
- Clinical Schools
- 35** Austin Hospital & Heidelberg Repatriation  
Hospital ..... *Assoc Prof Bernard Sweet*
- 36** The Royal Melbourne Hospital &  
Western Hospital ..... *Assoc Prof Robert Moulds*
- 37** St Vincent's Hospital &  
The Geelong Hospital ..... *Assoc Prof Wilma Beswick*
- 38** • Final Year MBBS 1994, Top Students, Prizes & Awards
- 39** • MBBS Graduates 1994
- 40** • Dean's Honours
- UMMS 1994 Elective Essays
- 41** The Maldives – Paradise or Paradox? ..... *Sonia Davison*
- 42** Evolution in the Cradle of Mankind ..... *Glenn Guest*
- 44** • Graduation Ceremony – Occasional Address ..... *Prof Bruce Singh*
- Departments of Surgery – Introduction ..... *Prof Richard Bennett*
- 46** Austin Hospital ..... *Prof Kenneth Hardy*
- 48** The Royal Melbourne Hospital ..... *Prof Gordon Clunie*
- 49** St Vincent's Hospital ..... *Prof Wayne Morrison*
- University of Melbourne Medical Society**
- 51** • School Album
- 52** • Notice of Annual General Meeting 1995
- Minutes of Annual General Meeting 1994
- UMMS 1993 BMedSc Prize
- 53** • UMMS 1994 Elective Essay Prizes
- 54** • UMMS Congratulates ...
- 55** • 1994 Reunions
- 57** • Reunion Announcements
- 58** • Obituaries
- Magazine**
- 66** • The AMA Archives Collection ..... *Dorothea Rowse*
- Not Just Doctors
- 67** Doctors and Birds ..... *Norman Wettenhall*
- 70** • Books ..... *Prof Harold Attwood*
- 75** • Three Long-Living Victorian Otolaryngologists ..... *Colin Richards*
- 79** • Medical History Unit ..... *Prof Harold Attwood*

**Front cover:** MBBS 1994, Clinical Schools, staff and students.  
Photographic montage.

**Back cover:** Dates to Remember.

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

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

ISSN 0814-3978 Copyright © 1995



## MEDICAL RESEARCH – FROM MOLECULES TO THE PERSUASION GAME

LATE LAST YEAR, the Dean asked me to give a University of Melbourne Medical Society Lecture with some unusual instructions: 'Just talk about yourself – for about an hour!' How to convert this into something other than self-indulgent nonsense? I was forced to look anew at my chosen *métier* of medical research and to attempt to distill out of my own struggling 40-year pilgrim's progress some messages that might be of interest to younger doctors and biomedical scientists. The required degree of introspection was unusual, but good, for me; and so I have been urged to share it with *Chiron's* readers.

My Austrian parents were forced to flee Hitler's 1000-year Reich in 1939, because of my father's Jewish ancestry. At not quite eight years old, and speaking not one word of English, I entered 3rd Grade at St Aloysius College, the smaller of the two Jesuit schools in Sydney. I spent nine very happy years at 'Alo's', the Jesuits not only sharing their centuries-old tradition of scholarship with me, but also moderating the effects of the disdain of my colleagues for my bookish ways and lack of sporting prowess. Somehow I had always wanted to become a doctor, and entered first year medicine at the University of Sydney at the ripe old age of sixteen, one of 600, including many returned servicemen and (a few) women. The woefully understaffed departments did their best, but really we more or less had to teach ourselves in those early years – and it was out of reading done for a self-assembled mutual help group that I first discovered a fascination with research. After fourth year, I was fortunate to do a Bachelor of Medical Science year under the virologist Patrick de Burgh, a critical thinker and fine mentor who introduced me to the experimental method. Through de Burgh I met Sir Macfarlane Burnet, later to be a Nobel Laureate, and spent three days in his laboratory. It took some time for me to admit it to myself, but that heady early experience sealed my fate: I was hooked on the idea of medical research pursued at an international level of excellence. I finished my medical course, did two years residency at Royal Prince Alfred Hospital, and started as a Research Fellow under Burnet in 1957.

To my dismay, Burnet had switched the Walter and Eliza Hall Institute's focus from virology to immunology, anticipating that the latter discipline would become a very major one. We knew little about lymphocytes in those days, and it was my good fortune to make some contribution to the question of how cells made antibody molecules. I also met my third mentor, Joshua Lederberg, one of the fathers of microbial genetics, who paid me the compliment of inviting me to Stanford University in California as an Assistant Professor from 1959 to 1961. This was an important period in my life, as it showed me that a young Australian could compete in the 'big league', an experience shared by many of the fine young ambassadors in medicine and science that we have sent overseas over the past forty years. Late in 1961, I returned to the Hall Institute as Deputy Director (Immunology), and in 1965, I succeeded Burnet as Director and Professor of Medical Biology within the University of Melbourne.

In that former, simpler era, I found that my medical background was a great advantage. Of course, I expanded the research of my own group in cellular immunology but I was also able to leverage my new position to think, write and lecture about immunology as the key discipline in organ transplantation, autoimmune disease, tropical parasitic diseases, and also as increasingly important in relation to cancer. It came home to me that the relationship between the basic

research which we did at the Hall Institute and the world of clinical care was really quite a complex one. On the one hand, we had to keep broadening and deepening the laboratory science, buttressing whole animal biology with ever more sophisticated and technology-intensive cellular and molecular biology and protein chemistry. This meant greater effort in recruitment, expansion and fundraising. On the other hand, to speed the process whereby our discoveries could actually help people, we needed them to be developed beyond the research stage and eventually to be tested in clinical trials. This meant new partnerships and alliances. In particular, it involved thinking hard both about the pharmaceutical industry and about our relationship with our neighbour and landlord, the Royal Melbourne Hospital. In unison with a number of other Melbourne research institutes and with the Government of Victoria, we planned and founded the AMRAD Corporation. This has become the chief commercialising partner of thirteen institutes and medical departments. Eight years on, this effort is proving enormously successful.

At the Hall Institute, we took the conscious decision not to leave the total burden of an interface with clinical medicine to one clinical research unit (no matter how distinguished!) but to make a number of other conjoint appointments with the Hospital, embracing fields as diverse as haemato-oncology,

infectious diseases, rheumatology, nephrology and soon neurology. The clinician/scientists who constitute these bridges face truly daunting challenges, needing both to be productive in the laboratory and superb at clinical care. Through the above efforts, the Hall Institute spans the spectrum from molecules to clinical care. Yet, I have learned that this is still not enough!

Inventing a health innovation is not much use if it is not deployed. The smoking/lung cancer association shows us how extremely difficult and lengthy the pathway from discovery to application can be. The same is true for vaccines – for example, the relatively low uptake of the measles vaccine in our own community is little short of a scandal. Preventive medicine, public health and positive health promotion are not as 'glamorous' as acute curative medicine, but are supremely important. I have been extremely fortunate in recent years to have been asked to take up two positions that give me some leverage in these fields. As Chairman of the Victorian Health Promotion Foundation, I work with the Board and Chief Executive not only on anti-smoking strategies, but also on a wide diversity of public health efforts in fields such as cancer, heart disease, mental health, accident prevention and health of the aged, of minority groups and of the handicapped. In the international arena, I am the Chairman of the group advising the World Health Organization on vaccines. This involves thinking about how to get the common childhood vaccines to all the 150 million children born each year; how to assure supply and quality; and how to ensure adequate research into new and improved vaccines, including developments that can simplify administration schedules. As a matter of fact, Australian scientists are remarkably prominent in most of the specialised agencies of the United Nations system, particularly WHO, FAO and UNESCO.

It goes without saying that any success the Hall Institute may have had in the past thirty years depends utterly on the brilliant scientists, older and younger, doing the research. Don Metcalf is unquestionably the world's leader in molecular haematology, as is Jacques Miller in research on the thymus. Jerry Adams and Suzanne Cory jointly lead



SIR GUSTAV NOSSAL



one of the world's top programs on oncogenes. In total, we now have five Professors and two Professor/Directors within our group and all nine Unit Heads have strongly established international reputations. In fact, *directing* medical research is almost an oxymoron. All one can do is to provide the climate, the boundary conditions, within which the creativity of colleagues can flourish.

In conclusion, medical science underpins the health professions at many levels. It is my honest belief that our health system, one of the best in the world for all its faults, owes a great deal to medical academics. Weaken the universities and teaching hospitals today and you will surely weaken the whole structure tomorrow. But fortunately, Australian medical scientists are not only very good, they are also tough, resilient and well organised! The hard times being experienced currently have placed medical research firmly on the national agenda and better times will come. My forty years in the game have convinced me that it is a great way to live a life. I hope it proves to be so for a good many of the readers of *Chiron*.

G J V Nossal

Director, The Walter and Eliza Hall Institute  
of Medical Research and  
Professor of Medical Biology, The University of Melbourne.

## Vale

PETER G JONES

MBBS, FRCS, FRACS, FACS, FAAP

1922-1995

The Faculty and UMMS records with deep sadness the death of Peter G Jones. A loyal alumnus, Peter, amongst his many other activities, was the founding editor of *Chiron*.

We shall miss his elegant wit, his erudite contributions to meetings and his generosity of spirit. We extend our sympathy to his wife, Dr Julie Jones, and to his children and grandchildren.

A memoir will be published in the 1996 edition of *Chiron*.

Graeme B Ryan AC

Dean

Faculty of Medicine, Dentistry  
and Health Sciences



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

### Ordinary Members Reminder to Renew!

**Membership year**  
**1 April 1995–31 March 1996**

If you are a member of UMMS you will have been sent your renewal form recently. 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 annual UMMS Elective Essay Prizes.

### 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 MBBS (Melb) Graduates

1991 graduates – \$30

1992 graduates – \$20

1993 & 1994 graduates – \$10

### Honorary Membership No cost

The UMMS office can now accept your membership 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 Victoria 3052

Telephone (+61 3) 9344 5888

Facsimile (+61 3) 9347 7084



## SEMINAR

22 JULY 1994

### A BETTER DEATH

#### Convener

Professor Richard Smallwood  
Professor of Medicine, The University of Melbourne  
Heidelberg Repatriation Hospital

#### THE PHILOSOPHY OF DEATH AND DYING

##### The right to die?

The Rev Dr Davis McCaughey  
Professorial Associate  
Department of History  
The University of Melbourne

##### A good death?

The Rev Dr John Morgan  
Warden, St John's College  
The University of Queensland

#### DISCUSSION

#### THE CARE OF THE DYING

##### Can nothing more be done?

Dr Ruth Redpath  
Palliative Care Physician  
Monash Medical Centre and  
Dandenong Hospital

##### On the receiving end

Ms Sanchia Aranda  
Senior Lecturer, School of  
Nursing, Faculty of Health  
Sciences, La Trobe University

#### DISCUSSION

#### WHO MAKES DECISIONS ABOUT DYING?

##### The patient's role in decision making

Professor David Lanham  
Kenneth Bailey Professor of  
Law, Faculty of Law  
The University of Melbourne

##### Limits of patient autonomy

Mrs Loane Skene  
Senior Lecturer, Law School  
The University of Melbourne

#### DISCUSSION



## A BETTER DEATH

## INTRODUCTORY REMARKS

PROFESSOR RICHARD SMALLWOOD



PROF RICHARD SMALLWOOD

**T**HE MORAL, LEGAL and practical questions which surround death and dying are of vital concern to all of us. Recent public debate has tended to focus on euthanasia and many of you may have seen the recent SBS television program on the much publicised activities of Dr Jack Kevorkian in Michigan, who has assisted twenty or so patients to die.

A recent ABC Four Corners program also explored the question of assisting patients to die, and the theme which emerged in discussions

with a number of people with incapacitating or potentially terminal illnesses, was the wish to maintain some control, to have some say, at the end of life. This might include the option of considering euthanasia, if existence day by day were to become unbearable.

Not surprisingly, doctors are divided in their attitudes to euthanasia. Recently Peter Baume, whom you will remember as a former federal minister, published a survey of over twelve hundred New South Wales doctors. The main findings were that about half of those who had been asked to hasten a patient's death had complied on at least one occasion. A similar proportion felt that their professional organisation should approve of euthanasia and that the law should be changed to allow it.

The euthanasia debate has been likened, somewhat fancifully, to the debate about the republic and the flag. There are strong advocates of change and strong opponents. Many of us, I suspect, sit somewhere in the middle, apprehensive about the consequences of change while conceding that there is an undeniable logic to it. And we do not quite trust those who seem so certain in their views, either for or against.

Brendan Nelson, President of the AMA, had this to say during his Arthur E Mills Memorial oration to the College of Physicians:

There are also times in our professional lives when we will sometimes find ourselves in a situation as doctors where the administration of a drug may not seem unreasonable, at the patient's request, to end suffering. Although the community may reasonably want to change the laws that govern our response, the concepts of trust and respect that are fundamental to a doctor-patient relationship are much more likely to be governed by morality, ethics and common sense than by laws.

The danger in seeking to change the law, albeit with the best of intentions, is that we may create more problems than we seek to solve, with our present legislative imperfections. Where the law sees patients and their doctors as adversaries, inevitably the interests of the patients are not well served.

I think Brendan Nelson was articulating a view which is commonly held amongst doctors. He made a further comment:

I suggest to you that the present debate about legislation is concealing the real problems of the dying patient.

Again, an analogy with the republic debate suggests itself. There are more urgent and practical things we need to get on with.

While we grapple with the moral and legal problems of euthanasia, what can we do now to improve our care of the dying? What do we, as a community, understand about palliative care? Are our palliative care services being used to best effect? Perhaps this is the area that deserves our greatest attention.

This seminar presents three sets of two speakers each. The first two speakers tackle some of the broad philosophical and ethical questions. The next two discuss the practical care of those who are dying — focussing particularly on palliative care. Finally, we have two speakers who will bring, inevitably but quite properly, a legal flavour to the discussion.

## THE PHILOSOPHY OF DEATH AND DYING

## THE RIGHT TO DIE?

Rev Dr Davis McCaughey

**I** FIND IT not at all easy, nor indeed congenial, to discuss ethical questions in terms of rights. I want to fasten, however, on a particular objection to the phrase 'the right to die', namely that it individualises death — it distorts by concentrating attention on the individual person who is dying. Death when it occurs is not really like that. Let me try to illustrate. I offer an instance which any of the medical practitioners and others in the audience could parallel.

Almost exactly a fortnight ago today there died in England a man of 53 years of age whom I had known throughout his life. He had had a distinguished career in the Royal Air Force and had just taken up an appointment with immense responsibilities for defence with the European Community. On a brief return to England — it may have been in the middle of giving a lecture — he suffered a massive stroke, which rendered him deeply unconscious.

After the customary and appropriate medical attention, it became clear that he was not going to recover the use of his faculties. It was agreed that if the doctors were convinced that he had suffered irreparable brain damage so that brain death could be diagnosed, he should be taken off life-support systems and permitted to die peacefully. His family accepted this. Before the support systems were removed, however, his immediate family, his wife and two daughters, his mother, his brothers and sisters (for he was a member of a large family of siblings) went to the hospital, as it were, to say goodbye.



DR DAVIS MCCAUGHEY

A week later that small intimate group, supplemented by others, gathered for the funeral service: an occasion when they would grieve together, be comforted by their memories, thanksgivings and proper pride in his achievements, by their common love and hope. A month or two later, probably September, the RAF will have a service in the church in London which they customarily use on such an occasion. Then his colleagues, and indeed the nation, can express their sense of loss and gratitude for what he has been and done. For no

one concerned will life be quite the same again.

Every death has its social context — this one perhaps more dramatically so than many others. 'Naked came I from my mother's womb, and naked shall I return' cried Job. These words have sometimes been used to provide comfort to the dying, suggesting that the cycle of life is over; but in the original poem this was an expression of horror. Job had been deprived of all the things that make life rich and tolerable — possessions, wife and family — stripped naked he now stood alone.

We have our own ways of stripping people naked, in life and in death. We remove them from their homes, to be born or die in hospital — and we do not seem to care how far from home that hospital may be, only to be sure that the patient does not stay there too long (often not long enough to establish some relationship of trust with the doctors and nurses), as short as possible in order to obtain maximum financial benefit for the institution.

So modern individualism would deprive us of those relationships which make life meaningful; and talk of the right to die isolates the individual, puts him or her where they cannot be, at the single determining centre of their own deaths, a position which could never be sustained in life, which indeed denies some of the most important characteristics of their lives. John Donne writing before modern individualism gained its full force knew better:



No man is an *Iland*, intire of it selfe; every man is a peece of the *Continent*, a part of the *Maine*; if a *Clod* bee washed away by the *Sea*, *Europe* is the lesse, as well as if a *Promontorie* were, as well as if a *Mannor* of thy friends or of thine owne were; any mans death diminishes me, because I am involved in *Mankinde*.

Every culture and religion has rites wherewith it rescues the death of the individual from that ultimate loneliness; and increasingly the treatment of the dying involves the cooperation, acceptance on the part of the patient (where that is possible), the understanding on the part of the family, and the responsibility which comes from special knowledge exercised by the doctor. It may be that we have no rights either to death or to life: the state, the condition is given us. But we, as members of the human race, have some say over the manner of our living and of our dying, the doctor especially so.

*A 'right to life' is no more useful a concept than a 'right to die'. Medical ethics has no place for either slogan in its vocabulary.*

This brings me to the second part of this brief paper. I assume as accepted practice that the patient must be informed at his or her level of understanding about the nature and possible effects of treatment being offered; and the patient must be given the opportunity to consent to any experimental treatment. Moreover any patient may at any stage refuse treatment. If, however, as I have suggested, 'right to die' is not a very helpful way to summarise the fundamental recognition which we ask of the doctor in dealing with the elderly or terminally ill, is there any other principle, guidance, or presupposition with which we can ask the doctor to operate? There is, I think, but it is best stated in terms not of a rule but of what Gordon Dunstan, that prince of British moralists, calls a presumption. He uses that phrase as it is used in British criminal law – for instance, every accused man is presumed innocent unless found guilty. The burden of proof rests with those who call in question the accused's innocence.

So too every intervention by a doctor into the lives of his patients shows, or should show, a commitment to life, to the preservation, enhancement, and respect for life through better health. That is what he or she is there for: the doctor is not a neutral figure, to administer life or death on request – the doctor is on the side of life.

That, however, does not involve a commitment, in all circumstances, to preserve life at any cost. A 'right to life' is no more useful a concept than a 'right to die'. Medical ethics has no place for either slogan in its vocabulary.

There is no unqualified duty to strive to keep alive. The presumption in favour of life which normally expresses itself in treatment may properly be eroded. The doctor's duty is to heal where possible, to care for life always. What is needed by the frail elderly, for instance, in Paul Ramsey's excellent phrase, is not recourse to supposed remedies, but to comfort and company. The doctor always has available three things:

Firstly, a knowledge of the patient's physical condition superior to that of anyone else.

Secondly, with that knowledge comes awareness of how to make a distinction between ordinary and extraordinary means of treatment. This important distinction is not to be interpreted as though 'ordinary' meant what is invariably or almost invariably used to deal with this condition and 'extraordinary' what is innovative. What is ordinary is what is apt to a particular case. Confronted by a dying patient the doctor does not cease to be a reasonable being making appropriate judgments.

Thirdly, the doctor has available the principle of double effect, whereby a drug administered to relieve pain, confusion, or weakness, may also shorten the life of a terminally ill patient. This has long been recognised as morally permissible. The doctor has the knowledge and the duty to lay hold of the means available to make life as tolerable as possible for men and women as they leave it.

Ronald Dworkin, towards the end of his splendid book, *Life's Dominion*, comments that if, as is indeed often said, our lives are lived in the shadow of our deaths, it is also true that our deaths are died in the shadow of our lives. To deprive a man or woman of the dignities of life in his or her closing months or years is a cruel tyranny. Some medical regimes still seem to the outsider to be at least faintly tyrannous.

All this throws back upon the doctor immense responsibilities. But where else? To whom else would we, should we, give such responsibilities? If we have to have legislation, let it be to prevent busybodies from interfering, but let us beware of attempting to define the indefinable. If life is, as it is, complicated, let us not confuse it by introducing either of the unhelpful catch-cries, 'right to die' or 'right to life'.

In this sphere we do not as human beings have rights, only obligations and responsibilities; and the heaviest of these are carried by doctors. In fulfilling them lawyers can help you very little, and slogans not at all.

What those of you who are doctors might properly ask of us who are not members of the profession – or are members of other professions – is that we should learn again to trust you, and some of us do not find that too difficult, for we have found you trustworthy and we are happy to leave it there.

## A GOOD DEATH?

The Rev Dr John Morgan



REV DR JOHN MORGAN

THAT REPOSITORY of fine 17th century prose *The Book Of Common Prayer* of the Church of England contains a service – The Litany – an extremely moving set of short petitions. One of the petitions of The Litany is 'From lightning and tempest; from plague, pestilence and famine; from battle and murder, and from sudden death . . . Good Lord deliver us'.

The reasons why one would want to be delivered from a sudden death in particular are a reflection of what was understood in the sixteenth and

seventeenth centuries to occur at death. It was the passage of a human from this world of travail to a better existence, hopefully to move towards God, and to embark upon this one should be properly prepared. The dying individual ought to have set their worldly affairs in order, received the proper spiritual preparation, including, if necessary, a full confession of sins and then received a blessing for the journey. This is, in fact, provided for in another service of the Prayer Book, The Visitation of the Sick, where the sick person is directed to set their worldly affairs in order, including the making of a will.

A similar ritual is found in the way in which the sacrament of Unction developed within the Roman Catholic Church. Originally intended as a set of prayers for the sick, together with the act of anointing, it changed to a form of sending off the sick person to their grave, that is, an act of 'extreme unction'.

For the citizen of past Western society, death was not something which was feared. It was the great leveller, the point at which one was stripped of all earthly accomplishments and pretensions. A similar view is found in the ancient Mesopotamian collection of texts which we know as the *Epic of Gilgamesh*, but here it is without any hope of a possible post-death state of existence.

The dwelling place of the dead is described as 'the house of darkness . . . the house whose occupants are bereft of light; where dust is their food and clay their sustenance'. So the *Epic* has an approach to the present life conditioned by the understanding of what happens at death, which is akin to an 'eat, drink and be merry' philosophy. The young seeker of eternal life is offered the following advice by Suduri the wine maiden:



*Gilgamesh, whither runnest thou?  
The life which thou seekest thou will not find,  
[For] when the Gods created mankind,  
They allotted death to mankind,  
[But] life they retained in their keeping.  
Thou, O Gilgamesh, let thy belly be full:  
Day and night be thou merry;  
Make every day a day of rejoicing.  
Day and night do thou dance and play.*  
(Heidel 1949: 70)

And so too in other ancient cultures, the Egyptian, the Taoist, or the Homeric Greek. In each of these a certain attitude towards death grew out of the world view. Ultimately belief, ethos and ritual reinforce each other. The attitudes that one has about death arise in part from what one believes about life itself and the unifying or directing powers of life (Stannard 1977: 8-11).

We live nowadays in a culture which in large part seeks to deny death while being fascinated by it. Consider the best seller status of books by Elizabeth Kubler Ross, Derek Humphry's *Final Exit*, and now, Sherwin Nuland's *How We Die* – and the spate of books on near-death experiences. This contrasts with periods during which death was feared by some because of the possibility of damnation and separation (while at the same time, it provided a gate to life immortal), and with the nineteenth century approach, in which death was viewed as a positive removal to a better world in which reunion with loved ones would take place. But in either case, death was a frequent occurrence within the setting of home and family.

For most people living in our contemporary culture, death is something which happens to others. It generally occurs in some kind of institution and only affects us when it is the death of someone close to us.

The locale of death has increasingly become the hospital, not the home of the dying person, and it often takes place with the whole panoply of the medical armamentarium deployed in some last ditch efforts to avert it. This may well represent an aspect of what Ernest Becker has described as 'the repression' which takes care of the complex symbol of death for most people (Becker 1973: 20).

In other words, the medicalisation of death also represents an aspect of our avoidance of it. The French writer Philippe Aries calls it 'invisible death' (Aries 1981: 469-501). The American ethicist, William F May, has written of the contemporary ambivalence towards death which arises from our inability to give meaning to it:

Our strategies and our rites are evasive, not because Americans react to death as trivial or incidental, but because they feel an inner sense of bankruptcy before it. Attempts at evasion and concealment are pathetic rather than casual . . . [and] reflect a culture in which men sense their own poverty before the event . . . Men are tempted simultaneously to conceal death and to hold themselves enthralled before it, because they recognise death as an overmastering power before which other responses seem unavailing (May 1972: 469, 470-1).

These cultural factors serve to give some kind of setting to the problem which we have when we try to ask 'what is a good death?' The more basic question, however, might be, what is ever 'good' about death? On the other hand there is the acceptance of death which is

*If it can be argued that  
autonomy is the chief value in  
contemporary medical ethics,  
then to actually choose most  
aspects of how, when and  
where we shall die is to  
exercise autonomy in the  
fullest and most radical of  
ways.*

gaining ground amongst some in our culture – it is represented perhaps in the desire for the 'quick fix' via the methods advocated by Dr Kevorkian and the Hemlock Society, in which the individual either alone, or with the aid of a 'euthanologist', is able to choose the time, and to a degree, the manner of his or her death.

If it can be argued that autonomy is the chief value in contemporary medical ethics, then to actually choose most aspects of how, when and where we shall die is to exercise autonomy in the fullest and most radical of ways. This in some sense is a rejection of the medicalisation of death – to take it back from the control of the medical profession and return it to the person who is dying.

But in this there is much that I see as a wrong-headed approach to death. It is partly the desire for removal from a world of psychic difficulty, a world devoid of meaning – not the medieval contempt for the world of the flesh against the hoped for joy of heaven – which has made some people in our culture exalt death.

The danger is that our denial of death makes us actually move towards death as a final release, a surrender to nothingness, and it does give cause for wonder if many in our secularised order do not long for some certainty other than simple physical and mental release from pain and suffering. The point is that death viewed in this way – as that which can be obtained by one's own volition – becomes another item to be acquired in our consumer society. And similarly we seem to want to dispose of our dead as quickly as possible and then find ourselves mourning without sufficient support from our culture.

The incidence of suicide, and particularly youth suicide, in Australia, is especially pronounced at present, as other causes of death decline in relative occurrence, and that is precisely where the deeply misguided attempts of Derek Humphry and the Hemlock Society to help very sick people make their 'Final Exit' by their own efforts are so pernicious.

Fortunately we have got away from seeking to punish people who have sought and failed to take their own life, but to publish such material and to make it freely available is irresponsible. Too many young people troubled by the difficulties of adolescence may well be tempted by such information which, in its way, perhaps not only destigmatises suicide but almost glorifies it.

The rejection of life, even before life has been fully lived and experienced, is becoming all too commonplace. It results in large part from what the sociologist Durkheim called *anomie*, when the individual finds life for one reason or another devoid of meaning and purpose, or sometimes simply too much to comprehend. The novelist Thomas Hardy depicted some aspects of this phenomenon in his last novel, *Jude The Obscure*, which tells of the ill-fated relationship between Jude Fawley and his cousin Sue Bridehead. Jude and Susan discover the lifeless bodies of their children, the younger ones hanged by the eldest who has then taken his own life. The son Jude leaves a note saying, 'Done because we are too menny'. Sue blames herself because she had talked with young Jude about her pregnancy and the burden that an additional child would impose. The older Jude replies:

No . . . it was in his nature to do it. The doctor says there are such boys springing up amongst us – boys of a sort unknown in the last generation – the outcome of new views of life. They seem to see all its tensions before they are old enough to resist them. He says it is the beginning of the coming universal wish not to live (Hardy 1935: 402).

This suggests in part what I want to say about death and particularly its setting within contemporary medicine. Depersonalisation and meaninglessness threaten the preciousness, the sanctity, with which human life has been invested within western society and which has helped to hold society together.

The sociologist Edward Shils has suggested that even though the religious underpinnings of this have become attenuated, we need to hold to the belief for its own sake. We need, he also suggests, to rediscover what gave traditional Western religion its persuasive power and led to a prior and impelling belief in the sanctity of (human) life and personality (Shils 1968: 38).

In this light the radical technologisation of death – either by needlessly prolonging life via sophisticated medicine, or by rushing to leave it with medical aid – is an abuse of both technology and medicine and threatens a view of life seen as human flourishing informed by hope.



The business of medicine is to assist where possible in human flourishing – to relieve suffering and to save life – within the bounds of the physician's covenant. Generally the suffering which is caused by extreme pain can be coped with. The hospice movement has done much to show what can be done and how an acceptable quality of life while dying can be achieved. Often hospice methods can be translated into the home setting and this trend is increasing, thus allowing people to die without the feeling of being abandoned.

There are those hard cases where pain cannot be coped with or alleviated and where people are threatened with dehumanisation as a result. In such cases the subtle relationship between doctor and patient comes into play, but the maxim 'hard cases make bad laws' warns us against embracing any kind of active euthanasia policy.

The abandonment of pointless medical intervention, particularly at a patient's behest or previously expressed desires, is now both approved and permitted in many jurisdictions in Australia, but in these there is no mandate for any abandonment of treatment of a patient unless the relevant medical indications are present. However, this approach of knowing how and when to let go and give palliative care only, needs to be extended throughout Australia, as does its legal authorisation.

The care of the dying, which involves care and not last-ditch medicine or simply abandonment, was aptly expressed by the American medical ethicist, Sissela Bok, in a piece which she wrote for *The New England Journal of Medicine*:

*I wish to live a full and long life, but not at all costs. If my death is near and cannot be avoided, and if I have lost the ability to interrelate with others and have no reasonable chance of regaining this ability and if my suffering is intense and irreversible, I do not want my life to be prolonged . . . I would then ask not to be subjected to surgery or resuscitation. Nor would I then wish to have life support from mechanical ventilators, intensive care services, or other life prolonging procedures, including the administration of antibiotics and other blood products. I would wish rather to have care which gives comfort and support, which facilitates my interaction with others to the extent that this is possible, and which brings peace (Bok 1976: 369).*

This is, of course, close to what was understood originally by euthanasia – a good or happy death. But until we have a reasonable conviction of what constitutes a good life and value life properly, seeing it as a basic, but not absolute good, we shall not understand fully what a good death can mean.

For many people there is little chance of 'death with dignity' given that we live much longer and that most of us die in different ways and from different diseases than our forebears. Sherwin Nuland's eloquent plea for the resurrection of the family doctor – someone who knows us as well as they know the pathways by which we can approach death – might, if realised, give us true 'aid in dying' (Nuland 1994: 266-269).

Perhaps The Litany really had it right. A good death comes from a life that is prepared for death, so that it does not catch us either in an unprepared spiritual state (whatever that means for us), or with our everyday lives unordered: *ars moriendi* is *ars vivendi* – the art of dying is the art of living.

## References

- Aries, Philippe, *The Hour of Our Death*, Alfred A Knopf, New York 1981.  
 Becker, Ernest, *The Denial of Death*, The Free Press, New York 1973.  
 Bok, Sissela, 'Personal directions for Care at the End of Life', *New England Journal of Medicine*, 295, 1976.  
 Hardy, Thomas, *Jude The Obscure*, Cottage Library Edition, Macmillan, London 1935.  
 Heidel, Alexander, *The Gilgamesh Epic and the Old Testament Parallels*, University of Chicago Press, Chicago 1949.  
 May, William F, 'The Sacral Power of Death in Contemporary Experience', *Social Research*, 39 (Autumn 1972).  
 Nuland, Sherwin B, *How We Die*, Alfred A Knopf, New York 1994.  
 Shils, Edward, 'The Sanctity of Life', in, ed Daniel H Labby, *Life or Death: Ethics and Options* University of Washington Press, Seattle 1968.  
 Stannard, David, *The Puritan Way of Death*, Oxford University Press, New York 1977.

## DISCUSSION



### The philosophy of death and dying

**Professor Smallwood [to Dr Morgan]:** If we seem to have gone culturally off the rails and are not facing death reasonably, either at the end of a long life or earlier, how are we going to change this?

**Dr Morgan:** . . . We are seeking to articulate a philosophy of death and dying that is not just simply an avoidance of it . . . There [has been] an individualisation of death . . . that death belongs to the person, but now the individualisation, as I see it, has become a lonely one, relatively unsupported and we are seeking to do something about that through the work of things like the hospice and palliative care movements . . .

**Q: Dr McCaughey,** when you say that if we have to have laws, let them be to prevent busybodies from interfering, who are the busybodies and what do you mean?

**Dr McCaughey:** . . . The doctor-patient relationship must not be subject to pressure groups which come in with ideological views about how patients can express themselves . . . There's a place for legislation but it is not to define in detail how the doctor-patient relationship is to be resolved when case after case comes up in its own individual and acute way . . . There is a grave danger once you take this to legislation [that] pressure groups of various kinds [will] get to work on the political process . . .

**Q: Dr Morgan,** do you feel multicultural influences are having some effect on the way that we're viewing death in this country?

**Dr Morgan:** . . . Our multicultural society consists of a plurality of communities, not a single community . . . Communities or particular sub-groups within the broader Australian society . . . have different strategies for coping with [death] . . . Compare the lavish funeral monumentary of certain cultural groups in our society, the regular visits that are made to the cemetery by them, against the fairly antiseptic crematoria disposal which the majority are starting to practise . . . I don't think any single pattern will emerge [from the influence of other cultures].

## THE CARE OF THE DYING

### CAN NOTHING MORE BE DONE?

**Dr Ruth Redpath**



DR RUTH REDPATH

**T**HERE IS PROBABLY nothing more devastating or overwhelming than to be told that we have, or someone near and dear has, an irreversible and progressive illness with a short life expectancy, for which 'nothing can be done'. This news may come after a long series of ups and downs, remissions and relapses, and a whole series of procedures. Or it may come suddenly out of a relatively clear sky.

In such circumstances we react in different ways according to a host of factors which may include –

- the nature of the disease process and how it is affecting us;
- our learned individual patterns of response to bad news;
- our cultural background;
- our experience of others who have faced similar situations;



*From such experience (mostly but not exclusively with cancer) it is impossible to escape the impression that many feel abandoned by the medical profession.*

- the strength of our supporting relationships;
- our system of belief.

Our reaction may also be affected significantly by the way in which we are told the dread facts or the lack of any offer of continuing assistance.

In my work, I have talked to many hundreds of people in this situation – in the wards and outpatient departments of our cancer centres and teaching hospitals, in district hospitals and in the privacy of their own homes. From such experience (mostly but not exclusively with cancer) it is impossible to escape the impression that many feel abandoned by the medical profession. Later, I will suggest some reasons for this problem. But the sense of isolation as the person adjusts to their new reality may be profound.

Of course, it has to be said that adjustment at this point is a very lonely experience – it affects the individual at the very heart of his/her being – and we cannot pretend to be able to take that pain away.

But there is still a place for the assistance of others, both within the person's own support network and professionally. The focus of medical attention is likely to shift away from the pathophysiology of disease and from procedures and operations to a more holistic view of the person within this new illness context, and their needs as they face deterioration and death.

### **What needs are they likely to have?**

*They will have physical needs* – the need for increasing physical assistance as their strength declines:

- There will be the specific problems associated with their condition – maybe pain which needs detailed assessment, and the implementation of appropriate medication or other strategies.
- A variety of other symptoms may be troublesome. And often there is concern about declining appetite and food and fluid intake.

*They will have emotional needs* as they face the large changes that their world is undergoing:

- They have been given a death sentence and they are numb, they 'can't believe it'. Lying awake for hours at night, with confused emotions by day, angry and tearful, euphoric and hopeful, pessimistic and despairing, as they begin to adjust to what they have been told.
- They are likely to be very frightened as they face the unknown. They will be contemplating the effect their illness and its fatal outcome is likely to have on partner and parents, on small children and teenagers, on estranged family members.
- They face loss of their employment, and their sense of personal identity and body image will change, as may their role within the family circle.

*There will be practical issues* – their physical care – maintaining and maximising their independence as long as possible, questions about where their care should be given (home or hospice), financial issues and the maintenance of some normality in the household.

All this physical/emotional/social/practical upheaval is occurring in an individual with a unique *spiritual frame of reference* which may also be called into question:

- Whether or not the person is overtly 'religious', when facing death, fundamental issues about the meaning of life and of suffering, guilt about the past, questions about the life beyond can surface powerfully.
- The person can be surprised, even appalled at the strength of the anger and other emotions which threaten their supposed spiritual equilibrium.

The person with the illness is *part of a circle of family and friends*. The interaction of the distress which they, too, are experiencing as they learn the bad news, watch helplessly the physical deterioration, and anticipate more pain and suffering, can be an additional burden for the sick one:

- Add to this *their* grief that someone dear is going to die; the change of roles *they* are experiencing, the additional financial and practical pressures the illness is imposing and there can be a scenario of comprehensive distress.

Granted that the dying person and the other significant people in their lives are likely to have such wide-ranging needs –

### **What can be done to meet those needs so that they have 'a better death'?**

The rapid advances of modern medicine seem to have made it increasingly difficult for health care workers to deal with the apparent failures of that science.

Modern medical practice, one can argue, quite rightly focuses on cure and does this by rigorous investigation of the disease process and interventions to relieve this – the biomedical model. But when current medical knowledge can provide no further answer (as is the case eventually with about 60 per cent of us who get cancer) the biomedical model is no longer adequate. It is not just that the body is being taken over by a disease. The whole person is caught up in the experience of illness – thus the dilemma: *The biomedical model is too narrow; the individual is too complex.*

It is only in the past twenty-five years or so in the Western world generally (and for about fifteen years in Australia) that there has been a specific response to this dilemma in the development of health services which focus on the needs of the dying. Such are called hospice or palliative care services.

The lay public has had a significant contribution in these developments and they have been able to harness a body of medical knowledge whose most famous exponent would have to be Dame Cicely Saunders. First as a nurse in a London Teaching Hospital and then as a social worker, she recognised the untreated pain and other symptoms which the dying were experiencing. She also recognised the sense of isolation which they felt when staff avoided conversation and the consultant did not come near them on his regular ward rounds. She became a mature-age medical student and, immediately on graduation, went to research the appropriate use of analgesics in cancer pain.

We owe much to Dame Cicely Saunders and to those who have followed for dispelling many of the myths about the use of morphine, and for enhancing our ability to control severe pain in more than 95 per cent of cases while also making a significant impression on many other symptoms and aspects of the person's distress.

The current palliative care services operating in most of our larger hospitals, in our inpatient hospices such as Bethlehem and Caritas Christi, as well as in a larger number of community-based services assisting in the care of the dying at home, are not just pain services, or symptom control teams, or nursing agencies. Rather, they operate within a philosophy which acknowledges the complex interaction of physical, emotional, spiritual and social factors when someone is dying, *and* the fact that the person and their close family and friends are the central and important players.

This is where teamwork comes in. None of us can claim to be able to assess, or attempt to alleviate, all the problems which may be operative. Doctors, be they hospital staff or family practitioners, need to be able to value the skills of, and work collaboratively with, nurses, counsellors, social workers, chaplains and pastoral care workers and even suitably trained lay volunteers.

The person and their wishes are paramount. When they learn what service is being offered they may choose to reject it – they and their family may feel they have the resources to handle the situation or it may be too confronting for them to accept this assistance immediately, with its implication of an irreversible illness.

However, I must insert here, that, contrary to some people's notion, we do not talk about death and dying every time we get to the bedside. Indeed such conversations are *not* frequent, and are usually initiated by the person themselves and often at the most unexpected moments.

And that raises another issue. One of the greatest needs of these people is for time – and not just the passage of time – as they adjust to what is happening. Health care workers (and their administrators)



who take on the care of the dying have to allow flexibility in the work schedule to accommodate unexpected changes in the physical condition of the person from day to day, as well as the unexpected ways in which significant conversations or new concerns arise. A task orientation or a rigid appointment system is unlikely to recognise, let alone meet, these needs.

Says Sheila Cassidy, an English palliative care physician, in her book *Sharing the Darkness*:

If I as a doctor, spend an hour of my clinic time talking to a woman who has only a few weeks to live, I am making a clear statement of her worth. I am affirming the worth of one individual person in a world in which the individual is at risk of being submerged or valued only for (their) strength, intellect or beauty. It is a statement about the unique value of the human person, irrespective of age, social class, or productivity.

I find it is a sad reflection on current practice that it is a common experience for palliative care physicians seeing a patient, to have them describe their symptoms in detail, listen carefully, assess the problem, explain the likely cause and suggest ways to alleviate it, and then hear the person say: 'You are the first person who has listened to me like that and explained what is actually happening in a way that makes sense'.

This brings me back to the point which I made at the beginning about the sense of abandonment which many feel when they learn that cure, or even remission is no longer possible. Sometimes it is related to the way in which they are told. I have heard many stories of people being given such news over the telephone, or when standing in a crowded waiting room, or lying in a hospital ward in full hearing of the other occupants and their visitors.

Not just the setting but the chosen words may not be helpful. Some doctors are very blunt in their communication. (Though some actually prefer it that way, others find it too hurtful.) The information may be very technical and convoluted and poorly understood. The words may be so vague that the real message is not conveyed at all.

I have often had nurses say to me, of specialist doctors, words to this effect – 'He said he told them, but I was there and he didn't'.

If ever there was a time for honest, clear and gentle communication it is in these circumstances. And not just when the news is first broken – most people absorb little if any detail in such an encounter – but in an ongoing way as the truth dawns, questions formulate and fear of the unknown future surfaces.

It is sometimes extremely difficult for people and their families (or their doctors) to obtain accurate information about the present situation of their disease process, so that they may make informed choices about the options offered and so that they may have better understanding of why they are having particular physical problems. Lack of information also makes it difficult to predict the likely course of the illness, not just in duration (and we all know how unwise it is to be too precise about the prognosis), but in the problems likely to be encountered.

Most people want to know these things, finding such information reassuring, rather than provocative of more anxiety, *so long* as it is accompanied by the knowledge that continuing help is available from people who understand, twenty-four hours a day.

We may need to act as advocates for such people when information is difficult to obtain – recognising that in their physical and emotional vulnerability it may be very difficult for them to assert themselves sufficiently to be successful in their quest. Having said that, we must also respect the person's individual wishes as to how much information they want. In this regard there is wide variation in cultural groups.

Several times I have implied that care of the dying can be less than optimal. In these last few minutes, I would like to suggest some of the barriers which I believe work against the best care, as well as what is being done or could be done to improve matters. I am sure most people here will have personal stories of relatives or friends who have encountered the kind of problems I will mention.

For want of better words, I would head the first group 'administrative barriers' and I would call the second group 'knowledge and skills barriers'.

## Administrative barriers

With the highly specialised nature of medical practice, a person may be under the care of several different specialists simultaneously, each focussing on a different aspect of their problem. In these circumstances it is often difficult to get an agreed and cohesive plan for overall care.

These situations are not easy to resolve, even for the doctors involved, and it may be difficult to arrange a case conference of all the players. The patient may find the process confusing and too exhausting to contemplate. It is frequently the case that they are not sure who is in charge of the decision-making and to whom they or their family should address the question as to where their care is heading.

It is also made more complicated when the person has been referred to a multidisciplinary clinic rather than to an individual specialist. They may be seen by a different doctor at each clinic visit – where unintentionally confusing information may be conveyed.

In these cases general practitioners are often frustrated in their desire to take a leadership role by the lack of communication from, or between the various specialists involved. In these days of quality assurance, there must be ways for hospital patient care committees to establish protocols for clarifying responsibility for the individual patient and for communications with their GPs.

## Knowledge and skills barriers

Until the past five years or so, medical students in Victoria were not having regular, identifiable education in the care of the dying, not even the most basic tuition in symptom control, especially pain control as it applies to the terminally ill. (An older generation of doctors may never have been exposed to the modern usage of morphine and still practice as if the old myths had not been dispelled.)

This lack of education is now being rectified. It is pleasing to meet interns and other HMOs who have had such a basic course as students, as they begin to look after these patients in the wards. One can see their confidence growing as they learn, under supervision, to assess and treat the symptoms of those who are dying, as well as to talk with them about broader aspects of their illness, its likely course and related issues. But it is very difficult to maintain that compassionate and detailed approach in the culture of a busy ward in an acute hospital.

Sadly, the *human* factors seem to undermine some of the best educational endeavours. As Professor David Allbrook said in a recent article, doctors are programmed into 'busyness' from their intern years, which can lead to fatigue and loneliness and lack of opportunity (and then inability) to acknowledge one's true feelings in the face of frequent encounters with suffering. This commonly leads to 'distancing' – the perceived inability to engage the emotional and spiritual issues which the presence of the dying expose. Says Sheila Cassidy again: 'We isolate our dying on the pretext that they want peace – when the reality is that their presence disturbs our sense of omnipotence and immortality'.

This programming can also lead to a retreat into the busyness of keeping on 'doing' something, even when rigorous scientific assessment (such as we would apply in other arenas) would give objective evidence of the futility of what we are doing.

So, again, in our education programs we endeavour to address not just the knowledge and skills base of our medical trainees, but also attitudinal matters. Using role play, case studies and video clips, we try to help them confront their own emotions and values as they learn about communication in the care of the dying, the responses to suffering and death of different races and faiths, and some self-care strategies to equip them a little better to cope as they establish patterns of response to illness in their intern years.

In summary (and speaking of doctors), what we want to convey is – to quote Professor Allbrook again – 'If they are ready to admit that they are not omniscient and not invulnerable, they can find extraordinary relief from the daily burden of coping' and that 'when someone has an incurable illness, they can be cared for in a compassionate, dignified and professional way without additional distress other than what their fading life naturally already brings'.





MS SANCHIA ARANDA

**M**Y ROLE HERE TODAY is to bring some insights into what it might be like to be dying and cared for by a palliative care team. The insights I share stem from a qualitative evaluation conducted within a domiciliary palliative care service in metropolitan Melbourne during 1992 and 1993. The study sought to explore the degree to which the philosophy of palliative care was lived out in the experiences of the clients and care givers receiving the service. For the purposes of this paper 'client' refers

to the sick person and 'care giver' to the person primarily responsible for their day to day care at home, normally a spouse. As it is not possible to report the entire study here I will confine my remarks to three main areas:

- the nature of the professional's relationship with clients and care givers;
- what palliative care meant and made possible;
- involvement of clients in decisions about care.

### The nature of the professional relationship

One of the key features of the client and care giver's experience of palliative care in this evaluative study was the sense portrayed that these professionals were valued friends and allies. Friendship was often mentioned as illustrating the nature of the relationship, as was the notion that the professional was in some way involved with the family in the acting out of the realities that the dying of a family member brings to life. For example:

- *Very compassionate, they were more friends, I think, than just coming, doing what they had to and leaving. They really got involved with the family and even asked us how we are going, how Dad is going. They got involved with the whole family rather than just the patient.*
- *I think it is the way they are doing it (care). They are as family. It is not like it is a stranger coming in the house, because we were like a family when they came here. If we cried they talked to us. They tried to tell us what we can expect and if we are happy they are happy, if we are crying they are like family. . . once you know them from the start . . . it's not just when you know them.*

There was a sense from the participants in the evaluation that the relationship that developed was one of openness and that the palliative care staff were welcomed into the family as friends rather than as professionals. Physical care may have been the first reason why the service was called in, such as to manage pain and other symptoms, but the care rapidly extended to a more social relationship that centred on the dying as a person not a disease. For many clients their worlds had contracted to a point where the daily visits from the palliative care staff were the only outside contact. The general social nature of the relationship was expressed through the following examples:

- *I think (it was) the personal interest . . . and they knew he had cancer. They knew he was going to die as much as I knew but I think they never gave him that feeling because they would talk and they (would) discuss with him the game (cricket). They were always interested in him as a person, they were not all doom and gloom . . . it was the positive way they talked to him – and talking to him and making him cheerful they gave me hope.*
- *. . . it became the highlight of my husband's day (the visit). After discussions of teaching the wife to change the syringes on the morphine pump: My husband said to me, "But they come and talk to me", and he became very upset when they said (to me) this is how they did it. I can understand their part of it. If I learn how to do it (I have to do it on Saturday and Sunday) it would save them time when they could look after some other patient . . . The morphine was important but a personal visit did a lot more . . . I said, "You are scared that I don't know (how to change the syringe)". He said,*

*"No, but they come and they are so cheerful and they talk to you and they make your day for you".*

What these examples highlight for me is the very different experiences many of our clients must have had to make such visits so significant to them. Many report being abandoned by friends and negative treatment in hospitals where they feel less than human and more a disease. The palliative care staff reaffirmed their importance as people and carried out a professional role from the stance of personal involvement in the importance of each client and family.

The importance of a friend to act on their behalf, often mediating between them and the health care team, cannot be understated here. Often the despair that families and clients have when facing terminal illness stems from a sense of uselessness, powerlessness and lack of control over their circumstances. Despair can also be related to a fear of what is to come and whether they will be abandoned by their professional carers at that time. The palliative care staff portrayed personal involvement and this led to a sense of trust in them that made the client and family feel safe at home: there was someone out there who cared about them, was skilled enough to help them and would be there when needed. These three constants were emphasised again and again in the stories recounted throughout the research.

One interesting difference found in the study concerned the experiences recounted by several of the non-English speaking participants. In these cases the acceptance of care from the palliative care team stemmed only from physical need and the relationship was kept on a more direct professional basis. The need to keep the experience within the confines of the family and to not have others intrude was apparent. While these differences could in some ways be explained by language barriers, they are at least in part due to culturally defined ways of dealing with death. For example, bereavement support was seen by several of the Italian and Greek families as making you relive pain that you would rather not express and that should be kept within the family, whereas the availability of a venue to express feelings was valued by other participants. This tentative finding is certainly worthy of further research as it has many implications for service delivery.

### What palliative care meant and made possible

Many of the stories relayed by participants in the study gave a glimpse of what the service made possible for the recipients. For many, care givers in particular, the involvement of the service made possible and supported their decision to care for the dying person at home. It is all very well to suggest that all people have the right to be cared for at home but the practicalities of doing so without some level of professional support are many. As one care giver said about the service:

*It was the difference between him being able to come home and not coming home. I think because of it, it gave him the mental peace, the knowing that we had someone to care for us, the professional care that we had and it gave him that and it gave me too. It gave us all this, so it wasn't just the professional care, it was the knowing this back-up was there.*

The theme of the back-up role of the service was a commonly recurring one throughout the research and reinforced my belief that many care givers feel unsure about their ability to provide a suitable

*Is it any wonder that calls for legislation of euthanasia get such support when many clients must feel that this is their only opportunity to exercise some control over their situation?*



standard of care to their loved family member. The following examples illustrate some recurring meanings that were ascribed to the support received:

#### Courage

*... they gave me just the courage and it is something that I never expected and if it was not for them I would find it very hard, I would find it difficult to manage.*

#### Guidance

*I felt that I was able to lean on them and they knew what they were doing and they were able to guide me even in that short time.*

#### Confidence

*I think just to have that back-up, it just gives me the confidence of doing things because you are not always sure about things and you've got to work out the mother-daughter relationship ... to work out how far to push.*

#### Reassurance

*Being there. Reassuring me, talking to me, telling me what's going to happen, telling me what to look for ... knowing that it would bug you that he was dying ... just consoling me and helping me.*

#### Support

*... knowing that you are not on your own, that you have the support if you need it ... the sisters come and do the medication that had to be done and they are there to wash Mrs R if she needs to be or help with, if she's having trouble with her bowel, and help her with enemas and different pieces of medication if she needs it.*

The following two quotes from participants illustrate the importance of the service to many care givers because of what they saw as having been made possible by it:

- I would have hated for her to be lying in hospital now, we don't leave her on her own much and I sleep beside her at night and if she stirs I'm there. I would have said take her off and let her die in hospital. It's been good having the support to be able to keep her at home.*
- I wouldn't have had what I had at the end if he'd been in hospital. I went in (to their bedroom) and put my arm under his head and kissed him on the forehead. My son was holding his hand and the daughter-in-law was by his side and this coming from a man who has never said it before except when we were married, he turned to me and said I love you, I wouldn't have got that in a hospital, would I!*

Despite the positive experiences of all of the participants, not all had been willing to have the service initially, and it is a testimony to the staff that this resistance was overcome in a way that engaged the clients' full involvement and support. The service provided a wide range of skilled activity to clients that one summed up by saying, 'It was just like having a hospice in your home', as if that had not been the intention. However, the possibilities raised by home-based palliative services are not something that anyone can really understand in anticipation and this was clear from the participants' reactions to questions such as were asked about their expectations of the service. Very few had expectations and few had been informed before referral about the nature of the palliative care service, an issue I will return to later.

### Involvement of clients in decisions about care

The soul of the hospice/palliative care movement rests on the premise that clients are the centre of the care team and involved fully in decisions about their care. Such decisions commonly centre around where to die and treatment. All of the staff interviewed for the study identified client direction of care as an key component of palliative care and one to which they personally ascribed. Evidence that clients and care givers were involved in decisions concerning daily care was commonly found in the stories gained throughout the evaluation. For example:

- ... they enquire as to my wife's condition, what I would like as far as their service is concerned and they comply with just what I want and I'm quite happy with what they offer and what they do. Well firstly they asked me what (her) condition is, what I would like, and when I say that I would like my wife to be washed, (or) if I say I don't want them to wash her because she may be asleep and I want her to stay in that condition, they'll comply.*

- Well they came, they actually wanted to come every day to help Mum to wash him, to clean him, to turn him, whatever, they would come everyday but Mum and I decided not to have them come every day because there was two of us ... we didn't know how they would work out but they were really nice.*

Decision making was usually a negotiated process involving the client, care giver and the palliative care team rather than the individualised process it is commonly portrayed as in the literature. The notion of an autonomous individual dying in complete compliance with his/her own desires is almost laughable in the context of palliative care, particularly in the home. Firstly, the client is usually dependent on the goodwill of family and friends for home care to be possible in the first place. Any decisions therefore need to take into account the experience of the care givers as well as the client and is often a compromise between the needs of each, these needs and desires often coinciding.

Secondly, the person is dying within the context of long-established relationships and patterns of decision making: a wife who has always deferred to the wants of her husband is unlikely to start asserting her own needs at the time of her dying. The role of the care team is not to directly challenge the social circumstances of a woman who has lived this way. At times they may be called upon to renegotiate such patterns of decision making – and what skill that entails.

Thirdly, while it is the person who is dying, the experience of death affects all concerned. The delivery of palliative care professes to be family centred and therefore the decision making of one individual can rarely take precedence over the needs of all involved. The negotiation of decisions to meet the needs of all concerned is an important component of care delivery.

One of the key decision-making issues to arise out of the evaluation did not concern the day-to-day provision of care but rather the decision for the palliative care team to be involved in the first place. Palliative care and hospice philosophy rests on an assumption that care is delivered in a context of open disclosure to a client who is aware of what is happening to him or her and who is involved in decisions surrounding the change in treatment goals if such a process has been negotiated. It became clear from the evaluation that such involvement in the decision to receive hospice and palliative care services was the exception rather than the rule and that such care did not necessarily mark a clear change in care direction.

Participants in the evaluation were all asked about the way they had come to be receiving palliative care. While the majority of the participants could identify a specific referral source, several were completely unaware of how they came to be receiving palliative care services. The following illustrates their experiences:

- All of a sudden one of the girls started showing up and just having a bit of a natter and that's about it.*
- I don't know how they got to know, let's say about my husband ... I don't know. Not the hospital. My daughter, she told me. Maybe her ... she must have talked to somebody.*
- Well as far as I can remember it was when I was at X (hospital) and I decided that the institutions weren't for me and I came home ... yes, they must have organised it and they expected me just to be home for the weekend.*

The final example is indicative of the vagueness with which many of those able to identify a referral source remembered their involvement in the decision. Decision-making power most often resided with a health professional as illustrated by the following:

- Well apparently one of the doctors from the X hospital contacted them because (they) contacted me direct. But unfortunately it was only about three or four weeks before Ruby died. I wish I'd known about them much earlier because they were really wonderful.*
- So he (doctor) organised with one of the nurses there to take charge and all of us were put in her hands.*
- A bereaved volunteer said: When I went in and told (boss) that they were referring us to (hospice home care) and she said you don't need anything like that, she said, 'He is not that bad yet'. And I said I didn't even know what it is, let alone whether I need it or not and she said, 'I don't really feel he needs it. I can come around and do whatever is necessary'. But he felt that was what the doctor recommended so he went along with that and he wasn't sorry that he did.*



Not only were the recipients of the service uninvolved in the decision to receive the service, many also had little idea of what the service was about, shattering the image of client and professional sharing a vision of enlightened care of the dying. For example:

- *I had no idea what it was, it was just a name to me and I didn't have a clue what it meant, what they did or anything. I'm well aware of it now.*
- *I don't know what I expected . . . I thought what nursing will be need because as far as I was concerned, he was still walking, very weak. No, I didn't know what this nursing service was, what they were going to do. I didn't have a clue.*
- *Well I didn't find out about it. I was notified from the X hospital when I left after a serious cancer operation that nurses would call twice a week to see me. Which they have regularly since I came home from hospital at the end of December.*

One can only begin to imagine from these examples the discussions surrounding the referral to palliative care that took place with the client and family prior to discharge. While it is possible to blame the ravages of illness for a lack of memory on the client's behalf for not remembering who referred them to the service, at least something about the nature of the service would be remembered if full involvement had been the characteristic of the decision. Additionally, the frequent reference to the service as a nursing service that characterised the responses at interview reinforced my belief that little discussion of the nature of palliative care took place between the referral source and the client or family.

It is clear from the referral information gained through this evaluation that a closer relationship needs to be established between acute hospital services and the palliative care community. The full participation of clients and their care givers in decisions about their future care is essential if our health care service is to respond adequately to the growing consumer movement in society at large. Is it any wonder that calls for legalisation of euthanasia get such support when many clients must feel that this is their only opportunity to exercise some control over their situation?

In summary, the evaluation is reported here from the perspective of the clients and care givers who participated. Domiciliary palliative care services offer a user-friendly delivery style that enhances the choices made by the dying and their families to be cared for at home and supports the rapidly reducing availability of hospital beds for the terminally ill. Such services not only provide professional physical care but offer a friendly style of support to those forced by circumstance to undertake health care roles that they fear may be more than they can manage. Palliative care in this evaluation seemed to allow opportunities for rejoicing in the joy of life by a lifting of some of the burden surrounding the immediate care needs of the dying person.

## DISCUSSION

### The care of the dying

**Q:** Towards death there may be up to ten per cent of patients who have conditions which simply cannot be palliated towards the end of their care. Advocates of voluntary euthanasia have no argument with palliative care, we support it fully. [However] what do you do if a patient's condition is beyond palliation, or they reject palliative care?

**Dr Redpath:** . . . We stay with them. We keep on wrestling with – dealing with their symptoms but we don't run away in despair ourselves. We have to stay with them and say, 'We're sorry we're not able to do this better', but we stay with them.

**Ms Aranda:** . . . Nearly all of our patients have the wherewithal to commit suicide – if that is what they want to do – and very few, if any, do that . . . Sometimes palliation means . . . rendering people (particularly with significant neurological pain) comatose and they then stay unconscious until death. That doesn't mean a lethal dose of one injection and a sudden end.

**Q:** . . . What is/would be the balance between the personal contact . . . and medical technology?

**Ms Aranda:** The personal involvement is ninety per cent of it because it gives the person in the family the opportunity to place their experiences in a context and to have their position heard. It never



ceases to amaze me how, when at an assessment visit when we ask the client to tell us their story, that's the first time anyone's ever asked them to.

**Q:** . . . How does a health practitioner cope with the stress [of a patient dying]? You become friends with that person, almost good friends. How do you deal with losing a friend every week?

**Ms Aranda:** It becomes a friendship relationship in the sense that it takes on some of the more meaningful social characteristics, but . . . it's still client-centred, time-limited and goal-oriented, so there are reasons why the professional was there . . . in a professional capacity. And the second part is that this care needs to be delivered within the framework of a team and not by an individual, so that there have to be opportunities for the professionals who are involved with those people to share their experiences and to have those kinds of relationships resolved in some way. There is no doubt that if that doesn't happen people burn out very quickly.

**Dr Redpath:** . . . Palliative care services usually also share, to some extent, in the bereavement and it is normal practice for those who have known the person best to be the ones who represent the team at the funeral . . . that is a 'goodbye' and a completion of a relationship that has become to some extent a friendship, though still with professional boundaries.

## WHO MAKES DECISIONS ABOUT DYING?

### THE PATIENT'S ROLE IN DECISION MAKING

**Professor David Lanham**



PROF DAVID LANHAM

**I** MAGINE that in most cases medical decision making is a consensual process, involving a kind of partnership between doctors, nurses and all other health care workers and the patient or the patient's family or both. It also seems reasonable to assume that all parties involved will agree, or at least will want to seem to agree, that the aim of the decision will be the restoration or promotion of the best possible quality of life and health of the patient. Since that is a consummation greatly to be desired by both

the law and society generally, few theoretical problems are likely to arise in this situation.

The issue of the patient's role in decision making is only likely to become an important matter of focus if there is some disagreement or conflict among the parties or interests I have just mentioned. The problem is likely to be at its most acute when someone, most likely the patient but not necessarily so, wants treatment – or no treatment – which will lead to the risk of death or in some cases to the certainty of death, not to the promotion of life and health. In such cases there may be not only disagreement among the parties immediately involved, but also opposition or reservations from the law, and so, indirectly from society.



*The principle of self-determination means that normally a competent patient cannot be lawfully given treatment against his or her will.*

Whatever the nature and extent of the disagreement or conflict, the principal player is the patient. He or she is the person most directly affected by whatever decision is made. Even by itself, this fact is enough to raise a presumption that the patient should be the decision maker. But that presumption cannot be absolute and will not be applicable in every conceivable case. What then is the legal basis for this presumption and what are its limitations?

Before discussing detailed legal principles I think we need to notice there are some fundamental distinctions which are no less tenaciously held because of philosophical attacks or awkward borderlines. The first is the distinction between acts and omissions. In this distinction lies the illegality of active euthanasia and the legality of refusing life-saving treatment. Both the distinction and its consequences have been trenchantly criticised by moral philosophers, especially those who would like to see the legalisation of active voluntary euthanasia<sup>1</sup>. But whatever the philosophical validity of these strictures, the law resolutely clings to this distinction. This tenacity is evidenced time and again in the cases and statutes which have in the common law world confronted the problem; and the distinction has received strong endorsement, despite doubts poured on its logic, by the House of Lords in *Airedale National Health Service Trust v Bland*<sup>2</sup>.

The second major division is between those with full decision-making capacity and those with something less. The first are usually called competent patients (though competence may suggest a greater range of abilities than the term conveys in this context) and the latter are called incompetent. To some extent incompetence may be regarded as a matter of degree, particularly where it arises from the age – or lack of age – of the patient, but the basic distinction, like that between acts and omissions, is firmly established<sup>3</sup>.

The question of competence was recently considered by Thorpe J in an English case *Re C*<sup>4</sup>. A 68-year-old paranoid schizophrenic refused to consent to the amputation of his gangrenous leg despite a warning of an 85 per cent risk of death. On the question of competence, Thorpe J rejected a minimal competence test – the capacity to understand in broad terms the nature and effect of the proposed treatment. The test was whether C's capacity was so reduced by his mental illness that he did not sufficiently understand the nature, purpose and effects of the proffered amputation<sup>5</sup>. The judge adopted a three-stage analysis:

- i) comprehending and retaining treatment information;
- ii) believing it<sup>6</sup>; and
- iii) weighing it in the balance to arrive at choice.

He held that C was competent on these tests despite the fact that his general capacity was impaired by schizophrenia.

The distinction between competent and incompetent patients is important in determining the extent of the patient's power to make a decision. The extent of that power will depend on how much weight is given to autonomy or self-determination and on how much is given to paternalism or beneficence. While there may be, at least in some circumstances, some mix of both kinds of consideration in the case both of competent and incompetent patients, the weight given to autonomy or self-determination is, as might be expected, much greater in the case of competent patients.

In the case of the distinction between competent and incompetent patients there is not only the problem of the borderline situation (for example, a child just below the age of minority), but also the intermediate situation of the patient who has been competent but who is incompetent (for example, unconscious) at the time that the relevant treatment must be given or withheld. This raises the question

of whether the patient can make treatment decisions in advance of the need of treatment.

These broad distinctions set the scene for an examination of the more detailed legal principles which have been brought to bear on the patient's power to make treatment decisions.

The most relevant legal principles can be stated in broad terms as follows:

- a) The principle of self-determination means that normally a competent patient cannot be lawfully given treatment against his or her will.
- b) The principle of sanctity of life means that no third person can lawfully take active steps to kill the patient (even if the patient wants to be killed), nor can they lawfully assist in the patient's suicide.
- c) The paternalism principle means that the best interests of the patient are at least an important factor in decision making for incompetent patients.

We are now in a position to narrow down the enquiry, at least for the purpose of this lecture. It does not make much sense to talk of incompetent patients as decision makers since someone else will have to make the decision. Even so, the wishes of incompetent patients, depending on the nature and degree of their incapacity, may well be relevant to the decision that others must make.

But it is the competent patient who can be regarded as the decision maker and the remaining questions are how that comes about and how far it goes.

On the first of these questions we have come to the point where we must make good, in more specific legal terms, the assertion that the principle of self-determination gives decision-making power to the patient to refuse life-saving medical treatment. The assertion is backed by three propositions derived from the law of battery or, as it is more popularly known, assault and battery. The first proposition is that any unwanted bodily contact with a person is presumptively a battery, which is both a criminal offence and a civil wrong giving rise to compensation. What is significant about this rule is that it is not to the point that the contact is minimal (despite the rather alarming picture conjured up by the notion of battering someone) nor that the contact is beneficial. Most batteries may cause some sort of physical harm but that is not an essential element of the crime or civil wrong<sup>7</sup>.

The second proposition – a point to some extent linked with the first – is that it is not necessary to prove any element of hostility in order to convict a person of battery. This may not always have been so. Certainly there are some old English cases which appear to require an element of hostility, an element which would be lacking in the case of most medical treatment<sup>8</sup>. This old view was endorsed by Chief Justice Barwick and Mr Justice Windeyer of the High Court of Australia in *R v Phillips* (1971)<sup>9</sup>, but was rejected a decade or so later by a majority of that court in *Bouhey v the Queen*<sup>10</sup>. Had the older view prevailed it could have had a considerably limiting effect on the patient's power of decision making.

The third feature of the law of battery which supports the patient's decision-making power is the absence, or virtual absence, of the defence of necessity. This is evidenced by an English case *Beatty v Cullingworth*<sup>11</sup> and a New South Wales case *R v Johnston*<sup>12</sup>. It is also implicit in a host of American cases recognising the right of patients to refuse life-saving treatment<sup>13</sup>.

The three battery rules so far considered confer wide decision-making power on competent patients. Now for the limitations. First, and most obviously, the law of battery provides no basis for allowing a patient to demand death dealing (or any other kind of) treatment. The law of battery prohibits unwanted contact. It does not require desired contact (like an injection) or the provision of any form of assistance. Theoretically the law of battery prohibits some forms of active euthanasia but more realistically it is the law of murder, manslaughter and assisted suicide which provides the main legal sanction.

That leads to the second limitation – the suicide limitation. While suicide is no longer a criminal offence it is still a crime for others to aid and abet suicide<sup>14</sup>, and anyone can lawfully use reasonable force to prevent suicide<sup>15</sup>. These measures place a limit on the right to refuse treatment both under the general (common) law and under the *Medical Treatment Act 1988*. If suicide were given a wide definition, this limitation would severely reduce the scope of the right of the patient to make life or death medical decisions. This would be the



case, particularly if refusing treatment knowing that it would probably lead to death, was regarded as a suicidal act. The law does not so regard it. To amount to suicide it is not enough that a patient foresees death. The patient must actually desire death. This is the state of mind which American courts call 'specific intent'<sup>16</sup>, a state of mind which excludes from the law of suicide mere foresight of death. Where, however, there is clear evidence of a genuine desire for death and the refusal of life-saving treatment is part of an overall attempt to commit suicide, the patient's refusal of such treatment can lawfully be overruled<sup>17</sup>.

The other main limitation on the right to refuse treatment is more controversial. It arises when the law's normal respect for the autonomy of the patient comes into conflict with its paternalistic concerns to protect the lives of children. The case which generates this conflict is that of the pregnant woman whose foetus can be saved only if the woman undergoes a caesarean section. American courts have been willing to order such operations against the wishes of patients<sup>18</sup>, but in *Re AC*<sup>19</sup> the District of Columbia Court of Appeals held that the exception applied only where there were extraordinary or compelling reasons to override the patient's wishes. Even more forthright was the decision of the Illinois Appellate Court in *Re Doe* (1994)<sup>20</sup> which held that the woman's right to refuse a caesarean section was absolute even if the refusal would be harmful to the foetus. The child's right to a healthy life could not be asserted against the mother's. On the other hand, an English court has recently made such an order<sup>21</sup>, and has been roundly criticised for doing so<sup>22</sup>.

After a good deal of agonising, I have come to the conclusion that even here the law should respect the patient's wishes and give effect to her right to self-determination.<sup>23</sup>

## Endnotes

1. For example, Rachels J, *The End of Life*, Oxford University Press 1986.
2. [1993] AC 789.
3. For a local example see the *Medical Treatment Act* 1988 (Vic).
4. [1994] 1 FLR 31. For an argument that depression should be capable of rendering the patient incompetent see Mendelson D, 'Medico-legal Aspects of the Right to Die Legislation in Australia' (1993) 19 MULR 112 at 126-129.
5. This test is broadly similar to those suggested by the Social Development Committee and the Guardianship and Administration Board for the purposes of the *Medical Treatment Act* 1988 (Vic): see Lanham D, *Taming Death By Law*, Longman, Melbourne 1993, p76.
6. This component has been criticised: Gordon R & Barlow C, 'Competence and the right to die' (1993) 143 NLJ 1719.
7. 3 Blackstone's *Commentaries* 120.
8. See Ormrod R, 'Is Consent Really Necessary' (1989) 29 *Medicine, Science and the Law* 4.
9. 45 ALJR 467.
10. (1986) 161 CLR 10.
11. [1986] Br Med J 1546.
12. (1903) 9 ALR (CN) 11.
13. See generally, Lanham D, *op cit*.
14. The Victorian provision in section 6B of the *Crimes Act* 1958. For a discussion of the Canadian version see *Rodriguez v British Columbia* (1993) 7 WWR 641.
15. See for example, the *Crimes Act* 1958 (Vic) section 463B.
16. See for example, *Re Conroy* 486 A 2d 1209 (1985).
17. See *Re Kinney*, unreported M2/1984. The case is discussed by Loane Skene in 'The Fullagar Judgment' (1989) 14 Legal Service Bulletin 42.
18. See Lanham D, *op cit*, pp24-26.
19. 573 A2d 1235 (1990).
20. 62 LW 1154 and 2632 (the child was delivered naturally in a healthy condition). See also *Curran v Bosze* 566 NE 2d 1319 (1990) (refusal to order twin minors to donate bone marrow needed to save their half-brother's life).
21. *Re S* (An Adult: Surgical Treatment) [1993] 1 FLR 26.
22. Bridgeman J, 'Medical Treatment: The Mother's Rights' [1993] *Family Law* 534. But see Wells C, 'Patients, Consent and Criminal Law' (1994) *Journal of Social Welfare and Family Law* 65, supporting the decision on the ground that it was necessary to save the woman's life.
23. See Lanham D, *op cit*, pp26-29.

## LIMITS OF PATIENT AUTONOMY

Mrs Loane Skene



MRS LOANE SKENE

PROFESSOR LANHAM has argued in his paper that, in making decisions about the medical treatment or lack of treatment for a person at the end of life, 'the principal player is the patient'. I agree. I shall suggest, however, that in addition to the constraints of the criminal law to which he has alluded, there are problems for health carers and for patients in using patient autonomy as the sole factor in making medical decisions for the dying. In fact, rather unfashionably, I shall argue that in some cases, the

best way to achieve 'a better death' may be for the law to allow some scope to health carers to act paternalistically!

## What is a better death?

First, let us consider what we mean by a better death. Do we want to die suddenly without warning? Whether this occurs violently, as in an accident, or peacefully in sleep, we would not know about it and medical treatment would be irrelevant. Do we want to die without pain and with time to put our affairs in order and to say goodbye to our families and friends? This may involve temporary use of artificial measures – intravenous or naso-gastric feeding, ventilator support or large doses of analgesics or sedatives to control pain and discomfort, to be withdrawn when we wish. Or is our prime concern in achieving a better death that we should not suffer the indignity of being kept alive, perhaps by invasive and painful procedures, as we slowly deteriorate to an even less comfortable existence? In the two latter cases, whether a death is 'better' takes into account not only the needs and emotions of the patient, but also of the patient's family and friends, and perhaps health carers as well. For a better death, we may want not only freedom from pain, discomfort and fear. We may also want control and time.

## Legal constraints on health carers

Except for a sudden, unexpected death, the time and manner of our death will depend largely on our doctors and other treatment staff; and the type of treatment that is given will be dictated not only by our wishes, but also by the law. The law gives two kinds of direction. First, it recognises, as Professor Lanham has said, that 'the patient is the principal player' and that patients are entitled to make their own treatment decisions, at least in relation to refusing (in contrast to requiring) certain types of treatment. And secondly, it prohibits acts that cause or accelerate death. Let us consider these in turn.

## The patient's right to decide

There has been an increasing acknowledgment throughout the Western world over the past generation of the right of competent adult patients to make their own treatment decisions. This is based on the ethical principle of individual autonomy, the right to control and determine one's life for oneself. According to this principle, any decision in exercising that right is a moral decision even if it involves medical treatment. It is not a medical decision. It is the patient who must decide, not the doctor, although the patient will obviously consider medical advice in making the decision.

The growing acceptance of this principle is evident in the development of the common law on 'informed consent' in North America<sup>2</sup>; in England<sup>3</sup>; in Australia<sup>4</sup>; and in New Zealand<sup>5</sup>. Thus, in the Canadian case of *Malette v Shulman*, a competent Jehovah's Witness recovered damages when given life-sustaining blood transfusions she did not want<sup>6</sup>. And, in England, a court accepted that a competent, adult patient was legally entitled to refuse to have his gangrenous leg amputated, even if he was certain to die without the operation<sup>7</sup>. If a patient dies in such circumstances, the doctor is not regarded as aiding or abetting the patient's suicide<sup>8</sup>.

The growing recognition of patients' rights to autonomy and self-determination is also evident in the legislation that has been passed or is being developed in many jurisdictions to allow people to



refuse treatment they do not want, to give directions in advance refusing treatment, and to appoint an agent to make decisions about treatment for them if they should become incapable of making their own decisions.

In the state of Victoria, for example, the *Medical Treatment Act* 1988, gives statutory force to the common law principle that patients are entitled to refuse medical treatment that they do not want<sup>9</sup>. If a competent, adult, properly informed patient clearly indicates to a doctor, in the presence of a witness, that he or she does not want medical treatment, or does not want treatment of a particular kind, for the patient's current condition<sup>10</sup>, then it is an offence for a doctor to give that treatment. The patient may also appoint an agent to make treatment decisions<sup>11</sup>. A doctor who gives or continues the treatment may be fined up to \$500. 'Medical treatment' is defined as an operation or the administration of a drug or procedure. The Act does not apply to 'palliative care', which is the provision of reasonable pain relief, and food and water.

Other Australian states have passed similar legislation. South Australia and the Northern Territory have each passed a *Natural Death Act* (1983 and 1988 respectively), under which an adult person of sound mind may make an advance directive not to be kept alive if he or she suffers from a terminal illness and loses the ability to communicate such a decision. Similar developments have occurred in the USA with the enactment of the *Patient Self-Determination Act* 1990.

To date, however, all of this legislation extends only to *refusing* treatment. Patients are not entitled to *require* that they be given positive medical assistance to end their lives. Although Bills to enable doctors to assist patients in that way have been prepared in Victoria and the Australian Capital Territory, neither has yet been passed. So although doctors may lawfully withdraw, or not initiate, life-sustaining treatment at a patient's request, that does not justify a positive intervention to cause or accelerate death, such as a lethal drug dose.

#### *Criminal liability for causing or accelerating death*

Such acts are prohibited by the criminal law, the second source of legal authority affecting decision-making for dying patients. As Professor Lanham has explained, any deliberate act that causes or accelerates a person's death may be murder, manslaughter or assisting suicide, even if it is done at the patient's request and in what the doctor believes to be the patient's best interests. This principle extends to both acts and omissions. A doctor may not lawfully administer a potentially lethal dose to a patient unless that type and quantity of drug is necessary to relieve pain and the doctor's primary intention is to relieve pain and not to hasten death.

Similarly, a doctor may not lawfully withdraw, or decide not to initiate, life-sustaining medical procedures except in a limited range of situations. Generally, these are first, where a competent adult patient after being adequately informed of the consequences, has refused a particular life-saving procedure; secondly, where the treatment is of no practical value<sup>12</sup>; and thirdly, where the burden imposed by the treatment exceeds the likely benefit to the patient<sup>13</sup>.

#### **The law and achieving a better death**

How does the law affect the achievement of a better death? Let us apply the legal principles to the factors suggested earlier that may be relevant to how we die: freedom from pain, distress and fear; time to adjust and say goodbye; and control over when we die.

#### *Freedom from pain, distress and fear*

In relation to pain, the law is generally adequate to ensure that patients can be kept reasonably comfortable during the final stages of life. Doctors may give increasing doses of pain-killing drugs even if that has the incidental effect of shortening the patient's life. However, there are several situations in which this principle will not be enough.

The first is where the pain is not able to be medically controlled, whatever the type or dose of drug administered. This was said to be the case with Mrs Boyes, an English patient suffering extreme pain in the final stages of rheumatoid arthritis who was given a lethal injection of potassium chloride by her doctor, Dr Nigel Cox<sup>14</sup>. It was accepted that this was not a pain-killing drug but he said that after other methods of alleviating pain had failed, the only way to relieve her pain was to end her life. He was convicted of attempted murder and disciplined by the General Medical Council.

*... the recognition of patient autonomy will not necessarily achieve a better death in all cases. To do that, we need to support our doctors and other health carers in making treatment decisions at the end of life.*

I am not able to say whether Dr Cox was right in his belief that he could do nothing else to relieve Mrs Boyes' pain. I have heard a palliative care expert suggest that if Mrs Boyes had been given a temporary anaesthetic block, for example, she might have passed through the most painful stage of her illness while unconscious and then been given effective pain relief until she died<sup>15</sup>. However, there would seem to be no doubt that there are some types of pain for which there is no medical relief available.

There are also aspects of *distress*, in contrast to pain, which it may be very difficult to relieve. Several such cases have been vividly illustrated on national television in the past few weeks. One program, *Four Corners*, showed a patient with advanced cancer of the throat, rapidly losing the power of speech and facing the imminent prospect of life on a respirator. The second, an SBS commentary on American Dr Jack Kevorkian, showed a patient suffering from Lou Gehrig's disease, a debilitating nerve disorder also known as ALS or amyotrophic lateral sclerosis, for which there is no cure. The distress of these patients, with the expectation of certain and progressive deterioration, cannot be alleviated by any medical means, except the most final.

It is perhaps because we know, from our own experience or that of others, what lies ahead in such cases, for us and for our families, that we experience such *fear* about our death. While the law remains as it is, that fear will remain. We cannot be confident that doctors will be able to relieve our long-term, 'existential' distress. It is no answer, in these cases, to say that the doctor will 'keep us comfortable' with increasing doses of morphine.

#### *Time to adjust and say goodbye*

The second factor in achieving a better death is the opposite of the first. Instead of wanting to go quickly, we may want to *gain* time, to adjust and say goodbye. A person's death does not affect only that person. Most of us would surely feel that our death will be easier and more meaningful if, as in life, we are able to make things easier for those we love. Medicine has the means to do this in some cases. But will doctors be prepared to embark on measures that have no long-term value, merely to give the patient extra time, if they know how legally and ethically contentious it may be to discontinue these measures when the patient is ready?

#### *Control over when we die*

The final factor I have suggested to achieve a better death is control over when we die. This is related both to dying earlier to avoid long-term decline and to gaining time in order to put our affairs in order. But it is wider. As mentioned earlier, there is growing recognition, both in legislation and at common law, of a patient's right to refuse life-sustaining treatment, either at the time it is needed, or in advance by making a personal direction or by appointing an agent to decide on our behalf when we are no longer competent to do so. These provisions will not, however, necessarily enable us to achieve a better death.

First, even if a patient has directed in advance that he or she is not to be given a particular type of treatment, there may be a problem in assessing whether the patient was in fact *competent* to make that decision. To date, there have been few cases in which courts have had to consider what level of understanding a patient must have in order



to be competent to refuse a procedure when the refusal will probably lead to death. One case, which has been mentioned by Professor Lanham, was *Re C*<sup>16</sup> in which it was held that a paranoid schizophrenic patient was competent to refuse a life-saving amputation if he could understand and retain information concerning the proposed treatment, if he believed it and if he could weigh it in the balance to arrive at a choice. However that case might be compared with the case of *Alice Hughes* in New Jersey, in which the court said that a pre-operative refusal of a blood transfusion by a competent, adult Jehovah's Witness undergoing a hysterectomy could be overridden because her refusal had been made in the context of an anticipated routine procedure and not in the knowledge that, without the transfusion, she would die<sup>17</sup>.

Lord Goff adverted to the problem of assessing competence in *Bland's case* in the House of Lords in 1993; although a patient's refusal to give consent, even to a life-saving procedure, was effective when given before he or she became unconscious, 'special care may be necessary to ensure that the prior refusal of consent is still properly to be regarded as applicable in the circumstances which have subsequently occurred'<sup>18</sup>.

These issues may prevent our achieving a better death by controlling the time of our death in two ways. First, as in *Alice Hughes'* case, our wish not to be given life-sustaining treatment may be overridden because it was not expressed in a full understanding of the circumstances that have occurred. But equally, if our wish is observed, we may miss our chance for a slower death to put our affairs in order and say goodbye.

Some flexibility may be gained by appointing a relative to make treatment decisions on our behalf but there are two limitations. First, the appointment must be done formally. Although doctors often ask a patient's relatives to consent to medical treatment on the patient's behalf, there is no legal basis for relatives to authorise treatment unless they have been appointed by the patient under an enduring power of attorney or the like, or have been appointed by a guardianship board, or a court, to make decisions for the patient. And secondly, even if an agent has been formally appointed, that person may only refuse treatment if the treatment would 'cause unreasonable distress to the patient' or 'there are reasonable grounds for believing that the patient . . . would consider the treatment is unwarranted'<sup>19</sup>. It is unclear whether the agent could override the patient's previous wish on the basis that it does not cover the situation that has arisen.

Finally, if a patient is not competent and has not made his or her wishes known in advance, doctors have only the most limited legal authority to withdraw treatment. Although a court could authorise the withdrawal, the power of an agent or guardian in that respect is problematic as they may refuse treatment only if it would cause unreasonable distress to the patient or would be considered unwarranted by the patient.

## Changing the law to help achieve a better death

Is it necessary to change the law to achieve a better death for patients? One option might be an extension of the *Medical Treatment Act* to enable patients not only to refuse treatment but also to request positive assistance in dying. That was the proposal of the Medical Treatment (Assistance in Dying) Bill launched by the Victorian Voluntary Euthanasia Society last year. The Bill included a range of administrative procedures to protect vulnerable patients. For example, it would apply only to terminally ill patients suffering pain that could not be alleviated by medical means; a second medical opinion would be required; and all cases of assistance in dying would have to be reported. The advantages of this approach are that it gives great weight to individual autonomy. Provided that they fall within the Act, people could make their own decisions about how and when they die and doctors assisting them would be protected from prosecution if they followed the prescribed procedures.

However, as I have suggested, the recognition of patient autonomy will not necessarily achieve a better death in all cases. To do that, we need to support our doctors and other health carers in making treatment decisions at the end of life. The law, and also community opinion, including that of religious leaders, has come some way towards this position. Many people believe that the administration of increasing doses of morphine, for example, to keep a dying patient 'comfortable', is justifiable, even if some question the logic of the doctrine of 'double effect' that is, that it is lawful to administer

increasing doses if it is done to alleviate pain but not if it is to hasten death.

Are we perhaps more likely to achieve a better death – with minimal pain and distress, and with time to arrange our affairs and say goodbye to our loved ones – and will this not be better also for our families – than if we require doctors either to be continually looking over their shoulders for fear of prosecution; or calling in colleagues and reporting on their decisions to monitoring bodies?

## Endnotes

1. Professor Max Charlesworth, Submission to the Social Development Committee of the Victorian Parliament, during its Inquiry into Options for Dying with Dignity, published in the Committee's First Report, *Inquiry into Options for Dying with Dignity*, 1987, pp 39-52. Cf Dr Helga Kuhse: 'it is our ability to choose, or to be self-determining and autonomous, which gives special value to the lives of persons': *op cit* p94.
2. *Schloendorff v Society of New York Hospital* 105 NE 92, 93 (1914); *Canterbury v Spence* 464 F 2 d 772 (1972); *Reibl v Hughes* [1980] 2 SCR 880; *Nancy B v Hotel-Dieu de Quebec* [1980] 86 DLR (4th) 385; *Rodriguez v British Columbia* (1993) 7 WWR 641.
3. *Sidaway v Bethlem Royal Hospital and Maudsley Hospital* [1985] AC 871, 882 (Lord Scarman spoke of the 'right of the patient to make his own decision whether he will or will not undergo the treatment proposed'); *Airedale NHS Trust v Bland* [1993] 2 WLR 316, 376 (Lord Goff said that doctors must give effect to the wishes of 'an adult patient of sound mind [who] refuses, however unreasonably, to consent to [life-sustaining] treatment . . . even though [the doctors] do not consider it to be in his best interests to do so'; *Re T (adult: refusal of treatment)* [1992] All ER 649.
4. *Rogers v Whitaker* (1992) 175 CLR 479 in which the High Court of Australia quoted with approval the reference of King CJ in *F v R* to 'the paramount consideration that a person is entitled to make his own decisions about his life': (1983) 33 SASR 189, 193.
5. *Smith v Auckland Hospital Board* [1965] NZLR 191.
6. *Malette v Shulman* (1991) 2 Med LR 162.
7. *Re C* [1994] 1 FLR 31.
8. Per Lord Goff in *Bland's case* n 3 above at pp318-9.
9. The operation of the Act is described by Professor David Lanham in *Taming Death by Law*, Longman, 1993.
10. Because the refusal is limited to treatment for a current condition, it is not an 'advance directive' as commonly understood.
11. Medical Treatment (Enduring Power of Attorney) Act 1990; Medical Treatment (Agents) Act 1992.
12. Glanville Williams, *Textbook of Criminal Law* (2nd ed., 1983) p279.
13. For example, *Re J (a minor) (Child in care: Medical treatment)* [1992] 3 WLR 507; the treatment in question (reventilation if the baby stopped breathing) was itself painful and the court acknowledged that it would not be justified in view of the baby's very poor prognosis.
14. *The Age*, 15 May 1992. The case has not been reported in the law reports. It is discussed by David Kelly in 'Treating the Dying – Emerging Issues' (1993) 12 *Bioethics News* 37.
15. This was suggested at an intensive bioethics conference on voluntary euthanasia convened at Warburton in 1993 by the Monash University Centre for Human Bioethics.
16. [1994] 1 FLR 31.
17. *In the Matter of Alice Hughes* Superior Court of New Jersey, Appellate Division (1992) 611 A 2d 1148; noted and discussed in (1993) 1, 2 *Medical Law Review* 278.
18. See n 3 above, at p318.
19. *Medical Treatment Act* 1988 (Vic) s 5B(2).

## DISCUSSION

### Who makes decisions about dying?

**Comment from audience:** I have just spent some time researching quality of life after people have been subjected to sophisticated life-saving techniques in an intensive care unit. I've spoken at length to a lot of these people after their lives have been saved and some of them have expressed their wish to me – they wish they'd been allowed to die. It seems to me that our health care system is failing these people by curing but not caring enough . . .

**Ms Aranda:** . . . I think one of the issues is that we don't have that foresight . . . We can't predict outcomes . . .

**Q:** . . . I teach medical students at the Alfred Hospital in palliative care and we've done a lot of evaluation over the past four years about their response to that training. Why hasn't this been . . . in any of their training up until fifth year – the question of what you do when someone's going to die and how to care for the family and . . . skills in how to deal with that?



**Dr Redpath:** This is one of the very big issues that I wrestle with because I have exactly the same experience of a very responsive student body – and then beginning to work with them when they become interns you see the struggles that they are having in resisting the pressures of the system . . . All I can say is that we have to keep working away at supporting them. We try to run tutorials for them [but] it's very difficult for them to free themselves to attend. We try and provide some sort of counsel and an availability to them to talk over the difficulties they've had and we try and debrief them when they've had difficult situations but we have to spread ourselves very thin in that process.

**Dr McCaughey:** For many . . . living in [our] rich, affluent pleasure-related society, death seems to come as an intrusion . . . We've lost the naturalness [of death]. That's one of the reasons why, in fact, I believe we have pushed death off into institutions, not just because of the medical technology that was available there when we were trying to save everybody and prolong life, but because it does come as an interruption . . . It's not accepted as part of the rhythm of our lives . . . I suggest that's one very strong reason why we can't face death.

**Q:** Who's going to be reporting [euthanasia] offences against the law? Is there any mechanism for this? Does the law indicate it's best to move



**Q:** Could you comment on agents acting on behalf of patients when they can't make decisions for themselves any longer. How does this impact on the grief of families after the person has died when they feel they've made decisions like: 'Yes, we'll turn the machines off'; or 'We'll stop treatment'; even though they know that is what the patient wanted?

**Mrs Skene:** One of the problems for the health carers is to try and relieve the pressure on parents and the guilt that parents feel in these circumstances. This is one reason why doctors and other health carers are accepting greater responsibility in the decision making . . . If it appears to the relatives that the decision that they have taken accords with medical opinion it will be easier for them to accept.

**Q:** May we have some comment on the moral and legal limits to patient autonomy in the case of the competent, healthy young adult who has recently suffered a traumatic paraplegia and requests the respirator to be turned off, bearing in mind that experience shows that many such patients subsequently reverse that decision?

**Mrs Skene:** What you describe of course is the unfortunate case of . . . whose death led in effect to the dying with dignity inquiry and the Medical Treatment Act which enables people to refuse treatment in these situations. And so it would appear on a literal interpretation of the Act, if you like, that here you have a competent adult patient who wants to end his or her life. And this would be in conflict with the doctor's duty of beneficence in dealing with the patient. And my answer, although this hasn't specifically arisen, would be to look to the recent judicial decisions in England where courts have been saying that you have to look at whether the patient had anticipated the situation that has arisen and understands enough about all of the circumstances of that situation to make his or her own decision. And you might say that the patient doesn't fully understand, even though he might have been told about this in the . . . case, that all patients go through this stage of depression but they come out of it and later they're glad to be alive. A patient who is not able to understand that, is not truly competent to make the decision to refuse treatment.

**Q:** What we can do about the problem that society in general has with death? Why is it such a big deal? Before we can examine what we can do about that we have to really examine why is it such a problem. It's, in effect, as natural as being born, as natural as comets hitting Jupiter.

to an environment where there could be a conspiracy and nobody will report?

**Professor Lanham:** The latest euthanasia case in England was almost like that where the deceased woman was in fact cremated before they found out that there was any question of euthanasia being practised. But I think that's typical of all kinds of crime pretty well. I think we've got to have criminal statutes in the shape that we want them to be, bearing in mind all societal interests, not only those of the person immediately wanting or desiring a quick death but also the other societal interests that are effected if we have legislation which allows that.

**Q:** How do we care for the care-giver, for the medical and the nursing staff who are involved in looking after not just the dying patient but the seriously ill patient?

**Dr Redpath:** . . . Some units get together, say, once a week or once a month . . . they might formally call it, say, a death audit or a complications audit . . . it is a mechanism where people can share their real feelings, not just the actual medical facts of something that happened. Within palliative care services we regularly in our team meetings discuss every death which has occurred and we sometimes hear . . . everything that happened in a particular household when there was a particularly traumatic death and a very emotional and difficult situation to deal with. We share that and we take that all on board. We laugh at the funny things and we virtually cry together over the sad things. That's how we support each other.

**Ms Aranda:** Acknowledging that a death has occurred is really important . . . having an opportunity to acknowledge what that person had meant to them and perhaps for some nurses to acknowledge the particular contribution of others who had been significant in the life of that person . . . I think one of the other important things that came out in the survey . . . is that the nurses in the survey, and some of the other carers as well, had come to the acknowledgment that they couldn't change the world, and that they weren't perfect and that all they could do was their best on that particular day . . . I think accepting that we are all human and that we can't make life perfect is also part of that and it relates back to that notion that death is not preventable. I think that's a myth that's in our society – that death is preventable. And we have to let go of some of those things.



# MENTAL ILLNESS: THE PUBLIC HEALTH CRISIS OF OUR TIME

60TH BEATTIE SMITH LECTURE

HELEN HERRMAN

Professor and Director of Psychiatry, St Vincent's Hospital



PROF HELEN HERRMAN

THERE IS a crisis worldwide in care of the mentally ill. Why has this occurred in this major field of health care and social policy? On the one hand, the United Nations has made a momentous declaration affirming the rights of the mentally ill – a move endorsed by our Commonwealth Government and followed by the National Mental Health Policy and Plan. On the other hand, we are faced by a seeming paralysis of our capacity

to respond to gross need in some of the most vulnerable members of our community.

Prominent psychiatrists have commented recently that:

The recent history of the treatment of those with severe and chronic mental illness must be one of the most significant social changes of our time. [It has been widely debated] but is typically an area in which informed opinion has had scant effect on the underlying policies or on their implementation. This seems tragic in view of the major impact that the change has had on the lives of tens of thousands of people, both patients and their relatives who are increasingly faced with the burden of their care (Thornicroft and Bebbington 1989).

There is a sense of despair in policy-makers and professionals. What may be seen as the underlying dilemma was clearly expressed a decade ago by British sociologist Kathleen Jones in her examination of the work of Andrew Scull, a radical theorist from California. 'If it is wrong to get patients out of the mental hospital, and wrong to keep them in, what are we to do?' (Jones 1982).

Institutions have failed, and there is a widespread perception that the move to the community has not been adequately achieved. What can people in the University, in psychiatry, in government and in the community do, especially when resources are withdrawn rather than offered to this area, and when policy makers still feel pressured to react rapidly and unilaterally?

We are faced in our daily lives with continuing evidence of the failures of our community to deliver adequate care to people with serious mental illness. Less immediately evident are the lost opportunities for prevention and early intervention in mental illnesses of various kinds, and for the adequate recognition and treatment of mental illnesses in people presenting to general practitioners and general hospitals. In this paper I shall give special attention to the crisis we already have and how it has developed; examine the extent of the crisis and illustrate it with local and international examples; and then comment on the opportunities for resolution.

A crisis is a turning point, a period of uncertainty, or a moment of danger. With this country's resources of talents, its traditions of fairness and robust political institutions, and the material conditions and money, we have the opportunity to understand and illuminate this area and to make this period a turning point. This requires the fostering of communal tolerance and a communal will to prevent and relieve the distress and disadvantage attached to mental illness.

Although there is evidence that communal attitudes in Australia are changing, and that attitudes are more tolerant than elsewhere (Reark 1993), people with mental illness are still regarded with fear,

distrust and dislike by the general public. *The Black Dogs* are abroad, here and elsewhere. Anyone who has read this book recently, as I know a number of my colleagues have at St Vincent's, will recall the image of the two big black dogs, the embodiments and remnants of evil, abandoned by the Gestapo, in the sun-soaked and remote hinterland of southern France in 1946. I think of them as representing the public spectre of mental illness. The heroine is stunned by a sudden and near deadly attack by these creatures as big as donkeys, and then watches them 'running down the path into the Gorge of the Vis . . . They are crossing the shadow line . . . and move into the foothills of the mountains from where they will return to haunt us . . . in another time' (McEwan 1992 p174).

Fear and secrecy and separation blind us to the links with human experience and illness of all kinds. They impoverish the lives of those marked out as seriously mentally ill, and also the practice of medicine and of psychiatry.

In the course of this lecture I shall be illustrating the issues with work done in Melbourne with colleagues with whom I have been privileged to work, many now associated with the University of Melbourne Department of Psychiatry at St Vincent's Hospital and the Department's other settings including Royal Park Hospital. I also appreciate the work with colleagues at Monash University.

## THE CRISIS AND ITS DEVELOPMENT

### The public face of the crisis: lurid attention and confusion

What is the evidence of a crisis? Anybody who has been reading newspapers or watching television or listening to the radio locally has been aware in recent months of a concentration of often lurid attention on this issue. In September 1993, the Federal Human Rights Commissioner released the report *Human Rights and Mental Illness*. The report is based on the National Inquiry into the Human Rights of People with Mental Illness, conducted by a commission chaired by Mr Brian Burdekin, with members Dame Margaret Guilfoyle and Mr David Hall. The commissioners spent two years collecting evidence. The result is a two-volume report. The chapter headings provide a catalogue of the shortcomings of our health, welfare, housing, education and legal systems in acknowledging the rights and problems of our fellows with mental illnesses. The preface draws particular attention to the need for relevant research in Australia relating to mental illness.

From this source and elsewhere there is widespread evidence of neglect of people with severe mental illnesses: people living in hospitals, in boarding houses or shelters, and in prisons. Others live with families who themselves suffer from isolation and uncertainty. There are special difficulties of people with drug and alcohol abuse, intellectual disability, and those with a non-English speaking background and from Aboriginal communities.

### The silent crisis

In addition to relatively public issues, there is the continuing failure to recognise and treat mental illness, particularly in the form of depression and anxiety, when people ask for help from general practitioners and from other doctors in general hospital settings. Approximately 20 per cent of general health care attenders suffer from a well-defined mental illness. Despite previous assumptions that these problems were self-limiting and benign, more recent studies have shown that a considerable proportion are chronic and are associated



with both substantial disability and increased utilisation of health care. Despite the personal and social costs of these disorders, most people with potentially remediable disorders are not treated (Sartorius *et al* 1993).

### Development of the crisis

As we look for new solutions, we can remind ourselves of previous efforts to deal with the consequences of mental illness. The discipline of psychiatry was created and practised in asylums in the eighteenth and nineteenth centuries, separate from the rest of medicine and society. A number of factors contributed to the alienation of psychiatry. Mind and body, as well as their disorders, were declared separable. Fundamental was the concern of reformers at the plight of the 'indigent insane' in the streets, poorhouses and prisons of the growing industrial cities. Asylums were built outside the cities and although there are differing views on this, it is likely that they initially provided a haven and a therapeutic environment. Their building was often an extraordinarily large and elaborate effort of public works for the community (Jones 1982).

They were also closed and separate. The community could put insanity and melancholy out of sight and out of mind. The 'moral treatment' of some of the early asylums, and the unchaining of the mentally ill were forgotten as the numbers of inmates grew and conditions deteriorated. The community avoided scrutiny of standards of housing and care. Asylums originally built for hundreds of inmates were holding thousands by the time of the Second World War.

Sociological studies of hospitals for the mentally ill after the Second World War were influential in changing the patterns of mental health care. The effects on patients of an institutional environment in itself were depicted, and 'institutionalism' and 'institutional neurosis' described. Studies demonstrated clearly an interaction between the immediate institutional environment and the negative handicaps of schizophrenic illnesses. The clinical poverty syndrome of social withdrawal, flatness of emotional expression and poverty of speech, was related very strongly with the social poverty of the hospital environment. The condition tended to improve and to deteriorate as conditions in the hospital wards fluctuated over time (Wing and Brown 1970).

Such recognition of the potentially damaging role of the institution or indeed nowadays of the boarding house, was a valuable counterweight to the profound pessimism about the course of schizophrenia which characterised professional thought in the first part of this century (Abrahamson 1993). Manfred Bleuler (1978) has pointed out the influence of the theory of schizophrenia as 'a continuous regressive process towards a state of idiocy' which 'in its own . . . way, promotes hopelessness and resignation among doctors, nurses, families, and among the patients themselves'.

Findings from large-scale, long-term studies of the course of schizophrenia have become available relatively recently. Despite marked variations, it is clear that progressive deterioration in the long term is not characteristic of schizophrenia. Deterioration, if it occurs tends to be a phenomenon of the earlier five to ten years, followed by a relatively consistent plateau (Bleuler 1978) or perhaps amelioration (Eaton *et al* 1992). Additionally, much evidence indicates that the person's social functioning, physical and family or institutional environment, others' expectations, and social class are all important influences on the course and outcome (Herrman 1989).

However in the overcrowded asylums the difficulties and pessimism were compounded, especially before the advent of medications which give effective symptomatic relief to many patients. This pessimism was enshrined in the organisation of the large mental hospitals. Resources were concentrated on acute wards in the expectation of decreasing returns later on. Diversion from acute to long-stay wards usually took place early in the first phase and may have increased the potential for deterioration, not least by the demoralisation caused by moves to chronic settings. Patients were subjected to enforced idleness or else the same activities continued well beyond their usefulness to the individual. There has been extensive debate about how the debasement of the asylums occurred over the course of a century, from the humane and optimistic ideal of 'moral treatment' practised in the early nineteenth century. However, 'social and economic pressures towards debasement were at the least insufficiently challenged and at worst legitimised by confusions in the supposed scientific basis of institutional practice' (Abrahamson 1993).

These practices are disturbingly analogous to the current shortcomings of community care. An important factor that may be added is social isolation for the mentally ill person living in a single room. Discharged patients report consistently that they miss the social contacts possible within a large hospital campus. There are grounds for apprehension that degradation of an important ideal is occurring again. The dichotomy between care and cure may again be institutionalised and the difficulty of dealing with long-term issues intensified as a result (Abrahamson 1993).

Nonetheless patients and their families time and again report that they prefer community to hospital care. Imaginative and flexible services may serve people with mental illness well in the community (Rosen 1992).

### Approaches to prevention

The supposed incurability of these severe conditions had the parallel effect of theoreticians and practitioners in the 19th and early 20th centuries developing a conviction that the causes were entirely biological. The idea has subsequently persisted that prevention of mental illness is 'all or none'. Professor Brian Cooper who has worked in Mannheim in Germany and at the Institute of Psychiatry in London, recently commented:

Present-day psychiatry is still identified with a specialty which traditionally has regarded the major forms of mental illness as 'endogenous' and almost all as non-communicable . . . (Cooper 1993 p906)

On the other hand, he continues:

The fundamental concept of disease as a result of population exposures to environmental pathogens has served for generations as the (background to) preventive medicine . . . The treatment and care (of mentally ill people) in the community, could serve to foster similar approaches to the problems of mental (illness) . . . (Cooper 1993 p906)

### Barriers to change

Two main barriers stand in the way to resolving the crisis of mental illness: a generally held concept of mental illness and community values and the stigma of mental illness.

#### *The concept of mental illness*

In planning action, it is easier to deal with conflict than with confusion (Sartorius 1990).

People with mental illness are often considered to be identifiable and different from the rest of the population. Yet the term 'mental illness' means different things to different people. Confusion and vagueness about this term have been powerful reasons in modern times for the low priority given to treating and preventing the manifestations of mental disorders. Mental illness has been seen as the province of psychiatrists and other mental health professionals, separate from the rest of health and social care.

A definition will necessarily have different emphases for different purposes: for the law, psychiatry and medical administration; even though desirably based on the same ideas. A medical definition of mental illness requires the recognition of characteristic symptoms and signs of disturbance of the mental functions of thought, perception, mood, cognition or judgement. Within the profession, standardised criteria and schemes for psychiatric diagnoses and their classification are now widely used. For example, the publication of the mental disorders section of the 10th revision of the *International Classification of Diseases* was the result of an enormous amount of work and represents an international consensus. Classifications of disability and handicap that may be avoidable or unavoidable consequences of these disorders are also becoming available and used by the research community.

*The World Development Report* was devoted for the first time to health in 1993. Estimates of the costs of mental illnesses are entered alongside the costs of other illnesses to the world's regions (World Bank, 1993).

Two potent sources of confusion about the idea of mental illness exist in the public mind. Cooper (1992) identified one of them as follows:

Mental illness as a legitimate medical concern has to be distinguished from other causes of social deviance also involving distress and abnormal behaviour.



Mental illness, folly or madness, and badness are different in meaning and also belong to different spheres of discourse. Some individuals may be labelled with more than one of these terms. Some mad people are also mentally ill, and some of the latter may also be evil. But the occasional co-occurrence of these characteristics in no way justifies using them as if they were synonyms. It is of cardinal importance to keep these terms separate. If mentally ill people are seen as ill rather than as mad or bad, it is easier to seek ways of providing them with appropriate health or other services; the mad, the unusual, and extraordinary can then be better understood; and the bad can be dealt with more easily in socially appropriate ways (Sartorius 1990).

Freedman (1978) saw [the second] confusion about the idea of mental illness in:

The tendency to overlook the highly specific dysfunctions because of their kinship with common misery and crises.

However, the illnesses of depression and anxiety for instance often have a quality difficult or impossible for those suffering the 'common misery' to understand. Readers of William Styron's *Darkness Visible* which describes the blackness and bleakness of the experience of depression, or of Richard Burton's *Melancholia* may be given a glimpse. Most of us experience such despair in a fleeting way, or have a momentary feeling of terror. However people with these illnesses do not get better quickly, or they may become ill repeatedly.

### **Community values and the stigma of mental illness**

The second major barrier to resolution of the crisis in mental illness is the place of mental illness in our society's system of values, and the associated stigma for patients, their families and to some extent the professionals working with them. A stigma was in Roman times a mark of shame or of enslavement. The word has come to mean a loss of reputation. The mentally ill and their families face stigma based on views of mental illness as shameful and chronic. The history of the asylum is a cogent influence. People may hesitate to bring symptoms to medical attention or to accept referral to a psychiatrist. Stigma affects recovery also because the prejudice of others and the patient's own expectations affect opportunities for work and social contact.

Prejudice has a pervasive influence on the interpretation of a patient's or former patient's behaviour by professionals and others. Otherwise unremarkable behaviour such as sloth or untidiness or even exuberance may be seen as evidence of illness in those once diagnosed.

The historical alienation of psychiatry has a continuing influence on both the professional and community views of mental illness. These in turn are important contributors to the crisis in mental health care. For instance, it is true that the use of large institutions has been discredited, but the contemporary emphasis in separate state-supported psychiatric services remains the treatment and care of people with serious mental illness of particular types. There are increasing difficulties in resourcing and developing an adequate system for this purpose. The professionals leave to work in more open systems and the patients and their families remain isolated and stigmatised.

Psychiatrists who work in the separate services have little interaction with those who work in private practice or in general hospitals. This tends to produce a division within the group of mental illnesses and in the approaches to treatment and care. The emphasis on use of psychotherapy and family therapy, and on medications remains different in the two systems, and some of the people most in need of skilled psychotherapeutic help for instance have little access to it. The division between the systems is arbitrary and paradoxical in terms of the needs of the patients.

### **A public health crisis**

I believe that it is helpful and even essential to think about this as a crisis of the public health. Public health was defined in the 1950s as 'the science and art of preventing disease, prolonging life and promoting ... health through organised community efforts ...' (Winslow 1979).

The general concept has its roots in the thoughts and deeds of Rudolf Virchow who sought to reform medicine on the basis of four principles (Eisenberg 1984), including:

- The health of the people is a matter of direct social concern.

- Social and economic conditions have an important effect on health and disease, and these relations must be the subject of scientific investigation.
- The measures taken to promote health and to contain disease must be social as well as medical.

Epidemiology is one of the basic sciences of public health; it is the study of patterns of illness and service use in a population. Psychiatric epidemiology has a strong record of contribution to understanding the nature of mental illness and to recognising needs for services. Epidemiological study allows the needs of the whole community to be considered in the program of reform, not only the needs of those who seek treatment from services as they are currently arranged.

Many notable epidemiological studies have provided insights into the nature of mental illnesses. It is curious that the recognition and treatment of neurosyphilis and pellagra, two of the great success stories of 19th century medicine and epidemiology, occurred in the setting of the asylum.

Certain traditional public health practices are now being challenged by a swing of opinion towards 'individual' principles: the protection of the human rights of a few is often seen as more important than the health of the majority; the quality of life is gradually becoming more important than its mere extension (Sartorius 1990); and the imperative to suppress disease is being supplanted by the imperative to learn to live with pain and disability. However none of these developments challenge the basic principles espoused by Virchow or by the tenets of social medicine and have been, if anything, anticipated by the debates in psychiatry about the nature of mental health and mental illness.

### **THE EXTENT OF THE CRISIS**

I turn now to local and international examples of the extent of the crisis in the care of people with mental illness. The examples illustrate the epidemiological approach to understanding the needs for services, and sometimes concurrently to understanding the nature of mental illness.

#### **Homelessness and mental illness**

Homeless mentally ill people became highly visible in cities in the USA in the late 1970s. They are still there. Torrey (1988) has described the situation as a national disgrace:

The vast hordes of mentally ill homeless persons are tragic by any measure. Crowded into public shelters they look like refugees from a war, which in fact they are. The generals in the war were mental health professionals and administrators who convinced the nation that deinstitutionalisation would work. It did not, and the psychiatric refugees bear mute testimony to its outcome (p9).

It did not work there or here because those same professionals and administrators did not or could not ensure that the money from closure of the institutions followed the patients and remained dedicated to treatment and care of mentally ill people, including those who have never spent long periods in hospital. Governments and administrations have been variably aware and concerned about this issue. Newer generations of administrators arrive and inform us that psychiatric services have more than their fair share of resources. The advocate is advised to avoid the alarming concept of unmet need when talking to pressed administrators. During the 1980s in Australia, the problems of homeless people became increasingly apparent to service agencies if less visible on the streets than in the USA (Herrman *et al* 1989; Teesson and Buhrich 1990; Virgona *et al* 1993).

The pictures of life for mentally ill people in boarding houses in our cities are reminiscent of the pictures we regard with horrified fascination from the period of decline in the great asylums. At the same time it is important to note that most homeless people are not mentally ill. Many advocates for homeless people are understandably at pains to emphasise this point. However it is helpful neither 'to (ignore) the presence among the homeless of those who would profit from treatment, nor to be foolish enough to think that the problem of homelessness will be solved in the absence of attention to the pressing social, welfare and housing issues that affect all homeless people' (Koegel *et al* 1988).

In the late 1980s a group of colleagues and I conducted a survey, sponsored by the Council to Homeless Persons, of homeless people living in marginal accommodation in Melbourne. Almost half of the survey respondents received at least one diagnosis of severe mental



# Boarding houses 'national disgrace'

By Julie-Anne Davies,  
health reporter

"My initial reaction to boarding houses in this area just made me cry... I wonder how such conditions can exist in this world and what I have seen I will never forget." — An expert witness giving evidence before the inquiry.

**C**ONDITIONS in most boarding houses throughout Australia are a national disgrace, according to the Burdekin inquiry report.

The report paints a damning picture of the largely unregulated boarding house industry that is home to thousands of mentally ill Australians.

Many of these houses, run by private operators, have become a de facto part of the mental health system — the dumping ground for mentally ill.

Boarding houses represent a form of scaled down re-institutionalisation, the report says, but without the major advantage of hospitals — medical treatment.

The report estimates that upwards of 80 per cent of boarding house residents are people with a chronic psychiatric disability.

Many boarding houses cater almost exclusively for mentally ill people.

The report says that mentally ill people provide boarding house owners with a "generally docile clientele who are easily controlled and prepared to accept minimum standards".

Psychiatric patients also represent a cash cow for unethical proprietors because of the guaranteed regular income generated by pensions and benefits.

In many boarding houses managers control all residents' money with their pensions simply paid into accounts which the manager operates.

Generally residents pay between 85-90 per cent of their pension for room and board, leaving very little money to buy anything else.



**Nowhere to go:** This is "Ben". He pays about \$80 a week for this small room in the city, but he's not complaining. "Ben" has nowhere else to go and is happy in his meagre surroundings. Like many, he is hidden behind high fences or in a small room in an old mansion. "They have no money for a bond, advance rent and furniture, they are single and have no chance on the private rental market," says the Rooming House Tenants' Association co-ordinator, Ms Carmel Boyce.

"It's about economics and what's available; there is little choice." She estimates that 30 per cent of rooming house residents have psychiatric problems and a further 40 per cent have personality or behavioral problems. Added to that are the alcohol and drug dependency problems many experience, making them open to abuse from exploitative landlords.

Picture: CRAIG SILLITOE

Published on 10 October 1993. Reproduced by courtesy of *The Sunday Age*.

illness for the month before interview, and over 70 per cent received lifetime diagnoses. About one in five were diagnosed as having a current psychotic illness, that is, schizophrenia or a related illness. Forty per cent had previously been treated in a psychiatric hospital. The results were comparable with those from surveys in the USA (Herrman *et al* 1989). Evidence from this work and from the day-to-day experience of many tells us that the instances photographed and reported in our newspapers are not isolated, but represent the conditions of life of hundreds or more likely thousands of mentally ill people in our community.

The implications are that the most vulnerable and disabled group in both Australia and the USA includes many people with severe mental illness. As government policies adversely affect the supply of affordable housing and eligibility for and levels of benefits, more of these vulnerable people will be forced to live without shelter (Herrman 1990). These studies, in common with work elsewhere, make us aware that we can no longer stand back and say that many of the people with severe mental illness are homeless or living under miserable conditions by choice. For most homeless mentally ill people that we saw, severe mental illness preceded homelessness rather than resulted from their distressing circumstances of life as marginally accommodated people (Herrman *et al* 1992).

Nor may it be legitimate to say that homeless mentally ill people have a choice of whether to use services provided for everybody else. Some people will choose to avoid all service contacts, but for many others the manner of service delivery clearly determines whether a real choice is available. How we provide services to people with severe mental illness is likely to affect their risk of becoming homeless.

## Mental illness in sentenced prisoners

Commentators here and elsewhere have speculated that over recent years prisons, jails, and remand centers have become repositories for people with severe mental illnesses. Until recently, however, there has been little information to support or refute these views.

In the late 1980s my colleagues and I followed our survey of homeless people with a study of prisoners in Melbourne (Herrman *et al* 1991). The aim of this survey was to estimate the prevalence of severe mental disorders in a representative sample of sentenced prisoners in Melbourne's three metropolitan prisons. Six prisoners

(3 per cent) received current diagnoses of psychotic disorders, and twenty-three (12 per cent) were diagnosed as having current mood disorders, mainly major depression. A lifetime diagnosis of at least one mental disorder each was made for 82 per cent of the respondents; 70 per cent received lifetime diagnoses of dependence on or abuse of alcohol, and other psychoactive substances. These findings do not indicate a large-scale shift of deinstitutionalised psychotically ill people from mental hospitals to prisons. They do, however, highlight the diversion into the corrections system of substance-dependent people and the apparent group of prisoners with largely untreated major depression. The study gives an idea of the scale of the problem, and our findings are consistent with those available overseas.

In a further arm to the study, the sample of 189 prisoners was matched with the records of state psychiatric service use in the Victorian Psychiatric Case Register (VPCR). Records of contact with the state services were found for 54 men (34 per cent) and 19 women (61 per cent). For 64 per cent of individuals with a positive match, the case-note diagnoses were substance use disorders only. The findings from this study contrast with the high rate of psychotic illnesses found in homeless people in inner Melbourne at about the same time. It seems that by and large people with psychotic illnesses do not find their way into the sentenced prisoner population serving time for serious crime. It is more likely that a 'revolving door' operates in remand centres and to a lesser extent in prisons, much as it does in hospitals. On the other hand it is evident that depression and alcohol and drug use are major problems among prisoners (Herrman *et al* 1994).

## 'Dual disability'

Once people become homeless, or enter the criminal justice system, they tend to become isolated from services that do exist in the community (Marshall 1992). The same applies to people who have drug and alcohol related disorders in addition to serious mental illnesses of other kinds, and to the large number of our fellow citizens with intellectual disabilities who also have serious mental illness. Rates of mental illness are high in people with intellectual disability, and we are aware of high levels of unmet need, in the form of distress and misery for the ill people and for their families and other carers. Dedicated clinical services and supported accommodation are almost



non-existent, and yet access to other services is achieved with the greatest difficulty for those most in need.

One of the major scandals of our time is the unknown number – but probably thousands – of people with intellectual disability who are suffering undiagnosed and untreated psychotic illnesses. The avoidable distress and misery may lead to disturbances of behaviour unmanageable for families, cottage housing, or staff of the remaining large institutions. In many cases these people are in prison. Advocates and administrators try in vain in individual cases, but the system cannot help at present. Moves are now underway to describe and enumerate the problem, but up to now the paucity of epidemiological information and of an assessment of the scale of need has been a hindrance to discussion and resolution (Einfeld 1992).

### Services for people of NESB and Aboriginal Australians

For different reasons again, people of non-English speaking background and Koori people have limited access to acceptable services. Important epidemiological and health services research illuminating these issues have been undertaken locally. The results have indicated that in both of these groups, illness rates are higher than in the rest of the population, and yet rates of service use are lower (Minas 1990; McKendrick 1992, 1993).

### Suicide

Suicide – linked in the public mind with mental illness – is a leading cause of death, and suicidal deaths are more common than road traffic accident fatalities. Suicide is more likely to occur in people with personality disorders, severe depression and schizophrenia, but a particular illness does not in itself cause suicide. Alcohol use is often implicated.

Ian Webster from Sydney and other commentators, including Norman Kreitman from the UK have noted the comparatively slow pace of progress in understanding and developing approaches to the prevention of suicide. Kreitman (1990) proposes a step forward in which we attempt to combine the findings concerning the role of social factors such as unemployment with more recent studies on the significant part played by psychiatric illness.

Older men are prone to suicide, particularly those who are physically ill and alone. Also one in five deaths in males aged 15 to 24 years is from suicide. On this issue, newspaper reports note the doubling or the rapid increase of suicide rates in young men and comment on the fall in suicide rates in older people. However, most deaths from suicide still occur in middle-aged or older men. This fact is important when considering preventive strategies.

### Violence

This is an area addressed by Professor Beverley Raphael in the 1992 Beattie Smith Lecture. According to a longstanding stereotype, mentally ill people are prone to violence – an image reinforced by the news and entertainment media. However most mentally ill people are not violent, and most violent people are not mentally ill.

The importance of this issue cannot be minimised in individual cases. However, empirical research provides less than definitive support for the stereotype. The epidemiological study of mental illness and violence is an important subject which is still piecemeal in its findings and yet is vital in the eyes of the community and the professions (Taylor 1993).

### Death and illness in patients with serious mental illness

A number of studies in various parts of the world have made systematic observations of the excess mortality and physical ill health of patients with mental illness (Ohman *et al.* 1989). For instance, from a study linking the records of mortality and general hospital discharge in a group of 600 patients diagnosed as schizophrenic in Oxford and the surrounding county, my colleagues and I were able to see that deaths among the patients over a ten year period were twice as numerous as expected based on rates prevailing in the Oxfordshire population over the same periods, and the numbers of general hospital discharges were also higher than expected. These findings were not surprising, although this was an unusual opportunity to observe these phenomena. It was the pattern of deaths and morbidity which were particularly thought-provoking. Ischaemic heart disease was the commonest cause of death in both sexes, but did not account for the excessive number of hospital discharges. Trauma and poisoning

accounted for the excess both of deaths in younger members of the study group and of general hospital discharges overall.

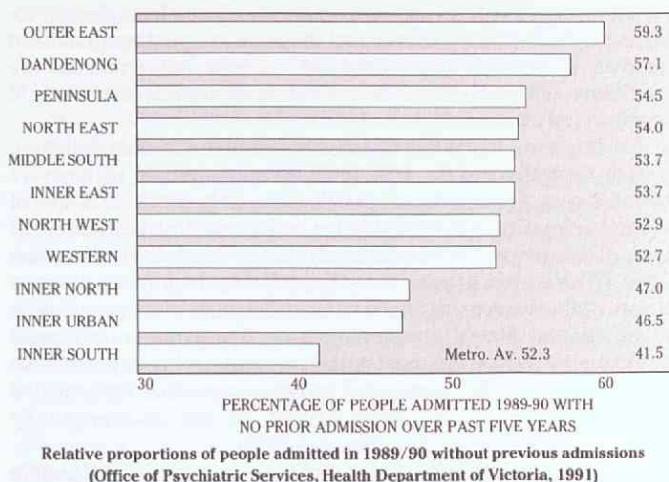
The major causes of premature death in people diagnosed as schizophrenic have changed over the past fifty years, and the pattern of morbidity appears to have followed suit. It appears that, while the inmates of the great asylums died prematurely from TB and neglect, young people diagnosed as schizophrenic today die from, or suffer disproportionately from, trauma and poisoning. This suggests that the living conditions and social environment associated with the diagnosis schizophrenia are important determinants of the pattern of illness and death among people so diagnosed (Herrman *et al.* 1983).

People with a history of mental illness have an increased risk of premature death and illness of other kinds, often avoidable and often not detected as a consequence of their mental state and the separate service systems. There is a need which is frequently unmet (Brugha *et al.* 1989), for regular medical assessment and care for patients with longstanding mental illness, whether living at home or in an institution.

### Victorian Psychiatric Case Register (VPCR)

The Oxford studies illustrate the use in epidemiological work of linked records over time of individual people. In Victoria, the Psychiatric Case Register established by Drs Alan Stoller and Jerry Krupinski in 1963 has remained as one of the longest-standing collections of information about use of psychiatric services in the world (Krupinski *et al.* 1982). It has been an invaluable resource in studies of service use and in studies of the course of schizophrenic illnesses.

For instance it surprises most people working in the services that approximately half of all people contacting our state psychiatric services in any one year are doing so for the first time. This group and their families by and large have different needs from those of patients with longstanding illnesses (OPS 1991). This same data base has shown in the period of a year spanning 1989-90, that 10 per cent of the people admitted to Melbourne state psychiatric hospitals, had three or more admissions during the period. These people accounted for 27 per cent of all admissions in this time, and a higher proportion of so-called occupied bed days. Without adequate domiciliary or other community-based services, a small number of highly disabled patients accounts for a sizeable proportion of hospital admissions.



Most contacts with a mental health service are from people with longstanding and severe illness, and any cross-sectional view or census of a service will reveal the same picture of a concentration of people with chronic rather than hopeless-seeming conditions. This 'clinicians' illusion' contributed to traditional views about the nature of mental illness. Even in the days of the asylum, those who got better left, and any who could avoid it did not enter.

### RESOLUTION OF THE CRISIS

Despite the sorts of evidence marshalled here, the basic concepts that underpin service provision for those with mental illnesses have remained unchanged by and large over several decades. Are there any reasons to believe that this situation can change? Can changes in understanding of the nature of the major forms of mental illness be



translated into changes in clinical practices, service delivery and community attitudes? The evidence is that possibilities for change exist in the two broad domains of service organisation and prevention.

## Services

Services may be organised to provide appropriate levels and continuity of care to those who need it. There is evidence that many of the people with severe mental illness who are out of contact with services can benefit from the provision of acceptable and accessible services. There is evidence that the 'revolving door' can be stopped; and outcomes for individuals improved when assessed in terms of symptoms, disability levels and quality of life (Rosen 1992).

There is evidence on the same types of measures of the efficacy of general practitioners' detection, treatment and consultation about patients with mental illness (Sartorius *et al* 1993).

Many people in Australia and in other countries believe that the organisation of mental health services and community attitudes to mental illness are important targets for reform. Clear evidence exists that in many contemporary societies, including our own, large-scale institutional care and the alienation of mental health care are no longer acceptable (Singh 1992). Practices have changed or are changing irrevocably throughout the world. In an unprecedented move, the United Nations adopted a *Charter on the Rights of Mentally Ill People* in December 1991. This adds to local imperatives, and focuses debate on how to enhance reforms in mental health care. National policies have been devised in many countries. *The Australian Mental Health Care Policy* and *The Australian Mental Health Care Plan* were both released in 1992, and represent a major achievement of consensus and resolve at national levels. They set broad guidelines and monitoring arrangements for a program of reform.

We come back, then, to Scull's dilemma. It is not acceptable nor effective to suggest a return to the asylum. What is required instead is the development of a flexible range of preventive, management and accommodation services for people with severe mental illness. Psychiatric services and services from other sectors need to work together. Yet we have not been able to achieve any of these things consistently over the past thirty years, and according to our newspapers and our own experience we are losing ground. The report just released by the Schizophrenia Australia Foundation, from a project team lead by Dr John Houlst (*Care of the Seriously Mentally Ill in Australia: a rating of state and regional programs*), demonstrates that in most areas of the country we are well behind what could be regarded as best or even adequate practice.

## Prevention

Prevention is rarely all or none, in psychiatry or any other field of action. Nor is the field of action restricted to the mental health care or health care sector. Worthwhile action often requires cooperation between different sectors of government and enterprise. There is enormous scope for prevention of disability and handicap associated with mental illness and for the promotion of mental health in our community. The opportunities are more clearly seen when the traditional barriers between different forms of illness are removed, and the fear and mystery surrounding severe mental illness reduced by its treatment in general health care settings and in the community. Mental illness is a form of human experience, and we are gradually learning more about the modifying factors in the course of various types of illness. We are also interested in the sources of wellbeing in the human experience and of resilience in the face of adversity.

An important aspect of mental health promotion concerns family caregivers. As services change, the locus of care in all fields of health care has moved from large hospitals to the home – for people with mental disorders including schizophrenia and dementia, for the frail elderly more generally, for intellectually and physically disabled children, and for people of all ages with disabilities of various kinds.

Families with responsibility for care can experience a sense of isolation from friends, family and the community, and frequently are not offered help or information by services with limited resources. Their wellbeing and health, physical and mental, is likely to suffer (Herrman *et al* 1993).

The Victorian Health Promotion Foundation has sponsored a program of research and health promotion based in the Department of Psychiatry at St Vincent's Hospital. One of the first tasks of the program was to undertake a community survey to estimate the prevalence of caregiving, in the sense of how many households in this

state contained an individual who identified herself or himself as having primary responsibility for caring for a relative or close friend with a long-term illness or disability of any kind; and to determine the effects on the caregiver. In the survey conducted in 1993 a caregiver was identified in five per cent of households, and most agreed to be interviewed; 80 per cent were women, and mostly middle-aged, and half of the care recipients were 75 years of age or more. However men and women of all ages and in many different circumstances were encountered.

An important preliminary finding was the low rate of contact with formal services or support organisations. Less than half of the carers had received any information about relevant services and organisations. Only five per cent of those surveyed had had any kind of respite care for their relatives in the previous year, and 20 per cent said that they would like it. Only 12 per cent of the carers belonged to a support organisation. This is particularly interesting in view of the fact that much past research was based on small samples of carers contacted through support organisations. These results suggest a number of means by which to support caregivers with the aim of improving wellbeing and preventing ill health (Schofield 1993).

Progress is currently rapid in recognition of the importance nationally of prevention in mental health, as in other countries (Raphael 1992). Australia has developing Goals and Targets for Health to the Year 2000, and the Australian Health Ministers have identified mental health as one of the four focus areas (the others being cancer, cardiovascular disease and injury).

Community attitudes, in particular stigma, have a significant effect on the level of wellbeing of mentally ill people and their families. Access to and use of services in particular is affected by community attitudes to mental illness; and studies demonstrate that attitudes to service use are in turn one of the main determinants of outcome.

In clinical practice with those in contact with mental health services there are important opportunities for prevention of added disability and handicap. Our basic task in medicine is to do more good than harm. In some instances we may not be doing this. There is growing evidence that the way in which we treat and regard people with psychotic disorders for instance has a profound influence on the course and outcome of the disorder, and in particular on the associated disabilities. The practices of the recent past and in many cases of the present day have added and do add to the burdens of stigma, isolation, and despair to which many young people and their families are prone upon receiving such a diagnosis. The Early Psychosis Prevention and Intervention Centre sponsored by the Victorian Health Foundation and the state government at Parkville Centre and Royal Park Hospital has taken a national lead in this area.

The situation can change, and there are international and national forces promoting reform. I return to the question of how do we overcome the seeming paralysis of our capacity to respond in this area, which we share with other societies, and how do we marshal our local resources to understand and achieve the changes required.

## CONCLUSIONS

There are three important points to be made:

1. A public health perspective assists us to reflect on the nature of mental illness, the needs for treatment and care, and the organisation of services.
2. Service reform is necessary to provide flexible and adequate community services. While planning an ideal mental health system is beyond reach, it is important to espouse the guiding principles to be used by planners. These are informed by history and current reality. They need scrutiny in order to avoid rigid adherence to ideology. Organisational principles and models of care that have worked in some places may be inapplicable in other settings. At the same time we need to be absolutely clear that large-scale institutional care and the alienation of mental health care are no longer acceptable. These practices have changed or are in the process of change throughout the world as noted above.

Mental health care today is desirably multi-disciplinary, provides community-based and domiciliary treatment and continuity of care where required, and is part of a general health care system. This entails limited inpatient care in general hospitals and close links with primary health care, and with accommodation and welfare services. Specialist services take their place as one of the several types of care available.

We can be clear about and have demonstrated to us the dangers of deinstitutionalisation imperfectly implemented. More positively,



the following points are also clear from local and world wide experience. Community care, properly provided, can indeed improve the quality of life of people with serious mental illness; however it is important to note the continuing need to provide asylum for the most disabled.

Adequate community provision is labour intensive and is no cheaper than institutional care and will be more expensive in the bridging period, when elements of both services are provided. Finally, the full potential of community-based psychiatric services will only be realised where the administrative and financial structures exist to integrate local services into a co-ordinated programme of care (Thorncroft and Bebbington 1989).

3. The scope for prevention of mental illness and the promotion of mental health is now widely recognised. Prevention in the field of mental health is not all or none. Rarely can we turn off a pump supplying polluted water and prevent an epidemic. In psychiatry we can be blinkered by that perspective on prevention, as well as by outmoded concepts of the nature of mental illnesses. We are usefully concerned with vulnerability to disorder, and modifications to the course of disorder, rather than narrowly concerned with avoiding precipitants. We are particularly concerned with attempts to modify community attitudes to mental illness and so indirectly improve the outcome for people with mental illnesses.

As the asylums empty and many prepare for closure, it is poignant to sense their original grandeur, tranquillity and humane intent. It is neither acceptable nor desirable to recreate the large asylums, but flexible and adequate community alternatives need to be provided: for patients and their families. I put it to you that the merging of psychiatry with the mainstream of health care, will make this possible if the community uses its will to provide adequate resources. Scull's dilemma is a misnomer. There is no dilemma, but only a failure of resolve and a failure of provision.

I remind you of the resources and the tradition of innovation in the Australian community. Solutions exist to the problems I have described. There are people in psychiatry, the health care professions, and in support and community managed organisations in our community who have the expertise, intelligence and will to work with the government in this area.

Those of us in the University, in the general hospitals and in private and general practice can contribute, along with those in state mental health services and community managed organisations. We must listen to and work with patients and their families. There is much work to be done, each of us using our professional expertise, and our understanding of the needs and resources of our local communities.

## References

Abrahamson D. Institutionalisation and the long-term course of schizophrenia, *British Journal of Psychiatry* 1993, 162:533-538.

Brugha TS; Wing, JK; Smith, BL. Physical health of the long-term mentally ill in the community. Is there unmet need? *British Journal of Psychiatry* 1989, 155:777-781.

Bleuler ME. The long-term course of schizophrenic psychoses in Wynne LC, Cromwell RL, and Matthysse S; eds. *The nature of schizophrenia: New approaches to research and treatment*. New York: John Wiley & Sons 1978, pp631-636.

Cooper B. Sociology in the context of social psychiatry, *British Journal of Psychiatry* 1992, 161:594-598.

Cooper B. Single spies and battalions: the clinical epidemiology of mental disorders, *Psychological Medicine*, 1993, 23:891-907.

Eaton WW, Bilker W, Haro JM, Herrman H, Mortensen PB, Freeman H, Burgess P. Long-term course of hospitalisation for schizophrenia: Part 11. Change with passage of time. *Schizophrenia Bulletin* 1992, 18:2, 229-241.

Einfeld SL. Clinical assessment of psychiatric symptoms in mentally retarded individuals. *Australian and New Zealand Journal of Psychiatry* 1992, 26: 48-63.

Eisenberg L. Rudolf Ludwig Karl Virchow, where are you now that we need you? *American Journal of Medicine* 1984, 77:524-532.

Freedman DX. The President's Commission: realistic remedies for neglect – pragmatic next steps – not a trip. *Archives of General Psychiatry* 1978, 35:675-676.

Herrman H, Baldwin JA, Christie D. A record-linkage study of mortality and general hospital discharge in patients diagnosed as schizophrenic. *Psychological Medicine* 1983, 13:581-593.

Herrman H. Schizophrenia and biological determinism. *Australian and New Zealand Journal of Psychiatry* 1989, 23: 48-52.

Herrman H, McGorry P, Bennett P, et al: Prevalence of severe mental disorders in disaffiliated and homeless people in inner Melbourne. *American Journal of Psychiatry* 1989, 146:1179-1184.

Herrman H. A survey of homeless mentally ill people in Melbourne, Australia. *Hospital and Community Psychiatry* 1990, 41:12, 1291-1292.

Herrman H, McGorry P, Mills J, Singh B. Hidden severe psychiatric morbidity in sentenced prisoners: an Australian study. *American Journal of Psychiatry* 1991, 148:236-239.

Herrman H, McGorry PD, Bennett P, et al: Use of services by homeless and disaffiliated individuals with severe mental disorders, in *Primary Health Care and Psychiatric Epidemiology*. Edited by Cooper B, Eastwood MR, 1992, pp142-159.

Herrman H, Singh B, Schofield H, Eastwood R, Burgess P, Lewis V, Scotton R. The health and wellbeing of informal caregivers: a review and study program. *Australian Journal of Public Health* 1993, 17:3, 261-266.

Herrman H, Mills J, Doidge G, McGorry P, Singh B. The use of psychiatric services before imprisonment: a survey and case register linkage of sentenced prisoners in Melbourne. *Psychological Medicine* 1994, 24:63-68.

Jones K. Scull's dilemma. *British Journal of Psychiatry* 1982, 141:221-226.

Koegel P, Burnam A, Farr RK: The prevalence of specific psychiatric disorders among homeless individuals in the inner city of Los Angeles. *Archives of General Psychiatry* 1988, 45:1085-1092.

Kreitman N. Research issues in the epidemiological and public health aspects of parasuicide and suicide. In Goldberg D, Tantom D: *The public health impact of mental disorders*. Hogrefe and Huber, Toronto 1990.

Krupinski J, Alexander L, Carson N. Patterns of psychiatric care in Victoria 1961-1978. A computerised patients' register study. Special Publication No. 12. Melbourne Australia: Mental Health Research Institute, Health Commission of Victoria, 1982.

Marshall M, Gath D. What happens to homeless mentally ill people? Follow up of residents of Oxford hostels for the homeless. *British Medical Journal* 1992, 304:79-80.

McEwan I. *Black Dogs*. Jonathan Cape, London 1992.

McKendrick JH, Cutter T, McKenzie A, Chiu E. The pattern of psychiatric morbidity in a Victorian urban Aboriginal general practice population. *Australian and New Zealand Journal of Psychiatry* 1992, 26:40-47.

McKendrick JH. Patterns of psychological distress and implications for mental health service delivery in an urban aboriginal general practice population. MD Thesis. University of Melbourne 1993.

Minas IH. Mental health in culturally diverse society. In: Reid J, Trompf P, eds *The health of immigrant Australia: A social perspective*. Marrickville: Harcourt Brace Jovanovich Group (Australia) Pty Ltd 1990.

Office of Psychiatric Services (OPS): *Acute psychiatric services for Metropolitan Melbourne 1989-90*. Health Department Victoria, Melbourne 1991.

Ohman R, Freeman HL, Holmkvist AF, Nielzen S. (Eds) *Interaction between mental and physical illness. Needed areas of research*. Springer-Verlag, Berlin, Heidelberg 1989.

Raphael B. *Scope for prevention in mental health*. National Health and Medical Research Council, Commonwealth of Australia, AGPS, Canberra 1992.

Reark Research Pty Ltd. *Community attitudes to mental illness*. Prepared for Australian Department of Health, Housing, Local Government and Community Services, December 1993.

Rosen A. Community psychiatry services: will they endure? *Current Opinion in Psychiatry* 1992, 5:257-265.

Sartorius N. Preface in Goldberg D, Tantom D: *The public health impact of mental disorders*. Hogrefe and Huber, Toronto, 1990.

Sartorius N, Ustun B, Costa e Silva J, Goldberg D, Lecrubier Y, Ormel J, Von Korff M, Wittchen, H. An international study of psychological problems in primary care. *Archives of General Psychiatry* 1993, 819-824.

Schofield H, Herrman H. Characteristics of carers in Victoria. *Family Matters* 1993, 34:21-26.

Singh B. Mainstreaming psychiatric services. *The Medical Journal of Australia* 1992, 156:373-374.

Taylor PJ, Felthous AR. Forensic Psychiatry: Editorial overview. *Current Opinion in Psychiatry* 1993, 6:747-753.

Teesson M, Buhrich N. Prevalence of schizophrenia in a refuge for homeless men: a five-year follow-up. *Psychiatric Bulletin* 1990, 14:597-600.

Thorncroft G, Bebbington P. Deinstitutionalisation – from hospital closure to service development. *British Journal of Psychiatry* 1989, 155:739-753.

Torrey EF. In: *Nowhere to go: The tragic odyssey of the homeless mentally ill*. (Ed Torrey EF). Harper and Row, New York 1988, 199-217.

Virgona A, Buhrich N, Teesson M. Prevalence of schizophrenia among women in refuges for the homeless. *Australian and New Zealand Journal of Psychiatry* 1993, 27:405-410.

Wing JK, Brown GW. *Institutionalism and schizophrenia*. London: Cambridge University Press 1970.

Winslow R. (1979) quoted after Hobson W. (Ed) *The theory and practice of public health* (5th ed) (xi-xiii). New York, Oxford University Press.

World Bank. World Development Report, 1993. *Investing in health*. Oxford University Press, Oxford 1993.



## ACUTE STROKE: A NEW ERA

PROFESSOR GEOFFREY A DONNAN

Director, Department of Neurology, Austin and Heidelberg Hospitals



PROF GEOFFREY DONNAN

**S**TROKE IS A SUBJECT which has been under-emphasised, in spite of the fact that it represents a significant burden on our society and affects those from childhood right through to those in their last decades of life. Perhaps even more importantly, the incidence of stroke peaks usually during the sixth decade of life, a time at which many have retired and are looking forward to twenty years or more of a more leisurely approach to life.

### The size of the problem

Approximately 37 000 new strokes a year occur throughout Australia! This represents approximately 100 cases a day. About one-third of these will die within the first month after the event and a high proportion of the remainder will be disabled. The social impact of stroke is therefore quite significant. The direct and indirect costs have been estimated to be around one to two billion dollars a year. Among recently released figures from the Victorian Health Department, stroke was listed as the prime cause of in-patient death for Victorian hospitals.

### Existing forms of therapy for stroke

If we are to talk of a new era in stroke, what eras have preceded this one? From earlier this century there have been surgical procedures which have ameliorated symptoms of acute stroke. Specifically, drainage of posterior fossa and hemispheric haematomas may occasionally be life-saving procedures. Clipping of cerebral aneurysms causing subarachnoid haemorrhage significantly reduces subsequent morbidity and mortality. Decompression of raised intracranial pressure due to cerebellar infarction may also be life saving on occasions.

Risk factor modification has been carried out since the 1950s when antihypertensive agents were first introduced. We now know that hypertension together with smoking and the ageing process are the major risk factors for stroke. However, it was not until the late 1980s that smoking was clearly established as a stroke risk factor and, latterly, our group has demonstrated that passive smoking (particularly living with a smoking spouse) may double the risk of stroke.

Anticoagulants have been in use in cerebrovascular disease since the 1950s, but it was not until the recent trials of Warfarin and Aspirin in non-valvular atrial fibrillation that the role of Warfarin as a primary prevention mechanism was clearly established in patients with non-valvular atrial fibrillation<sup>2</sup>. Aspirin has been the most effective antiplatelet agent as a means of secondary prevention after transient ischaemic attack or minor stroke and a recent meta-analysis of all antiplatelet trials suggested that the use of these agents may reduce the risk of subsequent stroke by around 20 per cent<sup>3</sup>.

It can be seen, therefore, that there have been major contributions made in the past to stroke therapy in terms of both primary and secondary prevention, as well as acute therapy. In the case of ischaemic stroke, however, there is still no proven form of therapy which may minimise the extent of infarction once it has occurred.

There is now a series of agents which are undergoing evaluation which may change this picture quite dramatically over the next few years.

### The rationale for therapy

There have been three main factors which have contributed to our expectation that forms of acute therapy may be of some value after acute ischaemic stroke. These relate to the concept of the 'ischaemic penumbra', the demonstration that a variety of neuroprotective and thrombolytic agents have proven to be effective in animal models of cerebral ischaemia and the remarkable advances that have occurred in clinical neuroimaging over the past twenty years.

1. *The ischaemic penumbra.* This refers to a 'penumbra' of potentially viable tissue surrounding the core of a cerebral infarct. The presence of this was demonstrated initially by Symons and colleagues at Queen Square during the late 1970s and early 1980s<sup>4</sup>. He showed this in animal models and in patients undergoing surgery for subarachnoid haemorrhage. By reducing cerebral blood flow to around 20 per cent of normal values a zone of electrical silence was created which could be reversed once the blood flow was restored. However, if the blood flow was reduced to 10 per cent or lower than normal values, influx and efflux of ions, particularly calcium, occurred and irreversible cell death eventuated. By using somatosensory evoked potentials (sensory stimuli from upper or lower limbs and recording over the cerebrum) during cerebral aneurysm surgery, he was able to show similar periods of electrical silence during reduction in cerebral perfusion. This was reversible after elevation of blood pressure. The presence of this penumbra surrounding infarcts has led investigators to believe that restoration or preservation of this tissue may occur when certain therapeutic strategies are adopted.

2. *Therapeutic success in animal models.* During the 1980s a number of neuroprotective and thrombolytic agents were shown to minimise the volume of infarction when administered after vessel occlusion<sup>5</sup>. Neuroprotective agents include calcium channel blockers, N-methyl-D-aspartate (NMDA) antagonists and free radical scavengers. The introduction of the technique of measuring the volume of infarction in response to various therapeutic agents (rather than assessing neurological deficit) was probably the turning point in evaluating the effectiveness of therapy.

The most important neuroprotective agents are associated with calcium metabolism. The final common pathway of cellular death is the influx of calcium and this may be prevented by either blocking the so-called voltage sensitive calcium channels with such agents as Nimodipine, or agonist-operated calcium channels with competitive (for example, NMDA antagonists) or non-competitive antagonists. In terms of total influx of calcium, the agonist-operated channels are probably more important than voltage sensitive channels. Blockade of either system will reduce the volume of infarction after vessel occlusion.

3. *Advances in neuroimaging.* Without the quite dramatic advances in neuroimaging which have occurred in recent years, it would not have been possible to carry out therapeutic trials of potentially effective agents in the clinical setting<sup>6</sup>. When one considers the pattern of the development of neuroimaging from the turn of the century, when X-rays were discovered, to the introduction of angiography by Moniz in 1927, through to the development of computerised tomography (CT) during the mid to late 1970s, one can see that it was not until the introduction of CT that any real advances in therapy could be undertaken. This is because there was a low sensitivity and specificity in distinguishing cerebral haemorrhage (about 10 per cent



of all strokes) from cerebral infarction based on clinical criteria alone. Since the introduction of CT there have been even further advances. Such modalities as single photon emission computed tomography (SPECT) to measure cerebral perfusion, positron emission tomography (PET) to assess cerebral blood flow, metabolism and oxygen extraction fraction (OEF), magnetic resonance (MR) technology with imaging (MRI), angiography (MRA) or spectroscopy (MRS) are now well established.

Ultrasonography has also been a major contributor to this field with duplex scanning of carotid arteries (a combination of Doppler and B-mode ultrasound technology), transcranial Doppler (TCD) to measure velocity in middle cerebral arteries and transcranial Doppler with emboli detection (TED) as a means of detecting in vivo emboli in the cerebral arterial system. Transeosophageal echocardiography (TOE) has completed this imaging package so that we are now able to image the vascular tree from the tip of the left cardiac ventricle right through to some of the smallest vessels in the brain. Recently, our group (specifically Dr Elizabeth Jones in collaboration with Dr Andrew Tonkin) were able to show that the arch of the aorta often had protruding or mobile atheroma which could be imaged using TOE and that this was an independent risk factor for ischaemic stroke.

Single photon emission tomography (SPECT) is particularly useful in assessing the extent of cerebral reperfusion in response to therapy (Fig 1). Its great advantage is the 'injection now and scan later' technique using 99m Technetium HMPAO. The HMPAO is injected intravenously, following which its neutral lipophilic qualities allow it to cross the blood brain barrier rapidly and be fixed intracellularly, probably to glutathione. This fixation enables the immediate distribution of cerebral perfusion to be mapped but the actual recording may take place up to four to six hours later since the HMPAO remains fixed intracellularly (probably for up to six hours).

We have used this technique (in collaboration with Associate Professor Stephen Davis at the Royal Melbourne Hospital) to assess the extent of reperfusion which occurs spontaneously in patients with ischaemic stroke under normal circumstances and shown that using the thrombolytic agent, Streptokinase, there was a trend towards better reperfusion in this group. SPECT has also been used to predict clinical outcome and to determine the site of cerebral infarction before that of CT.

Positron emission tomography (PET) is the most recent addition to our diagnostic armamentarium here in Melbourne. A small medical cyclotron has been installed at the Austin Hospital, together with a PET camera which now enables us to obtain reconstructed images of cerebral blood flow, metabolism, blood volume and oxygen extraction fraction (OEF). Early mismatches between these parameters may give us deeper insights into the pathophysiological processes involved in cerebral infarction and situations under which therapeutic intervention is more likely to be successful.

It should be emphasised that the time window available to clinicians before irreversible ischaemic cell death occurs in humans is unknown. Positron emission tomography has the potential to measure this time window and thus give investigators a guide as to when therapy might best be introduced.

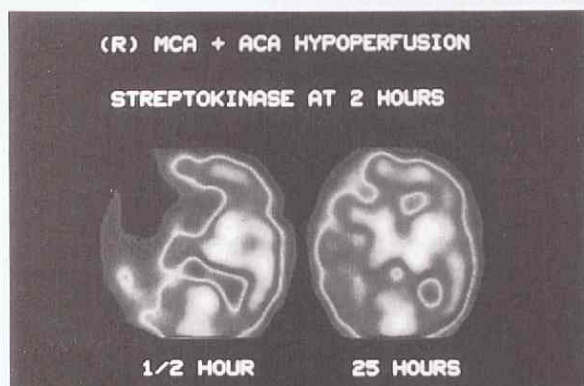


Fig 1: Profound hypoperfusion seen in the territory of the right middle cerebral artery (MCA) and anterior cerebral artery (ACA) half an hour after the onset of acute ischaemic stroke. Streptokinase was administered intravenously at two hours. Reperfusion is seen at 25 hours.

## The environment

In order to administer, manage and assess the efficacy of new therapeutic regimes, a satisfactory environment must exist in which to do so. Stroke Units have the potential to fulfil this role although they were originally set up (at least at the Austin Hospital) with the aims of improving stroke management, educating staff and providing a solid research base. It was realised that better organisation in terms of secondary prevention would be likely but, in view of the fact that no specific form of medical therapy was proven to be effective after acute ischaemic stroke, the possibility that lives may be saved was treated with some scepticism.

A number of trials have been performed to assess mortality and a recent overview by Langhorne *et al* has shown that patients randomised into Stroke Units of various types result in a 21 per cent protection against death at one year compared to those randomised to general medical wards<sup>7</sup>. The reasons for this are unclear but probably more active physical intervention which is likely to reduce complications such as deep venous thrombosis and pulmonary emboli is responsible.

In Australia a number of Stroke Units are now well established and include those at Royal Perth (WA), Queen Elizabeth (SA), Prince Henry and Prince of Wales Hospitals (NSW) and The Royal Melbourne Hospital, Austin Hospital, Repatriation General Hospital and Alfred Hospital in Victoria.

## The trials

The number of trials to test various therapeutic regimes after acute ischaemic stroke has escalated almost exponentially over the past ten years or so (Fig 2). This has been particularly so since the rationale for therapy, as described earlier, has become so apparent. A good example of a compound which has been tested in the acute stroke environment over a number of years is the calcium channel blocker, Nimodipine.

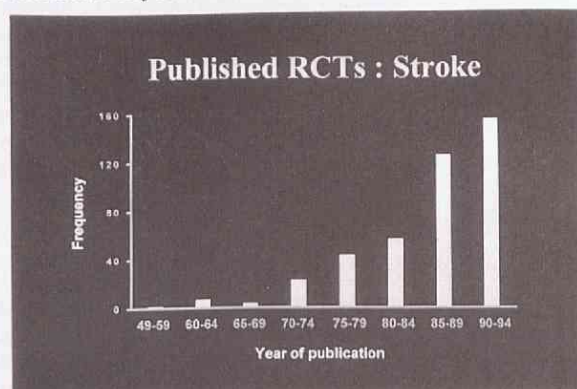


Fig 2: The increase in the number of randomised control trials (RCTs) from 1949 through to 1994. Data from the Ottawa Stroke Trials Registry.

A meta-analysis has shown that its overall effectiveness has not been proven when all studies are considered, but if a sub-analysis using a 12-hour time window for therapy initiation was taken into account, statistical significance was reached. Because this is a post-hoc analysis it should be interpreted with caution, but it does give some hope that, using very early time windows post-stroke for therapy administration, various neuroprotective agents may prove to be effective.

## Trials in Australia

Trials of therapy are now underway in Australia including the Australian Streptokinase Trial (ASK), the International Stroke Trial (IST), a trial of Nimodipine, and there is about to commence a major study using a competitive NMDA antagonist.

### Australian Streptokinase Trial (ASK)

This is the first major Australian study of acute stroke therapy. The hypothesis being tested is that the administration of Streptokinase within four hours of ischaemic stroke is likely to reduce significantly subsequent morbidity and mortality when outcome is measured at three months. There are now 40 centres Australia-wide recruiting patients and the study is planned to run from 1992 through to 1996 (Fig 3). Currently around 290 patients have been entered into the study and an ultimate sample size of 600 patients is required.



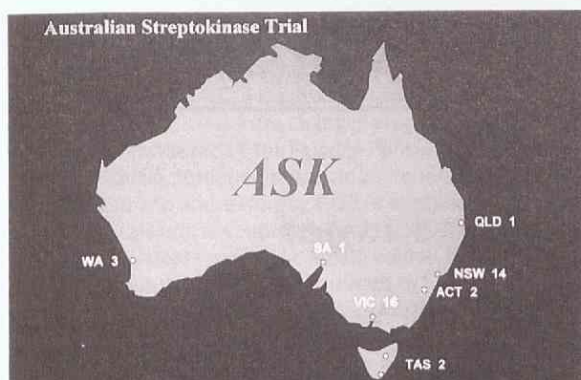


Fig 3: The geographic distribution of study centres for the Australian Streptokinase Trial (ASK).

### Trial overviews

An overview of all thrombolytic trials in acute ischaemic stroke to date has been performed by Joanna Wardlaw from the UK, who has demonstrated that if the endpoint of death or clinical deterioration are used, thrombolytic agents may significantly protect against this outcome. However, the numbers are still rather small and this result should be interpreted with caution.

### Cumulative meta-analysis

This technique involves the sequential addition of trials to overview analyses as they are completed and published. This has the potential to avoid situations such as occurred in, for example, the use of beta blockers post-myocardial infarction. Although a meta-analysis (if performed) would have shown these to be clearly effective as early as in 1975, it was not until later meta-analyses during the mid-1980s occurred that its usefulness was clearly established. In the case of thrombolytic stroke trials, the Thrombolysis in Acute Stroke Pooling Project (TAS-PP) group is undertaking a cumulative meta-analysis to enable clinicians worldwide to give an early indication of the likelihood of the effectiveness of this form of therapy. The Australian group is an active participant and member of this meta-analysis initiative.

### The future

As can be seen from the previous discussion, we are now in a position where all the basic elements for potentially successful acute stroke therapies are in place. We have the sound scientific rationale for its likely effectiveness, the tools to enable us to assess more precisely acute stroke subtypes and we are able to do this in the environment of a number of established Stroke Units. Given the number of trials that are now going on both in Australia and internationally, it appears likely that we will have some inkling as to the likely effectiveness of many of these agents within the next three to five years.

If the current generation of therapeutic agents prove to be effective it is likely to change the way we manage acute stroke irrevocably. The concept that 'time is brain' should not be taken lightly and the need for acute units to assess and administer these therapies is likely to expand dramatically. Hopefully this will have at least some impact on morbidity and mortality of this major blight on our society.

### References

1. Anderson CS, Jamrozik KD, Burwill PW, Chakera TMH, Johnson GA, Stewart-Wynne EG. Ascertaining the true incidence of stroke: experience from the Perth Community Stroke Study, 1989-1990. *Med J Aust* 1993; 158: 80-84.
2. Albers GW, Sherman DG, Gress DR, Paulseth JE, Petersen P. Stroke prevention in nonvalvular atrial fibrillation: A review of prospective randomised trials. *Ann Neurol* 1991; 30: 511-518.
3. Antiplatelet Trialists' Collaboration. Secondary prevention of vascular disease by prolonged anti-platelet treatment. *Brit Med J* 1988; 296: 320-331.
4. Astrup J, Siesjo BK, Symon L. Thresholds in cerebral ischaemia. The ischaemic penumbra. *Stroke* 1981; 12: 723-725.
5. Scheinberg P. The biological basis for the treatment of acute stroke. *Neurology* 1991; 41: 1867-1873.
6. Donnan GA. Investigation of patients with stroke and transient ischaemic attacks. *Lancet* 1992; 339: 473-477.
7. Langhorne P, Williams BO, Gilchrist W, Howie K. Do stroke units save lives? *Lancet* 1993; 342: 395-398. □



## CONTINUING MEDICAL EDUCATION

*Keeping up-to-date with  
Medical Literature using a PC and  
Mac and the Telephone  
Line on your Desk*

Keeping up-to-date with the newest medical information can now be done with a computer on your desk and a telephone line. Last year the School of Medicine Continuing Education Unit and staff at the Brownless Medical Library introduced this new course.

The course is designed to teach medical practitioners how to obtain the text of a medical journal article using a computer to gain access to an overseas database via the international telecommunications system, or on CD ROM. There was such a high demand for the course that it was repeated twice during the year and a decision made to run the course four times in 1995: in February, May, August and October.

After a short introduction to *Medline* (the computerised version of the indexing service *Index Medicus* - produced by the National Library of Medicine, Maryland, USA since 1879), course participants are given close tuition while they formulate a search for information on a topic first using CD ROM and then accessing overseas databases online.

The course is proving very popular with medical practitioners from a variety of areas of practice. Although the courses are filling fast, there may still be some places left. A full list of continuing medical education courses being offered this year is on the back cover of this issue of *Chiron*.

**CME**  
ENQUIRIES  
(+61 3) 9344 5888



## FROM THE DEAN

### HIGHLIGHTS AND ACHIEVEMENTS IN 1994

#### Academic Departments

##### Reviews

The first cycle in a series of rolling reviews of academic departments, a University-wide initiative, took place during 1994. The Department of Anatomy and Cell Biology and the Department of Biochemistry were each reviewed by two University-appointed external reviewers, in both cases one from overseas and one from interstate. The reports of the reviews were submitted to the University's Joint Committee on Policy in the latter part of the year where congratulations to the two departments and the Faculty were minuted, and the reports then referred to Faculty for consideration.

##### Department of Anatomy and Cell Biology

The review concluded that 'this is an excellent department that is fulfilling its missions in education, research, and service to the University and the wider community'.

##### Department of Biochemistry

The review concluded that '(the Department) would now rank among the best Departments of Biochemistry in Australia in the design of its teaching program and its execution . . . It has also emerged as a first-class research institute and would be included in the top two or three departments in Australia. Much of its research is of high quality and international standard'. The recommendation to change the name to the Department of Biochemistry and Molecular Biology was approved by the University, to take effect from 1 February 1995.

The Departments of Medicine (across the three general clinical schools), Microbiology and Paediatrics will be reviewed in 1995.

#### External Review of Key Centre of Teaching and Research for Women's Health in Society

A panel set up by the Australian Research Council's Institutional Grants Committee reviewed the Key Centre of Teaching and Research for Women's Health in Society during April 1994. The Centre was assessed as meeting the objectives of the Key Centre program at a high standard which merited continuation of ARC funding during 1995 and 1996, its eighth and ninth years of operation.

#### Establishment of School of Postgraduate Nursing and creation of Chair of Nursing

The 1993 Annual Report referred to the approval of a postgraduate Diploma in Advanced Clinical Nursing program for introduction in 1994 as a one year full-time postgraduate fee-paying course. In 1994 the first cohort of graduate nurses successfully completed specialty training in intensive care, coronary care, cardiothoracic, emergency and perioperative nursing (through the Royal Melbourne Hospital), and paediatric and paediatric intensive care nursing (through the Royal Children's Hospital). An additional specialty program in renal nursing (Royal Melbourne Hospital) has been approved for 1995.

Building on this foundation, and in accord with the Faculty's Strategic Plan 1994-1996, University approval in principle has been given to establish a School of Postgraduate Nursing within the Faculty on 1 January 1996. To provide leadership for the profession and to head the development of the School, a Chair of Nursing has been approved, to be filled as soon as possible.

#### Other academic developments

In addition to the postgraduate nursing development above, approval was given for the following academic initiatives:

- Establishment of the Beth MacLaren Smallwood Chair of Audiology and Speech Science.
- Creation of Professor/Director positions in:

**Dermatology** (St Vincent's Hospital/Skin and Cancer Foundation);

**Palliative Medicine** (St Vincent's Hospital/Caritas Christi Hospice/Peter MacCallum Cancer Institute/Mercy Hospice Care);

**Neonatal Paediatrics** (Royal Women's Hospital/Royal Children's Hospital);

**Allergy** (Royal Melbourne Hospital/Royal Children's Hospital);

**Infectious Diseases and International Health** (Royal Melbourne Hospital/Walter and Eliza Hall Institute);

**War-related Post-Traumatic Stress Disorder** (Austin Hospital/Heidelberg Repatriation Hospital): Head of the Federal Government National Centre for War-related Post-Traumatic Stress Disorder.

- Candidates were also admitted for the first time into the combined MBBS/BA program and the degree of Master of Women's Health program.

Faculty approved the offering in 1995 of an additional specialty program for the postgraduate diploma of Advanced Clinical Nursing (renal nursing) and new programs for the seven-year combined MBBS/BSc course (primarily in the first instance limited to mathematics and physics studies in Science), for the degree of Master of Public Health, the graduate diploma in Adolescent Health and the graduate diploma in Pharmaceutical Sciences. The Master of Public Health development arises from a Federal Government Department of Health, Housing, Local Government and Community Services Public Health grant awarded on a continuing basis (\$0.6m in 1994, \$1m per annum thereafter) to a Victorian Consortium of Public Health (Deakin, La Trobe, Monash and The University of Melbourne), involving the University's Department of Public Health and Community Medicine.

#### Teaching

##### Undergraduate programs

Faculty maintained its long-standing high priority commitment to quality of education processes and outcomes. Its constituent members were active participants in the special focus placed within the University in 1994 on assessing the quality of students' learning experiences and the results of feedback processes, both in regard to the University's Submission to the Federal Government's Committee for Quality Assurance in Higher Education, and to the Committee's visitation to the University in October. This role included the administering and evaluation of the 'stem question' questionnaires for all subjects terminating at the end of semesters 1 and 2, as well as the normal, on-going processes operating within the Faculty.

This Faculty has an effective policy for monitoring the quality of teaching. The processes in place for consideration of responses from student feedback are efficient and enable prompt deliberations concerning any identified problems. In addition, dissemination of information received from student feedback is conveyed to all students and to appropriate staff with minimum delay.

In a move to stay at the edge of teaching developments and innovations, Faculty invited and received submissions from its School of Medicine teaching units seeking Teaching Developments and Innovations Grants from the Faculty's Development Fund. Funds totalling \$0.82m were allocated in 1994 to 15 teaching/educational units, including \$0.345m (plus university-funded support of \$0.135m from the Federal Government's Committee for Quality Assurance Grant to the University) for the establishment over a three-year period of a Faculty Biomedical Multi-Media Unit, and \$20,000 towards costs (supported also by \$120,000 of the University's Quality Committee funds, and \$30,000 from Western Hospital) for a Tele-lecturing microwave link between Royal Melbourne Hospital and Western Hospital. Funding of \$10,000 was also given to the Brownless Medical



Library as a contribution towards costs for the instruction of medical students in the use of CD-ROM-based information retrieval systems.

Besides its strong involvement in quality of education initiatives during 1994, the Faculty's Curriculum Review Committee continued to monitor closely and to endorse changes proposed to undergraduate programs/subjects offered by the Faculty. Following the evaluation of the third year MBBS Student Questionnaire conducted in 1993, and the identification and addressing in 1995 of areas of concern, Faculty agreed to institute annual meetings of subject co-ordinators for each of the three pre-clinical years of the MBBS course. Reports of the third year MBBS meetings will also be circulated to Clinical Deans and to fifth year MBBS Departments to facilitate vertical integration in the course. The Curriculum Review Committee also established a working group on ethics teaching in the clinical years of the MBBS course to meet at least annually in the promotion of an integrated and consistent approach to ethics teaching across the course. The Committee agreed to form six *ad hoc* working groups, including student membership, set up to give further consideration to submissions made by an MBBS student group dealing with important educational issues.

The strong demand for biomedical teaching by the School of Medicine to BSc students (second and third years) and for BSc (Hons) teaching from the School's pre-clinical and clinical departments, continues. Since 1989 second and third year BSc teaching has increased from 279 EFTSU to 418 EFTSU in 1994. Teaching of BSc (Hons) students has increased from 56 EFTSU in 1989 to 102 EFTSU in 1994. Satisfactory on-going financial arrangements from 1995 for BSc and BSc (Hons) teaching have been negotiated with the Faculty of Science, where the agreed total target teaching load in 1995 is 477 EFTSU and 100 EFTSU respectively.

### Higher degree programs

Places in higher degree programs of the Faculty, particularly by research thesis, continue to be in strong demand. In 1994, 704 EFTSU (compared with 669 in 1993 and 585 in 1992) were enrolled as higher degree students in the Faculty. This is 20.2% of the total teaching load of the Faculty, compared with 19.2% in 1993, 18.3% in 1992 and 10.2% in 1980. For the University, the proportion of higher degree load to total teaching load in 1994 is 11.5%, compared with 12.9% in 1993. The proportion of Faculty higher degree load to University higher degree load in 1994 is 24.5% (compared with 22.7% in 1993 and 13.0% in 1980).

### Research

The research activities of the Faculty continue to generate very strong support from external funding agencies. For 1994 this Faculty again was successful in obtaining the largest allocation of NHMRC funding of any medical/health sciences faculty in Australia. Approximately \$10.4m of NHMRC funds were obtained to support 111 Project Grants and four Program Grants in the Faculty for 1994, as well as approximately \$2m of NHMRC funds awarded to associates of University departments in affiliated teaching hospitals. From all sources outside the University, this Faculty attracted in 1994 a total of approximately \$28.3m (40% of the University total) in funding to support research. If Faculty/University Trust Fund income is excluded, the proportion of University non-recurrent research income derived from this Faculty is 56 per cent.

Faculty remains a strong contributor to research outcomes for the University, the most recent data recording Faculty's research publications (40% of the total University effort), patents (nearly 50% of the total) and contracts (more than 60% of the total).

Faculty continues to maintain and develop major links with industry. At the end of 1994, the successful bid for the Co-operative Research Centre for International Food Manufacture and Packaging Science was announced. This involves Dr Barrie Davidson and Professor Dick Wettenhall of the Department of Biochemistry and Molecular Biology. Other major core participants are Swinburne University of Technology, CSIRO and the Victorian Department of Agriculture's Australian Food Research Institute. This is the fourth Co-operative Research Centre linked directly with this Faculty. The three others are the Co-operative Research Centres for Cellular Growth Factors, for Cochlear Implant, Speech and Hearing Research, and for Vaccine Technology.

Following its decision in 1993 to allocate \$0.5m from the Faculty Development Fund to provide stronger, more sustained funding for

basic infrastructural support, including equipment replacement, Faculty approved a further \$1m for this purpose during 1994. This is in addition to funding received by individual faculties from central University sources relating to research infrastructure support, equipment grant allocations (for teaching and research), and for large equipment items exceeding \$60,000.

## People

### Key appointments taken up in 1994

- Professor Peter Disler, Professor/Director of Rehabilitation Medicine (Royal Melbourne Hospital)
- Professor Kerr Graham, Chair of Orthopaedic Surgery (Royal Children's Hospital)
- Professor Oliver Hennessy, Professor/Director of Medical Imaging (St Vincent's Hospital)
- Professor John Hutson, Professor/Director of Paediatric Surgery (Royal Children's Hospital)
- Professor Margot Prior, Chief Psychologist with title of Professor (Royal Children's Hospital)
- Professor Eric Reynolds, Chair of Dental Science
- Professor Joseph Sambrook, Professor/Director, Peter MacCallum Institute Research Laboratories
- Professor Peter Smith, Professor/Director of Haematology & Oncology (Royal Children's Hospital).

### Key appointments to be taken up in 1995

- Professor Graham Brown, Professor/Director of Infectious Diseases and International Health (Royal Melbourne Hospital and Walter & Eliza Hall Institute)
- Professor Stephen Harrap, Chair of Physiology
- Professor Robin Marks, Professor/Director of Dermatology (St Vincent's Hospital and Skin & Cancer Foundation)
- Professor Robert Williamson, Professor/Director, Murdoch Institute for Research into Birth Defects and Research Professor of Medical Genetics (Royal Children's Hospital)
- Professor Lester Peters, Professor/Director of Radiation Oncology (Peter MacCallum Hospital).

### Other positions pending appointment

- Chair of Dental Medicine
- Chair of Microbiology
- Chair of Obstetrics and Gynaecology (from 1 January 1996)
- Professor/Director of Infectious Diseases (Austin Hospital)
- Professor/Director of Infectious Diseases and International Health (Royal Melbourne Hospital and Walter & Eliza Hall Institute)
- Professor/Director of Medical Imaging (Austin Hospital)
- Professor/Director of Orthodontics (Royal Dental Hospital of Melbourne).

### Retirement

- Professor David O White AO, Professor of Microbiology since 1967, awarded honorary degree of Doctor of Medicine at the conferring ceremony on 10 December 1994, and awarded title of Professor Emeritus by Council.

### Bereavements

- Dr James W ('Wally') Johnstone-Need
- Dr Michael R Luxton
- Dr Robert L Simpson

### Honours, awards and other appointments during 1994

#### Order of Australia

- Professor Graeme B Ryan, AC
- Professor Norman Beischer, AO
- Associate Professor Lorraine Dennerstein, AO
- Dr John P Paterson, AO
- Dr David Brownbill, AM
- Professor Francis T McDermott, AM
- Professor John D Mathews, AM
- Dr Bernard Neal, AM
- Professor Emeritus Peter C Reade, AM
- Dr Gad Trevaks, AM



### 1995 Australia Day Honours

Professor E Carlyle (Carl) Wood, CBE, AC  
Professor Kenneth J Hardy, AO  
Mrs Concetta Benn, AM  
Dr F Ian R Martin, AM  
Mr Ian S Russell, AM  
Associate Professor John K Harcourt, OAM

*Appointment of Chairman, National Health & Medical Research Council* – Professor Richard A Smallwood

*Honorary Life Membership of International Society of Radiology* – Professor Emeritus William S C Hare

*The Louis Barnett Medal (The Royal Australasian College of Surgeons)* – Professor Gordon J A Clunie

*Distinguished Research Prize, Gastroenterological Society of Australia* – Professor John B Furness

*William F Neuman Award, American Society for Bone & Mineral Research* – Professor T J (Jack) Martin

*McIntyre Prize, Australian Physiological & Pharmacological Society* – Dr I Mark Hargreaves

*Lennard Travers Professorship for 1995, Australian & New Zealand College of Anaesthetists* – Dr David P Crankshaw

*1994 Selwyn-Smith Medical Research Prize* – Dr Michael W Parker

*1995 Ian Simpson Award (Royal Australian & New Zealand College of Psychiatrists)* – Associate Professor Pat McGorry

### Appointments of Professorial Associates

Dr Glen C Begley (Medicine RMH/WH)  
Professor Ross L Coppel (Medical Biology)  
Professor Doreen A Rosenthal (School of Behavioural Science)

*University of Melbourne Medical Society 1993 BMedSc Prize*  
Mr Andrew Lovett.

### Affirmative action and other Equal Opportunity initiatives

Faculty maintained its policy of actively seeking and encouraging appropriately qualified women to apply for any vacancy within the Faculty, and is continuing its efforts to increase the number of female staff, particularly in academic positions. In 1988 when the percentage of women academic staff (at levels B, C and D) in the Faculty was 19%, a forward estimate for 1993 of 23% was made. The outcome for 1993 was a successful 26%. The setting of new forward estimates for the next five years is currently under discussion with the objective of further continued improvement.

### Students

Outstanding students continue to be attracted to the Faculty's undergraduate courses. The top 10 VCE students who received the 1994 Premier's VCE Award are all University of Melbourne students, with five of the 10 students being enrolled in the medical course, one of whom is undertaking the combined MBBS/BA course. During the year the 1994 Australian Students Prize winners were announced based on 1993 Year 12 performances. There were 129 Victorian winners out of a national total of 496, with University of Melbourne students gaining 94 of the 129 prizes. This Faculty's students received 50 (or 53%) of the 94 University prizes, comprising MBBS 39, MBBS/BA 8, BDS 2, BPhysio 1.

**Medicine:** The primary VCE Tertiary Entry Score (TES) cut-off was 166 (161 in 1993), students selected on the margin having scores ranging between 158 and 165. The primary TES cut-off for the 10 places in the MBBS/BA course was 170, with selection on the margin being confined to students with scores of 169. Of all students who had either Melbourne or Monash Medicine as first preference and who had a TES (calculated for Melbourne Medicine) of at least 166, 85% had Melbourne Medicine as first preference.

The first year quota of 169, including 10 MBBS/BA, comprised 48% female students, and included 10 students with social and/or educational disadvantage admitted under the University's Special Admission Scheme. The second year quota of 182 included three continuing first year students admitted to the MBBS/BA course, nine lateral entry students and nine Extended Special Admissions Scheme students, the latter gaining admission after the satisfactory completion

of two years of Science to prescribed standards. One student was admitted to the third year quota, and the first cohort of two students, provisionally accepted for MBBS/MDSc (oral and maxillofacial surgery) two years previously were admitted to fourth year following confirmation of completion of a two-year bridging program. Thirty-nine full-fee overseas students were admitted to first year, and 28 such students were enrolled in second year, 52 in third year, 35 in fourth year, 30 in fifth year, and two in sixth year. Three refugee students admitted to the course previously were undertaking studies in the later years in 1994, one of whom successfully graduated. Three students of aboriginal descent were enrolled in the medical course (in years one, two and five) in 1994. The final year graduation class also included eight students previously admitted to the second year of the course as Extended Special Admissions Scheme candidates, following the first cohort of nine such students who had graduated in 1993.

**Dental Science:** The first year quota for non-overseas students of 43 EFTSU was filled with a TES primary cut-off of 158 (cf 156 in 1993) with a selection margin range between 152 and 157. This quota included two Special Admissions Scheme students. Of the total first year quota, 45% were women. In 1994, two full-fee overseas students were admitted to first year, with a total of 10 such students being enrolled in years two to five of the course. One lateral entrant was admitted to third year.

**Physiotherapy:** The first year quota of 80 non-overseas students was filled with a TES primary cut-off of 156 (cf 152 in 1993) with a selection margin range between 151 and 155. This quota comprised 48% women, and two Special Admissions Scheme students. Ten students with appropriate tertiary studies were admitted as lateral entrants to second year. One full-fee overseas student was admitted to first year, with a total of two such students being enrolled in years two and three.

### Community Relations

The Faculty places a very high priority on promoting good relationships with alumni and with related professional groups in the community:

- **UMMS.** The University of Melbourne Medical Society, established in 1982, provides medical alumni with an opportunity to enjoy active links with the School of Medicine, the University and with fellow alumni. The UMMS journal *Chiron* has an important role in fostering these relationships and, in 1994, has again achieved the highest standards thanks to the work of its joint editors, Mr Peter Jones and Mrs Margaret Mackie. UMMS maintained a strong membership in 1994 and there has been continued interest in School of Medicine, University and UMMS activities and in medical graduate reunions. In the tradition of the annual UMMS Lecture, members enjoyed the privilege of hearing an inspiring personal story told by a famous medical scientist when Professor Sir Gustav Nossal delivered the 1994 UMMS Lecture, 'Medical Science and Human Goals – A Struggling Pilgrim's Progress'. For several years UMMS has sponsored an annual prize for the best BMedSc research report submitted by a medical student. Since 1993 UMMS has awarded prizes each year to final year students for essays submitted in connection with their elective studies, three such awards being made in 1994.

- **SAFODS.** The Society of Alumni and Friends of Dental Science enjoyed a most successful year with an increase in membership and a number of particularly interesting events. The Society co-sponsored the visit to Australia of an internationally known Periodontist, Professor Stan Holt, from Texas. Valuable support continues to be given by the Society to the School of Dental Science and a number of initiatives are planned for the new year.

- **Friends of Physiotherapy – University of Melbourne.** Providing mutual support and interaction between the School of Physiotherapy and the physiotherapy profession, this society increased its membership in 1994 and gave funding and support to meet various needs of the School of Physiotherapy.

- **Professional Education Programs.** The Faculty actively promotes high-quality continuing professional education, and both the School of Medicine and the School of Dental Science have well-established programs.

**Medicine:** Under the leadership of Professor Emeritus Priscilla Kincaid-Smith, the Continuing Education Unit offered twelve



medical courses in 1994. These popular courses, mostly for general practitioners, were developed by departments with the support of the Department of Public Health and Community Medicine General Practice Unit and the Continuing Education Unit.

**Dental Science:** Associate Professor John Harcourt, Co-ordinator of Continuing Dental Education, and full and part-time academic staff of the School of Dental Science, with the support of the Continuing Dental Education office, developed thirteen courses for dental practitioners in 1994. In addition, the School ran a series of continuing education days for first year graduates (interns) of the Royal Dental Hospital of Melbourne.

**School of Physiotherapy:** Occasional seminars, short courses and Bobath certificate courses for members of the physiotherapy profession and a summer school were offered during 1994.

**School of Behavioural Science:** Programs were offered for clinical psychologists and for members of the lay community as part of the University's Summer School.

- **Dean's Lecture Series.** The 34th Halford Oration, 'How enzymes dissolve clots and cure heart attacks: A blood curdling story', was delivered by Professor Joseph F Sambrook FRS as part of the 1994 Dean's Lecture Series. Other speakers in the series were Professor Robert J S Thomas, Professor Gavin Becker, Professor Helen Herrman (who gave the 60th Beattie Smith Lecture), Professor John Trinder, Associate Professor Bruce Levant, Professor Jerry Adams, Professor Greg Whelan, Professor Peter Smith and Professor Geoff Donnan. The 1994 Dean's Lecture Series concluded with the medical ethics seminar 'A Better Death', convened by Professor Richard Smallwood. The seminar attracted a large and diverse audience and stimulated considerable discussion in the media.

## Accommodation

The Faculty's continuing top priority is the relocation of the Department of Pharmacology into additional floors on the top of the existing tri-radiate Medical Centre Building. This will free up critical space for Microbiology in the Microbiology Building. Faculty is pleased to note that the University allocated \$100,000 in 1994 to allow preliminary planning to commence, and architects have been appointed for the project. The estimated project cost of \$11m has been identified on the University's forward capital plan for 1996/97.

## Faculty Management

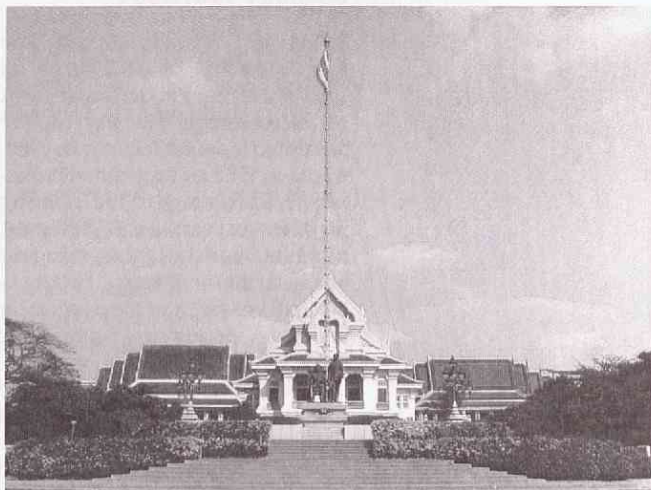
I wish to pay special tribute again to the outstanding support given to me and to the Faculty by its office-holders and by the administrative staff in the Faculty Administration Unit and the School's Offices. Thanks are extended to the Deputy Dean – Professor Gordon Clunie; the Associate Dean (Behavioural Science) – Professor Roger Wales; the Associate Dean (Dental Science) – Professor Clive Wright; the Associate Dean (Physiotherapy) – Professor Joan McMeeken; the Clinical Deans in the School of Medicine – Associate Professor Wilma Beswick, Associate Professor Robert Moulds, Associate Professor Bernard Sweet; the Clinical Dean in the School of Dental Science – Associate Professor Ian Johnson; the Assistant Dean (Undergraduate Studies) – Professor Neville Yeomans; and the Assistant Dean (Postgraduate Studies) – Professor Peter Phelan.

The administrative staff of the Faculty are led by the General Manager – Mr Darrell Mead, with excellent support from: the Executive Officer (Behavioural Science) – Mr Mike Drinkall; the Executive Officer (Dental Science) – Ms Joan Reese; the Executive Officer (Medicine) – Ms Kaye Lincoln (assisted by Ms Anne Szadura, Ms Claire Stevenson, Ms Rosemary Hogan, Ms Judith Hillier); the Executive Officer (Physiotherapy) – Ms Glenda Nicol; the Manager (Finance and Research) – Mr Cyril Yardin; the Manager (Continuing Education and External Relations) – Ms Robin Orams (assisted by Ms Liz Brentnall and, in Dental Science, by Ms Julie Meiken); the Faculty Information Technology Administrator – Ms Rosemary Cole; and the Office Manager, Faculty Administration Unit – Mrs Iris Welcome, who continues to run the Unit, including the Dean's Office, with wonderful efficiency and friendliness.

*Graeme B Ryan AC*

Dean, Faculty of Medicine, Dentistry and Health Sciences

## MEDICAL EDUCATION PROGRAMS DEAN'S VISITS TO SINGAPORE, BANGKOK AND JAKARTA



Chulalongkorn University, Bangkok.

**T**HE DEAN, PROFESSOR GRAEME RYAN, accompanied by Professor Peter Phelan, Assistant Dean (Postgraduate Studies), visited Singapore, Bangkok and Jakarta from 28 September to 4 October 1994. The visit's aims were to:

- Develop and foster links with major medical schools in these centres.
- Promote participation by high-quality overseas students in the Faculty's postgraduate and continuing education programs.
- Discuss with appropriate agencies access to scholarships for undergraduates and postgraduates and funding for short courses.
- Establish stronger links with University of Melbourne alumni groups, particularly medical alumni.

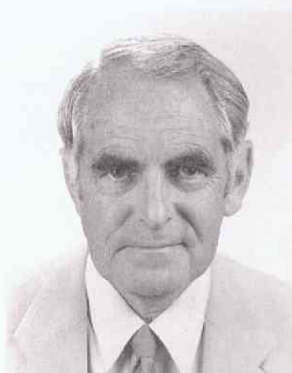
The visit followed and built on excellent working relationships and personal interactions established during a similar visit in 1993. Contacts made and outcomes of discussions included:

- The Permanent Secretary (Health)/Director of Medical Services, Ministry of Health, Singapore will provide support for selected medical specialist trainees in training posts in University of Melbourne teaching hospitals.
- The Dean, the Director of Postgraduate Studies and senior staff of the Faculty of Medicine at the National University of Singapore (NUS) will explore mutual exchanges of medical students during elective placements and the potential participation of recent NUS graduates in research-based postgraduate programs at the University of Melbourne.
- The Associate Dean for Research and International Affairs and senior staff of the Faculty of Medicine, Chulalongkorn University, Bangkok, will take steps to expand the numbers of recent Chulalongkorn graduates participating in training posts in University of Melbourne teaching hospitals and research-based postgraduate programs.
- The Dean and senior staff of the Faculty of Medicine, University of Indonesia, agreed on expanding the numbers of recent University of Indonesia graduates participating in training posts in University of Melbourne teaching hospitals and research-based postgraduate programs. The suitability was also confirmed of a paediatrics trainee undertaking a Master of Medicine program at the Royal Children's Hospital, to be supported by a University of Melbourne scholarship.
- Discussions with senior staff of the Jakarta IDP/Australian Education Centre emphasised particularly opportunities at the University of Melbourne for postgraduate training and research subject to AIDAB or other funding. Substantial interest was shown in the Faculty's short courses, especially those provided by the Key Centre for Women's Health in Society.



## RETIREMENT

### DAVID OGILVIE WHITE AO HonMD(Melb), MD,BS(Syd), PhD(ANU), MSc Professor of Microbiology 1967-1994



DAVID WHITE

DAVID WHITE joined the University of Melbourne in 1958 as a lecturer in the Department of Microbiology. He was rapidly promoted to senior lecturer in 1960, reader in 1963 and appointed Professor of Microbiology in 1967. During his thirty-six years at this University, he maintained the highest standard of scholarship and service. His teaching and research achievements in the field of virology are outstanding. Since 1958, he and his group received continuous funding from the National Health and Medical Research

Council, attracting in excess of three million dollars into the University.

David White provided leadership for the University in many ways. At different times he was Head of the Department of Microbiology for a total of thirteen years and his contributions to the department were immense. Good management, effective planning, hard work and a sympathetic approach were the hallmarks of his success. Relatively early in his career he accepted a number of important central University responsibilities, which he tackled with characteristic enthusiasm and originality. He was Dean of Graduate Studies in 1974 and 1975. From 1975 to 1978 he was Pro-Vice-Chancellor and in 1977 and 1978 he was Chairman of the Professorial Board. He was Assistant Dean (Pre-Clinical) in the Faculty of Medicine for many years and has served on many faculty and central University committees.

Outside the University, David White made major contributions to the profession of microbiology. He was President of the Australian Society for Microbiology and recently elected an Honorary Life Member of that Society. In 1992 he was appointed an Officer of the Order of Australia.

At the conferring of degrees on 10 December 1994, David White was awarded the degree of Doctor of Medicine *honoris causa* in recognition of his outstanding contributions to his discipline, his department, his faculty and the University. □

## KEY CENTRE FOR WOMEN'S HEALTH IN SOCIETY

### KEY CENTRE FOR WOMEN'S HEALTH

The University of Melbourne  
211 Grattan Street, Carlton Vic 3053

### BECOME A MEMBER!

The annual membership fee of \$30 supports the Centre's work and, in return, members receive three issues per year of the newsletter, *The Key to Women's Health*, one free seminar per year, the Annual Report and 10% discount on the Centre's monograph publications.

Telephone (03) 9344 4333  
Facsimile (03) 9347 4127

## Vale

### SIR IAN POTTER FAA BEc Hon LLD (Melb) 1902-1994

SIR IAN POTTER, former long-serving member of Council and major benefactor of the University of Melbourne, died on 24 October 1994, at the age of ninety-two. He is survived by his wife, Primrose (Lady Potter AO), and two daughters from earlier marriages.

Through the establishment of The Ian Potter Foundation in 1964, Sir Ian became one of Australia's greatest philanthropists. The Foundation has distributed in excess of \$20 million (equivalent to around \$35 million in today's terms) to support many important research, educational, conservation, cultural, health and community welfare initiatives throughout Australia, particularly in Victoria.

Sir Ian was a member of Council of the University of Melbourne from 1950 to 1971. During this period, he gave invaluable service as a member of the Finance Committee and the Investment Advisory Committee. At the same time he gave very generous financial support and, in conjunction with Mr Ken Myer, Sir Ian personally underwrote the financing of the building that was to become the Howard Florey Institute of Experimental Physiology and Medicine. He was particularly proud of the role that he played in the establishment and success of this prestigious medical research institute.

Major donations from Sir Ian and The Ian Potter Foundation assisted in the creation of University chairs, supported University appeals, University colleges and many University research projects such as the Poverty Survey in the Institute of Applied Economic Research. In recent years, the Foundation has supported the establishment of The Ian Potter Art Gallery and Conservation Centre, the Ian Potter Chair of International Finance in the Melbourne Business School and the Ian Potter Chair of Zoology in the Faculty of Science.

Sir Ian Potter was a great Australian of extraordinary distinction and achievement. He was a visionary, a public-spirited man who cared about others. He helped to shape the University. He helped to shape Australia.

Graeme B Ryan AC



THE UNIVERSITY  
OF MELBOURNE

## YOUR MEDICAL SCHOOL *Have you made a Donation or a Bequest?*

Over the years thoughtful donations and bequests have played a significant role in building 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 donation or a bequest to your alma mater.

If you would like more information, please contact Ms Robin Orams or Ms Liz Brentnall of the Continuing Education and External Relations unit, School of Medicine, The University of Melbourne, Parkville, 3052.

The telephone number is (03) 9344 5888/5889.

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



## SCHOOL OF MEDICINE HIGHER DEGREES AND DIPLOMAS CONFERRED 1994

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

### DOCTOR OF MEDICINE (*HONORIS CAUSA*)

David O White, AO, MD, BS (Sydney), PhD (ANU), MSc

### DOCTOR OF PHILOSOPHY

Julie Therese Arnold, BSc – Physiology  
Leon Ashley Bach, MBBS – Medicine  
Marilyn Leanne Baker, BSc – Paediatrics  
Nina Baseggio, BSc – Biochemistry  
John Dallas Boyce, BSc – Biochemistry  
Anne Margaret Brocklebank, BSc – Biochemistry  
Miao Chai BSc (China) – Pharmacology  
Nikola Chosich, MBBS (Monash) – Medical Biology  
Melissa Jane Churchill – Medicine  
Maurizio Edoardo Fabiani, BSc – Pharmacology  
Beverley Elizabeth Faulkner-Jones, MB, ChB (Birmingham) – Medical Biology  
Jane Rosamond Woodward Fisher, BSc (Qld) – Community Medicine  
David James Fitzgerald – Medicine  
Margaret Fraenkel, BMBS (Flinders) – Physiology  
Hong He, MB (Beijing Med U) – Paediatrics  
Yin Ling Hu, MMed (Peking U Med C) – Surgery  
Mark Darren Hulett, BSc – Surgery  
Mark Andrew Jenkins, BSc (Monash) – Medicine  
Henry Johnson, BSc (LaTrobe) – Medicine  
Deborah Anne Kool, BSc – Microbiology  
Jia Yee Lee, BSc – Microbiology  
Huang Jiu Li – Pharmacology  
Julie Anne Milland, BSc (Monash) – Biochemistry  
Susan Kaye Nilsson, BSc – Physiology  
Stuart Douglas Nuttall, BSc – Microbiology  
Louise Ellen O'Gorman, BSc (Monash) – Microbiology  
Stephen John O'Leary, BMedSc, MBBS – Otolaryngology  
Peter Rellos, BSc (Monash) – Biochemistry  
Sharon Denise Ricardo, BSc – Anatomy  
Anne Lavinia Rickards, MA – Obstetrics and Gynaecology  
Fraser Muir Rogerson, BSc – Medicine  
Fraser Donald Russell, BSc (Deakin) – Pharmacology  
Caroline Margaret Thew, MBBS (Qld) – Medicine  
Anna Tsykin, BSc (Monash) – Biochemistry  
Phuong Anh Thi Vo, BSc – Pharmacology  
Roger Xiangqian You, MMed (China) – Medicine  
BaoZhong Wang, MUrolSur (Tianjin) – Medicine  
Yifan Zhan, BMedSc (Jinxi Med Sch), MMedSc (Chinese APM) – Microbiology  
Michelle Irene Zorbas, BSc – Medical Biology

### DOCTOR OF MEDICINE

Geoffrey Howard Beemer, MBBS  
Andrew Donald Beischer, MBBS  
Peter Fook Meng Choong, MBBS  
Nicholas John Freezer, BSc, MBBS (Tasmania)  
Mark Peter Gianoutsos, MBBS (Sydney)  
Roland Leung, MBBS  
Mark Robert Newton, MBBS (Adelaide)  
Antonio Carmine Penna  
Philip James Robinson, BMedSc (Tasmania), MBBS  
Mark Peter Umstad, MBBS  
George Arthur Werther, MBBS, MSc (Oxford)

### MASTER OF MEDICINE

Trevor Gin, MBBS

### MASTER OF SURGERY

Douglas John Courtemanche, MD (British Columbia) – Paediatrics  
Charles Shun Shu, MBBS

### GRADUATE DIPLOMA IN AUDIOLOGY

Peter John Bartlett  
Kirsten Jane Gardner-Berry  
Elizabeth Jane Gill  
Elizabeth Gondopoulos  
Katherine Rebecca Henshall  
Yvette Just  
Angus Clifford McKenzie  
Paul John Secombe  
Andrea Lorelle Smith  
Sian Min Tan  
Sally Patricia Topham  
Marc Simon Vandenberg  
Shi-Ang Xu

### GRADUATE DIPLOMA IN EPIDEMIOLOGY

Omar Ahmed Abdulwadud  
Jennifer Anne Brosi  
Joanna Elizabeth Caust  
Marita Frances Dalton  
Vincent Delpizzo  
Gillian Sue Dite  
Leon Flicker  
Alan Johannes Gijsbers  
Jennifer Anne Stephenson  
Elaine Margaret Stevenson  
Edwin Roscoe Taylor  
Jennifer Margaret Tursi  
Maxwell John Watson

### GRADUATE DIPLOMA IN PSYCHOLOGICAL MEDICINE

Robert Samuel Dilipkumar Arulanantham  
Elizabeth Irene Lewis  
Nicole Kim Phillips  
Amanda Joy Rynie  
Christopher John Walsh

### GRADUATE DIPLOMA IN WOMEN'S HEALTH

Arvinder Aurora  
Annette Margaret Blaney  
Ingrid Marie Brett  
Anne Rosalie Goodwin  
Jo-Anne Pamela Graham  
Carolyn Leanne Gray  
Robyn Anne Jones  
Bronwyn Irma Lewis  
Lynda Margaret McBride  
Mary Elizabeth McGowan  
Mary Panjari  
Kay Lorraine Pfeiffer  
Jo-Anne Rayner-Smith  
Donna June Ribton-Turner



# POSTGRADUATE LIFE AT THE UNIVERSITY OF MELBOURNE

## Erkadius Physiology Department



ERKADIUS

I WAS BORN, raised, and completed my medical education in Padang, West Sumatera, Indonesia. As a typical Indonesian, I have a single name – Erkadius – which causes no end of problems for Western bureaucracies, journal editors and my supervisor.

In 1984 I graduated from the Universitas Andalas where later I became a lecturer in physiology. In 1986 I went to Michigan State University (MSU) in East Lansing, Michigan, USA, to obtain a Master's degree, which was completed in 1989.

Returning to Sumatera where I lectured and conducted research, the years after completing my Master's degree were rewarding; however, given the fact that I enjoyed the challenge of medical research, I sometimes wondered if I should work towards the next step – a PhD. During the Master's program in the USA I was without my family and I did not wish to repeat that experience, therefore I accepted an offer to do a PhD under a scholarship from the Australian International Development Assistance Bureau (AIDAB), an organisation which recognises the importance of family support and provided the funds to enable my family to accompany me to Australia. Professor Rudy Bernard, my adviser at MSU, recommended AIDAB to direct me to the University of Melbourne because 'there was a very good group working on salt appetite', one of the research areas I was interested in and worked on for my Master's degree.

While waiting for the result of the application, I received a letter from my present supervisor, Dr Robert Di Nicolantonio, offering an overview of the work I could do to complete the degree, which was especially useful because planning an interesting research project is usually difficult to do. I accepted the offer and came to Australia in January 1992 with a clear picture in my mind of what lay ahead.

The main experimental model I use is the spontaneously hypertensive rat (SHR) which has a much higher preference for salt

compared to its normotensive progenitor, the Wistar Kyoto (WKY) rat. It is not known whether this behaviour is genetically derived from the parents or due to some perinatal environmental factors, or both. The proposed method to examine this was to use embryo transfers between the two strains, and to follow up analysis of the effect of this transfer on offspring parameters *in utero* and in adult life.

A great deal of time was devoted to learning necessary techniques, for example:

- conducting vasectomy on rats,
- vaginal smearing of rats to determine estrus cycle and mating time,
- collection of foetuses and amniotic fluid,
- measuring tail-cuff blood pressure,
- measuring two bottle preference tests for salt appetite determination, and
- conducting gastric lavage to determine renal handling of salt loading.

The most important skill to be acquired was the collection and transfer of 1-cell embryos into the oviduct of SHR, WKY, and Sprague-Dawley (SD) rats. The latter strain served as a natural control for the two former strains. This exacting technique was learned from Dr Seong Seng Tan of the Department of Anatomy and Cell Biology, and his former assistant, Ms Linda Weiss. While donor rats were mated with males of their respective strain, recipients were mated with vasectomized males to make them pseudopregnant and ready to accept fertilised eggs from the donor. The major problem with the transfer rats was that almost half the mothers cannibalised all their offspring, leaving me with disappointment, frustration and delays in the research program.

However, most of the obstacles have been overcome and the results of my work presented at one national and three international meetings. One paper containing my findings has been published: Role of uterine factors in the development of hypertension in SHR, *Clinical and Experimental Pharmacology and Physiology*, vol 21, pp 239-242, 1994. Two other papers are 'in press', abstracts have been published in the *Journal of Hypertension*, *Clinical and Experimental Pharmacology and Physiology*, *Placenta* and in the *Proceedings of the Australian Physiological and Pharmacological Society*.

The research and the writing up will be completed at the end of 1995. I am happy to have had the opportunity to study at this prestigious university in the beautiful city of Melbourne and, most importantly, because AIDAB has made it possible for me to enjoy family life at the same time. □



Overseas Medical Students Society Annual Dinner.



## CLINICAL SCHOOLS

### AUSTIN HOSPITAL & HEIDELBERG REPATRIATION HOSPITAL

**T**HE YEAR (1994) SAW the twenty-fifth graduating class finish their final year. For the second year in a row the Jamieson Prize went to the Clinical School, with top marks in medicine going to Jeremy Freeman and Anne Peterson. Linda Mileshekin was the top student from the Clinical School and was awarded the Austin Hospital Senior Medical Staff Prize. In the fourth year results, Guy Bylsma was top student of the year with first class honours in pathology and clinical medicine and surgery.

The fourth year program in 1994 was similar to that in 1993, with an introductory two-week period followed by an intermediate term in medicine and surgery and then three terms, two in medicine and one in surgery. During the year students also undertook teaching in geriatrics and emergency medicine. The Clinical School continues to refine its longstanding program in ethics and communication skills. In radiology the teaching was done with small group tutorials. During the year each student rotated through two country hospitals in both medicine and surgery.

The fifth year program continued to be of two semesters and terms of paediatrics, community medicine, psychiatry and obstetrics and gynaecology. During the term of psychiatry each student group spent two half-days in a program of palliative care taught by the palliative care team at Heidelberg Repatriation Hospital.

Final year begins with an eight-week elective between the end of fifth year and the beginning of the formal final year teaching program. Many students travel overseas for their electives. In the same way the Clinical School accepts up to twenty overseas students a year for elective studies.

Formal final year teaching consisted of two fourteen-week terms in general and special medicine and surgery. The special seven-week term consisted mainly of formal tutorials and clinic teaching. During the general terms the students were rostered in twos or threes as 'student interns' to involve themselves with the Units. This scheme has been of variable success depending on the interaction between the students and the Unit doctors and has been influenced by the pressure of examinations. Emergency medicine and anaesthetics were rostered through PANCH (Preston and Northcote Community Hospital) as well as the Austin Hospital and Heidelberg Repatriation Hospital. Infectious disease was taught at Fairfield Hospital.

Clinical School programs, especially fourth year, were reviewed for 1995. Equal time in medicine and surgery, a longer introductory period, longer terms with each unit and a program for student counselling, are some of the changes planned.

The effects of budget cuts, bed closures and amalgamation of the Austin and Heidelberg Repatriation Hospitals are being monitored. Certainly there is more pressure on the medical staff but, in spite of that, teaching continues to be undertaken at the same level. The Clinical School would not be able to function without the goodwill of the staff and I wish to express my thanks to the medical staff for their support of the teaching programs.

*Associate Professor Bernard Sweet*  
Clinical Dean



**Austin Hospital & Heidelberg Repatriation Hospital**  
**Final Year Clinical School 1994**

**Back row L-R:** Kate Taylor, Patrick Bowden, Martin Miletich, Brian Ohis, Steve Alatakis, Christopher Ryan, Gilman Stynes, Malcolm Ferguson, Paul Anderson, Karen Gaunson, Daniel Sullivan, Seong-Yong Ang, Ilona Dibella. **Fourth row L-R:** Loretta Thorn, Angela Clancy, Matthew Roberts, Peter Papadopoulos, Brian Nathan, Adrian Murrie, Frank Malara, Tim Hwang, Juliet Lokan, Dugald McAdam, Christopher Mitchell, Bernard Yong, Fiona Lee, Christine Troy, Kevin Chan. **Third row L-R:** Tzung Ding, Anne Peterson, Rohan Wee, Leanne McNamara, Victor Lee, Joy Quek, Chris Oh, Kimberley Jeffs, Jeremy Freeman, Emma Readman, Pei Yoong Lam, David Fong, Sarah Moore, Shueh En Lin. **Second row L-R:** Prof Donald MacLellan, Nicole Urquhardt, Natalie Leung, Victor Tri, Dana Yek, Mae Fong Chen, Linda Mileshekin, Winnie Kwan, Christine Mirakian, Sara Cross, Robyn Parker, Joanne Said, Alice Law, Lana Horng, Prof Colin Johnston. **Front row L-R:** Sor Way Chan, Prof William Louis, Prof Kenneth Hardy, Assoc Prof Bernard Sweet (Clinical Dean), Mrs Rosa Poon, Dr Barbara Goss, Lesley Seow. **Absent:** Fiona Bassed, Daryl-Anne Gassenheimer, Julian Hughes, Peter Karamoutsos, Janette Kaval, Dorota Lisowska, Prof Roger Sinclair, Prof Richard Smallwood, Dr Helen Kouzmin.



## THE ROYAL MELBOURNE HOSPITAL & WESTERN HOSPITAL

AS IN PREVIOUS YEARS, fourth year was divided into two surgical and two medical terms, each of eight or nine weeks duration, and the core of clinical instruction occurred within general medical and general surgical units.

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

The introductory period consisted of a broad range of lectures, and also 'examination days' in which the students first saw a video tape or a demonstration of the examination of a particular system, then undertook self-examination under the supervision of tutors. Finally a ward tutorial demonstrated the examination on a patient. These examinations included the cardiovascular system, the central nervous system, the abdomen, the respiratory system and the musculoskeletal system. This introduction to physical examination proved extremely successful, and it is planned to continue and possibly improve the process during the 1995 introductory period.

The formal course in the teaching of communication skills continued in 1994. Two lectures 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 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. During the second or third terms, each student performed a 30-minute video tape of a patient interview. This was followed by a group tutorial in which they received feedback on their communication skills from a senior clinician in the unit to which the student was attached. Although this program is demanding for both tutor and student, it has been reasonably well received by students and we think it is an important component of the acquisition of communication skills.

As usual, a 'core' of daily lectures was presented in term one, and the pathology teaching in term two covered major areas. Lectures during

terms two to four and pathology teaching during those terms 'fleshed out' the term one 'core' teaching.

During the medical and surgical terms, students had special teaching in geriatrics, vascular surgery, ophthalmology, orthopaedic surgery, clinical pharmacology, emergency medicine, and dermatology. Geriatric medicine again consisted of a two-week block at the end of one of the medical terms, and for this teaching, all student groups attended North West Hospital. Teaching in emergency medicine consisted of attendance of either one or two weeks at the Emergency Department of the hospitals in which the students undertook their surgical terms. The other specialty teaching consisted of sessions during one of the four terms, either in outpatients or in the wards.

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

Overseas options were undertaken by students in the following countries: United Kingdom (9), United States of America/Canada (15), New Zealand (9), France (6), Greece (5), Africa (3), India/Nepal (3), South-East Asia (10), Pacific/Indian Oceans (10), others (3), and 60 within Australia.

General surgery and general medicine consisted of six and seven-week blocks respectively and in each case comprised a 'student internship' in a general medical or surgical ward at the Royal Melbourne Hospital or Western Hospital. In addition, student internships occurred in general medicine and surgery at Ballarat Base Hospital, consisting of three or four weeks at Ballarat Base Hospital and 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 medicine 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 specialties, and teaching occurring in outpatient clinics, at the bedside or in seminar format depending on requirements.



**The Royal Melbourne Hospital & Western Hospital  
Final Year Clinical School 1994**

**Back row L-R:** Sian Fairbank, Anna Rogers, Nick Cox, Nicole Rose, Claire Veith, Adrienne Deans, Zainuddin Gorji, Sie Hing Tang, Rohan Lourie, Paul Wraight, Carol Ting, Helen Maroulis, Miriam Watson, Hui Gan. **Third row L-R:** Dorothy Bugg, Thomas Hardy, Lynden Roberts, Wai Ling Choi, Jonathan Papson, Bernard Allard, Afshin Eimany, Woodrow Wu, Hai Phan, Peter Nguyen, Tas Zafiroopoulos, Tsung Hsin Chung, Chris Ho, Owen Chiu, David Wilkinson, Margaret Elder, Bette McCriston. **Second row L-R:** Amy Fong, Michelle Knuckey, Juliet Froomes, Genie Pastras, Maria Sestan, Sonia Davison, Assoc Prof Robert Moulds, Dr Christine Penfold, Madalena Liu, Tania Ash, Canh Truong, Li Lin Lim, Chiing Chiing Gan, Jennifer Kiing. **Front row L-R:** Victor Kwan Lee, Jenny Nicolopoulos, Cathy Evans, David Edis, Jason Chan, Steve Daniel, Wai Ting Choi, Samantha Bryant, Karen Dwyer, Robert Steele. **Absent:** Suzanne Bertrand, Suresh Chandra, Ley Chea, Caroline Dowling, Amanda Griffiths, Trung Toan Hau, Fiona Van Hong, Zubin Irani, Kelvin Khoo, Peter Kistler, Jason Kovacic, Cameron Leopold, Var Sing Lok, Jenni Morgan, Andrew Morokoff, David Topchian, Bernard Yan.



Daily case discussions were presented by the senior medical and surgical staff with interactive discussions of selected cases to illustrate points of diagnosis or management. Towards the end of the year each discussion was preceded by a trial short-answer question.

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

The new clinical school office at Western Hospital functioned well and the students have very much appreciated the new student quarters and teaching facilities.

The teaching program at Western Hospital has been greatly facilitated by the appointment of a Sub-Dean, Dr Anne-Maree Kelly, centred at Western Hospital. Dr Kelly is also a staff specialist in the

Emergency Department and has had extensive experience with both undergraduate and postgraduate teaching. Her experience and full-time presence at Western Hospital has been invaluable.

During the year 402 applications for elective placements were received, and 66 elective students were placed in various general and specialist departments and units at the Royal Melbourne Hospital and Western Hospital. These students came from United Kingdom (21), United States of America (15), Fiji (6), Germany (7), Ireland (3), New Zealand (3) and a variety of other countries (11).

*Associate Professor Robert F W Moulds*  
Clinical Dean

## ST VINCENT'S HOSPITAL & THE GEELONG HOSPITAL

**S**TUDENTS AT OUR CLINICAL SCHOOL had a busy and productive academic year, despite the major building activities and financial constraints resulting in bed closures which have affected all hospitals. A highlight for many students was the opportunity to tour the impressive new hospital building, which will be fully commissioned next year.

During 1994, the Clinical School had a complement of 205 students, with 53 in final year, 74 in fifth year and 78 in fourth year.

Sixth year began with the eight-week elective term, offering many the opportunity to travel overseas, often to Third World countries, which students find extremely rewarding. As there is considerable concern about the increased risk of exposure to infectious diseases including HIV in some areas, however, we have developed guidelines to assist students in making adequate preparations for their electives, particularly in the tropics.

Medical rotations again included four-week general medical terms at St Vincent's Hospital or Geelong Hospital. Two-week medical specialty rotations comprised the rest of the 14-week term, during which student groups attended St George's Hospital (Kew), The Royal Victorian Eye and Ear Hospital and the Peter McCallum Cancer Institute. For the first time, students attended some clinics at the Skin and Cancer Foundation, and, with the recent appointment of Professor Robin Marks to the Chair of Dermatology, it is anticipated that there will be increased opportunity to attend the Foundation.

Following discussions with student representatives at the Board of Studies, surgical rotations were amended in 1994, to enable all students to have some experience in each major surgical specialty at St Vincent's Hospital, which students found to be very satisfactory.

The year was very successful, all students passing their final examinations and a high proportion achieving honours results in medicine and/or surgery. Giuliana Antolovich and Richard Brouwer jointly topped the year, distinguishing themselves by obtaining First Class Honours in both medicine and surgery, as did Jillian Sass and Brian Cowie. The above students, together with Sabine Hennel and Garun Hamilton, achieved the honour of inclusion in the Dean's Honours List. Our congratulations go to all the 1994 graduates, and we wish them well in their careers.

The fifth year curriculum was similar to that of previous years, and students spent most of the year away from their parent clinical school. Our students particularly enjoyed the opportunity to visit rural practices, and to mix with students from other clinical schools.

Fourth year students had a very full year, which was marred by the tragic loss of one of their number, David Elliot, who was a gifted student, a true friend, and held in great affection by his colleagues. He will be greatly missed by us all.

Again, the emphasis of fourth year was upon the acquisition of good clinical skills, particularly in the field of communication and



**St Vincent's Hospital & The Geelong Hospital**  
**Final Year Clinical School 1994**

**Back row L-R:** Martin Schaap, Richard Brouwer, Garun Hamilton, Son Quach, David Fuller, Nicolas Clark, Robert Chu, Andrea Walker, Brian Cowie. **Fourth row L-R:** Chris Kearney, Peter Chin, Mary Lou Loughnan, Liz Barker, Laura Scardamaglia, Jose Smith, John Manderson, Chiew Ying Wong, Brent Uren, Jeremy Wilson, Glenn Guest. **Third row L-R:** Meng Shi Lim, Marlo Dunkley, Sabine Hennel, Alicia Dennis, Anthony Baresic, Carmel Pilgrim, Jens Kilian, Alexis Shub, Emma Greenwood, Giuliana Antolovich. **Second row L-R:** Rose Phan, Chooi Peng Lee, Kerrie Beecroft, Debra Wade, Nauka Desai, Annette Poon, Su-Ni Wong, Tween Low, Jillian Sass. **Front row L-R:** Kang Sim, Dr Jacqueline Walters, Yew Meng Wong, Nigel Beck, Rosemary Buchanan, Mark Westcott, Assoc Prof Wilma Beswick, Sophie Richmond, Jaycen Cruickshank, Justin Game. **Absent:** Katrina Harris, Paul Kearns, Richard Standish, Sam Wilson, Anne Gridley, Marc Cain.



physical examination technique. The clinical ethics program was expanded this year, and was included also in the program for students in Geelong. Student groups produced an impressive, enthusiastic presentation of ethical topics relevant to the management of their patients before an appreciative audience at the end of term.

Students greatly enjoyed the opportunity to work in Geelong, Warrnambool or Goulburn Valley Base Hospitals, and appreciated the variety of clinical material in these venues. With increasing numbers of students and expansion of the Clinical Teaching Curriculum during recent years, we rely heavily upon the excellent facilities and enthusiastic teaching at St George's Hospital, the Peter McCallum Cancer Institute, and particularly at PANCH, to complement the teaching rotations at St Vincent's Hospital in providing the essential clinical experience for our students.

We were very pleased with the academic results of our fourth year students who were well represented in the Dean's Honours list. Our top student in medicine and surgery was Angela Webb. Andria Economides and Gerard McCaffrey won the Harold Attwood Prize for pathology, and Rob Citroni won the prize in geriatrics.

As in previous years, third year students attended St Vincent's Hospital for the course in clinical method, and greatly enjoyed their

experience. We look forward to welcoming them as full-time clinical students in 1995.

During 1994, there was continued growth of undergraduate physiotherapy, and we welcomed Ms Sue Blake as Director of St Vincent's Department of Physiotherapy. Students from each of the four years of the physiotherapy course undertook clinical practice at St Vincent's Hospital, or Geelong Hospital. We are very proud of our first group of students who recently graduated, and look forward to the expansion of the program, but we are conscious of the constraints imposed by new models of health care and diminishing physiotherapy resources upon the teaching facilities.

We are most grateful to our clinical teachers in all the hospitals associated with the Clinical School for their continued support and enthusiastic teaching during the past year. We should like to thank all students and staff who put up with the noise and disruption of the past months for their patience, and are now looking forward to the move to the new hospital during 1995, and hope that the transition will proceed smoothly!

*Associate Professor Wilma M Beswick*  
Clinical Dean

## FINAL YEAR MBBS 1994

### Top Students

Joint top students in 1994 were Giuliana Antolovich and Richard Brouwer, both gaining First Class Honours in Medicine and in Surgery, and being awarded the Australian Medical Association Prize, the CIBA-GEIGY Prize and the Rowden White Prize.



GIULIANA ANTOLOVICH

**Giuliana Cinzia Antolovich**, BSc (Hons), PhD, also won the Howard E Williams Prize in Paediatrics, the Evelyn Coy Prize in Surgery (SVH) and the Sister Christina Welsford Prize in Haematology (SVH).

After schooling at the Catholic Ladies College in Eltham, Giuliana's association with the University began in 1982, when she enrolled for a BSc. She gained a first class honours degree, working on a project in the Anatomy Department, and then proceeded to a PhD, investigating foetal development, in which she studied the pituitary histology of foetal sheep and triggers for parturition. She worked with Dr Roslyn Gibson at Melbourne and Dr Caroline McMillan in the Department of Physiology at Monash, and produced several publications. A clinical career beckoned, however, and Giuliana entered second year MBBS in 1990, and came to St Vincent's Hospital and Geelong Hospital Clinical School in 1992, distinguishing herself throughout the course.

Giuliana comes from a small but close Italian family, her initial interest in medicine possibly having been sparked by her father, who is CEO at St Vincent's Private Hospital. She is justly proud of her talented sister, Luisa (a musician with the group 'Orange'), is a voracious reader and has been involved with Matrix since its inception. Outside medicine, however, Giuliana's major interest has been her husband Michael (an economist) to

whom she was married in early 1993. She is now looking forward to a year with no examinations at long last!

Giuliana will take up an internship at St Vincent's Hospital, and is interested in a career in paediatrics or internal medicine.



RICHARD BROUWER

**Richard George Brouwer**, a fellow student of Giuliana at St Vincent's Hospital and Geelong Hospital Clinical School, won the Margaret Ryan Scholarship in Medicine and the Institute of Medical Research Prize

in Medicine (SVH) in addition to the AMA, CIBA-GEIGY and Rowden White Prizes.

Richard, the eldest of three sons of Dutch and Dutch/Italian parents was educated at Xavier College. After leaving school, he entered the physiotherapy course at the Lincoln Institute. However, he transferred the following year to the possibly less physically demanding MBBS degree at the University of Melbourne, where he has excelled throughout the course, particularly in his clinical studies. He feels that the high spot of his undergraduate career was the elective period which he spent in India.

Richard's interests are many: he is a keen photographer, played basketball for Old Xaverians and is a cycling enthusiast, as befits one of Dutch forebears. He will take up an intern position at St Vincent's Hospital, and intends to follow a career in surgery.

## PRIZES & AWARDS 1994

### FINAL YEAR

#### Australian Medical Association Prize

Giuliana Antolovich, SVH/GH  
Richard Brouwer, SVH/GH

#### The CIBA-GEIGY Prize

Giuliana Antolovich, SVH/GH  
Richard Brouwer, SVH/GH

#### Rowden White Prize

Giuliana Antolovich, SVH/GH  
Richard Brouwer, SVH/GH

### MEDICINE

#### Keith Levi Memorial Scholarship in Medicine

Anne Peterson, AH/HRH

#### The Robert Gartly Healy Prize in Medicine

Anne Peterson, AH/HRH

#### Jamieson Prize in Clinical Medicine

Jeremy Freeman, AH/HRH

#### Upjohn Award in Clinical Pharmacology and Therapeutics

Garun Hamilton, SVH/GH

### SURGERY

#### Beaney Scholarship in Surgery

Jillian Sass, SVH/GH

#### The Robert Gartly Healy Prize in Surgery

Jillian Sass, SVH/GH

#### Proxime Accessit Prize in Surgery

Li Lin Lim, RMH/WH

#### Geoffrey Royal Prize in Clinical Surgery

Jillian Sass, SVH/GH



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

Li Lin Lim, RMH/WH  
Carol Ting, RHM/WH  
Jillian Sass, SVH/GH

**Smith & Nephew Prize in Surgery  
(AH/HRH)**

Peiyoong Lam, AH/HRH

**E H Embley Prize in Anaesthetics**

Marc Cain, SVH/GH

**Neil Bromberger Prize in  
Orthopaedics (AH/HRH)**

Rohan Wee, AH/HRH

**OBSTETRICS & GYNAECOLOGY**

**The Robert Gartly Healy Prize in  
Obstetrics**

Joanne Said, AH/HRH

**Prize in Clinical Gynaecology**

Kathryn Taylor, AH/HRH

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

Leanne McNamara, AH/HRH

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

Alexis Shub, SVH/GH

**PAEDIATRICS**

**Howard E Williams Prize in  
Paediatrics**

Giuliana Antolovich, SVH/GH

**Child Growth & Development Study in  
Paediatrics**

Hui Kong Gan, RMH/WH

**Clara Myers Prize in Surgical  
Paediatrics**

Amanda Griffiths, RHM/WH

**PSYCHIATRY**

**John Cade Memorial Medal in Clinical  
Psychiatry**

Peter Kistler, RMH/WH  
Joanne Said, AH/HRH

**COMMUNITY MEDICINE**

**RACGP Prize in Community Medicine**

Leanne McNamara, AH/HRH

**INFECTIOUS DISEASES**

**Sir Albert Coates Prize in Infectious  
Diseases**

Jillian Sass, SVH/GH

**GENERAL CLINICAL**

**Edgar Rouse Prize in Occupational  
Medicine**

1st Prize: Forbes McGain  
2nd Prize: Kah-Seong Loke

**Royal Australian College of  
Ophthalmologists Prize**

1st Prize: Glenn Guest

**Hedley F Summons Prize in  
Otolaryngology**

1st Prize: Chris Siaw Kang Ho

**Herman Lawrence Prize in Clinical  
Dermatology**

1st Prize: Suresh Chandra

**FOURTH & FIFTH YEARS**

**FIFTH YEAR**

**Community Medicine Prize**

Mandana Nikpour

**Crawford Mollison Prize in Forensic  
Medicine**

Nelson Chie Chong Yap

**Medical Officers of Health Section  
of AMA**

Jennifer Daniel

**The Fulton Scholarship**

James King

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

Kritika Chaiwatanatorn

**The Max Kohane Prize**

Jennifer Perret

**The Vernon Collins Prize**

Terrence Ong

**The John Adey Prize**

Robin Cassumbhoy

**FOURTH YEAR**

**The Harold Attwood Prize in  
Pathology**

Gerard McCaffrey

Andria Economidis

**Geriatric Medicine Prize**

Robert Citroni

**Manu Thomas Prize**

Guy Bylsma

**PRE-CLINICAL**

**THIRD YEAR**

**Pharmacology**

**Boots Prize**

Ashley Peng Chee Ng

**Pathology**

**Walter & Eliza Hall Exhibition**

Ashley Peng Chee Ng

**Microbiology**

**Microbiology Prize**

Yong Ming Por

**SECOND YEAR**

**Anatomy**

**Dwight Prize**

David Alexander

**Exhibition Prize**

David Alexander

**T F Ryan Prize**

David Alexander

**Physiology**

**Wellcome Prize**

Marcus Chuen Kae Choy

Sin Kuan Tan

Yu Pin Kevin Tsao

**General Biochemistry**

**Exhibition**

Roselind Webby

**Functional Biochemistry**

**Exhibition**

Zet Sheng Ee

**Neuroscience**

**Sunderland Prize**

Constantine Tam

**Physiology/Integrated  
Body Function**

**R D Wright Prize**

Sin Kuan Tan

**Behavioural Science**

**CIBA-GEIGY Prize**

Quang Minh Long Phan

**FIRST YEAR**

**Medical Physics**

**G A Syme Exhibition**

Sarah Bowen

Shu Fen Ho

Ivy Poon

**T F Ryan Roentgen Prize**

No applicants in 1994 – not awarded

**Introduction to Medicine**

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

Grace Li Shan Kam

Chia May Jamie Phang

**Medical Biology**

**W H Swanton Exhibition**

Kathryn Field

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

Emily Tse Lin Ho

**Chemistry**

**Exhibition**

Lee Hooi Lim

**Anatomy**

**Mathew W McKenzie Award**

Kathryn Field

Hans Tsung Han Tu

**MBBS GRADUATES 1994**

Steven Alatakis, Bernard Allard,  
Paul Anderson, Seong-Yong Ang,  
Giuliana Antolovich, Tania Ash,  
Ante Baresic, Elizabeth Barker,  
Fiona Bassed, Nigel Beck,  
Kerrie Beecroft, Suzanne Bertrand,  
Patrick Bowden, Richard Brouwer,  
Samantha Bryant, Rosemary Buchanan,  
Marc Cain, Jason Chan, Kevin Chan,  
Sor Way Chan, Suresh Chandra,  
Ley M Chea, Mae Fong Chen,  
Kien Yoon Chin, Owen Chiu,  
Wai Ling Choi, Wai Ting Choi,  
Robert Chu, Tsung Hsin Chung,  
Angela Clancy, Nicolas Clark,



Brian Cowie, Nicholas Cox, Sara Cross, Jaycen Cruickshank, Stephen Daniel, Sonia Davison, Adrienne Deans, Alicia Dennis, Nauka Desai, Ilona Dibella, Tzung Ping Ding, Caroline Dowling, Marlo Dunkley, Karen Dwyer, David Edis, Afshin Eimany, Margaret Elder, Catherine Evans, Sian Fairbank, Malcolm Ferguson, Amy Fong, David Fong, Jeremy Freeman, Juliet Froomes, David Fuller, Justin Game, Chiing Chiing Gan, Hui Kong Gan, Daryl-Anne Gassenheimer, Karen Gaunson, Zainuddin Gorji, Emma Greenwood, Anne Gridley, Amanda Griffiths, Glenn Guest, Garun Hamilton, Thomas Hardy, Katrina Harris, Trung Toan Hau, Sabine Hennel, Siaw Kang Ho, Fiona Van Hong, Lana Horng, Julian Hughes, Wei Ch'ng Hwang, Zubin Irani, Kimberley Jeffs, Peter Karamoutsos, Janette Kaval, Christopher Kearney, Paul Kearns, Kelvin Khoo, Jennifer Kiing, Jens Kilian, Peter Kistler, Michelle Knuckey, Jason Kovacic, Winnie Kwan, Pei Yoong Lam, Cheuk San Law, Chooi Peng Lee, Fiona Lee, Victor Lee, Victor Kwan Lee, Cameron Leopold, Natalie Leung, Li Lin Lim, Meng Shi Lim, Shueh En Lin, Dorota Lisowska, Madalena Liu, Var Sing Lok, Juliet Lokan, Mary Lou Loughnan, Rohan Lourie, Shiau Tween Low, Frank Malara, John Manderson, Helen Maroulis, Dugald McAdam, Leanne McNamara, Linda Mileschkin, Martin Miletich, Christine Mirakian, Christopher Mitchell, Sarah Moore, Jennifer Morgan, Andrew Morokoff, Adrian Murrie, Brian Nathan, Peter Trieu Nguyen, Jenny Nicolopoulos, Chris Oh, Brian Ohis, Panagiotis Papadopoulos, Jonathan Papon, Robyn Parker, Eugenia Pastras, Anne Peterson, Hai Phan, Rose Phan, Carmel Pilgrim, Annette Poon, Son Dang Quach, Joy Yee Quek, Emma Readman, Sophie Richmond, Lynden Roberts, Matthew Roberts, Anna Rogers, Nicole Rose, Christopher Ryan, Joanne Said, Jillian Sass, Laura Scardamaglia, Martin Schaap, Lesley Seow, Maria Sestan, Alexis Shub, Kang Sim, Joanna Smith, Richard Standish, Robert Steele, Gilman Stynes, Daniel Sullivan, Sie Hing Tang, Kate Taylor, Loretta Thorn, Carol Ting, David Topchian, Khoi Tuan Tri, Christine Troy, Canh Truong, Brent Uren, Nicole Urquhardt, Claire Veith, Debra Wade, Andrea Walker, Miriam Watson, Rohan Wee, Mark Westcott, David Wilkinson, Jeremy Wilson, Samantha Wilson, Chiew Ying Wong, Su-Ni Wong, Yew Meng Wong, Paul Wraight, Woodrow Wu, Bernard Yan, Dana Yek, Bernard Chee Yong, Tasoula Zafiroopoulos.

## DEAN'S HONOURS 1994

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

### FINAL YEAR

Giuliana Antolovich, Richard Brouwer, Brian Cowie, Karen Gaunson, Garun Hamilton, Sabine Hennel, Juliet Lokan, Linda Mileschkin, Anne Peterson, Jillian Sass

### FIFTH YEAR

Kirsty Buising, Robin Cassumbhoy, Christopher Fraser, Kirsten Herbert, James King, Alex Meakin, Mandana Nikpour

### FOURTH YEAR

Heidi Baker, Guy Bylsma, Catherine Drury, David Iser, Maryza Khalil, Samuel Morley, Angela Webb, Gareth Weston

### THIRD YEAR

Lean Peng Cheah, Rita Furlan, Lip Wai Lee, Andrew Keat Eu Lim, Ruth Pec Shian Lim, Sin Hing Mok, Genni Newnham, Ashley Peng Chee Ng, Cheng Kang Ong, Yong Ming Por, Nadesapillai Subanesan, Swee Teng Tan

### SECOND YEAR

Casey Ka-Shun Chan, Zet Sheng Ee, Adrian Fox, Jia Li Ng, Paik Yee Ng, Toby Syme, Constantine Tam, Sin Kuan Tan, Valerie Shiok Han Tay, Rosalind Webby, Kathryn Wiggins, Elaine Yee Hang Wong

### FIRST YEAR

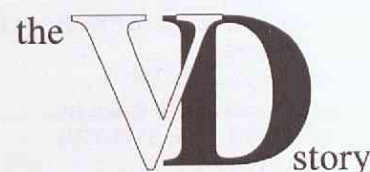
Sarah Bowen, Yu Jo Chua, Kathryn Field, Saman Gardliya Punchihewa, Celia Kemp, Weng Toon Ng, Alex Yu Hong Tan, Choon Chieh Tan

## THE MEDICAL HISTORY MUSEUM

Brownless Medical Library  
9-5 weekdays

## 1995 EXHIBITION

Curated by  
Dr D R Tibbits



### *The social, medical and political response to Venereal Diseases in Australia*

Title Display  
VICTORIAN ERA  
GREAT WAR  
INTER-WAR YEARS &  
SECOND WORLD WAR  
PENICILLIN  
PRE-AIDS ERA  
AIDS ERA  
Poster Display

*Old and new methods of promoting safer sex*  
*Sex, race and class issues*  
*Old and new treatments*  
*Old instruments*

Enquire at  
Information Desk for entry  
For further information contact  
Dr Di Tibbits  
9280 2330



## THE MALDIVES – PARADISE OR PARADOX?

Sonia L Davison, MBBS 1994

A WOMAN presenting with retained placenta after delivery of her first child – not an unusual scenario. But this followed forty-eight hours in labour, a two-day boat trip to the nearest hospital, removal of placenta complicated by uterine perforation, accidental sigmoid colon removal and shock . . . Such was the essence of my elective of five weeks (January-February 1994) in the Republic of The Maldives – a fiercely independent nation of islands occupying a 2000 km stretch in the Indian Ocean, south-west of India. The Maldives is the ultimate tourist destination for thousands of Europeans and yet it is a third world country where poverty mixes strangely with newly introduced Western technology.

I was immediately at a disadvantage setting foot in Central Hospital on Malé, the capital of the Maldives. Firstly, I was a foreigner, usually equated immediately with 'tourist'. Secondly, I was a woman, in a strict Muslim society where men were the chief decision-makers. The stares I drew with my fair skin and blue eyes, I returned, trying to gain insight into Islam, a culture that allowed a husband to deny a tubal ligation for his wife who, at forty-two years, had given birth to fourteen children. By the end of five weeks, the screams of six years old boys at their circumcision parties, or news of women with fourteen children, ceased to amaze me. I was more surprised by the younger women whose views were changing, away from traditional dress and large families, to Western clothes and the concept of family planning. I also realised that I had an advantage – I was a walking source of information about Australia and its medical system and, as such, I was much in demand.

I spent my time at Central Hospital largely in the paediatrics, obstetrics and gynaecology departments. However, a lot of what I gained both professionally and personally during the elective term, was from living amongst the locals on the tiny three-by-two kilometre island of Malé – which most Westerners only visit for a few hours, mainly out of curiosity.

Malé was a hot, humid, dusty tropical environment, brim full with a population of 60 000 and many resulting public

health problems. The contrast with the surrounding tourist resorts was remarkable. The locals had so little space they were forced to sleep in shifts, whilst the tourists lazed relaxedly on wide expanses of white coral sand.

Maldivian families could only obtain water from sources outside the thirty or so mosques on the island. Tourists swam happily in the warm, multi-coloured blue water, alongside many varieties of tropical fish. The local people bathed fully clothed in areas of the sea surrounding Malé which contained large quantities of sewage outflow, rubbish and oil wastes.

The impact of the Maldivian lifestyle really hit me after I had been on Malé one week, in constant temperatures of 33°C with 80 per cent humidity each day, and I had been unable to find a suitable place to swim. The surrounding beautiful islands with sand and palm trees seemed as far away as Melbourne, and it struck me that whilst I was going home eventually, the people of Malé experienced such conditions for a lifetime.

Public health issues did not stop there: answering my question regarding diet, one pregnant lady informed me through an interpreter that her special pregnancy diet was milk, coconut and bananas. The islanders making up the rest of the 200 000 population lived across the entire 2000 km span of islands and had little access to competent medical care. Their ideas on diet, childbirth and education were [culturally] restricted and they were physically distant from the capital – a slow 'dhoni' or boat trip taking anywhere up to three days to reach Malé.

Medical care was left mainly in the hands of 'health workers' who often only had the equivalent of Year Eight level education. In

extreme circumstances emergencies were dealt with by air ambulance. Many of the patients I attended at Central Hospital were islanders, having been referred to Malé by health workers.

'Fever plus splenomegaly equals . . . typhoid!' So was the dictum of the Indian paediatrician I worked with – the only paediatrician in the Republic. I was soon convinced that almost all the patients had typhoid and in the paediatric ward this was largely true. Infectious and tropical diseases such as typhoid, tuberculosis, rheumatic fever, worm infestations and osteomyelitis were common, yet I was shocked by the high frequency of wheelchair-bound polio patients, and the number of patients showing evidence of infection with leprosy.

It saddened me to see mothers, very obviously pregnant, by the bedsides of malnourished children, tiny for their age yet with huge bellies due to malnutrition. One woman was expecting her tenth child, and her four-year-old son was almost motionless with weakness due to kwashiorkor. Neglect was a common story, compounded by lack of money, few fresh vegetables or variety in diet, and large families. I wondered if the commonly seen sticker, 'STOP AIDS – LIVE THE MUSLIM WAY', had somehow missed the point.

If I quickly learned that 'fever plus splenomegaly meant typhoid', more splenic lessons were to come my way. 'Splenomegaly plus anaemia equals . . . thalassaemia!' was another common catch-cry. It amazed me that diagnoses were made with such haste and precision, and mostly based on vaguely elicited histories and often spectacular clinical signs. The prevalence of thalassaemia is 1 in 24 in the Maldives and is a huge problem, both in prevention and in finding

adequate donors for blood transfusions. Programs aimed at screening partners for the thalassaemia minor trait are now underway, however, usually occur after the birth of the first child with thalassaemia major. This late screening may still be of some benefit as the Maldives has the highest divorce rate in the world – easily gained by saying 'I divorce you' three times.

Expatriate workers and families on

Dr Davison at Central Hospital's 'no front door'.



Community water tap outside a mosque.





Malé have been trying to raise funds for the subcutaneous pumps required almost daily for use with desferrioxamine, but as yet pumps are in such small number that their use is greatly restricted. My sessions at the twice-weekly thalassaemia clinics meant that I was exposed to many children with the frank bony changes characteristic of poorly treated thalassaemia. The nightmare of repeated transfusions and [an inadequate] supply of desferrioxamine, was emphasised by the regular attendance of some families in which all the children were affected by thalassaemia. I did not see any patients over thirteen years old.

Central Hospital had no front door and was essentially open to the environment. It had constantly whirring ceiling fans in order to decrease the oppressive heat. The biochemistry laboratory was antique and fully manual, the patients had no meals supplied, and the 'intensive care unit', paradoxically, was isolated, unattended and had no ward rounds on weekends! I believe that the poor conditions in the hospital were mainly due to the expected opening of a newly donated hospital (four months from completion at the time of my elective), the 'Indira Gandhi Memorial Hospital', a gift from India. Yet it was incredible what could be achieved with poor equipment and in poor surroundings.

The doctors were from Cuba, Russia, India, Sri Lanka, Pakistan, Bangladesh, and also the Maldives. Many had received only four years training, however consultants in medicine, surgery, anaesthetics and paediatrics were available, as well as visiting consultants from India and Sri Lanka.

A girl presented to the paediatric clinic with abdominal pain. The doctor looked her up and down, briefly palpated her abdomen and hastily told the interpreter, 'Diagnosis – functional. Treatment – reassurance ... Next!' I was amazed at the often poor quality of the doctor-patient relationship, the doctor showing little respect for the patient, yet paradoxically being almost god-like in their eyes. This, plus the absence of medico-legal pressures on practitioners, resulted in a mostly doctor-centred form of consultation, one which I cannot say I felt comfortable with, especially in gynaecology clinics where traditional Islamic beliefs were shattered by rough, hastily performed examinations.

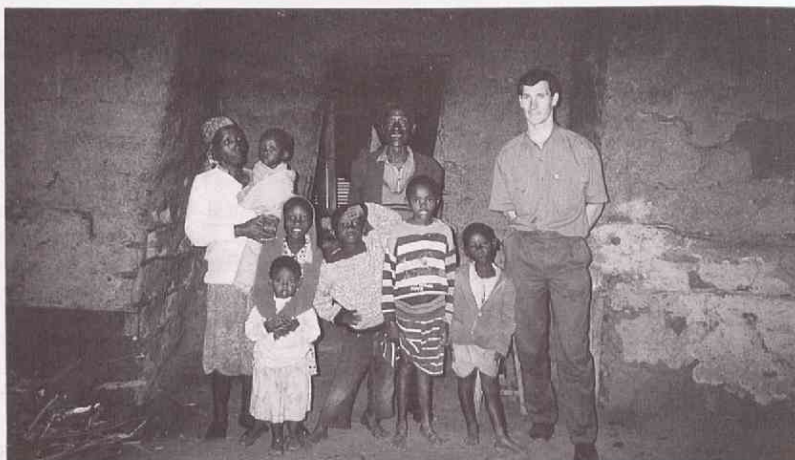
In January 1994, a young female doctor-to-be presented to the Central Hospital on Malé with enthusiasm, an open mind and a desire to explore a largely unknown culture and field of medicine. She returned to Melbourne safely and with a whole new perspective. And she did get that swim. □

## UMMS ELECTIVE ESSAY PRIZES

Prizes of \$100 are awarded each year. Details and application forms from Medical School office.

# EVOLUTION IN THE CRADLE OF MANKIND

Glenn Guest, MBBS 1994



Dr Guest and a Kenyan family living near Tumutumu Hospital.

**K**ENYA is just a few years older than I am. We were both born in the 1960s and endured a turbulent start to life. While I was rejecting mother's milk on account of pyloric stenosis, Kenya was similarly expunging its colonial status. We were both undergoing major upheavals. It seems ironic that Kenya, a country in its infancy – barely thirty years old – contains the cradle of mankind. Here there is a fascinating combination of old and new so I guess I should not have been surprised when I went to the dark continent for my elective expecting the experience of a lifetime and got a lifetime of experiences.

Tumutumu hospital is in the heartland of Kikuyuland, the central highland area inhabited by the largest tribe in Africa and nestled on the slopes of Mount Kenya which, at over 5000 metres and sparkling with equatorial ice, dominates the landscape. The Kikuyu people call the mountain Kerinyagga – Mountain of Brightness – and traditional belief is that their god Ngai resides on top. Having now climbed to the summit I can only hope that Ngai has a good set of thermal underwear and a haemoglobin as high as his age – some thousands of years.

This small mission hospital was where I spent eight weeks (December 1993–January 1994) experiencing a different sort of medicine and a different sort of life to that which I have back home in Australia and Kerinyagga seemed to provide some sort of barometer for my stay there.

It took a full week before I even got a glimpse of Mount Kenya's icy summit which at this time of year is almost continually shrouded in cloud and mist. During this first week I stumbled my way through the process of acclimatising, not just to the altitude but to the community of which I was now a part.

Everything was new: the language, the culture and not least of all the medicine. Even familiar tasks contained hidden traps. My routine question about smoking brought embarrassed laughter from the patients in the female ward – in Kenya women who smoke are generally prostitutes. I quickly learnt to tailor my histories to the culture and decided to omit this as a routine question in future.

My first night on call when I needed to put an intravenous line into a black arm in a dimly lit ward also met with multiple failures before eventual success, but not before one nurse remarked that she had not seen that much blood spilt since the gruesome Mau Mau rebellion!

The language was a mystery, with each word having thirty-nine different forms, none of which I could remember and the food was equally forgettable. The staple dish was ugali, a maize-based meal which had the appearance of mashed potatoes with the taste of cardboard, but not quite as flavoursome. That week I learnt that the old adage 'you are what you eat', holds no water (boiled for three minutes and purified of course). The people of Tumutumu are a fascinating and colourful people, a far cry from the bland ugali they devour in amazing quantities.

After a week of haze the clouds rolled back and from then on the real learning experience began. A lesson I learnt early on was succinctly expressed in the commonly heard saying 'no hurry in Africa'. The pace of life is certainly different there. There's seldom any rush because there is rarely any reason to rush. I got the feeling that they took the common sense philosophical stance that your future may be no better than the present so it's best to take your time and savour the moment. While it's true that as a consequence things move slowly in Africa, it's also true that very few people die of heart attacks in Kenya, so take your pick. I can appreciate the philosophy but could not fully embrace it after casually receiving a note one night while on call saying 'The patient in Ward 6 has stopped breathing, please come and review. 9:30 pm'. I received the note at 10 pm.

As the season progressed from wet to dry, Mount Kenya began to show its majestic peaks more often and I too felt more confident and competent medically. I began to appreciate that there is a significant gap between being a student and knowing what should be done compared with actually doing it. It took me a while to get used to the idea that the decisions I made would alter how a patient felt and recovered. There is a



word that accurately describes such feelings: responsibility. It did not sit easily with me to begin with and I always seemed to be wondering 'Am I doing the right thing for this patient?'. I never really stopped asking that question and I probably never should, but the more I asked the question the more it seemed I could answer it affirmatively.

Along with the doubts there was also the satisfaction of observing first-hand the difference one can make to another's life. I think it took a week for the sense of satisfaction to be dispelled after I administered intravenous glucose and watched a hypoglycaemic patient return to consciousness at the end of the syringe. Actually the feeling only lasted twenty-four hours as I was woken at 6 am the next morning to repeat the procedure, obviously having not explained clearly enough that she should not take her oral hypoglycaemic when she was not eating!

During my stay at Tumutumu I was rarely alone. I had been fortunate enough to choose a hospital with trainee nurses and we spent many evenings talking, laughing and cooking in the student accommodation which was jokingly referred to as 'the mansion'. Strangely enough when I had such company the ugali seemed less indigestible and the mansion seemed a lot less dilapidated and rat infested. Even the bats in the roof seemed to enjoy their company.

We had many interesting meals and discussions during my stay and probably the funniest game of Pictionary I'll ever play. Just

try drawing pictures to indicate 'aerobics' to someone who's never even heard of it! It was the interactions with these people which are my most treasured moments. They delighted in making a Kikuyu out of me and when I would tell people in the second largest market in Africa, 'D'mu Kikuyu, dukahenia ni rangi' (I'm of the Kikuyu tribe, don't be fooled by my colour), the sellers would break down in fits of laughter and I would have an instant friend. By the end of my stay the Kikuyu-speaking muzungu (white person) was well known in Tumutumu, and given local prices what's more!

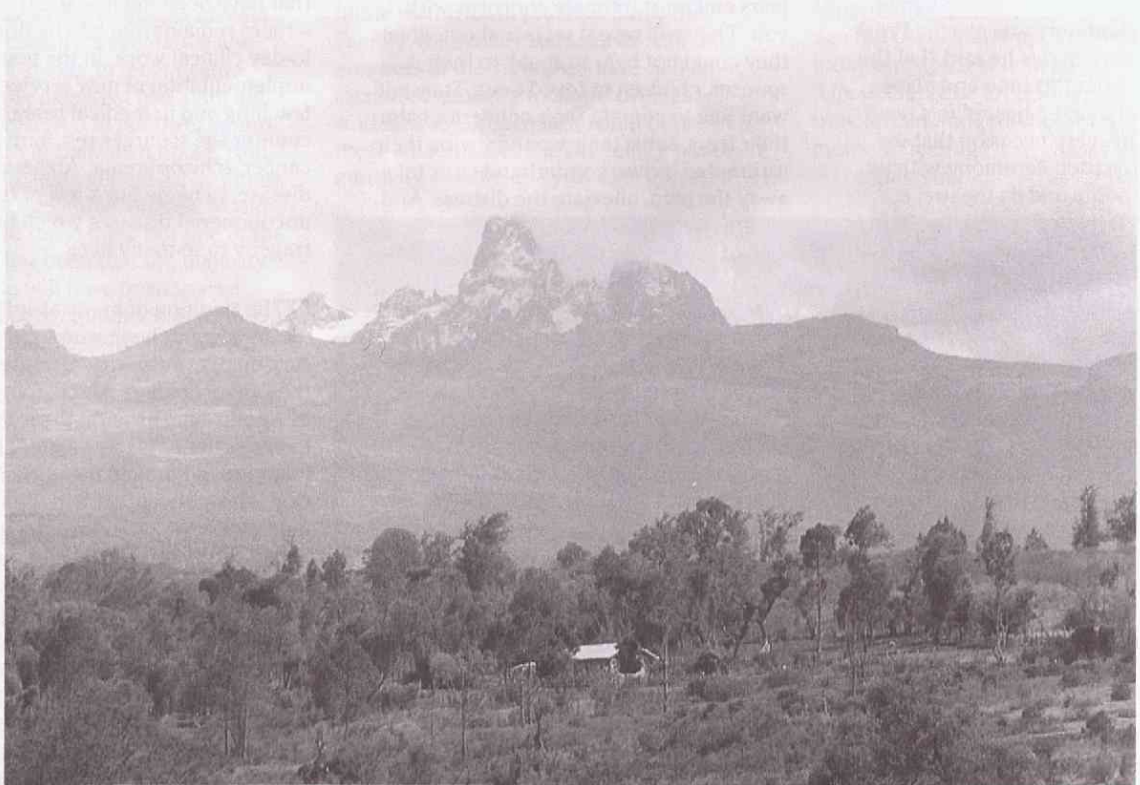
The opportunities available for practical learning in a hospital such as Tumutumu are numerous and varied. I learnt many useful skills but upon my return discovered some of them were not applicable to medicine back home. For instance the useful procedure of taking an aortic biopsy whilst trying to extract CSF appears not to be in vogue currently in Melbourne hospitals. Similarly my expertise in performing a bilateral tubal ligation under local anaesthetic for \$1.20 seems to be totally disregarded by the family planning experts. I was also dismayed to find no opening windows in theatres back in Australia. Surely surgeons must be frustrated at not having a view of tropical forest to soothe their nerves and the anaesthetists must live in constant fear of ether building up in poorly ventilated theatres?

Of course it did mean special equipment was needed in Kenya. Surely no operating theatre is properly equipped without the

trusty old fly swatter! Anyway, I failed to see any problem. I accepted the fact that wielding the swatter and maintaining a sterile field was a specialist skill and, without any monitors to watch, the anaesthetists seemed to be able to swat and ventilate without missing a beat, or should I say breath!

Eight weeks passed in a flash. No sooner had I begun to settle in than it was time for me to leave. There was so much still to be learnt from this experience, about their medicine, their culture and myself. But before I left there was one thing I wanted to do: climb Kerinyagga.

Two days and 5000 vertical metres later I sat atop the summit. In the rarefied, sub-zero air and pre-dawn light I could see the tiny village of Tumutumu nestled on the slopes below me. Three hundred kilometres away on the lightening horizon was the majestic snow-topped peak of Kilimanjaro. As the first rays of dawn lit up the peak I reflected on my experiences. From this vantage point I was gaining a new perspective on the world around me in much the same way as my stay at Tumutumu had allowed me to look at medicine and life in a new light. For me, medicine is more than just a profession, it is a doorway into other people's lives and culture. I sincerely hope that I am able to accept the privilege and through medicine give back a little something to the communities I work in, be they in Africa or Australia. I hope Kerinyagga will remain for me a symbol of the perspective I gained during my wonderful elective.



Mount Kenya from Tumutumu Hospital.



## OCCASIONAL ADDRESS

**Professor Bruce S Singh**

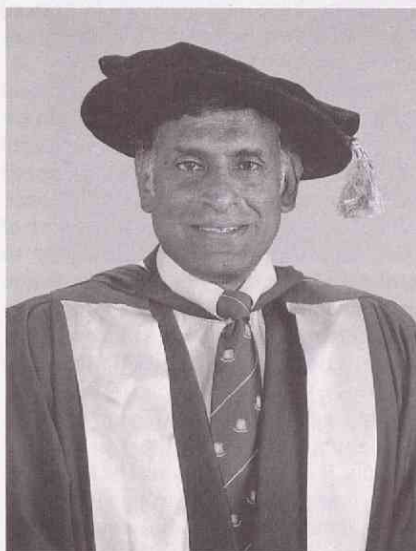
Cato Professor of Psychiatry, The University of Melbourne

**A** GRADUATION Ceremony is a momentous occasion both for the graduands and for the University. You are participating in a rite of passage, a ritual rich in symbolism, which has been occurring at this University for almost 150 years and for this Faculty since 1867. You are heirs to a magnificent tradition extending over a thousand years since universities first evolved in the Western world. You have walked into the hall as students, undergraduate and postgraduate, you will walk out as graduates. Your lives and the lives of those around you will never be the same. You will join an elite group of men and women in this country and around the world who can claim the University of Melbourne as their Alma Mater. I extend my congratulations, and those of my colleagues, to all of you and to your families.

I wish to spend the remainder of my time speaking specifically to the medical graduates and to spend a few moments reflecting on what it means to join such a profession – the rights, the privileges and the responsibilities of this ancient guild. When John F Kennedy was elected President of the United States he said, 'Let the word go forth from this time and place . . . that the torch has been passed to a new generation'. On every occasion that we conduct a graduation ceremony with its solemnity, its pomp and its theatre, a torch is passed on – from us representing your teachers, to you as novitiates of our profession. What is this torch, what does it represent, what impact will it have on your lives?

I approach this subject from the perspective of a medical practitioner, a medical scientist, a physician and a psychiatrist. My primary profession of psychiatry has much to say about the relationships that you will have with your patients and with communities.

In a speech delivered in 1899, Theodore Roosevelt, another American President, spoke of 'the doctrine of the strenuous life': 'I wish to preach not the doctrine of ignoble ease but the doctrine of the strenuous life; the life of toil and effort, of labour and strife . . . that the highest form of success comes to those who do not shrink from danger, hardship or bitter toil.' Although the practice of medicine has changed over the past few decades, most of you will indeed live the strenuous life, in its physical but more particularly in its emotional demands on you. Much will be expected of you –



PROFESSOR BRUCE SINGH

'To those to whom much is given, much is expected.'

Your patients will have great faith in you; at times they will expect you to be omnipotent. They will share their greatest fears and most intimate concerns with you. They will reveal secrets about which they could not bear to speak to their spouses, children or loved ones. They will want you to contain their concerns, calm their fears, salve their wounds, wipe their tormented brows, comfort and cure, take away the pain, alleviate the distress. And at times you will feel inadequate in the face of such expectations both real and imagined. You will feel overwhelmed by the extent of human suffering, you will feel weighed down by the burden of care, you will feel helpless in the face of death. In short, you will experience the range of responses that have been common to doctors for thousands of years, even though the therapeutic armamentarium at your disposal will be greater than for any group of doctors before you. But buoyed by your resilience and confidence in yourselves, your knowledge and your profession, you will cope well with these pressures. Isaiah puts it very clearly: 'But they shall renew their strength . . . They shall mount up with wings as eagles; they shall run and not be weary; and they shall walk and not faint.'

And what qualities will you bring to these encounters? You will bring intellect, personal attributes and knowledge. You are among the best and the brightest of your generation, you committed yourself to the study of medicine at this country's premier medical school, and you have

been tried in the fire of one of the most demanding professional trainings available today. You have been steeled by a rigorous exposure to all the preclinical and clinical disciplines necessary to practise the best medicine possible at the end of the twentieth century. During this time, some of you, full of idealism when you entered medicine, may have become somewhat cynical as a result of your experiences through the course. To a large extent this is understandable. Nothing is as it seems when one is young and the dreams and expectations of youth have to be tempered by the sometimes harsh realism engendered by contact with patients, other health care professionals and the health care system. But this is the moment to rekindle that idealism, this is a new beginning, a time to start to write your own professional life script, to give meaning to your career and to add enthusiasm and energy to the profession. Whatever the changes that are occurring in the health services of the state and the country you, as doctors, will play a key role in them, regardless of the advances that have been made – and there are many – there remains much to be done, in day-to-day clinical work, in the planning and implementation of new services, in teaching and in medical research to counter the scourges resulting from cancer, schizophrenia, Alzheimer's disease, to name but a few of the unconquered diseases which bring tragedy to so many lives.

**T**he tradition of medical authority you inherit has been summarised as Aesculapian authority, after Aesculapius, the God of healing. Aesculapius was a son of Apollo, who brought the art of healing to perfection. This was a great boon to mankind but proved the undoing of the God who, not content with healing living men, undertook to revive the dead. Zeus regarded the raising of dead mortals as a dangerous precedent and killed Aesculapius with a thunderbolt. Zeus then placed him among the stars as the serpent holder, the snake on a staff being regularly associated with the Aesculapian cult and this staff has become the symbol of healing. The Aesculapian authority you inherit over your patients and society is derived from three types – sapiential, moral and charismatic. Sapiential authority is the authority derived from expertise and wisdom. Doctors possess this because of their knowledge of medicine. They must know, or appear to



know, more about medicine than their patients do – not always an easy task in these days of information overload. Doctors so-called 'orders' are advice, for in reality the doctor cannot order patients to do anything.

The second ingredient of Aesculapian authority is moral authority, the right to control and direct that is derived from the rightness and goodness of the enterprise, that is, the concern with doing what is good for the patient. Until quite recently, what doctors practised was considered socially right as well as individually good – an unbeatable combination unmatched by any other profession. Unfortunately with the increasing cost of medical care and an aging population, the doctor's obligation to provide optimum medical care for the good of the individual patient may be in conflict with political and economic needs to ration medical care for the good of society.

The third ingredient is charismatic authority, the right derived from God-given grace to control and direct. This element reflects the original unity of religion and medicine that exists in many parts of the world. There are too many unknown and unknowable factors in illness for medicine to rest entirely on sapiential authority.

One of the major issues in the acquisition of Aesculapian authority is that it comes to those so appointed much earlier in life than to most other forms of authority. In addition, it now comes to many who have had little experience of illness, either in themselves or in their families, because of the immense success of medicine in both its preventative and curative roles. It is only in recent years that many people have reached adult life without being exposed to life-threatening illness and death in their own home. Pain, suffering and the fears generated by illness and death were inevitable and few would wish to return to those days. But one of the consequences has been that the majority of young people will have been spared these fears. What compounds this problem is that doctors and nurses are themselves products of this same excellent early health. Until now, we could safely assume that patients, their relatives and those who treated them had a well-established grasp of what would be expected of them. This is no longer true. A consensus no longer exists; but its absence has gone unnoticed.

The authority which you acquire as a result of your role means that each of you will be a leader, whether in your community, your institution, your state or your country. Many of your teachers have played that role – or find themselves playing it – in ways that they themselves would never have predicted when they were at your stage. In the inevitability of change that is part of our society, we in the medical profession must continue to influence those who are developing the policies which impinge so much on our capacity to treat, to teach and to conduct

research for the better. How difficult that can be is particularly apparent in my own field of psychiatry or mental health reform, when ideology abounds and attempts to improve the care of the mentally ill may well have paradoxical results.

I would like to say a word to the parents and families who are here today. You may well be bursting with pride, or just content in the sense of quiet satisfaction at the achievement of your loved one, as well you might be on an occasion like this. For all of you, the achievement will have come at a cost, only you will know what that cost has been. We know from the profile of those entering medicine that many would have been involved in establishing a new life in this country – I'm sure that you will agree that whatever its shortcomings, this is one of the world's special countries where opportunities and the freedom to excel abound. The motto of the University of Rochester in New York, where I spent a period of postgraduate training, is 'To each their farthest star'. Here, there are opportunities to pursue that farthest star, without fear of discrimination. There are few hidden shoals to inhibit those without a privileged background in Australia – in medicine, as in most fields of professional activity the meritocracy prevail – those who have the talent, the drive, the imagination and the will, receive both opportunity and encouragement.

I would also like to speak briefly to the overseas students who have completed their degrees and will be returning to their home countries to practise. Since the Faculty voluntarily reduced its student numbers in the 1980s, we have had an increased capacity to admit overseas students. The interrelationship between these students and the University has been mutually beneficial – you have gained a

prestigious degree, the University has continued to progress in its move towards increasing internationalisation. On you falls a particular responsibility to utilise the high quality education you have received, for the benefit of your communities and your health systems.

I will close by reminding all of you of what it means to be a University of Melbourne graduate. Wherever your career takes you throughout the world, your university will be known. The university is a wonderful institution, which transcends time and place – the concept of a university encompasses the entire corpus of teachers, students and graduates, all scholars who make up that body. No matter how substantive they appear, our institutions are only as strong as those who believe in them. The University of Melbourne exists in a geographical sense of course – you only have to look around you to see its buildings – but were all these structures to be demolished tomorrow, it would live on through the lives and ideals of its teachers, graduates and students. You will walk out of here today and some of you may never return again, but you never leave your university – you are always a part of it, and it is always a part of you.

In the tradition of the heritage that is bequeathed to you by this university and the profession you are about to join – a torch has been passed to you. Let it burn brightly in your lives for our communities, our nation and the world, and remember those wonderful words of Hippocrates spoken thousands of years ago but particularly apt for medicine today and applicable to all professions: 'Life is short, the art is long, experience treacherous, judgement difficult and the moment fleeting.'

I salute you.





# DEPARTMENTS OF SURGERY

## AN ERA OF CHANGE

Professor Emeritus Richard C Bennett AM

**T**HE DEPARTMENTS OF SURGERY within the University of Melbourne Medical School developed at slightly different times during a decade commencing forty years ago. It was an exciting era of change. The new departments were established in different hospitals, each of which had its own clinical staff, traditions and ethos.

Clinical departments and clinical schools throughout Australia were expanding rapidly at this time, due in no small measure to the vision and wise guidance of the late Professor Sir Sydney Sunderland who was then Chairman of the AUC and also Dean of the Faculty of Medicine at this University. Introduction of the new academic departments was generally welcomed, but could not be achieved quickly or without special adjustments in each of the hospitals.

While these new developments were made possible through government funding, the amount and manner in which the

financial support was provided differed for each of our new departments, as did the effect of the major cutbacks that were implemented after only a short time. For all these reasons development of the three Departments of Surgery was not easy, but in the long run proved successful in each case. An important new era of university-hospital collaboration had arrived and with it the fostering of a more scientific approach to the practise of surgery, an expansion of the surgical specialties and the introduction of new technology.

The new departments developed individually, according to the hospital bases upon which they were grafted: local needs, the allocation of special funds and existing staff structures were all important. Each department was associated with the development of special areas of expertise. It is not surprising that these areas differed nor that the activities of the three departments complemented each other.

With continuing growth, appointments have been made in each of the surgical disciplines and activities in these fields have been vigorously promoted. Departments have expanded geographically to incorporate sub-units in other metropolitan hospitals and now include teaching activities in a number of country centres.

The University's Departments of Surgery have together contributed to both the scientific and practical aspects of surgery at local, national and international levels, gaining world-wide recognition. While the Faculty did not have a Department of Surgery for the first seventy-nine years of its existence there can be no doubt that the steady development of the three departments over the past forty years, with their many contributions to the scientific, clinical and professional aspects of surgery, are achievements of which Melbourne can be justly proud.

## AUSTIN HOSPITAL

Professor Kenneth J Hardy AO



Mr Robert Jones (left) and Professor Kenneth Hardy performed the first liver transplant in Victoria, at the Austin Hospital in 1988.

**T**HE INAUGURAL PROFESSOR of the Department of Surgery at the Austin Hospital, Professor Howard Eddey, was appointed in 1966. Professor Eddey held the position until his retirement in 1975. He was a world-renowned parotid gland surgeon and developed considerable operative and teaching skills in this area.

Together with the Associate Dean (Clinical), Professor Sir Lance Townsend, the Professor of Medicine, Professor Austin Doyle, the Professor of Pathology, Professor Harold Attwood, and the Professor of Microbiology (Medical), Professor David Gray, Professor Eddey created the Austin Hospital Clinical School. A three-stage plan of hospital development was proposed. Stage one was the Clinical Sciences block to house the University departments, stage two the principal hospital building for medicine and

surgery and stage three, obstetrics and gynaecology. Stage one was completed by 1971, but political struggles saw development of stage two delayed – the initial excavation remaining a hole in the ground for many years. The magnificent stage two building, known as the Stokes building, was opened in 1984, but is not yet fully commissioned. The building's highlights include laminar flow operating theatres and intensive care.

The Departments of Medicine and Surgery started in a very small area above the spinal injuries unit, their access being via a wooden fire escape. When the medical students' quarters were completed, these departments moved to the students' quarters until the Clinical Sciences building was completed.

Professor Eddey was a powerful administrator who played a major role in the early development of the Department of Surgery. The University of Melbourne set up the Austin as a University Teaching Hospital, insisting the Professor be chairman of the hospital Department of Surgery. A divisional structure was set up and subsequently the University has played a major and successful role. A strong clinical group was recruited to the University at that stage.

In 1970 Mr Ken Hardy was appointed First Assistant in the University, and founded the University Department of Surgery at Repatriation General Hospital, Heidelberg. In 1973 a half-time lecturer joined that unit. In 1976 Mr Hardy took up the position of Professor and Chairman of Surgery of the Austin and Repatriation Hospitals. With the expansion of medical student numbers, the University in 1977 appointed Mr Gabriel Kune as

Professor of Surgery at Repatriation General Hospital, Heidelberg, and that hospital became a joint member of the Austin Clinical School.

From 1976 the department at the Austin directed particular emphasis to research. As the department was small, this research was to be of narrow width to allow in-depth exploration. Emphasis was on physiological mechanisms, but studies of the development of regulatory peptides of the gastrointestinal tract, in particular gastrin, were begun. A full-time physiologist and scientist, Dr Arthur Shulkes, was recruited, specially trained in the USA, and asked to head this research. This has proved a most fruitful experiment with a blending of scientists and surgeons. A large animal operating theatre, animal physiology laboratory, radioimmunoassay and peptide chemistry laboratory were established. Collaborative programs followed within the hospital, nationally and internationally, and further full-time scientific staff were recruited, all supported with NHMRC funding.

In 1988 a molecular biology laboratory was set up so that regulation of synthesis as well as secretion and storage could be examined. Dr Graham Baldwin, a molecular and cell biologist, will join the department in 1995 which will strengthen these research directions.

The adaptation of the foetus from par-enteral to enteric feeding requires a dramatic change in the absorptive, secretory and motility characteristics of the gastrointestinal tract. Although gastrointestinal peptides are involved in these functions in the adult, their role in foetal life was largely unknown. Two



major initiatives were important in instigating the research program. Firstly we developed a chronically cannulated foetal model which allowed the dynamic, longitudinal assessment of hormonal and gastric secretions in the absence of the complications of stress and anaesthesia. Secondly, specific radioimmunoassays and chromatography procedures for a number of regulatory peptides (gastrin, neurotensin, vasoactive intestinal peptide (VIP), somatostatin, calcitonin gene related peptide (CGRP), bombesin) were developed.

We demonstrated that gastrin is present in the circulation from early gestation with a substantial rise 15-20 days before delivery. The hypergastrinaemia was due to increased foetal production of gastrin and originated from the foetal antrum. Both the stored and secreted gastrin were present in biologically active forms. Despite these normal to elevated circulating gastrin levels there was only intermittent foetal gastric acid secretion. However, the foetus had the potential to produce acid as large doses of pentagastrin or histamine infused two weeks before birth reduced foetal gastric pH. This lack of gastric acid secretion implies a receptor defect or the presence of an inhibitor. In relation to an inhibitor, somatostatin was shown to be present in the foetal circulation and to inhibit foetal and adult gastrin and acid secretion.

Current work is identifying the receptors involved in the development of gastric acid secretion. Other studies have demonstrated that gastrin is present in foetal but not adult gastric juice, raising the possibility of a growth-promoting role for gastrin in the foetus. The finding that gastrin is transiently expressed in the foetal pancreas is of great interest since the pancreas is the source of most gastrin secreting tumours in the mature human. Information on the sites of synthesis, storage and the dynamics of secretion and clearance are fundamental requirements in determining physiological roles for particular peptides. A number of regulatory peptides have been investigated (neurotensin, gastrin, somatostatin, VIP). Studies were performed in the mature sheep, in the healthy human and patients with chronic renal failure or colorectal cancer. These studies were then followed by measurement of the effects on gastrointestinal and other functions including gastric secretion and blood flow.

A diagnostic service for peptide secreting tumours was established and samples are received from throughout Australia and South-East Asia. The first VIPoma, Neurotensinoma and CGRPoma in Australia were reported from our laboratory.

In addition to the gut peptide research programs, the department has research interests in liver and cardiac surgery. A hepatobiliary unit was formed in 1986, principally involving liver resection surgery. However, in 1988 the first Victorian liver transplant was performed at the Austin Hospital by Professor Hardy and Mr Robert Jones. Mr Robert Jones was subsequently appointed Director of Liver Transplantation when the Victorian

Liver Transplantation program was placed at the Austin Hospital within the University Department of Surgery. The overall elective patient survival is 93 per cent, and the five-year actuarial survival 85 per cent. Principal indications for surgery have been primary biliary cirrhosis and primary sclerosing cholangitis, and the main research topics have been transplantation for HBV patients, and xenotransplantation.

Transplantation for Hepatitis B (HB) is unsatisfactory despite ongoing prophylaxis with hyperimmune globulin, as the HB tends to recur. Most units consider HB is a contraindication to transplantation. Hyperimmune globulin is expensive and not very effective. Clinical outcome with gancyclovir and maladexic acid to prevent and treat recurrent HB post-liver transplantation include studies of the same patient PCR on tissue and blood, dot blots for viral DNA and sequencing of the virus.

The Austin Research Institute was opened in 1991 with Professor Ian McKenzie as Director. Postgraduate students are associated with the University through the Department of Surgery. One collaborative program concerns xenotransplantation. Because of the shortage of donors a program has been developed to use pig livers, initially for *ex vivo* perfusion and later, possibly, for transplantation to humans with liver failure. In the past (1965) *ex vivo* perfusion was done, but with no success, but recently has been used more successfully in the USA now that the mechanisms of rejection are understood. Humans have natural antibodies to other species and for the pig, these are, surprisingly, mostly to a galactose sugar (gcl a(1,3 gcl) present in pig tissue and absent from humans after transplantation. The natural antibodies bind to vessels in the transplant, complement is fixed and the vessels immediately are thrombosed – an event startlingly shown by Makowka (USA) in 1993 when the antibodies were removed prior to a liver transplant which lasted some 12 hours only to be 'rejected' when a blood transfusion (containing antibodies) was given. Our program with the ARI consists of:

- developing an *ex vivo* model in rats and pigs;
- binding antibodies by absorption with pig tissue on melibiose (galactose columns);
- developing pigs which do not express the galactose epitope;
- developing transgenic pigs which express the anti-complement substance CD46. We will be doing *ex vivo* perfusion work and pig to monkey transplants before pig to human studies.

Laparoscopic general surgery was pioneered at the Austin Hospital, the first cholecystectomy being performed in 1990, and common duct stone removal, adrenalectomy, intestinal by-pass, and splenectomy followed in 1991. Training courses and principles of introduction for the new type of surgery were developed between the University and the Royal Australasian College of Surgeons.

Mr Brian Buxton was appointed Professor and Director of Cardiac Surgery in 1991. His unit has been at the forefront of the introduction of the use of internal mammary arteries for coronary artery bypass operations. He arranged collaborative programs studying their pharmacology. Though the internal mammary artery has a three-year patency of 97 per cent compared to 30 per cent for vein grafts, they are not sufficient for multivessel disease. The physiological and pharmacological response of arteries such as the lateral thoracic are being studied before commencing human trials. Retrograde cerebral perfusion has been tested for the period of circulatory arrest for operations on the arch of the aorta. This is instead of deep hypothermia techniques. This method has moved to the human situation with initial rewarding results. As donor hearts do not match the recipient requirements, other methods of heart support have arisen. A major research study, which utilises an existing technique, has transformed skeletal muscle wrapped around the heart to augment ventricular function. The muscle is then paced to contract in synchrony with the heart. The animal studies are underway and patient studies are planned in an international trial.

Professor Kune made a study of the epidemiology of colon cancer a major research interest. He published widely in this area. He also published a book in the field of his clinical interest entitled *Current Practice in Biliary Surgery*. The retirement of Professor Kune, partly through illness, saw the appointment of Mr Donald MacLellan as his successor in 1991. Professor MacLellan has an interest in wound healing, establishing a Wound Management Foundation in 1993 to promote this research. Interest has focused on the benefits of a moist wound environment. A large range of pharmaceutical products have been developed to keep wounds moist. Professor MacLellan is studying these agents in the clinical setting. The epidemiology of venous leg ulcers is an associated program. The other major interest of the Repatriation group has been the study of *helicobacter pylori*. *Helicobacter pylori* (HP) is recognised as an association of about 90 per cent of duodenal ulcers, and after eradication of HP, patients have a low relapse rate. As a means of identifying pathogenic and non-pathogenic HP, a typing system is being studied based on large restriction fragment length. Other studies of HP involve the protein concerned in adhesion of the HP to epithelial cells.

In January 1995 the Heidelberg Repatriation Hospital became a state responsibility. In July 1995, it will amalgamate with the Austin Hospital into one hospital under one board of management. Where the merged hospital will be situated remains to be determined, as a move to the larger site requires considerable finances for a new hospital to be built, and there are major access problems. The Clinical School will expand to include a proposed new hospital, yet to be built, in Epping, to where the Preston and Northcote Community Hospital will relocate.



# THE ROYAL MELBOURNE HOSPITAL

Professor Gordon J A Clunie  
James Stewart Chair of Surgery



A graduate student undertaking microsurgery in laboratories at the Royal Melbourne Hospital.

**C**LINICAL TEACHING for students of medicine at the University of Melbourne commenced at the then Melbourne Hospital in 1864, although 'it cannot be said that the students were received with enthusiasm by the management, or indeed by the medical and surgical staff'.

Relations between the University and the Melbourne Hospital remained uneasy for many years and when it became apparent that rebuilding of the hospital was necessary, the University refused permission for it to be moved to vacant ground close to the University, leading to the establishment of the Alfred Hospital in Prahran.

The formal Faculty of Medicine within the University was established in 1876. A series of Lecturers in Surgery, later called Stewart Lecturers, were appointed to supervise surgical teaching, although many of the appointments were surrounded in controversy. It is important to note that the University had no input to the appointment of staff to the Melbourne Hospital at that time and this situation did not change until 1910, when the electoral system was altered and the University had some say in staff appointments. Although there were suggestions for the establishment of Chairs in Medicine and Surgery as early as 1913, it was not until 1952 that the University Council agreed to provide some financial support which had to be strengthened by an external appeal for funds. Applications for the Chairs were finally called in 1954, and in 1955 Richard Lovell was appointed to the Chair of Medicine at the Royal Melbourne Hospital, now functioning at last on the Parkville site, with Maurice Ewing being appointed to the Chair of Surgery, initially at the Alfred Hospital.

Subsequent development of Monash University and the establishment of a separate medical school south of the Yarra led to the transfer of the Department of Surgery to the Royal Melbourne Hospital. This was followed by the construction of the Clinical Sciences building, the first in Australia, establishing a proper physical facility which allowed Maurice Ewing to establish an academic department that provided leadership for Melbourne and indeed Australia. He was successful in gathering around him an active group of young surgeons, including Ken Cox, Vernon Marshall,

Peter Morris, Ken Hardy, Bill Kune, John Forbes, Brian Buxton and Oleg Eremin, all of whom moved on to head their own departments in Australia or overseas.

The department was in the forefront of the development of kidney transplantation in Australia and provided leadership in the fields of surgical metabolism and surgical education. Maurice Ewing retired after twenty-two years of distinguished service in 1976. His contribution is celebrated in the lecture theatre in the department which he established, where a plaque records the affection and esteem in which he is held by his colleagues and his pupils. By 1994, the department had undergone further substantial changes under the direction of Gordon Clunie, the second occupant of the James Stewart Chair of Surgery and, like Maurice Ewing, a graduate of the University of Edinburgh.

Progressive development of the Royal Melbourne Hospital as a tertiary referral centre has led to the establishment of important links with other hospitals for both undergraduate teaching and postgraduate training in surgery. They include a department at the Western Hospital (established under the leadership of Robert Thomas in 1992) and teaching and training at Ballarat Base Hospital, Wimmera Base Hospital, Wangaratta Hospital, Albury Base Hospital in New South Wales and Launceston Hospital in Tasmania.

The department is no longer made up entirely of general surgeons and even within general surgery the staff have been placed in sub-specialty units to reflect their particular interests. Although this may have led to some breakdown of the corporate structure of the academic department, the benefits to individual surgeons and to patient care are substantial.

Research undertaken by the department reflects the clinical interests of staff members, supported by full-time scientists and by Fellows, many of whom are surgeons in training. A continuing interest is the field of renal transplantation, led by Associate Professor David Francis, who heads the Surgical Renal Transplant Service at the Royal Melbourne Hospital, with Dr Lynette Dumble and Dr Patricia Mottram.

Particular research interests are the testing of immunosuppressive agents in a series of vascularised models of cardiac, renal and pancreatic grafts in rabbits and in mice. This work is undertaken in association with Professor Ian McKenzie of the Austin Research Institute, and Dr Tom Mandel of the Walter and Eliza Hall Institute for Medical Research. Cancer research involves studies of the effects of blood transfusion on tumour growth by David Francis and Professor Gordon Clunie, studies of a haematopoietic tumour suppressor gene by Dr Wendy Cook (NHMRC Research Fellow), molecular screening for colorectal cancer by Robert Thomas and Dr Wayne Phillips, and studies in association with the Ludwig Institute for Cancer Research.

Professor John Ludbrook, formerly of Adelaide University and now an NHMRC Senior Principal Research Fellow, leads a group studying CNS versus reflex mechanisms in the decompensatory phase of acute hypovolaemia, using a unique rabbit model; and Professor Duncan Blake, who heads the hospital Department of Anaesthesia, works with the group

investigating CNS actions of anaesthetic agents on circulatory control. Dr David Crankshaw, Senior Lecturer in Anaesthetics, has developed a unique programmed infusion pump for anaesthesia and undertakes extensive pharmacokinetic studies of anaesthetic agents in association with Professor Blake and other members of the hospital's Department of Anaesthesia.

Particular associations in specialty areas of surgery have been established with Professor Andrew Kaye in the neurosciences, with an extensive program studying cerebral tumours, extending through molecular biology of such tumours to studies of new photosensitisers and the mechanisms of uptake and localisation of photosensitisers in cerebral gliomas as they relate to phototherapy. Mr Ian Taylor, a Professorial Associate in the department, together with his colleagues in Plastic and Reconstructive Surgery undertakes an extensive series of investigations of angiosomes and venosomes and their relevance to osteomyocutaneous flaps in surgery as well as studies of the functional anatomy of anastomotic vessels in relation to flaps in animal models.

A particular strength of the department is its association at an academic and functional level with the Melbourne Tumour Biology Branch of the Ludwig Institute for Cancer Research, which was established in 1980 under the direction of Professor Antony Burgess. The Institute, which forms part of a world-wide series of cancer research laboratories, is now the largest research institute in Australia dedicated solely to cancer research, with its work undertaken at two levels. The first is in basic research, with the aim of extending our understanding of the basic biology of normal cells and the mechanisms involved in the transition of such cells into tumour cells. The second is clinical research which is designed to transfer the discoveries from basic research to the development of new forms of treatment. The recent appointment of Andrew Sizeland to head both the Ludwig Institute for Cancer Research Clinical Program at the Royal Melbourne Hospital and the Head and Neck Oncology Unit will strengthen the links between the institute and the department.

All clinical academic staff, whether full or part-time, maintain an active involvement in the care of patients in the Royal Melbourne or Western Hospitals as well as undertaking duties in other hospitals such as the Fairfield Hospital for Infectious Diseases and the Peter MacCallum Cancer Institute. In contrast with the situation in the last century, relationships between the University and hospitals can now be considered to be exemplary. The section of the department at the Western Hospital has been established over the past two years in high standard facilities which will allow for expansion.

The physical changes that have occurred within the past few years on the Royal Melbourne Hospital site in Parkville, across Royal Parade from the University, have meant that the staff are functioning in enviable circumstances in the hospital, the Clinical Sciences building and the refurbished Centre for Medical Research. This is accentuated by the academic and physical associations with the Ludwig Institute for Cancer Research in the Centre for Medical Research. The position of



the department in the middle of the 'Parkville strip' (undoubtedly the major centre for biomedical research within Australia), means that the department is well placed to continue its prime role in the development and training of academic surgeons.

#### Reference

1. Russell KF *The Melbourne Medical School 1862-1962*, Melbourne University Press, 1977, p32.

## ST VINCENT'S HOSPITAL

Professor Wayne A Morrison  
Hugh Devine Chair of Surgery



St Vincent's Hospital microsurgery team in action: L-R, Dr Samir Kumta, Prof Wayne Morrison, Dr Zahid Niazi (seated), Dr Michele Riccio and Dr Liz Whan.

ALTHOUGH THE DEPARTMENT of Surgery at St Vincent's Hospital is a relative newcomer, its Clinical School had early and august beginnings. At the time of the founding of the hospital in 1893 the medical profession, surgeons especially, enjoyed an era of unparalleled esteem. Eulogy was the routine at St Vincent's Hospital functions. Doctors at the hospital's second annual meeting in 1896 heard from a speaker that they were 'the greatest exponents of charity'. On the same occasion G A Syme assured the audience that 'the whole of the work I do at St Vincent's Hospital is a labour of love and I think that all hospital work from a surgeon's point of view is of that character'. At the hospital's 1906 annual meeting the Premier of Victoria thought 'It would need the Bank of England to pay the doctors for the services they provided free but these doctors were content to work without fee or reward in the noble cause of suffering humanity; they ought easily get to heaven'. In 1910 the Premier of New South Wales told the doctors they 'belonged to the noblest profession that we have in our civilisation; it has given us more princes among men than any other profession!'

This noble altruism however was not the only criterion for hospital appointment. An honorary post at major Melbourne hospitals helped private practice immeasurably and competition for appointment was fierce. At the Melbourne Hospital surgeons had to submit to the voting process of subscribers, a shabby process roundly lampooned by the press of the day<sup>2</sup>. Appointment to St Vincent's was by satisfying the shrewd judgement of Mother Berchmans Daly, the formidable founding administrator of the newly established Catholic hospital in Victoria Parade. William Morris

Hughes is reputed to have said, when a patient at Mount St Evins Hospital, the private section of St Vincent's, 'I didn't think I was afraid of anyone until I met Mother Berchmans!'<sup>3</sup>

Mother Berchmans was reputed to have been a brilliant selector of staff. Her first appointments included Sir Anthony Brownless, consulting physician, George Adlington Syme, William 'Gerry' Moore and Thomas Dunhill, surgeons, and Murray Morton initially as an anaesthetist. Hugh Devine was appointed in 1909. Hugh Berchmans Devine (no relation to Mother Berchmans) went on to become St Vincent's favourite son. He developed a worldwide reputation in abdominal surgery, wrote two textbooks, designed instruments and was pivotal in the establishment of the Royal Australasian College of Surgeons. The professorial position which was eventually to come at St Vincent's justifiably was named the Hugh Devine Chair of Surgery.

St Vincent's had acquired a medical staff of unexpectedly high standard. The next step was to establish a clinical school. This was applied for mainly through the influence of Thomas Dunhill in 1907 at a time when the Alfred Hospital had no recognised clinical school despite fifty years of existence. In their application the Sisters cited the example set by their parent hospital in Dublin. After initial refusal the University Council acceded to the request in 1909 on condition that it was represented at hospital appointments of medical staff and that a pathology service was established. This new recognition was the catalyst that helped the Faculty of Medicine to erode the infamous electoral system of selection of staff at the Melbourne Hospital. The University demanded similar arrangements to the St Vincent's agreement so that it had a voice in the appointment of its lecturers in medicine and surgery: their clinical school had limited credibility when the teachers were elected by subscribers and governors. It also allowed the University to influence appointments to the Women's Hospital and to force changes at the Alfred which would allow its recognition as a clinical school: changes acceded to by that hospital through fear of eclipse by St Vincent's as a clinical school.

Standards of teaching at all medical schools gradually slipped, especially during and after the war years, partly because of lack of paid and full-time appointees. In 1947 Sir Alan Newton of the Royal Melbourne Hospital proposed integration of all medical schools with rotation of supervisors and the appointment of a director of clinical studies. Upon Newton's death in 1949 this proposal was abandoned.

Despite its seminal role in the establishment and upgrading of the Melbourne clinical schools, St Vincent's in later years failed to attract a significant number of applicants from the pre-clinical years. In 1948 Charles Osborne, Dean of the St Vincent's Clinical School, reported that no student had given St Vincent's Hospital their second preference. Unstated was that, apart from personal associations or religious preference to choose St Vincent's Hospital first, the reputation of the school did not attract second preferences of others. The reasons stated included inferior clinical teaching, absence of clinical research, lack of amenities and the high incidence of TB among students. In 1955 applications increased -

of 127 medical students, twenty-nine nominated St Vincent's compared with twenty-two at the Alfred and fifteen at the new Prince Henry's Hospital, but sixty-one nominated for the Royal Melbourne Hospital. Little more could be done to alter the balance until academic and research departments were introduced.

The appointment of Professors in Medicine and Surgery of the University of Melbourne did not occur until 1955 - Professor Richard Lovell (Medicine) at the Royal Melbourne and Professor Maurice Ewing (Surgery) at the Alfred, seventy-nine years after the establishment of the medical faculty. The second medical chair was established at St Vincent's in February 1957 with the appointment of Professor Jack Hayden. Lobbying for a St Vincent's surgical chair took much longer. The hospital had agitated for the position for some years until, in 1963, a delegation led by Sister Alphonsus confronted the Vice-Chancellor, Sir George Paton. This encounter was described as two potentates going into battle. By 1964 Paton had agreed to the setting up of a Chair of Surgery and this was advertised in August 1965. Several impressive contenders applied for the post including Roy Calne who ultimately accepted a Chair at Cambridge to pursue his pioneering transplantation work. Richard C Bennett of Adelaide accepted the post and commenced in January 1966 as the Hugh Devine Professor of Surgery. He was thirty-five years old and there is an apocryphal tale told regarding his youthful appearance. At the time of his interview, having come across from Adelaide he was housed overnight in the students' quarters. In the middle of the night he was abruptly awakened by the night nurse superintendent who, after inquiring who he was and having heard the retort, 'Mr Bennett', assumed he was a medical student and summoned him forthwith to Casualty to pass a catheter. In typically obliging fashion Dick Bennett complied with the demand, to the everlasting gratitude of the patient.

Bennett had trained in Glasgow and at Leeds with Goligher in bowel surgery and then returned to Adelaide as first assistant with Jepson in vascular surgery. Unlike the medical professors Dick was not an inbred St Vincent's man and, without contacts and with little University money, the going was initially tough. John Doyle was appointed first assistant with an interest in vascular surgery and in 1967 Ivo Vellar became second assistant.

The university-funded Clinical Sciences building, which included laboratory and office space and separate animal holding and theatre facilities, was opened in 1969. Dick Bennett quickly established the renal transplant unit at St Vincent's and after the departure of Doyle and Vellar, John Rennie and later D T (Taki) Caridis were appointed. Dick continued his anorectal interest and was aided by the part-time appointment of Roy Fink who for many years undertook clinical research in this field. An appointment to the Peter MacCallum clinic commenced a breast surgery interest which was complemented by research into breast hormones and the establishment of one of the first laboratories for breast hormone testing in Victoria. Dick's strong links with British surgery attracted a steady stream of British postgraduate visiting fellows to Melbourne



including Roger Blamey, now Professor of Surgery at Nottingham, and Mark Kissin, consulting breast surgeon, Guildford, Surrey.

Paul Kitchen was recruited to augment the breast service and Michael Henderson commenced as senior lecturer in 1987, having returned from training in surgical oncology at M D Anderson Institute in Texas. He was influential in securing the City and North Eastern BreastScreen Service to be associated with St Vincent's. He has also close ties with Peter MacCallum Cancer Institute with its surgical oncology service. Pat Hayes most recently joined the breast and general surgery unit.

Dick Bennett developed a great interest in the affairs of the Royal Australasian College of Surgeons and became its Treasurer and Vice-President. He was editor of the *Australian & New Zealand Journal of Surgery* for many years and made a great contribution as Treasurer in establishing a College Foundation for education and surgical research. This has been immeasurably helpful to postgraduate students and research centres in initiating research projects and encouraging researchers to continue in academic careers.

Among the visiting medical staff of St Vincent's many contributed to its clinical and academic reputation, including the professorial associates John Connell (vascular surgery), John Clarebrough (thoracic and cardiac surgery), Jim Cummins (neurosurgery), Harry Crock (orthopaedics), Ivo Vellar (upper GI) and, more recently, Tony Costello in urology.

Without doubt the most spectacular surgical phenomenon to emanate from St Vincent's was Bernard O'Brien, a plastic surgeon who had trained in England and New York. Already he had a clear vision of the great potential of microsurgery in reconstructive plastic surgery but opportunities were limited – his bumptious and ambitious style unnerved hospital authorities and threatened some of his medical peers. He was a master of organisation and efficient use of his time, and to this end employed a chauffeur, enabling him to work and dictate while travelling, a scrub nurse to organise and assist his operating, and a research nurse as well as a secretary – all before he had the security of a fixed hospital appointment. Such was the conviction and confidence of his vision. With an appointment at St Vincent's and the support of Dick Bennett, he gained access to facilities where he immediately set about animal research. With Thelma Baxter he researched micro-vascular repair techniques, histological evaluation of repair and injury and the development of instrumentation which led to some of the earliest publications in this field. Soon he gained NHMRC funding and this support continued almost uninterrupted until his death in 1993.

Again showing his entrepreneurial skills, he convinced prominent businessmen of his mission and thus the Microsurgery Foundation was formed in 1970 which led to the establishment of the Microsurgery Research Centre. He recruited a team which included his surgical colleagues Allan MacLeod and Wayne Morrison as well as scientists and scientific advisers. Soon research fellowships were established which attracted high-quality trainees from around the world, many of whom would return to their own country and

establish themselves as international leaders in the field of microsurgery. Over 100 candidates from more than twenty countries completed fellowships of one year or longer. Research output became prodigious leading to more than 300 publications, innumerable chapters and two books, the first of which was translated into many languages.

During this period two senior lecturers left to take up important posts in the USA – John Buls joined an internationally recognised colorectal practice in Minneapolis, and Charles Mullany accepted appointment as cardiac surgeon at the Mayo Clinic. Both returned as specially invited lecturers for the hospital's Centenary Celebrations in 1993.

Bruce Gray was appointed first assistant and researched into liver cancer with the use of radioactive targeting and immunotherapy as well as hepatic infusion of the portal vein. In 1983 he was appointed Professor of Surgery at the University of Western Australia, Royal Perth Hospital. Chris Martin from Royal North Shore, Sydney, was appointed in 1981 with an interest in oesophageal surgery and developed an international reputation for his work with Barrett's ulcer, both clinically and experimentally. Chris attracted substantial NHMRC funding as well as several MS and MD students who were integral to his program. In 1993 Chris was appointed inaugural professor at Nepean Hospital, associated with the University of Sydney.

In early 1991 Dick Bennett retired after twenty-five years of service as the foundation Professor at St Vincent's. Still then a youthful sixty he assumed the title Professor Emeritus and continues at the Royal Australasian College of Surgeons as Executive Director for Surgical Affairs.

Entirely new directions followed the appointment of Wayne Morrison to the Chair in January 1992. For the first time the University of Melbourne appointed a specialist surgeon to a full chair and this was in recognition of the clinical and research reputation of the plastic, microsurgery and hand surgery unit that had developed at St Vincent's Hospital. Wayne Morrison was a graduate of the University of Melbourne in 1967 and had trained in plastic surgery at St Vincent's, Melbourne, in Glasgow and in Miami. He also spent one year in Paris training in hand surgery. He was appointed to the Plastic Surgery Department in 1976 and deputy director of the Microsurgery Research Centre soon after. He has had almost continuous NHMRC funding since 1980 for research projects at the centre. He gained an MD for his work in reconstructive microsurgery and has published a textbook on this subject.

In 1992 the new Department of Surgery aligned with the Department of Plastic Surgery under Mr Allan MacLeod and gained a new appointee, Peter Hayward, a Sydney graduate in plastic surgery with training in wound research and craniofacial surgery in Texas and at Harvard respectively.

Following the death of Bernard O'Brien in 1993 Professor Morrison was appointed Director of the research centre. Since then the Microsurgery Research Centre on campus at St Vincent's Hospital has been entirely rebuilt and is now renamed the Bernard O'Brien Institute of Microsurgery. A full and part-time staff of thirty includes surgeons, scientists, overseas

fellows and postgraduate students. The research fields currently funded by NHMRC are ischaemia reperfusion injury, angiogenesis and airway smooth muscle function. Other areas include transplantation, skin cancer, thrombosis and blood flow studies in flaps.

The original general surgical component of the Department of Surgery has now contracted but a new focus on surgical oncology has been targeted with strengths already in breast surgery and soft tissue tumours and by association with the Head of Plastic Surgery at Peter MacCallum, David Jenner, and with the Skin and Cancer Foundation, in skin cancer. These fields complement each other because of their reconstructive requirements.

Preston and Northcote Community Hospital (PANCH) surgical consultant staff had for twenty-two years taught St Vincent's hospital students and this hospital had become an integral component of the Clinical School teaching program, particularly because of the variety of, and easy access, to patients. In 1989 the University decided to enhance the academic standing of PANCH and appointed Hamish Ewing as Associate Professor, affiliated with St Vincent's Hospital Department of Surgery. Hamish had come from the Repatriation Hospital, Heidelberg, where he had a special expertise in upper GI surgery and introduced the new skills of laser to the treatment of oesophageal disease. Hamish continues his research interests in Barrett's oesophagus.

Geelong Hospital likewise had long been a valuable resource initially for postgraduate training and, after Monash University relinquished student teaching, as an undergraduate centre. The clinical schools of St Vincent's and Geelong amalgamated to become the University of Melbourne St Vincent's-Geelong Hospital Clinical School. In late 1992 Irwin Faris from Adelaide was appointed to the foundation Chair of Surgery at Geelong Hospital which is associated with St Vincent's Department of Surgery. Irwin graduated from the University of Melbourne and trained at the Alfred Hospital before taking up an appointment in Adelaide at Flinders Medical Centre as a vascular surgeon in the University department.

Irwin is internationally recognised for his work on the peripheral vascular problems in diabetes and he has published a book on this topic. In 1994 George Kiroff was appointed as senior lecturer. The Geelong appointments have greatly strengthened clinical and teaching links with St Vincent's Hospital.

Although, with the turn of the century, the public esteem of surgeons has lost some of its hyperbole by comparison, the Clinical School at St Vincent's has again returned to its former glories. Wilma Beswick, the Clinical Dean, has achieved unprecedented success with fourth year enrolments and final year graduation results over the last few years. The University Department of Surgery at St Vincent's and Geelong and their visiting medical officers along with their affiliated teaching hospitals at PANCH, Warrnambool and Shepparton, are justifiably proud of these results.

#### Acknowledgments

Much of the early history of St Vincent's has been extracted from the book by Bryan Egan, *Ways of a Hospital, St Vincent's Hospital, Melbourne 1890s to 1990s*. Allen & Unwin Pty Ltd, Melbourne, 1993.

Other sources: Rank BK, *Jerry Moore and some of his contemporaries*, Hawthorn Press, Melbourne 1975.



## SCHOOL ALBUM







## NOTICE OF ANNUAL GENERAL MEETING 1995

The Annual General Meeting of the University of Melbourne Medical Society (UMMS) will be held at 6.30 pm in the Sunderland Theatre, ground floor, Medical Building, The University of Melbourne, Grattan Street, Parkville, on Tuesday 16 May 1995. This meeting is preceded by the Dean's Lecture in which Professor John Hutson, Director of Paediatric Surgery, Royal Children's Hospital, will deliver a lecture entitled 'What maketh the man? Genital anomalies provide clues for understanding embryology of sexual development'.

### Business

1. Minutes of 1994 Annual General Meeting
2. Chairperson's Report
3. 1994 Financial Report
4. Election of Committee, 1995-1998

Nominations are called for the election of six (6) members of the Committee of UMMS for 1995-1998 and close on Tuesday 9 May 1995.

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

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

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

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

5. General Business

disease: Androgen receptor dysfunction in a hereditary form of motor neurone disease and to Mr Peter Mount for his study entitled *Production of a chimeric (mouse/human) monoclonal antibody against a colorectal carcinoma-associated antigen*. Both dissertations were excellent and it had been impossible to choose between them. A report on the awards was published in the 1994 issue of *Chiron*.

- In 1993 UMMS established an elective essay prize for sixth year MBBS students. Four prizes of \$100 each were awarded in 1993 to Jacqueline Brown, Peter Chu, Georgina Phillips and Shomik Sengupta. Georgina Phillips' essay was published in the 1994 issue of *Chiron*.
- Activities in 1993 included the annual UMMS Lecture 'How to Win Friends and Influence People - Forty Years in Public Health', which was delivered by Dr Nigel Gray to a full house. UMMS members enjoyed refreshments served prior to the lecture.
- Many attended the Dean's Lecture Series in 1993 which was completed by an ethics seminar entitled 'The Dead Do Tell Tales: Declining Autopsy Rates and the Quality of Health Care', convened by Professor Richard Smallwood. This seminar attracted a large audience and a considerable amount of media coverage. The Dean's Lecture Series will conclude this year with another seminar entitled 'A Better Death'. It will be convened, once more, by Professor Richard Smallwood and will commence at 2.00 pm on Friday 22 July 1994.
- Medical graduate reunions continue to be popular and details of reunions held in 1993 were published in the 1994 issue of *Chiron*.
- Members were reminded of the UMMS Lecture and function, details of which will be announced later this year.

### 3. Financial Report 1993-4

Copies of the financial report were distributed at the meeting. It was noted that UMMS finances were satisfactory, showing an income of \$108,763 (including \$52,047 carried forward from the previous year) and expenses of \$49,759 leaving a balance of \$59,004. A motion to accept the financial report was carried.

There being no further business the meeting closed at 6.45 pm.

## MINUTES OF ANNUAL GENERAL MEETING 1994

The Annual General Meeting of the University of Melbourne Medical Society (UMMS) was held at 6.30 pm on Tuesday, 24 May 1994 in the Sunderland Theatre, Medical Building, The University of Melbourne. The meeting was preceded by the Dean's Lecture entitled 'Is there still a role for medical practitioners in the treatment of drug and alcohol problems?' This was delivered by Professor Greg Whelan, Director of Drug and Alcohol Studies, St Vincent's Hospital.

### 1. Minutes of the Annual General Meeting 1993

The minutes of the 1993 Annual General Meeting, previously circulated, were accepted as an accurate record of the proceedings.

### 2. Chairperson's Report

The 1994 *Chiron* was published in May and Professor Ryan congratulated the editors, Mr Peter Jones and Mrs Margaret Mackie. Mrs Mackie was also congratulated on the quality of the design and production of the journal. The meeting recorded its appreciation by acclamation. He noted that the journal included a guest editorial by the new President of UMMS, Professor David Penington, whom he welcomed to the meeting. It was noted that Mrs Mackie, who had planned to retire at the end of June 1994, had agreed to continue in her role for the time being. Professor Ryan thanked the Medical Defence Association of Victoria for their continued generous support of *Chiron* and noted its importance in enabling the journal to flourish.

- Membership of UMMS as at 2 May 1994 is 2,209 compared with 2,193 at a similar time in the previous year.
- Two UMMS Bachelor of Medical Science Prizes were awarded for 1992: to Mr Wai-Ting Choi for his study entitled *Kennedy's*

## UMMS 1993 BMEDSc PRIZE

Andrew Lovett

for his study entitled

### A survey of the health status of homeless young people in Victoria

This project represented the first collection of quantitative data on a broad range of health issues facing homeless young people in Victoria. The information provides new insight into the nature and health needs of this population and provides the basis on which there can be advocacy for and development of appropriate health services.

The survey took place using an innovative methodology that involved the development of a new computer-based instrument for the self-report assessment of health status. The computerised questionnaire that was developed and piloted enabled the assessment of a broad range of health related behaviours, with a particular focus on mental health and wellbeing. A hundred and sixty-five homeless young people participated in the survey and were accessed through accommodation services, health services, drop-in centres, youth training centres and community schools throughout urban and rural Victoria.

Homeless young people were found to suffer from a range of illnesses which are common to all adolescents. These were exacerbated by the conditions associated with homelessness. These included acne, respiratory complaints and headaches. Strong evidence was found that respiratory complaints, in particular asthma, were uncontrolled and being left untreated.



Health-compromising behaviours were extremely prevalent when compared to a school-based population cohort of young Victorians of similar age. Ninety-one per cent of the study sample were smokers, with the vast majority describing themselves as medium or heavy smokers. Sixty-six per cent had drunk alcohol in the past week with 70 per cent participating in binge drinking. Ten per cent reported that there were at least ten occasions in the preceding two weeks where they had binged on alcohol to a level in excess of the NHMRC recommended level of safe drinking for an adult. Forty-eight per cent of males and 24 per cent of females smoked marijuana on a daily basis and 21 per cent claimed to have had more than thirty sexual partners. Twenty-five per cent of males and 35 per cent of females claimed they ate only one meal each day.

The prevalence of psychiatric morbidity was 59 per cent as measured by a mental health screening questionnaire. Fifty per cent of those aged sixteen or more years screened positive on a psychosis screening questionnaire. Surprisingly, the self-esteem component of the psychological assessment revealed scores at the higher end of the range found in the general adolescent population.

This important and comprehensive study has provided vitally important information about the health issues for homeless young people in Victoria. The data support the case for the development of specifically targeted health services, with both primary care and preventative approaches that meet the complex and special health needs of this most disadvantaged group of young people.

## UMMS 1994 ELECTIVE ESSAY PRIZES

In 1993 the University of Melbourne Medical Society established an essay prize for sixth year MBBS students. Prizes of \$100 are offered annually for the best essays of up to 1500 words describing the elective experience in both professional and personal terms. Prize-winning essays are also considered for publication in *Chiron*. The 1994 winners were:

- Sonia Davison, *The Maldives – Paradise or Paradox?* (*Chiron* 1995 p41)
- Glenn Guest, *Evolution in the Cradle of Mankind* (*Chiron* 1995 p42)
- Chris Oh, *Bagel Breakfasts and Body Bags*.

## Organising a Reunion Dinner?

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



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

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

Please contact Mr Ken French or Mr Philip Taylor-Bartels on 344 5254 for menus, costs, a tour of the facilities and further information.

## WHAT'S ON IN 1995

### Seminar

#### Caring for the Severely Disabled or Dying Child

Convener: Professor Richard Smallwood

#### Speakers

Dr Neil Campbell, Dr Frank Shann  
Emeritus Professor A Lindesay Clark AM  
Mrs Margaret Loughnan, Mrs Helen Nihill  
Professor Don RC Chalmers, Mrs Loane Skene

**Friday 28 July 1995, 2pm-5pm**

Sunderland Lecture Theatre, Medical Building  
The University of Melbourne

### UMMS 1995 Function

Watch for announcement

### UMMS Annual General Meeting

**Tuesday 16 May 1995, 6.30pm**

Sunderland Lecture 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) 9344 5888

### Alumni Association

The University of Melbourne Alumni Association is pleased to announce they have secured tickets to an MTC performance of David Williamson's new comedy *Dead White Males* at 8pm on Thursday 22 June 1995 at the Playhouse, Victorian Arts Centre. The cast includes Henri Szeps, John Howard, Anna Volska, Michelle Doake and Simon Chivers. The evening will conclude over supper with the cast.

Cost: \$36 (members), \$42 (non-members)

Enquiries and bookings: (03) 9344 7469



THE UNIVERSITY  
OF MELBOURNE



## UMMS CONGRATULATES...



Dr Effie Robertson, MBBS 1921.

**D**R EFFIE HONE, MBBS 1921, on the celebration of her 100th birthday. Dr Hone was born in Bendigo, Victoria, 11 September 1894, the daughter of school headmaster, James Robertson, and his wife Annie, a former teacher.

The third of six children born to the Robertsons, Effie grew up knowing she would have had twin elder brothers had they not died a few days after birth. She later shared the pain of hearing her elder brother, Alex, had been killed in action in Gallipoli – the month before she turned twenty-one.

Today Dr Hone has three generations of family of her own living around the world – including her son, Sandy, based in Hong Kong, and two daughters, Mrs Leon Chead in London and Mrs Elizabeth Lovett in Melbourne.

Tutored by her parents in literacy and numeracy before she started school, Effie Robertson did well as a student, showing particular pleasure and ability in reading. 'We had a fairly liberal upbringing. We read newspapers and discussed the issues of the day – and as family members we were entitled to our views', says Dr Hone.

Mr Robertson expected Effie and her two sisters, Bess and Jean, to matriculate and to learn to earn their own livings. Although he did not foresee his daughters going to university, when Effie's secondary education came round he sent her, on a scholarship she won, to the co-educational Continuation School – which became Melbourne High – because it offered subjects not then readily available to girl students elsewhere in Melbourne.



Dr Effie Hone receiving congratulatory messages on her 100th birthday.

Dr Hone says that, despite having no plans for university, she did physics and chemistry. 'But I knew some girls came to do the extra subjects offered at the school so they could go to university and get a BA.'

She says, 'My father thought that if a girl matriculated that was sufficient. In fact, having done that, I began attending a college of domestic economy – my father foresaw a rising demand for cooks in Australia. Then I learned I had won a scholarship. Unbeknown to me I had been entered for it by the Head at Melbourne High. My father was persuaded that I should go on to take an 'exhibition', as they called it – and that got me in to university. I did medicine because my father was against anything that wasn't practical. And engineering was out – girls didn't do it!'

Dr Hone's memories of medical school are that the lecturers 'expected the same from the women as the men. I don't remember anyone ever being unpleasant to me, but nothing was made easier for you. Mind you, we were fair game. You could be quite certain that a fair bit of questioning would come a girl's way in the clinics. You just had to be prepared for that.'

Effie Robertson graduated in 1921, aged twenty-seven. In her first two years out she worked as a resident in the Adelaide Children's Hospital and the Royal Adelaide Hospital. Later she worked in the Pathology Department at Adelaide University, thereafter specialising in pathology.

While in Adelaide Effie met and married Duntroon graduate, soldier and businessman Ronald Hone. Ronald Hone died in 1968.

**T**HE Australian Doctors Orchestra again! Giving its second concert, this time at the Melbourne Town Hall on Sunday 4 September 1994, the highly successful ADO has grown from 72 to 93 musicians – about the same size as the Victorian Symphony Orchestra.

The orchestra was conducted by Christopher Martin, senior lecturer in strings and conducting at the University of Melbourne Faculty of Music, and renowned violinist Carl Pini, concertmaster of the Melbourne Symphony Orchestra and violist, Hartmut Lindemann, were the soloists. The program included Beethoven's Overture to *Goethe's Egmont* Opus 84, Mozart's *Sinfonia Concertante* in E flat K364 and Dvorak's *Symphony No 8* in G major Opus 88.

In addition to providing pleasure and relaxation for 'musical medicos' (who pay their own travel and accommodation expenses), the orchestra raised about \$6500 for the Royal District Nursing Service and The Hollows Foundation. The 1995 concert will be given at the Sydney Town Hall and will support the Melanoma Foundation.



Backstage, ADO Concert Master Rowan Thomas gowning Christopher Martin, Conductor-Musical Director.

The committee is always on the look-out for 'new blood' and medical undergraduates are most welcome – in fact they comprise approximately 15 per cent of the orchestra. The standard is 6-7th grade AMEB and it is a prerequisite that the players are actively participating in an orchestra or chamber ensemble.

Enquiries to Mr M J Pohl, *Thirza Cottage*, 27 Kirksway Pl, Battery Point, Tas 7004.

- Professor Richard Smallwood on his appointment as Chairman of the National Health & Medical Research Council.
- Professor Judith Whitworth on her appointment as Chairperson, Medical Research Committee of NHMRC.
- The Australian Medical Association (Vic Branch) Arts Group on holding their 35th Annual Exhibition, which was opened by Susan Barnett on Sunday 16 October 1994 at the Victorian Artists Society Gallery in East Melbourne.
- John C Trinca, who has added to his list of achievements the publication of his book *Neither Hypocrite Nor Saint*, a biography of his father Alfred John Trinca.



## 1994 REUNIONS



**Class of 1944 – 50 Years Reunion**

**L-R, Back row:** A. Newell, A. Beech, R. Doig, P. Birrell, P. Blaubaum, B. Beavis, R. Galbally, R. Cole, R. Gough, J. Hurley, J. Williams. **In between:** C. Wilson, V. Stephen, L. Koadlow, G. Robinson, L. Morgenstern. **Second row:** J. Howqua, N. Cowling, G. Donald, M. Abrahams, N. Sutherland, B. Brodrick, J. Floyd. **In between:** R. Walker, Q. Whitehead, R. Bretherton. **Front row:** H. Hosking, N. Pinkus, G. Ryan, A. Gilchrist, L. Cebon, G. Pryor, A. Feddersen. **Photo:** S. Brand.

### **MBBS March 1944 Fifty Years Reunion The Melbourne Club 25 March 1994**

*From Allan Beech* – On 25 March 1994, fifty years to the day, 34 of the 79 medical graduates who graduated on 25 March 1944, attended a reunion dinner, held at the Melbourne Club. Several made the journey from other states of Australia and Leo Morgenstern travelled all the way from New York to join us. There were two graduating groups in 1944 – in March and December. Our group had all commenced their course in March 1939, but with the outbreak of the Second World War attended a foreshortened course, graduating in five years instead of six. The course included Army Service with the Medical Wing, Melbourne University Rifles, learning to march around Carlton and in January 1942 a camp at Bonegilla, and most of us served for a time after graduation in one of the three services.

The evening was attended by: *Mary Abrahams (Hoy), Ted Beavis, Allan Beech, Peter Birrell, Peter Blaubaum, Sol Brand, Rodney Bretherton, Bell Brodrick, Leon Cebon, Russell Colle, Ron Doig, Gwen Donald, Alan Feddersen, John Floyd, Bob Galbally, Alan Gilchrist, Roy Gough, Hal Hosking, June Howqua, John Hurley, Les Kowadlo, Nancy McNeil (Cowling), Leo Morgenstern, Andrew Newell, Newman Pinkus, Gordon Pryor, George Robinson, Geoff Ryan, Neil Sutherland, Val Stephen, Ruth Walker, Quin Whitehead, John Williams, Charles Wilson.*

### **MBBS 1949 Forty-Five Years Reunion The Lyceum Club 28 October 1994**

*From Valda Horton* – The formal dinner was beautifully presented by the Lyceum Club when the '49 graduates attended the 'Forty-Five

Years Reunion'. Apologies were received from twenty-four who, because of illness, distance or impending travel, were unable to attend. It was particularly pleasing that several of our number had travelled from interstate or overseas to join us: Colin Douglas-Smith (WA), Bas Harper (NSW), Audrey Officer (Adams) and Peter Gill (Tas), and Margaret O'Brien (England).

Following the loyal toast proposed by Noel Cass, Valda Horton read some extracts from letters sent by absent colleagues. Later in the evening Barry Grove read a synopsis of results compiled from answers to a questionnaire he had sent to graduates. No names were requested thus the answers quite frank. This has become a regular feature of our five-yearly reunions and Barry's efforts have proven to be informative, interesting, at times surprising, but always appreciated. His talk concluded – 'We have replenished the country with more graduate children than our own number, and our children are culturally way out in front of us'.

The night was a very happy one with lots of movement from table to table and plenty of conversation. Many commented that it was one of our best reunions and they hope to make our next – the jubilee. On behalf of the graduates, Kevin Coleman thanked Valda Horton for organising the reunion. We were sad that eight of our number had left us during the past five years.

The evening was attended by: *Dian Ashton (Alexander), Ron Beetham, Nan Bell (West), Keith Benn, Olga Bolitho, Chic Bond, Noel Cass, Kevin Coleman, Ian Collins, John Combes, John Cone, George Doery, Bryan Egan, Kendall Francis, Bob Fraser, Al Fullard (Booth), Barry Grove, David Gunter, Hazel Halse, Valda Horton (Slaweska), John Horton, John Kelly, Ray Kernutt, Hal Lanyon, Barry Loughnan, Colin Macdonald, Don Mclean, Terry McLaren, Ian McVey, Ken Millar, Frank Nagle, Alan Neal, Dorothy Newton, Colin Reid, Max Robinson, Len Rouch, Eric Stock, John Stubbe, Margaret Tatchell (Ferguson), Gordon Way, Max Whiteside, Mary-Grace Whyte (Asche), Bob Wilson, Ian Hedley Wood.*



**MBBS 1954**  
**Forty Years Reunion**  
University House  
12 November 1994

*From Norman Beischer* – The fourth reunion of the 1954 graduating year was held at University House. Guest speaker for the evening was Professor Graeme Ryan AC, Dean, Faculty of Medicine, Dentistry and Health Sciences. The loyal toast was given by John Macdonald. The 45th reunion will be held in 2000.

**MBBS 1959**  
**Thirty-Five Years Reunion**  
Peninsula Country Golf Club  
Hilton on the Park  
Dromana Estate  
18–20 November 1994

*From Clive Bennetts* – The week-end reunion of the 1959 medical group commenced on Friday 18 November 1994 when Drs Graeme Miller, Eric Cooper, Denis Bourke, Janet Fitzpatrick, Frank Gallichio, Clive Bennetts and Glynn O'Collins partook of the hospitality at the Peninsula Country Golf Club with lunch, golf and dinner. Many apologies were received, and it has been decided that this will be an annual event.

A 'graduates only' dinner was held at the Hilton on the Park on Saturday 19 November 1994 which was attended by: *Clive Bennetts, Denis Bourke, Don Brodie, John Cocks, Peter Corby, Mario Croatto, Bert de Voogd, Paul Duggan, Janet Fitzpatrick, Frank Gallichio, Bob Horsfall, John Hurst, Lloyd Jenkins, Geoff Klug, Ray Leeton, George Lipton, Mario Marchesani, John Mathew, Anna McBain, John McDonald, Anne McKenna, John McNamara, Gabrielle Medley, Colin Melville, John Meyer, Eric Miller, Graeme Miller, Glynn O'Collins, Tom Polinese, Ron Quirk, Kevin Rickard, Ian Robertson, Peter Rose, Norman Rose, Maurice Rosenbaum, Stan Schofield, Malcolm Scott, Ed Shen, John Spicer, James St John, Peter Sutherland, Rod Syme, Cliff Warmbrunn, Isla Williams.*

During the course of the evening Alice Cheah was telephoned in Singapore, she sent best wishes to all her friends from Melbourne University.

On Sunday, twenty-eight graduates and partners met at the Dromana Estate for lunch and wine tasting and again this was a most enjoyable occasion. It was a general consensus of all those attending that it was probably the best reunion we have had and we are to continue the same format for our forty-year reunion.

**MBBS 1964**  
**Thirty Years Reunion**  
University House  
23 November 1994

*From Campbell Penfold* – The 133 surviving members of our year were invited to celebrate thirty years since graduation with dinner at University House on Saturday 23 November. Seventy-seven graduates came with their spouses making up 123 at the dinner. Two were there from the United States and many came from interstate. A most enjoyable time was had by all.

University House proved to be an excellent venue; the evening commenced with pre-dinner drinks on the terrace accompanied by a string quartet, followed by a formal dinner in the dining room during which we made good use of the house cellar. The party was marked by its friendliness, informality and the pleasure felt at meeting so many 'old' faces again. Four keynote addresses were delivered: Harry Lawson (the students), Ted Heffernan (the teachers), Ian Cunningham (the University) and Tony Moore (the World). They were witty and well received.

The group thoroughly enjoyed themselves and decided to hold another reunion in five years time on the proviso that the organising committee includes women and more non-surgeons.

**MBBS 1969**  
**Twenty-Five Years Reunion**  
Mietta's and Melbourne University Lawns  
3–4 November 1995

*From Sandra Hacker* – MARCH 1964 – Orwell twenty years away. Vietnam, Beatles, hippies and hope. Fresh faced idealists descend on Melbourne University Medical School to absorb the skills they will need to save the world.

DECEMBER 1969 – One hundred and fifty battered and exhausted survivors, drawn close by the shared experiences of six gruelling years, assemble at Wilson Hall, excitement mixed with relief, to receive the tickets to their future and the right to inflict their new-found knowledge on an unsuspecting public.

NOVEMBER 1994 – Twenty-five years on – One hundred now senior professionals assemble from around the world at Mietta's, to celebrate a quarter century of practice. Orwell ten years gone. For many, hair gone and gravity on the attack – changed but unchanged; different, but oh so recognisable. What a night! Friendships rekindled; lost colleagues found; recollections shared; experiences relived; old times and old loves; old friendships and old debates; a thousand memories, larded with scurrilous stories, outrageous anecdotes and tantalising tales about each from Kevin Moriaty and Doug Coster (100 law suits pending). History recorded in a specially-prepared memento book, with contributions from those present and those who could not be. A joyous occasion – marred only by the absence of much loved colleague Michael Luxton, who, though ill, was so looking forward to the event but died (in the loving presence of Janet) on the night of the reunion.

1 am: Adjourn to the bar. Discreet curtains drawn.

1 pm that afternoon: The dark-glassed survivors, this time with families, re-assemble on the Melbourne University lawns to review the night and plan for the thirtieth.

**MBBS 1974**  
**Twenty Years Reunion**  
Sheraton Towers, Southgate  
18–20 November 1994

*From David Tuxen* – The MBBS 1974 Scientific Symposium and Reunion was a huge success. It was held primarily at Sheraton Towers, Southgate on the weekend of 18–20 November 1994.

The meeting commenced on Saturday 19 November with a Scientific Symposium at the Sheraton Towers Hotel. Speakers were Drs Romaine Holmes, Michael Richards, Brian Chambers, Rob Peterson, Prue Hill, Rob Gibson, Mike Hirshorn and Professor David Copolov. All were members of our year selected on the basis of a diverse range of specialties and achievements of interest. The Scientific Symposium was a great success and placed everybody in an excellent frame of mind for the remainder of the day.

Participants then boarded a boat which transported them up the Yarra river to a point close to the Melbourne Cricket Ground. A brief walk took us to the Landy Room, overlooking the Melbourne Cricket Ground, where a Sheffield Shield match was in progress. An excellent lunch was provided by the MCC and the beautiful weather, the entertainment of the cricket match and the relaxed surroundings enabled us to catch up with one another in an informal way.

Over two hundred attended the dinner dance held at Sheraton Towers, this also was a great success. Dr Tim Costello and Professor David Tuxen were the Masters of Ceremonies; the main speech 'The MBBS 1974–1994 Oration' was delivered by Dr Lou Irving who retraced our steps through the Medical School, including photographs of old buildings, lecture theatres and libraries, and records of interviews and photographs of many of our old lecturers. The oration concluded with a competition between the professors (and their affiliates) and the non-professors, of questions relating to recall of facts from our medical years. Although there was some bias in the regulation of this quiz, the non-professors won hands down. Music was provided by 'Cloud Nine' and my secretary, Regina Zielke, who had been an enormous help in organising the meeting, assisted the band by singing three songs. Her singing was a huge success and she received multiple recommendations that she was wasted as a secretary and received one offer of marriage. The evening concluded



at around 2 am when most were exhausted – although a few stalwarts continued on into the small hours in an attempt to empty Lou Irving's bar fridge in his hotel room.

An informal BBQ was held at Studley Park Boathouse for Sunday lunch which was attended by registrants and their families. Overall the meeting was a great success and thoroughly enjoyed by all.

### **MBBS 1983 Eleven Years Reunion Athenium Club 10 September 1994**

*From Alessandra Radovini* – We were a little bit late in getting ourselves organised and so our ten years in medical practice reunion was held on 10 September 1994.

Approximately seventy graduates and some partners attended a gala dinner at the Athenium Club. This proved to be a delightful evening with plenty of opportunity to catch up with familiar faces in between 'winning and dining' in this most gracious setting, a string quartet helping to set the mood.

Noel Cunningham gave the welcoming address and later in the evening John Pattison shared some of his thoughts on our student days and the intervening ten years. Our thanks to all who helped make the reunion a most enjoyable evening.

### **MBBS 1984 Ten Years Reunion Heidelberg Town Hall 15 December 1994**

*From Neal Finegan* – The ten-year reunion of the 1984 Melbourne University MBBS graduates, was held at Heidelberg Town Hall on 15 December 1994. The event was attended by 103 graduates and their partners. The event was a masked formal dinner dance, with an address by Vice-Chancellor David Penington, affectionately known as 'Smiling Death', when he was Dean of the Medical Faculty at the time of our graduation. None of us appear to have aged and all who attended seemed to be enjoying themselves. The next reunion will be held in 2004.

Graduates who attended the evening included: *Jenny Altermatt, Robert Arule, Ralph Audehm, Alex Baker, Chris Baker, Claudio Baldi, Tony Bartone, Andrew Bayliss, John Bemeleh (Hawes), David Bird, Janet Bodycomb, Richard Bonwick, Meredith Borland, Andrew Bridge, Peter Brothie, Charles Bush, Matthew Campbell, Grant Connoley, Michael Daly, Linda Danvers, Mike Ditchfield, Kirsty Dundas, Ian Faragher, Neal Finegan, Tim Fitzpatrick, Joe Garra, Chris Grant, Helen Grogan, Mark Harris, Anne Jackson, Sue Jacobs, Peter Karamoskos, John Kioussis, Trevor Lau-Gooey, Debbie Leach, Christopher Lewis, Carol Lawson, Ann Malatt, Leon Malzinskas, Tim Metcalf, Karim Miran-Khan, David O'Neal, Andrew Patrick, Mark Patrick, Michael Peck, Anthony Prochazka, Vani Reddi, Kathryn Robertson, Ken Sikaris, John Slavin, Leanne Myerscough, John Sutton, Doug Taupin, Pauline Tyndall, Mark Walland, Dougal Watson, Tony Yapanis.*

## **REUNION ANNOUNCEMENTS**

### **1995 REUNIONS**

#### **13TH YEAR OF 1982**

Dr Ian Mackay  
ah: (052) 32 1541

#### **15TH YEAR OF 1980**

Dr Rod Sitlington  
bh: (03) 9836 1777

#### **20TH YEAR OF 1975**

Dr Chris Hogan  
bh: (03) 9744 6222

#### **30TH YEAR OF 1965**

2 December 1995  
Rippon Lea  
Dr Peter Habersberger  
bh: (03) 9576 0021  
ah: (03) 9509 7419

#### **40TH YEAR OF 1955**

Dr John O'Brien  
bh: (03) 9387 9088

#### **45TH YEAR OF 1950**

Dr Guy Hutchinson  
ah: (03) 9792 1920  
Dr Mary Moreland  
ah: (03) 9817 4837

#### **50TH YEAR OF 1945**

24 February 1995  
Melbourne Cricket Club  
Dr Nathaniel Myers  
ph: (03) 9509 2578

#### **53RD YEAR OF 1942**

Dr John Tucker  
ph: (052) 51 3468

#### **55TH YEAR OF 1940**

Dr Norman Wettenthal  
ah: (03) 9827 6734

### **1996 REUNION**

#### **50TH YEAR OF APRIL 1946**

April 1996  
Dr John Snell  
ph: (03) 9882 6644

### **THINK AHEAD**

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

Please let the UMMS office know of your plans – we like to 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 can 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 take home something to remind them of the event, and those unable to attend enjoy reading about their old friends. We have quite a stock of reunion booklets at the UMMS office and would be interested and grateful to receive one from your reunion.

### **UMMS OFFICE**

Ms Liz Brentnall  
School of Medicine  
The University of Melbourne  
Parkville 3052  
Telephone: (+61 3) 9344 5888  
Facsimile: (+61 3) 9347 7084

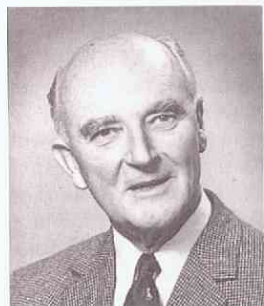
### **MBBS Graduate Anniversaries in 1996**

5th Year Class of '91	35th Year Class of '61
10th Year Class of '86	40th Year Class of '56
15th Year Class of '81	45th Year Class of '51
20th Year Class of '76	50th Year Class of '46
25th Year Class of '71	55th Year Class of '41
30th Year Class of '66	60th Year Class of '36



## OBITUARIES

### THOMAS HARRY (HENRY) ACKLAND, MID, MBBS 1932 MD, MS, FRCS, FRACS, FACS 1908-1994



TOM ACKLAND

**T**OM ACKLAND died peacefully at home, after watering his orchids on a sunny spring day. Thus ended a long, distinguished life and an outstanding surgical career.

He was endowed with a lofty intellect. Winning an entrance scholarship from Spring Road State School to Melbourne Grammar School in 1921, he proceeded to win prizes in English, French, Latin, Greek, Greek and Roman History, Scripture, map drawing and so on. In 1926 he was Head (or Dux) of the

school, with University Exhibitions in Greek, and Greek and Roman History.

Uncharacteristically, in the first year of his medical course, he obtained four passes. He was simply too modest to sit for honours in subjects which, unlike his colleagues, he had not studied at school. Thereafter, however, first class honours and exhibitions came his way in anatomy, physiology, pathology, bacteriology, obstetrics and gynaecology, and surgery. He proceeded to train at the (Royal) Melbourne Hospital, rapidly acquiring his postgraduate degrees from the University of Melbourne. He undertook further postgraduate studies at St Bartholomew's Hospital in London, became FRCS(Eng) and won a prestigious resident surgical post at St Mark's Hospital when Milligan, Morgan, Gabriel and Lloyd Davies were at their zenith.

From 1940 to 1946, he had a distinguished war record, serving in the 4th, 116th and 121st Army General Hospitals. In the Middle East, he became accustomed to operating with enemy aircraft overhead. He was a proud member of the Rats of Tobruk Association, though rarely participating in its activities. In 1942, at the height of the Japanese activity in New Guinea when stretcher-borne patients were not reaching Port Moresby, Tom volunteered, and organized American air transport, to take a forward surgical team north of the Owen Stanley Range into what is now the Popondetta region. No sooner had they begun operating in their surgical tent when they were strafed. Tom and the late Alan Wakefield dived together into a ditch, thereby preserving two distinguished surgical careers. Operating facilities were set up under better camouflage, and he continued working there for eighteen months. He rose to the rank of Lt-Colonel.

After the war, he was appointed to the Honorary Staff of the Royal Melbourne Hospital, which he served from 1948 to 1968. He also held the positions of Consulting Surgeon to the Heidelberg Repatriation Hospital (1946-73) and to the Peter MacCallum Cancer Institute (1955-68). He served on the Anti-Cancer Council of Victoria from 1955 to 1981, and was the founder of its Public Education Committee.

As a surgeon, he was an astute, deft, safe generalist at a time when there were true general surgeons. He never compromised on first principles, and believed in safe exposure. To see him operating was to witness intense concentration on the job in hand. At times of excitement, he didn't shout or invoke the Deity, but not uncommonly, after securing a deep vascular pedicle or ligating a major, he would 'Praise the Lord for Thirty Linen'. In earlier days, he had a major interest in surgery of the large bowel, and made fundamental contributions to better understanding of the pathology and treatment of strangulated haemorrhoids, thereby saving much anguish and many hospital beds. Later, he took particular interest in breast disease. After appointment as Robert Fowler Travelling Fellow in Clinical Cancer Research (1961), he introduced mammography to Australia in 1962, and pioneered adjuvant chemotherapy in the treatment of breast cancer in this country. In 1969, he was the first Australian to be appointed President of the St Mark's Hospital Association.

By nature a shy, sensitive perfectionist, he was of artistic temperament. He was a violinist in the Zelman Memorial Orchestra for many years and played his violin to the end. He was a recreational painter and voracious reader. His outdoor activities were boating and

fishing. In 1940, he married Joan, daughter of the distinguished artist John Rowell. He is survived by Joan, a writer and literary critic, and their three children, Judy, a microbiologist, Peter, an architect, and Michael, a paediatrician.

It is probably as a teacher that he will best be remembered, not only for the vast amount of teaching which he did, long after retiring from the teaching staff, but for its telling nature. Who can forget his precise phraseology, his memorable axioms, his breadth of knowledge, the occasional grand gesture to emphasize a point, and his willingness to teach from his own mistakes. Most of his students, and certainly all of his surgical protégés, will concur with Rudyard Kipling:

*Wherefor praise we famous men –  
Men of little showing,  
For their work continueth –  
Broad and deep continueth –  
Great beyond their knowing.*

D G 'Scotty' Macleish

### RODERICK RICHARD ANDREW AO, MID, MBBS 1935 MD, Hon MD(Monash), FRCP, FRACP 1911-1994

**R**OD ANDREW, had a long and useful life, well summarised in the headlines to an obituary written by Graeme Schofield in the *Australian* as 'Medico, activist, art critic'.

Born in Perth, Western Australia, he graduated from this medical school in 1935 and held residencies at the Royal Melbourne and Royal Children's Hospitals before returning to Perth where he became Acting Medical Superintendent to the Princess Margaret Hospital.

During the Second World War he served in the AAMC with the AIF in the Middle East and Papua New Guinea, and as OC of the Malaria Research Unit in Cairns. He held the rank of Lt-Colonel and was mentioned in dispatches.

It was during his period at Cairns that he and his colleagues identified a new form of tick typhus. In what may well have been his last publication he modestly states, 'privileged by an accident of time and place, to be in a position to identify a new form of typhus and so extend the understanding of this protean disease'. The original papers are in the *MJA*, July-December 1946. The quoted statement appears in *Milestones of Australian Medicine* edited by John Pearn and published by the Amphion Press in 1994.

As Dean of the Alfred Clinical School he was deeply involved in the setting up of the Monash Medical School and was appointed the Foundation Dean in 1960. Rod was a good initiator and facilitator and under his direction much was achieved quickly.

Rod wrote prolifically, publishing more than 160 articles in medical journals. However, he was never a cloistered academic, and spoke out and wrote to the *Age* against such things as the judicial hanging of Ryan in 1962. Having been a signatory to a letter in the *Age* in December 1972 advocating a change of government, he later criticised the new government for its procedures for funding biomedical research.

Widely read, he spoke clearly, incisively and amusingly. He was a good companion. Schofield tells of his friendship with Russell Drysdale when they were both at Geelong Grammar. At that time Drysdale could not draw well and Rod had to teach him the rudiments. Rod's interest in contemporary Australian art was long abiding and discerning. He enjoyed life.

Rod Andrew died in his sleep after a short period in hospital. *HA*

### JANET FRANCES BACON, MBBS 1971 1948-1994

**U**MMS records with sadness the death of Janet Bacon, a selfless doctor who devoted her life and work to the Aboriginal people across Australia. We join the directors, staff and patients of the Victorian Aboriginal Health Service and fellow members of St Hilda's College in mourning the passing of their colleague and friend. *MM*



**GEORGE BANKIN BEARHAM OBE, MBBS 1923**  
**MD DGO FRACOG**  
**1899-1994**

**G**EORGE BEARHAM always reminded me of one of Dickens' good characters because of his geniality, generosity and rotundity. Born in Bairnsdale where he had his early education he then resided at Ormond while studying medicine. After graduation he became interested in obstetrics and gynaecology and practised this specialty for most of his long life.

He served a much wider community than his patients. From his student days he was a committed Christian and in the Anglican Church he had held every office possible for a member of the laity. At St Paul's Cathedral he was elected to a Lay Canonry in 1938, was on many of the church committees and gave service to the Anglican Welfare agencies. For his work at Bethesda Hospital the Salvation Army awarded him its highest award for a layman – the Distinguished Service Cross.

As a Freemason ('initiated' 1927) he operated at the Freemasons Hospital from shortly after it opened in 1937 till quite late in his life and was a Trustee of the Freemasons Homes from 1947 until his death. As a Mason he rose steadily through the ranks and was Pro Grand Master 1955-57.

For his community work he received an OBE in 1973. George was however much more than this. As a Consulting Surgeon at the Royal Women's Hospital he was a great friend of more worldly characters such as 'Bung' Hill and Don Lawson. With them and their friends he dined regularly and happily. I shall never forget George, with a large white table napkin tucked into his collar and billowing gently over his waistcoat, as he gazed beatifically at a whole flounder set before him by David Triaca. George bred white turkeys at his home where he also had an excellent wine cellar. At one lunch in the 1980s he told me that he still had some bottles of Chateau d'Yquem from the year 1928!

George was known to many and beloved by all who knew him.

HA

**WINFIELD ROBERT CURTIS BENNETT, MBBS 1950**  
**1927-1994**



BOB BENNETT AT HIS FAVOURITE PASTIME

**B**OB BENNETT died on 13 August 1994. Retirement, once expected to be busy, turned out to be brief. A carcinoma of the prostate had metastasized extensively. Despite chemotherapy and several courses of radiotherapy, widespread destruction of bone caused him much suffering, which he bore with fortitude, but not with false hope. Walking became difficult and deposits in ribs and shoulders limited movement further; towards the end of his life, the sudden onset of paraplegia did eliminate much of his pain and he died at the home of his eldest daughter, Susan, amongst his family.

Bob was a highly respected radiologist. He was born thirty-two years after Roentgen's discovery of X-rays and appointed as foundation head of the radiology department at the Preston and Northcote Community Hospital at the age of thirty-two; he remained in that position until his retirement thirty-two years later. He built up the department, keeping up with the enormous advances in technological sophistication and diagnostic power in this specialty, and conscientiously contributed to the clinico-academic activities of the hospital. As well as teaching in radiology, Bob pioneered the teaching of radiological anatomy to medical students. In addition, he gathered

a significant quantity of apparatus and publications, now lodged in the Powerhouse Museum in Sydney and known as the Royal Australasian College of Radiologists Robert Bennett Collection.

In the practice of his specialty, Bob thoughtfully considered the welfare and morale of patients, decorating the waiting rooms with plants and cheerful photographs and reproductions of works of art. He was a keen and talented amateur painter and was one of the founders of the AMA Arts Group (Victorian Branch) being its secretary/treasurer and president for many years (see *Chiron*, Vol 3 No 1 April 1993, pp60-61).

Bob and his supporting, loving wife, Mira, had four daughters; all are married and have children and he relished the role of grandfather as long as he could. An interesting account of four generations of the Bennett family in medical practice appeared in the 1989 issue of *Chiron*. He has left a wealth of memories to his family and friends.

Herbert Newman

**MAURICE JAMES ETHERIDGE, MBBS 1943**  
**1914-1994**

**M**AURICE ETHERIDGE, MD, died at the age of seventy-nine years on Sunday, 1 May 1994, after a brief illness.

After completing a state school education, he worked full-time during his teenage years – the period of the Great Depression between the two World Wars – at the same time studying at night school until he passed the university entrance examinations. He entered the Medical School when he was twenty-three years old, at an age when most medical students would be expecting to graduate.

After graduating MBBS in 1943 he did the usual resident posts at the Royal Melbourne Hospital and began a long association with the Department of Physiology at the University of Melbourne, working with Roy Douglas Wright. By then married to Molly, he travelled to Britain and in 1949-50 worked under the redoubtable John MacMichael at the Postgraduate Medical School, Hammersmith, experiencing also the economic austerity of post-war London.

Returning to Australia Maurice commenced a mainly, but not exclusively, cardiological practice in Melbourne. He continued a lifelong attachment to the Royal Melbourne Hospital, and in those less frenetic days passed up through the ranks to become Physician to Outpatients in 1950 and ultimately Physician to Inpatients in the late 1960s. In the early 1960s he became actively involved in the fledgling Heart Foundation, and for some years was its Director. He was associated with the Peter MacCallum Cancer Institute for twenty years as a visiting physician.

Maurice was a kindly, generous man, who encouraged and helped his junior colleagues in a tangible fashion – a generation of residents will remember his patience and care. He retired from the Royal Melbourne Hospital in 1974, but continued in active consulting practice right up to his final illness. Throughout his life he kept a diary and many entries testify to his sense of vocation and delight in the practice of medicine, and to his intense loyalty to the Royal Melbourne Hospital.

Outside medicine there was nothing he enjoyed more than spending time at his property down on the Mornington Peninsula. He was an excellent golfer and for a time was President of the Rosanna Golf Club.

Maurice Etheridge's death marks the end of an era – he was the last of his generation of physicians. Condolences are extended to his widow, Molly, and their two daughters, Judith and Margaret.

Harold S Symons

**PETER ANTHONY FEAR, MBBS 1981**  
**1958-1994**

**T**HE PARALLEL careers of two young doctors – a husband and wife who worked together in London, Melbourne, Broome and Binga, Zimbabwe – ended tragically in February 1994 when Peter 'Spic' Fear died in a car accident in the area where he was District Medical Officer.

Peter was responsible for the medical care of some 90,000 people in Binga. He and his wife, Heather, had lived and worked there for





HEATHER AND PETER FEAR

four years, the whole of their time in Africa. Their son Ben, two and a half years old when Peter died, had been born there.

Peter's time with Heather included several years living in England where they met and worked together at the Haroldwood Hospital in Ealing. Later they worked briefly in Melbourne before taking up positions as resident doctors with the Aboriginal Medical Service in Broome, WA. They worked in Broome for about two years before going to Zimbabwe. Heather and Ben were not with Peter at the time of the accident. They have since returned to Melbourne.

Peter's death was reported in the April 1994 edition of *Great Scot*, the journal of the Old Scotch Collegians' Association (OSCA). UMMS joins Peter's school friends in expressing deepest sympathy to Heather and to Ben and the wider Fear family.

*Compiled by PR with thanks to Great Scot.*

# FRANK MENZIES CAMERON FORSTER, MBBS 1948 1923-1995

UMMS notes with regret the death of Dr Frank Forster, FRCOG, FRACOG, on 18 March 1995.

An obituary will appear in the 1996 edition of *Chiron*. HA

# GEORGE STRETTON GUNTER, MBBS 1945 1922-1994



GEORGE GUNTER

GEORGE GUNTER, MS, FRCS, FRACS, will be remembered by his many colleagues and trainees in plastic surgery as a brilliantly-gifted surgeon who enhanced his technical skills by combining them with superb clinical judgement and warm humanity. His many patients, young and old, remember him as a caring, accessible, kindly friend and a compassionate human being for whom the practice of medicine was a way of life.

He was the proud and loving father of a large family, sharing with them a love of music and of animals. Those of us who shared many happy moments with him, both professionally and socially, mourn his passing. We were privileged to have lived and worked beside him.

*Maxwell Kent*

# HAROLD BICKFORD HATTAM, MBBS 1938 FRCS, MRCOG 1913-1994

HAROLD HATTAM, distinguished surgeon and artist, was born in Scotland and educated in Australia at Ivanhoe Grammar and Scotch College. Jim Morgan, writing in the *Australian* described him as 'a man of paradox and contradiction' possessing 'the hands of a healer and great technical skill - attributes he used with distinction as a surgeon and painter'.

Shortly after the outbreak of the Second World War Harold joined an artillery regiment in the 1st AIF with the rank of captain, serving in the Middle East, New Guinea and England. He returned to Australia in 1949 with his English wife, Kate, and as a Fellow of the Royal College of Surgeons (England) and a member of the Royal College of Obstetricians and Gynaecologists (London).

From 1951 to 1966 Harold held the position of honorary surgeon at the Royal Women's Hospital and it was during this period that the Hattams became part of the Melbourne art world, Harold 'delivering artists' babies and going on regular weekend painting expeditions, painting Melbourne's outer suburbia with Blackman, Perceval, Williams and others'. Kate and Harold developed a discerning passion for Australian art and their collection rivalled that of John and Sunday Reed. Their household, where Harold indulged in his other passions - gardening and watching sport on television - became a haven for artists.

As much as he loved medicine, Harold gave it up to paint full time. Described as the 'last of the great sunbakers', he made it his project to depict this country in terms of the beach and in 1969 he held his first one-man exhibition - ten more were to follow during the next two decades, from which the greater part of the family's income was derived.

UMMS records the life and death of a paradoxical graduate, 'an artist with brush and scalpel' who acted on his passions, whose 'scepticism was wrapped in a cloak of charm, humility, and also arrogance', a man who above all believed in the family 'as a battlement from which to front the world'.

*Compiled by MM with thanks to Jim Morgan and The Australian.*

# DOUGLAS ROBERT LESLIE AM, ED, MID, MBBS 1937 MS, FRCS, FRACS, FACS 1914-1994



DOUGLAS LESLIE

COLONEL DOUGLAS ROBERT LESLIE was Consultant Surgeon to the Australian Army (1959-1977), during which time he was also Honorary Surgeon to Her Majesty the Queen. He was twice mentioned in dispatches.

Of all the honours showered upon him, his Army appointment pleased him most. He was a true soldier and a surgeon who would never spare himself if it were to the detriment of his troops and the wounded. On one occasion on the Kakoda Trail, he was working in a casualty clearing station and found that the wounded were being carried long distances down the trail without having had adequate treatment. He then took himself and his instruments and his little dog up to the forward area of the fighting - it was at this time that he was said to have treated approximately 280 battle casualties in ten days.

His greatest achievement was his appointment as a general surgeon to the Royal Melbourne Hospital in 1949. From that he progressed to being Chairman of Staff from 1969 to 1973, and a member of the Board of Management from 1963 to 1986.

He was a member of the Council of the Royal Australasian College of Surgeons from 1974 to 1984. He was also appointed Consultant General Surgeon to the Royal Women's Hospital from 1954 to 1977.

Douglas came from a missionary family. His father, the Reverend E T Leslie and his wife returned to England from India and Douglas



was born in Hitchin in England on 23 February 1914. Neither he nor his brother Kenneth, who later became the Bishop of Bathurst, New South Wales, appeared to thrive in England and consequently the family migrated to Australia, to our great benefit. He was educated at Trinity Grammar School and the University of Melbourne. In 1942 he married Margaret Blom, and they had two sons and one daughter. One son, John, is a practising general surgeon at present. Douglas never recovered from Margaret's death, and although he continued his intense interest in surgery, it was quite apparent that he had suffered a great loss.

His passing leaves a great hiatus in the field of surgery, the field to which he contributed so much. This will be very hard to fill.

*Bill Swaney*

## WILLIAM EUAN IRNSIDE LITTLEJOHN OBE DSC

MBBS 1951

1920-1994

UMMS records the passing of one of Australia's unsung war heroes, Bill Littlejohn, who was awarded the DSC for his services during the Second World War. At the age of twenty-three he went to war in the Mediterranean as commander of the British submarine, *HMS Shakespeare*, with a crew of seventy-five. Under his command the *Shakespeare* escorted allied convoys in enemy waters, and attacked and sank many enemy vessels.

In Melbourne he served as an honorary aide-de-camp to three State Governors and as the honorary physician to Government House. He worked as a general practitioner at Ivanhoe, and also served on many professional bodies. He was a Trustee of the Shrine of Remembrance.

Dr Davis McCaughey conducted Bill Littlejohn's funeral service in the Littlejohn Memorial Chapel, Scotch College, the chapel dedicated to his grandfather, Dr WS Littlejohn, the College principal for thirty years.

*Compiled by MM*

## MICHAEL RANDLE LUXTON, MBBS 1969

1946-1994

MICHAEL LUXTON, MD, FRACP, was an outstanding physician, committee man and contributor to Melbourne medicine. He had many special characteristics which were well recognised by those who were privileged to have known him – keen intellect, wisdom, integrity, deep commitment to causes in which he believed and dedication in all his personal and professional endeavours.

As a student he won many prizes and was equal top in his final year. He obtained his postgraduate training at the Royal Melbourne Hospital where he was in turn registrar to Sir John Frew and cardiology registrar. After a period as Wellcome Research Fellow in the University of Edinburgh, he was appointed a physician and cardiologist at the Royal Melbourne Hospital and held these positions until his death. His other appointments included cardiologist at the Royal Women's, Heidelberg Repatriation General and Mount Royal Hospitals. He built a large consulting practice in general medicine and, in particular, in cardiology. His opinion was vigorously sought and held in high esteem.

Michael's highly organised mind, broad reading and command of people and the English language made him an ideal committee man. He undertook many responsible public office and faculty roles; however he will be remembered most for his more recent positions as Chairman of the Senior Medical Staff and as a member of the Board of Management of the Royal Melbourne Hospital. He was a Councillor of the Medical Defence Association of Victoria.

Michael conducted his life with dignity through a protracted and wearing illness. He gained great strength from his wife, fellow medical student, Janet Rothstadt, from their four children and from his strong commitment to the Christian faith. In his brief forty-eight years he contributed much. Michael's friends and professional colleagues will remember him as the ultimate physician, caring for a broad spectrum of the Victorian community and commanding the respect of all.

*John P Collins*

## ANTHONY JOHN MEATHREL, MBBS 1964

1941-1994

Worries about quality of life and fears about working without professional support deter some potential country doctors. None of those anxieties bothered Terang doctor Tony Meathrel, who is part of the push to get more doctors to go bush.

*The Warrnambool Standard, 9 July 1994*

THE VICTORIAN Western District town of Terang lost a cornerstone of its community and a father figure to many when Sydney-born, Melbourne educated, Tony Meathrel, died suddenly from a heart attack in September 1994.

Tony Meathrel had lived and practised in Terang for twenty-five years. He was highly recognised for service as a rural GP and work at the Terang and District Community Hospital as well as for his role in the Rural Doctors Association (RDA), of which he was Vice-President, and the Australian Medical Association, of which he was Victorian Branch President-elect.

He was educated at Scotch College, Melbourne, and the University of Melbourne. After an internship at the Alfred Hospital and a residency at the Royal Women's Hospital he spent a year of internship in Shrewsbury, England.

A believer in working for change through personal involvement, Tony was strongly involved in encouraging and maintaining rural general practice and kept up a close liaison between the Victorian Branch of the AMA and numerous medico-political bodies.

He was an active member of the RDA from its inception in 1991, helped set up the Victorian Rural Divisions Coordinating Unit (becoming Director of that body in 1993) and was a member of the Liberal Party's Policy Assembly Health Committee June 1993–July 1994.

Tony Meathrel's untimely death was a great shock to his community and to his profession. UMMS extends its sympathy to his wife, Jillian, and to their three children, Kate, Tory and Paul.

*Compiled by PR with thanks to The Warrnambool Standard.*

## JAMES ALEXANDER MUNRO, MBBS 1958

1927-1994

JIM MUNRO started his working life as a technical assistant in the Physiology Department of the University of Melbourne. He was encouraged to do his Bachelor of Science and came increasingly under the notice of Professor R D Wright and Dr (later Professor) Derek Denton. He was encouraged to study medicine, which he did with unusual facility and at each examination either achieved top marks or was not far off.

Graduating in 1958, he undertook his first year residency at the Royal Melbourne Hospital, after which he joined that institution's Department of Cardiology. Within a few years he was invited to take over the running of Chelmer Diagnostic Group, a rather large pathology and radiology practice which had management problems at the time. He remained with the group for some twenty-five years and saw it prosper until increasing health problems led him to early retirement.

The foregoing is a very clinical picture of a remarkable man. He was one of a small minority who is granted the gift of unusual physical and intellectual talent. Indeed he had sufficient of these gifts to have taken him to the top of any field he chose. He had remarkable hands, being capable of fixing recalcitrant motor cars which he did often as a student and the same ability led him to be Prosecutor in anatomy. He played football with Carlton Seconds and later with Brunswick in the VFA – on recollection, with a minimum of training.

His intellect was penetrating and efficient, which led to early academic achievement, as well as encouragement by his superiors to reach for the top. That potential was only ever partly realised. Jim Munro was a gregarious and charming man who appeared satisfied spreading himself in a dozen directions at once rather than pursuing the profession's highest awards.

He was married four times, which led to two daughters and a son who were very close to him.

*Gad Trevaks*



**LEONARD JAMES THOMAS MURPHY, MBBS 1937  
1914-1994**

**L** EONARD MURPHY, MD, MS, FRACS, was the eldest of the three doctor sons of the distinguished Melbourne gynaecologist, Dr Thomas Murphy. From his father came a love of medicine and a love of scholarship, and when he died in his eightieth year Leonard had achieved fame both as a surgeon and as a scholar.

He entered the University of Melbourne after education in science and the classics at Melbourne Grammar School. He was a resident medical officer at St Vincent's Hospital and then joined the RAAF in 1939. During the Second World War he served in Australia and in New Guinea; subsequently he served the RAAF for many years as a consultant urologist.

Soon after the war he achieved the MS and FRACS and then travelled widely in Britain and the USA as the Gordon Craig Travelling Scholar of the RACS. On returning to Australia he joined Mr Henry Mortensen in the Urological Clinic at St Vincent's and was later head of that clinic from 1955 until 1966.

Leonard wrote a number of excellent articles on various urological subjects. His eminence as a urologist was recognised by his peers electing him to the Presidency of the Urological Society of Australia (1958-59).

His enduring fame, however, undoubtedly rests on his outstanding contributions to medical history. The urological writings of figures as diverse as the egregious Dr Beane of Melbourne, Nicolas Tulp of Amsterdam, and, above all, Leonardo da Vinci, provided Leonard with the inspiration for a series of fascinating papers. He retained a lifelong interest and affection for his illustrious da Vinci namesake, and became an authority on the life and work of the great Florentine. The achievements of Australian surgeons were also recognised by Leonard and he contributed impressive accounts of Harry Harris and Sir Douglas Shields to the *Australian Dictionary of Biography*.

Len Murphy's masterwork was his now famous *The History of Urology* (1972). The writing of this book, the definitive work on the subject, occupied many years of his life. The first part of the book is his translation of *L'Histoire de L'Urologie* (1914) by Ernest Desmos of Paris, who traces urology down the centuries until the latter half of the nineteenth. Leonard then took the story to 1972. His account is based on meticulous research, extraordinary attention to detail and a rare capacity to present such material in lucid prose which is a delight to read. The book gained wide acclaim on publication and, in 1973, the University of Melbourne recognised its worth by awarding Leonard the MD. This was the first MD awarded in medical history.

In 1987 his College awarded him the RACS Medal in recognition of his long and distinguished service to surgery and to the College, including membership of the Archives Committee and of the Editorial Committee of the *Australian and New Zealand Journal of Surgery*. He also served the AMA in similar capacities.

Of his many honours none pleased him more than being made one of the three Fellows in Australia of the Faculty of the History and Philosophy of Medicine and Pharmacy of the Worshipful Society of Apothecaries of London.

Leonard married Beatrice Henderson in 1940. She supported him through many years of distressing illness; without this loving support his many achievements would have been impossible. He was never physically strong, but was possessed of extraordinary courage in the face of great physical suffering.

Throughout his life he lived uncompromisingly to his own high standards in his personal life, his surgical practice and his scholarly pursuits. Despite increasing despair of human frailty there remained a certain nobility of spirit in Leonard Murphy that marked him out as a truly exceptional man.

Bernard Neal

**JAMES WALTER JOHNSTONE-NEED OBE, MBBS 1931  
MD MS MGO FRACS FRCOG  
1906-1994**

**A** S A STUDENT at the University of Melbourne, the tram I took passed a stately two-storey Victorian terrace in Middle Park. On the gate was a brass plate which fascinated me. It bore the inscription:

**MR J W JOHNSTONE DGO MS FRACS FRCOG SURGEON**

In 1947 as a fifth year medical student at the Women's Hospital we were summoned to the labour ward by five bells which indicated an honorary was at work there. We were met by a short, stocky man with wavy fair hair drooping over his left eyebrow. In a slightly high-pitched articulate voice he said, 'DOCTORS, you are about to witness a birth by BREECH'. A magnificent display followed of an assisted breech delivery accompanied in incisive tones by a historical account of the contributions of the master *accoucheurs* – the Mauriceau, Smellie, Veit-Liveset and Burns Marshall manoeuvres. Finally a majestic slap on the up-ended infant's buttock brought the first cries of the healthy newborn. Who was this man with the limp, the ready wit and smile and indefatigable energy? It was the surgeon, J W Johnstone, whose plate I had seen from the tram.

'Wally' Johnstone was then honorary in-patient obstetrician, honorary in-patient gynaecologist, and head of the Infertility Clinic. He had rooms in Collins Street, a practice in Middle Park and was Acting Professor of Obstetrics and Gynaecology. As such, he was, in his spare time, also writing the Professor's notes for his students.

As his last resident medical officer while he was Professor I came to appreciate that he was also the 'compleat' gynaecologist. The surgery was done with technical grace and ease while Wally talked of history and literature and quoted fluently and at length from Shakespeare and The Bible.

Barry Kneale



'Wally' Johnstone-Need presenting his cheque to the [then] Chancellor, the late Prof Emer Sir Douglas Wright.

**H** OW WAS IT that Wally acquired a limp, another nickname 'Hoppy', and had such a ready knowledge of literature? Born on a farm in Korumburra his schooling was interrupted by an osteomyelitis of the femur leaving him with an ankylosed knee which could not be bent. During this illness, while lying abed, he read voraciously and widely – an unusually retentive memory and a love of words and their sounds did the rest. Even in his eighties, when prompted to start, he could recite accurately and excitingly long passages from Shakespeare. It was natural that he should recite while he was operating.

Interruption of his early education did not impede his progress. Wally was Dux of his school, gained first class honours in several subjects during his medical course. He was the only holder of the triplet MD MS MGO.

Wally was also innovative for he saw the psychological needs of women and quickly recognised the necessity for biochemical aid in the diagnosis and management of infertility. In 1962 he organised the Endocrine Clinic in which Professor Jim Brown was to be of such importance. Hearing of Neil Moore's work in animal reproduction, a visit to the McCaughey Research Institute in Jerilderie enabled Wally to operate on a ewe and quickly grasp that artificial insemination, embryo transfer and *in vitro* fertilisation could be used in women.

An enthusiastic teacher he had an eloquence of his own. In the 1960s he welcomed delegates to an International Congress on Obstetrics and Gynaecology thus: 'I welcome you to a land where the trees shed their bark and not their leaves and where there are animals that lay eggs and suckle their young'. He captured the attention of his audience immediately.

Wally's first wife, Marjorie Rollason, with whom he had a son and a daughter, died in 1981. Later that year he married Muriel Ryan who had been his secretary when he was Acting Professor. In that same year, by deed poll, he changed his surname to Johnstone-Need, because his genealogical research found that it was the name of his great great-grandfather who had led an exciting life in India.



In his later years Wally was profoundly deaf and increasingly crippled, but Muriel looked after his welfare and she and their visitors were still able to enjoy his flashes of wit and marvel at his memory.

The death of Wally Johnstone-Need closed an era at the Royal Women's Hospital – an era when criminal abortion produced horrific trauma in women and often death from *Cl. Welchii* septicaemia; an era when there were over eight thousand births each year and many of these were complicated and difficult; an era when blood transfusion and intravenous fluids were not commonly used and antibiotics came in just in time to reduce quickly deaths from infections.

He was generous financially to his former college, Queen's, and in 1987 established an endowment of \$250 000 to promote the History of Medicine in the Faculty of Medicine. The fund was named The Walter Winston Johnstone Fund in memory of his only son who was tragically killed in an accident.

Walter Johnstone-Need was a good doctor of generous spirit who enriched his specialty and the lives of those fortunate to know him. *HA*

### MOSTYN LEVI POWELL, MID, MBBS 1926 1904-1994



Mostyn Powell in Test cricketer Ian Johnson's outfit. (Photo courtesy RCH Archives.)

**M**OSTYN LEVI POWELL, MRCP, FRACP, born in Melbourne, 7 July 1904, died at the age of ninety on 12 June 1994. He was one of this country's great paediatricians and will long be remembered for his pioneering work in infant heart disease. He changed congenital heart disease from an academic to a practical science and, through his innovations, in tandem with breakthroughs in heart surgery in the USA, he helped to lay the foundations for Australia becoming a world leader in this field.

Following his secondary school education at Melbourne High School Mostyn Powell went to Melbourne University where he graduated MBBS in 1926 with honours in medicine and in obstetrics and gynaecology. One year as a resident medical officer at the Royal Melbourne Hospital followed and then there were resident and registrar years at the (now Royal) Children's Hospital where, in 1929, he was appointed acting Medical Superintendent.

Overseas postgraduate study led Powell to membership of the Royal College of Physicians in London in 1931. He later became a Fellow of our own Royal Australasian College of Physicians and in due course played an active role in the Australian College of Paediatrics. While overseas he spent some time in Boston on a Carnegie Fellowship. In recognition of this in later years in Melbourne, at the Royal Children's Hospital, there was a catchphrase: 'I'm Mostyn from Boston but just call me Mick'.

When the Second World War broke out Powell served with distinction both in the Middle East and New Guinea and was mentioned in dispatches.

Powell was a passionate, strong and skilful squash player, travelling overseas as a member of the Australian Squash Veterans Team and continuing to play the game until the end of his seventy-ninth year.

'Play the game' sums up Mostyn Powell (known to his colleagues as MLP and to his close friends as Mick). He had several 'games' but his main one was paediatric cardiology. This was one of the many sub-specialties he saw develop within paediatrics and one which he was quick to recognise as important. It was at this time, in 1938, that heart surgery on children commenced in Boston. From a starting point of zero, open heart surgery became possible. Powell was involved in Melbourne in the sophisticated investigation necessary to permit the appropriate operative treatment of a wide variety of congenital heart conditions, as well as in case selection. His ongoing work in this area was to be recognised by the naming of the cardiac operating suite at the Royal Children's Hospital.

Powell was also a wonderful family man, a teacher and a respected and admired colleague – and while his name lives on in the operating suite, his work lives on in those he trained in paediatric cardiology and those whom they in turn have trained. The result is that the lives of innumerable children have been saved and their families have been helped in a manner Powell would have wished.

As a man Powell was a great person, in his involvement with his beloved squash, he was an individual and, as a doctor he always wanted to be known as part of the team. Although his main specialty in later years was in cardiology he always showed great skills in the diagnosis and care of a wide variety of paediatric problems. He was dearly loved by his colleagues, with whom he had excellent rapport.

*Nate Myers*

### ROBERT LYNDON SIMPSON, MBBS 1977 1952-1994



ROB SIMPSON

**M**EMBERS of the University of Melbourne School of Medicine, past and present, were shocked and saddened to hear of the sudden death of Rob Simpson, BA, MBBS(Melb), MPA (Harv), FRACS, FRACMA, AFCHSE, FAFPHM (1971-77), who tragically took his own life on Tuesday 10 May 1994.

Rob's entire life up to his last weeks, perhaps even minutes, was characterised by tremendous vitality, clarity and commitment; his departure leaves a terrible gap in many lives.

At school and at university he began to develop the commitments and skills required for a life of service to the public: a precocious political interest went in tandem with a ready aptitude for oratory.

None of the innumerable people Rob has engaged in argument will forget his commanding intellectual manner, in which a tinder-dry wit served a trenchant grasp of issues.

Rob's highly successful school career at Scotch College seemed to culminate in his HSC distinction in economics in 1969 and a future in politics or law beckoned when he entered Melbourne University Law Faculty in 1970. After only a term, however, he made the first of the risky but thoughtful manoeuvres that were to characterise his life. Rob decided on a career in medicine, returning to school to study sciences in what was left of the 1970 school year. Success in his bid to enter medicine at Melbourne University saw him flourish. In six years of incandescent activity he worked night shift in a hospital, travelled extensively throughout the world, ran successful businesses and, somewhere amongst all this (and a huge circle of loyal friends) succeeded in gaining his first medical degree in 1977.

During 1978-85 Rob achieved Fellowship of the Royal Australasian College of Surgeons and served as a registrar in hospitals in Melbourne, Port Moresby, Perth and Wangaratta.

In 1985, Rob's friends and colleagues confidently expected him to pursue a career as a general surgeon. Never one to conform to expectations, he surprised everyone. Perhaps the clue to his real direction lay in the BA in economics and politics he acquired between 1982 and 1985 – because Rob decided to take an administrative role in public health rather than continue his successful surgical career. He preferred to face very active disputants across the negotiating table than anaesthetised patients on the operating table.

By 1988 Rob was Director of Medical Services on the Moorabbin Campus of the Monash Medical Centre, where he was responsible for steering decisive administrative changes through the difficult course of medical politics.

In this same period (1987) he was the medical Director and First Fleet Surgeon for the First Fleet Re-enactment, responsible for the health of the nine crews involved throughout the dangerous voyage from Portsmouth to Sydney. During nine months Rob braved not only the perils of the sea but also negotiated the Fleet out of the dangers of financial collapse. His entry into Port Jackson, under sail, on 26 January 1988 was a moment of great exhilaration, a wonderful confirmation of Rob's love of Australia and its history.

The final phase of Rob's life looked like a haven of arrival. In 1988 he married Marilyn McMahon and in 1990 their son Ned was born. They formed a devoted and delightful trio. In 1989 he was appointed to the post of Deputy Chief Medical Officer in the Victorian Health Department, succeeding to the post of Chief Medical Officer for Victoria in September the following year. It is true that arrival for Rob



did not mean quiescence. He completed a Masters in Public Administration at the Kennedy School of Government, Harvard University 1992-93 and, as Chief Medical Officer of Victoria, was active on very many fronts of medical politics – institutional, educational and ethical.

Rob Simpson supported, sustained and inspired many lives. In both the domestic and political domains his was a posture of applying intense rational pressure with the aim of constructively resolving disputations, relieving stress, building the future. It is a matter of the sharpest, most poignant regret that he should have died in the service of the state. The University of Melbourne has lost an exceptional alumnus; Australia has lost an exceptional citizen.

*James Simpson, Girton College, Cambridge UK*

*John Simpson, Melbourne*

## ALEXANDER TAIT SMITH, MBBS 1940 1915-1994



'TAIT' SMITH

ALEX TAIT SMITH, MD, FRACP, FRCPA – or 'Tait' as he was generally known – was born at Ingewood, Victoria, 29 October 1915. Tait's primary education was at Middle Park Central School where his father was a distinguished headmaster during the 1920s and 30s. In 1938, his father died from metastatic cancer of the prostate, as did Tait sixty-eight years later.

Tait entered Melbourne Grammar School at thirteen with a junior Government Scholarship and a full tuition Council Scholarship. Two years later he won a JH Sutton Scholarship. As a prefect he played 1st team cricket and football, was the star performer of the debating team, acted in school plays and 'rose to lieutenant in the cadet corps'.

Aged seventeen, he matriculated with first class honours in English, French, Latin and Greek. During that decade, the 1930s, the University of Melbourne reluctantly, but finally, removed low level Intermediate Latin as a prerequisite for entry to the medical course – presumably on the grounds that practising physicians' hand-written Latinoid prescriptions were illegible anyway.

In 1934, Tait entered the medical course in the University of Melbourne with a resident scholarship in Trinity College. His steadily successful progress was suddenly and devastatingly interrupted that winter. The day following an intercollegiate football match, during which he was badly bruised, Tait developed paralytic poliomyelitis. For the next eight or nine months Tait was confined to bed with his trunk and lower limbs immobilised – the then current Australian treatment.

The following year, with some residual limp, relatively mild except when tired, Tait re-entered first year medicine. As a member of the 'Dialectic Society' he won the Behan Medal for oratory. He also won the Wigram Allen Essay Prize. His topic was 'Cosmos, or the Duke and the Doodle'. The provenance of this title is unclear, but there can be no doubt that Tait would have spoken eloquently and convincingly on the subject.

Whilst at college he wrote presentations for the historical section of ABC Radio and later wrote nonsense rhyming serials in the children's session. In 1938 he was elected President of the Students' 'Fleur de Lys' Club and had Dick (later Sir Rupert) Hamer as his secretary. Despite these distractions, Tait graduated MBBS with distinction in 1940.

Probably on the advice of Clive Fitts, then a tutor at Trinity and a member of staff at St Vincent's who had looked after him when ill, Tait applied for and was appointed resident at St Vincent's Hospital, where he was to stay with increasing responsibilities until 1946.

Winston Rickard writes: 'His post-polio limp made him unfit for active service and bound him to his profession at the hospital through these war years. He was a remarkable source of strength, competence and steadfastness. His sense of humour was unbounding; a fine musician, he could entertain on stage or in the quarters with a deep

resonating voice, particularly when he portrayed elderly spinster roles.'

As senior clinical registrar he obtained his MD and MRACP and with staff shortages he developed competence in many areas of practice. He did clinical pathology tests when needed and even the occasional post-mortem examination. This last interest finally prevailed and he was appointed Beaney Scholar in the University Department of Pathology.

In 1947, Tait went to London to work with Professor W G Barnard in the Pathology Department of St Thomas' Hospital. This period of training was interrupted for some months by treatment for pulmonary tuberculosis at Midhurst Sanatorium. In 1951, by invitation, he returned to St Vincent's as 'Pathologist to the Hospital'. He rapidly developed a reputation as a fine pathologist and as an outstanding teacher, particularly at post-mortems. He also enjoyed regular monthly histopathology slide exchanges with colleagues from the other teaching hospitals.

In 1956, suddenly and unexpectedly, he resigned and moved with his family to Sydney. W R writes: 'His resignation produced much dismay and questioning by the medical staff.' In Sydney he assisted in the busy general practice of his father-in-law, Dr Frank Graham, and when Graham was tragically killed on the roadway by a passing motorist, Tait managed the practice for about a year until other arrangements could be made. During this period he also held a teaching appointment in Professor Frank Margarey's pathology department at the University of Sydney.

In 1962, Tait became morbid anatomist and histopathologist to Prince Henry's Hospital, with a conjoint appointment as Associate Professor of Pathology in the University of New South Wales. In 1976, he returned to Melbourne as Surgical Pathologist to St Francis Cabrini Hospital where he stayed until his retirement in 1988.

Some two years ago he developed paraplegia from a hitherto unsuspected carcinoma of the prostate and from then on, apart from short episodes, he was confined to a wheelchair. Despite this he never complained and continued to show the same warm intelligent interest in others that he had always had.

Tait was an accomplished musician who had learnt to play the flute during his immobilisation from polio for, as he cheerily observed, 'The flute is the only instrument that can be played when lying flat'. In his home, with his wife Margaret, a very fine viola player, he enjoyed joining in quartets or small orchestras and his abilities extended over several instruments (cf Tait's obituary on Euan MacLean, *Chiron* Vol 3 No 1 1994 pp54-55).

Tait had a fine head, a commanding presence and a well-modulated, resonant voice. His 'Mr Chairman' could halt even an Annual General Meeting and what would follow would be pertinent and beautifully expressed. He was a delight to be with and is sadly missed.

Our sympathy to his wife, Margaret, to their children Graham, Frank and James and to his sister 'Meg'.

*Alan Jackson*

### UMMS records with regret the passing of

Mark J Anderson, MBBS 1974  
William P Caldwell, MBBS 1951  
Donald G Duffy, MBBS 1938  
Alistair J Fairweather, MBBS 1965  
Sir Abraham Fryberg, MBE, MBBS 1928  
John G Gibb, MBBS 1957  
Robert L Godfrey, MBBS 1955  
Jack M Kirkman, MBBS 1952  
Andrew P Letcher, MBBS 1991  
Cyril J McGurgan, MBBS 1948  
Chi Hung Mok, MBBS 1958  
Francis H Raynor, MBBS 1947  
Robert E R Skinner, MBBS 1926  
Charles I Slade, MBBS 1952  
Keith W Summons, MBBS 1943  
Joan Thorn (nee Darbyshire), MBBS 1928  
Robert Wallace, MBBS 1934  
Jessie Webster, MBBS 1949





Reproduced with the kind permission of the artist, Joe Greenberg, and J Ross Morris ('old Doc Morris'), MBBS 1940, 6 Aust Fd Amb AIF, who is now a resident of Mont Calm Nursing Home in Canterbury.





From the AMA Archives Collection, 'Royal Women's Hospital, 1917'.

# The AMA Archives Collection AT THE BROWNLESS MEDICAL LIBRARY

Dorothea Rowse  
Life Sciences Librarian

ONE OF THE several really exciting acquisitions to the Brownless Medical Library during 1994 was the collection of documents created at the Australian Medical Association in Victoria and known as its Archives Collection. This is not, in fact, a collection of the archival records of the AMA, but an amazing compilation of documents, photographs, newspaper cuttings, etc., created by Miss Ann Tovell over a number of years at the AMA and maintained since her

departure by succeeding AMA librarians. With the demise of the AMA Library, the Brownless was fortunate to inherit this collection and will continue to add to it in the future. The AMA rare book collection was acquired by Monash University Library, while the serials collection was dispersed to a number of academic and hospital libraries.

The collection is housed in envelopes in eight filing cabinets and is well indexed. Emphasis was placed on the medical history of Victoria, although material on the rest of Australia can also be found. The majority of the materials indexed are newspaper and journal clippings. These record the articles of individual doctors, hospital developments and the occasional 'scandal'. Publications were also included in these envelopes and during an exploration of the collection, a whole envelope of early volumes of rules and regulations for the Royal Melbourne Hospital emerged. The biographical details of doctors in Victoria were obviously of considerable interest and every obituary, or public reference to an individual, has been carefully noted.

In following up these biographical details, it is clear that individuals were encouraged to deposit documents and photographs with the AMA Library and these were added to the envelopes. The photographs cover a wide variety of periods and topics. A group photo of the Melbourne University graduating class of 1929 is accompanied by one of the class reunion in 1979. Another envelope contained photos of a group of self-conscious young men, each holding a baby, and is

annotated 'Royal Women's Hospital 1917'. Yet another find was a collection of visiting-card sized portraits of the professors in the Medical Faculty of Edinburgh in 1862, all looking suitably grave. A collection of leather-bound graduation certificate booklets, dating from the period at the end of the First World War, was also noted; each page covers an aspect of the degree and provides quite a detailed survey of the graduating doctor's student career.

The instruments and photographs which formed the Museum of the Medical Society of Victoria, held at the AMA, were also transferred to the University of Melbourne, this time to the Medical History Unit on the top floor of the Brownless Medical Library. It has been necessary to do some sorting of the donation but a number of quite fascinating items have been found. They will add considerably to the riches displayed in the Medical History Museum.

The collection's existence will be more widely advertised in the future, and will receive care and protection and further investigation of their riches. They do, however, promise to provide a treasure trove of research material for the history of medicine in Victoria and, in passing, for genealogical research.

Anyone wishing to donate photographs, new and old, or documents to the Archives Collection, or anyone wishing to use its resources, is most welcome to contact Mrs Dorothea Rowse at the Brownless Medical Library, telephone 9344 5717.



## DOCTORS AND BIRDS

Norman Wettenhall AM, MD, BS, FRCP, FRACP

*We reached home well satisfied with our wandering and better, mentally and physically, for the communion we had with nature.*

William Macgillivray

TOWARDS the end of 1994 I was at Barren Grounds Bird Observatory near Wollongong in NSW along with several other doctors. In recent years it has become a regular event after Australian Paediatric Endocrine Group (APEG) annual meetings to arrange a birdwatching outing, an activity from which an increasing number of us gain interest and pleasure. Why this should be so and why so many doctors have an interest in natural history, especially birds and botany, is a question often asked.

There seems to be a number of aspects to consider – birds are attractive (especially in Australia where we have very few big animals and those that we have are mostly nocturnal and difficult to see), and their flight, their colours, their calls and behaviour draw attention to their existence and our curiosity is aroused. Diagnosis is fundamental in any doctor's practice, including the need for accurate observation, and this skill is readily applied to the identification of birds. Almost all of us love to get outside from time to time, away from our clinical practice, and birdwatching adds to our enjoyment. It is then only a short step to seek particular species in different habitats such as swamps, grasslands, forests and the sea, and then to extend the experience to different parts of Australia and overseas. Ornithology is a subject which has a scientific side for which all doctors have basic training and my natural history bookseller friend, Andrew Isles, tells me that his customers include far more doctors than any other professional group.

Birdwatching can be pursued alone or in company and there are no time constraints. It can be full of pleasant and unexpected surprises; only last January, sitting inside my home in Toorak, I happened to look out the window and see three pelicans flying overhead – most unexpected in our concrete jungle! In the pursuit of this interest I have met many people I might not have otherwise met, and made good friends both in Australia and overseas. Once at a medical meeting in the USA I saw a pair of binoculars on a seat and waited till the owner returned – we went birdwatching that evening and have remained good friends ever since. My wife and I have stayed with his family in Los Angeles and they have stayed with us in Melbourne.

As in medicine, birdwatchers have mentors, and personally I owe a great deal to Charles Bryant, a solicitor who virtually ran the Royal Australasian Ornithologists Union (RAOU) for thirty years to 1958; and to Claude Austin, a farmer who was an outstanding observer in the field and organised some wonderful trips to the Mallee and around Australia with groups of friends. On the medical side, Alan Lendon and Mark Bonnin, both from Adelaide, were great companions and very good ornithologists. Alan in his day was Australia's expert on the parrot family and his books *Australian Parrots in Captivity* (London: Avicultural Society, 1951) and *Australian Parrots in Field and Aviary* (Sydney: A&R, 1973) have become classics. He was, of course, a very successful aviculturist. Mark Bonnin was also very



NORMAN WETTENHALL AM

NORMAN WETTENHALL AM (MBBS 1940), MD, BS, FRCP, FRACP, Consultant Paediatric Endocrinologist to the Royal Children's Hospital, was the first full-time paediatric endocrinologist in Australia and a Foundation Member of the Endocrine Society of Australia. He has combined his long and busy medical and family life with an extraordinary range of demanding non-medical activities.

Since 1956 he has played vital foundation, committee and chairmanship roles in such organisations as the National Trust of Australia (Vic), the Australian Conservation Foundation, the National Museum of Victoria, the Royal Australasian Ornithologists Union, the Victorian Conservation Trust, Heide Park & Art Gallery and many more. In all these roles, he has achieved outstanding success as a fundraiser. He applies the same vigour to his recreations, which include birdwatching, natural history, tennis and the collection of books and paintings.

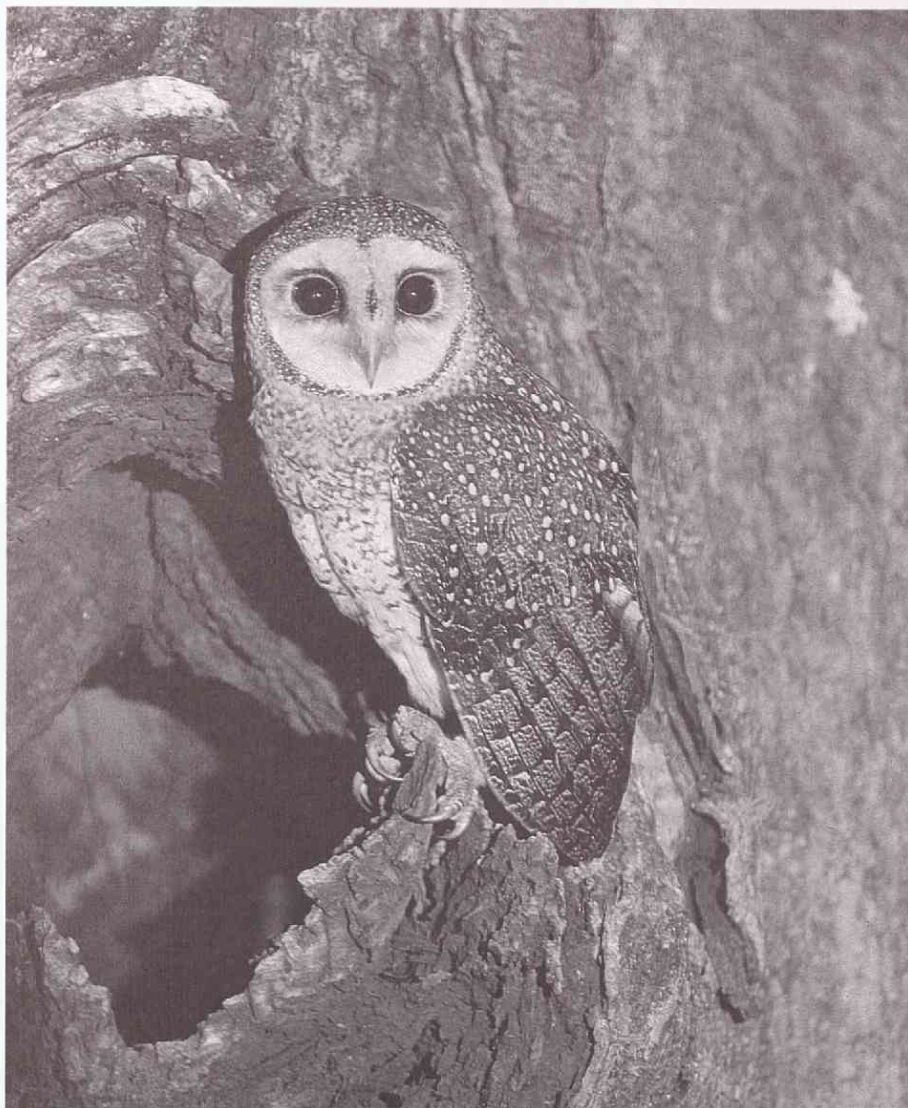


The strike – White-bellied Sea Eagle. Photo David Hollands.

good in the field and an excellent photographer; he played a very active role in the conservation of natural areas in South Australia.

THE association of doctors with ornithology goes back a long way, but this brief outline will be confined to Australia since 1788. John White, Surgeon General to the First Settlement, had a real interest in natural history and in his journal published in 1790 there are a number of excellent illustrations of birds found near Sydney. During the nineteenth century probably the outstanding doctor in this field was George Bennett who was the first director of the Australian Museum in Sydney. He wrote two large books and published many articles on





The Lesser Sooty Owl. Photo David Hollands.

natural history. He had a particular interest in the platypus, but his expertise covered the whole field of natural history.

Charles Snodgrass Ryan (1853-1926), surgeon of Melbourne, had a house at the top end of Collins Street and it was there that the founders of the Royal Australasian Ornithologists Union (RAOU) met in 1897 to establish the organisation, and continued to hold Council meetings there until 1916. Ryan himself was the third President of the RAOU (1905-07) and gave a presidential address on the need for protection of birds in Australia. He remained an enthusiastic supporter of this concept, and encouraged the introduction of nature study in schools and an Annual Bird Day. He served in the AIF as Surgeon General and was knighted in 1919.

A little younger than Ryan was William D K Macgillivray (1867-1933), who practised in Broken Hill. Like many others in those days he built a large collection of birds' eggs and bird skins, and employed William McLennan who became famous in his own right as a professional collector. Almost every year Macgillivray organised a field trip with two or three companions to remote parts of Australia and wrote most engagingly

about their experiences. In one of his articles, he expressed very well a sentiment which fellow lovers of birds can endorse right to the present day: 'We reached home well satisfied with our wandering and better, mentally and physically, for the communion we had with nature'. He became the tenth president of the RAOU in 1916, and in 1917 went overseas with the AIF, recording meticulously the birds he saw from the troopship. After the war the Great Barrier Reef became his major field of interest, especially the migrant and shore birds, and he was regarded as an expert in that area.

A contemporary and good friend of Macgillivray was Ernest A D'Ombain (1867-1944) who practised initially in Casterton, where he introduced William McLennan to field ornithology. Later D'Ombain became an eye specialist in Sydney and was a foundation member of the RACS. He wrote in *The Emu* on 'A comparison between the eyes of birds and of man', exemplifying the scientific application of medicine to ornithology. An earlier paper on 'Sight in birds' was written in 1916 by J C Lewis.

Doctors have made many scientific contributions to the study of birds, for example,

J Burton Cleland encouraged 'research of everything that related to birds even remotely - examination of contents of stomachs and crops of over 300 birds, search for parasitic worms, and blood films for protozoa...' (*The Emu*, Vol XI, 79-95; XII, 8-18). He was an early protagonist of compiling a bird census. His descendants carry on his inspiration for scientific accuracy, as exemplified by his grandson David Paton in Adelaide. Other doctors with an interest in birds in the years before 1940 include Lt-Colonel H W Bryant, Eustace Ferguson, George Horne, F M House and Professor Frederic Wood Jones.

**I**N the last fifty years interests have changed from egg collecting and building up private collections of bird skins. Identification of birds by field characteristics, the recording and publishing of results of behaviour, migration, etc, and concern for the natural habitat, have all become more important.

Bird photography, which requires much patience and persistence, has advanced remarkably and photos taken by David Hollands of both diurnal and nocturnal birds of prey are outstanding. He has published two books of world class in this field - *Eagles, Hawks and Falcons of Australia* (Melb: Nelson, 1984) and *Birds of the Night* (Sydney: Reed, 1992). Two other doctors skilled in photography are Mark Bonnin and Michael Seyfort, and no doubt there are more.

Diseases associated with birds, such as psittacosis and Murray Valley encephalitis, have been the subject of intense study. Australian expeditions to Antarctica always include a doctor, and in this specialty Arthur Gwynne and Michael Martin are amongst those who have made significant contributions.

Doctors have also contributed their skills as members of committees and organisers, for example, presidents of the RAOU in the last thirty years include Alan Lendon, Graham Brown, and Norman Wettenhall.

Ornithology is an interest which can be combined with other outdoor activities such as fishing, gardening, and bushwalking. Even indoors it can be manifested by collections of books and paintings. It can be rewarding both when one is alone or in a group, and the enthusiasm and knowledge of one or two individuals can stimulate the pleasure of a larger number. This is probably the explanation for the concentration of doctor ornithologists in Adelaide, and for the gatherings of the APEG.

In the study of ornithology, both amateur and professional, doctors have contributed much in a great variety of ways. Their involvement with bird life is of importance not only to ornithology but also to the balance of their own lives. As they continue to enjoy themselves and to find pleasure in applying their skills to another discipline, taking part in field studies and writing articles of general and scientific worth, it will be interesting to follow their progress. □



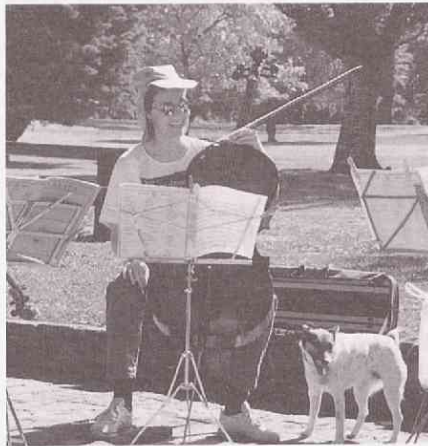
**MUSOs Kate Cherry, Judy Kermode and Ruth McNair are members of the Australian Doctors Orchestra.**



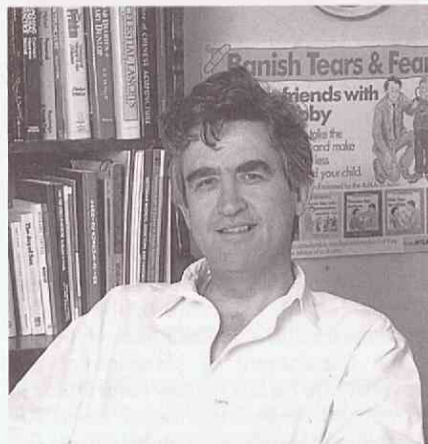
**KATE CHERRY, MBBS 1992**, has been playing music since primary school. Her principal instrument is the viola. She joined the Geminiani Chamber Orchestra when she was a student, and concert work was the main source of her income throughout the medical course. Since graduating she has less time for professional engagements, but continues to enjoy playing chamber music with friends and also finds the time to play at fundraising concerts. In 1995 Kate is a third year resident at the Austin Hospital, enrolled in the FRACP basic training program. She hopes to specialise in infectious diseases with a special interest in HIV medicine.



**JUDY KERMODE, MD 1991 (Melb)**, a medical graduate of the University of Western Australia, has played the cello since the age of twelve. She joined the Malvern Symphony Orchestra in 1988 shortly after arriving in Melbourne to take up work as a paediatric anaesthetist at the Royal Children's Hospital. She plays chamber music with three close friends (also doctors) – 'We perform the occasional concert which is always very satisfying.' Judy met her fiancé, who plays the oboe, whilst playing with the ADO. This year she has taken up a twelve months appointment in New Zealand as a consultant anaesthetist.



**RUTH McNAIR, MBBS 1986**, says that chamber music is her passion – 'I could do it all of the time.' She has played the cello since she was nine and though working in a busy country practice in Bacchus Marsh, Ruth indulges her passion by playing in numerous string quartets as well as making occasional appearances with the Ballarat Chamber Orchestra, Malvern Symphony Orchestra and the Camerata Orchestra. She is a committee member of the annual Mt Buller Chamber Music Summer School, now in its eleventh year.



**GP, AUTHOR, columnist, radio talkback medico Andrew Pattison, MBBS 1975**, loves being a GP – 'It's hard to imagine another occupation that gives such a clear view of human nature ...' He is particularly interested in preventive medicine and has been working with the idea of shifting the focus on health education back to young children. 'It makes a lot more sense than coming in like ghostbusters, trying to cure people after major illnesses have already occurred ... Talking lifestyle factors to an overweight fifty-year-old smoker with gout can be very difficult.'

Working with illustrator Virginia Barrett he developed the 'Doctor Toby' books for children between the ages of three and eight years (see Books, p71) and, he says, one thing led to another – promotional interviews led to the 3AW medical segment, which went for three and a half years, and to his current weekly medical column for the Melbourne

Age. He has strong views on the need for communication skills: 'Complaints from patients about their doctors are rarely about technical skills, but whether the doctor clearly explained what was going on and allowed them time to ask questions.' The aim of his broad range of activities has always been to encourage people to accept more responsibility for their own health.



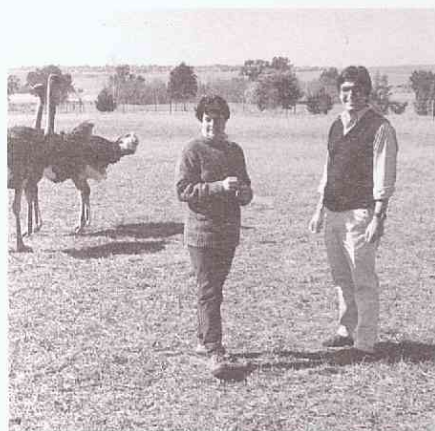
**SERGE LIBERMAN, MBBS 1967**, award winning author, essayist, editor, book reviewer and bibliographer is 'that unfashionable thing, a committed writer. Not to a party line, of course, but to a literature of engagement with humanity'. He began writing stories during 'the primeval days' of his medical studies and today, he says, he is a happily fulfilled full-time general practitioner in North Carlton/Brunswick, who finds continuing and mutually enhancing sustenance from both his medical and his literary work.

Born in Russia in 1942 of Polish-Jewish refugees, Serge arrived in Australia in 1951. He became smitten with the ambition to write while in fifth form in 1959 – 'very specifically on the eve of Good Friday after a viewing of Eugene O'Neill's *Desire Under the Elms*'. His first published story, 'The Professor's Daughter', written under the spell of another doctor-writer, Anton Chekhov, appeared in *Speculum* in 1966.

Four collections of stories were published through the 1980s – *On Firmer Shores*, *A Universe of Clowns*, *The Life That I Have Led* and *The Battered and the Redeemed* – three of these receiving the Fellowship of Australian Writers' Alan Marshall Award for Fiction, while *A Universe of Clowns* also collected the 1984 NSW Premier's Literary Award for Ethnic Writing. His *Bibliography of Australian Judaica* is now in its second edition.

Following a pattern already established at university when he was editor of the Jewish students' publications, *Situations* (1964) and then *Venture* (1965), he is currently Editor of the literary journal, *Melbourne Chronicle*, Literary Editor of the weekly *Australian Jewish News*, and serves on the editorial committees of the *Journal of the Australian Jewish Historical Society* and of *Gesher: Journal of the Council of Christians and Jews*, being also Corresponding Editor of *Outrider*, which began as a journal of multicultural writing.

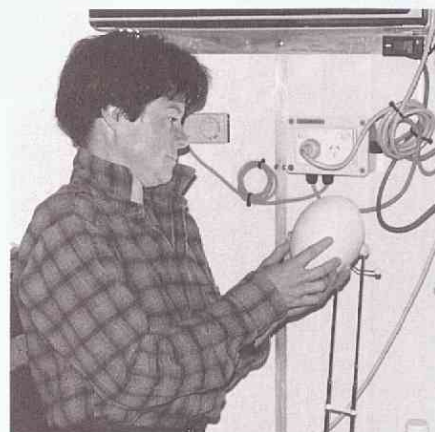




**OSTRICH FARMERS** Judy (nee Kenneally, MBBS 1979) and Bill Mackie (MBBS 1979) moved to Bathurst in 1989 after returning to Australia from a twelve months stint at Carlisle Infirmary. Judy is a geriatrician, and Bill a consultant general surgeon specialising in laparoscopy. They are the proud owners of 'Westbourne', a small property west of the city, and have been kept busy in their off-duty hours establishing the farm, restoring the homestead with its original 1820s brick kitchen, and rehabilitating the outbuildings which include a very old wattle and daub creamery.

Judy has changed her specialty to ostrich health care and horticulture, devoting her time to the growing big-bird community and to re-establishing the extensive garden around the homestead.

Rearing the birds is time-consuming, involving scientific supervision of diet, hygiene, humidity and temperature, and young birds require constant management during their first year. A female ostrich may lay an egg every two or three days in the open paddock and produce up to about fifty eggs a year. The eggs are collected immediately (a hazardous undertaking given that a male bird might stand eight feet tall and weigh 150 kg) and placed in an incubator which turns them every six hours. Each egg is 'candled' (held against a bright light) weekly so that development of the chick may be observed and infertile eggs discarded. Chicks hatch after six weeks incubation and are reared in brooder houses until they are strong enough to live in the open.



## NEITHER HYPOCRITE NOR SAINT

by John C Trinca

J C Trinca, Melbourne, 1994

Hbk pp307 illustrated

rrp \$40

This biography of Alfred John Trinca, by one of his sons, is a labour of love with a long gestational period – partly due to the fact that the book was also typeset and designed by the author – and what a wonderfully fine book has been produced. The 75 illustrations are excellent despite some being stills from old movies or enlarged from 35 mm negatives. The author also did this painstaking work.



A J Trinca, 1884-1981

'Neither hypocrite nor saint' is A J Trinca's summary of himself. The modesty of the father has been transmitted to his son, the author. John Trinca, MBBS 1942, former Director of the Commonwealth Serum Laboratories and a Senior Research Fellow in the Department of Medicine of this University (1973) is a regular contributor to *Chiron* and readers will recall his article 'Kitchener's Hundred', a meticulously researched record of the experiences of a particular group of medical graduates during the First World War.

In rounding out the life of 'this comparative stranger who was my father' the son introduces the reader to an unusual man with a wide range of interests who enjoyed to the full a long and useful life.

A J Trinca's medical career was wide ranging – anaesthetist, naval surgeon, medical officer in the RAMC, and pathologist. As a surgeon he used techniques which were strongly criticised by senior surgeons who were less knowledgeable.

His enjoyment of shooting and fishing are well told and illustrated and the reader is introduced to the Cormorant Club of which AJT was the inaugural president.

In this book there is much history and medical history which cannot be found readily elsewhere. The index is comprehensive and the appendices, glossary, bibliography, abbreviations and the numerous

notes to each chapter not only provide a mine of information, but are proof of the meticulous care taken by the author.

Originally this work was prepared as a gift to members of the Trinca family. Fortunately a small edition has been published and copies can be bought directly from the author:

Dr John C Trinca  
29 Parlington Street  
Canterbury, 3126.

I encourage medical historians and libraries to buy a copy before it is out of print, for this is an important addition to the medical history of Australia.

It is also a jolly good read.

HA

## PROPER CARE

**Heidelberg Repatriation Hospital**

**1940s-1960s**

by Gwynedd Hunter-Payne

Allen & Unwin, NSW 1994

Hbk pp313, illustrated

rrp \$34.95 plus \$3 postage from

Public Relations Department

Heidelberg Hospital

Banksia Street, Heidelberg, West 3081

This is the story of an unusual hospital which was created on 19 May 1947 when the 115th (Heidelberg) Military Hospital was taken over by the Repatriation Commission and became the Repatriation General Hospital, Heidelberg.

The Commission had inherited a large site, over fifty acres, and over 1414 patients in the wards. At that time it was the largest hospital in Victoria and much of the site was surrounded by a cyclone wire fence. When the staff entered the hospital they left the State of Victoria as they came under the jurisdiction of the Federal Government. The budget was controlled from the Victorian Branch of the Department of Veterans Affairs which was not in the hospital, but in central Melbourne. Outpatients were seen adjacent to this department, not in the hospital, which, moreover, did not have a casualty service. These differences tended to isolate the hospital and its staff and gave rise to misconceptions of what went on there.

For many years the hospital was considered to be a convalescent home and, like the adjacent Austin Hospital, it had its own entertainment theatre. The evidence for the expertise in treating war wounds with plastic surgery was hidden because it was not considered a good thing to put those mauled by war on view – although some were always brought out for the media on ANZAC Day. Excellent work was done in the treatment of tuberculosis both medically and surgically. There were no annual reports and, because of this, there were no research reports published. However the medical journals, particularly the *Medical Journal of Australia*, regularly printed original work from the 'Repat'.



The title, *Proper Care*, is taken from a statement made by Arthur Fadden: 'A grateful nation must see that those who are privileged to return from battle areas shall be properly cared for...' There is no doubt that the standard of care was high and relationships between staff and patients particularly friendly. Moreover, increasingly, visiting medical staff were drawn from consultants from some of the best hospitals in Melbourne.

Over the years special units developed and these often arose naturally from existing expertise. Specialisation in respiratory medicine grew out of the experience in treating tuberculosis and surgical treatment of this disease both at the Repat and at the Austin fostered thoracic surgery. Vascular disease in aging veterans was at first treated by simply cutting off the offending limb, but the upset to the patient saw the emergence of vascular surgery as a means of 'proper care' with the retention of the limb.

In the treatment of patients with cancer a team approach was developed at the Repat as in many other hospitals, but early on the Head of the Department of Oncology, Dr Zalberg, from an experience at the Austin of seeing a consultant treating 'patients as people', greatly expanded this concept of care. In a speech at a fundraising function to buy works of art and develop an Artist-in-Residence program, Zalberg told the audience that 'physicians know much about disease, but little about illness; know much about patients but have yet to learn about sick people'. He also appreciated the increased stress on his staff when dealing with cancer patients.

In the 1960s the hospital was recognised for postgraduate teaching and in 1964 Professors Maurice Ewing and Richard Bennett were permitted to teach their own students at the Repat, often on a Saturday morning. The need to do this was linked with the University of Melbourne relinquishing the Alfred and Prince Henry's Hospitals to Monash. In 1965, the University of Melbourne signed a formal agreement to establish a new medical school at the Austin Hospital. However, the Repat was at first excluded as a teaching hospital for undergraduates.

Undergraduate medical students entered the Austin Hospital Clinical School in November 1967, but despite the needs for access to more patients for clinical teaching, it was not until 1970 that an agreement was reached for a joint Austin Hospital-Repatriation General Hospital Clinical School. University first assistants in medicine and surgery were appointed and in 1976 Gabriel Kune was appointed Professor of Surgery and Jack Martin, Professor of Medicine at the Repat.

In the early years of the hospital only 20 per cent of the patients could be civilians or 'community patients'. By the 1980s all critical care areas were taken to be part of the state health service: 'Seventy-five per cent of patients in the coronary care unit, 25 per cent in intensive care and 60 per cent of patients attending accident and emergency

departments were community patients.' By the 1980s there were, then, two comparable teaching hospitals with just a hill between them.

In August 1988 it was announced that all Repatriation General Hospitals would be transferred from the Department of Veterans' Affairs into their respective state hospital systems. There followed for the Heidelberg Repat a period of uncertainty about who and what would survive and when this would be determined. The problems are carefully and sensitively recorded.

An addendum loosely inserted into this history states that, 'From 1 January, 1995, the hospital will be known as the Heidelberg Hospital (incorporating Heidelberg Repatriation Hospital)'. Moreover the hospital 'will amalgamate with the Austin Hospital on 1 July 1995'. The name of the amalgamated hospital had yet to be decided, but the site will be the 'Repat campus'. Will the recently erected buildings on the Austin campus disappear as Prince Henry's did?

This history excludes the earlier story of the 115th (Heidelberg) Military Hospital. That story will be published later as *The Duck-board Hospital*. Such handling of the history of the 115th GMH is justifiable for *Proper Care* has a defined beginning and end.

The amalgamated hospital will no doubt be an example of what is being called a 'boundaryless hospital'. A new vocabulary has grown up with 'clients and purchasers' and 'providers' for what were 'patients and medical and nursing staff or carers'. Day surgery units will be increased in size and pathology services are unlikely to be on the hospital site, but privatised and using modern technology not only for the processing of tests but also for the communication of results. Budgets will be determined by the Case Mix formula and enlarged rehabilitation centres will permit the earlier discharge of 'clients' from several hospitals to this one unit.

What will happen to 'proper care' in these brave new hospitals? I take comfort from the fact that in the amalgamation of the Repat and the Austin, both hospitals in the past held strongly to the concept of patients as people. It would be a tragedy if this ethos was lost. This is an important history and should be in all libraries as well as being read widely. *HA*

## THE STORY OF THE BIONIC EAR

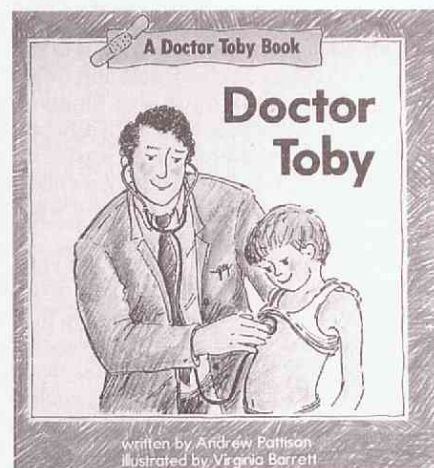
by June Epstein

Hyland House, Melbourne 1989

Pbk pp144 illustrated

Index, bibliography, rrp \$16.95

This is a sensitive account of the complex and contentious issues surrounding the development and marketing of the bionic ear. Whilst perhaps sufficient description for the lay reader, for those with some medical and technical knowledge there is a lacuna in the information about the fierce competition between the protagonists of the theory of learning traditional signing versus protagonists of early implantation of the device. A recommended good read. *Peter G Jones*



## DR TOBY BOOKS (A Series)

by Andrew Pattison

illustrated by Virginia Barrett

A Health Initiative endorsed by the Australian Medical Association (Victoria Branch) Hyland House, Melbourne, 1988-89 rrp \$7.95 each

Many readers will be familiar with the 'Doctor Toby' series of children's books. Written by Melbourne-based general practitioner, Andrew Pattison (see 'Not Just Doctors', p69), the series to date includes nine books for children between the ages of three and eight:

- *Doctor Toby*
- *Nick has Tonsillitis*
- *Clare has an Ear Infection*
- *Thomas has Asthma*
- *Kim has Eczema*
- *Dr Toby talks about Safety and First Aid*
- *Jane learns about Colds and other Viral Infections*
- *Sam has Bronchitis*
- *Ahmed goes to Hospital*

and an omnibus version is planned for later in 1995.

According to the publisher's statement on the back covers, the books fulfil several useful functions – 'to educate children about health, illness and the role of the doctor' and to 'make a visit to the doctor less worrying'. In a straightforward and approachable style the books come a fair way towards fulfilling these aims. By the use of medical terminology and the introduction of other health practitioners – such as the local pharmacist and a radiologist – children will get an idea of what to expect if they need to see a doctor, take medication, or go to hospital for particular problems. Most importantly, they are shown what some of their responsibilities are in the treatment of their condition and maintaining their health.

Virginia Barrett's illustrations are a key part of the success of the series. The drawings are clear and friendly. A mix of black-and-white backgrounds with bright colour to draw the eye to the most relevant elements is used most effectively. A puzzling omission is the absence of page numbers.

Six of the books deal with specific conditions or illnesses, such as eczema or viruses. A formula is used that introduces a child and



puts him/her into a social context. The onset of an illness is described, which leads to the doctor who diagnoses, educates and treats the child. The typical course of an illness or condition is outlined, ending with a happy child who has recovered or at least controlled the problem. Most usefully, a child's likely reaction to their condition and what they can do about it is discussed.

The tone of the books is generally very positive, whilst also touching on a little of the discomfort, anxiety or inconvenience that sick children can experience. However, the overall impression is that they are too 'neat' and do not realistically reflect many people's lives: children are never frightened, express no reluctance to visit the doctor or to be examined, never throw up all over the couch, or have to go out in the pouring rain to catch a tram to the doctor's. The doctor is always available, even at night (there are nice illustrations of crowded waiting rooms, by the way), there is always a quick and confident diagnosis, medicine is taken without protest, and in most instances there are two parents on hand to share the responsibility and to care for a sick child. If only life was really like that!

The lack of female health practitioners is disappointing. Perhaps Dr Toby's partner, Dr Karen (only mentioned in passing in the first book), could be given a higher profile in future editions.

To enhance their status as an educational resource the books could also refer readers to other key sources of information or support. Whilst not pretending to be definitive, the series would provide additional help by listing the names of relevant organisations such as the Asthma Foundation and the Child Safety Centre.

A major limitation of the series is that they assume a level of general education and a familiarity with medical terms that many in the community do not have. This could be easily remedied with a glossary of terms and simple diagrams. For adults to be able to offer comprehensible explanations to children, they too need simple definitions of common medical and technical terms. If these limitations could be addressed then the books could be usefully translated into the other languages now commonly used in community notices.

In reading the books the family of an ill child will often encounter mystifying words and complicated explanations, even with a well-intentioned doctor like Dr Toby. For example, in *Ahmed goes to Hospital*, Ahmed has a 'hernia' in his 'groin' – both these words beg questions requiring clear answers and despite the illustration of the doctor examining Ahmed's tummy, here is a case for a simple anatomical drawing. And what is an 'antibiotic' and how does it work? What does a 'thermometer' do and why do people get so hot? These are the questions children ask.

As an educational tool, the 'Dr Toby' books need to be read with an adult the first time, to talk about the general concepts and explain finer detail. This applies even to children with adequate reading skills. Once

the six illness-specific books have been read and discussed a few times there would seem to be little point in a child owning their own copy. However, the more general books might make a useful addition to a child's home library, especially if they are developing an interest in nursing or medicine.

These books would be well placed in schools, Maternal and Child Health Centres, kindergartens and creches and medical centres. General practitioners should know about the series and make the relevant edition recommended reading for a small patient or, ideally, their surgeries could hold a small lending library of publications that would help both the patient and the doctor overcome the anxieties that illnesses bring.

I have read several of the series with my four-year-old daughter, who expressed great interest in them. She now wants a microscope so that she can 'look at the germs'.

Marga Penny\*

\*Former Coordinator of the Victorian Injury Surveillance System, and a regular contributor to the VISS quarterly, *Hazard*.

## SOPHIA JEX-BLAKE

### A woman pioneer in nineteenth century medical reform

The Wellcome Series in the History of Medicine

by Shirley Roberts

Routledge, London & New York 1993

Hbk pp 207, illustrated, bibliography, index  
rrp UK £40 from Routledge, 11 New Fetter Lane, London EC4p 4 EE

Enquiries: Routledge/Law Book Co, Sydney.  
Tel(02)887 0177

Shirley Roberts has written another good biography.

When seven women entered this medical school in 1887 they did so with a minimum of fuss. In the year they were admitted they did seek, and were permitted to have, a separate dissecting room. They held this separate room for some eight years until the Professor of Anatomy and Pathology, Harry Allen, had to rescind his original decision as he needed the room for his research on diphtheria. The women expressed their indignation about this, but Harry Allen stood firm. This difficulty is minor in comparison to what is recounted in the story of Sophia Jex-Blake.

The social scene in Britain is well set and we are reminded that when a woman married her 'financial assets became her husband's property, and thereafter she was financially dependent on him'. When Sophia decided to become a teacher her 'relations were astonished, not at the occupation she chose, but at her intention to take up work of any kind'. When Sophia became a student at Queen's College in London she was asked to act as a tutor in mathematics and if 'the class numbered four or more students the tutor was paid a small salary'. When her father heard of this he chastised his wayward daughter and, despite a well-argued letter

from Sophia, she had to give up being paid for the first term. It is against this background that the story is set of Sophia's long struggle for women to gain an education in medicine equal to men.

In 1858 Elizabeth Blackwell had her name entered in the first British Register of Medical Practitioners. Elizabeth was lucky because, after that year, a foreign degree such as she had would not have been accepted. Elizabeth had graduated from the Geneva Medical College, New York State, and during practical training in Paris, as a student midwife at La Maternité, she lost an eye from gonococcal infection due to accidental contamination from a neonate. Elizabeth founded the New York Infirmary for Women and much of her work was done in America.

Elizabeth Blackwell inspired Elizabeth Garrett to take up the study of medicine and she obtained the Licentiate of the Society of Apothecaries and was registered a legally qualified medical practitioner in 1865. None of the medical schools in Britain would accept women to study medicine. The battle which Sophia Jex-Blake fought was to give women equal rights with men to study medicine.

The battle was long and hard and took Sophia to America, back to England and then to Edinburgh where the hostility was obdurate. Professor Robert Christison was the most powerful opponent and his antagonism seems to have arisen from his belief that women were meant to be housewives and mothers, but lacked the stamina to practise medicine. It has been suggested that Conan Doyle took Christison as his model for the arch villain Professor Moriarty. Whether this be true or not I was surprised to read that Professor Lister was also an antagonist.

The students were not content with verbal abuse. They resorted to pelting the women with refuse when they went to Surgeon's Hall. The women fought battles in academic committees and in courts of law. Sophia led these battles. It took some twenty-five years for Edinburgh University to admit women to its medical examinations.

What was Sophia like? The best summary is given in a quote from the first biography of Sophia by her colleague and friend Margaret Todd:

She held out at times about trifles – failed to see that they were trifles – and at times she terrified people more than she knew. Above all she cared nothing for the praise and blame of any but those whom she respected or loved. Of her indeed it might be said that she heard the beat of a different drummer. But there was another side to the picture after all. Many of those who regretted and criticised details were yet forced to bow before the big transparent honesty, the fine unflinching consistency, of her life.

This book should be read by all interested in medical history, medical education and social history.

HA



**HANC ARTEM MEAM PROFITEBUR****The Class of '64**

Eds John Thearle & John Pearn  
Amphion Press, Brisbane, 1994  
Hbk pp 163 illustrated rrp \$28

This is essentially an account of the 1964 medical graduates of the University of Brisbane, but as one might expect from the editors it is much more than just an illustrated reunion document. The translation of the Latin motto is given as 'May our patients profit from our skill and art'. From reading some of the biographical accounts it is obvious that many patients have.

Several innovations interested me and could be considered by anyone arranging a reunion document. In many cases photographs are provided 'as we were' and 'and now - maturity'. Three graduates have died - one tragically murdered by a deranged patient - and their photographs and short biographies are nevertheless included. Some details of parents, spouses and children are given and hobbies are often mentioned. A small number of teachers have been commemorated photographically.

John Pearn has written an interesting chapter on Doctor's Lives in which he mentions that of the 'three hundred children born to the graduating class, only 1 in 20 (5.5 per cent) have chosen to do medicine. John attributes this small number to the influence on the children of 'the inordinate demands of clinical medical practice'. Methinks there are other possibilities. An interesting and innovative book. *HA*

**THE BUSH****The story of the Mornington Bush Nursing Hospital**

by Hilary Abeyaratne  
Hyland House, Melbourne 1993  
Hbk pp127 illustrated rrp \$25

Mornington in the 1930s was a small fishing village of around two thousand permanent residents and 'an elite watering place on Port Phillip Bay' for Melbourne and country families who moved there for the summer months. It served a large country district for shopping and medical care.

The Mornington King George V Memorial Bush Nursing Hospital was opened on 18 July 1937, the forty-eighth of its kind since the Victorian Bush Nursing Association was founded in 1910. In later years it became known affectionately as 'The Bush'. Its growth and development through the vision and work of citizens is well documented and described by Mr Abeyaratne, a resident of the district for twenty years, an historian by academic discipline and a former senior English master at the Peninsula School in Mt Eliza.

Whilst perhaps of more personal interest to those involved, this informative history will reveal to the general reader the breadth and importance of the small hospital, its efficiency in terms of patient care and its difficulties in budgeting for the practise of medicine today.

*Peter G Jones*



Execution of William Burke. From an engraving by Walter Geikie. Edinburgh, 1829.

**BURKE & HARE**

by Owen Dudley Edwards  
The Mercat Press, Edinburgh, 1993  
Sbk pp300 illustrated  
rrp UK£9.95

In setting up this medical school one of the first things that the Vice-Chancellor, Anthony Colling Brownless, did was to arrange for the passing of an Anatomy Act in 1862. In the new medical school anatomical dissection was perfectly legal. The Victorian Act was based on the British Act of 1832 which arose, indirectly, from Burke and Hare's murderous provision of cadavers to anatomists in Edinburgh in 1828-29.

Much has been written about Burke and Hare or, more correctly, much has been rewritten about these men. This book is written by an Irish Catholic who is Reader in History at Edinburgh University. Edwards treats Burke and Hare as being 'human rather than monsters' and his originality can be summarised by the titles of some of the chapters:

- The Irishness of William Burke
- Burke, Hare and the Industrial Revolution
- Burke, Hare and Sex
- Burke, Hare and Immigrant Enterprise and lastly,
- The Damnation of William Burke.

The narrative flows easily and the reader is quickly captivated. Despite Burke's confession to the murders he is curiously likeable and staunchly defends his woman, Helen MacDougall, whose participation in the murders was found 'Not proven' - a verdict, under Scottish Law, which badly needs wider usage. Under the same legal system Burke was assured of legal representation and was defended by the 'the finest counsel in the bar'.

Burke also declared the receiving anatomist, Knox, to be innocent, although his culpability is obvious in that he never asked the source of the body despite the fact that those supplied by Burke and Hare were far too fresh ever to have been interred. Knox

paid as much as ten pounds for a cadaver and, with a night's lodging for Burke or Hare at four pence, such a sum would have given both of them lodgings for some nine months.

The trial is minutely analysed and it is clearly shown that Hare, who had turned King's evidence, had to be protected by his counsels despite obvious perjury in court. Indeed counsels did not pursue many points nor ask obvious questions, so that Knox was never implicated. If he had been, then Monro, Syme, Liston and Christison would also have been exposed.

Some twenty-five thousand came to see Burke hanged and as Edwards states, 'It may be doubted whether any more extraordinary spectacle ever graced a martyrdom of a devout saint, executed by persecuting officials in the presence of a bloodthirsty and brutish mob'.

Many of the mob yelled 'Burke him', which would have been more gentle than hanging: the victim was usually in a drunken stupor during which asphyxiation was ensured by placing a thumb under the chin and two fingers drawn in at the end of the nose whilst the accomplice lay across the chest. This is the meaning of the verb 'to burke'. There were few marks, but the cadavers provided by Burke and Hare were too fresh to have ever been buried. Burke and Hare were never grave robbers. They were murderers and Knox turned a blind eye to the obvious.

New and informative additions are provided from some letters written by Sir Walter Scott on the sequence of events and the trial.

This is a very different account of these murderers, their period and their relationships with the anatomists. Knox after all had to provide for the dissection needs of 504 students in the year 1828-29. This book should be in libraries and social and medical historians would find much of interest in it. I got my copy from John Smith & Sons, 57 St Vincent Street, Glasgow G2 5TB and consider it cheap at A\$27.93, including postage. *HA*

**A HISTORY OF PHARMACY IN VICTORIA**

by Gregory Haines  
The Australian Pharmaceutical Publishing Company, Melbourne, 1994  
pp 304, illustrated, appendix, bibliography, index  
rrp hbk \$35, sbk \$25 (inc postage) from  
Pharmaceutical Society of Australia (Vic Branch) Ltd, 381 Royal Parade, Parkville 3052

This book is immediately attractive because of its cover. Portions of the Sisson's mural by Leonard Annois which graces the Cossar Hall in the Victorian College of Pharmacy have been used imaginatively. For those who have not seen this mural it is worth a visit. It is as large as the mural in Wilson Hall, but more complex and to my eyes much more attractive.

On opening the book the reader is also immediately attracted by the writing:



### Chapter One – The Setting

The map and geography of Victoria are like the wallpaper and furnishing in a room of charm and strong character. They set pattern and tone while scarcely being noticed. This smallest of Australia's mainland states, the most fertile of all, was also the one best defined by nature rather than by the arbitrary lines which officials in England's Colonial Office drew red across Australia's face for no intelligent reason, but which pleased neat-minded bureaucrats and suited the designs of exploiters and entrepreneurs.

The writer is a pharmacist and a historian and teaches at St Ignatius College, Riverview, NSW.

I regret that I cannot give a full review in the time available to me, but the importance of Victorian pharmacists in setting standards for the rest of Victoria is carefully and lovingly set out in chapters which include Gold and Growth, Legal Protection, Education by Degrees and A Long Tradition of Excellence.

It was interesting to learn that as far back as 1880 there was a move to set up a school of pharmacy in the University of Melbourne. This is described from the attitudes of some doctors as '... their peddling of quack remedies, and their unashamed hide in asking for a school of pharmacy in the hallowed University of Melbourne. What temerity!'

The more recent protracted and failed amalgamation with the University of Melbourne is chronicled and the much more rapid and successful union with Monash given.

The book is enriched by many historically important photographs of people and places going back to 1858, and there is an excellent index and a select bibliography. There is also a six page appendix on Australian Pharmacy History and its Method, which is as interestingly and provocatively written as the rest of the book.

Gregory Haines and the Australian Pharmaceutical Publishing Company are to be congratulated on producing this book, which could be used by many historians as a model for how to write history.

It should be in all libraries. *HA*

### THE ALTERNATIVE '94

Overseas Medical Students Society  
Ed Winnie Cheng

Congratulations to OMSS for producing their fifth annual publication.

Much of this number is taken up with frank, pragmatic assessments of lecture courses and teachers – helpful for students they are also instructive for the teachers!

In a new section, 'Face to Face', appears profiles of lecturers which are short, biographical accounts by the teachers themselves – Assoc Prof Doris Young and Assoc Prof David J de L Horne. Both were interesting, but David Horne's daughter Katherine has written an account of her father which is delightfully different. This section certainly

broadens the students' knowledge of their teachers and has much to commend it.

In 'Miscellaneous' the progress of the OMSS Buddy System, by which junior students can seek help from matched senior students, is described as 'one of the most successful and satisfying ventures undertaken by OMMS in the last couple of years' and students are encouraged to 'support the Buddy System, whether it is to join as a junior buddy, or to become a senior – you will gain yourself a friend – and a free lunch'.

As usual there are accounts of the Annual Dinner and social events including a Horse Riding Trip in 1993.

'Food for Thought', under the pretext of answering a query from a starving student, gives a very useful review of the eateries available on and slightly off campus. I am now determined to make a visit to 'Top End' which, for your information, is opposite the Royal Dental Hospital on Royal Parade. *HA*

## BOOKS OF REFERENCE

### A BIBLIOGRAPHY OF DOCTORS AT WAR

by S C Due  
S C Due, Belmont, 1994  
Pbk pp 78 \$17 (includes postage) from  
S C Due, 5 Shackleton Street,  
Belmont Vic 3216

Stephen Due is the Chief Librarian, Geelong Hospital Library. He provides an interesting survey of the literature and then an annotated bibliography of Australian doctors at war from the Franco-German War (1870-1871) to Somalia (1993).

Added to these are smaller but fascinating sections on Defence Medical Services, Literature and Medicine, Medicine and War, Social Aspects of War, and Bibliographies and Reference Works. Author, subject and personal name subject indices are provided.

All these goodies come in a pleasant paperback of 78 A4 pages and for the trifling sum of \$17! This is great value and will reward frequent browsing or intensive research.

Appropriately enough *Speculum* appears as one of the reference works. *HA*

### THE PUBLICATIONS OF GEELONG & DISTRICT DOCTORS 1843-1993

2nd Ed  
Compiled by Stephen Due  
Geelong Hospital Library 1993  
Pbk, pp unnumbered

This small book lists 'about nine hundred and twenty publications by one hundred and eight Geelong and district doctors' who have 'lived or worked' in Geelong and district. For anyone interested in this area and this era it is invaluable. *HA*

### THE MEDICAL BOARD OF SOUTH AUSTRALIA 1844-1944

by G J Fraenkel & D H White  
The Medical Board of Australia, St Peters, 1994  
Pbk pp 140  
\$30 (includes postage) from  
91 Payneham Road, St Peters SA 5069

Most medical practitioners become aware of the Medical Board once a year when they have to pay their fee to be registered. A fleeting awareness may also arise when the annual report of the board is delivered. Yet the members of such boards do much useful and necessary work with a minimum of fuss.

This small, well-written reference book was produced to celebrate the 150th anniversary of the South Australian Board. It includes lists of officials and members, but also includes Some 'Refugee' Doctors Desiring Registration – what a wonderfully evocative way to use the word 'desiring'!

To me the most interesting chapter deals with Sick Practitioners. Here Professor Ross Kalucy tells, in some detail, of 'the discreet help provided to doctors who are ill or incapacitated in any way'. When a doctor has to be interviewed 'he or she is welcome to bring their spouse or partner'. About half the doctors do this.

It is also interesting to be reminded that the parents of Howard Florey and Hugh Cairns came to Australia because the climate was thought to be beneficial for those suffering from tuberculosis.

This is a good reference work. It also contains much of interest for a browser. *HA*

## BOOKS RECEIVED

### COMMITTED TO SAVING LIVES A History of the Commonwealth Serum Laboratories

by A H Brogan  
Hyland House Publishing, Melbourne 1990  
Hbk pp301 illustrated rrp \$29.95

### LIVING IN A CHANGED WORLD

by Leslie A Osborn, MD  
Vantage Press Inc, New York 1994  
Hbk pp234 rrp \$US16.95

### MELBOURNE'S MERCY A History of Mercy Private Hospital

by Susan Priestley  
Hyland House Publishing, Melbourne 1990  
Hbk pp254 illustrated rrp \$30.00.

### AND THEREBY HANGS A TALE A General Practitioner's Day

by Philip Goodman MBBS (1925)  
Sbk pp52 illustrated  
Privately published, rrp 'about \$18' from  
Thesaurus, Beaumaris or from  
Dr Goodman on 9589 4501



# THREE LONG-LIVING VICTORIAN OTOLARYNGOLOGISTS

Colin S Richards

MBBS 1942, FRACS, DLO(Melb)



'Fenestration of the Ear'. Barbara Hepworth, 1948. Pencil drawing and oil colour on wood, 26 x 37 cm. Garnett Passe and Rodney Williams Memorial Foundation Collection.

**T**HE MORTALITY RATE in otolaryngologists holding office in both the Otolaryngological Society of Australia (OLSA) and on the Court of Examiners of the Royal Australasian College of Surgeons was quite high in the period 1958-1974. Of the first three Victorians to be president of the OLSA two – John Shaw (MBBS 1921) and Tom Millar (MBBS 1923) – died in office in 1958.

In those days there were only two examiners at a time on the College for the specialty, each usually for a ten-year term. Four out of the five examiners for the period 1950-1972 died within a few years of completing their term on the Court – John Shaw, George Swinburne, Syd Cocks and Frank Ellis. As the fifth Victorian to be president of the OLSA and as a member of the Court of Examiners I naturally had a keen interest in these figures! Two of the founders of our own surgical College, Augustus Leo Kenny of Victoria and William Nathaniel Robertson of Queensland were otolaryngologists. Both were members of the first College Council and Kenny was the first secretary/treasurer in 1927.

In their early days the recognised surgical specialties were few in number

and did not include thoracic and neurosurgery. Otolaryngologists performed the bronchoscopies and oesophagoscopies and removed the inhaled and ingested foreign bodies, as well as dealing with the occasional brain abscess from mastoiditis. Antibiotics were non-existent, so acute mastoiditis was just as acute a surgical emergency as acute appendicitis.

It is refreshing to look now at the lives of three Victorian otolaryngologists – Cliff Scantlebury, the first president of the OLSA, who died at 86 years, Ray Hennessy who died in his 100th year, and Frank Stone who lived to 92 years of age. The major part of their professional lives was spent between the two world wars. They perfected the art of observing and recording details of changes in small structures, and they were good teachers with high moral standards. All three took the Edinburgh Fellowship.

During the 1939-45 war when all branches of the medical profession were short-handed and subject to manpower controls, these three continued to provide services in both the public and private sectors. New graduates were gazetted as captains in the army on graduation. They worked for about twelve months as resident medical officers before being

called up and if they preferred to serve in the air force or navy they had to arrange transfers.

Scantlebury, Hennessy and Stone also worked in the period which saw the dawn of microsurgery. Frank Stone visited Julius Lempert in New York soon after he had introduced the dental drill to ear surgery, and was using low and medium-powered binocular loupes with a headlight. Not long after the end of the Second World War the binocular dissecting microscope became available with its own light source and, most importantly, an adequate working distance. Enormous developments in microsurgery in ear work followed – the introduction of magnification of the order of 8 or 10 diameters when working on structures such as the stapedial footplate of 1 or 2mm size meant that steps had to be taken to control tremor in precision surgery. The first step was to sit down to operate; additional steps included resting the hand on a fixed surface or touching one hand with a finger from the other hand. With longer instruments a fixed hurdle in the endoscope on which the shaft of the instrument could be pivoted also helped. The additional advantage that the binocular microscope had over



the binocular loupe was that the field remained in focus irrespective of the movements of the surgeon's head, so that the surgeon could relax his neck muscles and look at infinity through the microscope without the need to converge on a fixed spot. I purchased my first binocular microscope for ear work in 1948. Gradually the other specialties began to appreciate the advantages.

These developments were taking place towards the end of their professional lives. They practised prior to the days of Medicare and the referral voucher, when they were able to confine their consulting rooms to one site – commonly the 'Paris end' of Collins Street – and they built their practices on their reputations, a far cry from the present practice of multiple offices and the geographical referrals to the nearest competent specialist.

The Second World War led to a decrease in the number of newly qualified otolaryngologists, and when specialist training resumed soon after the war ended, it was usually undertaken overseas. It was not until 1970 that the College set up the Specialist Surgical Training Committees which preceded the Surgical Boards. These committees established training programs in Australia and New Zealand, which are now the basis of our advanced surgical training. In 1962 there were some forty-two otolaryngologists practising in Victoria and by 1992 the number had doubled.

**GEORGE CLIFFORD SCANTLEBURY**  
MBBS (Melb) 1915, FRCS (Edin) 1921, FRACS  
1889-1976

Cliff Scantlebury died aged 86 years on 8 July 1976. The son of Dr G J Scantlebury, he attended Geelong Grammar and at the University of Melbourne was a member of Trinity College. In the First World War, immediately after graduating in 1915, he responded to the British Army's call for one hundred medicos and was shipped over with Frank Stone in 'Kitchener's Hundred' (recorded by John Trinca in *Chiron*, Vol 2 No 4 1991 p57) and was commissioned in the RAMC. Unlike the other Australians in that group, Cliff was sent to the Mediterranean with some Canadians and ended up at Cape Hellas in the Gallipoli Campaign. He also served in France.

Both Frank Stone and Cliff Scantlebury were demobilised in Britain and sat the Edinburgh Fellowship with Cliff obtaining his in 1921, the year after Frank. Cliff returned to Melbourne in 1922 to set up private practice and to a position on the visiting ear, nose and throat staff of the [Royal] Melbourne Hospital. He became the senior in the unit when Frank Andrew retired in 1925 and continued in that post until 1946 when he was succeeded by John Shaw. At that stage Cliff had an



GEORGE SCANTLEBURY

inpatient appointment as head of unit while there were two outpatient surgeons, John Shaw and Tom Millar, each with their own separate outpatient units. All three were to become presidents of the Otolaryngological Society of Australia (OLSA), though in tragic circumstances for Shaw and Millar. Cliff Scantlebury was the first president of OLSA, holding office from 1951 to 1953. His partner, Heyworth Watson, was the secretary/treasurer.

In 1957, when the presidency came to Melbourne, John Shaw was elected president and I became treasurer. John passed the badge of office on to me saying that I should 'care for it'. He subsequently had a severe coronary and died before the next Annual General Meeting of the Society. Tom Millar took over as president, saw through the AGM in Hobart and then died on the golf course in June 1958. The president's term was seen out by Jean Littlejohn.

During the Second World War, Heyworth Watson was away in the army and became a prisoner of war in Changi. Cliff was kept extremely busy running the practice on his own and fulfilling his responsibilities at the Royal Melbourne Hospital. In addition he was a major at Heidelberg Repatriation Hospital where he trained some who eventually completed ENT qualifications after the war. He was also adviser to the army on ENT equipment.

At that time Melbourne's ENT services were really strained, the pressure having to be taken by men like Scantlebury. Home visiting was the rule rather than the exception for specialists and Cliff's sister, Mrs Eileen Lester, recalls:

He did the work of himself and his partner who was on active service and was always ready to give advice to colleagues. A lady GP rang one day very reluctant to bother him but badly wanting advice which she hoped he could give by phone. He thought a bit and replied, 'I'll come out, but I don't

know what time it will be'. It was midnight when he made the home call.

Mrs Lester also recalls that

During one such attendance upon a fashionable lady in a satin-bedecked bedroom, Cliff felt that throat cauterisation was indicated. He decided to check with the referring GP and used the lady's bedside phone – loud and clear for all to hear came the reply, 'I don't mind if you cut her bloody throat!'

Cliff's relaxation came from golf and fishing. He was a member of Royal Melbourne Golf Club and the Peninsula Country Golf Club in Frankston and was a regular and worthy player at weekend competitions. Towards the end of his life, bilateral cataract operations tended to limit his enjoyment of these active pursuits, but he kept up his attendance at the MCC with his good friends, Walter Bassett and John Rogers.

A keen fly-fisherman, he was a member of the Khancoban Fishing Club, and was its president at one stage. In those days septal surgery was usually done using cocaine as a local anaesthetic. When I was a medical student he performed a septal resection on me and I well recall him talking about fly-fishing throughout most of the operation.

In 1966 I was collecting photos of the previous presidents of the OLSA while they were still with us. I was endeavouring to make contact with Cliff but could not raise him on the phone. And then the penny dropped – he had not heard the phone because of his presbycusis. I called at his flat and knocked on the door. He produced a photo, looked at it and then replaced it with a younger version which he retrieved from a pile under his bath.

Peter G Jones, who was his house surgeon at one time, recalls Cliff Scantlebury as a good teacher and a genial doctor who was kindly to patients. In his tribute in the *Australian Journal of Otolaryngology* (1977 4 No 2, p181) Rory Willis wrote:

... [he] had time to spend with even the most junior of his colleagues ... His daily stroll from his rooms in Parliament Place down to the Melbourne Club for lunch was regularly interrupted chatting with the many ENT men he would meet along Collins Street. This applied right to the end, even if one had to confront him and identify oneself, making allowances for his failing eyesight. He was an excellent clinician, valued for his thoughtful second opinions and he was an adept surgeon, particularly skilled in the difficult areas of the posterior nasal sinuses. One of his few publications was to the 1929 Congress on *Trans-sphenoidal Approach to the Pituitary*, long before antibiotics and microsurgery.

He was ruddy-faced, stocky, moustached and always well dressed, though not modishly so like Ray Hennessy. He was gregarious, enjoyed family life, the



Melbourne Club, and his Rotary Club activities included being President in 1950. It was fitting that his ashes, together with those of his wife, Lilian, who had died in 1964, were taken by their family and scattered in the Jindabyne Creek on one of his favourite stretches of water.

#### RAYMOND VALENTINE HENNESSY

DDSC 1917, MBBS (Melb) 1918, FRCS (Edin) 1922,  
FRCS (Lon) 1924, FRACS  
1894-1993

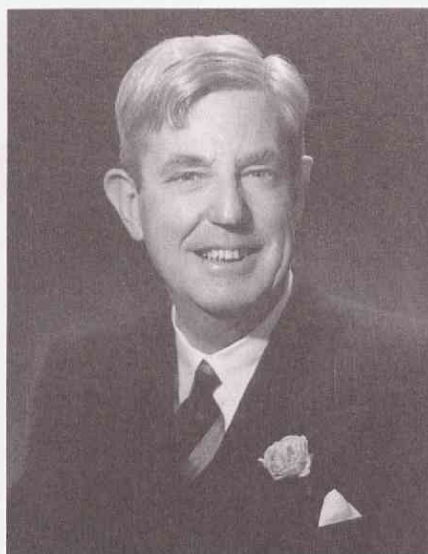
Raymond Hennessy's predecessors migrated from Ireland to Australia in the 1850s and set up a bakery in the northern suburbs. One member of the family became Lord Mayor of Melbourne, and one Hennessy girl married another Lord Mayor.

Ray was born in St Kilda in 1894. He proved himself to be very capable at school, and proceeded with a dental course at an early age, qualifying BDS in 1914. By this time, however, he had set his sights on a medical qualification which he completed MBBS in 1918, having picked up a DDSc in 1917 on the way.

There is an interesting sequel to this nine-year period spent in completing first a dental and then a medical course, which relates to two people: Edward Roland Garnett Passe, whose widow set out to perpetuate their memories when she established possibly the biggest medical bequest to come to Australia – the Garnett Passe and Rodney Williams Memorial Foundation, and Sir Arthur Amies, one-time Dean of the Faculty of Dental Science in Melbourne.

Garnett Passe graduated BDSc Melbourne in 1926, and Amies BDSc in 1924. Wishing to complete medical courses, these two dental graduates and another colleague sought accreditation towards a medical degree for some of their dental passes. Their request was refused, so they went off to Britain where, being given credit for their Australian dental subjects, completed the licentiate board qualifications – LRCS, LRCP in Edinburgh for Amies and in London, MRCS LRCP for Passe.

Ray Hennessy told me that when Amies returned to Melbourne he informed the Medical Board that Amies had received credit for his Australian dental subjects towards his medical qualification in Edinburgh. Ray then told Amies what he had done. Amies never spoke to Ray again! The Victorian Medical Board at first refused to register Amies but later, following threats of legal action, agreed to do so on the grounds that he had already been registered by the Medical Council in Britain. Amies later acquired a DLO (Melb) in 1933 and the FRACS in Laryngo-Otology in 1934. This was the No.1 certificate to carry the endorsement of the specialty.



RAYMOND HENNESSY

Ray served as a Resident Medical Officer and Registrar at St Vincent's Hospital, Melbourne, from 1919 to 1921. In 1921 he became Superintendent at St Vincent's, Sydney, before moving on to Edinburgh. He remained in Britain, returning to Victoria in 1925 when he joined the ENT staffs of the Children's and St Vincent's Hospitals. He served full terms at both hospitals before retiring in the mid-fifties as an Honorary Consultant ENT Surgeon. It was at these two hospitals that his friend Frank Stone's period of service overlapped, and subsequently both spent a period of time with Chevalier Jackson in his endoscopic unit in Philadelphia, each returning to Australia with a set of Pilling's instruments for bronchoscopy and oesophagoscopy (made to Jackson's design).

N A (Nate) Myers, another colleague, writes that:

[he] ... combined all the attributes of a great surgeon; he was a superb technical surgeon in his chosen field of otolaryngology, a wonderful teacher who provided a stimulating intellectual influence to all who worked with him. His diagnostic skills were impressive, both in the respiratory passages and also in the oesophagus; in most respects he pioneered both bronchoscopy and oesophagoscopy at the Royal Children's Hospital. His skills covered therapeutic as well as diagnostic aspects and his abilities reduced both morbidity and mortality following on inhalation or ingestion of foreign bodies.

The operations he performed were all carried out meticulously and with great respect for the many delicate tissues he encountered and he observed all the established principles of surgical practice. As would be expected, his greatest experience was in relation to tonsillectomy and adenoidectomy and it was a delight to observe his gentle approach to the procedure: he invariably dealt with the tonsils first, permitting

easier access to the post-nasal space for the adenoidectomy. He made a particular point of preservation of the anterior pillar and obtaining total haemostasis.

He was an excellent teacher both in the clinical and technical sense and his skills have lived on in successive generations of surgeons whom he taught. Above all he was a kindly man, sympathetic to his patients and their parents. He was held in high regard by those who benefited from his guidance and were fortunate enough to have been his residents.

In his eulogy Dr Edward Ryan spoke movingly:

It was extraordinary the influence he had – it was the golden, the second golden age of St Vincent's Hospital. So many of them – Devine, Dunhill, Shields, Julian Smith – on the surgical side, Rowden White and Lewis on the medical side – and in that company, Ray had an extraordinary influence. They went to him with their problems on practical surgery and medicine, and his advice was always worthwhile. He saw the emergence of the new specialties – Tom King in orthopaedics and Frank Morgan in neurosurgery, and once again it was fascinating to see him leaving his theatre, going in, watching them, and giving them good advice ... and they became great friends of course.

Ray Hennessy was [Sir Thomas] Dunhill's house surgeon after the First World War when Dunhill, who was noted for his thyroid surgery, was invited to set up a unit in St Bartholomew's. When visiting Dunhill in London, Ray told him that because of his own deafness and his familiarity with working in the mouth, he intended to become an ear, nose and throat specialist. Dunhill then introduced him to Boyle who had brought a Davis gag for throat work from America. Ray had not seen one before. Mayer and Phelps were making six gags 'on spec', and Ray purchased one for six guineas. He introduced the Boyle-Davis gag to Australia in 1925.

Ray was extremely well read and took great care to see that any books lent by him were returned – as I found from my own experience. He considered that the College Library could not be both a lending library and a reference library: it had to be one or the other (although the problem has been relieved since photocopying became available). He quoted the loss of the College copy of Cushing's book, *Tumours of the Nervous Acusticus*. He also told of a case of Volkmann's contracture that had come to litigation: Leo Doyle was involved and [Sir] Alan Newton was on the opposing side. Newton borrowed all the relevant literature from the BMA Library and Leo could not get access to it. This was before the days of the College Library.

In Ray's day the usual anaesthetic for most of his work was ether insufflated into the pharynx, through the Boyle-Davis



gag, through an oral airway incorporating a side tube, or through a bent copper tube; but in most cases a device was required for vaporising the ether and a supply of air under pressure was also required. Together with Tom Whittam, FFARCS, he developed a machine for ENT work which continued to be used at St Vincent's until 1956.

Ray was a devoted family man. Of elegant, natty appearance (a carnation in his buttonhole, Edward Ryan tells me, not a rosebud as reported in the obituary in the 1994 edition of *Chiron*). He was a lover of the arts, urbane and witty – sometimes mischievously so. He was, above all, a superb, generous teacher and a gentle, sensitive medical practitioner.

#### FRANCIS WILLIAM STONE

MBBS (Melb) 1912, FRCS (Edin) 1920  
1890-1982

'Frank' Stone and Ray Hennessy must surely share the record for being the longest living otolaryngologists in Victoria, and probably in Australia. Both studied their specialty in Edinburgh soon after the First World War and both worked on the honorary staffs of the Royal Children's and St Vincent's Hospitals in Melbourne.

Frank's father, William Stone, an electrical engineer and physicist, was responsible for the electrification of the Victorian railways between 1913 and 1919. He made early X-ray tubes and the Medical History Unit of the University of Melbourne holds some of his papers. He also wrote about Grayson's micro rulings. Two of Frank's aunts, Constance and Clara Stone, studied medicine. Constance attained her medical qualification in Canada in 1888 and in 1890 was the first woman registered by the Victorian Medical Board. Clara was one of the 'famous seven' women, the first to be admitted to the medical course in Victoria in 1887, and the first women to graduate in 1891. Both Constance and Clara played a significant part in the establishment of the Queen Victoria Hospital.

Frank graduated in 1912 and moved to Western Australia. The story is told that one day he drove a lass home in a buggy and gave her a farewell kiss when depositing her at the door of her home. Her mother opened the door saying, 'I see we understand each other'. Frank was somewhat surprised to find his engagement announced in the paper next day! Soon after this episode Frank, still a bachelor, set forth for Britain in 'Kitchener's Hundred'. He served with the RAMC from 1915 to 1918 together with Cliff Scantlebury, another future otolaryngologist.

After the cessation of hostilities Frank remained in Britain to train in otolaryngology in Edinburgh, where he was joined by Ray Hennessy. He returned



First World War doctors at a forward dressing station. Frank Stone seated.

to Melbourne in the early 1920s to set up practice at 91 Collins Street, adjacent to the rooms of Herbert Maunsell Hewlitt, a pioneer radiologist. In 1927 he visited the USA spending much of his time in Philadelphia at the Chevalier Jackson Clinic and returned home (as did Ray Hennessy) with a set of Jackson's instruments for bronchoscopy and oesophagoscopy.

In 1928, at the request of Murray Tallent, Frank and 'Pat' (William John) Denehy started the ear, nose and throat services at Prince Henry's Hospital (formerly the Homeopathic Hospital). He continued to provide this service until 1950 when he retired at the age of sixty to become consultant otorhinolaryngologist.

During the 1930s he also served on the honorary staffs of the Royal Children's and St Vincent's Hospitals, alongside his friend Ray Hennessy. In March 1937 he set out again on a trip to the USA leaving behind 29-years-old George Swinburne to look after his practice (George had acquired an English Fellowship two years earlier and took out his Australian Fellowship in 1937). He had intended to be away for six months, but in fact it was two years before Frank returned to Melbourne. One of his five sisters had married an American and was living there and Frank liked to stay with them, and having become interested in the stock market (at one stage Frank was the largest shareholder in the Western Mining Corporation) he played Wall Street, though did not do so well as he had done in Melbourne.

However, the most interesting reason for his long stay was that he had become fascinated by the work of Julius Lempert of New York, his endaural approach and with the fenestration operation. In 1939 he brought back a complete set of instruments including the headlight with an exposed globe and a concave mirror – so clearly depicted by Barbara Hepworth in her painting of Garnett Passe performing a fenestration operation (this

painting is held by the Garnett Passe and Rodney Williams Foundation); a pair of high-powered and a pair of low-powered Speera binocular magnifiers made by W Watson & Sons of London, two portable dental type drills in carrying cases complete with collapsible tripods (which fixed onto a base in the case), burrs, a set of Lempert curettes and the other appropriate instruments, Lempert reprints, and later even a stopple cutter for cutting a cartilaginous plug for the fenestra. Frank was a fairly quiet fellow so I do not think his colleagues were ever aware of what he was doing – I have many of these instruments, including the low-powered binocular magnifier, and one drill still goes.

In 1939, Frank proceeded to his first fenestration in Melbourne, but despite the fact that he was an excellent technician and had all the right instruments, he finished with a dead ear. He was both a competent operator and a sensitive person and he never performed that operation again. Several years later a possible clue to the tragedy emerged when I was having my own visual correction fitted to the same low-powered magnifiers. The optician informed me that the prisms were fitted the wrong way around, that they were diverging instead of converging, making binocular vision impossible.

Throughout the war and up to 1950, Frank continued his activities in both his medical practice and the share market. He lived with a married sister and remained a bachelor so he did not have the financial ties of family life. After retiring from medical practice, he once again visited his sister in America and then travelled to Britain, where he had difficulty in deciding whether to buy a Bentley or an Austin A40 – the Bentley won! Back in Australia and at sixty years of age he started out on a new career which lasted for the next thirty-two years. For a brief period he grew cotton, but soon switched to breeding Brahman bulls, which he did very successfully on a property, 'Stanley Park', at Guluguba near Roma west of Brisbane.

Frank Stone was a tall, rather thin person with an excellent sense of humour. In some ways he led a somewhat sheltered existence in that Jean, his married sister, cared for him, deciding which shirt or tie he wore. And he was also blessed with a marvellous secretary, Esther Williams, who looked after him for the last nineteen years of his practice period. She was so good and so much appreciated by the patients that they primarily came to see her and the consultation with Frank was almost incidental. His rooms were then at 61 Collins Street on the 4th Floor in what was previously a flat looking over Collins Street. The kitchen and bathroom were still intact and Esther would usually cook a hot meal for lunch. At one stage Sir



Osborne Smith, a former Governor of the Bank of India who was then living at the Occidental Hotel, would relieve his boredom by sitting in the corner of the kitchen. He was at times sent out to collect hot pies for lunch.

Practising in the pre-antibiotic days much of Frank's surgical work was the surgery of the nasal sinuses. He was ahead of his time in being well aware of the importance of infection of the ethmoidal sinuses and was an expert in the intranasal clearance of these cells. Like Garnett Passe, he had the jump on his colleagues in being trained by Lempert, immediately prior to the war, in the endaural approach and in fenestration surgery. But, unlike Garnett, he failed to capitalise on this advantage, and he ceased practice just at the time when the management of otosclerotic deafness was changing to a direct attack on the



Frank Stone in later years.

ankylosed stapes. For the rest of his long life he remained a successful player of the stock market as well as a successful grazier, dying on his beloved property on 14 October 1982 aged 92 years.

#### Postscript

Finally, lest someone should feel I have overlooked Cecil Cantor, let me recall that Cecil Nathaniel Cantor, a distinguished Melbourne otolaryngologist, died aged 90 years on 6 July 1992 (an obituary appeared in the *Australian Journal of Otolaryngology*, 1993 1 No 3, p287).

#### Acknowledgments

I most gratefully thank Edward Ryan, Nate Myers and Rory Willis for allowing me to use their material, also Catherine Green, Assistant Archivist of the Royal Australasian College of Surgeons, for her interest and helpfulness. CSR

## MEDICAL HISTORY UNIT

OPEN 9-5 WEEKDAYS BROWNLESS MEDICAL LIBRARY

Curator Prof Emer H D Attwood

Enquiries 9344 5884

**T**HIS has been an eventful year – an international conference on the history of medicine, the completion of another BMedSc report in the Medical History Unit, the appointment of a lecturer in the History of Medicine, a coat – for what purpose? and a federal review of university museums.

#### The conference

The 34th International Congress on the History of Medicine was organised by the British Society of the History of Medicine and held in the University of Strathclyde in Glasgow. It was a well-organised conference with happy social events. The *Newsletter of the American Association of the History of Medicine* (No 46 Oct 1994) notes that there was a '... total attendance of about 240. The 30 US participants were exceeded only by those from Britain and, suprisingly, there were more Australians (11) than participants from any two other European countries'. Not so suprising, for the Australian Society of the History of Medicine has many keen members, quite a few of whom gave papers.

The Curator was invited to be one of the keynote speakers and chaired the morning session on 'Scottish Medicine at Home and Abroad'. To me, one of the most historically important papers was read during that session – 'The Polish School of Medicine at the University of Edinburgh'. Few know of this school now. The paper was read emotionally, but clearly, by an aged Dr W Tomaszewski, a former Senior Lecturer in Medicine at the

University of Poznan, Poland and at the Polish School of Medicine at the University of Edinburgh.

Founded during the war in 1941 by the University of Edinburgh, the Polish School of Medicine was a unique, bilingual, Scottish-Polish academia. There seems no precedence for such a co-operative venture in any other university. The Polish Government, then based in London reached an agreement with the university: The School was an integral part of the university, but at the same time an independent Polish academic institution.

The university provided all the clinical and laboratory facilities as well as help from Edinburgh Professors who took up chairs for which there was no available Pole. Half the professional staff were Scots with Polish senior lecturers attached. The diploma bore the texts of the University of Edinburgh and the Polish School of Medicine. At first the diploma was valid only in Poland, but in 1947 it gained recognition in Britain through an Act of Parliament. When the war ended in 1945 no new admissions were accepted, however those already in the course were able to conclude their studies. Over the eight years of its existence there were 337 students of whom 227 graduated MB ChB.

The account of this very successful venture fascinated all who heard it because of the emotional delivery – oral history before an audience – and the fascinating pictures of students and staff, nearly all in uniform. The University of Edinburgh deserves much credit for creating this Polish *entente cordiale*.

#### Biographical Review of the life of the late Dame Kate Campbell

Karen Crozier, at present a student in St Vincent's Clinical School, has had her *Biographical Review of the life of the late Dame Kate Campbell* passed for the BMedSc degree. Karen's work has enriched the archival holdings on Kate Campbell and provided much that can be used in future exhibitions.

#### Lectureship in the History of Medicine

In January of 1995, Dr Warwick Anderson, BMedSc, MBBS (Melb), MA, PhD (Pennsylvania) will take up a lectureship in the History of Medicine based in the Department of the History and Philosophy of Science with an adjunct appointment in our faculty. Warwick has worked in a number of places in Britain and America and comes to us from Harvard. This is a major development which has long been sought by a number of people.

#### A coat – for what purpose?

From the Western Australian Museum came a letter from Phyl Brown, Assistant Curator in the History Department. Enclosed was a photograph of a garment 'which we were told was used in the Lunatic Asylum in Fremantle'. It had been classified as a 'straitjacket', but it was 'unlike any restraining device we have been able to locate ... It is 97.5 cm in length and brown in colour. From marks on the object it appears that a rod or metal





A coat – for what purpose?

bar could have been passed through one end of the device where the fabric has been formed into 'loops'. Stress marks on the fabric suggest that the rod has also run down the sides of the device to the smaller of the three sets of flaps and possibly across the width near these sets of flaps . . . Well, that's the challenge!

I did not think it was a straitjacket, but had no other suggestions so immediately referred it to the oracle, Eric Cunningham Dax, former Chairman, Mental Health Authority, Victoria, and almost by return came the answer:

"These articles of clothing were sometimes made to suit the needs of individual patients and it is highly likely that the canvas garment was designed for this purpose. It is improbable that it was made in any place other than a mental hospital.

"It is not a straitjacket – both the arms and legs are free and the various projections with holes for lacing are, I think, constructed to keep the top portion firmly in position. The rods or metal bars when in place could convert the upper part into a rigid frame so that the spine was immobilised.

"My feeling is that this garment was tailor-made for a person with some spinal lesion . . ."

I think the challenge has been met and answered.

### Survey and review of university museums and collections

Many universities have museums, both small and large, which present a range of subjects and interests. Some are departmental and of long standing. The

Harry Allen Museum of Pathology in this Medical School goes back to the 1880s and is probably the largest such museum still in existence in Australia. Some of the specimens on display were actually mounted and labelled by Harry Allen, the Professor of Anatomy and Pathology. This museum has been financed through the departmental budget.

Most departmental museums have begun and grown through the interest of a particular member of staff. In these the funding has been minimal and the displays rarely seen by the public. When the originator resigned or died, not a few collections have been neglected or discarded from lack of a continuing interest, or by the need for the space.

Recently, Simon Crean, the Minister for Education, Employment and Training, announced funding of \$94,000 for a survey and review of university museums and collections. The review would be carried out by a distinguished committee headed by Dr Don McMichael, a former director of the National Museum of Australia.

After completing a detailed questionnaire, in which the rarity of many of the holdings and their importance to Australian history was emphasised – at the same time admitting the paucity of the funding for staff and the obscurity of the site – the Medical History Museum received two visitations from the Chairman of the Committee and a representative of the Vice-Chancellor's office. The report from the committee is awaited with much interest, a little dis-ease, and a pinch of optimism.

Truly an interesting year!

### Extracts from the typescript autobiography of Professor R J A Berry, *Chance and circumstance, 1954*

"The greatest task any Vice Chancellor can perform is the removal of obstacles from the path of his staff"

*Sir Arnold McNair, Retiring Vice-Chancellor, University of Liverpool, in reply to a toast to his health.*

### Surgery in Edinburgh in the 1890's

#### ANAESTHESIA

"Taking an ordinary hand towel he will fold it into a square of about eight inches onto which will be poured out of an open bottle an unmeasured quantity of chloroform. This is held over the patient's face who is told to breathe quietly and gently. Some do. Some don't. Some struggle violently, but the process of pouring chloroform onto the towel is repeated until even the most violent patient succumbs."

#### THE OPERATING THEATRE

"Our patient is now ready and is wheeled into the operating theatre filled with many students, some suffering from colds in the head, but you will see no white coats anywhere. The chief himself is garbed in the brown frock coat he always wears at operations. It has been stained with the blood and gore of many previous ones. There are no signs of sterilisation to be seen. The instruments are laid out ready to hand. The sponges, drainage tubes – the latter an essential of all operations at this period – the swabs and such like are all to hand. The theatre Sister has seen to that and takes pride in her work.

The business is soon over, for the Chief is a dexterous and extremely rapid operator, and the patient goes back to her bed to suffer from post chloroform sickness for a long time, and a septic cellulitis of her leg for even longer."



## 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 centenary 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 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) 9347 3900

All enquiries (24 hours)  
(03) 9347 3900

Facsimile  
(03) 9347 3439

THE MEDICAL DEFENCE ASSOCIATION OF VICTORIA  
IS THE PROUD SPONSOR OF CHIRON  
THE JOURNAL OF THE UNIVERSITY OF MELBOURNE MEDICAL SOCIETY



## 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. Enquiries should be directed to: Continuing Education and External Relations, Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne, Parkville, Vic, 3052.*

### **Keeping up-to-date with Medical Literature using a PC or Mac and the Telephone Line on your Desk**

Saturdays; 18 February, 6 May, 12 August or 28 October, Brownless Medical Library, The University of Melbourne  
Director: Ms Dorothea Rowse

### **Psychiatry for Non-Psychiatrists: Recent Developments and New Treatment Approaches**

Friday and Saturday 3-4 March, Austin Hospital  
Directors: Associate Professor Fiona Judd and Professor Graham Burrows

### **GP Refresher Course in Ophthalmology**

Friday and Saturday 12-13 May, Royal Victorian Eye and Ear Hospital  
Director: Associate Professor Hector Maclean

### **Update in Dermatology for General Practitioners**

Friday and Saturday 2-3 June, The Royal Melbourne Hospital  
Director: Dr George Varigos

### **Update on Obstetrics and Gynaecology for General Practitioners**

Friday and Saturday 23-24 June, Royal Women's Hospital  
Directors: Associate Professor Doris Young and Professor Roger Pepperell

### **Radiography for General Practitioners**

Wednesday to Friday 19-21 July, Essendon and District Memorial Hospital  
Director: Professor Emeritus WSC Hare

### **Bones, Joints and Movement: Musculoskeletal Problems in General Practice**

Friday and Saturday 28-29 July, The Royal Melbourne Hospital and Essendon and District Memorial Hospital  
Director: Dr Stephen Wales

### **Practical Management of Wounds and Skin Ulcers**

Friday 11 August, Heidelberg Repatriation Hospital  
Director: Professor Donald MacLellan

### **Paediatrics for General Practitioners**

Tuesday to Thursday 22-24 August (Intensive Clinical Program), Friday and Saturday 25-26 August (Lecture Program), Royal Children's Hospital  
Directors: Dr Hubert van Doorn and Professor Peter Phelan

### **Update on Surgical Procedures in General Practice**

Friday and Saturday 8-9 September, Western Hospital  
Directors: Professor Robert Thomas and Miss Merron Pitcher

### **Update in General Medicine for General Practitioners**

Friday and Saturday 27-28 October, Austin Hospital  
Director: Dr Paddy Phillips

## DEAN'S LECTURE SERIES

*The Dean's Lecture Series is designed to illustrate current research and topics of interest in the fields of Medicine, Dentistry and the Health Sciences. Lectures are held on Tuesdays at 5.30 pm in the Sunderland Lecture Theatre, Ground Floor, Medical Building, The University of Melbourne. Interested students and graduates are invited to attend. For further information contact Continuing Education and Community Relations, Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne, Parkville, Vic, 3052.*

### **21 February**

*Nature versus Nurture: Individual Differences in Temperament and Behaviour*  
Professor Frank Oberklaid, Director of Community Child Health and Ambulatory Paediatrics, Royal Children's Hospital

### **7 March**

*What's Wrong with being Big Hearted? Understanding Left Ventricular Hypertrophy*  
Professor Stephen Harrap, Professor of Physiology

### **21 March – 61st Beattie Smith Lecture**

*The Current State of Psychiatric Epidemiology*  
Professor Scott Henderson, Director of the Social Psychiatry Research Unit, Australian National University

### **4 April**

*Sex Differences in Psychosocial Development in Childhood: What Messages are we Giving our Children?*  
Professor Margot Prior, Chief Psychologist, Royal Children's Hospital

### **11 April**

*Slip! Stop! Slap! – A Skin Cancer Control Program as a Model for an Approach to Common Skin Diseases in the Community*  
Professor Robin Marks, Director of Dermatology, St Vincent's Hospital, Melbourne

### **2 May**

*The Past, Present and Future of Rehabilitation Medicine*  
Professor Peter Disler, Director of Rehabilitation Medicine, The Royal Melbourne Hospital

### **16 May**

*What Maketh the Man? Genital Anomalies Provide Clues for Understanding Embryology of Sexual Development*  
Professor John Hutson, Director of Paediatric Surgery, Royal Children's Hospital

*This will be followed at 6.30 pm by the 1995 Annual General Meeting of the University of Melbourne Medical Society*

### **30 May**

*The Impact of Molecular Biology on Dentistry: New Prospects for the Prevention and Treatment of Oral Diseases*  
Professor Eric Reynolds, Professor of Dental Science, School of Dental Science, Royal Dental Hospital

### **13 June**

*Motor Disorders in Children: Gait Analysis and Outcome Studies*  
Professor H Kerr Graham, Director of Orthopaedic Surgery, Royal Children's Hospital

### **4 July – 19th Mathison Memorial Lecture**

*Gene Therapy – Expensive Dream or Exciting Reality?*  
Professor Bob Williamson, Director of the Murdoch Institute of Research into Birth Defects, Royal Children's Hospital

## **DEAN'S LECTURE SERIES SEMINAR CARING FOR THE SEVERELY DISABLED OR DYING CHILD**

Convener – Professor Richard Smallwood  
Friday 28 July 1995 – 2.00 pm to 5.00 pm