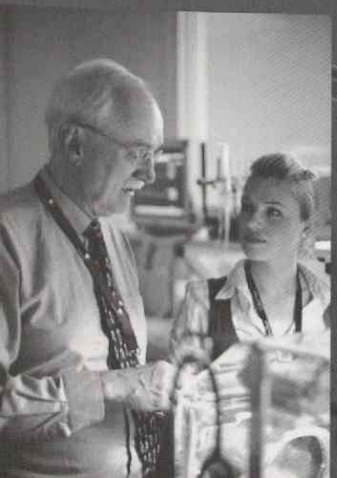
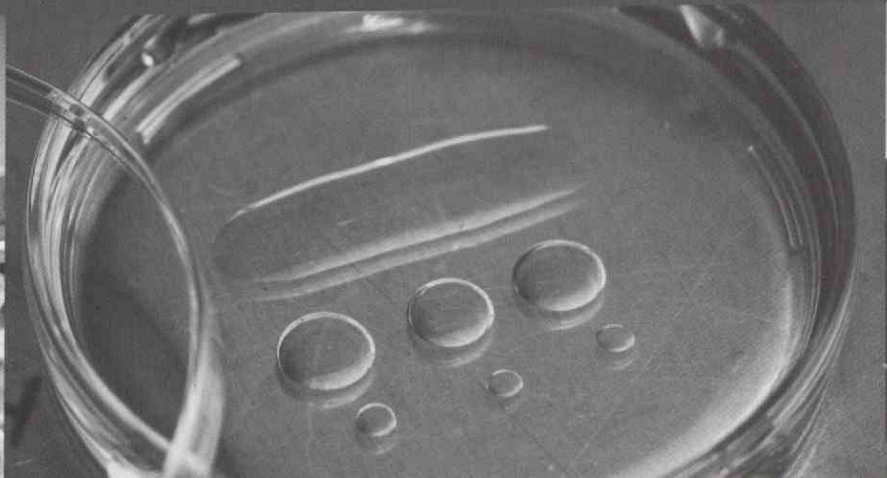
THE UNIVERSITY OF MELBOURNE

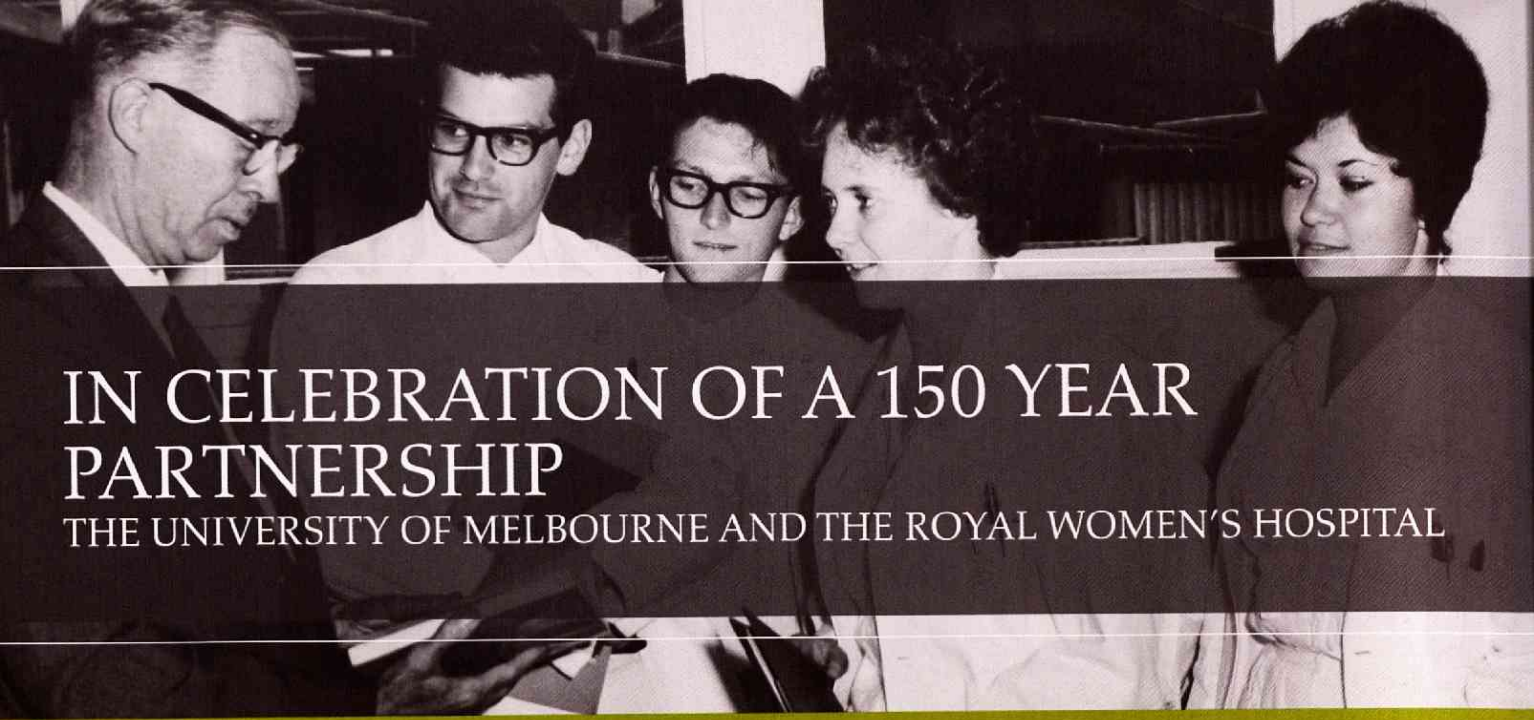
FACULTY OF MEDICINE DENTISTRY & HEALTH SCIENCES

CHIRON

Spring 2007







IN CELEBRATION OF A 150 YEAR PARTNERSHIP

THE UNIVERSITY OF MELBOURNE AND THE ROYAL WOMEN'S HOSPITAL

CONTENTS

COVER
This year, the University of Melbourne and the Faculty of Medicine, Dentistry and Health Sciences joined the Women's in celebration of its 150 years of leadership in advocacy and advancement of women's health care. The Royal Women's Hospital, Australia's largest specialist hospital dedicated to improving the health of all women and newborn babies, will enter an exciting phase next year when it moves to its new premises next to the Royal Melbourne Hospital. We look forward to the opportunities offered by this move, to build upon the 150 year partnership between the hospital and the university, and to strengthen and develop this important relationship. The photographs on our cover have kindly been provided by the photography and archives departments of the Royal Women's Hospital.

INSIDE COVER
Medical students at the Royal Women's Hospital with Dr McKelvey c 1963. Pictured from left, according to their name badges, are, Allan J Bond, Anthony R Moore, Julia E Taub and Anne E Thorpe. Photo courtesy RWH archives.

Chiron is published annually by the University of Melbourne Faculty of Medicine, Dentistry and Health Sciences.

The editors, Liz Brentnall, Linda Richardson, Jenny Conn and Janet McCalman, would like to thank Gil Meydan and Robyn Waymouth from the Royal Women's Hospital for their considerable assistance sourcing photographic material for this issue.

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ISSN 0814-3978

CLINICAL CONNECTIONS

THE VITAL ROLE OF HOSPITAL-UNIVERSITY RELATIONSHIPS

Emeritus Professor David Penington AC

The past century has seen huge advances in knowledge about human disease, its treatment and prevention. Great progress has been made with antibiotics and vaccines, effective strategies to handle vascular disease, successful chemotherapy for cancer and huge advances in reconstructive surgery. The explosion of biomedical knowledge and information technology in recent years has the potential to transform health care further, but the interface between research and services, so strong in major university hospitals internationally, remains fragile in Australia.

The commitment to research in our universities is young. The first two Australian PhDs were graduated from the University of Melbourne in 1947! Research and PhD programs were central to the life of major US universities and medical schools from 1900, but we were slow to catch up. Our teaching hospitals evolved on the British pattern, with clinical teaching controlled for many years by visiting honoraries—medical and surgical—who sought to monitor overseas advances during international visits, rather than contribute to them.

Western medicine underwent a revolution between 1800 and 1900 and Australia's first medical school was founded at the cusp of the transformation of medical thought by laboratory science that emerged from Germany and France. Anaesthesia and antisepsis enabled safer and more extensive abdominal surgery.

German medical education, with its strong base in medical science, differed fundamentally from the practitioner-controlled schools of London and Paris and had a great impact on America. Johns Hopkins University established a graduate school of medicine, opening a hospital staffed by the university in 1889. Similar changes followed at Harvard, at Columbia-Presbyterian in New York and elsewhere. Abraham Flexner's report in 1910 further reshaped American medical education with the closure of low quality 'apprenticeship' medical schools: and thus evolved the great American university hospitals whence came many big medical advances over the next hundred years.

At Australia's first medical school, however, led almost single-handedly by George Halford for its first 20 years, clinical teaching was delivered and controlled by the honoraries of the Melbourne Hospital. As the Alfred Hospital became a second teaching hospital in 1888, and St Vincent's a third in 1910, each gave the university a voice in selection of its staff, something still resisted at that time by the Melbourne Hospital. When Sydney's medical school opened in 1883, led by Stewart Anderson, an able Scot with German research experience, it, too, depended on a public hospital for clinical instruction.

In 1911 Harry Allen, as medical dean, sought a research institute for public health research at the Melbourne Hospital and the Walter and Eliza Hall Institute was founded in 1915. After surveying the Flexner initiatives in the US in 1912, James Barrett recommended appointing clinical professors and researchers in our hospitals, but to no avail.

The first real initiative to develop clinical research in Victoria was R Marshall Allan's appointment in 1925 as director of obstetrical research and his subsequent appointment to the chair of obstetrics at the Women's Hospital. Richard Berry's attempt to gain Rockefeller support in 1927 to create a university hospital, bringing the Melbourne Hospital to Parkville, was unsuccessful, despite Sydney's success in

David Penington

that area; they appointed clinical professors Lambie and Dew, who also failed to create a Hopkins-Flexner model, being kept at arm's length by hospitals constantly controlled by honoraries.

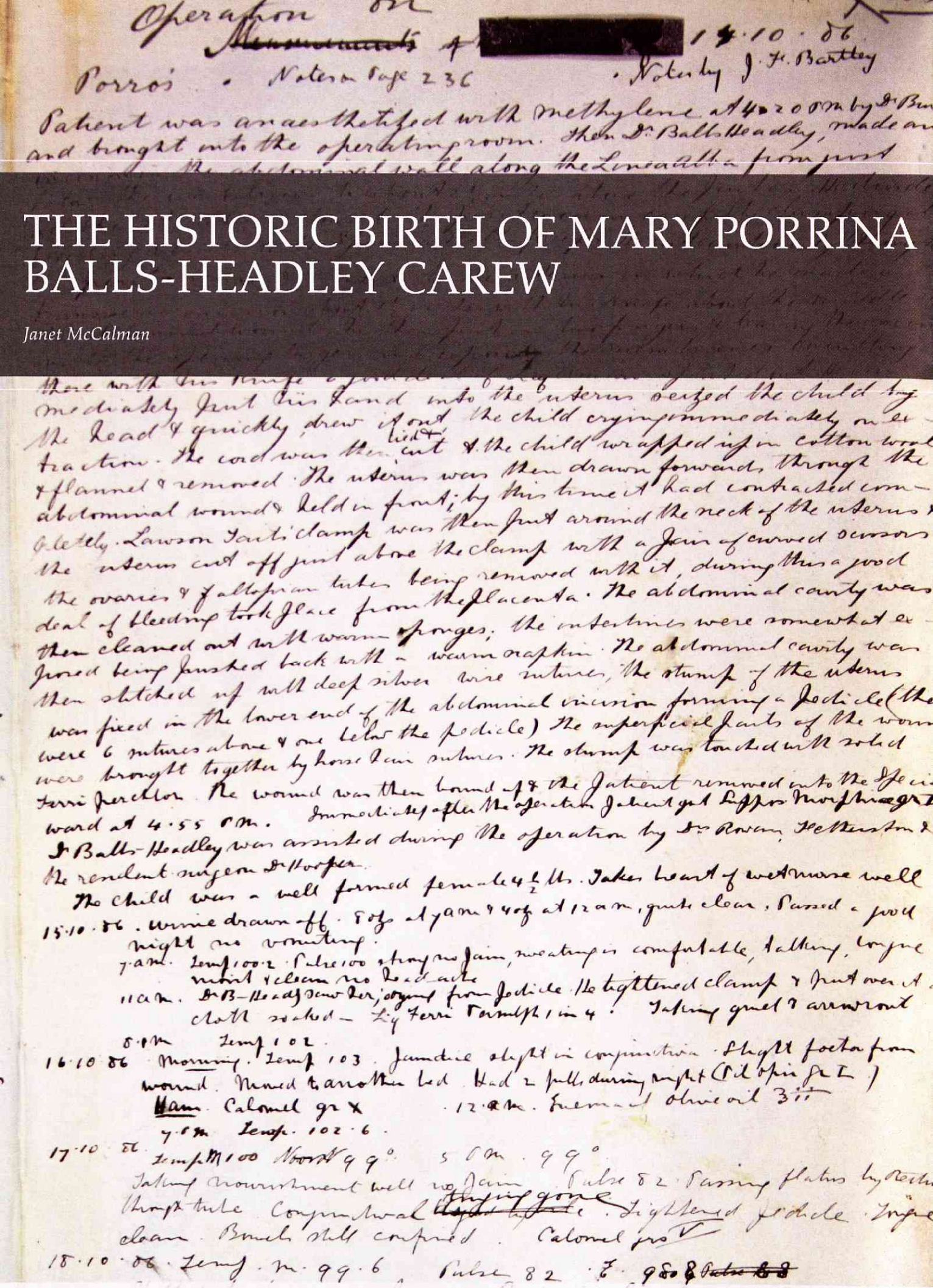
Melbourne gained its first professors of medicine and surgery in 1955, but their hospital responsibilities were limited to their own units. Burgeoning development of specialties in medicine and surgery subsequently evolved from professorial clinical departments linked with research. Gradually, clinical departments in medical schools evolved across the country.

Following the *Wills Report* in 1999 with enhanced funding through the NHMRC, medical research in Australia boomed. The *Grant Report* in 2004, however, raised serious questions about the research interface with health services. In Canada, Britain and the Netherlands, similar questions had led to well-funded initiatives which made research central to the life of hospitals. Despite important recent steps by the NHMRC to enhance support for clinical research, with the establishment of centres of excellence and clinical fellowships, gaining acceptance of the role research must play in every major hospital remains a fundamental problem.

Recent research advances in biomedical science and information technology offer great potential to transform the delivery of health care in our hospitals. At such a time as this, partnerships between hospitals and medical schools which reinforce the teaching hospital environment as one enriched by research, must be carefully nurtured and strengthened.

THE HISTORIC BIRTH OF MARY PORRINA BALLS-HEADLEY CAREW

Janet McCalman



Dr Balls-Headley's Case Book, 1886

Professor Janet McCalman is a professor at the Centre for Health and Society and in the History and Philosophy of Science program in the Faculty of Arts. Among her award-winning books is her history of the Royal Women's Hospital, *Sex and Suffering: women's health and a women's hospital*, (MUP 1998).

On 14 October 1886 Mary Porrina Balls-Headley *Carew* was 'untimely ripped' from her mother's womb. She 'cried lustily' and was 'immediately wrapped in a flannel' to be despatched to a wetnurse. She was 'well-formed', weighed 4½ lbs and took the breast well. This little girl with a very long name was the first born by caesarean section in the Women's Hospital, Melbourne, and her name celebrated the medical achievement of her mother's surgeon, Walter Balls-Headley (1841-1918), and of the Italian, Eduardo Porro (1842-1902), whose technique had ensured its success.

Mary's mother, Kate *Carew*, had been born with achondroplasia and stood just 3'10" (117cm) tall. The hospital was told that she was 17, but she was barely 16 at the first consultation in July. Kate, herself, was so terrified and distressed that she refused to speak and provided no history. She was stripped naked and photographed, measured all over and subjected to a pelvic examination that revealed that her *conjugata vera* was just 1½" (3.81cm). Her prognosis was dire. She would either die undelivered in agony, or be subjected to a destructive operation which would endeavour to perforate and crush the skull of her baby, decapitate it, then dismember the limbs so that all could be slowly extracted in pieces through a perilously small pelvic space. Not only would she certainly lose her baby, she might well lose her own life.

The 'caesarean' section does not date from the birth of Julius Caesar and its nomenclature remains a mystery. Nor are there many credible stories in the European tradition of women surviving the surgical removal of a living baby direct from the uterus. The operation was a last resort to save a living child from a dying mother, although there were reports of successful operations being observed outside Europe. One case was recorded in Uganda in 1879, where the patient was anaesthetised with banana wine, which was also used to clean the healer's hands. The healer made a mid-line incision, extracted the infant, then massaged the uterus to make it contract. The external abdominal wound was sutured with iron needles, and dressed with a paste prepared from roots. Similar operations were observed in Rwanda.

The problem was always the clean closing of the uterus so that it could heal. Dr Balls-Headley's colleague at the Women's Hospital, Dr Gerald Fetherston, had lost a patient in June 1886 whose fulminating cervical cancer made delivery of her eighth child impossible. She almost died on the operating table, but rallied, and after ten days of special nursing, with the external wound healed, was almost ready to return to the ordinary ward when she suddenly collapsed, dying nine hours later. The post-mortem revealed that the uterine wound had not healed at all and had turned gangrenous.

Most women who had to undergo a destructive operation for an obstructed labour, survived the ordeal, some of them more than once. Jane Mackie, for instance, recovered after a craniotomy and a crushing of the foetal head that took two and a half hours on 23 August and was discharged on 6 September. But Kate *Carew's* pelvis was too small and malformed for even this. She was fortunate, then, to be a charity patient in the hands of Dr Balls-Headley, considered the leading gynaecological surgeon of his time in the colony.

Walter Balls-Headley was one of the few Englishmen on an honorary staff of the Women's Hospital that was otherwise Scottish, Irish or native born. He was the only one to be ranked 'a gentleman' by a listing in *Burke's Colonial Gentry*. Educated at Cambridge he was destined for a distinguished London career when, while travelling in the Middle East as the personal physician to the Marquis of Bute, he began spitting blood and his tuberculosis became evident. He became one of a number of gifted men forced to emigrate for the sake of his health, first trying Queensland before setting up practice in the top end of Collins Street, Melbourne, in 1875. He quickly made his mark as an authoritative physician and an especially deft and neat surgeon. He was on the honorary staff of the Women's Hospital from 1878-1900, and lecturer in obstetric medicine and the diseases of women and children at the University of Melbourne from 1889-1900.

Balls-Headley was a medical intellectual, who published frequently and wrote the first scholarly book on gynaecological medicine in Australia: *On the Evolution of the Diseases of Women* (London 1894). He was a disciple of Herbert Spencer, the creator of the term 'survival of the fittest', and held bleak views of the fate of womankind. His remedy for the climbing maternal mortality rate in the 1880s was that the hospital should admit a better class of patient; he argued that the wounds, prolapses and infections that crippled childbearing women were nature's 'wise provision' against over-population; he blamed many women's sufferings on the improvidence and irresponsibility of their husbands. Like many medical men of his generation, his ideas remained a strange blend of constitutionalist and contagionist traditions with modern techniques and discoveries. He tried Listerism, but abandoned the practice of the carbolic spray as more trouble than it was worth, and not as good as strict 'cleanliness'. He fought hard for a new building for the midwifery department as the remedy for infection rather than changes to practices such as antiseptic midwifery. He did, however, return from a European tour in 1887, to advise that hospitals abroad were doing very much better now that they disinfected hands, bodies, instruments and patients and kept records of who touched whom, thus finally vindicating his local antagonists, such as Dr James Jamieson.

But when the terrified Kate *Carew* stripped before him on 7 July 1886, she was in safe but conservative surgical hands. She was carefully measured and the foetal heart was heard. The foetus' position was estimated, and it was resolved that she would be readmitted when she was supposed to be between eight and nine months gestation. Kate went home to Euroa to wait for her time.

When the time came to operate, Balls-Headley decided that the safest course was to use Eduardo Porro's technique where the uterus was removed and a pedicle left outside the body where it could be kept clean as it sloughed. Three honoraries assisted, as did the resident surgeon, Dr John Dunbar Hooper. Eight others watched. The incision was four inches, vertical between the umbilicus and the pubes. The bulging membranes were opened and the head expelled by the 'considerable uterine contractile force, and some external pressure around it, through the opening which was just large enough to let it squeeze through'. Mary was born:

> The hand then grasped the neck of the uterus, and Lawson Tait's uterine clamp was adjusted below the level of the opening of the ovaries and fallopian tubes. At this time the placenta was seen to be presenting at the uterine opening, and to be free from the neighbourhood of the neck, where by auscultation, it had appeared to be attached. A sound was introduced into the bladder, and as it appeared not to be included in the clamp, the latter was tightened up. The uterus was then cut away with scissors an inch below the level of the transverse incision, the abdominal cavity cleansed, and closed by six silver sutures above the stump, and one below it, and intervening horsehairs; the stump touched with solid perchloride of iron, and a strip of lint applied under the ends of the clamp wire, carbolic absorbent cotton over all, followed by Mead's plaster and a flannel bandage. There was practically no haemorrhage, except a little free bleeding when nicking the uterus, and what escaped from the uterine division after its constriction.[1]

Kate was removed to the special ward, given a suppository of morphine and closely watched. The next day at 11 am, Dr Balls-Headley visited, tightened the clamp on the pedicle and changed the dressing and Kate was able to take gruel and arrowroot. On the 16th her temperature rose to 103°F, jaundice and a slight foetor indicated a wound infection. She was treated with purgatives to deplete and 'quieten' her system, and the next day she improved a little. The fourth day she was nauseous, so the food was stopped, but she was cheered by a visit from her mother. The pedicle was sloughing nicely. She had just one more bad day and night, and by the 20th, her temperature began to fall. A fortnight after this major abdominal surgery her temperature was normal, the pedicle was dead and could be cut off, she was in no pain and her signs were normal.

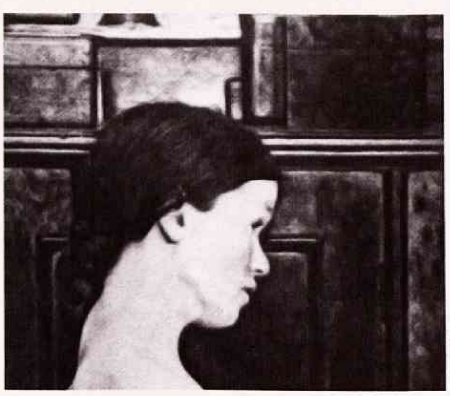
Balls-Headley's decision to use the Porro operation was characteristically conservative. We have no record if Kate gave consent to losing her womb (some of Dr Balls-Headley's colleagues were exemplary in seeking consent for the sterilisation of patients). Nonetheless, Kate could not afford to fall pregnant again. Braver surgeons had in fact attempted less drastic procedures. The late Frank Forster, in an elegant short history of the caesarean in Australia, discovered that the first caesarean was performed in Ballarat in 1872 by Dr Thomas Hillas, who closed the uterine wound with silver-wire sutures—a very early use of the technology. The patient, an unmarried Irish woman, Mary McCarthy, had been admitted to the lying-in ward of the Benevolent Asylum, until it was decided that she was not pregnant and was transferred to the Ballarat Hospital for surgery for an ovarian cyst. However, the operation revealed both a 13 lb ovarian cyst and 11 quarts of fluid and a gravid uterus. The cut in the uterine wall was extended to 5" (12.7cm) so that the placenta and the foetus could be extracted. The baby was alive and almost to term, but there is no record of whether it lived for long after birth. Mary McCarthy, however, was able to leave the hospital, perfectly well, three months later.[2]

The next two recorded cases (1881 and 1884) were both in NSW and resulted from surgery for an ovarian cyst that revealed a pregnancy. In the first the patient did not survive; in the second, a Porro's operation probably saved the patient.

The first planned caesarean section in Australia was undertaken by Dr John Cooke, at Melbourne's Alfred Hospital, on a 43-year-old mother of ten, who suffered from advanced cervical cancer. Cooke performed a classical caesarean section of a mid-line incision between the abdominal and uterine walls. After the baby and placenta were removed, the uterus was washed out with carbolised water, a drain was inserted and the 5 inch uterine incision closed with four carbolised silk sutures. The little girl weighed 7 lbs and was discharged well only to die soon after from gastroenteritis. Dr Cooke announced his significant achievement in *The Herald*, but his colleagues accused him of unprofessional conduct in advertising his skill. He continued to practise at the Alfred until his tragic death in 1913 from trying to board a train.

Dr Balls-Headley did enjoy his success with Kate *Carew's* case, having observed the proprieties of professional conduct and peer consultation. The first publication of the case in fact appeared in *Speculum*, the medical students' journal, and in the *Australian Medical Journal*. Balls-Headley's later article was baldly titled: 'Case of Porro's Operation on a Ricketty Dwarf—recovery'.[3]

The more significant surgical achievement in the Women's Hospital, however, belonged to Balls-Hedley's younger colleague, Michael U O'Sullivan, who performed the first conservative or classical operation on 28 May 1889. The mother had a contracted pelvis and the operation ensured that both mother and baby survived. O'Sullivan was as



The 17-year-old Kate Carew (a pseudonym), from the photographs taken at her first consultation (left) and after her caesarean.

strong in his religious convictions and medical theorising as Balls-Headley was in his medico-philosophical speculations. He was committed to advancing the technical ease and safety of the caesarean section because, as a Catholic, he could not countenance destructive operations. He also held strong views on the natural basis of health—that gynaecological ills were inflicted on those who departed from the laws of nature by practising birth control or induced abortion. He was not alone, however, in the medical fraternity for finding it inconceivable that reproduction could, of itself, undermine the health of women. Rather, the scandal of so much sickness in women under the age of forty was because they 'offend against the laws of nature by deliberately impeding their sexual organs in the due discharge of their allotted functions'.[4]

O'Sullivan was a brilliant gynaecological surgeon and for that 1889 caesarean section, he listed the most important components: (i) the turning of the uterus out of the mother's abdomen; (ii) constriction of the cervix with an elastic band; (iii) the use of a continuous suture of antiseptic catgut for the uterine wound; (iv) keeping the lower end of the uterine incision in the upper uterine segment. Thus, the uterus was 'meticulously repaired' and saved.[2] As Forster noted, the first such Sänger classical operation in the United Kingdom had been performed only the year before. The Americans were even further behind: the first Porro's operation in the US would not be performed until 1891 in Texas. Australian doctors may have been geographically on the periphery, but connected by shared international training, travel, scientific meetings and, above all, scientific literature, they were intellectually members of the metropolitan medical world.

Caesarean sections would not become routine for another half century and only with the introduction of safe blood transfusions were they contemplated with equanimity. Surgeons at the Women's Hospital remained conservative in their preference for mid-line incisions rather than lower segment operations that offered the chance of a second pregnancy with less risk of a rupture of the uterus. They have since been condemned for their reluctance to perform caesarean sections on unmarried patients in the 1950s and early 1960s, lest it affect their chances later in life of marriage and a normal birth. As a result, unmarried adolescents were at times condemned to labours of horrifying duration and suffering. Not until the 1960s and the wave of reform that brought a more assertive clientele to the hospital, did the caesarean become a preferred option over high forceps or heroic labours. The 'destructive instruments' remained part of the armamentarium of the Royal Women's Hospital well into living memory.

When Kate *Carew* returned to the hospital for her operation in October 1886, she seemed happier and the nursing notes contain hints that she began to form relationships with her carers—perhaps not with her surgeon, but certainly with the resident surgeon, Dr John Dunbar Hooper, and the nurses who cared for her. She owed her survival as much to them as she did to Dr Balls-Headley, for all survivors of late nineteenth century operations faced a long, closely-nursed convalescence after the anaesthesia wore off that, more often than not, involved a heroic battle with post-operative infection. By the 1880s, however, nursing and medical care had undergone a revolution: not so much in surgical cleanliness, but in the detailed practice of supporting the body and mind so that the natural healing powers could do their work. The success of these early caesarean sections therefore lay not just in the courage and precision of the surgeons, but in the hours of tender nursing that, over weeks, coaxed the sufferer back to health.

On 7 December 1886, Kate *Carew* was discharged 'perfectly well' and returned to Euroa, where 54 years later she died, still unmarried. As for little Mary, it seems that she did not go home with her mother, but disappeared into the complicated network of fostering and adoption that awaited babies whose mothers were either unwilling, unable or considered unfit to take them home. Despite her good start, the odds were against such a small baby surviving infancy. Mary Porrina Balls-Headley *Carew* disappeared into history.

Infirmary medical and nursing staff of the RWH, c. 1890. Back: Dr GH Fetherston, Dr Walter Balls-Headley, Dr RH Fetherston, Sister Pat Waters, Dr Stephen Burke, Dr Thomas Rowan, Front: Miss Findlay (matron), and Dr MU O'Sullivan. Photo courtesy RWH archives collection.

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A WIRE FROM SIR LANCE

Ann Brothers

The Pyrox wire recorder which sat in a cupboard in the Department of Obstetrics and Gynaecology at the Royal Women's Hospital for over 50 years before it was discovered and found to still hold a recording of Sir Lance Townsend's inaugural professorial lecture

A physiotherapist for over 20 years, Ann Brothers broadened her career path in 1987 with a history degree (Hons) at the University of Melbourne, followed by a graduate diploma in museum studies. She then worked for some years at the National Gallery of Victoria before taking up a Harold Wright Scholarship, in 1992-93, studying the history of printmaking and carrying out research in the print room of the British Museum. Returning to Melbourne, Ann became a curator at Museum Victoria engaged on exhibitions in the Human Mind and Body Program in conjunction with the Department of Anatomy and Cell Biology. Ann has been curator of the faculty's Medical History Museum since 2000.

In 2002 I received a call from Lucy Battistel, in the Department of Obstetrics and Gynaecology at the Royal Women's Hospital who, aware of the importance of safeguarding items of historical interest, had discovered an old Pyrox wire recorder, purchased by the department in 1948.

Mrs Muriel Johnstone-Need, former secretary to James Walter Johnstone (then acting professor in the department) recalls that the equipment was used to record lectures and messages left by visitors and was a, probably rather expensive, but innovative and impressive piece of office equipment. It was thought that the wire might have recorded the voice of Professor Lance Townsend when he was head of the department (1951-77) and hand winding the spools of the recorder, no longer in automatic working order, confirmed that this was the case. The problem now was whether anyone could be found with the specialist knowledge required for the repair of a wire recorder, and the skills to save the recording in a more secure format.

As sometimes happens, just this person was found, here on the Parkville campus, in Peter Liddelow, technical manager of music information technology in the Faculty of Music. Peter confessed his interest in the history of recording technology and, moreover, had seen one of these devices being serviced while working for the Pyrox company in the 1970s! Peter was prepared to tackle the restoration in his own time and, in due course, took delivery of one extremely heavy 'portable' recorder. Funding required for this work was made available through a successful submission by Lucy Battistel for assistance from the History of the University Unit.

The repair of the equipment, and the resulting compact disc recording of the voice Peter rescued, revealed that here we did indeed have something of historical value. It restored to us, in its entirety, Professor Lance Townsend's inaugural address, given on 9 August 1951, when he took up his appointment as chair of the newly established Department of Obstetrics and Gynaecology at the Royal Women's Hospital. The recording of his address, 'Obstetrics through the Ages' lasts for almost 49 minutes. (A five minute fragment of a lecture on uterine cancer given by Graham Godfrey was also discovered and transferred from the wire.)

Although the address was published in the *Medical Journal of Australia*, in April 1952, Lance Townsend's steady voice, coming across the span of 56 years, communicates in a very direct and personal way beyond that of the written word. The compact disc also provides a more reliable mode of delivery than the original wire, which at the first jump of the winding spool might just as easily deliver a tangled mass of fine piano wire, as the voice of the professor!

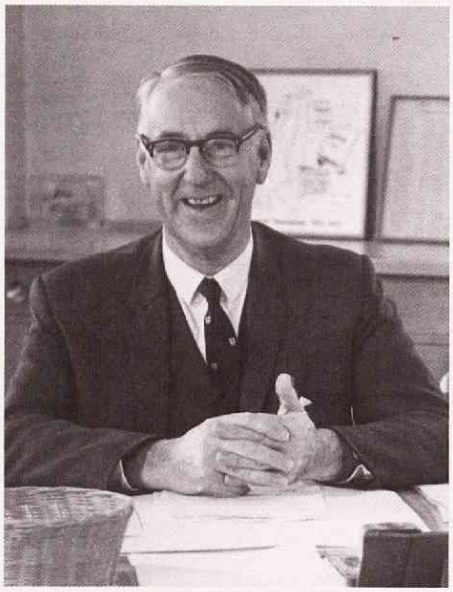
Whilst Lance Townsend's paper can be read in full in the *MJA*, we might briefly consider some aspects of what he covered. He commences his history of obstetrics with the biblical quotation which provided him with the key note for his paper and for the development of his argument. The quote, from the Book of Genesis, established for generations the fate of women in childbirth, 'that they bring forth their children in sorrow'. The necessity for this Lance Townsend refutes, step by step, as he traces

improvements made in the management of cases of un-natural labour and difficult childbirth to the present day (then 1951). Throughout history, he observes, human birth has always engendered alarm and sympathy, out of which grew the first efforts in the art of midwifery.

Although assistance to the labouring woman was (presumably) first rendered by women, offering such kindly services as natural childbirth required,' Townsend is also quite interested in the role that men played in the process. Whilst in the early period, men were probably largely indifferent, or at best passive witnesses to the baby's entry into the world, Sir Lance is obviously quite intrigued with a later development. This was the practice of 'couvade' (related to the French word today meaning brooding or hatching), a curious practice whereby, after delivery, the man went to bed for varying periods with the baby, whilst the woman carried on with her work. Fortunately such 'baby bonding' is not [so widely] practised in this way today.

Gradually, assistance became the role of someone wisely regarded in the community and given the status of midwife. Based on repeated observation, there seemed to be obvious things that could be done to help, but without the benefit of scientific knowledge, especially in cases of difficult labour, 'knowledge' more likely resulted in harmful practices that threatened the lives of mother and child. Some of the misinformation can sound amusing today but might easily have been harmful, or at best ineffective. For example, as the onset of labour was thought to be the voluntary act of the child anxious to escape the confines of its quarters, offers of food could be made to coax a child out, and pounding of the abdomen, or surpising by fright, were practised in other times and places (although we are not provided with these references). Caesarean section was performed from ancient times, but only on the dead or near dead mother, and was occasionally 'successful' in that some babies survived.

Townsend acknowledges things took a turn for the better from the sixteenth century, though women had yet to survive interference in what might have been a



Lance Townsend in his office at the Royal Women's Hospital in 1972

normal or successful delivery, wrought by superstitious practices, harmful medication, damaging instruments and the foul conditions of damp dark rooms, soiled linen, and dirty unwashed hands. Conditions proved equally dangerous in nineteenth century hospitals, where we know that women contracted puerperal fever and died from infection spread through the agency of examining fingers. It is truly an often miserable history for women, spelt out in ignorance and harmful interference.

Lance Townsend's heroes were to be found with the great expansion of human knowledge in the Renaissance, commencing with Ambroise Paré, who wrote on internal version and on induction in situations of haemorrhage before childbirth, followed shortly after by Andraeus Vesalius, whose first 'modern' illustrated book on anatomy gave a clear and accurate picture of the structure of the pelvis and its organs. Next, in the eighteenth century, was William Smellie who described the mechanism by which the baby's head moved through the maternal pelvis, and was thereby able to modify the straight forceps hitherto used to deliver the infant's head by the addition of a pelvic curve. William Hunter followed with his *Anatomy of the Gravid Uterus*, Semmelweis and Pasteur with their understanding and prevention of puerperal fever, and Lister, whose work on antisepsis made possible surgery never attempted before. Anaesthetists like James Simpson provided the next step in safe surgical procedures, and in the late 1800s Sanger laid down his sound principles for an operation that saved the uterus after the high incision for caesarean section then practiced. Then, in 1912, Latzko suggested the low uterine incision that is used today. Women were now surviving even emergencies in labour.

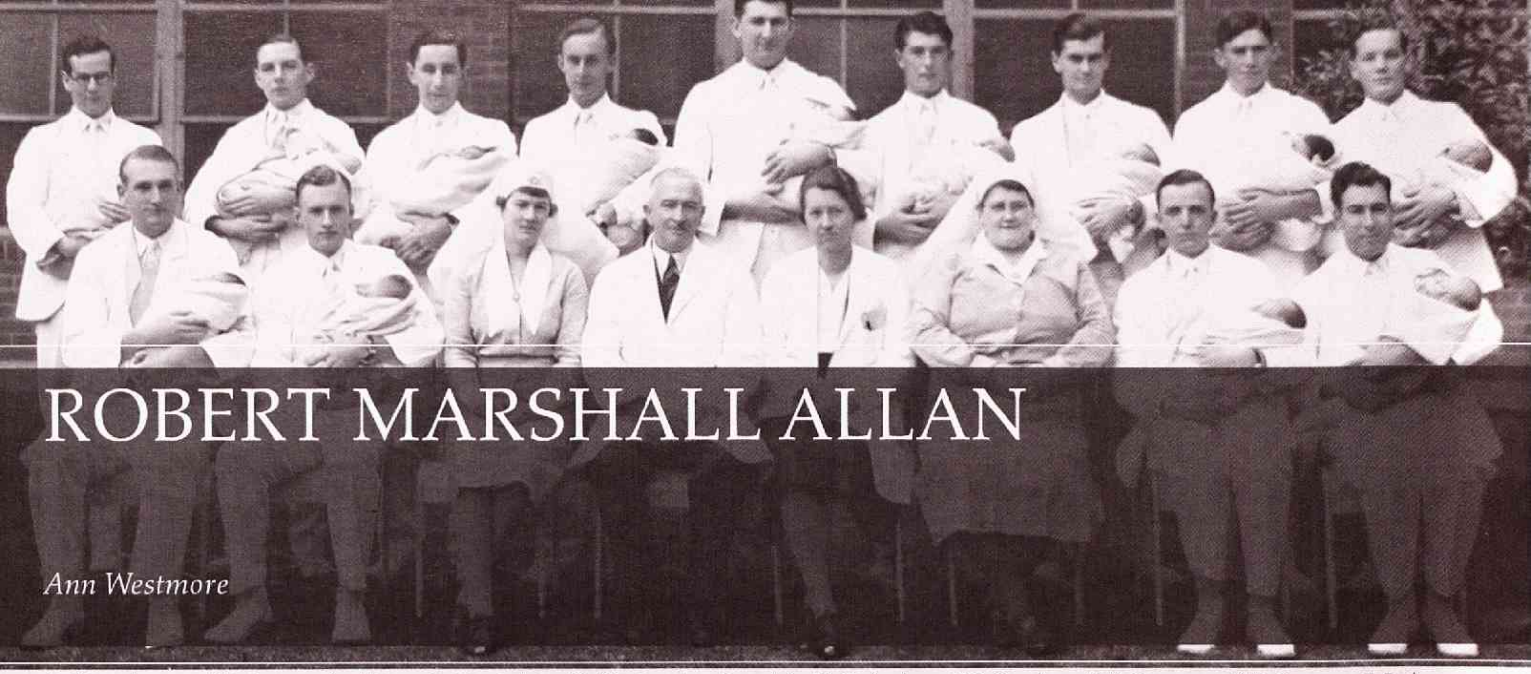
Although Sir Lance wrote his paper over 60 years ago, he made an important observation of what has become a widespread concern today, that:

> The lowering of the maternal death rate for caesarean section [to about 1% in 1952], has brought a regrettable tendency to resort to operation for the relief of each complication of labour, and to use a surgical rather than obstetrical approach to the problems. The high percentage of abnormal deliveries seen in hospital, the constant resort to interference, and the limited opportunities offered to students to observe normal labour, all combine to obscure the fact that nature is the best obstetrician. Smellie's principle still holds—unnecessary interference increases the maternal risks.

Sir Lance fully acknowledged, of course, the value of caesarean section over the forceful delivery in cases where normal delivery was impossible, or where mutilating operation on the live child was once necessary, and saw it as one of the greatest advances in this [his modern] epoch. Through this procedure not only had maternal mortality been reduced, but many babies' lives had been saved.

As to the Golden Age of Obstetrics, Lance Townsend looked to the future when the hazards of childbirth for mother and baby would be very small. Then we could challenge the expectations delivered in the Book of Genesis, and truly be able to say that 'a woman bringeth forth her children in joy'.

The Medical History Museum is part of the faculty's Johnstone-Need Medical History Unit and is located on level 2 of the Brownless Biomedical Library at the University of Melbourne Parkville campus. It is open to visitors from 9am to 5pm Monday to Friday. More information about the museum can be found at: www.chs.unimelb.edu.au/programs/jnmhu/museum



ROBERT MARSHALL ALLAN

Ann Westmore

Staff, students and babies at the Women's Hospital in 1942. Standing from left: FP Callaghan, DC Cowling, KW Summons, WE Swaney, T Early, HM Shaw, WG MacGregor, IM Tulloch, EW Bate. Sitting from left: GP Cromie, PR Bull, Sister E Stewart, Professor R Marshall Allan, Dr MA Mackie, Sister M Morrison, WA Cooper, MJ Etheridge. Photo courtesy RWH Archives.

Ann Westmore has worked in science journalism for the *Herald and Weekly Times*, and as a freelance medical and science writer. She has received awards for her medical writing from the Australian Medical Association and the Royal Australian College of Ophthalmologists. She is a research fellow in the Johnstone-Need History of Medicine Unit and is currently completing a book on the history of psychiatry in 20th century Victoria. Her commitments include the online historical compendium of the Faculty of Medicine, Dentistry and Health Sciences and the Australian Witness to Science and Medicine seminar program that began in 2003.

Surprisingly, the first University of Melbourne clinical chair was not in medicine or surgery, but in obstetrics. Created in 1928 with the help of a £20,000 donation from the Edward Wilson (*Argus*) Trust and government financial support, the chair's establishment probably involved some interstate rivalry. Sydney University had established a chair in obstetrics in 1925 but, being full- rather than part-time, the Melbourne chair could claim greater status than its Sydney counterpart.

The first incumbent, Robert Marshall (known as 'Marshall') Allan, had a solid reputation by the time he was appointed. Born in Brisbane in 1886 and schooled in both Brisbane and Sydney, Allan trained at the Edinburgh Medical School to graduate in 1910 with honours and the prestigious McCosh travelling scholarship. After six months residence at the UK's largest obstetric hospital, the Rotunda in Dublin, he toured major European centres, studying obstetrics, gynaecology and gynaecological pathology.

In 1911 he was appointed assistant master at the Rotunda, under the highly regarded Henry Jellett. By the time he returned permanently to Australia in 1919, he had taken turns in overseeing the Rotunda's obstetrics and gynaecology wards; taught students, nurses and postgraduates; undertaken research on pituitary extract in labour, for which he was awarded an Edinburgh MD in 1914; and served in the Royal Army Medical Corps and the Australian Imperial Force, winning the Mons Star medal and the Military Cross.

After practising obstetrics and gynaecology in Brisbane for some years, he successfully applied in 1925 for the newly-created position of director of obstetrical research for Victoria and, over the following years, amassed comprehensive data on the causes of maternal mortality and morbidity. In a 1928 report he detailed the contributions of infection (said to be responsible for 44% of puerperal deaths): pre-eclampsia and eclampsia (18%), haemorrhage (12%), accidents of labour (10%), ectopic pregnancy (4.5%) and abortion (4.2%). He found that cross-infection was rife due to inadequate sterilisation in 60% of public and private hospitals, the mixing of obstetric patients with medical and surgical patients, and too few isolation wards. The situation was worst in metropolitan Melbourne. One of the report's prime recommendations was the creation of a chair in obstetrics to improve the education of doctors about maternity care, to encourage research and lift the stature of the field.

Allan had the inside running on the chair and support from leading obstetrician, Dunbar Hooper, but some senior faculty members argued that the position should be advertised worldwide. In the end he was appointed to the chair based at the Women's Hospital and, simultaneously, state director of obstetrics. During the next 17 years he oversaw a major reduction in maternal mortality from 5.6 to 1.5 per 1,000 births, and a halving of neonatal deaths from 30 to 15 per 1,000 births. He also served as dean of the Faculty of Medicine (1944–1945), relinquishing the post after the first of a series of heart attacks that eventually claimed his life in July 1946.

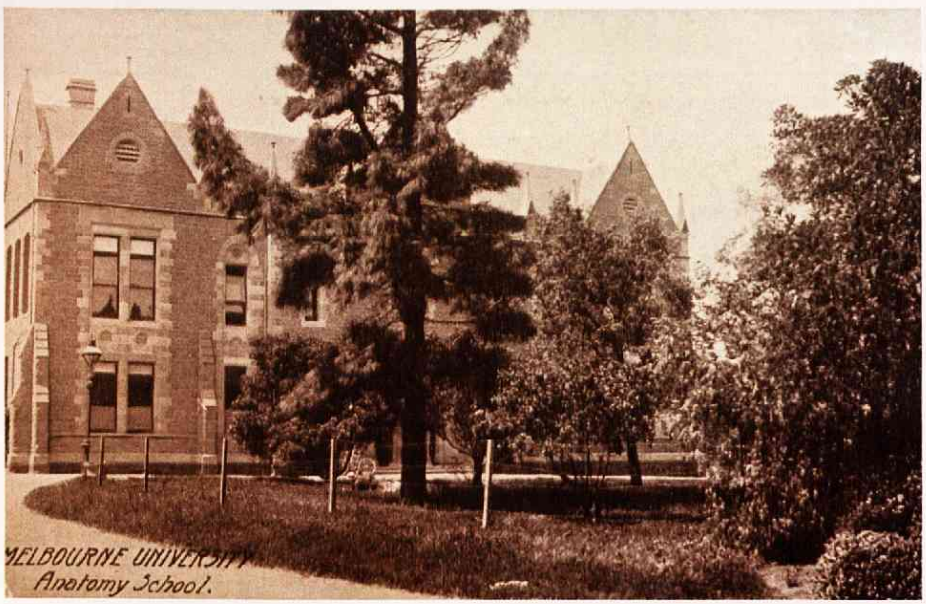
In 1951, after a long delay, Lance Townsend was appointed his successor and the chair was renamed for obstetrics and gynaecology. Thus, Allan was not only the University of Melbourne's first clinical professor, but also the first clinical professor to become dean and the first and only professor in obstetrics.

HUMANITY'S MIRROR:

150 YEARS OF ANATOMY IN MELBOURNE

Ross L Jones

On 31 July this year, the Department of Anatomy and Cell Biology celebrated the launch of *Humanity's Mirror: 150 Years of Anatomy in Melbourne* by the Governor, Professor David De Kretser, at the Mind and Body Gallery of the Melbourne Museum. As an introduction to the wealth of interesting material and entertaining stories to be found in Humanity's Mirror, we reproduce here some reflections made at the launch by the book's author, Dr Ross Jones, research fellow in the Department of History and Philosophy of Science and senior fellow in the Department of Anatomy and Cell Biology.



School of Anatomy c. 1910

Many remarkable individuals take the stage in the history of anatomy at Melbourne University and I am delighted that so many are present tonight. Who are those with the longest memories of the department? Many knew Sydney Sunderland. A number are present who had the privilege of hearing Wood Jones lecture in the 1930s. None that I know of can count themselves as students during Richard Berry's reign as professor. In fact, the oldest individuals here tonight predate even Berry, as they are from the era of the establishment of the medical school in 1862. I speak not of guests but of the gorillas in the glass case at the end of the corridor. They were the subjects of the first public controversy surrounding the teaching of anatomy in Melbourne—a controversy central to the very question of what it meant to be human. In this episode they also became the subject of perhaps the first internationally reviewed medical research project conducted in this university. The gorillas are important in a number of ways. They represent the very public face that the study of anatomy has had in the history of this city. Perhaps more importantly they represent the very diverse and fascinating areas of human endeavour and ideas that have been the subject matter of Melbourne's anatomists. The fourth professor of anatomy, Frederic Wood Jones, highlighted the reason for this in a speech in Adelaide, in 1923. He began, remarking that the community of scholars at a university expected less of a professor of anatomy than virtually anyone else. He said:

> So long as the Anatomist is acquainted with the structure of the human body, as a cabman knows the streets of the city in which he plies for hire … but little more is asked of him …

However, in one of his typical rhetorical ripostes, he then went on to argue that anatomy 'is in fact the father of the physiologist, of the embryologist, the histologist and the anthropologist.' In today's department this list is greatly extended.

The intellectual flexibility and all consuming curiosity of so many of Melbourne's anatomists is the reason the history has been an absolute delight to write. Flexibility is also the reason for the continuing survival and success of the department in a climate where the study of anatomy has been under intense scrutiny.

I think most here know the famous photograph of Halford and the anatomy class in 1864 that adorns the front cover of the book. What is less commonly known is that the group who attended the first dissection class in Halford's back shed in his Swanston Street home in 1863 contained no anatomists. It consisted of a physiologist (George Halford); a gynaecologist (GH Fetherston); a poet of very considerable talent (Patrick Moloney); a theatre critic, (JE Neild); and a future Presbyterian minister (Alexander Mackie)—an eclectic mix if ever there was one. This anatomy department has never been just a place for the dissection and mapping of the human body, however important that is. It has housed many men and women of high talent with an extraordinary range of interests.

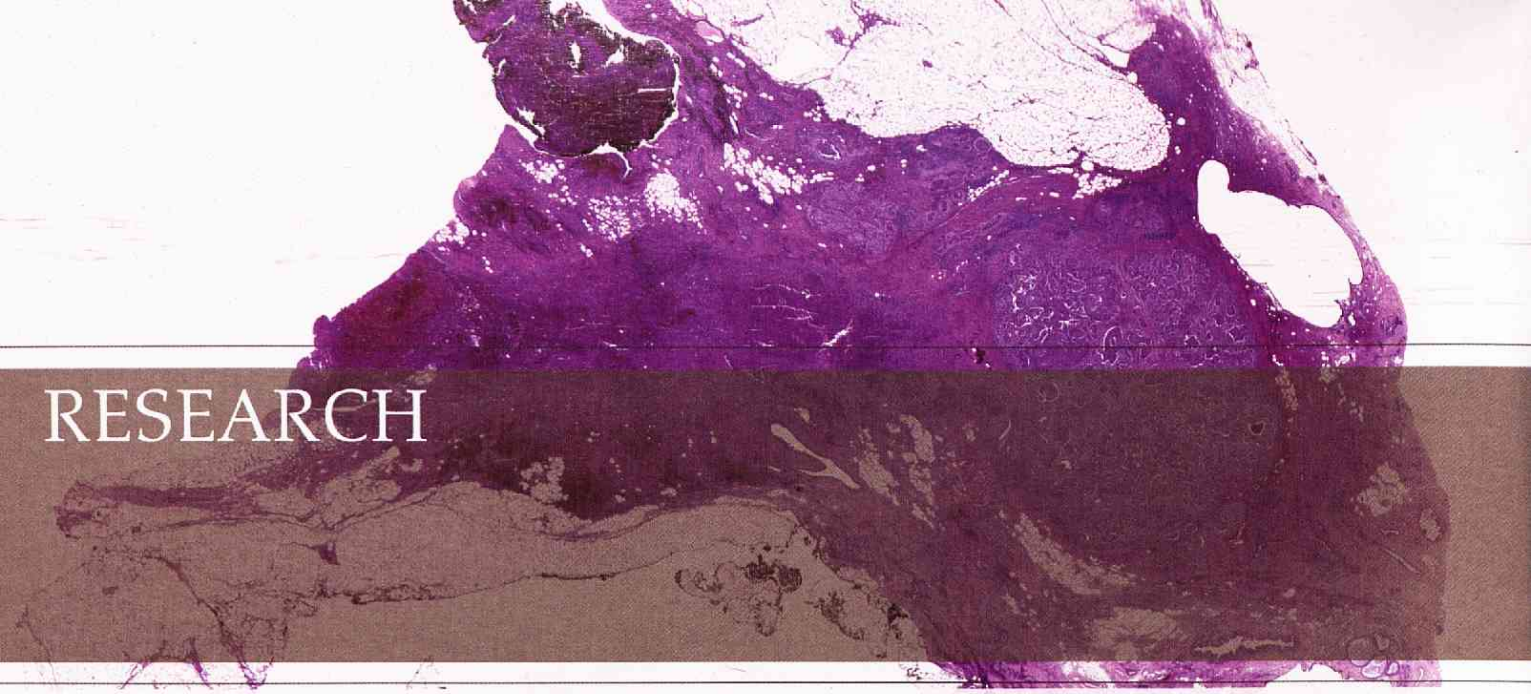
I wish to finish with a dedication to all the past students of the department. A reader will notice that many past students are represented in the history, mainly through the pages of *Speculum*, the medical students' magazine. Mostly they are poets. Mostly they are anonymous. One name that is known is that of John Charles Campbell, who graduated in 1910. He wrote the words to the 'Song of the Meds.'

> We'll cut off limbs for pastime—
> We're used to cutting work
> We'll probe down deep where microbes creep,
> And dread diseases lurk;
> And folk shall shout our praises
> Across all lands and seas,
> Who owe their lives to our deft knives,
> And also owe their fees.
> And old men shall grow frisky,
> And young men cease to sigh,
> And all folk will live on until—
> Well, just until they die.

Copies of Humanity's Mirror are available from the Department of Anatomy and Cell Biology or from the University of Melbourne Bookshop. To order a copy from the department contact Tricia Hartshorn on: 61 3 8344 5804 or go to: www.anatomy.unimelb.edu.au/aboutus/history_book.html

[1] *Wood Jones F. Life and Living, Kegan Paul, London, 1939.*

RESEARCH



Breast carcinoma. Image courtesy Veronika Gazdik, State Neuropathology Service, Department of Pathology

THREE PERSPECTIVES ON COLLABORATION

Melissa Southey

Associate Professor Melissa Southey heads the Department of Pathology's genetic epidemiology laboratory which she established in 2000. Genetic epidemiology focuses on population-based research, the joint effects of genes and the environment, and the incorporation of the underlying biology of the disease into its conceptual models. The laboratory is currently part of several large collaborative genetic epidemiological studies in conjunction with the Centre for Molecular, Environmental, Genetic and Analytic (MEGA) Epidemiology in the School of Population Health; and the Cancer Council Victoria's Cancer Epidemiology Centre.

Collaborative multidisciplinary research is increasingly necessary in the investigation of medical research questions. A growing number of scientific questions can no longer be addressed by single or small groups of researchers with limited resources and infrastructure. However, well designed and well resourced studies do not emerge overnight. Behind each collaborative publication are years, often decades, of planning and hard work to lay the foundations and establish the resources that will enable complex and broad research questions to be addressed and answered.

Melissa Southey in her laboratory

In the early years of my postdoctoral experience I set up and led the molecular diagnostic pathology laboratory at the Peter MacCallum Cancer Centre. One of its roles was to provide genetic testing in cancer predisposition genes for individuals referred from the Familial Cancer Centre. I have two powerful and lasting impressions of this period of my professional life: the limitations of the tools we used to try to identify individuals and families at elevated risk of carrying an inherited mutation in a known gene; and that, for the majority of referrals, we were unable to identify a genetic explanation for the family cancer syndrome. Clearly, large genetic epidemiological studies were required to address these issues in cancer genetics. Understanding the importance of these questions, and knowing how they could be adequately addressed, I went straight back to life as a full-time researcher and have never looked back!

Adequate laboratory-based expertise and support for biospecimen collections and molecular analyses are key elements of large genetic epidemiological studies. The Genetic Epidemiology Laboratory has the capacity to fully support the work of very large studies. The biospecimen repository section of this laboratory houses and manages more than 100,000 biospecimens that are part of national and international genetic epidemiological studies. The molecular section of the laboratory is structured and equipped to apply molecular genetic and molecular pathology analyses to our study resources in cancer genetics research.

Similar to other research areas, working within large collaborative research studies is absolutely occupying, and to thoroughly and appropriately engage is a full-time occupation. This is not a career that suits everyone. Successful collaboration is a fine art. Successful large scale international collaboration is, above anything else, time consuming. Luckily for Australians, time spent on teleconferences does not usually interrupt the laboratory-based work day. They are routinely held over breakfast, which throws up many challenges: participating in an international steering committee teleconference while preparing

Successful collaboration is a fine art. Successful large scale international collaboration is, above anything else, time consuming.

breakfast for a family, cutting lunches, finding lost pieces of school uniform and getting everyone out of the house on time.

Regular phone calls, however, cannot achieve everything and maintaining good collaboration involves face-to-face meetings. It is a privilege to have seen so much of the world while at work, although we are often faced with important discussions and making significant decisions without having had any sleep in the previous 36 hours. The fine art of collaboration becomes even finer under these conditions!

The size of collaborative studies is often paralleled by the size of the teams running them. These teams bring together researchers from a wide variety of disciplines and experiences which creates a most extraordinarily stimulating environment for research. Each discipline enriches and strengthens the collaboration but no one discipline can carry the studies alone. Individual contribution can be blurred into team productivity, which is highly desirable in the context of multidisciplinary collaboration. Open discussion and sharing of ideas is a recipe for progressive and well directed research questioning, and both research and researchers can really thrive in this environment.

In the early years of newly launched studies, during the period when the foundation work is being conducted, publications are rare (if achieved at all). This is sometimes in contrast to other researchers who use opportunistically collected research subjects and biological specimens and can publish small studies quickly and frequently. Foundation work can also be challenging as it usually requires the standardised collection of large amounts of data and biological specimens over a long period of time. It is during this period, when perceived rewards, acknowledgements and contributions to the field are low, that a network of supportive collaborators can be most beneficial.

Researchers who are most successful in multidisciplinary collaborative research are natural team players who can see beyond the early years of foundation work to their immense future value in addressing research questions. This is a particularly challenging aspect of this type of work as it is conducted within a professional culture that is predominantly driven and judged by publication, and by identifiably individual and independent leadership.

Collaborative multidisciplinary studies are now making regular and significant contributions to medical research, especially in the area of cancer research. This is evident in the increasing number of recent high profile publications that we and others have contributed to and led in recent years. Studies that definitively answer key questions and which can be readily translated into clinical practice are the reward. Increasingly, such outcomes cannot be achieved in any other way.

John Hopper

Professor John Hopper is the director of the Centre for MEGA Epidemiology and director of the Australia Twin Registry, which celebrates its 30th anniversary next year. He is an Australia Fellow and did his PhD in mathematical statistics. He has published more than 250 papers on the statistical methodology and its application for analysing twin and family data, addressing the genetic and environmental causes of variation in health-related characteristics. He is a principal or co-investigator on a number of case-control-family studies across a range of diseases and conditions, particularly breast cancer and colorectal cancer, prostate cancer, melanoma, childhood cancer and asthma. John Hopper explains how groundwork laid down in the 1990s enabled Melbourne researchers to participate in the international collaborative study, recent results from which were published in the article 'Genome-wide association study identifies novel breast cancer susceptibility loci,' *Nature 447, 1087-1093 (27 May 2007)*.

The main breast cancer susceptibility genes discovered to date (such as BRCA1 and BRCA2) have rare mutations that predispose women to a high lifetime risk of breast cancer. They were discovered by studying unusual families with multiple cases of the disease. Now a new set of breast cancer susceptibility genes have been discovered by using large scale epidemiological studies that compare typical cases with controls from the population.

John Hopper

These new genes have common variants which are associated with a small increase in risk. Their discovery proves that so-called cancer 'polygenes' exist. Risk of breast cancer varies greatly between women, and for most women depends to a large extent on their genetic make-up at many genes, perhaps hundreds, as well as some lifestyle and environmental factors.

Published in *Nature*, this research was the result of many years hard work, conducting more than 20 case-control studies across the world of over 50,000 women (half with breast cancer and half without) from whom a DNA sample was collected. Using new DNA chip technology, a genome wide scan of more than 200,000 markers was conducted on several thousand UK women. Successive analyses (phases I and II) reduced these to 30 high priority genetic markers that were then tested by the large international study (phase III), from which the five new breast cancer genes were discovered. This is the first time cancer genes have been discovered by this new epidemiological approach.

The current study was led by researchers from the University of Cambridge (UK). Melbourne researchers Associate Professor Melissa Southey, Professor Graham Giles, from Cancer Council Victoria, and I played a role through leading the Australian Breast Cancer Family Study (ABCFS) and the Melbourne Collaborative Cohort Study (MCCS) which together contributed data from more than 2,500 women.

These Australian studies are playing a major role in helping to clarify the roles of genetic and environmental factors on breast cancer risk.

Both the ABCFS and MCCS were established in the early 1990s as long-term genetic epidemiological studies, before the genes BRCA1 and BRCA2 were discovered, through funding from Vic Health, NHMRC and the Cancer Council Victoria. That foresight has now paid off because these Australian studies are playing a major role in helping to clarify the roles of genetic and environmental factors on breast cancer risk. The ABCFS was recently funded for a third time by the NIH for another five years, bringing the total funding from this overseas source to more than US$10 million. It has also been funded in recent years through the Victorian Breast Cancer Research Consortium.

Phases IV and V of this work have already commenced with other markers being tested by the large international consortium. The Australian studies have collected a large amount of epidemiological data from participants, and have extensive pathology data on the breast tumours. This will make them especially useful for the translational research now being conducted to find out how breast cancers in women with these new gene markers may be characterised, best treated and, if possible, prevented.

Louise Keogh

Dr Louise Keogh is a health sociologist, but first graduated in chemistry at the University of Western Australia. After working as a research chemist with a mining company, Louise retrained in social research by completing a master's degree in sociology at Monash University. She then pursued social research in health at the Centre for the Study of STDs at La Trobe University where she completed her PhD. Louise holds a (part-time) NHMRC postdoctoral training fellowship at the Key Centre for Women's Health in Society where she conducts research into the perception of risk for breast cancer, and the use of screening and genetic technology in the prevention of breast cancer. She collaborates with John Hopper and others at the MEGA centre and with Kelly Phillips at the Peter MacCallum Cancer Centre.

The Key Centre considers women's health issues in a social context. In order to interpret and understand women's health

Louise Keogh

it is necessary to understand the various social factors that play a role.

While John Hopper aims to interrogate and better explain the genetic basis of cancer, he does so with an awareness of the impact that his findings have on the delivery of health care, on the lives of at-risk women and the implications for public health. It is at this point that our research interests intersect. I am a health sociologist interested in how individuals make decisions about their health. I am specifically interested in how the factors which the lay person may weigh up in a health decision vary from those of their health care provider.

A better understanding of the genetic basis of breast cancer has obvious implications for individuals in a family with a strong history of the disease—to have a genetic test or not? And what to do about it if they do carry a mutation? It also has implications for the specialists involved in breast cancer treatment, and for public health practitioners involved in the prevention of disease. How do public health officials make recommendations for population screening when the levels of risk vary so dramatically within that population? Specialists treat breast cancer differently if it seems to be hereditary rather than sporadic, and may include the family in discussions about genetic testing sooner rather than later.

My postdoctoral fellowship aims to analyse some of these challenges in the dynamic context in which 'new breast cancer genes' are being discovered and where any news about breast cancer captures the headlines. I am undertaking a study of high-risk women's decision-making about screening and prevention of breast cancer. This is a qualitative interview study of women with a range of risks, recruited from the Australian Breast Cancer Family Study (ABCFS). Interviewing is nearly complete and I hope to be able to add to our knowledge about how this at-risk group perceives risk and make health decisions. An advantage of working with a sample is that hypotheses suggested from my qualitative study can be tested quantitatively in the larger population (ABCFS).

A better understanding of the genetic basis of breast cancer has obvious implications for individuals in a family with a strong history of the disease—to have a genetic test or not? And what to do about it if they do carry a mutation?

With John Hopper and Mark Jenkins from the MEGA centre we have looked at the uptake of genetic testing in the context of research studies. In the breast cancer study, 44% of those offered genetic information chose to have genetic testing and find out their results. In the colorectal cancer research study, 63% did so. I am interested in finding out more about this decision to undergo genetic testing, and what motivates those who choose to be tested and those who choose not to. Through taking a small sample of these populations and conducting an in-depth study, it will be possible to identify the things that enable a person to undergo genetic testing for cancer genes, and factors that act as barriers. It will also be possible to determine the differences between decisions to undergo genetic testing for breast cancer and genetic testing for colorectal cancer.

TREATING STRESS URINARY INCONTINENCE IN ELDERLY WOMEN

Margaret Sherburn

Margaret Sherburn is a lecturer and course coordinator for the women's health curriculum in the School of Physiotherapy. She also works in clinical practice, leading pre-natal exercise classes, and in a private continence practice. She recently completed her PhD, part of which has involved this recently completed NHMRC-funded clinical trial of conservative management of incontinence in older women. The clinical trial was undertaken under the supervision of Professor Mary Galea, foundation chair of clinical physiotherapy at Austin Health and director of the Rehabilitation Science Research Centre, Royal Talbot Rehabilitation Centre, and Professor Kari Bø, University of Sport & Physical Education, Norway.

Margaret Sherburn

This project was prompted by a high level of evidence for the effectiveness of pelvic floor muscle training (PFMT) in the treatment of stress urinary incontinence, but scant evidence of its effectiveness or otherwise in the elderly.

A systematic review of studies of older women (Wilson et al 2005), found only five studies available for review, each of which compared PFMT with a different alternative treatment or control, the proto–col for each training regime varying with the addition of electrical stimulation or EMG biofeedback. The only conclusion the reviews could make was that there was '... no good evidence to suggest that older women with urinary incontinence do not benefit from PFMT as much as younger women'.

Furthermore, there was some evidence for the efficacy of bladder training (BT) as a treatment of stress urinary incontinence in older women, which is contrary to clinical experience. This evidence came from the results of a large study which compared PFMT to BT and a combination of both treatments (Wyman et al 1998). However, in this study, pelvic floor muscle contractions were used as part of bladder training deferral strategies to combat sensations of urinary urgency. Thus, PFMT was a component of all treatment protocols in the study which found no differences between the three groups.

Given this background, we wondered whether PFMT was the active part of the BT protocol and what effect its removal from the behavioural components of BT might have. In order to address both the above issues we undertook a head-to-head comparison of PFMT and BT (cognitive behavioural elements only) on incontinence outcomes in older women with urodynamically proven stress urinary incontinence. A prospective randomised controlled trial was conducted with community dwelling women over the age of 65 years at Austin Health and the Royal Women's Hospital, randomised to either PFMT or BT for 20 weeks of intervention, with a follow-up period of seven months.

After randomisation, the women were assessed by their treating physiotherapist to ensure participants in the PFMT group could perform a pelvic floor muscle contraction, and to instruct participants in the BT group in completing a bladder diary. Each group then began an exercise classes with an education component. The PFMT group was trained in pelvic floor muscle motor control, strength and function, while the BT group was given a gentle exercise to music class which aimed to not affect the pelvic floor muscles. Education regarding deferral strategies formed the major component of the weekly sessions for the BT group. Both groups continued their program at home with weekly goals to be achieved.

The results of this study are now available. They show that the older women with urodynamic stress urinary incontinence who undertook a 20 week intensive PFMT program, demonstrated a greater improvement in incontinence symptoms compared to those who undertook a behavioural BT program. Both groups received supervised interventions with the same amount of attention, and were equally satisfied with their treatment. However, the PFMT group demonstrated and perceived a larger degree of change in symptoms than the BT group.

We have concluded that intensive pelvic floor muscle training is more effective than behavioural (bladder) training in treating stress urinary incontinence in a cohort of community dwelling older women. Increasing age should not be a barrier to prescribing exercise for older women with stress urinary incontinence.

TWO PERSPECTIVES ON WOMEN'S MENTAL HEALTH

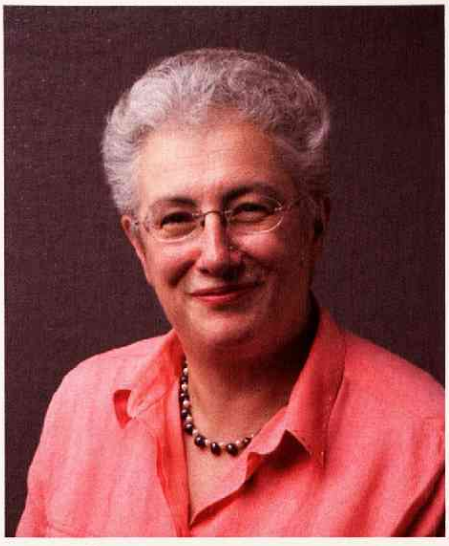
Fiona Judd

Centre for Women's Mental Health

The Centre for Women's Mental Health, an innovative partnership between the Pratt Foundation and the Victorian Government at the Royal Women's Hospital, was launched in August last year.

Professor Fiona Judd (MBBS 1978) commenced as director of the centre in February this year. Fiona has a long association with the University of Melbourne, as associate professor in the Department of Psychiatry at the Austin Hospital and then the Royal Melbourne Hospital before moving to the inaugural chair in rural mental health at Monash University in 2000. As director of the new centre, she returns to Melbourne University as a professorial fellow within the Department of Psychiatry.

Fiona has a long standing interest in consultation-liaison psychiatry, with a particular focus on the assessment and treatment of anxiety and depression in individuals with physical health problems. Her research has sought to understand factors contributing to the development of these disorders and the most appropriate treatments for them. In addition, she has wide-ranging interests in primary care psychiatry encompassing education, training for general practitioners and developing models of care, particularly at the interface between primary care and specialist practice. More recently, her research has focused on understanding how 'place' (geographic location and social circumstances) influences mental health and well-being.



Fiona Judd

The role of gender is increasingly seen as a powerful determinant of mental health. Gender differences in the prevalence of psychiatric disorders have long been recognised, in particular that depression and anxiety are more common in women. However, gender related differences exist not only in the prevalence of disorders but also in the expression, co-morbidity and cause of many illnesses. A variety of factors are thought to contribute to these gender differences in psychiatric illness. Research has demonstrated gender differences in brain anatomy and the different psychoactive effects of male and female reproductive hormones. Gender differences in psychiatric conditions may also be driven by psychosocial factors. Women are increasingly required to fulfil multiple roles and meet conflicting demands, and their traditionally dis–advantaged social status, lower wages and increased vulnerability to sexual and domestic violence may contribute to their higher rates of depressive and anxiety disorders.

There are also significant gender differences with respect to treatment. Women are 50% more likely than men to receive an antidepressant or anxiolytic agent during a medical visit. There are gender differences in the pharmacokinetics and pharmacodynamics of the medications, in part explained by the effects of oestrogen and progesterone. The effects of the menstrual cycle on psychotropic medication levels are unclear, and the use of exogenous hormones (e.g. oral contraceptives or hormone therapy) may also influence levels of medication.

A woman's individual background and social context, including her place in the family, will influence her experience of mental health service use. Her current circumstances including age, physical status, housing situation, role within the family and the presence of any children will impact on her service needs. Thus, there are particular priority areas for service delivery to women with mental health problems. These include providing services which are responsive to the needs of women with mental illness who are parents, and the needs of women with the experience of sexual assault, and developing inpatient and residential services that provide women with adequate safety and privacy. Older women and women who care for people with mental illness also have specific needs.

Historically, women's mental health has focused on the topic of mental health in relation to pregnancy and the reproductive cycle. However, it has become increasingly evident that women have particular mental health needs throughout their lifespan.

The Centre for Women's Mental Health has been established to provide expert clinical and therapeutic services for women, to undertake research and to provide education and training. The centre's work will be undertaken within a population health framework recognising that mental health and illness result from the complex interplay of biological, psychological, social, environmental and economic factors at all levels—individual, family, community, national and global. Interventions and research will be comprehensive and encompass the spectrum of interventions from prevention to recovery and relapse prevention. As the centre expands, clinical services will be developed to assist in meeting the mental health needs of women in the community as well as those who are patients of the hospital.

The centre's research agenda will reflect the priority clinical areas and be informed by known gaps in research into women's mental health. Thus, it is anticipated that the research agenda will include but not necessarily be limited to: gender and mental health; pregnancy and mother-hood; psycho-oncology; menopause, midlife and mental health; aging women's mental health; and culture and women's mental health.

Jane Gunn

The Diamond Study – investigating depression from a general practice perspective

Professor Jane Gunn is chair of the Primary Care Research Unit in the Department of General Practice. A 1982 MBBS graduate, she was an inaugural recipient of a general practice scholarship for doctoral research, and the first general practitioner to be awarded a PhD (1998) in general practice research at the University of Melbourne.
The first and youngest woman to be elected president of the Australian Association for Academic General Practice (2004-2006), Jane was also the first general practice academic to chair an NHMRC project grant review panel. Her research interests include depression and related disorders and the complex interplay between emotional well-being, physical health and illness. She is also experienced in translational research—getting research into practice and policy.

Jane Gunn

Throughout Australia around 27,000 general practitioners provide more than one million services per year to the Australian population. Depression is one of the commonest problems identified by general practitioners during these visits. Women are more likely to visit a GP than men and women are more likely to experience depression, stress and worry. Over the past decade public attention has been drawn to the problem of depression, as an estimated 121 million people worldwide suffer from it. These are alarming statistics and general practice is often the place that a person first turns to for help.

In the Primary Care Research Centre, located within the Department of General Practice, we have established a program of research aimed at understanding the challenges of detecting and managing depression in the general practice setting. Thirty general practitioners from across Victoria are participating in the Diamond Study and almost 800 of their patients (70% women) are assisting us to document what happens to people experiencing depression over three years of their life. This is the largest study of its type to be undertaken in Australia and it is already providing us with much needed information about the way that depression presents to and is managed in general practice.

Anyone familiar with the literature on depression will be aware that controversies exist around definitions, causation, identification and management. The cause of depression is complex and it is now commonly viewed as a complex gene–environment interaction; but the exact nature of this is not known. The management of depression is also complex. Antidepressants and psychological therapies both appear to be effective for many people experiencing depression. Yet a substantial number of people seem to have persistent and/or recurrent symptoms, no matter what is tried. Usually, with a medical condition, if a treatment works for a severe case it will work even more effectively for a mild case, yet in depression we find that whilst antidepressants are effective for around two thirds of people with major depression they are no more effective than placebo for mild cases of depression. It is a complicated area and we are still very early on in our understanding of it. Added to this is the fact that depression is experienced by the individual and we lack physical signs. We cannot measure depression in the same way as we can measure blood pressure, cholesterol or glucose levels. It is subjective. It is experienced. It is contested. Some see it as purely biological, others as purely social. Most agree it is a mixture. The literature is full of debate. The reality is that we do not have the definitive answer. We acknowledge that, for many, it is a recurring problem; not short-lived like a bout of influenza. And this is the context in which GPs work.

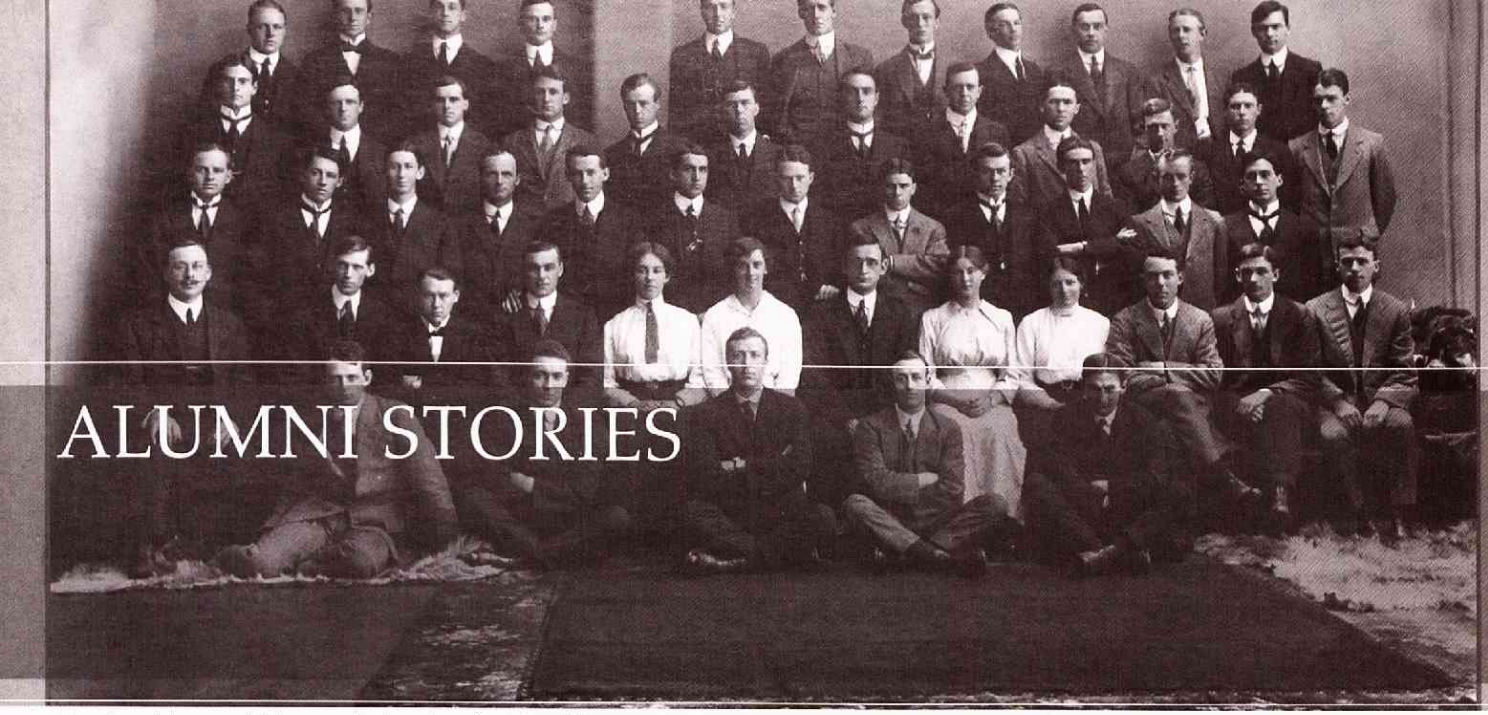
We cannot measure depression in the same way as we can measure blood pressure, cholesterol or glucose levels. It is subjective. It is experienced. It is contested.

Our emerging work with the Diamond participants' experiences highlights the complexity of the problem and casts doubt on the likelihood that a simple cause will ever explain all depressive illness. For the Diamond cohort, depression is associated with a mix of social, emotional and physical factors; extreme financial difficulty is a problem for 1 in 4, and around half of those with major depressive disorder have a history of childhood physical and sexual abuse, or partner violence. Other mental health problems such as anxiety, panic disorder, substance abuse, and bulima are also common; as are physical health problems. These problems are all commonly experienced by women.

Hence, a GP is never dealing with depressive illness alone, there will always be a number of other significant problems that require attention and many of them are beyond the scope of general practice to solve (abuse and violence, for example). Over the next few years we will be documenting what happens to the Diamond participants, interviewing them about their experiences of care and attempting to design better ways of responding to the seemingly ever growing problem of depression.

Interested readers can listen to Jane Gunn's lecture 'Everyone's normal is different: the challenges of detecting and managing depression in general practice', which she delivered as part of the faculty's Dean's Lecture Series on 7 August this year, by following the links provided at : www.mdhs.unimelb.edu.au/news/deanslecture/07aug07.html

More information about the Diamond Study can be found at: www.diamond.unimelb.edu.au



ALUMNI STORIES

Vera Scantlebury and fellow medical students from their fifth year photograph taken in 1913. Five students, absent when this photograph was taken, were added to the final picture as portraits but have not been included here. Vera is seated in the second row, fourth from the right. Photo courtesy University of Melbourne Medical History Museum.

VERA SCANTLEBURY – AN AUSTRALIAN FEMALE SURGEON IN THE FIRST WORLD WAR

HEATHER SHEARD

Heather Sheard is a PhD candidate at the University's Australia Centre. After working as a secondary teacher and assistant principal, she retired to complete a Master of Education—a history of Victoria's baby health centres. Her research introduced her to Dr Vera Scantlebury Brown, the subject of her PhD thesis, The Milk of Human Kindness: The Life and Vision of Dr Vera Scantlebury Brown. Heather is also a member of the Vera Scantlebury Brown Trust.

Vera Scantlebury's fifth year medicine photograph, in 1913, is a tremendous point of access into 57 lives: 53 men and four women who were to begin their medical careers in the context of a looming war.

After Vera graduated she took up residency at the Melbourne Hospital and then the Children's Hospital where, by late 1916, she was senior resident[1], a position that she coveted and enjoyed.[13] The strong enlistment rates of Melbourne's medical fraternity with the Australian Army Medical Corps (AAMC) or the Royal Army Medical Corps (RAMC) had, ironically, improved access to hospital positions for female doctors remaining in Australia.[15]

In 1916 she paid her own way to London to work as an assistant surgeon at the Endell Street Military Hospital, despite there being many reasons not to go.

Firstly, women doctors were not permitted to join the AAMC or the RAMC as doctors[2,14]. Whilst the French, Serbians and the Russians readily accepted female doctors and hospitals established by female doctors, Britain took longer to come to an accommodation and Australia consistently declined.

There were also practical difficulties for women other than nurses in getting to London. From mid-1916, both the British and Australian governments tried to limit anyone other than soldiers and nurses from boarding ships to England and made passports difficult to get.[5,3] Vera paid £129 for her return fare to England in early 1917 and needed to pay for her uniforms on arrival. Her letters reveal that she was 'stony broke'.[12]

Vera began life as a small premature twin and her health was never robust. Her diaries indicate that her father did not want her to take on the rigours of a wartime surgical role and that her family worried constantly about her health and diet while she was away.[12]

Finally, it was highly unlikely that any Australian female doctor would act as a military surgeon during the First World War. Those that did were a statistically elite group. Of the approximately 129 qualified female doctors in Australia at the outbreak of war, eighteen that I know of either paid their own way to England or were already there and provided their skills to military hospitals in England, France, Belgium, Serbia, Romania, Greece, Hungary, Russia and Egypt.[6,7]

Some of Vera's reasons were the same as those of the general populace. The Empire's rallying cry 'For God, Duty and Empire' expressed values central to her upbringing and education. The dozens of letters she wrote in carbon duplicate books and sent home between 1917 and 1919 indicate the enormous sense of duty she felt to make the best wartime use of her medical skills, but particularly toward the injured soldiers and less, in a sense, to the Empire.

More specific to Vera's world were the constant departures to war of colleagues, family and friends. War broke out in early August 1914. From Vera's fifth year, John Shaw McKay enlisted on 18 August and Joseph Robert Balfe on the 24th. Alfred Derham also enlisted in that first month and John Drummond Norris signed up in October. They sailed in early December and by 25 April Jo Balfe was dead—killed in the landing on Gallipolli. Gerald Stuart joined the 3rd Light Field Ambulance on 2 October 1914 and Dr Jolley on the 21st—they too sailed with the convoy.[8] In February 1915, Lord Kitchener issued his famous plea for one hundred Dominion doctors and amongst the group who came to be known as Kitchener's One Hundred were eleven of Vera's colleagues as well as her brother, Clifford. They left during March and April in 1915.[11] Around 10% of Australia's eligible male population and over one

third of the medical community enlisted.[9] Of Vera's 57 classmates, to the best of my knowledge, 50 enlisted over the four years of war, some twice. Six of her colleagues died and are buried in England, France, Turkey and Iraq.

Doctors and nurses at Endell Street faced the results of the wholesale use of armaments that produced multiple large schrapnel wounds, gaping holes and bones, not just broken, but smashed[4]. Treatment was complicated by the fact that the farmland soil that exploded around them with the shells and schrapnel was contaminated with animal and human material. The four to five days it often took for wounded men to get to a London hospital enabled infection to develop.

Vera's early diary letters reveal that at times she found the surgery horrible. Early in 1917 she writes '...a hard day. I am not at all keen on military surgery but I suppose I shall get used to it and do it better than at present but I think it is horrible.'[12] They also indicate how inadequate she constantly felt. 'In fact, never have I felt so small and helpless useless and insignificant as I do now since I became a member of the Endell St staff. Very good for me... Think what a beautiful strong character your little lass will be when in the dim future she returns a shrivelled mite—for she gets and feels smaller daily—to Australia. Her "colonial cheek" will prevent her fading altogether!'[12]

Vera stayed until the end of the war but wrote, 'my work will not count afterwards in the way of experience'. After the war, Melbourne's hospitals gave preference in their appointments to male doctors who had enlisted.[15] Many now had several years of intensive surgical experience and were up-to-date with the latest techniques. Many also took advantage of the inter-allied fellowship of medicine scheme—on their army pay—to study in London after the armistice. Vera's colleague, Bill Hailes, studied in a London hospital for nine months; Donald Coutts, Arthur Joyce, and Herb Puckle all stayed on to study, as did Vera's brother, Cliff.[8] Many of the female doctors had to earn a living after the war. Most had worked for organisations such as the Scottish Women's Hospital, which paid the doctors' salaries by fundraising. Endell Street was unofficially RAMC funded but I think such funding and the unofficial nature of the female doctors' commissions ended with the armistice. The only Australian War Memorial record for Dr Vera Scantlebury is her letter, in April 1919, requesting a refund of her £129— passage money to and from England. The repatriation commission awarded her half the fare.[8]

All of the Australian male medical participants and nurses received service medals and also many medals for valour from England, France and Serbia. To the best of my knowledge, Endell Street's Australian surgeons received none. Neither do Dr Vera Scantlebury, Dr Rachel Champion or Dr Mary De Garis appear in the navy, leather bound, gold-lettered volume that records the First World War service of the University of Melbourne's staff and graduates.[10]

Vera Scantlebury returned home in early 1919. She was never able to regain the position she loved at the Children's Hospital. Like many female doctors, her working life for the next seven years was a patchwork of honorary and paid part-time positions. It is ironic that her ultimate career choice, as Victoria's first director of maternal, pre-school and infant welfare, an enormous developmental role, was a part-time appointment because she was, by that time, married to Dr Edward Byam Brown.

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The Vera Scantlebury Brown Child Welfare Memorial Trust commemorates the life and work of Vera Scantlebury Brown (1889-1946). Vera, (MBBS 1914, MD 1924) was appointed as Victoria's first director of infant welfare in 1926, a role which expanded in 1944 to include early childhood services.

Her influence extended nationally when, in response to her report to the NHMRC on the needs of the pre-school child, a Commonwealth commemoration grant of £100,000 was made to establish Lady Gowrie child centres in each state for pre-school staff development and research. She was awarded an OBE in 1938 for distinguished service to preventive medicine.

When Vera died she was working with Dr (later Dame) Kate Campbell on A Guide to the Care of the Young Child (1947), a revision of her Guide to Infant Feeding (1929). The trust was established after her death and Victorian families donated thousands of pounds to commemorate her life. It awards an annual scholarship to help women pursue postgraduate study in an area which contributes to the health and well-being of the Victorian community.

The university has administered the trust since 2004 and, in addition to supporting the annual scholarship, has introduced the memorial lecture. The inaugural lecture was given in 2005 by Professor Dorothy Scott, foundation chair of child protection at the University of South Australia.

In September this year, Professor Fiona Stanley AC delivered the 2nd Vera Scantlebury Brown Memorial Lecture, 'Challenges for Preventive Child Health in the 21st Century'. Fiona, the inaugural director of the Telethon Institute for Child Health Research and professor in the School of Paediatrics and Child Health at the University of Western Australia, was Australian of the Year in 2003.

A link to the recording of Fiona Stanley's lecture can be found at: www.mdhs.unimelb.edu.au/news/deanslecture/20sept07.html

To make a donation to the Vera Scantlebury Brown Memorial Trust contact Wendy Brooks, Director, Advancement and Communications, Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne, 3010, Australia. T: 61 3 8344 6321. M: 0408 145 661. E: wbrooks@unimelb.edu.au

CHRIS BAYLY, MBBS 1977, MD 1991

Associate Director, Women's Services, Royal Women's Hospital

Like many others, I was drawn to obstetrics and gynaecology by the thrill of witnessing birth in my medical student days and the appeal of being able to prevent or ameliorate serious complications.

On my second day as a level one trainee, at the Royal Women's Hospital, Australia's first in-vitro fertilisation (IVF) pregnancy was announced at the gynaecology staff meeting. This window into the process of conception shaped the next phase of my career, in which I spent about 15 years involved mainly in infertility and assisted reproduction.

In the early days, IVF treatment was much more arduous for women and much less successful. Nevertheless, it was a heady time indeed for a young clinician—the pace of discovery and change was great and every positive pregnancy test was a cause for celebration by the team. The opportunities to meet and converse with experts from everywhere were extraordinary and it was my good fortune that the timing enabled my participation

Chris Bayly

in the establishment and early years of the Melbourne IVF group.

A yen for change drew me to study public health in the late 1990s, which complemented a new role in service development and management. During this period we have been learning as practitioners and developing systems to take a more comprehensive approach to women's health, with a greater awareness of social influences on health and women's concerns and expectations. It is both challenging and rewarding to develop practices and services which recognise and respond to cultural diversity, the impact of violence and mental health needs, and which also address health promotion and illness prevention, for example in the area of sexual and reproductive health of young people.

Although my clinical practice is limited to gynaecology, the early inspiration of obstetrics remains a driver of my work in improving the experience of women using maternity and women's health/gynaecology services and that of the staff providing their care.

Since I started my training, clinical developments have included less invasive surgical procedures for many gynaecological conditions, hormone delivering intra-uterine systems that can be an effective alternative to hysterectomy, and new contraceptive options. Vaccination against human papilloma virus is also likely to change practice further over time. We could not have imagined, in the early 1980s, that assisted reproduction techniques would contribute as many as 3% of Australian births a year, that caesarean section rates would more than double to 30%, or that men would be outnumbered by women among trainees.

KATE STERN, MBBS 1987

Head of Endocrine and Metabolic Service, Royal Women's Hospital; Director responsible for research, Melbourne IVF

Like many other people (or maybe not!), my life seems to consist of running around madly, but still never quite getting everything done!

I work as a fertility specialist, gynaecologist and reproductive endocrinologist, mainly in the areas of infertility and hormone dysfunction, seeing women in the reproductive age group.

This is an absolutely fascinating and engrossing specialty and I truly cannot believe my luck. Intellectually and scientifically we are continuously challenged by the extraordinary developments which have recently expanded our field, particularly in the areas of stem cell therapeutics and pre-implantation testing of embryos for significant genetic abnormalities. At times, however, we feel like we are forever struggling to catch up with the associated complicated ethical issues! Like many other areas of medicine, we are able to really get to know many of our patients, and can try and practice the art as well as the science of medicine. While current fertility treatments are extremely successful, sometimes the challenge for us is to help women and couples know when to stop treatment and either accept childlessness or explore other options.

My particular passion is the exploration of future fertility options for young people who have been diagnosed with cancer or other serious conditions requiring treatment that may destroy their fertility. Over the last ten years the importance of future fertility for these young people has become more accepted in the medical community. Recent developments in this field have made it possible for us to offer potentially useful options to adolescents and young people, prior to their cancer treatment. I am continuously amazed by the grace, intelligence and calm shown by these patients, especially when dealing with the trauma associated with being diagnosed with potentially life-threatening conditions.

I feel confident that, over the next few years, these gynaecological areas of women's health will continue to engage, perplex and stimulate us!

Kate Stern.

THE TRACY MAUNDERS

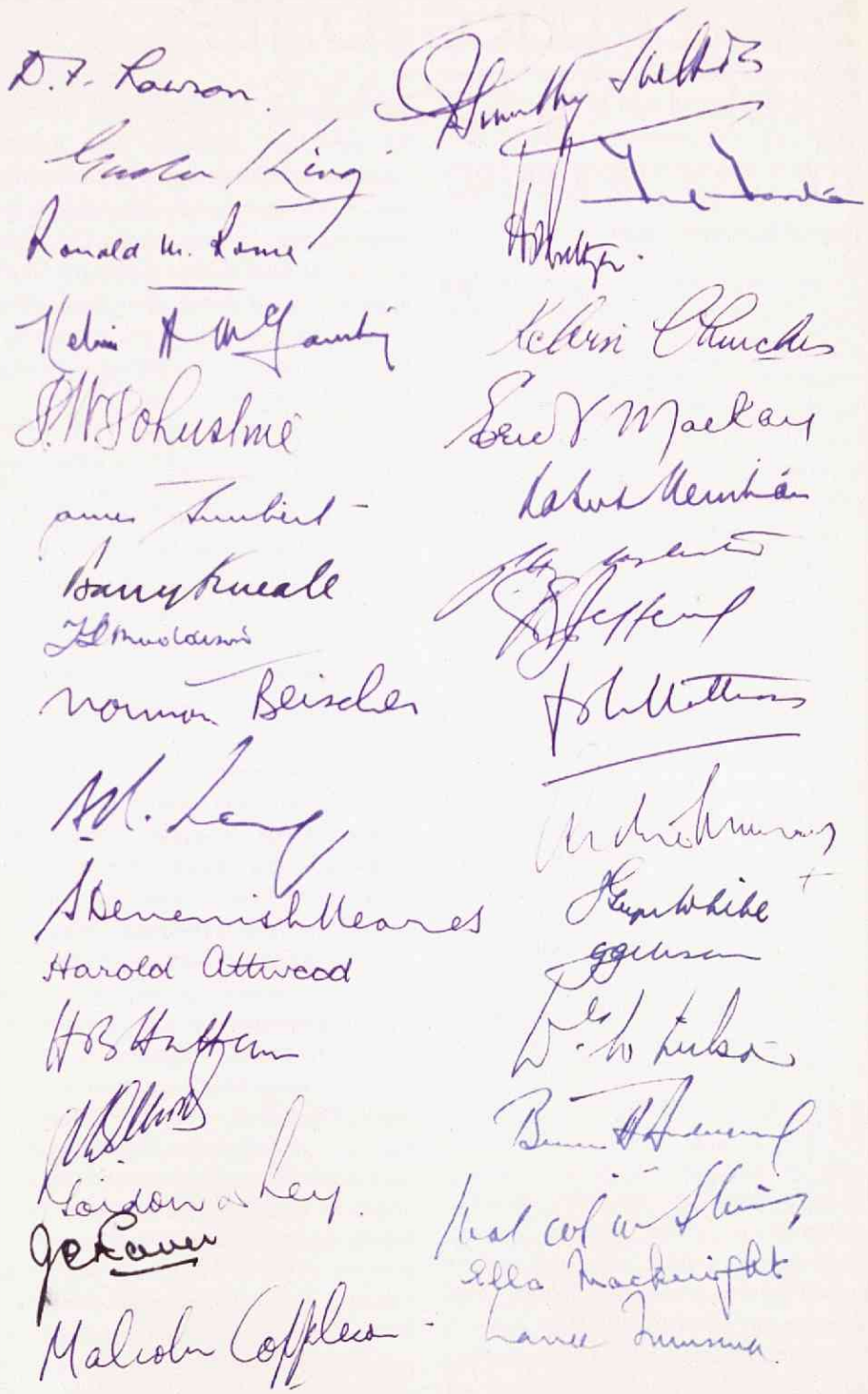
The Tracy Maund Society of the Royal Women's Hospital is a society of senior medical staff which continues to evolve in parallel with the culture of hospital doctoring. Named for the two medical founders of the hospital, Richard Tracy (1826-1874) and John Maund (1823-1858), the society was formed after Dr Colin Macdonald (snr.) moved that they '...consider the desirability, and the practicability of forming a Dining Club' in July 1962. The original name proposed was the Tracy Dining Club of the RWH. The motion was carried unanimously and Drs Hill, McColl, Jeffrey and Hallam were charged with looking into the practicalities. Membership was initially limited to: visiting honorary obstetricians and gynaecologists; honorary paediatricians; directors of radiology, pathology and anaesthetics; and the professor and first assistants.

The next development occurred in 1966 when Dr J Walter Johnstone (later Johnstone-Need) proposed the formation of a Tracy Maund Trust. He donated $500

> ...to develop and maintain the social welfare of the Staff' stipulating that 'a condition of the trust is that once in each and every calendar year the Staff shall drink the Tracy Maund Toast.

Following the establishment of the trust, the Tracy Maund Oration, an annual prestige event, commenced and, to encourage research, a scholarship was endowed to allow a young specialist to travel overseas to further their research for the benefit of the hospital's community.

There were generally four dinners a year and in 1976 junior consultants (no longer honoraries) were invited to join. New members were required to tell a funny story at their first dinner, an initiation which resulted in many a sweaty palm, dry mouth and tachycardia.



Signatures from the inside of a menu saved from the Royal Women's Hospital executive medical staff dinner held on 13 March 1964 to celebrate the centenary of the first successful ovariotomy in Victoria.

A partners' dinner was later introduced once a year and it became clear that, increasingly, senior medical staff did not want to dine away from their family. With formality becoming less appealing to many, activity in the Tracy Maund Society has slowed down over recent years. In the last 12 months, however, many have voiced a need for social intercourse and activity has picked up with a very successful dinner to celebrate the 150th anniversary of the Women's. The evolution continues; the most contentious debate in the planning for that dinner was whether it should be formal dress. It went to a vote, the black ties won narrowly. A Tracy Maund Oration is planned for this November and an annual levy has been reintroduced. Evolution progresses by stops and starts.

by Leslie Reti, Chair, Royal Women's Hospital Senior Medical Staff. With thanks to Ian Ross

2007 PETER G JONES ELECTIVE ESSAYS

THE TIP OF THE ICEBERG

Ingrid Laemmle-Ruff

During my elective I met families from Sudan, retired soldiers and great grandmothers from rural Eritrea, teachers and generals from refugee camps on the Burmese-Thai border and families from East Timor, Liberia and Sri Lanka. All for the cost of a zone one ticket, with time for coffee with friends in between.

I did my elective in immigrant health in Melbourne. I was interested in international health but a two month overseas trip wasn't an option. Immigrant health was, in a sense, a means of bringing international health to me.

Every week my time was divided between the Royal Children's Hospital, the Victorian Infectious Disease Service, the Western Region Health Centre in Footscray and the Victorian Foundation for Survivors of Torture. My scattered schedule reflected the distances and complexities that immigrants must negotiate to get health care.

Imagine receiving a letter in a language you don't read, from a hospital you don't know, about an appointment to which you must take public transport in a strange city with your six children in tow, along with recent blood test results and poo samples. Simple things help: having a volunteer to guide patients between departments; calling the day before appointments; translating letters; local community members to liaise between clinics and patients and provide transport; and organising appointments out of school hours.

Infectious diseases are often the main priority in immigrant health. Many of the patients I saw were having the full battery of serology, blood studies, vitamin levels and faecal specimens. I saw leprosy, malaria, syphilis, hepatitis B, oodles of latent TB and parasites galore including schistosomiasis, strongyloides and filariasis. The crucial difference is that, in Melbourne, these diseases are picked up on preventive screening.

Diet is also often a priority: both adapting to Australian produce and addressing deficiencies, such as iron and vitamin D. Australian supermarkets have vastly different fare to, for example, Egyptian refugee camps. The community centres I visited had cooking classes and shopping trips for immigrants. The young son of one family from Sudan, no doubt appreciating the change after living solely on rice, beans and oil for three years in a refugee camp, was overloading on a diet of fruit and chocolate in Australia.

Other common issues were dental problems, and musculoskeletal injuries and arthritis, often traced back to years of heavy labour. Pregnancy was frequently discovered, often already quite far along–important when considering vaccinations and TB treatment. Psychological issues, related to grief and traumatic experience, difficulties adjusting to Australia, and concern for family overseas often arose in consultations, and often manifested as physical symptoms.

Communication was influenced by differences in language, culture and religion. In the clinics, patients likened arthritis to 'rust', pain to 'pepper', headache to 'gas in the head'. Most were used to medical treatment only when sick. Attempts to explain preventive medicine in the asymptomatic were lengthy but often very useful. A number of patients were sceptical of blood tests, and concerned about the quantity taken. Investigations needed explanations and consideration of their implications. For example, an STD diagnosis could affect a marriage and a family severely. Patients sometimes felt pressure to please doctors, exemplified by one case of a family member donating a faecal specimen for another unable to perform under pressure!

Patients had a large range of different beliefs regarding issues such as circumcision (male and female), gender roles and family planning and size, which needed to be negotiated with cultural sensitivity and respect. Women who have borne five children in third-world settings might not see the need for the complex maternal screens imposed on them here.

A privilege of medicine is the intimacy it grants with the stories of people. Immigrants have amazing stories to tell. They come from a range of professions, often speak many languages and have a wealth of experience. The spectrum of forces—political, conflict and religious—that have directly influenced them are astounding. I would come home to the other side of town, to white, middle-class suburbia, and feel strongly the difference in my world. My friends and I would talk of job interviews, the latest break-up, where to go on holiday. It was astonishing how easy we had it, although the immigration experience is perhaps not so distant from my life. My grandparents arrived in Australia as prisoners of war, having to leave their rural agrarian communities and come to the new urban environment of Melbourne. I know how important being part of a community and living close to others who spoke their language was; how significant those people who helped them put their children in school, learn English and find work were; how strongly they remember their past and how important preserving that culture still is. How things change in a few generations. Perhaps the grandchildren of current immigrants might have as many opportunities as I. The tragedy is that they need to be in Australia to have those opportunities.

Ingrid Laemmle-Ruff, aged eight, with her maternal grandparents Agnes and Otto Laemmle, in 1990. Both Agnes and Otto came originally from the German colonies in Palestine. Agnes was interned in Cyprus and Otto spent six years as a prisoner of war in France and America before they migrated to Australia, in 1949 and 1951 respectively. Ingrid's paternal grandparents, also from the German colonies in Palestine, arrived in Australia in 1941 and were interned in Tatura in rural Victoria for six years.

Refugee and immigrant issues are not just relevant to a niche of Australian healthcare. They are an expression of global problems, where people are unable to live safely, peacefully or healthily in their own homelands. Those immigrants we do see in Australia represent just the tip of the iceberg—the fortunate few able to begin again.

TRIAL BY FIRE

Matthew Lin

Every year thousands of Australians suffer a diverse range of burns arising from bushfires, chemical spills, house fires and car crashes. However, it was the events of the Bali bombings which generated my interest in an elective with the Victorian Adult Burns Service. As I quickly discovered, a burn is a highly complex inflammatory insult with complications that can lie far beneath the skin. There is excruciating pain and psychological grief associated with such devastating injuries. I saw many patients come and go during my time with the unit. Let me introduce you to two of them.

This is 'Helen'*, anaesthetised and on the operating table with her arms splayed out like a cross. Helen is a young mother who was badly burnt in a car accident. There are three doctors and myself working on her burns. The basic principle is to excise the dead zones, removing all devitalised tissue, and graft any areas which need new skin. This surgery is not for the squeamish. It is also physically taxing as we remove blisters the size of squash balls and vigorously debride large chunks of dead flesh. The fact that the theatre is heated to a stifling thirty-five degrees makes it particularly gruelling (one of the perverse paradoxes of burns is that the patient is at high risk of hypothermia).

With the dead tissue removed and Helen's skin bleeding healthily, we proceed to harvest the skin grafts. I am handed the harvesting device, an electric dermatome that would look more at home in a delicatessen than in an operating theatre. However, I have used it before and, with encouragement, my hands become surer each time. I roll it firmly along the thigh as it shaves off a thin layer of epidermis leaving a neat denuded strip in its wake. The precious skin is then grafted onto the burns and the wounds are dressed. At last, Helen is wheeled away, wrapped like a mummy in metres of bandage. She will feel like her skin is on fire all over again when the analgesics taper, but has a committed and compassionate team to support her.

'Sam' is a mechanic who last year sustained melting burns to his face and upper body after being blasted with high-pressured radiator steam. Before his discharge he spent several tormented months in the unit, undergoing numerous grafts and facial reconstructions. He has been out in the community for a while now and has returned to the outpatient clinic for a review. Today Sam's face is vastly improved but it is still noticeably disfigured, appearing taut, hairless and shiny with a shrunken scar of a nose. Life on the outside has presented its own battles and he still finds it difficult to deal with the stares. Indeed, psychological recovery is slower than the physical recovery. Remarkably, he has some positive things to say about his experience. I vividly recall his words that 'a burn destroys you on the outside and turns you upside down, but it makes you stronger on the inside', and that 'you realise that if you can get through it all, you can handle anything else that life throws at you'.

It was a privilege to spend time with a truly multidisciplinary team whose commitment and support significantly enhanced the lives of their patients. I gained so much from working with this extraordinary team of doctors, nurses, therapists and psychologists. I learnt how to evaluate the severity of burns, how to manage relentless pain and how to care for the patients on the ward and in the theatre. I also gained invaluable knowledge about the complex management of the organic and psychological complications of burns. Above all, I took away a newfound respect for these incredibly brave burns survivors who had experienced the unspeakable.

To witness such resilience in the face of adversity was a most humbling experience.

** The names of patients have been changed.*

2007 ETHICS SEMINAR

RATIONING HEALTH CARE: PRIORITIES, PRINCIPLES AND POLITICS

The Faculty of Medicine, Dentistry and Health Sciences annual health ethics seminar is part of the Dean's Lecture Series. The seminar deals with a different aspect of health ethics and speakers include university academics, health professionals and distinguished members of the general public.

The 2007 seminar was convened by Professor Jeffrey Zajac, head of the university's Department of Medicine at Austin and Northern Health, and moderated by Professor Sam Berkovic, director of the university's Epilepsy Research Centre at Austin and Northern Health.

'I don't want to achieve immortality through my work, I want to achieve immortality by not dying'. With this quote, from Woody Allen, Sam Berkovic opened the seminar by alluding to a problem central to the vexed issue of rationing in health care. Thanks to medical science, life expectancy for most of us has been extended by approximately 30 years over the last century. Such progress, however, comes at a cost and rationing health care resources is now an every day part of medicine.

How to set priorities when rationing health care was first addressed by Associate Professor Lynn Gillam, senior lecturer in health ethics at the University of Melbourne. Lynn's approach was to outline two different ethical frameworks which can be used to consider ways in which health care rationing decisions should be made. Lynn admitted that while these ethical frameworks would not provide definitive answers, a combination of the two approaches she explored could bring us closer to making good decisions.

The practical effects of allocating resources to different, competing health programs were discussed by our next three speakers. Mr Mendel Grobler, director of Pfizer Australia put the case for allocating resources to cholesterol-lowering drugs. Cardiology patient, Mr Gregory Adams, gave an account of the brush with death which led to his cardiac defibrillator implant. Dr Sally Cockburn, general practitioner and health communicator, spoke about the pros and cons of the recent federally funded human papilloma virus vaccine program.

Professor Emeritus Lloyd Sansom, chair of the Pharmaceutical Benefits Advisory Committee, then addressed the issues considered by the committee when making decisions about which medicines to include in the Pharmaceutical Benefits Scheme.

To end the afternoon's program, Gregory Adams, Sally Cockburn and Lloyd Sansom joined the Honourable Robert Knowles, former Victorian minister for health and minister for aged care, and Dr Omar Farouque, director of the Department of Cardiology at the Austin Hospital, in a discussion of the issues raised during the afternoon.

A link to the audio recording of the seminar presentations and discussion is available at: www.mdhs.unimelb.edu.au/news/deanslecture/20jul07.html

FACULTY NEWS

Portraits of a pioneering past: Dr Elizabeth Shaw (centre) during her visit to the Department of Pharmacology holds a portrait of her father, Frank Herbert Shaw, the first professor and chairman of the department (1954-1964). With Elizabeth Shaw are Peter McIntyre, current professor and head of the department (left) and James Angus, current dean of the faculty and professor and head of pharmacology (1993-2003) with a portrait of Michael Rand, professor of pharmacology (1965-1992). Photo Lee McRae

In April this year, Elizabeth Shaw (MBBS 1962), and her husband, Michael Wright, who live in London, returned to Melbourne for the 45th reunion of 1962 MBBS graduates (see p.26). Prior to the reunion they visited the university, including Graduate House, where a portrait of Elizabeth Shaw's great uncle, Frank Leslie Stillwell, hangs in the new Stillwell Room. Frank Stillwell (BSc 1911, MSc 1913, DSc 1916), a geologist, travelled on the Australasian Antarctic Expedition led by Sir Douglas Mawson in 1911-13.

They also visited the Department of Pharmacology where Professor Peter McIntyre, head of the department, took them on a tour, meeting research staff and viewing the teaching and research facilities. Elizabeth Shaw's father, Frank Herbert Shaw, was first professor and chair of the Department of Pharmacology (1954-1964).

Elizabeth Shaw's family has a history of involvement with the University of Melbourne, which dates back over several generations. Three of her great aunts graduated from the university in the early twentieth century: Effie Stillwell (MBBS 1901-02), Florence Clucas (née Stillwell) (BSc 1901, MSc 1903) and Olive Stillwell (BA 1912 and MA, GDip Ed 1914). Her mother, Etta Shaw (née Stillwell), graduated BSc in 1931 and GDip Ed in 1933.

Professor Julie Bines, inaugural Victor and Loti Smorgon chair of paediatrics at the Royal Children's Hospital (RCH), met recently with Victor Smorgon and members of his family to share information about her work. At a lunch hosted by the RCH Foundation and the University Department of Paediatrics at RCH, Professor Bines explained her work in paediatric gastroenterology and nutrition.

Head of the Department of Paediatrics, Professor Glenn Bowes, said it was wonderful that the Victor Smorgon family members were able to meet such an outstanding Melbourne clinical academic and hear about the valuable work they are supporting. 'Professor Bines' simple and effective presentation conveyed outstanding science, clinical care and teaching skills', he said.

'The presentation was much appreci–ated by the guests. They wanted to know more about what Julie was doing and they are interested in following the outcome of their philanthropy', he said.

Victor Smorgon's family's engagement with the hospital dates back to the 1980s, when they gave generously to a building appeal that resulted in the glass building at the front end on Flemington Road, and other renovations of the old hospital. The hospital's front entry building is called the Victor and Loti Smorgon foyer and other parts of the hospital also carry the Victor Smorgon family name. The family's relationship with the hospital has resulted in the endowment for the Victor and Loti Smorgon chair of paediatrics.

Julie Bines commenced as the inaugural Victor and Loti Smorgon professor of paediatrics in the Department of Paediatrics in November 2006. She has been head of clinical nutrition at the Royal Children's Hospital since 1994, leads the RV3 Rotavirus Vaccine Program and is head of the Intestinal Failure and Clinical Nutrition Group at the Murdoch Childrens Research Institute.

Pictured at the lunch are: (front, from left) Victor Smorgon, Julie Bines; (back, from left) Lisa Jane Ryan and baby daughter Summer, Monica Edwards, Belinda Bardas (Victor's granddaughter), James Angus (Dean, MDHS), Barry Novy (Chairman, RCH Foundation board), Tony Cull (CEO, RCH), Peter Edwards (Victor's grandson).

CELEBRATING 150 YEARS OF WOMEN'S HEALTH

In September this year the Faculty of Medicine, Dentistry and Health Sciences sponsored a visit to Melbourne by Professor Donna Stewart, Lillian Love Chair of Women's Health at the University Health Network and University of Toronto. Her visit marked the 150th anniversary of the special relationship between the Royal Women's Hospital (RWH) and the University of Melbourne and culminated in her public lecture entitled 'Global Inequities and Women's Mental Health'.

Donna Stewart is an international pioneer in women's health research and the world's first chair in women's health. Her public lecture discussed global inequities between men and women with regard to childhood survival, nutrition, education, poverty, violence, human rights and sexual rights. She described how global disparities between the sexes affect both physical and mental health, and her work on the development of an international consensus statement on women's mental health. She also outlined a study building local capacity and monitoring women's health in low, middle and upper income countries.

Donna Stewart's research falls into the three main areas of women's health: public health, psychosomatics and mental health. She is president of the International Association of Women's Mental Health. A recording of her Melbourne lecture can be found at www.mdhs.unimelb.edu.au/news/deanslecture/11sept07.html

In Melbourne for a week leading up to her public lecture, Donna Stewart (pictured, at right, with Fiona Judd), took the opportunity to meet and talk with university and hospital staff. Photo Gil Meydan, RWH.

The university also co-sponsored the RWH Women's Health Conference, held in March this year. The conference program encompassed clinical, scientific and social perspectives, and showcased the hospital's research and clinical service achievements and its innovative social model of care.

Thirteen eminent national and international keynote speakers challenged delegates from across the health sector on issues facing women's health globally and presented the latest advances and new directions in maternity, neonatal and women's health care. Speakers included:

Professor Lynette Denny, gynaecological oncologist from the University of Cape Town, who focused on the issues facing women in South Africa, particularly low education rates, high adolescent fertility rates, maternal mortality rates, and prevalence of HIV and cervical cancer.

Kate Gilmore, who set up the RWH's Centre for Sexual Assault and is now executive deputy secretary general at Amnesty International in London, gave a global perspective on violence against women, particularly in areas of civil strife and war.

Professor Fiona Judd, director of the Women's new Centre for Women's Mental Health, who overviewed services being developed by the centre to address the gap in holistic care of women attending the hospital.

Dr Eric Moses, faculty scientist from Southwest Foundation for Biomedical Research in San Antonio, USA, provided an update on the collaborative research on genetic pre-determinants of pre-eclampsia that he is undertaking with Professor Shaun Brennecke, chair of obstetrics and gynaecology (RWH/Mercy), at the Women's Pregnancy Research Centre.

Professor Allan Templeton, from the University of Aberdeen and president of the RCOG in London, who provided an update on the clinical use of antiprogesterones in medical abortion.

Professor Ulla Waldenstrom, who occupied the first chair of midwifery in Australia, established at the Women's in 1995, and is now professor of nursing and midwifery at the Karolinska Institute in Sweden, challenged clinicians to review their practice in light of current evidence-based research.

Copies of the presentations are available from Rachimah Fraval at the Royal Women's Hospital at rachimah.fraval@rwh.org.au

Richard O'Brien

APPOINTMENTS

Associate Professor Richard O'Brien (MBBS 1981, PhD 1992) has taken over as the new clinical dean at the Austin/Northern clinical school.

Originally trained at the Austin Hospital, Richard, an endocrinologist, has spent the last 15 years at Monash University, much of that time as head of the diabetes service at Monash Medical Centre. He has maintained dual interests in teaching and research, the latter focusing mainly on aspects of atherosclerosis in diabetes including lipid abnormalities and endothelial dysfunction. He has been involved with the Australian Atherosclerosis Society for many years and is its immediate past president. As well as being active in undergraduate teaching, Richard has a long standing interest in continuing education for general practitioners, and is currently developing a vascular education program through the Australian Atherosclerosis Society. He is looking forward to combining his new role as clinical dean with continued research collaborations with colleagues at the Baker Institute and the Austin Hospital.

Patricia Desmond

Professor Patricia Desmond is the new Edgar Rouse professor, head of the university Department of Radiology and director of the Department of Radiology at the Royal Melbourne Hospital (RMH). She has been radiologist in charge of magnetic resonance imaging at the hospital for over 10 years and was awarded an MD in 2005 for her study of MRI in acute cerebral ischaemia.

Patricia is a 1984 Melbourne MBBS graduate who came to medicine after a BSc and MSc, majoring in physics. She has attracted sustained NHMRC funding in clinical neuroscience, acute stroke, schizophrenia and stroke in diabetes and significant funding from other sources and participates in multicentre funded research in the areas of Huntington's disease, stroke and glioblastoma.

A recipient of outstanding teacher awards in the university's MMed program, Patricia supervises postgraduate students in MD and PhD studies and is an honorary senior research fellow of the Howard Florey Institute. She is a member of the Neuroimaging Platform and the Neuroinformatics Platform of Neurosciences Victoria. A fellow of the RANZCR, Patricia is also a college examiner and has extensive involvement with many of its committees.

The Edgar Rouse chair of radiology is named for businessman and philanthropist Edgar John Rouse (1894-1974).

Edgar Rouse enlisted in the Australian Imperial Force in 1917 and travelled to England in 1918. However, he was diagnosed with tuberculosis of the lung, repatriated and discharged from the army. He started work at Kodak (Australasia) upon his return to Australia and was subsequently appointed Melbourne manager of the company in 1928 and chairman of the Australasian company in 1938.

A trustee of the Baker Medical Research Institute, Edgar Rouse was also an early benefactor of the Royal Australasian College of Radiologists and sat on the board of management of the Alfred Hospital in Melbourne. He had a particular interest in radiology and travelled to America in the late 1930s, buying stocks of film base and chemicals to ensure supplies of radiological film in the event of war. He was instrumental in the creation of a fund for the purpose of establishing a chair of radiology at the university, ensuring donations from Kodak and from the Baker Trust towards the fund.

Previous Edgar Rouse professors of radiology have been WSC Hare (1965-1988) and Brian Tress (1988-2007). Edgar Rouse is also commemorated by the Edgar Rouse Prize in Occupational Medicine awarded to Melbourne University medical students by examination each year.

DEPARTURES

Professor Lorraine Dennerstein AO retires this year as director of the Office for Gender and Health, in the Department of Psychiatry, after 30 years with the faculty. She has held a personal chair since 1995 in recognition of her outstanding internationally acclaimed research career and her initiation of novel teaching and clinical services in women's health.

When Lorraine graduated MBBS in 1970, women comprised 10% of medical students and the only female academic teacher during her undergraduate course was Professor Kincaid-Smith. Despite winning all the prizes in obstetrics and gynaecology, she was discouraged from entering this specialty. Senior male gynaecologists told her that no 'normal' woman would want to see a female gynaecologist. She entered general practice and was surprised when women made appointments to see her.

In response to questions posed frequently by her women patients, Lorraine conducted the first double blind randomised cross-over controlled trial of the components of the oral contraceptive pill, separately and together. In 1977 she was appointed lecturer in the Department of Psychiatry at the Royal Melbourne Hospital.

She achieved ARC funding to establish the Key Centre for Women's Health in Society at the university and was its foundation director from 1988-95.

In 1996 she consulted internationally to develop and obtain consensus on practice standards in women's health for the Commonwealth Secretariat. She has edited a number of books on different aspects of women's health for WHO, UNESCO and the Commonwealth Secretariat.

A pioneer of the development of gender friendly services for women, Lorraine established the first inpatient and outpatient specific service for post–natal depression in a maternity hospital (Mercy Hospital for Women) and established and conducted clinics for treating sexual dysfunction, premenstrual tension and menopausal problems at three teaching hospitals in Melbourne.

Lorraine's research interests have centred on phases in women's lives where hormonal, social and psychological changes occur simultaneously. She carried out one of the first international prospective studies of women's mood during pregnancy and postpartum in order to determine risk factors for postnatal depression. In the last 17 years she has been chief investigator on a prospective population-based study of Australian women's experiences of the menopausal transition.

Her research findings have been disseminated in over 220 papers in peer reviewed journals, 37 articles in non-peer reviewed journals, 23 books authored or edited, and 145 chapters in books. She has written two books for women in the general community and has edited and sat on editorial committees for research journals in her areas of interest.

Lorraine has been on expert panels for the National Institutes of Health (NIH) and WHO, held grants from national and international funding bodies, and was awarded a gold medal for lifetime achievement in sexuality research by the World Association of Sexology.

She has held many offices in national and international medical societies, most recently president of the International Society for the Study of Women's Sexual Health.

Encouraging and mentoring young graduates in their careers and research has been central to Lorraine's career and several of her students and registrars have become professors. She has been amply assisted throughout her career by a multidisciplinary research team.

Lorraine Dennerstein has demonstrated that one can establish both an academic career and a family life. The proud mother of two adult sons, she has three grandchildren and an extended family with whom she now hopes to spend more time.

Lorraine Dennerstein

Doreen Rosenthal

Professor Doreen Rosenthal AO will retire as director and professor of women's health at the Key Centre for Women's Health in Society in the School of Population Health in February next year.

Doreen's long association with the University of Melbourne began as a student in the 1960s. She has had a long and distinguished academic career and is an outstanding leader and mentor.

A developmental psychologist and an international expert in the field of adolescent sexuality, sexual and reproductive health and gender, and the social construction of sexuality, Doreen has published widely in the area of adolescent development, including over 120 research articles, four books and more than 20 book chapters. She has presented papers at major international and national conferences, including the prestigious annual lecture for the Trust for the Study of Adolescence in London. She has received more than $8 million in research grants, including a five-year NIH grant on the trajectories of homelessness among young people and Commonwealth funding for HIV/AIDS social research over a five-year period.

Doreen serves on the editorial boards of seven international journals and has been a member of numerous national and international committees including the Council of the International Society for Research in Adolescence, Australian Health Ethics Committee and various NHMRC and VicHealth research-related committees.

She was the foundation director of the VicHealth funded Australian Research Centre in Sex, Health and Society (ARCSHS), formerly the Centre for Sexually Transmissible Diseases, at La Trobe University from 1992 to 1999. Her leadership established ARCSHS as a centre conducting cutting-edge, multidisciplinary research. Notably, she appointed a community liaison officer to the centre to work with researchers and key stakeholders facilitating the translation of research into policy and practice. This was a first for a university and the position expanded to a unit within the centre which became a flagship example of research translation.

Well before her time in envisioning such a role, Doreen's appointment of a community liaison officer upon her arrival at the Key Centre made the centre an exemplar in research translation. She has been recognised internationally for her pioneering work in research translation and was recently invited to give a presentation to the National Institutes of Health in the United States on optimising research translation.

Between directing ARCSHS and joining the Key Centre in 2003, Doreen spent three years as Associate Dean of Research in the Faculty of Health Sciences at La Trobe University. The Key Centre has thrived under her leadership, substantially increasing its grant income and research output; developing new coursework programs in women's health; and developing an international reputation as a centre producing high-quality research on women, gender and health.

Doreen's contributions have been recognised through a number of honours and awards. She is an Officer in the Order of Australia; a Fellow of the Academy of Social Science (Australia) and on the Victorian Honour Roll of Women.

Doreen Rosenthal's energy, intellect and vision will be missed by her numerous colleagues and friends although we hope that she continues her association with the university. We wish her the very best in retirement.

Ann Kavanagh & Shelley Mallett

REUNIONS

MBBS 1961

Our reunion, held at the new RACV, was attended by 50 graduates plus guests making a total of 86. Of our original 136 graduates in 1961, this was a reasonable turn-up, particularly considering about half are still practising, many scattered throughout the world, and 20 have passed away.

We produced a book of 49 graduate biographies, each including photographs of 1961 and 2006, and one or two pages of lifetime highlights. Everyone has a great story to tell, of enormous interest, and there is a resolve to attempt a better and more inclusive book for the next reunion.

Despite the varied lifestyles pursued by graduates, a certain commonality emerged in these biographies. Most of us born just before the Second World War were significantly affected by it. Many were children of migrants of war-torn Europe and country Victoria. Medicine provided a most satisfying career and can be summed up by Bruce Rigg's conclusion: 'How would I change my life? Tell me anyone who would not have worked less hours, held onto real estate and BHP shares, spent more time with family and gone fishing more. Aside from that I have really enjoyed my work.'

A great night at a magnificent venue was enjoyed by all. Those retired were espousing this virtue and those working were seriously considering it. Hopefully, we will all meet again for the big 50 years reunion and maybe a Sunday lunch meeting!

Pictured at the reunion are Louise Buckle (Roberts), Eve Yuer, Joan Corrie, Flo Levy, Kristine Bredikis and Rosemary Crowley (Willis), behind Terry Rush (Vice) and Fiona Weir.

Barry Butler

MBBS 1962

On Saturday, 21 April 2007, the medical graduates of 1962 had a 45 year reunion at University House.

This was an informal dinner attended by 73 graduates. In December 1962 there were 144 graduates. The evening commenced at 4pm with afternoon tea. The expected walk around the university did not occur due to very welcome drought-breaking rain, but we all had a lot to discuss; the talking never stopped.

Final exam papers from 1962 and photos were provided on every table for the interest of all. Most of us agreed we had no hope of answering many of the questions now and were humbled by the amount of knowledge needed to pass the exams 45 years ago. Photos of previous reunions were also displayed and obviously many of us have aged.

Silver Pager (Topor) attended from Honolulu, Tong Uttaravichien, professor of surgery at Khon Kaen University Thailand attended, Sam Slutzki attended from Israel, Elizabeth Shaw from the UK and Peter Pletka from USA. We congratulated Warner Mooney on his recent Order of Australia Medal.

The next day, at the kind invitation of fellow 1962 graduate Governor David DeKretser and his wife Jan, graduates and partners visited Government House for afternoon tea. We had a very pleasant afternoon and were given a tour of the vice-regal premises, which was enjoyed by all. Naturally, we are all very proud to have David selected as our current Governor of Victoria.

The reunion committee consisted of Mary Dwyer, Ian Rechtman, Bob Dickens and George Santoro. Once again, without Ian Rechtman's hard work this reunion would not have been so successful. We would like to thank Mrs Loris Callander, MVO MBE PSM at Government House.

Pictured at Government House are (from left) Ian Rechtman, Mary Dwyer, David de Kretser and George Santoro.

George Santoro

MBBS 1945

The 62-year reunion of the 'year of 45' was held as an informal luncheon at a pleasant and co-operative restaurant ('Chez Bob') in Malvern on Friday 27 May 2007.

Unfortunately (or, more accurately, fortunately, according to all us 'wrinkled oldies'), the group photograph was very unsatisfactory for technical reasons, but it would, if successful, have shown 16 old graduates to be present. These were—Donald Cordner, Jack Critchley, Jim Gardiner, Joan Hosking (nee Mowlam), Jim Keipert, Ian Mackay, Des Prentice, Donal Rush, Kurt Schwartz, Anthony Shannos, Michael Shoobridge, Iris Solomon (née Leber), Jack Swann, Eric Taft and Gordon Trinca. Eight of us were accompanied by spouses or partners.

There were ten absentees, most of whom were unable to be present for geographic or health reasons—Tom Antonie, Bill Etheridge, John Farrer (UK), Dermot Foster (WA), Ross Hayes (NSW), Don Hewson, Paul Jeffery, Dorothy Menzies (nee Hurley), Mary Levinson (née Bennett, UK), Bert McCloskey and Keith Torode.

Judging from the feedback, this relaxed, convenient, informal and reasonably priced (pay your own way, BYO) format, with close, free, convenient parking, proved to be very popular, and will doubtless now be repeated annually 'for the rest of time!!'

Donald Cordner

CELEBRATIONS

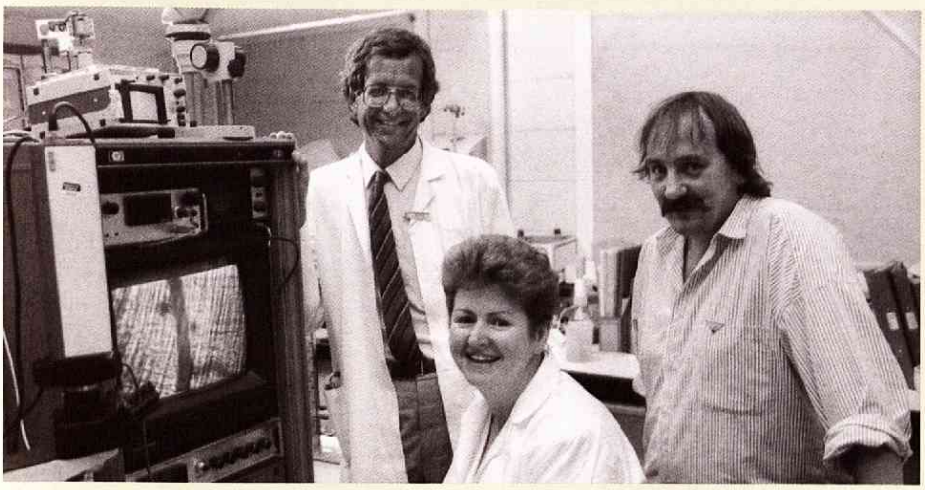
This year marks the fiftieth anniversary of the University Departments of Medicine and Surgery at the Royal Melbourne and Western Hospitals and of the Department of Medicine at St Vincent's Hospital.

The Department of Medicine at St Vincent's marked the occasion in May this year with a dinner to celebrate the department's achievements over the past 50 years and its bright future ahead. Professor James Best, head of the department and of the School of Medicine, welcomed staff members who had long affiliations with the department and key friends from the university and hospital. Toasts were delivered by the Dean, Professor James Angus, by Ms Nicole Feely, CEO, St Vincent's Health and by Professor Emeritus David Penington, formerly head of the department, dean of the faculty and vice-chancellor of the university.

The dinner also celebrated the official launch of the transcript of a witness to the history of Australian medicine seminar, which had been held at St Vincent's Hospital in August 2004. The transcript, compiled by Dr Ann Westmore, is a record of witness recollections of the department's first 30 years and was launched by Pehr Edman Fellow at St Vincent's Institute, Professor Emeritus Jack Martin. The evening also included arias performed by Hana Crisp from the Victorian College of the Arts.

Pictured, at left, at the opening of the Department of Medicine at St Vincent's Hospital (1956) are the pioneer colorectal surgeon and surgical tutor in the clinical school, Sir Hugh Devine, J Forbes MacKenzie, who was clinical dean for a while at St Vincent's before the Department of Medicine was established, John Hayden, the department's foundation professor of medicine, D Murray Morton, clinical lecturer in surgery and C Gordon Shaw who was also a clinical dean before the department's establishment. At the rear are Robert Hadley and Harry Furnell. Photographer unknown, courtesy SVH archives.

More information regarding the celebration dinner and witness seminar (including photographs of the event and historic photographs of the department) are available on the Department of Medicine (SVH) website: www.medstv.unimelb.edu.au



The departments of medicine and surgery at the Royal Melbourne and Western Hospitals celebrated their anniversaries with the launch of a commemorative website and exhibition at the Royal Melbourne Hospital in July.

The event celebrated 50 years of achievement and partnership between the hospital and the university. Joint university and hospital research projects and ventures provide a nexus between teaching, research and the clinical applications of discoveries which benefit the whole community.

One such achievement that continues to have a profound impact on the community occurred in the late 1950s when Maurice Ewing, the inaugural professor of surgery performed the first kidney transplant in Australia after the hospital mortuary was converted into a temporary operating theatre. The ensuing collaboration between Maurice Ewing and Richard Lovell, inaugural professor of medicine, ensured the successful introduction of kidney transplants into routine medical practice in Australia.

This was followed by pioneering work in kidney dialysis. When patients with complications of post-operative acute kidney failure had to be sent to Sydney to be dialysed, Maurice Ewing noted, with typical humour, that it was 'inappropriate for our Victorian dirty linen to be publicly exposed and washed clean in New South Wales'. He set about raising funds for the first artificial kidney machine in Victoria which was installed in the department of surgery at the Alfred Hospital in 1958.

The anniversary also provides the opportunity to celebrate important historical figures including the first professor of medicine, Richard Lovell (1918–2000) and Professor Kincaid-Smith AC CBE, renowned for her outspoken campaign against drugs that caused long-term damage to the kidneys and who, in 1975, became the first woman to be appointed to a personal chair at the university.

This photograph shows Richard Larkins, Marjorie Dunlop and Michael Hill in 1987 when they were studying the early changes in diabetic kidney disease and diabetic disease of the small blood vessels in the Department of Medicine at the Royal Melbourne Hospital. Richard Larkins was James Stewart professor and head of the Department of Medicine (1984-1999). He also served as dean of the Faculty of Medicine, Dentistry and Health Sciences (1998-2003) and is now vice-chancellor of Monash University. Marjorie Dunlop was a senior researcher with the department and is now an associate professor and the faculty's grant mentoring co-ordinator. Michael Hill is now a professor in the Department of Medical Pharmacology and Physiology, at the University of Missouri, School of Medicine. Photos courtesy RMH archives.

A link to the RMH/WH departments of medicine and surgery 50th anniversary commemorative web pages can be found from the hospital's website: www.mh.org.au

OBITUARIES

RECORDED WITH REGRET, THE PASSING OF:

P Sydney Allen PSM (MBBS 1963)
Grant L Barham (MBBS 1971)
Alfred J Barnett (MBBS 1939)
John Billings AM, KCSG (MBBS 1941 see below)
Roger F Bullen (MBBS 1953)
Solomon Brand (MBBS 1944)
George L Christie (MBBS 1948)
Peter V Corby (MBBS 1959)
Joyce M Daws DBE (see p.29)
Stevens Dimant (MBBS 1943)
Douglas JM Dunn (MBBS 1935)
Ross A Hayes (MBBS 1945)
Hyman J Hoffman (MBBS 1942)
Yumna E Holyoake (MBBS 1947)
Stanley B Johnson (MBBS 1964)
David Komesaroff (MBBS 1956)
Alvis Kucers (MBBS 1957)
John Q McCubbin (MBBS 1951)
Brian A Minto (MBBS 1951)
Helen M Moran (MBBS 1969)
Gladys W Morris (MBBS 1940)
Edmund N O'Brien (MBBS 1952 dec. Oct. 2005)
Bryan O'Day (MBBS 1942)
Noel D Panettiere (MBBS 1958)
Ilana Rischin (p.29)
Teg Robertson (MBBS 1939)
John J Sanders (MBBS 1950)
Denis U Shepherd (MBBS 1957)
Noel D Sherson (MBBS 1960)
Bill Sloss (MBBS 1941)
Gordon J Stewart (MBBS 1951)
Robert O Summers (MBBS 1951)
Frank G Tait (MBBS 1947)
David JA Thomas(MBBS 1968)
Joe Tjandra (MBBS 1981)
Geoff Wigley (MBBS 1951)
Frieda E Williams/Plarre (MBBS 1935)
Leslie Williams (MBBS 1938)
Robert D Wilson (MBBS 1949)
Victor Wynn (MBBS 1944)
Ee T Yap (MBBS 1959)
Lee Min Yap (MBBS 1995, see p.30)
Neville York (MBBS 1952, see p.30)
Norman V Youngman (MBBS 1935)
Stuart C Zoltak (MBBS 1978)

JOHN JAMES BILLINGS AM KCSG
1918—2007

John Billings was one of a group of young neurologists who, in company with senior physicians with an expert interest in neurology, established neurology in Australia as a separate discipline in its own right. Coping with many other responsibilities he remained first and foremost a clinical neurologist. In 1951 he was a member of the group who met in the old Anatomy School at Melbourne University under the chairmanship of Professor Sydney Sunderland to found the Australian Association of Neurologists. John Billings was the last surviving foundation member.

He was educated at Xavier College, Melbourne, where he finished as dux in 1935. He moved at once to the medical course in the University of Melbourne from which he graduated in 1941 with multiple high honours. After a year as a resident at St Vincent's Hospital he enlisted in the AIF in early 1943 and served until 1946. Just before enlisting he married Evelyn Thomas, always known as Lyn.

One posting was to an army hospital in New Guinea where his commanding officer was Colonel John Hayden, who recruited John to assist him in his private practice after the war. There were other postings, the last to the Repatriation General Hospital Heidelberg, Victoria, during which he gained his MD at Melbourne (by examination in those days) and the MRACP. A Nuffield fellowship took him to the National Hospital for Nervous Diseases, London. Later one of the consultants at that hospital remarked to me that his knowledge and clinical accomplishments were such that they thought he was already a fully trained neurologist and they wondered what he was doing there.

John and Lyn Billings at Government House with members of their family

He was appointed to the senior medical staff at St Vincent's Hospital in 1948 but did not achieve his own clinic and the appointment as honorary neurologist until 1951. Soon he became consultant physician to the Royal Victorian Eye and Ear Hospital and consultant neurologist to the Peter MacCallum Cancer Hospital. These put him in contact with groups of undergraduates and postgraduates at St Vincent's and postgraduates at the other two, thus founding a career of outstanding brilliance as clinical neurologist and medical educator.

He attracted a series of able registrars and encouraged those with an inclination for research. His combination of grave serenity and a warm friendly personality complemented his outstanding teaching. At the age of 50 he was still defeating his registrars on the squash court.

For the last ten years of his hospital career he combined clinical neurology with his appointment as the associate dean (clinical) at St Vincent's.

John was elected to the council of the RACP for 1952 and 1953, and again from 1960 to 1976. He was the college's representative on the NHMRC for much of this time, during which he was chairman of the research grants committee for some years. In recognition of his contributions the RACP established the annual John Billings scholarship at the end of his term of office.

John Billings was a man of strong loyalties to those to whom he had committed: people, institutions, the learned societies, his hospital and his Church. He served on many hospital committees, most notably on the advisory council and the advisory medical committee which he chaired for ten years. In the 1960s and 1970s he joined with Lyn in a scientific investigation and the subsequent production of a method of natural birth control compatible with the teaching of the Catholic Church, beginning with the earlier concept of a 'safe period'. They produced a system which was easily understood, even by the uneducated, and suitable for implementation in the home without drugs or medical assistance. For this they were each awarded an AM, and John was made a Papal Knight.

At the end of his hospital career John gave a small dinner, which I was privileged to attend, to farewell his last registrar. He looked around that small group and then, in a moment of unconscious self-revelation, he began: 'Carissimi…'.

Keith Henderson

JOYCE DAWS DBE
1925–2007

Dame Joyce Daws died in June this year, aged 81.

Born in Hounslow, England, she won a scholarship to Cambridge University where she specialised in classics. During the Second World War she enrolled at the Royal Free Hospital School of Medicine and graduated MBBS in 1949. She was awarded a postgraduate scholarship in surgery in 1952, the same year she passed fellowship examinations of the RCS.

In 1956 Lorna Sisely visited the Royal Free Hospital, looking for another woman surgeon to join the Queen Victoria Memorial Hospital in Melbourne, then staffed exclusively by women, and Joyce decided to accept the offer. She joined the

Joyce Daws

hospital as a resident that year, becoming part of a circle of remarkable women doctors, including Dame Kate Campbell and Dame Ella MacKnight.

A stalwart of the Victorian Medical Women's Association, she became its representative on the AMA branch council. She broke new ground when she became the first woman to be elected president of the Victorian branch of the AMA in 1975, the same year she was created Dame Commander of the British Empire. Her membership of the Victorian Medical Benevolent Association demonstrated her keen personal interest in the welfare of doctors and their families when in distress.

Joyce's retirement was taken up with a protea farm, originally started as a weekend project but which led to her participation in the International Protea Association, which she chaired from 1987-96.

Sandra Hacker and Lena McEwan

ILANA RISCHIN
1961–2007

Ilana Rischin was well-known to many international medical students in her role as a teacher of English language and cross-cultural clinical communication skills in the faculty's international student support program. Ilana's area of expertise was developing students' patient-centred approach to the medical interview, including responding empathically to patient emotions and distress. Cross-cultural clinical communication was Ilana's primary research interest and her work in this area informed the development of multi-media teaching resources. Her contribution to the faculty included raising awareness of the learning needs

Ilana Rischin

of international students and she was instrumental in setting up the Breast Cancer Network consumer consultation groups with semester five medical students.

When diagnosed with breast cancer, Ilana continued teaching in her smiling, thorough and dedicated way, never letting students know of her own health concerns. This dedication earned Ilana her reputation as an outstanding teacher, highly regarded by her students and colleagues. Ilana was a loyal, witty, and fun friend who made sure she enjoyed what life had to offer. Her friends and colleagues in the faculty miss her very much.

Robyn Woodward-Kron

ILANA RISCHIN MEMORIAL FUND

At a memorial service held for Ilana at the university, a fund was established to support an annual prize, named in Ilana's memory, for a high achieving international student in the School of Medicine. To date $3,000 has been raised to support the prize. If you would like to make a donation to the Ilana Rischin Memorial Fund please contact

Wendy Brooks, Director, Advancement and Communications Unit, Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne, 3010, Australia.
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M: 0408 145 661,
E: wbrooks@unimelb.edu.au

Lee Min Yap

LEE MIN YAP

1970–2007

Born in Kuala Lumpur, Malaysia, Lee Min attended Epsom College where he was a member of the school tennis team and an avid table tennis player. He transferred from medicine at Leicester University to Melbourne University in 1990. After his internship at St Vincent's Hospital he did basic physician training in Victorian hospitals before training in gastroenterology at Flinders Medical Centre in South Australia.

Lee Min travelled to England with his wife, Su Peing, in 2001, working at the Radcliffe Infirmary and the John Radcliffe Hospital in Oxford while undertaking laboratory research in inflammatory bowel disease for his doctoral thesis at Oxford. His FRACP was obtained in 2003, the year his first son, Elliott, was born.

Returning to Melbourne in 2004, Lee Min worked at the Royal Melbourne, the Alfred and Frankston hospitals as well as in private practice, and was instrumental in establishing the Alfred Inflammatory Bowel Disease service in earnest. His doctorate on the Role of Meprin Alpha Polymorphisms in Inflammatory Bowel Disease and Coeliac Disease was conferred in 2005, the year Daniel was born.

Lee Min was known for his commitment to his patients. He was an excellent physician: capable, approachable and available. Committed to research and clinical trials, he provided compassionate and expert health–care and was an amiable and selfless colleague, generous with his time and experience.

He also applied this boundless enthusiasm to his three great interests: Saturday Yum Cha with friends and family; researching the latest electronic gadgets; and finding the best deal for his friends, whatever they were planning to buy. He was a great raconteur with a down-to-earth sense of humour, and a loyal friend.

Neville York

A tireless husband and father, devoted son and brother, Lee Min attempted to create a balance to include time with his family. He glowed with pride when talking about his sons and loved nothing better than quiet weekends at home as a family. Elliott and Daniel were incredibly dear to him and they obviously loved him for his humour and gentle guidance. Su Peing was a constant delight and unfailing support to him, and Lee Min often paused to reflect on the happiness he enjoyed.

Lee Min embraced life with all its challenges and lived it to the full at all times. He leaves a lasting legacy and will be sorely missed.

Sally L James and Vincent Yap

NEVILLE GEORGE YORK

1925–2007

In 1947, following war service as an RAAF pilot in the South West Pacific, Neville York began his medical course with many other ex-servicemen at the Mildura Branch of Melbourne University. After graduation in 1947, he held RMO posts at the Royal Melbourne Hospital and Royal Alexandra Hospital for Children in Sydney. In 1957, he commenced general practice in Ermington, NSW, with his wife Jeanne Collison (later AO).

Neville and Jeanne retired to the Nelson Bay area where Neville, with characteristic enthusiasm, entered a new phase of his career as a civilian medical officer at Williamtown RAAF base. His previous Second World War experience as a pilot made him a respected, even revered, figure at the base.

Despite his own ill health over the last five years of his life, Neville lovingly cared for Jeanne during her terminal illness, nursing her at home until her death a little over a year ago.

John York

Cultural Collections Diary for 2008

The University of Melbourne has been collecting cultural material since its foundation in the 1850s and now owns 27 identified cultural collections, which link the history, scholarship and identity of the university with research, teaching and public programs.

Many of these collections and individual items are of high cultural and heritage significance. They include rare books, prints, maps, music, Australiana and other special materials held by several library branches; museums of visual art, indigenous cultures, classics and archaeology, medical history, dentistry, and anatomy and pathology; collections illustrating the history of academic disciplines and professions; natural history collections; as well as the Grainger museum and the university's archives.

The university's new Cultural Collections Diary for 2008 features highlights from these collections, including material held by the Medical History Museum and the Henry Forman Atkinson Dental Museum.

The diary measures 130mm by 185mm, has week to a page opening with 52 full colour plates and is available for AUD$24.95 from the Melbourne University Bookshop:
www.bookshop.unimelb.edu.au

IN BRIEF

CONGRATULATIONS TO ALUMNI, STAFF AND STUDENTS

Sam Berkovic AM (Medicine AH/NH, Epilepsy Research Centre)—fellowship of the Royal Society; appointed Laureate Professor of the University of Melbourne; 2007 NHMRC Australia fellowship. *Prithi Bhathal (PhD 1966; Pathology)*—awarded the distinguished pathologist medal at the Australasian division of the International Academy of Pathology. *John Best (MBBS 1963, MD 1970)*—AO for service to medicine and to public health through support for strategic health research and policy development, and as a contributor to the development of rural and remote health services and medical education programs, particularly in Aboriginal and Torres Strait Island communities and regional Victoria. *Kerry J Breen (MBBS 1964, MD 1976)*—AM for service to medicine through the advancement of medical ethics and professional standards of training and practice and to the specialty of gastroenterology as a clinician and teacher. *Ashley Bush (MHRIV, Pathology)*—Bethlehem Griffiths Research Foundation prize. *James M Butler (MBBS 1972)*—AM for service to medicine in the field of dermatology, particularly through the establishment of the Skin and Cancer Foundation, and to the Australasian College of Dermatologists. *Frank Carbone (PhD 1985; Microbiology & Immunology)*—2007 Fulbright senior scholarship. *Allan Carmichael (MD 1988)*—OAM for service to medicine as an educator and administrator through a range of government and professional organisations, particularly in the field of paediatrics. *Graeme Clark AO (Laureate Professor)*—2007 Klaus Joachim Zülch prize. *Bryony Coleman (Otolaryngology)*—2007 Victoria fellowship. *Alan Cowman (PhD 1983; WEHI)*—NHMRC Australia fellowship. *Helen Cox (PhD 2006; Burnet Institute of Medical Research)*—2007 Premier's Award for medical research. *Mary Galea (Physiotherapy)*—2007 Churchill fellowship. *Bill Heath (WEHI, Microbiology & Immunology)*—Federation fellowship. *Richard M Fox (former staff)*—AM for service to medicine in the areas of clinical oncology and research, to medical education and training, and through governance and leadership roles within professional organisations. *John G Fraser (MBBS 1958)*—OAM for service to tennis at state, national and international levels through administrative roles, and to sports medicine. *Peter R Harcourt (MBBS 1973)*—OAM for service to sports medicine as a practitioner, administrator and educator, and through contributions to the development of anti-doping policies in sport. *Doug Hilton (WEHI)*—2007 NHMRC Australia fellowship. *John Hopper (MEGA Centre, Population Health)*—2007 NHMRC Australia fellowship. *Nicole Joshua (MHRI)*—2008-09 Sir Robert Menzies Memorial Research Scholarship. *Jill E Keeffe (PhD 1992; Ophthalmology)*—OAM for service to public health, particularly in the area of vision testing, and as a contributor to the advancement of eye care education and practice. *Erinna Lee (WEHI)*—2007 Victoria Fellowship. *Robert MacInnis (GDip Eipdemiol & Biostats 1997, PhD 2006; Population Health)*—commendation in the 2007 Premier's Awards for medical research. *Tony Mariani (MBBS 1971)*—AM for service to medicine as a consultant physician in the fields of gastroenterology and internal medicine and through the development and promotion of preventive health care initiatives within the Italian community in Australia. *Colin Masters (Laureate Professor)*—2007 Victoria prize for science. *Maria McCarthy (Murdoch Childrens Research Institute)*—2008-09 Sir Robert Menzies Memorial Research Scholarship. *Kevin Moriarty (MBBS 1969)*—OAM for service to medicine as an anaesthetist and through honorary medical appointments at the Royal Melbourne Zoo and surf lifesaving organisations. *Doreen Rosenthal AO (Key Centre for Women's Health in Society)*—inducted into the Victorian Honour Roll of Women. *Ernst P Silberstein (MBBS 1951)*—OAM for service to medicine, particularly as a paediatric neurologist, and through executive roles with disability support organisations. *Kevin H Siu (MBBS 1965)*—AM for service to medicine as a neurosurgeon and through contributions to a range of professional associations. *Andreas Strasser (WEHI)*—2007 NHMRC Australia Fellowship. *Hugh Taylor AC (BMedSc 1970, MBBS 1971, GDip Ophth 1975, MD 1979; Ophthalmology, CERA)*—the Merck Mectizan award. *Jacinta Tobin (MBBS 1983, PhD 2006; Medicine RMH/WH)*—U21 scholarship. *Geoff Tregear (Howard Florey Institute)*—AM for service to scientific and medical research and through administrative roles within research institutions. *David Vaux (MBBS, BMedSc 1984, PhD 1990)*—2007 NHMRC Australia fellowship. *Garry Warne (MBBS 1968; Paediatrics, Royal Children's Hospital International)*—Minister's Award for Outstanding Individual Achievement in the 2007 Victorian Government Public Healthcare Awards. *Robin J Wilson (MBBS 1975, GDip Mental Hlth Sci 1999, M Hlth Sci 2002)*—OAM for service to the community through the provision of mental health services and to organisations that provide assisted accommodation for people who are unable to live independently. *Tien Wong (Ophthalmology, CERA)*—Amgen medical researcher award. *John R Zalcberg (MBBS 1975, PhD 1985; Peter McCallum Cancer Institute)*—OAM for service to medicine in the field of oncology through initiatives to assist cancer patients and their families and through the promotion of clinical research.

STUDENT PRIZES AND AWARDS

2007 UMMS PETER G JONES ELECTIVE ESSAY PRIZES

Essay prizes for 2007 were awarded to Arnab Ghosh for 'Broadening your differentials', to Sam Harwick for 'Just passing through but never leaving', to Ingrid Laemmele-Ruff for 'The tip of the iceberg' and to Matthew Lin for 'Trial by fire'. Edited versions of Ingrid's and Matthew's essays are published on pp 20-1. Other essays submitted for the prize can be found at: *www.medicine.unimelb.edu.au/ umms/publications/Chiron/pgjonesessays.html*

2006 DEAN'S HONOURS LIST

Semester 12 *Caroline Czarnecki, Linsey Utami Gani, Rominder Singh Grover, Andrew James Gogos, Jessica Anne Hetherington, Grace Huei-Hsin Huang, Alison Joanne Lee, Jacky Chien Hsing Loa, Michael Sze Yuan Low, Andrew Steven Macleod, Sarah Mc Guinness, Briony Lee Norris, Rebecca Anne Scambler, Sarah Jane Sparham, Lavinia Anne Spain, Mei Lin Tan, Anne Trinh, Brendan Mark Whiting.*

WHAT'S ON

2007 UMMS AGM

The 2007 AGM will be held in the Harry Brookes Allen Museum with this year's function for members on Thursday 29 November, commencing at 5.30 pm. RSVP (essential) by Wednesday 21 November T: 03 8344 4510.

2007 UMMS LECTURE

New Approaches to Aboriginal Child Health

Professor Jonathan Carapetis, Director, Menzies School of Health Research, Darwin.

7.30pm, Thursday 29 November 2007, Sunderland Lecture Theatre, Medical Building, University of Melbourne.

RSVP: T: (+61 3) 8344 9800

CONFERENCE

Health Bioethics and the Law: Inclusions and Exclusions

Joint conference of the Australasian Bioethics Association and the Australian and New Zealand Institute of Health Law and Ethics, International House, University of Melbourne, Wednesday 28 November – Saturday 1 December, 2007 Keynote speakers: Julian Gardner, Rob Moodie and Barry Jones AO. This conference will focus on the legal, philosophical and practical dimensions of healthcare inclusion, exclusion, protection and restriction.

Special interest sessions on philosophy theory, clinical ethics, research ethics, genetics, ethical decision-making processes, resource allocation issues, indigenous health, rural health and legal issues in relation to liability for health service provision are planned for the program.

Further information T: (03) 9349 2220, F: (03) 9349 2230, E: info@conorg.com.au

MBBS GRADUATE ANNIVERSARIES IN 2007

5th year of 2002; 10th year of 1997; 15th year of 1992; 20th year of 1987; 25th year of 1982; 30th year of 1977; 35th year of 1972; 40th year of 1967; 45th year of 1962; 50th year of 1957; 55th year of 1952; 60th year of 1947

PLANNING A REUNION?

University House is housed in a beautiful Victorian home dating from 1885. It is the sole survivor of a number of Victorian professorial houses that once lined Professors Walk. Situated within the grounds of the university, University House is located five minutes from the city centre and features function rooms catering for six to 300 guests. Contact the functions manager on +61 3 8344 5254 for information or visit the website at: *www.uniclub.com.au*

If you are organising a reunion, please contact the Advancement and Communications Office for a list of graduates for your year. To ensure you continue to receive information about reunions, please let us know of address and email changes.

UMMS, Advancement and Communications Unit, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne VIC 3010, AUSTRALIA

T: (+61 3) 8344 5888

E: umms-medicine@unimelb.edu.au

www.medicine.unimelb.edu.au/umms/index.html

Glenn Bowes, Associate Dean Advancement and Wendy Brooks, Director Advancement & Communications

SHARING OUR SUCCESSES, BUILDING RELATIONSHIPS AND ATTRACTING SUPPORT

Great advances are now being made by the faculty in areas such as neuroscience, immunology, genetics, and cancer which will contribute to dramatic improvements in the lives of many people.

The Faculty of Medicine, Dentistry and Health Sciences educates more health professionals than any other university in Australia and our numerous research and clinical partnerships with research institutions and hospitals extends and enriches our impact on global health.

Our research is extensive and far reaching: our dedicated team of more than 2,000 researchers and postgraduates work to find the solutions in prevention, treatment and cure for the world's most important health problems and produce more peer reviewed papers and are supported by more NHMRC grants than any other university in Australia.

The new bachelor of biomedicine will provide the next generation of health professionals and researchers with a rich academic undergraduate experience.

Given your close connection with the faculty we would like to personally involve you in this exciting new era. Your ideas, financial support and enthusiasm are essential to ensure that we continue to attract the brightest and the best and make an optimum impact on health - research and practice.

The faculty is very grateful for the all the support it receives from alumni and the wider community and is pleased to be able to list here those who have given $500 or more from 1 July 2006. Thank you also to those donors who wish to remain anonymous.

SUPPORTERS OF THE FACULTY OF MEDICINE, DENTISTRY AND HEALTH SCIENCES JUNE 2006 - SEPTEMBER 2007

Luminaries

Allan J Myers AO QC & Maria J Myers AO

Principals

Patricia M Desmond, James R Downie, Eva & Les Erdi, Robert N Gibson, Kevin & Tanith O'Brien, James J Tehan, Transport Accident Commission, Brian Tress

Benefactors

Joan A Anderson, Vincent Arthur & Family, Graham V Brown, Andrew A Heggie, Gabrielle O'Brien & Craig Andrews, John M Permezel

Associates

1979 Melbourne Medical Graduates, Australian Medical Association, Australian Society of General Dentistry, James A Angus, Sandra Bardas OAM, Jacqueline J Birrell & Family, Glenn Bowes, Stephen A Cantor, Eugene P H Chu, CJD Support Group Network Pty Ltd, Andrew Cuthbertson, Rod & Marie Dalziel, June Danks, David F Eckel, Footwork Podiatric Laboratory, James M Gardiner, Jacques Gosteli, James S Guest AM OBE, Ian Gust AO, Fumi Horiguchi, Thomas N Jackson, Helen Jennings, KM & WM Kelly & Sons, Frieda M Law, Jane M Matthews, Melbourne Pathology Pty Ltd, John O Miller AO & Ruth Wisniak, Sheila Mulvey, Merrilyn Murnane AM, Garry J Nervo, Ophthalmic Laboratories Pty Ltd, David A Lindsay, Enid Lindsay, Richard Mong Hoo Ng, David G Penington AC, John F Poppins & Helen B Brown, Paddy O'Brien, Graham B Senior, Jocelyn M Shand, Elizabeth J Shaw, Mr & Mrs C S Shum, Paul M Standish, Surgeons of the HPB & Liver Transplant Unit of Austin Health, Anne Swan & Robert Johanson, Sunya S Viravaidya, Verghese Zachariah

Enthusiasts

Andersen & York Consulting Pty Ltd, William L Armstrong, Australian Society for Endodontology, Rachel & Tamara Bach, Benjafield & Associates, Beiersdorf Australia Ltd, John W Brownbill, James Butler AM & Gail Littlejohn, Paul I Korner AO, Ian H Frazer, Jeremy P Graham, John K Harcourt OAM, June L Howqua, Francis J Kenny, Marion Kloss, Sze W Kwong, Bruce Mann, Robin C McCann, Chris McConnell, Richard & Barbara McMahon, North Concrete, Rita & Harry Perelberg, Margaret & Harold Ponsford, Roger B Rodrigue, Craig Rubinstein, KL Schilling, Malcolm E Scott, Jonathan Streeton,Danny M Ungar, Ben M Wadham, David J Warburton, Charles W Wilson, The Woombye Pub

Graduate Reunion

Melbourne Medical Graduates of 1979

Trusts & Foundations

The Aranday Foundation, ANZ Trustees, ANZAOMS Research & Education Foundation, Australian Rotary Health Research Fund, Australian Society of Orthodontists' Inc. Foundation for Education & Research, The Besen Family Foundation, Clive & Vera Ramaciotti Foundation, The Donovan-Johnston Scholarship Fund, The Dowd Foundation, Equity Trustees Limited, The Finkel Foundation, The Florence & Melville Hughes Trust, Florris J & H Dallas Wiseman Charitable Trust, The Fred Bladin Medical Foundation in Research & Treatment of Neurological & Allied Diseases, The Hugh Noel Puckle Fund, The Ian Potter Foundation, John Winter Research Fund, Melbourne Community Foundation's Towards a Just Society Fund, The Myer Foundation, National Australia Bank Trustees, Rae & Edith Bennett Research Fund, The Ray & Margaret Wilson Foundation, Sandhurst Trustees, Sir Edward Dunlop Medical Research Foundation, Snowy Nominees Charitable Foundation, Tattersall's Foundation Limited, Trust Company Limited, Victorian Lion's Foundation, Walter Cottman Endowment Fund, Wenkart Foundation

Estates

The Cosby Stopford Campbell & Marshall Stopford Campbell Bequest, Estate of Gordon P Castles, Estate of Grote Reber, Estate of John E Taylor, Estate of Kathleen C Condon, Estate of Leslie Eric Paddle, Margaret Walkom Bequest, Thomas Waitsen Williams Estate

FUNDS ESTABLISHED TO SUPPORT THE FACULTY

Cord Blood Stem Cell Cystic Fibrosis Program Fund
The Ilana Rischin Memorial Fund
The JHW Birrell Memorial Fund
The Karl David Yeomans Fund
The Marie Tehan Memorial Fund

Thank you again for your support. For further information about supporting the Faculty of MDHS through donations, establishing special funds or making a bequest, please contact:

Wendy Brooks

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CHIRON

Spring 2007