A chapter in the evolution of paediatrics in Australia

The University of Melbourne Department of Paediatrics at the Royal Children's Hospital 1959-2003

The fully-footnoted transcript of a Witness to the History of Australian Medicine Seminar held at the University of Melbourne on 14 November 2003
Edited by Dr Ann Westmore

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Apologies: Professor Bob Adler, Dr Kevin Collins, Dr John Court, Dr Robert Fowler, Dr Ian Hopkins, Professor John Hutson, Dr Julie Jones, Professor Lou Landou, Dr Bill Kitchen, Miss Mary Moore, Dame Elisabeth Murdoch, Professor Terry Nolan, Associate Professor Dinah Reddihough, Professor Don Roberton, Professor Graeme Ryan, Associate Professor Mike South, Dr Peter Smith, Professor F. Douglas Stephens, Dr Alex Venables, Dr George Werther, Dr Peter Williams, Professor Bob Williamson, Dr Geoff Tauro, Dr Peter Yule

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Origins of the Department

Glenn Bowes[1]: Welcome. There are many apologies as you would imagine from those you know well, but most notably Dame Elisabeth Murdoch.[2] She rang up personally to indicate how sorry she was that she could not make it today. Part of the process that we'll be discussing in the broader sense with this history project will be to take advantage of the opportunity to speak to key people, like Dame Elisabeth, on an individual basis.

Also, my apologies for the lateness of some of the invitations to you. With tremendous support from David McCredie[3] we were snowballing the names of those invited to come, and suggestions just kept coming forward.

This idea for this Witness seminar on the University of Melbourne Department of Paediatrics at the Royal Children's Hospital[4] started with a conversation I had with Janet McCalman[5] at the Vice-Chancellor's Annual Retreat earlier this year.

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[1] **Professor Glenn Bowes** MB BS PhD FRACP GradCert Mgmt (b.1948), a 1972 Monash medical graduate, trained as an adult respiratory physician before undertaking research towards a PhD in Canada on newborn respiratory physiology. On returning to Melbourne, he resumed practice as a respiratory physician at the Alfred Hospital, opening the first adolescent cystic fibrosis unit in Australia. He was appointed Professorial Associate and Director of the Royal Children's Hospital Centre for Adolescent Health in 1991 and later joined the Hospital's Board of Management. From 1998 to 2002 he was a senior medical administrator of the Women's and Children's Health Care Network and in 2002 was appointed Stevenson Professor of Paediatrics, head of the University of Melbourne Department of Paediatrics and Director of Postgraduate Education and Training at the Royal Children's Hospital.

[2] **Dame Elisabeth Murdoch** AC DBE (b.1909) is a compassionate and much admired worker, supporter and benefactor of the Royal Children's Hospital. Her association with the Hospital started in her teenage years when she visited it and knitted singlets for babies. In 1933, as a young mother, she agreed to join the Hospital's Management Committee. Six years later when one of her four children was critically ill and needed surgery, she had to leave the sick youngster in the care of medical staff, as was common practice at the time. Years later, as President of the Hospital (a position she held from 1954 to 1965), she argued that parents should be allowed to visit their children in hospital at any time.
Dame Elisabeth urged her husband, Sir Keith Murdoch, to support the Good Friday Appeal for the Hospital through the Sporting Globe newspaper and 3DB radio station which he owned. The Appeal, founded in 1933, became an annual event, raising millions of dollars for the Hospital over many years.
She also supported the development of a Hospital Research Committee which oversaw the Clinical Research Unit (established 1946, became operational 1948). The Committee evolved into a Research Foundation in 1960 with an autonomous Board, which she chaired for many years. In 1984 the Foundation evolved further into the Murdoch Institute for Research into Birth Defects (subsequently known as the Murdoch Children's Research Institute), the name commemorating Dame Elisabeth's leading role in promoting research in the Hospital. (For further information, see John Monks, *Elisabeth Murdoch: Two Lives*, 1994)

[3] **Dr David A. McCredie** MD BSc FRACP (b.1926) studied science and medicine at the University of Melbourne, graduating in 1949. He joined the Children's Hospital as a Resident Medical Officer in 1951 and after further training in Melbourne and overseas, he became Second Assistant and Associate Professor at the Hospital, 1963-91, serving as Hospital Nephrologist from 1973-79, and head of the General Medical and Professorial Medical Units from 1979-91. He has been involved in the Victorian Association of Youth Communities since the 1960s, and has also represented the Australian Kidney Foundation and the International Paediatric Nephrology Association. In 2004, he chaired the International Congress on Paediatric Nephrology in Adelaide.

[4] **The Royal Children's Hospital** (established as the Melbourne Hospital for Sick Children in 1870 and generally referred to as the Children's Hospital until 1953 when the Royal Charter was conferred) is part of

We discussed the possibility of a seminar and I thank her and Ann Westmore[6] who is leading us through this project today. It's gathered momentum and we're really very excited about it.

During the day, Kate Bride, manager of the Department of Paediatrics, and Natashya Kostas, who is secretary of our Department, will be popping in. In the versatile nature of administrative staff these days Natashya said she'd put on her black and whites and pour the wine for lunch. Also, a special thanks to David McCredie who's held my hand through this and I really thank you, David, for that support. David has an international visitor who arrived this morning and was at the airport at half past five. So thank you, David, for fitting us all in.

This is only the beginning of the history project. As many of you know the Faculty of Medicine, Dentistry and Health Sciences has undertaken a history project.[7] This seminar on the University Department of Paediatrics will fit into that both in the web-based form which is our first attempt, and subsequently as we move forward to the next stages.[8]

It's really been interesting for me that no-one has said, Why are we doing this seminar? There's been an implicit acceptance that this is an important and a timely thing to do. I

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the Women's and Children's Health Care Network in Victoria. It is recognised as a world-class centre of excellence in paediatrics and adolescent medicine, specialising in the diagnosis, care and treatment of children and adolescents and in research on diseases, disorders and illnesses that occur in younger age groups.
It is the largest paediatric hospital in the Southern hemisphere and is a major teaching centre in paediatrics, having the University of Melbourne Department of Paediatrics situated on its campus. It has a strong research reputation and was the site of Australia's first paediatric clinical research unit (established in 1946) which, by degrees, has become the Murdoch Children's Research Institute.

[5] **Professor Janet McCalman** PhD FAHA (b.1948) is Director of the Johnstone-Need Unit for the History of Medicine at the University of Melbourne. She has been the driving force behind the development of the Witness to the History of Australian Medicine seminar program. Her contributions to the history of medicine include *Sex and Suffering: Women's Health and a Women's Hospital,* published by Melbourne University Press in 1998.

[6] **Dr Ann Westmore** PhD (b.1953) is an Honorary Fellow in the University of Melbourne Centre for the Study of Health and Society. She is responsible for the conduct of the Witness to the History of Australian Medicine seminar program and the content of the online historical compendium of the University's Faculty of Medicine, Dentistry and Health Sciences (see note 7).

[7] **Gateways to the History of Medicine at the University of Melbourne** comprises a series of web-sites relevant to the study of the history of medicine, dentistry and the health sciences. The Historical Compendium to the Faculty of Medicine, Dentistry and Health Sciences (www.cshs.unimelb.edu.au/umfm) provides information about the history of the Faculty, its Departments and Schools, and relevant concepts and people. The Gateway to the Johnstone-Need Medical History Unit (www.cshs.unimelb.edu.au/jnmhu) provides a guide to research in the history of medicine around Australia. The Online Medical & Dental History Museum Catalogues (www.cshs.unimelb.edu.au/mhm) details the dental and medical museum collections at the University of Melbourne. Finally, the Australian Nursing History Project (www.nursing.unimelb.edu.au/anhp) is undergoing development to become a register of published and unpublished resources for the history of nursing.

[8] The transcript of this seminar was published online on 14 March 2005 at www.cshs.unimelb.edu.au/programs/jnmhu/witness/pdfs/witn-2003-11-14.pdf

think the timeliness was heightened by the recent passing of David Danks.[9] It's wonderful that you are here today, June[10], so thank-you. But it was a reminder to us of the importance of recording the history of events, particularly with regard to paediatrics and the role that the University Department played in paediatrics generally as well as specifically with regard to this University and the Royal Children's Hospital.

For me, as a lateral entry paediatrician, if you will, history's always been very important. One of the people who was most affirming and welcoming to me when I came to the Children's Hospital in 1991 was Howard Williams.[11] He took it upon himself, in the way

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[9] **Professor David Miles Danks** AO, MD FRACP (1931-2003) graduated in medicine from the University of Melbourne in 1954. During two years of residency at the Royal Melbourne Hospital, he spent a fateful six months as Resident Medical Officer to Professor Richard Lovell, the newly-appointed University of Melbourne Professor of Medicine who had just arrived from the UK. Lovell's interest in research had a big influence on Dr Danks who became aware of a range of methods to investigate the causes of illness.
In 1957 he joined the staff of the RCH as a Junior Resident Medical Officer and the following year he was appointed a Registrar in the Hospital's Clinical Research Unit. A period of overseas study followed in 1959 when an Uncle Bob Scholarship and a grant from the Felton Bequest enabled him to undertake training with leading human geneticists in London and Baltimore. After immersing himself in the rapidly developing science of medical genetics and its potential impact on human health, he returned to the RCH in 1962 and was appointed Deputy Director of the Clinical Research Unit.
In 1967, he established a Genetics Research Unit and pursued his major research interests - the cause and treatment of inborn errors of metabolism, particularly copper metabolism. He developed community screening of genetic conditions via a network of clinics (now known as Genetic Health Services Victoria), as well as developing a series of electronic visual aid systems (POSSUM and OSSUM) to help clinicians diagnose genetic syndromes more reliably.
He was a Reader in Genetics at the University of Melbourne for many years, lecturing to students of science, medicine and dentistry. He was also the University's Stevenson Professor of Paediatrics, 1975-83 and Professor of Paediatric Research, 1983-95. In addition, from mid-1975 he was Co-ordinator of Research at the Hospital. In 1984 he and his colleagues established the Murdoch Institute for Research into Birth Defects (incorporated in 1986) which became the premier centre for clinical genetics training in Australia and the Asia Pacific region. He retired as Emeritus Professor in 1995 and was honoured with many awards, including the Order of Australia. He lived to see the merging of the Murdoch Institute with the RCH Research Foundation in 2000, and the establishment of the Murdoch Children's Research Institute which combined genetic and clinical services, plus research. The Institute's objective was that "every child should be born healthy and with normal abilities".
(Personal communication, June McMullin (Danks) to Ann Westmore; Obituaries in *The Age* (14 August 2003), *The Herald Sun* (19 August 2003) and *The American Journal of Human Genetics*, vol 73, pp 981-985)

[10] **Dr June McMullin (Danks)** MBBS (b.1931) graduated in medicine from the University of Melbourne in 1954 and spent three years as a Registrar and Anaesthetics Registrar at the Royal Melbourne Hospital. After marrying David Danks and starting a family she gained wide-ranging experience in women's health, working in the areas of family planning, antenatal and postnatal care and menopausal medicine. (Personal communication June McMullin (Danks) to Ann Westmore)

[11] **Dr Howard Ernest Williams** MD MRACP (1910-1999), worked at the Children's Hospital for much of the period, 1939-75. He trained in medicine at the University of Melbourne, graduating in 1935, and was Medical Superintendent at the Children's Hospital from 1939-42, and Physician to Inpatients, 1948-75. He was a keen researcher and one of his earliest studies concerned pre-operative fluid replacement to reduce the life-threatening biochemical disturbances associated with pyloric stenosis. The death rate from the condition at the Children's subsequently fell from 16% to 2%.
He spent four years on active service during World War II and in 1946 he was made the Hospital's first full-time Director of Clinical Research. He started as head of the Clinical Research Unit in 1948 after a period of overseas study on a Nuffield Travelling Fellowship. During this trip he worked with Professor James Spence in England and visited paediatric research laboratories in the US, including Harvard.

that you will know, to sit alongside me at certain functions. I remember a bus trip that the Thoracic Society of Australia and New Zealand organized as part of a meeting in Queensland. Howard spent an hour each way on an excursion, giving me some history, as well as supporting and affirming me in my new role at the Children's Hospital. And he continued to do that.

So history's been very important to me personally. It was also very important to me in coming to the Children's Hospital, to receive the support that I got in that historical connection obviously from Peter Phelan[12] but also from John Maurice Court who, in his inimitable style, may pop in and out as he's still busy seeing patients.[13]

The research of the Unit focused on pulmonary and respiratory disorders, metabolic disturbances of the gut, and the body's homeostatic mechanisms.
He was appointed Executive Chairman of the Royal Children's Hospital Research Foundation when it was established in 1960. On his retirement in 1975 he became Professorial Associate to the Department of Paediatrics and took responsibility for postgraduate medical education until 1979.
According to Dr John Court (see footnote 13), many – if not most – of the professors in paediatrics in universities throughout Australia were taught by, or worked with Howard Williams. "He was never a professor, but he was a creator of professors". (Personal communication, John Court to Ann Westmore)
(For further information see V. L. Collins "The Development of Paediatric Services in Victoria: Part 2, *Medical Journal of Australia*, II, 1970, p 113, Charlotte Anderson, "An Appreciation", *Australian Paediatric Journal*, 12, 1976, pp 69-71 and David Danks, "A Tribute: Howard Williams Leader of Modern Paediatrics", *Fellowship Affairs*, July 1999, p 29)

[12] **Professor Peter Duhig Phelan** BSc MD FRACP (b.1936) graduated in science (1959) and medicine (1961) from the University of Queensland. He spent a year as a Junior Resident at the Princess Alexandra Hospital, a year as a Senior Resident at the Brisbane Children's Hospital and a further year as a Registrar at the Royal Melbourne Hospital in 1964. He joined the Royal Children's Hospital, Melbourne, (RCH) in 1965 as a Medical Registrar and subsequently did an MD supervised by Dr Howard Williams. After a period as a Postdoctoral Fellow in the Harvard University School of Public Health he returned to the RCH in 1970. He was Director of Thoracic Medicine at the Hospital 1974-83, and served as Stevenson Professor of Paediatrics and Head of the University of Melbourne Department of Paediatrics 1983-97, when he took early retirement. He trained many paediatric thoracic physicians from Australia, Asia, Europe and North and South America, and maintained a research program in thoracic medicine. His experience in medical education and administration was put to good use after 2000 when he became Planning Dean for the proposed new school of medicine at Bond University on the Gold Coast.
He is credited with developing numerous specialist paediatric professorial positions within the University of Melbourne including Chairs in Child and Adolescent Psychiatry, Paediatric Orthopaedic Surgery, Adolescent Health, Paediatric Surgery, Paediatric Haematology and Oncology, Community Child Health, Child and Adolescent Psychology, and Paediatric Critical Care. He was also influential in recruiting Professor Bob Williamson to lead the Murdoch Institute and become Research Professor in Genetics after David Danks' retirement. He also served in leadership roles within the Royal Australasian College of Physicians, the Australian College of Paediatrics, the Thoracic Society of Australia, the Paediatric Research Society of Australia and the Australian Medical Council. (Personal communication, Peter Phelan to Ann Westmore)

[13] **Dr John Maurice Court** AM, MB BS FRACP (b.1929) has had a working association with the Children's Hospital lasting around fifty years. A 1953 University of Melbourne medical graduate, he spent successive intern years at the Melbourne and Royal Children's Hospitals. In 1956-57 he worked as a Research Registrar in the RCH Clinical Research Unit under Drs Howard Williams and Charlotte Anderson, and was then appointed Clinical Supervisor of student teaching. In the late 1950s he was Assistant (then Acting) Medical Director and it was during this time that he developed the Court needle which enabled intravenous treatment without cutting into veins. He also persuaded the Hospital's Committee of Management to allow children with ongoing medical conditions to remain patients of the Hospital until age 18 (instead of 14 which was the previous age limit) and to introduce a unit patient record

I can see how if we don't provide our history in an accessible way, those who come after us, the wonderful young people who are coming through paediatrics in the University Department at the Children's Hospital, won't know. And it's really important that they do.

History's always important but it's particularly important in this time because of where child health is at in a nation that is increasingly ageing. It's important that we create this firm base on which to build our advocacy for children. Paediatrics is not under threat, but it is challenged by the demographics and by the economic nature of some of the decision-making on social policy.

It's also important – and most of you won't know, but Peter Phelan does, because he's been helping me with this – that the University of Melbourne and the Hospital are renegotiating their affiliation agreement. Now, in the past, these agreements have been, "We're good fellows, and it's all OK" to some extent.[14] But in these days of compliance and litigation, indemnity and costs, this has become a major project.

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system, thereby revolutionizing the management of patient histories. He was also closely involved in planning the new Children's Hospital in Parkville.
After further training in Birmingham in the early 1960s he was appointed University of Melbourne First Assistant to Professor Vernon Collins 1965-72, Physician to Outpatients 1965-75, and Physician to Inpatients 1975-78. In 1972 he left the employ of the University to establish the Hospital's Department of Developmental Paediatrics which expanded further in 1981 to include the Department of Adolescent Medicine. During the 1970s and 1980s he was Director of Diabetes Services at the Hospital and filled many positions in the wider medical community including the Medical Board of Victoria, the Australian Association for Adolescent Health, the *Journal of Paediatrics and Community Health*, and the Royal Australian College of Physicians. He continued working in the field of adolescent medicine during the 1990s and, as of 2004, he is still working in the field, including a day each week at the Children's Hospital. (Personal communication, John Court to Ann Westmore)

[14] **The University of Melbourne Faculty of Medicine Minutes Vol 8, p 344** refers to a meeting between representatives of the University and of the Children's Hospital Committee of Management on 8 April, 1952. A Draft Agreement formulated at that time stated that:

1. The Lecturer in Paediatrics [equivalent to a Director of Paediatric Teaching, p 165] shall have a normal allotment of in-patient beds at the Children's Hospital
2. There shall be a representative of the Committee of Management and a representative of the Clinical School of the Children's Hospital on the Committee of Advice appointed by the Council of the University to recommend the appointment of the Lecturer in Paediatrics
3. Concerning the relationship between the Lecturer in Paediatrics and his colleagues (sic) at the Children's Hospital from the viewpoint of teaching;
    a) the allocation of students to individual instructors within the Clinical School shall remain the responsibility of the Dean of the Clinical School but in making such allocation and in making timetable arrangements the Dean shall consult the Lecturer in Paediatrics
    b) the Lecturer in Paediatrics shall take such action as appears necessary to ensure that the teaching in the field of Paediatrics is efficient and comprehensive
    c) within the best interests of patients, the Lecturer in Paediatrics shall be allowed access to material for research purposes
4. The Children's Hospital shall provide adequate accommodation for the Lecturer in Paediatrics at the Hospital and the University shall provide any special fittings and equipment.

On 18 September, 1952, the Faculty was informed that the Committee of Management of the Children's Hospital had approved the Draft Agreement (p. 426) and on 20 November 1952, the Vice-Chancellor gave approval for a formal agreement (p 467).

It is among the most important strategic issues for the Committee of Deans of Australian Medical Schools. According to the Vice-Chancellor of this University, the relationship between its Medical School and its Teaching Hospitals is the single most important factor to be resolved at this University. It poses the greatest potential threat to this University of just about anything else at the moment because roughly half the University size economically is the Medical School, and the Medical School can't exist without its agreements with the Teaching Hospitals.

So it's a very important time for us to affirm the important role of academia, scholarship, learning and research, in the context of a teaching hospital. In order to do that in this agreement we have to be quite secure about where we've come from and who we are as an academic department of paediatrics. So it's quite critical to that too. Well, that's enough from me. Thank you again for coming. I'm sure we're going to enjoy the day and I'm now going to pass to Janet McCalman.

Janet McCalman: Welcome to this second Witness seminar. I'd like to give a little background on where the Witness idea came from. It emerged in London from the Wellcome Unit for the History of Medicine which is now part of the University College, London, Medical School. And it was developed in response to the medical profession's increasing feeling that their history was not really what historians of medicine were particularly interested in. They could see that while historians of medicine had developed great expertise in seventeenth century medicine, most things that had happened in the history of medicine had happened in the last fifty years and that history was simply not being recorded for posterity.

So they developed the concept of the Witness seminar which is essentially a sort of "group oral history" where people are brought together who have been significant in major areas of medical research, policy or practice. The exercise of reflecting on their experiences as a group was the way in which one person's memories stimulated the memories of others and the experiences of one qualified those of others. The seminars also provided an opportunity to reflect in hindsight about what was truly significant, and what had really been going on. And these are the stories that are not there in the articles in medical journals, the stories behind research and behind practice.

In the Australian context, as many of you will know, a huge amount of very significant work happened here [in Melbourne], only some of which has been published. An awful lot of medical advance happens as you know by accident, in clinical settings or by serendipity. And if we don't get that history, it's lost. So again these are stories that need to be recorded properly, and dispersed to the public realm by means of a web-site which can reach an extremely large audience.

Like Glenn, my introduction to the history of paediatrics came from Howard Williams and what little I know began with a sense of the significance of people like James

Spence, his formation, and obviously the formation of this specialty.[15] I'm sorry I can't be here for all of today. But I wish you well.

In a way, you're making history by doing this. Because this is really the first clinical Witness that we've done and I look forward to a really interesting day.

Ann Westmore: Now the device in the middle of the room is recording the whole seminar. We'll be trying to have a discussion, a conversation, and not a lecture. You should feel free to interrupt and make comments if you have something relevant to say. What we're trying to achieve is to gain a sense of the University Department of Paediatrics that may never have been enunciated before.

When people talk to each other and reminisce, they may take for granted what is special about an organisation, what issues have been of on-going concern or have bubbled up at times. We want to get a feel for those things today.

Let me first remind you of the pre-history of the University of Melbourne Department of Paediatrics at the Royal Children's Hospital. I've summarised some important events using information gleaned from Peter Yule's recent history of the hospital[16] and from Minute Books of the Faculty of Medicine.[17]

Key dates in the evolution of a University of Melbourne Department of Paediatrics

1862: University of Melbourne establishes a medical school with an intake of three students, becoming it the first University in the southern dominions of the British Empire to teach undergraduate medicine.
1867: University of Melbourne appoints a lecturer in obstetrics and diseases of children at the Lying-in Hospital (later the Women's Hospital).
1870: Melbourne Hospital for Sick Children (later Children's Hospital) opens in Carlton with six beds.
1882: Medical students receive Lectures in Diseases of Children at the Hospital for Sick Children for the first time.
1900: University of Melbourne invites the Children's Hospital to appoint a staff member to join the Faculty of Medicine and the Hospital selects Dr William Snowball.
1911: Medical students are required for the first time to attend the Children's Hospital for teaching in diseases of children or risk failure.

[15] **Sir James Spence** was appointed Professor of Paediatrics at Newcastle-upon-Tyne University, England, in 1928 and pioneered "social paediatrics" which emphasised family structure and function in child health. Spence stressed the scientific study of child health alongside an emphasis on the work of doctors in communicating with patients and families. He had a profound influence on Australian paediatrics and inspired Dr Howard Williams approach in the Clinical Research Unit at the Children's Hospital which became active in 1948. Spence wrote *The Purpose and Practice of Medicine* (1960) among many contributions on subjects with a bearing on child health.
[16] **Peter Yule**, *The Royal Children's Hospital: A history of faith, science and love*, Halstead Press, 1999.
[17] The *Minute Books of the University of Melbourne Faculty of Medicine*, hand-written with type-written inclusions, page-numbered and indexed, are retained by the University of Melbourne Archives.

1921-29: University of Melbourne Professor of Anatomy, Richard Berry, appointed honorary psychometrician to the Children's Hospital
1948: University suggests the Hospital appoints a full-time Clinical Supervisor to oversee undergraduate teaching.
1949: Faculty of Medicine approves in principle the payment of hospital staff for clinical teaching
1949: The Hospital's Clinical Research Unit (which became operational in 1948) requests that the University recognise it.
1950: Dr Bob Southby appointed Lecturer in Diseases of Children at the Hospital, an appointment paid for by the University for the first time.
1951: University passes Regulations allowing students to carry out research for postgraduate degrees at the Hospital.
1952: Agreement between the University of Melbourne and the Children's Hospital is ratified.
1952: Faculty of Medicine agrees to extend student's term of attendance at the Hospital from two to three months.
1953: The Hospital becomes the Royal Children's Hospital and the University classifies the Hospital as a Special Training Hospital.
1959: Creation of University of Melbourne Stevenson Chair in Child Health following a donation from Mrs Hilda Stevenson, Vice-President of the Children's Hospital Board of Management.
1965: [Stevenson] Chair in Child Health re-named [Stevenson] Chair in Paediatrics.
1983: Chair in Paediatric Research established.
1984: Chair in Child and Adolescent Psychiatry established.
1988: Chair in Paediatric Orthopaedic Surgery established.
1991: Chair in Adolescent Health established.
1994: Chairs in Paediatric Surgery, Child and Adolescent Psychology, Paediatric Haematology and Oncology, and of Community Child Health established.
1995: Chair in Paediatric Critical Care and Research Chair in Genetics established.

The move towards a University Department of Paediatrics intensified from the late 1940s. In 1948, the University suggested appointing a full-time Clinical Supervisor to oversee the training of medical undergraduates at the Children's [as well as the Women's] Hospital.[18]

The following year, Dr Howard Williams began weekly clinical meetings for Registrars and Residents. Also that year, the Dean of the Children's Hospital Clinical School, Dr Boyd Graham,[19] put a strong case to the Faculty of Medicine that the undergraduate

[18] **Early Clinical Supervisors** included Drs Harry Hiller, Bernard Neal, Tom Maddison and David Fearon.
[19] **Dr Howard Boyd Graham** DSO MC, MD (1891-1966), widely known as Boyd Graham, graduated in medicine from the University of Melbourne in 1915 and, after serving in the Royal Army Medical Corps during World War I, joined the Children's Hospital as a Resident Medical Officer. He was soon appointed Assistant Pathologist and, in 1923, became the first Medical Superintendent. He continued in that role until 1924 when he established a private paediatric practice, specialising in infant feeding, diabetes and rheumatic fever. He was an Honorary Physician to Outpatients at the Hospital (1925-52) and to Inpatients (1946-51), meanwhile continuing a long-standing interest in research.

course in paediatrics should be extended from two months to three months, in line with overseas developments. He argued that the course should be largely paediatric medicine, with paediatric surgery subordinate. And the Faculty agreed in principle to the extension.

Also in 1949, the Faculty of Medicine approved in principle the payment of hospital staff by the University for clinical teaching. That hadn't been done before [at the other Melbourne teaching hospitals; the Royal Melbourne, Alfred, St Vincent's and Women's]. The following year, Dr Bob Southby[20] was appointed Lecturer in Diseases of Children at the Children's Hospital.

In 1951, the University passed regulations allowing students to carry out research for postgraduate degrees at the Children's Hospital and, in 1953, the Hospital was classified as a special training hospital.

In 1958, funding for a Chair in Child Health was forthcoming. In that year, Mrs (later Dame) Hilda Stevenson, who was Vice-President of the Committee of Management of the Children's Hospital, donated either £80,000 or £100,000 to endow a Chair in Child Health.[21] Before today's meeting, I spoke to various people about that particular event,

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He was a member of the University of Melbourne Faculty of Medicine and Dean of the Children's Hospital Clinical School in 1950 when he sought Faculty approval to extend students' term of attendance at the Hospital from two to three months. Faculty agreed to introduce the change in 1952. He reported to Faculty that year that the Australian Association of Paediatricians had decided to urge all medical schools to establish Chairs of Child Health. (Faculty Minutes, volume 8, p 174)
In addition to his medical responsibilities, he was President of the Victorian Council of Social Services for several years. This appointment reflected his conviction that poverty and malnutrition were important influences on childhood illness. His memoirs on the Children's Hospital were published in the *Medical Journal of Australia* in 1953. (For further information see Robert Southby and Reginald Webster, "Obituary: Howard Boyd Graham", *Medical Journal of Australia*, I, 1966, pp 464-465)

[20] **Dr Robert ('Bob') Southby** OBE OStJ, MD FRACP FACST FAMA (1897-1991) joined the Children's Hospital in 1922 as a Junior Resident Medical Officer, a year after graduating in medicine from the University of Melbourne. He was appointed Assistant Pathologist of the Children's Hospital in 1923 and Medical Superintendent 1924-25. He was then appointed honorary medical officer to the Hospital's Venereal Diseases Clinic where children were treated for infection with syphilis and gonorrhoea, largely contracted during childbirth.
He was one of the last of the "general paediatricians", working in a general practice in Essendon while also serving as a Physician to Outpatients at the Children's Hospital (1935-45) and as a Physician to Inpatients (1946-57). The University appointed him Lecturer in Diseases of Children in 1950, which entailed giving 15 lectures a year to medical students.
In 1958 he was appointed Honorary Consulting Physician to the Royal Children's Hospital and, in 1961, Consultant Paediatrician to the Victorian Health Department (Maternal and Child Welfare Branch).
He was active in medical and community affairs, serving in senior positions with the Medical Board of Victoria, the Australian Medical Association Victorian Branch, the Hospitals and Charities Commission, St John Ambulance Brigade and the Aboriginal Affairs Advisory Council of Victoria. (See *Who's Who in Australia 1968*, and *Chiron*, 1991, p 71)

[21] **Dame Hilda Stevenson** DBE CBE OBE (1893-1987), daughter of H V McKay, the inventor of the combine harvester, was appointed to the Committee of Management at the Children's Hospital in 1938. During the 1930s and 1940s, she played a leading role in the Town and Gown Guild, a University of Melbourne women's organisation which raised ten thousand pounds for a new University Union Building, a sort of clubhouse for academic staff and students. The University awarded her the degree of Doctor of Laws *honoris causa* in 1973. She served as the Hospital's Vice-President, 1951-73. According to historian Peter Yule, "In late 1958…Mrs (later Dame) Hilda Stevenson, a vice-president of the committee of

including Dame Elisabeth Murdoch, who was President of the Board. Dame Elisabeth's understanding was that the money was actually given to the Faculty of Medicine in a general way and hadn't necessarily been ear-marked for a Chair. But in discussion, the idea emerged that it would be very important for the status of the Children's Hospital and for the University if a Professorship was established. I believe the University of Sydney already had a Professor of Child Health at this stage.

David McCredie: I don't know when this was, but the Professor was Lorimer Dods.[22]

Ann Westmore: So, perhaps there was a view that the University of Melbourne needed to do something equivalent [to what the University of Sydney was doing]. That something happened in 1959, when Dr Vernon Collins[23] was appointed inaugural

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management…donated 80,000 pounds to endow a chair of child health." (See *The Royal Children's Hospital: A History of Faith, Science and Love*, p. 336). The relevant University of Melbourne Statute differs over the size of her donation, and reports that she gave the sum of 100,000 pounds. Regardless of the amount, the name of the Chair commemorates her.
The Stevenson Chair in Child Health was renamed the Stevenson Chair in Paediatrics in 1965.

[22] **Professor (later Sir) Lorimer Fenton Dods** Kt MVO, MD ChM FRACP FACGP(Hon) DCH (1900-1981) was inaugural Professor of Child Health at the University of Sydney, 1949-60. He played an important role in the development of paediatrics as a medical specialty in Australia. According to Dr Howard Williams, "Many of the younger paediatricians will not know or fully understand how difficult it was in the immediate post-war period for paediatrics to become established as a discipline in its own right and yet be linked to adult medicine as a respected partner. At this time many adult physicians did not have any concept that paediatrics was a study of the factors responsible for the health and illnesses in a young developing child. To many, paediatrics was a study of illness in 'a little man'. Because Lorimer had the respect of his adult colleagues he was able to give them and the College of Physicians a better understanding of the importance and complexities of the study of children and so helped bridge a gap which could have easily developed between adult and children's medicine." (See *Australian Paediatric Journal*, 1981, p 72. See also *Who's Who in Australia 1950)*

[23] **Professor Vernon Leslie Collins** CBE, MD FRACP FRCP DCH FRS (1909-1978) was born and educated in western Victoria and, on matriculating, spent a year as a primary school teacher. He then embarked on medical training at the University of Melbourne where he graduated in 1933 and gained his MD in 1936. He spent 1934-35 at the Melbourne Hospital, before joining the Children's Hospital in 1936 as a registrar and serving as Medical Superintendent (a position roughly equivalent today to that of Chief Resident), 1937-39. He was in England from 1940-46, at first studying for higher degrees and then working as gastroenterologist at the North Middlesex Hospital where he gained first-hand experience of a different model of employing doctors in hospitals than the "honorary system" practised in most Australian hospitals. On returning to Melbourne in 1946 he spent several years in private practice combined with an appointment as Honorary Outpatient Physician at the Children's Hospital. In 1948 he became Honorary Physician to Inpatients.
He was Medical Director of the Hospital 1949-59 with administrative control and full inpatient physician status and teaching responsibilities. He was the first full-time salaried Medical Director appointed to a teaching hospital in Melbourne and he introduced some significant policies including salaried medical staff. He studied the latest developments in hospital planning and architecture in the USA and Canada in 1950 and 1951, in preparation for a proposed new Children's Hospital in Melbourne. The task of planning the hospital required close collaborations with medical and nursing staffs, the Hospital's Committee of Management, hospital administrators, engineers, architects, bureaucrats and many voluntary organizations involved in fund-raising.
He was appointed the inaugural Stevenson Professor in Child Health in 1959 and continued in that role (his title changed in 1965 to Stevenson Professor of Paediatrics) until his retirement in 1974, despite chronic ill health in his final years.

Stevenson Professor of Child Health. Later on, at the very beginning of 1963, the Hospital moved from Carlton to its current site at Parkville and in February of that year, the new Hospital was officially opened by Queen Elizabeth II.

I will now call on those who have some recollections of the early University Department of Paediatrics to tell us about it.

Early developments

Winston Rickards[24]: My comment really concerns the period before the Department was established. When I took over as Director of the Hospital's Department of Psychiatry in 1955, I found that the Medical Director, Vernon Collins, shared with me a vision of integrating paediatrics and psychiatry. We both recognised a need for doctors to inform

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He was active in medical affairs, serving on the Council of the British Medical Association (Victorian branch) from 1952-59, and the National Health and Medical Research Council (NHMRC), 1960-65. He also chaired the NHMRC Child Health Committee, 1966-69. He was well respected by his peers, serving as President of the Paediatric Society of Victoria in 1955 and President of the Australian Paediatric Association, 1969-70.
(For further information, see Vernon Leslie Collins Festschrift Issue, *Australian Paediatric Journal*, 10, 1974, pp 254-261, and H Williams and A. L. Williams, "Obituary", *Australian Paediatric Journal*, 14, 1978, pp 128-130)

[24] **Dr Winston Selby Rickards** BSc MD DPM FRACP FRANZCP FRCPsych CIPsych AFBPsS MAPsS (b.1920) graduated in medicine from the University of Melbourne in 1943 and then undertook his residency at St Vincent's Hospital. Army service followed, then postgraduate studies in the University of Melbourne Psychology Department (graduating BSc in 1949), at St Vincent's Hospital where he was assistant psychiatrist and demonstrator in clinical medicine (gaining an MD in 1950 and MRACP in 1951), and at St Vincent's and Royal Park Psychiatric Hospital where he undertook a Diploma in Psychological Medicine (graduating in 1951). In the meantime (1948), one of the leaders of psychiatry in Melbourne, Dr John F Williams, introduced him to the multi-disciplinary Child Guidance Clinic at the Royal Children's Hospital, a setting which became his life's work for over 30 years. In the early 1950s he went overseas on a Rockefeller Fellowship, training at the Harvard Medical School, Massachusetts General Hospital, and at the Institute of Psychiatry, University of London, and the Tavistock Clinic in London, as well as gaining some experience in residential care of mildly subnormal and geriatric individuals. He became a member of the British Psychological Society and later a foundation Fellow of the Royal College of Psychiatrists.
On his return to Australia in 1955, he was appointed Director of Psychiatry (later, Psychiatry and Behavioural Sciences) at the Royal Children's Hospital. His interest in the broad field of child development led to his involvement in the evolving disciplines of psychology, audiology, speech pathology and child psychotherapy.
For some years he lectured in Social Studies at the University of Melbourne (1955-74), and was a member of the University's Board of Studies. He also taught child psychiatry in the University Department of Paediatrics at the Hospital for more than two decades from 1965, encouraging paediatric registrars to get some training in Developmental Psychiatry as part of their training.
He contributed actively to the setting up of the University's Department and Chair of Psychiatry (established 1964), and for the following three decades he provided formal teaching and clinical sessions to medical students and trainee psychiatrists, mainly in the setting of the Children's Hospital but also in the adult Department of Psychiatry (situated at the Royal Melbourne Hospital), as well as being an Examiner in psychiatry.
In 1970 he was locum Director of Training at Washington University, USA, and visiting lecturer at the University of Chicago. In 1984 he became an Honorary Consultant Psychiatrist at the Royal Children's Hospital and began work in private psychiatric practice at the Melbourne Clinic.
(Personal communication, Winston Rickards to Ann Westmore)

themselves about the intellectual, emotional and social situations of children as well as their physical state of health or illness.

Arthur Clark[25]: I think I ought to pipe up at this stage. My name's Arthur Clark. Vernon, as you say, was appointed Professor of Child Health in 1959 and shortly afterwards, he did a tour of various places, including Boston and Canada. I joined the Department in 1961, from memory. Alex Venables[26] had already been appointed First Assistant [a University appointment equivalent to Associate Professor].[27]

Looking back on it now, it's struck me that Vernon was a very appropriate appointment, in the sense that the Hospital was at the centre of his life, he was more of a hospital person. Most of the research that was going on in the Hospital was undertaken by Dr Howard Williams' group where you would encounter the only people who were involved in research in the Hospital.[28] I don't think either Alex Venables or I, at that stage, were

[25] **Professor Arthur Colvin Lindesay Clark** AM, MD FRACP (b.1928) graduated in medicine from the University of Melbourne in 1951. After two years at the Royal Melbourne Hospital (RMH), he was appointed junior Resident Medical Officer and then Pathology Registrar at the RCH, 1954-55. In 1956 he returned to the RMH as Clinical Supervisor. He continued his paediatric training and haematology research in England and the US. He returned to the Royal Children's Hospital in 1961 where he worked under Dr John Colebatch (see later). He was Second Assistant in the Department of Child Health 1961-63, First Assistant 1963-65 and Physician to Outpatients 1964-65. He was appointed the Foundation Professor of Paediatrics at Monash University in 1965 and continued in that position until his retirement in 1993. Among many professional positions, he was President of the Royal Australasian College of Physicians in 1989. (Personal communication, Arthur Clark to Ann Westmore)

[26] **Dr Alexander Wynne Venables** MD FRACP (b.1922) was a 1946 University of Melbourne medical graduate. After serving as Resident Medical Officer (RMO) and Registrar at the Royal Melbourne Hospital (1946-48), he was appointed RMO at the Children's Hospital where he was RMO, Registrar, and Senior Medical Registrar until 1953. At that time he became Acting Outpatient Paediatrician at the Alfred Hospital and Physician to the Rheumatic Clinic at the Children's Hospital. Later that year, he embarked on further postgraduate training in the UK, in the Department of Child Health at Newcastle-upon-Tyne (headed by Professor James Spence), and at the National Heart Hospital in London where he was an Honorary Assistant Clinical Registrar. He returned to the Children's Hospital in late 1955 as full-time Paediatrician, Assistant to the Medical Director, Dr Collins, and Assistant to the Cardiac Investigatory Clinic. He was Physician to Outpatients, 1958-67 and from 1959-61 he was Sub-Dean of the Clinical School. In 1959, he was appointed Physician in Charge of the Cardiac Investigatory Clinic and from 1968 until his retirement in 1988 he was full-time Director of the Department of Cardiology, lecturing to students on paediatric cardiology during this time. (Personal communication Alex Venables to Ann Westmore)

[27] In fact, according to Dr Venables, he was never First Assistant. He was in the anomalous position of being on the Professorial Unit staff, but not a member of the Professorial Unit. (Personal communication, Alex Venables to Ann Westmore)

[28] The research group included Dr Charlotte Anderson (see later), Dr Bill McDonald who later became a Professor of Paediatrics at the University of Western Australia, and Dr Ron O'Reilly who was doing an MD in respiratory medicine. The resident staff good-naturedly nicknamed the research unit the "thought clinic", according to Dr Venables. (Personal communication, Alex Venables to Ann Westmore)
Even though there was not much formal research beyond the clinical research units (Drs Howard Williams, Charlotte Anderson and Douglas Stephens – see later), there was an atmosphere of encouragement to enquire and investigate clinical problems. This was fostered by Dr Collins, and shared by others who influenced the development of a formal approach to paediatric practice. For instance when an outbreak of neonatal infection occurred in the infants ward, Dr Court was encouraged to investigate the cause: *"Swabbing everything and everybody: it eventually incriminated the practice of how hand washing was done in the hospital, the culprits being the hand scrubbing brushes, and it was actually safer not to wash at all rather than to have wet hands."* In those days, the Hospital dominated the research presentations at the

doing any research in the University Department of Paediatrics and, for instance, we had virtually no research grants. This was 1961, but by 1965 that had changed and I was doing research.

I have a little hobby horse I just want to mention, and that is that I think paediatrics at that time had become too divorced from adult medicine and from research generally because of a preoccupation with developing paediatrics as a specialty. Some people were shocked if adult cardiologists ever laid a stethoscope on a child. It is an attitude that has changed today with much more contact between paediatricians and adult doctors. But vestiges of the former attitude remain.

Ann Westmore: So the development of paediatrics as a specialty was a major concern at the Children's Hospital in the early 1960s?

Arthur Clark: Yes, I think so. And I think it was continuing through the 1960s and effectively, of course, it took a few years for the University Department to get research students and research funding. And in fact I think this changed only when David Danks saw the same problem and went to the University and worked there and brought back University concepts.

Ann Westmore: Are there others here who agree with Arthur's point of view about paediatrics becoming too divorced from adult medicine?

Bernard Neal[29]: I'd like to extend Arthur's comments by just saying that to do this seminar properly, the more input you can get on the background psychological unspoken attitudes and so forth, the more you will throw a lot of light on the whole understanding [of what was happening].

I think there was what one might call a necessary, and not entirely happy, relationship in two different quarters. One was the teaching doctors in hospitals on the one hand [who

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annual meetings of the Australian Paediatric Association. (Personal communication, John Court to Ann Westmore)

[29] **Dr Bernard William Neal** AM, MD FRACP DipEd(Tert) BLit (Hons) (b.1924), widely known as 'Bunny' Neal, was unusual in combining paediatrics with training in education and literature. A 1947 University of Melbourne medical graduate, he joined the Children's Hospital in 1948 as a Junior Resident. For five years from 1950 he was a Registrar under Dr Stanley Williams, a Medical Officer in the General Clinic and Clinical Supervisor. His first formal taste of teaching paediatrics occurred when he spent 1955-56 as Lecturer in Child Health at Liverpool University.

On returning to Melbourne in 1957 he was appointed Honorary Paediatrician at Box Hill Hospital and Clinical Assistant to Outpatients at the Children's Hospital. Later he was Physician to Outpatients at the Children's (1962-73) and Physician to Inpatients (1973-87). He was also Dean of Postgraduate Medical Education (1979-89) and, in 1986, he furthered his broad professional training by studying decision analysis as a Visiting Scholar at Harvard University.

He served on many professional bodies and was President of both the Medical Board of Victoria and of the Australian Medical Council. His interest in education equipped him well to serve as Vice-President of the Australian Medical Postgraduate Foundation. He also served on the Ethics Committees of the Royal Australian College of Physicians, the National Health and Medical Research Council, and on the Committee of the International Paediatric Association. (Personal communication Bernard Neal to Ann Westmore)

were] in a state of tension re what they at first saw as pie-in-the-sky, academic, ivory tower conclusions from know-alls at the University and they wouldn't have a bar of them.[30] If you don't understand that tension, you'll miss a lot of the point.

And secondly, there was a somewhat similar dilemma, which Arthur Clark has rightly pointed to, in the relationship between paediatric medicine and adult medicine.[31] There was a lot to be said on both sides of this, and many many anecdotes about the disastrous effects of adult cardiologists putting stethoscopes on children and so on. And achieving the independence of paediatrics as a discipline, like many other independence movements, was not easily achieved. So that subsequently you had to get a happy marriage between academia, university and hospital, and we had to get a happy marriage between adult and paediatric medicine.

I just make these points on those two phenomena as part of the psychological background. I was an early Clinical Supervisor and, at that time, the training of medical students was about as far as the University came into the whole scene. Everyone was very happy to leave it at that because it wasn't their business, the teaching of medical students in paediatrics was done entirely by the Hospital, as you said before in mentioning Boyd Graham. There was a position called the Dean [of the Clinical School] with responsibility for many of these functions and this was entirely within the aegis of the senior medical staff. And they then appointed the supervisors and so forth who were obviously necessary.

Leadership

John McNamara[32]: The question of Vernon Collins as inaugural Professor of Child Health, or Howard Williams. I was a fifth year medical student at the time, but I gathered that when the appointment was made in 1959 there was some difference of opinion

[30] Suspicion was also directed in the other direction. In the early days of the University of Melbourne Department of Child Health, when Dr John Court was a member of the Faculty of Medicine, he detected "a certain amount of antagonism towards the department from older established members of the Faculty. This was something that Vernon Collins had to steer us through. There was also a lot of resistance from non-medical Faculties of the University towards the development of formal new departments as they felt that medical professors were potentially too numerous and thus too powerful in influencing the University as a whole. When I was Acting Professor in the department…I was very award of this attitude at Professors' meetings I attended. This certainly inhibited the development of University departments within clinical schools for a while." (Personal communication, John Court to Ann Westmore)

[31] A third area of tension existed between doctors in private practice working in an honorary capacity in the hospital, and full-time hospital medical appointees. (Personal communication, Alex Venables to Ann Westmore)

[32] **Dr John Martin McNamara** MBBS FRACP (b.1936) was a 1959 University of Melbourne medical graduate who joined the Children's Hospital staff as a Junior Resident in 1964. In 1968-69 he worked at Great Ormond Street Hospital for Sick Children, London, as a Resident Assistant Physician, before returning to Melbourne where he was a part-time First Assistant at the Children's and Mercy Maternity Hospitals. He was appointed Consultant Paediatric Physician and Senior Physician in the Department of General Medicine in 1975 and continued in that role until 1984 when he became Chairman of the Hospital's Division of General Medicine, 1984-92. He taught undergraduates and postgraduates for many years and was Vice-President of the Australian College of Paediatrics, 1995-97. He chairs the Hospital's history committee and is a member of the Medical Practitioners Board of Victoria.(Personal communication, John McNamara to Ann Westmore)

among the staff over who was most suitable. I just wonder about the feelings of people at that time.

Ann Westmore: Perhaps we can see it in terms of this difficult sort of marriage that was being attempted in the creation of the Department, a marriage between the Hospital and the University. People had been based wholly in the Hospital or wholly in the University and suddenly there was an attempt to create linkages between them.

Perhaps there were characteristics of Vernon Collins or Howard Williams that were better suited to creating those linkages. I think Arthur [Clark] has said that Vernon Collins was very much "of the Hospital". I don't know about Howard Williams. Was he more amenable to linkage with the University and would that have made a difference to the way the University Department of Paediatrics developed?

David McCredie: Perhaps a comment, having had my feet in both camps. I was a Research Fellow with Howard and, in 1960-61, I went on a Fellowship to America and I came back [in 1962] to find Vernon Collins established as the leader. They were both extremely good candidates and either one would have been suitable.

From my point of view, I worked between the two of them. Vernon Collins was very important getting the new specialty of paediatrics started. And at that stage we had research on respiratory disease under Howard, on cardiology under Mick Powell[33] and gastroenterology was just starting, Charlotte Anderson[34] having come back in the late

[33] **Dr Mostyn ('Mick') Levi Powell** MB BS MRCP FRACP (1904-1994) trained in medicine at the University of Melbourne, graduating in 1926. He joined the Children's Hospital in 1927 and was Medical Superintendent of the Hospital in 1929, Physician to Outpatients, 1935-47, and to Inpatients, 1946-64. After war service, he studied congenital heart disease at the Johns Hopkins Medical School and on returning to the Hospital, he was a paediatric heart specialist and Consultant to the Cardiac Investigatory Clinic. He retired from the Hospital in 1964 and continued in private practice for some years. (See *Who's Who in Australia 1968)*

[34] **Dr Charlotte ('Charlo') Morrison Anderson** MD MSc FRCP FRACP (1915-2002) studied science and worked as a research biochemist at the Baker Institute in Melbourne 1936-41. She then undertook medical training at the University of Melbourne, graduating in 1945. She spent a year at the Melbourne Hospital before joining the Children's Hospital in 1946, encouraged by Dr Bertie Coates at the Royal Melbourne Hospital. She accepted Dr Howard Williams' offer of a post as Registrar and Research Fellow in the new Children's Hospital Clinical Research Unit, 1948-50, as she was interested in clinical investigations of disorders of largely unknown origin. The work of the Unit soon led her to examine cystic fibrosis and coeliac disease and, by 1949, she had devised a test to differentiate one from the other.
She continued her work on malabsorption problems, 1951-53, this time at the Hospital for Sick Children, London, as well as at Birmingham University and Children's Hospital where she was involved in testing the claims of a Dutch group that coeliac disease was triggered by dietary wheat flour in susceptible individuals. The Birmingham group went on to show that wheat gluten was responsible for the disorder and a gluten free diet could control it.
On returning to Melbourne she continued to work on the two diseases with Drs Rudge Townley, Ruth Langford (later Bishop) and Pat Phair at the Royal Children's Hospital. With them she formed the Gastroenterological Research Unit in 1961and served as its first Director, 1962-68.
She was instrumental in establishing the Australian Society for Paediatric Research prior to her appointment as Professor of Paediatrics and Child Health at Birmingham University in 1968. After retirement she continued to conduct research and write in the field of gastroenterology at the Princess Margaret Children's Medical Research Foundation in Perth.

1950s, and nephrology was in the distant future a little bit. So Vernon and Howard were always very supportive of me.

That was probably the time when a more academic kind of research developed. Shortly after that, John Court arrived and started studying lipid metabolism with Marjorie Dunlop.[35] But also the name of the department was changed from the Department of Child Health to the Department of Paediatrics in about 1966, appropriately I'd say.[36]

Glenn Bowes: There is a theme here that we've sort of skirted around, and I think it's important to keep the discourse going about this theme. Because today with the Murdoch Children's Research Institute there's just as much need for the University Department of Paediatrics to perform a balancing act between a lab-based, high tech, hard science role and a clinical and public health role. It seems to me that there was a period right at the beginning of the Department where the roots of the same sort of tension were evident. So I don't think it's a matter of speaking ill of those who have been tremendous leaders in the past, but rather examining the roots of that tension. It's good to keep that conversation going.

Kester Brown[37]: I came a little later on the scene. I well remember my former chief, Margaret McClelland,[38] telling me that probably Vernon Collins' greatest contribution

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(See Charlotte M Anderson, "Obituary: Professor William Bowie Macdonald", *Australian Paediatric Journal*, 20, 1984, pp 2-3. See also *Who's Who in Australia 1968 and 197*1)

[35] **A/Professor Marjorie Elizabeth Dunlop** BSc MSc PhD (b.1945) gained research experience in pharmacology, paediatrics and medicine while completing her undergraduate and postgraduate degrees. She joined the Department of Medicine at the Royal Children's Hospital as a research worker in 1969, studying obesity and diabetes until 1982 when she moved to the Heidelberg Repatriation Hospital and to the Royal Melbourne Hospital where she was the NHMRC Principal Research Fellow and an Honorary Professor in the Department of Medicine. She is now working as a Project Officer with the University of Melbourne Faculty of Medicine. (Personal communication, Marjorie Dunlop to Ann Westmore)

[36] The name change of the Department actually took place in 1965.

[37] **Dr Thomas Christopher Kenneth ('Kester') Brown** AM, MD FANZCA FRCA FCA(SA) (b.1935) trained in medicine at St Andrew's, Scotland. He did his internship in London, Ontario, and worked as a General Practitioner in the North-West Territories of Canada, before undertaking training as an anaesthetist in Vancouver and Toronto. After spending a year at the Royal Melbourne Hospital in 1966, he worked the following year at the Children's Hospital as Medical Officer (Intensive Care). He was subsequently appointed Specialist Anaesthetist Perfusionist and, from 1974-2000, was Director of Anaesthesia. He was also the Hospital's Divisional Director of Specialist Services, 1979-96. The Australian Society of Anaesthetists named a lecture in his honour in 1997 and he was President of the World Federation of Societies of Anaesthesiologists, 2000-04. (Personal communication, Kester Brown to Ann Westmore)

[38] **Dr Margaret ('Gretta') McClelland** OBE, MB BS (1905-1990) graduated in medicine from the University of Melbourne in 1931. She joined the Queen Victoria Hospital as a resident medical officer, 1932-33 and was its Medical Superintendent, 1934-35. She moved to Sydney in 1936 and in 1937-38 she was Medical Director of Prince Henry Hospital (The Coast Hospital). Later she went to England where she became full-time anaesthetist at the Central Middlesex Hospital, London, gaining her specialist qualifications in 1942. She is credited with an important scientific contribution at this time, elucidating the toxic interaction of the anaesthetic agent, Trilene, with soda lime. This advance eliminated a potentially dangerous method of anaesthetic administration and increased the safety of Trilene.
On returning to Melbourne after the war with her own anaesthetic machine, she worked at the Royal Melbourne, St Vincent's and the Children's Hospitals. She was appointed Senior Paediatric Anaesthetist at the Children's in 1949, half-time Director of Anaesthesia in 1952 and the first full-time Director in 1956, a position she retained until her retirement in 1970.

was to get salaried doctors. That made it possible for doctors to specialise in paediatrics and paediatric surgery. It's for that reason that the Children's Hospital in Melbourne grew and expanded the wonderful staff it had, superseding Sydney. That was an absolutely key aspect of the development.[39]

I suspect that comparing these two people, Howard was much stronger in the research area and a great clinician. Vernon Collins probably had the disposition to get the political face of paediatrics up.

Don Kinsey[40]: Can I just mention, I was outside the Hospital then, I was in the media. But I remember every Good Friday [Appeal], stories used to come down from the Hospital. And in subsequent years, when I came to work at the hospital, through talking to people and reading about the Hospital, I think Kester has hit the nail right on the head. Both were very fine clinicians and Howard, particularly, a great researcher. But the word "politics" came into what Kester said. And from what I read and heard and understood at the time, and from my own relationships with him too, Vernon was the man who was a little more politically aware, and knew how to use the system to achieve the best results. That's not to decry the way Howard used to do things. But Vernon had perhaps a vision. As someone once said to me, some people can see the horizon. That's fine, but the true visionary sees over the horizon.

Bernard Neal: We don't want to go too far into the Collins/Williams thing because there are many personal undertones and conflicts and so forth. I think they both had great mutual respect and they were both greatly respected by those who worked with them. Naturally enough they had different personality traits. And I would agree entirely with what's been said. The word that comes to my mind is diplomacy. If there was something needed doing, Vernon had a surer diplomatic way to go about it, although the cause and views were held just as strongly by Vernon Collins and Howard Williams. If you had to seek a representative, in my view, Vernon had more natural skills.

Peter Phelan: I came to the Children's in 1965 and worked closely with Howard until he retired. In '75 I got to know Vernon very well. I have no doubt that the correct appointment was made. I don't think Howard had the skills in the area that Vernon had [them] to get the University Department [of Paediatrics] established. That's in no way to downplay Howard. His abilities were extraordinary but they were different. So I think the right decision was made. But Howard's students would have known his great

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Her research included the use of hypothermia for cardiac surgery and work on equipment to make anaesthesia safer and less traumatic for children. She trained large numbers of anaesthetists and was President of the Australian Society of Anaesthetists, 1964-65.
(See *Medical directory of Australia 1980*, and personal communication, Kester Brown to Ann Westmore)

[39] The issue of what constituted appropriate salary and entitlements for the medical staff remained contentious for many years, according to Dr Bob Fowler, a senior surgeon at the Royal Children's Hospital who was Secretary of the Association of Salaried Medical Specialists of Victoria.

[40] **Mr Don Kinsey** (b.1931) worked as a broadcaster and senior executive for 3DB radio station from 1957-76. In 1976 he joined the Hospital as Director of Public Affairs and, until his retirement in 1996, he advised management and staff on public opinion. (Personal communication, Don Kinsey to Ann Westmore)

disappointment at not being appointed. I'm sure June [McMullin (Danks)] would have heard the same things from Howard over the years.

June McMullin (Danks): I think Howard was disappointed that he wasn't recognised for his abilities. The right decision was made in appointing Vernon Collins – he was a wonderful administrator and organiser, and he had an outward-going personality. But Howard was the thoughtful one. I believe Lady Latham played an important part in the appointment of Vernon Collins, as well as in the issue of salaried medical staff, a system that was introduced at the Children's Hospital before it was considered elsewhere [in Victoria].[41]

Ann Westmore: Lady Latham played a part in the appointment?

Bernard Neal: In my opinion Lady Latham backed Vernon, possibly influenced by Vernon Collins' diplomacy.

Henry Ekert[42]: I wanted to talk about what may seem a little like ancient history, about research in clinical medicine. I was a Registrar of Professor Lovell[43] [at the Royal Melbourne Hospital] and Austin Doyle[44] [at the Austin Hospital]. And when I came to the Children's Hospital in 1965, I was amazed at the separation of research from clinical medicine. There was little real research, as Arthur [Clark] said. It was a sharp contrast with my experience at the Royal Melbourne Hospital where, working under Professor Lovell, research was integral to the hospital's activities. .

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[41] **Lady Eleanor Mary ('Ella') Latham** CBE, BA (1878-1964) The daughter of teachers and herself a teacher before marrying barrister, John Latham (later Chief Justice of the High Court, 1935-52), was foundation President of the Hawthorn branch of the Children's Hospital auxiliary in 1923. In 1933 she was appointed President of the Committee of Management of the Children's Hospital, serving in that position until 1954.
She is credited with modernising the philosophy of the Hospital through measures such as appointing a full-time Medical Director and other salaried senior medical staff, improving the quality of nursing and medical care by building closer ties to the University, and supporting the establishment of a Clinical Research Unit.
(For further information see Howard Williams, *From charity to teaching hospital: Ella Latham's presidency 1933-1954, the Royal Children's Hospital*, Melbourne, Book Generation, Glenroy, 1989)

[42] **Professor Henry Ekert** AM, MD BS FRACP FRCPA (b.1936) trained in medicine at the University of Melbourne graduating in 1960. He worked at the Royal Melbourne Hospital for several years before joining the Children's Hospital as a Research Fellow in Haematology in 1965. He became a clinical haematologist in 1970 and succeeded Dr John Colebatch as Director of Haematology in 1975. He was Chairman of the Specialist Medical Staff, 1984-92 and Chairman of the Hospital's Division of Medicine, 1992-98. During his career, he was involved in many important developments including the establishment of a Haemophilia Clinic at the Hospital, early bone marrow transplants, and a collaborative study about the impact on families of a child's death from cancer. (Personal communication, Henry Ekert to Ann Westmore)

[43] **Professor Richard Robert Haynes Lovell** AO, MD BS MSc FRCP FRACP Hon. FACP MRCS (1918-2000) was the first Professor of Medicine at the University of Melbourne. He was based at the Royal Melbourne Hospital and remained in the post, 1955-1983.

[44] **Professor Austin Eric Doyle** AO, MD BS FRCP FRACP (1923-1993) was the first University of Melbourne Professor of Clinical Medicine at the Austin Hospital, 1966-1985.

Ann Westmore: So it seems from what you are saying, Henry, that the teaching aspect of the Department was predominant in those early years, compared with research.

Henry Ekert: Most of the teaching was done by the consultants and salaried staff of the Hospital.[45] It had little to do with the University.

Glenn Bowes: May I raise one matter. The affiliation [between the University and the Hospital] wasn't formal at that stage. That came along later, as I understand it.

Peter Phelan: The first real formal appointment was Vernon Collins as Professor [in 1959].

Don Kinsey: Can I just say that when I first came to the hospital in 1976. I'd heard prior to that about the famous Burns Ward of the Hospital under A Murray Clarke, Julian Keogh, Wendy Swift et al.[46] I remember one of the first people to come and see me in my office was Murray Clarke who said "Where can I get some money for our research unit, the Burns Research Unit". On reflection, I feel that the Burns Research Unit was nothing to do with the University, and was run independently in the Hospital but supported by donations, and that burns research was extremely important in terms of paediatrics.

Kester Brown: Correct. One of the problems was probably that paediatrics was a relatively new and small field at the time. The people concerned had foresight. They also knew they had to concentrate their efforts and help set up the [Royal Children's Hospital] Research Foundation. [47] So that when the Department of Paediatrics started, I would

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[45] As a teacher, *"Dr Vernon Collins was excellent, and he listened to students' views. At the end of each term with students, we (Dr Collins and Dr John Court) would sit down with representatives from each small clinical group over lunch and ask them for their advice and comments to improve the course. And it was Vernon Collins who instituted a course of lectures to first year students at the University on growth and development, starting in the first week of the medical course. Sadly he was too ill to give consideration on their content or give the lectures, which I did, but it was a major development and very popular with students, at that time giving them a link between clinical studies and pre-clinical teaching. This was a radical move at the time, but the forerunner of later developments."* (Personal communication, John Court to Ann Westmore)

[46] The **Burns Research Unit** was established in 1955 under paediatric surgeon, Mr A Murray Clarke, who was inspired by the Melbourne visit of Birmingham burns pioneer, Dr Leonard Colebrook. At the time, 10 per cent of surgical beds at the Children's Hospital were occupied by children with burns, half of them aged between one and three. The Unit was the first of its type in Australia, and one of the first in the world. An early focus was evidence-based prevention of burns. The Unit was central to the development of Australian standards for children's nightwear, which led to the establishment of a Child Accident Prevention Foundation.

[47] **The Royal Children's Hospital Research Foundation** (subsequently **Institute**) was an extension of the Clinical Research Unit. It was established in 1960 to raise funds for research on health problems affecting children. Dr Howard Williams was its inaugural head and leader of one of three substantial groups formed at the outset (the other group leaders were Drs Douglas Stephens and Charlotte Anderson). Over time, a number of other groups were established, such as the Leukaemia/Haematology Group headed by Dr John Colebatch and the Genetics Research Unit, headed by Dr David Danks.
Drs Williams, Stephens, Anderson and Colebatch formed a management committee early on, taking turns as Chairman. They channeled funds into research, including some from the Good Friday Appeal. By 1967, the Foundation had twenty doctors, a team of science graduates, and eleven technicians and was internationally recognised for studies on a wide range of disorders affecting children and adolescents.

imagine that the Research Foundation was functional and had started providing funding to various groups to do research. And until such time as things moved along a bit and people got more involved in research, the Research Foundation had nothing to do with the University.

Having said that, many Departments in the Hospital had done research, and very high quality research. It did not rely on the University Department of Paediatrics or on the Research Foundation. So research went on across the Hospital, regardless of these things. But the quality of research was driven by the Research Foundation.

John McNamara: One has to also add that it was very difficult to obtain funding, not being affiliated to the University. So funding for research was, I think, limited to those doing paediatric sessions.

Pat Phair[48]: I found funding was easier to come by as part of a team. I worked under Charlo Anderson who was very popular with her patients. We always had adequate funding, though we were careful about how it was spent. In the mid-1950s when we worked on cystic fibrosis and other diseases involving abnormal mucosubstances, we were housed in a prefabricated garage with a small attached annexe on the roof of the old hospital. It was very hot in summer and cold in winter. In 1958, when I came back from England - where we were, by necessity, very self-sufficient and economical – we distilled and purified our own solvents and made quite a lot of simple glass apparatus ourselves and thus saved quite a lot of money.

But it was great at the new hospital because we all had a lot of say in the design of the labs in which we would be working, and the end result was terrific.

With the Foundation facing difficulties in raising funds, Dr Danks sought additional income for his Genetics Research Unit from charitable trusts, organisations and individuals. This led to the founding of the Birth Defects Research Institute in 1981, re-named the Murdoch Institute for Research into Birth Defects in 1986.
In 2000 the Institute merged with the RCH Research Foundation to become the Murdoch Children's Research Institute, with a staff of 600. It combines genetic and clinical services, plus wide-ranging research activities and is partly funded by the Foundation, partly by funds raised during the Good Friday Appeal, and partly by funds from other sources. (Personal communication, June McMullin (Danks) to Ann Westmore)

[48] **Dr Patricia Phair** PhD (b.1932) completed BSc and MSc degrees in the University of Melbourne Chemistry Department between 1950-55, then embarked on a PhD in the Department of Chemical Pathology, St Mary's Hospital and London University, on the structure of glycoproteins. She then worked as a research scientist with Dr Charlotte Anderson on cystic fibrosis (CF) 1959-69, except for nine months in 1964 when she worked in the Physiology Department at Cambridge University where she studied tissue culture techniques to use in her CF work. From 1969-70 she was Assistant Professor of Genetics at Cornell Medical School in New York, working on the basic biochemical defect in CF and on prenatal diagnosis of CF and some other genetic diseases. After a period out of the workforce for family reasons, she returned to the Royal Children's Hospital in 1986, working with Drs Harley Powell and David McCredie in the renal unit until 1992, then with Dr Julian Keogh in the Burns Research Unit until 1996 when she retired. (Personal communication, Pat Phair to Ann Westmore)

Ann Westmore: So what was the relationship with the University for a scientist such as you, working on research in the Hospital? Did you ever come up to the University, ever attend seminars, that sort of thing?

Pat Phair: In terms of the University I always felt something of an outsider.

I'd also like to say something about Charlo. I think she had a pretty difficult road to hoe. I think she was a fantastic researcher and fantastic to work for and was always very enthusiastic. I never felt she got her just recognition.

Ann Westmore: What part did Charlo play in the [University] Department?

Pat Phair: Well she would have been a little isolated.[49]

Peter Phelan: Vernon ran the Department of Paediatrics. When I came to the Hospital, his First Assistant was John Court. They ran a high quality clinical service, and Vernon played a major role in teaching. I don't think this role should be downplayed. Vernon did give strong leadership in teaching. He knew by name every student that came to the Hospital - 40, 50 or 60 students a term.

John Rogers[50]: And actually, Vernon would stand in the corridor and greet you by name as you walked into the Hospital on your first day. He would have studied the student photographs the night before and memorised the names.

Arthur Clark: And he made the rest of us do it too.

Peter Phelan: So the Research Foundation was largely Howard and Charlo [Charlotte Anderson] and latterly John Colebatch, and Durham [Smith][51] worked in the Surgical

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[49] When asked to elaborate on this, Dr Phair said the Hospital "was still rather male-dominated. Charlo [Charlotte Anderson] was very bright and internationally recognised and when she took up the Chair of Paediatrics at Birmingham, she was immediately involved in a wide range of high-powered committee work through the UK Medical Research Council etc as well as expanding her research capabilities." (Personal communication, Pat Phair to Ann Westmore)

[50] **Dr John Rogers** MBBS DCH FRACP Grad Dip Mental Health Sci (b. 1941) had three month periods as a Registrar and a Resident to Dr Vernon Collins during the 1960s. In 1971 he trained in paediatrics at Great Ormond Street Hospital for Sick Children, London, and at the Sheffield Children's Hospital. He undertook training in medical genetics at the Johns Hopkins Medical School, Baltimore, 1973-75. During the following 25 years he worked as Senior Lecturer in Paediatrics, Medical Geneticist, Senior Medical Geneticist and Director of Clinical Genetics for the Royal Children's Hospital Genetics Research Unit (now the Victorian Clinical Genetics Service). A long-standing interest in pastoral care of hospital staff was heightened by his personal experience of lymphoma in 1989 which in turn prompted him to undertake training in group psychoanalytic therapy. He was Chairman of the Ethics and Social Issues Committee of the Human Genetics Society of Australia in the late 1990s and early 2000s. In 2002 he was awarded the University of Pennsylvania Medical School's Distinguished Service Award for this work on Fibrodysplasia Ossificans Progressiva, an inherited disorder of bone. (Personal communication, John Rogers to Ann Westmore)

[51] **Mr Edward Durham Smith** AO, MD MS FRACS FACS (b.1922) graduated in medicine from the University of Melbourne in 1948 and, after undertaking training as a surgeon in Melbourne, London and Boston, joined the Alfred and Royal Women's Hospitals as a Paediatric Surgeon. He was a member of the

Research Unit established by Doug Stephens.[52] [53] But they had very little formal or informal contact with the University Department. Their interest was in pursuing their field of research and clinical services. The Research Foundation was established in about 1960 but that grew out of Howard's Clinical Research Unit and Doug's Surgical Research Unit. But it [the Research Foundation] was to some extent a bucket of money for these research groups.

Arthur Clark: I think Peter, if I could interrupt you, Vernon actually was very important in getting the research funds going too, within the Hospital.

Bernard Neal: Another point where Vernon Collins was crucially important related back to this payment of medical staff.[54] Until about the time when the people of my generation were coming along, paediatrics was something that the adult specialists did and there were a few people in general practice who were on the staff at the Children's Hospital who seemed to have a good bedside manner with children. That's about all it was.

Vernon Collins could see that there had to be properly-trained, full-time paediatricians. And I was lucky enough to be about when there was a little bit of money and Vernon Collins would talk to us individually about the steps we could take to make a career in paediatrics. That was how Alex Venables, Tom Maddison,[55] myself, just a small handful

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senior surgical staff of the hospital from 1965-86, and a senior surgical associate in the University of Melbourne clinical school for the same period. He was also a Consultant Paediatric Surgeon at the Royal Women's and Mercy Maternity Hospitals. He retired in 1986. He was active in the Royal Australasian College of Surgeons, serving as chairman of its Board of Paediatric Surgery, 1980-86; Senior Vice-President, 1985-87; President, 1987-89; and Executive Director, Surgical Affairs, 1989-92. (See *Who's Who in Australia 2002* and personal communication, Durham Smith to Ann Westmore*).*

[52] **Dr Bob Fowler** was another key member of the surgical research unit

[53] **F. Douglas ('Doug') Stephens** AO, DSO, MB MS FRACS FAAP (Hon) (b.1913), graduated in medicine from the University of Melbourne in 1936. After serving in the Australian Army Medical Corps during World War II he studied surgery at the Hospital for Sick Children, London. On returning to Melbourne, he was appointed research surgeon to the Children's Hospital, 1950-55 and honorary consultant surgeon to the Royal Women's Hospital. He was one of the first three near full-time surgical appointments made in 1952 at the Children's Hospital and in 1955 he became a full-time member of staff.
He was Director of the Hospital's Surgical Research Unit 1957-75, then left Australia to take up posts in Chicago of Professor of Urology and Surgery, Northwestern University Medical School, and Director of Surgical Research at the Children's Memorial Hospital. On retiring in 1986, he returned to Melbourne. He was then appointed Honorary Senior Consultant Surgeon and Honorary Surgical Research Fellow, Royal Children's Hospital Research Foundation and subsequently Honorary Research Fellow of the RCH Department of Surgery. (Personal communication Douglas Stephens to Ann Westmore; *Who's Who in Australia 1988 and 2004)*

[54] *"In 1953, he [Vernon Collins] was directly responsible for the introduction of salaried sessional staff within this hospital. In so doing, and this feature remained unique in Victorian teaching hospitals for twenty years, he created the necessary opening for a career in paediatrics for many young people."*
From a tribute minuted at a meeting of the senior staff of the Royal Children's Hospital on 18 April, 1978, and reported in "Obituary Alan L Williams", *Australian Paediatric Journal*, 14, 1978, p 129. See also Vernon Collins' detailed discussion of the salaried staff negotiations in "The Development of Paediatric Services in Victoria: Part 2", *Medical Journal of Australia*, II, 1970, pp113-116

[55] **Dr Thomas G. Maddison**, MBBS (1924-1989) was an Adelaide University medical graduate who came to the Children's Hospital as a Resident in 1949. He established a private practice in general paediatrics and developed expertise in neonatology. He was the first neonatal paediatrician at the new Box Hill Hospital in 1957. In 1960 he was appointed a Physician to Outpatients at the Children's Hospital, continuing in that

of people, and Vernon would say there's a bit of money for outpatient sessions and various bits and pieces were hung together. And Vernon Collins was pre-eminent in establishing a core of well-trained full-time paediatricians. So he may not have been doing research in the laboratory, but he was very important in putting paediatrics on the map.

Durham Smith: Just a little anecdote. I don't think there's any doubt about Howard Williams' desire to become Professor of Child Health. In 1959, Howard and I flew together for 8 hours on a plane trip to the World Congress of Paediatrics. I can remember two things. One was that he was really generous in his comments about Vernon. He made no derogatory comments at all. He was very supportive.

Secondly, he said, if I am appointed, I hope to be able to introduce a research program, and I think he certainly would have given the Chair a stronger research element than it developed under Vernon Collins.

Peter Phelan: Howard was very disappointed at not getting the appointment and there were probably a complex of reasons. He was not a good administrator, could be abrupt with his less competent colleagues and didn't tolerate fools gladly. Vernon was a consummate administrator and diplomat, a visionary who was adept at the politics. Both he and Howard had a broad view of paediatrics. Overall, I think Vernon was the better appointee as Foundation Stevenson Professor although Howard was a better teacher and clinician.

Ruth Bishop[56]: In going through the Collins/Williams contest, I guess, you're really repeating what must happen with the appointment of every professor in any department. If you could design the ideal professor, you need a mixture of diplomacy, clinical acumen, interest in research, and undergraduate and postgraduate teaching. Now, you will never find all this, you'll never find the perfect professor with apologies to imperfect professors in the room.

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role until 1973 when he was appointed a Physician to Inpatients. He was head of the Hospital's Department of General Paediatrics and was clinical supervisor overseeing undergraduate medical education and head of the hospital's Phenylketonuria (PKU) Clinic. (See Peter Yule, *The Royal Children's Hospital: A history of faith, science and love*)

[56] **Professor Ruth Frances Bishop (nee Langford)** AO, DSc PhD (b.1933) studied science at the University of Melbourne graduating in 1954. She was a Research Assistant at the Royal Children's Hospital, 1954-57 and obtained her PhD in microbiology in 1960. She then worked as a Research Fellow at the University of Liverpool, UK, 1962-65.
She was appointed Research Fellow with the Royal Children's Hospital Research Foundation in 1968 and led the team that isolated and identified rotavirus, a major cause of severe childhood diahorreal illness, in the early 1970s. She also helped develop a possible vaccine against rotavirus, for which she was awarded a Clunies Ross National Science and Technology Award and the Pasteur Award of the Children's Vaccine Institute, World Health Organisation, Geneva, in 1998. Her hand-written notes on rotavirus research survive.
She was a Professorial Associate in the University of Melbourne Department of Paediatrics, 1990-94, and she has been a Professorial Fellow since 1995. She is also Senior Principal Research Fellow (National Health and Medical Research Council), Royal Children's Hospital Research Institute and Director of the World Health Organisation Collaborating Laboratory for Research on Human Rotaviruses. (Personal communication, Ruth Bishop to Ann Westmore)

And I think that just listening – and my husband[57] was a bit peripheral because he'd gone through the Children's and knew Vernon as a Resident and Howard as a member of the Clinical Research Unit - he knew there was this contest and was a bit surprised at Vernon Collins' appointment because he appreciated Howard's skills as a clinician and his research focus. But I think listening to everybody here that, at that time, what was needed was somebody like Vernon Collins to establish it. But I think that contest goes on in every university department endlessly.

Roger Hall[58]: Anecdotally, my presence at the Children's Hospital began in 1960 and it was due both to Howard and to Vernon, and most directly to Vernon. When I graduated [in dentistry] I went down to the Orthopaedic Section of the Children's Hospital at Mt Eliza which stimulated my interest in paediatrics. The following year I joined the Dental Faculty of the University and I wrote my first paper on tooth defects in patients with Vitamin D deficient rickets.[59] Howard Williams helped me write and publish it.

At that time I expressed my interest in some day coming to the Children's Hospital if a position arose. Howard then actually referred me to Vernon [who was Medical Superintendent] and there must have been discussions among the senior medical staff prior to that. Dr Lawrence was the dentist at the time; they weren't entirely comfortable with him.[60] He wasn't full time and Vernon wanted a full time appointment. He said I should go away to England and do my postgraduate training and come back. The timing would probably be about right. [While I was in England] I received a telegram from Professor Atkinson (my department head) at the Dental Faculty who was also on the selection committee, stating that if I wanted this job, I'd better get on a boat and come home!

I had finished my paediatric dentistry training at the Eastman Dental Hospital in London and I had to cut short my oral surgery training. I returned and subsequently appointed. At that time I was very involved in research, as I had been ever since I graduated. I retained

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[57] **Professor Geoffrey J. Bishop** AM, MBBS, MGO, FRCOG (b.1932).

[58] **A/Professor Roger Kingsley Hall** OAM, MDSc FRACDS FICD (b.1934) did his undergraduate dental training at the University of Melbourne before undertaking postgraduate studies in oral surgery and paediatric dentistry at the Eastman Dental Hospital and the Royal College of Surgeons in London. In 1960 he was appointed the Hospital's first full-time Paediatric Dentist with a special interest in facial and jaw trauma and cleft lip and palate. When the Hospital's Department of Dentistry was created in 1967 he was appointed its head, serving in that position until 1998 and he continues as Senior Dental Surgeon on a sessional basis. He has worked closely with geneticists to identify genetic syndromes with a dental component, and in 2003 was appointed an Honorary Fellow of the Victorian Clinical Genetics Service. In 1973 he founded the Australian Society of Dentistry for Children, with the encouragement of Vernon Collins and other staff members, becoming Foundation President from 1973-76. He was President of the International Association of Dentistry for Children from 1985-87. In 1994 his textbook, *Pediatric Orofacial Medicine and Pathology* was published. In 2004 he was a Principal Fellow of the University of Melbourne, where he has held teaching appointments continuously since 1957. (Personal communication, Roger Hall to Ann Westmore)

[59] Roger K. Hall, "Gross tooth hypocalcification in vitamin D resistant rickets, *Australian Dental Journal*, 1959, 4, pp 329-330.

[60] **Dr Anthony J. Lawrence** was Honorary Dental Officer at the Hospital, 1957-60.

my research interest through the Dental Faculty initially. I think a few other people did research in other University Departments while they were appointed to the Children's where it wasn't very easy to get research funding or to get a project up and running.

With the [establishment of the Royal Children's Hospital] Research Foundation [in 1960] I obtained a grant and did a long period of animal research on developmental anomalies of tooth enamel.

Also Vernon was mentoring me all the way and he was also indirectly responsible for the establishment of Paediatric Dentistry as a specialty. I started to promote that in the 1970s but it was Vernon's influence and our occasional conversations that gave me the drive, together with my experience in London.

That's all anecdotal, but it's my experience of the two men, both of whom contributed in significant ways to my career at the Royal Children's Hospital and to the recognition of Paediatric Dentistry as a specialty area of dentistry and medicine, both at the Hospital and in Australia.

New directions in patient care, research and teaching

Ann Westmore: Thank you for that comment Roger because that leads us into one of the issues that comes up quite a lot in historical writings on Vernon Collins' impact, that is his focus on an holistic approach to the welfare and care of children rather than an emphasis on, say, physical or organic aspects of ill-health alone. Is that something that struck those of you who knew him well?

David McCredie: To pick up on something that was said earlier, I think it would be a bit unfair to give the impression that Vernon wasn't interested in research because I think he certainly was. He fostered research and did support a number of projects with a biochemical approach in the 1960s and 1970s and he was responsible for introducing quite a bit of new technology.

Graeme Barnes[61]: Vernon appointed me in 1971, and I think others also, with a whole year's salary in order to do research. So he certainly had a strong sense of supporting it, even though he wasn't directly involved in it himself.

[61] **Professor Graeme L Barnes** AO, MD FRACP (b.1941) trained in medicine at Otago University, graduating in 1965. His first contact with the Children's Hospital was 1970-72 when he was a Registrar and a Research Fellow in Gastroenterology. During 1972 he spent three months on a Heinz Travelling Fellowship studying paediatric departments in Britain, then lectured in paediatrics at Otago University, 1973-75. On returning to Melbourne he became Director of the Hospital's Department of Gastroenterology, 1975-95, during which time he played a leading role in community and professional education about common gastrointestinal problems and in research on the treatment of childhood diarrhoeal diseases in developed and developing countries. From 1996-99 he was Scientific Director of the Royal Children's Hospital Research Institute and was involved in plans to merge it with the Murdoch Institute. Since 1999 he has been a half-time Senior Gastroenterologist working with Professor Ruth Bishop on rotavirus vaccine development and a Professorial Fellow, Department of Paediatrics at the University of Melbourne, mentoring and teaching postgraduate students. (Personal communication, Graeme Barnes to Ann Westmore)

John Rogers: I worked with Vernon in 1968 as a Junior Resident and one of the things he set about doing was to try to teach me how to talk to families and parents. He did this by having me sit in with him at the beginning and then he would brief me and line me up to talk with a family and debrief me at the end of it. He put great focus on the ability to actually be able to handle families and counsel them. He gradually stepped up the difficulty of what he set me to do on my own until in my very last week there he sent me in to see a family whose child had leukaemia.

Bernard Neal: A very quick one sentence about Vernon Collins. He called us together one day – I think it was 1950 - and told us about interviewing parents after the death of a child and acquiring their permission for a *post mortem* to be carried out. Because up until that time in the old [Children's] Hospital, there was a little notice near the door from the Act of Parliament about permission for autopsy. And it was assumed that the parents had read that and their permission was implied.

Vernon had a talk to us and said, I think the way we've gone about this is rather mean. I remember "mean" was the precise word he used. He said, I don't think that's good enough. In future, when you see the parents, you must discuss the question of autopsy and you must get their permission. And from that time onwards, autopsies have been done with parental permission.[62] And that was a wonderful example of his foresight and broad care. And so indirectly, of course, all that generation of paediatricians were trained in this ethical question that you shouldn't do things to children without their parents' permission.

Glenn Bowes: Can I just jump in there. The visionary thing that was referred to earlier is this - that exact piece of teaching of Vernon was picked up last year by Paul Monagle in the national and international debate about autopsy and consent that followed the Bristol and Alder Hey issue in cardiac surgery departments.[63] And Paul Monagle found that quote and used it in his advocacy to State and Federal Governments about the tradition of the autopsy consent process. That's now been codified under the Australian Health Ethics Committee. So, forty years after the event, it had already been forgotten and had to be rediscovered, to remind us of the importance of it.

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[62] According to Dr Bob Southby (see footnote 20), the introduction of a personal interview with the parents of each child who died in the Hospital, a complete explanation of all the circumstances and a request for a post-mortem examination resulted in an increase in the proportion of autopsies conducted, much to the surprise of many of Vernon Collins' colleagues. (See Robert Southby, "Professor Vernon Collins", *Australian Paediatric Journal*, 10, 5, p 255)

[63] Public concern about the retention of human tissue and organs without what the community considers to be informed consent was sparked in 1999 by inquiries into incidents in the United Kingdom at Alder Hey Hospital, Liverpool and the Royal Bristol Infirmary. Dr Paul Monagle, Director of Laboratory Services at Royal Children's and Royal Women's Health, Melbourne, took part in the development of Guidelines on Requesting Consent for Non-Coronial Post-Mortem Examination.

Frank Oberklaid[64]: Another anecdote about the influence of Vernon Collins. In 1968, while taking ward rounds with Resident Medical Officers, I remember him asking us what medications a child was on. He made us taste the medicine, some of which was foul. That just opened up our eyes. Little things like that had a profound influence.

Max Kent[65]: I wouldn't like this section to go by without saying what an impression Howard's clinical skills made on me. I'm a surgeon and I'm always in a hurry. My wife thinks I'm still in a hurry. One of the most important things was that Howard would give the time and patience in managing the child and family.

Ann Westmore: You clearly knew Howard well as a very able clinician and researcher. Do you think perhaps that his political skills may not have been quite what was required?

Max Kent: He had many talents, but they were different from Vernon's. What I would say is that he wasn't unskillful politically.

Unidentified female voice: I felt that Vernon Collins had a whole range of talents and strengths. He broke with the traditional dichotomy between physical and mental health and saw paediatics as extending care to the whole child - physically, intellectually, emotionally and socially disadvantaged child. To him, paediatrics was an occupation that required an awareness of the child's optimal functioning.

Ann Westmore: Does anyone else have any comments about the holistic approach that Vernon Collins was noted for?

Bernard Neal: He was very involved in freeing up the opportunities for parents to visit their children in hospital. I worked in England in 1954 and I was interested to note that the arrangements for parents visiting their children in hospital were actually superior back in Melbourne.

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[64] **Professor Frank Oberklaid** AOM, MD BS FRACP DCH (b.1945) completed his medical training at the University of Melbourne in 1969 and after Resident years at the Royal Melbourne and Children's Hospital, he spent a year traveling overseas, during which he completed a DCH in London. He resumed work at the Children's Hospital in 1973 and spent half of 1976 doing research with David Danks. Later that year he went to Harvard Medical School on a Fellowship and returned in 1980 to become Inaugural Director of the Department of Ambulatory Paediatrics which emphasised prevention and early intervention. He became Professor/Director when the Emergency Department was split off from the Department of Ambulatory Paediatrics which became the University's Centre for Community Child Health in 1994. (Personal communication, Frank Oberklaid to Ann Westmore)

[65] **Mr Maxwell ('Max') Kent** MBBS FRACS (b.1929) was a 1952 University of Melbourne medical graduate who was on the staff of the Children's Hospital for four decades. He undertook surgical training at the Alfred Hospital and was appointed Assistant Surgeon at the Children's Hospital in 1958. In 1960 he was awarded the Uncle Bob Scholarship to train at the Chicago Children's Memorial Hospital. There he studied paediatric surgery with an emphasis on neonatology and thoracic and cancer surgery. Some years after resuming work at the Children's Hospital, he was appointed Chairman of the Division of Surgery, 1979-84, and Chief of Surgery, 1981-86. One of his legacies was the establishment of a Combined Cancer Therapy Clinic at the Hospital, which survives to this day (see later). It provides a regular forum for the discussion of individual cases of childhood cancer by medical, nursing, paramedical and support staff. (Personal communication, Max Kent to Ann Westmore)

Arthur Clark: As it was for a further twenty years.

Bernard Neal: Previously parents could visit once a week on Sunday afternoons and that was it because the children often cried after they went home. It sounds barbaric, but that was the arrangement at the time.

Also, in the Vernon Collins' era, we used to have, at about lunchtime every day, in the old hospital a little parent information discussion/consultation. That was when the parents were all told they could see the Resident and find out how their child was getting on and what was happening to them. Until then, parents had no right of access to medical staff, or to their own children!

Max Robinson[66]: Another aspect of care of babies who had just been delivered and were in the nursery. Vernon Collins promulgated the view of "living in", mothers having their babies beside them. This had a number of benefits, apart from bonding which is the obvious thing. Secondly, infection. It limited the spread of infection to babies by minimising the time they spent in the nursery.

Bernard Neal: There was opposition from some of the nursing staff to these changes. They thought this was terrible.

Ann Westmore: And how were these innovations regarded by doctors in other hospitals?

Arthur Clark: I think I must mention here a paper published in the mid-1950s about the adoption of more liberal visiting hours by Kate Campbell and Marion Ievers, who was a children's ward sister at the Queen Vic.[67] They had adopted these changes while the Children's was still letting parents in on Sunday afternoon. I don't want to put down what's been said about Vernon, but he picked that up and said this is what we have to do.

Ann Westmore: Thanks for that point of clarification, Arthur.

Kester Brown: Vernon told me about how when he was a young fellow during the war, he gave anaesthetics for tonsils in England. The patients went home on the same day. I

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[66] **Dr Maxwell James ('Max') Robinson** AM, MD FRACP (b.1925) was a 1949 University of Melbourne medical graduate who joined the resident medical staff at the Children's Hospital in 1951. He was Chief Resident in 1954, Physician to Outpatients, 1958-70, Senior Physician in 1966, and Physician to Inpatients 1970-73 before joining the University of Malaya in Kuala Lumpur as Emeritus Professor of Paediatrics, 1974-78. After returning to Melbourne, he spent a year at Monash University, where he worked with Professor of Paediatrics, Arthur Clark, on the undergraduate teaching program. He resumed work at the Royal Children's Hospital in 1979, where he became Chairman of the Division of General Medicine in the early1 1980s. His contributions to undergraduate medical education included two textbooks which he edited or co-edited, *Paediatric Problems in Tropical Countries* (1978) and *Practical Paediatrics* (1982). He was appointed University of Melbourne Reader in Paediatrics and Associate Professor in the mid-1980s. He has continued his close relationship with the Hospital as President of the Alumni Association. (Personal communication, Max Robinson to Ann Westmore)

[67] Marion Ievers, Kate Campbell, Mona Blanch. "Unrestricted visiting in a children's ward. Eight year experience", *The Lancet*, 5 November 1955, pp 450-453. The visiting hours' policy of the Children's Hospital officially changed in 1952 after some liberalisation in the early 1950s with nursing support.

think this experience was probably something that encouraged him to introduce a half-time, then a full-time Director of Anaesthesia in the search for better care.

Roger Hall: Someone mentioned before about translating a clinic to a department. It was Vernon who guided me in 1967. I felt by that stage we were large enough and encompassed a number of different dental specialties. It was appropriate that we should be a Department [of Dentistry]. And Vernon was the person - rather than others in the hospital's administration - who guided me as to how this should be brought about. He went about it with a couple of discussions. I felt he still retained that bit of an interest in my progress as a clinician.

Henry Ekert: I think it's important that I mention that whilst we are talking about influential figures in the department, a third figure who didn't have his foot in either camp was John Colebatch.[68] I worked with John on his research. I think he was on the

[68] **Dr John Houghton Colebatch** AO, MD FRCP FRACP DCH (b.1909) was a 1933 University of Adelaide medical graduate whose first appointment at the Children's Hospital, Melbourne, occurred in 1935. From 1937-39, he undertook physician training at the London Hospital and Great Ormond Street Hospital for Sick Children under Dr Donald Paterson, a leading Harley Street paediatrician. And during a course in haematology conducted by Dr (later Dame) Janet Vaughan DBE, FRS FRCP (1899-1993) at the Hammersmith Hospital in 1938 he learned to perform marrow puncture of the sternum and conducted research on normal bone marrow in fifty children in hospital for problems unrelated to their bone marrow. After returning to Australia as World War II was declared, he renewed his acquaintance with the Children's Hospital, working as an Outpatient Physician and in private practice.
Following service in the armed forces, he was reappointed Physician to Outpatients at the Children's Hospital (1946-55) and also worked in private paediatric practice (from 1947). It was at this time that he read US reports of the new treatment, aminopterin, which had reportedly extended the lives of children with acute leukaemia for several months. In October, 1947, he started working with this and other drug therapies as they became approved for trials, sending any patients with leukaemia whom he saw in private practice or outpatients to the Children's Hospital where he had access to beds, courtesy largely of Dr Mostyn ('Mick') Powell. During the next decade he sought to evaluate which chemicals in what dose and for what duration, most reduced the symptoms of leukaemia.
In 1948 and again in 1953, he put forward a proposal to establish a Haematology Research Unit at the Hospital with the aim of clarifying the most effective timing of chemotherapy to disrupt cancer cell division. The Senior Medical Staff opposed this proposal on both occasions but Dr Vernon Collins, the Medical Director, was sufficiently supportive to overrule their decision in 1953.
The Unit made significant progress, enabling Dr Colebatch to present some promising findings at the Annual World Congress of Paediatrics in Copenhagen in 1956. By 1959, there was definite evidence that chemotherapy increased survival time, sometimes for up to three years or more, and three of Dr Colebatch's patients with leukaemia entered states of remission. (According to Dr Colebatch, the final written records of these three patients appear to have been mislaid.) From 1960 onwards, the duration of remissions increased, giving rise to expectations that in some patients this state of affairs would continue. In retrospect, he achieved what was regarded as his first cure in 1960. From the 1960s also, more drugs became available for chemotherapy every year.
Dr Colebatch was Physician to Inpatients at the Royal Children's Hospital, 1957-67, during which time he obtained grants from the Hospital and the Anti-Cancer Council of Victoria (ACCV) to continue his studies. In 1962, he was awarded a Rockefeller Fellowship to study chemotherapy for leukemia and other cancers in the USSR, the UK and the US. He was also awarded the ACCV's Robert Fowler Travelling Fellowship which enabled him to study the US National Cancer Institute's approach to organising studies in multiple research centres. He then gained Australian Cancer Society support for a trial of chemotherapy in childhood leukaemia involving 14 paediatric hospitals and departments nationwide. This was a milestone in Australian medical history, being the first formal randomised clinical trial of any kind conducted nationally.

outer and had a very tough time combining his clinical work with research into the treatment of childhood leukaemia. If not for his obsessive drive, I don't believe that the prospects for children, which were regarded as hopeless, would have improved as far or fast as they did.

Arthur Clark: Can I come in to support these opinions and to say that Vernon sort of delegated me to work with John Colebatch in 1960. John was isolated in many ways, but Vernon was one of the few people who supported him.

Ann Westmore: So he was doing major work with chemotherapy in young patients who otherwise were expected to die of leukaemia within a few weeks? Can you recall, Arthur, what Vernon's support for John Colebatch amounted to?

Arthur Clark: It amounted to recognition that this was an appropriate thing to be doing. It wasn't financial support or support in the sense of getting a department established. There were lots of other people in the hospital who wished John would go away, including Howard who was very critical of John's approach. Vernon said, this is something that needs to be done and he supported him.

David McCredie: We were also criticised in some quarters for prolonging the life of children with kidney disease by using unpleasant procedures [for example, kidney transplantation[69] and renal dialysis].[70] There was John [Colebatch] getting a respectable number of patients with some increases in length of life, but still they were sick and miserable. Perhaps it's inevitable that whenever a treatment is pioneered for a condition that is universally fatal, you are bound to get some criticism.

Ethical issues in research and treatment

Bernard Neal: I came increasingly from the ethics point of view.[71] Although it [John Colebatch's research] wasn't widely recognised as such as an ethical problem. Should you prolong the miserable life of these children by giving them unproven drugs as research and so forth? A number of people thought that this was putting research ahead of

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In 1967, he helped to conduct six linked studies of chemotherapy for leukaemia and a study of the impact of radiotherapy on preventing or limiting infiltration by leukaemia into the brain and spinal cord. He was also Executive Chairman of the RCH Research Foundation 1970-72.
After retiring from medical practice, the ACCV appointed him in 1976 to the position of inaugural Executive Secretary of the Victorian Chemotherapy Co-operative Group, established to encourage collaborative research studies between cancer clinicians. He continued as the Executive Secretary of the re-named Victorian Cooperative Oncology Group until 1982 when he became a consultant to the ACCV. (Personal communication, John Colebatch to Ann Westmore)

[69] David McCredie was a member of one of the first teams in Australia to perform a kidney transplant.

[70] After some years of public debate, legislation was passed in the Victorian Parliament dealing with the procurement of body tissues and the clinical diagnosis of death.

[71] The central creed of medical practice since Hippocrates has been to first do patients no harm. But medical research, by its nature, often entails some risk to patients' health and well-being. Recognition of this situation in Australia resulted in the development of a system of regulation by committees to scrutinise proposed research. Membership of these committees includes people with broad research experience who do not have any allegiance to the institution where the proposed research is to be conducted.

patient care. That's a very difficult debate and these days you would then bring your ethical principles to bear to debate and discuss. But there were these two camps about whether to stop the John Colebatch work. All sorts of people, including the vivisectionists, were set against him. What we were really doing was beginning to realise that there was an important ethical aspect to what goes on at the Children's Hospital.

Ann Westmore: So how was that resolved within the University, the Hospital and paediatrics more broadly?

Henry Ekert: John's support from the Anti-Cancer Council of Victoria and importantly the establishment of COSA [the Clinical Oncological Society of Australia] enabled his work to flourish and attract support. From that beginning, the results improved and the support of colleagues followed to the point where ethics was no longer an issue.

Ann Westmore: Presumably that same sort of dilemma arises now where a treatment causes suffering and provides minimal assistance to patients in the first instance, but shows promise for the longer term. Can someone clarify the mechanisms now within the hospital to deal with this situation?

Durham Smith: That situation would be dealt with by the Hospital Ethics Committee.

Frank Oberklaid: Ideally, we would have Ethics Rounds at the Hospital where clinicians would present particular cases to a panel including their peers, ethicists and ministers of religion. The rounds would be open to the entire Hospital and University community. Clinicians would be exposed to a debate that they would incorporate into their thinking, without any obligation to do one thing or another. I've seen this sort of thing work successfully in hospitals elsewhere.

Bernard Neal: Two more quick examples. One is child abuse, where there are many ethical problems. Do you send the child, you suspect of being abused, home and when do you involve the police? The other one is in the neonatal ward; when do you turn off the treatment for a very small premature baby? The extent of treatment for sick newborn is a very important matter.

David McCredie: We started a very similar thing – a sort of brainstorming – on the issue of when to use dialysis and transplantation in renal failure. We had a lot of things to contend with regarding treatment of newborn. It was a very difficult problem.

Glenn Bowes: The clinical ethics thing is still unresolved today, the journey hasn't been completed. But there's a theme that seems to come through the Colebatch example and David's example. And Peter Phelan might like to speak about cystic fibrosis. There's a sense that there were a whole range of illnesses in childhood, in which it was felt we should let children die peacefully rather than intervene. Is it only the leadership for change that came from the Children's Hospital and/or the University members involved, or both, that actually gave rise to the persistence, the doggedness, to actually continue?

Peter Phelan: I think that's true. Certainly when I started my paediatric training in another part of the country in about 1963, there was a much more pessimistic view of a lot of other illnesses. The attitude to leukaemia was that it was unfortunate when a child died within 24 hours of diagnosis, and with cystic fibrosis you didn't try.

Coming to Melbourne, it was quite clear that there was already a different attitude, already starting to treat children humanely but to do all that's possible, remembering, first to do no harm. There was a dramatic change in attitude that rapidly spread during the late 1960s and early 1970s. There were many people who were criticized, including Doug Stephens for some of his surgical research. But that was the only way we made progress. And at the Children's there was a supportive environment and, I suspect, Vernon was the key person in providing that supportive environment for people to try something new.

A number of things that turned out to be very successful would, I fear, in today's environment, not get ethics committee approval. And I think that's very worrying.

Dick Cotton[72]: I would like to support Peter there. Back in 1973, I persuaded David Danks to inject tetrahydrobiopterin into a patient with a disease related to PKU (phenylketonuria), and blow me down, it worked. Now, that treatment is used in every paediatric hospital around the world for diagnosis of tetrahydrobiopterin deficient PKU. And, so, one wonders if today that would even be tried.

Durham Smith: In 1961, we established a spina bifida clinic. We were about the first group in the world to advocate a selective process of deciding the babies on which we would operate or not, taking account of quality of life issues. In 1964 I visited the Sheffield Children's Hospital where they had an annexe full of spina bifida patients in desperate circumstances because they did not use any selection process. The paediatrician attached to the unit said the annexe was formerly the conservatory of an old home where they grew flowers. But now they "only grew vegetables". It's a very good example of the use of ethics to help determine policy on treatment in the 1960s and '70s.

[72] **Professor Richard Graham Hay ('Dick') Cotton** BAgSc PhD DSc (b.1940) graduated in agriculture from the University of Melbourne in 1963, after which he completed a PhD. He then undertook postdoctoral studies in Canberra, before joining the Royal Children's Hospital Research Foundation in 1968. Later, at the Scripps Clinic in the US and at the MRC Laboratory of Molecular Biology in Cambridge he undertook fundamental and pioneering studies of the monoclonal antibody technique. He helped establish the original Murdoch Institute at the Royal Children's Hospital in 1984 and initiated the successful international journal, *Human Mutation*, in 1991. He established and was foundation President of the group now referred to as the Human Gene Variation Society in 1994, and gained an appointment as a National Health and Medical Research Council Senior Principal Research Fellow in 1996. The same year, he established the Genomic Disorders Research Centre at St Vincent's Hospital, Melbourne. He has written two books and many scientific papers on the detection of mutations and he is Treasurer of the Human Genome Organisation (HUGO) which co-ordinates the sequencing and analysis of human genetic information. (Personal communication, Dick Cotton to Ann Westmore)

Anne Rickards[73]: From 1968 I worked with Dr Bill Kitchen on a multi-disciplinary randomized controlled trial that had started in 1966.[74] It was a longitudinal study that compared the mental and physical development of children who weighed 1000 to 1500 grammes at birth who either received the routine care then given to babies which amounted to devoted nursing care or a more intensive form of care that included intravenous glucose feeding and careful control of electrolytes. It was my job to talk to the children and assess their cognitive development and behaviour using sensitive measures. In two papers published in 1978 and 1979 we showed that there were significantly more survivors in the intensive care group, but they tended to have more handicaps during childhood than those given routine care.[75] In other words, the intensive treatment was helping the more vulnerable ones to survive. I think that had quite a profound effect at the time, causing some hospital nurseries to undertake less aggressive treatment on babies with a very low-birthweight.

Kester Brown: A fascinating piece of history occurred in April 1970 when positive end expiratory pressure ("PEEP") was used at the Children's Hospital for the first time to keep the airways open of a baby with hyaline membrane disease. It happened during the Hospital's Centenary Meeting after Dr Mary Ellen Avery[76] gave an address about putting

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[73] **Dr Anne Rickards** BA(Hons) MA PhD MAPS (b.1933) undertook training in clinical and research psychology at the University of Melbourne and the Royal Children's Hospital Department of Child Psychiatry. She worked at the Women's Hospital on longitudinal studies, 1968-98, and also worked in the Psychology Department of the Children's Hospital, 1964-67 and 1979-2000. She was later involved in a research project examining the effect of home based intervention on pre-school children with developmental delay conducted by the Hospital's Department of Child Development and Rehabilitation. (Personal communication, Anne Rickards to Ann Westmore)

[74] **Dr William ('Bill') Henry Kitchen** AM, MD BS FRACP FRACOG (b.1926) was a 1949 University of Melbourne medical graduate who joined the Children's Hospital in 1953 as a Junior Resident and the following year was Research Registrar for a year under Drs Howard Williams and Charlo Anderson. Until 1965 he combined work as an Outpatient Physician at the Hospital with a private paediatric practice. In 1965 he was appointed to a full-time position as First Assistant (equivalent to Associate Professor) in both the University of Melbourne Department of Paediatrics and the Department of Obstetrics and Gynaecology, continuing in this post until 1991.
His main research interest was in the long-term outcome of extremely low birthweight infants, initially involving only those born in the Royal Women's Hospital, but evolving into the Victorian Infant Collaborative Study (VICS), comprising all extremely low birthweight infants born in Victoria. He was convener of this project until 1991. He was also convener of the Steering Committee which resulted in the establishment of the Neonatal Emergency Transport Service (NETS) in 1977 and served on its Advisory Committee until 1991.
From 1967 he was associated with the Consultative Council of Obstetric and Paediatric Mortality and Morbidity in Victoria, serving as its Medical Coordinator for the period 1992-97 when he fully retired. (Personal communication, Bill Kitchen to Ann Westmore)

[75] The articles were Kitchen WH, Ryan MM, Rickards A et al (1978) A longitudinal study of very low-birthweight infants I: Study design and mortality rates, *Developmental Medicine and Child Neurology, 20*, 605-618 and Kitchen WH, Rickards A, Ryan MM et al (1979) A longitudinal study of very low-birthweight infants II: Results of controlled trial of intensive care and incidence of handicaps, *Developmental Medicine and Child Neurology*, 21, 582-589

[76] **Dr Mary Ellen Avery** MD discovered, with Jere Mead, in the 1950s that a lack of surface active agents in the lungs (surfactants) of newborn babies led to respiratory distress and caused many of them to die. A Johns Hopkins University Medical School graduate of 1952, she was physician-in-chief at the Boston Children's Hospital 1974-85, a Professor of Paediatrics and Chair of the Department of Paediatrics at the Harvard Medical School, and a council member of the US Institute of Medicine and the National Academy

positive pressure on the airways to keep the alveoli open. At 10.30am Dr John Stocks,[77] having heard the address, made arrangements for the expiratory gas to be bubbled under water to a depth of 5cm to achieve positive pressure. That was the start of the Hospital's use of a technique that completely transformed neonatology in my view. It made possible the survival of a whole crowd of babies. Before that, babies in respiratory distress because of a lack of surfactant, were treated with increasing amounts of oxygen to counter their inadequate oxygenation. But most of them died. After this new technique was introduced many more survived.

We had another very interesting problem consequent on that. We didn't realize that 100% oxygen was having a toxic effect on the babies' lungs. We found that out over lunch in the doctor's dining room, now long extinct, in a conversation between Alan Williams[78] and me. He said, what are you doing to the babies? It was then that we realised what the problem was and corrected it. There are a lot of fascinating bits of evolution around the babies of that time.

But the question of how far you push a treatment is a terrible ethical problem. If you don't take into consideration the quality of life, I think that's a great sadness to all concerned.

Garry Warne[79]: I'd like to pick up something that reverberates from Vernon, through to people like John Colebatch. It seems that for some time there was discussion within the

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of Sciences. In 1991 she was awarded the US National Medal of Science for her work on respiratory distress in newborn. Later, she became President of the American Association for the Advancement of Science.

[77] **Dr John Stocks**, MBBS FFARACS (1930-1974) trained in medicine at the University of Sydney before moving to Melbourne in 1963 to train in paediatric anaesthesia at the Royal Children's Hospital. He became assistant, then deputy, to the Director of Anaesthesia, Dr Margaret McClelland, and in 1969 he also took on the position of Director of Intensive Care. The following year, he was made Director of Intensive Care and Anaesthesia, remaining in the post until his premature death from a chronic condition in 1974. Among his most important contributions was his development of Intensive Care at the Hospital, using prolonged nasotracheal intubation and ventilation. His *Notes on Paediatric Anaesthesia* were read widely, there being a dearth of literature on the subject. Paediatric surgeons often acknowledged that they could not have made their advances without the support that anaesthetists such as Dr Stocks provided. Twenty-five years after his death he was commemorated as having made the greatest contribution to paediatric intensive care in Australasia. (Personal communication, Kester Brown to Ann Westmore)

[78] **Dr Alan Llewelyn Williams** MD MCPA MAPA (c.1920 -1978), graduated in medicine from the University of Melbourne in 1942. After wartime service, he joined the Children's Hospital as a Resident Medical Officer in 1947. He was Assistant Pathologist 1948-59 and Director of Pathology for many years from 1959. Dr Cliff Hosking considered Dr Williams was his most influential mentor and supporter, and had a significant influence on the RCH. "He showed visionary leadership in pathology for many years and the breadth of his feeling for the institution was incredible … he was influential in the institution of the play therapy program at RCH which would have to be unusual for the Director of Pathology". (Personal communication, Cliff Hosking to Ann Westmore. See also "Obituary Alan L Williams", *Australian Paediatric Journal*, 14, 1978, p 129. See also *Who's Who in Australia 1971*)

[79] **Dr Garry Leigh Warne** MBBS FRACP (b.1944) graduated in medicine from the University of Melbourne in 1968 before working at the Royal Melbourne Hospital for five years, during which he was Assistant Endocrinologist. In 1974, he joined the Royal Children's Hospital as a Junior Resident and in 1975-77 did laboratory research on foetal steroids at the University of Manitoba in Winnipeg. On returning to the Children's Hospital, he was Assistant Endocrinologist to Dr Norman Wettenhall, 1977-80 and then

profession about ethical matters, but probably not in the community. I just wonder, as a student of the 1960s, to what extent Vernon Collins was effective in speaking to the community about these difficult ethical issues.

Glenn Bowes: I've seen a number of newspaper cuttings of utterances of Vernon Collins, including several in Peter Yule's history book. When he came back from his study tour to look at medical education, a Vernon Collins'quote that I carry in my head is that the most important thing was not so much curriculum but the enthusiasm of clinicians. And his comment about recruiting staff to a world-class Children's Hospital by building a research base to attract a variety of talented individuals provides another example of his approach.

I'd like to ask Arthur, about the issue of leading change and pushing boundaries. At Monash University when I was there in the 60s and you were heading [the Department of] Paediatrics, what percentage of the University do you think cared that you and Vernon played a role in ethical debate.

Arthur Clark: I think it was a role, certainly it was a role for Vernon because he already had a long track record of offering opinions to the public about these issues. He was given to commenting on matters as they came up and it was expected of him. I inherited that but I tended to be a spokesman on paediatric matters rather than being associated with a particular hospital or university. It seemed to work for us. But now I have no idea, I suspect the role is all over the place.

Glenn Bowes: The issue here that I'm interested in is the actual leadership as Henry pointed out in relation to John Colebatch. What's the role of the academic head of department in enabling some of that to happen, to make progress?

Peter Phelan: Glenn, if I could comment. By the time I became Stevenson Professor of Paediatrics, the Hospital Ethics Commitee was alive and well and starting to flex its strength. It had been created at about the time I took over from David Danks – we discussed membership and he found a teacher from Camberwell Grammar and I produced one of my patients. Both were, in fact, marvelous community representatives.

I saw my role very clearly to get the committee to try to understand the importance of doing new things and not being overly constrained by, for example, uncertainties over side effects. So, it [the ethics] moved from that public one to this very constrained institutional role. That was occurring in the early 1980s.

Arthur Clark: It was earlier than that, Peter. In about 1975 the National Health and Medical Research Council (NHMRC) established a Sub-Committee on Ethics in

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became Senior Endocrinologist. He was Foundation Director of the RCH Department of Endocrinology and Diabetes 1983-99 and, since 1998, has been Director, Royal Children's Hospital International, and Senior Endocrinologist. (Personal communication Garry Warne to Ann Westmore)

Research, of which I was a member, and that led to the establishment of the NHMRC's Medical Research Ethics Committees a few years later.[80]

Peter Phelan: I well remember David [Danks] and my discussion about how to get the right people on the Ethics Committee.

Dick Cotton: That's a fascinating perspective. One of the longest-serving members of the Ethics and Human Research Committee at the Royal Children's Hospital is Ron Lambourne, a senior master at Camberwell Grammar.[81] I guess when he started he was probably a junior master. That was a link through David himself?

Peter Phelan: Yes, that's correct and I suggested Mrs Patricia Kee.[82]

Don Kinsey: While we're talking about this idea of constraint and restraint, the way I saw some of these things and I was interested to listen to Glenn on the electronic media in the last couple of weeks, the thing that most recently came to my mind was the fact that Glenn spoke out on behalf of the medical profession – he made it quite clear he was not speaking on behalf of the Hospital, that wasn't his role. But the question I had was, who is speaking on behalf of the Hospital and the kids?

In our early days, there was a very, very, strong and influential group on the Committee of Management, subsequently called the Committee of Governance, but it depends on who wields the influence. In media terms, Bernard, back in my early days at *The Herald*, you always had the President of the Committee of Management or the Medical Director, with the backing of the President, or the Professor with the backing of Lady Latham and the President of the Hospital. It was a very concerted effort to get things done and move ahead.

The Ethics Committee is sort of an aside which is a necessity, but it shouldn't be a hindrance. I can remember one particular case, if we're talking about parent contact and holistic treatment, and experimentation or research, I can remember being deeply involved with a particular cardiac surgeon, Roger Mee, who's still working in America.[83] A baby had been diagnosed in early pregnancy with an ectopic heart. I remember Roger coming in to my office one day and I think the pregnancy was about six or seven months

[80] The Medical Research Ethics Committee of the National Health and Medical Research Council was established in December 1982 and, the following year, Professor Richard Lovell was appointed inaugural chairman. He had just retired as University of Melbourne Foundation Professor of Medicine at the Royal Melbourne Hospital.

[81] **Mr Ron Lambourne** BSc

[82] **Mrs Patricia Kee** AM was a medical laboratory technologist with personal experience of serious childhood medical conditions (Personal communication, Peter Phelan to Ann Westmore)

[83] **Mr Roger B.B. Mee** MB ChB FRACS (b.1944) trained in medicine at the University of Otago School of Medicine, Dunedin, New Zealand. He did his surgical training at the Auckland Hospital; the Brigham & Women's Hospital, Boston; the Children's Hospital of Boston; and the Green Lane Hospital in Auckland. From 1979-93 he was Chief Cardiac Surgeon at the Royal Children's Hospital, Melbourne. In 1993 he joined the Cleveland Clinic, Ohio as paediatric cardiothoracic surgeon specialising in neonatal cardiac surgery, congenital heart surgery, transplantation, and thoracic and vascular surgery. (Personal communication, Roger Mee to Ann Westmore)

down the track, and he said, I've got a case at the Women's [Hospital], I think you should come up and talk to the parents. I think I can do something for them.

So up I went and he told me what he proposed to do. I was then asked, what would happen if it became public. I went through it, chapter and verse, with the parents about radio, press, television, the paparazzi, if it was successful, or, particularly, if it wasn't.

The baby, whose name was Daniel, was born at the Children's by caesarean section and whizzed into the operating theatre where there were intensivists and cardiologists. After about 12 hours of surgery, the baby went to intensive care. I was in constant contact with the parents, as was Roger. At day 5, when the baby was doing well, we decided to blow the whistle and invite the media. The parents were totally involved. I don't know if it ever went to the Ethics Committee.

Day 6 little Daniel got a temperature and developed an infection, and finally succumbed on about Day 11. We had kept in touch with the parents all the way through and I asked them if they wanted to go ahead with the agreement to run a press conference. And they said, yes, we want to do that.

We called a press conference for the Sunday morning and every skerrick of the media was there. Just before we started, Daniel's Dad called me and said, "We're going to come in but we don't want any questions". I let the media know and then Dad decided to sit in on the press conference. The doctors told the story and then, right at the end, Dad said, I want to say a word. "I came in to make sure you got this story right. When we were told that our little boy had this problem, we were referred to Mr Mee. He gave us a 1% chance of survival after surgery. We agreed to go ahead with it. When the baby was born, we had a 3% chance of survival and by day 5, a 70% chance. I want you to get that right. It was not experimentation; we were given the opportunity to give our little boy life and we did so. And get that right."

That was total involvement of everybody. And I doubt whether, had that case gone to the Ethics Committee, it would have got that far. But there may have been a chance for that little boy Daniel to have been alive today.

Formalising the research effort

Ann Westmore: The Research Foundation was an important development for the University Department of Paediatrics for the reason referred to earlier, namely as a way of attracting certain highly qualified staff. There was also a reasonable expectation that it would further develop scrutiny of entrenched practices. Perhaps someone would provide some background on the Foundation.

Peter Phelan: As someone said, the Research Foundation was established in 1960 with an independent Board. It had grown out of previous activities that had really started in the immediate post-war period with Howard Williams and Doug Stephens. It was formalized in 1960, initially with three major research groups – a Clinical Research Unit, headed by Howard; Gastroenterology headed by Charlotte Anderson; and Surgery headed by Doug

Stephens. There was subsequently a fourth unit [Haematology], headed by John Colebatch.

By the early- to mid-1960s, Howard Williams was Executive Chairman, they didn't appoint a Director, and when Howard became Dean of Postgraduate Studies about 1970 or '71, John Colebatch became Executive Chairman. And the Research Foundation supported those Units and gave small grants to other research activities in the Hospital.

Vernon was involved and supportive. So it was partly a bucket of money and partly supporting those research workers. Then, in about 1973, it was decided to appoint a Director of the Research Foundation and Don Cheek was appointed.[84] It was a disaster both for Don and for the Research Foundation. He was an inappropriate appointee at an inappropriate stage in his career and he was a sick man.

There was anger among some in the hospital for the way Don Cheek had been treated when at the Hospital as a researcher in the 1950s. He and Howard Williams clashed – Howard thought Don was a woolly thinker with no clinical skills or perspectives. Howard opposed his having any clinical responsibilities. Don left Melbourne and went to Johns Hopkins Medical School in Baltimore and built up a good research reputation. Those who felt he had been badly treated pushed for his return as Director of the RCH Research Foundation. When he came back he was sick and clearly past his prime. He set up his own research group, pushed the gastro research unit out of the Research Foundation, disbanded the Clinical Research Unit and the Surgical Research Unit. Doug [Stephens] went to Chicago which was a tragedy, and Charlotte [Anderson] had already gone to Birmingham.

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[84] **Dr Donald Brook Cheek** MD DSc FRACP (b.1924) was a 1947 University of Adelaide medical graduate who worked as a Resident Medical Officer at Royal Adelaide Hospital 1947-49. He was appointed Research Fellow at the University of Adelaide where he worked on Pink Disease with the Professor of Human Physiology and Pharmacology, Professor Cedric Stanton Hicks, 1949-51.
During the following years he gained experience as a Research Fellow at Yale University School of Medicine (1951-52), the Hospital for Sick Children, Toronto (1953) and the Children's Hospital Research Foundation, University of Cincinnati 1953-56. He then moved to the University of Texas South Western Medical School where he was Assistant Professor and then Associate Professor, 1957-59.
He returned to Melbourne to become a Senior Research Fellow at the Royal Children's Hospital, 1959-62, including a period as Director of a research unit on Electrolyte Metabolism. After falling out with Howard Williams over the clinical care of patients with electrolyte disturbances, he went overseas again, joining the Johns Hopkins Hospital and Medical School, Baltimore, where he was head of the Division of Growth 1962-73, wrote *Human Growth* (1969) and was appointed a Professor, 1970-72.
In 1973 he returned to Melbourne to take up the position of Director of the Royal Children's Hospital Research Foundation, his arrival being delayed by heart problems. He continued in the role until 1980, during which time he wrote *Fetal and Postnatal Growth Hormones and Nutrition* (1975).
In 1980 he became Visiting Research Professor at the University of Adelaide, collaborating on zinc deficiency research in Aboriginal children in the Kimberley region. Although the deficiency was present, he and his colleagues concluded that it was not the factor responsible for growth retardation in Aboriginal children.
(See Sir Cedric Stanton Hicks Papers, University of Adelaide Library, Series 14. See also *Who's Who in Australia, 1971, '80, and '88.)*

Then, soon after that, Vernon retired, having been very unwell for some time. Again, the tragedy was that someone hadn't helped Vernon to retire earlier. The University had difficulties in appointing a successor to Vernon. They offered it twice and it was refused.

Then David Danks was approached by the then Dean [of Medicine][85] and asked would he apply and he did. That was fortunate because, at least, there was someone to give research leadership. And while David didn't play an active role in undergraduate teaching, he built his own unit.[86] More importantly, he was appointed to the position of Hospital Co-ordinator of Research and he supported research activities in the rest of the Hospital and the University Department [of Paediatrics].

So research then spread more widely through the Hospital through David's initiatives. And fortunately David had John Court and then Max Robinson to run the undergraduate teaching. But, the Department [of Paediatrics] again didn't have a particularly high profile in the Hospital. David had a high profile, but he was known more for his research interests than as the Stevenson Professor.

Don Cheek agreed to retire in 1982 and David was then appointed – the appropriate person for the appropriate job - to the Director of the RCH Research Foundation, Professor of Paediatric Research, and I was appointed Stevenson Professor.

David McCredie: Don Cheek had a brilliant mind, there's no doubt, but it sometimes went a little astray. One of the problems was that Don was appointed to senior positions when he had almost no clinical ability. In fact, before he was made a Professor and went overseas, there was a stage where all electrolyte results automatically went to Don Cheek. I was chief RMO [Resident Medical Officer] and I had to go around after him and correct a lot of the comments made in the [patient] histories. With the right backing, he could have made a success of things. But he really shouldn't have been in a clinical position.

Henry Ekert: At the stage when Don came back, those of us who were not in the Foundation but had University appointments, felt that he would be a breath of fresh air and would come in with a great research record which he had had in Baltimore. I can still remember my intense disappointment when it was not possible to pin Don down to any thought process of any duration. It was obvious that some change had taken place in this man. It was a very destructive phase for research and the Research Foundation because of the disorder he was suffering from. He must have been very different once upon a time.

There was a political push to get Don back by people who did not necessarily know him well enough at that stage in his life and saw him as he had been in the past.

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[85] **Professor Sydney Lance ('Lance') Townsend** Kt VRD, MBBS MGO DTM&H FRCS FACS FRACS FRCOG FRACP FACMA FAustCOG (1912-1983) was Professor of Obstetrics and Gynaecology at the University of Melbourne, 1951-77. He was also Dean of the Faculty of Medicine 1971-77. In 1978 he was appointed Assistant Vice-Chancellor of the University. (See The Historical Compendium to the Faculty of Medicine, Dentistry and Health Sciences www.cshs.unimelb.edu.au/umfm)

[86] David Danks established the **Genetics Research Unit** at the Royal Children's Hospital in 1967.

Ruth Bishop: As someone who lived through this, I guess there were two camps. It was very clear to some of us that it wasn't just that people wanted to appoint Don [Cheek as Director of the Research Foundation], but they didn't want to appoint David. And it was a blocking manoeuvre. And that caused endless trouble in the Research Foundation. It got people in the wrong places at the wrong time in their careers. A lot of unfortunate things flowed from that. They finally got it right, but it took a long while. And it cost a lot of money and a lot of pain to a lot of people.

John Rogers: I was working in Baltimore with Victor McKusick[87] at the time who was one of Don Cheek's referees for the job in Melbourne. I was driving him home one night and Victor said to me did I know that Don Cheek had come back to Baltimore and was looking for another job somewhere in the States. I said, "Will anyone give him one", and he said, "Not if they're in their right mind". Clearly by the time I got to Johns Hopkins he was well in decline. And I think that there's a history of that in medicine over the years.

Ann Westmore: So the appointment was made at a Board of Management level? Who made those sorts of decisions?

Peter Phelan: There was a Research Foundation selection committee and Alan Williams and L.E.G. Sloane[88] were the two who pushed for Don. He was at the Children's for nine years from 1973 to 1982 and he gradually fell further and further apart, it was a tragedy for everyone, particularly for Don – he was so unhappy.

Max Robinson: Peter, was he Director [of the Research Foundation] for nine years? That doesn't ring a bell?

Ruth Bishop: He retreated from a role in the Research Foundation, didn't he?

Peter Phelan: I was appointed Director of Thoracic Medicine in 1974 and that was as a result of the changes brought about by Don. I can remember David coming into my office to tell me that Don had been appointed. It was just unbelievable. Meanwhile David was teaching at the University as Reader in Genetics and running the Hospital's Genetic Research Unit.

Ann Westmore: How did he [David Danks] respond, June, to the prospect of becoming [Stevenson] Professor.

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[87] **Professor Victor A. McKusick**, from the Johns Hopkins Hospital, Baltimore, trained a number of clinical geneticists at the Hospital including David Danks and John Rogers.

[88] **Dr Lionel Eric George Sloane** MBBS FRACP FRACMA (b.1924), widely known as 'LEG' Sloane, graduated in medicine from the University of Melbourne in 1952. He was Clinical Superintendent, Prince Henry's Hospital, 1957-58 and then gained paediatric experience in a number of Victorian Hospitals before becoming Medical Director of the Royal Children's Hospital, 1965-81, with the exception of 1977. He was Registrar, Australian College of Paediatrics, 1986-90 and, later, Honorary Consultant Paediatrician to the Hospital. (See *Who's Who in Australia 1988 and 1996*.)

June McMullin (Danks): He said he wouldn't take the position unless he was asked to do so. He didn't feel he had had the support [in the past], and he wanted to be sure of that.

Peter Phelan: I remember David told me when we were at a meeting in Buenos Aires. I remember having breakfast together and he said that as he was about to leave Melbourne [to attend the meeting] he had received a call from the Dean of Medicine, Lance Townsend, asking him to take the position.

The biggest change from what I saw once he was appointed Professor was the building up of research more broadly in the Hospital through David's role as Co-ordinator of Research. I saw that as the big change.

Henry Ekert: To me the biggest change was that Don was marginalized totally and he left.

David McCredie: I think that one of the big changes was that under the Vernon Collins regime, Vernon was a godlike figure and we were all the young ones. Under David it was much more egalitarian. Don't regard me as the head, we're all equal, was the way he looked at it.

Ann Westmore: Do you remember a meeting where that sort of thing was said?

David McCredie: Yes. And in fact, I remember saying to him on one occasion, "You're the boss David" and he said, "No, I don't want you to think like that." So it was a very different style of leadership. Vernon was a benevolent dictator, I suppose you could say. We all admired and respected him, but he was definitely up there, and we were here. It was a big change when David came. Although he was technically the boss, it was a much more egalitarian relationship.

Training Programs

Max Robinson: David was good at delegating. If he gave you a job to do, he said I don't want to interfere, but if you've got a problem I want to know about it. If you don't tell me you've got a problem, I'll be pretty angry. And he could be. But he was great to work with. He left me alone and I informed him of what was going on with the students. He was primarily interested in research and established the Department of Genetics, and this of course was the first [hospital genetics department] in this country.

My role was essentially a general physician in the hospital and I was Director of the undergraduate paediatric teaching program. So I worked out the programs. John Court was the first to do it and I followed John. It seemed to work reasonably well.

Arthur Clark: I did that job from 1960 to 1965 with Vernon, but I didn't have the title.

Ann Westmore: What role was the University Department of Paediatrics taking in paediatric training, not only for the future paediatricians of Victoria and Australia but for medical practitioners more generally.

Peter Phelan: Howard Williams was appointed Director of Postgraduate Studies and he was succeeded in 1975 by 'Bunny' [Bernard Neal], and those two really ran the training program for paediatricians and the continuing education for General Practitioners came under the same program. Howard had an office with David [Danks], reflecting their close personal relationship. And, I think, Howard had a part-time appointment with David in the University Department of Paediatrics when David took over [as Stevenson Professor] which allowed him to continue his research in Brunswick.[89] His major interest was in postgraduate studies and he retired in 1975 when 'Bunny' took over.

I don't think you had any attachment to the University Department of Paediatrics, did you 'Bunny'? So the postgraduate program was really running quite independently.

Bernard Neal: It was a time when the marriage referred to earlier was starting to show some cracks at the seams and it was time for reform. I think I was the last occupant of that position before it reverted to a different administrative system.

It was uncomfortable during my term of office because it seemed anomalous that there was a Department of Paediatrics that was supposed in the eyes of the Hospital to confine itself to undergraduate teaching. There was no ill-will on any side but it was a marriage of incompatibles that was not going to last.

Frank Oberklaid: In those days, in the late 1960s and 1970s, the Royal Children's Hospital in Melbourne was *the* Australian paediatric hospital to be trained in. So if you wanted to be an academic, you had to spend some time at the Hospital.

Bernard Neal: There was a steady stream of visiting people from around the world. I happened to be involved with the International Paediatric Association and I, and others, would look after people who came from Africa and China and many other parts of the world, and running courses for General Practitioners and so on. But looking back, it was pretty miniscule really, and it was an area that needed a lot of development.

Peter Phelan: In the early to mid-1980s, at any one time, the Children's Hospital had anything between sixty and eighty overseas trained paediatricians working at the Hospital. It was a time when the Victorian Medical Postgraduate Foundation was responsible for visa organisation and it collected data. The next largest number of oversees trainees at any hospital in Australia was at the Royal Prince Alfred in Sydney

[89] Dr Williams established the Brunswick Family Study in 1977, recruiting as Research Fellow, Dr Allan Carmichael (later Professor of Paediatrics and Child Health and Dean of the Faculty of Health Sciences at the University of Tasmania). According to Professor Carmichael, the study followed 304 infants consecutively born in Brunswick, an inner Melbourne suburb, for 44 weeks in 1978. The children were later reviewed at the ages of 4 and 11 years, and the pattern of medical services used by their parents was assessed. The study found a high prevalence of postnatal problems, leading to later learning problems. (Personal communication Allan Carmichael to Ann Westmore)

with thirty. So the Children's was way ahead of any other hospital in attracting overseas paediatricians to come here and train.

Kester Brown: It [the intake of overseas-trained specialists] was all across the Hospital and the last figures I saw on this was that 50% of overseas people who came for postgraduate medical training to Australia came to Victoria, and 50% of those came to the Children's Hospital. That's 25% overall.

Max Robinson: It should also be mentioned that undergraduates from overseas came to work with us.

Kester Brown: It was not only in paediatrics that people sought training, but in anaesthesia, surgery and so on.

Ann Westmore: So the University Department was not involved very much in this [postgraduate] training. It was the rest of the Hospital as well?

John Rogers: I came back to the Department in 1976, primarily as a medical geneticist. The only appointment that was funded at the time was a Senior Lecturer in the [University] Department of Paediatrics. Teaching paediatrics to undergraduates was regarded as part of my workload.

I think it is fair to say that at that time the clinical commitment of David [Danks] was all within genetics and metabolic disease. That was his area of focus and of his research. He handed over, or delegated, all of the rest of the work to other people.

Surgical research and training

Durham Smith: Is it appropriate to mention something of surgical research? Douglas Stephens was away at Great Ormond Street in the early 1950s and came back in about 1953. He was appointed first as a staff surgeon and, being full-time, he had time for research. That was then formalised after the Research Foundation was established in 1960 and he became Director of Surgical Research.

Just as John Colebatch was out on a limb in one way, as Henry [Ekert] mentioned, Douglas was also [in a similar situation]. He was not part of the University Department of Paediatrics, he was a clinical surgeon and his appointment as Director of Surgical Research was a Research Foundation appointment.[90]

Just as in other disciplines it [Doug Stephens' leadership] was immensely important. There was a stage between 1956 and 1970 when every single adult urologist in Melbourne had come through the Children's Hospital under Douglas' influence for short periods or long periods in paediatric surgical research. Quite remarkable.

[90] In the early 1960s, senior medical staff of the hospital endorsed the establishment of a Chair in Paediatric Surgery. (Personal communication Bob Fowler to Ann Westmore). However, such a professorship did not come to pass for several decades.

He was intensely interested in young people, he was immensely stimulating to young surgeons and there seemed to be enough money at that time. Many of us, myself included, had up to five or six sessions a week on research salaries, being paid as an assistant or consultant, and we could confine our attention entirely to paediatric surgery. So Douglas Stephens' influence was quite profound, as a number of people trained as Paediatric Surgical Registrars over a period of years And in terms of overseas people, roughly half our surgical registrars were overseas appointments. We didn't need to train that many local paediatric surgeons and, out of four surgical registrars, almost always two came from elsewhere, from virtually any country in the world.

That continued in happy relationship through the 1960s and through the beginning of the 1970s. But then money became tighter, then the fuss occurred over the Directorship of the Foundation. Douglas Stephens found he was unable to secure as much funding proportionately as he had previously and that was reflected in a decrease in the number of young surgical trainees who came to visit. It was one of the major factors that caused him, at the end of 1974, to accept a job offer in Chicago. And he left the hospital early in 1975.

So surgical research was strong from 1956 until 1972. It then deteriorated and, after Douglas left in 1975, as I recall, no surgeon was appointed in the Research Foundation at all. That continued for a decade, until John Hutson came on the scene.[91] I think that was in the mid-1980s. So we had a decade of great hiatus in paediatric surgical research. To my shame, I was part of this and I didn't do enough, I'm sure, to encourage a more strenuous search for a research leader.

Since then, things have improved under John Hutson, apart from a local hiccup in the last few months.[92] So surgical research has never been part of the University Department of Paediatrics. It was part of the Research Foundation and proceeded from a brilliant period in the '60s, less brilliant in the '70s, non-existent in the late '70s and early '80s and now coming back again.

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[91] **Professor John Medwyn Hutson** MBBS Hons MD (Mon) MD (Melb) FRACS (b.1948) studied medicine at Monash University, graduating in 1972. He did his Residency at the Alfred and Royal Children's Hospitals, before gaining a scholarship earmarked for surgical research at the RCH, 1977-80. He was a Surgical Research Fellow at the Harvard Medical School, 1980-83 before gaining additional experience at the Hospital for Sick Children in Glasgow.
On his return to Melbourne in 1985, he was appointed Director of the RCH Surgical Research Unit and Lecturer and Senior Lecturer in Paediatric Surgery in the University of Melbourne Department of Paediatrics 1985-93. In 1994 he became Professor of Paediatric Surgery and Director of the Department of General Surgery at the Hospital. In 2000 he was appointed Associate Director (Clinical Research) for the Murdoch Children's Research Institute and Honorary Secretary of the Royal Australasian College of Surgeons' Board of Research. He has written a number of books on paediatric surgery and has been awarded patents for treatments he devised of undescended testes and male infertility. (Personal communication John Hutson to Ann Westmore. See also *Who's Who in Australia 2002*)

[92] The very public resignation of Professor of Surgery, Paddy Dewan.

Peter Phelen: That's true of general surgery research. However Bill Cole was appointed a First Assistant in the Department of Paediatrics, in about 1979 or 1980.[93] He rapidly built up an outstanding research group in the Department of Paediatrics in molecular biology related to bones.

John Rogers: He was actually back earlier because he formed the Bone Research Unit in the mid 1970s.[94]

Peter Phelan: John Bateman joined soon after Bill [Cole] was appointed.[95] They were the major attractors of research money into the University Department of Paediatrics, other than David's [Danks] group.

Ruth Bishop: I just wanted to talk about John Hutson's appointment. I think I'm right about this. David [Danks] had recognised the lack of surgical research and, probably with Peter [Phelan], he had actually been budgeting for a surgeon for quite some years before John returned and it was very strong support from David and Peter that John's appointment was made and the salary handed over by the Research Foundation to the University Department of Paediatrics. I think it's largely been sustained in that way ever since.

Peter Phelan: A third of his salary was initially paid from the University and two-thirds from the Research Foundation.

Finding funds for research

Ruth Bishop: This is one thing David did when he took over. He did have a plan, it was largely in his own mind and sometimes you got a bit of a surprise when he revealed what it was.

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[93] **Dr William G. ('Bill') Cole** MSc PhD FRACS (b.1942). After graduating from the University of Melbourne in 1965, Bill Cole trained in General Surgery at the Royal Melbourne Hospital and then in Orthopaedic Surgery at St Vincent's Hospital and the RCH. During a two-and-a-half year fellowship studying paediatric orthopaedic surgery and molecular biology of cartilage at McGill University in Montreal, Canada, he received further paediatric orthopaedic training as well as research training in the molecular biology and genetics of connective tissue diseases. He returned to Melbourne as a First Assistant in the University of Melbourne Department of Paediatrics and as an Orthopaedic Surgeon at the Royal Children's Hospital in 1977 where Dr John Bateman soon joined him. Together they established the Orthopaedic Research Unit which won strong support from the National Health and Medical Research Council for work on genetically-determined skeletal dysplasias. In 1988 Dr Cole was appointed Foundation Professor of Orthopaedic Surgery in the University of Melbourne Department of Paediatrics and Chief Orthopaedic Surgeon within the Royal Children's Hospital. In 1992 he moved to his current positions of Professor of Surgery and Professor of Genetics, University of Toronto, and Head, Division of Orthopaedics and Senior Scientist, Research Institute, The Hospital for Sick Children, Toronto. (Personal communication Bill Cole to Ann Westmore)

[94] See previous footnote.

[95] **Professor John Bateman** BSc(Hons) PhD was Senior Professorial Research Fellow and Executive Head of the Cell and Matrix Biology Research Unit, and Associate Director of Laboratory Research at the Murdoch Institute in 2004. The unit specialises in research into skeletal dysplasias.

It did impact on me at one stage because I'd been comfortably going along with grants from the Research Foundation, small ones but they sustained me. It was David who took me aside one day and said, "It's time you tried to find your money outside the Hospital". And I had to apply for an NHMRC research grant, which I got in 1975, and I was probably the first NHMRC grantee at the Hospital.[96]

Thereafter, I was expected to get my own money externally. It was often added to by the Research Foundation. They stood behind me. Every five years they would say, "We will guarantee your salary if you are unable to get it externally". But David pushed me into the outside world and I'm sure he later pushed many others into the outside world.

He also had a strong appreciation of what [basic] scientists added to research. He had an early relationship with Dick Cotton, and his own research group was built up around a core of basic scientists, of whom Dick was one. And professionalism in a laboratory sense slowly crept in through the Research Foundation. Then, a really sustained kick in the pants to go elsewhere and find your money first and only come back if you couldn't find it elsewhere.

Ann Westmore: I see a number of heads shaking in agreement. Are there others who had this experience?

Peter Phelan; There was a great interest in NHMRC funding by the Research Foundation.

Ruth Bishop: The NHMRC system of awarding grants was also evolving.

Bernard Neal: I was on the NHMRC for a number of years and I've been staggered by its growth. I remember how excited we were when we had a whole $13 million to dispense across the country. It's probably more like $300 million now.

Frank Oberklaid: The Children's Hospital was very different from other paediatric hospitals. For example, it was one of the first to conduct psychological research whereas at some of the other hospitals, it was purely clinical. And none of them had attached paediatric research institutes. I think that differentiation has become less. But in those days, this was the place to do your training. And the culture, ethos and expectation was that you would undertake research.

Peter Phelan: The Royal Alexandra Hospital for Sick Children [in Sydney] had a research institute. It was seen as an isolated group in some quarters. Whereas in Melbourne, it [the Royal Children's Hospital Research Foundation] was always part of the mainstream.

[96] Peter Yule's history of the hospital suggests that much earlier, Drs Reginald Webster and Douglas Galbraith, who were doing research at the Hospital in the late 1930s and 1940s, were the first of many Children's Hospital staff members to be awarded grants by the NHMRC. (See *The Royal Children's Hospital: A History of faith, science and love*, p 270)

Susan Sawyer[97]: In terms of that culture of change, in my generation the expectation was that you would do a higher degree. Where did that come from?

Peter Phelan: David really started it, as Ruth said, as a way of encouraging the scientists (including medical graduates) because they had been axed from the Hospital to a very large extent and were smarting at the encouragement of purely clinical people. Then I built on what David did, almost to give the expectation that if someone saw their career as an academic paediatrician, part of their training would be a higher degree.

Bernard Neal: This was part of the function of the Hospital being in postgraduate medical education myself. We organised the lecture program with the expectation that a pretty high percentage of Registrars would be seen as trainees for scholarships at the College of Physicians and so forth, and we were proud of our high success rate. Everyone around the Hospital participated but the basic organisation of it took place from this Hospital appointment of the then Postgraduate Co-ordinator.

Peter Phelan: The other thing that should be said is that a key to getting training clinicians involved in research was the establishment of a number of scholarships. Barry Catchlove, who is a controversial figure in some respects, was a key to getting those scholarships going in about 1983.[98] He was extraordinarily supportive.

Glenn Bowes: Those research scholarships continue to this day. So that's twenty years. And the current amount of funds on those research scholarships is a quarter of a million dollars a year that's invested in clinicians doing higher degrees by research, enrolled through the University Department of Paediatrics, being conducted at the Children's Hospital. And those folk who have come through and are coming through are the outstanding leaders in paediatrics nationally.

Don Kinsey: I think for the record, we should say that there were other sorts of scholarships earlier – the Uncle Bob Scholarships.[99]

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[97] **A/Professor Susan Sawyer** MBBS MD FRACP (b.1960) trained in medicine at the University of Melbourne before undertaking resident training at the Royal Melbourne and Royal Children's Hospitals. After specialty paediatric training at the Children's Hospital she attended the Harvard School of Public Health in Boston where she specialised in adolescent health and respiratory medicine.
She returned to the Royal Children's Hospital in 1995 as Senior Lecturer in the Department of Paediatrics and with clinical appointments as an adolescent physician and respiratory paediatrician. In 1998 she was appointed Deputy Director of the Centre for Adolescent Health and, in 2001, Acting Head of the Department of Paediatrics, working in this role when Professor Bowes was absent. (Personal communication Susan Sawyer to Ann Westmore)

[98] **Dr Barry Rex Catchlove** MB BS FRACMA FRACP FCHSE (b.1942) was Chief Executive Officer of the Royal Children's Hospital 1981-90 after holding similar positions at the Royal North Shore Hospital in Sydney, 1972-80. (See *Who's Who in Australia 2002*)

[99] The **Uncle Bob Scholarships** were established in 1960 by the Uncle Bob Club, a charity formed by a group of donors who contributed the price of a glass of beer (a 'bob') each week to support an up-and-coming researcher at the Royal Children's Hospital. Seventeen scholarship winners up to 2004 became professors. (Personal communication, Don Kinsey to Ann Westmore)

Peter Phelan: I think the sum initially available [for the research scholarships] was $50,000 or $100,000 from the Good Friday Appeal, separate from the amount that went through the Research Foundation. In about 1975 or '76, I would think, when Don Cheek's area was off on its own, David convinced the Board of Management of the Hospital to put aside 40% of the Good Friday Appeal for hospital research. If the Hospital was to have research, there must be money that he could distribute as the Co-ordinator of Research. When he became Director of the Research Foundation it moved back.

In addition to that, [Barry] Catchlove said, "We need to have money to train younger people". And so, that was the origin of the scholarships.

Henry Ekert: Graeme Barnes was the originator of the document that came through with the scholarships. He was the first one to write to Barry [Catchlove] to say that we needed those.

Ann Westmore: Those specific scholarships were for younger people. Was it an attempt to develop their scientific skills in addition to their clinical skills?

Peter Phelan: That's right, to allow them to work towards an MD or PhD. And the aim was, much as happened with Ruth; the first year we'll support you, in your second and third year we expect you to go seeking an NHMRC Postgraduate Scholarship. If you don't get it, we'll probably continue to support you, but our idea is to allow you to get up and demonstrate that you have research abilities, and then look for external funding to complete it.

Glenn Bowes: That theme, identified by Ruth, that came from David's era has clearly come through. Now, you cannot apply for the internal hospital scholarship if you haven't concurrently applied to the NHMRC. It's a necessary requirement. So that's endured in a strengthened way to push to national competitiveness.

June McMullin (Danks): One person who's not here who would perhaps know most about David's early days as Research Co-ordinator is Anne Cronin.[100] He put her on part time in about 1975 or '76. They worked very closely together and she really executed David's plan. There was never any money to appoint a secretary and her appointment was quite a step, a big step, in the direction of a more business-like approach.

Peter Phelan: Remember, the Research Foundation was being run by Don Cheek and David was trying to patch up things from every possible source.

[100] **Anne Cronin** worked as both a research scientist and administrator in the Genetics Research Unit, starting in 1976. By the time the Murdoch Institute for Research into Birth Defects was incorporated in 1986, she had left the laboratory and was full-time in the role of business manager, having gained management and accounting qualifications. She is now the Director of Operations and Finance of the Murdoch Children's Research Institute. (Personal communication, Anne Cronin to Ann Westmore)

Arthur Clark: Can I throw in a slightly discordant note. Because I left the hospital to go to another organisation in 1965 when there was virtually no funding from hospital sources. So if you were going to do any research it had to come from NHMRC money or money from some other outside source. So we had to go to the NHMRC long before Ruth got her first grant from that source. But in a sense, looking at it from the outside, I thought research was a bit of a soft option in the 1970s at the Children's in that you could get money when you weren't ready. It's not like that now. But at that time, I'm sure it was the right thing to do to try and get research money, but the lack of external competition wasn't good for the Hospital.

Kester Brown: I think that's a reasonable comment because there was only a limited amount of money to go around. I ran research in the Anaesthetic Department largely by collaborative work with outside organizations which had the facilities and we had the projects and we worked together. And I did get one grant from the National Heart Foundation in about 1977. But it wasn't easy to get money from the Hospital because there were other people who were researchers taking most of it to start with.

Glenn Bowes: I think it's a fair comment that whenever there is internal money there is a danger of being soft. And I think that for the last 25 years or so, the Children's Hospital moved from having some relatively soft money internally through to the point where that money was used absolutely to get leverage on external national and internal competitiveness. And there was a period of transition that was moved through during that time.

Peter Phelan: That would be my interpretation. Clearly there's some money that you could say was a bad investment. But we all make bad investments.

Susan Sawyer: Going back to research scholarships. Thinking of that as an investment in terms of later appointments to the Children's Hospital, we recently audited them. If we look at the last ten years, 80 per cent of those paediatric trainees who were funded through, what have now become known as, an MCRI scholarship,[101] have subsequently been appointed to the Children's Hospital. So the leverage you're talking about in terms of grants from external money, we can use the same sort of thinking about leverage of research funding in terms of investment back into the Royal Children's Hospital.

Kester Brown: I'd like to make one comment. You mentioned John Hutson, and the major contribution he's made to surgical research. I think we should recognize the fellow whose foresight brought John Hutson to the Children's Hospital. That was Bob Fowler.[102]

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[101] Murdoch Children's Research Institute scholarships

[102] **Dr Robert ('Bob') Fowler Jr** MD FRACS (b.1928) graduated in medicine from the University of Melbourne in 1950. After completing his resident and registrar training at the Alfred Hospital, he was research scholar at the Baker Medical Research Institute, 1953-54. In 1955, he joined the Children's Hospital as a surgical registrar, a post he combined with training in general surgery at the Alfred Hospital. From 1958-60 he held a Fulbright Scholarship in conjunction with a Research Fellowship at the University of Cincinnati where he worked with nephrologist, Dr Clark West, on immunology, transplantation and renal disease. On returning to Melbourne in the early 1960s he undertook a research MD degree at the Children's Hospital with a thesis on homotransplantation studies.

He had a good intellect and was involved in surgical research early on. He sort of got marginalized during all this time. He picked John Hutson – I don't know how he got on to him – and brought him to the Children's to do a research job when he was still a trainee surgeon. And then he [John Hutson] went back and finished his training and came back to us then to do research.[103]

Glenn Bowes: John was an outstanding graduate of Monash Medical School. If he didn't top the year he was near to doing so. I think he'd been dux at Melbourne Grammar School and was an outstanding resident intern at the Alfred Hospital. It was in that period that he was attracted [to the Children's].

Durham Smith: Bob Fowler should be mentioned in the research connection. He had a first-class research brain. He started off with research interests and did some training in Cincinnati for a couple of years and he came back really steamed up with the whole transplant scene. I know he had difficulties with management and made a personal decision that he didn't want anything to do with research, he just wanted to be a clinical surgeon.[104] And his research ability was lost to the Children's.

I think all of us are responsible for that. I don't think we as a staff cared for Bob enough. I shared an office with him for twenty-five years and I don't think we as a staff, including myself, really went out of our way to really encourage him in research.

Max Robinson: Can I make a comment about conditions prior to the establishment of the Research Foundation. Many of us on the staff, while we didn't do basic research, we contributed to the literature based upon clinical experience and observations. And I think the Royal Children's Hospital did as much as any other hospital in this country in that

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For three decades from 1962 he was a surgeon at the hospital, holding positions including Head of the Surgical Unit 1975-88, Chairman of the Senior Medical Staff 1975-76, and Senior Surgeon 1988-92. In 1993 on retiring from public hospital practice, he was appointed Honorary Consultant Surgeon to the hospital and continued in private surgical practice until 1998.
Throughout his career he combined his clinical and administrative work with research and teaching appointments at the RCH. In particular, he was Deputy Director of the Surgical Research Department 1961-68 and a member of the Board of Research, 1976-77. He authored or co-authored numerous research articles on body water metabolism and circulation, immunology and transplantation, and surgery to correct pelvic trauma and abnormalities in childhood. He taught paediatric surgery to several generations of University of Melbourne medical undergraduate and postgraduate students, 1957-92, and was on the University's Board of Examiners in Surgery, 1964-93. (Personal communication, Bob Fowler to Ann Westmore)

[103] After Doug Stephens went overseas in 1975, Dr Fowler wrote a letter to the Hospital's Committee of Management suggesting the establishment of a scholarship earmarked for surgical research. Three people applied, including Dr Hutson, who duly won the scholarship and so began working at the Hospital. (Personal communication Bob Fowler to Ann Westmore)

[104] The "difficulties with management" occurred in 1968, about three years after Dr Fowler returned from overseas. Dr Fowler believed the hospital was seeking to alter unilaterally his contract of employment to less favourable terms than applied to other members of the clinical staff. Following these difficulties, he reduced somewhat his level of involvement with the Hospital, but continued as a senior member of the specialist surgical staff and remained active in research until the early 1990s. (Personal communication Bob Fowler to Ann Westmore)

way before the establishment of the Research Foundation. And this all had to be done in one's spare time. There was no money available, you did it after hours.

Susan Sawyer: Some things don't change.

Establishing sub-specialty departments

Glenn Bowes: There was a point made by John Rogers about the emergence of a specialty department in genetics during the Danks era. I was just wondering how the specialty departments in the Hospital were supported either by the University Department of Paediatrics or the Research Foundation. Was that a pathway for the creation and support of hospital sub-specialty departments?

Peter Phelan: Well certainly thoracic medicine and gastroenterology, and haematology and oncology grew out of their research units when Don Cheek was appointed and Max [Robinson] was chairman of a medical staff committee that recommended that. And a certain amount of funding was ear-marked initially as Research Foundation money that then somehow or other, it seemed, was loaded onto the Health Department to fund those. Whereas neurology, nephrology, adolescent medicine, endocrinology partly grew out of the University and partly out of Norman Wettenhall's own enthusiasm,[105] immunology grew out of pathology probably more than anything else – well, no, I think going back to what Durham said, I think Bob Fowler was the one who really started the immunological work and Cliff Hosking [106]came to work with him – so it indirectly grew out of the

[105] **Dr Henry Norman Burgess Wettenhall** AM, MD BS FRCP FRACP (1915-2000), affectionately known as "Wettie", was the son of Dr Roly Wettenhall, an honorary dermatologist at the Children's Hospital, 1920-25. Dr Wettenhall (Sr) wanted his son to become a diplomat but instead, he chose medicine, graduating from the University of Melbourne in 1940. He was discharged from the Navy due to illness in 1943 and joined the Children's Hospital as a Resident, remaining on the staff for much of the next four decades until his retirement in 1980. He was at various times, a Senior Physician 1948-73, Dean of the Clinical School, 1961-64, and head of the Endocrine Clinic, 1972-80.
He was Australia's first specialist in paediatric endocrinology and the second doctor in Australia to prescribe pituitary growth hormone, according to Dr Garry Warne. He learned his specialty at Johns Hopkins University, Baltimore, where he worked in 1956 and again 1971-72. By 1962, he had converted one of his paediatric clinics into a *de facto* endocrine clinic. In 1972, the Hospital recognised his expertise and appointed him head of the newly created *official* Endocrine Clinic. He organised trials of growth hormone and was for some years Chairman of the Human Pituitary Advisory Committee, an advisory body to Federal health authorities. On his retirement he stimulated his colleagues to establish the Australasian Paediatric Endocrine Group and subsequently played an active role in it. (Personal communication Garry Warne to Ann Westmore and Jane Halliday to Ann Westmore)

[106] **Dr Cliff Hosking** MD FRACOP FRCPA (b.1938) studied medicine at the University of Queensland, graduating in 1962. After working in Queensland and New Zealand hospitals, he moved to Melbourne in 1969 as a research fellow at the Royal Children's Hospital Research Foundation. After further studies at the Institute of Child Health in London he became medical officer to the Immunology Laboratory at the RCH, 1972-80. Over the period, 1980-91 he was Director of Immunology at the RCH and from 1984-91 he combined this position with Chairman of the Hospital's Division of Pathology. In 1987-90 he was an Associate Research Director at the Commonwealth Serum Laboratories, an opportunity that "broadened my education and enhanced that organisation by bringing some clinical focus and expertise".
He moved to Newcastle, NSW, in 1991 and spent the next decade as staff specialist (part-time) in paediatric immunology at the John Hunter Hospital. Then, from 1992-99 he chaired its division of paediatrics, while also working as a consultant immunologist to CSL (1992-97). In 1999-2001 he was director of clinical governance at the Belmont District Hospital in the Hunter Valley and from 2002-04 he

Research Foundation. That's the origin. It was a mixed way those departments developed. But cardiology had existed, it grew out of the University many years earlier because of the role of Alex Venables.

Max Robinson: Peter I must correct you. I was never Chairman of the Medical Staff.

Peter Phelan: I thought you were Chairman of the Committee that recommended specialties.

Max Robinson: No, I was a member of the committee that recommended Donald Cheek's appointment!

David McCredie: I think the Chairman of the committee Peter's referring to was David [Danks]. June might be able to confirm that.

Arthur Clark: It was David, because David was interested in haematology, oncology and endocrinology at Monash Medical Centre.

Glenn Bowes: There's a story here that we should hear from Henry.

Henry Ekert: David was Chair of the Committee [that recommended specialties] and at one stage his idea was that there was too much centralisation of specialist departments within the Children's Hospital. A proposal was made that a couple of the specialist departments should leave the Children's and go to the Monash Medical Centre. One of them was haematology/oncology, and the other was paediatric endocrinology.

Ann Westmore: So what happened to this plan?

Arthur Clark: There was a lot of opposition from certain quarters.

David McCredie: I could make long comments, but I won't.

Arthur Clark: It wasn't a plan, but a proposition.

Ann Westmore: And so it fell on its face?

Peter Phelan: Yes, it didn't get up.

David McCredie: And Arthur and I nearly fell out at one stage.

Winston Rickards: I remember Max Robinson talking about this. Although some specialty groups became more concentrated, in psychiatry we increasingly drew on a multi-disciplinary team including psychologists, speech therapists, psychiatric social

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was visiting medical officer in paediatric immunology and allergy at the John Hunter Hospital. He maintains close contact with the RCH Department of Allergy through a continuing research association with allergist, Dr David Hill. (Personal communication Cliff Hosking to Ann Westmore)

workers, psychotherapists and audiologists. They were all pertinent to the study of the behaviour and personal life of children and their parents.

Ann Westmore: That raises the question, Winston, of the nature of the relationship between those allied health professional groups and the University Department of Paediatrics.

Winston Rickards: It was an interesting relationship. On the one hand participating in the Paediatric program we tried to expose Paediatric trainees to this multi-disciplinary team and to understand the importance of Child Psychiatry. On the other hand, the University Department of Psychiatry needed more and more of my time and sought opportunities to expose students and trainees through sessions and lectures in Child Psychiatry. This [University] Department was necessarily concerned with adult psychiatry because major psychiatric problems were pressing and more apparent in adulthood.

Glenn Bowes: Roger [Hall] talked earlier about the relationship between dentistry and paediatrics, which has continued on. During either David's or Peter's era – I'm not sure which era it was when Bob Adler[107] came – the beginning of that relationship between academic psychiatry in the University of Melbourne and academic paediatrics really began.

Peter Phelan: That was during my era. There had been a formal review of the Department of Psychiatry in about 1983 and one of the recommendations which Winston strongly supported was that there should be a Professor/Director of Child Psychiatry. I think that was probably in about 1984 or '85, Winston?

Winston Rickards: Yes, 1985. The thing was how much was the appointee to work in psychiatry, and how much in paediatrics.

Ann Westmore: And how was that resolved?

Peter Phelan: There's an important principle here. The University Department [of Paediatrics] was not a Department of Paediatric Medicine. It's unusual in the University of Melbourne Medical School that paediatrics is responsible for the teaching of all of child health and illness so it covers paediatric medicine, paediatric surgery, child psychiatry, community paediatrics, adolescent health, whereas it's not a Department of Medicine. I think that's been one of its great strengths. So, we've had a holistic approach - to some extent the Vernon Collins idea.

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[107] **Professor Robert George 'Bob' Adler** MB BS PhD FRACP FRANZCP (b.1945) trained in medicine at the University of Sydney, and spent 1972-75 as a Psychiatrist Registrar at the Royal Prince Alfred Hospital. After some years as a Consultant Child Psychiatrist he was appointed Senior Lecturer in Child Psychiatry at Newcastle University, NSW, 1980-84. He was Director of the Department of Psychiatry and Behavioural Science at the Royal Children's Hospital 1985-98 and, after resigning from the position he continued in private psychiatry practice in Melbourne. (See *Who's Who in Australia 2002)*

Durham Smith: I don't think you can separate paediatric medicine and paediatric surgery. I think all the great paediatric surgeons have been much better at teaching than many physicians. And the working relationships have been extraordinarily close.

Peter Phelan: So that tradition that paediatrics encompassed all illnesses at the Children's was very easy to build on. But psychiatrists also wanted a finger in the pie. So it seemed appropriate that the Professor/Director of Child Psychiatry got an appointment in both. But at no stage did any adult department of surgery or psychiatry ever come to me and say, "We want a share in the paediatric surgery or psychiatry".

I think one of the tragedies in the adult hospitals is that the teaching of medicine, surgery and psychiatry is not integrated. They are still taught as distinct disciplines. I raised this issue a number of times recently and people just laughed. I said it's happened since day one in paediatric teaching.

Bernard Neal: At long last the adult medical world is starting to learn a little bit from the paediatric medical world. Whereas when we started, it was the other way around.

David McCredie: Max [Robinson] and I were just saying to one another over lunch, that one of the best paediatricians in the Hospital was Nate Myers.[108] We all very much respected Nate's opinions and when we'd refer a patient to him we'd often be quite embarrassed by his medical summary of the case.

More on medical education

Max Kent: It would be wrong for this day to be spent without acknowledging Nate Myers who was very significant in paediatrics, paediatric surgery and paediatric teaching. He spent more time in the Hospital than anyone in this room. For a long time he was Vernon Collins' second in charge, and that was both on the medical and surgical side.

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[108] **Dr Nathaniel Albert Alfred ('Nate') Myers** AM, MD FRACS FRCS (1922-2004), graduated in medicine from the University of Melbourne in 1945 and the following year joined the Children's Hospital as a Resident Medical Officer. He stayed at the Hospital 1946-1954, including the last three years as Chief Resident Medical Officer. He seriously considered becoming a physician, a surgeon and a paediatric psychiatrist, and eventually chose the second of these.
He studied surgery at the Children's and Royal Melbourne Hospitals then undertook further training in thoracic surgery at the Great Ormond St Hospital for Sick Children, London, 1955-57. Returning to Melbourne, he began a private consultant practice in 1957 and also worked at the Royal Children's Hospital as Surgeon to Outpatients, 1957-1970; Senior Surgeon, 1967-1987, Chairman of the Department of Surgery, and Chairman of Senior Medical Staff. . He continued as Emeritus Consultant Surgeon to the Hospital after 2000. His particular area of expertise was thoracic surgery and together with Dr Russell Howard, he pioneered surgery for oesophageal atresia. He was a prolific contributor to the medical literature and was editor of several major international surgical journals.
Throughout much of his working life, he was a Professorial Associate of the University of Melbourne Department of Paediatrics. He was also active in professional activities, being a founder member of the Royal Australasian College of Surgeons' Board of Paediatric Surgery, Chairman of the RACS Victorian State Committee and of the RACS Archives Committee. He established the RCH Medical Alumni Association during the 1980s and remained its secretary until the year before his death. (See *Who's Who in Australia 1988*)

Bernard Neal: He originally intended to become a child psychiatrist.

Max Kent: He was the leading figure in the training of every resident and every surgical trainee. He had a wealth of knowledge and he saw no distinction in his role, he was a surgeon paediatrician. His was the example many of us followed in terms of having a solid paediatric background being a *sine qua non* in practising in the specialty.

David McCredie: Max in your early days, I believe that someone christened you Neo-Nate.

Peter Phelan: With the introduction of Medibank in '75, there were three levels of appointment, Professorial Associates, Senior Associates and Associates. And Nate and Howard Williams were the two appointed as Professorial Associates in the Department of Paediatrics.

Kester Brown: I think Peter Jones should be mentioned for his significant role in medical education.[109] He may not have been within the University Department of Paediatrics specifically, but his contribution to medical education was substantial in that he was the person who stimulated the production of many of the text-books out of the Children's Hospital, including my own. Well, I mean, he helped me with getting it published. His *Paediatric Surgery* was the text-book that came out that he got all the staff involved with.[110] His book on the pathology of tumours with Peter Campbell[111] was an

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[109] **Dr Peter Griffith Jones** MB BS MS PhD FRCS FRACS FACS FAAP (1922-1995) graduated in medicine from the University of Melbourne in 1945. In 1948-49, he undertook paediatric surgical training in Cleveland, Ohio and then proceeded to train at the Hospital for Sick Children in London and at Cambridge University. After returning to Melbourne in 1953 he joined the Royal Children's Hospital as a staff surgeon and a demonstrator and later as a clinical instructor in paediatric surgery and a lecturer in community medicine at the University of Melbourne. He remained on the staff of the Hospital until his retirement in 1988.
His major surgical contributions were in surgery to the pancreas, abdomen and heart. He also specialised in the diagnosis and treatment of tumours in childhood. In the mid-1970s, he contributed to the surgical separation of two sets of Siamese twins. His friend and colleague Dr Nate Myers once commented that "To operate with Jones was a pleasure – one of our visitors, commenting on our co-operation, once said he had not previously seen a 'four-handed surgeon'."
He played an active role in many medical organisations including the Royal Australasian College of Surgeons, the Australian Association of Paediatric Surgeons and its British and Pacific equivalents, the Association of Surgeons, and the Medical Defence Association of Victoria. He was also the foundation editor of the *Australian Journal of Paediatrics*. In later life he completed a PhD on Dr Rodrigo Lopez, personal physician to Queen Elizabeth I who was convicted of treason for plotting to poison her. He also had considerable expertise in heraldry and designed the coat of arms for the Royal Children's Hospital. (Personal communication Julie Jones to Ann Westmore)

[110] *Clinical Paediatric Surgery: Diagnosis and Management by the Staff*, compiled and edited by PG Jones, Blackwell, Oxford, 1976 (Revised version with Alan Woodward published 1986)

[111] **Dr Peter Ellis Campbell** MD FRACPA FRCPA MACLM (b.1930) graduated in medicine in 1953. He then undertook resident training at the Geelong Hospital, 1954-56. He became a trainee in Pathology with the Hospitals and Charities Commission in 1956 and spent the next five years in a range of metropolitan hospitals' pathology departments, including that of the Royal Children's Hospital. The year he spent at the Children's Hospital was seminal and, on graduating as a Pathologist, he was appointed to the Pathology Department under Drs John Perry and Alan Williams. A year later he was awarded the Uncle Bob Scholarship and spent a year at the St Christopher's Hospital for Children in Philadelphia.

outstanding contribution in that area.[112] I believe that Peter Jones was one of the great contributors to postgraduate and undergraduate medical education.

Frank Oberklaid: Kester, he was the first editor of the *Australian Paediatric Journal* with Charlotte Anderson.

Kester Brown: And he was a heraldry expert.

Roger Hall: When I published my book,[113] Peter and I had a lot of discussion about it, and the book is dedicated to Peter.

I'd like to add another quick word about Nate. When he'd refer me patients, he'd usually write a little note with some aside about something he'd picked up while seeing the patient.

Don Kinsey: Just a quick flash-back about Peter Jones. He designed the Hospital's coat of arms. You'll find the pelican is floating on the water. He chose the pelican in his original design because it always lives in a community and looks after its family and looks after the family of others. That's why he proposed the pelican. It was standing in the original design, but he found that the University of Barbados had a coat of arms with a pelican standing, so we had to have ours swimming.

Henry Ekert: I'd like to say something about the Combined Cancer Therapy Clinic at the Children's Hospital which was originated by Max Kent, Alan Williams, Peter Campbell and the late Cyril Minty[114] from the Peter MacCallum Cancer Institute. It had more to do with the University of Melbourne than the Research Foundation. It is a unique clinic in terms of cancer therapy, bringing together paediatric oncologists, pathologists, radiologists, radiotherapists and surgeons.

Bernard Neal: And general paediatricians, which was very important. As a general paediatrician I would retain the care and overall direction, having had the assembled views of these experts. And that was a great model.

After returning to the RCH, he was appointed Director of Anatomical Pathology. At this time his interest in paediatric tumours led to co-editorship of a book with Dr Peter Jones (see following footnote) and an MD. In 1976, Dr Williams developed an interest in Sudden Infant Death Syndrome (SIDS) and when he retired, Dr Campbell performed most of the relevant autopsies, counselling families who had lost a child to SIDS, and working closely with the Sudden Infant Death Research Foundation.
In 1993 he retired from the RCH and became a forensic pathologist, joining the Victorian Institute of Forensic Medicine where he continued to work part time. (Personal communication Peter Campbell to Ann Westmore)

[112] Peter G Jones and Peter E Campbell (eds), *Tumours of Infancy and Childhood by the Staff of the Royal Children's Hospital*, Oxford; Blackwell Scientific Publications, Philadelphia, 1976

[113] Roger K Hall, *Pediatric Orofacial Medicine and Pathology*, Chapman and Hall Medical, London, 1994

[114] **Dr Cyril Minty** was a radiation oncologist with a special interest in paediatric oncology. He was a consultant appointed by the Peter MacCallum Hospital to the Royal Children's Hospital and participated in the Combined Therapy Clinic and in the Children's Cancer Study Group clinical research studies on leukaemia.

Henry Ekert: Correct. And surgery was a driving force behind it.

Max Kent: It started forty years ago, in 1963, after I arrived back from Chicago. In Chicago they had a primitive form of consultation on cancer cases and related cases. I approached Russell Howard[115] on my return about starting something similar. He took it up. I then went with Russell to John Colebatch and he was very enthusiastic about it. We got it going and it's still going in much the same form. It's been a tremendous patient service, as well as a valuable experience particularly for the recorder of all the discussions. Other hospitals have attempted to repeat the model, but without the cohesion to keep it going.

Jim Keipert[116]: In general, the functions of a University Department of Paediatrics, I presume, are administration, clinical work, teaching and research. It seems to me we've focused on research today, but not very much on clinical work or teaching. I wonder if we should be pursuing those things.

Ann Westmore: I believe that undergraduate teaching became a particular focus under you, Peter.

Peter Phelan: I was fortunate initially to have Max [Robinson], but he decided to retire about four years after I took over. Max and I had initiated some fairly major curriculum changes when I took over. We progressively reduced the number of formal teaching sessions, increased bedside teaching, gave students more time to pursue independent research. I thought it was important that the Stevenson Professor had a high profile in the learning activities and we generally got the best reports of any of the teaching programs in the clinical years. So the students saw it as a very effective group.

Ann Westmore: So was this more of an apprenticeship model?

Peter Phelan: Yes we sought to teach better, and we tried to reduce the size of teaching groups in the ward, it had been six or seven, and we tried to break that down. And we were also fortunate in being able to recruit people from outside. Arthur [Clark], once he

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[115] **Dr Russell Norfolk Howard** ED MD FRCS FRACS (1905-1992) moved to Melbourne from Tasmania to study medicine, graduating in 1928. After two years at the Melbourne Hospital he undertook his Residency at the Children's Hospital in 1930 and served as Medical Superintendent, 1931-33. He gained further experience at the Women's and Austin Hospitals before undertaking additional surgical training in England. From 1938-46 he was Honorary Surgeon to Outpatients at the Children's Hospital and, after active service during World War II, he returned to the Hospital where he was Surgeon to Inpatients from 1946. In 1952, he accepted a position as the first full time Chief General Paediatric Surgeon, a position he held with distinction until he retired in 1970 having set a high standard of patient care and having introduced several novel surgical procedures.
He was President of the Australian Paediatric Association 1966-1967 and, for some years after 1970, he was Honorary Consulting Surgeon to the Hospital. (See *Who's Who in Australia 1988).*

[116] **Dr James A ('Jim') Keipert** MBBS DCH FRCPE (b.1922) graduated in medicine from the University of Melbourne in 1945 and joined the Children's Hospital in 1964. A general paediatrician with a special interest in paediatric dermatology, he was Physician to the Royal Children's Hospital 1970-87 and Senior Associate, the University of Melbourne Department of Paediatrics at the Hospital until his retirement in 1988. (Personal communication Jim Keipert to Ann Westmore)

retired from Monash, kindly agreed to come back and teach. We started to rotate students to country hospitals, in effect we had a rural clinical school before they became popular. And we had many overseas elective students.

Ann Westmore: So were you able to show that this was a better model?

Peter Phelan: We certainly managed to attract an outstanding group of people into paediatric training over those years.

Susan Sawyer: But Peter, I have heard that one of the reasons for that was your personal involvement with students. And someone told me a few years ago that before each student rotation, you already knew which were the outstanding students by name and photograph, and would be approaching each of them very early on in their rotation at the Children's Hospital and formed a personal relationship with people which I'm sure would have been a very powerful way of attracting a very high calibre of future paediatricians.

Peter Phelan: I did. Absolutely. I make no bones about it.

Kester Brown: I'd like to make a comment about the student teaching. I'm not sure if it was during your time or before when anaesthetics got a session.

Peter Phelan: I think that was before my time.

Kester Brown: I think that was a very important step because there was no exposure [of medical students] to anaesthesia in our Hospital, yet we had a Department full of outstanding people. So we arranged a situation where we had one hour for a lecture, and we tended to talk about the basic science applied to what we were doing. The students were allocated each specifically for a session and they had one-to-one teaching in that time. And a lot of those students found that very useful.

Another thing we got involved with, through the University Standing Committee on Anaesthetics, was the third year extension course that used to go for six weeks on a Wednesday afternoon. We ran a course on basic science applied to paediatric anaesthesia because I had always felt that in the traditional medical school set-up you learnt your basic science and nobody told you how to apply it to what you were going to do. And then you went along to the clinical side and you'd forgotten the basic science. We managed to combine those.

And there were a few very informative reports written at the end by the students. One fellow wrote to us afterwards, and thanked us for running this course because before that he had been so disenchanted with his pre-clinical course, not knowing where it was leading him, and he was thinking of quitting. Now having had basic science explained in clinical terms, he could see where he was, and was all fired up to carry on. I think the new curriculum is hopefully addressing that because it's absolutely key. I've felt it for years, that it is one of the defects of medical education. And I was very appreciative of the Department letting us have the medical students for that period.

Henry Ekert: To me, Peter Phelan's era in terms of education was very similar to that of Vernon Collins in the sense that he took a great interest in education, he extended it beyond the undergraduates to postgraduates, extended it to graduates doing research and he also oversaw the choice of appointments of the future, which Vernon did also. So in many ways it was a case of *déjà vu* as far as I was concerned. Both had a vision of the Hospital and were benevolent dictators. I think David Danks had a vision also, so I'm not saying they were unique. But they had a vision which extended into the clinical services of the hospital and the link with the community. And I think that was a very, very strong time for the Children's Hospital. I was on many committees with Peter. He knew who he wanted to attract to come back for the second or third year appointment and was prepared to resource their areas of strength. I think that was a very good teaching program.

David McCredie: Another thing that happened in the '80s was the introduction of advanced study units. Students came in their second and third years for a six week course. I know I ran one for a number of years on fluid and electrolyte metabolism, Ian Hopkins ran one on neurology,[117] Henry [Ekert] did one, as did Kester [Brown]. This was a terrific introduction, because it integrated what they were learning in their physiology and anatomy with clinical medicine and showed that it was important to learn how things worked and to understand how it related to disease. I found these sessions very satisfactory from the point of view of teaching, and many of the students kept in touch for some time afterwards and said how much they enjoyed these sessions.

Peter Phelan: Two other things that were innovations. By about 1994 there was clearly widespread dissatisfaction among the student body about the lack of any clinical exposure in the early years of the course. When I talked to the Dean of the day, Graeme Ryan[118] he said, what would you think of having first year students spending a half day or a day in the wards of the Children's Hospital. And so, that went on for a number of years until the new curriculum came in which then formally had clinical experience.

The other thing that developed in the late '80s was a series of postgraduate diplomas which were first, important financially and second, gave opportunities to extend the teaching areas beyond the traditional paediatric graduate diplomas. There was one in

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[117] **Dr Ian J. Hopkins** MB BS MD MRACP FRACP graduated in medicine from the University of Melbourne in 1957. After completing his general paediatric training at the Royal Children's Hospital and gaining an MD, he undertook specialist training in child neurology at the Hammersmith Hospital and the National Hospital, Queen Square (1963-64) and at the Johns Hopkins Hospital and the University of Kentucky Department of Neurology (1965-66). In 1966 he was appointed to the University of Melbourne Department of Paediatrics as Second Assistant, later becoming First Assistant and Associate Professor, teaching generations of undergraduate and postgraduate students in child neurology and general paediatrics. At the same time, he was appointed assistant neurologist at the RCH, becoming neurologist in 1969 and senior neurologist in 1988. He retired from his University appointment in 1990 and from the RCH in 2001. (Personal communication Dr Hopkins to Dr Westmore)

[118] **Professor Graeme Ryan** AC, MB BS PhD FRCPA FRACP, was Dean of the Faculty (over the period when it changed its name from the Faculty of Medicine to the Faculty of Medicine, Dentistry and Health Sciences) from 1986 to 1995. (See the Historical Compendium to the Faculty of Medicine, Dentistry and Health Sciences www.cshs.unimelb.edu.au/umfm)

adolescent health, genetic counseling, infant mental health. There were six or seven of them and they attracted large numbers of people.

Susan Sawyer: I'd just like to comment on the benevolent dictator notion because I think that while we clearly recognise the strengths of that model, I continue to be impressed by Peter's vision in being able to identify gaps that were clearly emerging in terms of new service models and new areas of specialisation. But I think from the mid-1980s there was a period of about five years where the changing demographic of paediatrics - with an increasing number of women entering the specialty – was not reflected in appointments. So, for example, 1987 was the first year at the Children's Hospital when there were equal numbers of male and female trainees in paediatrics. A lot of women had gone through beforehand but, at that time, if you looked at the appointments and the staff profile at the Children's Hospital it was overwhelmingly male dominated. And, into the 90s, although there were changes, I think we need to recognise that there was quite a lag and a level of dissatisfaction amongst female trainees in terms of career opportunities.

Jim Keipert: In regard to teaching by clinicians, when one was appointed to the Hospital, presumably on merit, I always thought it rather quaint that you were automatically appointed as a teacher without any assessment of your ability in that regard. I always thought it would be desirable if the University assessed our abilities as teachers and, if necessary, taught the teachers how to teach. I thought I was a pretty good teacher but that was what you might call a somewhat biased opinion. So I pestered the Department [of Paediatrics] during my years there to get somebody to assess how good we were as teachers. Eventually, they got somebody from the University Department of Education to come and sit in on one of my sessions and they were going to do it on a lot of the other outpatient sessions. After that, they gave me verbal feedback. And they were going to give me a full report. But unfortunately there was a very regrettable upset in the Department of Education and we never heard anything further.

The other thing, when I was at Monash with Arthur [Clark], we used to get feedback from students in questionnaire form at the end of their term. I thought this was very helpful. It probably helped the students as much as the teachers but after some years it gradually died out.

During my time as a teacher at the Children's I found by far the most satisfactory form of teaching I had was in the general clinic area where Residents or Registrars brought cases that they were worried about. We gave them help with diagnosis and talked about management, prognosis and treatment. We also gave service to the patient. That seemed to me to be the most satisfactory form of teaching that I had because it was a small group and it consisted of parents, patients and, of course, students.

Ann Westmore: Does that continue?

Jim Keipert: I don't know.

Bernard Neal: I just want to add to what Jim said. When I succeeded Howard Williams as the Dean of Postgraduate Medical Education one had to apply for the position. The specifications for the position included, apart from your paediatric experience and so forth, some knowledge of the principles of the science of education or a willingness to acquire it.

I put in my application that I didn't claim to have this knowledge but that I thought it was very important to acquire. So I had to put in how I was proposing to acquire it. I made inquiries and found that at Monash University, rather than at Melbourne, there was something called the Diploma of Tertiary Education. I put it to the Committee and they approved and paid for me to attend part-time at Monash and acquire the Diploma of Tertiary Education so that I could apply educational principles in the postgraduate training. And I found it an absolute eye-opener, learning about student evaluation, checking that the students had understood what was said to them, all sorts of stuff. To this day, I'm appalled at the ignorance among the teaching community in universities of basic principles of teaching.

Glenn Bowes: Before John McNamara jumps in, I'd like to come back to the gender issue.

John McNamara: I was going to say something on that. I'd like to comment as one of the people on the selection panel for junior medical staff. We tried to base it on merit.

Susan Sawyer: I'm not wanting to be critical.

Glenn Bowes: I'll tell an amusing story the other way, John. I was amazed when I came to the Children's in the early '90s because I was invited to one of these selection processes which I think used to occur traditionally at dinner at the Melbourne Club, which was a useful representation of the fact that there was at least some semblance of gender inequity that was likely to occur, at least in the balance of the people meeting for dinner to make those judgments about who were going to be the future leaders. So I think it was a sign of the times. I think that's where some of those meetings were held.

Peter Phelan: The informal parts.

Glenn Bowes: The informal parts. Yes, the important ones.

Frank Oberklaid: My comment is about graduate teaching. When I came back from Boston in 1980, the focus really was on paediatric training. And at that time the majority of trainees in Victoria were residents coming to the hospital not destined for a career in paediatrics but for a career in general practice. That was glaringly apparent. So we approached the College of GPs[119] and developed a Working Party that used to meet at seven in the morning, I recall, and developed a curriculum.

[119] **Royal Australian College of General Practitioners**

There was a tutorial every day for those three months and we developed resources, outside GPs were brought in, and so on and so on. That then subsequently became the core of the national program in paediatrics and child health for the College of GPs. We then started developing continuing medical education programs for GPs in child health, which continues to this day. The Children's Hospital now manages the national education and training programs for GPs, community nurses, we did pharmacy there for a while, child care, family and day care. So that's greatly extended [the training focus]. I think for a long time the focus was just on paediatric education, not realising that the vast majority of children who are unwell don't go to a paediatrician.

Academic outreach

Peter Phelan: With Frank's appointment as Professor/Director of the Centre for Community Child Health, it was Ambulatory Paediatrics as I remember, that brought that activity generally more within the Department of Paediatrics.

Glenn Bowes: That reminds me, because I was the beneficiary of it, that with John Court and Barry Catchlove during Peter's era, the Centre for Adolescent Health was established as the first national academic centre in adolescent health.[120] That was well ahead of its time nationally and one of the first internationally. And similarly the Centre for Community Child Health that Frank took on as Professor/Director. They were both parts of Peter's extension of paediatrics into a broader domain beyond hospital-based excellence in the organ-specific paediatric disciplines.

Frank Oberklaid: I 'd just like to tell an anecdote which says something about Peter's vision. I still recall a knock on the door of my office one day and when he sat down he asked me what I was going to do for the rest of my life. I was just recovering from a serious illness and I said, I just want to stay healthy. He pooh poohed that. He was the first person to float the idea with me of an academic centre for community child health and then forced me to do my MD. And nothing after that was the same. I think that was an example of the Professor of Paediatrics, as you said Glenn, having a vision, encouraging people, building morale and the rest follows.

Susan Sawyer: The corollary of having influence is not just the changing or expanding of practice but influencing policy. Peter, my sense when I was training in paediatrics was that the Children's Hospital was very active in the State Department of Health at that time in a way that then, under Peter Smith, didn't seem to be sustained.[121] Was that correct?

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[120] The **Centre for Adolescent Health** was established in 1991.

[121] **Professor Peter Smith,** RFD MD FRACP FRCPA studied science and medicine at the University of Queensland, graduating in 1970. He trained in paediatrics at the Brisbane Children's Hospital and undertook specialist clinical and research training in haematology and oncology at the Royal Children's Hospital, Melbourne, and at St Judes Children's Hospital in Memphis.
Returning to Brisbane in the 1980s he was Foundation Director of Oncology at the Royal Children's Hospital and in 1988, Professor and Deputy Head, Department of Pathology, University of Queensland and

Peter Phelan: That was true and it related to some personal relationships, of which Frank was the key. One was with David White, who Frank happened to have been at school with.[122] And then Frank had relationships with bureaucrats, and both Frank and I had close personal relationships with John Paterson who took over as Secretary of the Health Department.[123] So those linkages became very important.

Ann Westmore: The community outreach of the Department of Paediatrics seemed to take off then, but there had been very vibrant areas like the Burns Research Unit that I was aware of from an earlier time.

Peter Phelan: I saw the need to put some strong academic foundations to community paediatrics and adolescent health. But many of the Departments in the Hospital had very strong community links.

Garry Warne: For instance John Court with diabetic education and the diabetic camps. That goes back two generations. Also, David's [Danks] involvement in the Little People of Australia.

Peter Phelan: There were a huge number of these links. I don't think it was anything new, but it gave a formal academic underpinning to these [links]. And also I believed by having that formal academic underpinning there was more prospect of influencing government policy. And clearly, there was an absence of any significant input at a Federal or State level from the early 1980s into child health policy. 'Bunny' had been on the NHMRC – you were the last paediatric nominee on the NHMRC 'Bunny', is that right?

Bernard Neal: Probably, because the constitution [of the NHMRC] allowed the Australian Paediatric Association to nominate someone. Then, when that disappeared I think the real change happened.

Foundation Chairman of a joint experimental oncology program established by the University of Queensland and the Queensland Institute of Medical Research.
Having established a strong reputation in childhood cancer research, he moved to Melbourne in 1994 as Professor/Director of Paediatric Haematology/Oncology at the Royal Children's Hospital and University of Melbourne, and Divisional Director of Laboratory Services for the newly amalgamated Women's and Children's Hospitals. He was Stevenson Professor of Paediatrics 1997–2001, after which he moved to Auckland to become Dean, Faculty of Medical and Health Sciences, The University of Auckland. (See www.health.auckland.ac.nz/administration/peter_smith.html)

[122] **Mr David Ronald White** BCom BA MBA (b.1944) held the Legislative Council seat of Doutta Galla for the Australian Labor Party 1976-96 and, after serving as a Minister for Minerals and Energy, and for Water Supply, he was Victorian Health Minister for several years in the early 1990s.

[123] **Dr John Pryde Paterson** AO, BCom PhD (1942-2003) initially worked in the areas of environment and planning and water resources. From 1982-84 he was president of the Hunter District Water Board and from 1984-88, Director-General of Water Resources in Victoria. He then moved departments to become Director-General of Community Services Victoria (CSV) 1988-92. In 1992 he designed the amalgamation of CSV with the State's Health Department to form the Victorian Department of Health and Community Services which he headed 1992-96. (See Rob Hudson, "Tributes flow for Dr John Paterson," *Human Services News*, March 2003)

Peter Phelan: So I saw that one way of achieving this [political imput] was to get high profile, successful academic units and I think that's occurred.

Kester Brown: Can I talk about education for a minute. I was involved in the '70s in a very interesting educational activity in the Casualty Department when John Hurst was in charge.[124] He organized that I and a pharmacist would go down and talk to the residents about the common drugs they used. The question of taste came up, and also toxicology aspects. But the fascinating thing about it was that, during those sessions, the transfer from using aspirin to using paracetamol occurred. During one rotation, the whole switch occurred. It wasn't from an outside source, it was from inside the hospital.

Glenn Bowes: To come back to a point Jim raised, under [David] Penington as Vice-Chancellor of the University,[125] student assessment became codified, so that became part of the whole University ethic. And John Hutson's teaching in the Department of Paediatrics has been rated among the highest by students over more than a decade, and continues to this day as one of the most highly rated and appreciated student teaching sessions in the Medical Faculty.

Ann Westmore: I'd like to pick up on a point about career paths for paediatricians in the University Department of Paediatrics. What happens when you have an exceptionally good teacher among the surgical or medical staff? Is that talent made use of and rewarded?

Peter Phelan: The first point here is that there are many advantages in having a mixture of Visiting Medical Officers and full-time staff as teachers as they bring somewhat different perspectives to the students.

Second, not all doctors are intrinsically good teachers. Train the trainer sessions are very clearly necessary as I have learnt since becoming more involved in postgraduate training.

The third point is that we do not provide enough acknowledgment for our best teachers. Many overseas universities have annual awards for the best teacher, we don't in general in this country. We get student assessments back. I used to tell people who were very good, but had difficulty telling those who were bad.

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[124] **Dr John Hurst** was a General Practitioner who ran Casualty for several years. Dr Kester Brown recalls that he organised for a pharmacist and he (Dr Brown) to teach Resident Medical Officers about common medications for an hour a week. Over the course of a three-month period, this interchange resulted in usage of paracetamol largely replacing the use of aspirin because of the latter's potential toxicity. (Personal communication Kester Brown to Ann Westmore)

[125] **Professor David Penington**, AC MA DM BCh FRCP FRACP FRCPA (b.1930) was Dean of the Faculty of Medicine at the University of Melbourne 1978-83, and Vice-Chancellor 1988-95. (See The Historical Compendium to the Faculty of Medicine, Dentistry and Health Sciences www.cshs.unimelb.edu.au/umfm and *Who's Who in Australia 2002)*

Glenn Bowes: To pick up on the comments of Max and Jim. The University Department now has a half time lecturer, Jenny Gough, who has an education background.[126] She teaches a range of people including training Registrars in how to teach and supervise Residents in group or one-on-one teaching. In the new course, Jenny has been the backup to Michael Marks, a senior lecturer who is full-time, and gives the tutors introductory material, sits in on tutorials and gives feedback.[127] It [the teaching program] has predominantly been focused on the Registrars and Fellows but we are working through the more senior staff.

This is something that's two or three years old, she started doing that half-time when the medical education officers were appointed in the hospitals. The other half of her time is as an academic continuing lecturer in the department. So, it might have been a long time coming, and it certainly has a way to go, but that is the direction it's been taking.

Kester Brown: One aspect of assessment. I remember when we got anaesthetic registrars to talk about their view of their training, one of the views from a senior fellow was, "Nobody ever told me how I was going". It's vitally important to tell people if they're doing very well, they're doing OK, or if they're weak the problems that should be addressed.

Garry Warne: During Peter Smith's time, the Master of Medicine course for overseas postgraduates was revamped. The Department of Paediatrics did a terrific job in getting an orientation about basic things to do with coming from a non-English speaking background, such as that people who were accepted had a good grasp of English. RCH International had also been advocating for language testing for potential postgraduate students. This is now policy throughout the Hospital.

Don Kinsey: I know the seminar is drawing to a close, but there is one quick matter of semantics. We've heard about benevolent dictators. I don't believe that's a true description of these great leaders we've been talking about. Dictatorship means you are putting somebody down but leadership means you are encouraging and leading them

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[126] **Ms Jenny Gough** BA DipEd GDipEd Admin GCertTESOL MEd (b.1951) trained in education at LaTrobe, Ballarat and Melbourne Universities. She was responsible for supporting and developing the new Child and Adolescent Health curriculum for 5th year medical students. She now devises and conducts teaching skills development programs for staff, conducts relevant educational evaluation and research, and supports other education programs in the Department of Paediatrics.
She is developing and refining an innovative program in which medical staff "rehearse" with actors various difficult conversations they may have to have, such as breaking bad news to parents. (Personal communication Jenny Gough to Ann Westmore)

[127] **Dr Michael Marks** MB BS MD MPH FRACP (b.1961) trained in medicine at the University of Melbourne and joined the Royal Children's Hospital in 1987, completing his specialist qualification in paediatrics in 1991. He completed a research doctorate (MD) in the Department of Paediatrics in 1994 and then spent two years in Boston, gaining a Master of Public Health at Harvard School of Public Health. He returned to the Department of Paediatrics as a Senior Lecturer in 1996 and became co-ordinator of the undergraduate paediatric course in 1998. He subsequently led the Department's introduction of the new medical curriculum (first cohort of new students in 2003). He also co-ordinated the Advanced Medical Science (AMS) Paediatric Unit from 2001, the AMS being a year of research in the new curriculum undertaken by all undergraduate students. (Personal communication Michael Marks to Ann Westmore)

along. And I would rather say my mate on my right [Peter Phelan] was a great leader, not necessarily a dictator. I'm just making that point for posterity.

Glenn Bowes: I think it's been a terrifically generous thing for you all to do today, to share your experience, thoughts and wisdom. I've been thinking all day what joy it's going to be to share the product, these stories and the important themes - the origins of the Department and its influence on the environment today and on paediatrics at the Children's, and our training programs. We will be considering what steps we can take beyond this, to continue to develop the history of paediatrics. So thank you all for coming.