The Royal Children's Hospital Melbourne
50 Flemington Road
Parkville Victoria 3052 Australia
TELEPHONE +61 3 9345 5522
www.rch.org.au

Royal Children's Hospital Alumni

ALUMNI NEWSLETTER MAY 2015

President's Letter
by Andrew Kemp

"Take some more tea," the March Hare said to Alice"

I have at home three souvenirs from the previous Children's Hospital building which I still use. These were not purloined by me, but were items that I found in my office when I commenced my appointment at the Children's Hospital in 1990.

Many readers will recognise these items as being from the old dining room. They consist of a cup and two saucers in a delightful shade of green and come from a well known manufacturer, Grindley, in the United Kingdom. Grindley dominated the UK tableware market; in the 1930s 95 out of every hundred hotels in the UK utilised Grindley ware.

Reflecting on these items brings back memories of the Children's Hospital dining facilities at that time (1960s-70s). For a number of us who lived in the hospital the hospital was our home. There was a doctors' area, which had table service in the dining room on the ground floor. The doctors' area has subsequently been closed and meals are now take-away or eaten in a cafeteria. It is my impression that most of my colleagues regret the closure of the doctors' dining room, particularly because of the loss of collegiality. This feeling is not unique to the Royal Children's Hospital Melbourne. Dr Vineet Arora, a physician at the University of

Chicago teaching hospital has performed extensive research, particularly on hospital staff and intern matters. She captures the feeling concerning doctors' dining rooms in a piece regretting the dining room closure at her hospital. "I can always count on getting a coffee there and hearing some good conversation – doctors asking for input on interesting cases, laughing, sharing stories both personal and professional and catching up on each other's busy lives". To the extent that the demise of the doctors' dining room may have produced some tangible benefits, it can be argued that these are outweighed by the losses.

As with a number of things in the computer age, we now have a somewhat inferior replacement for personal interaction. This is a computer website entitled *Doctors' Lounge*, which aims to replace the real thing. It is notable that the current open plan design of the office spaces in the new hospital is also an attempt to deal with a perceived lack of interaction among medical staff from different disciplines. I would also argue that the incorporation of medical students into the communal life of the hospital through the staff dining room can play a role in introducing paediatrics to interns and trainees at a crucial stage in their career.

It may be noted that we now tend to take our tea/coffee from a disposable container, huddled at our desk, rather than from vitreous china in the doctor's dining room. Presumably many others do likewise. In Australia disposable cup usage is large - 2.7 million a day or nearly 1 billion a year.

So here we have three items of chinaware specially made for the Children's Hospital. Although it may only be a small thing, somebody (or some people) cared about such things. The loss of a collegiality that they symbolise makes we want to discard my styrofoam coffee cup, turn off the doctors' lounge TV and go to the luncheon in the doctors' dining room before the grand round – "Milk and one sugar, thank you".

A paediatrician's reflection on euthanasia

by James Keipert

Repeated polls have shown that 70 to 80 per cent of Australians are in favour of euthanasia, and as a result there is growing pressure on our politicians to legalise euthanasia.

For a patient with terminal disease associated with pain and suffering, euthanasia to end life at a time of the patient's choosing has a very obvious attraction, and it is not surprising that euthanasia has such strong public support.

However, little comprehensive information has been made available to the public by the media regarding many aspects concerning euthanasia, so I shall attempt to rectify this.

A Chambers Dictionary definition of euthanasia is “an easy mode of death: the act or practice of putting painlessly to death, especially in cases of incurable suffering”.

In practice euthanasia would only be applicable in patients with terminal illness.

Euthanasia is also known as assisted death, assisted dying, or physician assisted suicide.

The Netherlands was the first country in the world to legalise euthanasia in 2002, followed later by the Northern Territory of Australia. It is a surprising fact that both these centres had inadequate palliative care facilities both at the time they legalised euthanasia, and thereafter.

After the introduction of euthanasia, an investigation by a group of United Kingdom specialists of the Netherlands’ palliative care facilities showed them to be rudimentary.

Regarding the more recent situation in the Netherlands, a report in 2012 stated that six specialised teams, each consisting of a doctor and nurse, are criss-crossing the Netherlands to carry out euthanasia on patients at home, because their own doctors refuse to do so.

One of the Netherlands’ largest lobby groups for doctors questions whether “Life-end clinics” doctors would be able to form a close enough relationship with a patient to assess if their life should be ended. I think this is a significant understatement.

The reluctance of doctors to participate in euthanasia is not confined to the Netherlands as a report this year states that in the United Kingdom 77 per cent of general practitioners and the Royal College of General Practitioners are opposed to a change in the law legalising assisted dying and the Australian Medical Association and the Royal Australian College of General Practitioners do not support the legalisation of voluntary euthanasia.

A limited number of countries in the world have adequate palliative care facilities, and few have optimal facilities. Australia does not have optimal palliative care facilities but the situation is gradually improving with the provision of more facilities and specialised physicians, the introduction of specific medicines for palliative care available on the Pharmaceutical Benefits Scheme, and in an indirect way the greater use of Advance Care Planning.

I’d like to consider the problems that euthanasia may create with some groups of people in the community.

1. *Doctors.* There may always be a very small percentage of doctors in the community who are excessively enamoured of holding the power of life and death in their hands.

Acting in collusion they could be responsible for the premature demise of some patients whose problems could be satisfactorily controlled by expert palliative care.

Dr. Philip Nitschke recently helped a 45 year old man without a terminal illness, but who probably had depression, to end his life using a euthanasia drug. Dr. Nitschke was reported as saying he did not believe he had any obligation to refer the man for assessment of his mental health.

And this could lead to the slippery slope situation where people, and some doctors, might feel that euthanasia should also apply to people without a terminal illness who professed the desire to die, even at an early age. It is reported that indications for euthanasia in the Netherlands and Belgium have widened to include non-terminal patients and depressive illness.

2. Some *patients* with a prolonged terminal illness who are being cared for by relatives will have sufficiently serious problems that it is demanding for the relatives to provide that care.

Another group of patients with similar problems can be in a care situation that consumes large amounts of money which the patient knows would otherwise go to the relatives if the patient died.

In both these situations the patient may feel that they owe it to their relatives to take the option of euthanasia even though they might prefer to continue living and keep hope alive.

Past studies have confirmed that being a burden to others is a common source of distress for the terminally ill.

3. Some *relatives* may feel that the care of a sick and elderly relative is making inappropriate demands on their resources, time and energy, or is decreasing the inheritance they will ultimately receive from that relation.

This may lead them to place insidious or explicit pressure on their relative to consider the possibility of euthanasia, even though this may not be what the patient desires.

4. If euthanasia is legalised it may lead the *community* to believe that physician assisted suicide is the most appropriate way to die, even though natural death is often peaceful and is a natural end to life.

I surveyed the Obituary notices in The Age on 6 days. Of a total of 100 death notices over those 6 days, the entry said that the deceased had died peacefully on 61 occasions – that is 61% were peaceful deaths.

It is possible that of the remaining 39% a number were also peaceful deaths, but the person making the entry didn't think it was necessary or appropriate to mention it.

Also, five professors who are palliative care specialists writing in The Age recently said that the overwhelming majority of media reports about end of life care focus on conceptions of dying as always being painful, undignified and traumatic.

They stated this is untrue. We cannot claim everyone can be guaranteed a peaceful death. We have, however, witnessed thousands of deaths where, in the lead up, the dying person has been comfortable, able to communicate their wishes, and families have valued sharing this final phase.

5. When seeing a patient with a problem, it is the doctor's aim to make an accurate diagnosis of the cause of the physical, emotional or mental health problem and hopefully to prescribe treatment to restore the patient to normal health.

It is debatable whether it is part of the doctor's duty to kill – or put more softly to end the life of – the patient, and I wonder if patients might start to view us in a more unfavourable light if we do so. Also, some doctors may refuse to co-operate with euthanasia, as has happened in the Netherlands and the U.K.

With the terminally ill patient with unrelieved pain and suffering who does not wish to continue living there is a legal alternative to euthanasia.

In this situation it is legal for the doctor to administer increasing doses of pain relievers even to the degree that the dose of pain relievers may kill the patient, always provided that the doctor is giving pain relievers with the aim of relieving the patient's pain rather than with the aim of killing the patient. This should provide a satisfactory solution to most patients in this situation.

Relatives may unsuccessfully hope for euthanasia in 2 situations.

1. Where the patient is in a coma and is taking much longer to die than anticipated.

Euthanasia here would be to relieve the distress of the relatives as the patient could not consent to euthanasia.

2. The patient with dementia who has loss of cognition and mental ability and then continues living with no quality of life for 5 or 7 years or longer. Here again the patient can't consent to euthanasia.

Depression is a very important factor in regard to euthanasia. If a person with depression requests euthanasia, it is very likely that if their depression was cured they would not then want euthanasia.

In a patient with unrelieved pain and suffering, symptoms from the pain and suffering can be very similar to symptoms of depression. The same difficulty applies to symptoms of mild dementia, and in both these situations psychiatric assessment is highly desirable, as

successful psychiatric treatment may completely reverse the patient's desire to end their life.

It is hoped these problems would be avoided, as under legislation to legalise euthanasia the person's condition would have to be verified by two medical practitioners, and the person would have to undergo a mental health assessment to ensure they were of sound mind.

But, unfortunately, this is not as simple as it sounds.

It is presumed that legislation legalising euthanasia would expect of certifying doctors that they

- can reasonably predict the course of a progressive illness – this prediction is not always easy or accurate.
- are certain the request is being made voluntarily.
- know the patient concerned, and his or her personal and family circumstances, well enough to say with assurance that there is no pressure, subtle or otherwise, at work in the background.
- know what level of capacity is required for a decision to request euthanasia and who is able to confirm it is present in the patient concerned.

This may be difficult or impossible as the doctor may not know the patient well enough, or because a significant number of patients will tell the doctor what they want him to know, or think he should know, rather than the true facts, and this is more likely with vulnerable, terminally ill patients.

Further evidence that assessing capacity for physician assisted suicide is difficult comes from the American State of Oregon where the law was changed 16 years ago to allow terminally ill, mentally competent adults the choice of a physician assisted death. Only 6 per cent of Oregon psychiatrists report confidence in assessing capacity for physician assisted suicide at a single consultation.

Another Oregon study found one in six of those legally supplied with lethal drugs had undiagnosed clinical depression, and in a terminally ill Canadian cohort, those with a significant desire for death had a higher prevalence of mental illness.

It is significant that over the years in Oregon, the proportion of terminally ill patients opting for an assisted death has remained relatively constant at around 0.25 per cent – that is 1 in 400.

This is because most of the patients who express an initial interest in assisted dying find that their needs are met with conventional palliative care. It might also be partly related to people feeling that while there's life there's hope.

Currently, a little over 30,000 people die annually in Victoria. In the past year about 15,000 people in Victoria used home based palliative care. Some of these people were admitted to a hospice or hospital before their death.

The facts in this article are presented to give people (and writers and presenters in the media) a rational basis for making a decision about whether legalised euthanasia is an appropriate course of action for our community.
There could seem to be many good reasons why our government should strongly concentrate on increasing and improving palliative care facilities until they are present to an optimal degree and available to all people, before they consider legalizing euthanasia.

Peter Jones: a great surgeon

by Kester Brown

There have been few males
Who have told so many tales
In the dulcet tones
As the great Peter Jones.
He always had so much to say
That in the theatre there was never a dull day
When he was around
To create some sound,
Be it taking off a Swede
Or recounting some extraordinary deed
Of a surgeon extraordinaire
Who operated with great flair.
Peter Jones seemed to have been everywhere
Cincinatti, London, Stockholm and Baalbeck
As if he went just to check
Their medicine, history or just to stare
At all the magnificent things
That his embellished story rings.
He studied everything in detail –
History, surgery, heraldry and publishing,
So that he could use the information to regale
Us with ideas we found so nourishing.

In the hospital he was a great surgeon
Whose reputation across the world did burgeon.
He designed the flag and coat of arms,
He wrote books full of information,
Taught students successfully to graduation,
And when a nurse hadn't a clue,
He showed her what she ought to do.
He inspired others to write books too,
Which doctors all over the world bought
To find out exactly what Peter's colleagues thought.

Peter at the hospital was great,
He always tried at any rate
To put good ideas for admin to view
Even though they were sometimes left to stew.
But make no mistake,
Plenty others also suffered the same fate.
But through a long life of happy chimes
There were also some sad times.

Overall he was a family man
And with Julie he raised a clan.
When they were nippers
They had no need of slippers
For they had a house up market
With wall to wall, warm carpet.
Rockley Street was their home,
Berwick was where they used to roam.

Peter was a good bloke
But he did like to smoke.
To our unimaginative administration
He was the cause of great consternation.
When smoking in the hospital they wished to stop,
Peter Jones and many more refused,
And probably would have run amok
Had the situation been defused,
And Peter Jones retired.
He was always one we admired.
A great raconteur, colleague and friend
Right to the very end.

Thoughts on a Dark and Stormy Night
by *Geoff Mullins*

Yes, it was a dark and stormy night and the last thing I wanted to do was fly to northern Victoria to retrieve a critically ill baby from a regional hospital. Yet here I was with an intensive care nurse, resuscitation and transport equipment rushing out of the hospital into the darkness and rain, leaping into a taxi and speeding along the freeway to the Essendon airport. All the time I ruminated on why these emergencies always seem to happen at night, always after a long day in the intensive care unit and God knows when I would get home to the safety of my warm bed.

The taxi drove straight onto the rain spattered tarmac to the awaiting twin engine air ambulance plane whose engines were already roaring. The plane was tiny. It had room for a pilot, a co-pilot, a stretcher and two seats against one wall facing the stretcher. The nurse and I clambered into these seats facing the stretcher.

The pilot seemed surprisingly cheerful despite the weather and offered me the co-pilot's seat. Climbing forward I faced an array of instruments and through the pouring rain could view the poorly lit runway. The plane moved at first slowly and then faster and faster, the engines roaring louder and louder and the plane began to rattle and shake violently. Just as I began to fear the plane would skid out of control and fall apart it lurched upwards into the darkness

The pilot showed no signs of alarm as the plane continue to shake violently as it ascended through swirling black clouds and rain. Once through the clouds the plane levelled out, the shaking and rattling subsided and although still noisy was now flying smoothly. The pilot became talkative and needed to shout to be heard above the engine noise. He talked of his love of flying, how it had been a passion since childhood but alas remained a hobby as he was a dentist by profession. He related how he and another dentist, also a qualified pilot, had secured the contract to provide emergency flights for the Victorian Paediatric Emergency Transport Service and of how much they enjoyed these occasional flights.

I began to look closely at the pilot as he continued to talk eagerly about flying. I guessed he was in his late 50's. He had a lined ruddy face, was probably a little overweight and had a packet of cigarettes in his shirt pocket. As the flight continued I began to nod off to sleep until suddenly I realised the pilot was asking me if I would like to take a turn at the controls. Taking up the offer I became focused on keeping the plane on course. The plane was very responsive to moving the controls. A small movement of the controls up or down resulted in a smooth ascent or descent of the plane. I began to enjoy this experience above the clouds out of the storm and my tiredness and thoughts of the storm and the plane disintegrating faded.

The pilot took back the controls, and began to give a long and detailed history of all his past and present ailments and surgeries and in particular a recent history of indigestion and heartburn. I tried to listen to the pilot but my eyes kept closing and my mind wandered. As the pilot droned on in my half asleep state I mused about his multiple risk

factors for cardiovascular disease – age, over-weight, ruddy complexion, smoker and a stressful occupation. I was now suddenly awake and recalled reading of the enormous stresses pilots are subjected to especially on taking off and landing. I then began to ruminate on what would happen if this pilot suddenly slumped forward onto his controls and died. I knew I couldn't fly, let alone land the plane so if the pilot died we would all die. Then remembering the pleasure I had when briefly piloting the plane, I thought maybe, just maybe I could attempt some loop the loops in the plane before dying.

Despite my fears the pilot didn't drop dead, the flight was uneventful and the plane made a bumpy landing on a dark wet landing strip in northern Victoria. We were met by an ambulance and driven to the hospital to be greeted by the bleary eyed staff and the anxious parent. The baby had developed severe upper airway obstruction and after several attempts had been successfully intubated. The baby was now sedated and stable but in need of ongoing care at RCH. We reassured the family their child would get the best of care at RCH and then the flight nurse and I prepared the baby for departure. Knowing that any interventions in the dark crowded cabin of the plane would be extremely difficult we paid close attention to securing the endotracheal tube and the intravenous line and keeping the baby warm before departing the hospital.

Once back in the plane I was pleased to see the pilot remained hale and hearty. We placed the baby on the stretcher in the plane, covered him with a space blanket and the nurse and I sat strapped in the seats facing the baby. The plane took off once again with much noise and shuddering and lurched into the dark night. As it bumped through the black clouds the baby suddenly started to move. I quickly reached for a syringe to give some more sedation into the intravenous line when I noticed blood dripping from the intravenous site onto the floor.

This to me was a catastrophe. Here I was in semidarkness in a plane being buffered by winds, with a seriously ill intubated baby who was now moving and with no working intravenous line. The nurse lent forward and removed the blood soaked dressing as I undid my seat belt, knelt beside the baby and desperately tried to find a vein to cannulate. I began to sweat although the cabin was cool. Finally on the third attempt, success! Now I just had to secure the line in place with the help of the nurse. My back was to the nurse who seemed strangely quiet and when I asked for her help, she mumbled she couldn't. Annoyed and holding on to my precious intravenous canula in the baby's arm I turned to see the nurse leaning forward and vomiting into a sick bag as well as over the floor. I began to despair, not only about my precious intravenous line but the whole situation I was in. As I held onto the intravenous cannula and waited for the nurse to stop vomiting I fantasised about parachuting out of this mess into the darkness and slowly floating downwards and downwards and onto my home and warm bed

The nurse soon recovered, the line was secured, I injected the sedation and the baby slept. I sat back exhausted beside the mute pallid nurse in the cabin reeking of vomit occasionally looking longingly out of the cabin windows for the lights of Melbourne.

Finally I saw some light in the sky and realised it would soon be morning. The distant light gradually changed from a soft pink hue to yellow and then as the plane began to descend to the airport the weather cleared. Climbing from the gloomy interior of the

plane we walked with our sleeping baby under a warm cloudless sky to the waiting ambulance and I realised I was smiling.

How I "chanced" on Melbourne
by James Wilkinson

At the age of 24 (or thereabouts) I decided that paediatric cardiology was for me. I had first had contact with the challenge of caring for patients with congenital heart defects three years earlier when, in September 1965, my application to do an elective in Rhodesia (now of course Zimbabwe), as a final year medical student, was rejected. Instead I was informed that I could do a surgical elective in Minneapolis for three months.

It was there, in the "fall" of that year, that I found myself on the surgical service of Dr C Walton Lillehei. I rapidly came to recognise that he was a formidable figure in the emerging story of the surgical management of congenital heart disease. He it was who, a decade earlier (1954), had done the first surgical repairs of VSD, Tetralogy of Fallot, AV canal defects and many more. He had initially operated on children using "cross circulation" – a technique in which an adult is connected to the patient via several arterial and venous tubes and provides the pump function and lung function to sustain the circulation of the child while the heart is open and being repaired.

Within a year he had developed a "bubble oxygenator", in conjunction with Dr Richard de Wall, which proved an effective heart lung machine and came into use in Minnesota and in many other centres around the world over the following decades. They had not followed the examples of others who had been struggling to produce an oxygenator over the previous decade and more, using a "thin film" oxygenator (as developed by Gibbon and later brought into use by Kirklin) or a rotating disc oxygenator (Melrose and others). Instead they produced a simple "bubble oxygenator", using readily available components, and succeeded in bringing their system into clinical use within a year of the first surgical procedures using cross circulation (by early 1955).

In 1968 I found myself, as a paediatric RMO, assigned to a cardiology rotation and it was during this time that my enthusiasm for studying the mysteries of congenital heart pathology and trying to understand the embryology and pathophysiology of these defects was seriously aroused. I spent many hours in the pathology department and the library and in discussions with my Spanish registrar and consultant colleagues.

The necessity to pass the MRCP (equivalent to the FRACP in Australia) took me away from the specialty for some time, as I did a stint of neonates and then spent time in other specialties before starting training in adult cardiology in 1971, having by then "fooled the MRCP examiners".

Up to that time I had assumed that my future would involve a return to paediatrics and then climbing the ladder in the UK. I maintained an ambition to eventually have a consultant position in one of the UK centres. However "chance", which had been a

regular feature of my student and postgraduate career so far, brought my first serious taste of what Australia might have to offer.

I was introduced to a theatre sister who hailed from Sydney, could beat me comfortably at squash, swam with speed and energy, could easily drink me "under the table" and was an altogether most congenial companion. She agreed to cast her lot with me and we moved to Liverpool where I was appointed to a position as Lecturer in Paediatrics in the University Department in the following year. I had been accepted for a fellowship in San Francisco, which was due to start in 1973, but had to postpone that as my Liverpool academic position did not fit well with that plan.

The following fifteen years saw us well established and settled in Liverpool, with four sons who by then were in the later stages of primary school or early secondary school. I had been a consultant there from mid 1974 (then aged thirty) – as a locum for the first year and thereafter in an established post. My appointment as a consultant prevented me from embarking on another fellowship (this time in Boston), which I had organised for 1975 / 76.

As our boys were approaching adolescence I had wondered whether there might be an opportunity for us to spend time with my wife's Australian family. With this thought I had explored the various centres in Sydney and elsewhere that I might approach with the thought of an "exchange" for perhaps a year. I knew a small number of the Australian cardiologists and surgeons in the field – Dr Richard Hawker and Dr Tim Cartmill from Sydney and Dr Alex Venables from Melbourne. These were individuals who I had met at meetings and Dr Venables had visited us in Liverpool. One of my former senior registrars was an Australian working in Adelaide. In 1984 an advertisement was brought to my attention for a position in Melbourne and I applied for it, with little expectation that it would come to anything. In point of fact, once I had done some more research on the post in question, I decided that it was *not* what I would want to do, being a joint position between the Children's Hospital and The Queen Victoria Medical Centre (prior to its move to Monash Medical Centre).

I subsequently became aware that Alex Venables' position, as head of cardiology at the Royal Children's Hospital, was likely to become vacant when he retired within a couple of years. However I heard, via the grapevine, that a prominent young Australian, then working in Canada, was the favoured candidate for the position and I largely forgot about it. I did not see the position advertised and was somewhat surprised when, early in 1987, I received a phone call from Alex Venables, who informed me that the appointment of his successor had fallen through and they were looking for other possible candidates.

In July that year, my wife and I visited Melbourne and had the opportunity to talk to the team and explore the options. My wife, a good Sydneysider, viewed Melbourne with mixed feelings, but the opportunity was too good to refuse and within a few weeks the die was cast and we started to plan our move across the world.

Our arrival in Melbourne, and the start of my life at the Royal Children's Hospital, happened in early 1988. I spent many months adjusting to Australian medicine and coming to know my colleagues in a moderately large and complex department with its

close liaison with our surgical, intensive care, anaesthetic and medical imaging colleagues. During that early period we set up the Paediatric Heart Transplant program, acquired a range of new echocardiography equipment and set the seeds for our computerized cardiology and cardiac surgical database, which continues in active use 27 years later.

Our sons went through secondary and tertiary education in Victoria, New South Wales and Queensland – one having trained as a paediatrician at RCH Melbourne.

The many achievements of the years that followed are another story and may be told on some other occasion. I reflect often on the chances that brought me to Melbourne – the happy acquisition of an amazing Australian wife who introduced me to this country, the chance meetings with such prominent individuals such as CW Lillehei, Alex Venables and others and for me, the happy chance that another much worthier candidate than I withdrew from the Melbourne position and opened the way for the Royal Children's Hospital to look to far distant Liverpool for another candidate who might fill the post.

I was never very good at planning systematically and seldom had any clear idea of where I was going in my career or where I would end up. I suspect that for many of us (perhaps for most?) the choices that decide our career path are dictated more by chance (serendipity?) than by careful premeditated planning.

A trouser tale from Brittany
by Garry Warne

I once split the seat of my trousers from top to bottom half an hour before I was due to have a crucial meeting with the CEO of a big hospital in France, but got there on time, having bought a new pair of trousers on the way, and had a big win.

RCH International was, for five years, responsible for coordinating the training of 117 surgeons, physicians, nurses, technicians and administrators to staff the Hue Cardiovascular Centre in Vietnam. We hoped that a group of them could receive their training at a university hospital in Rennes, the capital of Brittany in France, which had a very famous Chief of Cardiac Surgery. The hospital administration, however, was throwing up all sorts of Gallic obstacles and so I decided that it would be necessary for me to go there in person and persuade the CEO to be more helpful. On a visit to Saigon, I had met the eminent French cardiac surgeon, who was just about the most terrifying person I had ever met, so I was under no illusions that his boss, the CEO, would be a pushover.

Olivier, our man in France, had arranged our overnight stay near Rennes at a 17th century chateau, which boasted an extensive park laid out by Le Notre, its own 9-hole golf course and an inviting clubhouse restaurant. As our meeting at the hospital was to take place immediately after lunch, we sat outside in the sun and enjoyed a pleasant meal designed to induce relaxation in me before what was to come. As I stood up to leave, the seat of my suit trousers snagged on my chair. I heard a loud rip and I experienced my derriere

being fanned by a cool breeze, which was entering freely through a 25 cm tear. Although I was unquestionably in a predicament, I found the absurdity of the situation highly amusing and I bent over, laughing, to show Olivier and my wife the full catastrophe. What I didn't realise was that behind a one-way mirrored glass wall, an entire restaurant full of diners was watching my performance. They were unkind enough to roar with laughter and applaud from inside.

Merde alors! What to do? We had half an hour and the hospital was some kilometres away. Madame from the chateau said there was a large chain store in a nearby town, so we rushed there and within the space of a few minutes *("Je voudrais acheter un pair de trousers tout de suite!"* did the trick) I found a pair of cheap grey trousers that I could get into. The trouser legs, however, were 15 cm too long, so my ever-resourceful wife bought a pair of scissors and the cashier, having quickly become a participant in the emergency situation, produced a needle and thread from under the checkout counter and gave it to us without charging for it. My wife and I threw ourselves into the back seat of Olivier's car and as we sped towards our destination, Elaine was able to cut the trouser legs down to size and sew up the hems, which was quite a feat, considering that she had to do it while I was wearing the trousers.

The moment we walked into the hospital, we were shown in to the office of the CEO, Professor Leguerrier. I had no time to get nervous. He graciously asked what sort of a trip we'd had, giving me the perfect entrée for telling him the trouser tale. We all had a good laugh and after that, he no longer had it in him to be difficult. After a short discussion about the needs of the trainees, he immediately agreed to accept them. It was a big win, but it was an episode I was glad to put behind me.

The end

On the march
by Garry Warne

Retirement is a liberating experience in many ways. I absolutely *revel* in in feeling free to attend political demonstrations and write 'helpful' letters to politicians, with no fear of what the parents of my patients, my medical colleagues and my institutional managers might think. Life can truly begin again.

Last year, Professor Louise Newman's stirring lecture on Australia's treatment of asylum seekers and that unforgettable RCH Grand Rounds where The Hon Malcolm Fraser, The Hon Alastair Nicholson, The Hon Frank Vincent and RCH's own Dr Georgie Paxton got a 10-minute standing ovation from a packed auditorium, got me fired up. Not only me – David McCredie had a powerful letter published in *The Age*, Bob Adler and David Isaacs

wrote of their experiences at Australia's offshore detention camps and Georgie Paxton's compelling position statement was featured on the RCH website.

I joined the board of Children's Rights International in 2012. I was proud to carry the CRI banner at the 2014 and 2015 Palm Sunday marches, which focused public attention on refugees and asylum seekers. It is exhilarating to be in a crowd of 30,000 demonstrators when the cause is such an important one. Quite a few past and present RCH were marching: Lloyd and Jan Shield, Marg Rowell, Margot and John Prior, Bob Adler, and Michelle Telfer, to name several. Janice Peeler supported friends who are members of Grandmothers Against Detention. James Keipert and Kevin Collins are champion letter-writers who challenge the consciences of our politicians.

Large demonstrations inevitably attract media attention and send a message to the silent majority that there are plenty of ordinary citizens who do care. "The only thing necessary for the triumph of evil is for good men to do nothing." *Edmund Burke*.

Grey activists, Bob Adler and Garry Warne (photographs: Bob Adler).

Notices to members

Dates for your diaries:

- **June 18th 2015**. Luncheon ($18/person) at 11:30AM in the back room of Café Adamo, followed by a talk by Dr Catherine Crock at 1PM in the Vernon Collins Lecture Room on "Hush music and family centred care".
- **September 30th 2015, 12:30 PM.** Alumni-hosted RCH Grand Rounds with guest speaker, Professor Shurlee Swain, Professor of History at the Australian Catholic University.

New members. Welcome to:

- **Professor Adrian Herington**, former Director of Laboratory Biochemistry at RCH, now QUT-TRI Associate Director, Faculty of Health, School of Biomedical Sciences, Queensland University of Technology.
- **Associate Professor Elisabeth Northam**, formerly Academic and Research Coordinator, RCH Psychology Service.
- **Professor Bob Adler**, formerly Director of Psychiatry at RCH.
- **Ruth Wraith, OAM**. Head of the Dept of Child Psychotherapy at RCH from 1995-2005. Extensive experience as a counsellor in disaster situations and as an adviser to the Victorian government on disaster preparedness.
- **Dr Pat Phair**, Senior Research Officer working with Prof Charlotte Anderson and Mr Julian Keogh, retired 1995.

Alumni home page on the RCH website

We will soon have our own Alumni home page on the RCH website, where you will be able to find a number of features, including :

- A blog to keep you up to speed with what's going on and what people are talking about
- Links to Alumni newsletters
- Mini-biographies of members
- A picture gallery
- And more. Watch this spot!

The 2015 Alumni Executive

Professor Andrew Kemp (President)
Dr Kevin Collins (Vice President)
Professor Garry Warne (Hon Secretary). Email garry@warnefamily.net.
Tel 0421 699 039
Dr Peter Loughan (Treasurer)
Dr Karin Tiedemann
Professor Margot Prior