Alumni Newsletter
September 2015

Royal Children's Hospital Alumni

Table of Contents

President's letter
Andrew Kemp

As dictated by our constitution a president's term of office is limited to 2 years and as I am approaching that point it seems appropriate to reflect for a moment on the activities of the Alumni over that time. I will summarise this under the headings of communication, Children's Hospital and camaraderie.

Communication
When the executive commenced their term of office it was obvious that an essential step was to adopt modern forms of communication utilising the advantages provided by Email. This involved development and updating of the data base. This was readily accepted by about 95% of our membership and has greatly facilitated the capacity of the executive to communicate with you the members. I must particularly acknowledge the skills of our secretary Garry Warne whose computer skills have been invaluable. The data base has enabled us to email the newsletter to the alumni. In addition with the help of the RCH medical staff association our news letter has been sent to all members of the MSA. On occasions the MSA members have received the news letter prior to our own members! Electronic communication has also played a role in the collection of subscriptions with many members utilising a direct debit option with our bank. Thanks to your treasurer Peter Loughnan for arranging this.

Following on from the previous executive there have been four formal lunch time meetings a year with lunch and a speaker on a wide variety of topics. A significant period of time has been allocated for interaction prior to lunch.

An important step facilitating communication has been the development of the newsletter which now extends over a number of pages of news and comment from our members. In order to produce the newsletter I would emphasise the importance of contributions from the wider membership.
An exciting new development is the the alumni web page and its content of mini biographies of our members. Garry Warne has been instrumental in this initiative and it is with great interest that we follow its progress .

Childrens' Hospital
It is important to remember that a principal reason for the existence of the alumni is to provide ongoing dialogue between our members and the Hospital. In fact a major criteria for membership is having been a member of the RCH staff at some stage during ones professional career. The presidents of the Alumni and RCH MSA have been reciprocal guests at hospital and Alumni activities. The support given by Christine Kilpatrick and Peter McDougall to the activities of the Alumni is greatly appreciated.

Camaraderie
Camaraderie may be defined as "mutual trust and friendship among people who spend a lot of time together". I believe that camaraderie is one of the principal benefits that arise from membership of the alumni. Many members are at a stage in their lives where they have the time and inclination to interact with other members. Many have acquaintances established during their working careers. The alumni provide an opportunity for continuation of such interactions once one has retired from professional activities. A new initiative partially fulfilling these needs is the alumni dinner. This will be held at the Kew golf club. I would encourage the alumni to attend. An attractive venue, excellent victuals and an engaging speaker all promise a memorable event.

What's new?
Garry Warne, Honorary Secretary

We have launched the Alumni home page on the RCH Website!!

On it, you can find information about

- who we are
- news items
- upcoming events
- personal profiles of individual members
- how to download Alumni newsletters and read them on-line

There's even a photo gallery!

Here's a guide on how to open the various sections of the home page.

The Alumni website is a non-departmental website within the larger Royal Children's Hospital website. To view the Alumni website please follow these steps:

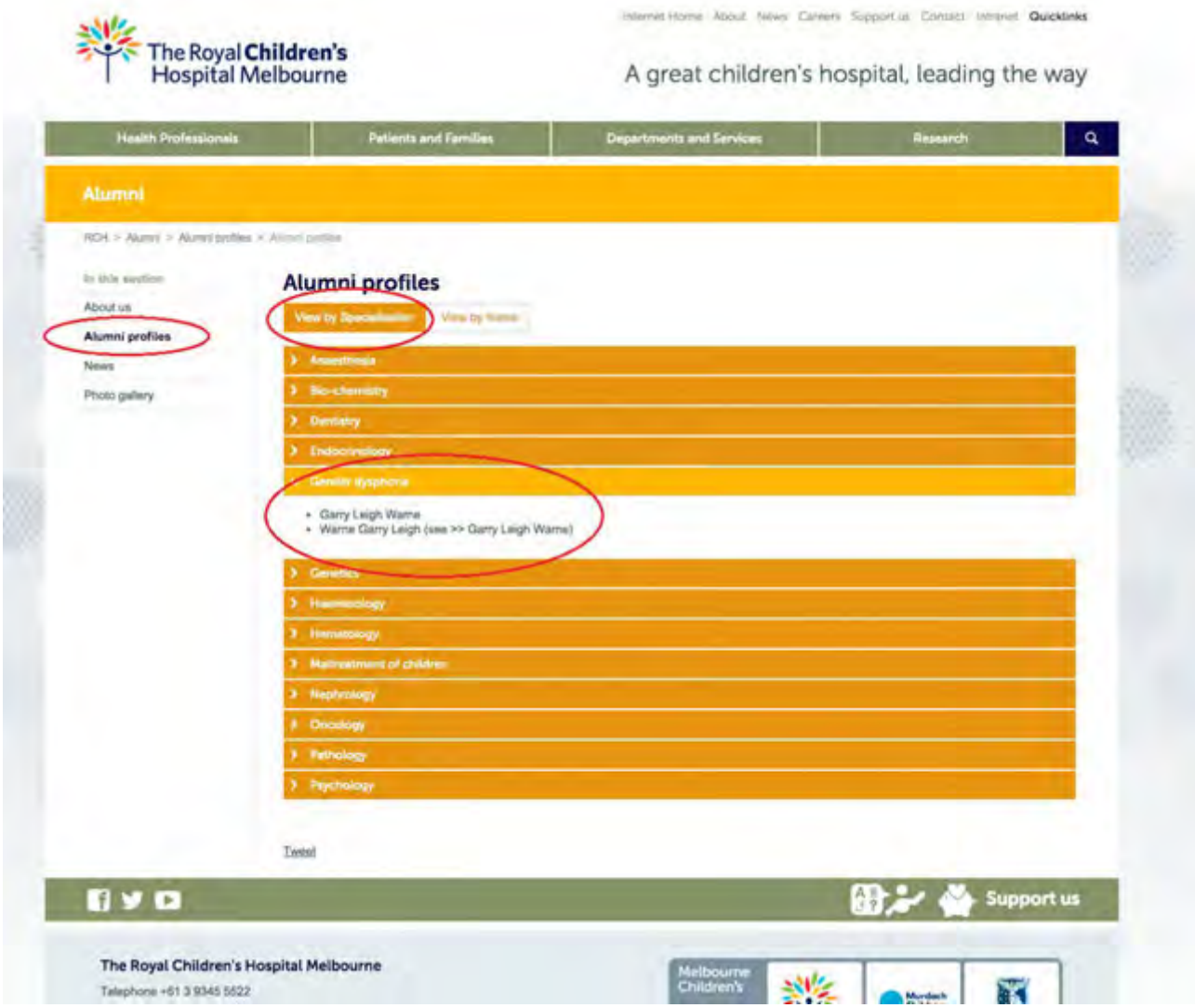
1. Open your internet browser on your computer and type http://www.rch.org.au/alumni into the address bar at the top

2. You will be taken to the 'About us' page of the Alumni website, as denoted by the page heading circled in red in the image below. This is the home page.

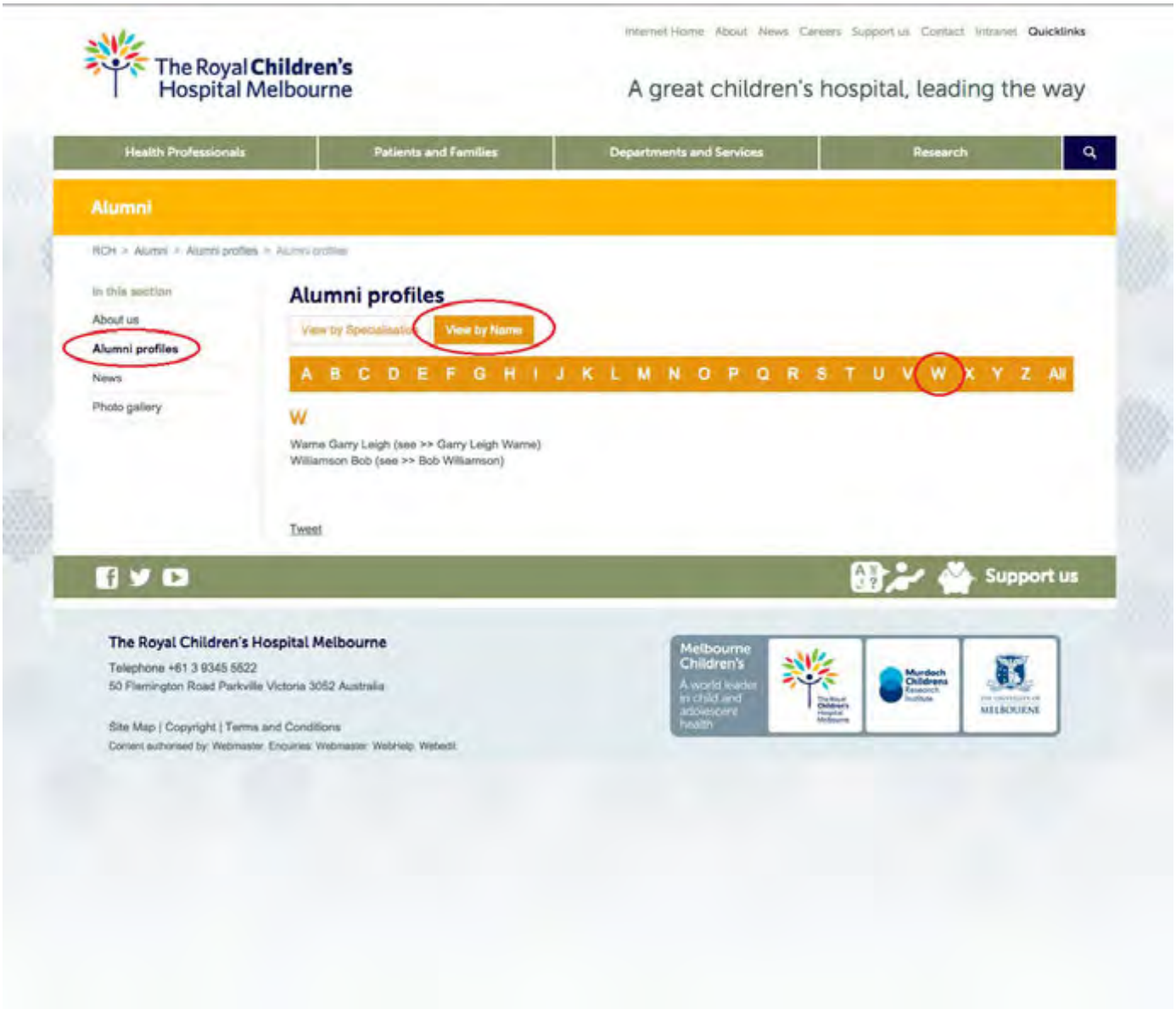
   It shows a blurb of information about the group, and underneath that a scrolling news feed. This feed shows a summary of the latest news and events concerning the Alumni. To read the story behind the summary, of any of the scrolling items, simply click the title of the news item such as the heading 'Upcoming event November 24th' circled in red in the image below. The news feed will scroll automatically but if you would like to control it, click one of the arrows on either the left or right of the feed (circled in red). If you click a news item and want to get back to the 'About us' page, just click the words 'About us' in the list on the left-hand side of the screen.

   In this left-hand side list which appears under the heading 'In this section', there are 4 items called 'About us', 'Alumni profiles', 'News' and 'Photo gallery'. This is the navigation for the Alumni website. Click any of these items to be taken to that area of the website. This list will be available no matter what page you are on, so getting to a different area of the site is really easy. You can see in the image below that 'About us' is in bold navy blue text. This tells us that we are on the 'About us' page. Depending on where you are in the website the corresponding item in this list will appear in bold navy blue text. See image below.

3. Click the next item down the list on the left-hand side called ‘Alumni profiles’. This will take you to the Alumni profile page. You can see in the image below that there is a list of specialisations. If you click one of them, such as ‘Gender dysphoria’, you will be shown a list of Alumni who worked within that specialisation. An Alumni may appear under more than one specialisation, so have a look through them all.

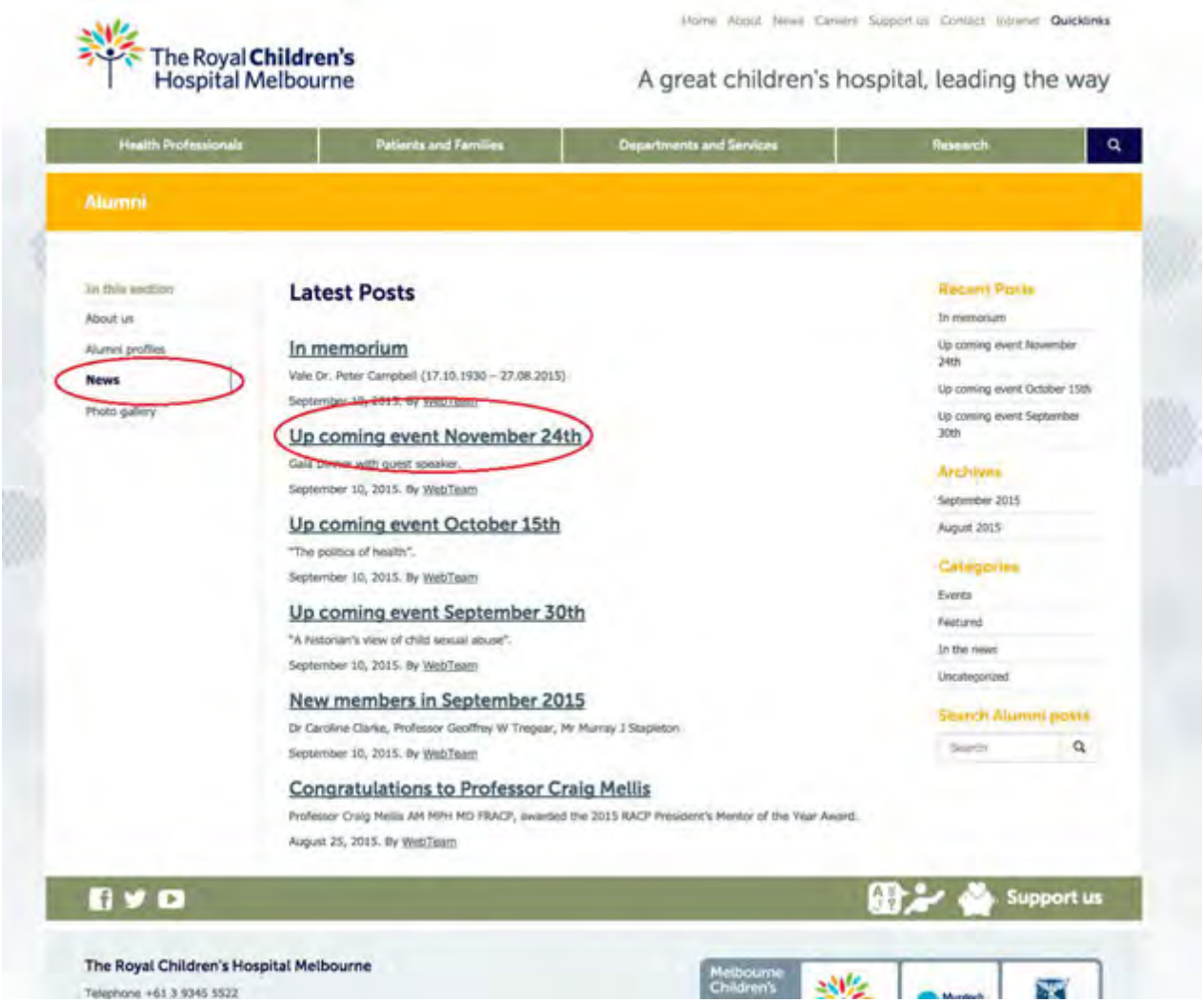


4. Next to the button circled in red above that reads 'View by specialisation' you will see another button that says 'View by name'. If you click this you will be presented with an alphabetical list. You can click any given letter to find Alumni, either by first name or surname. See the image below for an example.



The 'Alumni profile' area of the website is a fantastic historical resource as well as a space to tell the world a bit about what you've been up to since retirement. If you'd like to contribute your profile, please contact Garry Warne.

5. Moving down the list of the left-hand side of the screen, the third item is called 'News'. If we click this we will be taken to a list of items of interest for the Alumni. See the image below.



6. From this list, you can read any of the items by clicking on the heading (as circled in red above). This will take you to the item page.

   On this page you can read the story and even leave a comment if you'd like. Just type your comment in the large box and press the yellow 'Submit comment' button.

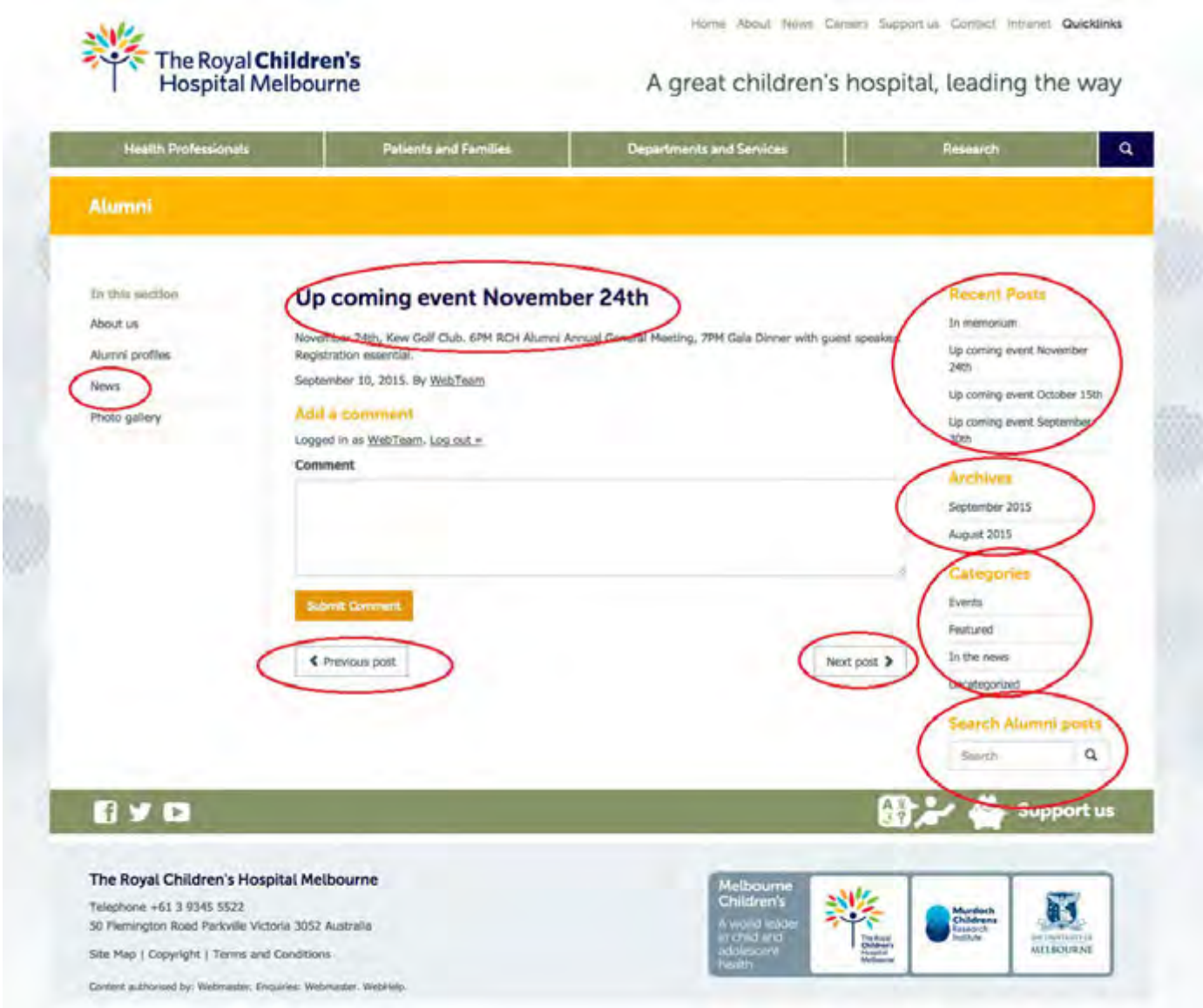
   At the bottom of the page (circled in red) you will see a 'Previous post' and a 'New post' button. These buttons will navigation you through all the other stories in the 'News' section of the Alumni website.

   If you click on the items listed under 'Categories' (circled in red) on the right-hand side of the screen, you can see posts that have been categorised under certain sub-groups such as 'Events' and 'In the news'. If you have an item of interest to include in the 'News' section, please contact Garry Warne.

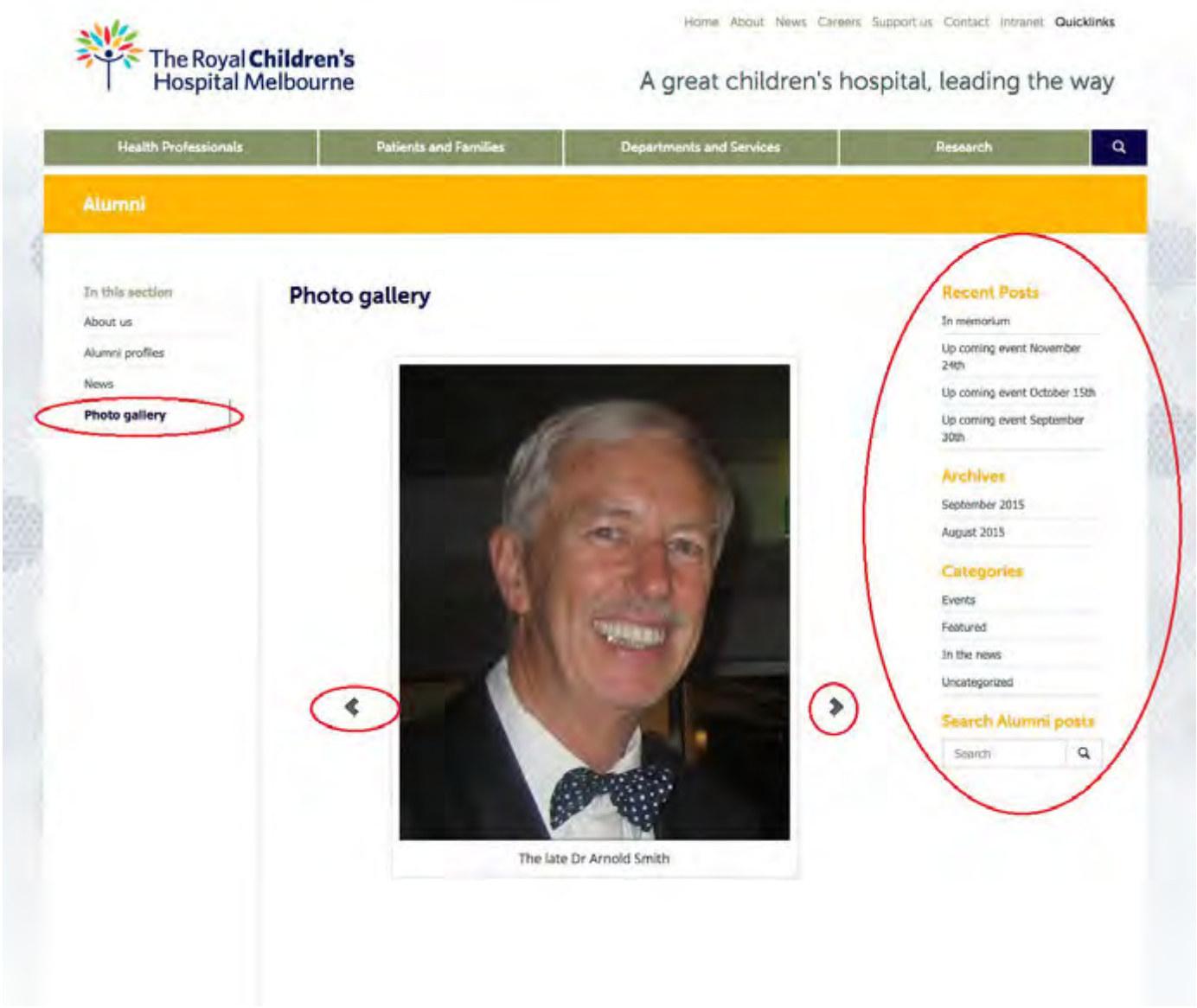
You can also click any of the headings of other news items to the right of the screen, under the heading ‘Recent Posts’ to be taken to that recent item.

To see what has been posted in any given month, click on the month listed under ‘Archives’.
And finally, right down the bottom you can enter text into the ‘Search Alumni posts’ box to search for something specific. Just type your words into the little box then click the magnifying glass image.

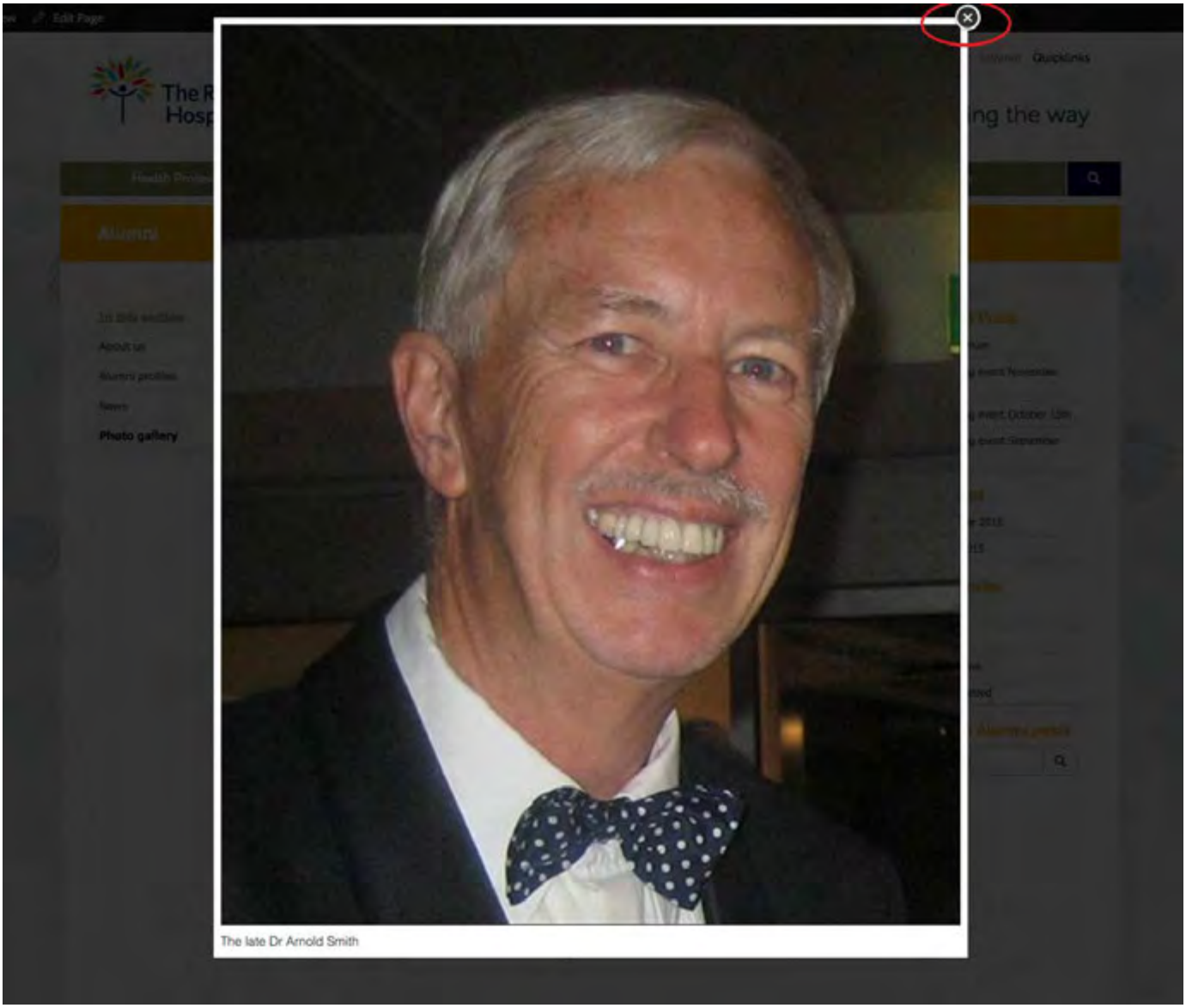
To see the full list of news items again, click the item ‘News’ in the list on the left-hand side of the screen.



7. The final area of the Alumni website is the 'Photo gallery'. Click the last item in list on the left-hand side of the screen to navigate to it. This contains photos of the Alumni and is a work in progress so please send your images to Garry Warne to have them included. The images will scroll automatically but you can also control them by clicking either of the arrows on the left and right of the image (see the image below). While in the gallery, you still have access to the 'Recent posts', 'Archives', 'Categories' and 'Search Alumni posts' items on the right-hand side.



8. If you'd like to see any given image in the gallery closer up, double click the image and it will increase in size and pause the rotation of images. Click the cross in the top-right corner to close the enlarged and to resume the photo slide show (see image below).



New members

- **Dr Caroline Clarke** DM FRACP FRACMA, former sessional endocrinologist and Executive Director of Medical Services
- **Dr Tony Catto-Smith** MD FRACP MRCP, former Director of Gastroenterology
- **Dr Tony Cull** MB ChB (Otago) MRCP (Paed). Former Chief Executive Officer of RCH.
- **Mrs Marg Loughnan**, RN, ADWS, SW, Social Worker
- **Ms Bronwyn Parry-Fielder** B App Sci (speech path), M Ed St, Grad Dip Health Services management, Speech Pathologist
- **Dr Anne Rickards** BA Hons MA Hons PhD MAPS, Clinical Psychologist
- **Mr Murray J Stapleton** MBBS FRACS, Plastic Surgeon
- **Dr Suzanna Taryan** MB ChB (NZ) FRANZCP, Cert Child Psychiatry, Consultant Child Psychiatrist
- **Prof Geoffrey W Tregear** AM BSc PhD Hon DSc FRACI FAA**, (pictured right)** distinguished research scientist and member of numerous committees and boards advising research to the RCH and MCRI for nearly 30 years
- **Professor Graham Vimpani** MBBS (Adel) PhD (Edin) FRACP FAFPHM
- **Professor Annette Webb** MBBS FRACP MD Dip Clin Hypn. Gastroenterologist
- **Ms Gigi Williams** B AppSci FRPS FBCA FAIMBI, Department Head of the Educational Resources Centre

In memoriam

Dr Peter Ellis Campbell
17 October 1930 -27 August 2015

Dates for your diaries:

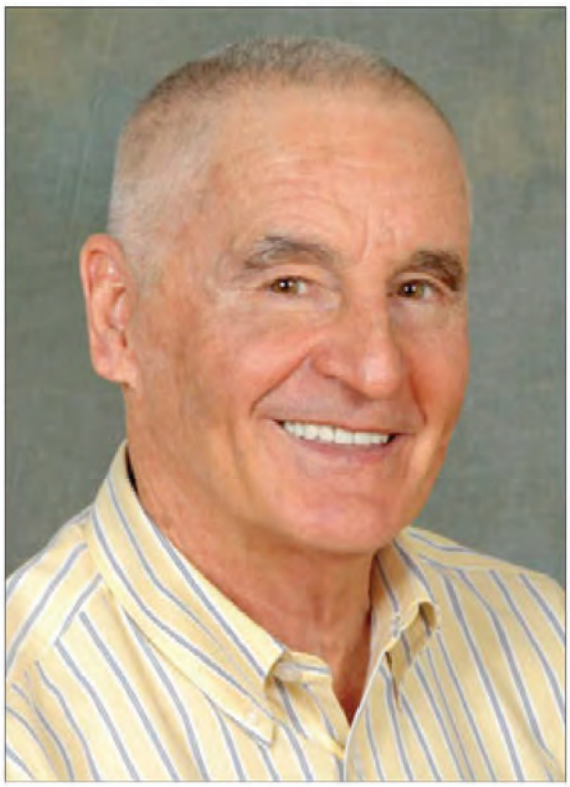
Sept 30th, 12:30PM (lunch for Alumni and guests at 11:30AM). Alumni-sponsored RCH Grand Round. Speaker: Professor Shurlee Swain, Professor of Humanities at ACU. "A historian's view of child sexual abuse"

October 15th. 5:45 PM. The 2015 Vernon Collins Oration.

November 24th, Kew Golf Club
6PM Alumni Annual General Meeting
7PM Gala dinner with guest speaker

“The role of a mentor - and how to be an effective one”

Professor Craig Mellis AM MPH MD FRACP
Professor of Medicine and Acting head,
The University of Sydney



To my great surprise and wonderment I have been awarded the ‘RACP 2015 mentor of the year’! Since receiving this, I’ve reflected on, and researched the topic of mentorship. Despite being a mentor to many over more years than I care to mention, I now realize how little know about the topic. Nevertheless, I will give you my brief version of the role of a mentor, and how to be more effective.

I see mentoring as both a coaching and educational role. My mentoring style is best described as informal, ‘as needed’, casual, mostly un-planned, and sometimes un-noticed (at least by me!). Indeed, many paediatric trainees (now senior paediatricians) tell me that I mentored them. This often comes as a surprise –but a very satisfying one. In many cases I saw my role simply as someone who was able to pass on practical advice on how to pass written &/or clinical assessments (especially to RACP trainees); how to get started with clinical research; or advice on career options in paediatrics. At the other extreme of the style spectrum is the highly formal - with regular scheduled meetings, specific agenda and milestones – the method you need to revert to when supervising phD students.

I suspect the reason I am sought by mentees is that I have been fortunate enough to have multiple careers. Consequently, I can offer advice in many disciplines – paediatrics, respiratory medicine, research methods, biostatistics, evidence based medicine, and medical education. As a result, I have acquired broad expertise (read that as.. “un-focused!”), and an extensive network of colleagues in a number of disciplines.

My first real experience of being a ‘mentee’ was in the mid 1970s, when I arrived at RCH as the fellow in respiratory medicine. My three mentors were all legends - Peter Phelan, Howard Williams, and Lou Landau. Peter taught me how to be an efficient manager / administrator, and networker; Howard perfected my ‘work-life balance’ (he & I would quietly sneak out of RCH early most Friday afternoons for 9 holes of golf!); while Lou instructed me on how to do research & how to write scientifically. For that, I remain heavily indebted to all three throughout my career.

An obvious question is ‘how effective is mentoring? While there are no randomised trials to guide us, a systematic review of observational studies did conclude the following: Physicians in academic medicine with mentors publish more papers, and have more grant success than their non-mentored colleagues. Being mentored is also believed to have an important influence on personal development, career

guidance, and career choice. And interestingly, women perceive more difficulty finding mentors than their male colleagues [ref#1].

'What are the desirable attributes of a mentor?' While there are numerous lists of characteristics in the literature – I believe the three key attributes are generosity (with time and sharing skills, knowledge, and 'tricks of the trade'), and enthusiasm (for teaching / training, and for the mentee's success). And you also need to be readily accessible.

Finally, 'how should mentors choose mentees, and vice versa?' Qualitative research suggests that mentoring works best when mentor and mentee have similar 'chemistry'[ref#2]. Presumably, that means plenty of common ground - such as values, interests, 'gripes', and politics (and supports same AFL team?). If true, this would imply that mentors should not be assigned, but rather, they should be self-identified. However, the quality of current published evidence does not allow strong recommendations to guide mentors in doing a better job, nor to assist mentees in choosing an ideal mentor [ref#1].

For those interested in finding out more about mentoring I strongly recommend the short book [ref#2] by Sharon Strauss & the late Dave Sackett - of Evidence Based Medicine fame. I have borrowed heavily from this brilliant book, which is a summary of the world literature, much of it their own research. It is an easy read, and there are some wonderful practical suggestions - for example teaching your mentee "how to say no …nicely" and "protecting your mentees from sharks." All young academics should at least read those two sections!

Further reading:

1. Sambunjak D, Straus S, Marušic´ A. "Mentoring in Academic Medicine: A Systematic Review."JAMA (2006) 296: 1103-1115
2. Straus,S and Sackett,D. "Mentorship in Academic Medicine" Publisher: Wiley. Ed 1: 2013 (172 pages).

Alumni: if you would like to comment on this article, write to Craig Mellis at craig.mellis@sydney.edu.au

Why I won the Wearing Award in 1971
By Peter Loughnan

I received the award because I attended court (reluctantly) on my afternoon off to give evidence at an inquest. While waiting outside the court a smooth looking well dressed gentleman came up to me and said, “Are you from the Royal Children's Hospital. Can I have a look at that patient record?”

I assumed he was a smart shifty lawyer.

So I stood up, looked him in the eye, and said: "And who in the #*$$#-!ing hell are you?"

He replied: "I'm Mr Reginald Hooper, Chief of Neurosurgery”.

David Hill and Peter Loughnan, Wearing Laureate 1971

Eponymous, not Anonymous
Andrew Kemp

What do Ian Hopkins, Peter Campbell, Craig Mellis, Howard Williams and Winita Hardikar have in common? Yes, at some stage in their career they have been employed at the Royal Children's Hospital Melbourne. More noteworthy, however, is that they all have their names attached to a medical syndrome. Let's have a look at these entities in chronological order. In 1960, Howard Williams and Peter Campbell described a form of severe bronchiectasis that was due to lack of bronchial wall cartilage. The condition, which is rare, became known as the Williams-Campbell syndrome.

In 1974, neurologist Ian Hopkins described a new syndrome of a poliomyelitis-like illness associated with acute asthma and published a report in the Australian Paediatric Journal. Since then, there has been a steady stream of further reports of Hopkins syndrome.

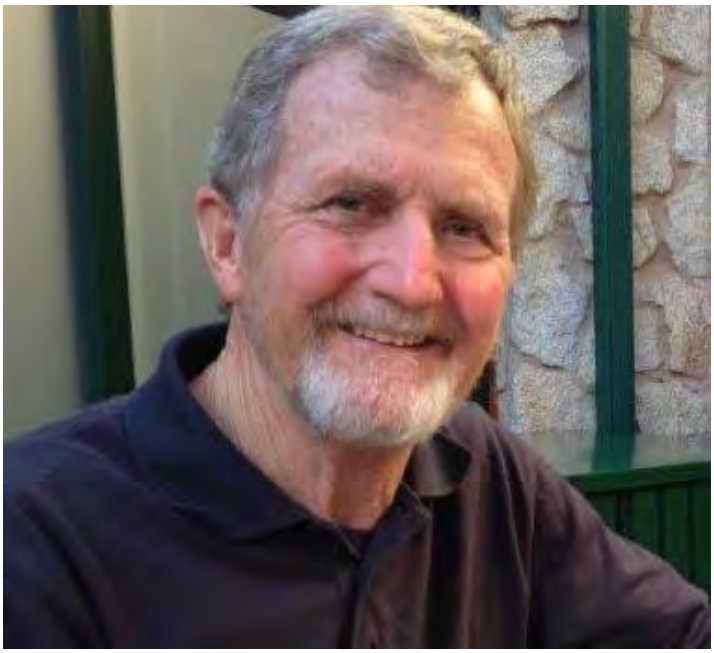
In 1976, Craig Mellis and Pat Bale from the Royal Alexandra Hospital reported familial hepatic veno-occlusive disease associated with immune deficiency in five infants from three families. The defect underlying this disorder was identified in 2006 as a mutation in the SP110 gene.

In 1992, Winita Hardikar of the Department of Gastroenterology described a disorder characterised by cleft lip/palate, liver and biliary tract disease, intestinal malrotation, obstructive uropathy, and retinopathy. This unusual constellation of features is recognised as the Hardikar syndrome.

The most widely referenced Australian eponymous entity has been that described in 1963 by Douglas Reye, a pathologist at the Royal Alexandra Hospital in Sydney. Clinical features included encephalopathy, liver damage, a skin rash and hypoglycaemia. The disease, generally referred to as Reye or Reye's syndrome has been considered to be exacerbated by aspirin. In 2015 PubMed shows 1303 references to this condition.

Should we use eponyms in medicine ? Some say eponyms add confusion. Thus some diseases have multiple names, some names refer to multiple diseases and some diseases have different names in different countries! Eponyms represent a shorthand code for something more complex and in some cases provide a more succinct way of referring to a disease entity. In addition they may reveal facts concerning a disease that would otherwise not be appreciated. Thus in the absence of eponyms we would be less likely to appreciate the contributions of our colleagues as detailed above.

This Kenyan Life
Geoff Mullins



It was my second day in Africa. I sat at an old wooden desk with an interpreter by my side in a very large room in a hospital full of the noise, heat, dust and smells of Nairobi. I was one of six doctors there to select perhaps forty babies and children to undergo operations within the next 2 weeks to correct their severe facial deformities There were at least one hundred adults, almost all women, crowded into this room. Clinging to their side or in their arms was a baby or child with a large ugly gap in their upper lip and nostril disfiguring their otherwise beautiful brown, smooth and sometimes tearful faces.

They all suffered from the same birth deformity - a cleft lip and palate deformity - a large gap in the upper lip which extends into and distorts the nose and nostril and commonly involves the palate making feeding very difficult and normal sounding speech impossible. In Australia these children would have this deformity repaired early in the first year of life and thus avoid the feeding difficulties, the suffering and of the baby and as they got older the taunts directed at those whose appearance and speech are different. But not so in the third world where money and often the expertise is lacking.

The wide open windows failed to cool the oppressive heat and the noise of the outside traffic added to the cacophony of loud excited voices, anxious whispered conversations and crying of children all in a language foreign to my ears.

Looking up from my desk I faced before me a sea of anxious faced women in vividly coloured dresses and headscarves. They were crowded together either sitting on benches or standing in the narrow aisles between the benches all with a child in their arms or clinging to their side. These people were Bantu people and their language Kikuyu. They talked loudly and excitedly to each other with occasional and anxious glances towards me and the other doctors who had the power to decide if their child would have the operation that would finally remove this blight on their lives.

It was difficult communicating with these people through an interpreter. It was hard to hear or be heard and these women appeared shy and sometimes even fearful when I asked questions of their child. They watched my face intently as I examined their children as if searching for clues to my decision.
It was important for me to only select healthy children, as the risks of operation in this hospital were too high in children with untreated or hidden diseases. The noise and the heat added to my anxiety about my responsibility in deciding the fate of these children and their families.

I was sweating, tired and increasingly irritable in this hot crowded chaotic room as I worked through a seemingly endless line of anxious women clutching their children desperate to be accepted.
Suddenly there was a hush in the room. I looked up from my writing as the interpreter beside me whispered “Maasai”. My eyes scanned the room and stopped at the open single doorway to the room.

There was a man standing there, tall and motionless. He was a young slim dark faced man of medium height. He wore a grey threadbare suit with the jacket carefully buttoned up at the front and a dirty white shirt with a tattered collar open at the neck. His face betrayed no emotion and his gaze fixed straight ahead. Despite the shabby clothing his whole demeanor radiated a calm almost regal dignity that seemed to demand attention and respect. I stopped writing and with many others in the room was staring silently at this man. Looking at his dignified expressionless face I finally came to focus on the gaping deformity in his upper lip and knew why he had come.

Distracted from my work I reflected on the stories I had read of the Maasai - their warrior culture, their initiation ceremonies, their lion hunting, their aloofness to physical pain, their unearthly cries in prolonged mourning for the loss of a family member and above all their resistance to “civilization”
Looking at his face I thought of the life time of suffering he must have endured and the courage and determination he would have needed to come alone to Nairobi to seek an operation and enter this room overflowing with Bantu women and children.

Returning to the anxieties of my work I felt strangely envious of the quiet dignity, grace and courage of this shabbily dressed “uncivilized” Maasai man and humbled by his presence. I saw there was going to be much for me to learn in Africa.

My time at the Educational Resource Centre and the developments from 1982 to 2015
Gigi Williams, Department Head, Educational Resource Centre (ERC)

Garry Warne has asked me to write about my time at ERC and some of the developments I have overseen as I will be leaving RCH at the end of October and joining the hallowed ranks of the RCH Alumni. This is my 33rd year being at the hospital and my 26th as the Department Head. In that time I have seen so many changes, had the privilege of working with the "best of the best" and thoroughly enjoyed contributing to the Hospital as a whole and the industry in which I work.

Early Days

I started at the hospital when the department was still the photography department on the 4th Floor but just a few weeks later we moved to the brand new 'ERC' – the Educational Resource Centre on the ground floor. ERC grew out of the medical photography department which dates back to the 1930s.

In 1982 Lynda Stephens was the Department Head. Together with Tony Skoroplas, the Chief Medical Photographer, they appointed me as one of three medical photographers. The appointment of Lynda was probably the most marked change for the department. She had managed to convince Barry Catchlove, the then CEO to find funds from the Good Friday Appeal for the new rebuild. The concept was that it should be a department servicing community medicine across the state. She employed one graphic designer and one video producer taking the total number of staff to eight. The department was organised so that it had three distinct sections – photography, graphic design and video, providing the basis for the Department as we now know it. It was opened by the Honourable Tom Roper, the then Minister of Health.

In 1985 I was appointed as Chief Medical Photographer. We were still producing diazo slides - the white on blue slides that were so popular - but then we discovered a leading edge process that meant the change from diazo slides to colour-on-colour, a process we thought was the 'bees knees'. We thought being able to give our doctors yellow on red slides or yellow on blue was just the 'best thing since sliced bread'.

The digital age

Then along came computers. Moving into the digital age was certainly one of the highlights of my time at RCH. In 1986 we won a developmental grant from the hospital to set up a routine computer graphics service. Up until then there were no computers, no email or internet and the cameras all used film and lasted 30 years! We had a dark room and chemicals to worry about.

Scholarships and awards
Another highlight and certainly a life-changing event for me was being awarded a travelling scholarship in 1987 that allowed me to benchmark our services in Europe and North America and this provided the foundation for ERC to become the world-class service it is today. Many years later I was delighted to receive a chairman's medal, something I will always cherish.

Research
In the research area, in 1988 we investigated photogrammetry, moiré interferometry and light sectioning working very closely with the physiotherapists and their burns patients and later investigated ultraviolet and infrared photography. Shortly after I was appointed Head of the Department. We wrote in refereed journals, won international awards for our work, appeared in the popular press, and in the process also got to meet some of the giants in our field both in the US and the UK.

Funding
As we entered the 1990s ERC was faced with a number of major challenges. The growth in use of visual communication within medicine was combined with the cutbacks occurring in health care budgets. This has led to developing an extensive range of services and adopting a business approach to their delivery. Competitive neutrality and corporatisation of our activities had become important. In 1996 ERC merged with the Royal Women's Hospital and provided all its services to over 380 departments and 2700 staff at Women's & Children's Health for ten years as well as to over 500 external clients. In 2006 the Network was dissolved and we returned to RCH as our main employer. Today we generate over half our budget from external funds using a partial cost recovery model that enables RCH clinicians to obtain a more diverse range of services.

3D imaging centre
Today we have our very own 3D imaging area within the photography area that is providing 3D imaging as core business, at the leading edge of clinical research and practice.

This was established in 2004 funded from external sources in collaboration with the Department of Plastic and Maxillofacial Surgery. The service provides a 3D image of the patient from which accurate measurements can be taken and is used in the treatment of patients who are undergoing plastic surgery and orthotic treatment (in particular helmet therapy) to assist with pre-operative diagnosis, planning treatments and post-operative outcomes.

A few years later, after successfully obtaining philanthropic funding for an additional 3D medical photographer we published a paper in the Journal of Visual Communication in Medicine that was awarded Best Paper and a Premier's Excellence Award. Today a quarter of all ERC patients are photographed using the 3dMD system.

Digital medical photography
In 2008 we secured philanthropic funds for a fully integrated digital medical photography system that was successfully implemented in 2009. This was a huge change and highlight. It took 8 years to get the system approved but it changed medical photography significantly. It meant we no longer had film cameras or their associated costs of developing and printing, nor the volunteer labour that we used to stick the photos into the case history. Instead we had digital cameras and the patient photos were uploaded and available to the clinician within a day or two, sometimes within hours instead of the weeks and sometimes months that it took previously. Again this set RCH at the leading edge and enabled us to manage a 79% increase in numbers of patients from 2008 – 2012.

Recording the great events
Of course being privileged to record the Hospital's momentous events has also been a highlight. From the Queen opening the hospital in 1963 to the Queen opening the new hospital in 2011, to the Princess of Wales, and Prince Ranier of Monaco to the Pope; from Celine Dion and Michael Jackson to Mickey Mouse and Humphrey B Bear, Shane Warne to David Beckham we've been there. From the Foo twins, Priestley twins and then Trishna and Krishna who followed, to the discovery of rotavirus and the ectopic heart we've been proud to be part of the team.

Graphic Design
In the graphic design area the digital age brought efficiency and a whole new world of possibilities for design. From posters to medical illustrations and annual reports we were able to do more, quicker and more beautifully. Interior Design was also a service we provided for a number years and many of the areas of the hospital were transformed. Our external work enabled us to generate revenue to be able to appoint more graphic designers and now we have four permanent graphic designers and a pool of freelancers to draw on when the workload needs them.

Video
In the video area our highlights have been the influence of, once again the digital age in bringing editing and recording into a much more user-friendly mode, but also the development of RCHTV in particular, 'Going Nuts with Macadamia'. This was a one-hour interactive show for the patients of the Royal Children's Hospital and was produced by ERC in collaboration with the Educational Play Therapy Department. It was a live to air broadcast that was taped once a week, every week and replayed twice a day. Macadamia started as a voluntary show until a sponsor was found. The staff of Safeway really got behind this show and together with Educational Play Therapy and the Good Friday Appeal, we have nurtured our relationship with them.

For the last 18 years the staff of Safeway has raised a massive $11.8 million dollars for the Hospital as a whole, a small percentage of which goes to fund the RCHTV shows. Today there are two new shows on RCH TV – 'Be Positive' which replaced Going Nuts with Macadamia, and 'Lingo'.

'Be Positive' is hosted by a play therapist and two loveable puppets, Jazz and Rocco, and together they help children know and understand more about hospital. Lingo is like playing Bingo but uses pictures of all the things found in a hospital to familiarise the patients with medical equipment and the patients even win prizes.

Web
In the early days of course there was no web and so a real highlight was establishing one! Again this took years but in 2000 the generous support of Tattersall's funded our webmaster and the work of the RCH web team for five years.

In 2010 we redeveloped the RCH intranet, applied a completely new look and feel to the internet in 2011 in time for our move to the new hospital, and implemented a new content management system in 2012 that involved 12 months of intensive work migrating thousands of pages of content from one system to another.

It now has over 8000 pages and, according to Hitwise/Experian, (the industry measurement body) it is the most popular Australian hospital website and second internationally only to the Mayo Clinic. We have three web developers and 400 CMS trained content contributors with the most popular sites being the Clinical Practice Guidelines (CPGs) and the Kids Health Info (KHI) sites. App development is the next

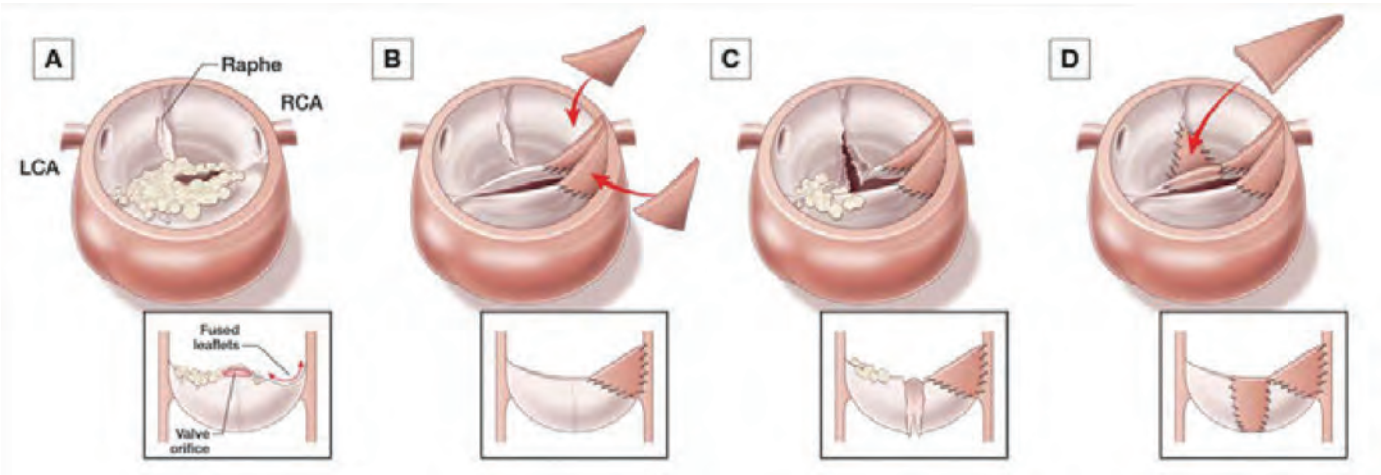
exciting thing to be working on and the web team have developed companion apps for the KHI and the CPGs.

New Hospital
Moving to the new hospital in 2011 with new equipment and leading-edge facilities was another highlight. Recording the actual day of the move was wonderful to be part of with photographs and video footage that were exclusively taken by ERC, being securely released to the media on the hour via the web team. The new environment and logo has also afforded us many opportunities for developing the brand guidelines and designing, photographing and videoing in a beautiful new environment full of natural light and interest and this has really made a difference to the quality of our work.

Staff
I am proud of the department and its staff – past and present - who have also been passionate about excellence and service. Over the years many of them have also been privileged to travel the world to benchmark their areas of expertise and this has led to improved services, staff exchanges, international conferences, research, and writing and giving papers just as any medical or allied health professionals would do.

Together we have made this department a world leader as evidenced by the national and international awards we have received over the last twenty years and which we continue to receive to this day. Over 30 of our staff have won over 150 awards – 115 international and 41 national from our professional bodies such as the Institute of Medical Illustrators (UK), The Biological Communication Association (USA), the Health Sciences Communication Association (USA), the Australian Institute of Medical and Biological Illustration, Hitwise (Experian) and the Victorian Government.

Our hybrid funding model allows us to employ over 20 staff working in four sections and the convergence of those sections can be seen in annual reports, in web sites and more recently in the development of apps such as Okee in Medical Imaging which was developed for the Medical Imaging Department by the Play Therapy Department, ERC and gaming agency Conduct and has just won a Victorian i-award.
We are nationally and internationally recognised.



Our clients

I have had the privilege of working with so many distinguished people over many years and like my staff, it seems dangerous to single any out. From Elizabeth Turner who gave the first penicillin to a child in Australia, to Howard Williams who was one of RCH's greats, to all of you in the alumni, it has been a real honour to make a small contribution to support you to illustrate the significant improvements you have all made to medicine and make RCH a truly great hospital. Even when people retired ERC was privileged to still receive visits from many. It's been a marvellous place to work because we see such a broad range of people from all over the hospital and I feel lucky to have worked here with such talented people, for so long.

From RCH to Aceh, Indonesia – the Indian Ocean tsunami: mental health challenges and outcomes

Ruth Wraith OAM
Head Department Child Psychotherapy 1994-2005

Writing this reflection presents a conundrum – how to tease out and describe my role of Mental Health Technical Advisor in a complex, multilayered, dynamic and endlessly challenging and rewarding set of circumstances over the four years of the Aceh Health Services Reconstruction Project.

First a brief summary of the facts of the disaster. The earthquake that precipitated the tsunami of December 2004 was of 9.1 magnitude, centred 30 km below the floor of the Indian Ocean 150 km off the north west coast of Sumatra, Indonesia and with a rupture that lasted for ten minutes. It caused damage to buildings in Banda Aceh and in some areas along the coast subsidence resulted in land, villages and infrastructure to permanently sink below sea level.

The tsunami, caused by the earthquake, swept in along the West Aceh coast 25 minutes later in a raging torrent of immense force at an estimated speed of a jetliner. It swamped an area equivalent to the distance between Melbourne and Sydney by road. Together, the earthquake and the tsunami killed an estimated 170,000 people in Aceh Province with countless thousands more physically injured. Over half a million surviving people were made homeless, with their entire villages and towns destroyed and without the means to earn a living. Many families were wiped out, for other families one or two members survived, children were orphaned, and more women than men died. The tsunami salt water inundated poorly drained low lying agricultural land and destroyed major and minor roads linking cities, towns and villages.

Essential infrastructure of power, water, medical services, food supplies and schools for example were severely damaged and unable to function. A huge barge permanently anchored off-shore to generate electricity was swept 3 km inland and community health centres were inundated with the water scouring all before it - patients, staff, equipment and records.

The social and political context in which this disaster occurred was fraught with complexity. For three decades the Province of Aceh had been absorbed in intense conflict between the local Free Aceh Movement and the Indonesian Government about independence. It was reported that these decades were marked by wide spread torture, brutality, starvation, abduction and murder resulting in a death toll estimated to be between 15,000 and 30,000. Limited health, education and other services were available. By mutual agreement this period came to a tentative close in the days immediately following the tsunami and was formalised in August 2005 when the parties signed a Memorandum of understanding in Helsinki. With varying nuances, the agreement holds today.

For the Acehnese people the physical, social and mental health residues from the Conflict followed by the earthquake and tsunami were profound to say the least.

The world wide humanitarian response to Aceh and the other impacted countries in the region enabled water, shelter, food, and some essential medical and social services to be supplied as soon as was practically possible. Unfortunately, the mode of delivery as described to me by some Acehnese was experienced as a 'second tsunami' – meaning the aid was imposed, not culturally sensitive or relevant and undermining rather than supporting the remaining local systems and people. A practical example of a mismatch were the generous donations of new state-of–the-art humidicribs to a hospital without a reliable power supply, instructions written in the language of the country of the donor, no accompanying

demonstration of how to use or repair the machine and no spare parts. What was needed in this hospital were surgical gloves, disinfectant and other basic infection control measures.

It was in this context that Dr Yati Soenarto of the University of Gadja Mada (UGM) Medical Faculty, Yogyakarta, Java, contacted her long standing colleague at The Royal Children's Hospital Melbourne, Prof Graeme Barnes, seeking assistance from RCH to meet requests of them from the Indonesian Government to assist with specific areas of the medical recovery. The development and management of the Project that had four specific Programmes is itself a fascinating and worthwhile story. The Programmes were Clinical Services, Child Health, Information Management and Mental Health. The partners were the University of Gadja Mada (primary service providers), The Royal Children's Hospital Melbourne, through RCH International (Prof G Warne, project director and technical advisors), the University of Melbourne Department of Paediatrics (Prof Trevor Duke, technical adviser), World Vision Australia (funding body) and Nossal Institute (Project Manager).

One of the UGM Programmes being established focussed on the social and emotional health of the survivors of the tsunami. This became the Mental Health programme based in the Crisis Centre within the Faculty of Psychology. At that time, among other professional roles, I had been consultant advisor to the Victorian State Disaster Recovery Unit for twenty years and consequently involved in most major and many minor disasters in Australia over that period. Clinically I specialised in the treatment and management of traumatised children, families and communities and had established the RCH mental health consultation programmes to Bendigo and Mildura during the pioneering stage for rural child and adolescent mental health services. Also, I had just announced that shortly I would be retiring from my position at RCH as Head of Department of Child Psychotherapy. It didn't take much persuasion from Garry Warne for me to agree to take up the challenge of Technical Advisor (Mental Health) to the UGM Project, working with the Psychology Faculty.

The Indonesian National Health budget as a percentage of GDP in 2005 was 2.4% (Australia 9.2%) and of this only 1% was dedicated to mental health (Australia 9.6%). Of this allocation 97%was used to run mental hospitals to accommodate the most seriously ill and disturbed psychotic patients – adults only. There were 0.21 psychiatrists per 100,000 population (Australia 14), 0.09 nurses with mental health specific training, 0.3 psychologists, 1.5 social workers and no occupational therapists. Due to the shortage of psychiatrists, patients in the hospitals were seen in groups of up to six for fifteen minutes for review of medication. Psychiatrically ill people usually stayed in their village, often constrained in a bamboo 'cage' or chained, for their own and other people's safety. Community nurses were starting to establish programmes to provide practical assistance patients and families.

The only community mental health clinic in Indonesia providing psychological management and treatment was established in 2004 adjacent to UGM in the Sleman district of Yogykarta Province with a staff of six psychologists. It was finding its way. There were no trained and skilled staff or services specifically for infants, children or adolescents anywhere in Indonesia. Indeed the notion that infants and children could experience mental ill health including serious illness, did not have currency.

Within the broad general and health professional communities, the understanding of mental illness was limited to psychosis, with families struggling on as best they could. I found the concept of mental 'health' to be new along with the notion of psychological damage occurring as a result of experiences originating in the environment.

So to my role, officially spanning the years from 2005 to 2008 but continuing to the present in a different and limited way. The broad parameters included working with the UGM Crisis Centre Mental Health team

to build technical (clinical) and managerial capacity, reviewing and appraising the tsunami response programme, providing the team with a good understanding of international standards in mental health programmes especially those related to disasters and providing long term support in Indonesia and from Australia. The focus of course was the mental health and well-being of those who had survived the earthquake, the tsunami and the conflict, including responding to people and communities whose mental health had been compromised. A goal was to ensure that services developed would be sustainable beyond the life of the Programme and that they would follow the principles of a culturally appropriate community development model.

The Memorandum of Understanding between UGM and World Vision included service delivery requirements and parameters, and the financial agreements. These provided boundaries for the Programme and were integrated with the goals and practice details to form a Log Frame that became a tool for guidance, monitoring and evaluation. However, while important and helpful, the Log Frame was not always an easy path to follow and required much patience, perseverance and good will on the part of all Team members.

UGM established three teams, the lead team was based at UGM. It resourced the two regional teams located in Aceh at Meulaboh and Bandah Aceh and managed the Programme. At their busiest each of the three teams had eight to ten members comprising psychologists and support staff. A psychiatrist was seconded to work with the Programme

My role required visits of two to three weeks duration every two to three months depending on the needs of the Programme, travelling between UGM Yogyakarta and the cities of Meulaboh and Banda Aceh – by single engine planes over seismically active mountains. My visits to Indonesia were interspersed by constant email contact to support programme development and implementation.

The initial phase of the Programme was challenging for all parties, many of whom had not worked together previously or indeed met each other before. The 'getting-to-know-you' included finding and sharing the common ground of humanitarian concern, identifying goals for the programme including what was feasible, establishing priorities, methods and timelines as well as dispelling preconceived ideas about each other's cultures, attitudes and expectations. An example is one of the Team believed that western people did not value family life. For him this was a major impediment, until dispelled, for us being able to work together successfully in a family centred social culture.

Additionally for me the challenges also included understanding the knowledge base, experience and skills of the Faculty team members in clinical work, theoretical knowledge, disaster mental health and community recovery. I learned that the expertise of the Psychology Faculty was in educational and organisational psychology and not in mental health, disaster psychology or community health service delivery. While most of the people I worked with had varying levels of competency in English I did not speak Bahasa and, despite the best efforts of the Team (and much to their hilarity), my skills did not improve.

The middle phase was where the 'real' work took place. It was intense, satisfying and demanding for all – and is impossible for me to fully describe here. My role was multifaceted and included moving between most aspects most days. With the UGM Teams in each of Jogyakarta, Melabouh and Banda Aceh increasingly taking the lead role as their skills developed, it included:

- visiting 'temporary' housing sites and meeting with residents to gain an understanding of issues and resources relevant to mental health, and for me to enhance my cultural understanding,
- meeting with community groups such as mothers, village leaders, and school teachers to discuss their concerns while weaving in information about mental health and disaster recovery,
- visiting health facilities and talking with staff – child and maternal health, general community health centres from small local to larger district centres and hospitals,
- similarly meeting with District or Provincial Health authorities and local politicians and additionally discussing current and future service needs, models, policy development, staff – numbers, professions, training, salaries and career pathways,
- contributing to the development of community education about mental health and disaster recovery via radio interviews and messaging, newspaper articles, leaflet distribution and street banners
- participating in training workshops for Religious leaders and other community leaders in mental health and disaster recovery. The UGM Team developed Training Modules that I reviewed
- providing in-service training both formally and informally to the UGM mental health teams, covering patient symptoms, diagnosis, treatment and management, the concept and functions of multidisciplinary teams in mental service delivery as an option to the existing rigid professional silos, patient report writing and record keeping, the role of advocacy for patients and mental health services, introducing and discussing relevant international literature and research.
- supporting links between universities, professions and professional bodies and other tsunami recovery programmes
- providing formal lectures and informal discussions to medical, nursing and psychology staff and students at UGM and University of Syiah Kuala (USK) Banda Aceh.

All through these, the Team members had the opportunity for supported experiential learning to apply the theoretical knowledge I was sharing during more formal training sessions. Thus my role included advisor, mentor, teacher, role model, advocator and supervisor. It did not include any direct clinical work.

The UGM Team managed the Project budget so efficiently there was funding available to bring selected UGM and USK staff, Acehnese politicians and health administrators to Melbourne in November 2007 to give them the opportunity to experience a developed community mental health system as well as a world leading psycho-social disaster recovery system. It also provided the opportunity to meet with local professional colleagues. This visit would be described as part of the final phase of the Project.

However, the life of the Project continues. One of the young psychologists on the UGM Team was awarded an AusAid scholarship to study for a PhD at Melbourne University to research the 'Development of a Curriculum for Psychologists Working in Primary Health Care in Indonesia'. She graduated early this year and is now back at UGM heading a new department of Community Mental Health within the Faculty of Psychology. A few months ago I was invited to return to UGM to assist with this and also to review the curriculum for training undergraduates in child and adolescent mental health.

On reflection, what were the highlights of this Project for me? Without doubt, the warm, respectful, trusting and valued relationships that grew between us as well as the experience of a journey shared, with all its varied textures and challenges.

The challenges included the slow cultural familiarization, new food (avocado and chocolate smoothies for instance!), 'special' morning coffee at a roadside café watched over by a chook laying an egg in a cardboard box at my elbow, impenetrable clouds of mosquitoes and being caught in an earthquake inside a crumbling building.

Finally, at a personal level I revelled in being able to draw on the multiplicity of skills and depth of knowledge acquired over my professional life. Acknowledgement must go to RCH for the support provided over many years to pursue two key clinical interests when they were in the pioneering stage – community based mental health services for children and adolescents and child trauma and recovery from disasters.

How to apply for membership of the RCH Alumni

APPLICATION FOR MEMBERSHIP FORM

The Royal Children's Hospital Alumni

Surname:		**Title:**	
First Name(s):		**Date of Birth:**	
Postal Address:			
Email:			
Mobile Number:			
Home Phone:			

Qualifications:		
Australian Honours:		
Year of Commencement at RCH:		
RCH Appointments:		
Tenure at RCH – Do you still work at RCH?	☐ Yes – Proposed Year of Retirement from RCH:	☐ No – Year of Retirement from RCH:
	Year:	Year:

Signature:		**Date:**	

Please return completed form to:
RCH Alumni
Executive Offices
4th Floor, West Building
The Royal Children's Hospital
50 Flemington Road
PARKVILLE VIC 3052