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The Royal Children's Hospital Melbourne

RCH alumni newsletter

April 2016

Whisky Bay Sunset
Photograph by Gigi Williams (see next page)

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The 2016 RCH Alumni Executive

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Credits

Editors – Profs. Garry Warne and Jim Wilkinson.

Graphic design – Dan Warne

Anyone for a photography master class?

Many of you will know that Gigi Williams, a much awarded photographer, has moved into a different phase of her life after leaving RCH.

Together with her husband Robin they are thinking about running master classes on an occasional basis for a convivial group of intelligent and committed learners.

They are aware that there are already many competent or aspiring photographers amongst the RCH alumni and this would be a wonderful way to keep connections.

Gigi and Robin are trying to get an idea of how much interest there might be so please email Gigi (gigifwilliams@gmail.com) if you would like to discuss.

From the President

Welcome to our first newsletter for 2016.

As always, the Alumni executive welcomes your suggestions for more, fewer or different activities in the future, as well as for other ways in which we can enhance our role and better meet the needs of *all* members.

Like many others, I was struck by the warm, happy and convivial atmosphere at our dinner last November and at the recent lunch preceding Frank Billson's talk, and reflected that despite our varying personal and institutional experiences of RCH, we do indeed seem to enjoy one another's company!

Our secretary has reminded me of my duty to write an article for this newsletter. My predecessor's contributions are indeed a hard act to follow – the meaning and purpose of *alumni*; the virtues of patience and persistence in following our career goals; and the green Grindley crockery in the former RCH doctors' dining room. What topic of general interest could possibly remain?

Recently, after reading an article co-authored by one of our members, I have been exploring an idea from a pioneer of modern psychology, which seems relevant to many of us, as health professionals contemplating or completing retirement from clinical practice, or supporting others through that process.

Raymond Cattell (1905-1998) was a British and American psychologist whose papers and books are among the most highly cited in peer-reviewed psychology journals of the past century. According to one biography, in over 50 books and 500 articles, he developed a theory of human behaviour rivalled in scope only by that of Freud, and second to none in its adherence to research-based empirical evidence. Cattell analysed the multiple factors involved in personality, learning, motivation and ability.

In 1963, he wrote a landmark article providing research evidence for an idea he had proposed some 20 years earlier – the *Theory of Crystallised and Fluid Intelligence* – still widely accepted, and the subject of ongoing study in neuropsychology and brain imaging research.

Crystallized intelligence is the ability to use skills, knowledge, and experience, relying on accessing information from long-term memory. It correlates with abilities that depend on knowledge and experience, such as verbal skills, vocabulary and general information, and improves somewhat with age.

Fluid intelligence is the capacity to solve novel and complex problems that cannot be solved automatically by relying on past experience. It correlates with working memory, a short-term memory buffer that transiently holds, processes, and manipulates information. It is evaluated using visually based, non-verbal reasoning tests and is said to decline with age, after peaking in early adult life...

For example, a mechanic who has worked on aircraft engines for 30 years might have a huge amount of "crystallized" knowledge about the workings of these engines, while a new young engineer with more "fluid intelligence" might focus more on the theory of engine functioning. These different abilities might complement each other and work together toward achieving a goal.

These ideas resonate with my own experience, and that of others. As health professionals, many of our familiar clinical tasks can be competently managed without much mental effort – with one hand tied behind our back, as it were. Indeed, we may be gratified and reassured to see how much more efficient than our younger colleagues we are in handling these tasks.

But in our later years, with a decline in our *fluid* intelligence, if a clinical challenge does not readily fit one of our familiar patterns, then making the appropriate decision or finding the right solution may be more difficult than before, and this can be an unfamiliar, disconcerting or confronting experience.

Further, as scientific progress accelerates, it becomes more difficult for us to continually update the hard-won knowledge underpinning our *crystallized* intelligence, so that we risk working from *fossilized* knowledge, with predictable results.

While this may appear obvious, it is thanks to Cattell and his successors that we have an evidence base for these attributes, which we can consider, along with other cognitive and personal factors, in planning when to relinquish clinical practice.

Kevin Collins, President, RCH Alumni
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To end on a more optimistic note, research suggests that personality traits may impact on cognitive function in later life. One such personality trait is *openness*, or openness to experience.

People who are open to experience are described as intellectually curious, open to emotion, sensitive to beauty and willing to try new things. They tend to be, when compared to closed people, more creative and more aware of their feelings. They are also more likely to hold unconventional beliefs...

While the relationships between personality traits and intelligence are complex, there is evidence that such openness may have a positive long-term impact on fluid intelligence, and potentially be a buffer against cognitive decline.

So perhaps one message is for us to try to foster openness to experience in ourselves ... or at least be more accepting of it in others!

Footnotes

1. My apologies to psychology colleagues for oversimplifications and inaccuracies.

2. Because this is intended as light reading, and not as an original scientific contribution, I have not cited the references used in preparing it. However, I would be happy to provide these on request.

For your consideration...

Suggested refinements to our Constitution

Kevin Collins, President, RCH Alumni
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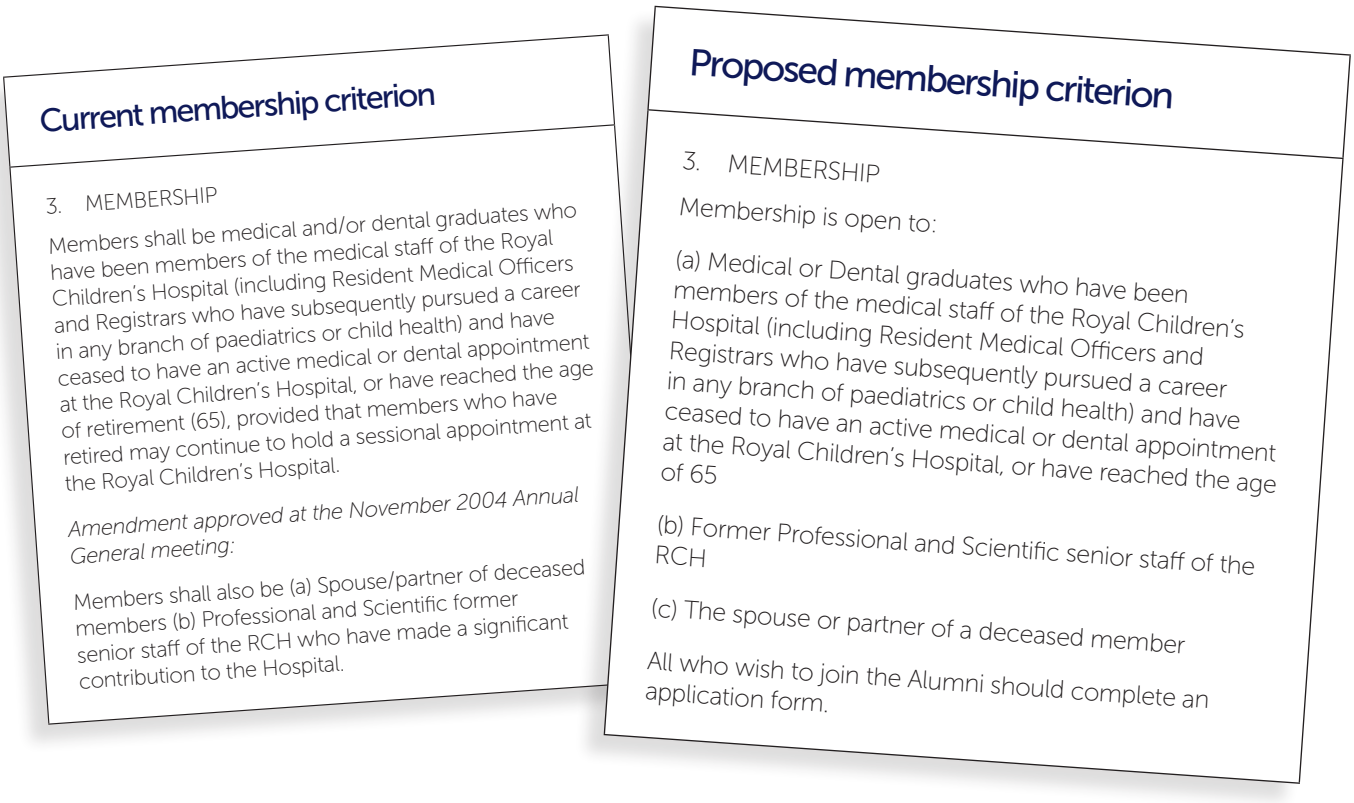
The members of your Executive have reflected on the range of views canvassed at last year's Annual General Meeting. We have explored and agreed on some relatively minor changes, confined to the *Membership* section of the Constitution (last modified over 11 years ago) and now seek your comments, during the months before this year's AGM.

We believe that with these small changes, our constitution would more accurately reflect the broader base of our current membership, as well as conveying an inclusive and respectful welcome to our professional colleagues from disciplines other than medicine.

The current and proposed *Membership* text is set out in the table below, followed by a brief explanation.



Current membership criterion

3. MEMBERSHIP

Members shall be medical and/or dental graduates who have been members of the medical staff of the Royal Children's Hospital (including Resident Medical Officers and Registrars who have subsequently pursued a career in any branch of paediatrics or child health) and have ceased to have an active medical or dental appointment at the Royal Children's Hospital, or have reached the age of retirement (65), provided that members who have retired may continue to hold a sessional appointment at the Royal Children's Hospital.

Amendment approved at the November 2004 Annual General meeting:

Members shall also be (a) Spouse/partner of deceased members (b) Professional and Scientific former senior staff of the RCH who have made a significant contribution to the Hospital.

Proposed membership criterion

3. MEMBERSHIP

Membership is open to:

(a) Medical or Dental graduates who have been members of the medical staff of the Royal Children's Hospital (including Resident Medical Officers and Registrars who have subsequently pursued a career in any branch of paediatrics or child health) and have ceased to have an active medical or dental appointment at the Royal Children's Hospital, or have reached the age of 65

(b) Former Professional and Scientific senior staff of the RCH

(c) The spouse or partner of a deceased member

All who wish to join the Alumni should complete an application form.

The thinking behind the changes

1. The only real change to the meaning of the present Membership rules is the deletion of the final words: *who have made a significant contribution to the Hospital.*

   This condition could be construed as implying a double set of standards for Alumni membership. By removing it, we affirm the collegial relationship among all professional staff at RCH, both during our working careers and now, when we meet together as alumni.

2. The other changes to the first main paragraph comprise:

(a) Deletion of the words: *of retirement* - because a mandated age of retirement no longer exists

(b) Deletion of the words: *provided that members who have retired may continue to hold a sessional appointment at the Royal Children's Hospital* – because in our view (and with no disrespect to the authors of the Constitution) the meaning of this clause is unclear, and it does not affect the scope of the other Membership provisions.

3. Finally, we have added the explicit requirement to complete an application form, so that applicants' professional background and connection to RCH are specified, and their contact details are made available.

These suggested changes are presented for your comments and to promote discussion. Alumni members are warmly invited to communicate their views to the Executive via Garry Warne, our Honorary Secretary (garry@warnefamily.net).

2015 Gala Dinner

Kew Golf Club, 24 November 2015

Jim Wilkinson & Garry Warne

This function followed the RCH Alumni's AGM and was held at Kew Golf Club. The arrangements for the function were made by Karin Tiedemann, with involvement of several of the Alumni executive. There were 62 members and partners present and the CEO, Prof. Christine Kilpatrick, was an invited guest.

A relaxed dinner at tables for six or eight guests was followed by a brilliant and highly amusing speech by Dr Kevin Collins, introduced by the President Prof. Andrew Kemp. The mock-serious title to which Kevin spoke, "French advertisements and public signs – a window on the national soul?" was illustrated with a hilarious collection of photographs that showed the contrast between the absurdities and sublime aspects of French culture. The talk was received with acclamation and gales of laughter by a very appreciative audience.

The talk was recorded on video and can be viewed at:

https://youtu.be/BEoySSpJxqM

It was an altogether most congenial evening. The guests were able to move around and mingle after the talk and before the gathering broke up.

The assembled company listening to Dr Collins

Prof. Andrew Kemp (outgoing President) introducing Dr Kevin Collins (Speaker and Incoming President)

Dr Neil Roy, Dr Karin Tiedemann, Elaine and Garry Warne

Mrs Barbara Ekert and Prof. Henry Ekert

Dr Jim Keipert and Mrs Lois Keipert

Mrs Paddy Keith, Mrs Jan Shield, Dr Lloyd Shield

Mr E Durham Smith

Dr Kevin Collins delivering his talk

From the CEO

A report from the CEO of the Royal Children's Hospital

Professor Christine Kilpatrick

Electronic Medical Record

It is now just 50 days until 'go live' for the new RCH Electronic Medical Record.

At a cost of $48million the EMR is high impact, and high risk, and I am pleased to report that the very robust governance and monitoring systems we put in place a year ago to help us manage this vitally important project have stood us in good stead. All emerging risks have been dealt with promptly and effectively and, with the true test of our work still ahead of us, I am at this stage confident that we are on track.

Training of Senior Medical Staff and other craft groups is now well and truly underway, and feedback about the system itself has been very positive as our staff get their first detailed, whole-of-system introduction to the EMR.

The commencement of training comes in the wake of a major communication effort to ensure all staff understand the magnitude of the shift from paper to electronic patient care; and are well positioned to encourage and advise families as to how the system can benefit them through the direct access My RCH Portal into the EMR, which will be phased in via a pilot project through Specialist Clinics.

Over the next six weeks you will start to see banners, posters and leaflets appear around the hospital and detailed information, including regular e-newsletters and intranet bulletins to heads of department, are available via the dedicated EMR section on the RCH intranet.

RCH Compact

More than 150 doctors, Executives, Board members and supporters gathered in the kitchen and reception areas of Level 3 West late last month to formally launch, and sign, the RCH Senior Medical Staff-Executive Compact (see image, below).

Containing 15 pledges from Senior Medical Staff, and 15 pledges from the Executive, the Compact is about creating a new era of respectful, trust-based cooperation and collaboration between those who lead the delivery of bedside care, and those who are responsible for the hospital's overall operation and sustainability.

It's not been an easy, or a swift process. The notion of a Compact for the RCH, modelled on the Physician Compact developed by the Virginia Mason Medical Center in the US, was first tabled at a Grand Round presented by Chief of Surgery Mike O'Brien in April 2014. In February the following year we took a group of 80 doctors, nurses and Executives to Inverloch for an intensive retreat designed to understand where our culture could be strengthened, and how we might attempt to achieve that outcome.

Since then we've held 58 conferences, workshops and meetings; engaged 930 staff directly in the development of the Compact through facilitated training sessions, and invested (conservatively) more than 7,300 hours of time.

Now that the Compact has been drafted, our focus will shift to activating its principles in our everyday working lives. At the start of March more than 30 Senior Medical Staff and their respective nursing or allied health counterparts took part in a five-hour Compact Leaders' workshop, and on March 16 about 20 doctors will take part in a full-day workshop with the Executive. These sessions are facilitated by an external specialist.

So much to do, so little time...

Lloyd Shield

Is it possible to change persona? Definitely yes, at least for me.

Many alumni will be aware of my interest in photography from when I gave a talk to the association on the topic of *children, photography and social conscience*. But photography is more than an interest; it is now my occupation, and my persona is that of photographer.

Very occasionally I do a commercial, usually architectural, brief using digital technology, but my real world is that of large format (LF) photography. Large format refers to the size of the film, not the size of any resulting print. My technology is of the 19th century - wood, brass, bellows, ground glass, silver halides, darkroom chemicals and enlargers. I like working with 5" x 7" film. Great detail. Great tonal range. Metallic silver oozing visual substance. My dalliance with glass plate technology was not overwhelmingly successful but I may try again.

Photography is a wonderful art form for personal expression, but for those interested, it can also encompass the sciences of optical physics and darkroom chemistry. Hard to beat for those who have lived with science in one form or another. It has been said that the most important equipment for photographers is not the equipment in their hands but the equipment between their ears: the ability to previsualise the final image before the shutter is triggered. For those who photograph in black and white it additionally requires the translation of colours of the world into shades of grey. To almost alchemically transform a previsualised concept into a framed silver-rich image on the wall is a source of great satisfaction.

Image making for a LF photographer is time consuming, laborious, sometimes frustrating, but ultimately enormously rewarding. There is almost total personal tactile control over the process from beginning to end. Effort brings rewards; sloppiness does not.

LF photography is essentially a solitary pursuit. Despite this, there is a strong and vibrant LF community, if that is not an oxymoron. In Victoria, three groups have sprung up over the last ten years, with a strong overlap of participants. Four weekend workshops are held in various parts of country Victoria each year, in addition to some informal day trips. Active participation in these three groups has facilitated great friendships with like-minded people from all walks of life and with differing approaches to their own photographic journeys.

I do use modern LF cameras, but pre-1900 mahogany, brass, leather and ground glass machines with character and longevity are those I value most (fig.1). Restoring and refurbishing these has become a rewarding activity to complement image making with their modern equivalents.

Self evidently, LF photographers do not shoot weddings or AFL Grand Finals. They make relatively few images in this over-imaged digital world. Carefully considered image making is the philosophy, not shooting a dozen frames

Fig. 1: E &T Underwood 'Instanto' ¼ plate, 1880s

Fig. 2: Stick Shed, Murtoa

Fig. 3: Under Echuca wharf

in the expectation that one will 'come out'. Industrial and architectural heritage, urban landscape and the natural environment are my preferred subjects (figs 2&3). Regrettably, portraiture is not a strength. I prefer to work with themes or series of images, rather than single images from here or there.

Over the last 8 years my major project has been to photographically record over 100 extant post offices in Victoria built in the Victorian era (fig. 4). One day they may appear in book form. An exhibition in 2011, *Cathedrals of Industry*, comprised 30 images of the industrial heritage in Melbourne's west (fig. 5).

For some time I was less than enthusiastic about images taken with pinhole (lensless) cameras, but last year, having seen some stunning results obtained by careful attention to technical detail, along with artistic vision, I decided to branch out into this discipline as well. Getting there, but still a way to go (figs 6&7).

Photography offers many possibilities, so to complement image making and collection of Victorian era wooden cameras, I have recently embarked on crafting wooden cameras. The first completed camera has been particularly rewarding, not only because of the technical challenge, but also because of the provenance of the wood from which it was built. Some 7 or 8 years ago, Ian Hopkins, for reasons that neither of us can recall, gave me a small rectangular block of mahogany. I kept it, knowing that some day I would 'do something with it'. As many alumni will know, Ian has a reputation as an exceptional fine woodworker. Amongst many other things, he crafted in marquetry the RCH Coat of Arms, which used to hang in the Board Room foyer of the 1963 – 2011 hospital building. Late last year I decided to construct a 5" x 7" pinhole camera with the mahogany and while falling short of the finessed end product that Ian would have produced from his block of wood, nevertheless I am happy with the result of my first camera construction project (fig. 8). A replica of an 1850's sliding box camera is literally on the drawing board.

For now, photographic image making, collecting, restoring and constructing keep me mentally stimulated, physically active and artistically fulfilled (fig. 9).

Fig. 9: 'Selfie' (digital) with Wisner 8" x 10" field camera

Fig. 4: Flemington Post Office (1888). B&W print toned with thiocarbamide

Fig. 5: Hanging in the balance. Cathedrals of Industry exhibition, 2011

Fig. 8: 5" x 7" pinhole camera constructed from mahogany block given by Ian Hopkins

Fig.6: Tree and lake. Pinhole (lensless) camera.

Fig.7: Torsional Wave sculpture Canberra. Pinhole (lensless) camera.

My Indian adventure

Margot Prior

In 1997, I had a life changing experience when I went to India on a Community Development Program with the NGO Community Aid Abroad CAA, (now renamed as Oxfam Australia). There were about 20 of us, mostly young people but also few more mature ones like me, and all with a keen interest in social issues. We had two wonderful leaders who shepherded us around various places in India, taught us an enormous amount about the social issues faced by Indians living in villages and towns, and about the approach of Community development in bringing about benefits for people who were struggling with all aspects of their lives. Their approach was to facilitate the village people to dig their own wells, to create their own small businesses, to grow vegetables themselves, and to care for their environments, with leadership and some support from Oxfam but essentially the responsibility was theirs. These leaders and educators provided for me at least, a model of pure goodness and care for humanity.

We began with a weekend workshop in the beautiful Yarra Valley where we were instructed in the theory and practice of community development, heard about some of the previous programs and the people who took part, and began to get to know each other. The next day we met at the airport and flew to Singapore. Here three of us were bumped off the Air India plane, (a not uncommon happening with this airline). We had to take a different plane and stay overnight in Singapore before going on to Mumbai the next day. This meant we arrived in the dead of night and endured a hair raising trip by taxi to our destination of Pune, where CAA had its offices. Being on the roads in India is a constantly terrifying experience. Drivers seem to compete at risky driving. The next day we met with a number of local people who were working on a variety of social issues in India, and heard about some of their programs and about the 'dirty politics' in India. I had been to India before and knew that it was a society built on class/caste, that Ghandi had been a major influence in offering a humanistic and peaceful view of life, and about his role in finding ways to escape from the grasp of the British Raj and find freedoms.

We knew that over 200 million people lived in poverty and squalor, that children were dying of hunger and malnutrition, and that women suffered from ill treatment (sadly it seems that little has changed in these domains now in 2014). We knew that although literacy was improving it was still not so for 50% of the population especially girls and women. We had a wonderful talk about social issues in India from Dr Jayant Patel which was made the more appealing and memorable by his wise and saintly face and the fact that he had known Ghandi and followed his philosophy. It was enormously inspiring to hear about what these people were trying to do to help those most disadvantaged and in need.

We visited the Aga Khan's palace where Ghandi and his people had been imprisoned and where his collection of memorabilia is on show and greatly prized.

Over the next 3 weeks we worked in small groups and had some gruelling road trips to various places where we would see programs in operation. The CAA community development programs were based on a 'bottom up approach' rather than the dysfunctional 'top down' strategies (of which failed indigenous programs in Australia are prime examples). That is, partnerships with the villagers and their active participation in improving their circumstances were central features. For example the villagers had to contribute labour for projects, to contract to dig the wells, or to set up the kitchen gardens, or plant trees on waste land, or start small businesses for their villages themselves, with CAA providing materials and expertise to guide their efforts. There was an emphasis on empowering women as CAA had found that they were more likely to complete and sustain their projects compared with the men. We heard about CAA's years of painstaking work to motivate the villagers to change. Given the language barriers it was not easy for us to talk with the villagers, but we managed somehow (it helped that one of our group spoke Hindi) to communicate in the many community meetings we shared. Everywhere there was much smiling and great warmth between us all.

During the trip we had a free day in Mumbai, where we went shopping (I bought a beautiful carpet), visited the University, had a boat ride around the harbour, and I had dinner with Kirti a medical colleague and friend of my son David; they had been together in Cardiology hospital work in Ohio some years before. I recall that the Kirti's nephew called for me in an air conditioned car and we took one hour in impenetrable traffic to travel 15 kms. to meet Kirti. He was one of the upper class living and working in luxury compared with what we had seen in the countryside. And the restaurant was extremely posh!

At the end of our brief respite we all got on the train at Mumbai Central Station to go north for the next part of the program. Life on an Indian train is very good theatre and we enjoyed good company with people telling jokes, talking politics, eating and sleeping, although I found the latter almost impossible lying in my narrow bed under the freezing air conditioning, with the noise, shaking, roaring, speeding, and frequent stops. It was a relief when after 18 hours, day came with breakfast and coffee delivered and we were nearly there.

This brought us to the state of Rajasthan and its main city Jaipur. The atmosphere was very different here and the temperature much cooler. We saw the Rajasthani forts on top of distant rocky outcrops as we approached the city, -- very spectacular. Rajasthan has a population of 43 million and half of it is dry desert; the literacy rate is the lowest in India, it still has child marriages and suttee (wife immolation), female infanticide, and abuse and atrocities in the lives of women. Our Indian guide described it as having more closed and backward systems compared with other states. The focus of the CAA agency programs here was on women and children, natural resources, health, education, and conservation. Again in smaller groups we visited projects and talked with the wonderful Indians, many of whom were Social Workers dedicating their lives to the betterment of the lives of severely disadvantaged people. As well as learning much about the difficulties in this part of the country we enjoyed some tourism around Jaipur. We were surrounded by, on the one hand a seething life in laneways, dilapidated, filthy living conditions, huge noise and smells and great liveliness, and on the other hand the famous Lake Palace, and massive old forts very grand and decorated but run down, including the legendary Amber Fort.

A highlight for me on this part of the program was to experience the "barefoot teacher" scheme. The teachers were of about 8th grade education level, predominantly young women, who were selected by their village and then given 12 days training (*capacity building* --- an expression we heard all the time in India) and who received a very small wage. We learned that it is hard to get girls to school; they have to walk long distances, they are required to help at home with the family, etc., and when they get there conditions are poor. (Only 22% girls are literate in the villages) We watched one class of very young children with a very young teacher sitting on the dusty ground with no materials except a sheet of paper stuck to an easel which the teacher used to make her points.

We had meetings with teachers and with villagers and often everybody would get very excited and the atmosphere was just electric. Some of us began to sing and dance and everybody was enjoying the freedom to express themselves. This was amongst the Rajput women who are not allowed out of their houses by their men.

Later in the evening, we all sat down on the ground with the village people to talk about literacy, teaching, and difficulties in managing their manifold problems. Men and women attended this meeting. Some of the men proudly showed us the effect of their school education by writing their names in the dust. A young teacher whom I had befriended earlier in the day (Banji) sat down beside me and shyly put her hand in mine smiling lovingly up into my face. She grasped my hand for the entire meeting and I felt intensely what a hard life she had and how much I would have liked to be able to make her life easier, and to stay as her friend and supporter. One of the most powerful learnings from this Rajasthan experience was about the lives of women in this culture. Violence and repression of women seems to be hard wired, with minimal signs of improvement, even as I write today some 18 years later. CAA is very conscious of the value of women and their greater potential for bringing about change, and for improving their lives and the futures of their families. CAA directs much of their financial assistance to women's matters in the knowledge that it is more likely to bring about progress and greater community welfare than if directed to the men.

At the end of the community development program and our stay in this amazing countryside we were taken to the Sariskar Palace Hotel, a very colourful, highly decorated and imposing palace with lovely gardens. Everything was very grubby and deteriorated but the grand ambience of the place was unimpaired This was the final episode for us and we sat around on the roof of the palace in the warm dusk to discuss what it had all meant and to make our farewells, before leaving the next day to go to Delhi and them back to Australia.

We all felt close to each other, drawn by our unforgettable shared experiences in India and our strengthened intentions to try to contribute to making the world better for the "have nots" in some way. I have remained attached to CAA/Oxfam and supported their work in various ways over many years. On this trip and afterwards we had many valuable discussions about social problems including some around the problems of indigenous people in our own country something which troubled us all. (Some time after this trip CAA did take up a special interest in indigenous affairs and provided some social programs).

Key messages from this memorable trip for me were: the problems of being female in so much of the world; the need for full education for children especially girls, the need for men to change their attitudes and to respect and value women and girls, widespread corruption almost everywhere, endemic and entrenched poverty in much of the third world, Australia's failure so far to effectively mitigate the problems of their indigenous peoples.

Our well bonded group followed up the program with a meeting each year for a couple of years. Not everybody came but many did and many were clearly continuing their interests and education in community program development and 'good works'. And I thought to myself, this is a very special group of people with strong motivation to care for people who will go on to make valuable contributions to humanity.

The Priest

"The doctors, they are good people but they don't understand these matters"

Geoff Mullins

It was apparent to me as the doctor responsible for the care of the child and my staff that the child was dying. The pale emaciated body had all the signs of the long cruel fight for life that had taken place over the last two weeks in the isolation room of the intensive care unit. The child was motionless except for the rhythmic rise and fall of his chest as the ventilator delivered the life sustaining oxygen. His bed was surrounded by medical equipment that crowded his grieving family who were trying to be as close to him as possible. The monitors' vivid displays of the child's vital signs snaked across their screens and beeped incessantly. Multiple syringe pumps and tubing infused drugs and fluids into the immobile body in what now seemed a vain attempt to prevent the child from dying.

Working in the intensive care unit we were all too familiar with this scene. We knew from past experience that up to ten per cent of the children admitted to the intensive care unit would die, but when death appeared inevitable it always produced strong and mixed emotions. Sometimes it was a refusal to accept that further attempts at treatment were futile. At other times frustration and a feeling of impotence at the child's failure to respond to their treatment. Most commonly however it resulted in a general sadness that would permeate the whole unit. This was particularly so with children who had been in the unit for a long time. The unit would become subdued. The good natured banter amongst staff with each other and visitors would disappear, voices would be lowered and the child and family would often be avoided by all except those involved in the immediate care. Ostensibly this was to allow the family private time with their dying child but often it was combined with a sense of guilt and frustration that we had failed the child and the family and despite all our knowledge, clever drugs and equipment we were powerless to prevent the death of their child.

In the face of these emotions there was a still a familiar routine that I needed to undertake with the family of a child whose death was thought to be inevitable. As the senior doctor responsible for the care of their child I would need to sit with the family and talk with them repeatedly and at length. I would talk to them of their child's medical condition and the lack of response to all the treatments in place. I would emphasise how hard the staff had tried to prevent this outcome. I would tell them how sorry I was to have to tell them that their child was dying. I would tell them I would do everything to ensure their child would not suffer through this dying process. Frequently they would want to know when their child would die. I would then have to talk of my uncertainty in these matters, that it may be hours or even many days and that the precise time was beyond my knowledge. This admission of uncertainty exposed to families how little we doctors knew about dying despite all our clever talk and drugs and equipment.

I would always offer to arrange a chaplain to visit if these meetings had not already been in place during the child's illness.

There were two chaplains permanently attached to the unit, a Roman Catholic priest and an Anglican priest. In addition the intensive care unit had contacts with representatives of almost all other religious faiths who were usually willing to come to the unit at short notice. The two unit chaplains were well known to all the unit staff. The Catholic priest was a young cheerful man in his late twenties always dressed in a dark black suit and the trademark clerical collar. He confined himself to approaching families registered as Roman Catholic or those who asked for a Catholic priest. He was popular with the staff, often attending the unit social functions and he enjoyed being made to feel part of the team. He would often wander into the unit just to chat with the staff about the technical and medical aspects of the care of patients rather than religious matters. He was new to his calling and often appeared ambivalent about his career choice and overawed by the role he was expected to play in bringing comfort to families in such distressing circumstances.

The Anglican minister was a more conservative man. He was middle aged, sandy haired and solidly built. He always wore a tweed sports coat, a tie and light coloured slacks. There was no indication in his appearance that he was a clergyman. He never spoke of religion to the staff and seemed almost apologetic about this aspect of his work. He was often asked to talk with families who professed no religious faith as he was always content to just sit quietly with families and listen.

The family of the dying child had not wished to see either of the unit's chaplains during their two week vigil over their child but finally after my last discussion with them they asked to speak to a Greek Orthodox priest. Calls were made and I was advised that a priest would come to the unit as soon as possible.

Within the hour of the call for the priest, a booming voice came over the intercom from outside the unit announcing "I am the priest". Before the invitation to enter was given a big imposing man with a massive black beard and wearing a tall black chimney-pot hat strode into the unit. He wore a large flowing black sleeveless robe with a cross hanging on

his upper chest and a large medallion down the front of the robe. He held a chain attached to a gold censer that swayed gently as he made his way purposely to the central desk. His appearance and air of authority immediately attracted the attention of all the staff. He was followed by a much smaller balding man in a conventional dark suit who was carrying a large beautifully embossed gold edged book and a small black box. The priest announced in a loud voice he wished to speak to the doctor in charge of the child.

I sat and talked with the priest. I told him of the plight of the child, that I felt death was inevitable and how I had tried to prepare the family for this outcome. The priest listened carefully, nodding thoughtfully as I spoke and finally asked "when will the child die?" and went on to explain that the prayers he would say for the child and the family differed depending on how long it was before death. My reply to the priest was as usual couched in terms of my uncertainty in these matters and how it was beyond doctors to know these things and that it may be hours or days. The priest nodded as if he understood and seemed to sympathise with this uncertainty that doctors have at these times and then asked to see the child and family. I introduced the priest to the family and then quietly returned to the central observation desk outside the child's room. The priest's assistant still holding the large book and now also the censer stood attentively in the ante room adjacent to the child's room

From this position I could clearly see the priest, the family and the child. I noticed that the Anglican priest was also watching the activity in the isolation room with considerable interest.

We saw the priest move a chair to sit between the parents and start talking earnestly to them. The parents appeared calm and very attentive to whatever the priest was saying and were nodding frequently in response. The priest finally stood up, moved towards the child and leaning over the bed he appeared to be carefully studying the motionless body before beckoning to his assistant. He took a bowl from the assistant and then once again leaning over the child began gently dabbing the limbs and body with presumably holy water from the bowl. When this procedure was completed he positioned himself at the foot of the bed and taking the gold chained censer from his assistant he began to chant loudly in a deep sonorous voice as he gently swung the censer backwards and forwards towards the child. The loud voice of the priest resonated from the isolation room to the central desk area and beyond into the rest of the unit along with the smell of incense from the gold censer.

Watching from the central desk area I was fascinated by this ritual and also saw that many other staff and families were watching or listening with equal fascination. I also saw that the Catholic priest had joined the other observers at the central desk. We all watched as the Greek priest's assistant then placed the large gold edged book in front of the priest and the priest began to read aloud in his powerful booming voice. Finally he stopped and closed the book. There was silence.

Those of us at the desk then suddenly noticed, just as the priest closed the book, that the child's electrocardiogram trace on the central monitor beside me first became distorted and then rapidly changed to a straight line. The child had died.

I hurriedly entered the child's room and saw that the family already knew. They were standing calmly beside their child and were shaking hands with the priest and thanking him before sitting down again to continue their sad vigil. Their appearance of calm acceptance contrasted so vividly with the tears and grief of the previous two weeks. I left the room to allow the priest more time with the family and resumed my seat at the central desk area. Soon I saw the priest talking with the nurse in the room and then stride out to the central desk area. With a sweeping gesture he thanked the staff for their care, wished them well and turned and strode from the unit with his assistant following behind. The two unit chaplains who had been watching from the desk area appeared to be in awe of this performance and I was deeply moved by what had occurred.

Sometime after the priest had left the unit the nurse caring for the child told me that the priest had confided to her that "The doctors, they are good people but they don't understand these matters". These words caused me to ponder on what I had witnessed - the rituals performed by the priest, the parents' apparent calm and acceptance of the death of their child and the abrupt death of the child at the finish of the priest's reading from the book. Although I have little religious feeling, I have over many years of caring for critically ill patients seen the powerful and comforting effects of religious faith on the dying and their families as well as many inexplicable changes in the course of patient's illnesses that still mystify me.

Three memorable dinners

Durham Smith

The photo below is of some of the surgical staff of the RCH in 1968, and colleagues will recognise (from left) Douglas Stephens, Max Kent, Nate Myers, Peter Jones, "Leg" Sloan, Durham Smith, Dr Mark Ravitch, Russell Howard, Murray Clarke. Sadly only Max and Durham still survive. Dr Ravitch is the focus for the first of the Dinner recollections. He was the Surgical Guest of the Hospital in that year, an established paediatric surgeon, but a significant contributor in other ways. His appointments at that time were as Associate Professor of Surgery, Johns Hopkins University School of Medicine, and Surgeon-in-Chief Baltimore City Hospitals. Mark was of Russian ancestry and spoke fluent Russian, and came into prominence in 1948 by introducing a Russian stapling instrument into the USA. and demonstrated its use in a bowel resection. As his career progressed, with a very sharp and incisive mind, he became a professional editor of several major surgical journals; he established relationships with major publishers and was a great guide and mentor to surgeons wishing to publish. He facilitated the publication of my first book (on spina bifida) with Charles C Thomas, Publishers.

In 1964, Mark was President of the Surgical Section of the American Academy of Pediatrics, and chaired the annual dinner of the Academy, which I attended. One of the privileges of the presidency was to choose the after-dinner speaker. Mark chose a Russian surgeon, who spoke in Russian, and Mark translated as he went along. The speech was totally absorbing and hilarious from end to end. The gesticulations of the speaker, the sly digs at the political scene made it memorable. But nobody picked it – it was a complete hoax! The "Russian" was an American carpenter friend of Mark's, who knew not one word of Russian, and his extraordinary verbal dexterity in made-up sounds went on for nearly 30 minutes! The "translation", of course, was entirely Mark himself who had a wicked sense of humour. Remarkably, not a single person in the room of 500 people knew any Russian.

I was also a witness to another remarkable speaker, again at an Academy Dinner. The invited speaker had launched a campaign in America, to clothe all the naked animals, horses, pigs, cows, large dogs, etc.! He made an impassioned speech, with every technique of the charismatic evangelist, deploring the immorality of such daily spectacles bombarding the tender minds of American youth. The horror of the images conditioned in young minds by the sight of ..... "I'm sorry, I cannot say the words", things unmentionable in a civilized society! He described the success of the campaign, with brochures showing the picketing of the White House by supporters, the thousands of dollars raised by donations from supporters (sent to a post-box address in Chicago), the capitulation of a major Bank in Manhattan (which had a full-sized stuffed champion race horse in a window as a show piece) to put a drape over the back end to hide the offending appendages, and so on. (All of these things were true). His speech was said in dead earnest, and most members of the audience really believed he meant it, however bizarre it might

L-R: Douglas Stevens, Max Kent, Nate Myers, Peter Jones, LEG Sloan, Durham Smith, Mark Ravitch, Russell Howard and Murray Clarke

appear. At the end, someone finally asked "Is this a hoax?" "Of course it is" he replied in a total change of character. His explanation was that he, and another journalist, believed (in their view), that Americans were gullible and easily duped by flamboyant evangelists of any persuasion, especially in questions of personal morality, and they set out to prove it. The post-box in Chicago to which thousands of dollars had been sent was actually a broom cupboard in an apartment!. They gave all the money away to charities, and I believe a film was made about it, "The Great American Hoax".

Colleagues who visit Japan will have experienced much warm hospitality, and after the professional engagements, a visit often ends with a Dinner with the local host and his or her Department, often a very formal one in a traditional restaurant, each guest being personally waited on by an elegantly dressed, mature aged Geisha, highly trained in the classic tradition. The meal is formal, followed usually by a display by the geishas of ancient forms of Japanese music and dancing, all in impeccably good taste. Then the mood changes, the atmosphere relaxes, and guests are invited to partake in simple games with the geishas (Paper, Scissors, Stone, etc.) which the guests invariably lose, the penalty being a noggin of sake at each loss, much to the delight of the locals, and the increasing confusion of the guest! I was familiar with this procedure from several visits to Japan, and on one occasion decided to brave a break with tradition, with the approval of the host. I challenged the geishas to a game of my own (a stupid little trick in the manipulation of turning scissors in one's fingers), and beat them every time – with the equal demand of the same penalty for the losers. This was readily agreed to by the geishas, rather too willing it appeared to me, and it is recorded as the only time such elegant geishas were known to be drunk!

The 2015 APS Meeting in Slovenia.

Jeff Prebble

My wife, Robyn and I attended the Australian Paediatric Society Meeting last year in Slovenia and had a great time. I would recommend this meeting to all paediatricians (general and subspecialty).

Slovenia – The Republic of Slovenia is a nation state, formerly part of Yugoslavia. It is bordered by Italy to the west, Austria to the north, Hungary to the northeast, Croatia to the south and the Adriatic Sea to the southwest. It is a beautiful mountainous country still largely undiscovered by tourists.

The A.P.S. meeting – The meeting combined medical presentations (e.g. clinical cases, clinical governance, selected updates) and discussions with non-medical presentations (e.g. yachting, magic, reflections etc), tourism activities and some lovely dinners. Each registrant was invited to give one medical and one non-medical presentation. Usually half the day was allocated for the meeting and the other half offered time to explore and some trips arranged.

Travel – All travel & accommodation arrangements were efficiently made by the APS travel agent who joined us at the meeting and took care of every detail. We flew into Ljubljana, the capital and were driven to Lake Bled, the venue for the first five days. While there we toured the Bohinj Valley and the Poklijuka High Plateau. On day 6 we bused to Venice and boarded the Le Lyrial, a ship of the Ponant Line for a 3 day cruise down the Croatian coast. Some of us stayed in Venice for a few extra days before returning home.

Friendship –25 Australian paediatricians and their partners attended the meeting and it was a wonderful time to renew acquaintances or make new friends.

Jeff Prebble and his wife Robyn

2017 – The next overseas A.P.S. Meeting will be held in May 2017 in Portugal and Spain. It is planned for the main venue to be Porto with a cruise down the Douro River. If anyone is interested please contact the executive of the A.P.S.

View from our hotel: Lake Bled looking towards the castle.

Life in an aged care home in 2016

Eileen Anderson

First I will tell you something about myself and my place in the RCH so you will know who I am. I trained as an Occupational Therapist and after a short time at the Observatory Clinic (now the South Eastern Child Psychiatry Clinic) I went overseas. By ship of course taking eight weeks to get there as we got caught up in the Suez Crisis in 1956 and had to go around Africa.

I worked at two psychiatric hospitals, a general hospital, an Aged Care hospital and at the Hospital for Sick Children in Toronto,Canada. Those were the days when you just walked in to a place and asked for a job, which I did in Canada, and later at the RCH.

I joined the RCH in 1961 at the old Children's Hospital in Carlton and helped move to Parkville later. I have an old photo of two girls in gowns loading a bird in a cage into a car.

I worked for a while as an OT, then had the opportunity to move to the Dept. of Psychiatry as it was then called, to work with Miss Ruth Drake while Margaret Eriksen was at the Tavistock in London, I was trained by Dr (Winston) Rickards often with the young doctors who were training in psychiatry. We were called Play Therapists then and Ruth Drake had a remarkable rapport with children. I did Psychology 1 at Melbourne University and in1972 went to the Tavistock Clinic in London. This was funded by the Creswick Foundation and the RCH. The Tavistock was in Hampstead and followed the teachings of Melanie Klein. I lived nearby and used to walk to the Tavistock by Freud's house where Anna Freud ran her Clinic. The Kleinians and the Freudians hardly spoke to each other!

I was in London for a year and then came back to the Dept. of Psychiatry and Behavioural Scence. By then we were called Child Psychotherapists and for a time I was Acting Chief Child Psychotherapist, with Dr Bob Adler as Head of Department.

I resigned when I inherited a house in Ballarat where I went to school and spent the next two or three years before I retired working as the manager of the Child and Adolescent Psychiatry at the former Lakeside Hospital. There was a CEO I used to call "she who must be obeyed", as she was rather severe. The three senior managers had to take turns at being on duty at night and weekends for the whole hospital. For a short time I was Acting CEO of Lakeside Hospital. We eventually merged with the Base Hospital and one of the most interesting things I did there was to be on a committee which supervised the revamping of the old Queen Victoria w w. Ward for Child and Adolescent Psychiatry. It now looks stunning and the outside still looks like the 1800s. I retired from all that in 1995.

That is a summary of my working life which is more interesting than later on.

When I retired I moved to a smaller house and not long afterwards I was diagnosed with cerebellar ataxia type 6, the first sign of which was extreme fatigue. Type 2 is the best one to have if you have to have cerebellar ataxia - mine progresses very slowly. I am in a wheelchair and use a walker a bit in my room. I can walk about twenty steps with a walker and do exercises twice a day. My balance is terrible: backwards, forwards and sideways. I had lots of help but when my name came up for this place, I moved in. I have been here three years now, and it is a very good place. I think the bond to come in and the monthly fee is very dear, but I'm told that Melbourne is much dearer.

We have recently moved into an older area which was revamped. New carpets, new curtains, paintwork and fittings. All on the ground floor with a terrace, a garden and a view over a lake. It suits me as I have a scooter and I don't need to use a lift any more.

The food and the care are very good and we have a hairdresser, a chiropodist, several physios, two chapels and ministers from the Uniting Church and the Anglican Church visit and have regular services. The chaplain for this place is Catholic but he visits everybody. I have learnt a lot about the Catholic Church since I have been here: my best friends are a woman who was a decoder at Bletchley Park, UK ,during the war, a Christian Brother who is teaching me cryptic crosswords, and a woman hotelier. I play Scrabble every week with the lady who was a decoder and go out a lot. I pay a friend to take me to U3A, to my Book Club and to a monthly lunch with a group of friends. Otherwise I am busy with the crossword, the iPad, friends who visit and I read a lot. I have a lady from Library in the Home, run by the City Library, who brings me books. Reading is my favourite occupation. Most of the residents are about 90 and are deaf so they are not good conversationalists! So I am lucky to have the friends I do have.

My life is greatly enriched here with all the different people I meet: the residents and their families, the carers, the nuns and the management. So I have no regrets.

I joined the Alumni after my friend Ruth Wraith showed me a copy of the Newsletter and then sent me the application form. It is a good way of knowing what is happening to people I used to see often. I'm sorry I can't attend any of the functions or the talks. There seem to be some very interesting speakers, but I look forward to reading the revues of them in the Newsletter. I hope the Alumni will gain more members and go on for a very long time.

Our most recent Alumni event

Garry Warne

On March 15th 2016, **Professor Frank Billson, AO** spoke to the Alumni on "Women in Medicine and a deeper understanding of the Hippocratic oath".

Frank grew up in Melbourne, graduated in medicine in 1958 and after specialist training in England and a period of research in Melbourne, he became Head of Ophthalmology at the Royal Children's Hospital Melbourne in 1968. About 10 years later, he became the Foundation Professor of Clinical Ophthalmology at University of Sydney. He vacated that position some 30 years later in 2008, now holding the title of Emeritus Professor. He has received many awards, including being made NSW Senior Australian of the Year in 2006, in recognition of his humanitarian work in Australia over 40 years in the honorary care of prevention and treatment of blindness in premature babies.

Frank's lecture highlighted the contributions of a number of outstanding women, one of whom was Dame Kate Campbell, with whom he collaborated in pioneering work on retinopathy of prematurity. The very first infant to receive laser treatment for ROP, a boy, went on to graduate with first class honours in Engineering, then studied Medicine and is now completing a PhD in Neuropsychiatry. This young man, Dr Patrick O'Brien, was present in the audience to hear Professor Billson's lecture to our group. Professor Billson, Dr O'Brien said, was the person who inspired him to study medicine and he recalls that whenever he came to see Frank, he was made to feel "the most special person in the world".

Dr Patrick O'Brien, Professor Frank Billson AO and Alumni secretary, Prof Garry Warne

An invitation

Welcome to the Shy-World a personal insight into the lived experience of social anxiety

The Royal Children's Hospital Melbourne Alumni

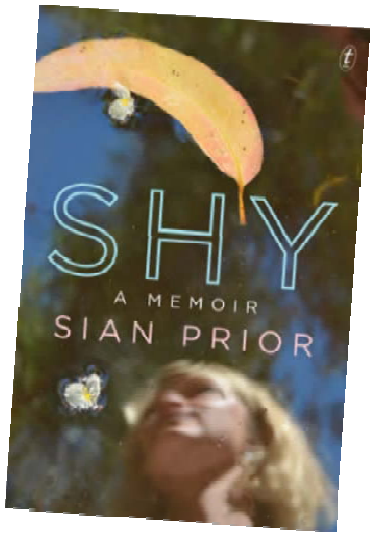
Guest Speaker Dr Sian Prior

The second event of the Royal Children's Hospital Alumni for 2016 will be held Tuesday May 24th in the RCH Foundation (2nd Floor, 48 Flemington Road, Parkville)

Lunch from 11:30AM - 1:00PM ($20.00)
Lecture at 1:00PM

Registration is only required for those wishing to attend the lunch.

Many of us will be aware of the impact of 'shyness' on our own lives or those of friends, colleagues or family. It is not often discussed openly and Dr Prior's book provides new insights on its influence. Dr Sian Prior is a journalist, ABC broadcaster, opera singer and creative writing teacher. In 2015 she completed a PhD in Creative Writing, for which she researched and wrote 'Shy:a memoir' (Text Publishing 2014).`



To help you make your way to the event, we have included parking and public transport tips below:

Parking: Enter via carpark entry 4 from Flemington Road. Take the Larwill Hotel lift to the ground floor, cross the foyer and take the silver lifts marked 48 Flemington Road, to level 2.

Public transport:Take the 59 tram from Elizabeth Street or the 55 tram from William Street in the city and get off at stop 19 - The Royal Children's Hospital.

Please RSVP by email to garry@wamefamlly.net by Friday 11th of May 2016. Please advise –

Name I

will be accompanied by .....

Payment for the luncheon ($20.00 per person) can be made by:

Bank transfer

Account name: RCH Medical Alumni BSB 063113 Account number 10076105

Cheque

Made out to RCH Medical Alumni
Mail to: Prof Garry Warne, Secretary, RCH Alumni, Executive Suite, Royal Children s Hospital, Parkville VIC 3052.