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

The Royal Children's Hospital Melbourne Alumni

# RCH alumni newsletter

December 2016

Hopetoun Falls in the Otways recorded in reflected infra-red by Gigi Williams. Gigi wrote her post-graduate thesis on infrared and ultraviolet photography in medicine to obtain her Fellowship of the Royal Photographic Society.

# Contents



## The 2016 RCH Alumni Executive



## Credits


Editors – Profs. Garry Warne, Jim Wilkinson, Margot Prior

Graphic design – Dan Warne

# From the President

## Membership

From November 2015 to October 2016, our membership has increased by 18 to 163. Currently there are 114 men and 49 women members. You are encouraged to suggest names of potential new members.

Your executive has proposed some minor modifications to the wording of the constitution regarding membership criteria and we commend these to you for your consideration and support at the forthcoming Annual General Meeting.

## Events

There have been several well-supported Alumni events in the past year. The various attendance figures are listed in the Treasurer's detailed report.

November 2015 end of year dinner at Kew Golf Club: This new initiative proved to be a most convivial and enjoyable evening. Current enrolments for 22 November suggest that those attending this year's function will enjoy a similar experience.

Lunch presentations: In March, Frank Billson, our distinguished Sydney member gave a thoughtful talk about women in medicine, in the Vernon Collins Theatre. In May and July respectively, we had record attendances at our new venue, the RCH Foundation space, for Sian Prior's presentation about shyness, then from Lynn Gillam and Ros McDougall about ethical approaches to parent-doctor disagreements regarding patient care. We appreciate the warm welcome extended to us by Sue Hunt, RCH Foundation CEO and her staff, in making available their very convenient combined venue for both lunch and presentation.

The Vernon Collins Oration, entitled Disability at the Crossroads, was given in early October by Professor Dinah Reddihough, who kindly agreed to present a modified version of her inspiring and moving Howard Williams Oration from the RACP conference in May this year. Discussions are in progress to raise the profile of the VCO and to enhance the search process for future speakers.

An afternoon at the movies with former RCH nursing staff (LOFT) filled most of the Ella Latham Auditorium later in October, followed by afternoon tea in the HELP area. The large combined group enjoyed watching digitised versions of two historical RCH movies, from 1963 and 1972, and a 1972 comedy movie, whose director (David Bannister) and male/female lead (Brian Edis) were present and acknowledged with acclamation. The contributions of Sue Scott from the nurses' group, and Rob Grant, senior video producer are gratefully acknowledged. A similar event in 2017 is already being discussed.

## Newsletters

An eclectic magazine with diverse contributions from members was circulated by email in April and you are now reading the second and final edition for this year. Contributions for future editions, whether in prose, poetry or pictures, fact or fiction, are warmly invited from all members. Thanks and congratulations to the editorial team - Jim Wilkinson, Margot Prior and Garry Warne – and to Dan Warne for lending us his expertise for the layout of this production.

## Alumni home page

The Alumni home page, at www.rch.org.au/alumni is ably maintained by Jim Wilkinson, and now includes 25 alumni profiles, details of past and future events, recent issues of our newsletter and a photo gallery. More alumni profiles would be most welcome!

## Honours to Alumni

During the past year, Professor Glenn Bowes was appointed an Officer in the Order of Australia (AO), Professor John Hutson received the American Academy of Medicine Medal in Urology and Professor Margot Prior was awarded an Honorary Doctorate of Science by the University of Melbourne. Congratulations to all three distinguished colleagues.

Kevin Collins, President, RCH Alumni
kevincollins.doc@gmail.com

## Executive

All four office-bearers on the present executive are applying for re-election at this year's AGM. Others are of course welcome to apply, and expressions of interest from possible future co-opted executive members are also encouraged.

On a personal note, I wish to thank my executive colleagues for making the past year a stimulating and enjoyable one –

**Garry Warne** for his untiring creative energy, despite a major health scare, and his relentlessly opportunistic pursuit of possible new members;

**Jim Wilkinson** for his seemingly effortless yet meticulous attention to the details of our finances as well as maintaining the membership database and Alumni web page;

**Karin Tiedemann** for so willingly and efficiently taking on duties relating to catering for large and small events; and finally our three wise seniors –

**Hugo Gold, Margot Prior** and **Andrew Kemp** – whose comments, however brief, always give me food for thought and provide a valued different perspective.

With thanks for your support this year, and best wishes for 2017.

# How we started heart transplantation at RCH

By Prof James L Wilkinson

The option of heart transplantation for patients with end stage heart disease emerged in the late 1960s, having been pioneered by Dr Christiaan Barnard in South Africa and heavily based on research at Stanford by Dr Norman Shumway. A number of surgeons did a small number of cases over the following few years but most patients transplanted in this time period survived only for weeks or a few months. Immuno-suppressive drugs were in their infancy and management of rejection was generally inadequate. Renal transplantation had been established with moderate success, but failure of the transplanted kidney, due to episodes of rejection, could be managed with dialysis whereas with heart transplantation no such option was available.

Dr Shumway and Dr Barnard were among a very small number of surgeons who persisted with their programs through the seventies and it was the emergence of the immunosuppressive agent Cyclosporin, a fungal metabolite developed by Sandoz in the late 1970s, which was the major factor that made heart transplantation a realistic option.

This led to the establishment of several transplant programs and my initial interest in the transplant arena followed the emergence of that at Harefield Hospital on the outskirts of London, led by Professor Magdi Yacoub, in 1980.

The Harefield program, which involved both heart and heart-lung transplantation, included a paediatric arm. The paediatric cardiologist who managed this was a friend and colleague, Dr Rosemary Radley-Smith, with whom I had worked as co-organiser of poster sessions for the first World Congress of Paediatric Cardiology held in London in 1980. At that time, I was working in Liverpool in the UK and during the eighties I referred a number of patients for consideration of transplant at Harefield and was subsequently involved in follow up and management of a number of post transplant patients.

In Australia two transplants had been done in the late 1960s, one in Sydney and one in Melbourne, during the first wave of enthusiasm after Dr Barnard's well publicised cases in South Africa. As happened elsewhere the initial enthusiasm rapidly faded and no further transplants took place for more than a decade until the commencement of the program at St Vincent's Hospital in Sydney, in early 1984, led by Dr Victor Chang.

Several patients from Victoria were referred to St Vincent's for consideration of transplantation and a number were operated on there in the mid-eighties. A small number of children requiring heart lung transplants were referred overseas to Harefield, but these required government approval if their substantial costs were to be found.

Herald Sun Article 21 July 1988

Victoria ready for baby heart swaps

BY CALVIN MILLER
MEDICAL REPORTER

Heart surgeon Dr Roger Mee and his colleagues at the Royal Children's Hospital are ready to perform Australia's first heart or heart-lung transplant on a small child.

The program for babies and children is one of only a handful in the world and is expected to do five to 10 transplants a year, although patient numbers could increase as the program becomes more established.

Three or four sick children now at home are considered to be candidates if a heart becomes available.

Dr Mee said that young heart patients presented special problems and could not be treated as if they were small adults. He felt that a children's hospital was better equipped for performing transplants in children, especially infants.

"We're talking about small-body technology," Dr Mee said.

"Infants and children differ

would prefer to start with only a heart transplant."

Cardiologist Dr Jim Wilkinson said that children could require a new heart if the heart muscle developed a degenerative disease, as also happened in some adults who became transplant candidates.

"Also, some infants are born with a very poorly developed left ventricle, so the heart can-

arteries and veins so badly misplaced and misconnected that it's a plumbing disaster, and a transplant could be the answer."

Dr Wilkinson said that children with cystic fibrosis who developed irreparable lung disease could become candidates for heart-lung transplants, as well as children who developed other degenerative lung

fants has been controversial and has met meagre success in other centres. However, at the Loma Linda University Hospital in California, 10 of 14 infants had survived.

Heart-transplant success rates for older children and adults typically vary between 80 and 90 per cent.

While most of the transplant patients would be children,

will be the problem," he s

For the rest of their lives transplant patients will be ing drugs to prevent their mune systems from attac and rejecting the donor h However, the doctors said small children taking drugs had normal physical intellectual development.

Drs Mee and Wilkinson that some people might ob

Three of the Royal Children's transplant team (from left): Dr Jim Wilkinson, Dr Roger Mee and Dr Rob Eyres.

There were plans to start an adult transplant program in Melbourne, but at which hospital and when this might happen was uncertain at the time of my appointment to the role of Director of Cardiology at RCH in 1987. When I visited RCH in July that year I was made aware that the CEO, Dr Barry Catchlove, and the director of cardiac surgery, Dr Roger Mee, were hopeful that a paediatric heart transplant program might get approval from the State Government if we chose to apply for it.

With this prospect on the horizon I agreed to participate in a paediatric cardiac transplant meeting in Philadelphia in the latter part of that year - a few months ahead of my planned start date at RCH in early 1988. I also entered into discussions with Dr Rosemary Radley- Smith and Professor Sir Magdi Yacoub at Harefield Hospital in an effort to learn about their protocols for assessing and managing children prior to and after transplantation. These discussions continued by mail in the following months after my arrival in Melbourne in January of 1988 and in April 1988 I accompanied a young heart-lung transplant patient, who had been referred to Harefield, when he and his father flew to London. I was able to spend some time with the Harefield team while I was in the UK that week.

We developed our own protocols for the assessment and management of transplant patients over a period of six months between February and August of 1988, and these included both heart and heart-lung transplants.

We formally applied for approval from the State Government and this was given in September of that year.

At much the same time the Alfred Hospital in Melbourne obtained approval to start their adult program and recruited one of the surgeons from the St Vincent's team - Dr Don Esmore, to lead their program when it started early in 1989.

Our transplant program at RCH started on 4th October 1988 with the successful transplant of a heart into Michael Sofoulis, a fourteen year boy old with a dilated cardiomyopathy. He had been diagnosed with a cardiomyopathy several years earlier and had suffered an out of hospital cardiac arrest in 1987 from which he had been successfully resuscitated. He had suffered some brain damage but made a good recovery over several months. The St Vincent's team turned him down for transplantation in Sydney, because of his neurological injury, but later assessment at RCH indicated that he would be a good candidate and hence he became our first patient to be transplanted. He survived for more than twenty three years, marrying and having two children of his own.

Our third transplant, in December 1988, was a heart lung transplant, which was successful. Thereafter we performed a number of transplants, averaging about 5 per year, over the next three years. These included five heart lung transplants during that time. In 1991 the RCH paediatric heart transplant program was approved for national funding becoming the first program to be given the status of a "Nationally Funded Centre".

Our staffing was very limited with me, as the paediatric cardiologist involved, taking on all the assessment and follow up of patients in the first phase. Roger Mee was the main surgeon, though Dr Tom Karl and other members of the team assisted him with energy and enthusiasm. The management of the heart lung recipients was shared with our respiratory physicians. We appointed a transplant coordinator, Ms Anne Shipp RN, in 1990, and this provided much needed help for the patients and their families as well as for me. During the early years we had visits from Dr Radley-Smith and Professor Yacoub from Harefield Hospital, who were both helpful with advice and discussions.

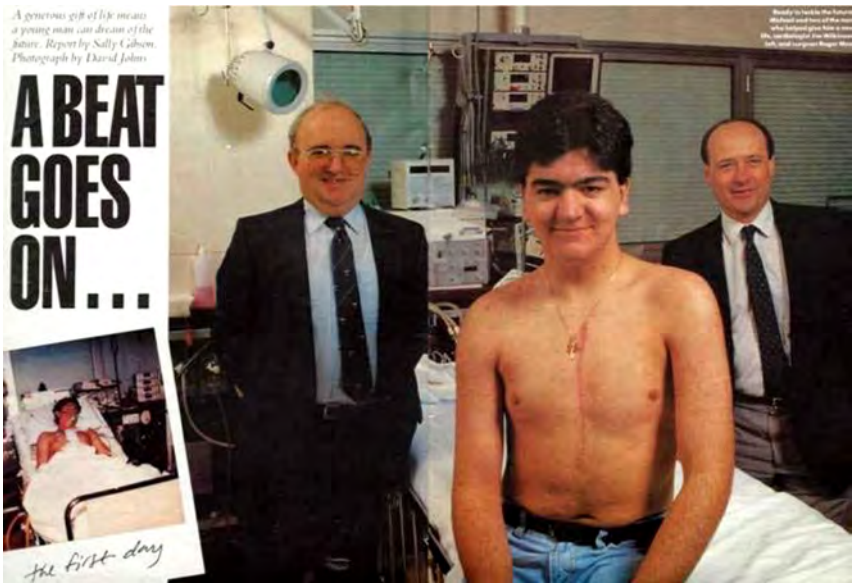
Patients were referred for consideration of transplant from all over Australia. During the first five years of the program (1988 - 1992) we assessed 60 patients for possible heart or heart-lung transplant. 16 were from interstate (NSW 3, SA 9, QLD 1, TAS 2, WA 1).

The appointment of Dr Robert Weintraub as a paediatric cardiologist with a major interest in transplantation in 1992 was an important step forward. After his arrival I was able to pass on the running of the transplant program to him. Since then the program has continued and expanded steadily. By mid 2015 a total of almost 300 patients had been assessed for possible transplant. 137 heart transplants had been performed (including two re-transplants) and 14 heart-lung (8) or lung (6) transplants. All heart-lung and lung transplantations were taken over by the Alfred Hospital team from 2001 as they had excellent results and we had no plans to perform such procedures on pre-adolescent children.

The results have been encouraging with survival for the heart transplant patients done between 1988 and 2007 being 87% at 1 year and 71 % at 15 years (figures that are better than the International Heart and Lung Transplantation Registry data). 5-year survival has improved with 40 children transplanted between 1988 and 1995 having had a five-year survival of 77% and 41 operated between 1996 and 2002 having a five-year survival of 86%.

The evolution of mechanical support options, including Ventricular Assist Devices (VAD), led to important changes during the 1990s and subsequently, with an increasing number of children being supported with such means prior to transplant in the past five years. Of 18 transplants done in 2014 and 2015 ten were transplanted after periods on VAD.

**Michael Sofoulis - One year post transplant, with Jim Wilkinson and Roger Mee, Sunday Herald, 1 Oct 1989**


A BEAT GOES ON...

the first day

# RESPECT – what it means to me.

By Mike O'Brien, Chief of Surgery

*"Thank you and please are two little keys*
*That open up every door*
*If you say one you're sure to get some*
*If you say both you'll get more"*

I was taught this rhyme by a theatre nurse (KA) many years ago and have driven my children and many surgical registrars mad with it ever since. Growing up in the south-west of Ireland in the 60's and 70's I was imbued with a strong Judeo-Christian sense of right, wrong and respect for others and for authority. Respect, then, was a curious mix of politeness, courtesy, deference, unquestioning loyalty and always spoken of as something that had to be earned.

At RCH we have set ourselves a big hairy audacious goal, to be 'a GREAT children's hospital, leading the way'. Having initially struggled with the apparent arrogance of this, reconciliation came by asking myself "If not GREAT then what, if not now then when?".

Fred Lee in his book "If Disney Ran Your Hospital. 91/2 Things You Would Do Differently" identified three levels of caring in healthcare – competence, courtesy and compassion. In his opinion what distinguishes a great hospital from a good hospital is not competence. No one goes to hospital expecting to be treated by someone that is incompetent. Unfortunately, all too often this is the case, rarely through ill-intent, usually through a failure of the system. It is not courtesy and no one expects hospital staff to be rude to them – though sadly and often many are. No, it is compassion, the human connection, the physical manifestation of empathy that distinguishes great care from good care.

In the early to mid 20th century with the advent of antiseptics, vaccines and antibiotics, the emphasis in medical care shifted from art to science. Since that time scientific advancements have resulted in an exponential increase in medical knowledge, therapeutic options and technical expertise. Based on current trajectories medical data is set to double every 73 days by 2020. It is no longer feasible for a single doctor to possess all the required knowledge to treat patients even within tightly defined sub-specialties. We need to return to a more compassionate team-based delivery of healthcare, recognising that everyone has a contribution to make. As Atul Gawande says "We hire and train people to be cowboys. It's pit crews we need.". More than that with the evolution of IBM Watson, DaVinci robots etc. we will rely less on our doctors for their medical (technical) expertise or IQ and more on their EQ to empathically explain and deliver the best evidence-based care. In many respects this represents a sort of 'back to the future' for healthcare.

In common with most (probably all) healthcare organisations we have made the patient experience the centrepiece of Great Care. In part this emerged to emphasise the primacy of the patient above all others. On initial reading this seems intuitive however I think it reduces quite a complex relationship to an over-simplified binary choice of patient or doctor. A sort of 'the customer is always right' approach if you will. In many respects this approach has contributed to the current healthcare funding crisis with direct marketing of drugs to patients, patients demanding the latest and most expensive investigations or treatments where additional benefit has not been clearly demonstrated. In the digitally connected age in which we now live the historical paternalistic approach is equally no longer acceptable to patients. This is just as true in the manufacturing, retail and service industry sectors. Some of the most successful companies now operating in this space have created a movement – Conscious Capitalism – which emphasises the primacy of their stakeholders rather than their shareholders. Their approach, to maximise the benefit for all stakeholders (staff, customer/consumer, shareholder, board, society) has seen many of them succeed and exceed more traditional competitors weathering the GFC storm better and outperforming


all of the Jim Collins 'Good to Great' organisations.

Though not a keen political analyst I had to question the visceral nature of my reaction to the outcome of the recent American presidential election. Why did I feel sick at President-elect Trumps success? It was not because I was pro-Hillary, rather it was because his campaign message was perhaps the most negative, divisive, intolerant ever, even by American standards and that is saying something. He took the normal 'them v. us' political divide to previously unfathomed depths. For the past 30 months here at RCH we have been consciously working on developing a kinder, more respectful and inclusive culture trying to take our organisation in the diametrically opposite direction. The RCH Senior Medical Staff and Executive Compact, ratified on 23rd of February 2016, clarified and made explicit the unconditional pledges that SMS and the executive made to each other the interdependent nature of our relationship and our shared commitment to delivering great care. The process was heavily influenced by a previous US president, JFK who challenged his fellow Americans to "ask not what

your country can do for you, ask what you can do for your country." It is too early to assess the full impact of this work but already examples of a positive impact have been seen. We continue to work on a broader whole of RCH Compact the conversations alive and real.

The Compact is only one step on the road to a more respectful, successful and sustainable RCH. A few of us recently travelled to America to study and experience first-hand exemplars in the application of lean thinking, principles and methodology in healthcare. Lean is not a new concept and has been tried in many industries in the past unsuccessfully – usually because a failure to grasp one of the central tenets of lean – Respect for People. Lean finds much of its origins in the Toyota Production System. Its history can be traced back further but it was Taiichi Ohno at Toyota who wove all the elements together. When he spoke of 'respect for people' he referred not only to civility and courtesy (a given in Japanese culture) but also of a model of servant leadership. Leadership where all staff were listened to; not only expected to do their work but empowered to improve their work; where they were given the necessary training and equipment to do their work; where they understood how their work contributed to the overall aims of the organisation; where seeking help was lauded not derided, seen as a sign of strength not weakness; where the role of leaders was to enable and ennoble not to dictate and demean. Respect for people is actually a dilution of his original principle which literally translates as 'deep reverence for humanity or humaneness'. It recognised the importance of having a sense of purpose in one's life and that this can be found through meaningful work. It recognised the disrespect in wasted talent and ability.

It would later be captured by Dan Pink in his book 'Drive' where he postulates that what motivates people to perform to their best are a degree of autonomy (in Toyota this manifests as an expectation that you will improve your own work. They generate 60,000 improvement ideas a year of which 85% are implemented), mastery (in Toyota staff are given extensive training 6 weeks per annum for every 60 seconds on the production line) and a sense of purpose. As George Bernard Shaw said "This is the true joy in life, the being used for a purpose recognized by yourself as a mighty one... the being a force of nature instead of a feverish selfish clod of ailments and grievances complaining that the world will not devote itself to making you happy." When viewed through this lens respect becomes the most powerful challenge we could face. It requires us to consider not only our actions and behaviours but the broadest consequences of those actions including how they affect the well-being and sense of self of those affected.

In closing I return again to an American president Abraham Lincoln, who in his first inaugural address on 4th March 1861 said "We are not enemies, but friends. We must not be enemies. Though passion may have strained it must not break our bonds of affection. The mystic chords of memory, stretching from every battlefield and patriot grave to every living heart and hearthstone all over this broad land, will yet swell the chorus of the Union, when again touched, as surely they will be, by the better angels of our nature."

*"be the change you want to see in the world"*
*– Mahatma Gandhi*

# Meet Matt Sabin, the new Chief of Medicine at RCH

Associate Professor Matt Sabin is Chief of Medicine and Director of Endocrinology and Diabetes at The Royal Children's Hospital. He trained at Guy[1]s and St Thomas[1] Hospitals in London (UK) where, so many years ago, great men such as Thomas Addison, Richard Bright, Sir Alexander Fleming, Thomas Hodgkin and John Braxton Hicks all worked. His admission criteria for entry into medical school was Grade B in three Advanced Level high-school studies and, with one A grade, one B and one C, he narrowly gained entry into such a prestigious medical school. The Dean at the time said that most students were taken on their academic achievements but a few were also admitted on the feeling that they possessed qualities that would one day make them great doctors.

Following general adult and paediatric medicine clinical rotations, and then gaining membership to the UK Royal College of Paediatrics and Child Health, Matt began specialist training in paediatric endocrinology and diabetes and undertook a PhD in the area of childhood obesity and diabetes. In 2006, he moved to work at The Royal Children[1]s Hospital (RCH) in Melbourne where he continued his specialist training and gained membership to the Royal Australasian College of Physicians. This was no easy feat. Having not worked in the UK as a Consultant, because of his PhD studies delaying his progression to a Consultant level, he was welcomed to the Royal Australasian College as a basic trainee and was made to sit both the written and clinical exams again.

He commenced work as a Consultant Paediatric Endocrinologist in 2010, and continued to be research active in the area of childhood obesity. By this stage, his research program had developed to involve basic science, clinical research and epidemiological studies in collaboration with important national and international groups. Professor George Werther was a colleague, a careful mentor but, perhaps most importantly, an inspiration. In 2014, George resigned as Director of Endocrinology and Diabetes and Matt was appointed by the RCH Executive to be the new Director in 2015.

In 2016, he was appointed Chief of Medicine - providing oversight and guidance on quality to 17 medical departments. This is a busy job, with a multitude of committee meetings, a huge amount of reading and >150 emails/day.

He also continues as an Honorary Principal Fellow of the University of Melbourne and a Senior Research Fellow at the Murdoch Children's Research Institute.

Matt has contributed significantly to the Melbourne Children[1]s Campus in the three important areas of clinical service, research and education. He has established The RCH Weight Management Service, which is the largest specialist service for obese children in Australasia. He has published 100 research papers - many in leading international medical journals such as the New England Journal of Medicine, Pediatrics and Nature Reviews. He is Deputy Chair of The RCH Human Research Ethics Committee, a council member of the Australasian Paediatric Endocrine Group, Deputy Editor of Clinical Obesity (an international journal published by Wiley) and an examiner for undergraduate and postgraduate students, as well as an examiner for the clinical examinations of the Royal Australasian College of Physicians.

Matt is married to Louise (a Consultant neonatologist at the Royal Women's Hospital) and has 2 boys aged 9 and 5. He lives in McKinnon and enjoys adventurous activities such as kitesurfing and snowboarding. Most of his 'free time' is, however, spent reading his children bedtime stories!

# RCH last century

By Janet Fitzpatrick (1961—1972)

After a serious year at RCH I decided paediatrics may be preferable. In 1961 I started work at the "old" hospital in Pelham Street Carlton. Some of the hospital buildings are still visible; on the North East corner of Pelham & Drummond Street the red brick building is now fashionable apartments. Previously it was medical wards & that was where I started with Dr Stanley Williams, an entertaining consultant.

There is another building recognisable at 151 Rathdowne Street. It is three stories & the male residents lived on the third floor. A couple of common rooms provided space for some lively parties. An American registrar often led the music with "Those old cotton fields back home".

The women had their own quarters, again a three storey red brick structure, but in the centre of the scattered hospital buildings. There were only about eight of us and we were thoroughly spoilt by Mrs McCrory She believed we worked VERY hard and would bring tea & hot buttered toast for breakfast

Casualty was a small area with large burgundy coloured floor tiles. It was common to do a myringotomy for a bulging ear drum [something I hated] At night if there was a urine or CSF to be examined we went to the lab to do it ourselves. No microbiologist on call then!

My second term was spent at the Orthopaedic unit at Mt Eliza. Children who had suffered polio, scoliosis or other spinal problems were treated there. Most were in a hip spica or full spinal plaster, and spent several months at Mt Eliza.

The ward was a long open balcony looking towards the sea.

The registrar [P Curwen Walker] & I had our own quarters & dining room. We ate there in style, sometimes joined by Dr Davies, the Medical Director. On Tuesday or Wednesday, the Orthopaedic Specialists came to review their patients & operate or change plasters ----Eric Price, Peter Williams & Bill Doig.

The RCH Ski Club was first formed at the old hospital and to raise funds for it Sisters Jeanette Pollock & Kate Harden organised a stall in outpatients where there was a long hall with wooden benches down the middle. As a foundation member my family & I enjoyed lots of skiing & work parties with RCH friends [Cass, Lane, Williams & even Dr Colebatch - I don 't think he skied but he came to some work parties.]

When we moved to the "new" hospital in Parkville in 1963 there was great excitement. At the time I happened to be the admitting officer, so I like to say that I admitted the first patient, although not the one for whom the queen cut the ribbon. As a registrar I enjoyed working in neonates, and general wards. From 1964 I changed to part time work in Clinic A. It was a section of emergency where we saw children who came to Emergency with a doctor's referral letter. We managed & reviewed them there & only referred them to outpatients when necessary (other Clinic doctors were Una Shergold, Shirley May , Pam Triplett). As well as that I did part time relieving in the Dermatology Clinc with Bob Kelly, and in the Staff Clinic. When I had a young baby he or she would come to work with me for the first few months!

If I were busy, the "pinkie" would happily look after the baby. What a luxury. I'm sure you could not do that now!!!

There was always a great sense of camaraderie at the old hospital; I hope it continues in the very beautiful and much more complex structure that is now RCH.

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# ECMO ballad

By Peter Loughnan (who won an award at the annual ECMO Conference in Salt Lake City for this song.)

Once there was a neonate suffering from hypoxia

Where can I go to get more air?

Ventilated, paralysed, dopamine and all the rest

Bad do I feel. It's just not fair!

ECMO, ECMO come along and sa-save me

Otherwise I am down the tube.

Down came the scientist, randomised me to control

Down went my pulse rate and pO2.

Now my ghost may be heard as you pa-assby the ICU,

Stuff the bloody scientist - I need ECMO!

(Tune: WALTZING MATILDA)

# Two Memorable Dinners

By Durham Smith

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!

On another occasion, in 1973, an American Paediatric Surgeon, Dan Hayes, and I were guests of the Japanese Society of Pediatric Surgeons, and we gave lectures, etc. in a number of Centres around Japan, with a car, a driver, and a Japanese interpreter. Each visit usually ended with a formal Dinner, described above. But on one occasion after a formal meal, we were taken to a very modern "Bar" in which the host had reserved a private room. Here we found eight surgeons (no wives), and to our embarrassment each of us was seated next to – how shall I put it? –well, not a class 1 geisha, dressed in modern décor, at least what there was of it. There was much bantering and joke telling, and we could see the inevitable objective of the evening. Dan and I became increasingly alarmed, but the evening came to a halt when, in a moment of temporary quietness, one surgeon leaned over and asked me a question in very broken English (Note again the context we were in and the reader may appreciate the special significance of the question). He asked me "Have you got the public disease?" It is the sort of question that does command one's attention. I looked at Dan, and our first line of attack (as we rapidly conferred in English) was that we did not understand the question. By now there was complete silence as the vultures waited on our reply, and the question was repeated in louder volume. Another conference between Dan and me, and we announced that we had had enough, that we were offended by such a personal question, especially one referring to venereal disease, and that we would get up and leave, despite the offence this might be to the host. To our astonishment this was greeted by hilarious laughter, and it was some minutes before order was restored. In total confusion we could only respond "come on, you've had your fun, what's going on?". Another surgeon, who in better English, said "All he asked you was "Have got much pollution in your country?" Such are the hazards of pre-judgement!

There was, in fact, a sequel, not known to us at the time. I was aware of the provocative attempts of my partner to attract my attention, and detected her resentment when there was no response, especially when we were departing. What we did not know was that a host, in these situations, may have a contract with the management, for a so-called "2-hour" or "8-hour" booking of the ladies. A "2-hour" contract is for the period of the after-dinner room fellowship of chatter and jokes; the "8-hour" contract has the expectation that the guest will continue the liaison back at the hotel! It is just as well for my girl; she would have been very disappointed.

# Tales of Cobargo

By Reuben Glass

I graduated in 1955 and after a year as an intern at the Alfred Hospital in Melbourne and then a year at the Children's Hospital I thought I had enough experience in city teaching hospitals and was sufficiently confident to enter General Practice in a country town. We came to be in Cobargo as my family had been friendly with a Mr Pretty, who had been a high-school Principal but had retired with his family to farm there. Cobargo is a small country town, 20 km inland from Bermagui, on the South Coast of New South Wales, between Bega and Narooma. Like many country towns, its population was diminishing, with the expansion of the nearby market towns.

Cobargo had a doctor, but he had left, rather suddenly, before I appeared; the townsfolk had formed a doctor's committee to attract a successor, with the promise of a rent-free home and no ingoing charges. So, with my wife Pauline, I went to Cobargo. It had a hotel (where no-one stayed), a garage, grocer, butcher and newsagent, and was on the Princes' Highway, between Melbourne and Sydney, a main road then partly unsealed. Our house was on the top of a small hill overlooking the valley.

We had a new baby, Rachel Susan, no money and no family guarantors. Furniture for the consulting room, bought on Hire Purchase, was sent from Melbourne. A laminex table and a few chairs, a bed, and a few wooden tea chests were our furniture.

The very day we arrived, the phone rang. The caller, a Mrs Mavis Allen, asked me to see her ill son, Gordon. He had been in the local Bega District hospital for six weeks, during which time he was seen by the three good GPs in the town, and was not improving. Mavis, who was a skilled ex-army nurse, had decided to take him home and nurse him there. She gave me precise directions.

"Drive down the hill from your house to the highway, and down to the bridge where there's a signpost to the Yowrie road. Drive four miles along the road and you will see a signpost at a fork in the road. There used to be a sign to Yowrie, but it fell down a few years ago. Take the left hand road and drive another three miles, and you will come to a row of large pine trees on the left. Our farmhouse is just behind those trees."

I followed the directions. Mavis met me and showed me inside the house, and into Gordon's bedroom. There I saw the sickest 3-year old child that I have ever seen. He was deathly pale, feverish, and sitting up in bed gasping for breath. Mavis told me how he had been treated in the District Hospital for acute rheumatic fever with heart involvement.

The "doctor's House" where we lived at the top of the hill.

When I put my stethoscope on his chest, I heard the loudest duct murmur that I had ever heard.

When I was a medical student we had wonderful teachers in my clinical years. I remember especially those at the Children's Hospital who made sure that we knew how to examine a child's heart with the stethoscope. We were shown children who were being assessed for the newly developing heart surgery.

When I listened to Gordon's heart murmur, I knew It was not the murmur of rheumatic heart disease. The experienced local doctors had not had the privilege of my training. But although Gordon had a patent ductus, why was he so feverish? He must have had an infection of the lining of that duct. I had never seen that before, though I have since learned that it occurs in 1% of those patients.

Mavis had taken Gordon home pending the arrival of the new doctor. With her nursing background she would have taken Gordon to her teaching hospital in Sydney if the new doctor didn't have the answer. Now I had to phone the teaching hospital, and ask them to admit a 3-year-old with patent ductus and endarteritis. The admitting doctor was understandably incredulous. But when Gordon arrived in Sydney, the specialists agreed. His infection was treated with intravenous antibiotics, and his patent duct was later closed by the thoracic surgeon. Gordon returned to Cobargo cured.

Gordon's parents were very grateful for my help. His father, George, phoned and said he was about to bring some vegetables and a chicken from their garden. This provided a small diplomatic problem. At the time, Pauline and I followed the Jewish laws regarding Kosher slaughter of animals, and I had previously had some lessons in a Melbourne abattoir about the approved method of dispatching a chicken, using a single stroke with the sharpest of knives. I explained this to George, who kindly suggested that I should come to the farm and choose the bird myself. I was not used to assessing livestock for cooking, and arrived home with a generous sized rooster, which did not excite Pauline at all. She declared it would be tough eating, and so it proved to be. But meantime it had the free run of our large back garden, crowing loudly for a day or two.

When the time came for the deed to be done, I went to the back yard to catch it. The rooster had other ideas, and managed to squeeze through a space next to the front gate and set off at full speed down the hill of our street, with the town's doctor in hot pursuit. Luckily for our menu, it ran to a large drainpipe that was in a driveway to a house, in the gutter between road and footpath, then poked its head and neck into the pipe, and remained stuck there until I caught up with him, extricated him, brought him home and dispatched him. Pauline then had her first experience (and by her choice, the last experience) of the necessary plucking and preparation. After that, our prepared meat had to come from Sydney, some 300 km away.

Mavis Allen was a wonderful mother. She had four older boys as well as Gordon. When Pauline was in Bega hospital giving birth to our second child, Deborah, she looked after our little Rachel. She remained a close friend and occasional surrogate mother during our 3 year stay in Cobargo. Mavis and Pauline had the occasional phone chat after we moved back to Melbourne. Mavis visited us briefly in our holiday house in Aspendale when she came to join in the celebration of one of her sons joining the priesthood.

A few years later, tragically, our elder daughter, Rachel Susan, died. We were sitting with family and friends in our new house in South Yarra in the Jewish mourning custom of low chairs, when the phone rang. It was an excited Mavis. "Gordon and his wife have a new lovely baby and they've called her Rachel".

When Mavis heard our sad news of the death of our Rachel, she was devastated. "I'm coming down as soon as I can get a bus". We could not dissuade her from making the long and tiring overnight bus journey, even though she was then well over 80 years old. We decided that we could go to our seaside holiday cottage in Aspendale, to unwind and to offer Mavis more comfort than we could provide in our inner city South Yarra town house.

We relaxed at the seaside and when bedtime came we settled Mavis into a spare bedroom where she could be comfortable. The next morning, we enquired if she was able to sleep well.

She replied: "I went to sleep last night, but about four o'clock in the morning I woke up because I saw a strange reddish glow in the corner of the room. I don't know what it was, but I couldn't get back to sleep". We wondered if the stress of the long journey and our sad loss had been too much for her ageing nerves. I looked at the corner of the room where she had spent the night. There was a power point nearby, but no appliance connected to it, nor any sign of any discolouration of the walls or any electrical smell. There was a cast-iron open fireplace a couple of meters away, but no smouldering wood or ashes. Likewise, on the other side of the wall, in the front room overlooking the sea, there was no sign of anything that would explain what appeared to be Mavis's dream or vision.

After breakfast we welcomed an electrician. We had arranged to connect two ceiling fans in the front living room. He brought the fans, connected and checked them. I asked him to check the wiring and the power point in the adjacent bedroom where Mavis had seen the "glow" in the middle of the night. He obliged, checked everything electrical and reassured us that all was in order. We paid him, and he left. After opening the gate, he turned around and came back. He asked if there was a trapdoor which would allow him to look under the house. I invited him to look.

He found the trapdoor and crawled underneath the wooden floor of the house, only to emerge, white-faced, and relate that sometimes wooden houses of our vintage caught fire without explanation. He had found the wiring beneath the power point in Mavis' bedroom and discovered that the insulation around the wires had been chewed off by some animal, perhaps a rat! Probably during the night there had been a short circuit, and some sparks had caused a glow in the fog particles of the seaside night air. It certainly was the way some houses just burnt down unexpectedly.

When we explained all this to Mavis, who had saved our lives, she said simply:

"God sent me".

# An orthopaedic intervention

By Noel Cass

There was always music in our house during my early years, played by a Sonora wind-up gramophone. My father played the violin by ear and my mother the piano. So in due course my sister, Norma, and I learned the piano. She became an adept sight-reader but I earned poor marks for sight-reading but high marks in the ear tests. So playing by ear was the easier option, and I played for parties and dances during the teen years.

Next came entry to the University and the inevitable distraction of undergraduate and postgraduate training, and for 20 years the music took second place though I had dreams of playing in a jazz band. So the rest of this story is how this came about by orthopedic intervention in 1964.

The Surgeons and Anaesthetists were meeting at Wrest point, and a friend invited me to a party where we played music on a piano, washboard and string bass (made from a plywood tea- chest!) Next morning at the coffee break an orthopedic surgeon, Bryan Keon-Cohen, who had heard about the party, came over and suggested I contact Max Wearne (also an orthopedic surgeon) who had played trumpet at the London Hospital Revue during his training in England. While working at the Hyperbaric Oxygen Unit at Peter McCallum Clinic I had also met John Andrews, a nuclear medicine consultant who has played drums for dance music in London during his medical course. A further contact was Douglas Lampard, Professor of Electrical Engineering at Monash University, with whom I shared interests in biophysics, pharmacology and anaesthetics. Doug was a polymath with multiple talents including playing the banjo and the piano.

Later in the year another orthopaedic surgeon, Bill Swaney and his wife Marie (an anaesthetist) invited us to play at a party at their home so the four of us played together for the first time (in company with a superb French Horn player from a visiting Stage show!) and so my dream came true, thanks to the encouragement of three orthopedic surgeons! Following this party, we arranged to meet at our various homes each fortnight, and a very steep learning curve started for me as I had played only in the key of C and had to learn to play in the keys of B flat, F, E flat and A flat which were preferred by the reed players and horns.

As the months went by we were joined by several other players and invitations began to come, from charitable events, weddings, anniversaries and medical dinner dances (including the Medical Staff Annual event at the RCH!) Some events were quite memorable: The Royal College of Surgeons 50th year Anniversary dinner dance at the Hyatt Hotel, and audiences of hundreds at the McClelland Fund Raising Parties at Cruden Farm (where Dame Elisabeth would come and sit with us, enjoying the music!)

So for 50 years the band played together, recruiting players from time to time, until illness and mortality finally reduced us to trios and quartets which still play from time to time. And so the dream was fulfilled by this chance event, with many happy hours and close friendships as a consequence.

# Pipes, pedals and pain

By Garry Warne

When I was 16 and growing up in Bendigo, my cousin Hedley Jones, a fine organist, agreed to give me lessons on the pipe organ. I was very excited. I loved the fact that the organ could make enough sound to make the windows of a large building rattle and cause the floor to rumble. I also loved the wide variety of tones this one instrument could produce, from rich diapasons, to gentle flutes, bright mixtures and brilliant trumpets. And then there was the ability of the organist to stir up the voices of the congregation in church or accompany a choir.

My mother took me out to buy the pair of shoes I would need to wear when playing the pedal keyboard on the organ, a pair of black slip-ons with leather soles and a decent heel. I've now been playing the organ on and off for 56 years and believe it or not, I still play in that pair of shoes that Mum bought me. They have holes in them and the sole is coming adrift from the uppers, but they are my organ shoes and I hope they'll see me out.

Playing the organ has been something that has brought me enormous pleasure. The repertoire written for the organ is huge. J S Bach wrote some of the greatest works and not all of them require an advanced technique. There is plenty of good music that someone with average ability on the organ, like me, can choose from because there are churches all over the world and composers over the centuries have had to provide church musicians, who are rarely virtuosos, with plenty of music.

I have played on quite a few different organs, starting with the one in the Golden Square Methodist Church and then at Queen's College when I came to university. Once I was asked to play in Wesley Church in Lonsdale Street for an ordination service in which the Queen's College Choir was to sing. The church was packed to the rafters and it was thrilling to be playing for such a grand occasion.

After I was married, I was the organist at St Mary's Anglican Church in North Melbourne. One day, when I arrived to play for a Sunday service, I started warming up with a few scales and to my surprise, many of the notes didn't sound at all, making the organ unplayable. A quick look inside the organ revealed that someone had come in during the night and stolen most of the metal pipes! That was the end of that organ and as a result, St Mary's got a new instrument that proved very popular with recitalists.

Not all organs are pipe organs and I have had to play a few electronic ones. Twice I had excruciating experiences playing these because I was unfamiliar with them. One of these occasions was for the wedding of good friends of ours. I arrived at the church and found that it had a small electronic organ with half a pedal board, rather than the complete one I was used to. There was no one to show me how the organ worked and I could not get it to make more than a very small sound. I just had to accept that and I was very embarrassed to be playing the wedding march at almost inaudible volume. I had the same experience at another wedding in another church. Give me a pipe organ any time!

I am currently the organist at St Stephen's Anglican Church in Richmond, which was built in 1849. The organ was built not long after, in 1865, and it is quite a famous and historic instrument. It was originally commissioned from the company of J W Walker in England by a Mr William Phillpott who installed it in the ballroom of his house 'Rose Hill' near the corner of Glenferrie and Toorak Roads. In 1869, he sold it to the church. It has three manuals and a pedal board, so it is quite large and it is in almost original condition. There are only two of these organs left in the world, the other one, considerably modified, being in Launceston. It is fully mechanical, meaning that depressing one of the keys operates a series of wooden levers and allows air to flow into the bottom of a pipe, which makes the sound. Only the bellows has been electrified. Being 151 years old, it is showing the effects of age and it needs a complete restoration, but that would cost hundreds of thousands of dollars.

There have been many organists at St Stephen's before me. One of them is remembered because he murdered his wife and was hanged. Another guarded the organ very jealously and was so determined that no one else would play it, that he installed a padlock on the case and kept the only key with him at all times. Many concerts have been played on it, the most recent being in the annual Historic Organs of Richmond Hill series in October 2016.

In July this year, while I was accompanying a soloist during the Sunday morning service, I experienced a severe burning pain in the chest, radiating up to my jaw. I finished the piece I was playing before surrendering to the pain (we organists have a certain standard to maintain) then went down the few steps to floor level and sat in a chair for a moment. I started to sweat and to feel nauseated, so I knew I was in serious trouble. I decided that I would be needing an ambulance, so I walked to the door at the other end of the church. I asked the person sitting there to call an ambulance, then at his suggestion, I lay down on the floor and waited for the ambulance. Meanwhile, the service continued. I confess that I did not pay a lot of attention to the sermon, being in severe pain, and I suspect that most of the congregation was more interested in the commotion going on around me than in anything else. They will certainly remember that particular service, but I'm afraid for the wrong reasons. I was carried out to the ambulance as the organ, played by the Vicar, struck up for the last hymn. My transfer to the Epworth in the MICA was with lights and siren, quite a change from bells and smells. My number was clearly not up on that day, and with three stents to keep blood flowing through my coronary arteries, I am here to tell the story.