

RCH Alumni

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The Royal
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Melbourne

Aluminations

FROM THE RCH ALUMNI

July 2020 | In this issue:

Alumni reflections on infectious diseases and epidemics

Photo: Buttermere, Lake District UK (Gigi Williams)



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The 2020 RCH Alumni Executive

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Reflections: our invitation

Bronwyn Hewett (former RCH Archivist)

At the April Executive meeting of the RCH Alumni, it was agreed that to help engage our members in such uncertain times, one idea would be to provide you with a platform and invite you to draw upon your personal experience or research on subjects of interest which members may then like to reflect upon.

The first topical subject which came to mind was infectious diseases and epidemics. The poliomyelitis epidemics which especially affected so many children is one such topic. While there were significant outbreaks of this disease in the 1920s and late 1930s, it is from 1949-1960 when the later waves of outbreaks occurred that are likely to be the subject of living memory.

In trawling through Victorian newspapers at the start of that period, I was struck by the similarities of the progress of the 1949 outbreak of poliomyelitis with our current pandemic. The same issues were being reported in the papers - at first denial that there was anything to worry about and that it was not an epidemic, then a graph showing the rapid rise of the disease and eventually acceptance that it was an epidemic. This was followed by discussion about whether children should be at school or not, even though pre-school children were still allowed to attend kindergartens. General healthcare



advice was offered for parents, also on hand hygiene and ideas for how to entertain children once they were confined to home. The first use of an iron lung in Sydney in combination with a tracheotomy was reported in early 1950, followed by discussion about the Salk vaccine and its pros and cons. The Children's Hospital (as it was at that time) was not often mentioned in the newspapers in 1949, as infected patients needing hospitalisation were mostly sent to the Fairfield Infectious Disease Hospital or to specialised wards at the Royal Melbourne. However, patients were transferred to the Children's Hospital Orthopaedic Section at Mt Eliza (which had opened for patients in 1930) and sometimes to the Convalescent Home at Hampton, for prolonged treatment and recovery.

There were many other infectious diseases which weren't necessarily epidemics which you may like to reflect upon and would be of interest from any of many perspectives. Please email your reflections to rch.alumni@rch.org.au We look forward to hearing from you.

Photo: "Reflections", courtesy Mrs Billie de Bondi, U3A Hawthorn



From then to now: some things change, some don't.

Ruth Wraith

Measles, mumps, chicken pox, rubella, scarlet fever. Living with the COVID-19 pandemic over recent months has caused me to reflect on some similarities with my experience of these 'childhood infections' all of which I had before the age of six. This was before vaccinations had been developed for each one and before sulfa drugs and penicillin were available treatment options for the general population. They were the years of World War 2 with resulting rationing of some basic foods, also clothing and petrol. Windows were blacked out for security management and there were no new toys for children as resources were needed and dedicated to the war effort. The desperate years of the Depression and the sequelae were still alive in the minds and experience of Australians.

To provide community protection physical isolation of infected children was an essential component of the treatment regime. Naturally this also meant social isolation. Other than my mother caring for me, each illness meant I was in my room alone for the duration of the decreed transmissible infection period. Children were not allowed to visit the house, adults stood at the bedroom door to say 'hello'. Books were my world, to look at only as I was not yet able to read. Detailed observation of the outside world through my window engrossed me - birds carefully landing on the fence, leaves moving differently in a breeze or strong wind, the sun traversing the sky from morn to dusk creating different shadow patterns on the furniture. These I still enjoy.

Ward 24 in 1945 did not have potted plants, flowers and I think wall heaters but it did have the windows papered over. While it was a barren environment I always felt safe and at ease.



COVID-19 has brought my scarlet fever episode alive for me and as I write this I am excited with this new chapter.

The diagnosis by our family doctor meant a hastily arranged ambulance trip, alone, to Fairfield Infectious Diseases Hospital and Ward 24. Visitors, including parents, were not allowed for the month of hospitalisation, telephone calls in or out were not available.

Ward 24 was of the era, a long narrow room which seemed to me to stretch on for ever, beds and cots ran along each pale wall like tram tracks and the space in the middle was to me an empty no-man's land. The environment was post-depression/wartime severe with no colour, no toys, entertainment, TV or iPad; no out of



bed activity and the only sounds were from the children and the nursing and cleaning activity. But somehow an older girl of maybe 10 years, whose bed was on the opposite wall, and I became friends talking to each other across the void.

My mother wrote letters (snail mail) almost every day and would include a stamped addressed envelope and blank paper for me to draw pictures to send to family. During the COVID-19 period I have been sorting boxes of papers of my deceased parents and came across some of the drawings with little dictated messages written in a primary school age child hand and signed with the name of my Ward 24 friend. After some hours of Google exploration and email writing I tracked her down. She rang me, as excited as I was that we had connected. We shared our hazy and fragmented memories of this time, aspects of which are so clearly etched for each of us. It is a world and an experience that no one, in either of our lives, has ever had any idea of.

The most vivid memory for each of us? Discharge.

We were led in our hospital garb, on wobbly legs having been in bed for four weeks, to a small red brick building near the main entrance of the campus and into a room with a big old stand-alone tub and put into a bath of phenyl, disinfected in the smelly water including hair, dressed in our own clothes from home, directed with wet hair through a door opening to a verandah and 'released' by ourselves to the outside world and to the waiting arms of our parents, into a taxi and home.

When we are through this current episode of isolation my re-discovered Fairfield friend and I will meet in person once again - a life having been lived in the 70+ intervening years.

Ruth Wraith OAM is President of the RCH Alumni. [View her full profile](#)

Interrupted education during the polio epidemic

E Durham Smith

I was a Resident at the Alfred in 1949 and remember the polio epidemic. In fact, I remember one of the few wins I ever had over my Registrar was a little girl with a weak arm (polio) which he missed.

But my memory goes much further back.

I was a boarder at school in 1937 onwards and we were all sent home for a term in 1938, because of a polio epidemic at that time.

No internet, of course, and we were sent lessons through the post for home learning for that term. Many schools closed at that time, and there was a feeling of panic in the community. Just a memory now.

Durham Smith AO, aged 98, is a past President of the Royal Australasian College of Surgeons. [View his full profile.](#)



Schoolboy memories of the 1930s poliomyelitis epidemic

Jim Keipert

I was born just three years too late to experience the Spanish Influenza pandemic, so I'll comment on the poliomyelitis epidemic in the late 1930s, just over eighty years ago. In a similar fashion to the coronavirus pandemic the spectrum of disease severity with the polio epidemic varied from very mild to extremely severe, with many patients with mild disease recovering completely, and the most severe cases with respiratory failure died.

The optimal hospital for those patients requiring inpatient care was the Fairfield Infectious Diseases Hospital – a great institution in its time.

Many juvenile patients with residual paresis or paralysis spent extended periods of rehabilitation at the Children's Hospital Orthopaedic Section at Mt Eliza.

We had several friends with residual paralysis severe enough to cause them to live the rest of their normal life span in a wheelchair, despite which they lived a satisfying and fulfilling life with many great achievements.

I presume that during the polio epidemic the government gave general advice to the community about what was considered optimal behavior, especially regarding limiting the spread of the disease, but I don't think there was anything like the degree of government intervention as has happened with the coronavirus pandemic in the form of virtually closing international travel into and out of Australia, closing some state borders, stopping most sporting activities and artistic performances, closing some businesses, encouraging working from home and isolation at home where possible and closing schools.

If I remember correctly in the polio epidemic a lot of the decisions about the degree of activity and movement in the community of individuals and families were taken by those individuals and families.

There was anxiety in the community about the polio epidemic – not much in the beginning when cases were few, but rising over time – although not to the level we are seeing now with the coronavirus pandemic.

As an aside the decisions taken by governments in the coronavirus pandemic were presumably responsible for the fact that in comparison with the global mortality of over fifty million deaths in a much smaller population in the Spanish influenza pandemic, the global mortality so far of one half a million deaths looks positively minuscule in the coronavirus pandemic.



On the lighter side, at the time of the polio epidemic I was a boarder at School House on the hill at Scotch College, and there was no indecisiveness or ambiguity about the freedom of movement in the community for boarders. We were completely isolated at school and not allowed outside the school grounds, even to go to the dentist in the local very small shopping centre at the corner of Glenferrie and Riversdale Roads.

There was however one notable exception. We were allowed or really compelled to attend the weekly 11 AM Sunday service at Hawthorn Presbyterian Church, after walking about one kilometre down Glenferrie Road and sitting in a then fairly packed congregation.

We students presumed that the teachers who authorized this exception from total lockdown did so on the basis that being in a place of worship with an all-powerful deity would have no problem in protecting us with contact or infection from the polio virus. We students did not share this view and regarded it as irrational, unfair and exposing us to harm.

On this Sunday morning we decided to revolt and told the master on duty that we did not intend to attend church. Our bravado was significantly reinforced by the fact that the master in charge was a somewhat weak and indecisive character. For a while it looked like we would win the day with a brilliant victory until he had the inspirational and very regrettable thought that the very decisive senior house master lived just across the road from the school. To compound our woes he was home, was across the road in a flash, said right you lot line up, everyone gets three strokes of the cane on your bottom and off to church.

Jim Keipert, aged 97, practised as a general paediatrician. [View his full profile.](#)

My Holiday Job...

... as a Temporary Medical Orderly at Fairfield Infectious Diseases Hospital just after a major poliomyelitis epidemic

Roger Hall

In an earlier era, it was usual that during school holidays the more senior boys at most schools and university took a 'holiday job' and after various different work experiences, in January and February 1956 and 1957, I was accepted as a temporary Medical Orderly and Nursing Assistant at Fairfield Infectious Diseases Hospital (as it was then called), to assist the nursing staff in the 'convalescent polio' wards.

This is the story of my experiences there – some sobering and sad, others amazing and challenging and some absolutely hilarious.

In March 1949 a severe epidemic of poliomyelitis came to Australia and 200 cases were admitted to 'Fairfield'. Poliomyelitis is caused by an enterovirus contracted orally from infected faecal matter from hand transfer or handled objects. There are three wild types of poliovirus (WPV1,2&3). Polio is contagious during the incubation and acute phases of the disease. Protection from all three types is necessary.

In 1955-57 there was an unexpected and extraordinary reduction in the incidence of 'polio', which was at least partly due to the introduction of the Salk vaccine intensive immunization campaign. Other virus infections as a cause of admissions to Fairfield increased however, most significantly including the 'Asian Flu'.

In 1957 Ward 12 reopened after renovation to accommodate the large number of convalescent polio patients requiring in particular assisted respiration in an 'iron lung' and who came to look on the hospital and Ward 12 as their new 'home'. Among those were several noted personalities. A fully respirator-equipped and medically fitted out Volkswagen bus was donated to the hospital by Victorian Associated Brewers for the use of polio patients and this contributed greatly to their 'lifestyle'. Also at this time the Herald donated television sets to the Children's ward which had also been refurbished.

Both the Department of Health and the Hospital and Charities Commission had now recognized the specialist role that Fairfield played in the diagnosis and treatment of infectious diseases. The hospital was appointed a 'test hospital' for the safety of the injected Salk vaccine, manufactured by CSL which had been introduced after a

visit by Dr Keogh (a Board member) to Dr Salk in the USA and found to significantly reduce the number of cases of polio. The orally administered Sabine vaccine was introduced in 1967.

Well.....enough background!

I was first employed in 1956 as a "temporary medical orderly and nurses' assistant" by Matron Burbridge to work in the male convalescent polio Ward 12 for two months during my holiday period and the following year was elevated to the upstairs children's ward.

"Convalescent" was something of a euphemism, as many of the children, in particular, were 'just over' the acute infective stage! As a result I acquired antibodies to all three types of WPV and became a long-term useful subject for Dr Bazeley's research. Dr Bazeley was at that time Director of CSL Melbourne and was testing a 4 in 1 killed virus serum (whooping cough, diphtheria, tetanus and polio) for vaccination (which took 4 months to manufacture). I was interested to participate in his research but he was not the best vene-puncturist I ever encountered!

The male convalescent polio ward was most interesting to work in but very sobering on first encounter! The charge sister was ex-army and knew all the tricks that male patients get up to and as might be expected a stickler for routine. From the first day I was introduced to the rules and regulations for the ward.

I have now forgotten the number of beds and of iron lungs in the ward, but there were at least 12 iron lungs and I think at times up to 20! They were elongated sealed cabinets which enclosed a patient up to the neck. A mechanical pump produces negative pressure, replacing the action of the respiratory muscles during inhalation; exhalation occurs when the negative pressure is released.

Sister rode her motorbike to the hospital and parked it outside the 'pan-room' which had a 'back-door'. After checking that the morning's procedures were running smoothly she seemed to spend the rest of her time cleaning and fiddling with her motorbike. Matron Burbridge was apt to make unexpected visits to the ward and our task as minions was to say to matron ..."Oh Matron, Sister is just in the pan-room – I shall go and tell her you are here" - whereupon with dignified haste one of us would hurry to the pan-room and out the back door to warn sister who would rush in cleaning grease off her hands before appearing before matron – all innocence and efficiency! This I must say was a frequent occurrence and I don't believe fooled matron for a moment!

My day began with an early bicycle ride on my old Lawrenca some 4 kilometres to the hospital (later in my recently acquired MG). Then the day's fun began with about 20 'bed-pans' – shared between two of us. Fortunately this refurbished Ward 12 had rather

good emptying and pan-cleaning machines! Next was breakfast – some men with upper limb paralysis or in iron lungs (at least 12) needed total feeding help, others mostly managed if they could sit up and had good enough arm and hand control. The food was designed for each man's ability. Now we could head off from the ward to have our own breakfast.

As you might imagine this was quite daunting and challenging at first but with advice from our ex-army charge sister we soon developed considerable efficiency while maintaining a pleasant and when possible jovial manner. The rest of the morning was more relaxed and often passed pleasantly and at times amusingly – these men had developed quite a camaraderie – many were most intelligent and we had the odd radio or stage personality! The fortitude of these men never ceased to amaze me!

Parents were usually only allowed to visit on weekends. The Brewer's bus, as it came to be known, took the men on quite adventurous outings and on home for once-a-month, weekend leave where possible.

Now here it became quite amusing as a game was afoot! On their return from 'home leave' the men were each greeted at the door to the ward by Sister. Now the men of course tried to smuggle in items they should not have (cigarettes of course and chocolate). They hid them on their person and in their wheelchairs, but sister knew every possible hiding place, discovered them and confiscated all 'contraband', locking them in her cupboard. But she really had a heart of gold and on an appropriate occasion when patient cheering up or an award was appropriate she would hand them out to all! The men all loved her and on return from leave always seemed to have a gift for her – farmers brought a chicken or potatoes or tomatoes, others chocolates or cake.

I must say that I really enjoyed this experience in the men's ward, I learnt a lot about polio and about nursing partially- or totally-paralysed bed-ridden patients. The permanent staff were most impressive and I tried to join them in contributing as much as I could to our patients physical and mental wellbeing. I was absolutely amazed at the ability of our patients to retain a sense of humour under their most difficult circumstances!

So ended my first year at Fairfield!

The following year, before commencing Paediatric Dentistry at the Dental Hospital, I returned to Fairfield for a short period and found that I was promoted to the children's ward upstairs in a newly renovated ward, with a long balcony looking across a green garden to the children's diphtheria and whooping cough ward, which also had a balcony on which patients from both wards would be taken in their beds to get some fresh air and sunshine. Following much the same routine as in the men's ward, we lined up the beds on the balcony.

Now this was a mixed male and female ward – with pre-adolescents only. After establishing them on the balcony next to their friends (boys and girls together), with sufficient space between the beds so that they could not actually touch each other, we were sure, we felt we could leave them to the Ward Sister for a short time while the temporary and other nursing staff went off for morning tea. How wrong we were! On our return to the ward and the balcony to check on our patients we found to our utter amazement that one or two boys had actually managed to move their beds together!! In one instance a boy had actually managed to roll into bed with his girl 'friend' – we could not believe it – these patients were paralysed from the waist down but had normal arm movements of course and they proceeded to demonstrate to us how they did it! That episode resulted in a complete revision of balcony arrangement with the separation of boys' and girls' times on the balcony.

As if that was not enough embarrassment for us!

Prior to balcony time we bathed the children – boys and girls together in a saline bath, which was a large stainless steel affair, designed for 4-6 children at a time. We would prop them against the sides and let them play for a while, as we did other jobs – keeping a general eye on them. On one occasion our eyes must have been otherwise occupied, as on returning to check them we found one boy enjoying full arousal much to the delight of his female companion! So... more embarrassment and reproof from Sister and a decision that from then on, boys and girls would bathe separately!

On another occasion with our boys on their balcony and the patients from the diphtheria and whooping cough ward on their balcony opposite, our young charges decided that they needed entertainment and challenged the boys opposite to sing popular songs of the day. After their first rendition our boys would call across to the diphtheria ward balcony "sing it again" (we had of course warned them that it was not good for the healing throats of the children opposite to sing, but of course that only encouraged them more!!). So.. another change of arrangements with different balcony times established between the wards! Ah! The joys of paediatric nursing of long-term convalescent children!! Again I learnt a great deal about child behaviour.

Another phase of my adventure with chronically disabled and ill children now occurred with my secondment to the Royal Children's Hospital as Dentist in Residence full-time for six months at the Orthopaedic Section of the Children's at Mt Eliza, primarily to undertake dental examination and dental care for the many long-term orthopaedic patients who because they were bed-ridden had not seen a dentist for many years, if ever. There was also a long-term medical ward adjacent my dental surgery.



Roger Hall operating

This was a most privileged position which I was told I had earned by coming top of Dentistry during the course. I was also able to select the dental nurse who would accompany me!

The long-term orthopaedic patients were varied and many were in fact convalescent polio patients, but all children with various problems and disability, requiring orthopaedic surgery for backs and limbs were in the wards (this time separate boys' and girls' wards!). There was a strong physiotherapy presence of course, working with these children, making and fitting Thomas splints, plaster casts, callipers and special boots and teaching their patients how to use them. They also supervised the swimming pool therapy (see picture, following page).

Children were taken to the adjacent beach at Canadian Bay on weekends, some with their parents and I was able to join in this activity. I felt privileged to meet many of RCH Orthopaedic Surgeons of the day and their superb anaesthetist Jeff Cornish, who also gave dental anaesthetics and who anaesthetised for me for a case each week at the end of the Orthopaedic session at Mt Eliza.

The 'physios' were of course very active at Fairfield - so busy that there was no time for fraternization and again I admired the essential work they were doing. Interestingly I have just learnt that Professor Joan McMeeken (the

first Professor of Physiotherapy at Melbourne University) in her student days had worked as a Physio Assistant at Fairfield at the same time I was there and recalls helping to mobilize joints and stretch muscles, also making plaster splints and abdominal corsets. Reading a paper she had written, "Remembering Australia's Polio Scourge" (published by the University of Melbourne), I discovered that her mother, Freda Kimpton, graduated as a physiotherapist in 1937, at the peak of the first large polio epidemic and immediately joined the Children's Hospital domiciliary service treating children in North Melbourne, Carlton and Footscray.

Since caring for several children with Syndromes and other Rare Disorders during my final year of the Dental course, I knew that Paediatric Dentistry for patients with such disorders and disabilities was where my future career lay. In 1958 I was appointed to the Full-time Staff of the University of Melbourne, an appointment which I have held and hold to this day (62 years). I approached the Children's during that year and met with Lady Murdoch (as she was then) and Dr John Perry. They told me that I had strong dental support for my wish to work at the Children's and they had plans to employ a full-time dentist soon, but were not quite ready to do so yet and that I should go overseas and undertake post graduate study in Paediatric Oral Surgery and Paediatric Dentistry and they would let me know when they were ready to make an appointment. This they did and I returned to take



Hydrotherapy pool Mt Eliza

up a full-time appointment together with the continuation of my University position in 1962.

So...poliomyelitis played a role in my selection of a career!

A sobering addendum to this account of my time at 'Fairfield', is a reminder that thousands of Australians still suffer the late effects of polio with "post-polio syndrome (PPS)". This consists of a series of new and unexpected symptoms presenting 30-40 years after the initial infection- and now considered to be a second phase of polio. There is no definitive test for PPS which is a symptomatic diagnosis where unexpected fatigue, new muscle weakness and pain with joint pain, together with difficulty in sleeping, breathing and swallowing and increased sensitivity to cold temperatures are the presenting symptoms. The cause is unknown, but overuse of polio-affected muscles is the popular theory. The most recent research on this disorder was undertaken at the Sydney Prince of Wales Medical Research Institute in the 1990s.

Associate Professor [Hon.] Roger K Hall OAM, Faculty of Medicine University of Melbourne and Emeritus Dental Surgeon, Royal Children's Hospital Melbourne. [View his full profile.](#)

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Fever Hospital. A History of Fairfield Infectious Hospital by W.K.Anderson, Melbourne University Press 2002

Remembering Australia's Polio Scourge by Professor Joan McMeeken, University of Melbourne

ALSO:

U.S.National Authority for the Containment of Poliovirus

[CDC Centers for Disease Control and Prevention](#)

[Polio Disease and Poliovirus](#)

[Smithsonian National Museum of American History](#)

Remembering polio

Joan McMeeken

The current coronavirus pandemic has brought Victoria's poliomyelitis (polio) epidemics to the fore in memory. Before this worldwide event I had written about polio in Victoria and continue to undertake research in the area. There are parallels in the fear induced in the community, the emphasis on hygiene, the potential use of serum in treatment, state borders, schools, pools, and theatres closed, travel restricted, quarantine measures introduced, and the search for a vaccine. It took fifty years for a vaccine to be produced to protect against the three strains of the polio virus.ⁱ

Polio severely paralysed 14 year-old Ron Jones in the 1949 epidemic. Yet two years later he returned to the Orthopaedic Branch of the Children's Hospital



Ron Jones returns to the Frankston Orthopaedic Branch of the Children's Hospital.^{iv}



at Frankston where, as reported in The Sun on 28th December 1952, he 'amazed the doctors and sisters.' Ron Jones had left the hospital paralysed in both legs and his abdominal muscles and with weakness in his arm and back muscles. By 1948 Dr Douglas Galbraith had returned to be responsible at Frankston.

Some idea of the annual physiotherapy load at the time is indicated by the physiotherapy treatments in his report to the hospital board. Physiotherapy comprised 2731 muscle re-education treatments, 2042 sessions of hydrotherapy in the pool, 180 sessions of managing splints, 117 plasters made and 3000 treatments in the Hubbard bath.ⁱⁱ

At the time a teacher undertook the children's education and craft workers provided diversional therapy. As education for occupational therapists had recently commenced in Victoria, Galbraith hoped to soon recruit a fully trained occupational therapist. For the children with polio 'their routine management consisted of prolonged rest in "double Thomas" splints and physiotherapy followed by graduated ambulation with or without protective apparatus. All improved with treatment and on discharge to their homes they were transferred to the care of the Outpatients department of the Children's Hospital or to the after-care scheme of the Consultative Council for Poliomyelitis,' the Itinerant Physiotherapy Service (IPS).ⁱⁱⁱ On Ron's discharge home in March 1950 he wore callipers, braces and a corset. Now he used none of these supports.

Ron's physiotherapist had visited him at home two or three times a week since his discharge from Frankston. She provided full range movements for all joints, stretches for tight muscle groups, specific muscle re-education for each of the individual muscles affected, made plaster of Paris splints as required and continued to monitor the fitting of splints such as his callipers. Growing adolescents like Ron often needed treatment modifications as they grew. She also taught his parents the exercises to enable them to motivate Ron to continue with them daily. Freda Bolwell (nee Kimpton) formally assessed the muscle strength of all muscles every six weeks and as he improved introduced additional functional activities such as walking, managing stairs and falling safely as she gradually reduced his splinting. He thus required less and less support from his various splints. Freda, his experienced physiotherapist, was my mother. In the school holidays my siblings and I read in the car or went walking in rural Greensborough whilst our mother treated Ron.

Freda had been visiting people with polio (also known as infantile paralysis) since she graduated at the height of Victoria's largest polio epidemic in 1937/38 when 2166 cases were notified. The Children's Hospital, under the guidance of Dr Jean Macnamara had introduced an additional Itinerant Physiotherapy Service (IPS) in the polio epidemic of 1931. This was not the first time

physiotherapy had been provided to children with polio at the Children's Hospital. At the beginning of the twentieth century, physiotherapists commenced working as honorary practitioners at the Children's. Misses Dora Clerk and Ada Rundell were first mentioned in the Annual Report in 1902-1903.^v In their years as students at the University of Melbourne and in the clinics at the Melbourne and Children's Hospitals, physiotherapy students (then known as massage students) had learned much about polio from Dr William Colin Mackenzie who lectured and assessed the students' knowledge of infantile paralysis.^{vii} At the time, from 1906 until World War 1, he also worked at the Children's Hospital. Mackenzie published a definitive text on the management of this illness.^{vii} If massage should be used, it was only a preliminary to the more important muscle stretching and the exercises of muscle re-education.

During the polio epidemic of 1908, the Children's Hospital recruited more honorary physiotherapists, the students treated the patients and some salaried physiotherapists began to be employed. Over the following four decades physiotherapists provided the only effective orthodox treatment for polio sufferers. Epidemics placed huge demands on these practitioners whilst hospitals such as the Children's and Fairfield Infectious Diseases Hospital could be overloaded with patients. In the 1931 epidemic the Children's set aside half of the general medical beds

Footscray polio clinic. Freda Kimpton second from left. Child in double Thomas splint with her mother on the right



for polio patients'.^{viii} The same year the IPS began with three physiotherapists funded by the Charities Board through the Children's Hospital, providing treatment to children who were frequently discharged home early from the acute wards. Such a service run initially by the Children's and later by the Department of Health continued to operate for decades.

Freda studied the full fee paying course of physiotherapy in 1935, 1936 and 1937. Dr Charles Hembrow and physiotherapist Vera Carter then taught the specialised muscle re-education. Clinical work at the Children's Hospital began very early in the course and made studying very interesting.

On graduation Freda and her fellow graduands all began working with people with polio and Freda in the IPS. Most of her patients lived in Footscray, North Melbourne, Flemington and Carlton, then depressed areas of Melbourne. On a Wednesday afternoon the new IPS physiotherapists would assemble at Dr. Jean Macnamara's Clinic at the Children's Hospital and learn how to do the necessary plastering and also more about splinting Freda passed on her knowledge to physiotherapy students as a tutor in 1938/39 whilst continuing to visit her patients.^{ix}

During World War 2, the increased demand for physiotherapist kept them all working. Phyllis Frost graduating in 1938 said, 'got my first job at the Children's by being dragooned into it the day I passed my exams'. She recalled issues during pregnancies and childbearing. Initially a Children's itinerant physiotherapist, during the war Frost went to Yooralla at Macedon, working seven long days each week, with no paid overtime.^x

Frost married in 1941 and in 1944 took three weeks leave before her first child was born, returning to work six weeks afterwards. A nurse assisted with the breast-fed baby, travelling to Macedon with Frost.^{xi}

With a short leave (unpaid) when I and my two siblings were born, my mother continued working in the IPS. The kindergartens were closed, and kindergarten teachers cared for us and other children of physiotherapists to enable the latter to treat those with polio.

As we grew up most of Freda's patients lived in the orchard areas of Doncaster and Templestowe and the surrounding areas of Kangaroo Ground, Eltham and Greensborough. She would bring home fruit from the orchardists and sometimes the polio-affected children came to stay with us to give parents the opportunity to holiday unencumbered by splints and a daily

Children who suffered from polio loved to play in the sand^{xii}



commitment to the splinting, stretching and exercising. With some patients and their families, lifelong friendships formed.

The physiotherapists at the Children's Hospital and the IPS were exposed to the polio virus and as soon as the Salk vaccine became available they and their children received the first shots of the vaccine in 1956.

As a teenager I began working as a physiotherapy assistant with people with polio at Fairfield Hospital during summer vacations.

These experiences with people in acute care, those in the iron lungs and cuirasses in the respirator ward, (where I learned glossopharyngeal breathing too) and those undergoing rehabilitation, influenced my decision to become a physiotherapist.

The Royal Children's Hospital played a significant role for me as a physiotherapy student on the Parkville site and when I visited Frankston.

The Royal Children's Hospital became critically important later in my career with responsibility for the School of Physiotherapy at the University of Melbourne and as a member of the Hospital Board.

The Royal Children's Hospital, in its clinical care of patients, its important research and the education of students has made major contributions to the profession of physiotherapy. In the decades when polio wreaked havoc in our community physiotherapists developed more sophisticated knowledge and clinical skills and gave back the fruits of those developments to the hospital, its patients and their families.

Joan McMeeken AM PhD is a Professorial Fellow in the Faculty of Medicine, Dentistry and Health Sciences in the University of Melbourne. She was the first Professor of Physiotherapy at Melbourne university.

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- xii *Child in a double Thomas splint at the beach at Frankston*. RCH archives. Children loved their time on the sand and in the water. What it did to the metal and leather of the splints must have kept the splint makers very busy. The splint makers at the Children's had often suffered polio themselves.

Identifying sources of cross-infection

Jim Breheny

When I was an active acute trainee physician at RCH in 1960's I vividly recall the fact that three infectious diseases were a serious cause for worry and research.

1. *Pseudomonas pyocyaneus* in the sick neonatal infants hospitalised in the 9th floor ward. No ICU at that time.
2. High incidence of bronchiolitis in 6-12 month old infants.
3. Gastroenteritis due to little understood viral infection.

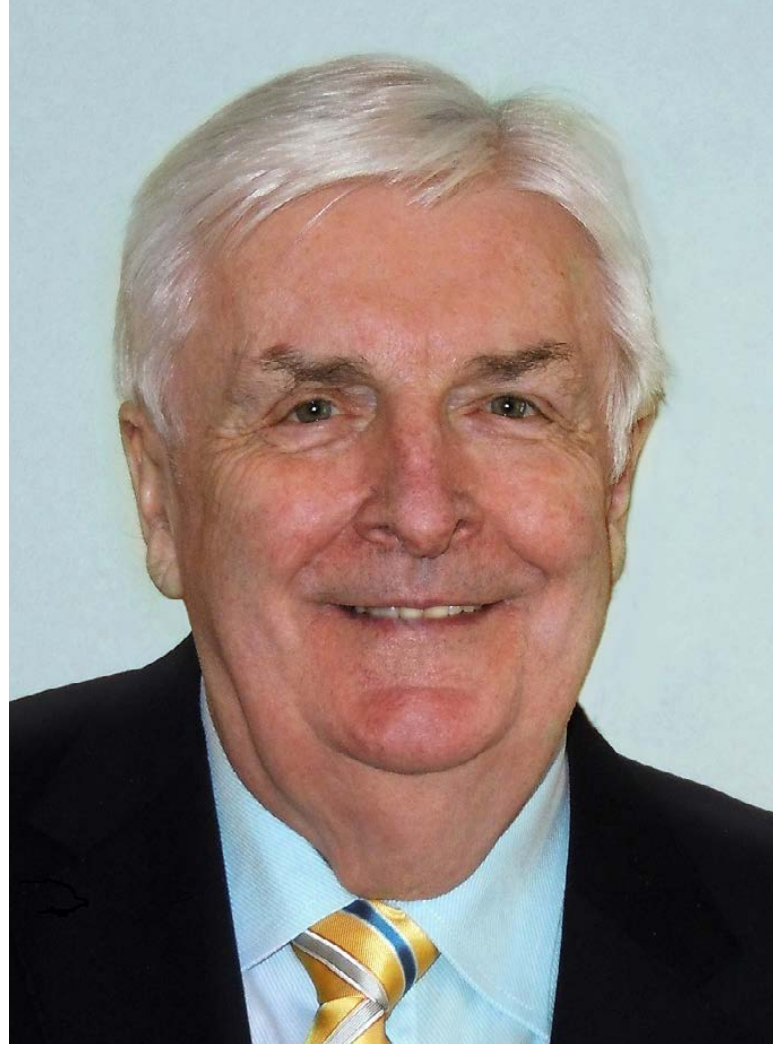
There was a very high number of deaths of neonates due to infection by *Pseudomonas* and this was not always responsive to the available antibiotics.

Research was initiated and undertaken by the staff of Pathology and took two lines of approach to the problem:

1. Where was the source of the bacteria?
2. How was it being spread?

The studies gave rapid and clear results:

- Every wash basin in the wards was accompanied with a cake of soap and a hand scrubbing brush. Each of these items, when tested, grew a pure culture of *Pseudomonas pyocyaneus*. This resulted in total removal of caked soap and hand scrubs from throughout the hospital.
- At the same time Pathology deployed staff to observe the behavioural practices of nurses and doctors in the ward. It was routine for the doctors and nurses to wash



and scrub their hands prior to touching patients and to frequently use gowns and gloves as thought required. This explained the transfer and high rate of infection.

- There was however an added finding - some staff members, mainly doctors, but also some nurses, when gowned and supposedly sterile, would inadvertently scratch an itchy nose or itchy scalp without realising their action.

The shared knowledge of these findings brought surprise and shock plus a sense of shame resulting in immediate correction and good professional behaviour. The real benefit was a marked reduction in infections and greatly reduced number of deaths.

In the world of today it is hard to believe that this is a true story, but it is.

Incidentally, the only pseudo-ICU in the hospital was an area in the post anaesthetic recovery area on the 2nd floor. (Dr Kester Brown always gave me thanks and credit for pushing for and promoting the need of a proper ICU which was established in about 1970 following my time as Medical Director).

Dr Jim Breheny OAM, on RCH staff for 25 years until 1986. Acting Medical Director 1969.





A coolabah tree at dawn at the Coongie Lakes, which are fed by Cooper Creek in outback South Australia (Courtesy Professor Frank Shann)

A microbiologist's memories

Margaret Deighton

Early in 1963, shortly after the move to the "new" hospital in Parkville from the initial site in Pelham St Carlton, I joined RCH as a Medical Scientist in the Department of Microbiology Department in. The Queen officially opened the new hospital during her visit to Australia later in 1963.

Recruiting in the 1960s was rather different from today's much more complicated procedures. After returning from overseas, I contacted my old department at The Alfred Hospital. This resulted from a phone call from Glen Buckle, Head of Microbiology, to Dr Alan Williams, Pathologist at RCH. All was done by word of mouth. There was no job description, no requirement for a CV; in fact, I believe the position was created for me after I turned up. I was interviewed by Alan Williams at old RCH (Pelham St) late in 1962 but had to wait until the "new" hospital was up and running before starting work early in the New Year.



Margaret when she was working at RCH

Alan Williams was very interested in tracking infections acquired in hospital and a brand-new hospital was a good place to start. Unfortunately, it wasn't too long before infections began to occur among burns patients, newborns and in the Intensive Care Unit. My job was to keep an eye on these infections and attempt to discover how they were being transmitted between patients. This was before the era of Infection Control Nurses attached to Microbiology Units. I regularly joined the ward rounds in the burns Unit, where I worked closely with medical and nursing staff. Burns frequently became colonised with *Pseudomonas aeruginosa*. At that time, there were no molecular typing methods available to follow the patterns of transmission of potential pathogens. We relied on a very crude method of typing based on the range of pigments (pyocins) produced by different *P. aeruginosa* strains.

In the 1960s, although *Staphylococcus aureus* was still important as a hospital-acquired pathogen, we were beginning to see the emergence of other antibiotic-resistant Gram-negative bacilli as significant pathogens among newborn babies and patients being managed in Intensive Care Units (ICU). The source and transmission patterns of these bacteria were unclear at that time, so we sampled the ward environment and compared the isolates with those from patients. However, it was very difficult to identify possible "epidemic" strains, as we only had available at the time conventional biochemical tests, with media produced in house, and antimicrobial resistance patterns. As most isolates were multiply resistant, differentiation was difficult. Today, microbiologists have available a much larger range of biochemical tests in the form of commercial kits or automated systems, as well as various forms of molecular typing. As an aside, I happened to be in ICU taking some environmental samples, when, during a huge storm, we watched while the roof of the squash courts blew off to be deposited on the tennis courts.

The bacteriology diagnostic laboratory was also a very different place from the modern laboratory. Much reliance was placed on a well-prepared Gram stain, and having the skills to choose the most appropriate range of media depending on the site of infection and likely pathogens, skill in identifying potential pathogens based on colonial morphology (especially in the presence of other flora) and choice of the most appropriate biochemical tests. All media for culturing microorganisms, identifying them and performing antimicrobial susceptibility testing were made on site. Antimicrobial susceptibility testing was done by hand-streaking test strains onto plates containing a range of antibiotic concentrations. Although there were very careful checks and balances, and the use of several control organisms with known susceptibilities, there were inevitably some problems, but these could be identified before any results were published, for example, if all streptococci came up as resistant to penicillin, there

was clearly a problem with that day's batch of plates. Virology culture and electron microscopy was conducted in the virology laboratory run by Ian Jack. At the time, RCH was the only hospital in Melbourne that had the capability to perform viral culture. In addition to culture, electron microscopy to examine samples for viruses was performed by the Virology Department. As with bacteriology, virology testing was very slow compared with modern methods, as discussed below.

We could see automation coming into the biochemistry laboratory and prided ourselves in that such a change would never be possible in microbiology - well, it did happen. First came standardised identification kits, consisting of small plastic strips with ~20 mini cups each containing a different dried substrate. After inoculation, rehydration and incubation the test results could be converted to a profile number which was then decoded by referral to a database. Later automated versions became available and finally came polymerase chain reaction technology (PCR). The latter relies on amplifying and characterising a segment of DNA (or RNA in the case of some viruses) unique to a given organism. In many cases PCR can be used in place of culture. Its advantage is a same-day result, compared with standard culture and susceptibility testing that usually takes two days or more in some cases.

In the 1960s, most cases of diarrhoea in children went undiagnosed. *Salmonella* spp. and *Shigella* spp. were readily isolated and identified, but only one of the five pathotypes of *Escherichia coli* had been discovered at that time. The great majority of diarrhoeal stools sent for culture failed to yield a pathogen. Several years later, however, Dr Ruth Bishop (now Professor) from RCH and Dr Ian Holmes, electron microscopist from the University of Melbourne, reported on a new virus found in duodenal biopsies of young children with severe diarrhoea admitted to RCH. They named the new virus duovirus (duodenum), but were just beaten to publication by a French group who reported similar findings and called their virus Rotavirus because it resembled a wheel on electron microscopy. The majority of cases of diarrhoea in children under five were shown to be caused by the newly discovered virus, explaining why bacterial cultures generally failed to yield a pathogen. Further work resulted in the development of two live attenuated rotavirus vaccines, Rotarix (containing one attenuated human strain) and RotaTeq (containing five human-bovine reassortant strains). Both have been available in Australia since 2007. They have similar effectiveness. Vaccination of infants at ~6 weeks and 2 months of age has led to a marked reduction on hospital admissions due to childhood diarrhoea.

In the 1960s, there were no vaccines for prevention of meningitis due to *Neisseria meningitidis*, *Haemophilus influenzae* or *Streptococcus pneumoniae*. The Bacteriology Laboratory closed at 5 or 6 pm on weekdays and at lunchtime on Saturdays. If a child was admitted

with meningitis outside these times, a bacteriologist would be called in to perform Gram stains and set up cultures, to identify the three main types of bacterial meningitis and distinguish them from viral meningitis. The Gram stain findings would inform treatment with antimicrobials, which would be modified, if necessary, once cultures became available the following day. The prevalence of meningitis in infants and children has been greatly reduced since vaccines against H. influenzae type b and S. pneumoniae and N. meningitis (serotypes A, C, W and Y) as well as serotype B have become available as part of the routine schedule of infant immunisation.

Some of the basic observational skills possessed by microbiologists before the development of molecular techniques have, I think, been lost by some modern microbiologists who rely very heavily on identification kits and molecular tests. It is still critical that a result makes sense, for example if an identification kit detects a very rare pathogen, some additional checking, including "old fashioned" conventional microbiology may be indicated. Another related change that has occurred in recent years, mainly because of the huge increase in

laboratory workloads, is that there is less time available for discussion of laboratory findings within the laboratory and importantly with clinicians.

When I told Dr Alan Williams I was pregnant and would be leaving RCH, he encouraged me to apply for a M.Sc., based on published papers, from work done at RCH. The first step was a meeting with Professor Sydney Rubbo (Head of Microbiology, Melbourne University), which Alan Williams arranged. I am very grateful for this. Before my first child was born, I had to resign from RCH as was expected at that time. Women in science did not usually return after having children, and most became stay-at-home mums. This was not really my style and I gradually returned to microbiology, at first with part-time teaching and later in academia. It was the experience, friendships and commitment to microbiology that developed during my time at RCH that led into to continuing to work in microbiology until retirement.

**Professor Margaret Deighton (nee Shallard)
PhD is a retired microbiologist.**

Car with five wheels (Garry Warne)



The Lessons of HIV on the COVID19 pandemic.

Henry Ekert

There are two sorts of epidemics, those that attack the body and those that attack the mind. Both can be very deadly and persist for a long time. Herd immunity only appears after a long time and vaccines are not always available.

It's been my misfortune to have experienced both.

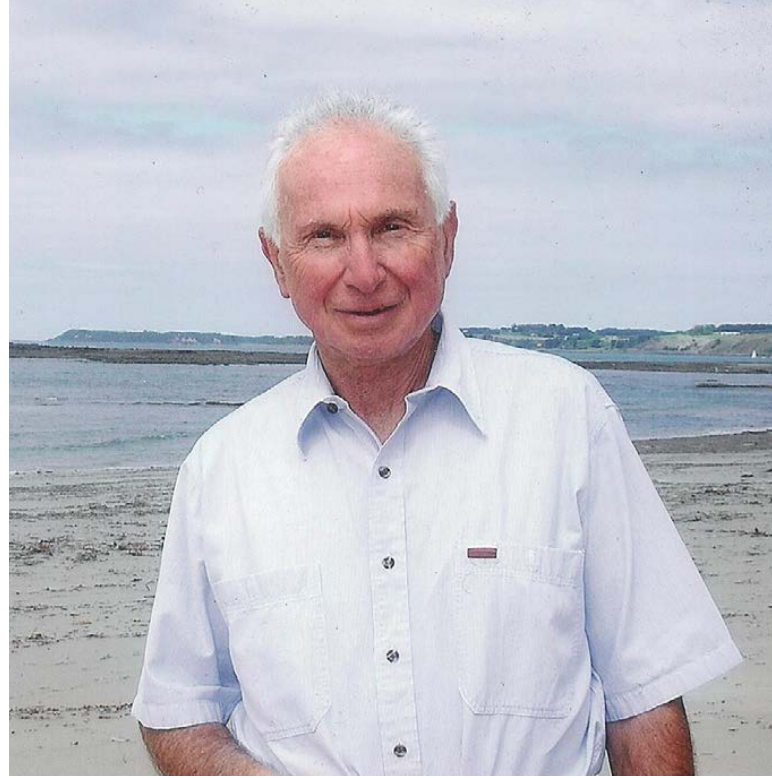
The one that attacks the mind was Nazism and the Holocaust. I lost all but my immediate family and though I survived, my childhood was taken from me at the age of 3 years. I witnessed horrors and brutality. I lived in fear and I lived a lie about who I really was. I survived with an intact body and only somewhat scarred mind.

The one that attacks the body was HIV in the 1980s. At that time, I was Director of Clinical Haematology at RCH and prominent in the management of bleeding disorders as well as childhood cancer. Virtually all children and young male adolescents with Haemophilia A and B in Victoria were my patients.

In 1980 the news media began to publish articles on a strange illness that affected the gay population on the West coast of the USA. There were all sorts of theories as to the cause of this disease which manifested itself predominantly with rare infections and lymphomas which were fatal. They were of interest because the cause was unknown and appeared to be linked to the gay community.

Not long after this, investigators in France and the USA were able to show that the cause was a virus called Human Immunodeficiency Virus (HIV) and in 1983 it became clear that in addition to the male gay community, recipients of blood products could also develop the same disease, with the first cases reported in the UK and USA. All of the blood products used to treat these first patients were manufactured in the USA. It was considered that the HIV contamination was peculiar to the USA and most haematologists did not alter their practice policies. Then there appeared reports that in the UK haemophilia treated only with UK-derived plasma also developed the disease, which by that time was called acquired immunodeficiency disorder: AIDS.

In Australia we had a policy of self-sufficiency for all blood transfusions and manufactured plasma products which we used in the treatment of bleeding in our



patients. We blessed this policy thinking it would prevent AIDS in our patients and we trusted the CSL which made these products to ensure that best practice manufacturing procedures would be used. A particularly controversial one was heat treatment of the blood clotting products because of the fear that heat treatment could destroy the clotting factors that were required for treatment. We were blasé and naïve.

At the end 1983 and early 1984 all haemophilia treatment units in Australia began reporting AIDS in their patients and we at RCH were among of the first.

The reaction to this hitherto unknown disease in blood product recipients was one of devastation. After recovering from this shock, the next phase was anger and distrust of their treating doctors and nurses and of the blood transfusion and fraction services.

Families refused treatment unless it was absolutely necessary because of pain and disability. Even then they questioned the need and wanted to know what product was to be infused and if you could guarantee its safety. Children of school age suffered discrimination from their friends whose parents instructed them to avoid close contact. In a few instances, parents' homes were smeared with offensive graffiti.

The reaction from the general community also included compassion and understanding that the disease was only spread by contact with body fluids and that these children were innocent victims of this disaster.

There was also compassion from the government at all levels, with new treatments becoming rapidly available at no cost and eventual financial compensation being granted to the families and young people infected with HIV through blood products.

The scientific community saw a great opportunity to do rewarding research and generously shared their research with all the world.

The impact on the health workers working with HIV infected children was severe. Many felt guilt that they had used infected products and watched their patients develop AIDS with horrible sometimes disfiguring infections. Many passed into a state of depression and some refused to continue involvement with their patients. Some elderly haematologists took early retirement so that they no longer had to face distraught families. It was tough!

The blaming game came to a finish when it was realised that HIV could infect people with all sexual preferences and the scale of the disaster in Africa became mind boggling. Instead of blame the world attention started to focus on cure. There is no doubt that public pressure through multiple organisations and the media accelerated progress.

Now children and adults with bleeding disorders can be treated with highly sophisticated products produced by molecular engineering with no risk of infection. These techniques have eliminated shortages of treatment products which had severely affected Australian haemophiliacs for so long. Furthermore, there are great

improvements in treatment of infected individuals which while not a cure can be expected to give a normal life span. But, there is still no vaccine despite 30+ years of trying to find one.

The similarities between HIV and COVID 19 pandemics are clear to see.

We must shift attention to what is to be done now rather than seek blame. We see protective measures such as masks which mimic the use of condoms during the HIV pandemic. We wash hands frequently as we did then and use disinfectants just as we used then. We make treatment available and cost free and those many who have lost jobs are being financially compensated.

Our research which is now more advanced than it was in the 80's and 90's will find a way forward just as we did with HIV. Meanwhile we should not lose hope that we can overcome this virus and trust that good scientific research unhampered by politics and ultranationalism will become widely available to all scientists who want to help, just as it did with the HIV pandemic.

Professor Henry Ekert AM was Director of Haematology and Oncology and a Divisional Director at RCH. [View his full profile.](#)

Two visits to Vietnamese villages

Garry Warne

In 1995 I visited Hanoi for the first time and renewed contact with David Hipgrave, an Australian paediatrician trained at RCH, who was employed as a research officer in a project aimed at measuring the efficacy and uptake of a hepatitis vaccine. David invited me to go out with him and his team of Vietnamese colleagues to visit community health centres serving a group of villages. Crammed into two vehicles, we bumped along smaller and smaller roads until finally we entered the single dirt carriageway built on a levee between paddy fields that led to the first village. Picture banana palms, small houses, gardens, dogs, chickens, farmers in conical hats bent over their crops in the rice fields, water buffalo and children.

In general, there was one health centre for every three villages. A health worker was attached to each community health centre, but these health workers were basically farmers who were able to work part-time as health workers if the villages could pay them. The amount



of money needed was minuscule – about USD \$1/month per village – but even so, hard currency was so scarce that this was not always possible.

On arriving, David's team consulted the local health worker, looked at his records, and then spread out to audit each of the villages, walking between them along earthen dykes separating the rice fields. Groups of curious, high-spirited, laughing children followed us wherever we went.

In theory, there should be no malnutrition in Vietnam, because every house in every village is supposed to have a vegetable garden, a pond for raising several different species of fish, a pig and a rice field. The pig is fed on sweet potato, pig manure feeds the fish, and human excrement goes on the rice field. This is known as the 'garden, fishpond, pigsty' plan (VAC in Vietnamese) for the nutrition of the people and it was developed in the Red River delta. If practiced in its pure form, it works. In reality, however, the people often ate little more than a bowl of rice topped with sweet potato twice a day, because they sold their produce at the market for cash with which to buy consumer items such as motorbikes, radios and TV sets.

It was said that the influence of the Communist Party stopped at the village gate, but this was not quite so, because a great deal of help was provided to the research team on the day we visited by members of the Vietnamese Women's Union. This is an extremely powerful organisation with a current membership of 13 million. They knew who lived in every household and where they might be found. Their support is also essential for public health programs such as vaccination.

I noticed that between villages, on what appeared to be an island surrounded by banana palms and rice paddies, was a building. This, I was told, was where people with disabilities are housed, in isolation from the rest of the community. It is rare to see people with any kind of disability in Vietnamese towns and cities and this is why.

I had few other opportunities to visit villages during my subsequent visits to Vietnam because the work of RCH International was hospital-based, but I vividly recall one other visit.

The Director of the National Hospital of Pediatrics in Hanoi, Professor Nguyen Thanh Liem, received a request from the Ministry of Health to go to a village where there was an outbreak of a strange neurological disease affecting a number of people. A small van was provided to take a group of hospital staff and me to the village. On arriving there, we were invited by the village officials to partake in a leisurely afternoon tea and were then ushered into an adjoining room where a few of the affected patients were waiting. They seemed to have a range of unusual symptoms and signs, but did not appear to be very ill. After a short time of seeing them (neurological examinations were cursory) we all returned to the meeting, where the real business took place. What the village lacked was a

telephone and if Professor Liem would recommend that they should get one, it would be of great assistance. He agreed to include that recommendation in his report and everyone was very happy. There was no further discussion, and we set off for home.

On the way back to Hanoi, we detoured down a side road that led deep into a forest where there was an isolated property with a restaurant. Everyone was in high spirits as we waited in the restaurant and I was not told what was special about it. Eventually food came out and I don't know what kind of meat it was, but I have never tasted anything so terrible. My Vietnamese friends, who consumed it with relish, would not tell me what it was but I can only presume it was a wild animal of some kind. Civet cat? Monkey? Pangolin? I have no idea.

We read about the wet markets of China and their link to the COVID-19 pandemic, and wet markets also exist in Vietnam, or they did then. The consumption of wild animals is widespread in both countries. Hanoi has a whole district of snake restaurants where large numbers of snakes of all kinds are kept alive in the garden – draped over the branches of trees and in the undergrowth. The customer points through a window to indicate which one he wants. I was taken there by our Vietnamese hosts as a special surprise at the end of a day tour given as a reward for a series of 10 lectures that I had given. Our group chose a cobra. It was then hauled down from a tree, brought into the restaurant, and expertly dissected at the table. First the beating heart was removed and swallowed whole in a glass of alcohol. Next the gallbladder was found and the gall was drunk with alcohol. I hasten to add that I did not accept the offer of either heart or gall, but two French surgeons who were with us did, with no apparent ill effects. Finally, the snake was taken out to the outdoor kitchen where the meat was prepared for cooking. It came back as a number of small dishes, tasting more of the sauces and flavourings than of anything else. Snake is associated in the mind of the Vietnamese with male virility. Perhaps I was virile enough already as I didn't notice any increase. Whether eating snake meat prepared in this way is dangerous or not, I do not know.

I was generally extremely cautious about the food I would eat in Vietnam (far more cautious than many of the RCH people who came to Hanoi with me) and I also took Travelan tablets before most meals. As a result, or perhaps by good fortune, I was rarely sick. The one time when I really was sick with terrible vomiting and diarrhoea was following a meal at the most expensive fish restaurant in Hanoi, hosted by a senior Ministry of Health official. It was said, and this is worth remembering in developing countries, that the only difference between a street stall and an expensive restaurant is the wallpaper.

Garry Warne AM was Director of Endocrinology and Diabetes, and Director of RCH International, at RCH. [View his full profile.](#)



The Parthenon, Athens. (Murray Stapleton)

Where have all the sprouters gone?

Elizabeth Loughlin

Small squares of red, bright blue, clear green, appear moving over the wide grass of the Gardens, a little on, back a little, further on, miniature flashlights.

Looking closely, the colours are knee high to their dads.

More sprouting over there. A different pattern.

My youngest grandchild and I come into the large green space. She follows the magpies' hop, hop and stop and hop, a careless walk. No need to fly away from this follower. She laughs at their game, I hover, impressed but careful.

Two firs, branches close to the ground. Three separated families watch their toddlers climb into the low simple swirl of trunks. Brothers and sisters hang from the neighbouring fir. Play in the circle of bark chips under the trees.

Then excitement. The asphalt pathways are peopled with two-year olds and their siblings, all speeding on miniature scooters along the empty straight paths. Joy uninterrupted.

Rules relax, the doggies group returns, the prams parade and stop to gather. The playground takes off its red and white prohibition. Less dads.

I spot two tiny people still at play with the wooden chips under the roundabout for a day or so.

Elizabeth Loughlin has combined parallel careers in Medical Social Work and Dance Therapy. Earlier in her life she was an actor on the stage in London.

Occasional essay

The relationship between mental illness and superior leadership skills in times of crisis – discussion of these skills and some of the leaders who showed them.

Jim Keipert

Nothing is new in this world as shown by the following quotation: “Why is that all those who have become above average in politics, philosophy, poetry or the arts seem to be melancholy, and some to such an extent that they are seized by disorders of black bile?”

This quotation is from Aristotle in *Problemata*, Section 30, written over 2300 years ago.

For this paper I have drawn heavily on information from a fascinating book, *A first-rate madness* by Nassir Ghaemi who runs the Mood Disorders Program at Tufts Medical Centre, and also the works of other authors.

Most of us not unreasonably assume that in general, sanity produces good results, and insanity is a problem, especially so regarding our leaders.

In settled times without crises, and when things are calm and predictable, we're better off with mentally healthy leaders who generally have a variable degree of the following qualities: often from privileged backgrounds and had little exposure to adversity; not had mental illness; often have slightly inflated ideas of their own powers and are too optimistic; having not suffered much themselves, may be insensitive to suffering; the past has served them well and they intend to preserve it; often think the political or world situation is better than it is; might not respond optimally to new and novel situations.

However, in times of crisis, the reverse is true and we often benefit from being led by mentally ill leaders, who have the most common form of mental disorder, bipolar disorder or manic depressive psychosis, characterized by intermittent abnormal moods of depression or mania.

People so afflicted may be psychotic (usually defined as out of touch with reality) during some episodes of depression or mania, but most of the time they may be well in touch with reality.

Depression causes sadness, guilt, remorse and despair; slowing bodily functions, lack of energy, fatigue; loss of interest, difficulty in thinking, poor concentration, difficulty reading; loss of appetite, sleep disturbance; separation from people, especially loved ones leading to broken relationships and divorce; suicidal thoughts.

Mania: at its core, is impulsivity with heightened energy; mood is elated, with fast thoughts continually coming; loquacious, dominate conversation and often irritate friends; can be irritated themselves because listeners can't keep up; need much less sleep; impaired judgement in many activities; high libido often leads to inappropriate activities and choice of partners, extravagant spending beyond their means, high speed driving and impulsive travelling. In its worst form it is the perfect antidote to the goals of most people to keep their family, home, job and a stable life.

Despite these problems, mania confers benefits that patients and psychiatrists recognize. Liberation of thought processes enhances flights of ideas. This gives creativity.

There are three forms of mental abnormality which are mild manifestations of abnormal personality, that are just as biologically induced as mental illness. These are:

- **Dysthymia.** Person is a little depressed, low in energy, sleeps more than average, is introverted and this is a mild form of depression.
- **Hyperthymia.** Upbeat, outgoing, high energy, sleeps less than average, high libido – correlated with a mild form of mania.
- **Cyclothymia.** A little of both, alternating between high and low in mood and energy. Correlated with a minimal form of manic-depressive disorder.

These basic temperaments are set by age 3, correlate with adult personality aged 18 and (even though we may get wiser as we get older) change little even into old age.

Many leaders have hyperthymic or cyclothymic personalities.

The definitions we will use are:

- **Mental illness** – the presence of disease: manic-depressive disorder, schizophrenia, or anxiety disorders
- **Mental abnormality** – abnormal temperaments (dys-, hyper- or cyclothymia)
- **Mental health** – absence of mental disease, plus near the statistical average of personality traits

The best crisis leaders are usually either mentally ill or mentally abnormal.

The worst crisis leaders are usually mentally healthy.

In bipolar disorder the combination of mania and depression promote and enhance four special leadership skills: creativity, realism, empathy and resilience – all factors leading to superior crisis leadership.

All accompany depression, especially realism and empathy.

In manic disorders creativity and resilience are more marked.

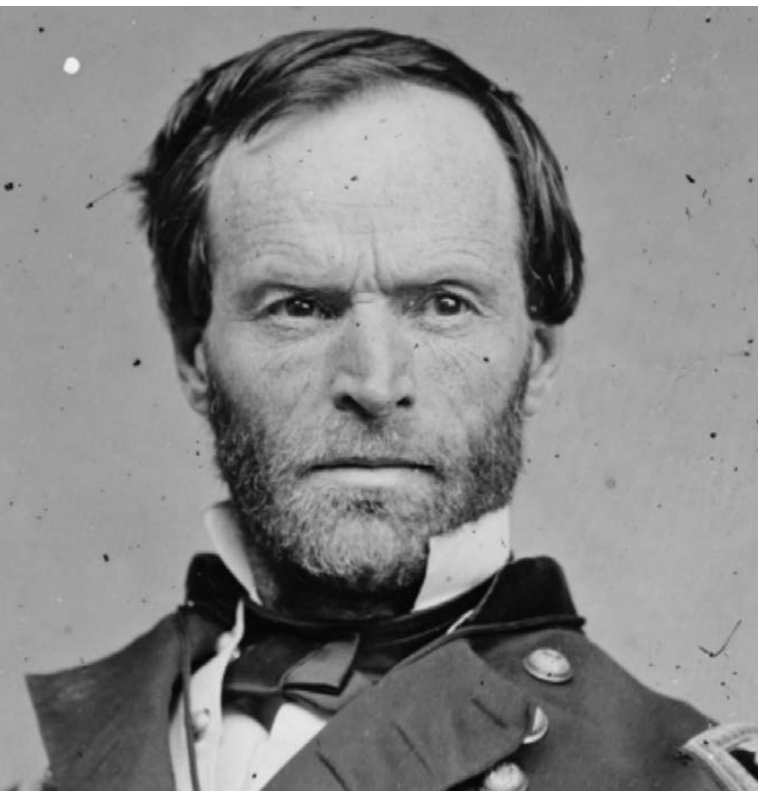
Apart from resilience they are not present in the other mental disorders, schizophrenia or anxiety disorders.

These factors may have shaped the last 60 years of the 20th century more than any other factor.

We will be discussing the mental state of the leaders we consider, so I should mention there is no specific test for most psychiatric conditions, the diagnosis of which is mainly made by four sources of evidence.

1. The patient's symptoms. Important is the history from other observers.
2. Genetics is very important as bipolar disorder runs in families. Identical twin studies show bipolar disorder is about 85% genetic. Depression is about 50% genetic.
3. The course of the illness which has a distinctive pattern
4. The treatment and response to it.

General William T Sherman



In the American Civil War, Generals Lee and Grant were fighting a traditional Napoleonic conflict of direct frontal attacks, relying on the mass of forces on each side, resulting in little positive outcome but a ghastly carnage. In the American Civil War 1861-65 118,000 soldiers were killed in action and there were 344,000 deaths from communicable disease.

General Sherman took an entirely creative and successful approach. Sherman attended West Point graduating near the top of the class despite loss of points for misbehavior. He then married his childhood sweetheart. But 13 years later the lack of prospects in a peacetime army and poor pay led Sherman to leave the military and pursue a career in business.

In this capacity he exhibited manic behavior moving from city to city, borrowing large sums of money for his often unsuccessful ventures. He started a bank in San Francisco. Within four years he was bankrupt with debts equivalent to \$3 million in today's currency. For the next two years he continued with an unsuccessful business career in several cities. In 1859 with the help of influential friends, he was appointed superintendent of a military college in Louisiana.

He was strongly opposed to war between the north and the south, but war came, and he went from 2nd in command, to command in Kentucky.

Although not engaged in battle action, and without apparent provocation, Sherman became severely manic for about two weeks, followed by deep depression with psychosis in the form of paranoid delusions for two months. He was frequently suicidal. He went home to his family. There was a history of insanity in the Sherman family.

Six months later Sherman was significantly improved, and again with the help of influential friends – including representation to President Lincoln – he returned to the army under the supervision of General Ulysses S Grant, performing well in the battle of Shiloh, and in the first Union military success with the brutal siege of Vicksburg.

Sherman then acted separately from General Grant, and showed great creativity by devising a totally different form of warfare by not engaging in military confrontation, but laying waste to the countryside and cities of the south by stripping the country of corn, cattle, hogs, sheep, poultry and in fact everything he could lay his hands on.

From Tennessee he crossed into Georgia. He only had minor engagements before taking Atlanta. All citizens were forced from their homes. It was stated that they were given a one-way ticket to the north. Atlanta was then completely burned, being the last U.S. city ever destroyed in warfare.

Avoiding attempts of the Confederate army to coax him into battle, he headed deep into Southern Territory through South Carolina with his men foraging off the land, destroying other food supplies and property, tearing up rail tracks, destroying roads, gradually destroying the South's ability to wage war, and devastating civilian morale. This continued for three months.

He reached North Carolina in March 1865. Not long after, he met General Grant in Virginia and General Lee was forced to surrender, ending the war.

Sherman primarily showed great the creativity possible in some people with bipolar disorder, but also showed the other characteristic of realism of what was possible, and perhaps surprisingly more empathy towards his defeated opponents than expected.

Realism

Experiments in the 1970s showed that, compared to normal people, depression led to a more realistic assessment of how much control one had over one's environment. This was because normal people overestimated their degree of control. Many experiments since then have confirmed these results.

An interesting experiment with people recovering from treatment for cancer shows the majority felt they had changed for the better. They thought they had a greater control over their disease or recovery than was actually the case from expert assessment, and the psychologically healthier patients were the most unrealistic.

Other experiments confirm that normal people have an illusory sense of control, especially if things seem to go well for them. They also are generally more optimistic than circumstances warrant and exaggerate their skills, beauty and intelligence. This is a state of positive illusion – the opposite of depressive realism.

Everyone suffers at some time. Life's pain can come earlier or later, harshly or gently.

For the lucky, suffering is delayed, and less frequent and severe. The unlucky, who early in their life endure hardships or tragedies – or the challenge of mental illness – tend to be more realistic about how much control, they have over their environment and about the world, and how they might change it, especially in times of crisis, leading to the emergence of such great leaders as Sherman, Lincoln, Roosevelt and Churchill.

Abraham Lincoln

Born 12.02.1809. President 1860. Civil War 1861.

He rose from very humble circumstances. He had typical symptoms of manic depressive illness, more severe on the depressive side. This was present in multiple relatives.

The course of his illness was typical of manic depression. Recurrent episodes of depression were mostly precipitated by adverse life experiences. He frequently contemplated suicide.

He was treated very non-specifically with recurrent bleeding and with mercury tablets for their purgative and

laxative effects, not surprisingly without beneficial effect. Even extremely cold showers were not beneficial.

Physically, he almost certainly had Marfan's syndrome, a rare inherited disorder affecting connective tissue generally, but particularly in the skeleton, eye and cardiovascular system, producing characteristic features and appearance in those affected, and in his day leading to a relatively early death.

Lincoln's depression led him to developing a high degree of realism and empathy which contributed to make him a superb crisis leader.

He had a natural empathy for the suffering of slaves and opposed slavery, but this was combined with practical realism which made him appreciate he could not attempt to abolish slavery prior to the Civil war, as the U.S. Constitution specifically sanctioned slavery and the South was perfectly within its rights to insist that slavery be protected, and he was trying to compromise with the South to prevent war.

Lincoln the man believed slavery was wrong but Lincoln the politician had to compromise until he could alter the Constitution.

He adopted a containment policy preventing its expansion to the west, with the aim it would die out gradually as abolitionist views were spreading.

Lincoln was a great war leader for the North during four years of turmoil. He found difficulty in finding satisfactory leaders of the military forces until he appointed General Ulysses S Grant in 1863 followed by the resurgence of General Sherman.

He was a president with rare political skills. He had the knack of appealing to fellow politicians and talking to them in their own language.



He had a talent for smoothing over personal difficulties and holding the loyalty of men antagonistic to one another.

He was not vindictive. After the South was beaten, the advice he gave - that when your enemy is most vulnerable, when you could hurt him badly, that is when you must not do it - was later followed by Dr Martin Luther King.



He concluded an address at the end of the war saying "with malice towards none, with charity for all, with firmness in the right as God gives to see the right, let us strive to finish the work we are in, to bind up the nation's wounds, to care for him who shall have borne the battle, and for his widow and his orphan, to do all which may achieve and cherish a just and lasting peace, among ourselves and with all nations".

In so many of his appropriate actions he displayed the realism and empathy of the depressive.

Had he lived, the empathist in him would have been disappointed that the Civil War did not produce full freedom for the blacks but replaced slavery with segregation, but the realist in him would have appreciated that is was probably the best that could be achieved at the time, as it took another century and the empathetic policies of another great depressive leader in the form of Martin Luther King and his no-violent resistance movement, together with the actions of that other great depressive leader John F Kennedy to complete that task.

Empathy

The term didn't exist until the 1950s and was originally used to express appreciation of a work of art.

In 1903 the German physician Theodore Lipps applied it to psychology with the word *Einfühlung* (ein - into, *fühlung* - feeling; feeling into another person's experience). The English translation of 1910 derives from the Greek roots *em* (into) and *pathos* (suffering) - into suffering.

Empathy could reflect imagining oneself in another person's place, or actually experiencing what that other person is experiencing.

There is a neurobiological basis for empathy. Only 3% of animals are monogamous. Besides humans the only other species is the orangutan.

Comparison of a highly monogamous species of voles with a highly polygamous species of voles shows that the monogamous brains contain markedly more oxytocin receptors especially in regions involving emotional processing.

Oxytocin activity peaks during orgasm and is high during childbirth and breast feeding, and it produces feelings of emotional attachment in socially significant moments, like sex or breast feeding. Its constant presence is associated with sociability, its absence with isolation.

It seems that people with great empathy naturally have lots of oxytocin receptors. Italian scientists discovered where empathy worked in the brain.

When a monkey moves his arm the part of the motor cortex of the brain governing that movement lights up. But other parts of the brain also light up - the insula which is involved in processing emotions and the anterior cingulate gyrus.

Another monkey watched the monkey move his arm. In the brain of the watching monkey the insula and anterior cingulate gyrus lit up but not the motor cortex. The brain of the watching monkey acted as if he were moving his hand even though he was only watching someone move their hand. His motor cortex did not light up because he was not moving his hand.

Researchers found that 10% of the human brain is wired to turn on as if it doing what it is only observing.

There are different manifestations of empathy.

Cognitive: thinking another person's thoughts

Affective: feeling an emotion another person feels

Motor: moving the way another does

Sensory: feeling a physical sensation another person feels

There is a reason for the existence of empathy.

It is estimated that at least half of human communication is non-verbal. So, we need other methods to understand each other. Without empathy communication between humans is impaired.

Apart from being born with many oxytocin receptors, how can one attain a high degree of empathy?

I presume that in an attempt to modify or improve any behavioural characteristics, training may be effective.

However, there is a more certain way. Many well conducted studies have shown that depressed patients have much higher scores on emotional empathy scales than controls, and the more depressed the patients were, the higher their empathy scores.

Emotional empathy produced by depressive episodes may prepare the mind for a long term habit of appreciating others' points of view.

Mahatma Gandhi

He had an attack of adolescent depression leading to an attempted suicide. He had several other depressive attacks during his life, with a severe attack for the last two years of his life.

He had a dysthymic personality associated with chronic mild depression and anxiety. His son probably had depression, but knowledge of other relatives is insufficient to know whether any had depression. He rejected western treatments, few of which were available anyway.

He pioneered the politics of non-violent resistance, which is a highly empathetic approach to solving problems.

Empathy was prominently displayed in many of Gandhi's statements. For instance, he said "It is contrary to my nature to distrust a single human being, or believe that any nation on earth is incapable of redemption. By a long course of prayerful discipline I have ceased over 40 years to hate anybody. But I can and do hate evil wherever it exists. I hate the system of government the British have set up in India. I hate the domineering nature of English as

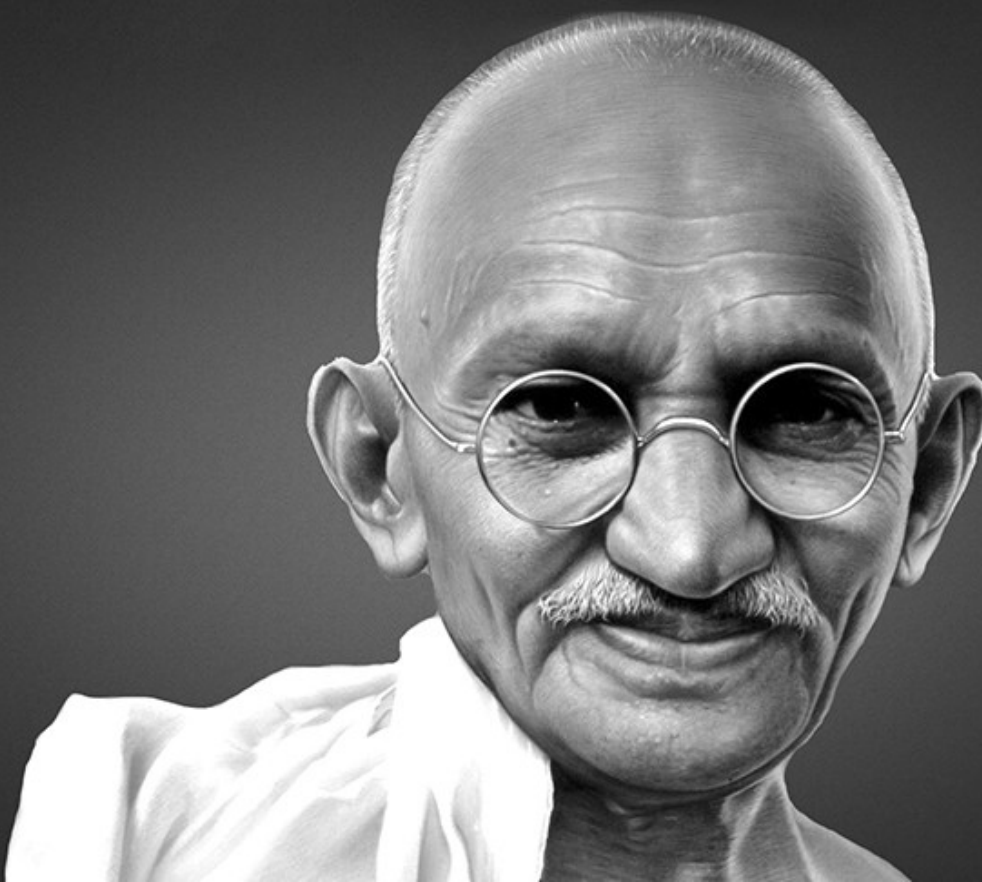
a class in India. But I do not hate the domineering English and refuse to hate the domineering Hindus. I seek to reform them in all the loving ways open to me. My non-cooperation has its roots not in hatred, but in love."

Gandhi tried to persuade Indians to value their British rulers while they sought to free themselves from British rule. He attempted to sway his Hindu followers to respect the untouchable caste and to live tolerantly with Muslims. He tried to preserve a united India and Hindu-Muslim unity. He considered every man as his blood brother. He said that three quarters of the miseries and misunderstanding of this world will disappear, if we step into the shoes of our adversaries and understand their viewpoint. We will then agree with our adversaries or think of them charitably – empathy at its best.

Gandhi achieved greatly with his improvement of conditions for Indians in South Africa.

In 1920 in India Gandhi was the dominant figure on the political stage, commanding an influence never attained by any political figure in India or perhaps in any other country.

Gandhi's empathetic preaching of non-violence had its successes in the form of Indian independence and somewhat less stigma for the untouchables, but it failed lamentably with the Hindu-Muslim conflict, as shown by the Hindu-Muslim riots in 1947-48 that preceded, accompanied and followed partition, and caused at least one million deaths. This was despite Gandhi, preceding and during partition, moving from province to province, frequently living with Muslim families, trying to prevent violence.



Gandhi eventually realized that non-violence had never truly occurred in India. When his followers were repressed by the British and were without arms and weak, they were non-violent, but when independence had strengthened them, they armed themselves and made war on each other.

Gandhi had invented a new non-violent resistance and politics based on radical empathy for all. It had worked for 30 years but failed when needed most. India's masses had responded initially, but ultimately rejected his call. Gandhi could empathise without limits. His people could not. This was because Gandhi had depression, but the people of India did not, or not enough of them did.

And a decade after Gandhi's death, a young black minister from Georgia, who was also another great depressed empathetic leader preaching non-violence - Martin Luther King - placed a wreath on Gandhi's grave.

Resilience

Resilience may be defined as "good outcomes in spite of serious threats to adaptation or development".

Resilience is often best seen in people with a genetic predisposition manifested by a positive outlook on life, and in people with a mental illness such as bipolar disorder. Both groups experience harmful life events of varying severity, with the interaction producing a good outcome.

When people experience trauma or harmful effects, some are injured psychologically, while others are not.

Half the U.S. population experience a major trauma at least once, but only 10% of them meet the diagnostic criteria of post traumatic stress disorder, so most people who experience major trauma don't develop post traumatic stress disorder. Sometimes people get even stronger after such events, a steeling effect that protects them against future stress - a bit like immunization against disease.

The stress might be illness. This might be a physical disease such as poliomyelitis producing the permanent paralysis of the legs affecting President Roosevelt, or the recurrent - often life threatening - illnesses of President Kennedy - two very resilient people.

Alternatively, the stress might be a mental illness like manic depression, in which the periodicity of attacks acts as an immunizing agent to promote resilience as occurred with General Sherman, Abraham Lincoln, Winston Churchill and John F Kennedy.

Others stresses are the terrible traumas of war, natural disasters, terrorist attacks, child neglect and abuse, sexual abuse, crime and major accidents.

Since World War 2 a lot of research has shown the relationship of trauma to resilience. In one trial a group of adults who had experienced sexual trauma but didn't have psychiatric problems in later life (the resilient group) was compared with a similar group who had severe psychiatric consequences (the non-resilient group). The resilient group had little social and parental support in childhood and vice-versa for the non-resilient group. A harsh childhood predicted adult resilience, a benign childhood post-traumatic stress disorder.

Probably the most common hardship is loss of a parent by death or divorce. A study of predictors of greatness in 699 historical figures found that 61% of great leaders lost a parent before age 31, 52% before age 26, and 45% before age 21.

Studies have shown adults with high neuroticism scores experience more post-traumatic stress disorder than those with low neuroticism scores. Hyperthymia enhances resilience.

John F. Kennedy Born 1917

In the 1960s he had clinical depressive episodes, a number of which were precipitated by severe - and sometimes life-threatening - infections due to his then undiagnosed Addison's disease. He probably had bipolar disorder, and was suicidal for significant periods.

His family history is fascinating. His father was a typical hyperthymic. Sister Rosemary had intellectual deficiency and possibly bipolar disorder. His nephew - Ted's son -



had bipolar disorder. JFK had 8 siblings with 27 cousins in the next generation. Of these 35 people, 2 were assassinated, one died of a drug overdose, four died by accident and four had substance abuse problems.

He was not a good student. Because of poor school performance his principal arranged psychological evaluation when he was aged 17. "He is a very able boy but is definitely in a trap – he has established a reputation in the family for thoughtlessness, sloppiness and inefficiency, and feels entirely at home in this role."

JFK suggested suppression of this report, as it might have an adverse effect on the work of those students who thought it was compulsory to work hard and do well at school in order to become President.

From an early age he had multiple infections, with many of which he was much sicker than expected, and some of which appeared life-threatening. At age 17 he was diagnosed with leukaemia – negated on further testing. At age 29 he had a further life-threatening infection in London, and Sir Daniel Davis made the diagnosis of Addison's disease, in which defective adrenal glands do not produce mineralocorticoids controlling electrolyte balance, or glucocorticoids which give an adequate response to stress and proper functioning of the immune system.

This had previously been a fatal disease, but a mineralocorticoid, desoxycortisone acetate (DOCA) had just been discovered, and was given as pellets implanted under the skin every 3 months. Three years later the glucocorticoid, cortisone was discovered improving the control of Addison's disease.

Aged 35 JFK was healthier than he had ever been, and with indefatigable campaigning, he was elected to the Senate, defeating the Republican Henry Cabot Lodge in a Republican state in a Republican year.

Within a year, chronic back problems had increased and affected his legs, so that he could barely walk with crutches. Against the advice of most doctors, he agreed to the fusion of an apparently unstable sacroiliac joint, with a bone graft and a metal plate. Post-operative wound infection occurred, precipitating an Addisonian crisis. He became comatose and was not expected to live, and the last rites of the Catholic Church were administered. He recovered, but the metal plate had to be removed. A large infected cavity took 7 months to heal. He was severely depressed.

Aged 36 to 40 he had 7 hospitalizations for various infections often associated with Addisonian crises, despite which at the age of 39 he almost became the Democratic vice-presidential nominee.

With the cooperation of the press, he publicly denied any serious health problems, thinking the American people wanted a healthy President, and forgetting they revered President Roosevelt for his enormous ability despite his great problems.

In this period and for a short period after being elected President aged 44, he was not always compliant with his essential medication, and was also taking amphetamines and testosterone in doses in excess of those recommended by his physicians. He also took barbiturates – self-administered.

These factors no doubt contributed significantly to his failures with the disastrous Bay of Pigs fiasco, and his dominance by Soviet leader Khrushchev at the Vienna Summit, in his early Presidency.

In the second year of his Presidency, a new physician rationalized his treatment regime, leading to the years of his greatest achievements in the form of his spectacular staring down of Khrushchev in the prolonged Cuban Missile Crisis in 1962, his famous speech in West Berlin 8 months later, and then in 1963 dramatically placing the Alabama National Guard under federal command, to protect black students wishing to attend university, thereby abolishing educational segregation for black students.

He then made his dramatic speech to the American people calling for new civil rights laws that would end segregation and extend voting rights to blacks, and followed this with full federal support to enable safe civil rights marches in Mississippi and then Washington, where Martin Luther King gave his famous address.

After that speech the President met with King, extended his hand and whispered "I have a dream". It was dream thought up by a depressed leader and brought to reality by a mildly manic one. President Kennedy's dream of civil rights laws for blacks were passed shortly after his death.

Despite all his problems President Kennedy showed great resilience, but also a good measure of creativity, realism and empathy – all characteristics likely to result in superior skills shown by mentally ill leaders in times of crisis.

Taken in conjunction with the great leadership skills shown in times of crisis by those other mentally ill leaders – Churchill, Roosevelt, Curtin, Martin Luther King and Hitler, I hope these vignettes will support my thesis that in times of crisis we often benefit by being led by mentally ill leaders.

Jim Keipert, aged 97, practised as a general paediatrician. [View his full profile.](#)

Report: Inaugural RCH Aluminar

“Covid-19: How to Stay Safe” (A/Prof. Lou Irving)

Caroline Clarke

Over the past few months members of the RCH Alumni Executive Committee have been considering how to keep members connected and fill the void created by our current extraordinary COVID-19 times.

The committee has been meeting virtually using Zoom technology since March, so we decided to put our new found technical skills to the test and experiment with running some lunchtime meetings this way. Jim Wilkinson creatively came up with the suggestion of calling these “**Aluminars**” which we enthusiastically decided to adopt. We are on a steep learning curve with our technological skills but seem to be getting there.

Somehow I found myself the apparent technical expert, I certainly know a lot more about the nuances of Zoom teleconferencing now than I did 3 months ago. Thanks particularly to Gigi Williams for her help and support in this space, and to the other committee members for their encouragement!

Our inaugural **Aluminar** was held on Wednesday, 24th June and the talk was given by A/Prof. Lou Irving, Director of Respiratory and Sleep Medicine and Director of Clinical Training at the Royal Melbourne Hospital. The **Aluminar** was entitled “Covid 19: How to stay safe”.

Our Alumni President Ruth Wraith and executive committee member Peter McDougall were the “MC’s” for the session. Lou gave a masterful talk on many aspects of COVID-19 including a background to the virus, timelines for development of the pandemic, various aspects of transmission of the virus including the value of face masks, clinical features and complications of the disease, and treatment modalities that are currently being investigated.

At the end of the session participants were able to utilise the “chat” function on Zoom to ask questions. We had an excellent attendance of nearly 60 people including participants in Jakarta, Indonesia and Lucknow, India, as well as Western Australia and Queensland.

The session seemed to be a success and technically appeared to work well. After the session we circulated a survey for those who attended and whilst this is still being analysed, the general sentiment seems to be very positive.

Most people found accessing the **Aluminar** very straightforward and were happy with the video and audio quality. A number of people have reported that they have been unable to attend lunchtime meetings because of inability to get to the hospital at those times, or because they live too far away (as evidenced by our interstate and overseas participants). Several attendees also said they would like to see the option of videoconferencing running alongside face to face meetings to broaden access. We will take on board all feedback provided and are excited about being able to continue to bring these presentations to our members.

Upcoming Aluminars:

August 6 **Indigenous child health, children’s rights and the law**

Speakers:

Dr Niroshini Kennedy, Paediatrician

Mr Justin Mohamed, Victorian Commissioner for Aboriginal Children and Young People

Sept 10 **22 years in China - A dynamic View of the Australia-China Relationship**

Mr Ed Smith (CEO RMH Foundation)

View a replay

“Covid-19: How to Stay Safe” (A/Prof. Lou Irving)

McMonty Hood

Dr Forbes McGain
ICU, Western Hosp

Prof Jason Monty
Engineering, Uni Melb

How to Stay Safe
Engineering controls of environment

Fan exhausting air through a HEPA filter
Flow rate of 40 L/sec of a volume of 1.2 m³
About 120 air changes per hour
cf – ICU 6/ hr
neg pressure room 12 / hr

ORIGINAL ARTICLES
Aerosol generation related to respiratory interventions and the effectiveness of a personal ventilation hood

Crit Care Resus May 2020

For a limited time this **Aluminar** will be available to view online. To request a link to view it, please email rch.alumni@rch.org.au



What's on the Alumni website?

Jim Wilkinson

The Alumni website is accessed from the Royal Children's Hospital website (rch.org.au). From the main RCH website "Alumni" can be found via "Departments and Services".

The site opens with a page called "About us" which contains information about the executive committee, our Email contact address and the location of Alumni functions at the hospital and in the RCH Foundation offices in the Front Entry Building (48 Flemington Rd).

Additional information and links include the constitution of The Alumni Association and application for membership. There are links to past grand rounds, including video recordings from many meetings over the past few years and access to archives and photo albums from the past history of the Children's Hospital since the nineteenth century.

Links to Alumni Profiles allows the visitor to read the individual stories of many Alumni past and present. A photo album includes a range of informal and relaxed pictures of Alumni members and friends.

News items appear regularly to notify members of upcoming meetings and provide reports on such matters.

The regular "Newsletters", which appear 3 - 4 times per year are also notified and can be accessed from the list of News Items as also can notices of important events.

Recent news items included Queens Birthday honours recipients, with three Alumni members (Alex Auldist, Graeme Barnes and George Werther) having received an AO.

Notices about forthcoming **Aluminars** are on the website.

Death notices were included for our past president Prof Andrew Kemp AM and Dr Margaret Garson AO, the widow of past member, plastic surgeon, Mr John Barnet.

The most recent newsletter, from May 2020, was also included.

The website includes a link allowing access to earlier "Newsletters" over several years. From this edition onwards, these are named "**Aluminations** from the RCH Alumni."

Members of the Alumni are invited to submit articles, profiles or photographs for the Website and for Aluminations. They should be forwarded to the Hon. Sec. via rch.alumni@rch.org.au

If you have comments about whether the Alumni website meets your needs, or ideas about how it could better serve the community, we would also be very interested to hear them.