THE EARLY YEARS OF THE NEWCASTLE MEDICAL SCHOOL - THE ACADEMIC PERSPECTIVE

Emeritus Professor Geoffrey Kellerman AO

This talk is my attempt to put into context the progress of the Faculty, with emphasis on its interactions with the Health Services during the first 10 years of its planning and development. It relies on my personal memories and is therefore as much a history of my own actions as it is of the topic about which I have been asked to speak, and as such must be accepted with those biases and some of it presumably taken *cum grano salis* as my memory is far from infallible. I shall therefore also observe the rule “no names, no pack drill” most of the time, so you will hear mainly general comments.

CONCEPTION

My first serious consideration of the Royal came from a study of the Karmel report of 1973 on “Expansion of Medical Education”, put together by a committee including a good spread of stakeholders who undertook a very wide consultation, including submissions by all our hospitals, our city council, our University and an especially careful document from a group from the Central Northern Medical Association, later renamed the Hunter Medical Association, under the chairmanship of the late and greatly respected Alan Hewson. Some members of that group are here today. The Karmel report was written at a time when it had become apparent both that the accumulation of knowledge relevant to the practice of Medicine had greatly increased and that the method of delivery of health care to the community had altered, so that the most appropriate organization of the undergraduate medical courses and postgraduate training had to be reexamined and updated. The continual development of the Internet and Dr Google has made further changes necessary. Amongst the recommendations of the report were an increased emphasis on the psychosocial aspects of medicine, increased attention to community medicine, more effective interaction between preclinical and clinical components of the curriculum and some reconsideration of the most appropriate student selection processes. (There is an interesting discussion of all these points, including all the internet advances, in the NEJM issue of September 28 this year.) The committee rejected the idea of the Royal being a clinical school of the University of Sydney in favour of the establishment of a full medical school in Newcastle, taking into account the strong local support and the need for an increase in the

number of graduates, with the additional advantage of this being likely to improve the local area medical workforce after graduation.
David Maddison, then Dean of Sydney medical school, was initially a consultant expert for the University of Newcastle in the recruitment of its Foundation Dean of Medicine, but soon changed sides of the table to become the successful applicant for the job. He was presented with a budget for a medical sciences building on campus and teaching additions to the Royal and Mater hospitals, along with an earmarked budget increase to the university funds to pay for staff recruitment and essential expenses.

GESTATION

He was then faced with managing an "allograft" on two fronts - into the existing University and into the hospital/community medical services. You all know the problems of allografts better than I; rejection on the one hand and Graft versus Host disease on the other. We have recently lost a GVHD patient, and many grafts suffer from threatened or actual loss by rejection that needs expert management. Would we could have sprayed the University and the Hospitals with some Tacro or cyclosporine in those early days!
David had almost 3 years (1975-77) to recruit Foundation staff and to plan the course, with the first students to come in 1978. According to the Karmel suggestions and his own priorities, these included recruiting staff to increase emphasis on psychosocial issues, community priorities and proper interaction between basic and clinical sciences, along with a reconsideration of optimal student selection processes. By about September 1976 a half dozen Professors had been appointed, including Community Medicine and Behavioural Science, two of the areas on which emphasis had been placed in the Karmel report and much of the supporting submissions, and a specialist in Medical Education. Further staff came progressively during 1977 and subsequent years. As a group we opted for the first two years to comprise a problem based course with minimal lectures, to be undertaken in small discussion groups with tutors, following the success of such a course at McMaster University in Canada. The problems on which we concentrated during the first 2 years were those identified as common, preventable or effectively treatable; we left the rarer and intractable problems till later in the course. Designing such a course was a steep learning curve for some of us staff members, who mostly came from very conservative schools. . Each year we had to plan the course as it were on the run, with evaluation of its success as we went, with modification in the second and to a lesser extent in the third

iteration. This meant that the first group of students, represented here by Doug Routley, were quite unique and really semi-colleagues who played a large part in course design. This structure was chosen in the expectation that it would encourage students to be more active and self-motivated in the learning process, rather than passive listeners to lecturers, leading to complete acceptance of the need to become serious life-long learners. We hoped that they would consider more deeply the above identified issues, be more receptive to new ideas as research produced more results, more innovation oriented and perhaps more involved themselves in research. Such a course required considerably more resources than lectures and we had the support of many health professionals from the whole community as tutors, and many continued to operate for many years. We also had the enthusiastic collaboration of essentially all the medical workforce in the last 3 years when the students were attached to tutors in all the necessary branches of medicine - general practice, all the specialties and in their country terms. These latter encouraged a number of the graduates to set up their own practice in the country, to the benefit of both. The initial plan of 2 years of directed problem study followed by 3 years of real life problems as experienced in the various practice situations is still the basic structure. As for student selection, we designed a process which did not concentrate solely of end of school examination marks, but incorporated also interviews and other tests; after some 5 years an evaluation showed that this was indeed a better way. Subsequent developments in the course included the introduction of a Bachelor of Medical Science degree requiring an intercalated year of study, and the very successful Indigenous Student program which meant that at one stage we had more Indigenous graduates than all the rest of Australia together.

It all sounds simple when it is spoken so quickly - but every step demanded so much effort!

PROBLEMS - A) University

The University problems were the lesser, and I will say little about them, merely that there were two major components. On the one hand some Professors were disappointed that David insisted on having his own staff for basic sciences, so that they received none of the expected staff enhancements (those must have been monumental University Senate battles, to which I was not privy): we had some minor niggles thereafter but that is all forgotten in the University reorganisations that have followed.

On the other hand there was the problem that the rest of the University at the time was suffering a downturn in student numbers and funding cuts, whereas we had earmarked (quarantined) funding - like a parasite growing in a capsule within a cachectic patient - again all forgotten with the growth of the University that recommenced about 1982, and the termination of the quarantined funds in 1984.
A third, and near catastrophic problem, was that David died suddenly in November 1981 when our first cohort of students were at the end of their fourth year and I had to act as Dean for the next 2 years until John Hamilton arrived - a job for which I was unprepared and from which I derived little pleasure. John will give you his version of events after that date later on today.

PROBLEMS B) Health System

The Karmel report alluded to the desirability of academic appointments (presumably Professors) becoming the heads of the relevant hospital services, and by implication working to achieve an appropriate balance of expert specialist staff to cope with the patient care and educational responsibilities of a first class teaching hospital on a par with those in the capital cities. This was a slow process, requiring funding enhancements for the recruitment of the staff and the necessary clinical and research support facilities, and there was a variable acceptance of the need for this process, its extent and the rate at which it could be achieved. We began the ongoing process whereby hospital and community medical staff members are appointed to Conjoint University positions at a rank appropriate to their achievements. Initially we were welcomed, and most of that goodwill survived and flourished, especially in the area of Obstetrics and Gynaecology and some areas of Pathology (especially my own where John Dickeson was outstanding, and consequently I am here today!). However, a couple of our Foundation Staff achieved personality clashes with existing senior hospital staff and/or administration to the extent that they had little or incomplete success in improving their areas, and therefore departed for other positions elsewhere in Australia as a result. We suffered for some years from David's belief that the surgical reputation of the Royal was such that a Professor of Surgery was not necessary, which led to some very scathing comments from some staff members about our proposed course. It led to very uncomplimentary comments about our Professor of Surgery when he was finally appointed, but when he demonstrated his consummate skill at the operating table the critics became supporters by lunch time. Credit where credit is due - faced with evidence they accepted it whole heartedly. We made slow

progress with the Department of Medicine in the face of the departure of our Foundation Professor and the delay in recruiting a replacement, coupled with some very strong support from the administration and members of the hospital board for some outcomes not supported by the said professor and our Dean. John Hamilton had to sort this out after he arrived.

One traumatic aspect was that David introduced the process of evaluation of tutors' skills by students at the end of the first year, which led to angry resignations by a couple of tutors with the attitude of "how dare you expect ME to accept evaluation by mere students".

We had a revolt by students on the matter of continuous assessment, which we initially had attempted to introduce, so that we had to give in to their demand for an end-of-year assessment (we could not, of course, call it an examination!).

Another problem was that several hospital specialists had made up their minds that this was a nonsensical way to educate students and were very dismissive of the process; fortunately when they met the students in their final year they were very surprised and changed their attitudes very quickly. I cannot praise such people too highly in this regard - they accepted evidence and changed their attitude in accordance, and became firm supporters thereafter.

One of our students did his final year elective at Harvard, and impressed the students there with his ability to cope with an unsolved problem. I met the Dean of Harvard in Sydney and discussed our course with him, and subsequently Harvard reorganized their course and stole one of our staff to help.

Some minor, but very time and energy consuming problems came up unexpectedly. There was a very reasonable library at the Royal, with a good range of journals, and the incorporation of this library into a coordinated University library faced significant opposition on the basis that "the hospital paid for them". While this seems ludicrous to us today in the Dr Google era when almost no one looks at bound journals any more, it was serious in the 1970's and was not helped by the University Librarian being perceived as a dictator.

A more serious problem was one of semantics; the Karmel report had emphasized the need to modernize the curriculum, to add some things, hence to subtract some others and to try to develop problem solving skills rather than just rote memory. This was promulgated as a "new breed of doctor" (an unfortunate shorthand phrase) instead of, perhaps, a "new graduate with a somewhat different subset of knowledge and skills

appropriate to-day to entering the graduate education portion of the necessary education" (a horrible mouthful). But the short phrase roused indignation in a couple of influential and much respected specialists who insisted that "I am a good doctor and you do not need a new type - I am insulted."

DIAGNOSTIC FACILITIES AND EQUIPMENT

You will not be surprised to hear that we also were much involved with the development of up-to-date diagnostic facilities. In 1976 there were small, old fashioned, even "beaker and bucket" type laboratories in some smaller hospitals, with no centralisation for more complex tests. The Royal had a good chemistry service and other services were variably good, but there was no coordinated "Pathology Service" such as we have today. Peter Hendry had set up a regional Pathology service before the words had even been invented; I loved and respected him but he was a formidable competitor! We even had a couple of dedicated alcoholics employed in the service. The radiology service was very definitely below par, with essentially all the good equipment being in the private sector and good radiologists likely to leave the hospitals to join the private groups.

We were commissioned to write a report for the Royal on its equipment and its radiology service, which highlighted the deficiencies in comparison with Sydney hospitals and the private services and formed the basis for modernising in subsequent years.

POLITICAL ISSUES

If you think the above discussion shows that we were busy enough, let me remind you that we had a political side as well. David had sat on the Boards of the three city hospitals (Royal, Mater and Wallsend) in 1976 and asked me to take on the Mater when I arrived. I found this an interesting task and had very pleasant interactions with the other Board members. In that position I was able to make analyses that showed the degree of underfunding per unit of operation that our hospitals had in comparison with the Sydney institutes (I am not at all sure that this does not still apply, certainly in my own discipline). As a byproduct of that association, our requests for a proper cancer unit with on-site radio- and chemotherapy were accepted, then built and staffed; a large part of the credit for that belongs to Jan Bishop, then the Pathologist at the Mater, who wrote an exemplary report on the needs and possible modus operandi of such a service that completely swamped the "one-liner" submission from the Royal. I became involved with all the local politicians, especially when I was acting as dean, and was able to

persuade them of some of these problems; I was invited, by the good offices of Owen James, to address the local Unions, and ultimately to meet and discuss our issues several times with the Minister for Health in the State Parliament. He was very direct in his discussions with me and gave me a rapid introduction into the realities of government decision making. He made no secret of his own financial problems and the multiple demands made on him, but we were ultimately able to achieve the allocation of sufficient funds (my guess of $150 million was apparently close enough to match the final allocation). I deserve little credit for this success, being very much low man on the totem, the Union bosses being at the top! Dr Tim Smyth was appointed to sort out all these issues, which led to the commitment to build the John Hunter Hospital, which had the advantages of being on land already owned by the health service and also of being at more or less the geometric centre of the Newcastle/Lake Macquarie city area. It would have given us a plethora of beds, especially as length of stay was declining from a mean of about 7 days to somewhere about 3.5 days 10 years later, but the earthquake that destroyed more than half of the Royal in 1990 remedied that imbalance overnight.

SUMMARY

Successful grafting of the educational system but with ongoing changes over the years; partially successful but as yet incomplete grafting of clinical systems; the usual research imperatives of a University faculty; an extensive International presence with other “innovative” medical faculties and community oriented programs, about which for lack of time I have deliberately said nothing.

I leave it to John Hamilton to continue the saga from the year 1984 and to outline the enormous progress that he was able to achieve.