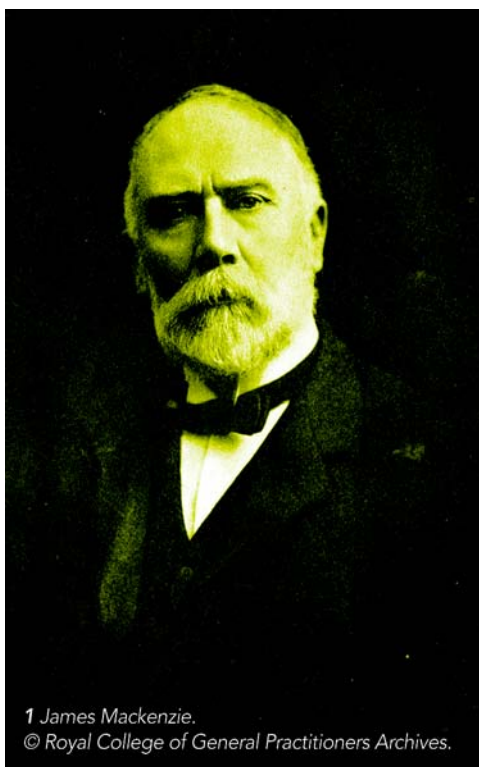


Challenges, conflict and change

David G Penington

Growing up in a medical household with a father who was a consultant physician, the idea of becoming a doctor was with me as early as I can remember. As a teenager, however, deeper thinking about life led me away and then back to medicine. I was fascinated by the wide diversity of human personality, and was an avid reader of biographies. One that influenced me greatly was that of Sir James Mackenzie¹ (pictured, Figure 1). He was an Edinburgh graduate who became a general practitioner in Burnley, Lancashire in the second half of the 19th century. From clinical experience, he became keenly interested in the way the heart behaved in arrhythmia. He developed the application of the smoked drum polygraph to interpret the venous waves in his patients' necks and their relationship to various forms of arrhythmia. As his findings eventually became recognised, he moved into the limelight. He moved to London, practised in Harley Street, headed a new cardiac department at The London Hospital (Figure 2), was knighted, and became the father of clinical cardiology. He was never as happy as he had been as a country family doctor, a role to which he finally returned in Scotland. I was fascinated by the story of how he applied science to resolve problems in a very human context.

During my 2nd and 3rd years at Melbourne University medical school, I was confronted with huge masses of information to be reproduced in examinations — particularly in anatomy. Physiology, on the other hand, offered, under “Pansy” Wright, an opportunity to explore ideas. (Wright was Professor of Physiology and the *enfant terrible* of anti-establishment Australian academia — later Sir Douglas Wright AK, Chancellor of the University!) Nearing the end of my 3rd year in 1950, I was aware that my grasp of science was too shaky to enable me to distinguish fact from the arrogant assertion then so common among clinical teachers. I jumped at the chance of a scholarship to Oxford, offering 2 more preclinical years and 3 years of clinical education at the Radcliffe Infirmary.



1 James Mackenzie.
© Royal College of General Practitioners Archives.

The years in England

Life as an undergraduate in Oxford was all I had dreamt of. There were opportunities to explore ideas of every kind among able people. On arrival in Oxford, I was told by the Professor of Anatomy that I could forget most of the topographical anatomy taught in Melbourne, just study his book *The tissues of the body*,² and go anywhere library reading led me. Lectures, he told me, did not matter! Tutorials were a great experience, encompassing independent learning and critical discussions with a tutor who was a senior scientist. Perhaps the most memorable teaching I ever experienced was Howard Florey lecturing on general pathology, covering topics such as inflammation, tissue regeneration, cancer, immunology and responses to infection.

There were many other fascinations at Oxford — music, theatre, and sport. My College in Oxford (Magdalen) was second in the intercollegiate “summer eights” (rowing). In my 2nd year, after a major falling out between the several “public school” factions and others, and dire predictions of disaster in the next intercollegiate contest, I

was asked to become captain of the boat club. I spent every afternoon over five terms rowing. I missed many classes, but learned a great deal about building a team amid conflict and dissent.

Clinical education in Oxford again offered a great clinical experience in an environment where conventional wisdom could be challenged and innovative ideas (such as treating haemophilia with animal Factor VIII produced there in the laboratory, and new approaches to managing severe poliomyelitis, or multiple sclerosis using tuberculin) were being explored. After graduating, I married an Oxford medical graduate whose clinical years had been spent at The London Hospital. We had four children over the next 8 years, and my wife committed herself to bringing up our children rather than pursuing her own career. Our marriage was to last for 26 years.



Bio21 Australia Ltd, Melbourne, VIC.
David G Penington, AC, Chairman.
Reprints will not be available from the author.
Correspondence: Emeritus Professor David G Penington, Bio21 Australia Ltd,
157 Barry Street, Carlton, VIC 3053.
dgp@unimelb.edu.au



2 The London Hospital, circa 1950s–1960s. © The London Hospital.

A career in medicine

My early resident positions in Oxford led to an exciting 6 months as senior resident at the Hammersmith Postgraduate School, with challenging discussion of cases before leaders such as John McMichael, who headed medicine with a commitment to advance practice based on research, and John Dacie, who was an international figure in haematology. On gaining membership of the Royal College of Physicians (MRCP), I accepted a Junior Lecturer position at The London Hospital in 1957.

There I found a very different environment. There were many outstanding senior clinicians, but the academic medical unit was stuck in a time-warp, grounded in views on renal disease formulated in the 1930s. Recent research on renin and angiotensin was regarded as a passing fad of no relevance to human disease. However, the position offered great clinical experience and a major commitment in clinical teaching, along with an isotope laboratory for measuring red cell survival in renal failure. I was fascinated by experimental reports on erythropoietin as a regulator of red cell production, thought to be produced by the kidney. I set about devising an assay, using hyper-transfused rats, assessing erythropoiesis with Fe^{59} . After 6 months, my boss, Professor Clifford Wilson, asked what I was doing. I told him about erythropoietin and he sensibly asked me to prepare a literature review. Three months later, I asked him what he thought and he replied that he “did not really believe in humoral factors in disease”. However, by then I was successfully assaying erythropoietin in several forms of anaemia. He relented and let me get on with it!

The publication of my first independent research paper in *The Lancet* in 1961,³ reporting absence of elevated erythropoietin in renal anaemia, led to an offer of a research fellowship in Boston with Ted Astwood (the man who had first isolated adrenocorticotrophic hormone) at the New England Medical Centre. A year of full-time research in Boston, seeking to isolate erythropoietin, was exciting, and exposed me to first-class people. After returning to The London Hospital in 1963, I was appointed Consultant Physician at the age of 33, and gained research facilities supported by the Medical Research Council.

Life as a teaching hospital consultant, with clinical duties, teaching and research, was challenging. I established the hospital's first haematology clinic which grew rapidly. As my National Health Service appointment was part-time, I succumbed to urging from colleagues to begin private consulting in Harley Street. This practice grew like Topsy. While it involved dealing with many interesting people as patients, and was highly remunerative, it was not what I wanted to do with my life. I could never find sufficient time to do justice to my developing research on control of platelet production or to keeping my teaching fresh and vigorous. In 1966, I visited Australia for the first time in 16 years, attending an International Haematology Congress in Sydney. I seriously thought about returning to Australia and to academia.

In 1967, Carl de Gruchy, Professor of Medicine at St Vincent's Melbourne and renowned author of *Clinical haematology in medical practice*,⁴ approached me with the offer of a post as his first assistant, at a salary about half that of my London income. While I also considered a comparable post in Oxford, the lure of Australia was strong. Colleagues at The London Hospital suggested I must have been in need of psychiatric help to think of

resigning, but at the end of 1967, my family and I shipped out to Melbourne.

An academic career in Melbourne

My next 2 years at St Vincent's Hospital were splendid, with time for research, for teaching and clinical practice. I completed an Oxford doctorate with research on megakaryocytes. However, when Carl unexpectedly resigned, I was appointed Professor of Medicine. The hospital at that time was staffed primarily by generalists, as honoraries. The few salaried specialists who provided diagnostic services were not regarded as part of the senior staff of the hospital. For St Vincent's to become a modern teaching hospital, providing appropriate tertiary services, education and postgraduate training, there was a great need for development of clinical specialties nurtured by research. A real challenge! As an “outsider” in a tight-knit Catholic hospital, tackling this was not an easy task.

Although the University of Melbourne was in dire financial straits at that time, I finally got agreement to make two new academic appointments — one in gastroenterology, and the other in endocrinology. Development of specialties, with research facilities initially within my unit, became the pattern for change. Hospital grand rounds, of the calibre of those at Hammersmith, were part of my vision. Resistance by vested interests — those who had previously controlled the destiny of the hospital — was inevitable and had to be lived with; but some senior honoraries who had experience of leading centres in the United States and the United Kingdom were strongly supportive.

At the end of 1972, following Whitlam's election victory, it was clear that Medibank would bring a new pattern of health care delivery with many opportunities for the public sector. Money became available for developing community health centres. In the preceding year I had become Chairman of the university's Board of Social Studies and saw a health centre, with cross disciplinary collaboration, as both a useful community service and an opportunity to provide a new environment of undergraduate teaching in primary health care.

When I formed a planning group, the Victorian branch of the Australian Medical Association (AMA) was outraged, and I was “declared black”. I was brought before hospital authorities and castigated for involving St Vincent's in what was deemed to be a socialist experiment which would inevitably be involved in doing abortions and other wicked things! However, I had accepted the challenge and was not going to let go. I thanked both for their views and continued on my way! The state Liberal government would only approve the clinic if it had a fee-for-service doctor, complying with AMA demands. This was agreed. By mid-1975, after many battles, the clinic was built and opened within a high-rise housing estate near the hospital, managed by the local community. It had strong input from the Royal District Nursing Service, and social workers were integral to its team. Its doctor had just completed a PhD in my laboratory. To this day it provides service to its low-socioeconomic-status community with many immigrant groups.

Deanship and what followed

In 1976, returning from a sabbatical year in laboratory research in Oxford, I became Deputy Dean of the Faculty of Medicine and was also recruited to chair the National Blood Transfusion

Committee of the Red Cross. In 1978, I became Dean of Medicine, succeeding Sir Lance Townsend, but continued as Professor at St Vincent's, with patients, research and teaching. I embarked on seeking to transform medical education from its preoccupation with peddling facts to a process of teaching students to think, to solve problems and to understand broad clinical responsibilities. Quality of teaching mattered enormously and needed attention. A critical decision by the faculty to change the curriculum to reflect these objectives was won on a vote of 57 for and 55 against, after two recounts, in a meeting attended by many faculty members who had not been near the university in years! From that point reform rolled on.

The faculty needed change. Its resources were concentrated in the older, established departments rather than in those growing in research and doing new things. Again, vested interests were strong, but with persistence we shifted resources to clinical departments with strong research and away from anatomy and some other pre-clinical departments that justified their "wealth" on historical decisions and a large teaching load of questionable quality.

The AIDS challenge

The National Blood Transfusion Service was an amalgam of independent state fiefdoms. It badly needed better decision making and regulation to safeguard standards, but this was strongly resisted by state directors unwilling to concede any authority. In my last meeting (February 1983), at which I announced my intention to retire, the news of AIDS cases linked to the use of fresh cryoprecipitate for haemophilia was reported in the *New England Journal of Medicine*.⁵ I relayed this to the council of the National Health and Medical Research Council (NHMRC), on which I then served, and was asked to set up a committee to advise on possible public health implications.

Ian Gust, a virologist from Fairfield Infectious Diseases Hospital, Melbourne, joined me and played a key role in all our activities. Ron Penny of St Vincent's Hospital, Sydney, who diagnosed the first Australian case of AIDS, covered immunology, and others contributed in further areas. As the story unfolded over the following year, there was great public fear of the unknown, and great potential threats to the male homosexual community. The gay community welcomed discussions early on, but a decision by the Sydney Blood Transfusion Service to exclude gay donors led to protests and cries of discrimination. We established good links with the Centers for Disease Control in Atlanta, Georgia, and benefited from weekly, if not daily updates on developments in the spread of AIDS and the search



3 Transmission of AIDS by blood transfusion hit the headlines in 1983 and 1984. The AIDS Task Force was seen as the bulwark of defence for the community. Illustration by J Spooner, reproduced with permission from *The Age*, Melbourne.

for its cause. The challenge was to ensure the crisis was handled objectively, on the basis of evidence as it became available, and that rational safeguards were put in place to minimise spread.

The NHMRC provided funds to support research, but we resisted pressure from the Sydney gay community for them to control our research, as we could not accept their view that the disease was primarily a social or political problem. A huge amount of my time was devoted almost daily to press interviews to ameliorate scare stories of a "new black death about to sweep the world", and also to oppose inappropriate moralistic haranguing of gay people, which threatened serious social disruption.

Applying experience in epidemic control was essential. As evidence moved strongly to a viral cause, liaison with research laboratories in Paris and the US through Ian Gust became enormously important. Development of a national network of viral laboratories was supported, and when testing became possible, Australian Factor VIII concentrate was shown to be contaminated. Matters came to a head late in 1984, when three Queensland babies were shown to have died following transfusion from a single donation by a gay man. A National Health Ministers Summit was called by Neal Blewett (then federal Minister for Health). Our committee was expanded and renamed the AIDS Task Force (Figure 3). A second advisory committee, the National Advisory Committee on AIDS

(NACAIDS), chaired by Ita Buttrose, was established with special responsibility for advising the public, for liaising with affected community groups and with Neal Blewett's office, which maintained close links with the gay community. That committee channelled valuable support to the gay community in their development of very important "safe sex" education programs. Neal Blewett's national leadership was critically important in gaining government support and funding.

Our advice continued to be sought on containment of risk, and we made preparation for widespread testing for the HIV virus as soon as it became possible. In May 1985, we became the first country in the world to test every single blood donation for HIV. I had many memorable meetings with special interest groups. The gay community feared the consequences of being found to have a positive test, and repeated attempts were made to have the task force wound up over 2 years. The telephone used to ring at 6am almost daily, with requests for comment on the latest story from Australia or overseas. Maintaining public dialogue was important for preventing inappropriate behaviour and to get the public to see the problem as a virus which could be handled rationally, rather than as a gay plague.

A different challenge

In 1984, another public issue became a challenge. I was asked to chair a Committee of Inquiry into Rights of Private Practice in Public Hospitals. This arose from a heated dispute between the federal government and the AMA, and withdrawal of specialist services over the introduction of the new Medicare. The committee included Dr Brendon Kearney of South Australia representing government, and Dr John Cashman, a private radiologist nominated by the AMA. We had a protracted chase to get data from the federal government which purported to show excessive private use of pathology and radiology facilities in public hospitals. In reality, the rapidly expanding use of such services was outside the public hospitals, but the advisors who developed the legislation thought control could only be achieved in public hospitals. Apart from gaining access to the necessary data, public hearings across the country over 4 months, attended by the AMA and many specialist groups as well as by government, played a part in gaining a fragile consensus which largely defused the dispute. Finding common ground was the key. Oversight of diagnostic testing in hospitals was a reasonable expectation of government, and was finally agreed. After a general election at the end of the year, Prime Minister Hawke intervened to resolve the remaining issues with New South Wales surgeons and made available new funding to update equipment in public hospitals.

My role when first appointed to the task had been damned by the Victorian AMA on the grounds of being a known “left-winger”, but in the end I received an apology and was later invited to address an AMA National Conference on the role of the profession.⁶

Two weeks after completing our inquiry, I remarried — a haematology colleague, Sonay Hussein, who still shares my life. By the end of 1986, I was so busy with AIDS issues that I stepped down as Dean of Medicine, continuing as Professor of Medicine. My last research paper was published in 1989.⁷

Life as a Vice-Chancellor

Early in 1987, I was appointed to be Vice-Chancellor of the University of Melbourne from the start of 1988. Before I took up the appointment, however, John Dawkins became Minister for Education with an agenda for radical reform. He was dismissive of what he termed “ossified old universities” and, at the end of the year, announced his intention to create the “unified national system” of higher education. While there was no doubt need for

reform, the model of central ministerial control had many dangers, including those inherent in research policies which were to be shaped according to perceived national priorities.

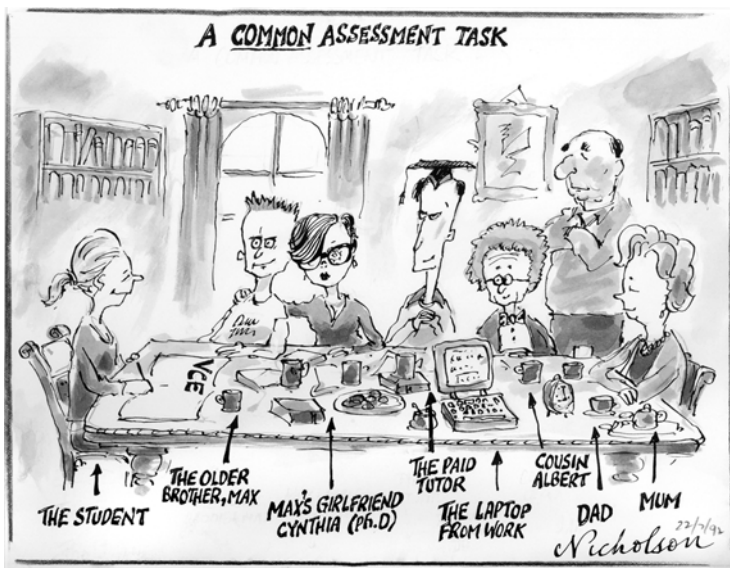
I was surprised to find fellow Vice-Chancellors reluctant to speak publicly about what many agreed privately was wrong with many aspects of the Dawkins reforms. While there was a good case for several major institutes of technology being upgraded to universities, a Commonwealth Tertiary Education Commission review of efficiency and effectiveness in higher education in 1986 had advised against combining the university and advanced education sectors.⁸ Other good aspects of that report had been incorporated into the Dawkins package, but when I declared myself as supporting some of these, Dawkins was outraged that I

had publicly opposed others, particularly those relating to research and amalgamations. A review of research policy was finally agreed, which led to many improvements and additional funding for research infrastructure which currently continues. Other public issues laden with controversy included an attempt to regulate university education in terms of “competency skills”, and principles guiding relative funding of universities. Mobilising public opinion was the key to successfully resisting some of the Dawkins changes.

By 1990, the University of Melbourne had moved into strategic planning and adopted objectives and principles in its own reform agenda. Seeking excellence

in its teaching, research and public contributions ran counter to the prevailing political preoccupation with equity and equality. We were regularly under attack. One issue in Victoria during this time was the proposed replacement of most external assessments of secondary education by what were termed “common assessment tasks” — work done independently by students (Figure 4) — to be used in university selection. This was led by left-wing teacher groups, outraged by talk of striving for excellence in education. We threatened to introduce our own entrance examination. I led much of the public debate, supported by a group of school principals, which finally achieved rational compromise.

Changes at the University of Melbourne were widespread. We concentrated on the quality of teaching, of supervision of research training and of academic management. Finally, a School of Graduate Studies was established to provide a collegial environment for graduate students, comparable in many ways to what I had experienced in Oxford. Getting a common commitment across the University to take pride in the quality of our work was the key to success. When Peter Baldwin (Dawkins’ successor as Minister for Higher Education) introduced “quality” as a major issue for the federal government, we came up “smelling of roses” in the first review.⁹



4 The “Common Assessment Task” was seen by its advocates as largely taking the place of external examinations in Year 12 for selection into universities. Illustration by P Nicholson, reproduced with permission from *The Age*, Melbourne.

Life after Vice-Chancellorship

Expecting to move into a placid retirement at the age of 65, I was asked by the Premier of Victoria, Jeff Kennett, to lead a review of illicit drug policy at the end of 1995. Deaths from heroin overdose and open trafficking in the streets were both escalating. I headed a group of outstanding individuals with widely varied expertise.

The challenge was the need to see drug dependency as a health problem to be handled through education and treatment rather than moralistic preaching and the law. While strong legal sanctions for the trafficking industry were appropriate, education was critical in prevention. Finally, when our 70-odd recommendations were unanimous, I addressed the first ever public joint sitting of both houses of the Victorian Parliament. We thought most of our recommendations would be adopted, but after a state election, with very strong lobbying by conservative politicians and the media, political support waned.

National trials of new forms of treatment were implemented. A proposal for a multi-state heroin treatment trial was supported by the Kennett government, but subsequently stopped by Prime Minister Howard. Limited reform, with improvement of services, was achieved and, subsequently, a national policy was adopted for diverting arrested drug users to counselling rather than to courts in the first instance. A repeat review of illicit drug policies, including proposals for heroin injecting facilities, was undertaken in 1999–2000 after election of the Victorian Bracks government, but public and political reaction was a virtual rerun of 1996.

National contributions to the drug debate were made through chairing the Capital Cities Lord Mayors' Drug Advisory Committee 1997–99, and as keynote speaker in the NSW Parliamentary Summit which preceded the establishment of the Kings Cross heroin injecting facility. The College of Physicians was supportive of the changes sought.¹⁰

Challenges continue. These now mostly centre on improving support for and management of research in bodies I have chaired

and seeking to bring the benefits of medical research to the community through commercialisation or other appropriate public means. Perhaps the most fulfilling have been the great growth and achievements of Cochlear Ltd as a public company and the creation of the new Melbourne Museum in its controversial new modern building.

The host of challenges which have come my way over the years have presented many opportunities to contribute to the development of medicine, of education and of the community. Bringing about change has frequently involved conflict, but change would not have been achieved if popularity was what drove me. It has been a real privilege to work with outstanding colleagues at every stage and to have had such a variety of interesting and often exciting challenges — they still come!

References

- 1 Wilson RM. The beloved physician Sir James Mackenzie. New York: The Macmillan Company, 1928.
- 2 Clark WELeG. The tissues of the body. Oxford: Oxford Clarendon Press, 1945.
- 3 Penington DG. The role of the erythropoietic hormone in anaemia. *Lancet* 1961; 1: 301-307.
- 4 de Gruchy C. Clinical haematology in medical practice. Oxford: Blackwell, 1958.
- 5 Desforges JF. AIDS and preventive treatment for hemophilia. *N Engl J Med* 1983; 308: 94-95.
- 6 Penington DG. Government and the professions. *Med. J Aust* 1990; 153: 242-245.
- 7 Chamberlain KG, Tong M, Chiu E, Penington DG. The relationship of human platelet density to platelet age: platelet population labelling by monoamine oxidase inhibition. *Blood* 1989; 73: 1218-1225.
- 8 Commonwealth Tertiary Education Commission (CTEC). Review of efficiency and effectiveness in higher education. Report of the committee of inquiry. Canberra: AGPS, 1986.
- 9 Penington DG. Managing quality in higher education. *Aust J Education* 1998; 42: 256-270.
- 10 Penington DG. The quandary of policy on illicit drugs. *Aust N Z J Med* 2000; 30: 75-80.

(Received 3 Oct 2005, accepted 6 Oct 2005)

□