**Three Careers**

**An account of a medical life**

**in**

**Anaesthesia,**

**Family Planning**

**and**

**Sexual Assault**

**by**

**Mary Lindsay Kille**

Three Careers

Introduction

***“….and we must take the current when it serves, or lose our ventures.”***

(Shakespeare, Julius Caesar.)

Maybe intimations of mortality, or a self-directed curiosity to understand why one had pursued a certain path, coupled with a determination to get the facts straight, are the incentives for me to record some memoranda for my family, who may, or may not be interested. All of them could do something similar, and all would be fascinating to me!

The choice of an individual’s career may be quite arbitrary, a matter of chance, or imposed upon one by circumstance. For some it may be to fulfill some deeply felt need, to counter injustice, or to pursue scientific truth. Those who have a choice are fortunate, as I have been, with my three careers.

As children during the War, we had the company of a stalwart, kindly and devoted home help called Nellie Shotton. Years later, when she was dying of cancer, she told me that my brother Murray, at a very young age, had asked her bluntly why she didn’t have a husband; she explained that he had been killed in an accident. “Well”, said Murray, “we’ll have to do something about that!”

Whether her presumption that this had inspired Murray’s choice of career is something yet to be discussed; he did, however, progress to be, for a considerable part of his working life, Britain’s foremost expert on all aspects of motor vehicle accidents, and an international authority.

My enigmatic elder brother, Alan, may quote Richard P. Feynman, as to why he studied X-ray crystallography at Birkbeck: “Physics is like sex; sure it may give some practical results, but that’s not why we do it!”

But physics led to a distinguished career, as researcher, (he predicted the existence of quasi-crystals, acknowledged in the citation for the 2011 Nobel Prize for chemistry, awarded to Daniel Shechtman who confirmed their existence), FRS, philosopher, poet, artist, creator of Sho Takahasi, and Emeritus Professor Birkbeck College.

I am still trying to find out why my sister Sheila became an architect.

Of the three parts to my medical life, one of these specialties, Anaesthesia, was quite fortuitously organised for me, and the other two, Family Planning and Sexual Assault, arose through the inspiration of the struggles of others against ignorance, prejudice, and downright opposition.

I realise that the three careers I have chosen to write about all cover the same 20-30 years of radical change in knowledge, techniques, and social behaviour. Thus in **Anaesthetics,** I was one of the very last doctors to be trained in giving inhalation anaesthetics, (“open ether”), in **Family Planning**, it was a time of opposition and uninformed prejudice, and in **Sexual Assault** a period of denial that such problems not only existed, but were universal and serious.

“Life is short, and the art is long, the right time an instant, treatment precarious and the crisis grievous.”

(Hippocrates)

However, I guess I rather drifted into Medicine, having declared throughout my adolescence that in no way would I “follow in my parents’ footsteps!” It was not too hard in those days (1950), with the right results in Higher School Certificate, to enter a Medical School, (much easier than it had been for my mother in 1918).

Having declared at age 17 that I might study Medicine after all, I was a year too young to enter an English Medical School, and two years too young to go, as my father wished, to a Scottish School. Long before the availability of present–day choices of a year working or studying a different discipline, or travelling abroad, or “taking a year off to find oneself”, I took the tame option of a wasted year at the Wolverhampton Technical College, studying badly-taught biology, and also learning Anatomy with physiotherapy students.

Thus I found myself, with my mother, at an interview in the Board Room of the Birmingham University Medical School. Here we were confronted with the misogenistic Sub Dean Professor “Charlie” Smout. He asked my mother what medical work she was doing at present, and she had to reply that she was only involved in once-a week factory visits. As we left the room at the end of a non-committal interview, Professor Smout commented audibly to his colleague “I told you it is a waste of time accepting women!”

In spite of Charlie’s prejudice, I was accepted, to start in Second Year, September 1950.

Fortunate, in those days, to have an excellent memory, which was all that was needed to pass exams, and without needing today’s analytical and scientific approach to Medicine, my student days were fairly carefree, financially cushioned, and conventional.

Throughout Third Year, I was able to “coast”, taking time off to play tennis and attend afternoon concerts at the wonderful Barber Institute in the University grounds. Here there were free performances by outstanding musicians. I still savour lounging in leather chairs, listening to the magnificent voice of Dietrich Fisher-Dieskau, singing *Die Sch*ö*ne Mullerin,* with Gerald Moore as accompanying pianist. By Fourth Year I was attending Teaching Rounds at the ancient (1897), Birmingham General Hospital in Steelhouse Lane, for Medicine, and the modern Queen Elizabeth Hospital at Edgbaston for Surgery.

I had read little Medicine in Third Year, but had found two rather obscure diseases, namely *Henoch*-*Schönlein*-*purpura* and *Polycythaemia rubra vera splenomelia non-hypertonia,* which involved all the systems of the body, and so could be trotted out as differential diagnosis in most medical diseases! (but my ruse was soon rumbled!).

Most of my time at Medical School I lived at the YWCA in Bournville, and was able to cycle, or take a bus, to most lectures and hospitals. Most “residences” we took as students were at hospitals in Birmingham, but I had some time in Glasgow, when I was attached, for psychiatry, to an old WW1 friend of my father, Dr Angus McNiven, who was Superintendent of the most appallingly Dickensian Infirmary for the Insane at Gartnavel.

I became engaged to fellow student John Kille, in 1953.

Married six months after qualifying, in December 1955, I filled three successive resident posts at the Warwick Hospital, where some married accommodation of sorts, went with the job. John, already set on a Surgical career path, and thus determined to work in the major teaching hospitals, did not have such provision, and we rarely met. For many months our off-duty weekends were alternate, but did not coincide (!), and our rare Thursday half-days were spent travelling by train between Warwick and Birmingham. Occasional nights we shared his single bed at the General Hospital interrupted frequently by emergency calls.

When John became Anatomy Demonstrator at the Birmingham Medical School, I was, for a short time, a housewife, though taking various locum General Practice jobs, the last being somewhat trying, as I drove our MG TD around Warwickshire finding that a very pregnant abdomen did not fit well under the low-slung steering wheel!

After the birth of Alison, in 1957, John, who was away in London at the time, taking his Primary FRCS, then moved to the Warneford Hospital in Leamington, as SHO in Surgery. Here we met our first hard-drinking, party-loving Australian would-be surgeons, over in UK to gain their FRCS, at this time worth so much more than the Australian equivalent. They were all anxious “to cut, cut, cut!” i.e.: to notch up the greatest possible number of operations before going back home to Oz. The RSO, Geoff Northcott, was one of these, and his wife, Patsy, having a new baby of Alison’s age, it was “arranged” ?! over a drink, that “Patsy could easily look after two babies, and Mary can do the Anaesthetic job” then vacant at the Warneford.

So that’s how I came to be an **Anaesthetist!**

**Family Planning** was something quite different. I took this up in 1969 when John had obtained his Consultant Urologist post in Hull. I added this on to my Anaesthetic commitments in England, then later on in Australia, without difficulty.

**Sexual Assault Services** became my third career choice, and this, also, dovetailed, occasionally overlapping, with my other two subjects.

Thus I have decided to write down some of my experiences in these three areas of work, for my family, because I believe that they all cover an historically interesting period of medical, political, and social change.

I have been so fortunate.

***“We do not pass twice through the same door or return to the door through which we did not pass.”***

(T.S. Eliot, The Family Reunion.)

**Part 1 of Three Careers**

**Anaesthetics**

***“There is properly no history; only biography.”***

 **(**Ralph Waldo Emerson)

This personal and anecdotal account is bound to seem unbalanced and egocentric, as I am writing so little about my husband’s struggles, experiences, and acquisitions of skill, and his achievements in becoming a first-class Urologist. Sadly, he died in 2015, and details are in his multiple obituaries. However, he will appear frequently throughout this account!

Once John was determined to set foot on the surgical ladder, the course ahead was bound to be exceedingly hard, and many who started with himfell by the wayside, failing their exams, or unable to obtain the appointments necessary for accreditation. The times were some of the most challenging in surgical training history, coinciding with a huge post-war “bulge” created by surgeons returning from the War, many very distinguished and experienced, and at once claiming precedence in either taking up their old positions, or in filling new vacancies. Consequently, all the bright young post-war hopefuls had to fight their way through difficulties and selection processes which had never applied to their predecessors. Those who continued as surgeons in training were, in the 1960s and 70s, still seeking their first Consultant job from Senior Registrar positions which they had filled for 10 to 12 years.

(In fact, with the aim of creating positions, the Surgical Registrars at Birmingham created “The Vacancy Club”, in which they would invite the Consultant Surgeons to accompany them on climbing weekends to Snowdonia, in North Wales, in the vain hope that one of these established surgeons might fall off a precipice, and so create a vacancy!) I went with John on several of these expeditions, climbing Snowdon, Cader Idris, and Tryfan, always ending at the Climbers’ Club at Pen Y Gwryd on the way home.

Thus John and I knew that it would be always a matter of him finding the right job, in the right place, and at the right time, and family and my career would trail along wherever this led. Starting with his toe in the revolving door of the Birmingham Medical School Training circuit, this meant a change of place, type of surgery, and home, almost every year until 1968 when he finally achieved his Consultancy in Urology.

**Warwick**

**House Surgeon**

Imagine working for Sir Lancelot Spratt! This character as described by Richard Gordon (“Doctor in the House”) could indeed have been modelled on the man who was my first boss; Geoffrey Taylor, larger-than-life huntin’, shootin’, and dining friend of the Earl of Warwick, clad usually in immaculate tweeds or occasionally a pin-stripe suit, and with the authority of God on the life, death, or happiness of his patients and staff.

For my first encounter, as his House Surgeon (HS) at Warwick Hospital, I was informed by Bill Hegarty, (of whom more later!) that I should meet him as his immaculate black vintage Bentley swept up to the hospital, open the car door for him, then escort him to the Surgical Wards. So there I was in my first crisply-starched white house-surgeon’s coat, rushing down the steps to open his car door, when, to my confusion, he swung his legs across to the passenger seat and let himself out of that door. He explained condescendingly that he always got out on that side, as the brake on the other running board got in his way: (Lesson 1).

Opening hospital doors presented more difficulties, (which persisted with most of the consultants for whom I worked). Sometimes I was treated with charming gallantry, sometimes as a sexless minion, so it was always chancy as to who actually opened the door for whom.

Lesson 2: Treat your boss as if he *were* God, and he’ll agree with you!

Lesson 3**:** If a man like Geoff Taylor makes a comment to a patient, his booming voice reverberating through the whole ward, whether telling a woman she’s “a silly old trout!”, or a man in pain “bloody feller!”, the patients will adore him, believe that whatever he does for them is exactly right, and they will live, or die, happy.

Lesson 4: Never, *ever* telephone him at night.

The Registrar and I were there to learn responsibility, and, if we made mistakes, that was a part of our training. Hence, I soon had notched up my first 100 appendectomies, (long before John!), though most were probably “lily-white”, and there had been no need to have taken them out in the first place. (But, as my boss said comfortingly, “they might have been marooned sometime on a desert island, so you may have saved them from a painful death!”)

Warwick Hospital, built as an emergency facility during WW2, consisted of widely-spread prefabricated units, with long pathways between. It functioned in conjunction with the Warneford Hospital in Leamington, sharing some staff, and alternating surgical nights on call.

My Registrar initially was John Saunders, one of the quieter Australians who created a constant supply-chain of trainee surgeons, each ensuring that a friend back in Oz would be available to fill his post. He was fair and pleasant, and later became a G.I. surgeon in Perth, W.A.

Gordon Rathbone was the House Physician (HP), a quiet man who loved poetry, birds, and the organ (and later, played at our wedding).

But it was Anaesthetist Bill Hegarty who showed me what delights there could be in his speciality. From Eire, with a quiet brogue, devastating wit, and irrepressible sense of humour, he showed me not only how to give anaesthetics, but *how to manage a surgeon!*

There was, for a time, a huge Turk, as Orthopaedic Registrar, a brutal surgeon; memorable for keeping a woman in his room for several weeks, her presence known only to dear Mrs Mitchell, an elderly maid who mothered all the Residents, bringing cups of strong tea to wake us each morning, and finding that the Turk wanted two helpings of everything!

For a while there was another H.P, Andrew, whom Geoff Taylor despised in part because he was lazy, but mainly because he ran a racing-green Bentley (with a big leather bonnet- strap) which made “a disgusting racket”, unlike Geoff’s sibilant black treasure.

I loved surgery, and would like to have continued, but there was no chance of my succeeding in this, and, anyway, I never did learn to tie knots with one hand!

We were married at Pattingham Church at the end of my Surgical job, John having a few days off from his work at the General Hospital, Birmingham, and we received a charming telegram from Geoff Taylor, saying he missed me!

**House Physician**

My Physician boss was even more of a social snob than Geoff Taylor, and less kind.

Dr Stephen Whittaker, bachelor and rose-growing aesthete, had a reputation for attracting bright young men to be his house physicians, and many did indeed quickly obtain their “Membership” (MRCP) and become equally distinguished consultants. Consequently, his house job was much sought-after.(I believe I was only appointed because he knew my father when in the RAMC in the Middle East, I was already working in the Hospital, and he felt it looked better if he had a *female* junior every now and then, *and* I was married.) The only other female HP I knew who had worked for him was my friend Marion Hommers, who (as described with delight by Bill Hegarty) had disconcerted him mightily as she was so sexually attractive, as well as being highly intelligent.

Most of the medical mistakes I made in my time with Stephen Whittaker were of etiquette.

On one occasion he was almost apoplectic with anger. Whilst on call the previous night I had admitted an overweight, plethoric, hypertensive man with what I thought dangerous nose-bleeding, and I had placed him, for constant observation, in the middle of the busy surgical ward which was full of the day’s post-operative patients, where there was much moaning and groaning and to-ing and fro-ing of nurses.

I was greeted on the next morning’s rounds with “How dare you put Colonel Blennerhasset in the Surgical Ward! The Chairman of the Board! He should have been in a Private Bed!” Stephen charged into the Surgical Ward to see him: “My dear fellow! I’m so very sorry, we’ll move you at once!” To my joy, and vindication, the Colonel replied: “My dear Stephen, I wouldn’t have missed the experience for the world! I learnt so much, and I have to thank this young lady for her care!”

**Paediatrics**

During my third house job, at Warwick, the Paediatric Consultant, Malcolm MacGregor was away most of the time helping to set up a new Medical School in Nigeria. My teacher was Graeme Stevenson, a “time-expired” Medical Registrar, one of an increasing band of dispirited physicians who would never become consultants, and who would later be moved sideways into specially-created SHMO positions. He covered both Medicine and Paediatrics. In Medicine he did all the “rubbish” (Stephen Whitaker’s words for old people with strokes, chronic vascular conditions, and skin diseases), whilst Stephen exulted in the brilliant differential diagnoses of esoteric and complicated neurological and endocrine disorders. In Paediatrics Graeme was gentle and painstaking with the children, and I learned much from him.

For the first time, there was married accommodation available. This went with *my* job. (For those doctors with Teaching Hospital employment nothing was provided, but to attract doctors such as I to a peripheral hospital, often a few rooms, a flat, or even a small house, might be provided.)

In this case, there was a tiny flat in a grim brick Victorian mental hospital edifice in the Warwick Hospital grounds, directly above the Pathology laboratory. An ancient enamel bath with lions’ feet and solid brass taps, and a closet-sized kitchen were part of the accommodation. Lacking a refrigerator, in moments of desperation, and in the few warm days of summer, I would place milk, meat or a non-setting jelly, on one of the shelves of the Pathology refrigerator, alongside glass pots containing surgical or post-mortem specimens of some of the interesting patients I had known.

John occasionally stayed there too, coming and going from Banbury, where he did a GP locum job, and later, from Birmingham, where he took up the position of Anatomy Demonstrator at the Queen Elizabeth Medical School.

Now we had JAX 333, a spectacularly beautiful MG. TD, cream enamel body and scarlet upholstery, bought for ₤250. Our earnings were about ₤280 per year each, (including food and laundry, and for me, the flat). It was a joy to drive at night with the hood down, through the ancient walled streets of Warwick, or, in the few hours we had off together, through the leafy lanes around Stratford upon Avon.

But for my job my old school bicycle was the way I got quickly to the Hospital for night calls.

**Domesticity**

After Warwick, it seemed a good idea to live together for a while! John found a house in Bearwood, Birmingham, where we had a sitting room, a bedroom with twin beds, and a share of the bathroom and kitchen. Our landlady, Mrs Bird, a somewhat unworldly widow, took us as tenants only on condition that we made no noise on Thursday evenings. On this night each week three shadowy men in sombre suits arrived and disappeared into the front parlour, from whence issued Schubert and Beethoven string quartets, played with varying degrees of enthusiasm and expertise. Somewhat of a trial for John, who spent most evenings wrestling with his work for the Primary Fellowship. His days were spent at the Medical School, teaching students, or classifying fractures in monkey bones, imported from Africa, so that his eminent boss, Sir Solly Zuckerman could publish the data in one of his papers on monkey behaviour. Much of the “hack work” was done for him by his succession of Anatomy Demonstrators, who received little credit. (Ironically, many of Sir Solly’s conclusions were in later years, discredited, for he had extrapolated social behaviour

in the wild from what he had observed in caged monkeys.)

Meanwhile, I had become pregnant, a fact I quickly conveyed to the milkman, for the grateful Government was offering a daily pint of free milk to those prepared to increase the population, and I omitted to tell the landlady, who soon found out when the milkman’s bill arrived. I believe she thought that the provision of twin beds would have acted as a contraceptive, and she was decidedly opposed to having a child in the house. So I went home to my parents in Wolverhampton, and Alison was actually delivered in the Queen Elizabeth Hospital in Birmingham whilst John was in London taking a “crash-course” for the Primary Surgical Fellowship.

John did indeed pass his Primary Fellowship examination that year, a considerable achievement, the failure rate at that time being about 90%.

**Leamington Spa**

“You’ll never get anywhere as a Surgeon with a surname like yours! Change it!” John was given this advice on several occasions on his way up the surgical ladder. At the Warneford Hospital, in Leamington, his boss was Chris Savage. Consequently, sometimes the operating lists read: “*Savage and Kille*”, and even, after I had gained more experience in anaesthetics: “*Savage, Kille and Kille.”*

John said his surname had stood the test of time, (tracing back to Mediaeval times to East Meon in Hampshire) and he wasn’t going to change it for anyone.

John started as SHO in Surgery, and I joined him as a beginner in Anaesthetics. There

was an assortment of other young doctors in Residence: Australians Geoff Northcott and Jim Harris, and two dilettante young men, John Davey and Kerry Merifield (they both adored opera, playing “The Barber of Seville” most nights, and singing-along in Italian,) and Anaesthetic Registrar, Mike Cooke, a charming man who would occasionally go berserk and vandalise telephone boxes.

I was able to work because Patsy Northcott so generously took charge of Alison whilst I was in the operating theatre. Her own baby daughter Kim, had bilateral congenital dislocated hips, and the poor little mite was strapped, for a year, to a “broomstick”, a bar of padded wood between her legs, to keep her hips in the correct position. For six months, the two babies cooed at each other from their huge black second-hand prams, and Patsy somehow kept them happy. She didn’t even object when her husband Geoff added a stray black mongrel dog to their ménage

and he called it “Nigger”.

When six months later, the Northcotts left for Southampton, our au-pair, Margrit Sielemann arrived from Germany, and we were allowed an extra little boxroom for her in the Victorian house which we shared with other Residents, just across the road from the Hospital. Margrit was a fresh-faced, pretty and intelligent girl, with a good command of English (my brother Murray introduced her to Dylan Thomas, and she would quote his poetry on occasion, even with a Welsh accent!) She was very popular with some of the Resident doctors, who would just drop in at our apartment “to see how Alison was getting on!”

However, after six months, Margrit became homesick for Germany and her banker love, Heiner Pott, and she left, having directed me to the local club for emigrants, where I met Martha Liebermann. Martha was a very different au-pair, from Austria, of peasant stock, flat-faced, a good cook, and utterly dependable.

So I had three “treasures” to help with Alison’s upbringing; they all adored her, and I am sure she didn’t suffer from my absences. We paid the au-pairs a pittance, but that was the going rate in those days, and they had few days off.

And that was how I was able to start learning the craft of Anaesthetics, coming home at lunchtime, and in the evening, reeking of ether, but Alison greeted me with joy just the same!

**Trainee Anaesthetist**

**“*For some must watch whilst some must sleep: so runs the world away.”***

(Shakespeare, Hamlet.)

Dr James Knott, J.P., Anaesthetic Consultant and a true gentleman, was my teacher and mentor. He showed me methods which had been current for the previous hundred years, but he was also learning for himself how to administer the very latest agents.

I learnt Anaesthesia at a highly significant time of change; all who started training when I did were the last year of the “rag and bottle merchants”, those who administered “open ether.” Anyone who has ever been given an ether anaesthetic remembers, for life, the feeling of suffocation, the nausea, and the lingering smell. But at least they lived to remember it. Ether was a safe agent, unpleasant as it was for the patients, but it required time to acquire the skill to give it smoothly, and to present a quiet and relaxed patient to the surgeon so that he could perform his surgery safely and without rushing.

We used a Schimmelbusch mask, with layers of gauze next to the patient’s face, and dropped ether from a glass bottle, until the patient, feeling suffocated, just had to breathe in the vapour.

Stages of anaesthesia with ether, were very easy to recognise:

1. *Dizzy and Delightful*
2. *Drunk and Disorderly*
3. *Dead Drunk*
4. *Danger of Death*

*Dead Drunk* was the desired level for surgery. The skill was to try to take the patient ever so gently from stage 1 to 3, but lingering in stage 2 was exhausting, noisy, and unpopular! Ether was safe, in that the deeper a patient got, the more shallow the respirations, so overdosing was not a problem.

It was a horrid agent to use for Caesarian sections, but that was what I was expected to use for most of the more than 200 women I anaesthetised in the 20 months I was at Leamington.

For babies, we sometimes induced with ethyl chloride, a highly toxic, but sweet-smelling vapour (it was flavoured with eau-de-Cologne). This had in the past caused a significant number of deaths, (later, my father told me that in the 1920s, he had a baby die, when, as a GP, he was giving such an anaesthetic).

Chloroform had completely gone out of use, but Dr Knott, who had used it in his early days, once gave me a demonstration on a patient who was subsequently quite grateful for the smooth induction.

We used Boyle’s machines, with carbon dioxide absorbers, and with nitrous oxide, which we sometimes used as the induction agent instead of ether.

We gave transfusions of blood and saline from glass bottles, with thick rubber tubing, and huge steel intravenous needles, or Gordh cannulae.

Thiopentone was transforming the scene. Welcomed during WW2, for fast and pleasant induction, it quickly acquired the reputation “*dead easy, easy dead”,* and “*fatally easy to give*”, as it was all too often given as an overdose in the young, the old, and the very ill, (the latter, of course, included many battlefield casualties).

So I was taught to use this intravenous agent, so welcome to the patients, with the greatest caution.

Dr Knott, and Bill Hegarty, taught me some of the most important functions of an anaesthetist in the operating theatre. For example:

*1. To be almost invisible!* (i.e. one’s work should not intrude on the surgery).

There was good advice in my little green book “Anaesthetics for Medical Students” by Gordon Ostlere (alias Richard Gordon, author of “Doctor in the House”).

*“Always keep an eye on what the surgeon is up to. Unobtrusively however. Nothing annoys a surgeon more than seeing his anaesthetist flying round the theatre like a septic poltergeist. A good anaesthetist should have the character of Jeeves: he should exercise a strict but subtle control over his surgeon, anticipate his wants, cool his unwise enthusiasms and encourage him in despair - but from the background. The anaesthetist should make himself the centre of the theatre only when the surgeon is in difficulties before an audience of his distinguished contemporaries.”*

*2*. *Always be aware of tension* in the theatre, especially during the dangerous part of the operation, and do your best to *make the theatre an oasis of calm* concentration.

*3. Gossip and stories* should be at the ready, but only when the tension of the operation is over. *Always laugh at the surgeon’s jokes*, however weak.

*4. Show appreciation for the surgeon’s claims* *to have invented something of* *supreme importance*. Many a surgeon believes he is the sole inventor of a stitch which the theatre staff and I have known from our childhood, e.g. blanket-stitch, back-stitch, or the method of bowel anastomosis which differs little from setting in the sleeve of a garment; (it is useful to be wearing a mask to conceal one’s smile when he claims that the method should bear his name!).

*5. Monitor everyone* in theatre, as well as the patient and the surgeon. The great privilege of the anaesthetist is usually to be the only one sitting throughout the operation (with the exception of a urologist, or a gynaecologist). Thus one can monitor the medical students or new nurses (“*if you’re going to faint, fall backwards, not into the wound!* (Sir Lancelot Spratt). The houseman or registrar may have been up all night and be swaying with fatigue, or may be friskily playing footsie under the table with the prettiest nurse. (With a Caesarian, one has three patients, the mother, the baby, and sometimes the father who may fall in a swoon, or become hysterical).

*6*. The most reliable help for the anaesthetist is the experienced, strong hospital orderly. On many occasions I have been saved from imminent catastrophe in the anaesthetic room by the prompt actions of these unsung men.

Few people realise (and just as well!) that in anaesthesia we take a patient very close to death, and then have to bring them back again. The beginning and the end of an anaesthetic are, like an aeroplane flight, the most dangerous and challenging times, the time in the middle may be monotonous, and, one hopes, uneventful.

*“****Care-charming sleep, thou easer of all woes, Brother to Death…”***

(John Fletcher)

**Wanderings**

Whilst I worked at the Warneford, John transferred to the General Hospital Birmingham,where he was Casualty Surgical Registrar, along with Jim Lawson.

A year later, he was appointed Surgical Registrar to the Churchill Hospital, Oxford,when we rented a whole house on the main London Road, to the east of the city. That was the end of my anaesthetic work for four and a half years, but, as a housewife, I managed to pass my Diploma of Anaesthetics in London. In my Viva I was shown a strange-looking needle, with a balloon attachment, which I guessed was for spinal anaesthesia. “Give it a name!” I was commanded by the imperious-looking examiner. I hazarded the most famous name I could think of, Mackintosh, and he smiled with pleasure. (I later found that he *was* Mackintosh! Such is vanity.)

However, my achievements were eclipsed by those of John, who in one year gained both his Surgical fellowships, Edinburgh *and* London. The examiners in Edinburgh even gave him a sherry with his handshake!

In June 1961 John was RSO at the Queen Elizabeth Hospital (QEH) in Birmingham,a career step which included producing the Hospital Christmas Show (particularly challenging that year as most of the cast were hit by a virulent ‘flu bug and were literally swaying on their feet!).

Alison and I were once more homeless, and we went again to my parents. Murray was born in the QEH whilst John was on a ward round.

Transferring to the Artificial Kidney Unit at the General, John did pioneering work with Jim Lawson, on artificial dialysis, mixing teaspoons-full of electrolyte solutions in plastic buckets, and experimenting with various membranes, and then moving to the Urological Unit, and hence to the coveted position of RSO, meant that we actually stayed in one place for over two years, in Birmingham.

The house in Wake Green Road was huge, three stories, with high ceilings and damp corridors, with three flats. We were on the ground floor, with access to a large overgrown garden, another would-be surgeon John Webb, and his wife and three children on the first floor, and trainee radiologist Peter Hicken and wife Jan on the top.

**Gags, Gas and Guillotines**

After such a long time without giving an anaesthetic, it was exceedingly hard to start again. Manual skills are lost so quickly, and drug usage changes.

I was thrown in at the deep end, with some sessions of “Guillotines” at the Woodlands Hospital. These consisted of tonsillectomies on children (this operation would later come to be considered unnecessary). It was an horrific procedure, anaesthetising the child on the operating table with ether and a mask, then a gag, and a couple of seconds of surgery as the tonsils were literally sliced out of the pharynx with an extraordinary sheathed blade, the patient turned on the side, head down, blood everywhere, to cough the way back to consciousness. The recovery room was like a battlefield. Amazingly, the children survived.

I also gave transitory anaesthesia for Electro-Convulsive-Therapy sessions.

Other physically challenging work came with sessions in the Casualty Theatre at the ancient (1897) Birmingham General Hospital. Here I encountered the “Birmingham Irish”, a tough, fighting breed of working men so used to the stupefying effects of alcohol that either they were already drunk and needed little extra, or they required a prodigious amount of anaesthesia. We gave nitrous oxide until they were purple in the face, the anoxia adding to the anaesthetic effect, and literally fought to control these men, relying on the help of orderlies and a huge restraining leather strap. Recovery was equally dramatic, as they returned to consciousness through the “drunk and disorderly” stage; sometimes they became embarrassingly amorous.

For each of these sessions I earned ₤4.12s 6d.

**Nihil Sine Labore**

The maternity hospital at Sorrento was an old two-storied house which had once belonged to a wealthy Birmingham merchant. Labouring women were expected to struggle up the steep stairs to the first floor, past a stained- glass window bearing the family coat-of-arms which bore the motto “Nihil Sine Labore” (nothing without labour!). Giving anaesthetics for Caesarean sections for Obstetrician Jeannie Hallam was a different form of hard work!

**Staffordshire**

At the end of 1964 we moved to a slum cottage in the grounds of the old Bradwell Hospital, Newcastle-under-Lyme. John worked at the City General Hospital, Stoke-on-Trent, and I covered four sessions a week at the same hospital.

**Back to Brum**

With John back at the QEH, we took a house at Kingsdown Road, Northfield. Alison

now started her third school, and Murray his first. I took on four weekly sessions for the Dudley Road, then for the Selly Oak Hospital Groups. Strangely, some of these were classed Clinical Assistant, and some Consultant, but the work was the same.

**Yorkshire (Settled at last?)**

After all his years of struggle, John achieved the pinnacle of Surgery, a Consultant post as Urologist to the Hull Royal Infirmary (HRI) at Sutton. Our families breathed a collective sigh of relief, expecting us to stay in one place for the rest of our working lives.

So, there we were in Yorkshire, living in an old village in a charming house, with adjacent stabling and pasture for Alison’s Welsh cob, Fortel; children happily settled in conventional schools, and John practicing the specialty he loved. He even bought a sleek Rover, and we had our first Labrador puppy.

I covered anaesthetic sessions at both sections of the HRI, Anlaby Road and Sutton, and at the Women’s Hospital.

Techniques by then were less dramatic and far safer, with the use of barbiturates for induction and halothane for maintenance.

However, I had to learn different forms of anaesthesia when I started working for several dentists, and they insisted on old-fashioned methods which within a few years came to be considered dangerous.

In the ancient town of Beverley I would work throughout the morning with two dentists. These sessions were on the first floor of an old house, the stairs of which were so steep that they were an excellent test of fitness: if the patients could reach one of the four surgeries without becoming blue or breathless they were considered fit for the anaesthetic. I dragged the heavy old anaesthetic machine around from room to room, where there was always a new patient awaiting me. The two dentists worked in alternate rooms, so they were always rested! One of them was a delightful musician, who continually practised his tenor part in the St Matthew Passion, (produced annually in Beverley Minster), and I, and some of the patients, found this a relaxing premedication.

I also worked with a dentist in Hull, where, at least, there was a reclining dental chair, which made things a little safer.

**So, did we stay in England?**

***“Let us go then, you and I,***

***When the evening is spread out against the sky***

***Like a patient etherised upon a table……”***

(T.S. Eliot, The Love Song of J.Alfred Prufrock.)

**Adventure called! Tasmania**

My first sight of an Australian doctor in an Australian hospital, was of a pair of lean bronzed legs below a very short pair of grey shorts, spring-heeling along the corridor of the old Burnie Hospital.

***“Oh brave new world that has such people in it!”,*** or, as this modern Miranda said: “Wow!”

The vision was of Bob Tonge, a Paediatrician, and, like us, a product of a conformist upbringing, (in Switzerland).

Coming as I did from the strict British hospital system with its white starched coats and rigid hierarchy, this was a revelation!

Suffice it to say, that, after completing a 1973 holiday in Tasmania, on our return to U.K. we packed up all our worldly goods and emigrated at Christmas that year.

**North West General Hospital, Burnie**

John was appointed first as a General Surgeon at the North West General Hospital (NWGH) in Burnie, which entailed dealing with a very wide range of cases, including Accident, Orthopaedic and Neurology, as well as his specialty of Urology.

This meant that all his nights and weekends were shared with only two colleagues.

I also started work at the Burnie Hospital, as one of six anaesthetists, and, for the first time since my training in Leamington Spa, I was rostered on call at nights and weekends (Friday night to Monday mornings when a list would start at 9am).

All of the anaesthetists worked with all of the surgeons at some time, so we had to cover obstetrics, gynaecology, and ENT, as well as general surgery.

Most emergencies were for trauma, and weekends were dominated by motor-cycle accidents.

From Casualty on a Saturday night emanated the smell of alcohol, blood, vomit, black leather, and fear.

When seat-belt legislation was enforced in Australia (15 years before U.K.), and later, the breathalyser and the “booze bus” came into use, a dramatic fall in the number of these cases was welcomed.

However, there persisted an amazing range of trauma from chain-saws, tree-felling, spear-guns, sting-rays, fire, and general larrikinism.

Obstetrics made up 50% of anaesthetic emergency calls.

My most respected teacher and colleague was Dr John Taylor, a product of St George’s Hospital London and wartime experiences in Italy. Always keeping up-to-date and ready to try out new techniques, he worked to the highest standards, and was always willing to help with difficult cases. He taught me to do epidural anaesthetics, being a master of the art himself.

**Dangers**

Some of the most challenging patients were babies and young children with the distressing suffocating condition of acute epiglottitis. Shortly after I retired from anaesthetics the preventative haemophilus vaccine came into use and obviated the need for tracheotomy and the accompanying anaesthetic dangers.

All surgery and all anaesthetics carry risks to a greater, or lesser extent, of failure, injury, and disaster.

Increasing litigation has created shortages of obstetricians, neurosurgeons, and anaesthetists, the three specialist groups paying the highest medical protection premiums. Currently most surgeons have one or more cases in litigation, producing what can be an unwelcome distraction and sometimes an intolerable burden to bear, as they continue to carry out their jobs, perhaps in the same theatre, with the same staff, on similar cases, over a number of years.

I was involved in one such claim; the surgeon and I were aggressively pursued by the lawyers for nine years until the case was settled, literally at the doors of the Court, with the jury already empanelled. It was only then that I discovered that the outcome had been decided upon years before.

**Dentists**

Dental anaesthetics in Burnie were an interesting side-line.

I worked first for the charming and ambidextrous Don Bryan, (so easy for him, when one hand was tired the other could take over!).

At that time a couple of dentists were still using the old-fashioned techniques of quick snatches in the upright dental chair. One was even doing full dental clearances this way. I didn’t continue working with them for long.

Other dentists such as John Kay and Trevor Wright were embracing newer methods, having the patients comfortably reclining, and with nasal intubation, allowing for safe anaesthesia and an unbattered patient.

**Nursing staff**

The assistance of nursing staff varied over the years. Most were exceedingly helpful and often elected to work in the anaesthetic room. Some joyfully took up the challenge of making the patient’s experience a happy one, with music, restful pictures on the walls (and ceiling!), and toys and stickers for the children.

There were no fully-qualified Anaesthetic Nurses, (unlike the current situation in the U.S.A., where most anaesthetics were given by them, with supervision over several theatres by one “Anaesthesiologist”).

The pattern here has been for some retreat from responsibility by the nurses, as a direct result of litigation. When I first started at Burnie, all my drugs would have been drawn-up and waiting for me when I arrived for an emergency Caesarean. All this stopped abruptly after edicts from the Nursing Council, certainly reducing the speed with which a patient could be induced, and eroding the nurse/doctor relationship.

However, the general theatre atmosphere was one of help and friendship, and mutual support, and this was largely due to the two splendid Theatre Superintendents with whom I was privileged to work, Pat Hodgetts and Cheryl Robinson.

**Diversions**

We were determined never, ever, to embarrass a patient. However, once it was I who was taken aback. An elderly gentleman presented for a urological operation. As a part of my general encouragement, attempting to soothe all worries as I induced the patient, I said gaily: “Just a little prick, Sir!” The patient replied: “Yes, Doctor, that’s always been my problem!” and fell asleep.

The nicest commentary I’ve had from a patient on the role of the anaesthetist was from a small boy whom I heard describing to his mother what had happened in the anaesthetic room: “A lady in a white coat pricked my arm, and I disappeared!”

More seriously, several patients, facing yet another perhaps unnecessary and dangerous procedure, have said to me “I just don’t want to wake up”.

**“Mad, Bad, and Dangerous to know!”**

***“a good surgeon must have the eye of an eagle, the heart of a lion, and the hand of a lady****.”*

(Anon)

I have worked with many surgeons, some very young and inexperienced, some old and doddery, some occasionally drunk, or angry, and some, intermittently mad.Some, astonishingly, unable to change a tyre, fix a washing-machine, or even to sew on a button.

There are two requirements for a surgeon, one is to give an opinion, and the second is to be a good operator, the first being equally, or occasionally, more important. Knowing when to operate, or not, prescribing the best (and not necessarily the latest) procedure, and having regard to the needs and wishes of the patient, may be more essential than carrying out a meticulous operation.

Of the many surgeons with whom I’ve worked, I can say (and perhaps surprisingly without bias!), that one of the very best would be my husband. He would spend much time, often out of hours, explaining to a patient what an operation entailed, and what his expectations were. To watch him (wearing a second pair of glasses placed upon his nose by a trembling young nurse!) handle the gut or the tiny ureter of a new-born baby, or performing orthopaedic carpentry on a much larger scale on an ancient woman with a fractured femur, was a revelation to some nurses and surgeons-in-training.

When he retired, characteristically, on being asked by his theatre staff if he would like them to give him a farewell dinner, he replied that all he wanted was his old urological operating stool for his workshop. This was autographed by all in the theatre, with comments such as “the best teacher I’ve ever worked with”, and

“To Sir, with love”.

**Of Cabbages and Kings**

But, of course, there are good and bad anaesthetists.

Certainly, recent advances have made for greater safety, particularly in regard to monitoring equipment, and new techniques.

However, whereas when I first started, an anaesthetist could turn down a patient for surgery as too young, too old, or too ill, these parameters have changed and hardly apply.

Pre-anaesthetic Clinics, established since my time, allow for patients to be reviewed weeks before an operation, when conditions such as obesity, hypertension, and diminished lung function (affecting smokers in particular) can be treated, so minimising the dangers of anaesthesia and surgery.

Increasingly sophisticated and complicated metabolic Intensive Care Units have meant safer treatment of the seriously ill, but have changed the requirements for anaesthetic knowledge. Monitoring during anaesthesia has improved greatly.

As Physiology students, my friend Myrtle and I used to chant the mantra of Claude Bernard: ***“La constance du milieu interior est la condition de la vie libre”.***This maxim is still valid for the human body under stress, but implies a complexity of anaesthetic care now far from the old “rag and bottle” days.

It cannot be said that we used “***not poppy nor mandragora, nor all the drowsy syrups of the world, to medicine thee to such sweet sleep”.***

(Shakespeare. Othello.)

*“*An-aesthesia” means literally “no feeling”. I can have a measure of pride in belonging to those who were able to administer what has been regarded as ***“the*** ***greatest boon ever granted to mankind - the power to induce a temporary but complete insensibility to pain”.***

 (Howard W Haggard, Devils Drugs and Doctors.)

***“Life is a watch or a vision, between a sleep and a sleep.”***

 (Swinburne)

**Part 2 of Three Careers**

**25 years in Family Planning!**

***“Moore for delit than world to multiplye.”***

 (Chaucer 1390, Nun’s Priest’s Tale.)

My first contact with a family planning clinic was in 1963, when, as a doctor, with two young children, trying to achieve some certainty in my professional life, I went to a Brook Advisory Centre in Birmingham for my first prescription of the pill. Dosages were huge, and the side effects many, but the confidence one gained to be able to undertake scheduled work was so worthwhile.

It wasn’t until I went to Hull in 1969, where I worked as an anaesthetist, that I started training with the Family Planning Association, with an elderly pioneering woman, Dr Griffiths, who had set up the clinic in Anlaby Road. The FPA were insistent on quality training and certification, and I gained my certificates in FP and in IUCDs, after training in London, where I met the redoubtable pioneer, Dr Helena Wright. and with practical sessions in Hull, eventually conducted a regular Thursday evening clinic, for four years.

I attended a challenging FPA Conference at the Royal Festival Hall, in London, in 1969, where the main guest speaker was Dr Paul Ehrlich, (later Prof. of Population Studies, Stamford Uni. California), who expounded grim warnings of world-overpopulation, and diminishing food supplies. Widely criticised at that time as being unjustifiably alarmist, his theories now seem prophetic. About this time the United Nations Declaration of Human Rights expressed the rights of individuals to ensure that all children were born wanted.

From the outset, I was entranced by the practical, down-to-earth and humorous approach of the FPA, inculcated into all their training. A lovely red-haired sister, Shirley Evers, at the Hull Clinic, exemplified this, spreading confidence and gaiety amongst staff and patients. When I left the Hull clinic to emigrate to Australia, I was presented with a phallic-shaped silver-plated sugar-caster to remind me not to take things too seriously!

The FPA set great store on encouraging their doctors to be able to teach, both within the organisation, and outside in the community. I attended a weekend FPA seminar at York University on Public Speaking, which I failed, but received the assessment: “this doctor needs further training, but has potential.”

**“Ubertus et Fidelitas”**

At Christmas 1973, I emigrated to Australia, with my urologist husband, and two children, as “₤10 Poms”. We at once took up employment at the North Western General Hospital in Burnie, Tasmania, I as Anaesthetist.

Whilst working in UK I had learnt much of the history of the family planning pioneers, and of their struggle for acceptance of the right of all couples to regulate their own fertility. This acceptance was now so widespread in England, that I presumed it to be a battle also won, in Australia.

I was not aware of the slogan “Populate or Perish” and its place in the Australian national consciousness. Also, I did not find out until later, the motto of Tasmania, emblazoned on its escutcheon, with two rampant kangaroos supporting the words “Ubertas et Fidelitas” (Fertility and Faithfulness!)

Thus I was unprepared for personal attacks on the grounds of family planning being equated with population control, and informed that, with its small population, Tasmania “did not want a bar of it.”

However, shortly after my arrival in Tasmania, I made contact with the FPA in Hobart, learning that apart from a small post-natal clinic at the Royal Hobart Hospital, and Catholic Family Welfare which taught only abstinence methods, there was no contraceptive teaching available until the first two FPA Clinics had been opened in 1973, in Hobart in May, and in Launceston in August.

Many General practitioners were giving little, or restricted advice and services.

To illustrate the situation, I was telephoned one day in 1977 by the FPA, who were concerned that the only doctor on the Tasmanian West Coast, a Dr Bracken, at the mining town of Zeehan, was refusing to prescribe the contraceptive pill. I was much amused to receive from my sister, then living in California, a cutting from a San Francisco newspaper, describing this as an example of antediluvian attitudes in the outback of Australia! An “emergency service” was organised, and I travelled several times to Zeehan in an undercover operation to run some clinics for the women there.

The Royal Commission on Human Relationships, set up in 1974, visited Burnie in 1976, and I made a personal submission to Justice Elizabeth Evatt and Commissioner Anne Deveson on the lack of contraceptive and sexual assault services, and on the need for law reform in these fields. (As an example, it was against the Law to not only sell, but even to display, “any contraceptive device” in Tasmania). The FPA also had input to the Commission, whose report came out in 1977 to widespread condemnation from the Fraser Government. (It is interesting to note that most of

what Malcolm Fraser called “the appalling recommendations” have since been implemented!)

**The Family Planning Association of Tasmania**

I attended my first Family Planning Seminar in Tasmania, in March 1974, at the Medical School in Hobart, where I met Sister Pat Hewitt, a dynamic and dedicated nurse, with enthusiasm and vision. She and Professor Wendell Smith had been the principal driving forces in the establishment of the FPA. in the State.

Also at the seminar were other emigrants from UK, Drs Pauline Carruthers, and Hilary Wallace, already working at the new clinics in Launceston and Hobart, and Dr Janette Hatwell. I thought dark-haired Janette looked so smart, in a purple suit, with matching lipstick. It was not long after that we were informed of her early death; she had suffered from a heart condition and was found dead in her bath. Subsequently the Janette Hatwell Travelling Fund was established in her memory, and this enabled several nurses and doctors to travel to other centres for training.

**North West Tasmania**

From 1973, several approaches had been made, by FPA, to general practitioners in the NW, but had met with concerted opposition to the establishment of dedicated family planning services.

The first FPA worker on the NW Coast was Sister Philippa Sharman. She had trained in family planning in Hobart, and, lacking any doctor to support a clinic, she had made herself available as a contact, with her name in the telephone book, under “Family Planning”. When I met her, I was so impressed by her kindness, her dedication and discretion, and her welcoming smile, that I knew she was the ideal person to help me open a clinic in Burnie.

However, I felt that there was such antagonism to the establishment of a service, from the general practitioners, and also from some gynaecologists, and to a lesser extent, amongst some church groups, that the best way to gain trust and medical respect, was to work within the North Western General Hospital. In this I was greatly encouraged by the Superintendent, Mr Edgar Heath, the Administrator, Mr Bruce Miller and by Matron Fran Donaldson, and her successor, Anne Burchall. Some consultants gave me considerable support, especially psychiatrist Dr Bill Kerr, and paediatrician Dr Bob Tonge. Many women’s organisations, social workers, midwives and nurses, and, of course, the FPA, were supportive, the latter assured that their standards of practice, training, note taking, and statistical collection, would be observed. From Sgt Heather Innes, of the Burnie Police I also gained encouragement. She, along with Sister Pat Hewitt, had been awarded Churchill Fellowships in their fields of social problems, and was particularly keen that I should be available also for work with sexual assault victims.

Not all general practitioners were against the idea of a clinic, and Dr John Coutts invited me to work in the surgery in Somerset, using the facilities there, but seeing patients only on a referral basis. During the 18 months I worked there I had referrals from ten different doctors.

My application to the Board of Management of the NWGH in March 1976, for a Family Planning Clinic in the Hospital, was approved, and the clinic was opened in the Out Patient Department on April 5th 1976, to be held every Monday evening. Sister Philippa Sharman was appointed as the salaried Clinic Sister. Such was my anxiety to have the service approved, that I offered to work on an Honorary basis and this was accepted, and continued for nine years.

The main argument that convinced the Board, was that the Clinic would provide teaching of doctors, midwives and nurses. The Royal College of Obstetricians and Gynaecologists had warned that if facilities were not available for the training of house officers in family planning, then recognition of the hospital for the Diploma of the College could be withdrawn. Also, the Royal College of Midwives, and the Child Health Service were seeking training facilities, and general practitioners wanted experience in the insertion of diaphragms and IUCDs. Medical students, coming to the NWGH in increasing numbers, were also to be offered time in the clinic.

**More on Family Planning Tasmania**

The Organisation continued to expand over the years, extending their range, from the provision of clinic facilities to patients, to training of doctors and nurses, and latterly, with a major thrust into the field of education in schools.

I served for three years, on the Council of FPA Tas, at a time when it included three professors, Colin Wendell-Smith, Anatomist, Ian Lewis, Paediatrician, and Joe Correy, Obstetrician and Gynaecologist. The contribution of these three distinguished academics was exceedingly important in the early years, when FPA Tas. was seeking status and “respectability”, but over the years, a more widely-qualified Council evolved, and a much more professional approach started with the appointment of a professional accountant, Paul Duncombe, as Director.

“FPA Tas.” became Family Planning Tasmania, now known for its huge range of teaching and clinical expertise.

From the onset of my involvement with FPT, I attended and contributed to training

and updating seminars and courses for doctors, nurses and midwives. FPT used the system of evaluation of doctors during their actual consultations and procedures, implementing self and peer-assessment (and with contribution from the patients themselves!) long before it became a part of the training of the Royal College of General Practitioners. In 1982 I became an Accredited Instructing Doctor.

For many years the Biological Sciences Committee of the Association of FPAs of Australia (AFFPA) ran high-quality seminars, presenting new research. I attended their seminars at Adelaide ’78 and ’90, Thredbo ’83 and ’88, Leura ’86, Launceston ’87, and Hobart ’75 and ‘94.

FPA’s qualifying and updating seminars have always been of the highest standard, with one notable exception. This involved the invitation to Professor Michael Briggs and his wife, Dr Barbara Law, to lecture on their research on oral contraceptives sponsored by the drug companies, Schering and Wyeth. Michael Briggs was an adviser to WHO, and was Professor of Human Biology and Dean of Science at Deakin University. I attended a session in Launceston in 1981 where he presented the results of his laboratory work on the latest contraceptives, which appeared to be fortuitously consistent. I remember being surprised that he claimed to have a large series of “control patients” regularly turning up for blood sampling and other tests. All family planning doctors wanted to be swayed by his glowing endorsement of the new formulations of oral contraceptives, and also on his work with copper-containing IUCDs. I even wrote to him from the Burnie Clinic for some advice on the IUCDs, receiving a charming letter in reply. It was not until several years later that his research results were found to be fraudulent. (Many others had been duped by his attractive plausibility, for example, Robin Williams had frequently used Michael Briggs for authoritative commentaries on the ABC Science Show.)

Family Planning personnel are always made welcome at clinics and teaching facilities in other states and countries. In 1975 I visited the Brook and the Margaret Pyke Centres in London, and also the Planned Parenthood Centre in San Francisco, and in 1977 the Centre in Christchurch, New Zealand, and in Perth, W.A.

**The NWGH Clinic**

In addition to the services of Sister Sharman in the Hospital Clinic, another sister, Beverley Heron, volunteered to help. She had trained in family planning in South Africa, and was full of crusading zeal. A breakthrough came when Dr Ray Jensen made her welcome to talk informally with his post-natal patients on the maternity ward, and she would be available there twice a week, with a basket stuffed with sample contraceptives and the excellent pamphlets which were produced by FPT.

**Enter Prue Lake**

In 1981, Philippa Sharman informed me that she would be leaving the NWGH Clinic, as she and her veterinarian husband were moving to Launceston. In her typically responsible fashion, she said she had “found her successor”, her neighbour, Prue Lake. So Prue came to see me at the Clinic, and this was my first meeting with a dynamic woman who was to transform the nature of family planning in the NW. When I said I would like to have a few weeks working with her “on trial”, as I knew nothing of her, in forthright fashion she said that she was indeed, the right person for the job, and needed to be recognised as the Clinic Sister, before undertaking her special training in family planning. This was very reasonable, as she had three children and needed to organise her family and training around them. She had already qualified in Nursing and Midwifery in Queensland, and had a few adventurous years in New Guinea behind her.

Thus began Prue’s work in a field where she would strive to extend the range of health services to women. Continuing as Sister in the Hospital Clinic, in 1986, FPT started their clinic, with the felicitous address: “Poke Street, Cooee”! So keen was Prue to get this up and running, that she, almost single-handedly, painted the inside of the three-roomed prefabricated building which was purchased, on a shoe-string, by FPT.

The two clinics ran in complementary fashion, with interchange of nursing staff, and with training offered in both clinics to doctors, medical students, nurses, midwives, and Child Health sisters. The educational resources of FPT were sourced from the Poke Street Clinic, which, eventually, had clerical and administrative staff in addition to those giving clinical services. Unlike the Hospital Clinic, which was run as a free service to patients, FPT, funded by somewhat miserly Federal grants, was obliged to charge for their services, although the fees remained very low.

In January 1992, the FPT Clinic moved from its cramped quarters in Poke Street, to a larger and more convenient building in Pine Avenue, Burnie, which became the regional centre for all family planning services. The educational role of FPT was extended significantly, with the recruitment of trained workers from within and also from outside the nursing profession. Sister Helen O’Neill, with a background in midwifery and lactation teaching, was a valuable new recruit to the service, as was Sister Carmen Heathcote, who was Clinic Sister for several years before moving interstate in 1997, then working in many challenging new fields of health education in Victoria and Queensland. Victoria Bishop added a touch of wide understanding of schoolchildren to the educational side, and the coverage of schools in the NW increased very significantly.

Prue, whilst maintaining her clinic appointments, developed her interests in a range of health services, for women of gradually increasing age. From work with teenagers, she progressed to menopausal problems, then to older women, moving on to women with physical and mental disabilities.

**Other services**

In 1989, the Department of Health ran some pilot programmes to Rural Women in Tasmania, to fill a perceived gap in cervical and breast screening services.

I was happy to be involved, and spent much time traveling, in mid-winter, to the West Coast for special sessions in Waratah, Rosebery, Savage River, and Queenstown. I also conducted several clinics at Currie, on King Island. Everywhere, the patients were so grateful to be able to talk with a woman doctor, and I found many cases of clinical conditions that had not presented before, due to the reluctance of the women to attend the male doctors who served these areas.

I continued these visits over the next four years, thoroughly enjoying meeting these resilient women, who were coping with the isolation and challenges of living in these often beautiful, but remote areas.

In January 1995, the Burnie Hospital (now called the Burnie Regional Hospital) moved all its facilities from the decaying old building opposite the docks, to a spectacular new site on Brickport Road, on a hill looking over the sea, and the Hospital family planning clinic moved into the new Outpatients area there.

**Sexual Assault Services**

As to be described in Part 3, from late 1976, I ran a very low-key, but professional Sexual Assault Service, for women and children who were the victims of alleged sexual assault. (The first medical service in Tasmania, and only the third in Australia). This operated out of the NWG Hospital, and several hundred cases were seen over the years that I worked there. Many involved examinations for the Police, but many were for those where there were no charges made, but much psychological, and occasionally, physical hurt had eventuated from recent sexual assault, or sometimes from episodes of assault and abuse many years before.

The two family planning clinics were an excellent venue for women to present, ostensibly for some routine service, but in confidence, to reveal their sexual assault problems. For many years FPT had the policy of distancing their clinics from such cases, but eventually included the recognition and treatment of sexual assault in their philosophy and training. I certainly saw many women who felt able to talk of their recent, or long-term assault problems, through their attendance at the clinics where I worked.

**Attitudes and History**

I first became aware of the conspiratorial nature of contraceptive knowledge, when, as an 11yr old, in England, exploring one day my mother’s bureau in her absence, I came across some books in a brown paper bag. Of course, any child would investigate the contents, and I was astonished to find that they were books on “Birth Control” by *Helena Wright.* (I have one in my hand now, as I write: *“Birth Control. Advice on* *Family Spacing and Healthy Sex Life*”. Published 1935. Price one shilling net.)

This was a revelation to a girl who had been wading through the pages on “Reproduction” in the Encyclopaedia Britannica, and finding little illumination on what was actually involved in human sex.

My mother, although somewhat of a radical herself, had, as a woman doctor, conducted some classes, for adults, on “sex education”, but whilst sympathetic to the cause of the early pioneers, she never chose to work in family planning clinics. I think this was because she felt that would have an adverse effect on her husband’s medical practice, first as a General Practitioner, then as an Honorary Physician at the Royal Hospital, Wolverhampton. In addition, he held executive positions in the British Medical Association, which from the 1860s, had taken a belligerently opposing role to all the early workers, and especially to Marie Stopes, the Racial Hygiene Association, and the Family Planning Association, in their efforts to make contraception freely available to all women in UK.

I remember a wild-haired woman in tweeds visiting our house, and always being made welcome. This was Mrs Strange, (wife of a charming Dr Strange who was an anaesthetist at the Royal Hospital) who ran the Birth Control Clinic in Wolverhampton, from 1925, the first to be established outside London.(She was also involved in the temporary clinic for miners’ wives during the seven-months’ lock-out at Cannock Chase Colliery in 1926) Although there was so much opposition to her work, she was made a Magistrate, and served on the Bench, with my mother, for many years.

**Medical School**

At Medical School in Birmingham, there was scant time given to the teaching of contraceptive methods, and what was taught, by the Professor of Obstetrics and Gynaecology, Hugh McLaren, a Catholic with a family of eight children, was so highly prejudiced that many of us felt our medical education ill-equipped us for the problems met as students, and after qualification.

This was before the oral contraceptive came into use, but relatively effective methods such as the diaphragm and condoms were available, but these were roundly condemned by the good professor.

Several women students in my Medical year, and the years above and below, became pregnant before they became registered as doctors. Some never qualified, and others returned to medicine only after their children were born and raised, and then with the greatest effort, and difficulty.

**Books of Influence**

One book, that was always on the bookshelves at home was *“Devils, Drugs* *and Doctors” by Howard W. Haggard*. pub 1929. In this I read of the dreadful history of midwifery : “In sorrow thou shalt bring forth children”, of the denial of chloroform to women in labour, and of the skulduggery of Peter Chamberlen, who invented the obstetric forceps, and of his descendants, who kept secret their design and use, for four generations of lucrative private practice.

 It was really not until I encountered the angry literature of the feminist movement, in the late 1960s, that I became aware of the long-term injustices that had been imposed on women, in denying them control of their own fertility *“Gyn-e-cology*”, a book by Mary Daly, exposed the patronising and prejudiced behaviour of gynaecologists to their patients. “What you need is another baby!” “Real women don’t have a libido.” “Your whole duty is towards your husband!”

But rather than the polemic of the feminists, it was the documented history of the fight for contraception that enthralled me. My most treasured find was a battered paperback that I bought for 40cents, from, of all places, the Salvation Army Op-Shop! This was “*The Birth Controllers*” by Peter Fryer. Pub.1967. This to me, is the most authoritative, comprehensive, unbiased, and at times astonishing account of the pioneers and freethinkers from early history. Later, I acquired Shirley Green’s illustrated and amusing book “*The Curious History of Contraception”* 1971 dedicated “to Women’s Lib, with love” but with no acknowledgment to Peter Fryer from whom, in my opinion, she had derived a great deal of her information.

From here I was led to the life, books and letters of Marie Stopes, an extraordinary and quixotic woman, (who latterly became extremely odd as a disciple of theosophy). However the actual letters written to her by desperate women, and men, urgently seeking contraceptive help, and detailing how their attempts to obtain such advice from the medical profession had failed, even when the women were in situations when another pregnancy could be fatal, were utterly compelling.

I was able to start a continuing collection of “*Home Doctor*” books, and find these a rich source of misinformation. The formidable, be-whiskered J.H. Kellogg, M.D. in his “*Handbook of Domestic Hygiene and Rational Medicine”* 1905*,* exemplifies all that was patronising and erroneous about Victorian males in authority giving advice to women in their homes on everything from the dangers of pursuits such as skating, hair-washing, and “mental taxation” during a monthly period, to “the evils of mental unchastity, and the sexual crimes of the prevention of conception and intentional abortion.”

I have one book “*Ladies Handbook of Home Treatment” by Eulalia Richards*, Australia

1912, updated 1939, in which I discovered a secret pocket, between the back covers.

It was empty, but after much searching, through second-hand book stalls, I discovered another copy, with an insert in the secret pocket! This was a small leaflet, with some diagrams of the female pelvis, in different conditions, pregnancy, prolapse. etc. All far from titillating! But I found out that the pharmacists, who sold this book, would only sell a copy complete with the insert in the secret pocket, to a woman if she was wearing a wedding ring!

Of the books by Australian authors, “*Populate and Perish*” by Stephania Siedleky, (1990) gives the most factual history of the contraceptive movement in Australia. The book that has most moved me, however, for its authenticity, is *“Sex* *and Suffering*” by Janet McCalman, the history of The Royal Women’s Hospital Melbourne, 1856-1996, constructed around the actual case notes of midwives and medical students, and detailing the appalling morbidity and mortality rates from obstetric complications and infections following induced abortions, especially during the depression years of great social hardships during the 1930s and early 1940s, equated with the lack of adequate contraception.

On a wider view, “*The Hospital by the River*” (2001) by Catherine Hamlin, gives an utterly factual account of the work of a woman doctor who went to Addis Ababa in Ethiopia in 1959, to operate on young girls and women with appalling vaginal rectal fistulae, the result of child marriage or rape, and lack of obstetric care. She stayed there until her death in 2020 at the age of 96. A truly inspiring life.

**Severing connections**

In 1996, I decided to retire from the Pine Avenue and NWR Hospital Clinics, with many regrets, but with aims of fulfilling ambitions in other fields. At that time, I was so happy that there were such thriving FPT services in Hobart, Launceston, and Burnie, and that the Burnie Hospital Clinic also was continuing.

Family planning in Tasmania continues as a force for the promotion of the sexual health of present and future Tasmanians. The emphasis of FPT over the last years, has become more towards professional training and community education, and cooperation with General Practitioners. The Annual Reports of FPT catalogue impressive educational services for health workers, teachers, and other workers in the community, whilst continuing to provide up-to-date clinical services to the thousands of clients in the clinics.

Certainly working in family planning has been a challenge, a pleasure, and a privilege. What I most miss is the contact with the lively minds of the medical students, the interns, midwives and nurses, with whom I had such a stimulating relationship, and, of course, with the patients, of all ages, who were often astonished and grateful to contribute to an open discussion of their needs, and how they had been informed and educated. Especially I miss the teenagers who kept me up-to-date with their open-minded approach to life.

I continue my enthusiasm for Medical History in general, and in the History of Contraception in particular, and take pleasure in the expanding interest in Tasmania in these subjects fostered by my friend Dr Philip Thomson, a general practitioner in Hobart.

After more than two decades of (often frustrated) attempts to establish a Tasmanian

Medical Archive, at last, in 2017, Philip was able to open COMA, “Collection of Medical Artefacts Tasmania” now housed in Jane Franklin Hall, Hobart. Here we have a growing display of medical instruments, books and documents, and a centre for seminars, exhibitions and research, reflecting the fascinating history of medicine in Tasmania.

My time in family planning was indeed privileged: I worked with like-minded and dedicated people who had a great sense of past injustice, a desire to change things, and an astonishing sense of humour.

At a delightful farewell dinner given to me by all my family planning colleagues, I decided to turn the tables on them, by asking them to make impromptu speeches. I had prepared small gift-wrapped parcels for each of them and their partners, containing mystery objects on which they were asked to speculate on their possible use - as contraceptives! Amongst these were a miniature crocodile plus its dung, a pair of glamorous black stockings with the legs tied together, a facial mud-pack, hair rollers, a combination padlock and chain, balloons, a scorpion, a 3-way tap, nappy-pins, dried bananas, a half-lemon, honey, acacia, seaweed, sponges, and a pennyroyal plant. As I had anticipated, all my friends there, who were used to rapid thinking and riotous jokes, came up with some marvellous and original suggestions,

such as Rosemary Cornish’s explanation for a pair of bulldog clips as being a good contraceptive method for Eskimos! It wasn’t until I got home and found a bucket labelled “Stud Adhesive” that I realised there were many possibilities I’d missed!

So, I end this part with Robert Browning:

***“There may be Heaven, there must be Hell;***

 ***Meantime, there is our earth here - well !”***

# Part 3 of Three Careers

**Sexual Assault**

*“****The expense of spirit in a waste of shame is lust in action.”***

 (Shakespeare, Sonnet 129.)

It all really started with Heather Innes! A somewhat remarkable policewoman, Heather had recently returned to Burnie after some months in the UK and Scandinavia, where she had travelled on a Churchill Fellowship to study the application of the Law in regard to moral behaviour. Her particular interest was in child molestation, defilement, and pornography.

In October 1975, a little Burnie girl of 8 had disappeared on her way home from school. Search parties, consisting of police, and hundreds of volunteers, including many workers from APPM, off work through industrial action, failed to find her, until four weeks later, when her body was identified in a pine plantation. She had been abducted, sexually assaulted, and murdered, by a local youth aged 21.

During the investigations, Heather was made aware of “a staggering number of women who reported that they had been sexually assaulted in the past, but had failed to complain because of the stigma associated with this type of offence”. She took this as “an awful indictment of our justice system”. She made these comments to Dr Peter Bush, Victorian Police Surgeon, and they were quoted in his book “Rape in Australia” (1977).

Dr Bush was invited to lecture at the NWG Hospital in Burnie, and I was there, along with a large audience of doctors, students, and police officers. At the end I was introduced to Peter Bush, a gentle, thoughtful man, and from that day I was actively concerned with the problems and injustices of sexual assault victims.

It was clear that victims, mostly woman and children, were subjected not only to the physical events of the sexual assault, but to the subsequent interventions, which should have been supportive and healing, but instead, grossly compounded the trauma. Police were often unbelieving, insensitive, and judgemental, and the attitudes of the examining doctors were similar, accompanied by their ignorance of what was required in the way of forensic evidence. The Court procedures served to further traumatise the victims, and they were identified in Press reports, there being no restraints on the media at that time. Reactions from friends, relatives, and partners increased the hurt; there was very little knowledge of the short and long-term effects of all these burdens. Remarks from the women were frequently “It was worse than the Rape”, “I would never have spoken if I’d known what would follow”.

Heather somehow persuaded the Police to authorise me as a doctor to work *with* the Police (I never worked *for* them!), as a medical examiner, but only in respect to sexual assault cases, and she asked Dr William Bradley, a pathologist and Police Surgeon, from Launceston, to take me out to lunch, during which he assured me that I could do it! He gave me a specimen report from one of his cases, and this became a prototype for me.

I was treated so gently, with my first Police case! I was asked to examine a mentally backward girl of 16 “in respect of Defilement”. At that time Defilement was a criminal offence, and consisted of “unlawful carnal knowledge of a minor”. So there I was, in the clinic at the hospital, full of anxiety as to my fitness to testify to this, when the girl arrived, accompanied by a policewoman, totally unconcerned, and very obviously about eight months’ pregnant. So that was easy!

So that was the start of the small, low-key Sexual Assault Referral Service, at the Burnie Hospital.

**Other early Medical-based Services**

The first Australian hospital-based service was established in January 1976, by Dr Carol Deller, at the Sir Charles Gardiner Hospital, in Perth, West Australia. Tasmania Police invited Carol to give a lecture at the Police Academy, Rokeby, near Hobart, in October 1979, and I was invited to hear her. I was accompanied by four uniformed policewomen, making a very pleasant (and fast!) journey in a police car, lots of laughter all the way, and travelling over the lovely Central Plateau.

Dr Bush and Stephen Cordner and others worked in Melbourne, and soon there was a Service in Sydney. In Adelaide, Dr Aileen Connon, a gynaecologist, who later became a friend, established a Service at the Queen Elizabeth hospital, Adelaide.

Both Carol Deller and Aileen Connon collected and published their statistics, and I collected mine in a comparable form.

All these services developed protocols, designed to give confidence to the examining doctor that all the relevant questions had been asked, and forensic specimens taken and handled in a way which made them validated for a Court case. I built up the Burnie protocol, as an amalgamation of the best of these, with constant updating as requirements and my experience increased.

**Counselling Services**

***“We know accurately only when we know little; with knowledge, doubt increases.”***  (Goethe)

Recognition and documentation of the effects on victims of sexual assaults began with the Americans Burgess and Holmstrom, who published their accounts of what they called “The Rape Trauma Syndrome” in 1974, and on “Coping Behaviours to Rape” in 1976.

Inspired by such accounts, many strongly feminist groups launched into their own work, first collecting anonymous stories, through phone-ins, and articles in women’s magazines.

I met some splendidly dedicated women in The Women’s Electoral Lobby, (WEL), and in Women Against Rape, (WAR). These women were certainly activists, and were the driving force behind the exciting National Conference on Rape Law Reform, which was held in Hobart, at the University, in May 1980. This was an attempt to reach some consensus amongst such widely-differing groups as the Police, the Law, social workers, and the women’s groups.

I sat at the back of the packed auditorium amongst policewomen and angry women, as we listened to speeches from a distinguished judge, lawyers, and others. It was an extraordinary gathering, and an occasion when it seemed that the agenda was well-prepared and the conclusions wrapped up before we started!

One of the first speeches was from a very belligerent Police Inspector Colin Fogarty, one of the first officers to have an academic background, and as he spoke I felt a rising tide of anger around me. Also speaking was Jocelyn Scutt, a lawyer, and very much in the public eye as a reformer and confrontationalist.

During question time, Heather Innes made an unexpected speech from the audience, on the desirability of ending “the speech from the dock,” the final plea of a defendant which had produced much new special-pleading that could not be contested, and had demolished many prosecutions in sexual assault cases.

Following the Conference, the women of WAR and WEL put together their proposals to the Law Reform Commission, to which I also made a submission. I attended some of their sessions in Hobart, and was especially impressed by the work of Terese Onsman, a lawyer, and Marjorie Luck, a “survivor”.

In 1981 a State-wide “phone-in” was organised by WEL, resulting in 106 callers, with accounts of sexual assaults, including incest: 69% of the rape cases had not been reported to the Police; attitudes of Police, doctors, and the Courts were heavily criticised.

The following year WAR started a phone-in support service.

My psychiatrist friend, Dr Ruth Redom started a counselling service in Launceston; but it wasn’t until 1986 that State-funded services were set up at Laurel House in Launceston, and Hobart (SASS). Janine Coombs, then Celia Taylor, and later, Jo Flanaghan, were the coordinators in Hobart. Burnie did not get a SASS service until 1992.

**Tasmania Police**

The Police in Tasmania were at the forefront in implementing the new discipline of “Victimology”, holding a ground-breaking week-long course at the Rokeby Academy in 1976. This highlighted the recently-recognised short and long-term effects on victims of armed robberies, physical and sexual assaults, road accidents, bushfires and other trauma.

I was soon persuaded to take part in lectures at the Academy, starting with a Course for Policewomen in 1979. So began a thoroughly enjoyable, and I believe worthwhile relationship with the Police, with a teaching role which continued until I retired from the work in 1996.

Many of the courses were designed for police officers only, but soon they included lawyers, forensic scientists, and social workers. For me to take part was a privilege, and an exciting extension of my medical work, allowing me to go beyond the confines of my own profession, and learning to work with these people, and to recognise their differing requirements and disciplines.

Often I stayed several nights at the Academy, a splendid purpose-built complex beside a beautiful bay. I loved the discipline, the good manners which were inculcated into the recruits, (and the uniforms!). I would sleep in a little sparsely-furnished but comfortable single room in the recruits’ dormitory, having meals with police officers and many interesting visitors.

All recruits, and visiting police officers, whatever their rank, were expected to be in the gymnasium at 6.30am, for some preliminary exercises before setting off on a 10km jog around the grounds. On several visits, I would be in the gym, in my track-suit, with the police, at 6.30, take part in the exercises, then joining the back row of the joggers as they left the gym for the run I would duck down to the sand dunes, where I could have a leisurely unseen walk along the beach, keeping an eye out for the exhausted returning officers, rejoining the tail end as they re-entered the gym! However, even the most junior of the embryo detectives would be well-aware of my subterfuge!

For 5 years I was a lecturer at “Inspector Development Courses” at the Academy. There were many sections in these courses which I did not attend (like Firearms and Security) but one aspect was especially attractive to me: the officers were expected to know how to behave as gentlemen at formal dinners! Several times these were dress affairs, with the officers handsome in full mess-dress, navy with wide pale blue revers, and I always had an escort arranged for me, who would collect me and take me to my seat, replenishing my glass and generally being attentive. I was usually one of only two or three women present, a ratio which I thoroughly enjoyed! I was also specially favoured in being invited to a formal Recruits’ Graduation Dinner.

Travelling to the Academy was always a pleasure, as often I took my time and went by the Lake or Poatina Highways, but on quite a few occasions I was offered return travel by air from Wynyard, by Air Tasmania, in a Bandeirante or Chieftain. Several times I would find myself sitting chatting with a passenger I knew, and enjoyed seeing the expressions on their faces when I was met by a uniformed police escort and whisked away at speed in a police car, leaving them to wonder what criminal act I had committed!

**The Victims**

***“No one brings flowers to a Rape victim.”***

 (a survivor)

A while ago I shredded all my case notes. There was a great pile of them, reflecting trauma and unhappiness for over 300 people who had suffered some form of sexual assault. I no longer wanted that burden.

Counselling services now allude to victims as “survivors”, but some did not survive.

It was obvious very early on, that what they needed was assurance of safety, and for their story to be believed; to be offered complete confidentiality, and medical help if indicated for injuries, infections, and the possibility of pregnancy, and if there were to be any chance of a successful prosecution, forensic evidence, to be taken as soon as possible. They needed protection from the media, and help with the legal processes.

When I first started working in Sexual Assault, the pattern was for a woman to be taken to Casualty, flanked by two obvious detectives, maybe to wait in a dishevelled and possibly injured state, in view of staff and patients, for a busy house surgeon, with no protocol and no experience, to perform what might be a humiliating and useless examination.

There was no follow-up, no help for partners and family, and no protection from the ravening Press.

Maybe many months, or years later, she might be summoned to Court, with no help with procedures or with understanding of the Law, to be harassed and bullied by a belligerent Defence Counsel who would do his best to prove she lied, and who probably won his case.

Because there was so little understanding of the extent and nature of rape and its consequences in Tasmania, I thought it important to publish my first 100 cases (obviously all unidentifiable), and after considerable hassles (no computers then!) I eventually had the satisfaction of receiving the galley-proofs of my article which was published in the Medical Journal of Australia, September 1986.

In 1991 I was invited to submit an article on “Injuries associated with alleged sexual assault” for Australian Family Physician. (July ‘91) However, to my chagrin, it was published in a volume entitled “Sporting and Recreational Injuries”! I was somewhat mollified by publication in the next edition of letters pointing this out, and an editorial apology; but one letter-writer criticised me for including some self-inflicted

injuries. I was able to reply in print, that I had seen several cases where such injuries were apparent and the seriousness of the legal consequences to a wrongly accused person.

When I ceased working in November 1995, I had seen 308 cases, of which 186 (60%) had involved the Police, but in 122 (40%) there had been no Police involvement.

These figures hardly compare with those seen in the Counselling Services. For example, NW SASS saw 171 people in the year 1994-95 alone.

Nearly all those I saw were women or children, and of the children only a few were boys. Only recently, with encouragement for men to come forward, a whole new unrecorded field is unfolding, especially concerning boys in schools, institutions, and under the care of abusing clergy.

**Children**

***“What manner of man is there of you, whom if his son ask for bread, will give him a stone?”***

 (Luke iii.9)

If, in the 1970s, we knew so little about sexual assault of adult women, we knew almost nothing about child sexual abuse. Knowledge has been gained with such difficulty, and the proof is even harder. Only by listening to the confidences of adult survivors, or, sometimes to the detailed confessions of the abusers, can we begin to understand the scale of the occurrence, and the extent of the damage caused.

More often than with adults, intervention and well-intentioned efforts to help have caused more trauma to the children.

A poem written by an unnamed 12-year old American girl, and quoted by visiting expert Kee McFarlane at the International Conference on Child Abuse and Neglect which I attended in Sydney in 1986, says it all. (see later in this chapter.)

There were concerned people in Tasmania, but it was so hard to know what to do for the best. As far as doctors were concerned, proof of sexual abuse was difficult to obtain, appearances of the genitalia of children were hard to interpret, and most examinations were done far too late to be of forensic value.

In 1983 Dr Terry Donald set up a Child Abuse Unit at the Royal Hobart Hospital, and

the Child Protection Board on which I served for six years, became very active. However, those most involved were the social workers, who carried such heavy case-loads, and frequently resigned, quoting “burn-out”.

Our small group of Tasmanian doctors compared notes with others in Melbourne, Sydney, and Adelaide, and tried to build up a body of knowledge. But:

***“Data ain’t information, Information ain’t knowledge, and Knowledge ain’t wisdom.”***

(Anon)

After I spoke as a guest lecturer at the Conference of Family Lawyers at Bicheno in 1993, the distinguished Judge in the Chair said that he hadn’t realised that medical evidence of child sexual abuse was so rare, hard to obtain, and often equivocal.

**Recruiting doctors**

***“True ignorance is not the absence of knowledge, but the refusal to acquire it”***

(Karl Popper)

To enthuse other doctors, let alone persuade them to work with sexual assault victims, has been my greatest challenge. Who wants to be on call, maybe 24 hours, to be got out of bed to go to a hospital to meet a police officer and a dirty, dishevelled patient, and to perform a long and extensive forensic examination, make meticulous notes, then later present a full statement to the Police? This is followed, maybe many months, or even years later, by a disturbing summons to Court.

For all the years I worked in this field, I tried to be an evangelist, and persuade doctors just how challenging, and worthwhile it could be to do this work! I gave lectures regularly to General Practitioners, hospital doctors, and medical students. They all assured me that the subject was fascinating, but just didn’t want to be involved. I was beginning to despair about local doctors, until at the end of one talk, Fiona Joske, a G.P. from Smithton, came up to me and said “well, that’s very straightforward! I’d like to work in that way!”

A few concerned doctors in Hobart and Launceston expressed their interest, and in 1985 I was invited to set up a residential Course at the Police Academy. This was a great challenge! I was given full cooperation by the Staff at the Academy, and carte-blanche on the programme, the lecturers, and the participants. Accommodation was offered for three nights and four days of lectures, with a splendid formal dinner thrown in.

The Guest-in-Residence was Dr Aileen Connon, from Adelaide, and other lecturers included senior Police Officers, a Barrister, a Pathologist, a Forensic Scientist, and a Paediatrician.

39 attended as participants. Amongst these were 28 doctors, of whom four were Gynaecologists, and two, Paediatricians. There were nine police officers, from Constables to Senior Sergeants.

From the doctors participating, 13 went on to be active in making themselves available for Police examinations. Cathy Broun of Devonport was one who volunteered following this course, and twenty years later, she was still providing this service, eventually having more experience in Court cases than anyone then working in the field in Tasmania.

In 1986 I was able to run a similar course, this time with Dr Margaret Moody, the head of the SARS unit at the QEH Adelaide, as our Guest-in-Residence. Amongst new lecturers we had Dr Wilfred Lopez, a psychiatrist working with offenders, Mr. Brian Walpole, Surgeon A & E at the RHH, and Barrister, John Kable. Inspector Syd McLymont gave a dramatic lecture on Laws of Evidence, and Sgt Gary Leonard and several policewomen gave us a very practical demonstration of Interviewing Techniques.

At this Course we introduced five workers from SASS Hobart, and there were 10 participating doctors, one nursing sister, and 10 police officers. However, from all this effort, only one new doctor volunteered to work in sexual assault.

The low point of my career was in 1988, when, after organising a similar Course at the Academy, as the week approached, one doctor after another who had promised to attend dropped out, until on the day of the commencement, I sat at the windows of the Academy, with Sgt Gary Leonard, who had done so much to help me, looking out on the parade ground with the lovely Ralph’s Bay beyond, and we decided to call it off.

A centre which had more success was in New Zealand, where a remarkable group of doctors in Auckland, Carol Shand, Juliet Broadmore, and Robyanne Milford, set up DSAC (Doctors for Sexual Abuse Care), an association which quickly evolved to train doctors and to give a nation-wide service. They published the best manual for the Medical Management of Sexual Abuse that I had ever seen, and ran seminars which soon attracted participants from overseas.

I attended one of their Courses in 1990, and was greatly impressed by their enthusiasm and new ideas. On a Saturday afternoon, we all took over the Auckland Criminal Court, where we had a rôle-play before a judge, with a real barrister and all participants taking part as jury or the public. Three of the DSAC women doctors appeared as Medical Witnesses, the first two showing just how *not* to do it! One was too informal, one too flirty (plunging neckline and a glimpse of black lace!) but the third, neatly and appropriately dressed, showed us just how to present our evidence, and to face up to cross-questioning. This technique for confidence-building, I found so helpful, that when, in 1995, I made another attempt to attract doctors to an Academy Course, this was incorporated.

Our 1995 Course at the Academy was a great success, helped by Jo Flanagan, from Hobart SASS, as my co-ordinator. This time we had endorsement from the R.A.C.G.P. programme, and from the National Institute of Forensic Science. Dr Juliet Broadmore came from New Zealand to explain the success of DSAC, and we had the irrepressible Margaret Scott as our speaker at the formal dinner. This time we had 16 doctors, all of whom were working in sexual assault, or subsequently volunteered. Duncan Kerr, then Minister for Justice, and Michael Stoddard, Crown Counsel, and members of SASS were speakers, and I was delighted to have Drs Felicity Wivell, Fiona Joske and Michael Boxhall, working in Launceston, Smithton, and Hobart, as Chairpersons.

We had a Court simulation after our second formal dinner, with lawyers Roland Browne and Penny McMahon cross-questioning three of us. I took the part of a radical-feminist doctor, wearing old jeans, huge earrings and chewing gun, to show just one way *not* to give evidence!

I had some insight into other ways of using doctors, in learning how Police Surgeons performed their roles in UK, and Australia. In 1983 Professor Alan Usher, visiting Tasmania, explained that in UK all sexual assault charges involved examinations by Police Surgeons, and were usually carried out at police stations, with no follow-up, let alone counselling.

In 1988 I was a guest speaker at AAPAPMO, the Association of Australasian and Pacific Area Police Medical officers at their Biennial Conference at Broadbeach in Queensland. Here I was made aware of some opposition, even hostility, to the use of doctors other than Police Surgeons for forensic examinations. However, it was a great pleasure to meet Dr Peter Bush again, as he was President of AAPAPMO, and to say how much he had influenced me, since his lecture in Burnie in 1976!

**Going to Court**

*Elizabeth the Second, by the Grace of God, Queen of Australia and Her other Realms and Territories, Head of the Commonwealth, to ……………..*………… *and John Doe,*

*We command you and every one of you personally be and appear before the Supreme Court of Tasmania and its Dependencies at ……….Criminal Court on…………….at 10 o’clock in the forenoon of the same day and from day to day, until the case hereinafter mentioned shall be heard and determined, then and there to testify the truth, and give evidence between Us and ………..on our behalf in the case of a crime, and this you or any of you are not to omit under the penalty of Two Hundred Dollars, to be levied on the goods and chattels, lands and tenements, and such of you shall fail herein.*

When I first received a Summons to Court, expressed in these terrifying terms, I telephoned Heather, and asked what I should do. She gave me excellent advice: “Just stack them up, and carry on with your life!” and so I did, finding that even although I received several of these documents in regard to a particular case, very seldom was I actually called to Court.

I have attended a County Court in UK, and in Tasmania one Coroner’s, 9 Magistrates’ and 9 Supreme Courts.

It seems that, unfortunately, an inexperienced doctor is more likely to be called than an experienced one. That first appearance can be so traumatic, especially in sexual assault cases, that many doctors have sworn they will never again make themselves available. Harassed by aggressive Defence Lawyers, who may try to discredit their qualifications, experience, skill, or interpretations of their findings, some doctors have felt that they, too, were being victimised.

This is why it has been so important to equip doctors with the knowledge to cope, if not with equanimity, at least with confidence, with going to Court, and why it is possible to assure them, that if they have adhered to our strict protocols, asked all the necessary questions, and taken all the relevant specimens in the approved manner, then they have nothing to fear, even from their first appearance.

They may even, in time, come as I have, to enter Court as something to enjoy, as playing one’s part in a sort of “Rumpole Land,” where the lawyers make the rules, (wear the fancy dress!), and are the principal actors. If we can show that we know our place, don’t try to be clever, funny, or to score points, and most of all, show we are utterly impartial, then we can have some satisfaction in having played our part well, however the judgement goes.

So, an essential part of all the training Courses in which I’ve been involved is to repeat the advice pertinent to any witness before a Court appearance:

***“Dress Up! Stand Up! Speak Up! Shut Up!”***

**The Law and Law Reform**

“***He who passively accepts evil is as much involved in it as he who helps to perpetrate it. He who accepts evil without protesting against it is really cooperating with it”***

 (Martin Luther King)

However one has played one’s part as an impartial witness in Court, one comes away smarting with the many injustices apparently happening. In all the work done by WAR and WEL, by social workers and doctors, and by lawyers themselves, so many factors have been identified as in need of reform.

This is why the collection of statistics and the first-hand accounts from the victims of the trauma they have suffered at the hands of the Police, the doctors, the Law, the Media, and the public, have been so important as a basis for the push for Law Reform.

Many of those seeking reforms gave evidence at the Royal Commission on Human Relationships when Justice Elizabeth Evatt and Commissioner Anne Deveson visited Tasmania in 1976.

The Tasmanian Law Reform Commission presented recommendations on reform of Rape Law in 1976 and 1982, but 1986 was a major year for lobbying by all the groups concerned for new Sex Laws to be introduced to Parliament.

I found it very interesting that the push then seemed to shift from the more radical groups to the “middle-of-the-road” people. Business and Professional Women, for example, took up the cause, with splendid work done by Carol Thomson, who put together the legal arguments for reform, for presentation to the then Attorney-General, John Bennett. At the BPW State Conference in Launceston in 1986 they gave me the platform, which resulted in some useful media exposure (including a T.V. appearance). Justice Michael Kirby was a supportive guest speaker.

At last, in 1987 the Evidence Amendment Act and the Criminal Code (Sexual Offences) Bill were passed in Parliament.

These reforms gave greater protection to victims in Court proceedings, and from identification in the media, and widened the definition of rape to include other sexual assaults, abolished the immunity of husbands, and supported the establishment of more sexual assault services.

The most helpful change in the functioning of the Law came when Barrister Michael Stoddard was appointed Senior Crown Counsel, Sexual Crimes Liaison Officer of the Director of Public Prosecutions. Instead of the victim having no legal assistance, or maybe being met by an unknown Police Officer or lawyer on the day of the trial, it became the practice that any victim of an alleged sexual assault be contacted within 24 hours of notification of an offence, either by Michael or by his deputy, and thereafter be supported for the whole time, maybe many months, through the whole legal process, including direct representation in Court.

Other changes were still necessary, and in 1994, along with many other individuals and groups, I made a submission on “Women and Justice” to the Office of Status of Women. Under the later reforms of 1995, the evidence of children might be given by video, and the abolition of an unsworn statement such as the right of the defendant for the “speech from the dock” was removed.

**Stepping aside**

Following the Police Academy Course in 1995, at which I announced that I was retiring from sexual assault work, the doctors willing to continue decided to form an Association: Providers of Sexual Assault Care (PSAC. Tas. Inc.) and, to my astonishment, asked me to be Patron! I was delighted to continue this as an on-going medical interest.

The stalwarts at that time in PSAC were Doctors Cathy Broun, Erica Cox, Jane Fuller, Fiona Joske, Frank Lawrence, Felicity Wivell, and gynaecologist Raoul Fullerton. Michael Stoddard and some of his colleagues from the DPP gave the legal support, forensic scientist Debbie McHoul the scientific updates, and SASS workers, especially Doreen McDonald, and senior Police Officers were also essential to the wide-ranging representation of all the professionals providing care for the sexual assault victims.

However, at a later meeting of PSAC I attended, (2005) I was very disappointed to find that there had been no new doctors recruited, no detailed statistics seemed to be available, no training courses or lectures to GPs and medical students, and that my out-dated protocol (1995) was still in use. The guest lecturer, the dynamic Dr Angela Williams from the Victorian Institute of Forensic Medicine, said that in Victoria there was the same perennial problem in recruiting doctors. One of the innovations in rural Victoria is to train nurse practitioners to take the forensic specimens.

How can we persuade doctors that this work is so worthwhile? I know it is painful, inconvenient, and tiring, without worthwhile financial reward, but then:

“***Real life is what happens when you’re busy making other plans.”***

(John Lennon)

and isn’t that what being a doctor is all about?!

“***If you love what you do, it will never be a labour.”***

(Confucius)

**The Rape**

Of course she asked for it,

she likes it rough,

tight low-necked jumper and bouncing boobs.

What a tart.

Easy game.

Knock her off in a couple of shakes.

Your turn, mate!

And the woman with the torn vagina

bleeds on the carpet.

Stupid cow!

Then they’re off in the stolen car,

leave it in a side-street,

and back to the booze

and the telly.

And she takes her violated body

in the soiled jeans,

back to her home,

where her mother calls her a whore,

and her father turns his back.

The Casualty doctor with the cold hands,

tho’ sympathetic,

expresses a wish for non-involvement.

Later, a police officer arrives,

with brown paper bags and other receptacles,

and her body fluids

are collected painfully, named and sealed,

and taken to rest on a dust-gathering shelf,

for a couple of years.

At last she’s in the Court,

in the witness box,

but it feels like the dock,

where her principal attacker smirks at her,

then shrugs his shoulders,

trying to form an alliance

with the men on the Jury.

The Prosecutor deals gently with her,

lulling her into a sense of false security;

but the Defence lawyer

flays her alive.

Please verify that these garments

belonged to you;

and a pathetic package

containing her stained knickers

is displayed to the jury.

By now she is shaking uncontrollably.

And you didn’t resist the advances

of this man and his friends?

There were no major injuries on your body.

No sir.

Distorted faces float across her recollection.

She had no chance to explain her fear,

her despair at the inevitable.

I can’t go through with this.

Case dismissed.

And the leering man in the dock

leaves the Court, but never leaves her thoughts.

He goes off to the pub,

to celebrate with his mates,

and she returns to an empty bed,

and a ruined life.

*Mary Kille*

*Published in Happenstance 2007*

**Poem of a 12-year old girl**

I asked for your help

and you told me you would

if I told you the things

my dad did to me.

It was really hard for me to say all those things

but you told me to trust you.

Then you made me repeat them

to fourteen different strangers.

I asked you for privacy

and you sent two policemen

to my school in front of everyone

to” go downtown” for a talk

in their black and white car

like I was the one being busted.

I asked you to believe me

and you said that you did.

then you connected me to a lie detector

and took me to court where the lawyers

put me on trial like I was a liar.

I can’t help it if I can’t remember times and dates

or explain why I couldn’t tell my mum.

Your questions got me confused –

my confusion got you suspicious.

I asked you for help

and you gave me a doctor

with cold metal gadgets and cold hands,

who spread my legs and stared just like my father.

who said it wouldn’t hurt, just like my father

who said not to cry, just like my father.

He said I looked fine –

Good news for me you said

bad news for my “case.”

I asked you for confidentiality

and you let the newspapers get my story.

What does it matter that they left my name out

when they put in my father’s

and our home address?

even my best friend’s mother won’t let her talk to me anymore

I asked for your protection

and you gave me a social worker

who patted me on the head and called me “Honey”

mostly because she could never remember my name.

She sent me to live with strangers

in another place with a different school.

I lost my part in the school play and the science fair

whilst my father and others all got to stay home.

Do you know what its like to live

where there’s a lock on the refrigerator,

where you have to ask permission to use the shampoo

and you can’t use the phone to call your friends?

You get used to hearing “Hi, I’m your new social worker

This is your new foster sister, dorm mother, group Home.

You tiptoe around like a perpetual guest

and don’t even get to see your own puppy grow up.

Do you know what it’s like

to have more social workers than friends?

Do you know what it feels like

to be the one that everyone blames for all the trouble?

Even when they were speaking to me

all they talked about was lawyers, shrinks, fees,

and whether they’ll lose the mortgage.

Do you know what its like when your sisters hate you

and you brother calls you a liar?

Its my word against my father’s.

I’m twelve years old

And he’s the manager of a bank.

You say you believe me….

Who cares if nobody else does?

I asked you for help

and you forced my mum to choose between us.

She chose him of course.

She was scared and had a lot to lose.

I had a lot to lose too.

The difference was you never told me how much.

I asked you to put an end to the abuse.

You put an end to my whole family.

You took away my nights of hell

and gave me days of hell instead.

You’ve exchanged my private nightmare

For a very public nightmare.

  *Anon*

**Later additions to Sexual Assault Chapter**

**Rolf Harris**

Since I wrote this section on Sexual Assault, in 2005, revelations concerning the extent of child sexual abuse have rocked the public, and those of us who have striven to establish the truth.

At the International Conference on Child Abuse and Neglect held in Sydney in 1986, the much-admired, high-profile entertainer who opened the Conference wasRolf Harris.

In his welcoming speech to delegates he launched his own teaching video, “Kids Can Say No!” price $40 (plus p and p.)

I bought this video, as did hundreds of others present, and we used this in our subsequent lectures and demonstrations to social workers, teachers, police officers,

and the public.

Today, as I write, I have accessed this film on the Internet.

In this Harris is shown talking with very young children about ‘Yes’ and ‘No’ feelings, ‘good and bad touching,’ keeping ‘bad secrets,’ going with strangers who ask you to do ‘yucky things’ and even with adults you know.

“You have a right to feel safe, you can tell someone you know and trust, your Mummy or Daddy, a teacher, or a policeman.”

He advises what to do about an adult who says “you mustn’t talk about these ‘No’ things or I might go to prison.”

The video ends with all the children singing a catchy song: “Your body, my body’s nobody’s body but mine.”

In 2014, after an 8-week trial in the UK, Harris was found Guilty of 12 counts of Indecent Assault against four girls, the youngest just seven years old, and sentenced to be jailed for 5 years. He was released from Her Majesty’s Prison Stafford in May 2017.

He was stripped of the CBE he was awarded after he painted Queen Elizabeth’s 80th Birthday portrait. The multi-million fortune he had made as a painter and entertainer is currently diminishing in a flood of compensation claims against him as a convicted paedophile.

**Kee McFarlane**

At this same Conference in Sydney, in 1986, the Key-note speaker was American Kee McFarlane, a sincere and likable social worker from Los Angeles, where she was the Director of The Children’s Sexual Abuse Diagnostic Centre of the Children’s Institute International.

She had already spent over 13 years studying and working in the field of child sexual abuse.

Her innovative ideas on practical ways of eliciting a description of abnormal sexual happenings to very young children appealed to many of us who had been struggling with these problems.

One of these suggestions I thought worthwhile, was her use of “anatomically correct dolls”, so much so that on my return I adapted two dolls, male and female, with the addition of a (floppy) penis and a small pouch to represent the vaginal area, and an open mouth.

The aim was to allow the child to use these dolls to facilitate their description of where, and how they had been touched, or hurt. The children anyway probably did not have names, or only names used in their family, for these parts of the body.

Sometimes this was successful, and often helped the children to feel they were understood, and felt free to talk as they displayed accompanying fear, or hurt, embarrassment, or distress. Another method was to draw, or have the child draw, representations of their family, father, mother, siblings and friends. Maybe a stranger would come into the picture, and a raw emotion would be revealed.

Very early on I found the greatest draw-back was the vulnerability of the child, and the examiner, to suggestion. Many children, may say “yes” to a leading question, whatever the truth, or just reply with an answer they think will please, or that doesn’t make them uncomfortable. Also their idea of what was “last week,” or “last year,” may be confusing, just as “how many times?” may elicit the response “hundreds and hundreds”.

Kee McFarlane was caught and overwhelmed, on her interviewing methods, in what came to be called the McMartin Preschool Abuse Trial of 1987-90 in California. She described herself as “simply a somebody who has been in the eye of the storm.”

The ramifications continue.

An allegation had been made, by a parent, of traumatic anal penetration of her 2-year old son by a male teacher at the local primary school. This led to upset and anger throughout the parents and then the whole community, with interviews of all the children demanded. Kee McFarlane was be the interviewer, alone with each child, but with a recording made of each.

She used the interviewing methods which she had been developing, and as she progressed, and as parents questioned their own children, ever wilder accusations began to fly, even leading to tales in the community of Satanic practices and conspiracies. More and more of the children, and also more teachers, were implicated, until, with media hysteria fanning the flames, 360 children were reported as having been sexually abused.

The Trial continued for years, with the original male teacher eventually cleared of 52 of the 65 counts which had reached Court, and on the other 13 counts he was found guilty, and he went to prison for 5 years. At a retrial the jury were deadlocked, and he was then cleared of all counts.

The lawyers were gainfully employed for very many years, as were members of the Media, with a recrudescence of interest including an investigation of “The McMartin Hoax” in 1989, and a new T.V. Investigation in 2019.

At the centre of it all were Kee McFarlane’s interviewing techniques, revealing her use of leading questions and suggestability, words and actions being put into the minds of the children.

All this has gravely upset the balance of proof of the actual sexual abuse of children, and made doctors, counsellors, social workers, and the Police extremely wary and reluctant to present evidence.

**Current developments**

At the time when I first started medical forensic examinations for victims of alleged sexual assault and abuse, in the 1970s, there was an acute lack of doctors in Australia prepared to volunteer for this work.

As a consequence, there was little authenticated evidence that a sexual act had occurred, and that the accused person was indeed the perpetrator. If there was, then the defence frequently relied on the supposition that the victim consented. Even when there were injuries, it could be claimed that the victim “liked it rough!” However, some perpetrators *did* make confessions, thus it was possible to correlate physical and behaviour findings.

With improvements in medical and forensic practice, including authentication of the chain of evidence and analysis of the specimens, more cases were being successfully prosecuted.

However, with the use, from the 1980s, of DNA examination of the accused, and of the specimens taken, the defence now seems to be reverting again to the issue of consent, and so the weight of proof again turns on the prosecution, and the victim.

With the explosion in numbers of adult victims of “historical” child sexual abuse now coming forward, there is recognition of life-long damage and suffering. The high profile of some of the alleged perpetrators, in positions of ecclesiastical or temporal power has rocked the community.

However, to some members of the public, the taint of compensation now awarded in some cases, adds to their disbelief that these behaviours really happened.

So complexities and doubts are still very much a part of the picture, and victims continue to suffer, and perpetrators to go free.

Much has been achieved; but the appetite of the media and the public in general, for the lurid details of sexual crimes remains unabated.

A new issue has arisen, unforeseen during the Law Reforms of 1987, in that a few of the victims do *not* want their identity suppressed, because they want to publicise their stories.

I do, however, consider that the striving for truth and justice (these two aims continue to be very different, and sometimes contradictory!) and for advances in understanding and care for those who have suffered and continue to do so, have been worthwhile.

On a lighter note, here follows a piece of doggerel I wrote instead of a speech, given at a Farewell Dinner given for me in Launceston, when I retired from Sexual Assault work, 20th April 1996:

**Farewell dinner**

|  |  |
| --- | --- |
| I was really quite excited, | when I found myself invited |

to be with you at this quite auspicious time;

 so I rise with some elation

 and a little trepidation

 and confess, with hesitation

my propensity for saying things in rhyme.

|  |  |
| --- | --- |
| Now, my primary objective, | is a little retrospective - |

to pay tribute to the ones that went before -

 who bravely opened all our eyes,

 and led us all to realise

 that it was time to criticise

the Police, the Courts, the Doctors, and the Law.

|  |  |
| --- | --- |
| There are some that I could mention, | who came to my attention, |

but many would prefer to have no name,

 there were some, just so courageous,

 some politically outrageous,

 but their zeal was quite contagious,

with reforming of the Law their common aim.

|  |  |
| --- | --- |
| There was widespread discontent, | which was very evident, |

with the reasons for much suffering and pain -

 the Press interest just salacious,

 the Law’s arguments fallacious,

 and some doctors’ care disgracious,

so the victim was just victimised, again.

|  |  |
| --- | --- |
| When the Police seek for assistance, | doctors usually show resistance, |

say they’d like to help, but at some *other* time,

 they ignore there’s someone’s mother,

 someone’s sister, daughter, brother,

 who has just become another

victim of the latest sad and sordid crime.

|  |  |
| --- | --- |
| So you say, that, after all, | you’d agree to be on call |

and you read up all the things that you should know

 but the ‘phone rings without warning,

 and your partner lies there snoring,

 or grunts “see you in the morning!”

and there’s no-one else but you prepared to go.

|  |  |
| --- | --- |
| When you’ve really done your best, | thought of each forensic test, |

and you feel you’ve covered everything you ought,

 then, with a touch of agitation,

 perspiration, palpitation,

 comes the solemn obligation

to present yourself as Witness to the Court.

|  |  |
| --- | --- |
| Tho your dress is quite immaculate, | statements clear, impartial, accurate, |

and the Prosecution treats you gently and with grace,

 there’s the stunning revelation

 that the Court’s obfuscation

 seems to bear no true relation

to the Fairness, Truth and Justice of the case.

|  |  |
| --- | --- |
| But, at least, one’s had a go! | and in the process, come to know |

such friendship! Now, at last, I’ve done!

so, to those who’ve gone before-

 reformers for a fairer Law -

 and those Police who’d not ignore

 those injustices they saw,

|  |  |
| --- | --- |
|  | Social Workers - p’raps a score, |

 and the Doctors (we need more!)

here’s my thanks to each and everyone!

**End of Three Careers**

***One should never be sorry***

 ***one has attempted***

***something new…***

***never, never, never!***

(Sybil Thorndike)

There is still so much to sample and to explore, so many new interests, and so many adventures to share with the family and friends I treasure.

(and, if it appears that there are too many quotations in these notes, I can only say that I take joy in finding that someone has *already said* whatI wanted to say,

and has said it so much better!)

***A child is a grub,***

***A man’s a cocoon,***

***Music’s a butterfly……***

***Sing me a tune.***

(Michael Lunig)

**Biographical note:**

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Mary Lindsay Kille (neé Mackay)

b.1932 Wolverhampton.UK

MB. Ch.B. Birmingham 1955

D.A. London 1960

Emigrated to Tasmania with

Urologist husband John Kille

and two children December 1973.

**Anaesthetist:**

UK from 1957 to 1973

Burnie, Tasmania, 1974 to 1986

**Family Planning:**

UK from 1969 to 1973

Tasmania from 1974 to 1996

**Sexual Assault Services:**

Tasmania from 1976 to 1996

**Published papers:**

Kille.M.L.

A sexual assault referral service based on a hospital in a small Australian town *Medical Journal of Australia*. 1986. Vol 145 No 5. 189-194

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Dr Mary Kille. Interview with Rob. Willis. 16/9/2007

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**Books of Poetry**

*Happenstance* 2007

*Proving Flight* 2011

*The furgling Fairy-Wren* 2018