THE ANATOMY OF TWO MEDICAL ARCHETYPES: A SOCIO-HISTORICAL STUDY OF AUSTRALIAN DOCTORS AND THEIR RIVAL MEDICAL SYSTEMS

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(Edith Cowan University)

This thesis is presented for the degree of Doctor of Philosophy of
Murdoch University

2007
Declaration

I declare that this thesis is my own account of my research and contains as its main content work that has not been previously submitted for a degree at any tertiary education institution

........................................

Christine Victoria Farag
This thesis is dedicated to the memory of my mother and step-father,
Victoria and Peter Malouf, who were always so proud of our small achievements.
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<td>Australian Army Medical Women’s Service</td>
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<td>Australian Army Nursing Corps</td>
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<td>Australian Accreditation Committee</td>
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<td>ACCC</td>
<td>Australian Competition and Consumer Commission</td>
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<td>ACT</td>
<td>Australian Capital Territory</td>
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<td>The Australian Centre for International and Tropical Health and Nutrition</td>
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<td>Australian Defence force Academy</td>
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<td>Australian Medical Council</td>
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<td>CB</td>
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<td>Commonwealth Department of Health and Ageing</td>
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<td>KCMG</td>
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<td>KB</td>
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<td>Non-government Organization</td>
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<td>MC</td>
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<td>MRACP</td>
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<td>MRI</td>
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<td>World War One or Great War</td>
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Acknowledgements

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Abstract

In this thesis it is argued that the migration of ideas and personnel from Britain to colonial Australia resulted in the reproduction of two distinctive medical archetypes, namely, the soldier/saviour and the generalist (family) physician and surgeon. These have been both conceptualised as “ideal type” carriers or expediters of two rival forms of medical professionalism. They each emerged in the ‘modern’ era as institutional products of distinctive educational processes and work practices available for doctors in 19th and 20th century Britain and Australia. While Freidson (1988) asserts one of the problems of dealing with studies of professionalism is that researchers have failed to clearly define work patterns, he could be seen as being close to Foucault (1973) whose emphasis was on the different social spaces in which practitioners worked.

I show firstly that the career of the ‘imperial’ army medical officer was revived in the 19th century so that in colonial contexts they could alternate between military and civilian servicing, especially as administrators and managers in public office. The soldier/saviour was also associated with the 19th century revival of Masonic and quasi-Masonic military and religious orders, consecrated by royal sovereigns and exported to Australia. In contrast, the Scottish pedagogues and other generalist doctors coming to Australia from Britain were influenced by Edinburgh University’s Medical Faculty’s humanist traditions and design of the “modern” medical curriculum producing the generalist physician and surgeon who met community needs. Within wider imperial social relations, these generalist doctors were looked upon as ‘dissenting’ or counter-hegemonic.

The aim of this thesis is to examine these archetypes in terms of their characteristics of rationalisation to analyse and understand their professional differences historically as well as in the contemporary period. The significance is that one does not often come across studies which specifically look at doctors within the same society in such terms. Furthermore, by locating them within wider hegemonic and counter-hegemonic social relations, links between ideas about medical professionalism and issues of human rights become evident. This follows the World Health Organization’s directives to treat health or medical issues and human rights as a cross-cutting research activity. To my knowledge, no study has been undertaken in Australia of the background and impact of these different traditions.
CHAPTER ONE

Introduction

… (I)t is scarcely fruitful to look for a relation of anteriority or dependence between the two terms of a private, “liberal” medicine, subject to the mechanisms of individual initiative and the laws of the market, and a medical politics, drawing support from structures of power and concerning itself with the health of a collectivity…(I)t is equally inadequate to posit the existence at the historical threshold of modern medicine of a singular, private, individual medical relation, “clinical” in its economic functioning and epistemological form, and to imagine that a series of corrections, adjustments, and constraints gradually came to socialize this relation …(Foucault cited in Rabinow, 1994, p.273).

Introduction

The status of doctors working within the domain of medicine at any given historical moment largely depends upon the way medical knowledge and power relations are constituted. After the birth of biomedicine, the resultant changes to how medical knowledge was defined were also accompanied by the demise of a social or humanist medicine. For example, in early 19th century Germany, the “causal relationship between social misery and disease” was an acknowledged factor (Rosen, 1974, p.61). However, when Robert Koch’s theories about the study of infectious disease were accepted, they were also used as a basis to unwittingly exclude “any social considerations and reflections on social policy” (ibid). This thesis will show that eventual changes to medical education were accompanied by changes in public health policy and medical practices within frameworks which either acknowledged or rejected social issues. In the following pages of this introduction I will firstly outline how assumptions developed for this thesis as well as provide some historical background of differences in the background of British doctors migrating to Australia. Secondly, the aims and significance of the thesis as well as the content of the following chapters will be summarised.

This significant division in doctors’ attitudes has again become visible in Australia today; consequently my research not only explores such differences, but also shows that two completely different “western” medical and socio-cultural traditions have been evident in Australia from the 1880s to the present. I argue these traditions were carried forward into the contemporary era through the influence of two distinctive
archetypes whose career paths originated in England and Scotland and whose cultural background differed appreciably about ideas surrounding medical professionalism and patient servicing. In addition, I show how these have in turn impacted in significant ways on the prevailing health care system and are directly reflected in two dominant medical genres which stand in hegemonic and counter-hegemonic positions in Australia today. Foucault’s above words are used as a starting point to reinforce an argument that it is unwise to assume or assert any form of homogeneity in regard to medical professionalism.1

Foucault (1973) placed emphasis on the different social spaces in which doctors practised and also showed it unrealistic to expect that individual doctors have power over the way medicine is defined and practiced. In addition, Freidson (1985, pp.19-22), has found definitions of “profession” or “professionalisation” in functionalist or post-modern theories of “ideal” types problematic. This is because of the tendency to treat professions as a universal concept rather than as a dynamic historical reproduction with particular roots in industrial nations strongly influenced by Anglo-Celtic institutions. The other gap, of course, is the absence of an examination of gender and ethnic relations within the 20th century context.2

Freidson (1988) also points out one of the problems of dealing with studies of professionalism is that researchers have failed to clearly define work patterns. In this assertion, he could be seen as being close to Foucault (1973) in the attention given to the different social spaces in which medical practitioners choose to work. However, as my methodology not only links history to sociology so as to understand the present, but also incorporates a consideration of values, culture and pluralism within the medical profession, I have positioned myself as a sociological eclectic drawing on both historical and poststructuralist perspectives within the sociology of health and illness. At the same time, it is mainly from Weber’s influence I have tried to ensure that my conceptual and theoretical treatises are empirically grounded and embedded in social action.

1 This is in keeping with Arney & Bergen (1984, p.2) who assert that Foucault’s work rather than medical sociology is more useful as a productive starting point, without the necessity of understanding his “archaeology of knowledge” method, nor locating his work in the “intellectual currents of our times”. Quoting from Said (1977), they maintain that “to treat his work as a starting point is to see it as no more, but equally as no less than being “of overriding interest”

2 Gender will be given only limited consideration in this thesis. The topic of ethnic relations was examined in my previous work (Farag, 1992).
As heuristic devices ordering my conceptual framework, the two medical archetypes introduced are the soldier/saviour\(^3\) reflecting a heroic and crisis-oriented genre, and the generalist (family) physician and surgeon\(^4\) reflecting a humanist and community-oriented genre.\(^5\) I have introduced the term “archetype”\(^6\) to denote historically reproduced “ideal type” carriers of rival professional systems present in Australia with diverse value-orientations that unwittingly reflect the differences of doctors described by Rosen (1974) above.\(^7\) The dictionary meaning of the word is “a very typical example of a certain person or thing” (Soanes and Stevenson, 2005).\(^8\) These archetypes are representative of practitioners, whose differences in work and educational patterns were established in the 18\(^{th}\) and 19\(^{th}\) centuries and became fully formed in the 20\(^{th}\) century, including differences in ideas about developments of medical knowledge and patient servicing (Foucault, 1973). As Bosk (2006, p.1) asserts:

One of Freidson’s broadest and most enduring legacies was simply this; all of us who follow are obliged to treat what were once unquestioned theoretical assumptions about the nature of professional work as open issues for empirical enquiry (Bosk, 2006, p.1).

Therefore, in the following pages and chapters, not only have I questioned the “common sense” ways history has been constructed, but I also offer new insights into the agency of doctors within the Australian medical profession. In pointing to the different orientations of these archetypes, this thesis challenges some of the commonly held assumptions about the historical and political impact of the medical profession in Australia. First of all, I would like to explain what led me to undertake this thesis.

**How assumptions developed**

The genesis of this thesis arose a few years ago when I returned to tertiary study in Perth, Western Australia, after having lived in Alexandria, Egypt and worked in an administrative capacity for the World Health Organization, Eastern Mediterranean

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\(^3\) Hereafter referred to as the “soldier”

\(^4\) Hereafter referred to as the “generalist”

\(^5\) As the status and skills of the “generalist” have both been eroded, this is unlike the way one views today’s general practitioner.

\(^6\) Other researchers have referred to medicine as one of the “archetypal professions” (see Freidson, 1970, Turner, 1987, p.10). Turner (1987, p. 10-11) uses the term “archetypal” professions when referring to Foucault’s assertion that the police and medical men replaced priests as guardians of the social reality. However, it is not synonymous with the term “archetype” used in Jungian psychology as an image or symbol believed to be universal in human culture and which, for Jung, exhibited a “collective unconscious” (“archetype” Calhoun, 2002, p.1).

\(^7\) The theoretical, conceptual and methodological issues in relation to these archetypes as “ideal type” representatives of medical professionalism will be discussed in the following chapter.

\(^8\) (“archetype noun”, Soanes and Stevenson, 2005).
Regional Office (WHO/EMRO). My studies pointed to the fact that tertiary-educated immigrant professionals, especially those from “Mediterranean” countries, were mainly unemployed or under-employed and suffered a considerable loss of status after arriving in Australia. At the time, researchers concluded the significantly lower occupational level attained could have been attributed to the “quality” of education tending to be “lower” in “those” countries. They also pointed out the “generally low level of economic development in those countries makes it harder for migrants to adjust to “advanced industrial societies” such as Australia ...” (McAllister & Kelley, 1984, pp.53-68). I found these comments ethnocentric to say the least. Also, because I had worked with many international professionals from “Mediterranean” countries, I doubted the efficacy of these conclusions and found the logic to be flawed. For example, the occupational closure which still exists in Australia would mean if the WHO/EMRO Regional Director wished to practice medicine in this country, he would not be recognised as a specialist, despite his postgraduate education and experience in Europe. This is because his undergraduate studies at Ain Shams University in Cairo are not recognised here and he would have to pass the Australian Medical Council (AMC) exams which would push him into the general practitioner workforce. I subsequently completed my Honours’ thesis on the topic of the non-recognition of qualifications of overseas-trained doctors (Farag, 1992).

The completed work encompassed a comprehensive literature review on issues surrounding Australian immigration, medical regulation and social closure, leading to the conclusion that Australian examination processes discriminated against such doctors, especially specialist practitioners, pushing them either into the general practitioner workforce or into other positions of underemployment. My findings show those responsible for such outcomes were a distinctively authoritarian, anti-democratic and exclusionary group of medical administrators who remained steeped in colonial traditions. However, an unexpected outcome was that the same could not be said of many other practising Australian doctors, who showed empathy towards the overseas-trained, as well as displaying other attitudes, values and practices which were distinctively egalitarian. I also found some medical educators and general practitioners appeared to be subordinated to the wider interests of the medical status quo and the general practitioner of today had been redefined to suit such interests (Farag, 1992).
On reflection, I found the issues were not only about ethnic and gender participation but also about different attitudes and values. These issues surrounded the control over medical knowledge and access to power and influence not only by other Australian medical professionals, but also by male and female medical students. Eventually these issues led me to embark on this thesis so as to find an explanation for the differences I encountered. I also found these extant ambiguities within the Australian medical profession itself have caused both medical historians as well as community doctors to call into question the idea of a homogenous “Australian” medical profession and to question the current research on the subject which takes for granted that studies mainly of the eastern states could be generalised to other Australian states (see Martyr, 1995, Saint, 1981). From the outset my analysis was somewhat confirmed by finding, in Saint’s (1981)⁹ evaluative study on Community practice in medical schools, his assessment was expressed in the following terms:

The institution of medicine has evolved as a conservative, hierarchical body, with attitudes and values not always consonant with the rapidly changing health needs of the community it is supposed to serve: it is a proper subject for sociological analysis. Thus arises the subject, one which causes discomfort in the minds of many doctors and students, unwilling to have conventional values challenged, of medical sociology, which analyses the mores and values of cultural groups within communities, the providers as well as the consumers of health care (ibid, p.34).

Few researchers have given such influences the attention they deserve regarding the social and cultural values and attitudes behind ideas about medical intervention and patient servicing, especially in relation to Australian developments. Therefore, Saint’s statement led me to explore what types of values, attitudes, mores and other distinctions were evident in the evolution of both the conservative and the more patient-centred medical professional attitudes.

Taking the above into account, for the purposes of this thesis, one should ignore notions of a hierarchical elite and rank and file within the Australian medical profession itself.¹⁰ So as to give the reader an idea of the early differences between doctors, some historical background on British medical migration, education and training, as well as ideas of medical professionalism are outlined below.

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⁹ As I will show later, Eric Saint was one of the last generations of Adelaide generalist medical educators.
¹⁰ Older general practitioners and community-oriented doctors have never viewed themselves in such terms.
The migration of British doctors to Australia: an overview

Medical migration to Australia started, of course, with the First Fleet when naval doctors received land grants to encourage them to settle in Australia (see Best, 1988). In the early 19th century, army doctors began to arrive with their regiments. However, the knowledge and professionalism of doctors arriving in Australia during the 19th century has not been fully examined from this point. Well before Australian Federation, preferences were articulated for a selective “blood, breed and racial type” of British male as well as for “surgeons having all the Dublin Dissector in their heads and all the hospital experience of Paris in their hands” (cited in Webb and Enstice, 1998, pp.88-89).

Those articulating such views placed “other” doctors under a banner of inferiority describing them either as those who “failed to make the grade in England” or as belonging to an era when doctors could not “cure” and therefore were “backward” or “unscientific” (see Pensabene, 1980, Willis, 1989). Of course, such mythologies later paved the way for the advocates of biomedicine who, as I will show, would claim they were taking medicine out of the “dark ages” (Worboys, 1993).

Most early studies of medical professionalism did not critically analyse the different forms of medical education and training available in 19th century Britain or Australia. The mythology was put forward that Australia has been a “dumping ground” for those doctors who failed to make the grade in England. The explanation for this argument was borne out by the assertion that few doctors came from the prestigious Oxford and Cambridge Universities (see Willis, 1989, p.22). The truth is that, for religious reasons, Oxford and Cambridge in the 18th and 19th centuries produced only small numbers of doctors. Most medical students went to Edinburgh University to pursue their medical studies (see Rigby, 1992, Trevelyan, 1937). Moreover, many highly-qualified doctors were excluded from practising in government posts in England. Rigby (1992, p. 199) states:

From the 1840s old statutes were recalled by Poor Law Commissionners in defining the medically qualified. In doing this they effectively excluded some of

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11 The term “army” has been used synonymously with “military”.
12 This same argument was used in the 1970s and later to denigrate the expertise of overseas-trained doctors coming to Australia (Farag, 1992).
13 As early as the 16th century the Royal College of Physicians tried to control competition inasmuch as it was the sole professional body at the time able to restrict competition in the vicinity of London by refusing to accept non-university graduands as suitably qualified (Rigby, 1992)
the most highly qualified doctors from poor law practice, among them being several hundred graduates of prestigious and widely respected universities including those of Edinburgh and Leyden (Rigby 1992, p.199-209). Oxford and Cambridge denied entry on the basis of religious “dissent”. Edinburgh, Leyden, London and Dublin universities were linked by more enlightened initiatives which were humanist and secular in orientation (Rigby 1992, pp.199-209).

The influence of doctors educated at the Edinburgh medical faculty has been well-documented (Digby 1994; Downie and Charlton, 1992; Foucault 1973; Nicolson 1993). In the 18th century, those at the Edinburgh Medical Faculty designed the “modern” medical curriculum with the explicit aim of producing a generalist physician and surgeon who might later pursue a specialty of interest. They also sought to flatten any hierarchical associations between doctors and promoted diagnostic practices which respected the patient narrative (Geyer-Kordesch, 1995). Medical students came from all over the world to this medical faculty which gained international status as one of the most prestigious medical institutions during that century (Digby, 1994; Downie and Charlton, 1990). After the Napoleonic wars Edinburgh’s popularity was superseded by the rise of the French surgeons and the Paris hospitals.

Meanwhile, in England, private medical schools flourished and a complex licensing situation remains into the contemporary era (see French, 1993, p.99). While sociologists had first asserted there was a distinctive division of labour consisting of physicians, surgeons and apothecaries, later researchers argue there were no rigid boundaries in how doctors practised as they responded to the market for their services either as surgeons, physicians and later obstetricians (Digby, 1994; Parry and Parry, 1976). However a Scottish doctor reflecting on practice patterns in the 19th century argues that in the three United Kingdom capitals, there was a fairly defined “cleavage” between physicians and surgeons, the latter practising what was called “operative medicine” (Scot-Skirving, 1924, p.137). He also stated that this was evident in most instances “where a man (sic) held a teaching appointment in a subject he professed as his own” (ibid).

The traditions of Edinburgh medical faculty were passed on to the medical faculties at the Universities of London, Dublin and, for a time, Adelaide, Melbourne and Sydney. These doctors combined knowledge of literature and arts with medicine, while botany was a culturally-valued discipline taught into the 20th century. This was not only due to a humanist stream of university medical education which can be traced to Padua,
but also to a revival of Hippocratic tenets and patient-centred focus.\textsuperscript{14} In the 19\textsuperscript{th} century such practices became more or less typical of Britain as a whole (see Nicolson, 1993, p.80).

The idea of medical professionalism passed on initially to the Scottish doctors called for a view of medical knowledge as being continually shaped and reshaped by observation of the living human body. For example, it was stated:

What fitted a man for the profession was not knowledge of medical tradition or even general literature and science but “the habitual observation of the living human body as affected by disease and as influenced by remedies (Alison, n.d. cited in Saunders, 1950, p. 337).

While, as I will show later, many such generalists migrated to Australia from Britain, the generalist tradition was established in Australian medical faculties by institutionalising the curriculum and practices in the Edinburgh Medical Faculty tradition.\textsuperscript{15} Although universities were established earlier, the Australian medical faculties established in Melbourne, Adelaide and Sydney first began to take students between the 1870s and 1880s. From the outset there were many problems before a collaboration of university and hospital personnel was established. Initially in some spheres the professors were excluded from teaching or practising in the hospitals (see Dyason, 1984). However, for a number of reasons until the 1960s, many Australian medical students also went to the Edinburgh Medical Faculty for all or part of their education (see Pensabene, 1980). Postgraduate diplomas in specialties were initiated by the universities after the 1920s but, until the 1970s, Masters or Fellowships in the various specialties remained under the control of the Royal Colleges in Scotland and England (Opit and Southby, 1978, p.4). The university-based medical academics were part-time medical educators and part-time generalists who could also act as consultant physicians or surgeons in the hospital sector. They introduced a bedside medicine into Australia at a time when it was being phased out in other western countries.

In contrast, career paths had long been established for soldier doctors, so they could alternate between military and civilian positions, with hospitals provided by the army (Royal Army Medical Corps (RAMC), 2002). Over the 100 years between 1788 and the Boer War in 1899, Australia was in essence a military establishment (Grey,

\textsuperscript{14}As opposed to Newtonian “science” which drew on the ideas of Paracelsus (see Webster, 2005).
\textsuperscript{15} Education in general to the 1950s and medical education in particular was predominantly influenced by Scottish people who were, in the main, Presbyterian (see Barcan, 1980, Gilmann, 1980).
1990). In addition, from 1810 until 1870, Sydney became one of the garrison stations of the Empire hosting a continuing reinforcement of British regiments (McIntosh, 1948, p. 486). Doctors who enrolled in the NSW Volunteer forces in the 1870s were either surgeons or assistant surgeons (ibid, p. 487). When the British sent their regiments home, the soldier doctors and others in Australia favoured for government employment were those who were known to have been in “active” service, meaning they had already been initiated on the battlefield receiving some kind of recognition or award (see Grey, 1990; McIntosh, 1948, p. 486).

As far as education and training is concerned, the original legacy of the soldier doctors was the colonial hospital-based apprenticeship system appearing in the early 19th century where, after a period of training, a “topping up” of a year’s further training was undertaken in England to obtain a surgical diploma in the form of Membership of the Royal College of Surgeons (MRCS) (Best, 1988). Some colonies, such as South Australia, never had such a system (Best, 1988; Verco, 1919). Army surgery was “operative” or “procedural” surgery which placed its emphasis on amputation and dissection of dead bodies to understand the diseases of the living (see Bourke, 1996; Foucault, 1973).16

The British Medical Act (1858) established the General Medical Council (GMC) to act as a governing body to oversee educational and training requirements of doctors in Britain and its colonies. Until this legislation was enacted, the British government had refused employment to highly qualified Scottish doctors in England (see Downie and Charlton, 1992). Once in place, the Act served to effectively make formal qualifications a mandatory prerequisite to medical practice by establishing the first Medical Register which had a counterpart later in each Australian colony (Farag, 1992). The legislation also appeared in the wake of the establishment of the British Medical Corps when soldier doctors were heralded as “saviours and miracle workers” (see Illich, 1976).17 From the Sudan War in the 1880s, the soldier doctor began to wield influence in Australia. The Sydney University Medical Faculty, established at that time, although organized to produce a generalist, was subjected to both army and government

16 The “Father of Surgery” was Ambrose Paré whose life-saving skills were in treating gunpowder wounds, amputation and finding ways of preventing the need of caesarean births by turning babies in the uterus. He was also Paracelus teacher who is sometimes referred to as the “Father of Chemistry” (see Magner, 1992).

17 In the meantime, in England the military family was elevated as an example of good breeding and discipline and order and the military officer, the embodiment of ideal masculinity and citizenship (see Dawson 1994, Summers, 1988).
influence. In 1890, an Australian Census Conference held in Hobart in March 1890 agreed upon a “Systematic classification of classes and orders” (Gale 1892, pp.172-173). The next census using these classifications of class structure, defined the first class of professionals as

Embrac(ing) all persons mainly engaged in the government and defence of the country, and in satisfying the higher intellectual and moral requirements and special social wants not included in the material services rendered by other classes hereafter specified (Gale, 1892, p.172). 18

The production of statistics showed that death and disease in the population were accepted in a fatalistic fashion and statistics documented that fate. 19 As far as records on Australian health statistics are concerned, Palmer and Short (1989, p.262) point to the impossibility of being able to produce national statistics because of the lack of uniformity of definitions throughout Australia making it difficult to compare performances of State hospital systems. They state:

It is possible that official statisticians and governments in this country in the past may not have wanted the issue of social inequality to be featured too heavily in the policy-making agenda of the “lucky country”! (ibid: 263).

Soldier doctors served British interests through the expansion of Australia’s northern zones, which could not be seen as something separate from its other colonial territories (see Farley, 1991, p.19). As Farley (1991, p.19) states:

The dual mandate, or the idea that British and colonial interests must be made reciprocal was, in many ways, merely the Old Empire in new clothes. The concepts of the old mercantile Empire were retained in the new Empire which still needed European brains, capital and knowledge to make the colonies productive for the benefit of the civilized world. The old idea of a civilizing mission was also retained: the British genius for governing would bring law, liberty, responsibility, justice and other advantages (to its natives).

While for most of this period, army medicine was controlled by the India office, by the end of the century the specialism of Tropical Medicine became administered under the colonial office’s mandate (Farley, 1991, p.19). Through affiliation with

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18 I have chosen to analyse the 1891 Western Australian Census Data, as it would reflect the format of the same data collected in the other states at that time (Gale, 1892). The NSW Registrar General began to periodically publish a comprehensive account of various “achievements” of the Australian colonies and New Zealand as well as producing statistics on “disease” populations (Coghlan, 1891,1900)

19 While in England the incidence of illness and disease have since been enumerated by district and social class, no comprehensive tabling of health statistics had emerged in Australia into the 1980s (Palmer and Short, 1989). Although Hacking (1992, p.118) states that William Farr, the British statistician, rejected fatalism for a strict social determinism, there is very often a lack of congruity between intentions and outcomes.
volunteer army units, training in military medicine was offered and developed separately (Pearn, 1985). This type of medicine appeared earlier in regional and provincial areas of Queensland, but had wider appeal in other colonies from the 1890s, especially after the advent of “germ theory”, which became a tool of imperialism (Worboys, 1993). At the same time a “war on disease” was declared with the source of disease germs and the main enemy proclaimed as indigenous groups (Farley, 1991, p.18) and women.20

Perpetuating the heroic and “life saving” imagery attached to the soldier, at the end of the 19th century, Lt. Neville Howse21 was the only doctor to receive the Victoria Cross when the Permanent Medical Corps in New South Wales (NSW) was established as a full time medical service. These personnel were the instructional and administrative soldiers who carried out medical duties in connection with the permanent troops. After Federation they became advisers to governments, a role which they maintained into the 1930s (see Butler, 1930). As a consequence, Public Health at the Federal level was treated quite differently to that of the Australian states.

So, from the beginning of the 20th century, army medical officers adopted the same career pattern as that which had first become institutionalised as the Indian Medical Services (IMS) model, one which was also readopted by the RAMC (see Arnold, 1993). Arnold (1993, p.1398) asserted that where the professional medical class was weak, medicine was a military affair and that:

Members of the Indian Medical Services, the premier medical agency, combined military and medical rank and, in times of war, were likely to be switched from civilian posts back to military duties. As late as 1924 the Indian Medical Services was referred to as “primarily a military service” and much the same description could be applied to other colonial medical services … at that date …

As will become apparent, NSW and Queensland doctors initially exhibited such patterns. At the same time, British Royals became Colonels of the Land Forces and Heads of the so called “Brethren in chivalry” (see Smyth, 1991). These military and

20 Public Health Acts were only enacted in each colony at the end of the 19th century. However, sanitary conditions did not reach an acceptable standard until much later, the initial interest in bacteriology and microbiology being to alleviate animal diseases rather than those in human populations (Todd, 1995), Canguilhelm (1980, p.40) states, the “germ theory” of contagious diseases owes much of its success to the fact it embodies an ontological representation of sickness. While he asserts a “germ” can be highly visible despite undergoing a complex process via the use of stains, cultures and microscopes, others have shown it also took on a range of anthropomorphic features surrounding ideas of “British stock”, “social purity”, “the imperial race” and so forth (see Wright, 1988 cited in Lupton,1994, p.62).

21 Howse later became the first Director of the medical corps within the Australian Imperial Forces (AIF),
religious orders were specifically The Most Venerable Order of the Hospital of St John of Jerusalem\textsuperscript{22} and the United Religious, Military and Masonic Orders of the Temple and of St John of Jerusalem, Palestine, Rhodes and Malta of England and Wales and Provinces Overseas\textsuperscript{23} the former becoming the only working order of chivalry (Smyth, 1991). Their English founders established three foundations, the St John Ambulance Association, the St John Ambulance Brigade and the St. John Ophthalmic Hospital in Jerusalem. The first two foundations were established in Australia and other colonial territories with the express aim of inculcating western medical values into the colonies (St. John Ambulance, 2002).\textsuperscript{24}

Because members of chivalric Masonic orders also worked at all levels of the Order of St John, it virtually became a quasi-Masonic military and religious order and was popular with keen volunteer soldier doctors whose allegiance was to regal and vice-regal representatives. For the soldier doctor, this was the real or imagined revival of the Hospitaller tradition which had its origins in the times of the Crusades when a hospital was established in Jerusalem to care for the needs of sick and injured travellers and pilgrims (see Howie-Willis, 1983).\textsuperscript{25} It not only sustained the hospital-centred focus of army doctors, but also had a “crowd” orientation to service large numbers of people originally connected to the battlefield. In addition, the extension to hospital medicine was the laboratory. So in 1910, the first laboratory was established in Queensland as the Institute of Tropical Medicine incorporating distinctly wider military influences in the areas of hygiene and sanitation. It was, financed from colonial merchants and officers, and administered by the Minister of External Affairs who offered government scholarships to students (Patrick, 1987).

In 1911, after spending a period in England, an ex-Boer War veteran, Dr J. Cumpston, returned to Australia to become head of the Commonwealth Quarantine Service, which underpinned the extent of Federal responsibilities for Public Health until

\textsuperscript{22} Referred to as “the Order of St John”
\textsuperscript{23} Referred to as “the United Orders”
\textsuperscript{24} Only after World War II these two foundations merged to become St John Ambulance.
\textsuperscript{25} Freemasonry was also exported to Australia and other colonies through the military lodges (see Knight, 1984). There was “Craft Masonry” to which most men belonged and a chivalric or “secret” masonry like that which stood behind the Order of St John. Freemasonry became very popular in Australia because it provided a social function for those migrating and also served well to create both patriarchy and hegemony (see Knight, 1984; Howie-Willis, 1983; Rich, 1989; Robinson, 1989; Smyth, 1991). All such institutions were generally headed by the same regal and vice-regal persona and over-represented by military men (see Knight, 1984; Smyth, 1991). As this information is only a background to understanding the nature of the St John Ambulance and Brigade at that time, apart from the role these played in imperialism, more detail on this topic is beyond the scope of this thesis.
1925. Such a focus paved the way for legislation which allowed for movement of “contagious” populations who could be quarantined, segregated within and others excluded from without (see Williams, 1990). The strategy of creating a crisis milieu was used to justify new legislative moves. As Gillespie (1991, pp.37-38) points out:

Cumpston’s judicious use of crisis to support claims for strong coordinating control – cleared the way for complete Commonwealth control under the Quarantine Act (1920) and the quarantine service became the administrative backbone of the department.

World War I created new culture heroes responsible for Field Laboratories and Tropical Units, after which time the Federal Government was given a mandate to control New Guinea (see Butler, 1930). In 1925, Dr. Cumpston became the first Director of Public Health, and his soldier colleagues became the new public health officers, while at the same time international funding from Rockefeller and Carnegie shaped the way campaigns about Public Health and changes to the Sydney medical faculty were to take. In 1930, the Sydney Medical Faculty was the only one in Australia to be given the resources to undergo a scientific greening along the lines of the American Flexner model with, not only Carnegie, but Bosch as benefactors (see Willis, 1989). This not only entailed a reorganization of the roles of teachers within the medical faculty, but also defined the professions of law, medicine and theology by someone not associated with these disciplines. The perceived objective characteristics of the new “scientific” professionalism had “elective affinities” with those of army officers, especially on the following points:

a) with raised admission standards, entry would be kept out of the reach of the majority of the population who could not afford the cost or time it would take to enter a profession (Pitchett cited in Berliner, 1975, p.586); and, as far as doctors were concerned;

(b) teachers were refused the rights to private practice becoming medical scientists divorced from the practical application of therapies (Berliner, 1975, p.585).

Mirroring these changes were the effects of institutionalising a new medical paradigm equally divorced from reality, being one which conceptualised the body “as a series of unrelated parts which together make up the whole and which emphasized research and therapy on machine breakdown and repair (pathology and cure)” (ibid).

26 Berliner (1975, p.584) points out that it is more productive to see the Flexner report as representing a conflict between the average medical practitioner of medicine and the scientific medicine physicians.
This view of the body, of course, was compatible with craft or task-oriented medical specialisms.

Also, what became the School of Tropical Medicine and Public Health was established alongside the University of Sydney, headed by sanitarian or hygienist soldier doctors who preached the benefits of a negative eugenics and trained their students to take up public service and overseas posts. However, while Gillespie (1991, p.38) also emphasises the strong influence of army medical officers in public health administration, it is useful to acknowledge that, as advisers to governments, the operative surgeons were also very much part of the early soldier coalition.27

As far as other work patterns are concerned, while the soldier doctors worked either in public hospitals, laboratories or in administrative roles in the military and civilian public service, the generalist doctors were initially the medical educators and others who offered the type of family medicine generally sought out by patients. The soldier and generalist differed not only by being socialised into different systems of medical training, but also from inherent social attitudes and influence of peers and colleagues. One was associated with militarised imperial relations, while the other was immersed in education and community relations. For each, not only interpretations of “public health” but also meanings behind “social” and “preventive” medicine differed completely.

In brief, the soldiers became extremely influential at the national level acting as policy advisers to the Federal government for decades shaping attitudes towards Public health and Tropical medicine, which was colonial medicine and a biological discipline rather than a medical one (see Farley, 1991). Professional isolation and the belief of their inherent superiority were two distinctive characteristics of army doctors. They tried to apply army principles to civilian life. For example, some were active volunteers shaping the St John Ambulance Brigade as a reserve army ready to be mobilised in war time. In contrast, the generalist professionals originally wielded their influence within the early Australian medical faculties and within their communities, working as part-time medical educators and as family doctors.

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27 These social relations exhibit what Foucault has described as “bio-power “which operates across two axes: an anatomo-politics concerned with the hospital patient and a bio-politics concerned with the population (see Bunton and Petersen, 1997, p.5).
So, while at the macro-level, soldier doctors wielded power and influence within national politics, at state levels doctors remained resistant to national health schemes, successfully overriding government legislation on the basis that it was seen as “civil conscription”. The result was until the early 1970s the Australian medical workforce was, in essence, general practitioner based with only part-time specialisation, that is, many generalists were multi-skilled, becoming practising physicians, surgeons and obstetricians as well as educators and consultants. As these patterns were extant within rival medical systems, medical students underwent different socialisation processes through their medical education and work experiences, which most of the time were reflected in their social attitudes and diagnostic practices.

Therefore, even though biomedicine with its disease or “scientific” focus began its ascendancy from the late 19th century, doctors in Australia have never been homogenous in their full acceptance of what eventually was promoted as “real medicine” or how it should be practiced and how patients should be serviced. After World War II, intra-professional and state politics dictated that those doctors who held dissenting political or “unscientific” ideas were excluded or marginalised from positions of authority or influence. At the same time, military medical administrators were entrusted with the role of planning future national needs for “medical manpower” and from that point influenced the national restructuring of medical education and hospital servicing (Gillespie, 1991). Because the British Royal Colleges remained reluctant to loosen their hold over Australian specialist qualifications, the first “specialist” doctor examined by an Australian specialist body graduated in 1975 (Best, 1988; Opit and Southby, 1978).

In conclusion, in this introductory chapter I have given a brief overview of two completely different traditions: the “western” biomedical and socio-medical traditions which have been evident in Australia from at least the 1880s. I argue these traditions were carried forward into the contemporary era through the influence of the two distinctive archetypes originating in Britain and that they differed significantly in ideas surrounding medical professionalism and patient servicing. I will show these archetypes have in turn impacted in significant ways on the prevailing health care system today and are reflected in two dominant biomedical genres which stand in hegemonic and counter-hegemonic positions in Australia today. In the following chapters I will expand
considerably on the above-mentioned overview by outlining the specific actions of
doctors in order to address the following research question.

How can a sociological examination of these archetypes and their medical
systems offer new insights into ideas about medical dominance and medical
professionalism and what are the accompanying implications of the findings?

**Aim and significance of thesis**

To address the above question, the aim of this thesis is to present an historical
analysis of these different medical archetypes, the resultant effects of their actions and
how they have influenced the present. I show how each of these types of doctors,
emerged as representative of medical systems designed to meet certain priorities, as
well as economic and social interests. It is at least as important today as it has ever been
to understand the power relations supporting Australian doctors and their colleagues,
who have, in the past, either helped or hindered the shaping of policies which form the
basis of such attitudes.

Consideration needs to be also given to the fact that Australians have neither had
any legal right to health, nor any constitutional guarantee of human rights (Reid, 2004,
p.3). According to WHO, human rights violations have a direct impact on health
outcomes, not only in regard to patient servicing, but also in the way health policies or
programs are designed (WHO, 2005, p.1). This thesis therefore sets out to:

- explain the background of the archetypes and the rival medical systems they
represent;
- document the historical development of these medical archetypes into two
competing Australian medical systems;
- identify the relationship to contemporary competing medical systems;
- show how the archetypal distinctions over time are associated with different
attitudes towards medical education and public health as well as diagnostic
practices and patient rights;
- provide a conceptual framework of variables in each medical system which can
be readily identified for comparative studies

The significance of this work is two-fold. Firstly, my thesis stands outside
mainstream sociological studies of medicine, as it not only begins at a different starting
point in terms of theories about professionalisation, but it also encompasses some
under-researched areas, namely, military medicine and medical education and their
association with imperial institutions. Secondly, while there have been many studies comparing the modern medical professions in different societies, one does not often come across critical sociological studies specifically focussing on differences among doctors within the one society.

Although Australian sociologists and medical historians have recognized both qualitative and ideological differences among doctors (Daniel, 1991; Dyason, 1988; Willis 1989), to the best of my knowledge, there has been insufficient critical historical scrutiny of the agency of doctors within the different Australian states exploring how their resultant attitudes and actions impacted on health and medical institutions at the meso and macro levels of Australian society. Also, to the best of my knowledge, apart from the work of Gillespie (1991) there has been little scrutiny of the agency of army medical officers at the Federal level, nor has there been any critical sociological scrutiny of all Australian medical faculties existent before the 1960s.28 In addition, while debates about medical dominance have introduced the terms of managerialism and deskilling, few qualitative researchers have scrutinised the past to explain the present dynamics (see Lupton, 1997).

As stated, these archetypes have been closely related to hegemonic and counter-hegemonic discourses which in turn link medical professionalism to political and human rights issues and follow WHO directives which propose that any research topic on health or medical issues should regard human rights as a cross-cutting research activity (WHO, 2005, p.1). The outline of my thesis chapters is as follows.

**Thesis outline**

Chapter two contains the literature review and outlines the conceptual, theoretical and methodological considerations.

Chapter Three shows how the soldier archetype was constructed to evolve first within Britain and then within Australian society to become part of a culture of military medical professionalism producing its own body of knowledge. Espousing an ethic of chivalric brotherhood, in association with British and Masonic chivalric orders, the soldier also referred to himself29 as “life saving” and humanitarian. However, within

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28 While Willis (1989) discussed the topic of medical education, this was not the primary focus of his work and he relied on secondary sources.

29 I am using the masculine here because of the fact that all soldier doctors, especially in the upper echelons of military and chivalric institutions, remained male even into the contemporary period.
colonial dominions, coercive, punitive and even violent actions were sometimes replicated. Such coercive actions were not confined to war situations, but entered into social relations, even with other doctors. I show that, within Australia, this soldier archetype played a central role in administrative and managerial capacities to become part of a mechanics of power constructed in a way close to Foucault’s argument about the influence of the military on politics or to Weber’s thesis about the rationalisation of bureaucracy. An understanding of the imprints the soldier made on shaping Australian public institutions at this time is also a way of understanding the present.

In Chapter Four I show how the generalist archetype emerged firstly in Scotland via Edinburgh Medical Faculty traditions whose leaders produced “the modern medical curriculum” and a body of knowledge rejecting Cartesian as well as Newtonian “science” and mechanical ideas about the body. This took place within a social milieu favouring an ethics of humanism and rights-based discourses. I then document the cultural reproduction of such influences in South Australia and Victoria, the only two states which did not have penal colonies. I also show how the lifestyle and practices of these doctors reflect different socialising influences as well as differences in the ways medical knowledge was defined and practised. An understanding of the imprints the generalist made on Australian medical education at this time is again also a way of understanding the different forms of medical education presently available in Australia.

Chapter Five takes us into the World War II period and beyond when the Federal government gives military medical administrators responsibility for medical education, national health, and the planning of medical “manpower”. At this time, the soldier begins to dominate all such institutions and excludes generalists from hospitals and from other positions of power and influence. Accompanying these actions, the wider social milieu undergoes a process of medicalization when the people are offered free “life saving” drugs and begin to believe the “real” doctor is the “specialist”, an attitude also influencing new medical students. This also marked the era where medical experimentation was most visible.

Chapters Six and Seven show how each archetype becomes transformed into two distinct genres in the contemporary era and situated within different Australian medical schools and institutions, holding opposing medical and social outlooks about patient servicing and human rights.
Chapter Eight, my conclusion, revisits the conceptual grid of the two archetypes in terms of the defined characteristics of rationalisation remaining remarkably true to form over time and reviews my findings in relation to the aims and research questions and to current debates surrounding medical professionalism.
… even within the single profession of medicine, the differences between “client-dependent and “colleague-dependent” practices are of critical importance for the way work is performed, and the differences between the practicing and the scientific worker’s work experience are of critical importance for the way each looks at himself and his work. That the name “doctor” is shared by … scientist and physician, practitioner and researcher, should not lead us to assume that they are all the same (Freidson, 1970, p.189).

Introduction

Freidson’s (1970) The Profession of Medicine and Foucault’s (1973) The Birth of the Clinic were two texts regarded as ground-breaking in their day in changing the way sociologists understood, researched and wrote about the medical profession. As highlighted in the opening quotations in the previous chapter and this one, both writers avoided conventional explanations and notions of medical professionalism and guarded against viewing doctors as a homogenous group. For Freidson, the differentiation could be analysed in terms of work patterns and rationalisation processes, for Foucault the differentiation could be analysed in terms of social spaces and power relations (see Germov, 2005).¹

In short, by questioning both past and present developments of medical professionalism in Australia and linking the analysis to human rights issues, this thesis draws on the ideas of these scholars and others to situate the medical archetypes as doctors extant within left and right political spaces. As others have noted, there has been quite a difference in conceptual distinctions about what is meant by terms such as profession, professionalism and professionalisation (Freidson, 1994, p.13-19; Willis, 1988, p.170). In the previous chapter, I have already pointed to the historical production of different ideas of professionalism within both professional and outside circles. So by medical professionalism, I mean a historically constituted way of doing things which can be interpreted as comprising distinctive systems of rationalisation that

¹ Freidson (1994, p.7) also acknowledges that Foucault’s (1973, 1975) work has created another intellectual current of researchers contributing to the topic of professionalism.
can be subjected to analysis (see Germov, 2005; Kalberg, 1980). This definition forms the basis of my conceptualisation which will be fully explained below. Also intrinsic to this notion of professionalism is the view that there can be competing models of rationalisation within which medical professionalism operates. Thus the necessity for linking past and present, history and sociology, individuals and social groups and an ethics of practice within both meso and macro levels of society (see Bosk, 2006; Kalberg, 1980, 1996).

This chapter will firstly begin with a literature review surrounding sociological work on professionalism and professionalisation as this historically developed generally and then in Australia. This will be followed by pointing to the more contemporary work on the topic. I will engage with this literature to highlight my own position in terms of how this thesis fills a void identified in the literature in both contexts. The literature review will be followed by a discussion of the methodology used and the conceptualisation of the medical archetypes arising out of the empirical data. The approach taken will locate my work within a broader conceptual framework which analyses these archetypes as representatives of “ideal type” professional systems of rationalisation.

**Literature Review**

**General literature**

There has been little sociological interest in revisiting historical accounts of medical professionalism (Armstrong, 1993; Willis & Broom, 2003). Few have gone back to the late 18th and 19th centuries to explore the present biomedical system (Armstrong, 1993). However, research on medical professionalism has been presented from a number of perspectives, some of which are highlighted in the following review.

Firstly ideas about medical professionalism began with sociologists in the United States of America, particularly advocating the “trait approach” aligned to functionalist theory (see Germov, 1998, p.232). However, Talcott Parsons’ thesis on “the sick role”

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2 This was “a general theory that assumes that professional status can be achieved by meeting a set of criteria (usually defined as specialised expertise and training), by having the exclusive right to practice in a particular field, by self-regulation (based on a code of ethics), and by charging a fee for service” (Germov, 1998, p. 232)
stimulated debate and led to a questioning of the consensual idea of the professional role and the doctor/patient relationship (ibid, p.14).

Freidson (1970a, 1970b), who also limited his research to the United States, was critical of mainstream studies about professionalism. His two classic works on medical professionalism paved the way for new ways of thinking about the topic. Not only was he the first to coin the idea of medical dominance, but also one of the first to acknowledge the issue of patient rights. He thus turned the doctor/patient relationship from being a consensual one into one of conflict and one that denied patients their right to make choices about their treatment. As Bosk (2006, p.643) states:

Instead of a consensual and cooperative working relationship between physicians and patients, Freidson sees conflict and diverging interests. Freidson takes the medical profession to task for manipulating patients by their selective use of expert knowledge. By failing to communicate the range of treatment options and choices to patients, physicians rob patients of their autonomy and, as a result, their fundamental liberty to make important life choices.

Freidson (1970a, p.187) also asserted that formally, the status of professional work is based not on empirical determination but on the belief that they “have a licence and mandate to control their work”. Others whose work adopted this conflict perspective, such as Johnson (1972) maintained that maintaining professional dominance, not only brought the hospital into their territory by using strategies of social closure, but also included their right to define health.3

Around the same period, Ehrenreich and English (1979) were among the first feminist researchers to highlight the patriarchal nature and oppressive role of male-dominated medicine. As far as the disqualification of American women from medical practice is concerned, Walsh (1977, p. 8) alludes to the idea of medical professionalism as being linked to a professionalisation process underpinned by licensing and college training. She states:

Once the public had come to accept licensing and college training guarantees of up -to- date practice the outsider, no matter how well qualified by years of

3 See also Davis and George (1988) and Freidson (1994) for other aspects of Johnson’s work. Also Davis and George (1988) bring together the work of sociologists who described the effects of such processes including some of the Australian authors.
experience, stood no chance in the competition. Women were the casualties of medical professionalisation.4

Like Ehrenreich and English (1979), feminists have been the most trenchant critics of the physician dominance position, the harmful effects of medical/male intervention on women’s health and the lack of choice5 given to women (see Eckerman, 1994, Edwards, 1988, Ripper, 1994). In Australia, this brought about the women’s health movement and the establishment of women’s clinics (see Hunt, 1994). They also saw the medical profession as an institution of social control responsible for defining sickness as well as deviance designations. Although Conrad and Schneider (1980) also adopted this latter viewpoint, they concluded that physicians who are in positions of authority are not typical of the medical profession in general and their activities and concerns are far removed from the “rank and file” of medical doctors. However, the notion that doctors might not think of themselves in such hierarchical terms was never canvassed. Foucault’s (1973) work brought with it a new way of thinking about relations between doctors but, although first published in 1973, it took some time to be acknowledged by sociologists.

In Foucault’s (1973) Birth of the Clinic, the emphasis on the topic of medical professionalism was in his argument that an epistemological rupture and cognitive shift occurred in late 18th century France heralding the birth of medical positivism. Also his argument, that Western medicine is inextricably linked to the social as it is historically and culturally produced, is one that has been highlighted by a number of researchers (see Armstrong, 1997). Foucault (1973) wrote as a historian and philosopher, defining Birth of the Clinic as a structural analysis of “the discourse6 of medical experience” before it changed into a more systematic form in the 19th century (ibid, pp. xvii-xviii). As far as clinical practice was concerned, he distinguished between the “old age of the clinic” which he defined as a medicine of social spaces (originally a bedside medicine which was classificatory and incorporated a botanical emphasis) and a medicine of

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4 Patriarchal attitudes in the medical profession were not monolithic. As I will show, from the early 20th century, excepting for hospitals, Australian women doctors were accepted into the medical profession much more readily than their colleagues in the United States of America at that particular point in time.

5 Bury (1986, p.162) states that “Today it is the ‘New Right’ which attacks medical autonomy and clinical freedom as part of a general argument in favour of individualism and choice in a consumerist view of health.”

6 In this study, Foucault (1973, p.xvii) referred to creating a “systematic history of discourses”. For him, discourse was not only a statement or text but consisted of a set of multiple signifiers which would eventually come together to form a system. Meanings could be assessed by differences in relation to others.
pathological spaces which incorporated “the language of positive science”. Another medicine of spaces, seen as operating outside of the clinic, was referred to as a “family” or “assistance” medicine. His aim was not to appear to be against medicine or against one type of medicine and in favour of another (p.xix). However, he was not always successful in doing this.

Foucault (1973) explained differences between doctors and their practices in terms of emphasising how they not only worked in different social spaces, but also how they exhibited different attitudes towards patients. He also pointed to the role military surgeons played as the first teachers within hospital medicine, although this was not elaborated upon to any degree. His thesis offered an analysis of the different forms of cognitive rationality that affected their practices. Fox (1998) has been the most critical of Foucault’s work in its application to sociology and argues that Birth of the Clinic “subtly re-reads the Weberian analysis for the rationalisation of capitalism which set the scene for the era of modernity” (ibid, p.428). While this might be partly true, as I will discuss more fully below, the central aim of Birth of the Clinic was to show the differences inherent in professional practices and to argue against the notion that one has been subsumed into the other.

The method Foucault used, that of cognitive structuralism, was also used by Armstrong (1983) when writing about medical knowledge in 20th century Britain (see Warren, 1984). There were two distinctions made in the doctor/patient relationship, one was the interaction between the “gaze and the face” and another between the “glance and the silent body”. Armstrong focused on the way the “gaze”, along with accompanying discourses, began to slowly detach itself from a single focus on the body, moving on to focus on connections between the body by producing different specialisms.

In addition to the above forms of medical professionalism, Foucault’s subsequent work began to examine how processes of professionalisation were explained as not only confined to the hospital and the laboratory, but also to the reshaping of

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7 As Foucault’s work has been integrated into my conceptual framework, a more detailed explanation of these points will be provided below.

8 This is from my own reading and will be fully explained below as part of my conceptualisation.

9 Other concepts from Birth that have been taken up by Foucauldian scholars are that of death (Armstrong, 1987, Prior, 1987) and space and time (Armstrong, 1985, Prior, 1988).
administrative and bureaucratic forms of organization. In *The Politics of Health in the 18th Century* Foucault argued that the emergence of bio-medicine was linked to the notion of bio-power, described as working across two axes, one in the anatomo-political space of the hospital and the other working as a “bio-politics of population” (see Bunton and Petersen, 1997, p.5). In *Discipline and Punish*, Foucault (1975) then begins to draw out the military influence on politics, which placed him in a position similar to the social control theorists. For example, he introduced the idea of the Panopticon, both an architectural organisation of social and building space and a system of social control with the aim of inciting subordination and obedience to create docile bodies. This brought a punitive system into the contemporary period (Dreyfus and Rabinow, 1982). He also argued that the idea of the Panopticon involved the operation of two simultaneous processes both embodying utopian visions of society: one of domination which had as its ultimate goal a disciplinary society and one of exclusion which embodied the notion of a “pure” community (Foucault, 1975, p.198).

Because this is an analysis of the way power relations operate at the macro-level, the failure to account for micro or meso-dynamics of power would make these strategies appear as operating across all sectors of society. Unlike Weber who saw this type of rationality as the “iron cage” of bureaucracy, Foucault argued that the chief characteristic of the techniques of discipline was their failure (ibid). The idea of the “pure” community, however, fits in well with Weber’s notion of ascetic practices.

Illich (1976) reinforced the idea that medical positivism in the 1770s was not only attached to the hospital, but also to the “discovery of both the hospital and laboratory from which the emergent disease-specific focus came into being (p.165).” If one begins to link other types of research to the time, period, one can see that, while Scheibinger’s (1987) work did not necessarily take up Foucault’s (1978) ideas in the *History of Sexuality*, she unwittingly adds to another facet of these developments, that doctors also began to define female sex differences. For example, she argues that “from the 1750s doctors in France and Germany developed an unprecedented strong interest in defining sex differences in parts of the human body … so as to demonstrate inherent deficiencies of the female sex (cited in Lupton, 1994, p.133).

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10 To the best of my knowledge, there has been no acknowledgement of this particular underpinning which as I will show, is also present in Foucault’s *Birth*
Similar processes began to occur in England in the 19th century. Illich (1976, p.164) applied Foucault’s ideas to the broader social context of the times. He reiterates some of the latter’s arguments in a different way by explaining that while generally throughout the 18th century illness was regarded as primarily non-technical and the hospital was a place to avoid, in a few decades this idea of illness changed dramatically giving birth to a new image of a doctor and an accompanying industrial enterprise. He also elaborates on the way those in administrative roles, other than doctors, accommodated a “disease-specific” focus. For example, he states:

… by the 1860s even the ordinary citizen recognised the medical names of a dozen diseases. The sudden emergence of the doctor as saviour and miracle worker was due not to the proven efficacy of new techniques but to the need for a magical ritual that would lend creditability to a pursuit at which a political revolution had failed. If “sickness” and “health” were to lay claim to public resources then these concepts had to be made operational. Ailments had to be turned into objective diseases that infested mankind, could be transplanted and cultivated in the laboratory, and could be fitted into wards, records, budgets and museums. Disease was thus accommodated to administrative management; one branch of the elite entrusted by the dominant class with autonomy of its control and elimination. The object of medical treatment was defined by a new, though submerged, political ideology and acquired the status of an entity that existed quite separately from both doctor and patient (ibid, p.165).

While Digby (1994); Illich (1976) and others have also argued that in the mid-19th century, medical practitioners in England, as elsewhere, still viewed sickness as personal suffering and showed empathy towards women, these cultural differences were not investigated. Neither was the idea taken up that a military medical professionalism had developed with a distinctive body of knowledge and medical practices. The only acknowledgement of military medical influence was in their role and function within colonisation contexts (see Arnold, 1993; Curtin, 1989; Denoon, 1988; Farley, 1991; Ramasubban, 1988), or in relation to war (Cooter, 1993) in relation to nursing (Summers, 1988) and to practices of amputation (Bourke, 1996). Curtin points out that that after the Napoleonic wars ended in 1815, an extensive cross-fertilisation of information occurred between British and French military circles. In addition, many French and British publications on hygiene and public health in tropical regions were written with a view to sustaining their recent acquisitions which, at the time, were Algeria and India respectively (see Curtin, 1989, pp.105-106). Again, referring to events taking place in the 1860s in England, he states:
By the 1860s, an international network existed by which any hygienic discovery or development rapidly became common knowledge within the broader fraternity of military men in the tropical world. More important still, by the 1890s, the medical attitudes these publications formed and reinforced were closer to present-day medicine than they were to the traditional styles of medical thought still dominant in mid-century (ibid, p. 107).

As most researchers on the topic of medical professionalism have not accounted for such developments, the rise of modern medicine or biomedicine has generally been understood in Kuhnian terms and based on Cartesian/Newtonian influences (see for example Capra, 1982). As a consequence the predominant idea of medical professionalism has been connected to a technologically-oriented profession who consider themselves “expert” (see Habermas, 1976; P.Harris, 1994; Larson, 1977) basing itself on “the notion of the body as a machine, of disease as the consequence of breakdown of the machine, and of the doctor’s task as repair of the machine” (Engel in Capra, 1981, p.118).

This had the result that most sociological work between the 1970s and 1980s was either focused on “the transformation” of medicine in different countries (Coburn, Torrance and Kaufert, 1983; Larkin, 1983; Starr 1982), or adopting the medical dominance-medical power position. Many of these researchers framed their work within a Marxist structural perspective treating the medical profession as a class and arguing that the medical profession had shifted from an individualist to a corporatist mode. Willis (1983 & 1989), who authored the Australian landmark study of medical professionalism, was among this group. Neo-Weberians, such Starr (1982), adopted a similar position to that of Conrad and Schneider (1980) eschewing any notion of homogeneity within the medical profession.

The result was that most sociological work between the 1970s and 1980s was framed within a Marxist structural perspective around the medical dominance-medical power position treating the medical profession generally within a changing political economy but as a class in itself (see Coburn et al. 1983; Larkin, 1983; Willis, 1983, 1988) or within a class congruence theory (Berlant, 1975; Navarro, 1988) or as using the Weberian idea of social closure as a means of maintaining occupational control and power (Johnson, 1972). More recently those working within a Marxist perspective that have argued against the physician-dominance position, such as Navarro (1988) have
not been included in the research that has brought together the literature around the topic (see Coburn, 2006; Hafferty and McKinlay, 1993).

The first real challenge to Marxist structural theories and ideas about medical professionalism appeared with social constructionists, such as Bury (1986) and Wright and Treacher (1982). These researchers not only advocated the idea of a medical pluralism, but also argued that medical knowledge should not be taken for granted and the ways in which it has been taken up and examined should be a topic for sociological investigation (ibid.) As Lupton points out, social constructionists, like others influenced by post-structuralism, have been criticised for not concentrating on medical discourse at the macro-level, for making broad generalizations, and for not recognising human agency (1994, p.12).11 Even some Foucauldian scholars, such as Armstrong, consider constructionism in the sociology of health and illness to be a “heresy” because of the similarities of its outlook to some aspects of Foucault’s work (see Armstrong, 1997, p.21).

By no stretch of the imagination is this review exhaustive and, before I move on to the more contemporary work on the topic, the Australian sociological work on medical professionalism is first reviewed. Once again, I will engage with the data to reassert my position and my central aim, which is to offer new insights into ideas about medical dominance and medical profession.

**Australian literature**

Finding sociological work on historical aspects of medical professionalism is difficult to locate in the Australian literature because sociology as a discipline did not emerge until after 1965. Even then it struggled to survive because of the lack of textbooks or books of reference.12 The first sociological research on professionalism in Australia emanated from Anderson and Western (1967, 1968) when they began focusing on professional socialisation and education. Two years’ later they produced another study of social attitudes of four professional groups, including medical students (ibid, 1970). Their research found that many of these students developed conservative ideas before they graduated.

11 Of course, this is not an excuse to guard against making unsubstantiated broad generalisations.
12 For a further discussion on this topic see Encel and Bryson (1984).
Other researchers have also followed with critiques that the medical education system not only encourages self-interest (Shapiro 1987, Shapiro 1989), but also historically many doctors have lacked sensitivity to patients whom they see as deviating from the so-called social “norm” of approved behaviour (Albrecht, Walker and Levy, 1982 and Najman, Davis and Ray, 1986 cited in Najman and Lupton 1989, p. 369).

In the 1970s, Australian Educational Reviewers also seemed to embrace a positivist view equating the “superiority” of scientific medicine as the basis of “real” medicine. They asserted that the major deficiency in medical education was that of “waste, not of money or resources, but of talent”. For them knowledge held by primary care physicians is accorded a diminutive status as “talent” and ‘intelligence’ is needed for the “hard sciences”. They state:

… for probably inappropriate reasons a large proportion of the top 2 - 5% of our high school students elect to study medicine, and many of these ultimately work in primary care - which makes demands that could easily be met by those of lower intellectual ability (italics my emphasis) (Sheldrake, Linke, Mensh, Newble and Rosinski, 1978, p. 5).

While Freidson (1994) has argued that the work-setting had more of an influence on the professional than formal training, while the effects of such professional socialisation might diminish these are sometimes hard to ignore. For example, in Durkheim’s theory of group or “collective consciousness”, he maintained that humans are socially influenced to the extent that most of their thinking is shaped by categorisations they form collectively (Douglas 1993, p.54). Although each view has some credence, the latter view gains some ground when one considers assertions made by sociologists and doctors (Kamien, 1990; Shapiro 1987; Shapiro 1989). Even into the 1990s, Kamien (1990, p. 105) was still stating that:

The students learn that other forms of authoritarian behaviour, to both themselves and to patients, are not uncommon. Not infrequently the elderly, the poor, the minorities or even those patients with disorders which do not interest technologically orientated doctors are referred to in a disparaging way by senior staff.

However, as will become apparent, the above views were probably partly also due to the effects of other events occurring in Australia after the 1960s and were not views shared by all medical graduates. For example, Fett’s (1975) examined attitudes that existed before then by interviewing Australian doctors who graduated between
1925 and 1970. Although the aim of her thesis was to show Australian women doctors’ contribution to medicine, she also analysed male doctors’ attitudes.

Fett pointed out that during World War II the maximum age of recruitment of male doctors into military services was 65. With the resultant depletion of doctors in civilian services, women doctors provided extensive medical servicing for their communities, assisted by the easier availability of domestic help. She also showed that, until the honorary system in hospitals was phased out in the 1970s, women honoraries spent longer hours than men in that capacity. Fett’s (1973) preliminary findings were published in *The Medical Journal of Australia* and used by medical educators to counteract an argument that women “wasted” educational resources (see Karmel, 1973).

Fett (1975) emphasised that male and female doctors interviewed expressed discontent with the authoritarian structures of medical education. She asserted that she saw elements of goodwill among those interviewed and that this goodwill needed to be “tapped into”. Other studies on the contribution of women doctors to Australian medical practice have remained set apart from other studies of medical professionalism and have not acknowledged the ways in which women doctors have historically also established their own hospitals to service women patients (Hutton-Neve, 1980; McCarthy, 2003; Morgan, 1970).

The next work on medical professionalism was by Pensabene (1980) who analysed the rise of the medical practitioner in Victoria. He adopted a technological determinist view when he argued that the 1930s was “stratification era” when surgical elite asserted their dominance. This position was against the consensus view that such attempts were due to social rather than technological factors (Daniel, 1990; Dyason, 1988; Willis, 1989).

As stated, in Australia, Willis (1989) has been the benchmark study of medical dominance. This was defined as meaning that, although continually challenged, the medical profession remains the most powerful of the health professions in many of their functions. Willis’ original work was a historical sociology incorporating a political economy perspective. In an overview of his work, he was critical of Freidson’s (1970a) argument about dominance, saying that “it was inadequately located in a theory of class relations central to an analysis of autonomy and professionalism” (Willis, 1988, p.71).
Willis (1989) also argued that, in the state of Victoria, medical dominance occurred before doctors had made proven scientific gains, its heyday beginning in the 1930s and ending in the late 1970s. His argument is based on the premise that the enactment of legislation gave doctors authority and control over the behaviour of their members and over their own work. This event followed industrial action which effectively allowed them to break away from the yolk of the friendly societies and lodges (ibid, p.173). He also asserted that the state’s underwriting of medical dominance in Australia was unprecedented in any western country and was sustained at three levels, which were autonomy, authority and sovereignty.

Like others of his time (Coburn et al. 1983; Larkin, 1983; Starr, 1982) he also stated that, although there were qualitative differences in the outlook of doctors, the medical system had changed from an individualist mode to a corporatist mode. However, in another article, Willis (1988) also asserts that the form of dominance after the 1960s moved from an overt to a more covert form because of the influence of administrators and medical committees, a fact that I have also shown (Farag, 1992). Therefore, while research surrounding professionalism has moved to examining issues of disempowerment, such as deprofessionalisation, it is sometimes difficult to gauge where this is occurring. In terms of my own work, the limitation of Willis (1988, 1989) work is that of his implicit assumption that the biomedical model of professionalism is homogenous and that what happened in the state of Victoria could be generalised to what occurred in other parts of Australia.

Nevertheless, Willis’ work has been considered a major contribution to Australian Health Sociology and has never been challenged by other sociologists. It has not only received recognition by The Australian Sociological Association as one of the most influential texts, but also has been revisited in two special issues, one produced by the Milbank Quarterly (1988) and the other by the Health sociology review (2006).

Other ideas about medical professionalism published in sociological journals around that time did not have the same impact (Waters,1989). Waters (1989) argues, while previously the idea of collegiality was seen as having been subsumed into bureaucracy, the possibility of an “ideal type” representation of a collegiate social organisation is possible and can be based on the idea that, although professionals work in different spheres and in different forms of specialisation, they can regard themselves
as a “community of equals” (see Waters, 1989, pp. 954-956). After Waters (1989), Freidson (1994) states that the principle of collegiality is central to “distinguishing professionalism from both the unfettered individualistic competition among workers in a free market and the hierarchies of rational legal bureaucracy” ibid, p.175).

This seemed to be the one criticism of Gillespie’s (1991) work when he examined the relations between medical practitioners and the Federal government between 1900 and 1960, also acknowledging the influence of military doctors in administrative and policy areas. He argues that from 1920 to 1950 “advocates of a national health policy attempted to subordinate the general practitioner and ‘curative’ medicine within a broader framework of preventive public health, with national co-ordination, or even direct control by the Commonwealth Department of Health”. However, after this time this “vision” was lost (p.ix). This point of view was based on Gillespie’s (1991) assessment of generalists which focused on the behaviour of market competitors rather than on professional attitudes. This observation is not meant to diminish the overall contribution of his work, but to highlight this other “individualistic” space in which doctors’ work is criticised.

Gillespie (1991) drew on sociological ideas of medical professionalism. He asserts that the definition given to medical dominance in Australia, based on the premise that doctors have been given “autonomy” to successfully restrict competition by subordinating competitors, is misleading. Instead, after Johnson (1982), he draws on notions of “professionalisation” and “partial autonomy”\(^\text{13}\) as a basis for his conceptualisation of contradictory relations between the medical profession and the state (ibid, p.xi). He asserts:

“Medicalization”, the transformation of western notions of the body, health and illness through the dominance of scientific medicine, should not be reduced to a question of social control, or of the dominance annexed by one social / professional group, but should recognise the important differences in which knowledges are taken up, the contradictions within the profession and the strength of lay knowledges (ibid.)

The above argument was close to those of Freidson’s (1994) who also pointed out that, “with the exception of M. Larson (1989, 1990), the questioning of the influence

\(^{13}\) For Johnson (1972) this partial autonomy was “limited to specific areas of independent action which are defined by an occupation’s relationship to the state; areas of autonomy which arise from time to time and place to place” (cited from Gillespie, 1991, p.xi).
of the knowledge and concepts of professions on human consciousness and state policy has been given too little attention by sociologists” (p.7).

Gillespie (1991) sees the major shifts during the 1950s and 1960s not in the decline of medical-dominance/medical power but in the shaping of the health scheme’s “private government” or an “informal network of health professionals in the Commonwealth Department, private practice and the insurance funds”. The effects were that policymaking was influenced by BMA leaders and medically-trained departmental officers who were part of “a closed and secretive informal network” (p.281). Gillespie’s (1991) analysis ended at this point in time.

**Contemporary perspectives surrounding professionalism**

The last body of literature around the topic of medical dominance/medical power has again been from Marxist structural perspective or political economy perspective appeared in a special edition of *The Health Sociology Review* and influenced by Willis (2006) who invited researchers to revisit the topic. The consensus of these writers were that, although the medical profession was still the most dominant in the health division of labour, its power to define its own practices was increasingly diminishing (for example, see Allsop, 2006; Broom, 2006; Coburn, 2006; Long, Forsyth, Iedema and Carroll, 2006). For many, important changes were occurring and, in order to assess and analyse these changes, the shift in interest moved to the corporate sector and for both Marxist and Weberian scholars, the main conflict was seen to be between the medical profession, other health professionals and managerialism (see Germov, 2005).

Corporatism as a process was examined by Hartley (2002) using the notion of “countervailing powers” to examine managed care in the USA. This entails the reshaping of medical services to become consumer-driven rather than provider-driven and involves a coalition of health professionals and others working together at one level so as to push both physicians and nurses into conflict with each other and therefore destabilise working relations which maintain physician dominance at another level.

Freidson (1994) not only supported Waters (1989) work on the concept of collegiality, but also began to distinguish between a corporate sector and a service sector and stressed the importance of acknowledging Weber’s “ideal type model of rational-legal administration or bureaucracy” in understanding contemporary
organizations, because of the corporate sector exercising significant influence and
control on shaping health policy. He states that the single most important feature of this
type of organization is a task-orientation described in formal written rules calculated to
obtain maximum efficiency. It is within such organizations that individuals are
employed solely on the basis of their competence to do one job alone and their work is
limited to that job (ibid, p. 206-207).14

In Australia, Germov (2005) examined the effects of managerial processes using
a neo-Weberian ideal type framework of hyper-rationality to examine public sector
health professionals within bureaucracies.15 The idea of “partial autonomy” rings true
when applied to his findings. These were that while, on the one hand managerial
processes restricted the clinical autonomy of individual health professionals, on the
other hand, professionals were able to organize themselves to sustain a “collective form
of professional autonomy”(Germov, 2005, p. 753). In addition, Lewis (2006) combines
an analysis of social and political networks to argue that

While many claim that the medical profession has lost power in health policy
and politics, this analysis yields few signs that the power of medicine to shape
the health policy process has been greatly diminished in Victoria. Medical
expertise is a potent embedded resource connecting actors through ties of
association, making it difficult for actors with other resources and different
knowledge to be considered influential (p.2125).

Germov concludes that the “the traditional Weberian bureaucracy may be passé,
but the processes of bureaucratisation continue – the iron cage lives on in new
bureaucratic forms” (ibid, p.754). Apart from these managerial processes, another
particular development that will be shown as creeping into the Australian context is that
of “meso-corporatism”16 which has been occurring in Ontario (Coburn, 2006, p.440).
Coburn states:

The professions and the state, the main regulator of professions, are
permeable rather than impermeable. In much of the 20th century, medicine in
Ontario constituted part of state policy institutions and the profession ‘governed’
health care and the health care division of labour. More recently, however, the

14 Of course, the military influence on administration and bureaucracy has been one that has been
explored in-depth by Dandeker (1990).
15 As Germov (2005) states, “this ideal type was derived from a combination of four forms of rationality
identified in Weber’s work, namely, practical, formal, substantive and theoretical rationality applied to
the social organization of health care work”. It is also one that I have drawn from for my own
conceptualization. .
16 This is defined as “the devolving of state powers onto institutions in civil society” (Coburn, 2006,
p.440).
State seeks to use professional organizations to constrain or regulate their members in a meso-corporatist fashion. Meso-corporatism implies the devolving of state powers onto organizations in civil society. But this meso-corporatism is weighted … in the direction of the state (ibid).

However, those who surveyed professional-dominance debates began to question the extent and impact of developments, such as, deprofessionalisation, proletarianisation\(^{17}\) and managerialism (see Coburn, 2006, p.433).\(^{18}\) Those conducting research on doctors at the micro-level (which, for Freidson, would be the service sector), such as Lupton (1997), have inadvertently shown that maybe there is a life outside the iron cage after all when she examined issues of deprofessionalisation and consumerism. In her study, she interviewed both doctors and lay persons to examine the effect of consumer education on doctors’ attitudes. In her conclusion, she stated that many doctors were grateful that they were no longer regarded as “gods” and had no problem in responding to the patient’s questions and needs in the medical encounter.

As a result, Lupton (1997) argues that the deprofessionalisation thesis should be changed to one of reprofessionalisation because, as doctors still see themselves as professionals, focussing on issues of disempowerment is not relevant. She also argues that researchers should focus more on understanding the micro-levels of power relationships which she found to be far more complex than originally envisaged. She has used the word “doctors” in the medical profession and calls for more qualitative researchers to use the Foucauldian notion of power as relational to examine the complexity within the medical encounter.

As an adjunct to Lupton’s (1997) findings in terms of public opinion, in a recent *Image of Professions* survey, 670 respondents were asked to judge professional ethics and honesty. The results were that 81% considered doctors to be the most ethical; 85% considered pharmacists as the most ethical and 91% considered nurses to be the most ethical. The trend shows that over the past decade or so there has been an increasing respect for professionals working in the spheres of health, engineering and education (Roy Morgan Research, 2007).

\(^{17}\)Proletarianisation assumes that doctors are being forced by capital into an employed or working class status.

\(^{18}\)As stated earlier, the political economy approach has been criticised as having limitations because of the fact that it neither takes biomedicine as a given, nor introduces the notion of the agency of doctors (see Lupton, 1994, 1997).
Also drawing upon Lupton’s (1997) argument as well as those of Freidson (1994), Jones and Green (2006) conducted a study of general practitioners in the United Kingdom and argued that the workplace has the capacity to help redefine professional identity. While in part they rework Armstrong’s (1983) thesis, they argue that:

The ‘new general practice’ resonates with the social values of reflexive modernization, and has the potential to enable new, less paternalistic, forms of relationships with clients, although it remains to be seen whether this potential is realised in healthcare delivery (Jones and Green, 2006, p.1).

From the above one can conclude that there are now two “ideal type” modes of professionalism, one operating in the corporate sector emphasising a task-orientation and the other operating in the service sector emphasising a collegiate orientation. However, one also has to guard against falling into the trap of equating professionalism with individualism. In this regard, Bosk (2006, p. 645) points to Freidson’s (2001) last work, Professionalism, the Third Logic. In this work, the diminishing autonomy of professionals was recognised because of the constraints imposed on them by others, but there were three logics or heuristic devices to understand how “health care delivery as a commodity” was distributed (Bosk, 2006, p.645). These three logics were outlined by Bosk (2006) as follows:

(1) determination by pure market forces, a world where individuals compete with one another to sell goods and services at the highest possible price and buy them at the lowest;
(2) determination by large social organisations, either public or private, in which elaborates rules determine who gives, and who is entitled to goods and services; and
(3) determination by workers with specialised knowledge who do not exploit their exclusive rights to control the distribution of goods and services because they are guided by both a pride in their own craft and a desire to serve the public (p. 645).

In the third logic, professionalism has been transformed from its negative aspects to one where it has the capacity to serve the public interest (ibid). From the above, one can see there is much in the above research which give useful insights into what it happening at all levels of society. However, the link has not been made back to an influence coming from military medical professionalism, a distinctive determining feature being its professional isolation from colleagues (Hackett, 1983). In addition, there has been no acknowledgement or interest in examining the idea of a “collegiate culture” as central to professionalism.
Before concluding one might point out that, within the medical world today there exists two projects, one is a medical professionalism project which is aimed at reasserting the central values of medical professionalism, while the other is to create a task-oriented workforce, so that it either can be mobilised in emergencies or to provide a workspace for military medics to slot into after retiring from the army.

In regard to the first, the reworking of the idea of medical professionalism, although gaining an international impetus, is an issue which is not without contestation (see Breen, 2003; Irvine, 2006; Van der Weyden, 2002; Woollard, 2003). The basis of this medical professionalism project was a Physicians’ Charter published by the Royal College of Physicians in 2002 and based on three principles. These are social justice, principle of primacy of patient’s welfare and principle of patient autonomy (Van der Weyden, 2002, p.1). The preamble states:

Professionalism is the basis of medicine’s contract with society. It demands placing the interests of patients above those of the physician, setting and maintaining standards of competence and integrity, and providing expert advice to society on matters of health. The principles and responsibilities of medical professionalism must be clearly understood by both the profession and society. Essential to this contract is public trust in physicians, which depends on the integrity of both individual physicians and the whole profession (ibid.).

In contrast, the current definition of military medical professionalism quoted by the Commander of the United States Armed Forces and President, George Bush, states:

Military medicine is a model of professionalism and organization – it starts with the combat medic – the first health care a soldier receives within minutes of injury. Patients are then treated by forward surgical teams and then transferred to combat support hospitals. (CNN Live Event, 2003).

It is from those with such a view of professionalism who are today using the time-old strategy of invoking crisis situations that do not exist and pushing for workforce reform and task substitution (see Ellis, Robinson and Brooks, 2006). As military doctors historically have tried to reshape civilian society to mirror a military medical model, this definition needs to be augmented, not only by the empirical data, but also by the explanation of a military analyst in the United Kingdom of the limitations of applying such a model to civilian society today as well as yesterday. For example, von Bertele (2006, p.56) states:
… compared with a military population, civilian populations include both elderly and paediatric patients, and more women. Military health professionals in the United Kingdom are not specifically trained in the relevant specialties for treating these patient groups…. Currently UK military medical doctrine for care of military personnel is based on delivering essential treatment in the theatre of operations, followed by evacuation to Role 4 facilities in the U.K. Any civilian patient receiving care in a military Role 3 facility will be handed over to the host nation or humanitarian medical agencies at the earliest opportunity. At Role 1 and 2 facilities, emergency lifesaving interventions may be undertaken but whenever possible, patients will be delivered to local facilities (even if these do not meet UK standards of care) [my italics].

While the above literature brings many significant insights into medical professionalism and professionalisation processes, in order to understand the present, there needs to be a further questioning of how such historically constituted traditions developed and what the effects of such practices are. This is essential to grasp the central values of the two “ideal types” of medical professionalism and what they can mean for the rights of patients today. This is because the most distinguishing feature of the “iron cage” is that it never works outside the box, but continually tries to reshape itself with new disguises. Now I will turn to the issue of methodology.

Methodology

From the above literature review, one can now state that researchers writing on the topic of medical professionalism have differed significantly in terms of how professionalism is defined. In considering the methodology to be used, while Foucault’s work is seductive, Weber provides a much more rigorous framework for organizing research material in such a way that it links history with sociology. The researcher does not begin with any a priori theories or abstract ideas but immerses herself in the historical data from where she extracts her concepts. In short, the methodology is data-driven rather than theory-driven and based on inductive logic, that is theoretical concepts are produced from the empirical data.

A methodology based on “ideal types” is perfectly compatible with such a methodology. However, while these “ideal types” are only heuristic devices and often exaggerated, they are logically constructed concepts which are derived inductively from social history (Ritzer, 1996, pp.117-119). While it is useful to attach these ideal types

19 I haven’t tried to distinguish between countries for operational definitions, because a feature of the military is that they generally tend to be very similar in forms of organisation and outlook.
to theory, it is not enough to offer a carefully defined set of concepts based on abstract definitions. Concepts had to be empirically adequate, so that, in order to produce ideal types, researchers had first to immerse themselves in historical reality and then derive the types from that reality (Kalberg, 1980, pp. 1145-6; Ritzer, 1996, pp.117-119).

However, as an “ideal type” construction is based on a combination of rational characteristics, it very rarely meets up with what happens in the real world. However it can form the basis for a conceptual model which might be used for comparative and historical purposes. As Ritzer (1996, p.119) states:

They are a one-sided exaggeration based on the researcher’s interests of the essence of what goes on in the real world. In Weber’s view, the more exaggerated the ideal type, the more useful it will be for historical research.

The method of interpretation used is Verstehen, one that has been subject to a variety of critiques, particularly that it is based on “intuition” (see Ritzer, 1996, p.115). Rather, it is a tool for macro-level analysis which can also be applied to meso- or micro-levels to interpret behavior within wider professional and bureaucratic structures in which actors exist and which support or constrain their thoughts and actions. As such it has involved painstaking and demanding research which unravels a “history (of) interaction which has to be interpreted in terms of the rival plans of various actors” (Lachlan in Ritzer, 1996, p.115). In his concluding words in The Protestant Ethic Weber acknowledged its inherent contradictions and the necessity to define the social groups that are attached to a mode of “ascetic rationalism’ and show its significance in relation to others attached to a “humanist rationalism” (Weber, 1930/1989, p.183).

Regarding the collection of data, the research has been primarily library-based augmented by key informant interviewing. It has entailed a systematic search for primary data on issues surrounding medical professionalism in both medical and general academic libraries. These primary data have been augmented by cross-disciplinary material so as to understand the social context in which events took place. The distinction between primary and secondary data should therefore not be based on what they are, but on the value they add to the research (Deflem, 2000). However, because there is a distinctive lack of secondary data, the primacy in this research has been given to the voices of doctors and others through their texts and the historical material has been retrieved from the following sources:
Journal articles and books surrounding topics such as the historical relationship between generalists and specialists, medical education; military medicine; community medicine; hospital practices. As *The Medical Journal of Australia* is the only peer reviewed journal that has been in circulation since 1914 my primary data was almost entirely from this source. Another important primary text was the Journal of the Commonwealth Department of Health (CDOH) entitled, *Health*. Military medical journals, such as *ADF Health* and *Australian military medicine*, have only has been available in the last few years.

Documents or manuscripts in archives and libraries that are not well known or have not been readily accessible to researchers in previous years.

Texts, biographies and autobiographies of military doctors as well as community doctors and medical educators.

Data published by doctors’ organizations together with reports and government enquiries on education and other relevant issues;

Historical data on hospitals and medical schools as well as other secondary and cross-disciplinary data to augment and contextualise the research so as to also link it to human rights issues.

Data on Freemasonry and the Order of St John available either through university libraries, their own libraries or from internet sites.

The limitations are that sociological data on medical professionalism before the 1960s is lacking. Also, as there was no computerisation of data in the medical journals until 1997, the selection initially was chosen by screening title pages and indexes. Then the journals were as carefully scrutinised as possible in the many months spent at the University of Western Australia Medical library immersing myself with the life-world of doctors across time and space. Some data were used to gain a background understanding, while other data from earlier journal articles as well as more recent papers have been integrated into the related chapters. The military medical journals have only been available from the 1990s and, as an electronic resource, only in the past few years.

**Conceptual framework**

The medical archetypes represented as “ideal types” are based on Weber’s cultural conception of rationalisation. For example, unlike Jung or Durkheim, Weber did not have a “group-mind” concept (see Douglas, 1993; Jung, 1968). That is each of these “ideal types” is the professionally trained “carriers” and “expediters” of a system rationalisation (Kalberg, 1980, p. 1169; Kalberg, 1996, p. 51). These “ideal types” are
classified as “general sociological ideal types” which can be seen to have emerged over and above the past one hundred years of Australian history.

I have maintained the term rationality as it is one which suits the idea of the historical transformation from a modern to a post-modern system. In my conceptualisation, the soldier doctor is the “ideal type” representative of military medical professionalism carrying with him\textsuperscript{20} values of chivalric brotherhood and ascetic ideals of creating a “pure” community. In addition, the soldier was an administrator with a penchant for bureaucratic organization.

On the other hand, the generalist doctor is the “ideal type” representative of medical professionalism, carrying with him humanist values institutionalised into medical education and professional practices. An idea of the body is included into this conceptualisation to acknowledge its importance within medical rationalisation systems. Each “ideal type” arising out of the empirical data can be seen to reflect a conceptual grid which shows “elective affinities” between substantive, theoretical or cognitive, practical and formal rationality outlined in Table 2.1 below.

For Weber substantive rationality was the only type of rationality that had the potential to influence methodological ways of life. Ethical substantive rationality was seen to be analytically central. Rationalisation processes regarded as long term “are seen to be linked to values rather than interests” (see Kalberg, 1980, pp 1169-1170). On the other hand, theoretical rationality was cognitive which he believed had a highly limited ability to suppress practical rationality and seems more of an end product than a producer. For Weber, practical rationality is reaction to situations rather than an effort to order them (ibid.). However, as other interpretations are possible, I have drawn on Foucault’s rather than Weber’s ideas about cognitive rationality, its practical effects being seen in the way doctors interacted with their patients.

In Ritzer’s (1996, p.576-577) work on hyperrationality, he stresses that in modern societies, formal rationality becomes an over-riding facet in bureaucratic

\textsuperscript{20} Both “ideal types” were originally male, therefore I have retained masculine pronouns when referring to them.
Table 2.1:  *Types of rationality and characteristics*

<table>
<thead>
<tr>
<th>Type of rationality</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substantive rationality</td>
<td>Values and norms in the rational choice of means to ends</td>
</tr>
<tr>
<td>Theoretical rationality</td>
<td>Deals with rational cognitive processes</td>
</tr>
<tr>
<td>Practical rationality</td>
<td>Day to day rationality of medical intervention</td>
</tr>
<tr>
<td>Formal rationality</td>
<td>Rules, efficiency and calculability or precepts such as quality, public accountability and social justice (Germov, 2005; Kalberg, 1980)</td>
</tr>
</tbody>
</table>

processes dominating other parts of the system which becomes irrational and de-humanised. Table 2.2 below outlines the conceptual grid which can be seen to be dynamic rather than static with the ability of bringing us into the 21st century. While some details arise out of the empirical data and will become self-explanatory, it is necessary to provide some explanations. The “ideal types” could also be seen as expediters of rationalisation processes in terms of Tonnies’ differentiation between *Gesellschaft* and *Geimenschaft*. Also, it was Weber’s argument the rationalisation characteristics carried by some social strata would eventually belong to a group (see Kalberg, 1980, 1996).

As clinical rationality is seen as the centre-fold from which other forms of rationality can be better understood. Firstly, Armstrong (1997) considered the rest of ‘Birth’ was “dense” and not fully exploited, and suggests it would best be combined with notions of power or surveillance described in Foucault’s later work. To a degree this suggestion has been taken up earlier by other researchers who have focused on analysing discourses surrounding the construction of “the body” by doctors (see Petersen, 1993, Turner, 1987) However, he also points out, for sociological eclectics such as Turner, Foucault’s work can have a number of different readings (1997, pp. 21-22). As one of those sociological eclectics, my reading provides an analysis of competing ideas of clinical rationality also arising out of my empirical data. After explaining the other forms of rationality, I will also briefly refer to a subtext of power
relations and human agency underwriting Foucault’s work and its applicability to the subtext underwriting this thesis, that of human rights.

Foucault’s (1973) *Birth of the Clinic* was used not only as a starting point, but also as an educative text used for an understanding of clinical rationality and its practical manifestations within and outside the hospital. This work is significant in that it not only opened the way for others to “read” medicine, it also provided insights into ways of understanding the nature of medical practices relevant to this thesis. I will divide this reading into theoretical or cognitive rationality and practical rationality.

**Cognitive rationality**

In Foucault’s (1973) *Birth of the Clinic*, clinical experience was defined as “that opening up of the concrete individual, for the first time in Western history, to the language of rationality”. He argued the new emphasis on anatomical dissection transformed the way doctors visualised the body (ibid, p.xiv). He also asserted when “modern medicine” was born, it was in fact a metamorphosis of a “millennial gaze” whose empiricism operated at the “level of the perceived” (ibid, p.xii).

Although Foucault recognised the basis of hospital medicine or what he later called “the anatomo-clinical method” included a knowledge of chemistry and physics, he did not attach the notion of ‘positive science’ to the Cartesian/Newtonian influences on medicine, but to the idea that because disease had become detached from notions of evil, it began to be attached to space and language, and a legible basis of death.

He also referred to the Edinburgh clinic as a model of a time the relationship between doctor and patient at the bedside first constituted an interaction between “a gaze and a face” (ibid, p. xv), explaining that the type of medicine linked to the proto-clinic incorporated a botanical rationality, totally different to what eventually emerged. For Foucault, this is a medicine of spaces which has historically been linked to a “doctrine of sympathies” where each idea is forced “to reinforce the other to find a correct balance of the system” (p.11). He states:

> The botanical model has a double importance for medical thought….First the order of disease is simply a ‘carbon copy’ of the world of life, the same structures govern each, the same form of divisions, the same ordering. The rationality of life is identical with the rationality of that which threatens it. … (ibid, p.7)
The above lines of rationality established a connection between Edinburgh practices, the botanical model and the “doctrine of sympathies” or a reinforcement of the idea of bodily balance.21 My conceptualisation differs from Foucault (1973) in that what he called the medicine of spaces was also a product of Edinburgh medical education which included teaching in the proto-clinic and the community. In Foucault’s terms, this medicine had the ability to move between two spaces.

Clinical teaching inside hospital medicine was very different to practices of other doctors and first took shape within the French military and naval hospitals (ibid, p.58). These military doctors had no room for the patient narrative. When the clinic emerged, the older nosological classifications used in the botanical model were replaced by disease categorisations, isolating them within the organs or tissues of the individual. These changes were well suited to a morbid pathology interested in cases which could compare what occurred within living organisms to what was understood from dissecting dead organs (ibid).

Foucault recognised esoteric systems of thought and practice had been integrated into French hospital medicine, not simply like the earlier practices of preserving knowledge by keeping it in Latin. He likened the clinic to a sect where teaching practices and theoretical structures become a form of initiation into a truth only to be unravelled and understood by the initiated (see Foucault 1973, p.115). Clinical experience then rests on a “precarious balance … that all there is visible is expressible, and that it is wholly visible because it is wholly expressible….Total description is a present and ever-withdrawing horizon; it is much more the dream of a thought than a basic conceptual structure” (ibid). The practical rationalisation processes were described in the following ways.

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21 What was left out of this equation was that Padua, Leyden and Edinburgh, like Montpellier and others mentioned were part of a humanist tradition, with the latter undergoing a Hippocratic revival in the 18th century decrying the suitability of Isaac Newton’s influence on medicine. These doctors adopted the idea of anatomy as being in a dynamic or animated state (animata animata) or a vital force. This view did not entertain Cartesian dualisms or mind/body separations, but was aligned with trends related to the Protestant Universities north of the Alps, a geographical region which historically remained outside Roman influences (see Comrie, 1932; Geyer-Kordesch, 1995).
Table 2.2  *Ideal type conceptualisation of historically emergent actors and their medical systems using Weberian characteristics of rationality*

<table>
<thead>
<tr>
<th>Rationality</th>
<th>Definitions</th>
<th>Applications</th>
<th>Generalist</th>
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<tbody>
<tr>
<td>Substantive</td>
<td>Culture heroes Paré, Paracelsus/Newton</td>
<td>Soldier/saviour</td>
<td>Hippocrates</td>
</tr>
<tr>
<td>Value-Based</td>
<td>Military medical professionalism Ethic of chivalric brotherhood Patriarchal and xenophobic Professional isolation from civilian doctors Deontological (doctor-centred)</td>
<td>Medical professionalism Ethic of humanism Egalitarian Collegiate culture – peer reviewed not individualist Patient centred</td>
<td></td>
</tr>
<tr>
<td>Theoretical</td>
<td>Cognitive rationality</td>
<td>Medical positivism operates at two levels: a) esoteric and b) mechanical Normal and pathological passive body: understood as having a number of unrelated parts Health is the absence of disease and needs chemical and surgical intervention</td>
<td>Medical practice based on knowledge of when to apply science also operating at two levels: a) therapeutic and b) curative Health and normality Vital active living body. Health is multi-faceted and not just absence of disease. Works on principle of bodily balance of whole person.</td>
</tr>
<tr>
<td>Practical</td>
<td>Professional and diagnostic practices Experimental Signs: “Glance and silent body” Primarily those doctors who work in positions with little contact with patients or community specialists reflecting sub-disciplinary interests i.e. Clinical chairs/examiners in medical schools; surgeons and other senior doctors practising mainly in operating theatres, laboratories, theatres of war; and as administrators and directors in military and civilian public service.</td>
<td>Non-interventionist history taking and observation Symptoms and Signs: “gaze and face” Primarily those doctors who work in positions with contact with patients or community, i.e. generalist medical educators; family practitioners, consultant physicians and surgeons; community doctors.</td>
<td></td>
</tr>
<tr>
<td>Formal</td>
<td>Type of authority Task-orientation; efficiency, calculability Executive administrative and managerial authority</td>
<td>Social contract, transparency, quality, accountability in doctor/patient relationship Professional authority</td>
<td></td>
</tr>
<tr>
<td>Basis of medical system</td>
<td>Tertiary and secondary health care sector</td>
<td>Primary and secondary health care sector</td>
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</tbody>
</table>
Practical rationality

Foucault argued the “hospital doctor sees only distorted, altered diseases, a whole teratology of the pathological; (while) the family doctor “soon acquires true experience while waiting until the disease takes its course in its natural environment. These practices were differentiated as an “active and expectant medicine” or between an interventionist and non-interventionist practices (p.117).

To the best of my knowledge, most readings of his work do not acknowledge the distinction made in the doctor/patient relationship of what he calls interaction between the “gaze and the face” (or the interaction between doctor and an individualised active body so as to create the body both as subject and object) and the interaction between the “glance and the silent body” (or the interaction between doctor and a passive, inert body).22

The other practical manifestation was, when the clinic was born, the emphasis of medical diagnosis shifted from the elucidation of symptoms to examination of the patient’s signs. The patient was no longer asked “What is the matter with you?” The question changed to “where does it hurt?”(ibid, p.xv). This meant that doctors were required to look for a single cause for an illness which could be explained under a “disease” label. No account was made of other intervening physiological and/or social factors which usually contribute to the manifestation of ill health. Therefore, the clinic which eventually emerged with hospital medicine was much more calculating and represented an interaction between “a glance and a silent body” (ibid, p.xv). This is because the hospital doctor’s role was to “discover the disease … often buried in the patient, concealed within him like a cryptogram” (ibid, p.59). In other words, this doctor was interventionist. The difference between the two practices is described as follows:

In the hospital, the patient is the subject of his disease, that is, he is a case: in the clinic, where one is dealing only with examples, the patient is the accident of his disease, the transitory object that it happens to have seized upon (ibid, p.59)

The broader practical effects were to link hospital practices to a laboratory medicine, excluding family doctors from these spaces. He points out the influence of

22 Fox’s (1993) research into the surgical ward round would be an excellent example of the way these facets of the doctor/patient relationship are distinctively at work especially regarding the strategy of maintaining authority in sustaining the silence of the patient, whether awake or sleeping.
the Faculté (university authorities) was limited after conflict with doctors whose authority was buttressed by Ministers of the Crown and doctors interested in pathology connected to the Royal Society of Medicine (and the laboratory). Later, however, this Society no longer consisted only of doctors interested in pathology, but became “the official organ of a collective conscience of pathological phenomena … (operating) at the level of experience and the level of knowledge, in the international as well as national space” (italics in text, ibid, p.26-28).23 In my conceptualisation, I have placed this type of professionalism as rationalised to operate primarily in secondary and tertiary care (hospital and laboratory). On the other hand, I have placed the generalist type of professionalism as rationalised to operate primarily in primary and secondary care.

From the above it can be discerned that Foucault’s *Birth* has provided conceptual insights which have been subjected to critical scrutiny. At the same time, if his work on professionalisation processes is also seen as a sub-text for Weberian ideas of rationalisation, as such it suits my purpose in being to locate ‘elective affinities’ between medical professionalism from its link to Edinburgh traditions and the military traditions linked to those of modern medicine, the hospital and the laboratory. This reading of Foucault differs from other readings especially in introducing the significant portrayal of the “glance and the silent body” as well as highlighting the cross-fertilisation of knowledge between French and British military doctors and, therefore, its application to comparative and historical ideas of professionalism.

Apart from the above observations, as stated earlier, the medical military fraternity of surgeons became part of an international network of colonisers isolating themselves from the mainstream social milieu of their own countries. As to what forms of substantive rationality these relations and actions invoked, we need to look to Weber for an explanation of the characteristics identified.

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23 The definers of “truth” and those who remained the power behind British medical politics were the Royal Society of London whose membership also consisted of both French and English doctors. The culture hero was Isaac Newton, for whom Paracelsus held the key to pure knowledge derived from astronomy, alchemy and mathematics (see Webster, 2005, White, 1997).
**Substantive rationality**

**Ethic of chivalric brotherhood**

In my conceptualisation of the soldier, I have included the ethic of chivalric brotherhood. This was because of the inter-relationship of military medical doctors and the Masonic and quasi-Masonic chivalric orders. While Foucault emphasised the focus on death in the hospitals, Weber emphasised how the idea of death operated in the army and, thus, the reproduction of a heroic genre of medicine. He states, as far as the soldier or warrior is concerned, the army was regarded as a “community until death”, the most glorious kind being a heroic death. The heroic death is the one that ritually becomes the symbol of ultimate sacrifice (Weber, 1948, p.335). Army and religious leaders can be strange bed partners as they each can combine to create heroic communities “professing the ethic of brotherliness” (ibid). Weber states only those who perish in “their callings” are in same situation as the soldier who dies on the battlefield (ibid). When salvation aristocracies are charged by the command of their God to tame the world of sin, for His glory, they give birth to the ‘crusader’ (ibid, p.338).

Also in the *Birth of the Clinic*, Foucault (1973) mentions the emergence of esoteric ideas and influences at the time.24 Here one should emphasise events occurring in the Masonic lodges across England, France and Europe during the 18th and 19th centuries were important, because their members were attached to Royalty, the aristocracy, and the professional and commercial classes in the upper echelons of elite society. Not only were ideas of regeneration connected to occult influences on the lodges, but they appeared to go hand in hand with religious and pseudo-scientific ideas, as well as being known to have both “pietist and quietist tendencies” (Roberts 1972). Weber (1948) has also written on the influence of such sects in early 20th century America. He states:

Today, the kind of denomination (to which one belongs) is rather irrelevant. It does not matter whether one (is a) Freemason, Christian Scientist, Adventist, Quaker, or what not. What is decisive is that one be admitted to membership by “ballot” after an *examination* and an ethical *probation* in the sense of the virtues which are at a premium for the inner-worldly ascetism of Protestantism and hence, for the ancient puritan tradition (Weber, 1948, p.307).

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24 At the time, aristocratic and professional and commercial classes were recruited into the fold of a chivalric Masonry which took its origins from the Kings, Knights and Princes of the Crusaders (Roberts 1972).
In Australia, the cult of imperialism was sustained by the exporting of craft Freemasonry as well as a number of military and religious orders whose officers would be in a closer relationship to royalty. Therefore there was a close cross-fertilization between military medical professionals and the chivalric and craft Masonic orders. The Order of St John was the only working order of chivalry emphasising origins in Crusades carrying on the Hospitaller tradition and life-saving qualities of its members. After the revival of the Order of St John and its establishment as a British Royal Order of Chivalry in 1888, both in England and in Australia military doctors were teachers within its foundations and in hospitals, often working long hours on a voluntary basis (see Howie-Willis, 1983).

One does not need to point out the significance of the cross-interrelationship between military medical professionals, the chivalric orders, and the religious and military ideals of the sovereign. They were soldiers first, with their military credentials always placed before their medical ones. Again, according to Weber (1948) the most distinguishing behaviour of a sect member was voluntarism, a crusader spirit and a lifetime spent continually trying to prove oneself.25 These characteristics are evident in the empirical data presented in the next chapter.

Ethic of humanism

The generalists in Australia, who brought the humanist Edinburgh tradition with them, were educators. As far as their role as educators are concerned, while Calvinists were renowned for their jealousy of free thought, Protestants generally had always been eager to give education (Thut 1957; Trevelyan 1937; Weber 1930/1989). The Protestant sects which emerged “were the only Western people who were motivated on religious grounds to establish a literate laity, and it is for this reason mass education originating in the form of vernacular reading schools appeared in Protestant countries long before those of other religious persuasions”(Thut, 1957, p. 118).

25 Knighthoods in the British Royal Orders are only granted if the person is Anglican. In the Victorian army, not only was the Colonel of the Regiment Master of the Lodge, but they were also intensely Church of England (see Farwell, 1980, Gould, 1899). The largest group of doctors in the Australian Imperial Forces (AIF) were Anglican and Catholics who were both Episcopalian, that is, their church organization was hierarchical. Both had similar brotherhoods, which mirrored another intensely hierarchical organization and allegiance to a sovereign power, such as King, Queen or Pope. The Catholic and Anglican brotherhoods in the Hospitaller traditions formed a coalition in 1967.
While Weber (1930/1989) recognised there were more complex reasons for Protestant attitudes towards education, he also pointed out their attitudes to women were egalitarian. Weber also argued the Protestant woman was a highly-educated person whose recreational pursuits were sought in discussions of science, literature, arts and music. He asserted it was the religious atmosphere of the home community as well as the parental home that had a large bearing on the occupational and professional careers of the children. For example, he stated:

The explanation (for their involvement) is undoubtedly that the mental and spiritual peculiarities acquired from the environment, here the type of education favoured by the religious atmosphere of the home community and the parental home, have determined the occupation and the professional career (Weber 1930/1989, p.39).

Also referring to the Scottish pedagogical programmes, he stated they displayed particular ascetics of practice which were accompanied by a fides implicata.²⁶ (Weber 1930/1989, p.249). Scottish doctors coming to Australia were mainly Presbyterian which was known for its anti-hierarchical mode of organization mirrored in other relations. For example, Farwell (1980) stated in the 17th century, the Sutherland Highlanders were considered the most religious regiment, described as shaping itself in the form of a “constant removable parish” (p.33). This regiment had its own minister and elders chosen from the ranks, consisting of two sergeants, two corporals and two privates only (ibid.).²⁷ Although many doctors volunteered for military service in the two world wars, they were first and foremost doctors and very rarely warriors.

**Formal rationality**

I will not make any further comment on the conceptualisation as the elements of formal rationality can be identified from both the theoretical and empirical data from which they have been taken, especially with reference to the task-orientation of managerialism. As far as power relations are concerned, both “ideal types” have the capacity to be liberatory or oppressive, but one more so than the other. Before

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²⁶ *Fides* means faith, trust, belief or truth. The word *implicata* has no direct translation in the Latin dictionary, but I assume the word could mean something connected to faith.

²⁷ Many regiments were reified as characterising particular virtues or personalities, a practice which had striking parallels to the lodges. This is not surprising given that from the 18th century the Colonel of the Regiment was also Master of the Lodge (Gould, 1899).
concluding, I will briefly discuss issues of power relations and human agency in Foucault’s work.

**Power relations and human agency**

While *Birth of the Clinic* was a structural study reformulating the history of ideas, for Foucault (1973) it also had another purpose, very much similar to mine. This was to lay the foundations for understanding “the original language of medicine” which would make a critical (and sociological) understanding possible because in France, at the time of writing his thesis, a “liberal” medicine was beginning to reassert itself. He states:

> Clinical experience – that opening up of the concrete individual, for the first time in Western history, to the language of rationality … was soon taken as a simple, unconceptualized confrontation of a gaze and a face or a glance and a silent body … recently in the interests of an open market, so-called “liberal” medicine has revived the old rights of a clinic understood as a special contract, a tacit pact made between one man and another. This patient gaze has even been attributed with the power of assuming – with the calculated addition of reasoning (neither too much or too little) – the general form of scientific observation (pp. xiv-xv).

Foucault then seemed to reflect on what he said about the likelihood of such a change occurring stating “miracles are not so easy to come by” (p. xv). As Warren (1984, p.622) points out, the idea of power as embodied in social relations is implicit. She states: “For Armstrong, as for Foucault, social structure is practically isomorphic with cognitive structure. Power, similarly, is embodied not in the social relations of production but in the gaze and its discourse” (ibid.). Also, while Foucault eschews any leaning towards substantive rationality, in the last paragraph of the preface, he articulates his idea of human agency as follows:

> What counts in the things said by men is not so much what they may have thought or the extent to which these things represent their thoughts, as that which systematizes them from the outset, thus making them thereafter endlessly accessible to new discourses and open to the task of transforming them (p. xix)

Implicit in the above quotation was an assertion of the freedom and ability of human agency to transform or effect social change. From the above, one can discern the idea of power as relational is embodied within the social relations in which these cognitive structures have been produced. Therefore, while Foucault has been criticized for a neglect of the idea of the subject and power in his earlier works (see P. Harris, 1993; McNay, 1994) it does seem here there is a neglect in the way he wrote at that
time, rather than in the way he thought, as he never intended his version of power to become theoretical (see Dreyfus and Rabinow, 1982). As Foucault (cited in Gordon, 1983, p. 229) later stated:

When I think back now, I ask myself what else it was that I was talking about in *Madness and Civilization* or *Birth of the Clinic* if not power? Yet I’m perfectly aware that I scarcely ever used the word and never had such a field of analyses at my disposal then.

This notion of power as relational has been used by other Foucauldians, such as Lupton (1997) in her research on the effects of consumerism of doctors in the Australian medical profession and their patients. As in Lupton’s work, power should be treated as an “analytic of power” rather than a theory. Again, Foucault asserts:

If one tries to erect a theory of power one will always be obliged to view it as emerging at a given place and time … but if power is in reality an open, more-or-less coordinated (in the event, no doubt, ill-coordinated) cluster of relations, then the only problem is to provide oneself with a grid of analysis which makes possible an analytic of relations of power (cited in Dreyfus and Rabinow, 1982, p.204)

**Conclusion**

In the above pages I have pointed to the various ways professionalism and professionalisation processes have been understood in both international and Australian contexts and have shown where gaps are in the data which can accommodate my thesis. I have explained the way the medical archetypes are analysed as “ideal types” and used as heuristic devices to interpret the empirical reality of their rationalisation processes. I have acknowledged the conceptualisation of these “ideal types” are an exaggerated “pure” form which probably cannot be found anywhere in reality, but can be used as a measure against what exists today.

Reviewing the contribution of Foucault, Freidson and Weber, one could assert that, while each have made significant contributions in different ways to my analysis, a Weberian conceptual grid enables the researcher to integrate these aspects into specific characteristics of rationality giving a more analytical understanding of the empirical data gathered and the extent of the differences between the two. In addition, while many refer to a return to the “iron cage” of bureaucracy, the capability of the humanist professional project to counteract the authoritarianism and task-oriented tendencies of the latter is one to be explored.
As will be shown, the emergence at the political level of any different type of medical rationality will only visibly come into focus when a new social milieu arises ready to receive it. However, as the medical professions across the Australian states were not subjected to national bureaucratic or administrative organization until after World War II, each archetype was able to sustain its inherited values and approaches to medical practices. The different forms of rationality inherent in each have historically placed them into conflict.

Until one can show the extent of political (and therefore social) convergence of ideas and practices, that is, how certain doctors and their medical practices became accepted, while others became excluded, under what historical conditions and with what resultant consequences, one will not be in a position to develop a clear understanding to make an informed assessment of the present actions of doctors in our communities. For this reason, the final critique can only centre on the issue of human rights and, as Rose (1989) would say, it then becomes a matter of our freedom. For example, he states:

The location of ethical statements within the field of science is double edged. On the one hand, in freeing many questions concerning the proper conduct of life from the authoritative prescriptions and proscriptions of political, religious and social authorities, it pluralizes the answers that can be provided, opening up the field of diversity within which each subject is obliged to locate themselves. On the other hand, in relocating these questions of the conduct of life within the field of expertise, in tying it to norms of truth and health, it binds subjects to a subjection that is the more profound because it appears to emanate from our autonomous quest for ourselves, it appears as a matter of our freedom (ibid, 1989, p.256).
CHAPTER THREE

Jewels of Empire: the emergence of the soldier/saviour archetype

... It may be that war as strategy is a continuation of politics. But it must not be forgotten that “politics” has been conceived as a continuation, if not exactly and directly of war, at least of the military model as a fundamental means of preventing civil disorder. Politics, as a technique of internal power and order, sought to implement the mechanism of the perfect army, of the disciplined mass...While jurists or philosophers were seeking in the pact a primal model for the construction or reconstruction of the social body, the soldiers and with them the technicians of discipline were elaborating procedures for the individual and collective coercion of bodies (Foucault cited in Rabinow, 1984, pp.185, 187).

Introduction

In NSW and Queensland, army medical officers, who were mainly surgeons, took on the imagery of the soldier archetype and, subsequently, sought to introduce their own values and traditions into various Australian medical military and civilian institutions.¹ Even before the formal restructuring of such military zones, from the outset Queensland established an army-style structure mirrored in complete state control over hospital and medical servicing of the population as well as over schools and other institutions. Later, under the original Commonwealth defence scheme, the Australian continent including Tasmania comprised six Australian “military” districts. This military map² of Australia is slightly different from the map of the Australian states and of Aboriginal Australia. It shows military districts in number order with Queensland combined with the Northern Territory (NT) in first place, followed by NSW, Victoria, SA and WA (Butler 1930, p.19).³

The ethos of the soldier archetype, therefore, mirrored the function of the military which dealt with the “management of violence” or the application of physical

¹ Also, aligned with Foucault’s above words, one might take note of those of an 18th century Englishman, a Henry Lloyd, who claimed that “natural genius” was reflected in the command in war. For Lloyd, “warlike practice was divided into two parts. The lower was mechanical and could be learned: the upper lay among arts and excellence (and)...could be no more readily taught than in sculpture or music” (Lloyd, 1781 cited in Hackett 1983, p. 85).
² See Appendix I where I have included maps of civilian, military and Aboriginal Australia for comparison. In 1911, Queensland took over the administration of the Northern Territory from South Australia.
³ In each military district the central camps for continuous training were located within fifty kilometres of the capital city. In order of military district, these were at Ennogers, Liverpool, Broadmeadows, Mitcham, Blackboy Hill and Claremont (Butler, 1930, p.24).
force as the solution of social problems (Curtin, 1989; Grey, 1990). However, force need not necessarily be confined to the battlegrounds of war. Force or coercion can and has been applied by other methods, such as in over-zealousness in maintaining law and order by police, by cultural and economic deprivation, as well as by suspect forms of education, political intervention as well as social and medical experimentation. Violence can also be in the form of refusing to take responsibility for another’s health or well-being and human rights. Such influences have not been totally cast off.

In this chapter, I will show how the soldier tradition evolved first within Britain and then within Australian society to become part of a culture of military medical professionalism, producing its own body of knowledge and its own characteristics of rationalisation. While, in association with British and Masonic chivalric orders, the soldier defined himself as humanitarian, coercive, punitive and even violent actions were sometimes replicated from that time onwards. Such coercive actions were not confined to war situations, but entered into social relations, even against other doctors. I show that, within Australia, this soldier archetype played a central role in administrative and managerial capacities to become part of a mechanics of power constructed in a way close to Foucault’s argument above or to Weber’s thesis about the rationalisation of bureaucracy. An understanding of the imprints the soldier made on public institutions at this time is also a way of understanding the present. As these doctors had a past in Britain, one needs to step back just a little to understand the context at the time the soldier along with the disease-politics of biomedicine began to appear in England.

**Background**

*The medical chivalric orders*

Since the 17th century, army medical officers have been able to pursue a career made available to them both in war and peace. A medical officer and assistant warrant officer were appointed to regiments which provided a hospital and where the Colonel of the regiment was traditionally also Master of the travelling Masonic Lodge (Gould, 1899; Royal Army Medical Corps (RAMC), 2001). This work pattern became known as the Indian Services Model (IMS) and, as stated, was adopted by the RAMC at the end of the 19th century (Butler, 1930).
Around the middle decades of the 19th century, many influential chivalric orders were messianic in their zest to find ways to alleviate human suffering on the battlefield. In pointing to the influence of the Knights of Malta on the European Red Cross, Hutchinson (1996) has singled out Henry Dunant as an example of one among many whom, in his book, he dubbed the *Champions of charity*. Therefore initially, from 1863 onwards, leaders of these “brethren in chivalry” formed international contacts with surgeons aligned with the Red Cross and other Protestant or Lutheran Knights of St John (Hutchinson, 1996; Howie-Willis, 1983, International Committee of the Red Cross (ICRC), 2002).

The creation of a crisis milieu has generally always accompanied attempts at structural changes influenced by military considerations. A crisis milieu was first invoked after losses of human life incurred in the Crimean war and Sepoy Rebellion, when many influential individuals expressed both messianic and apocalyptic sentiments in their zest to find ways to alleviate human suffering on the battlefield.

Cast in the imagery of a soldier, the idea of the doctor as saviour and miracle worker appeared when a history was constructed of a glorious mythical Anglo-Saxon/Teutonic lineage and a shared association with the Knights and Princes of the Crusaders (see Banton and Harwood, 1975; Howie-Willis, 1983; Roberts, 1972). This history carried with it prophetic notions and imperial themes closely aligned with Elizabethan notions of an Empire “as a (purified) religious institution” (Yates, 1979, p.85). Such themes not only incorporated a symbol called the Monas, a Christian Cabbalist symbol, including a Latin cross thought to have magical powers, but also gave the monarch supremacy in both church and state (ibid., p. 84-88).

One broader effect was to elevate the status of military doctors, who saw their history as contemporaneous with the revival of ascetic ideals of piety and celibacy and discipline, as well chivalric values of self-sacrifice, martyrdom and courage (see Douglas, 1978; Pearn, 1985). Such ascetic ideals were also reflected in their attitudes towards women. With the increased attention on women’s bodies, another effect was to appoint surgeons as surgeon/gynaecologists to protect “women’s chastity” (see Jordanova, 1989, Lupton, 1994). Such practices were legitimated by the enactment of

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4 This is the title of a book written on the United Orders (see Smyth, 1991).
5 Yates (1964, 1968 and 1972) has written several historical texts surrounding occult philosophy in science.
Ellenborough Act (1863) which set the precedent for other countries to follow in the control of women’s fertility (see Davis, 1974).6

In 1863, a resolution was passed at the Geneva Convention International Conference which recommended that government patronage be institutionalized internationally and extended to relief committees and to the medical corps, ambulances and military hospitals (ICRC, 2002). In doing this, the British and others began to seek responses to the frightening carnage of war, while simultaneously creating institutions which did not leave room for questioning the necessity of warfare (see Summers, 1988). The soldier archetype was therefore both a product and carrier of these militarised relations also legitimated by the emergence of the Order of St John.

The most significant chivalric institution which appeared was the English Order of St John which evolved in the wake of its German counterpart.7 For the military and religious orders, service on the battlefield and the Hospitaller tradition of the Knights of St John had “pride of place” (Smyth, 1991, p. 4).8 Lechmere, one of its principle founders, extended the idea of chivalry into civilian society and defined it as “someone willing to take enormous risks” (Howie-Willis, 1983, p.115). Alongside of this was the nurturing of the ethos of “life saving” (ibid.).9

Members of the Orders of St John have been described as “clubs for aristocrats who wallowed in nostalgia for a remote chivalric past” (Howie-Willis, 1983, p.104). There may also have been a nostalgic yearning for secretly accumulating more wealth. For example, one of the original founders, the Duke of Manchester was an author of books on military and historical subjects, a Doctor of Laws from Cambridge University, a Knight of the Most Illustrious Order of St Patrick (an elite British order comprising the sovereign and 22 knights) and a Knight of the Order of the Iron Cross of Prussia. He was also President of the Royal Colonial Institute and an investor in commercial

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6 This topic is one that has been well documented by feminist researchers. For example, see Lupton (1997) especially chapter six.
7 This German Order of St John, the Johanniterorden, was restored in 18527 and was the first to set up “branches across Europe and Canada to run hospital and ambulance services” (Khangure and Howie-Willis, 1997, p.12). Also, Summers (1988) has covered some aspects of royal and aristocratic involvement in Germany in relation to nursing and military medicine.
8 The English order was not authentic, but was created as a Protestant carbon copy of the original Catholic order, the Sovereign Military Order of Malta, which was considered to be the originator of administering first-aid on the battlefield to the wounded. Official relations between the Protestant and Catholic St John orders were severed until the 1960s (Howie-Willis, 1983, p.19).
9 While the Masonic knights had been involved at all levels of the Order of St John, they kept their identity virtually a secret. As a consequence, the increased influence of the Masonic chivalric orders was accompanied by the formation of a network comprising “brethren in chivalry” (Smyth, 1991)
ventures in Australia and Canada. This Duke ruled the Order for 27 years (Howie Willis, 1983, p.105).

In the 1880s the Order of St John was made a British order of chivalry and given the name “The Most Venerable Order of St John” (referred to as the “Order of St John”). While, on the one hand, the Order of St John promoted voluntarism and a life of continually working to attain a higher level of recognition, on the other hand, it was structured in a way similar to the hierarchical arrangement of both the military and the Escopalian churches where no executive positions existed for women in their upper echelons. Such developments served to form a military and religious status quo with allegiance to royalty as well as a hospital-centred tradition and a “crowd” or, “battlefield” orientation (The Order of St John, 2004, p.1).

The Order of St John was also the only British chivalric order which has a major working role and a clear aim of “inculcating western medical values” across the various Commonwealth dominions (St John, 2002). Such influences had the effect of shaping a medical division of labour which, not only legitimated “scientific” ideas, but also legitimised feudal and chivalric structures with the express purpose of also spreading “British virtues” initially through the St John’s Ambulance Association. As far as its impact on the British colonies is concerned, St John Ambulance (2002, p.1) has pointed out

The British Order of St John has always had strong royal connections. Indeed Queen Victoria …, in 1888, made it a Royal Order of Chivalry and became its Head. Victoria ruled the largest empire the world has ever known and …part of (the Order’s) role (was) to spread western medical practice in the colonies. A branch of Ambulance was also seen as a way of encouraging local people to learn British virtues: whether in India, Hong Kong or Australia, it was like a little bit of England

The main function of such an order was to intervene in times of disaster; however, at times their humanitarian ideals seem contradictory. For example, humanitarianism is inscribed in notions of serving the community and practices of philanthropy and voluntarism. However, this sense of humanitarianism sits at odds with traditions linked to acts of barbarism romanticised through the glorification of war, martyrdom and blood sacrifice (see Howie-Willis, 1983; Knight and Lomas, 1996, 1997; Partner, 1982; Robinson, 1989).
The structural relationship between the Masonic and British military and religious orders and their royal masters, became cemented within wider imperial relations, especially from 1910 when the Duke of Connaught, became the Grand Master of both the British and Masonic chivalric orders, a position he occupied until 1939. Table 3.1 below shows the extent of regal patronage of both the United Orders and the Orders of St John. Members of these United Orders claim a close spiritual connection to the Hospitaller tradition and many worked at all levels of the British Order of St John (see Smyth, 1991, p.131).

In essence, the ethos which appeared at this time was first and foremost a chivalric one linking the “crusader zeal” of imperialists to a humanitarianism ideal of “saving” based on notions of who needs “saving”. These ideals embedded in their “relations to science” had a significant impact on medical practitioners of the time. The social prestige such relationships carry also seems an important facet in more generally binding people to the British Monarchy (see Cannadine (1983). In England, the above developments were accompanied both by social and structural changes after the enactment of the British Medical Act (1858). An understanding of the specific nature of military medical knowledge and the effects of such changes form the remainder of the background for understanding the emergent tensions between the two medical archetypes in Australia.

**Developments in military medical knowledge**

For the British, India was the first “field laboratory” and there seems little doubt the already entrenched notions of biological, ethnic and masculine superiority were reinforced by the British interaction with the Hindu caste system. By the end of the century, subconsciously some ideas must have been borrowed from the Brahmin caste because notions of pollution of food, water and environment took on social metaphors and older contagionist doctrines once again came to the surface with moves to regulate “disease-populations” through quarantine and immigration control. .

Developments in military medical knowledge in the IMS became part and parcel of the knowledge base of the soldier’s medical system. While initially the IMS surgeons established an almost exclusively hospital based and anatomical focus, their knowledge began to include mathematics and biology also producing statisticians and sanitarians or
hygienists as the early public health doctors. An IMS medical officer first introduced a sanitary perspective and also produced a requirement that all officers report on climate

Table 3.1.    Royal Patrons, Past Grand Masters and Sovereigns of the Great Priory of the United Orders and Grand Priors of the Order of St John

<table>
<thead>
<tr>
<th>Period of office</th>
<th>Royal sovereign</th>
</tr>
</thead>
</table>
| 1791-1805        | HRH Prince Edward, (Duke of Kent, 1799)  
                  | Royal Patron                                                                                                                                         |
| 1873 – 1901      | H.M. Queen Victoria  
                  | Grand Patron                                                                                                                                         |
| 1901 – 1910      | H.M. King Edward VII (Past Grand Master)  
                  | Patron                                                                                                                                             |
| 1937 – 1952      | H.M. King George VI,  
                  | Past Grand Master                                                                                                                                     |

(Smyth, 1991, pp.130 and 136)

(or meteorology), medical topography and sanitary statistics, as well as stations and cantonments under their care. These details were required to provide a basis for guidelines for sanitary improvements in barracks, hospitals, and transport ships and for

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10 Sanitary science was part of military medical knowledge and the application of “germ theory” to purify water and take hygienic measures to improve sanitation.

11 The Duke of Connaught’s nephew, the Duke of Gloucester, was Governor-General of Australia in the late 1940s. Since then successive Duke’s of Gloucester have stood at the helm of the Order of St John.
a better selection of camps (Ramasubban, 1988, p.39). In Britain this coincided with an official sanction being granted for the production of medical statistics with the establishment of a statistical department at the Board of Trade (Pelling, 1978).

When considering influences on Australia, there are several other important factors to note. One was that the military orientation of health policy in British India and imperial colonisation policy were seen as complementing each other (Ramasubban, 1988, pp.38-40). The second was the accompanying work patterns and practices appearing after the 1860s, that is, those who held executive positions and were responsible for the medical and sanitary care of British troops in India were officers of the Army Medical Department (later to become the RAMC). They were also employed as executive medical officers in British station hospitals, in staff appointments and in specialist duties (ibid, p.84). The third was the predominant practice of physical and social segregation forming part of the cultural repertoire of the IMS doctor. Although the belief in sanitary reform in the army supporting quarantine and environmental control was in keeping with understanding of disease in England, taking account of underlying ideas of spiritual pollution, social and physical separation often justified on medical grounds was also driven by fear of the “natives” as well as the inherent racism already existent (Worboys, 1993; p.517).

Throughout the 19th century an international network of military doctors, working in colonial contexts, produced bodies of knowledge drawing from each others experience (Curtin 1989). At the end of the century, however, scientific rivalry became an integral part of national rivalry where the oath of allegiance to the sovereign and the secret appeared central to this new development and military medical doctors were the only ones entrusted to guard research agendas. Here we can see the key role played by military doctors in contrast to civilian doctors, their relationship to the state, and the widening of their responsibility for “defence” to incorporate what generally might not be regarded as a concern of the military, in this case the “secrets” of research. For example, Worboys (1988, pp. 54-55) states:

Scientific rivalry was an integral part of national rivalry. Among European powers leadership of the “new science” could not be left in the hands of a foreigner, nor applied to civilian ends. Its role in relation to the army had to be

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12 Again this structure is clearly aligned to Foucault’s argument that there were two arms of medicine linked to government servicing, an anatomo-politics (hospital medicine) and a bio-politics (where the doctor’s role was first of all hygienist) (Foucault in Rabinow,1984, pp.273-279)
worked out first. Sponsoring of a research institution towards Indian princes and Indians in general … had strong overtones of what Salisbury (the Prime Minister of Britain) referred to as the “damned nigger attitude” … and seen as a threat to the professional monopoly of the British Army Medical Department in India. The leadership of the Bombay Plague Research Laboratory was taken over by a Royal Army Medical Corps official. It followed only those with both medical and military training would be appointed to head research laboratories.

 Appearing in addition to the above developments was the emergence of Tropical medicine, the only type of medicine named after the region it was directed to service. It was also not interested in the treatment of disease (see Farley, 1991). At the end of the 19th century, Nobel died leaving a considerable fortune for Nobel awards. From this time this latter arm of the heroic soldier genre and disease politics was institutionalised both in colonial as well as international contexts.13

**Tropical Medicine and the health of the “public”**

The Generals, Patrick Manson and Ronald Ross were at the helm of Tropical medicine, leading their brave soldiers in their crusading quest for new discoveries (Curtin, 1989; Farley, 1991). By 1903, Tropical Medicine developed into a “specialism” and two schools were established, one in London and the other at Liverpool, serving to make it an imperial project. The Berlin Institute of Tropical Medicine also emerged in response to the English Tropical Institutes established by both (Charlesworth, Farrall, Stokes and Turnbull (1989, pp.218-222). Ross, who was the first to attract a Nobel Peace Prize for malaria,14 was later joined by Koch, for bacteriology (or “germ theory”), as well as the German chemists, Behring and Ehrlich, the latter producing Salvarsan as a remedy for syphilis (see Pelling, 1993; Worboys, 1988).

The emphasis of Tropical Medicine was on the study of vector-borne diseases generated by the science of parasitology or the study of the behaviour of animal or plant parasites (see Farley, 1991). Laboratories were manned by military and chivalric doctors who worked in “ideal settings” in isolation from their professional colleagues. The association between Tropical Medicine and colonial imperialism has, of course, been recognised as well as its language, imbued with military metaphors (Worboys, 1988).

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13 While the idea the Nobel Prize has encouraged secrecy and questionable competitive practices has not been lost on researchers, Charlesworth et al. (1989, p.252) have asserted the vast amount of literature on the subject has ignored its sociological significance, as well as “the Nobel Prize is as kind of sacramental ratification of the primacy of competitive individualism in science” (ibid).

14 Literally this is an Italian word meaning “bad air”.

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1993, p.512-513). It is also easy to see how it was part of the soldier tradition in its language of heroism and its legitimation by specialist-oriented culture heroes. Worboys (1993, pp. 516-518) points out:

Tropical Medicine was monopolistic by inclination. The expansion of the idea of “empire” at this time along with the rise of new political and economic imperatives … made medicine more than ever an empire-wide project. Generals Manson and Ronald Ross and research institutions across the world could … relay news of “latest medical discoveries” to the remotest regions.

With the inception of Tropical medicine, its endeavours were described as no longer being in the “dark ages” and in terms of “diseases in the tropics” and “medical geography” (Worboys, 1993, p.514). Of course, one should point out the association with the “dark ages” to such doctors was that malaria, syphilis and typhus were three diseases which caused the fall of the Roman Empire (MacLaurin, 1925). Worboys 1993, p.513) also argues:

The term “tropical” has served an ideological function in associating the causes of the diseases with “natural” rather than social, economic or political factors. A characteristic and revealing feature of the emergent specialism of “Tropical Medicine” linked to a progressive and heroic genre had its origins in the legitimation of the emergent specialism and sustained in autobiographies and biographies of leading figures during this century. A characteristic and revealing feature has been the predominance of military metaphors. Tropical Medicine “marched on in triumph”, practitioners “fight and struggle” in a “war” against “foes and enemies” of humankind.

This war was documented as an epic adventure centred on Ross’s attempts at “discovery” of the cause and effects of malaria, a quest beginning in the early Christian era, taken up by a French military doctor in the 1880s and followed through by others ending with Ross and Manson’s work in London. In this epic adventure, Ross took on a likeness to the travelling surgeon who had no home and whose knowledge base was formed through experimental work. His experiences in India were painted as a crusade where Ross became a heroic soldier refusing defeat. It also seems these values were taken very seriously as others conducting “scientific” experimentation at the time had no problem using living patients. Like battlefield practices, here the sacrifice of human blood was allowable with an end in mind of destroying the disease or the “enemy”. Not only were patients drawn from the Indian population, but also from doctors’ families who “volunteered” their bodies. For example, to prove the theories about the causes of infection, mosquitoes were bought to London after being fed on infected patients when “…they were refreshed by a meal of human blood provided by two gentlemen who
voluntarily made the sacrifice in the interests of science, one being Dr P. Thorburn Manson, the son of Dr Patrick Manson” (Verco, 1916, p.537).

The other important built-in facet was the idea the “enemy” was female and presented as the mosquito and the “blood-sucker”. For example, Verco (1916, p.537) states:

Malaria, therefore, does not come, as we formerly thought, from the water of the marsh, nor the effluvia which arises from it, but from the mosquito, which lives around the marsh and lays her eggs upon its water, and whose larva live in it, and out of which comes the mosquito free from all disease, until she sucks the blood of an infected man, and then she becomes a menace and a scourge. I call the mosquito “she” because only the female is a blood-sucker; the innocent male is a vegetarian [italics added].

Also, with its advent, sanitarians or hygienists became interested in microscopic work and were predisposed towards eugenic ideas (see Wyndham, 1996). Biologists at this time were known to draw their ideas from the revival of 16th century figures (see Farley, 1991; MacLaurin, 1925). One of these was Spinoza, whose microscopic studies were related to studying insects (see MacLaurin, 1925). One key soldier figure was Harvey Sutton who made no secret of drawing on what was happening in Germany during Nazi occupation in World War II. Sutton, also had been in England as a Rhodes scholar and, upon returning to Australia took a special interest in child development and medical experimentation, and had a most dangerous influences on the direction such a “preventive medicine” was to take.

In summary, I have shown some key developments in medical knowledge as it particularly pertains to the soldier tradition and to the way military medicine, Tropical Medicine, and tropical hygiene developed during the 19th century. The point to be highlighted here is that much written on military hygiene, tropical hygiene and public health during this time was largely informed by doctors whose attitudes and experiences were formed in India or other parts of the colonial empire. Explanations for the mortality rates of Europeans, soldiers and others in colonial territories were shown to be based on statistical surveys or “fact” but reflected assumptions based on ideas of British

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15 Joseph Verco held an M.D. degree from London University and therefore was more inclined to be patient-centred. However, he was also a Freemason as well as a Major serving in the Australian Army Corps in World War I. I will refer to Verco again later in relation to his role at Adelaide University medical faculty. This doctor is a prime example of the difficulty one confronts in neatly compartmentalising dimensions of human behaviour.

16 Harvey Sutton was an ardent eugenic enthusiast and was influential in teaching preventive medicine and promoting medical experimentation See Chapter Five, especially from p.181.
superiority. This meant there was a leaning towards explanations, which contained reference to “natural” and “biological” rationalization, without taking into account social factors.

These developments were buttressed by a perception that the army offered the advantage of a more critical training, a view which also nurtured notions of superiority towards civilian medical colleagues. In addition, notions of a nomadic existence were kept alive by associating army professionalism with professional isolation from colleagues (see Osler, 1906, p.117). This idea of professional isolation from colleagues has been seen by others as being the single most distinguishing factor of military professionalism (Hackett 1983). Also while there had been a previous interrelationship between British and French surgeons, also British, North American and Australian military doctors seemed to share some similar characteristics because many served or were involved with those who served in the IMS (see Osler 1906, p. 107). Before moving on to Australia, it might be useful to briefly outline some of the effects of military medical dominance over the civilian medical population in Britain.

**Effects on the civilian medical profession**

The effects on the civilian medical profession within England and Wales were, as a military medical elite gained status, the generalists were subordinated and excluded\(^\text{17}\) from positions of power and influence within England and Wales (see Curtin, 1989; Summers, 1988; Rigby, 1992). Its beneficiaries were practitioners adhering to ascetic ideals of purity or ritual purification which later becoming reoccurring themes. For example, Youngson (1979, p.13) shows that the types of doctors evident in England during this period were:

\[
\text{… pure physicians, socially, financially and by education at the head of the profession; pure surgeons, who were not expected to be men of superior education and whose claim to be qualified, it was said, was that they were uncontaminated with the slightest knowledge of medicine; pure apothecaries; and doctors, apothecaries, physicians and surgeons in general practice who looked after the bulk of the population [italics added]}\]

At this time and later, those in positions to wield power and influence were not necessarily the most experienced medical practitioners. As Curtin (1989) has shown military medical doctors produced the nosology which categorised the body into

\(^\text{17}\) These terms have been borrowed from Willis’ (1989) analysis of the three strategies used by the Australian medical status quo to sustain dominance over the division of labour.
sections and which included categories of accident, punishment and “in action”. As far as the emphasis on a craft or task-orientation is concerned, this really did not change much from the time of Downie and Charlton’s (1992, p.23) observations when they state:

(The) need for reform in the public interest was formulated against a background of approximately eighteen degree, diploma and licentiate awarding institutions, with variable and incompatible standards of entry and tests of proficiency. Some institutions awarded their certificates as a blatantly commercial activity, with hardly any pretence of rigour - rather like the bogus correspondence colleges of today. There was no consensus as to which qualifications were recognised where highly competent practitioners often operated under threat of prosecution by institutions attempting to enforce ancient monopolies (for example, even superbly trained Scottish graduates were, for a while, not allowed to practise in London).

The consequence of these changes were that “reforms” of medical training and education was given a sense of some sort of “unity” in that everyone had a formal qualification and letters after their name to distinguish one from the other. It was never a reform in the sense of a change in ethical and social practices within mainstream professional practice. It did not stop the growing importance of universities in education, beginning with the establishment of the University of London in 1830, nor dispensaries and other provincial universities since that time (see Loudon, 1995). However, it had the effect of widening divisions and polarizing the archetypes. The association between the hospital-based surgeons, later accompanied by physicians, increasingly became more specialised and technologically oriented with the express intent of distancing themselves from the generalists and aligning themselves to regal and vice-regal patronage and imperial interests through their Royal Colleges and their chivalric orders.

At the same time, the generalists were covering all aspects of medicine, but were excluded both from hospitals and from teaching, as well as being treated by the physicians and surgeons as an “under-class” (Loudon 1995, p.242-243). Even before the 1858 Medical Act was passed, the situation was such that the controversial Thomas Wakley (1843), editor of the *Lancet*, criticized the Royal Colleges. Here again, the significance of the difference between the “pure” practitioner and the generalist is illustrated when he states:

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18 It was around that time that the Apothecary/surgeon was being reshaped to become the “new breed” of general practitioner.
The Royal Colleges have discovered the most extraordinary ground for creating professional distinction that ever entered the mind of man. With them, the chief qualification for eminence in the healing art is ignorance for one or the other half of it. A physician need not know much of physic \(^\text{19}\), an entire ignorance of surgery will be sufficient to give him a respectable standing; a surgeon need not possess any real knowledge of surgery, but if he be sufficiently ignorant of physic - if he does not know the gout from the measles - that will render him “pure” and make him eligible for the higher appointments, but a general practitioner - a man so preposterous as to understand both physic and surgery - is fit only to become a subordinate (cited in Loudon, 1995, p.243)

What is also relevant is many changes occurring during this period, displacing the importance of the generalist in favour of the soldier, would reoccur again in a somewhat metamorphic form in Australia beginning in the period of the Cold War. \(^\text{20}\)

In both instances, structural change seems to have occurred within some type of real or imagined crisis and in the wake of military reforms, culminating in the enactment of legislation institutionalising civilian reforms favouring a status quo aligned to military and religious chivalric orders. As Hackett (1983) has stated, civilian reforms have always been made in the wake of military reforms, and rarely vice versa.

Therefore, globally the 19\(^{\text{th}}\) century not only had its wars and rebellions, it was also a time when the soldier archetype began to not only subordinate civilian doctors, but also most of the population within colonial dominions. Also the devastation meted out on Indigenous peoples caused the greatest mortality revolution since the agricultural revolution occurred (see Curtin, 1989). It was also a period when patriarchal attitudes were institutionalised into medical practices so as to reassert male superiority and recast women as inferior. However, these attitudes were recast in notions of “British” and “white” superiority.

In conclusion, in England from the 1860s onwards, St John army doctors were the teachers who institutionalised their medicine and their values into the London teaching hospitals. These army doctors were those who had served in colonial outposts and were either surgeons and sanitarians or hygienists. Because the IMS model was a guarantee of work, many doctors used the army as a stepping stone into civilian practice. As soon as soldier/surgeons were able to wield their influence in the teaching hospitals, generalists and others who might exert power or influence began to be excluded (see Downie and Charlton, 1992; Digby 1994; Rigby, 1992). The London teaching hospitals became the modern Temples, while the soldier doctors became the

\(^{19}\) Meaning medicine.

\(^{20}\) These aspects will be outlined in Chapter Six.
gods or high priests. From the 1880s onwards, the period which marks the emergence of the biomedicine, there was an increase in the doctors migrating to Australia from the United Kingdom. This sets the background for understanding events in Australia as well as the influences medical students and others would be likely to encounter when going to England to study. It was also around the 1880s when the soldier/saviour began to be constructed in Australia.

Creating Australian soldier/saviours

After the Sepoy Rebellion in India and the Waikato war in New Zealand, violence against Indigenous peoples escalated in Australia (Grey, 1990). These patterns were repeated towards the end of the century in Africa, as well as Australia, and not confined to the British. While, in Australia Indigenous people were believed to by “dying out”, in Africa, the image of the tropics slowly changed from being the “white man’s grave” to that of “triumph of disease” (see Curtin, 1989; Farley, 1991).

The murder of General Gordon at Khartoum and the Sudan war in the 1880s was not only a time which induced another crisis milieu, but also it coincided with the Prince of Wales becoming the Grand Master of both the Order of St John and the United Orders.21 As symbolic “jewels of Empire”, New South Wales (NSW) army surgeons22 acclaimed their coming of age” in the Sudan war declaring themselves as having “joined to other chivalric nations of the Knights of the East and West” (McIntosh, 1948).23 These army surgeons volunteering in both the Sudan and Boer wars underwent their ritual obligation to give service on the battlefield as a rite of passage for acceptance into the chivalric fold. Many of these soldier doctors began to take leadership roles in government positions during the early 20th century. Others continued in active service during World War I within the Australian Army Medical Corps (AAMC) and the Australian Imperial Forces (AIF).

Military doctors of that period were not only “practitioners of high standing, but were also keen and enthusiastic soldiers” (McIntosh, 1948, p.489). Military medical

21 It was also the time when the Masonic Lodges in many Australian colonies became united under the umbrella of a Grand Lodge.

22 Until the end of the 19th century army doctors in the Victorian/Edwardian army were surgeons, after which time they were joined by hygienists or sanitarians.

23 The presence of the Knights of the East and West and a myriad of other such orders are known to have existed in Australia (see Jackson, 1994; Smyth, 1991). The language of the Knights of the East and West seem to appear in their symbolic historical association with the “jewel” and the “hecatomb” (Jackson, 1994).
officers became the “policemen” of the colonies where the rhetoric of “saving” or “salvation” had its parallels in the “protection” legislated in terms of the “White Australia” policy. In different periods, British troops introduced diseases to Indigenous peoples in India, Africa and Australia and refused to accept responsibility for their health (Broome, 1994; Curtin, 1989; Worboys, 1993).

In addition the “natural” bed partner of biological racism and “blood ties” was the soldier archetype whose attitudes internalised notions of purity and pollution as well as ideas of “whiteness” that progressed to being xenophobic. As stated in chapter one, these ideas mirrored the “dissector” as the ideal type of doctor. Apart from “breed” or “racial type”, the social value given to the age of institutions was a key factor for public acceptance of a shared history between the chivalric orders and the monarchy.

Also before World War I and similar to India, Australia became known to the outside world as a “social laboratory” (see Ramasubban, 1988, Wyndham, 1996). The first attempt at selective breeding was based on differentiating people on the basis of skin colour was established along with the “castle and fortress” model of military defence.24 The Immigration Restriction Act (1901) became a “colour bar” as well as a political cordon sanitaire to protect the fortress from outside “disease populations”, while quarantine laws and segregation were used to protect those within its “castle” (see Rivett, 1962; Williams, 1995). Evidently such actions were not confined to Australia because, as Foucault (1978, pp.149-150) states:

… (T)he thematic of blood was sometimes called on to lend its weight towards revitalising the type of political power that was exercised through the devices of sexuality. Racism took shape at this point (racism in its modern “biologizing” statist form) … accompanied by a long series of permanent interventions at the level of the body, conduct and health, and everyday life, received their colour and their justification from the mythical concern with protecting the purity of the blood and ensuring the triumph of the “race”…The eugenic ordering of society with all that implied in the way of extension and intensification of micro-powers in the guise of an unrestricted state control was accompanied by the …exaltation of a superior blood; the latter implied both the systematic genocide of others and the risk of exposing oneself to a total sacrifice.

The military award system only acknowledged the feats of high-ranking officers and the ritual benediction of one of the first Australian soldier culture heroes had to wait until the end of the century. The hero ritual associated within the Medical Corps was

24 Hackett (1983) has argued that this model of defence was popular in colonial contexts.
reinforced in the Boer War (1899-1902) when an Australian godhead figure was created to stand alongside others who stood against the Indian Mutiny.\(^{25}\) As stated, in 1900, Lieutenant Neville Howse, a surgeon, made history when he was awarded the Victoria Cross (VC), remaining the only Australian medical officer who achieved that distinction.\(^{26}\) The relations cemented in the ceremonial ritual were described by ADFA (2001b, p.2) as follows:

(Howse) award was presented to him in a ceremony by the Chief Justice of New South Wales, Sir Frederick Darley, and Howse shook hands with two men who had won the Victoria Cross in the Indian Mutiny and since immigrated to New South Wales.

Other army awards were given on the basis of seniority alone. For example, after the Boer War, other military officers by the names of Williams, Kelly, and Eames were created Companions of the Most Honourable Order of the Bath (CB) while Fiaschi, Roth, A.E. Perkins, T.A. Green and A.H. Horsfall were created Companions of the Distinguished Service Order (CDSO) (McIntosh, 1948). The award received depended on the rank of the individual. For example the CB or CMG was given to Colonels or Brigadier Generals.\(^{27}\)

Of equal relevance to the cultural and social reproduction of each archetype is that from approximately the 1880s until the 1960s, the practice of “topping up” of Australian qualifications with British ones, led to Australian “specialist” qualifications being obtained in Britain from the Royal Colleges. After Federation, this practice was also extended to hygienists or public health doctors and others before they took up leadership positions after Federation.\(^{28}\) Within emergent militarized relations, such

\(^{25}\) Graham Dawson (1994) has argued that the construction of solder heroes was integral to the construction of British heroic masculinities and imperialism. This Britishness was in essence always in the context of its own inherent racial superiority over significant others. In Australia I argue that this inherent superiority was always part of the internalisation of military values where professional isolation from colleagues was an important practice of instilling subordination.

\(^{26}\) As I will show later, during the period from about 1925 to 1930s, Lieutenant Howse became a Major General in the Australian Imperial Forces (AIF) and then became Minister of Defence serving alongside other prominent military figures who entered national politics during this era (ADFA, 2001b).

\(^{27}\) The Order of St Michael and St George and the Order of Bath were the only two orders available to Australians. The only military order was the Order of Bath, while the Order of St Michael and St George although primarily given to civilians, such as diplomats, was also given to military men such as Howse. For full detail on military awards given to Australian see (Digger, 2006). As an aside, they state: “The wags say: CMG stands for 
\[\text{Call me God;}\] the KCMG stands for \[\text{Kindly call me God},\] and the GCMG stands for \[\text{God calls me God}\]” (ibid, p. 3).

\(^{28}\) This practice of “topping up” was not limited to gaining medical degrees or diplomas. For example, the Council of the Royal College of Surgeons in England was known to give honorary fellowships to Australian surgeons, such as Sir Earle Page, not because of his proficiency as a surgeon, but because of his “distinguished career as a Statesman” and his involvement in imperial politics (Page, 1963, p 427) These connections seemed to be more visible at this level.
practices seem to have its parallels in structural changes to short-term recruitment in the military, the reasoning being that it was better for soldiers to come back to England on a regular basis so national sentiments could be reinforced (see Ramasubban, 1988; Worboys, 1988).29

More generally, between 1901 and 1902 military and volunteer arms of medical contingents were united through Federation, when defence, quarantine, and external affairs became linked responsibilities of the Federal government. After this time, there were several areas of administration and organization which military doctors undertook: one was in their involvement in the Commonwealth Department of Health (CDOH) where quarantine and immigration and external affairs became interlinked portfolios; the second was their involvement in Tropical medicine later united with Public Health; the third was their involvement in both public health campaigns and changes to medical education influenced by American philanthropists; and the fourth was their role in the St John’s Ambulance Brigade.

From 1901 the NSW Corps, as well as other various colonial units, were subsumed into the Army Medical Corps and “given the King’s Colour by the King Emperor” who was the previous Prince of Wales (McIntosh 1948, p. 491).30 They then became part of a Permanent Army Corps whose function was to act as advisers to the government, a practise which they maintained until the 1930s (see Butler, 1930).31 Early medical leaders were men such as Williams, the first Director-General of Medical Services (DGMS) of the armed forces of the Australian medical services who served in the Sudan War, the Boer War as well as World War I and later remained in the Permanent Medical Corps of NSW. Other NSW military medical officers, who were mainly advocates of White Australia and/or eugenics, were such men as Neville Howse, who was promoted to Major-General and Director of Medical Services of the AIF. Howse was awarded several knighthoods, one as a Knight of the Bath (KOB) a strictly

29 This practice was not confined to those in Australia. From living in the Middle East for a number of years, there was an established practice that undergraduate degrees were obtained in the home country, while postgraduate studies were pursued either in London, France or Germany. As far as the generalists are concerned, Australian medical students trod a well-worn path to Britain, many choosing to go to Edinburgh for their education, the effects of which will be explained in the next chapter.
30 The account of the Australian involvement more generally in the Boer War by Grey (1990) differs in some degree to that of the account of the military medical historian whom I have cited.
31 Under the constitution of the Commonwealth of Australia, the Governor General is the representative of the King or Queen as well as being Commander-in-chief of the Commonwealth Forces now known as the Australian Defence forces (ADF) (Governor General of Australia, 2005). At the next level, the everyday administrative affairs are handled by the heads of these Defence Forces and their officers (ibid.).
military order, another as a Knight of St John (KStJ) and another as a Knight of the
Order of St Michael and St George (KCMG) (Australian Defence Force Academy
(ADFA), 2001).

The British War Office insisted on recruiting Australians into the military forces
only if they had been in “active” service, meaning they had undergone a previous
initiation on the battlefield. Nevertheless, administrative control and seniority were only
as high as army-corps control so, in essence, these personnel were part of imperial
rather than Australian structures. As Butler (1930, p.i) states:

Apart from the expedition to New Guinea, Australia was not responsible for the
complete organisation of any military force. Certain important medical units were
not contained within the organisation of the AIF and, though its medical director
came to exercise personal influence outside the Australian Army Medical Corps,
his authority was always confined within its personnel.

Originally when the Permanent Medical Service was first established under the
DGMS, the arrangement united both volunteer army medical corps as well as the
militia32 There was also a reserve of officers created from registered members of the
medical profession deemed “duly qualified” and willing to enrol, as well as retired
officers of the army medical service. In addition, the Australian Army Nursing service
(later the RAANS) was categorized as a voluntary body formed “for the purpose of
supplying trained and efficient nurses under an organized system, available for duty at
Base Hospitals and Stationary Field Hospitals in times of national emergency” (ibid,
p.6).

In addition to the above, the AIF were expeditionary forces formed for service
overseas and organized to be more self-contained and autonomous. Above, I have
pointed to their attitudes to war when talking about the expeditionary force officers.33
The powers of the General Officer Commanding the AIF were listed in a document
given the title of the Magna Charta. Outlined in Table 3.2 below, it was drawn up to
symbolize administrative freedom, authority and autonomy (ibid, pp.7-9).

The first Assistant Director of Medical Services, then Lieutenant-Colonel, N.R.
Howse, V.C, would later play a decisive role as Major-General and Director of the

32 The militia consisted of “Regimental Medical Establishments, Mounted Bearer Companies, Infantry
Bearer Companies and Field Hospitals”. A militia army medical corps principal medical officer was
employed on a part-time basis and placed in control of the service in each District (Butler, 1930, p.6).
33 Williams (1995) has also examined the role of the AIF in his research on Australia’s reactions to
modernity.
Medical Services during World War I (ibid, p.33). After the war, it seems some powers listed in this *Magna Charta* gave AIF medical officers a number of rights over others. The danger was in the capacity for such powers to be transferred into civilian life when Howse later made his way to the Ministerial battle front.

The most dangerous is the point allowing the commanding officer to delegate power over civilian personnel outside of war conditions. Even, when this type of power is secretly or even subconsciously transferred to civilian life, it can be undemocratic to say the least. For example, from 1911, when the first military district geographically combined Queensland with the NT, the Federal government gave Queensland a range of administrative responsibilities over the NT. Also there were many times the surgeons especially tried to establish dominance and in a number of instances imposed their authority without rhyme or reason. However, as there was no national organization of either undergraduate or postgraduate education, or of public health, other than quarantine regulation, the process of the soldier doctors achieving structural dominance over established institutions was slow and incremental and did not culminate until the 1970s, when for a time it became more covert.

Table 3.2. *The “Magna Charta” of the commanding officer of the AIF*

- The power within authorized establishment to change, vary, or group units in such manner as he considers expedient from time to time;

- the power to appoint and promote subject to confirmation officers who, in his opinion are suitable and qualified to fill vacancies in the authorized establishment;

- the power to remove officers and men who are unfit by reasons of wounds, sickness, or other causes, and to arrange with the High Commissioner in London for their return to Australia;

- the power to detail to units the personnel of first and other reinforcements in order to make good wastage due to any cause; and to delegate such power if necessary; and the power to employ, discharge, attach, or remove civilian personnel required from time to time [italics added]

(Butler, 1930, pp.7-9)

A number of AIF and AAMC doctors were particularly prominent from the 1920s onwards. Apart from Dr Cumpston, who became Director of Public Health, one
of the most well known was the medical advocate of White Australia, (later Sir) Rafael Cilento who went to Queensland as the first Director of the Institute of Tropical Medicine and served in the Territorial forces in New Guinea with F.A. Maguire. In turn, both F.A. Maguire and Hugh Poate, also World War I veterans, were involved with the NSW St John Ambulance Brigade. Maguire was the first Hospitaller for the St John Ophthalmic hospital as well as a NSW Masonic leader.34 AIF surgeons returning from the war reinforced the idea of the doctor as a hero and saviour, also insisting they were “owed a debt of immeasurable proportion by the community” (Pensabene, 1980).35 This attitude has persisted into contemporary times.

In wartime the soldier seriously became linked to the idea of chivalry suggested earlier by the Order of St John leaders, incorporated lifesaving practices which endangered the lives of rescuers (see Howie-Willis, 1983, p.115).36 These “lifesaving” practices not only endangered and killed doctors, but also endangered and killed many more young men who were sent to the war as cannon fodder.

Many Australian young men experienced few benefits of this “Great War”. They were indeed “heroes” sacrificed during this war as 65% of those enlisted did not come home (see Butler, 1930). At the same time, those who survived but were injured did not always receive what one would consider humane medical treatment or consideration. Bourke (1996) has documented how, during this war, amputation was a favoured practice among British military doctors. However, the belief in the glorification of war and its benefits were shared by military and religious leaders as well as other chivalric brethren whose ideas about their relationship to “god” took on other

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34 As far as I am aware, Gillespie (1991) is one of the only texts which has documented the involvement of military men in public health policy after World War I. His work has been an invaluable supplement to my analysis. Grey (1990) has pointed out that no-one has been interested in documenting the martial tradition.

35 While Pensabene (1980) has noticed this characteristic, he did not look at it as a military ethos.

36 Later the idea of “paths of practical chivalry” extended the idea into civilian life to all classes. This concept was coined by the Reverend John Flynn who was acclaimed as founding the Royal Flying Doctor Service. This idea added a further dimension which widened and extended chivalric practices to all classes in civilian rescue work (Howie-Willis, 1983, p.330). For example, the idea is kept alive in the imagery depicting hospital medicine as “life-saving” accident and emergency work found in a number of television shows today. It is also sustained through volunteers who continue to work in St John’s Ambulance, and other State Emergency volunteer rescue teams who are mobilised during fires, floods, high winds or other natural disasters.
dimensions. The association of war with ritual purification and cleansing also found its way into ideas about public health.\textsuperscript{37}

One of its main proponents involved in Federal public health was John Cumpston.\textsuperscript{38} In his initial role of first Federal Director of Quarantine, Cumpston first lectured members of a Masonic lodge on the advantages of war, as well the rise in national sentiment he predicted it would invoke. As all soldier doctors were soldiers first, it is not surprising that, during World War I, his lecture published in \textit{The Medical Journal of Australia} where Cumpston (1915, p.459) stated:

This stirring of a nation’s soul under a common danger is one of the most wonderful effects of war, and is, I firmly believe destined to be one of the most profound and far reaching effects of the war upon the public health.

Cumpston then elaborates on how he sees this occurring. Firstly he points out: “War improves the mental tone of those returning in terms of being a part of a concerted action in the face of great danger” (ibid). Then he equates a ritual initiation on the battlefield as a profound religious experience which would translate into improved physical benefits. He also states war “… entails somewhat of a profound mental conversion amounting almost to a religious reformation. A nation which passes through such an experience cannot fail to benefit by improved physical tone (ibid). The subject of death was cleverly avoided. The words uttered also omitted the object of military medical treatment in the war was to “save the nation” by returning soldiers to the front line (see Willis, 1994, p.40).

During the war and shortly after, both Cumpston and Butler were two soldiers who became busy educating others about their attitudes towards public health and “preventive” medicine which were linked to their ideas about the “social” fabric of Australian society. They were also supported by the Dean of the Melbourne Medical Faculty, a Professor Allan.\textsuperscript{39} After the war, others returning to Australia formed a coalition of the faithful with those who held the fort at home. They began to shape notions of public health and preventive medicine to begin the social experimental process of “purifying” the Australian population. Below the role of brotherhoods and

\textsuperscript{37} Garvie (1921, p.83) researched British attitudes shortly after this war and stressed that the idea of entering into battle was powerfully entangled with religious sentiments and ideas of moral regeneration.
\textsuperscript{38} Cumpston, originally from WA, served in the Boer war and, in accordance with the established pattern of “topping up”, he went to England for professional training before taking up a key leadership position in Australia.
\textsuperscript{39} See Wyndham (1996) for further elaboration as she has covered the topic of eugenics in Australia.
chivalric orders in Australia are briefly discussed, before discussing the managerial and administrative functions of the soldier.

The role of Freemasonry

Freemasonry was exported to Australia with the military travelling lodges, and subsequently became over-represented by military men (Farwell, 1981; Knight, 1984). The concept of Freemasonry, as being synonymous with an “imperialist identity”, is useful when analysing the period between the 1880s and the 1950s in Australia (see Harland-Jacobs, 2000, p.268). In regard to medical officers, such influences cannot be discounted especially because, according to Masonic historians, a chivalric order, the Knights Templar, became a favourite one with medical officers in British Army Lodges (Gould 1899, p.130). For example, Gould (1899, p.206) states that military surgeons, along with others working in the medical departments of armies, had attained the highest distinction as Freemasons more than any other profession. He asserts:

> whether, indeed, the Military is entitled to rank before, or with, … the medical profession, in respect of the influence it has exercised on Freemasonry is a point on which there will be a difference of opinion, but a combination of the two may be instanced with confidence, as the most favourable condition – certainly in former times –under which the highest distinction in the Craft could be attained (ibid, p.197)

Service in the military was also considered an unselfish act because of the choice made between private interests and serving the country and nationalism was considered the “soul of the race” (Bean, 1919, pp. 14-15). Freemasonry in the army was not at all democratic in the Victorian/Edwardian era. As Farwell (1981) states:

> Many, perhaps most, officers and senior non-commissioned officers were Freemasons. Freemasonry grew rapidly in the Victorian-Edwardian era. … Certainly it was popular with royalty, the Protestant aristocracy, and the senior ranks of the army. … Freemasonry as practiced in the army made no pretence of being democratic … it was impossible for anyone under the rank of sergeant to become a Mason, but that immediately a man who wanted to make the army his career reached that rank, he looked for someone to sponsor him. In Kipling’s story “The man who would be King”, the prestige of Freemasonry is equated with that of royalty … (ibid, p.223).

No doubt, the idea of such a cultural movement “permeating” the social landscape is appealing, because Masonic leaders not only promoted patriarchal ideals,

40 The Knights Templar later became part of the imperial Masonic chivalric orders referred to earlier and called “the United Orders” whose members saw themselves as having a spiritual association with the Order of St John (see Smyth, 1991).
but also promoted Enlightenment concepts and Newtonian science (see Oliver, 1989; Weisberger, 1993). For example, Rich (1989) has used Gramsci’s notion of hegemony in interpreting the significance of the practice of also attaching the Masonic lodge to the grammar school so as to reinforce the cultural reproduction of professionals loyal to imperial ideals. As Harland-Jacobs (2000) points out:

The lodges comprising the network, which stretched from Britain to the colonies and back again, were composed of citizens who felt a sense of obligation to the empire, specifically to promote imperial unity, to defend the empire against external threats, and to civilize the empire’s “subject races” (pp. 268-269). Rich (1989, p.110) has also argued “the British lived by right in a foreign country, while its natives came to England as invited guests”. While within Craft Masonry an ethos of voluntarism encouraged men to develop some social conscience, this was not so in the elite imperial echelons, where relations left a social legacy which taught “not to acquire empathy for the masses” (Rich, 1989, p.88).41

At the same social level of vice-regal patrons, from 1913 to 1914, Dr C.U. Carruthers, an Officer of the Order of St John (OStJ) was elected as a leading figure in NSW Freemasonry. An Irish-born hospital surgeon involved with Balmain District Hospital, he had come to Australia after serving on the battlefield and receiving his honours (see Henderson, 1988). While, as a Balmain resident, Carruthers diligently lobbied for improvements to the sanitary environment, at the hospital he was seen to have been one of the first to take the attitude that it was a “professional mortal sin” for patients to have a choice of doctor (see Best, 1988, p. 29). Such a doctor-centred position seems to be one which was grasped quite distinctively when he described such attitudes towards patients as one between “the glance and the silent body”. However, although Foucault (1973) coined this phrase as symbolising the doctor/patient relationship within the new Paris hospitals, such a phrase could be extended to other doctors whose work isolates or distances them from patients.

From individual photographs of Australian Masonic Grand Masters over 100 years (ibid.) those in these upper echelons, such as Carruthers, all had a significant number of letters after their name, as well as a dress code exhibiting a large number of jewelled pendants and ribbons. These distinctive elements are known to be favourite

41 While not referring to Freemasonry, there has been no shortage of interpretations and critiques about doctors and health services in Australia by historians and sociologists (see Dickey, 1980; Edwards, 1988; Hicks, 1981, Patrick, 1987; Willis, 1989).
practices of those belonging to “secret” fraternities (see McKenzie, 1967). Before turning to the topic of the Order of St John, Carruthers’ photograph is depicted on the next page as an example of what I have called the soldier/saviour archetype who was, in essence, a military medical officer associated both with Freemasonry and the Order of St John, a quite different kind of doctor to the generalist archetype of the time in every aspect of his persona, despite being almost the same age of the generalist whose picture is also supplied in the next chapter. Below the establishment of the St John Ambulance Association and the St John Ambulance Brigade in Australia is briefly discussed.

The St John Ambulance Association

Both the John’s Ambulance Association and St John’s Ambulance Brigade slowly emerged in colonial dominions to institutionalise “western” medicine or a disease-specific orientation and to create civilian reserve armies of labour ready to be mobilised in times of war (Howie-Willis, 1983). While chivalric Masons kept their identity a secret, they could work through the St John’s Ambulance Association or the St John Ambulance Brigade, whose traditions of battlefield, hospital and accident or emergency medical servicing ran in tandem with the need to defend the Empire. Many Masonic knights also supported the main charitable foundation of the British Order, the St John Ophthalmic hospital in Jerusalem (see Howie-Willis, 1983, Smyth 1991, pp.130-131).

A significant point is it met with armed forces regulations for a uniformly organized medical system across the Empire for ease of mobilisation in emergencies (see Tanner, 1980).

The work of the Order of St John spread to Commonwealth countries with the first St John Ambulance Centre being established in Victoria in 1883. Both the St John’s Ambulance and the St John Ambulance Brigade were introduced into some Australian colonies as foundations of the Most Venerable Order of St John at St John’s Gate, London (see Khangure and Howie-Willis, 1997). While the St John’s Ambulance was present in most states, this organization was more involved with administering civilian first-aid and home nursing until after World War I (Butler, 1930, p. 15). Also when the Australian branch of the British Red Cross was formed in 1913, it was different in function to its British counterpart. The Governor-General’s wife at this

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42 This charity was not extended to many Aboriginal people suffering from trachoma and cataracts. As Dr Fred Hollows, the Australian Ophthalmic Surgeon, who later performed outstanding work in Australia and Africa in this area, found out later that some Aboriginal people had their eyes gouged out rather than treated (see Hollows and Corris, 1991).
Soldier/saviour surgeon, Dr U.C. Carruthers (1853-1937), first surgeon Grand Master of the United Grand Lodge of New South Wales, 1913-1914 and Officer of the Order of St John (OSJ)

(Henderson, 1988, pp.101-102)
time established a tradition for later wives of Governors and Governors-General to act as Red Cross patrons (Burrow, personal communication, May, 2002). Their role was to actively participate in raising money and nurturing goodwill to supply comforts and services to soldiers at war (Butler, 1930, p.14). Again the St John Ambulance medical staff was required to play an exclusive role in any training given. For example, Stubbings (1992, p.9) states:

Those who understood the importance of the wish of the King, that the Order of St John and the Red Cross should cooperate in war work, decided that all instruction in first aid, and home nursing would be given by the St John Ambulance Association.

Many doctors spent their lives as volunteers in providing administrative leadership and first-aid training for the St John Ambulance Association. By the end of the century, the St John Ambulance Brigade was established in some colonies and, especially in NSW, it played a special role.

The St John Ambulance Brigade in NSW

The St John Ambulance Brigade, with its uniformed volunteers, had a distinct military structure. Its principal aim was to prepare a civilian reserve army of volunteers who could be readily mobilized in time of war. However, it was not immediately popular, being regarded by some as closely aligned to the idea of civil conscription (Howie-Willis, 1983, p.182).

The Brigade was mainly supported by the NSW Centre of the Association, some of its volunteers being those military surgeons who had received medals or awards in the Boer War (Howie-Willis, 1983, p.180-181; McIntosh, 1948, p. 485). In addition, due to an irregularity, the Brigade established in WA acted in a secondary role as the local Corps of the AAMC with one doctor maintaining a dominant and autocratic position for a number of years (see Khangure & Howie-Willis, 1997; Howie-Willis, 1983, pp.180-181). As such, the Brigade was subjected to inspections by the Surgeon-General of the Commonwealth forces and other military leaders on their WA visits (Howie-Willis, 1983, pp. 180-181).

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43 Tanner (1980) has provided a historical analysis of the way the idea of civil conscription was pushed by politicians and how it was received by the broader Australian population between the time of Federation and World War I.

44 One was Major R. E. Roth, who was Medical Officer in Chief of the Brigade and was later sent to the Northern Territory (see Kelly, 1994). However, while Queensland from the outset had a strong military presence, it did not initially involve itself in such developments (Howie-Willis, 1983, p.178).
Both the Orders of St John and its Masonic counterparts were very much served by the same people and they stood as a symbolic link to an ancient tradition of charitable works and the defence of western Christian civilisation (Howie-Willis, 1983, p. 179). However, while there will not be much more reference to such pseudo-chivalric Masonic influences, it might be prudent to point out that Masonic Knights were often army officers who did not identify themselves publicly as such, but worked through organizations like the Red Cross in England and the St John’s Ambulance and Brigade in Australia as well as through their various professional bodies (see Gould, 1899, 1903; Jones, 1956; Hackett, 1983; Knights and Lomas, 1996, 1997; Mackenzie, 1967; Partner, 1982; Roberts, 1972; Robinson, 1989).

In summary, from around the 1880s in Australia, military medical officers associated with the United Orders and the British Knights of St John in Australia were caught up within a Hospitaller tradition which projected a chivalric and crusader zeal of life saving. While St John Ambulance was established throughout Australia, such developments also represented the establishment of a military and religious medical system with a bias towards hospital servicing and a craft or specialist orientation of its doctors. This medical system was shaped within a feudal relationship linked to royal interests and a set of values serving imperial aims and goals. As Ross has articulated, one might also assert these doctors performed more than instrumental functions in the line of defence, they also performed other symbolic functions (see Smyth, 1991; Ross 1985, p.11). As a Masonic Knight, the doctor could imagine himself as a high priest, associating sin with sickness and emphasising “healing through repentance and reformation” (see English Masonic Bible, 1964, p.18).

For the St John Brigade in NSW, the period before World War II was considered a “golden age”. Such developments had a significant bearing on the influence of a leading Sydney surgeon, Hugh Poate (later Sir), like other such doctors, who wielded their influence at the time. Poate, like many of his colleagues, was a volunteer, who devoted over thirty years, the greater part of his adult life, to furthering the work of the St John Brigade, the aim being to prepare civilians for mobilization in times of war (Howie-Willis, 1983, pp.282-283). He joined the country’s first Brigade Division, Glebe as a Divisional Surgeon in 1910 at the age of 27, becoming the NSW Acting Commissioner in 1926 when he formed a staff school of instruction for Brigade
members. At the time, the St John Brigade comprised 29 Ambulance Divisions, 19 Nursing Divisions and 13 Cadet Divisions (ibid, p.283).

The aim of the school’s instructors was to give advanced training “in Brigade lore and medical knowledge and practice for future Brigade officers” (ibid). Exactly what this knowledge consisted of was not spelt out, but generally training covered lessons in anatomy, physiology and first aid (Khangure and Howie-Willis, 1997). “The recipe for success” set up by Poate and his colleagues was linking personal pride and ambition to the goal of a more effective Brigade (Howie-Willis, 1983, p.285). Promotions depended upon the successful completion of the course at the school and approximately 30 Brigade “other ranks” were selected annually for a year-long program of instruction and examination to prepare them for eventual duty as commissioned officers. This all served to make the Brigade more efficient and professional and developed increased the pride in wearing the Brigade uniform and gaining rank. Fifty years later, graduates of the school still felt great pride at having been selected for training and graduating from the school (ibid, pp.283-284).

The Brigade actually took on the character of an Army Corps, with numbered divisions divided by geographical regions. This meant by the time World War II became imminent, Poate had a large civil defence force under his control. This was a well-trained, disciplined, highly efficient and coordinated body of men and women who could be placed at the disposal of military and government authorities (ibid, p.285). For example, as far as the Western Australian Brigade was concerned, Khangure and Howie-Willis (1997, p.32) state:

What emerged…(was) a uniformed, disciplined force which was hierarchically structured, with a major horizontal dividing line between the “commissioned” officers and the “other ranks”, whose various insignia of rank resembled those of the army. … (Its) members were grouped locally into “divisions” which, analogous to army platoons, consisted of between a dozen and sixty individuals. Gender was the basis for another dividing line, the men belonging to “ambulance” divisions and the women to “nursing” divisions (but) “…combined” divisions were eventually permitted. The various ambulance, nursing and combined divisions were grouped regionally into “corps”. A series of contiguous corps comprised a “district”, the commander of which was called a “commissioner”, the first to hold the position being a career military officer, Colonel Edward Talbot Thackeray, who was appointed in June 1893.

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45 One must also assert that Poate was just as much part of this machinery as his brigade followers, because he volunteered his time and effort for exactly the same reasons.
Now one needs to turn to the administrative and managerial roles played in association with the Federal government.

Public health administrators and “social” and “preventive” medicine

Intensely popular quarantine and segregation measures continuing into the 20th century are associated with contagionist doctrines, being the older “less scientific” kind of medicine. They are more akin to practices of boundary maintenance through expressed fear of pollution, a fact emphasised by other researchers (see Douglas, 1978; Nettleton, 1992). An important and contradictory factor, which still persists today, was while the contagionist school recommended quarantine measures, it otherwise did not consider the spread of contagion to be preventable. Therefore a continual search for vaccines prevails. In colonial contexts, the doctrine could be used to justify sitting back and letting the poor and the “natives” die, since nothing could be done about it (Curtin 1989, p.75; Arnold, 1993). Curtin points to a key example of a doctor in Madras 1863 making his sanitary report on cholera in anti-contagionist terms, that is cholera was caused by atmospheric and physical states deriving from decaying organic matter and so forth, but then describing the workings in decidedly contagionist ways where human congregations are analogised with “collective pollutions” and “pilgrims” radiate their incubated germs which they get from a “contaminated centre” (Curtin 1989, p.75).

In Australia, as in the United States of America (USA) and Germany, ideas such as “social hygiene” and “preventive medicine” incorporated practices promoting vaccination and quarantine, as well as improving the domestic environment in regards to safe drinking water and sanitation. In Germany, these terms became underpinned by eugenic ideas in their attachment to the science of bacteriology or what has come to be known by the colloquial term of “germ theory”, a term generally associated with the rise of modern medical professionalism and biomedicine (McKeown, 1979; Helman, 1994; Weindling, 1999). This theory, as conceived within imperialist Germany, not only stressed notions of inherited predispositions but also emerged into “scientific racism” (Weindling, 1999).

At the Federal level from the 1920s, public health doctors were mainly military medical men administrators or managers for whom “White Australia” leanings and its eugenic connotations, underpinned their attitudes not only towards public and tropical

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46 Germ theory originated from Paracelsus whose “esoteric medicine” was linked to alchemy. His father was also a leader of the Knights of St John (see Skogmo, 2005).
health, but also immigration, quarantine or segregation (Powles, 1988; Wyndham 1996). Cumpston (1915, p.457) at this time defined “public health” as a practical science involving

the study of all factors which may prejudice the health of the community and of the methods by which (they)… may be removed. … It began by the collection of a few scattered facts concerning the pollution of water by human excreta and a vague association of ideas between malaria and marshes.

In addition, Cumpston pointed to the close alliance between the science of public health and the science of eugenics and the aim of improving health and, therefore, “national energy” effectively so as to lead to the “saving” of many lives (ibid.). He stated:

… the study of public health has as its province the whole environment of man (sic.) on a large scale and in detail, and its effect upon his life and health. Moreover the new science of eugenics, which is closely allied, is concerning itself with the individual himself (sic) and while the hygienist is striving to improve the environment, the eugenist is seeking indications of the correct method of improving the human stock (ibid.)

Cumpston also pointed out, having undergone a rapid evolution, those involved in public health began to also concern themselves with studying environmental effects on human health. In regard to the shaping of the medical institutions, Cumpston stressed the importance of the laboratory to public health and tried to introduce measures to promote “national hygiene” and “scientific practices”. Such measures had no direct patient focus and included:

- the examination of the “purity” of food, air, water and soil as well as the study of infectious diseases and the part played by animals and insects in their diffusion; and
- the regulation of the hours of labour as well as the particular environments relating to trades and occupations (ibid)

Apart from Cumpston’s influence, developments after World War II resulted in elevating the status of Howse, as well as other officers and doctors serving in the AIF and the AAMC. When the CDOH moved to Canberra in the depression years of the

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47 After 1912 under Galton’s will, a special chair and special laboratories were endowed at the University College, London (Siedlecky and Wyndham, 1990, p.110).
48 As shown below, given that public health at this time was closely aligned to eugenics the idea of community would not have been all-encompassing.
49 There were a number of other interpretations of eugenics and, as I will show, other definitions buttressed the idea of a pure community and supported sterilisation and institutionalisation of the “unfit”, especially children.
early 1930s, severe restrictions were made on government spending and staffing in the
government service. However, positions usually given to temporary clerks in the CDOH were
given to Royal Military College cadets, causing quite a lot of ill-feeling at the time
(“Two recall”, 1978, p. 20). At the same time, the maintenance of racial hygiene to
establish a “pure” community was seen as a woman’s national duty. In support of such
policies, Catholic Irish doctors were allowed to become the most vocal and some
women gynaecologists shared similar views (Siedlecky and Wyndham, 1990). Debates
were raised around the “evils” of contraception and abortion, in which religious,
eugenist and feminist groups were all involved (see Bacchi, 1981; Garton, 1994;

In sum, dominant NSW and Queensland soldier doctors who began to take
leadership roles during the early 20th century were those who had already been actively
involved in the Sudan and Boer Wars forming “elective affinities” with others after
1920s. These men formed the new aggressive generation of soldier/saviours who took
upon themselves the goal of reshaping Australian medical institutions after the war to
suit their own interests.

**Surgeon administrators**

Firstly, until the late 1920s generalists across Australia remained reluctant to
reproduce the hierarchical relationships they had left in Britain (see McGrath, 1975).
Practising surgeons at the time would study for an MS. degree at university or go to
England to obtain an FRCS. Howse was one of the most influential and, after the war,
worked as a part-time Director of Medical Services (DGMS). Between 1925 and 1927
he became Minister of Defence and Health when he bought $100,000 worth of radium
for the treatment of venereal disease and cancer, establishing one of the largest radium
banks in the world (Page, 1963, p.429).50 As Repatriation Minister he championed the
cause of ex-servicemen, especially the disabled as well as other changes taking place at
the time, especially the move to Canberra (ibid.).While he died from pancreatic cancer
in 1930, he is still regarded as an important culture-hero in Australian medical military
history (ADFA, 2001a).

Like other officers working at this level, Howse was a capable administrator with
experience in moving and organising large groups of people and looking after their

50 The fate of this radium bank needs to be explored.
needs. After the end of the war, he arranged for the training of his officers and nurses in London before returning to Australia (ADFA, 2001). Howse also sent some of these newly trained surgeons to Melbourne so they could establish their influence in that city (see Egan, 1988, p.273). Later, in 1925, after travelling with the Royal Commission on Public Health across Australia, he gained support from other surgeons to establish an Australasian College of Surgeons (ACS). This was formed in 1928 with the assistance of Earle Page, whose service in the war as a surgeon, and position as a senior medical officer helped determine his later influence (see Moorhouse, 2001, p. 8). Several years later, the ACS tried to establish itself as self-declared elite. This strategy of course not only reflected the unwritten rights of soldier over civilian interests, but was also similar to strategies employed by brotherhoods.

Apart from the ACS, the other organizations over which surgeons held sway were the St John’s Ambulance Association and the St John’s Ambulance Brigade, where a Sydney surgeon, Hugh Poate became a legendary figure, being so successful in training civilian army medical reserves (ibid.). As I will show in chapter five, Poate was to become the Australian leader of the Order of St John when it gained independence from England.

Workforce considerations

Cumpston’s greatest wish was to subsume private medicine under the rubric of public health and train doctors in preventive medicine and in methods for carrying out policing functions to regulate the population as he thought doctors were not “scientific” enough and needed training. He even wanted to institutionalise punitive measures if doctors did not conform to his regulations (see Gillespie, 1991).

The topic of military authority over public health was also a topic close to Butler’s (1921) heart. He saw the need for the military doctor to play a leading role not only in the promotion of a high ideal of citizenship, but also in providing effective guidance in promoting national health and efficiency. To do this, he considered the “community” would be best served if public health was based on the principle of

51 Later the Royal Australasian College of Surgeons (RACS).
52 In Australia well into the contemporary period, military or ex-military medical doctors were leaders of the Australian St John Ambulance organizations, the detailed histories of which have been written in a highly reflective and analytical fashion by their librarians and historians (see Howie-Willis, 1983; Khangure and Howie-Willis, 1997).
53 Butler was a Queensland army surgeon and retiring President of the BMA in that state at the time, as well as an ex-AIF man and official medical historian of World War I.
cooperation. Key players were to be the military medical profession, the clergy, engineers and educators. Butler (1921, p.567) points out:

A subject of prime importance in public health and of great sociological interest is that of cooperation by bodies outside the medical profession. In the engineering profession, in the teaching profession and in the Church, for example, we have agencies whose effective cooperation, remunerated or voluntary\textsuperscript{54}, is essential to success. In the case of the latter, one might be permitted to hope that the principle of prevention, embodied in a central prayer of the church may be translated into cooperation, to the end of physical health.

As a consequence, in the name of “public health” and “social” and “preventive medicine”, plans began to escalate for more military influences on civilian medical institutions. Already assuming authority, he pointed to a resolution made at a recent conference to exert military authority over public health organization and stated:

Principles which underlay the success of military medical administration during the war can be applied to civil life and implies inter alia “the organization of the medical profession so that every member of the profession has his part in the public health organization and that the closest cooperation exist between administrative medical officers and medical practitioners (Butler (1921, p. 562).

However, Butler (1921) did not leave it there. His ideas were not only based on military ideas about administration and organization, but they were also based on military medical values which were at this point in time eugenist and racist in outlook.\textsuperscript{55} He emphasised the role of AIF doctors in peacetime arguing “White Australia” should become an ideal of “preventive” medicine. For example, he stated:

As with the Australian Imperial Force before Amiens, on us devolves the duty of holding the bridge-head. And as a profession, it is we who have most urgently called for a white Australia as a practical ideal of modern preventive medicine\textsuperscript{56} [italics added] (ibid, p.562).

Referring to a book entitled The Rising Tide of Colour Butler goes on to explain how this issue affects the medical profession and how he in fact justifies his own self-deification:

I do not purpose to deal at length with this matter, though it is a truism that the problem of the teeming, overcrowded yellow races and this continent with its handful of whites, not only is one of the vital importance in the future of

\textsuperscript{54} At this time organizations such as St John’s Ambulance Association were made up almost completely of volunteers.

\textsuperscript{55} One translation for the word fascism means despotism. Some researchers have either referred to the Deans of the Medical Colleges as displaying a “benevolent despotism” or to others such as Cumpston, Sutton, as displaying fascist leanings (see Roe, 1984, Powles, 1988, Wyndham, 1996)
Australia, but that it intimately concerns the medical profession. The future is in the lap of the gods, but with the Psalmist: “I had said “ye are gods.”” (ibid, p.563).57

Then he refers to the words of Macrossan, barrister-at-law, to the Queensland BMA, who argued the function of law was similar to medicine, that is to “order the physical life of the people” (Butler (1921, pp.567-568). He explains this as follows:

The last phase in which medicine is enlisted in the service of public health, as contrasted with the interests of individual patients, serves to illustrate a striking analogy between the functions of medicine and law. The object of law is order – order in the political, social and economic life of the community. The object of medicine too is order – order in the physical life of the people…

Then Butler (1921, p.569) described a utopian dream of the “new era” in medical organization reflecting medical organization based on army principles, almost reading like a spy thriller. He states:

I visualise the Branch (of the BMA) as the “advanced general headquarters” of the medical service in the offensive, which we have pictured as being launched against the malign natural forces, which hinder our advance. Here, we picture, is the “advanced depot of medical stores” whence we draw our intellectual supplies; and here originate in solemn debate of council the deep-laid plans for the annihilation by means of poison gas of *Xenopsylla cheopis* and for the extinction of plumbic peril (also not without gas), with Dr D. and Dr G. as the “adviser in bacteriology” and consultant specialist respectively. Here, too, if rumour is to be believed, are centred the machinations and subterranean plots which are said, even in the Australian Army Medical Corps, to have characterized the subject of promotion. And here, the “school of instruction” whereto congregate the “other ranks” of our service for perfection in the intricacies of the special “stunt” to which they have been assigned.

As Gillespie (1991) has argued, the word “nationalisation” became an ambiguous one and led to it having emotive connotations for many doctors. Knowing this, medical administrators later used this as a ploy to achieve specific political outcomes in their favour. They have never ceased their attempts to eradicate the influence of their main adversary, the generalist. In addition to the penchant for taking over all spheres of medicine, the hygienists’ notions were more concerned in improving the human “stock” by selective breeding, which Butler first dubbed as “preventive” medicine, a subject on which Sutton later became the chief exponent.

In summary, while the dreams of Cumpston and Butler were more or less explained in terms of a planned assault, the later onslaught was an aggressive style, as

57 Earlier I point to the jokes made about such attitudes in the army.
Waldby (1996) has stated, more in line with guerrilla warfare. Also, among these soldier
doctors, Cumpston had no time for generalist practitioners; Queensland doctors had no
time for women, children, Indigenous people or people of ethnic origin; while Sutton
had no time for children he viewed to be “defective”, proposing many be classified as
“degenerate” or “unfit” and rendered a fate of life-time incarceration. I will say more
about these aspects in chapter five. The other influence of military medical
professionals has been the role played in the creation of national institutions existent
today.

**National developments**

The other two inter-related factors which should be kept in mind as being
associated with the CDOH was the institutionalisation of a “disease” or pathologically-
oriented system of medicine from the outset surrounded by a militarised medical
system, which utilised hospitals, ambulance services and laboratories. From 1909,
Quarantine stations were established across Australia to control “infection”. Then in
1921 laboratories were established in Rabaul, Toowoomba, Albury and other locations
generally isolated from mainstream communities. Simultaneously, after the world-wide
influenza epidemic in 1919, the Commonwealth Serum Laboratories came into being to
address shortages of vaccines and other biological products (Dewdney, 1972, p.23).

In 1935, the National Health and Medical Research Council (NHRMC) was
established and the 1936 Medical Research Act was enacted to give the NHRMC power
to take over the work of the former Federal Health Council (see Page, 1963, p.439).
Along with these developments came the associated acts of faith that (a) laboratory
medicine was responsible for the “great advances” and therefore was “real medicine”;
and (b) the “progressive” way forward was through research in the laboratory. These
acts of faith, along with others developed during this period, would again continually re-
emerge in the 1970s and later.

What has consistently remained missing is any type of “public health” policy
which tries to engage in assessing and meeting the needs of the wider Australian
community. Indeed as I will show later, the idea of “community” seemed, at times, to be
particularly selective and the idea of a national health insurance scheme not particularly
favoured. In fact, in 1937 a secret agreement was made between British and Australian
Ministers of Health and in 1938 a Royal Commission was appointed to investigate
doctors’ remuneration under a national health scheme. The Commission’s report was never completed because of several unusual events. First of all, the five BMA senior representatives who were key men in the enquiry were killed when the plane crashed in fog into a Dandenong hillside (Dewdney, 1972, p.31; Pensabene, 1980, p.169). Then in November 1939, the Chairman of the Royal Commission died and, because of the outbreak of World War II, the Government’s plans for a national health scheme was finally shelved (ibid). These incidents left the way open for an “invasion” of the BMA, by the surgeons, as well as delaying any sort of comprehensive national insurance scheme being offered to the Australian public until the 1970s.58

The above developments had a profound effect on the way imperial influences impacted on Federal Australian military and civilian institutions. Such influences were not only connected to the construction of a task-oriented medical division of labour, but also to the shaping of Tropical Medicine which, when linked to Public Health, was not only linked to the expansionist goals of colonial interests, but also became an enterprise based on research using both simulated and human medical experimentation. The medical system was shaped, on the one hand, to reflect a bias towards hospital-oriented and ambulance services linked to a militarised structure of emergency defence personnel. These comprised both military officers and others who could be mobilized in the event of crisis.

From the 1920s, the links to the USA began to be reinforced by Rockefeller and Carnegie, who first funded Hookworm campaigns, that were organized at the Federal level, but carried out in the states of New South Wales and Queensland in which Harvey Sutton played a part, taking a specific interest in obtaining blood samples from Aboriginal people (Cole, 1927; Lendon, c1935; Thompson, 1927). In 1925, the CDOH was established to support medical experimentation especially on Indigenous and non-Indigenous children in NSW and Queensland.59 In 1928, Rockefeller and Carnegie, as well as Bosch, provided the resource-backing for reforms which led to the restructuring

58 The BMA (later the AMA) was initially an organization established by generalists. The subject of national health insurance is beyond the scope of this thesis and will only be touched upon where it is directly related to the discussion in certain instances such as the above. See Gillespie (1991) for an explanation that Australia is the only nation to legislate for national health insurance only to have it dismantled.

59 Unfortunately, this issue cannot be dealt with in this thesis. However there is evidence from this time that Aboriginal families were coerced into giving blood for the Hookworm campaign, while children in NSW and Queensland came under intense medical scrutiny which led in some instances to thousands being “recommended” for tonsils, adenoids to be removed and others seen to have “defects” (Lendon, c1935, Cole, 1927, Thompson, 1927).
of the Sydney Medical Faculty along America’s “scientific” or “Flexner model” designed to produce research-oriented doctors (Willis, 1989). In the 1930s a new departure was in the appointment of full-time professors of medicine and surgery at the medical school, as well as building live-in quarters for them within the grounds of the Royal Prince Alfred Hospital.

As Sydney Medical Faculty was originally designed to produce generalists, no other large medical school experienced such a rapid change in the type of professional staff as occurred in Sydney within those years. As Professor Anderson Stuart, the former Scottish Dean, had passed away in the 1920s, there was less of a problem in Sydney in initiating change. However, Australian medical educators in Melbourne and Adelaide retained the right to private practice, a position they maintained until moves were made to bring medical education under Federal (and secretly military) control from the 1950s onwards (see Russell, 1977; Willis, 1989). These changes will be highlighted in chapter five.

The orientation was changed from a patient-centred focus to a research focused one. So instead of generalist teachers who were part-time lecturers and part-time practitioners, the new staff consisted of ten professors and one associate with no right to private practice. Also the first year was changed from being spent in the study of Arts to being spent in studying the physical and biological sciences (Windeyer, 1930, pp. 547-558). If one thinks about this structure, it leaves the professors to undertake research on “esoteric” subjects, while students are encouraged to pursue more practical or technologically oriented specialisms.

The Australian benefactor was George Henry Bosch, a Sydney engineer and capitalist, and the new professors reflected his interests (Windeyer, 1930, p.548; Willis, 1989, p. 88). The engineers’ influence was similar to that exerted in the USA when “the surgeon as engineer at least for a time overshadowed the surgeon as physician” (see Stevens 1971, pp.78-79). Other links were to the Mayo surgeons who were well-known Masonic figures (GLBCY, 2006). The “Flexner model” of education reflected the idea of an academic medical professional as “objective” in that such a professional was divorced from empathy, sympathy or emotion for the masses. In fact, Carnegie wanted

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60 Sydney University, while not a state institution was treated like one and its medical faculty, like other faculties, was influenced considerably by the army.
to establish further restrictions to make education of such professionals only accessible to the more wealthy classes (Berliner, 1975, pp.586-589).

The other change made was in offering a new range of Scholarships to those who supposedly were regarded as “worthy” students. Although some of these were available to both to young men and women, most scholarships were specifically offered to students from Fort Street Boys or St Paul’s, sons of Freemasons, teachers or officers of public instruction, members of the AIF or the Loyal Orange Order.61 Also as changes occurring at this time created contemporary problems and contradictions in the field of medicine, it is useful to look critically at the processes at work, as they were not confined to Australia, but emanated from changes occurring first in Germany and then the USA after 1910 (see Navarro, 1988). Outlined below is an elaboration of points introduced in chapter one:

(a) While changes to medical education at this time appeared to represent a move to make medicine “scientific” they in fact began to institutionalise a paradigm which conceptualising the body as a series of unrelated parts. The emphasis was on research to be centred on specific parts to be repaired on machine breakdown (pathology and cure) (Berliner, 1975, pp. 587-593).

(b) Such an approach not only represented one a military surgeon would be more likely to take, but also represented a method compatible to the work of other para-medical professionals, such as chemists. It was a disease or lesion-centred approach which can be seen to emerge out of an association with task or craft-oriented practices.

(c) The changes also represented a move to mechanise and subordinate the medical workforce and promote specialisms or sub-specialisms which, not only alienate doctors from their patients, but also promote a type of “assembly” line medicine which relies on technology (see Berliner, 1975; Shapiro, 1987). In the United States between 1908 and 1914 following the trend in scientific management, Henry Ford, was promoting similar types of processes in his vehicle manufacturing plants.62

(d) The aim within this type of medical education was to establish the dominance of the specialist researcher over the medical practitioner (Berliner, 1975). It was intended that professors of clinical medicine would be paid fixed salaries and not have the right to private practice, so as to devote more time to teaching and research (Willis, 1989, p.87). The model used was of “professional education” rather than “medical education” and is the reasoning used by

61 Earlier in 1922, the Knights of the Southern Cross were established in order to promote the interests of Catholics and to counter perceived Masonic and “Orange” influence on the community. Their main objective was to promote catholic immigration and they were more active in Western Australia (see Commonwealth, 2001, p.21).

62 See for example Peabody, (1927) who published a critique on the depersonalising tendencies of “scientific” changes in the USA at the time.
Carnegie to claim it to be “objective and scientific” (Berliner, 1975, pp. 587-593). As such, no patient needs were considered and therefore research, teaching priorities and workforce considerations were completely divorced from real requirements.

While women were admitted to the faculty, they appeared to suffer more hostility from students than from the staff. While most excelled in their work, many hospitals refused to take them on as residents. Some affluent women doctors established their own hospitals, such as the Rachel Forster Hospital for women, while others went to Adelaide for their hospital training (Hutton-Neve, 1980; McCarthy, 2003). I will say a little more about women doctors in the next chapter when I discuss the Adelaide medical faculty.

Also while the 1930s supposedly marked a shift to “scientific” medicine, it would seem such principles as applied to medical education in Sydney were open to question. Stephanie Siedlecky, a Sydney medical student in 1933, stated some doctors were driven by their religious beliefs and refused to even talk about the subject of contraception and the Rector, a Reverend J.C. Thompson, also conducted lectures. Students were told that they needed to know about “this unsavoury topic” so that they could refuse patients’ contraception requests and refuse the “poisonous propaganda” and “pseudo-scientific arguments” of the birth control advocates. Thompson warned students about the policy euphemistically known as birth control which would “seek” to counter our lives from (the) beginning”; its malice would cause ‘race suicide’ and have dangerous consequences for mental and physical health (Siedlecky and Wyndham, 1990, p.77).

In summary, it is apparent from the above that the soldier archetype had the capacity to influence those around him in a significant way. As stated above, another significant figure was Sutton, who became the first Director of the School of Public Health and Tropical Medicine also established in the grounds of Sydney University.

**The School of Public Health and Tropical Medicine (SPH & TM)**

The predecessor to the SPH & TM was The Australian Institute of Tropical Medicine (AITM) established in Townsville in 1907 as a field laboratory and Dr Rafael Cilento, the chief medical author of a “White Australia” became its first Director, after which time Dr H. Breinl, a German doctor took up the position. This was in fact laboratory medicine which included proto-zoology and bacteriology (Denoon, 1988; Patrick 1987). This was part of the training in military medicine developed in the latter part of the century separate to the universities and was more pronounced in regional and
provincial areas of Queensland (Pearn, 1985). The AITM was administered by the Minister of External Affairs who offered government scholarships to study there, but the Institute itself was mainly financed from colonial officers’ and merchants’ coffers.

After the war there was a clearer picture that the disciplines of Public Health could be merged with Tropical Medicine as products of the military medical knowledge associated with the soldier tradition. This was not only because of the investigation of polluted water as well as insect and human environments which might cause malaria, but also because of emphasis on quarantine, immigration control and vaccination to prevent disease.

This type of outlook treated public health issues in terms of disease, sanitation, ventilation, medical topography and the like. After the war, one of the changes suggested by Howse during the Royal Commission on Health in 1925 was to establish a School of Preventive Medicine and Tropical Hygiene at the University of Sydney (Windeyer, 1930, p.556). As the School’s function was to train medical graduates for Diplomas in Public Health and Tropical Medicine, as well as research into the associated issues, the Commonwealth Government was responsible for the costs. In 1926, a conference held “between the Commonwealth Government, representatives of the League of Nations, and Powers having territorial interests in and around the Pacific Ocean” recommended the School’s function be extended to investigate health problems in the Austral-Pacific zone (ibid., pp.556-557). Consequently, the School of Public Health and Tropical Medicine (SPH & TM) was established, with Dr Harvey Sutton becoming its first Director, a position he held from 1930 to 1947.63 He was also appointed Lecturer in Preventive Medicine at the Sydney Medical Faculty (“Scholars”, 1930, p.570). In relation to Sutton’s appointment and other concerns, this article states

Another important innovation is the appointment of a Professor of Preventive Medicine at the University of Sydney in the person of Dr Harvey Sutton, Director of the School of Public Health and Tropical Medicine. This recognition of the preventive side of medicine has been long overdue in all three schools. The establishment of a chair of obstetrics at the University of Melbourne has been more than justified. It is to be noted that the University of New Zealand is making provision for a chair in obstetrics. _Thus Adelaide alone of the medical schools in Australasia has not fallen into line_ [italics added] (ibid).64

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63 Sutton also belonged to Family First in Australia. Today it has become a political party which emphasises socially conservative family values.

64 You can see by this military metaphor, just how much these values permeated discourses at that point in time.
Before the SPH and TM was established, no special teaching unit or national focus for most of these studies existed in Australia. The School’s function was to provide courses for the Diploma in Public Health and in Tropical Medicine (DPH and TM) for the school and industrial medical officers, civil servants, factory inspectors, medical students and others. Its aim was to establish research projects in all relevant fields in cooperation with Australia’s northern and Pacific neighbours. It began with a staff of thirteen offering units in preventive medicine, Tropical Medicine, bacteriology, pathology, biochemistry, medical entomology and parasitology (“School”, 1980, p.11).

Sutton was a known advocate of experimental medicine and of using eugenic ideas to influence coercive methods of social control. In 1913 when working at state level as Director of Medical Services, a relationship was formed between the Education department, hospital-based doctors, dentists, and the criminal justice system. This had far-reaching consequences in the post-World War II period. In Tolstoy’s *War and Peace*, he presented an interesting analysis of the way power operated. This could be easily applied to the period under review:

Where (power) does not (bend) to the collective will of the masses, one sector will attach itself to an arm of government which will use a variety of methods to force the collective will into its own mould: A variety of methods will be used …: establishment of truth through control of the media; the control of political dissent through the control of migration; the control of intellectual and professional knowledge through maintaining ownership over “security” or “secret” knowledge (Tolstoy, 1859/1957, p.1411).

As stated earlier, the influence of doctors on the eugenics movement has been recognised by other researchers and it is beyond the scope of this thesis to engage in a wider appraisal of the subject (see Wyndham, 1996). Also imperialists shared right-wing sentiments that virtually operated in the frame of a “mainline eugenics” which can be fascist (or despotic) in character.

As far as attitudes to women are concerned, Sutton pointed out that the plan of sex chromosomes, which gives the female two X and the male an X and Y, was similar to the plan for mammals and flies (1944, p.24). It does seem that his views were typical of others intent on microscopic investigations and who appeared not to distinguish between the behaviour of female mammals or insects and human life and behaviour. While Spinoza’s interests focused on the weird marriage rights of a species of spiders called *Arachnida*, as in Ross’s work referred to earlier, the description of investigations
tend to take on anthropomorphic forms. For example, MacLaurin (1925, p.260) becomes totally subsumed into the spider web when he states:

The female is considerably larger and more powerful than the male; and she sits quietly waiting with a naughty gleam in her bright eyes, at the centre of the web. He, insignificant despicable wretch, dances timidly towards her, two of his paws held out with the caution of a professional pugilist. They meet, he continuing his excessive caution. Then a moment of love, an almost imperceptible caress, and he flees literally for his life with hell at his heels. Should the dutiful wife catch him, woe was the day for the husband. The wicked creature, having sated her sinful lust, devours him claw spinnerets and all.

Then turning to the mosquitoes, he continued in the same way:

Personally, I should fancy that the male has about an even chance. I have often watched among the mosquitoes only to find after an hour that the male could not approach at all, dare he never so wisely. But I have seen horrid orgies of cannibalism should the husband be a shade too slow. It is feminism in excelsis; she, great, big, hulking brute that she is, cannibalistically eats her dear little mate with his slender and spiderly grace. And likes to do it too (sic) (ibid).

**Conclusion**

I have shown that the soldier archetype, as a military surgeon, hygienist or sanitary, influenced the Australian Federal landscape mainly from the end of the 19th century and adopted the career structure and knowledge base of those who previously formed the IMS. These developments were buttressed by a perception the army offered the advantage of a more critical training, a view which also nurtured notions of superiority towards civilian medical colleagues. In addition, notions of a nomadic existence were kept alive by associating army professionalism with professional isolation from colleagues (see Osler, 1906, p.117). This idea of professional isolation from colleagues was the single most distinguishing factor of military professionalism. The soldier doctors sometimes saw themselves as “gods” and as intellectually and morally superior to the broader population in their roles as defenders of Empire. There was a leaning towards explanations, which contained reference to “natural” and “biological” rationalization, without taking into account social factors.

Through their association within either or both Masonic and British orders of chivalry, their internalised notions of “purity” were extended to embody ideas of “race” and “breed” and brought with them an inherent fear of others. In an anthropomorphic sense, the alien “other” was equated with infection or disease. After Federation, their role as advisers to governments ensured a “castle and fortress” model of defence was
shaped to isolate people from within through segregation and quarantine and from without through Immigration policy. Disciplines such as Tropical medicine and public health and legislation promoting the creation of a “White Australia” became underpinned by a “social” and “preventive” medicine guided by an emphasis on eugenics and social control of the population.

As I will show in chapter five, Dr Harvey Sutton, had similar ideas about the definition and application of a “preventive” medicine.\(^{65}\) Therefore, a collegiate relationship was not moulded with civilian doctors, but with clergy, engineers and especially with lawyers, establishing legislative foundations of punitive and coercive practices designed to further imperial aims and aspirations. These attitudes and practices entered into the political realm as well as the culture of the Commonwealth public service. Within the St John’s Ambulance Association and St John’s Ambulance Brigade their role was to institutionalise “western” medicine or a disease-specific orientation into civilian organizations as well as create civilian reserve armies of labour ready to be mobilised in times of war.

Acting as advisers to the Federal government, by the 1930s the soldier surgeon and hygienists became visible as part of as bureaucratic framework dedicated to imperial service where an ethic of chivalric brotherhood and a “life-saving” ethos was sustained. I have also shown that boundaries were established within and outside Australia for immigration control, quarantine, and segregation, making their mark on a number of institutions in Queensland and NSW especially in both military and civilian public service and playing a central role in cultural reproduction.

From the time of its establishment, the administration of the CDOH by soldier doctors ensured the institutionalisation of a “disease” or pathologically-oriented system of medicine utilising hospitals, ambulance services and laboratories. From 1925 the foundations were laid for many of today’s federal institutions, such as the NHRMC, the Australian Intelligence Service Organization (ASIO) and the Commonwealth laboratories and there are parallels in yesterday’s quarantine sites and reserves for Indigenous people, and today’s mandatory detention centres for refugees. Also the great act of faith persisting into the 21\(^{st}\) century was that most of the great advances in medicine emerged out of laboratory research, the “secrets” of which are still waiting to

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\(^{65}\) At this time, Harvey Sutton was Director of Medical Services for the Education Department in New South Wales.
be discovered. The other belief that they were owed a considerable debt by the civilian population has never disappeared, nor has their wish to assume a leadership role within the medical profession, subsuming generalist doctors into their “scientific” and task-oriented organizational grid.

The legacy of rights coupled with British imperialism was mirrored in a legacy of reluctance to take responsibility for the Indigenous, the poor and the disabled. The volunteers or “workers” were encouraged to develop a social conscience and an ethos of voluntarism, but the social legacy left to those in the upper echelons were taught “not to acquire empathy for the masses” (Rich, 1989, p.88). This seemed to also result in exclusion from any social right or consideration and reflected in treatment of such people, as well as women and children. The question of how deeply these values were embedded is still to be explored in chapters five and seven.
CHAPTER FOUR

The generalist physicians and surgeons: their involvement in Australian medical education and patient care in Victoria and South Australia

… humanity is an essential attribute of the successful medical practitioner. When humanity is lost, medicine is not a noble career. It is true that Medicine is a science, but it is a science in which the expert is not dealing with things but with people. The academic physician of today has much in common with the physicist, the chemist and the biologist. At the same time he remains irrevocably linked to the priest, the psychiatrist and the social worker… Medicine is something more than a pure science. To a certain extent the art of Medicine lies in knowing when and how to apply the science of Medicine (Girdwood 1963, pp.631-632) ¹

Introduction

As already stated, medical knowledge is not neutral, it reproduces the social relations from which it emerges. Scottish medical educators were originally those who institutionalised the generalist tradition into the Australian medical faculties and, as Girdwood (1963) states above, this tradition was one which retained its integrity into the post-war era, defining medicine not as a “pure” science, but as a humane practice. However, as medical education has been an under-researched area, the impact of these medical traditions and the different social and cultural aspects of such influences in Australia, have been relatively downplayed or unnoticed.²

In the United Kingdom, generalists were also well-known for their humanist and egalitarian ethos which embraced a respect for women and empathy for children.³ The organization of their life and their institutions reflected that of their churches which guarded against any hierarchical social arrangement (Gillman, 1988, p.107).⁴ Such medical professionals and educators migrating to Australia found a real home within a South Australian social milieu ready to receive them. As Pike (1967, p.v) asserts, the short history of this “dissenting” colony is too often seen to “lack antiquity and ancient glories … (as) the most disparaged umbilical cord linking colony to mother country.”

¹ At the time, Girdwood was Professor of Therapeutics at the University of Edinburgh.
² While there have been a number of socio-historical studies investigating early cultural aspects and values, they have generally been confined to one Australian state or city. For example, see Hicks (1981) or White (1994).
³ More generally, Scottish Presbyterians were known to have influenced many Australian educational contexts until the 1950s (see Barcan, 1980).
⁴ Later generalist described themselves as “A” body’s body” “a “body” being a Scots colloquialism for “anybody” (see Winton, 1983).
Also until the 1930s at the University of Sydney medical faculty and until the 1960s at the Melbourne and Adelaide University medical faculties, the clinical teachers were also part-time practitioners and the curriculum was designed to produce the generalist. Also, such cultural reproduction was further reinforced because many Australian medical students went to the University of Edinburgh for their education (Dyason, 1988; Geary, 1995; Pensabene, 1980). The result, in both Melbourne and especially in Adelaide, was that the generalist tradition remained exceptionally strong within medical education for almost seventy years.5

In this chapter, the shaping of the humanist generalist tradition emanating from Edinburgh Medical Faculty, as well as career paths and developments in medical knowledge are examined so as they can be juxtaposed against those of the soldier. Secondly the generalist lifestyle, educational qualifications within wider statutory regulation will be highlighted. As the generalist was both an educator and family practitioner, some historical aspects of medical education in Melbourne and Adelaide University Medical Faculties between the 1880s and the 1950s are examined as well as how their ideas about the body and sexuality differed significantly from their military medical counterparts. As to how the soldiers began to flex their muscles so as to subordinate generalists within various situations, I have endeavoured to draw on textual data showing power relations at play. Again the role played by medical educators and practitioners during this period helps to understand medical professionalism today as an egalitarian and collegiate culture.

Background

Humanist medical traditions

In contrast to the imperial context, the ideas of Edinburgh medical pedagogues were produced within the Scottish Enlightenment period when the dignity of the Scottish people and the rights of “natural man” were reasserted. In this context, the poet Robbie Burns, while somewhat idealistic, stressed while Scottish cultural values espoused tolerance and broad- mindedness, they did not expect human nature to be “perfect” and reinforced the self-worth and virtues of their customs. Burns is quoted by MacLean (1970, 203) to have stated the Scots displayed

5 No doubt it made a wider impact outside the sphere of medical education. Most research about doctors in Australia has emanated from Victoria (Pensabene 1980, Willis 1989, Dyason 1988).
... tolerance and broadmindedness and a strong emphasis on human nature with all its virtues and all its shortcomings. Scots could see themselves with new pride as “men for a’tat”, as human beings more human than most, warm-hearted and open-handed to a fault, great drinkers and lovers and sturdy fighters for freedom and the rights of man [italics added].

While, until this time, any means of political self-expression had been denied, such self-expression found its place in this social milieu. Ideas extended into much intellectual work in this era included a reassertion of dignity and respect for Scottish traditions, including those of their women, as well as the work of John Gregory from the Edinburgh Medical Faculty (see Rendall, 1999, p. 135). On the subject of men and women’s roles, Alexander, a Scots historian, inadvertently shared values expressed by Australian generalists who later stressed complementarity of roles. Alexander (1779) stated:

To each sex (the Author of our being) has given us different qualifications; and … these, upon the whole, when properly cultivated and exerted, put men and women nearly on an equal footing with each other, and share the advantages of life impartially between them (cited in Rendall (1999, p.136).

As Sennett (1979, p.89) argues, the meaning of human rights has been lost, but it originally arose because of the opposition between nature and culture and, from the time of Elizabeth I, nature was associated with any cultural or religious ideas not conforming to what was defined as the “ideal” Englishman. For this reason, such Scottish values and ideals also need to be placed in the context of wider debates between English and Scottish intellectuals whose Enlightenment ideals differed. For example, in 18th century England the social milieu had become increasingly competitive and there was a Hobbesian revival promoting the idea that human beings were motivated by self-interest (Baker 1993, p. 862). Thus, the Scottish enlightenment philosophers, Frances Hutcheson, David Hume and Adam Smith were busy countering these arguments by introducing notions of “humanity and sympathy”. As Baker (1993, p. 862) points out:

(R)evising or refuting Hobbes was ... tantamount in the project of developing an ethic for a competitive capitalist society in the context of a mechanistic scientific culture. Three such projects dominated 18th century thought: John Locke’s theory of natural rights grounded in the social contract; the subjugation of self-interest of Bentham through the calculus of utility which postulated universal happiness as the end sought by everyone (thereby reasserting teleology); and the theory of moral sense and sentiments ... (for these philosophers) moral sentiments, particularly “humanity and sympathy” offset the antisocial proclivities inherent in a competitive world motivated solely by rational self-interest, thereby providing a basis for morality.
John Gregory, who was a friend of David Hume, became the first medical ethicist, formulating an ethics of practice regarded as still being very much alive today. It was Gregory’s view that the effectiveness of the humanist physician “derives as much from empathic understanding of illness as from medical science” (ibid, pp. 862-863). This ethical stance is not only expressed by Girdwood (1963) but is also part of what Veatch (1989) has referred to as being derived from Protestant thought and will be referred to again in Chapter six.

In the Australian early 20th century context described previously, the word “human rights” was not one which graced the social milieu. However, the notion was inadvertently reflected in one doctor’s words spoken at the outset of World War I; words which reflected the generalist outlook favouring the “laws of health” as opposed to the “laws of disease” (see Moore, 1914, p.317). Moore’s (1914, p. 317) words below seem to be just as relevant today as it was almost a century ago. He states:

The laws of health must be made known to the people at large, and schemes laid before them to a national organisation for the elimination of disease. Disease is no longer an affair of the medical profession; it is a national concern of vital importance. The problem is not a class question, all humanity stands face to face with it now … it has been realised that disease can never be conquered by private bargains for fees between individual patient and individual doctor … People cannot live healthy lives in ignorance of the fundamental laws of health merely by paying casual visits to physicians, and no one class in the community can be healthy until all classes are healthy (ibid, pp. 321).

As Nicolson (1993) points out in the British context, the outcomes of this way of thinking was that the generalist physician and surgeon looked upon disease as “an expression of the experiences of the suffering individual” where “listening to the patient narrative was central to arriving at an accurate diagnosis” (pp. 808-809). In contrast, the patient narrative was lost within the disease-specific and pathological models of their soldier counterparts where the focus was much more on laboratory analysis of the parts of dead or docile bodies (see Canguilhelm, 1980; Foucault, 1973, p.7). It is in such statements where differences in the doctor/patient interaction between the “gaze and the face” and the “glance and the silent body” can be understood.

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6 As stated in chapter two, Foucault (1973) referred to such ethics as a “doctrine of sympathies”
7 This comment reverberates with the caption on the front page of Nelson Mandela’s autobiography, which was worded along the lines that he can never be free until every black African is freed from prison.
Medical career paths

In Scotland, medical developments, career paths and ideas about medical professionalism differed significantly from those of the soldier. By the end of the 17th century, reformist physicians emulated the practices of surgeons by beginning the planting of herbal gardens and establishing chemistry laboratories (ibid). Such distinctions formed part of the background of various influences coming to bear on Protestant universities and their academic staff after they underwent a process of secularisation (see Geyer-Kordesch, 1995).

More generally, Scottish educators initially mounted their own crusade to combat illiteracy and reach out to the general population (Saunders, 1950, p.251). This crusade was mounted on an act of faith in individual self-worth regardless of class location and expressed by Lewis (1835) in the following words:

… that knowledge and virtue were allied, domestic refinement as well as useful and entertaining knowledge could be diffused abroad, the spark of individual genius fanned and local scholarship encouraged and organized (cited in Saunders, 1950, pp. 251-252).

These actions contradicted practices associated with the British aristocracy and nouveau riche of the rising industrial and professional classes who found common ground in their attachment to the English chivalric fraternities and their imperial enclaves. Such a closed circle membership not only guaranteed access to positions of status and power but also to a cultural stance which did not particularly believe in providing opportunities for education or the betterment of the “lower classes”. In Australia, such anti-egalitarian ideas were embedded in the very same Census documents placing professionals in health and education in a subordinate status to those associated with defence, law, religion and philanthropy and where “paupers” were placed in the same category as criminals (see Gale, 1892).

Within Scottish universities, original reforms incorporated efforts to dismantle elitism and hierarchical modes of organisation by producing a contemporary parallel to their traditional community physician: a doctor who was first and foremost a general practitioner but who could later pursue a “specialty of interest” (Geyer-Kordesch, 1995). By the end of the 18th century, teaching in the Edinburgh and Glasgow Medical Faculties was internationally acclaimed by students and academics alike as the leading

8 Unlike the early practices of English apothecaries, their use of chemistry was not linked to alchemy.
centre of medical education in Europe (Geary, 1995, p.51). For example, Geary (1995, p.51) states:

Students were drawn from the farthest reaches of the empire and beyond, attracted to the Scottish capital by Enlightenment-inspired teachers and by the quality of the systematic and clinical instruction they offered. The absence of religious tests and barriers, the existence of extra-mural and university schools, the relatively low cost, as well as the eclecticism of the courses, appealed to disparate groups of students, aspirants to all shades of medical practice, and contributed to Edinburgh’s ascendancy.

As well as John Gregory, pedagogues like the Glasgow surgeon, William Cullen, made a significant impact on the direction the generalist tradition was to take. Clinical teaching became the hallmark of the humanist tradition extended to London and Dublin by the end of the 19th century (Saunders, 1950, p. 332). Reforms occurring again in Scotland in 1833-1834 linked curriculum changes to an approach which reasserted what medical professionalism ought to be. As cited in the opening chapter, Professor Alison pointed out:

(W)hat fitted a man for the profession was not a knowledge of medical tradition or even general literature and science but “the habitual observation of the living human body as affected by disease and as influenced by remedies” (cited in Saunders, 1950, p.337).

Such developments were rubber stamped by the passing of the Scottish Universities Reform Act (1858). Towards the end of the 19th century among professional classes doctors became distinguished for exhibiting “a conjunction of technical efficiency and social intelligence” (Saunders, 1950, p.341). As such, for the majority of such doctors “case approaches” or “localising disease” did not enter into their world view (Digby, 1994; Lawrence, 1993). Scottish society at that time was exposed to epidemic infection and urgently needed a general and improved medical service (Saunders 1950, pp.341-342). This provided the justification for the Scottish medical schools to raise the standards of the general practitioner, rather than encouraging specialised research and forms the background on doctors discussed throughout this chapter. As Saunders (1950, pp.341-342) states:

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9 While Geary (1995) has observed that medical education at Edinburgh influenced students from different backgrounds and outlooks. While he has tended to homogenise the influences on Australia, especially in regard to the type of impact made by Alexander Stuart, he has provided useful statistics on the late 19th century period.
There were some who distrusted the new type of family doctor and accused him of a less deferential bedside manner... But general practice was now attracting the best men and the public responded by an increasing confidence in the integrity, skill and sympathy of its doctors. Nor was the general practitioner condemned to isolation and routine work... It was an age of great family physicians; some of them achieved academic distinction; many, as able and as worthy, were content with a local repute, or some articles in a medical journal written (so) as to retain a human as well as a technical interest 100 years later.10

In sum, such developments produced the generalist (family) physicians who became the stereotype of the medical practitioner in Scotland as well as in rural and middle-class Britain as a whole (Digby 1994; Nicolson 1993). Where this influence was felt, physicians as well as surgeons gave primacy to the “patient narrative” and very rarely to the examination of the patient (Nicolson 1993). In England as in Australia, at the level of every-day practice, a “bedside” or patient-centred medicine and a hospital medicine or “case approach” operated side by side and the physicians were the last to become “scientific” (Jewson, 1974). As they were subjected to exclusionary practices in the United Kingdom, this would have helped to push many to colonies such as Australia. Some effects on Victoria were remarked upon by Dyason (1988, p.106) who asserts:

For the colonial period approximately a quarter of the medical immigrants from the United Kingdom...were university graduates. These figures were not equalled elsewhere in the Empire during the 19th century. Obviously Victoria was not merely a dumping ground for Britain’s incompetents. A lower doctor-patient ratio resulted in financial benefit to the practitioners who remained behind, but Victoria gained much more than Britain from this imperial “brain drain”.

With the above as background, the following explains the associated developments in medical knowledge, which the soldier doctors relegated to the realm of the “dark ages”.

**Developments in medical knowledge**

In researching developments in medical knowledge, linear models of developments are somewhat misleading and less than useful in the construction of such a history. The context of Scottish medicine differed from England because both surgeon/apothecaries and the reformist physicians shared a common ground in cultural

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10 This statement is made with a proviso that “ideal types” are heuristic devices and therefore do not represent reality. Like Alexander Stuart in Sydney, people are pulled in many directions by various influences. Saunders (1950, p.452) has also pointed out that a detailed study of the general practitioner of the period depends on both local and family records as well as on professional knowledge.
reproduction of customs and traditions. The English apothecaries who later became apothecary/surgeons were quite different from the Scottish surgeon/apothecaries. In 1617, the English apothecaries were the first to adopt alchemical precepts by drawing on Paracelsan ideas to distil chemical substances rather than herbs for medicinal purposes (see The Worshipful Company of Apothecaries, 2002). 11

By the end of the 17th century in Scotland 12 learning botany was considered absolutely necessary for an apprentice to learn medical knowledge compiled by surgeons. 13 At this time, a laboratory was fitted up for the training of the “intrant apothecaries” in the “art of chemistry” (Comrie, 1932, p. 263). By 1670, reformist Edinburgh physicians established a Physic Garden with over 1,000 types of plants, as well as endeavouring to establish the Institute of Physicians. The study of botany, alongside the study of anatomy, were emphasised as being the most important preliminaries to perceptions of medical and “scientific” knowledge (ibid).

Apart from these developments, others within and outside Protestant universities later found a meeting ground in Scotland. For example, in the 17th century, a Cambridge physician, William Harvey, introduced a theory about the circulation of the blood which influenced Protestant “divines” and founders of the iatro-mathematical and mechanical school of thought within academia. These were Archibald Pitcairne and Herman Boerhaave, two medical educators at the prestigious University of Leyden. However the later shift away from mechanical methods seems partly due to the fact that, while Herman Boerhaave may have been a firm supporter of the same, he was also an eclectic and advocated no particular philosophy (McGirr, 1993). Comrie (1932, p.273) refers to the reception by Pitcairne and Boerhaave of such mechanical metaphors by stating:

They developed their ideas from Harvey’s demonstration of the circulation for when the importance of the dynamic principle was grasped, in contradiction to that of the leisurely ebb and flow of humours, its adherents attempted to prove that all bodily activities, including even those of the nerves and of the digestion, 

11 In early 19th century England, they linked themselves professionally with their surgeon “brothers” through an educational process known as the “College” and “Hall” making them apothecary/surgeons.
12 Minutes of surgeons meetings from 1646 disclose that surgeons by that time had planted a garden exhibiting all kinds of medicinal herbs. The earliest professor on the subject in Britain was a Robert Eliot the first to become a professor at the Town’s College. Alexander Munro (1697-1767) became his successor (Comrie 1932, pp.254-255).
13 Scottish surgeons were known to be in the possession of certain books and “rarities” (ibid).
were mere mechanical exercises. Although this idea could not persist for long, it formed for a century after Harvey a fruitful working hypothesis.\(^{14}\)

Boerhaave had a great impact on many students, one of whom was William Cullen who at first approved attempts to explain “the patho-physiology of disease in mechanical terms” (McGirr, 1993, p.153). After the 1730s, the university-based academics not only tried to dismantle structures of medical elitism but also found Newtonian ideas about the body to be faulty. The University of Edinburgh Medical Faculty, particularly through the influence of people like William Cullen and John Gregory, helped to shape a new medical curriculum and produce new texts.

Cullen was a Glasgow surgeon, but moved to Edinburgh around 1750 at a time when the new Edinburgh Medical School had organised access to the new Royal Infirmary for its professors of medicine. While such attitudes were influenced by his teachers, they differed from his predecessors and contemporaries and became one of the most influential figures of 18th century classificatory medicine. His insights lived on within University of Edinburgh Medical Faculty (ibid, pp.153-154).

Cartesian notions of the mind/body split were not popular with Cullen or his contemporaries. Cullen put forward the notion that the mind and the body had a reciprocal influence on each other and, subsequently, shared the interests of other colleagues in understanding the nervous system. He was also concerned about the role the nervous system played in beginning disease.\(^{15}\) This seems to have found its medical expression in Cullen’s theory which underpinned his system of classification of disease which moves away from Cartesian ideas.\(^{16}\) For example, McGirr (1993, p154) asserts:

\begin{quote}
(Cullen) based his theory on the premise that the brain regulated the tonus of the body and so determined the state of health. He believed that the brain’s control was impaired in disease and that this (condition) led to an exaggeration of nervous activity (“spasm”) or to a depression of it (“debility” or “atony”).
\end{quote}

The 18th century was a time when medical practice was driven “hither and thither” by conflicting theories and systems (ibid, p.153). Cullen’s ideas were

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\(^{14}\) William Harvey was a Cambridge physician and member of the Royal College of Physicians, when he put forward his theory about the circulation of the blood. However, while Harvey himself devised a quantitative methodology without becoming a mechanical thinker, his ideas were not always interpreted as such (see Magner, 1992). It is also a well-known fact that the Cambridge physicians were linked to the humanist tradition in Padua (see Temkin, 1977).

\(^{15}\) The impact of “stress” on the nervous system which in turn reduces immunity to illness might be one contemporary equivalent of such thinking.

\(^{16}\) Foucault (1973) refers to this type of medicine as the classificatory model.
considered all-important and, as a teacher, he attracted thousands of students from all parts of the world (Comrie, 1932, Porter, 1995). Thus the rejection of mechanistic models and the adoption of “vitalism” came at a time when Cullen’s clear mind and power of expression as a pedagogue as to the nature of life and vital processes were considered all important” (Comrie, 1932, p.315).  

Cullen designed the forerunner of the “modern” medical curriculum to incorporate humanities as well as medical subjects and reinstated the integrity of the psyche in medical diagnosis (Bynum 1993, McGirr 1993). He did so in an environment which reinstated notions of dignity and respect. Cullen considered the psyche was the most vital part of the body, as the activity of the brain could not be divorced from the activities and functions of the human senses.

In keeping with his experience, Cullen’s *Synopsis Nosologie Methodical* was designed to deal with the spasm (or atony) which he considered as being produced from the effects of the disease. Most importantly, neither Cullen nor other contemporaries of clinical medicine, such as Thomas Sydenham, known as the “English Hippocrates”, had considered themselves to be infallible or perfect. Cullen claimed “I have myself been jealous of my being sometimes imperfect in these respects” [italics added] (cited in McGirr, 1993, p.154).

While the examples taken from Cullen’s discourses and those of his predecessors are not all-encompassing, they are seen as some of the most important reflections of differences in attitudes from those held in the soldier tradition. The other factors are the absence of notions of self-deification, heroism or perfection. In addition, Cullen’s ideas appeared within the wider social dynamics occurring at Edinburgh in the latter part of the 18th century and in the same period when Robbie Burns and Walter Scott made their impact at the peak of the Scottish Enlightenment spanning the period from 1746 to 1832 (see Lenman, 1981).

At the end of this era, these dynamics followed on to other sweeping reforms where Professor Alison brought in new definitions of medical professionalism and other curriculum approaches. As such, the course of study covered two sections, the first incorporating the “medical sciences” which were Anatomy, Chemistry, Botany,

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17 As Comrie (1932, p.315) points out, this is contrary to what occurs when humans accept the mystery of life as a fact and only look into ways in which it is manifested.
Zoology, and the Institutes of Medicine; the second section contained subjects relating to professional study and practice and were Materia Medica, the Practice of Medicine, Surgery, Pathology, Midwifery and Medical Jurisprudence. This course was offered by the Edinburgh medical faculty during the 19th century where migrating or student medical populations studied and these influences were partly mirrored in the subjects offered in the early Australian medical faculties. Significant absences from this curriculum were subjects such as Biology and Physics. Such influences, after being brought to Australia, had a profound impact on reproducing a medical profession in the generalist tradition.

The generalists in Australia

At the time of the British Medical Act (1858), the General Medical Council (GMC) was established to oversee curriculum developments for England and its colonies. Until the 1870s, Australia was governed by regulations of war and the Privy Council was the ultimate decision-making body. Also, while the early Australian medical faculties reflected the calibre of its teachers, one evident reason for medical students going overseas to study is that Australian universities were denied status and prestige. Traditions associated with the Edinburgh Medical Faculty and its “dissenting academies” were seen as being replaced by those carried forward by France and Germany and later, the United States of America. These countries which all exhibited militarised medical relations were those seen to offer the latest in “scientific” knowledge. For example Geary (1995, p.53) points out:

The refusal of the United Kingdom government to recognise colonial medical degrees until 1890 placed them under a ban of inferiority. … There was (also) a great consciousness of distance … and Australian isolation was seen as a major professional disadvantage for colonial teachers and students alike. It was conceded that the most able and enterprising would always be drawn to Europe to observe and learn from the leaders of the profession there and to (place) themselves intellectually against European students.

From the 1890s, when the GMC was given power to accredit the portability of Australian degrees, they accredited the medical degrees awarded at Sydney and Melbourne universities so an Australian medical graduate could go to England to work and gain experience (Geary, 1995). However, the idea that Australian medical faculties were tarred with a stigma of inferiority should be applied to Adelaide Medical Faculty mores than the others. This is because, despite the calibre of faculty teaching staff at the Adelaide Medical Faculty, the GMC failed to accredit this faculty until the end of
1913. However, in spite of such efforts to denigrate Australian institutions and despite the dominant place of the hospital in the development of colonial medical services, Australian medical education originally developed within a university-based context influenced by humanist traditions and a generalist orientation. The lack of national regulation of medical servicing until the early 1970s ensured that this tradition left an indelible influence on Australian medical educators.

Nevertheless, while many students preferred to go to the United Kingdom for training and examination, Australia developed within a dual-system of hospital-based and university-based systems of training and education as in Britain. It is also significant that “bedside medicine” and a patient-centred orientation to medical servicing were introduced into Australia at a time when hospital-centred “case” approaches were being promoted elsewhere as being “scientific”.

Equally significant were other patterns which reinforced the generalist orientation for many years especially because of the ethno-religious dimension, as 35 percent of students were Presbyterians which in Australia was generally associated with Scottish heritage (see Gillman, 1988). In contrast, in the AIF, the main religious groups were Anglican and Catholic with Presbyterians taking a third place (see Williams, 1995). As such, the history of the medical faculties needs to be placed within the wider set of social relations extant in England and Australia which excluded and subordinated many highly qualified Scottish, English and Irish doctors regarded as “dissenters” who were increasingly denied access to positions of power and influence.

As I will also show in the coming chapters, those doctors denied control over their own knowledge base were doctors whose ideas about medical professionalism were far removed from that of their soldier counterparts, especially in relation to notions of patient-rights. The following section explains the social context and life experiences of general practitioners who migrated to SA in the late 19th century and who carried on this tradition in that state.19

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18 This is because in 1887, the Adelaide Medical Faculty tried to gain approval to couple the MB with a similar degree in surgery, as well as establish the higher degree of Master of Surgery (MS.) as in the British Universities. However, the MB alone was not sufficient for students to qualify for registration in the United Kingdom and it was not until this time that a supplementary charter was granted to recognise the surgical degrees (Lendon, c1935, p. 83).

19 Queensland which took over responsibility of the Northern Territory from South Australia in 1911, and had a distinctive part to play in social control and regulation of Aboriginal and Torres Strait Islander children, those from British New Guinea, as well as the wider non-Indigenous population of children.
Some accounts of early life experiences

While in Queensland and NSW, generalists often chose to practice away from dominant political influences, in colonies such as WA and Tasmania initially generalist influences were weak. In WA, professional and social isolation was a key feature of this period, where “men often endured continued sense of pressure, isolated from contact with the profession and perhaps with only the resident magistrate and clergyman as social and conversational equals” (Bolton and Joke, 1982, p.25). Later Fremantle Hospital became a meeting ground for more congenial and collegiate relations developing among both male and female doctors with one woman becoming an orthopaedic surgeon (Garrick and Jeffery, 1987). Also, Dr Roberta Jull became the first President of the British Medical Association (BMA), initially an organization created by English generalists (see McGrath, 1975; Rigby, 1992).

Unlike other states, both SA and Victoria were never penal colonies, nor were they dominated by a military medical status quo as in NSW and Queensland. The colonial surgeon provided the first services to early settlers until generalists appeared to take over private practice. As shown in the photographs, the differences between the generalist doctors and their soldier colleagues were not only in their different traditions, but also in their hairstyle and the way they dressed in the early part of the 20th century. These differences extended to details of life experiences and reminiscences they selected to share with their readers.

Turning more specifically to medical and nursing services, in early times in SA, all surgical operations and midwifery were carried out in people’s homes. There were no certified nurses, but obstetric nurses, who were mostly middle-aged women, attended confinements. They were women who had gained their knowledge by experience without specialised training. There were no private hospitals, as we know them today, but there were some houses which were de-facto hospitals where people knew they could go for confinement or for care when ill (Verco, 1919). There was an extremely high rate of infant mortality. As a result of a citizen’s meeting in 1876, the Adelaide Children’s Hospital was founded to serve a dual purpose. The first was to address children’s needs and the second was to provide a training school for nurses (Stokes, 1937, p.165).

Also in Queensland, the characteristics of education took on the imagery of the Roman state where the men’s roles were both farmer and soldier, and women’s roles were as housewives and breeders.
SA was the first state to introduce the Nursing Registration Act in 1920 giving nurses’ official professional status. This was shortly after a similar act was passed in Britain. The history written by the South Australian Trained Nurses’ Centenary Committee acknowledges the interest and respect paid to the nurses and their work by many of the early honoraries including Dr Verco referred to above. They particularly refer to Dr Lendon’s personal interest in their work and the help extended to them (“Nursing in”, 1938, p.70). At least one President of the BMA thought it a “curious anomaly” that nursing remained unrecognised as a profession for seventy years after registration of doctors (Stokes, 1937, p162).

Another interesting factor is that Adelaide never formed a “Bush Nursing Association” because it appears to have never needed one as in other states. From early times, nurses had formed the District Trained Nurses Society and assisted the Australian Inland Mission to form a tradition of caring for both rural and urban needs (Idriess, 1934; “Nursing in”, 1938). Doctors, like Verco and Poulton, also made a significant contribution to medical education in Adelaide. They were the predecessors of those involved in the Adelaide Medical Faculty in the 1930s when another medical generation stood on the shoulders of their teachers (Lendon, c1935, p.232).

For an understanding of their early careers and life experiences in the late 19th and early 20th century, I have used texts of two retiring medical practitioners who were Presidents of the BMA in SA. Like the texts of the soldier, it would be reasonable to assume that these experiences were somewhat similar to others of their time because, until the turn of the 20th century, Australia was very much a rural society. Also, although the texts used were written twenty years apart, the ideas seemed to converge as both shared a common interest in early local history of practice patterns, as well as the way transport, communication and technology later impacted on their lives and their medical practices.

As would be expected of a new colony in the late 19th century, facilities such as transport, communication, and technology were still to come. Until roads were built, the early doctors travelled along tracks by foot or horseback, in the latter case taking

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19 Dr Lendon will become more familiar to the reader of this thesis, as I have drawn on much of his manuscript on the Adelaide Medical Faculty released to the public in the 1990s.
20 Idriess (1934) has written a biography of John Flynn’s life and his connection with the Royal Flying Doctor Service of Australia and Presbyterian Church Missions and Missionaries. As stated earlier, Flynn was also a supporter of “practical chivalry”.

prerequisites in saddlebags (Stokes 1937, p.162). One BMA President was Joseph Verco (later Sir) who was an early Adelaide doctor and leading figure in that colony in medical education. As London (c1935, p.176) points out, Verco was a “mathematical man” who gained entry to the newly incepted London University through matriculation and came to Australia after graduating as a doctor.\textsuperscript{22} He wrote many articles in \textit{The Medical Journal of Australia}, Varco’s photograph is depicted on page 126, symbolic of the generalist family doctor of this period.

Practice patterns between doctors and patients were also mirrored in the prevailing cultural manifestations, namely in the type of transport, communication facilities, physical appearance, dress, and other technology available. The progression from horseback was to using various types of horse and buggy combinations which came into vogue. There were the “pill boxes” which were small hooded gigs driven by coachmen. Soon after came the light American spider buggies called “Abbott’s”, followed by the open Victoria’s and the closed Broughams. The hansom cabs were the last before the arrival of the motor car which eventually sent the horse and buggy fashion into extinction (Verco, 1919, p.41, Stokes 1937, p.162). Verco’s Brougham was apparently the last such vehicle driven by a doctor either in the city or suburbs of Adelaide before finally succumbing to the changing times (Verco, 1919, p. 41).

As Stokes (1937, p.63) pointed out, prior to the formation of the South Australian Branch of the BMA in 1879, a South Australian Medical Society\textsuperscript{23} had existed with a membership renowned for fiery and vigorous quarrels. However, remembering the “olden times” seems linked to a nostalgia for those who were part of those horse and buggy days (ibid, p.162).

Diverging a little to the subject of technology, it might seem useful to consider the practical implications of the import of technology and “scientific” ideas, as like the impact of theories brought into “scientific” medicine by figures such as Pasteur, Koch and Erlich, nothing makes an immediate impact. Technological innovation, like laboratories and hospitals, need practical things such as electricity to be able to use

\textsuperscript{22} Because of his leanings towards mathematics, Verco must have been a Freemason, but was one who trod a fine line across the generalist and soldier tradition and used his influence to allow the generalist tradition to flourish in SA. He served in the World War I as a medical officer. I will say more about this point later.

\textsuperscript{23} As shown in Chapter 3, historically organizations ending with “society”, “company”, and “fraternity” were generally Masonic organizations (see Jones, 1956, p.103). The military presence in Craft Masonry has always been over-represented (see Knight, 1984).
equipment and this did not appear in Adelaide until the early 20th century when even transport was still unreliable. For example, when Stokes began country practice in SA in 1910, technology for the motor car and its accessories were still in an under-developed form. While travelling time could be considerably shortened, this was only as long as there were no mishaps. Side-lights consisted of kerosene lamps and gave poor visibility, while punctures were not infrequent and the “normal” life of the tyre being only about three thousand miles (approximately seven and a half thousand kilometres) (ibid.).

As far as the issue of lighting more generally is concerned, one should also consider that, if Balmain hospital in Sydney was at all typical, electricity was only introduced there in 1912 and it was only from that time that X-ray machines could be operated (Best 1988, p.29). On the other hand because of the lack of subscriber support for Perth Hospital, X-ray equipment was not available in Royal Perth Hospital until the 1930s, and then this was only because a doctor bought the equipment from his own funds (Bolton and Joske, 1982). Verco particularly reflected on the general impact of technological changes on doctors’ every-day lives over the span of his 40-odd years of practice. He states:

How did we manage our long distance journeys then? What can now be done in a day then took nearly a week. And yet we did our work. Yes! but not so much was done; we were content with less visiting and so were our patients and thus it seems ever to be. Machines, whose work is more rapid, do not reduce the hours of labour. They simply augment the amount of finished work demanded, as we see for instance, in the sewing machine. And this change in transport has entailed a corresponding change in professional costume. In olden times we almost all appeared in black silk top-hats and long black frock coats and shall I say it, some of us in long flowing beards. But with the coming of the motor car the chimney pots vanished, and the long tailed coats, while bowlers and soft hats and sac suits became the fashion and more or less clean-shaven faces. Now a doctor in a frock coat and bell-topper driving in a motor car would seem prehistoric. (Verco, 1919, p.41)

Statutory regulation and medical qualifications

In the following, I will briefly elaborate on statutory regulation in Australia and the qualifications of those migrating at the end of the 19th century. In all colonies, excepting SA, colonial surgeons introduced an apprenticeship system of training, after which time medical students would go to England for a “topping up” with a one-year’s surgical diploma to become a Member of the Royal College of Surgeons (MRCS) in England. In WA, the colonial surgeon was also responsible for organising medical
servicing which included staff at what later became the Royal Perth Hospital and Resident Medical Officers (RMO’s) in small country centres. Like in other colonies, some RMO’s often complained about the activities of quack doctors, but the government was reluctant at first to protect the profession by passing legislation for a Medical Board. One of the reasons given by the Governor was that several Government officers practising medicine had no qualifications. After 1861, a bill was drafted and those wishing to practise had to pass an examination before a board consisting of the colonial surgeon and two senior practitioners. This practice became standard from this time, although it was not until 1869 that an ordinance was passed to formalise the Medical Board’s powers (Bolton and Joske, 1982, pp.24-27).

As far as SA was concerned, the first Medical Act was enacted in 1844 when a Medical Board was established with five members appointed by the Governor. The aim of the Act was to prevent unqualified persons practising and claiming to be doctors (Stokes 1937, pp.162-163). In essence, similar to England, in all the Australian colonies these early medical acts only served the purpose of meeting medico-legal requirements for signing death certificates and attending coroner’s inquests (Willis, 1989; Patrick 1987). Where a military status quo was predominant, generalists who sought to become registered would only have had their surgical qualification registered, despite some having higher degrees (McIntosh, 1948; Hughes, 1967).

So as to understand the type of qualifications held by doctors migrating to Australia before the end of the 19th century, Table 4.1 below shows degrees or licences awarded to doctors migrating firstly to Victoria but trained in England, Scotland and Ireland. In this table, a differentiation has been made between the university-oriented generalists, the majority of whom were educated in Scotland, and doctors who would lean towards craft-oriented practices. Some were non-degree graduates, while other degrees were granted by Irish colleges. The second group of figures shows the Licences, memberships or fellowships held by doctors. The Glasgow Faculty of Physicians and Surgeons stands on its own as there is no equivalent elsewhere. Furthermore, if one wanted to identify the craft-surgeons referred to in chapter one, they would most probably hold a qualification from within one of the second group. Likewise, those “Dublin dissectors” mentioned in chapter three, most probably would have some connection to the Royal College of Surgeons, Dublin rather than the Dublin University.
Table 4.1. *Qualifications of doctors by country of accrediting British institution registered in Victoria before 1901.*

<table>
<thead>
<tr>
<th>Qualification</th>
<th>English</th>
<th>Scottish</th>
<th>Irish</th>
</tr>
</thead>
<tbody>
<tr>
<td>University degrees</td>
<td>68</td>
<td>645</td>
<td>92</td>
</tr>
<tr>
<td>Royal College of Surgeons degrees</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Queen’s College degrees</td>
<td>-</td>
<td>-</td>
<td>13</td>
</tr>
<tr>
<td>Total degrees:</td>
<td>68</td>
<td>645</td>
<td>106</td>
</tr>
<tr>
<td>University licence/membership</td>
<td></td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Other Licentiate, fellows, members</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Royal Colleges of Surgeons</td>
<td>719</td>
<td>594</td>
<td>202</td>
</tr>
<tr>
<td>Royal Colleges of Physicians</td>
<td>122</td>
<td>592</td>
<td>400</td>
</tr>
<tr>
<td>Faculty of Physicians and Surgeons,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glasgow</td>
<td></td>
<td></td>
<td>215</td>
</tr>
<tr>
<td>Apothecary Societies</td>
<td>347</td>
<td>-</td>
<td>56</td>
</tr>
<tr>
<td>Total licences/members:</td>
<td>1,188</td>
<td>1,415</td>
<td>661</td>
</tr>
</tbody>
</table>

(Dyason, 1988, p. 105)

The conclusions drawn from these figures are that the most popular and prestigious universities for generalists were the Scottish ones, while the most popular and prestigious licences sought after were those granted by the Royal College of Surgeons of England. English apothecary/surgeons would gain qualifications from both Surgeons and Apothecaries, known as the “College” and “Hall” type of qualification. All in all, these figures show that these doctors reflect leanings towards two different traditions, one generalist oriented and the other craft or specialist-oriented.

Table 4.2 below shows how such differences are reflected in doctors registered in Victoria before 1901. The following turns to an examination of the impact of the generalist tradition on the Australian medical faculties of Melbourne and Adelaide universities.

24 It is not generally a well-known fact that the English apothecaries were first to dispense medicines like laudanum that were produced in the laboratory from chemical substances. The significance was that such practices were linked to Paracelsan ideas and alchemy.
Generalists and Australian medical schools

Until the 1930s at the University of Sydney medical faculty and until the 1960s at the Melbourne and Adelaide University medical faculties, the clinical teachers were also part-time practitioners and the curriculum was designed to produce the generalist. The result was that, in both Melbourne and especially in Adelaide, the generalist tradition remained exceptionally strong within medical education for almost seventy years.25

The medical faculties of the three Universities of Sydney, Melbourne and Adelaide were all established during the 1880s. They remained the only ones in Australia able to confer medical degrees until the establishment of one at the University of Queensland in 1936 (Australian Committee on Medical Schools (ACMS), 1973). Both Queensland and WA showed an anti-intellectual bias to the training of doctors and, although universities there had been established in the early 20th century, medical schools were not established until 1936 and 1956 respectively. In contrast, although Tasmanian administrators placed value on education and had established a university at the end of the 19th century, this state struggled economically for many years because of the loss of population from the gold rush years. A pattern emerged for Queensland Grammar School graduates to study at Sydney University; for Tasmanian medical students to study for a year at Tasmania University and then go to Melbourne University, while those from WA would go to Adelaide University.

Although the University of Melbourne was legally established in 1853, the doors were opened to students in 1855. Its affiliated residential colleges were Trinity, Ormond, Queen’s and Newman which, apart from providing residence, played other roles in student life, such as tutorial assistance and special assistance for intending ministers of religion. In recollecting his student days at Melbourne, one Tasmanian doctor pointed out that the Master of Ormond made two texts obligatory for medical students. One was Thomas Hardy’s (1899/1974) *Tess of the D’Urbervilles*, the first edition published in 1891, and Osler’s (1906) *Aequanimitas* (Crowther, 1946).26

25 No doubt the generalist tradition made a wider impact outside the sphere of medical education. However, most research about doctors in Australia has emanated from Victoria (Pensabene 1980, Willis 1989, Dyason 1988).
26 Osler’s (1906) text was and still remains a medical classic written by a well-known humanist physician, medical historian and educator. Thomas Hardy’s classic is a critique on the cruelty, double-standards and hypocrisies of the 19th century English class-system and relations between rich gentry and poor maidservants often forced into unwanted pregnancies with resultant devastating consequences.
Table 4.2  *Educational background of doctors registered in Victoria before 1901*

<table>
<thead>
<tr>
<th>Institution</th>
<th>Licentiates, Fellows, Members</th>
<th>University Degrees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal College of Physicians, London</td>
<td>122</td>
<td>-</td>
</tr>
<tr>
<td>Royal College of Surgeons, London</td>
<td>719</td>
<td>-</td>
</tr>
<tr>
<td>The Apothecaries Society of London</td>
<td>347</td>
<td>-</td>
</tr>
<tr>
<td>University of Durham</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>University of London</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>University of Oxford</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>University of Cambridge</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Royal College of Physicians, Edinburgh</td>
<td>592</td>
<td></td>
</tr>
<tr>
<td>Royal College of Surgeons, Edinburgh</td>
<td>594</td>
<td></td>
</tr>
<tr>
<td>Faculty of Physicians and Surgeons, Glasgow</td>
<td>215</td>
<td></td>
</tr>
<tr>
<td>University of Edinburgh</td>
<td>13</td>
<td>301</td>
</tr>
<tr>
<td>University of Glasgow</td>
<td>1</td>
<td>207</td>
</tr>
<tr>
<td>University of Aberdeen</td>
<td></td>
<td>86</td>
</tr>
<tr>
<td>University of St. Andrews</td>
<td></td>
<td>51</td>
</tr>
<tr>
<td>Kings and Queens College of Physicians, Ireland</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ireland</td>
<td>188</td>
<td></td>
</tr>
<tr>
<td>Royal College of Surgeons, Ireland</td>
<td>202</td>
<td>1</td>
</tr>
<tr>
<td>The Apothecaries Hall of Ireland</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>University of Dublin</td>
<td>2</td>
<td>78</td>
</tr>
<tr>
<td>The Queen’s College, Ireland</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>Totals:</td>
<td>3,052</td>
<td>755</td>
</tr>
</tbody>
</table>

*(Dyason, 1988, p.106)*

While the colleges in Melbourne were similar to the Oxbridge arrangement in Sydney, they were unlike them in that they formed no part of the university, nor were their lecturers recognised as University lecturers and it remained a distinctly non-residential university (Browne 1927, pp.163-164). As far as Adelaide was concerned,
the University was wholly non-residential until 1925 when St. Mark’s College was opened. This was followed by St Andrew’s College and a women’s residential college was also planned; while the former college was distinctly Anglican and the other Presbyterian, they were both open to other denominations (Lendon, c1935, p.1-5; Schultz, 1927, 172-173).

In contrast to Sydney, both Melbourne and Adelaide Universities and their medical schools received unfavourable press from prophets of doom who argued that they were both premature. As a result, the medical faculties relied on the generosity of benefactors so as to be able to comply with the regulations and requirements of the GMC in London (Lendon, c1935, p.154). Highlighted below are some factors that can be generalised across the two medical faculties.

Within the medical faculties, the medical curriculum itself was fashioned after the Edinburgh tradition, reflecting the practice of combining theoretical with practical training. In this tradition, many lecturers were practising general practitioners as well as clinical physicians and surgeons in hospitals. For example, Hughes (1967, p.155) points out:

The medical faculty (in Adelaide) was established in 1885 ... when all lectures as well as clinical instruction in the subjects dealt with in the clinical years were solely in the hands of men engaged in private general practice. Like Melbourne, this type of system continued for many decades, in this case almost 70 years, they were teachers in clinical subjects as well as honorary physicians and surgeons at the various hospitals.

However, hospital administrators had a problem with this type of instruction and exhibited hostility to these university professors in Melbourne and Adelaide who, for different reasons, were unable to coordinate university education to training of medical students in the hospitals until the late 19th or early 20th century (Inglis, 1958; Lendon, c1935; Hughes, 1967; Russell, 1977). The “Hospital Row” occurring at Adelaide hospital was one such instance involving a clash between government and doctors as well as preventing the training of medical students. The dispute was only resolved after a lengthy period of time because administrators and doctors did not see things in the same light (see Hughes, 1967; White, 1994). For example, Lendon (c1935, p.110.) states that perhaps the greatest factor leading to a resolution was because the Premier,
Mr. C.C. Kingston, who had brought in doctors from England to replace the striking doctors, moved on from state to Federal politics.

Also, while women doctors were accepted into all medical faculties, with those attending Melbourne and Sydney generally graduating at the top of their classes, they were not readily accepted by these hospital administrators, or sometimes by their medical colleagues. For example, in 1896 two Melbourne women medical graduates, Janet Greig and Freda Gamble, were among the top six, obtaining honours, while Janet’s sister, Jane, came seventh. After a heated battle they were finally accepted at the Melbourne Hospital as Resident Medical Officers, making the paths much easier for the women graduates coming after them. In Sydney, restrictions to resident posts in teaching hospitals were not lifted until 1909 (see Morgan, 1970; Hutton-Neve, 1980). Although medical educators were known to have had a determining influence on the students they taught, many women had to go to Adelaide for their hospital training (see Inglis, 1958; Russell, 1977).

Other women doctors used their own funds to establish hospitals by women for women both in Sydney and Melbourne. These were hospitals such as the Rachel Forster and the Queen Victoria hospitals which became teaching hospitals founded by women for women patients as well as for women students in obstetrics and gynaecology (Hutton-Neve, 1980; McCarthy, 2002). The Adelaide general hospital and the Queen Victoria became the two largest hospitals of their nature in the southern hemisphere. (Hughes, 1967; Russell, 1977). In respect to women’s contribution to hospital work more generally, Fett (1975), an anthropologist, conducted a study of both female and male medical graduates from the early 20th century, analysing their contributions in time spent at work. Her findings showed that women doctors had spent a great number of hours in honorary work.27 I will explain women’s involvement within the Adelaide Medical Faculty in the following pages.

In sum, in both Adelaide and Melbourne doctors battled consistently for their rights to institutionalize the teaching of what was called “bedside” medicine as well as nurture an ethos of collaboration between doctors which they succeeded in doing for

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27 Karmel, the Chairperson of the Committee on Medical Education (1973) drew on previously published accounts of Feeth’s (1975) work to counter an argument raised that medical education for women was “wasted” (see Farag, 1992).
number of years (Inglis 1958; Hughes, 1967; Lendon, c1935; Russell, 1977). However, while neither Adelaide nor Melbourne medical faculties underwent the “scientific greening” process until the late 1940s or early 1950s, there were consistent additions to the curriculum and calls for change which sometimes restricted the choice of subjects as well as the extent of authority and influence of faculty staff.

While I will introduce you to both of these faculties to highlight the distinctive features relevant to understand the place of generalists in the wider scheme of things, I pay more attention to detail as well as the power relations played out in the Adelaide Medical School. This is not only because of the available data but also because Adelaide Medical Faculty was at times treated as the “poor cousin” of the other faculties. The other reason is that until the 1950s, the lecturers there were well-known leaders in community medicine, such as Dr Eric Saint and others, who had far reaching effects on WA students. Some of these students became reformers, bringing back the tradition of linking teaching to medical practice in the community. These factors will be discussed further in Chapter Six.28

The University of Melbourne and its Medical Faculty

Until the 1950s, many lecturers at the Melbourne Medical faculty were practising general practitioners and clinical lecturers in medicine and surgery. When the Melbourne medical school was established in 1864, the first Dean appointed was Professor George Halford, a highly qualified doctor from London University. However, his anti-evolutionary views which were shared by many of his colleagues were subjected to much condemnation and criticism by the status quo at the time (see Russell, 1977). This hostility continued for some time and, like in Adelaide, the faculty was originally only able to give the degree of the MB. This meant that graduates could only work as house physicians in hospitals and not become trained as surgeons. The reason was that hospital by-laws only accepted those with either a surgical degree or surgical qualification acknowledged by a British Royal College. Only in 1876 was Royal Assent given for the degree of BS or ChB to become part of the medical course. After this time, the problem became the supply of bodies for anatomical dissection (see Russell, 1977).

Despite the fact that the Melbourne faculty began to be fully operational by the 1880s, the university’s professors were excluded for many years from accessing

28 As Willis (1989) states, while much of the historical work on doctors has concentrated on Victoria, there are always differences in what one extracts from the data.
honorary positions in hospitals such as the Melbourne and the Lying-in- Hospital and students could not avail themselves of the benefit of practical training. This resulted in many students enrolling for one year in Melbourne and going to Edinburgh to complete their medical training (see Geary, 1995, Russell, 1977, Pensabene, 1980).

In a similar fashion to Adelaide, Melbourne had to rely on donations from benefactors as well as students fees for survival and resources for research were incredibly limited (Russell, 1977). As already stated, in Melbourne before the World War I, the chair for gynaecology was subsidised from outside sources. For example, Dr Balls-Hedley was lecturer and “expert” in gynaecology and elected head of the United Grand Lodge of Victoria (UGLV) between 1905 and 1907 (see Henderson, 1988).

It therefore seems that in Melbourne as well as Sydney there was some duality in aspects of training. That is, while the clinical lecturers maintained their original focus on combining theoretical and practical training, other lecturers redirected students to more hospital-centred approaches focussed on the diagnosis and treatment of disease. This duality was reflected in the fact that while 710 graduates, undergraduates, past students and teachers of the medical school served in the World War I in the AIF or RAAMC, only a small number received military awards, and an even smaller number received knighthoods or chivalric awards. For example, a total of 710 went to war, with 57 losing their lives and a small number receiving honours from France, Belgium, Italy and Egypt. From this number, 135 received military and chivalric honours only awarded to military medical officers. In relation to military honours 40 were awarded a DSO, while another 60 were presented with a military cross. This left 35 who were given chivalric recognition with a minimal number awarded knighthoods, such as KCMG, KBE, and KB while others were entered the chivalric orders at a lower level, being awarded a CMG, CBE. and CB. Another nine received OBE’s (“The medical”, 1920, p. 287). As the general public was not likely to have any knowledge about this system of awards, it must have had the result of reinforcing the place of military medical officers at a higher social level to other doctors.

As far as medical degrees go, in the early 1920s, there was the MB, BS for undergraduates, as well as the MS and MD for postgraduates. Also from that time, Melbourne, like Sydney, offered postgraduate Diplomas in Public Health, (DPH). Melbourne also offered a Diploma in Tropical Medicine (DTM). (“The medical” 1920, pp.273-277; ibid, pp. 283-287). Melbourne even introduced the topic of Military
medicine into the curriculum, where “selected officers with war experience” were chosen to give three lectures in “medicine, surgery, pathology, bacteriology and hygiene” from a military standpoint (ibid, p.285).

The student atmosphere at Melbourne did not reflect the intense pressure of influences brought to bear on Sydney students and, as in Sydney, interaction with other students was facilitated when a new student social club was opened just prior to the war. While the curriculum was divided into pre-clinical and clinical subjects, as today, both parts also had a practical orientation. The emphasis on bedside clinics formed the core of clinical teaching. Students were split up into small groups and assigned to in-patient or out-patient department physicians and surgeons. They were allotted “cases” and expected to examine patients in wards other than their own. For surgical experience they were expected to attend in the operating theatres. They learned their obstetrics by living in at the Women’s Hospital and attending external cases with the district nurse. Attendance at specialist clinics was compulsory, as was attendance at the Children’s Hospital (Russell, 1977).

Except for the one mentioned, there were no “chairs” in the Melbourne faculty organization as had been established in Sydney from just before the 1930s. During 1939-1940, there were six professors employed to teach anatomy, bacteriology, obstetrics, pathology and physiology. Departments of medicine and surgery did not physically exist in either hospital or university and the medical faculty remained intensely under-resourced. The University had relied for a long time on the goodwill of senior physicians and surgeons prepared to give their time and skill to teaching undergraduates. They were given the titles of Stewart lecturers in medicine and surgery and, effectively, were heads of clinical departments responsible to the university for teaching and administration. The payment they received was very low because, while these doctors were senior honoraries in their own hospitals, they were also honoraries to the university (ibid.). Until this time such doctors resisted being pulled under the “scientific” umbrella and refused to give up their rights to private practice.

In instances such as those outlined above, it sometimes becomes difficult to understand what influences are at work. However, while many volunteered to go to war, in terms of the distinctions awarded, many were doctors rather than soldiers in outlook. The medical curriculum designed for undergraduate students remained focussed on producing the general practitioner and, apart from military doctors providing some
insights to their perspectives, there was no qualitative change until 1947, sixty years after the inception of the faculty. It was also at this time that the first woman lecturer, Jean Littlejohn, was appointed as a member of the faculty. Only shortly after this time, the clinical lecturers and supervisors were despatched out of the system and the medical faculty began to undergo its “scientific greening”. The result was that research monies increased four-fold between 1947 and 1954, doubling again later (see Russell, 1977, pp. 183). Now I will turn to Adelaide which, again, is a somewhat different story.

**The University of Adelaide and its medical faculty**

The chief credit for the Foundation of the University was owed to the efforts of a Congregationalist minister, a Reverend James Jefferis. After meeting with other “Free Denomination” representatives, it was decided to establish a theological institution called “Union College” (Lendon, c1935, p.1; “The medical”, 1920, p.297). The expressed aims were firstly to provide “young men” the opportunity of further education beyond the school course and secondly, specifically to encourage some to enter the Christian ministry. However, it does seem that the first aim held more sway (Lendon, c1935, p.1). This was because of the success enjoyed by the College when it offered a curriculum of classical subjects and, in 1872, attracted a donation of ₤20,000 from William Watson Hughes (later Sir), a former master mariner and pastoralist. Instead of using this sum for the College, the money was used to found a University where all secular studies could be included, while the “Union College” could carry on with theological training (Lendon, c1935, pp.2-4; “The medical”, 1920, p.288).

However, there is a suggestion of delaying strategies at work because of the immense time lag between the above events and the date when the university became fully operational nine years later. For example, two years after Hughes” donation the University was established, while it was only in 1881 that degrees were recognizable abroad. For example, “The medical” (1920, p.287) stated that:

> The University of Adelaide was established by an Act of Parliament in 1874, and in 1881 Royal Letters Patent were issued by Her Majesty Queen Victoria, declaring that degrees granted by it should be recognised as rank precedence and consideration throughout the British Empire, as if granted by any University in the United Kingdom.

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29 The greatest benefactor of the University was Sir Thomas Elder who gave approximately ₤100,000.00, of which ₤20,000 was earmarked for the medical faculty (Lendon, c1935, p.111).

30 In the 1880s, this was accompanied by a government grant consisting of 50,000 acres of country lands and five acres of park lands as a site for university buildings. The government also promised a sum of five
The Act of Incorporation of the University also ensured that provision was made for women to be accepted by all the Faculties. The first Lecturer in Physiology and later the first Dean of the Medical Faculty was Australian-born, Edward Charles Stirling, MD. (Cambridge), FRS. Stirling (later Sir) was involved in state politics where he succeeded in gaining the rights of franchise for women (Lendon, c1935). In 1886, lecturers were appointed to staff the faculty. Dr J.C. Verco, whose voice was heard above, was the second Dean and leader of the profession in SA, also establishing a reputation across Australia (ibid.). Dr Verco’s photograph is placed on the following page as representative of the generalist archetype of that period.

As stated above, the medical degrees offered, MB. and BS did not qualify for registration in England. While, an amending act was passed in 1888 to rectify this, it was not until September, 1913 that a supplementary charter was granted to the University which recognised university degrees as being portable outside Australia (Lendon, c1935). In spite of these restrictions, he points out the opportunities for bedside study were greater in Adelaide than in London because of the teachers as well as the lower student numbers.31 Lendon (c1935, pp.230-231) states:

In 1885 it so happened that there was in Adelaide a band of medical men all in the prime of life, possessing the highest degrees of the Universities of London, Cambridge, Edinburgh, Glasgow and Aberdeen: they were joined by the newly-appointed Professors Rennie and Watson. Primitive as the equipment was for teaching the subjects required to be studied before the student went to the Hospital, in my opinion it was little inferior to that of The Middlesex Hospital of London. As regards the opportunities for bedside study they were greater in Adelaide than in London because the students were so few in number.

31 This section on Adelaide is taken from Lendon’s work which was not released until 50 years after his death, as well as from The Medical Journal of Australia.
To bring home the point made above about the teachers, Table 5.3 below, lists the names, the disciplinary interests and qualifications of the first lecturers of the medical faculty. Excepting for the Resident Superintendent of the Lunatic Asylum, the doctors there were all general practitioners "in the fullest sense of the word" (Lendon, c1935, p.18). Apart from their lecturing responsibilities, Doctors Verco, Way and Hayward were also Lecturers on Clinical Medicine at the Adelaide Hospital (ibid.).

The only one with a totally different type of educational qualification was Professor Watson, appointed as the Lecturer in Pathological Anatomy and Operative Surgery. This surgeon's disciplinary interests and characteristic eccentricities were those manifested by soldier figures in Victorian/Edwardian times and regarded as "normal" (see Farwell, 1981). In this instance, Lendon (c1935, p.111) asserts that he had established himself as a man of profound learning, and of great surgical skill, and in addition was "hail fellow well met" with all and sundry in Adelaide: his alleged eccentricities were condoned.

The first Dean, Edward Stirling, was awarded a CMG. in 1893 and knighted in 1917. Although he was responsible for gaining the franchise for women, his influence on developments in the medical school was regarded as being "very similar to the benevolent despotism of the perpetual Deans of the sister universities." (Lendon, c1935, p.37). However, where the Dean was not seen to be of such calibre, a "perpetual" appointment of the Dean was not to be the case in Adelaide where a one-year plan of appointment of Deans was established. Such a pattern was seen as objectionable due to the time it took for each new Dean to learn the job functions, but it also had minor

32 I will refer to this topic again in the next chapter.
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He had established himself as a man of profound learning, and of great surgical skill, and in addition was “hail fellow well met” with all and sundry in Adelaide his alleged eccentricities were condoned

The first Dean, Edward Stirling, was awarded a CMG in 1893 and knighted in 1917. Although he was responsible for gaining the franchise for women, his influence on developments in the medical school was regarded as being “very similar to the benevolent despotism of the perpetual Deans of the sister universities” (Lendon, c1935, p.37). However, where the Dean was not seen to be of such calibre, a “perpetual” appointment of the Dean was not to be the case in Adelaide where a one-year plan of appointment of Deans was established. Such a pattern was seen as objectionable due to the time it took for each new Dean to learn the job functions, but it also had minor advantages in that it gave each faculty member a better insight into the conduct of business (ibid, p.78). As stated earlier, this seems to be a strategy of trying to destabilise the faculty and render it weaker than other universities where leadership positions were occupied for up to 20 years or more. However, in 1889 this short-term practice changed for a time when Dr Joseph Verco became Dean and new clinical lecturer on surgery while Dr. Poulton was employed at the Adelaide Hospital.

Again, despite the calibre of the lecturers, the Adelaide medical faculty was the only one forced into bringing in outside examiners for both the 2nd and 5th year of study, so rather than giving credit to the faculty, the “standards” were supposedly set by the

32 I will refer to this topic again in the next chapter
examiners of the other universities (Lendon, c1935, p.75; “The medical”, 1920, p. 289). As far as examinations were concerned, it was stated:

… in the final examinations at the end of the second year in anatomy, physiology and chemistry, and at the end of the fifth year in medicine, in surgery and in gynaecology, besides being examined by their own teachers in these subjects, papers are set by “outside examiners” belonging to the Universities of Melbourne and Sydney, who form their own estimate of the merit of candidates and either pass them or fail them or mark them doubtful; this estimate chiefly determines success or failure (ibid, p 289).

Regarding assessment of “standards”, these examining schools stated that:

Although this policy “entails much departmental work and considerable expense, it presents many manifest advantages” and it is a guarantee in some measure of the standards of the school. “The hallmark of the Adelaide degree in medicine is in effect perpetually attested by the authorities of the other universities who really act as independent censors of the school.” (ibid)

In Table 4.3 below, you can see, some disciplinary overlapping existed, such as the subject of pathological anatomy and operative surgery and ophthalmology, many subjects offered, such as physiology, materia medica, medicine and therapeutics as well as Forensic medicine, were similar to those taught at Edinburgh Medical Faculty. Physics, which generally went by the name of “natural philosophy” was a prerequisite for entry and not originally offered in the curriculum (Lendon, c1935 p.64). The favoured subject of Botany was gradually being excluded in most medical schools, yet the faculty hesitated to do this because of its perceived cultural value. Due to the cultural value placed on botany as an intellectual discipline, some of these values were transferred to ideas about the application of medical knowledge, an assertion repeated by senior lecturers at the Adelaide Medical Faculty (see Lendon, c1935). For example, as Foucault (1973) has pointed out, this “botanical model” is sometimes referred to as the “gardener’s model of nature” which focuses on keeping people healthy rather than only treating them when they are sick or “diseased”. Within this medical system, disease is not regarded as idiopathic or inherent in the individual or somehow resulting from some sort of immoral or deviant behaviour. Instead, disease becomes a condition resulting from the effects of life’s stresses and traumas.

33 For a discussion of the transformation of sickness to deviance, see Conrad and Schneider (1980).
Table 4.3. *Names and qualifications of first Dean and lecturers appointed to The University of Adelaide Medical Faculty from 1886*

<table>
<thead>
<tr>
<th>Name</th>
<th>Discipline</th>
<th>Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>E.W. Stirling</td>
<td>Physiology</td>
<td>MD. (Cambr.), FRS</td>
</tr>
<tr>
<td>W. L. Cleland</td>
<td>Materia Medica</td>
<td>MD. (Edin.)</td>
</tr>
<tr>
<td>J. Davies Thomas</td>
<td>Medicine and Therapeutics</td>
<td>MD (Lond.), FRCS. (Eng.)</td>
</tr>
<tr>
<td>J. C. Verco</td>
<td>Medicine and Therapeutics</td>
<td>MD (Lond.), FRCS. (Eng.)</td>
</tr>
<tr>
<td>W. Gardner</td>
<td>Surgery</td>
<td>MD. (Glas.)</td>
</tr>
<tr>
<td>M.J. Symons</td>
<td>Ophthalmology</td>
<td>MD. (Edin.)</td>
</tr>
<tr>
<td>E. W. Way</td>
<td>Obstetrics and Diseases of Women</td>
<td>MB. (Edin.)</td>
</tr>
<tr>
<td>A. A. Lendon</td>
<td>Forensic Medicine</td>
<td>MD. (Lond.)</td>
</tr>
<tr>
<td>A.S. Paterson</td>
<td>Aural Surgery</td>
<td>MD. (Edin.)</td>
</tr>
</tbody>
</table>

(The Medical School of Adelaide, 1920, p.289)

However, as demands increased for additions to the syllabus they felt that something had to be thrown overboard, so “Botany was the baby thrown out to pacify the wolves”, an action that was regretted (ibid, p.76). Lendon states:

> Botany, even when only descriptive, or anatomical rather than physiological, is a fascinating study besides being a good intellectual exercise. Perhaps I was more attached to it because I used to listen to Prof. Thomas Oliver at University College, London, and he was one of the best lecturers I can recall. Botany has been a great comfort and hobby for many medical men in practice (ibid).

However the “whirligig of time … brought partial revenge” because, in 1934, first year students had to pass in “so-called” Botany and in Zoology. Changes, therefore, were regarded as superficial (ibid.). In 1921, the faculty altered the period of medical study into a six year course and instead of the previous five annual exams in November; only four remained, in years 1, 3, 5 and 6 respectively. Further changes continued to be
made when, in 1932, another examination in the second year was added. Changes did not bring about any qualitative shifts and the subject of Botany was reinstated into the curriculum, along with Physics and Chemistry being included in the first year.

Another interest was in the topic of medical ethics, first championed by Dr Poulton who brought up ethical concerns in regard to students. One was that graduates with a Bachelor Medicine had no right to assume the title of “Doctor”, while another was the practice of students acting as *locum tenens* for a medical practitioner taking a vacation (ibid, p.95). While these were resolved at the time, more serious issues were raised in the early post-war years when a Dr Hayward gave a course of three lectures on medical ethics. These were regarded as timely because of the fact that anaesthetics were being used extensively in the Adelaide Hospital resulting in an excessive number of deaths (ibid, p.171).

During World War I, the university, its staff and its resources were placed at the disposal of both Federal and State governments. In addition the staff had to contribute ten percent of their salary to the war effort, a factor not mentioned by other medical faculties. For example, Lendon (c1935, p.141) states:

> The University had promptly placed at the disposal of the State and Federal Governments the services of its staff and the whole resources of the institution, in any professional, scientific, or technical work that might be within its scope. At the same time all members of the staff contributed 10% of their salaries to Patriotic Funds.

Also in 1916, the position of Chancellor of the University was given to the Lieutenant-Governor of the State and Stirling was reinstated as Dean for the war period (ibid). The number of medical doctors who volunteered for war service is hard to define, as no statistics are available of hospital staff. However, due to the population there at the time, the numbers were much smaller than Melbourne or Sydney. For example, there were 56 names on the Roll of Service for the AIF.

Only a few medical students went to war and only 13 enrolled and graduated before the end of the war. One woman doctor enlisted, receiving the rank of Major. Another two medical students enlisted, one joining the Royal Air Force (RAF) because he was in England when the war broke out. Other medical students were returned to complete their studies and only one served in the war after graduating in 1917. However, in view of the much smaller numbers, deaths and casualties in this small
group far outweighed the Melbourne figures. Here 71 doctors lost their lives, while 17 were wounded. The distinctions numbered 31 with DSOs and MCs awarded as military honours, while the highest chivalric awards were the CMG, CBE, and OBE. (ibid, pp.131-134).

However, while many doctors in the war were given military insignia, none were aware of the rule that only “soldiers”, that is men who were in some way permanently associated with the armed forces, were able to receive awards. So it was not understood why many doctors who served in the war were not fortunate enough to even be “mentioned in despatches” or to be acknowledged by their superiors. Not surprisingly, the distribution of honours was deemed to be somewhat “quaint” as well as discriminatory. For example, Dr Cavanagh Mainwaring was thought deserving of an imperial distinction, having lost his life, and this doctor was posthumously awarded The Order of the White Eagle of Serbia. However, this award was meaningless and had no military or imperial status. Dr Mainwaring never served in Serbia, so this could not have been an award offered to him by that country. Secondly, it was not consistent with the usual military awards given for distinguished services such as a DSO or MC (ibid. p.137).

Not all Adelaide students received discriminatory treatment. For example, Rafael Cilento was a student who, as stated earlier, served in the Territorial forces in the World War I. On his return, Cilento was jointly awarded the Everard Scholarship with another student, graduating in 1918, when he married a fellow-graduate of that same year, a Dr Phyllis McGlew. Cilento was a soldier because, after the Armistice, he was commissioned to New Guinea and Malaya on service, accompanied by his wife. During this time he studied Tropical Hygiene and later became “second in command” at the Health Department in Canberra. In 1925, as Director of the Australian Institute of Tropical Medicine (AITM), the Federal Health Department published his exposition on The White Man in the Tropics (Cilento, 1925). In 1934, he became Director-General of Health for Queensland when he received a knighthood (see Patrick, 1987, p.36434; Lendon, c1935, pp. 143,185). The reception of Cilento’s treatise was that, while his work showed evidence of wide reading, the conclusions drawn were inconsistent with more recent work (ibid, p.214).

Patrick (1987) offers a great deal more information and detail regarding the topic of White Australia in Queensland. Fedora Fisher has extensively studied Cilento’s life (see Fisher, 1986). For the history of the Queensland Medical Faculty, see Doherty (1986).
The Cilento’s were not the only Adelaide medical students to end up as marriage partners. There were another two couples who received mention and this leads me into the topic of women students. For example, there was Laura Fowler, the first woman student to graduate there and who later married a colleague, Charles Hope. They were recognised for their work in India as medical missionaries. During the World War I, they volunteered to serve in Serbia at the same hospital and became prisoners of war of the Germans (Lendon, c1935, p.75). The other woman doctor was Ethel Heyter Reed, graduated in 1924 marrying Howard Florey who moved to Oxford as Chair of Pathology (ibid. p.180-181).

Other women medical students at the time seemed to be high achievers. For example a Dr Helen Mayo was the first medical student to win the Everard Scholarship established in 1902. A grand-daughter of a well-respected doctor, she had also received the Davis Thomas Scholarship previously, and was followed by Constance May Cooper. Helen Mayo became a member of the University Council in 1914, but delayed proceeding to the MD until 1926 when she presented her thesis. This made her the only Adelaide woman to attempt this degree between 1900 and 1935. In 1927, she became the first woman to be appointed as Clinical Lecturer (ibid, p.174). During these years, Dr Mayo worked as senior physician to the Adelaide Children’s Hospital and as a clinical lecturer on Medical Diseases of Children in charge of the hospital laboratory’s vaccine branch. She was also President and founder of “Mareeba”, originally a private hospital, and then a Red Cross Society Hospital operating as a Women’s lying-in Hospital. “Mareeba” was purchased by the government in 1917 and converted into a Babies” hospital and a teaching site for medical students (ibid, p.174). Adelaide Hospital seems to have had a good track record in encouraging women students. As Hutton-Neve (1980, p.13) states:

The Adelaide (now the Royal Adelaide) Hospital had long been regarded as a broadminded institution where, in the early days, when medical women in N.S.W. and Victoria were denied resident ships in the teaching hospitals, no discrimination had been shown on the grounds of sex. The early records of the R.A.H. show the names of many Melbourne and Sydney women who served their year’s resident ship in Adelaide.

A survey of the SA Medical Register for 1935 showed that 67% (311 out of 484) of practitioners had been Adelaide students; 16% were graduates of either Sydney or Melbourne; while around 17% came from the United Kingdom or “other parts of the
Empire”\(^{35}\); while the remainder, less than 1%, graduated in other countries (Lendon, c1935, p.233). This led to the fact that in the 1930s the new generation of doctors were equipped to be better teachers than their predecessors because of the better opportunities available to them. In turn, they became the mainstay of the medical faculty and its teaching hospitals. Practically all the lecturers and professors at the university as well as the honorary staff at the Adelaide and the Children’s hospitals were people who were still in the prime of life. Also the teaching staff at the Adelaide Hospital consisted of some who would have to retire because of regulations stipulating a maximum length of service rather than age (ibid, pp. 231-232).

Until the 1950s, there were no clinical “chairs” attached to research interests. The faculty consisted of seven Professors, about sixty Lecturers, Tutors, Demonstrators and Clinical Assistants with the Adelaide and the Adelaide Children’s Hospital. The Queen’s (Lying In) Home was also used as a teaching hospital for medical students, especially after 1923 when Obstetrics and Gynaecology were once again joined together as one discipline (ibid, 234). The medical faculty continued to survive without any major qualitative shift until the post World War II period.

Unless disciplinary interests attracted funding from government or private sources, generally, the medical faculties remained understaffed and under-resourced. Many medical educators preferred to be employed part-time because they linked their teaching to their experiences with their patients to consistently broaden the scope of medical knowledge to meet the current needs in the population they served. For example, if like today many of their ageing patients were suffering chronic complaints, they would take the opportunity to try to understand and alleviate some of their ills. In fact generalists did not value the work of the research-oriented doctors because they did not appear to immediately build on medical knowledge in the community (see Russell, 1977; Lendon, c1935).

Despite other influences, the generalist tradition remained strong in Victoria and SA as well as across middle Australia. In Adelaide, Dr Joseph Verco was one of the most respected and long-standing clinical teachers, but neither he nor Lendon professed to be perfect and they sometimes made regretful mistakes.

\(^{35}\) I have sometimes left Lendon’s exact words to show that he, like others, was not immune to the impact of the wider social and political forces.
Other considerations

**Ideas about the human body**

The generalist tradition that evolved in Australia virtually mirrored sentiments integral to what were called “vitalist”\(^\text{36}\) notions of the body. While medical educators were secular in orientation, some doctors took on the role of the priest/physician in promoting an “active Christianity” while practically applying their medical knowledge to life circumstances, in essence reflecting some of Girdwood’s (1963) sentiments expressed at the beginning of this chapter. The difference is that Girdwood was in Edinburgh, Scotland while these doctors were mainly from Victoria, Australia.\(^\text{37}\)

The values and beliefs of “31 leading medical specialists” referring to themselves as family doctors were integrated into a text called the *Modern medical counsellor* (1959), first published in 1943 (Swartout, 1959). The organs and anatomical parts of the body were fully illustrated in colour plates with the pelvic organs of the female placed opposite those of the male with no kind of sexual connotations as in that described in *Gray’s Anatomy* by Petersen (1998). The following will also take on more meaning after Sutton’s fascist ideas are outlined in the next chapter.

The generalists saw the human body as “the crowning work of material creation” (Swartout 1959, p.19). Unlike the soldier, the generalist did not regard humans as morally or hierarchically ordered according to census data, nor as innate machines. The primacy of the psyche was reasserted and expressed in the belief that humans could achieve their individual goals and desires if given educational opportunities. For example, they argued that what one commonly calls “nature” is “really the power of the Creator operating in harmony with the laws of health. The biblical interpretation given does not equate sin or nature with sickness or disease but stresses that there is an all-forgiving God who is able to heal (ibid., p.177).

The “laws of nature” and “the laws of health” were seen as the true or “natural” remedies which are “pure air, sunlight, abstention, rest, exercise, proper diet, the use of water, and trust in divine power” (ibid., p.177). Furthermore they argued that the proper use of such things will do more than anything else to maintain a high general resistance to disease, and “it is these alone that can really restore health” (ibid.). Swartout’s (1959,
... those diseases that come from wrong habits rarely call for the use of drugs, but are best treated by natural remedies alone - the most important part of the treatment being the elimination of wrong habits and the formation of correct habits to take their place. Certain other diseases may need drugs or surgery, especially during the early stages, for the purpose of removing or correcting specific causes; but, *the actual restoration of health depends entirely on natural remedies*. In any case, after a person has done his part in conforming to the laws of health, trust in divine power can be an important factor in the cure of disease, not wholly because a “miracle” may be possible, but also because this trust banishes disease-promoting worry and generates disease-fighting hope. In some extreme cases, however, only divine power working in a miraculous way can bring recovery [italics added].

The following section encapsulates basic values about aspects of reproduction and sexuality.

**Ideas about reproduction and sexuality**

Ideas on reproduction and sexuality were part of custom and tradition expressed in the idea of the complementarity of roles between men and women, rather than assumptions about differences. For example, from the perspective of family life, there were no dominant/subordinate or active/passive dichotomies appearing in their texts. While in the early to mid-20th century, these ideas remained within a world view that looked upon heterosexual relationships as the basis of marriage, they saw the male/female relationship fused after marriage and children into the one-sex or “one flesh” model referred to earlier as having been being replaced by a two-sex model. (see Petersen, 1998). The fusion into a one-sex or “one flesh” model is based on the belief that the production of children is the result of the effort of *both* husband and wife (ibid).

As far as sexual discipline goes, these physicians were not without their ideas about sexual intercourse and what they regard as “natural”. They state that possibly only half of the women in the world are naturally predisposed to the sex act although they begin to enjoy it more after marriage. In addition, they point out that some women are indifferent to sex or view it as being distasteful. In contrast, Swartout, (1959, p.187) stated that there are “few men who do not naturally derive keen pleasure from the sex act” [italics added]. As regards sexual habits, Swartout asserts:
Doubtless because of the pleasure it affords them, a great many men maintain that they should have the right to indulge in sexual intercourse as often as they please. There are even those who argue that trying to control the sex urge is harmful to health. This is not true. The secret of health and power of mind and body is not in indulgence of appetites and passions, but in controlling them. It is not the steam that is “blown off” that runs the locomotive (ibid.).

As far as women’s health is concerned, it was seen to be under threat if childbearing occurs too frequently and therefore no moral arguments were offered about women being compelled to reproduce. In contrast, it was suggested that sterilisation might be offered as an alternative to contraception, a procedure available to both males and females. For example, Swartout (1959, p.184) states:

Some persons think of (sterilization) as a means of putting an end to any further increase in the size of a family, which they believe is already large enough, others as a means of avoiding the burdens and responsibilities that a family involves. Each individual or each married couple must settle the question in harmony with conscientious convictions. It is simply stated here that sterilization of either male or female is possible without “unsexing” either one, and that of the two it is a simpler operation to sterilize the male

**Ideas about medical intervention**

One distinction made was between “natural” and “rational” types of medical intervention. Surgery was regarded as a “rational” procedure or remedy which either restores a displaced or dislocated part to its normal position, or removes some infected part of the body which endangers life, such as an abscess, tumour or inflamed appendix. As such, surgery was neither considered a restorer of health in itself, nor a healing process. Modern surgery facilitated through the use of anaesthetics, was also considered a “rational” remedy, but also a poison. In addition, it was argued that while discourses around nature/natural/rational had some solid truth, “healing” cults and patent medicine advertisers found it easy to capitalise on such terms. Swartout (1959, p.177) asserts that “a truly natural remedy is always rational; although some truly rational remedies can hardly be described as natural.”

The second distinction was between Cartesian and non-Cartesian notions of the body. For example, all doctors believed in notions of the special senses but these generalists were not sense empiricists, whose practises became specialised. In Australia until the 1960s and later, generalists used their five senses as a doctor’s laboratory and
again the integrity of the psyche is given primary place in explaining how senses function. For example, it was stated:

We are accustomed to saying that we taste with our tongues, hear with our ears, and see with our eyes, but in reality all senses depend as much upon the nerves and the brain, as upon the sense organs. For instance, if the nerves leading from a man’s eyes were severed, or if that part of his brain to which those nerves lead were badly injured, he could not see at all, even though the eyes remained in perfect condition (ibid. p.69).

As the text of *The Medical Counsellor* runs into just under one thousand pages, it is not possible to do more than highlight some differences in medical perceptions in comparison to those present within the soldier tradition. For these generalists the idea of “active” was not related to initiation on the battlefield, but was an “active Christianity” focused on the vicissitudes of life. While some of the recommendations and prescriptions might be seem out-dated in 2006, especially in using biblical quotations to bring home a point, they were part of the culture of early 20th century Australian generalist practitioners who were still practising into the 1970s and even later in rural areas.

Significantly, Swartout placed a great emphasis on the idea of interconnectedness between the structure and function of the body, the integrity of the psyche and the resilience of human nature to ward off illness. From this example, one might deduce that the value placed on education was not confined to teaching medical students, but extended to education of the general population in ways that would promote good health. As such, the above ideas represent the integration of medical and social values which in turn affected the way medical practice was pursued. While these doctors may have brought in biblical quotes, their moral prescriptions were not generally dogmatic. These doctors were not in awe of “scientific” advances because as Lendon (c1935, p.314) concluded:

Sixty years ago the best text-book on medicine was an American translation of Niemeyer, a professor at the ancient University of the much smaller town of Tubingen. Koch was then merely a country practitioner; Pasteur’s laboratory was a wretched cellar.

As far as Indigenous health issues were concerned, generalists, like many others of their time, believed Aboriginal people to be a “dying race” (ibid. p.213). However, the 1930s was a time when subtle clashes of interests began to occur within the doctors’ camps. In the following, I point to two examples.
Soldier/generalist relations

Knights and mere mortals!

As far as relations between surgeons were concerned, the new “boys club” in Australia seems to have been an inner circle of younger soldier doctors whose aim it was to replace their senior more qualified peers.38 A good example of this was the ousting of a highly respected Adelaide plastic surgeon, Sir Henry Simpson Newland, M.S and F.R.C.S who succeeded a Melbourne surgeon, Sir George Syme, both as Chairman of the Federal Council of the BMA and President of the recently founded College of Surgeons. Newland also had a distinguished history of war service, receiving both the DSO and CBE in acknowledgement of his work as a plastic surgeon.

However, even these distinctions were not enough to save him because as a teacher he was obviously not of the same mould as his arrogant brethren. In this case, what happened was that, although he had been a senior lecturer at the Adelaide medical school for a number of years, in 1934 new regulations specified that Lecturers could not hold such positions after ceasing to have beds as a surgeon to the Adelaide hospital. As a result he was forced into retirement as a teacher, only being offered reappointment for a year.

Apparently the medical faculty had no say in this decision which was looked upon as a severe loss of a man who was quite capable of giving efficient service for a number of years to come. His soldier/surgeon successor, Dr Ivan Bede Jose, MC, MS., FRCS, who first became a lecturer in 1933, seemed to be waiting in the sidelines.39 This doctor was seen to make a very rapid rise from the post of medical/surgical registrar in 1923 to the post of senior hospital surgeon in 1933 (Lendon, c1935, pp.154-155).

Simultaneously, anomalies crept in at the Adelaide Children’s hospital so that all senior positions held by clinical physicians and surgeons and accompanying monetary rewards were given to four surgeons.40 This effectively displaced the position and influence of senior physicians who had worked there for many years as clinical lecturers on medical and surgical complaints of children (ibid, p.156).

38 This was similar to a process occurring in 19th century England after 1858 when the Poor Law Commissioners were in charge (see Rigby, 1992). In this case it seems that the invisible regulations of the “Magna Charta” were invoked.
39 MC is a military symbol standing for “Military Cross”, while M.S and F.R.C.S are medical symbols.
40 In all probability, they would have tried to install “operative” or craft-oriented surgeons.
Blackburn (1951) also stated that until WWI specialist recruitment was small and spasmodic and came from the ranks of general practitioners, some of whom were able, from time to time, to visit Europe to intensively study some branch of their work for which they had a particular flair. He commented that probably the stimulus behind these activities was the demand of the teaching hospitals for documentary evidence of expertise in a particular area. No doubt other added attractions might have been that the work was “more congenial, the fees larger and the leisure more abundant” (p.21).

This latter comment would seem nearer the truth if, according to Lendon (c1935), the practice of changing the rules was accomplished without any rational argument or justification. Blackburn (1951) attributes these changes as partly due to Australian army medical officers taking the opportunity of flexing their muscles, having been given an opportunity to undertake post-graduate study in Britain for six months pending their discharge. Many of these medical officers took advantage of this period to obtain training in one or other of the specialties then practiced (ibid, p.21). This was followed by the beginning of attempts by surgeons to dominate the BMA even though, since its inception, it had been a general practitioner-driven organisation (McGrath, 1975; Rigby, 1992).

In the 1950s, when structural changes occurred within medical education across Australia professorial chairs were established in the principal clinical subjects – first medicine in 1953, followed by obstetrics and gynaecology, and surgery in 1958. The new professorial status quo tried to block out the history of the medical school by sometime later producing press releases that the “full-time professor of medicine … has established a firm and fine academic tradition in the med school” (Hughes, 1967, p.164). This statement ignores the previous 70 years of what is virtually Australian history. Other similar instances will be referred to in the next chapter.

In 1956, the Adelaide hospital also began to change its attitudes towards women graduates. Hutton-Neve (1980, p.13) points out that, because of previous non-discriminatory practices, the refusal to give resident posts to women graduates was unbelievable and strong protests by the SA Medical Women’s Society forced the Board to revise their decision. She states:

41 Since its inception in England during the 1850s the BMA had always been a generalist organization (see Rigby 1992).
It was all the more amazing, therefore, when after some 50 year, the Board of the Hospital (at that time the only teaching general hospital in SA) suddenly announced, on the publication of the 1955 final examination results, that none of the three women graduates – all of whom had reached a high standard during their course and had come well up in the finals – would be given resident posts for 1956 (ibid.).

The following describes a somewhat wider clash of interests occurring between the College of Surgeons and the General Practitioners section of the BMA.

**Who shall reign supreme?**

Until the inception of the Australasian College of Surgeons (ACS) founded by Neville Howse, postgraduate training at a level suitable for senior degrees in surgery was only available through studying for a Fellowship of the Royal College of Surgeons (RCS) in England. It was not until after negotiations between the Australian and English Colleges resulted in the English college agreeing to send out examiners on the condition that a sufficient number of candidates were available and that the Australian universities were willing to provide the necessary facilities. Subsequently, the first exams were held in Melbourne in August, 1931 and some years later in New Zealand (Russell, 1977, p.154).⁴² One must also state that, while these concessions were made, the English Royal Colleges remained in control of the examination process until the late 1960s, moves which seemed to have both positive and negative outcomes. For example, Perth Public Hospital became a recognised hospital where postgraduate studies could be undertaken to meet with the regulations established for MD and MS. Degrees. This also had the unintended consequence of drawing the attention of SA doctors to WA which at the time was seen to be “forging ahead” (see Lendon, c1935, p.106).⁴³

During this period one of the first visible clashes between the soldier doctors and the generalists occurred when the latter group published an article blaming the College for the “insidious form of “white anting” of the BMA”, so as to make others believe that loyalty to the BMA was synonymous with loyalty to the surgeons as the self-declared elite of the profession (Fitchett, 1930, p. 1).

The generalists also accused the College of establishing its own hospital policy to help its own Fellows at the expense of other surgeons and issuing fee schedules for

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⁴² One must also state that, while these concessions were made, the English Royal Colleges remained in control of the examination process until the late 1960s (see Opit and Southby, 1978).

⁴³ It also seems a similar arrangement was made with Launceston hospital.
both. While the College’s “Constitution” was seen to be a model for the College of Physicians, it was one the generalists thought should be avoided. Some of its aims were as follows:

a) to cultivate and maintain the highest principles of surgical practice and ethics;

b) to safeguard the welfare of the community by indicating that its Fellows have attained a high standard of surgical competency and are of high character; and

c) to educate the public to recognise that the practice of surgery demands adequate and special training (ibid, p.2).

The criticism here was that they were trying to sell themselves commercially as a superior product with an inbuilt slogan which was translated into meaning “None genuine without our trade mark. Beware of imitations.”(ibid.). The generalists continued to critique every aspect of the College’s policies claiming them to be arrogant as well as “using power tyrannically” in the hope of exerting influence over hospital committees, post-graduate surgical training and research (ibid.). A further article called the College “a Star Chamber of autocrats” who were aiming at asking the public to discriminate in its favour as an “exclusive section of the profession” (Shaw, 1930, p.4). The justification for this criticism was that, should the College’s actions be motivated by altruistic reasons, then they would be expected to accept the “modern practice of teamwork” so as not to undermine the honesty of the general practitioner (ibid.). For example, Shaw (1930, p.4) prophesises future developments when he states:

It is in the best interests of the patient that the trusted family adviser should be in the closest possible contact with his patient when a surgical operation is necessary. It is obvious that the maintenance of this close supervision is best achieved by the collaboration of a visiting surgeon specialist in the manner previously indicated, rather than by the patient submitting himself to the exclusive care of a surgeon, who will, by working in his own special hospital, render it impossible in many cases for the general practitioner to attend the case at all.

Perhaps much more deeply embedded reasoning for such reactions could be seen in Fitchett’s (1930, p.2) following words:

Sir Lancelot had no need to educate the public to recognise the competency of his skill at arms, nor Sir Galahad to vaunt his chivalry. But then of course, their accolade was not self-bestowed. By all means, let these modern Knights of the
Table Round “safeguard the welfare of the community” by attaining a high standard of competency and being of high character, but we beg them to refrain from “indicating” these, and still more to refrain from directly or indirectly advertising the supposed significance of the indication (sic).

If one uses the theme of “clashes of interest” to show wider differences in practice outlook, it might be a useful exercise to contrast those of Brisbane and Adelaide doctors. Other than issues of “racial and patriarchal superiority”, soldier/surgeons were renowned for their discriminatory attitudes, especially towards women and children as patients. In Adelaide and Melbourne, hospital based services for women and children were established as soon as practicable. In Sydney, these services were established by elite women doctors but, in Brisbane, they were contested, and when they did emerge, they expanded to mirror specialist or surgical interests rather than those of the children.

To explain this situation, as far as children’s health issues were concerned, the surgical staff in Brisbane did not appear to have any interest in the subject of paediatrics as understood by other doctors at the time. In that state, the treatment of sick children in hospitals was frowned upon as it was considered that this encouraged mothers to neglect their duty (see Jackson, 1986; Thearle and Gregory, 1986, pp.179-188).

While the Brisbane Hospital for Sick Children was established in the 1880s as a general hospital, it was treated as an annexe. Soon however, sections were opened reflecting different surgical and specialist interests, rather than paediatric interests. One of the first wards was for infectious diseases, the most prevalent at the time being diphtheria where treatment using the ancient procedure of tracheotomy was favoured. In 1886, the next ward to be established was that of ophthalmology. Then, in the 1890s, the first Ear, Nose and Throat surgeon attempted an adenoidectomy. The resident, Dr Ellen Kent Hughes, quickly became skilled and worked side by side with the surgeon on twice-weekly tonsillectomy lists where “an ancient and painful guillotine method” was used. Then, in 1919, an Orthopaedic ward was opened to reflect the interests of a new surgical speciality (Thearle and Gregory, 1986, pp.179-188). According to Sutton (1944), orthopaedic surgery was defined as the surgery of deformity and defect (ibid. p.113)\(^\text{44}\)

\(^{44}\) From the Greek *orthos* meaning straight, and *paidos* meaning child
In contrast, the Adelaide Children’s Hospital established in 1884 had a staff of six members who were all honorary and no house surgeon when 224 patients were admitted. It remained a general hospital and in 1934 patient numbers increased to almost 3,000, with over 50,000 out-patient attendances. At that time, the staff had increased to fifty with six resident medical officers (ibid.). As stated, during these years, Dr Mayo worked as senior physician to the Adelaide Children’s Hospital and as a clinical lecturer on Medical Diseases of Children in charge of the Vaccine branch of the laboratory at the Adelaide Hospital (ibid., p. 174).

Secondly, on the issue of women’s hospitals, the nuns who owned and ran the Mater Hospital in Brisbane, like others of the time were dazzled by the mystique of surgery. However, they were equally dazzled by the degree of energy expended by administrators in trying to abolish plans for a Mothers’ Hospital, which was eventually established as late as the 1960s (see Jackson, 1986, p.217). In contrast, in both Melbourne and Adelaide, Women’s and Babies’ hospitals were established very early in the piece (Lendon, c1935, pp.174, 234).

Before concluding, the following pages will highlight the generalists’ traditional practice patterns, as well as social and medical ideas about the human body, reproduction and medical intervention, which was very much part of Australian culture during the 1950s and possibly much later.

**Workforce considerations**

The generalist (family) physician and surgeon became one of the stereotypes of the Australian doctor mainly for two reasons. The first was because, apart from the soldier surgeons’ influence already documented, there was no attempt to assert any type of national control over medical education or medical practice until after the World War II. The second was that the generalist tradition was, in essence, the established “modern” medical tradition designed to provide communities with a medical service connected to their needs. Also, Scottish Presbyterian educators and benefactors were largely responsible for nurturing humanist as well as educational values within the wider Australian community, a factor which has been acknowledged by other researchers (see Barcan, 1980; Gillman, 1988). As Pensabene (1980) has also
highlighted in the 1950s Blackburn (1951, p.21)\textsuperscript{45} who wrote an extensive review of the period, points out that:

The presence in all the states of so many highly efficient, self-reliant all-round doctors with a natural aversion to pruning from their practices branches with which they regarded themselves as fully competent to deal, was undoubtedly a factor in retarding the development of some of the specialties as full-time occupations for longer in Australia than in other parts of the world. Another important cause for the delay was … the absence of any local facilities for post-graduate study.

Such was the profile of the “traditional” Australian generalist (family) physician and surgeon who remained in practice until the 1970s and probably later in some rural areas. Australian general practitioners were known to develop a “specialty” of interest and to remain well-able to take on a variety of positions as practitioners, researchers, administrators, honorary physicians and surgeons in hospitals. As such, the effect was that they became highly flexible in being able to integrate, among other things, general practice with sessional teaching and hospital care. They were not only skilled in a number of minor surgical procedures but also performed a gate keeping function as patient advocate when referrals were made to a consultant or specialist.

As shown, doctors at this time were in a sense quite different from the general practitioner of today as they essentially played a primary role in maintaining a medical system aimed at meeting community needs. Some of these characteristic practices are still in living memory of older Australians and look somewhat like the tradition of British rural general practice shown in television serials such as Country Practice where the general practitioner follows patients to the district hospital, discusses their case with the consultant and then makes follow-up visits at hospital and at home, also assuring they have the necessary social support in place to help recovery. As I have also shown, before doctors were paid for their hospital work, general practitioners were also honorary physicians and surgeons in many hospitals (see Blackburn, 1951; Fett, 1975). In addition, while they referred their patient to a specialist, he/she was regarded as a consultant, so the generalist was there with the patient on admission to ensure the patient’s well-being. The doctors were family doctors who ensured the patient was satisfied that whatever was going to be done would not adversely affect any other

\textsuperscript{45} This was Sir Charles Blackburn who was himself an Adelaide medical student who later moved to take up a teaching position at Sydney University medical faculty (see Lendon, c1935).
medical condition and at the same time they were not worried about their family at home.

The need to make a medical living, as well as to remain abreast of rapid developments, was reflected in the ways doctors established themselves in the various colonies despite the particularities of different forms of economic, political and social development. Accordingly a pattern developed that defies simplistic dichotomies such as private practice versus salaried employment, or general practice versus specialist practice (Dewdney 1972, p.28), or in some instances even allopathic versus homeopathic medicine because in the early days some were eclectic (Templeton 1969; White 1994).

While analysis of the specifics attached to the economics of health care remains outside the scope of this thesis, doctors could operate a mixed mode of practice and receive different forms of remuneration, either working as generalists or specialist practitioners. What it actually means is that doctors defined their own interests, made their own financial arrangements, and thus took responsibility for accumulating specialized forms of knowledge that could make them flexible and multi-skilled operators, well-able to cope with new needs brought about by social changes and different demands of the marketplace.

In terms of working patterns, it also meant that, as far as generalists in many of the Australian states were concerned at least until the 1960s, a generalist or specialist practitioner could be one and the same person. For example, private salaried practice or “public” practice could be undertaken by the same practitioners. Doctors could work in private practice as well as treating their own patients in hospitals for obstetric or operative conditions. They could undertake sessional teaching work either in universities or hospitals and provide honorary assistance without remuneration in the large public hospitals. Equally a salaried full-time “specialist” in a public hospital might also have limited rights to conduct private practice outside normal working hours”; or a

46 See Doherty (1986), Patrick (1987) for Queensland’s developments of health services and medical practice. For WA, Bolton et al, 1982 and Garrick and Jeffery (1983), to whom I have referred, have documented a social history of Perth and Fremantle hospitals respectively. Best (1988) gives a good overview of NSW history, presenting biographies of various doctors practising into the contemporary era. Victoria has been well-documented, not only by sociological work, but also as far as the social histories of the various hospitals and the professional context were concerned (Dyason, 1988; Inglis 1957; Pensabene 1980; Willis 1989). Hicks (1981) has reviewed the colonial period, while more recently Gillespie (1991) has researched national and state medical politics up to the 1960s.
predominantly private practitioner might undertake part-time salaried work in hospitals or in industrial practice while at the same time maintaining his own independent practice (Dewdney, 1972, pp. 280-281). The one significant pattern was that, whether they were educators or researchers, they generally maintained private practice to keep abreast with community developments.

**Conclusion**

Generalists who came to Australia were highly qualified medical practitioners whose knowledge and practices integrated the idea of doctor as scientist with the idea of the doctor as humanist. While the Edinburgh Medical Faculty was the first to introduce the “modern” medical curriculum, their idea of a generalist was based on the value placed on the family practitioner whose interests and practices were related to the needs of their communities. While the Edinburgh Medical Faculty was the first to introduce the “modern” medical curriculum, they encouraged doctors to firstly work as generalists before pursuing a “speciality of interest”. The influence of these doctors within the Australian medical faculties, especially at Adelaide University, was often subordinated to wider social interests. They held a real notion of stewardship and a professional interest in passing on their knowledge and experience to future generations of students, some of whom would also become teachers.

Especially before the 1930s, there were sometimes meeting grounds among practitioners of all persuasions and it is difficult to show how rival medical traditions work unless one juxtaposes hospital practices within different Australian social contexts. As I have shown, as a militarised or “police state”, Queensland allowed the soldier/surgeon to dominate for many years while SA, as “the paradise of dissidents” was comfortable with the egalitarian ethos and practices of the generalist physician and surgeon. At the level of everyday practices, both generalist and soldier doctors coexisted for many years, at times laughing at each others eccentricities or idiosyncrasies. These practice were somewhat railroaded when the younger “pumpkified” doctors began to brandish their swords.

All in all, the deeply embedded nature of the cultural values associated with the generalist tradition were expressed in (a) the humanist secular and intellectual tradition passed on through medical education; (b) the patient and community centred focus; (c)

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47 This was a term used by Maclaurin (1925) when pointing out that some doctors thought of themselves as deified.
the concern for both women’s and children’s health, and (d) the concern for ethical and non-harmful practices in medical consultation rooms and in hospitals. These values were mirrored in their approaches to medical knowledge and practice. As far as hospital practices were concerned, the result was that, especially in Adelaide “bedside medicine” was introduced into Australia at a time when those in other countries were moving towards clinical medicine.

I have drawn attention to the significance of understanding that generalists were both anti-Cartesian and anti-Newtonian in outlook, drawing on humanist professional values helping to produce a distinctive type of medical professionalism where the doctor was physician, surgeon and teacher who linked developments in medical knowledge to meet with the needs of the community served. The emphases on botanical metaphors were associated with the belief in culture/nature interdependence as well as the complementarity of roles between men and women. As a result, one of the most important features of this tradition was its humane and egalitarian outlook. In reasserting the dignity of the psyche in social and medical expression, Scottish doctors and their colleagues were the first to link ideas about health with notions of human rights.

My analysis has therefore pointed to the fact that this generalist physician and surgeon was, first and foremost, a family doctor, a patient advocate and an educator whose allegiance was to the community. While in times of war, allegiance was to the nation and Empire, they were doctors not soldiers. I have emphasised how the deeply embedded nature of cultural values work their way into contemporary social relationships and expressions of medical knowledge and practice. This doctor was the type of person who could integrate, among other things, general practice with sessional teaching and hospital care, as well as providing continuing care for the patient. Most of all, there was a significant emphasis on producing students as teachers who could carry on their traditions of conducting research which would add to medical knowledge to

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48 The use of botanical metaphors was distinguishable from the botany of the “naturalists” such as Charles Darwin and Sir Joseph Banks who travelled to Australia. The best example of the Botanists and Naturalists who belonged to the status quo were those belonging to various “Societies” which did not have to struggle for resources. For example, one such Botanist and Naturalist, a Dr Ferdinand von Mueller, was the inaugural President of the RS of Victoria As well as the first Government Botanist of Victoria, a position he held for 43 years, from 1853 until he died. There was always some kind of an “exploratory” dimension to their work. As well as being Director of the Melbourne Botanic Gardens, he was naturalist to the North Australian Exploring Expedition. The Masonic connection with such a status quo is also evident in his photograph showing him in a suit over which are placed silk sashes and breast jewels (Australian Science and Technology Heritage Centre, 2001).
alleviate problems extant within their local communities. Their culture was a collegiate one.

For the generalist, there was little or no divorce between practice in the community, practice in hospitals and teaching in medical schools. This constituted an important facet of the generalist who practiced “bedside medicine” and, sometimes, a speciality of interest linking educational aims and knowledge to the actual needs of the men, women and children they saw on a day-to-day basis in their communities. From those early times until the 1970s in Australia the term “general practitioner” carried with it a much broader definition and higher status than it carries today. In the next chapters, one will begin to understand how this situation changed and how the principles for which they stood reappeared later in substance, if not in form.
CHAPTER FIVE

“Jewels in jeopardy”: saving the nation and purging of infection

…If we look past the “cosy comfortableness” evoked by “the Fifties” we see dreamers tossing uneasily, haunted by Cold War fears of global atomic annihilation, and more local concerns about threats to a “White Australia”, erosion of the social and moral order and the pressures of maintaining the image of domestic bliss and material prosperity. Similarly, if we look closely at the road to this dream, we see it was often a rocky one which could lead those pushed onto it to unanticipated destinations (Haebich, 2000, p.418).

Introduction

To understand the context of the 1950’s in the above terms, one must firstly ask why such feelings of threat were invoked and why a crisis orientation was needed to “save the nation” as well as “purify” the moral and social order from “infection”. What happened beforehand to create feelings of threat and what role did the doctors play in this drama? While, as in the past, the medical status quo remained aligned to chivalric sentiments aligned to Hospitaller traditions, in the crisis milieu of the post-war period, many brethren in chivalry looked upon themselves as “jewels in jeopardy” (see McKnight, 1994, p.24, p.293). Therefore, as the notion of “jewels” was an anthropomorphism of the soldier’s elitist self-identity, the “other” could also take on many anthropomorphic faces to be treated as “enemies” associated with disease, infection, germs or glands on which a war could forever be waged. For example, drawing on the work of both Lupton (1994) and Bauman (1995), Higgs (2003, p.182) points out:

The discovery of germs is only part of the picture, especially when this particular theory of illness causation can be overextended to account for many other “social” processes. This can happen because an idea like that of the “germ” can catch the public imagination and become part of popular mythology. It has been used both to label certain individuals or groups as potentially dangerous and as a metaphor for social persecution when the undesired group are seen as “germs” infecting the wider society.

This chapter first of all provides the background of the decade leading up to this crisis milieu beginning at the end of the 1940s. This decade marked the establishment of an independent Order of St John in Canberra as well as the United Nations in San Francisco and the documenting of its first Human Rights Declaration. In contrast, the Nuremburg Code, drawn up to guard against indiscriminate medical experimentation,
was sanitised and a military stamp became overtly imprinted on emergent structural changes in the ensuing “Cold War” environment. In this case, a crisis milieu is created to block out opposition and effectively counter threats to the status quo. At the same time, ASIO virtually became an arm of government, leaving no space for dissent.

In pursuing the theme of “saving the nation and purging of infection”, in this period one can see the idea of “saving” as operating at different levels concerning defence, foreign relations and human rights. As such, the idea of “salvation” was widened to support other types of “life saving” in relation to medical and social practices. These issues are important because they help to show the continuous relationship between the widening of the soldier function in the militarization of civilian society in its administrative, management and policy decisions which affected the reshaping of medical institutions and research projects, at this time controlled by the SPH & TM. The events occurring in the 1940s and 1950s in one way or another affected others occurring within the 1970s and later in the 1990s. Again, these events and their resultant changes are placed within the social milieu of their emergence to show the links to rights-based issues.

Social context

Beginning with the outbreak of World War II, Australia left herself undefended by sending troops to assist Britain in the Middle East. At this time, Dr Herbert Vere Evatt, the Curtin Labour government’s Minister for Foreign Affairs, discovered Churchill and Roosevelt had made a secret deal to allow Japan to invade Australia, leaving Germany for them. The real “saviour” at this time was Dr Evatt, who was successful in getting them to reverse the policy (Pilger, 1992, 156-157). For example, Pilger (1992, p.156) states:

“Bert” Evatt was a central figure in every civil rights struggle in Australia for a generation and the youngest judge to sit in the High Court., where his opinions established universal precedents of freedom. During the Second World War … Evatt may well have done more than any individual to save his country from invasion when he secured from Churchill and Roosevelt the reversal of a secret policy known as “expendable Australia” or “Germany first”.

However, the proclaimed “saviour” of the period was not Evatt, but the United States of America (USA) for coming to Australia’s aid when the Japanese invaded

1 The terms Britain and the United Kingdom are used interchangeably in this thesis.
Darwin. This event was seen as having the consequence of moving Australia’s imperial capital to Washington. However, both Evatt and Chifley\(^2\), who became Prime Minister after Curtin’s death, wanted to cut Australia’s imperial ties. Evatt tried to do this immediately after the war, not only becoming the first President of the United Nations, but also being responsible for drawing up the first Declaration of Human Rights (Pilger, 1992; Ryan, personal communication, April 4, 2005). Pilger, (1992, p.157) points out:

Immediately after the war, Evatt proclaimed Australian independence as his goal: a policy he called “the New World”. Australia was to be in the southern hemisphere as Sweden was in the north: libertarian, non-aligned, prosperous, and envied and, above all, at peace. At San Francisco in 1946 Evatt was a dominating figure in the framing of the United Nations Charter and, as first President of the United Nations, it was he who announced the Declaration of Human Rights. This was one of the highest points in white Australia’s history, for which Evatt was to pay dearly.

To make matters worse for those feeling threatened by such “libertarian” actions, the accompanying emergence of an anti-war movement caught many by surprise and the returning chaplains were looked upon with suspicion as if, like the troops, they were “infected with unsound ideas” (McKernan, 2004, p. 496). These sentiments were ignored by some church leaders aligning themselves with the government and the army in representing the Cold War era as the “new age of martyrdom and persecution” (McKernan, 2004, p.496-497). For example, McKernan (2004, p.497) states:

The Catholic Church promoted a “crusade for the safety of Australia” alarming adherents with the threat of an internal or external takeover of Australian society by communists. Similar campaigns in other churches promoted “moral rearmament” to fight the foe and there was a certain apocalyptic feel to the 1950s in Australia. The Korean War pitted Australians against a communist enemy for the first time and alerted Australians to the strength of the movement perhaps even more dangerous than the enemies so recently defeated.

These apocalyptic sentiments were also invoked by others whose concerns encompassed race mixing and breeding. For example, Churchill’s actions were seen to be justified by his view of Australians as predominantly “bad stock” because of convict origins. His High Commissioner called us “inferior people” and Robert Menzies, who was to become Prime Minister of Australia in 1949, thought of Australians as “repugnant” (Pilger, 1989, pp.156-161). Menzies (later Sir) remained in office during

\(^2\) While Chifley was racist and Anglo-centric in relation to the White Australia policy, nevertheless, he also initiated the immigration program which brought this to an end (see Pilger, 1992, Farag, 1992). However, after the 1970s after the military doctors gained control, they began to institutionalise exclusionary practices against migrant doctors (see Farag, 1992).
the 1950s and most of the 1960s and was a member of NSW Freemasonry (UNGSLW, 2005). Menzies also seemed to have many chivalric leanings, becoming a “Knight of the Thistle, Companion of Honour, Fellow of the Royal Society, Knight of the Order of Australia, Lord Warden of the Cinque Ports, and President of Kent County Cricket Club” (Pilger, 1992, p.161). In the late 1960s, he became Chancellor of the University of Melbourne, occupying this position for a number of years. Robert Menzies was also the culture hero of a later Australian Prime Minister, John Howard, to whom I will refer again in Chapter Eight.

Alongside these events were the threats imposed by the generalists to the emerging “scientific” research enterprise. In this respect, issues of medical experimentation within the Nazi regime during the war were brought to public attention with the Nuremburg trials. These trials led to the formation of the first set of international ethical guidelines on human experimentation. The document, known as the Nuremburg Code (1947), was drawn up by both British and American military authors (Hazelgrove, 2002). However, while this Code was supposed to guard against medical experiments having the remotest possibility of death or disability, in anticipation of public criticism, the doctors ignored and sanitised it through introducing the practice of “informed consent”. In the UK, however, it was seen to have made little difference to controversial research practices which had been strongly debated by generalists and seemed to put them in “the firing line” (Hazelgrove, 2002, p.109). For example, Hazelgrove (2002, p.109) states:

… despite British involvement in the formulation of the Code, the experience of war time and changing career structures were more influential in shaping the approach of investigators to their subjects. Where medical debates ensued, primarily over controversial research practices at the British Postgraduate medical school, Hammersmith Hospital, they were set in the context of a much older division between “bedside” and “scientific” medicine.3

Outside these developments, there were other ideas of “saving” and “purging” through fascist or eugenic ideas conflated with breeding out traits such as skin colour, disability, feeble mindedness and any other characteristic seen to be “defective”. Perhaps if the idea of “infection” is conflated with “race”, the support of Federal and state government officials to “save” Indigenous children by taking them away them

3 Unfortunately I cannot elaborate on the issues Jenny Hazelgrove raises within the paper. This whole issue of medical experimentation in Australia needs to be more thoroughly researched. At the moment, it is beyond the scope of the present project.
from their parents might be understood. However, this practice did not stand alone, as the same kind of thinking was conflated with “poverty” and part of the practices behind “saving” or “rescuing” of British migrant “orphan” children as well as other Australian children who were institutionalised especially around that period.

Today, several studies, as well as government reports and enquiries, have highlighted the destructive and punitive nature of policies and institutional practices involving British, as well as Australian Indigenous and non-Indigenous children, many taken away from their parents and placed in institutions little different from concentration camps (National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families (NISATSIC, 1997, Australian Parliament Senate Community Affairs Reference Committee (APSCAR, 2001, 2004). While these practices in themselves show a complete disregard for human rights, I want to draw attention to the medical experimentation on children which appeared during the 1950s, and how this relates to methods and eugenic ideas promoted by Harvey Sutton in the SPH & TM. As far as the removal of Indigenous children from their parents is concerned, during the mid-20th century, this practice shifted from being ad-hoc to becoming a systematised strategy or final solution operating at both State and Federal levels (see Gardiner-Garden, 1999; Haebich, 2000). These arguments are in contrast to Van Krieken (1991) thesis on Australian children and the welfare system as he felt Haebich’s (1988) earlier work on West Australian Aboriginal people was “exaggerated” and “state policy in (the area of Aboriginal children) did not fit the model of one dominant group regulating and … transforming forever the everyday experiences of another, almost entirely against their will” (Van Krieken, 1991, p.8). As Gardiner-Garden (1999, p.5) points out:

The third Native Welfare Conference in 1951, at which the newly appointed Federal Minister for Territories, Paul Hasluck⁴, advanced assimilation as the remedy to the inconsistent policies which made a mockery of Australia’s attempt to promote human rights internationally, did nothing to stem the removals. Indeed, States began to widen the scope of their removal policies and in the 1950s and 1960s children were being removed not just for alleged neglect, but to attend school in distant places, receive medical treatment and to be adopted out at birth (Gardiner-Garden, 1999, p. 5).⁵

⁴ Paul Hasluck (later Sir), as Governor General between 1969 to 1974, became Head of the Order of St John in Australia. Also, Hasluck was made a Knight of the Garter and, in 1995 after his death, his banner as Knight of this Order, was placed in St George’s Cathedral (Khangure and Howie-Willis, 1997, p.121).

⁵ A.O. Neville the “protector” of Aboriginal people in WA was influential in shaping these decisions. As Haebich (2000) states, like others in the status quo of his time, he was a Freemason.
These issues are important because they help to show how systemization in terms of structural changes at one level accompanies systemization of other practices at other levels. As in 19th century England, changes which occurred within this crisis-oriented climate virtually blocked the voices of those expressing notions of freedom or human rights. Again, the starting point begins with the continuing influences of the medical “jewels” and chivalric orders.

The “Jewels” of the chivalric Orders

The chivalric orders imported a culture dominated by doctors within military and Masonic institutions, which both served to encourage their members to value secrecy and privacy as well as a chivalric ethos which had wider appeal. An admirer was the Reverend John Flynn who became the legendary “Flynn of the Inland” and, as mentioned previously, thought the Order of St John promoted “paths of practical chivalry” (Howie-Willis, 1983, p.330). However, in 1939 the dual regal leadership of the Masonic and British chivalric orders was severed and, in 1941, Dr Hugh Poate became the first Commandery Lieutenant or administrative director of the Order of St John’s new national Australian Commandery established in Canberra.

The function of the new Commandery was to coordinate the national affairs of the order as well as its three foundations, the Brigade, the Association and the Ophthalmic Hospital. After the Order achieved full Priory status, Poate became its head as the first Chancellor (Howie-Willis, 1983, p. 85). He was also the first Australian to be awarded the Bailiff Grand Cross, the highest rank of the order, remaining as Chancellor until his death in 1961, to be succeeded by a Colonel George Stening, a surgeon and resident graduate of Poate’s hospital, the Royal Prince Alfred Hospital, Sydney (ibid, p.370). As such changes occurred within the context of World War II, apart from Poate, other army colonels were prominent Sydney and Brisbane surgeons, as well as other professionals strategically placed in positions of influence, some enjoying a similar social status to regal and vice-regal representatives.9

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6 The English also sent “orphans” to other countries, such as Ireland.
7 This is another example of how difficult it is to easily categorize people.
8 In the Orders” terms a Commandery was similar to a branch given a degree of autonomy from the English Order.
9 Previously while researchers have pointed to the role of military doctors, the problem was identifying “which military doctors” because of the large numbers of doctors automatically volunteering their services during the war (see Gillespie, 1991).
By 1941, the Air Raid Precaution agencies and the St John Ambulance and Brigade worked together in regard to staffing and training. The Brigade members were deregistered from the Voluntary Aid Detachments (VAD) and handed over to the National and State Emergency Medical Services (EMS) to act as an administrative body within Australia. Women volunteers as well as doctors and nurses went to war and, alongside the Australian Army Medical Women’s Service (AAMWS), took over the VAD function (Howie-Willis, 1983). As I will show, the EMS administrative role in war was later emulated in peacetime.

While St John medical leaders were sometimes also heads of the Australian Red Cross, the emphasis on charity was preserved by the practice of wives of Governors-General (or another person nominated by the Governor-General) becoming President of the Australian Red Cross. This was a condition specifically incorporated into the Royal Charter of the Australian Red Cross (ARC) (Barrow, personal communication, May 9, 2002). However, not long after the war the Australian Red Cross began to distance itself from its link to the Order of St John (see Stubbings, 1991).

The Australian leaders of the Order of St John, called Priors and Sub-Priors, were mostly Governors-General and state Governors whose influence also spread to Craft Freemasonry. For example, in 1945, as well as being Grand Master of the UGLNSW, Lord Gowrie was a Knight of Grace of St John and Governor-General of Australia. Between 1945 and 1947, the next Governor-General was the Duke of Gloucester, who was the Duke of Connaught’s nephew, replacing his uncle as head of the British Order of St John, but not as head of the United Orders (see Smyth, 1991). 10

In 1947, WA became a Commandery responsible to the English Order, but has not been able to exert the same influence as the national body (see Khangure and Howie-Willis 1997, pp. 258-260). As far as the United Orders are concerned, this period marked their “golden years” (see Smyth, 1991). In terms of the role played by Governors-General and State Governors, one of the first projects which called on their help to wage a “war on disease” is explained below.

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10 Smyth (1991), a Masonic historian, documents the global nature of the United Orders. However, the extent of such influences in military circles today cannot be ascertained.
**Other developments**

From 1922, the Knights of the Southern Cross had established themselves to promote the interests of Catholics and counter perceived Masonic and “Orange” influences in the community generally. One of their objectives was to promote child migration (APSCAR, 2004, p.23). In fact, most of the chivalric orders were originally Catholic. For example, the Knights Templar was originally an order formed by Benedictine Monks, such as those at New Norcia in WA.\(^{11}\)

Simultaneously, excessive concerns from those belonging to chivalric orders seemed to come into play when Sydney University and Ipswich Grammar “old boys” became leaders of various civilian institutions as well as others associated with Intelligence and Defence. Not only does McKnight (1994) assert those in ASIO belonged to such orders, but also between 1938 and 1952 several of the Ipswich Grammar “old boys” became Defence Force leaders or Professors of Preventive Medicine.\(^{12}\) At the time, these networks were hard to define, and the BMA could not support their objections to excessive military control because of the difficulty in identifying key players (Gillespie, 1991, pp.116-117).

Such objections were highly valid. For example, in Table 5.1 below I have listed the key “soldier” figures between 1930s and 1960s.\(^{13}\) Each one had some role to play in the militarization of medicine and the medicalization of wider society explained below with the added advantage of being able to influence structural changes to medical organization and health policy within the crisis orientations of both the World War II and the “Cold War”. I will briefly explain some features of the “Cold War” crisis milieu created in which such changes occurred.

\(^{11}\) Also the original Hospitallers, the Catholic Sovereign Knights of Malta, established itself in Rome where it was given diplomatic status. Of course, these were not the only chivalric orders. A glance at Delbert’s Handbook will show the presence of a number of orders in Australia, such as The Most Excellent Order of the British Empire, The Royal Victorian Order, The Queen’s Chapel of the Savoy, as well as the Pontifical Knightly Orders (Orton, 1987). Except for the Catholic orders, while structures included women at all levels, like big business or professional groups open to both women and men, one does not generally see a woman’s name in the upper echelons excepting for the present Sovereign.

\(^{12}\) Such assertions are not based on any kind of “conspiracy theory”. It was simply the way things were at the time. The Ipswich Grammar School (2006) website attests to the special historical role it played in producing national leaders.

\(^{13}\) This table is not to be taken as fully representative and only lists those who have been mentioned in this thesis extant in this period. For the military history of the Australian Intelligence Corps see Coulthard-Clark (1976).
Cold war environment

In 1949, Robert Gordon Menzies\(^{14}\) was sworn in as Prime Minister of Australia, while Sir Earle Page became Minister of Health. As stated, the creation of a “Cold War” environment brought with it a crisis milieu where effective obstruction to structural change could be blocked. Like others of his kind, Dr Evatt was subjected to the McCarthyism so much affecting freedom of expression (see Pilger, 1992). This era saw new legislation enacted for security regulations which gave ASIO extended powers. In ASIO’s view at the time, anyone who was seen to be a pacifist in outlook or left wing in political leaning was a security risk or a “communist” and unable to be trusted (see McKnight, 1994, pp. 127-130).

Table 5.1 Some key soldier/saviour leaders, surgeons and hygienists in positions within federal, state and defence institutions, 1930-1969

<table>
<thead>
<tr>
<th>Name</th>
<th>Period of service</th>
<th>Involvement in medical administration, research and politics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Harvey Sutton</td>
<td>1930-1948</td>
<td>Director, SPH &amp;TM and Lecturer in Preventive Medicine at Sydney University Medical Faculty. Sutton’s interest was in experimental medicine and child health and known to correspond with Butler(^{15}). He also helped to establish the Institute of Child Health in the Sydney University grounds.</td>
</tr>
<tr>
<td>Dr F. A. Maguire</td>
<td>1930-1949</td>
<td>Surgeon at RPAH, Sydney. First Hospitaller and Almoner of Australian Order of St John. Long-standing member of the NHRMC and of the BMA NSW Branch. Alderman of the Sydney City Council (1949) and effective ruler of NSW Freemasonry for intervening twelve years (Henderson, 1988, 114-115).</td>
</tr>
<tr>
<td>Dr Hugh Poate</td>
<td>1942 -1961</td>
<td>Dr Hugh Poate, the leading Sydney surgeon connected with training St John’s Ambulance Brigade volunteers, is made head of The Most Venerable Order of St John at its inception in Canberra as an independent order (Howie-Willis, 1983)</td>
</tr>
</tbody>
</table>

\(^{14}\) Previously leader of the United Australia Party which in 1945 became the Liberal party.

\(^{15}\) For the link between Butler and Sutton, see Wyndham, (1996); for Wunderly, see “Health People”, (1971, pp.34-35).
Dr A. Wunderly 1947 – 1957

Wunderly served in the AIF, later to become Federal Director of Tuberculosis who put into effect own scheme deemed successful. In 1954, he was knighted, but resigned from the Federal Department of Health in 1957. He joined WHO, becoming chief of the Tuberculosis unit in Geneva in 1961, acting as an advisor to several Asian countries, and becoming a member of the WHO Expert Advisory Panel for Tuberculosis from 1959 to 1970. Both Wunderly and his wife donated $18,000 for travelling scholarships for both New Zealand and Australian doctors in the areas of tuberculosis and thoracic medicine.

(Sir) Edward Ford 1948 – 1967

Sydney University graduate and Sutton's successor as next Director of the SPH & TM. He had served during the war as head of the Allied Army Malaria preventative campaign (Page, 1963).

Sir. Earle Page 1949 -1969

Page served in the First World War and was involved in Federal politics in 1925 when he became co-founder of College of Surgeons with Major-General Neville Howse (Page, 1963). In 1949 he became Minister of Health in Menzies liberal government and was responsible for establishing the first voluntary National Health Insurance system in Australia (1953) (ibid.)

John Donald Kenneth 1952- 1955

Ipswich Grammar “old boy” and Professor of Preventive Medicine at the University of Queensland (Ipswich, 2006, p.2).

Gwyn Howells 1966

Dr Gwyn Howells, an English chest physician and hospital registrar who spent nine years in Thoracic medicine in Toowoomba joins Federal Department of Health. (Health, 1971). Howells becomes Director-General of the Federal Health Department during the 1970s.

As we know from Foucault’s theory of the “truth/power/knowledge” nexus those who hold positions of power are also able to control the truth and the dissemination of knowledge (Petersen, 1993, p.120). At this time, vetting of most university staff in many disciplinary areas became an established practice. In medical education it almost led to total exclusion of general practitioners from medical faculties as well as hospitals.

According to McKnight (1994, pp. 127-135) some ASIO-directed exclusionary practices were as follows:
a) Qualified people with dissident ideas were excluded from the public service. This was done by “purging” the public service left wing so as to prevent them taking up positions;

b) Migrants were kept apart by throwing a political *cordon sanitaire* around them;

c) Organizations such as the Australian Union of Women and the Australian Peace Council, among others, were secretly vetted; and

d) Writers and academics were also secretly vetted.

In the case of academics, one of these was an eminent WA Professor, Walter Murdoch, who openly supported peace. Others were people like Anglican rector and well-known anthropologist, Professor A. Elkin, who took a stand against the prevailing negative view of Aboriginal people and another anthropologist, Peter Worsley, who was refused permission to travel overseas. The list was extended to include Senior Lecturers and Professors in a number of disciplinary areas, including those in physics, law and science (see McKnight, 1994). As far as doctors are concerned, not only were the medical practitioners who taught within a number of medical faculties replaced by those brought in from England, but doctors like Eric Dark, who was a well-known for publishing dissident and socialist views, was immediately excluded from any position of power or influence.16 As Gillespie (1991, p.255) states:

Certainly, there is much evidence of a major change in the political atmosphere by early 1950. The minority of doctors who had supported Labour’s schemes felt the force of official disfavour. Page ordered his officials to prepare a list of Victorian doctors who had participated in the pharmaceutical benefits scheme, and compared it with lists of known communists prepared for the Royal Commission on Communism. At the same time, well-known socialists were arbitrarily removed from sources of income controlled by the Commonwealth. Eric Dark, who earned his living as a repatriation local medical officer in the Blue Mountains, was removed from repatriation lists, and was forced to move to a salaried post in remote western New South Wales.

In sum, because of such security vetting, there would have been many such professionals who were subsequently denied positions in universities and public service organizations (see McKnight 1994; Gillespie, 1991). As McKnight (1994, p.127) states, the underlying rationale served to function as a system of sifting out “ideological impurities as infections”. Researchers have referred to this period in a number of different ways. G. Gray (1991, p.19) points to the era as one of “coercive Federalism” while Gillespie (1991, p.253) refers to it as a period in which health policy was framed

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16 He became the culture hero of the Doctors’ Reform Society which emerged in the early 1970s when, among others, the present Western Australian Labour politician, Dr Judith Edwards, became one of its foundation members.
within “the blackest days of Australian conservativism”. However, while researchers have acknowledged the eugenics-inspired ideas behind public health and population planning, until recently there has been no examination of how these ideas were institutionalised and what their connection was to medical experimentation carried out on children during this period (Amberey, 2000; Wyndham 1996; APSCAR, 2000, 2004, McKnight, 1994). As Farag (1992); Haebich (2000); Kunz (1975); Martin (1978) and McKnight (1994) have already shown, it would seem these times were hard for people who had any social conscience, or were in vulnerable social positions, whether as doctors or patients, especially those of a migrant, Indigenous, refugee background. The overt patterns appearing in this period became systemised and covert, affecting health, immigration and social policy, as well as foreign and defence policy. As McKnight (1994, p.127) asserted:

The numbing effects of systematic discrimination on the Australian cultural scene for almost twenty years can only be guessed at … deeply affect(ing) formation of foreign and defence policy, health and social policy and immigration policy

In the following, a number of specific changes to medical education and hospital servicing are documented.

**The militarization of medical schools and hospitals**

Among the ranks of the EMS were leading hospital surgeons associated with the Order of St John (see Howie-Willis, 1983). They began to design a medical system to suit state prerogatives as well as the experiences of the military-oriented doctors who were specialists in their specific fields. The practice of strategically placing themselves and colleagues across a number of institutions led to the overwhelming influence of the medical “jewels” on the wider social landscape. These were mainly patrician surgeons as well as ex-AIF surgeons who became leaders of the Order of St John, the RACS and the Sydney Medical Faculty and would eventually dominate the BMA later to become the Australian Medical Association (AMA) (see Gillespie, 1991; Maddison, 1977).

Beginning with the medical faculties and the hospitals and then postgraduate medical education, institutional changes occurred over an approximate twenty-year period. The new medical system brought with it shifts in the attitudes and behaviour of doctors as well as patients and ultimately altered the doctor/patient relationship in significant ways. Finally, national health legislation established a new scheme of
financial payments biased in favour of specialist practitioners. Although not strictly in chronological order, the following will explain how such changes occurred. The first battle the soldier/saviour waged was the war against its medical peers in civilian life: the generalist surgeons and physicians.

**Undergraduate medical schools**

Between 1949 and 1969 when Menzies remained in office, the administrative authority of the EMS was extended in peacetime. Taking charge of “medical manpower”, they planned post-war reconstruction of medical education and hospital servicing introducing a “quota” system into each medical faculty (Andrew, 1974; Gillespie, 1991). These doctors really seemed to invoke the Magna Charta as they gained control of political processes and excluded or removed unwanted doctors from civil service posts. They reformulated educational prerogatives and services to meet the needs of ex-servicemen (Gillespie, 1991). They excluded generalists from universities by recruiting hospital-based examiners (Best 1988). This was followed by excluding generalists from hospitals, marking the beginning of the phasing out of bedside medicine, as well as excluding generalists from other positions of power and influence (Goldman, 1986).

This shift created a medical system which moved from a dependency on clients to a dependency on colleagues for referrals, one which had already been established earlier in the United Kingdom (Johnson, 1972). The system also relied on inter-dependence with industry and state, in areas of research, scientific and technological innovation and hospital privileges. This inter-dependence served the interests of the soldier surgeon and research institutions, such as the SPH & TM, The Institute of Child Health, the national pathology and biology laboratories and the NHRMC. The accompanying changes in medical education appear to have involved several strategies which resulted in definitive outcomes with new lecturers who were “specialists” and the guardians of esoteric knowledge. Later in this chapter, I will show the focus on “interesting and rare or exotic diseases” appears to have been more in line with the research work of the SPH & TM in that era.

At the same time, the generalists lost control over their own knowledge base and any effective means to educate future doctors in their tradition. There were, in fact, two processes occurring, one noisy and visible, and one operating quietly and not so visible.
While visible changes made to medical faculties and hospitals slowly began to be interlinked, policy directives were not immediately apparent, except in the area of national emergency. The process which occurred was described as having involved an “extraordinary deterioration of economic status of key men in medical service during the previous 50 years” (Blackburn 1951, p. 22). Ideas of life-saving benefits were interlinked with both new medical drugs and the “specialist”. These developments involved a process of a wider medicalization of the population whose behaviour began to show an acceptance of the “specialist” as the “real” doctor along with accepting the accompanying definition that “health was the absence of disease”. I will return again to some of these issues below.

In the meantime, the British system of “old boys” networks was kept alive through public school, military and Lodge affiliations, as being a useful source for senior hospital appointments (see Best, 1988; Rich, 1989). Those at the helm of the Order of St John had wide-reaching influences on these developments, when new specialist academics were brought in from Britain and ex-servicemen were trained for the specialties (see Best, 1988; Plant 1991; Rich, 1989). As Foucault (cited in Rabinow, 1984, p.190) states:

The power in the hierarchized surveillance of the disciplines is not possessed as a thing … it functions like a piece of machinery. And although it is true that its pyramidal organization gives it a “head”, it is the apparatus as the whole that produces “power” and distributes individuals in this permanent and continuous field. This enables the disciplinary power to be both absolutely indiscreet, since it is everywhere and always alert, since by its very principle it leaves no zone of shade and constantly supervises the very individuals who are entrusted with the task of supervising and absolutely “discreet”, for it functions permanently and largely in silence.

Also, as alluded to above, the vetting of university academics involved military and secret service intelligence officers treating people with left-wing ideas as if they had contracted some deadly disease likely to “infect” students with “subversive doctrines” (McKnight, 1994, p.156). This was accompanied by the rise of an intellectual conservatism, the formation and character of which has been researched by Brown (1950), while sociological research into tertiary education and conservatism in recruits to the professions was carried out in a number of studies.17

The consequences from 1945 onwards were that soldier doctors in charge of post-war reconstruction of the medical division of labour gave ex-servicemen educational opportunities at the expense of civilian doctors. Science subjects were made a requirement of secondary education and a system of meritocracy established displacing the system of the previous 50 years based on an “educational ladder” (see Barcan, 1980). Subsequently, over the ensuing post war years, the existing medical faculties were subjected to a process of slow structural transformation. In many, but not all, instances the previous system of coordinating between the faculty, the hospital and the community was discontinued. Accordingly, the new system was like that institutionalised at Sydney Medical Faculty involving new recruiting practices for “academic” medical teachers and reorganizing the medical faculties to introduce disciplinary “chairs”. In effect, medical education was skewed to meeting the demands and interests of the various disciplinary specialist “chairs”, many of whom, as stated, were recruited from England (see Best, 1988). These “chairs” replaced the previous generalist-oriented system where the part-time generalist educators were also part-time practitioners linking their teaching practices to the prevailing health issues in their communities.

As the medical schools were transformed, the part-time generalist academics were discredited as “not real academics” and excluded from teaching positions and the “gods” or “jewels” took over. The following is taken from an account by John Best, an Australian medical practitioner, who graduated from Melbourne University Medical Faculty in 1963. Best was the son of a Melbourne general practitioner who did some work for the Repatriation Hospital (ibid, p.1).

After graduation, Best’s father impressed upon him his concern for helping people. However the new doctor’s experiences of education and hospital practices during the 1960s were very different. The traditions impressed upon the students were of a hospital-based medicine linked to an association with “British traditions” reinforced by “British myths”, one of which I will refer to below.

As Best’s medical education was drawn from models of the British tradition, there was no discussion of anything distinctly Australian within the academic content. Those mentioned were Howard Florey, who, as stated previously, was an Adelaide

18 John Best (1988) published a book for the bicentenary incorporating biographical accounts of the work of some outstanding medical practitioners and health professionals
graduate who became the Chair of Pathology at Oxford, and Sister Kenny, whose therapeutic practices on polio victims were strongly contested (ibid, pp.1-2). The representations of all things British were reinforced on film. During Best’s childhood, he remembers seeing The Citadel which told the life story of a Welsh practitioner, A.J. Cronin played by Robert Donat. The story described him leaving the environment of a simple Welsh mining village to bathe in the glories of success in Harley Street (ibid.).

As new graduates, Best and his colleagues were also exposed to other films, such as the life story of a medical student and resident doctor at the imaginary hospital of St. Sit-in’s. In this film, the role of Simon Sparrow, a “well-mannered, shy, and impoverished” medical student was played by Dirk Bogarde, whose path was paved to become the modest heroic doctor dedicated to his patients (ibid.). This heroic imagery as well as the imagery of the doctor as “god” seemed to have lived on with them. For example, Best (1988, p.1) further states:

… the honorary specialists at the teaching hospitals were gods, whose experience had been derived against a background of WWII or Korean War. Mere mortal young graduates worked very long hours for a pittance; everybody knew his (sic.) place in this teaching hospital order. It was the way (my italics).

From the foregoing, one might venture to assert that at least within medical and non-medical academic circles there were two main camps which could be identified during this period. One camp was the “us” who could be easily identified as militaristic, conservative, and atavistic in outlook and supporters of the White Australia policy. As well as others mentioned earlier, quite a few researchers agree there was a particular type of Australian fascism also operating during this period (see Gillespie, 1991; McKnight, 1994; Powles, 1988). In contrast, the “them” were pacifists who nevertheless were as patriotic as the next person when volunteering their services during the war. However, they generally did not support the White Australia policy, nor were they against women entering the profession. Some were free thinkers advocating left or radical politics (see McKnight 1994; Tanner, 1980).

Military and security intelligence were never completely successful in vetting staff but, to some degree, their actions led to another form of systemic discrimination. McKnight (1994, p.154) points out, although they were never successful, there was circumstantial evidence of informal ties between some vice-chancellors and ASIO officers. He points out:
The Organization was never able to systematically veto or vet staff appointments at Australian universities, though it would have liked to. But it did all it could to hamper the work of academics whom it regarded as “security threats” and, on occasions, actually stopped academic appointments. In the case of the Australian National University and other universities there is circumstantial evidence that vetting of staff occurred through informal liaison between vice chancellors and ASIO.

In the ensuing years, although ASIO’s direct influence on such institutions was officially diminished, in some instances there is evidence of informal liaison between vice chancellors and Faculty “chairs” being an established practice during the 1970s at the Sydney Medical Faculty. In many respects, this practice served to diminish the Dean’s authority and influence (Maddison, 1977). It was not until a few years later when medical faculty organization and medical curriculum content came under criticism and was challenged. The other major development in medical education was between the period 1956 and 1974, when medical faculties were established at the Universities of Western Australia, Tasmania, New South Wales, Monash and Flinders, all with different pre-requisites for admission and criteria for selection and quota systems (Andrew, 1974). As with the other medical faculties, each has their own specific histories. While it is beyond the scope of the thesis to cover all of these institutions, like the Adelaide medical faculty, other such universities or departments have been singled out and discussed in the next chapter.

In sum, the result of these structural changes was to change the educational product from a generalist to a specialist-oriented type of doctor to suit the developing medical system. As a result, medical students were socialized within the parameters set in place by militaristic doctors who were not traditionally pedagogues, but examiners and did not have much interest in medical education. Rather than link their teaching to community needs, they linked their teaching to their own “esoteric” interests and placed importance on their students accumulating written factual information, subsequently leading to overloading the medical curriculum. The soldier tradition and inherent characteristics were thus transferred to the hospitals.

Changes in the hospitals

In the 1950s after the change of government, the hospitals began to change their recruiting practices in line with an increase in specialist numbers. One key factor in this system was the interdependent relationship formed with State health services,
administrators and specialists, severely restricting the role general practitioners were able to fill in the hospitals (Goldman, 1986). The public hospitals’ emphasis on specialist appointments was also reflected in difference in remuneration between specialists and generalists. The outcomes inevitably were that general practitioners were excluded from hospital practice. As Goldman (1986, p.59) states:

... various restrictions have been introduced in the last 30 years on the role general practitioners could fill in hospitals. These have led to their virtual exclusion from hospitals – an exclusion bitterly resented by many established practitioners and the significance of which is perhaps not fully appreciated by new graduates.

Hospital privileges accorded the “specialist” doctor are paramount in this medical system. For example, in such a system the hospital focus is on high quality care for the patient’s main “disease”, so the higher level of service is regarded as the “sacred” realm of the operative specialist, while the lower level of service is relegated to the “profane” or general practitioner type of service. As such, this kind of patient care neither gives adequate attention to concurrent diseases, nor does it provide any social support or personal continuing care (ibid.).

At this point, the soldier tradition and the associated system of medical education was transformed from having an overt military/religious stamp into one having a covert military/religious stamp extending itself into hospital practices. For example, as observation of patterns of behaviour is a valid analytical device, one might make a comparison between the eccentricities of those “soldiers” in the British land forces and the doctors in the operating room. It is only here one can make sense of the “British tradition” to which they referred. First of all, with regard to the characteristics of those in British regiments carrying their military lodges with them until the late 1940s, Farwell (1981, p.17) points out:

Firstly, while they not only created and maintained the British Empire, no one person commanded or controlled it. Secondly, despite this factor a rationalization of homogenous values were invoked and maintained. While acknowledging their own eccentricities it regarded them as “normal”. The “normal” was based on the inherent superiority to other forms of human endeavour. The “real” soldier was the professional officer and other ranks. The men who fought in wars were not “real” soldiers, only armed civilians.
In comparison, the dialogue below shows what these same “British” traditions meant to surgeons. This dialogue was one of a number used to “enliven” dinner tables when doctors met to “talk shop”. Best, (1988, p.2) states:

When the monocle fell out of the anaesthetist’s eye into the surgical wound created by the leading Melbourne surgeon, it was in accord with the eccentric side of medical practice, which the British tradition allowed. The surgeon removed the monocle, the accompanying caustic comment having been lost with the passage of time.

Of course, although this type of behaviour was more in keeping with the activities of those surgeons in the teaching hospitals, the point is such behaviour was part of a “British tradition” which permeated and transformed the whole medical system in post-World War II Australia. As these doctors were well known for their atavistic tendencies, it is not surprising the end-result was that in undergraduate teaching programs, the graduating medical students held a biased view towards medicine as a specialized, esoteric and crisis-oriented system. Neither did they have any insight into community health problems nor any understanding of the role of the general practitioner (Bates, Hinton and Wood, 1973, p.608). As a result, it is also not surprising a teaching hospital resident doctor likened the hospital system to the army. For example, Bates et al. (1973, p.609) quotes one medical resident, interviewed in Sydney in the early 1970s:

They’re creating a system a bit like the army – the army goes out to destroy your soul. They take everything away from you so you’re a good institution man. You can see a lot of it reflected in the senior consultants. They’re pretty uninspiring. They haven’t got any spirit. There’s no interest for them except medicine. This is because they’ve been through this machine. They’ve been ironed out – they’re not individuals any more – they’re just there to do a job. They put you in a uniform. You have to take orders and no real communication. It’s something you have to take. The amount of hours you have to work is soul destroying – it takes a lot out of you that in the end you get so tired you can’t be bothered arguing about it and you begin to accept it like past generations.

The organization of such a system reinforced the importance given to crisis care and hospital-based medical intervention. In addition, the hospital was the hub around which “specialist” type of medical and paramedical staff and St John Ambulance were organised, while simultaneously keeping alive the chivalric ideal of “saving the nation” from impending doom. In such a system, the doctor/patient relationship takes on a different face because in the hospital, the doctor is the hero and the patient is grateful and subservient. In other settings, however, the heroic genre completely displaces the
patient in its quest for research into “esoteric” pursuits which were generally the domain of the researchers. In the following I will detail some of the developments at this point with regard to postgraduate specialist training.

**Postgraduate specialist training**

From the 1920s, specialists were generally practitioners with post-graduate qualifications who were Fellows or Members of a specialist organization. Traditionally, the institutionalized practice of “topping up” qualifications in England automatically reinforced the prestige of a Membership or Fellowship from a British Royal College. Also limiting the growth of specialism in Australia was the absence of postgraduate study, apart from the sections of special interest established by the state branches of the BMA. As previously mentioned in 1928 the ACS was the first to establish itself outside the BMA in 1928. The next, in 1933, was the (Royal) Australasian College of Physicians (RACP), made up of honorary physicians in the Australian and New Zealand teaching hospitals. From 1934, others following represented Anaesthetists, Radiologists, Orthopaedics, Urologists and Ophthalmologists (see Pensabene, 1980, p.163), some being sub-surgical specialties.

One of the reasons for this delay was, although the (later Royal) Australian College of Surgeons and the Royal Australian College of Physicians were established in 1928 and 1938 respectively, the English and Scottish Royal Colleges continued to dominate Australian specialist training schemes until World War II (Opit and Southby, 1978). Opit and Southby (1978, p.4) argue these consultant-dominated colleges were obsessed with maintaining dominance by trying to sustain their “purity” and continued (to) adopt a variety of policies to maintain the purity of medicine and surgery undiluted by manual or trading operations and to stem the rise of the general practitioner. One important method by which they achieved this end was by refusing to broaden the scope of their examinations to cover anything but pure medicine and surgery respectively.

Since the war, however, the Australian Royal Colleges became independent from the UK after which time other specialist colleges were established in Australia. While traditions and style were closer to programmes in the USA, the old links and ways of doing things leaned more strongly towards the UK, especially in regard to the treatment meted out to generalists (ibid, p.5). The first regulation was for states to demand specialist registration. In 1939, Queensland was the first to establish a register, while in other states progress was even slower because of generalist opposition. SA was
the last to follow in 1966 (Pensabene, 1980, p.163). As I will explain later, in the 1970s the issue of specialist registration was finally resolved in favour of the specialist bodies.¹⁹

As previously mentioned, until the late 1960s, young Australian physicians in training generally considered it a mandatory ritual to make their way to the UK as the most logical place for the formal part of their specialist training. However, during the 1970s, the position changed dramatically and included major changes in procedures and admissions to colleges (see Opit and Southby, 1978). From that time onwards, the postgraduate training of the different Australian specialties began to mirror the “closed circle” types of organization similar to their counterparts in other countries (see Newble, Jolly and Wakeford, 1994; Spielman, 2000).

Two exceptions to this picture might be the Royal College of Obstetricians and Gynaecologists (RCOG), and the College of General Practitioners whose leaders established branches in NSW and Victoria, with the expressed aim of taking control over their own knowledge base from others. For example, in 1947, the Obstetricians/Gynaecologists formed a corporate body to gain control of teaching practices of gynaecology from surgeons. In the first place, it had to gain control of knowledge transfer within medical schools with the expressed aim of preventing the ongoing mutilation of women’s bodies through educating medical students in this field. The College could not regulate existing practitioners because there was no mandatory recertification requirement in force (Shaw, 1947).²⁰ However, the College was the first to introduce these requirements during the 1970s long before re-certification became a major issue for the other specialities (see Newble et al, 1994).²¹

As far as the College of General Practitioners was concerned, they began to form links with their British counterparts so as to establish corporate bodies with the aim of educating new general practitioners. This was originally an individually induced action rather than a political one and began from a meeting between two country general practitioners, one practising in England and the other in Australia. They wanted to find a way to gain control of their knowledge base which they considered was being eroded.

¹⁹ For those interested in more detail about Victoria, see Pensabene (1980).
²⁰ This coincides with the year the first woman was appointed to Melbourne faculty to lecture in obstetrics.
²¹ In actual fact, Hamilton (1992) states one of the foundation professors at Newcastle Medical School was the person responsible for initiating such reforms.
They began by raising consciousness amongst the general practitioner population within the highly conservative environment of the 1950s (Winton, 1983, pp.16-17). Some of the effects this produced will be outlined in the next chapter. Between about 1953 and 1978, changes to the nature of specialist medical developments in Australia were also accompanied by developments in planning for national emergency, a supposedly unrelated influence of the soldier tradition, as well as structural changes to the types of postgraduate education available for those wishing to pursue a specialty. Compulsory national service was reintroduced by the Menzies Liberal government after taking up office, remaining in place until abolished by the Whitlam Labour government in the early 1970s. At this time, most senior medical lecturers in medical schools and in public service positions seemed to favour those who had been actively engaged in the army, as well as those more likely to have remained active in an army reserve or in the St John’s Ambulance Brigade (see Best, 1988; Gillespie, 1991; Howie-Willis, 1983).

**Planning for National Emergency**

Besides the fear of communism induced by the Cold War environment, the post-war period brought with it the fear of nuclear warfare and the need to plan for national emergency. As far as army medical reforms were concerned, in 1949, the Australian Army Medical Corps received its Royal prefix (RAAMC). One of the first health professions to be included in these plans were Australian army nurses who, in 1951 received the “Royal” prefix, becoming the Royal Australian Army Nursing Corps (RAANC). At the end of 1952, a RAANC Company, called the Citizens Military Forces, was established in each state so as to provide a reserve army of trained nurses in the event of a national emergency (see Dewdney, 1972, p. 260). In the following decades, it became clear that not only nurses, but most hospital senior staff were important elements in this type of planning. For example, another crisis-milieu was being created when between 1967 and 1969 the Medical Journal of Australia printed several articles warning about the threat of nuclear attack (“Allocation of”, 1973, pp.29-31).

This fear of nuclear war resulted in the establishment of a National Medical War Planning Committee to take responsibility for allocation of medical personnel in such a

22 David Armstrong (1983) has researched the 20th century English context. In Australia, Daniel (1990) has studied the different political persuasions of the various medical colleges and societies.

23 See R. Goodman (1988) for the history of the RAANC.
national emergency. This Committee brought civilian and military medical and non-
medical authorities together, its members consisting of those at the highest echelons of
the Federal Department of Health as well as Army, Air Force and Navy Medical
Services, Civil Defence and Veterinary Hygiene. There were also representatives of the
AMA\textsuperscript{24}, the Australian Dental Association (ADA), as well as State Health authorities
and the Departments of Supply and Labour and National Service. The Committee
Secretariat was provided by the Federal Department of Health (ibid, p.29).

Similar to the model set by the nurses and others in voluntary organizations like
St John’s Ambulance Brigade or the medical army reserves, such planning involved a
process of nominating “medical cadres” who would consist of specific staff members in
teaching hospitals made ready and available for mobilization in the event of a disaster.
These “cadres” were to include physicians, surgeons, anaesthetists, radiologists, as well
as nurses, porters and technicians who would be removed to a safe area to perform
predetermined functions for the state (ibid, pp.29-30). The two questions raised here are
what were the priorities about who should be saved and who would suffer?

The plan was, in the event of a national emergency occurring without warning, to
evacuate these medical cadres for the purpose of (a) removing “a cross-section of the
medical and paramedical personnel so that they would be available to treat casualties”;
and (b) preserving “a nucleus who could train students and enable the professions to be
re-established when the crisis was over” (ibid, p.30). In relation to benefiting the
“community”, the organization of such personnel centred on “Hospital towns” and
“Medical Reporting Centres” where country doctors and other practitioners would be
expected to report (ibid). It was regarded as inevitable that the general public would be
left without sufficient medical care to benefit the “community” as a whole, due to the
withdrawal of up to 50% of doctors from their everyday practices to augment medical
cadres in hospital towns (ibid). It was stated:

This would reduce the relatively small number of doctors in country areas
to a level where very few remain to treat the general public, but this must
be done if the whole of the community in a State is taken into consideration.
At such a time all elective surgery would be postponed. As casualties would
be in such colossal numbers it is only to be expected that normal medical
practice would suffer severe limitations during the emergency period (ibid).

\textsuperscript{24} The Australian Medical Association (AMA) was established in 1961 to replace its predecessor, the
British Medical Association (BMA) (see ref.).
While thankfully, in hindsight, one can see there was no such disaster and hopefully there will not ever be one, this type of planning must have inevitably been a significant influence on reinforcing the institutionalisation of a hospital-centred medical system by those who believed disaster was inevitable. As a result, such a system was systemically skewed in favour of those who held a chivalric ideal of “saving the nation” and themselves through planning for such a national emergency. Significantly, if a national emergency occurred, this very system discriminated against the welfare of the general public, one might ask which “nation” was to be saved? Consequently, such a system reinforced the importance given to crisis care and hospital-based medical intervention. The hospital was the hub around which specialist type of medical and paramedical staff were organised, while simultaneously keeping alive the chivalric ideal of “saving the nation” from impending doom. It was the “birth of the clinic” in Australia where the soldier physician and surgeon reigned in all their glory and the ethos was ultimately one of self-preservation! Gordon (1976) is quoted by Daniel (1990, p.83) as stating:

Medical practice, like nursing, is closely identified with the hospital and the status of medicine has been firmly tied to the ascendancy of the modern hospital, now the citadel of medical science. In Australia, the hospital “is regarded as the most important place in medical treatment, where all the serious business of medicine occurs, where all the drama of medicine occurs, where the real miracles of modern medicine occur” [italics added]

In such a system, the doctor/patient relationship takes on a different face due to the deontological nature of the system; that is, it is geared towards the preservation of “specialist experts”, the virtual exclusion of generalists and the complete disregard for the patient. This was, in effect, a metamorphosis of a process which had occurred in 19th century England after military medical reforms. In favouring such a system, the medical schools, the hospitals, laboratories as well as the already present SPH & TM and the NHRMC were all part of the heroic genre of medicine. The National Medical War Planning Committee left no doubt the “elect” to be “saved” would be carefully chosen. For example, it states:

The National Medical War Planning Committee is planning the best service possible under emergency conditions and has asked every doctor to provide certain personal particulars. The information provided has given the Committee a clear indication of the medical resources available and where these resources are located. At a later stage surveys of paramedical personnel will be carried out. (ibid, p.31).
And of course, as in previous instances, the success of any project to a large extent depended on the cooperation of all persons involved, in this case all medical and paramedical professions were to be relied upon to enable the establishment of an effective plan (ibid). The reward structures were to be set in stone (metaphorically speaking) after National Health legislation was changed to favour the operative specialists. Not only this, but also the model of teamwork between the soldier, surgeon and sanitarian came into play during most of the 1970s. In the meantime, another process began to occur alongside these changes, that of the medicalization of the wider community.

The medicalization of the wider community

With the accession of the Menzies Liberal government in 1949, Professor (later Sir) Edward Ford, took over from Harvey Sutton as Director of the SPH & TM and, as shown, other ex-army officers were to forge a partnership with the new Minister of Health, the surgeon, Sir Earle Page, as well as the surgeon-dominated Federal branch of the BMA. At this time there were two assaults on the community, one invoking the rhetoric of a “war on disease” and the other putting a planned campaign into action to make “wonder” life saving drugs freely available to the public. The burning question is as always, whose interests did these campaigns serve? Co-opting the help of the Governor-General and State Governors, one of the first projects was designed to wage a “war on disease”.25

Waging war on disease

Following the 1925 Royal Commission on Health, recommendations for control of tuberculosis, people had continued to die at an unacceptable rate. Finally, in 1948, a Tuberculosis Act was passed by the Federal government which provided for an all-out Federal/State campaign to control the disease. In 1949 leading surgeons at the helm of the Order of St John co-opted their colleagues and sought the cooperation of the

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25 Sir John Northcott, was a Knight of St John and Governor of NSW between 1946-57 as well as Grand Master of the United Grand Lodges of New South Wales. He became acting-Governor-General between 1952 to 1955. In 1964, Sir Charles Gairdner was Governor of Western Australia and Deputy Prior of the Order of St John. Later Sir John Kerr and Sir Zelman Cowan were Priors and Grand Priors of the Order during the 1970s.
Governor-General and State Governors, some of whom assumed the leading rank of Grand Prior of the Order of St John.  

This campaign on tuberculosis was headed by Dr (later Sir) Harry Wunderly mentioned in Table 5.1 above who formalised the arrangements between the Governor-General and State Governors in setting out principles for punitive assault on those citizens thought to be “infected” and who could be detained like suspected criminals (Boag, 1976, pp.8-12). For example, Boag (1976, p.9) stated:

Unlimited money was made available to “attack and defeat a single disease; unprecedented power was given to achieve the aim and citizens would be obliged to co-operate under threat of penalty. … Authorities had the power to detain infectious persons and there was a requirement for notification to be made on reasonable suspicion of disease.

In this scenario, one needs to ask where the funds were actually going and who takes the blame, the perpetrators or the victims as, despite there being known cures for tuberculosis before 1925, nothing was done about it. For example, although not speaking about tuberculosis specifically Dr Florance, who practised in Victoria during the late 1920s, commented on their seemingly successful open-air treatment of many patients with typhoid and other infectious diseases at Mooroopna Hospital from around the 1890s. Dr Florance also found it quite strange some remedies were not used until long after they were discovered. More revealing, however, is his description of similar kinds of punitive attitudes towards patients who were regarded as rebellious for not embodying politically correct values (Florance, 1928, pp.173-174). Referring to gland treatments which had opened up a new field of inquiry and experiment during the late 1920s, he tells as much about the dominant medical attitudes of researchers still extant today when he states:

We are unexpectedly having our temperaments and individualism assailed (over) affairs which we have always understood were a matter of heredity. But your hormone advocate even considers, so I have heard, that the rebellious spirit of the socialist is due to some peculiarity of those ductless glands. A time will come they say, when by suitable injection, the rebellious may be converted into docile long-suffering citizens [italics added] (ibid, p.173).  

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26 As mentioned, as far as the Governor-General is concerned, this rank and position is combined with his other rank as commander in chief of all military forces (see Pilger, 1992, p.215).

27 One contemporary example of “blaming the genes” is of a study undertaken at St Thomas” Hospital in London when the research team surveyed the impact of genes on the sexual behaviour of twins. As far as results were concerned, although there appeared to be no significant cause/effect correlation between genes and infidelity, the media report giving an account of the study was entitled Female infidelity: it’s in the genes (see News in Science, 2004).
As we know, “wars on disease” have been one of the most common military metaphors used in cases of Cancer, AIDS, SARS and other infectious diseases, a subject taken up by a number of researchers (Lupton, 1999; Sontag, 1990; Waldby, 1996). The above “wars” were waged selectively when funds were released for administrators to mount their campaigns. There was no shift from earlier approaches which have shown a consistent lack of compassion for those deemed “undeserving”. In Chapter Eight I will refer to some contemporary examples. Now I will show how the “disease” model was sold to the public.

**Selling the heroic genre to the public**

As Page has explained in his autobiography, a restructuring of attitudes which would ultimately benefit the surgeons, was methodically planned. Firstly, he resolved to carry out a little political manoeuvring so as to ensure certain measures to establish a new health scheme were effectively unopposed. His first move was to institute new regulations after Parliament had adjourned and within three months of his policy declaration to the Federal Medical Association. His purpose was to effectively gain the confidence of the public for his reforms by firstly providing new and costly “wonder” life-saving antibiotic drugs free of charge. He did this so as to make it difficult for the Labour government to use its majority in the Senate to reverse the benefits when Parliament resumed (see Page, 1963, p.432).

Originally the Liberal and Country party put forward a comprehensive National Health Scheme which worked on the basis of self-help, which is helping those who helped themselves. In an era when the word “contraception” was banned on the radio until the 1960s, when women could not work in many places after marriage, and when ideas associated with White Australia and eugenics had not been abandoned, the following five principles were advocated.

i) Adequate nutrition for mother and child to give a National Health scheme a flying start;

ii) Prevention of disease to *preserve the health so founded* [italics added];

iii) Rapid action to ensure the availability of the curative means of controlling disease;
iv) Provision of sufficient hospitals, ample beds, and modern equipment; and

v) Action to bring within the means of the people the cost of preventive, diagnostic and curative medical care (ibid, p.431).

The BMA agreed in matters of medical treatment, the Pharmaceutical Guild in supply of medicines, and Friendly Societies in respect of insurance provision. The visions they shared were (i) curative medicine needed more life saving drugs; and (ii) curative medicine needed more hospitals, beds, and technology [italics added] (ibid).

These ideas were embodied in Page’s first National Health Act (1953) (ibid, p. 435). To carry out this plan, he firstly sold the heroic genre to the public based on the “life-saving” potential of curative medicine in terms of pharmaceutical as well as medical intervention. In actual fact, Page went to the USA not to find out about health systems but about voluntary health insurance schemes, and consulted those at the highest levels, including President Roosevelt. Apart from children being given milk, immunization to protect them from some diseases, there was absolutely neither any social component nor any coordination within the system. It was based on supposed stages of need. As Page (1963, p.435) states:

The health scheme, enshrined in Federal legislation, touches every successive stage in the life of the country’s population. Children are given milk and immunization; young people especially are protected from tuberculosis; the community is provided with free life-saving drugs on doctors” prescriptions; Government subsidies to hospital and medical benefits are made available to encourage the patient and cheapen the cost of treatment by hospital and medical insurance; pensioners are provided with free doctors and medicine; and provision is made for handling those otherwise unable to insure fully because of age or chronic disease.

In regard to this point, Page might have imagined himself as part of a medical system where his warrior counterparts waged their wars on disease, while its saviours offered their “magic bullets” or “healing hands” to perform curative life-saving functions. To further buttress such servicing, during 1953 further funds were expended to “improve mental health” by relieving conditions of overcrowding in institutions (ibid, p.436). The danger of a patient getting misdiagnosed or displaced in such a system is only now being realised. Blackburn (1951, p.22) commented at the time:
(The) process is in danger of disintegrating into a number of separate departments in which particular aspects of disease or organs affected by disease are investigated and treated without reference to the general background as the only person who has the additional information essential for the presentation of a composite picture may be quite unaware of what is going on.

In addition, Gillespie (1991, p.259) has shown the availability of new drugs created immediate problems of over-prescribing with resultant adverse effects on patients. While this created problems for Page, the other result was that patients must have begun to measure doctors by their self-projected social status and real or imagined link to scientific progresses based on the amount of money charged for the consultation. While, on the surface, the Act seemed to support and maintain the generalist orientation of medical practice, it also began phasing in the idea of the “specialist” by paying doctors by “task” or “procedure” so as to encourage doctors to practise surgical intervention. It was stated:

Government is doing a positive disservice to the public by putting a price (so to speak) on the tonsils, the appendix, and other organs, thus promoting their removal when they might otherwise be left in situ. “Round here”, a cynic remarked, “the indication for a hysterectomy is any woman over 40 who still has her uterus.” (Fox 1963, p. 678).

The effects were that patients began to bypass their family practitioner to seek out “specialists” who demanded higher monetary rewards. For example, Blackburn (1951, p.22) refers to this “medicalization” process as follows:

(T)he peculiar mental effect the word specialist (has) on the emotional background of the public, for whom, in spite of the modern wide diffusion of knowledge, medicine has never quite divested itself of an element of mystery and magic.

The diminished status of the general practitioner in the post-war period might have been assisted by the fact that general practitioners, during the depression and the war, had not increased their fees to patients. However, it may also due to their becoming so familiar to their patients, they had lost the mystique created by their specialist counterparts (ibid).

Again, Blackburn (1951, p.22) points out:

This matter of bypassing of the family doctor ….is unquestionably the most serious disintegrating factor in medical practice today, and unless some means can be devised for controlling it there will be an increasing tendencies for specialties to become isolated medical cults rather than parts of a coordinated
system. Any attempt to correct this drift away from the family doctor must be based upon the possibility of counteracting the causes that are bringing it about.

While others have attributed the rise of the specialist to the simultaneous rise in technological development and specialist numbers (Opit and Southby, 1978; Pensabene, 1980), this might be regarded as the effects of the process highlighted above and attitudes may have also been pushed along by other “selling factors” created by the surgeons themselves.

For example, as military developments have almost always carried some cachet, one might take into account the soldier/saviour image was again positively reinforced by Dr Michael De Bakey, an American surgeon, acclaimed as the “grandfather of modern surgery”. De Bakey was not only a key figure in inventing surgical instruments, but was also responsible for the improvisation of the Mobile Army Surgical Hospitals (MASH units) used both in the Korean and Vietnam wars (McKimmie, 1995, p.38). The popularity of the emergency/accident type of medical servicing in war and in peacetime was kept alive through the humorous television series of the same title about surgeons and nurses working in such units.

In this environment, the generalist practitioners had to wait some time for their place in the sun. Until the crisis milieu abated, the generalist family practitioners and educators were pushed to the background, many such medical men and women still working in different ways to raise the standards of health care in Australia (Dewdney, 1972, p.343; Fett, 1975). As late as 1972, Dewdney (1972, p.473) was reluctant to release any names, when he stated:

> It is tempting, but perhaps unwise, to name those who today are developing the strengths, exposing the weaknesses and, where necessary, attempting to recast the foundations of the Australian health care system.

As I will show in the following chapters, this is still a battle which is being waged as a medical system backed by the pharmaceutical companies to benefit the surgeons and hospital-centred types of service became dominant in Australia. In this scenario, the final step was to reward the major-generals in monetary terms, so as they could put into effect the prerogatives of their Magna Charta which allowed them to relegate civilians to a subaltern status. These actions were partly inscribed in changes made to new National Health legislation (1970) which, unlike the previous Act, sanctioned the official structuring of a medical system from one unofficially generalist–
driven and family or community centred to one officially specialist-driven and hospital-centred. This was the final blow to the status of Australian generalists.

**Rubber stamping: changes to National Health Legislation**

The National Health Act (1970) replaced the first National Health Act (1953) introduced by Page. While the first Act aimed at restructuring the system to favour the specialist, it actually maintained the status quo of Australian medical practice as a general practitioner service and delayed the development of full-time specialization until the 1970s. The new Act, however, was the result of negotiations with the Australian Medical Association and the Gorton liberal government and appeared instrumental in shaping the new specialist-oriented and hospital-centred medical system through legislating for differential rewards for medical procedures.\(^{28}\)

The Act also seemed more in keeping with providing adequate remuneration for the senior specialist cadres. This is because it led to the establishment of the “most-common fee” which was to the detriment of the general practitioners (Dewdney (1972)).\(^{29}\) In effect, different levels of payment were made for a medical procedure, depending on whether the practitioner was classified as a general practitioner or specialist. This was despite both these practitioners being equally competent at performing many of the same surgical procedures. No doubt this dual-fee structure was the final insult to the older general practitioners who, as shown above, had by this time been excluded from many positions of power and influence. Thus, the social elevation of the specialist led to the denigration of the generalist. Dewdney (1972, p.71) points out:

The introduction of differential benefit scales was held by some practitioners to be nothing short of a public avowal that general practitioners were “second-class” doctors, which would lead to their becoming mainly referral agents for the specialists and consultant physicians. It was suggested that the costs of the medical benefits scheme would rocket upwards as patients refused to be treated by general practitioners and demanded referral to specialists. No one, it was said, would submit to surgery at the hands of a general practitioner when, at apparently no extra cost to oneself, the operation could be carried out by a

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\(^{28}\) Health legislation should not be conflated with health policy, although each should complement and reinforce the other.

\(^{29}\) Dewdney (1972) gives a detailed account of repeated attempts of governments to introduce health insurance schemes. He also documents the historical outcomes of numerous enquiries and senate select committees, especially about barriers to government attempts to try and institute some sort of a “free” national health scheme. Crichton (1990) has historically documented two hundred years of conflict over health policy in Australia.
specialist surgeon. It was also seen that the demand for specialist services would be so great that it could not be met by the present specialist workforce.

Most of us, as consumers of medical care, are well qualified to judge the quality of Dewdney’s predictions without any help from the writer. Some of the immediate consequences within the profession were the creation of institutional rifts within the Federal caucus of the AMA and the state branches, as well as among general practitioners, such as the General Practitioners’ Society (GPS) and the Royal Australian College of General Practitioners (RACGP) (see Daniel, 1990). The special power and ability to define specialists and grant them higher status and rewards was first set in motion in 1969 when the state supported the establishment of a national specialist body to oversee the implementation of such National Health Legislation (see Dewdney, 1972; Farag, 1992; Opit and Southby, 1978).

The National Accrediting Specialist Qualification Advisory Council (NASQAC), numerically dominated by procedural specialists, was established to form a gate-keeping role to monitor payments made to bona fide “specialists” (Farag, 1992). NASQAC’s main function was to ensure correct payments were made under this legislation and the medical or surgical specialty was one included in their handbook (Health 1972, p.15). Under new government regulations, the specialists were in fact given a mandate to define who could enter the specialties.

The consequences of the National Health Act (1970) were that it cemented the social differentiation between general practitioners and specialists foreshadowed previously. This is despite that, in terms of knowledge and skills, the act did not reflect reality or easily differentiate between what general practitioners and specialists did at that time. These moves were accompanied by increased specialist domination of medical education, as it also marked the beginning of postgraduate specialist education in Australia. It also marked changes in community perceptions especially when technological innovations, such as ultrasound and cat scans, began to appear. The result was that a syndrome was produced of general practitioners being “failed specialists”. This was not easy for older general practitioners to deal with and many retired from practice.

Thus, between the 1950s and 1970s, medical care across Australia began to be slowly transformed from a generalist-oriented and patient-centred medical system into a
specialist-oriented and hospital or case-centred one. Most aspects of this transformation took place within the crisis milieu of the Cold War when military administrators were given a mandate to implement Federally-directed changes to hospital recruiting and servicing, undergraduate and postgraduate medical education across Australia. These changes were also linked to reversals of policies and practices within the Federal Council of the BMA and led to directives which assisted the institutionalisation of the soldier/saviour archetype across Australian medical institutions. The Liberal government had already built partnerships with doctors who served in the AIF as well as the Sydney Medical Faculty and the SPH & TM, the latter widening its role to promote national and international objectives.

Gillespie (1991) has already documented the EMS activities during the war and the existent conflict between military authorities, the government and the BMA before the Cold War period. However, there does not seem to have been a policy shift as regards the eugenic underpinning of “public health” and “preventive” medicine. By 1944, over 2,000 medical students had studied at the SPH & TM under the influence of Dr Harvey Sutton. After the Menzies government came into office, there seemed to be more than passing interest in “child health” and medical experimentation which were two of Sutton’s favourite interests. An Institute of Child Health was also established as an adjunct to the SPH & TM. Apart from health legislation for voluntary insurance, some researchers believe there was no attempt to frame a national health policy until the 1970s (see Dewdney, 1972). However, as I will show, Federal health policies continued to be linked to the soldier tradition and to its eugenic and sometimes, fascist, underpinnings. Although Sutton’s reign was in the period preceding Menzies, his influences seemed to have lived on. The following is a brief sketch of the research blueprints of the SPH & TM under Sutton and some resultant effects after the 1950s.

The SPH & TM: its research blueprints

The goal of the School was to provide courses for the Diploma in Public Health and Tropical Medicine (DPH & TM). Its expertise was regarded as being particularly beneficial during the World War II for training of medical officers in the armed services. Apart from medical students, 1,742 men with “service” backgrounds graduated from the School, some of whom would later take up posts in the Federal Public Service (“School of”, 1980, p.12). In recommendations made for legislation to support public health administration, Harvey Sutton, the School’s Director, stated doctors should never
cease to be soldiers by continuing to work as General Medical Officers (GMO’s) in the Army, Navy and Air force. As far as the generalists from the civilian population were concerned they were to become subsumed under state regulation through legislation requiring them to carry out their supposed key role, to monitor the prevention of the spread of infectious diseases (Sutton, 1944, p.585).

Up to the time of the war, the school had offered courses in public health, tropical medicine and preventive medicine, encompassing parasitology and medical entomology as well as bacteriology, pathology and biochemistry. Thus the main areas of study were in the laboratory concerned with investigating cells, tissues, germs, glands, insects or blood. After the war, the number of staff gradually increased to 106 and new subjects added were industrial health, vital statistics, environmental health, molecular biology and nutrition (ibid, pp.11-13).

As mentioned, the soldier tradition underpinning both public health and tropical medicine was informed by eugenic as well as utopian ideas about building a pure and white Australia. However, it is one thing to advocate such ideas to an adult audience and another thing to make them the basis of lectures for medical students and prospective public health administrators. This seemed to be the legacy of Sutton’s ideas published as Lectures on Preventive Medicine (1944), after being Lecturer in Preventive Medicine at the Sydney Medical Faculty and Director of the SPH & TM for 14 years (see Sutton, 1944). The book itself was not only on Public Health Administration, but encompassed other chapters entitled, Human life history; Environment and Communicable diseases. The Appendix covered the construction of a pedigree chart, vaccination against smallpox, stages of growth, heights and weights, hair and eye colour, infantile mortality, milk and meat inspection.

Harvey Sutton was first and foremost a soldier and is one of the groups shown in Table 14 who rose in power and influence during the 1940s and 1950s. On the title page of Sutton’s (1944) text, his military credentials are placed before his medical ones, namely, OBE (Mil.), Lieutenant-Colonel, AAMC reserve; MD, DPH. (Melb.), BSc (Oxon.), F Roy. San.Inst, FRACP. Today this text remains within the University of Sydney Public Health Library.30

30 While Dianne Wyndham (1996) like others such as John Powles (1988) has recognised Sutton’s fascist leanings, it does not appear any research topic has actually shown how such eugenic ideas became institutionalised.
What is of interest here are the ideas taught were about eugenics research and medical experimentation. Aspects selected in the following discussion, of necessity, will not enter into any in-depth discussion on eugenics or differences in outlook to other prevailing ideas on the subject (see P. Gray, 1999; Kevles, 1981; Weindling, 1999; Wyndham, 1996). As P. Gray (1999, p.48) states, a reminder is necessary that “belief that human intelligence could guide evolution led the world to concentration camps” (P. Gray, 1999, p.48). Sutton’s ideas echoed those of German scientists at the time, as he believed the so-called “unfit” should either be sterilized or institutionalised for life. This was one of a number of “scientific” ideas taught in a syllabus for medical students under the title of Preventive medicine. While Sutton retired in 1948, he left a legacy of his lectures, parts of which are outlined in the following paragraphs in respect to the above aspects.

First of all “preventive” medicine was defined as “the province where medicine joins hands with commonsense” (Sutton 1944, p.ix). However, it seems to entail more than “commonsense”, as Sutton further states “one of the fundamental studies in preventive medicine and in social hygiene is the science of heredity (genetics)… the story of the making of the individual and the handing down of characters derived from parents and forebears”(Sutton 1944, p. 1). As far as research interests were concerned, they were not to be confined to the laboratory, but were to be extended to research among the population (ibid, p.xii). Sutton particularly referred to the importance of teamwork between the soldier, the surgeon and the Sanitarian.

To digress briefly, the extent such soldier surgeons and sanitarians dominated in many civilian and military institutions at this time has already been highlighted. During most of the period between 1930 and 1949, both Sutton and Dr Frank Maguire were in dominant positions in NSW. The latter was claimed to have been the effective ruler of NSW Freemasonry for twelve years and was also a surgeon at the RPAH, Sydney, a Knight of St John, Hospitaller and Almoner of the Order of St John in Australia, a long-standing member of the NHRMC, council member of the BMA NSW Branch and alderman on the Sydney City Council (Henderson, 1988, 114-115). This is important, because while the SPH & TM prioritised the research, the NHRMC was the funding body for experimental medicine to which I will again refer below.
Coming back to Sutton, much of the book closely follows the views of Francis Galton and Karl Pearson at the Galton Institute of Biometrics as well as the Eugenics Society in Australia of which he had been a long-standing member (Sutton, 1944, Wyndham, 1996). He believed, as far as the research enterprise was concerned, biology and statistics stood side by side with microscopic and laboratory investigation in developing studies of families and populations (Sutton, 1994, pp.596-599).

Furthermore, the class exercise on the “Construction of a Pedigree Chart” was based on suggestions from Frances Galton’s work and structured along the lines established by the Eugenics Society (ibid). Sutton defined eugenics as “the study of agencies under social control that may improve or impair the racial qualities of future generations either physically or mentally” (Galton cited in Sutton, 1944, p. 25). With the expected outcome of human betterment, the aim was

… to study the underlying causes of changes in racial characters both in families and in populations. To do this it applies the knowledge of genetics to the history of human development past and present, and thus tries to direct man’s intelligence to man’s biological evolution (Huntington cited in Sutton, 1944, p. 25).

The negative views about “race” present throughout these years were “(a) race mixing was degenerative or repressive and progeny died out after two or three generations; and, (b) an extreme but widely held view was that race mixing led not only to human degeneration but to apocalyptic disaster” (Haebich, 2004, p.135). This latter view promoted by a European theorist, Count Gatineau, who described “race mixing as an “inner poison” adulterating the pure blood of distinct races and leading to the eventual collapse of human civilisation (ibid). In regard to these ideas, Sutton advocated the control of migration and of miscegenation (or race mixing) (ibid, p.17).

While ideas about “breeding” were inter-related with race, they were also extended to encompass other sectors of the population who were regarded as defective and, in Australia and England, children were targeted. For instance, the extreme example at the time was national socialist Germany where, under Hitler, Jews, Romanies, the feeble minded, the diseased, insane and handicapped were marked for compulsory sterilization and legal abortion (ibid, p.271). In this respect, Sutton made no

31 As Moore ( 1951, p.163 ) states, Francis Galton promoted the idea of fingerprinting criminals.
32 There were no homogenous points of view from church groups or others on such issues especially in discussions of migration (see Rivett (1962). As Haebich, (2000, p.133) stated even before Australian Federation such “views encouraged a heroic vision of a colonial past and provided a way forward that would stamp, once and for all, white ownership and supremacy across the continent.”
secret he was watching the German programs of sterilization closely and this influence is clear when he describes the strategies and methods of achieving “human betterment”. The three strategies suggested for this purpose were as follows:

i) progressive improvement of the worthy;
ii) guarding against degeneration by getting rid of the “duds”; and
iii) attacking the enemies of “mankind” (sic.) (Sutton, 1944, p.25).

Sutton points out:

The aim is human betterment: First the progressive improvement of inherited worth in its broadest sense – the best seed in the best soil. Second, the guarding against degeneration of the race by greater numbers and proportion of “duds” - (a) deficient, disordered or deviated mentally, deformed and disabled, drunkards and dope addicts; (b) degraded morally; (c) degenerate sexually; (d) delinquent; (e) destitute, especially where those are capable of handing on their defect or the tendency of the defect to their children – the worst seed in the worst soil. Third, by attacking the enemies of mankind, those factors that hinder improvement in succeeding generations (Sutton 1944, p. 25; Wyndham, 1996)

Sutton then goes on to state eugenics puts forward certain measures for ideas of “human betterment”, some which could be seen to be at work after the 1950s. These are summarised as follows:

a) Encouragement was needed for “the mating of the fit” and discouragement for “the handing on to offspring of defect and disease” (Sutton, 1944, p.25).

b) It was a fallacy that children of unskilled workers could have the potential to achieve because “birth and breeding” or “intelligence and ability” were inter-related factors (ibid.).

c) Educational authorities should vet the potential of children and “do their duty” to institutionalise the “defective” and the “feeble-minded” who should be cared for and controlled. This is because their families generally are afflicted with venereal disease, as well as criminality, vice, destitution and alcoholism (ibid, p.27).

d) Legislation should be advocated for “elimination of the unfit through processes of sterilization” (ibid, 25-27).

As stated earlier, Sutton was also an active member of an organization by the name of Family First. However, the idea of “family” seems a selective one. Along with arguments for institutionalizing “feeble minded” children, he expected those in Education Departments to recognise and train “defectives”. He later points out the best means for control of the “feeble-minded” was through sterilization, segregation and supervision (ibid, p.47). He elaborates about how much of a “good” thing it was for
“these people’s lives”, very few cases being carried out without consent (ibid, p.47). While the detection of “feeble mindedness” was seemingly measured by IQ tests for intelligence, the title “defective” was given to children for needing adenoids and tonsils removed or a tooth which needed attention (ibid, pp.102-103). Sutton then justifies his views by stressing legislation for sterilization had been enacted in Germany, Denmark, Norway, Sweden and Switzerland and California where The Human Betterment Foundation had, between 1909 and 1934, arranged sterilization in 8,504 cases, with numbers increasing in the later years. Sutton also defined malnutrition as the result of an imbalanced diet and, therefore, was found in wealthy children as well as those of the poor (ibid, p.100). Of course this ignored that malnutrition in the poor could be due to lack of food.

In conclusion, in Harvey Sutton’s world there was no room for imperfection, poverty or ill health. His soldier’s world was that of the rich, the “pure” breed, and the physically perfect and intelligent - the rest were beyond salvation! In 1948, Sutton was succeeded by Ford, an ex-University of Sydney graduate and head of the Allied Army Malaria Preventive Campaign during the war, remaining as Director until 1968 (see Page, 1963, p. 424). Ford and other ex-army officers were to forge a partnership with the surgeon-Minister of Health, Sir Earle Page, and the surgeon-dominated Federal and State branches of the BMA in Queensland and NSW during the 1950s.33

The School also maintained national reference laboratories for bacteriology gave extended assistance to the Commonwealth Health Laboratories and played its military role in helping to guard against the entry of major “infections” into Australia, such as smallpox, cholera, rabies and typhus.34 In the late 1960s and early 1970s, the School offered (a) Diplomas of Public Health; (b) Diplomas of Tropical Medicine and Hygiene; (c) Diplomas of Occupational Health; and (d) Diplomas of Nutrition and Dietetics.

However, while the above details Sutton’s ideas and the School’s work, one needs to at least say a little about the desolation which occurred and which mirrored programs of “human betterment”, leading to the institutionalisation of Indigenous and non-Indigenous Australian as well as British and Maltese migrant children. There is now a burgeoning literature consisting of government enquiries on the subject of the institutionalisation and experimentation on children who were treated like inmates of

33 See Gillespie (1991) in relation to the politics of the BMA around this period.
34 As I will show later, the contemporary parallel would be Bird Flu.
concentration camps. We need to backtrack a little to the beginning of the century to see what was previously happening in NSW and Queensland.

**Medical surveillance of children**

Government reports and other research has highlighted that children in orphanages and other homes have been used as guinea pigs for experimental medications and drugs especially in the post-World War II period (see APSCAR, 2001, 2004; Gill, 1998; NISATSIC, 1997; Penalise, 2005; Starke, 2004). For this reason, I find it imperative to take a sojourn into the time when child health, medical experimentation and welfare or judicial systems first came together and where they did not. This is because the institutionalisation of children was more systematised across Australia after World War II and, because of Sutton’s previous involvement with the NSW Department of Education, I have chosen the topic of medical surveillance of school children to analyse differences. My argument is that medical experimentation on children was a particular interest of Harvey Sutton who also influenced his Queensland colleagues and set the agenda for future practices, whereas before the 1930s, no similarities appeared in practices within Victoria and South Australia. In this section I look at both NSW and Queensland and then juxtapose Victoria and South Australia in assessing the outcomes for children and parents.

**New South Wales**

In 1913, medical surveillance of school children was established in NSW for the “promotion of personal hygiene” (Cole, 1927, p.58). At the time both the Department of Education as well as the Child Welfare Department was the responsibility of the Minister of Education (ibid, pp.58-59). Also while the Minister of Justice was responsible for the judiciary system of New South Wales, the court had developed a close relationship with both the Child Welfare and Education departments: the stated aim of “modern education” being “welfare” for the young beginning with medical and dental services. A system of inspection developed where pupils of each school were examined every three years (ibid).

In 1923 when the principal medical officer was Dr Harvey Sutton, a sanitarian and ex-AIF man, whose interest was in experimental medicine, an intricate relationship between education, child welfare, health and the criminal justice system was in the making. In his Presidential Address to the Sanitary Science and Hygiene Section of the
Australian New Zealand Association for the Advancement of Science (ANZAAS) at the time, Sutton talked about the recent advances in child hygiene in NSW with several important investigations brought to fruition in cooperation with the International Health Board of the Rockefeller Foundation.

With Federal Government support, the NSW State government mounted a Hookworm campaign which found a six per cent incidence of hookworm in the children of the North Coast area, with the heaviest incidence among the Aboriginal population. In the south around the Kempsey area, school medical officers were engaged in propaganda work and in the collection of specimens\(^{35}\), while a full-time school nurse assisted in home visiting. A map of “goitrous” districts was being prepared, hot, dry plains and seaports seen to be very free from this ailment. Experiments were to be conducted with methods of goitre prevention among other things.

In addition, examination of school children and recommendation for treatment was obtained at outpatients’ general or special hospitals or at School Dental Clinics. A second School Dental Clinic was established in the Outpatients of the Children’s hospital to promote strict oral and dental cleanliness prior to operations on the nose and throat (ibid).\(^{36}\) By 1925, the Education Department employed 19 Medical Officers, 19 Dentists, including 8 part-time Dental Officers, 8 Nurses, 15 Dental Assistants, and 12 Clerks. One does not have to press home the point of the Benthamite mould of this department. Apparently this large number of medical and dental staff was required because of the numbers of children being examined. In fact, 185,770 children were medically examined (inclusive of those examined by a Travelling Hospital, but excluding those examined by the Dental clinics). Of this total, 96,754 (approx. 52 per cent) of children were found to be “defective”. Out of these 74,476 cases were dental, 25,152 were ears, nose and throat, 10,598 cases were linked to vision and 5,029 cases linked to hearing\(^{37}\). Treatment was subsequently meted out to 52,065 children (Cole 1927, p.60). A very similar pattern occurred in Queensland to which I will now turn.

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\(^{35}\) The type of specimens are not indicated.
\(^{36}\) Sarah Nettleton (1992 ) has documented an account of the rise in dentistry in the United Kingdom and the association of the movement linked to oral hygiene and the fear of contamination. On another note, such practices are still alive today in some areas. For example before undergoing surgery, my friend was told to go to the dentist, and to check every part of his body for any cuts or infection.
\(^{37}\) While additions seem wrong, some children may have had more than one “defect”. I am grateful to Mick Campion for this observation.
Queensland’s role

From the outset, Queensland established a hospital-based system of medical servicing and the status quo were resistant to university-based teaching and learning (see Patrick, 1987). As far as medical servicing was concerned, the influences of the chivalric orders were identifiable, not only through their state’s armorial emblem, but also because of the excessive emphasis placed on ophthalmic cases. For example, in western districts ophthalmic inspectors were placed at forty centres and the Department supplied “Blight” outfits to schools in other centres with head teachers being called on to give treatment (Thompson, 1927, p.314).

The penchant for mathematical calculation and tabulation was also evident. In this respect, it was considered the appointment of a full-time medical officer especially qualified for ophthalmic work helped to keep the department in closer touch so as to coordinate and standardize the work of all inspectors. It was also considered that without such an officer, standards would vary greatly and statistical comparison would be dangerous. The result was the incidence of Blight in children was minimized and plans were made for the prevailing system of part-time officers were to be extended (ibid, p.315).

In 1911, after the Federal government took control of the NT from SA, Queensland army doctors took over responsibility for its administration as well as the NT health services. (see Kelly, 1994). The emphasis on quarantine and protection was evident in their control of the then British New Guinea and the administration of the Aboriginal and Torres Strait Islander populations. Their interests in these sectors of the population became more prominent from 1923 onwards when they became interested in the work of US army educators in the Philippines and Hawaii (ibid, p.312).

38 Queensland administrators, like those in WA, showed a bias towards not showing any political will to educate the non-Indigenous population. Especially doctors in Queensland and NSW showed the military penchant for administration through dividing practices such as segregation and quarantine. Queensland displayed the most visible trends of its agrarian bent for pushing the education of girls for domestic Labour and boys for farming. The administrators also had a craft-oriented focus as no higher education except for technical colleges, existed until after the early decades of the 20th century (see Barcan 1980, Thompson, 1927).
39 Blight or “Sandy Blight” was an eye condition, as the name indicates, caused by the sandy environments of many districts.
40 Farley (1990) has emphasised the aggressive nature of the US medical corps in their treatment of people in the Philippines.
The Queensland administrators were also responsible for schools in British New Guinea which were segregated into government elementary schools for white children and native schools managed by Missionaries and subsidized by the Papuan government. Native schools taught carpentry/manual work for boys and lace making for girls. In the Torres Straits Islands, the native schools were mostly under direct control of the Queensland’s Chief Inspector of Aboriginals with the Teachers Island Superintendents representing the government and undertaking many other duties besides teaching. The first detailed inspection was made in 1924. Natives were typecast as mainly of Papuan and South Sea Island stock and were regarded as quite distinct from the Australian Aboriginals “whose ‘language’ provides no word for a definite number above ‘two’” (ibid, p.312).

Also in 1911 a Medical Inspector, a Dental Inspector and a School Nurse commenced inspection in Brisbane schools with the emphasis on sifting out those children seen as being “defective”. It was found, if educational retardation was to be avoided, 3,068 Brisbane children (31.7 per cent) needed medical attention. Also an investigation with 1,199 children in western Queensland showed 45.6 per cent needed such treatment, increased incidence being due mainly to eye trouble. An ophthalmic inspector was appointed in the following year (ibid. p.313). Thompson (1927, p.313) states:

Modern educational and army investigations caused us to appreciate increasingly the value of promoting healthy growth in children. Many Queensland families are so far removed from doctor and dentist that expense involved almost prohibits journeys for such treatment. The State for its well-being must ensure those engaged in primary production are not penalized for their enterprise. It must also be certain that town parents give their children the opportunities that the free Children’s Hospital and Dental Institutions afford.

Queensland administrators stressed their responsibility for maintaining complete control of children’s health through a thorough system of mental and dental services under the total surveillance of the State School system. The State Baby Clinics, the State Children’s Department, the Bush Nurses’ Association and Country Women’s Association were not considered to be able to adequately cope. This was despite their success in helping mothers in their task of rearing a healthy family (ibid, p.314).41 In other words only the “experts” were capable of adequately assessing whether or not a child needed medical or dental treatment (ibid, pp.314-315).

41 In Queensland primary schools only fathers attended school open days – no mothers.
Medical officers travelled to various towns to give lectures to people about the importance of their work, with the result lack of funds remained the only obstacle to progress. Expenditure on medical and dental inspection rose from Aust £1,312 in 1911 to Aust £14,118 in 1925, as well as a full-time medical inspector being appointed. As in NSW, large numbers of staff were employed. There were 19 part-time medical inspectors, 6 in Brisbane and one in each main country town, while 5 full-time school nurses assisted Brisbane Medical inspectors and, when epidemics occurred, assisted the Department of Public Health in safeguarding school children (ibid)

The influence of eugenic ideas came not only from Harvey Sutton, but also from Queensland army doctors involved with the Rockefeller Hookworm campaign. In the town of Cairns, their personnel conducted an examination of height/weight of Queensland children alongside the microscopic investigation of the “Hookworm Disease” claiming a cause and effect relationship between infection and mental retardation. A later study of the effects of the hookworm disease on mental development was made by the Director of the Hookworm Campaign who used tests such as the Goddard’s revision of the Binet-Simon Test and the Porteus mazes. Their findings also concluded the degree of infection definitely affected the amount of mental retardation (ibid, pp. 285-286). Apparently this kind of thinking lay behind the idea of “feeble mindedness” referred to earlier. Now let us look at the other two States.

**Victoria and South Australia**

In Victoria, the medical staff at the Department of Education consisted of eight full-time School Medical Officers, four District Health Officers (who act as part-time school medical officers), as well as two School Nurses. It was also proposed to appoint a small number of specially-trained “Teachers of Hygiene” who would travel each year to all parts of the State and give instructions in the schools (Browne, 1927, pp. 128-129). Over a twelve month period, the 4 medical officers examined 13,350 primary school children, the percentages of “defects” found were minimal and were recorded as vision 6, hearing 3, nose and throat 12.2, dental 41.3.42

The great test of effectiveness of school medical inspection was measured on the outcomes which in this case was the treatment received by children after the “defects”

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42 How they arrived at the percentages in these cases is not clear, as they do not add up to 100%. However, it is assumed the remaining percentage free of any malady is not quoted.
were notified. The procedure was in the form of a printed note to parents informing them of “every defect” found and considered remediable, records being kept by the schools. Two school nurses visited homes in the metropolitan area following up cases where the defects had been notified. If necessary, the nurses took the child to the hospital for treatment or operation and, in some primary schools where enthusiastic head-masters cooperated with the school nurse, the treatment percentage was as high as 85 or 95 per cent (ibid.). In the metropolitan area with hospitals and lodge doctors there was little difficulty or expense involved in obtaining treatment, but those in rural districts were not so fortunate or unfortunate, depending on what needed doing.(ibid, p.129).

South Australia’s medical surveillance system was different again because it was predominantly serviced by women doctors. In 1913, a medical inspector, a trained nurse and health officer were first appointed to carry out state medical supervision of school children and, in 1921, a dentist was added to the staff. From 1925, the medical corps was expanded to employing a woman chief medical officer, plus 5 additional doctors (4 women and a man), 3 male dentists, 4 nurses and a disinfecting officer. The Administrative head of the branch responsible to the Director was the Chief Medical Officer. Her duties include lecturing in Hygiene to the students of the Teachers’ College and medically examining girls and women who entered the education service, as well as paying frequent visits to schools accompanied by the medical officers supervising various districts. The women doctors examined the children in infant schools and in lower grades of the primary school and the girls in the central and high school, both in the metro area and in the country. The male doctor, in addition to country work, examined boys in upper grades of primary, central and high schools, as well as male entrants to the Teachers’ College (Schultz, 1927, pp. 213).

The medical examination included weighing and measuring children. Sight and hearing was tested, the mouth, throat and chest examined and defects noted as well as any conditions of anaemia, malnutrition or curvature of the spine. A report of the results was then sent to parents advising them to consult their own doctors. No treatment was undertaken by the medical staff. Should the parents fail to obtain medical treatment for the children, another letter was sent. This was followed up by a visit from the school nurse who, if the parents wished, took the child to the hospital for treatment, which might be an operation for the removal of post-nasal growths, or some such
malady (ibid, pp.214-215). Neither statistics, nor any mention of “defective” children, were given.

Doctors held mothers’ meetings in the schools at the conclusion of the examination of the children. The value and reasoning behind the medical exam were pointed out as well as the obligation of the parents to secure treatment if anything was found to be wrong. Each doctor was assisted by a nurse who helped with examining the children in the large schools. It was hoped all children in the State might be examined three times in their school life both in the city and country centres on entering school, at 4th or 5th grade, and again in high school. In small country schools the children were examined every three years. Medical officers reported on sanitary conditions of the school, out-offices, and so forth. On the outbreak of an infectious disease, an officer visited the school for the purpose of taking swabs for bacteriological examination or any other means of preventing spread of disease. Each doctor was appointed to a special district. Each woman doctor in turn spent three months of the year in the metropolitan area under supervision of the chief medical officer (ibid).

Other considerations

In summary, although expenditures were not raised in the latter two examples, the differences in medical attitudes towards children, in the case of NSW and Queensland, were illustrated by doctors wanting to find “defects”, while in the other two states, the interest seemed to be in keeping children and parents well informed and healthy. In Queensland, there was an obvious underlying influence of an Order of St John because of the prevalence of ophthalmologists there. Also from this early time, the association between infection and mental retardation gained currency. Moreover, although many children were subjected to operations, there was no proof taking out adenoids, tonsils, or other organs was beneficial to the child’s health (see Taylor, 1979). So one might ask, who in the end was the benefactor? What I want to say is all such practices in Australia emerged from their link in one way or another to the predominant views underlying the soldier tradition whose influence on research and policy still remains evident today. At this time, as far as the general population was concerned, these doctors in NSW and Queensland appeared to have a despotic mindset and showed neither heart nor soul.
As recent senate enquiries show, in these post-war years, the Walter and Eliza Hall Institute of Medical Research was developing vaccines. In looking for “subjects” it was decided to trial the vaccines on children in orphanages, the justification being they were the most susceptible to disease and needed protection from epidemics which could sweep through an orphanage (Commonwealth, 2004, p.115). Of course, such logic justifying experimentation was severely flawed. The results reported in several medical journals were of experiments carried out on babies at St Joseph’s, Broadmeadows, the site of the large army base of “physical perfection” in Victoria. These actions made a mockery of human rights. As one senate enquiry states:

The initial two studies carried out at St Joseph’s Broadmeadows. The first was between 1946 and 1948 when two experiments were conducted to vaccinate babies against herpes simplex. There were a total of 83 babies aged between 7 and 10 months old used in two experiments which were unsuccessful as the babies contracted the disease … The second lot of studies were carried out in 1950 and 1951 at the same institution referring to influenza outbreaks and epidemics. This time there were approximately 250 children under the age of three living at Broadmeadows (APSCAR, 2004, p.115).

Another such study (the topic of Amberey’s PhD thesis) concerns a medical experiment. This particular study was conducted during the 1950s when Lesley Owen Bailey established “Hopewood” in NSW. Amberey’s mother was one of 68 children at this centre which was part of a scientific experiment to turn its inmates and protégées into models on which the “breeding” of a “super race” could be based. Their health was monitored by doctors and dentists and results published in medical journals (Amberey, 2000; APSCAR, 2004).

The above are a few examples of several cited in these Senate enquiries and other enquiries into the incarceration of Indigenous, migrant and Australian children and show most of these practices intensified and became more systematised from the 1930s onwards. These reports, now called the trilogy, are:

National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families (1997). *Bringing them home. Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children and their families*


What they all show is gross inhumanity and brutality meted out to children in orphanages and institutions which were little better than concentration camps, sharing similar characteristics to recent claims of the treatment of refugees. The irony is authorities couched practices of taking children from their parents in the language of being “for their own good” doing children a favour in “saving” or “rescuing” them.43 This was the same logic applied for taking babies away from Indigenous families also appears similar to the logic behind taking babies away from their British parents.44 For example the Department of Immigration and Multicultural Affairs (DIMA) stated:

The concept of rescuing “war babies” and underprivileged children from orphanages in war torn Britain and offering them a new life in Australia had popular appeal, and the fact that these migrants were children was thought to give them an advantage in being able to more readily adapt and “assimilate” into the Australian community (cited in APSCAR, 2001, p.24).

The treatment meted out to these children has been shown to be totally inexcusable and apologies have now been made by the large number of institutions involved in such actions. However, there needs to be further research into the withholding of medical treatment, the extent of medical experimentation and deaths in custody which were part and parcel of these young lives. While the difficulty, of course, is in uncovering the evidence because many records were destroyed, a recent work by Joanna Penglase (2005), who was one of these children, drew on her first-hand experience to describe what she calls a “reign of terror” in Australian institutions during that period.

**Conclusion**

The changes outlined above effectively militarised undergraduate medical education, the hospital system and postgraduate specialist training, buttressed by a system already dominated by soldier surgeons and sanitarians through networks created via the Sydney Medical Faculty and the SPH & TM. The only difference was the new medical system was organized on a national basis to encompass all state university medical faculties, hospitals as well as research institutions. The whole medical system

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43 See Haebich, 1988. Apparently these practices have also received some fairly recent attention in Britain (see Reder and Duncan, 1999).

44 This thinking is very similar behind the reasoning for the war in Iraq.
that emerged was not a “health-care system” in the true sense of the word, but a system geared to a soldier culture reflecting a crisis-orientation as well as expansionist and so-called “preventive” agendas. The first National Health Act (1953) began to shape a medical system favouring a task or “procedural” orientation to medical practice with its successes dependent on “life saving” drugs. At the same time, these developments were also accompanied by the imagery of the MASH units, enhancing the popularity of the disaster-oriented traditions and its doctors. So, while this era marked the “birth of an Australian clinic” dominated by soldier surgeons, the overwhelming distinction between the two medical archetypes was the definition given to what constituted “real medicine” with the partnership extended to the ex-hygienists or sanitarians who became the public health administrators of the 1970s and later.

From the 1960s onwards, many generalists were excluded from involvement either in undergraduate teaching programmes in universities or in the hospitals. Medical schools became linked to a “quota system” and military doctors became attached to disciplinary interests and laboratory-oriented research. Not surprisingly, medical graduates also likened the hospital to the army. Patients began to bypass the family doctor and seek out the “specialist”. Thus, the medical system that emerged was expert-focused and based on cure and prevention of disease, paying doctors for “tasks” or “procedures”. When the National Health Act (1970) was enacted in the wake of planning for national emergency, administrators effectively restructured medical education and hospital servicing to reward the procedural specialists and the research-oriented practitioners. In doing this, they tried to completely block out the influence of the generalist, by redefining the generalist to perform the specific function of acting as referral agents.

The most depressing part of this chapter is that thousands of medical students passing through Sydney Medical Faculty and the SPH & TM were subjected to lectures on eugenics. Even more depressing is the extent of brutality and mistreatment of children that was also a part of this era. The issue of medical experimentation needs further scrutiny as does the reasoning behind the complete absence of patient rights. In the following chapters I will show how both the generalist and the soldier realigned themselves from the 1970s onwards to issues of medical servicing and to the rights of children and of patients within or outside of institutional care.
CHAPTER SIX

The generalist genre: as general (family) practitioners, academics and public health administrators

The Black Report in Britain and the Australian National Health Strategy have demonstrated the link between social status, poverty and ill health even in two fairly well regulated and prosperous countries. *For the future, our doctors will have to face their political responsibility and its ethical imperatives not only in the broad political sense of health but also in the focused sense of medicine in the care of the individual patients, whose lot of life often ails them more than their illness* [italics added] (Hamilton, 1995, p. 583).

Introduction

Even during the 1950s when Faculties of the College of General Practice were being formed across Australia, generalist family physicians and surgeons envisaged a medical system which was informally existent at the community level at that point in time (see Blackburn, 1951). In addition, they asserted

… it seems clear that in the future as in the past the health of the public at large will be best served by a system in which each individual is under the personal care of a doctor competent to advise him on all matters of health including those occasions when there is need to obtain the opinion of a specialist (Blackburn, cited in Winton 1983, p.21).

However, as shown previously, these generalists, who were not general practitioners in the way one understands their role today, were excluded from positions of power and influence. This resulted in the reorganization of the health care system after the National Health Act (1970) ensuring generalists remained structurally situated outside a specialist dominated medical education and hospital-centred medical care system.¹ It was only when the Whitlam Labour government came to power from 1972 when a social space was opened for them and their like-minded colleagues within which to pursue their goals.²

One could argue that from the 1970s, Australian generalists began their battle for a place in the sun. Their vision was for a medical system based on a patient-centred focus but widened to include notions of community-oriented medicine or primary

¹ This should not be confused with Medicare or the health insurance system.
medical care. Such ideals were overtly pursued by doctors influencing changes to health policy, medical education and medical practice overtly from the 1970s onwards.

As a representation of the generalist genre in contemporary Australia, the above quote was from Dr John. Hamilton, who had previously worked on a WHO collaborative project in Nigeria to help establish a community-oriented focus within medical education (Hamilton and Ogunbode, 1991). Hamilton came to Australia to take up the position of Dean of the Medical Faculty at the University of Newcastle between the late 1980s and early 1990s. From its inception in the 1970s, this medical school was a pioneer advocate of an educational philosophy to orient all graduates, regardless of their interests, to an awareness of community needs. This perspective was one shared by other Australian medical academics who initially became the first members of the faculty staff as well as a number of undergraduate and postgraduate educating bodies within and outside Australia, especially the RACGP.

The generalist today has now become a generalist genre which also encompasses community-focused medical academics, practitioners and administrators committed to a belief that doctors’ responsibilities needs to incorporate social considerations. The re-emergence of the generalist genre was because of the inherent conflict in their attitudes towards medical professionalism. Apart from differences in outlook about what should comprise useful medical knowledge, those whose interests remained far removed from the community and its needs had a problem coexisting with those having a community focus at its interface.

In light of the above, implicit in this chapter is a projection of an Australian generalist genre continuing as a counter-cultural movement, reflected not only in Saint’s (1981) words highlighted in chapter one, but also in keeping with Armstrong’s (1995) study of 20th century developments of general practice in the United Kingdom. For example, in his examination of the British context, Armstrong (1995, p.405) asserts:

The rise of a major new form of medicine during the 20th century offers a fundamental reform of the epistemological, cognitive and physical map of illness and it might be added its very close alliance to the social sciences – merits recognition.

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3 Primary health care and general practice should be understood as a family and/or community oriented medicine not confined to the general practitioner as we know her/him today. In simplified terms, for generalists the starting point is the patient – not their microscopic representation of cells or genes.
Given new socialisation processes were not all-encompassing and take time for one to begin to analyse effects, the following is a critical review of professional ethics and expected outcomes of educational programs outlined below rather than an attempted analysis of any direction in corporate activities associated with general practice which today is also not a homogenous enterprise. This latter subject has recently been debated in the *Health Sociology Review* between leading doctors representing the Royal Australian College of General Practitioners (RACGP) and Australian health sociologists (see Watts and Pinskier, 2001; White, 2001) and has also been the focus of a recent thesis (Cook, 2001). So as to place the material in this chapter and the next in terms of such work which focuses on the market, one might point to Freidson’s differentiation between three heuristics or logics referred to earlier in Chapter two. The generalist genre referred to is seen to lie in the third logic, while the heroic genre falls into the second.

Of course, this kind of analysis has its wider implications for theories surrounding professionalism and for understanding its collegiate culture. In this chapter, I have used the texts of generalist and community-oriented doctors written in terms of their experiences of interaction with the establishment, and as in other chapters, it becomes necessary to give primacy to these texts. As I will show, the reproduction of earlier clashes in social relations and differences in attitudes become eminently visible. What I will show will completely dispel any notion of homogeneity. Theoretically one could see these clashes either from Foucault’s truth/power/knowledge nexus and the relationship to ethics, or in Gramsci’s terms of a hegemonic and counter-hegemonic culture, or from both.

In the following pages, I will again show how those within the generalist genre interacted with a social environment which encouraged them to draw on rights based discourses to influence the health policy environment in different ways. In both this and the following chapter, the theme of “a tale of two archetypes” is worked to show the extent of differences in situations where the two are at odds with each other over different issues. Also some background is given to the social context, values and ideals of generalists and their like-minded colleagues who continued to be counter-hegemonic. In the case of generalist academics within traditional medical schools, Kamien (2003, p.8) points out:
General and “community” practice was born to struggle within medical schools. It was unlike new medical specialities that were based on new knowledge or new technology. It was person- rather than disease-oriented and was set up to teach and research outside of teaching hospitals. It was a medical education reform movement, a threatening counter-culture to the established basic science and hospital-based clinical departments. It also began at a time of diminishing resources for universities.

It is well to pay attention to the backgrounds of such people because, as Kamien (2003) later states, their attitudes and personalities had a distinct bearing on what they brought into the faculties. Although Kamien didn’t speak about himself directly at the time, one should point out he is now a retired WA practitioner who was the founding Professor of General Practice at the University of Western Australia (UWA), an aspect of other developments which will be discussed later. For the present, one should state he was one among the last groups of WA students educated at Adelaide University Medical Faculty. In 1960, the year Kamien graduated MB, BS, there were only 15 students (Notable Australian, 1993, p.2).

In such respects, socialisation influences in medical of educators cannot be ignored because Professor Eric Saint referred to previously, was one of Kamien’s mentors and a contemporary culture-hero of others, such as Richard Lefroy who has since published some of Saint’s work. Also, in recollecting the idea of the traditional generalist, one should bear in mind that Saint, like many others of his time, had a diversified career and experience in many areas. For example, Saint was an outback general practitioner, a research fellow, a director of clinical research, a professor of medicine and Dean of the Faculty of Medicine both in WA and Queensland Medical Faculties (Saint, 1998). The other important feature of their practices was the way they linked medical education to the needs of the community. No doubt, Kamien’s own values are reflected in his description of his student days when he states:

Professor Eric Saint (was) known for his humanity and breadth of intellect, Ken Pawsey for his gentleness and capacity to make students feel more clever than they were, Dick Lefroy who showed me it was possible to understand medicine and Dick Joske as a role model of clear thinking (“Notable Doctors”, 1993, p.4)

Kamien first thought about going into psychiatry and worked with several psychiatrists, such as John Cawte who introduced him to the idea of “the doctor as an
agent of social change working with Aboriginal communities” (ibid.). So, with the above as some introductory background to the contemporary generalist genre, I will now turn to explaining the social context within which they re-emerged.

**Social context**

The timing of changes occurring within the medical division of labour in Australia differed from most other English-speaking countries whose generalists had shared similar experiences at some earlier point. The outcome was that during the time the Australian soldier doctors were given a mandate to change direction, overseas critics began to see the rise of the specialist/technological enterprise was diverting doctors “… from a more purposeful sociological objective of improving the lot of mankind (sic) and sustaining a supportive and sympathetic medical environment” (Hurley and Cummins, 1982, p.24). Table 6.1 below has listed some key initiatives associated with the generalist genre over the period under review.

As far as Australia is concerned, one needs to acknowledge also during the post-war years, an “Australian spirituality” and goodwill was evident within the medical profession as well as in the wider community (see Fett, 1976; McKernan, 1995). The “spirituality” had nothing to do with some church leaders who “failed to discern the spirit” (McKernan, 1995, p.497). As stated earlier, Presbyterians remained one group whose values were community-oriented.

Also, disenchantment with the specialist/technological enterprise was part of a critique of modernity which grew in reaction to the devastation visited on many in Australia and elsewhere throughout the major part of the 20th century. For example, Schoepflin, (1995, p. 432) stated that this critique

… grew in part out of the “apocalyptic” horrors of modern warfare, economic depression, the Holocaust, human experimentation, and the atomic bomb. In each case, the horrors in part had been set in motion by the application of rationality, science and its offspring technology and (carried out) in the name of liberty and equality.

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4 There is much more to Kamien’s life and the article covers many aspects of his medical training, career and family life and is written with humour. As to Weber’s idea of ‘elective affinities’ some of his friends were doctors in the calibre of Gordon Briscoe and the late Fred Hollows.

5 This position differs to that of Pensabene (1980) who defines the “stratification era” as occurring from the 1930s onwards. I lean more closely to Willis (1989) who recognises that a qualitative shift occurred but doesn’t elaborate on the timing. Willis (1989), however, describes the process of medical dominance as one coinciding with a shift from an individualist mode to a corporist mode.
Before the 1970s, the above views had been gaining ground in both the USA and the UK and supported by academics, health administrators, social scientists and other concerned and involved community groups (Hurley and Cummins, 1982, p.24). In Australia, this marked the time when the Whitlam Labour government came into office intent on giving support to a number of new reforms. So, while the independent Australian specialist and scientific/technological developments emerged quite late in comparison to these other countries, they also emerged within this wider local and international context. Outside these circles, doctors from different areas of medical education and practice found a meeting place in the concept of community medicine (ibid).

The impetus for new community programs and educational developments began in 1973 when generalists were given support by the Whitlam government. At this time, two reports were produced, one reviewing medical education and the other outlining a community health program for Australia (Committee on Medical Schools (ACMS), 1973; National Hospitals and Health Services Commission (NNHHSC, 1973). The result was during the ensuing decades, the two genres concerned with medical and health servicing began to operate side by side. Best and Keller (1991) have given a similar interpretation of social change stating “there is no radical break or rupture. Two competing systems operate side by side.”

One of the first programs involving doctors was the Family Medicine Program (FMP) established by the RACGP. When the first community health centres were established, they were linked to specific programs, such as Community Health and Community Mental Health, Alcoholism and Drug Dependency. Across Australia, there were a total of 356 Community Health and 109 Community Mental Health projects which were approved for Australian government funding, with the first Australian Community Health Centre opened in 1974 at Deer Park in Victoria (Department of Media, 1975, p.9). These centres worked to “ensure a high standard of community based health care services in co-operation with the States, local government bodies, voluntary agencies and community groups” (ibid.). As such, they differed completely from those shown in the next chapter as being singled out by the Director-General of Health, Dr Gwyn Howells to represent “community” based projects.

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7 This of course does not fall in with Kuhn’s ideas of paradigm shifts or “scientific revolutions” (see Ritzer 1996, pp.635-637 for a succinct explanation of Kuhn’s work)
Table 6.1. Some benchmarks affecting generalist doctors in primary health care and community medicine, 1970 – 2004

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>National Health Act (1970) gives financial rewards to specialists for carrying out same procedure as generalists</td>
</tr>
<tr>
<td>1972</td>
<td>Dr Sydney Sax, Chairman of the National Hospitals and Health Services Commission (NHHSC) and introduces a Community Health Program for a medical system based on primary health care where generalists would work in coordination with others</td>
</tr>
<tr>
<td>1972</td>
<td>Generalist submit Family Medicine Program (FMP) plan for government approval. Whitlam government and doctors worked within UN human rights conventions and anti-conscription climate and FMP generously funded.</td>
</tr>
<tr>
<td>1972</td>
<td>Dr David Maddison becomes Dean of Sydney Medical Faculty: spends two years in curriculum innovation.</td>
</tr>
<tr>
<td>1972</td>
<td>Karmel review of medical education Chairs of General Practice or Community Medicine battle for respect and status establishing themselves in “traditional” universities WA Foundation Professor of General Practice was Dr Max Kamien.</td>
</tr>
<tr>
<td>1974</td>
<td>Newcastle Medical Faculty established.</td>
</tr>
<tr>
<td>1974</td>
<td>Flinders Medical Faculty established</td>
</tr>
<tr>
<td>1977</td>
<td>WHO Declaration of Alma-Ata. Health for all cited as global strategy using primary health care principles. Australia visited by Director-General WHO, Dr Halfdan Mahler</td>
</tr>
<tr>
<td>1978</td>
<td>NHHSC disbanded by new Liberal govt.</td>
</tr>
<tr>
<td>1985</td>
<td>New directions for Nobel Peace Prize given to two cardiologists, one from USA and the other from Russia, who were foundation Presidents of the International Physicians for the Prevention of Nuclear War (IPPNW), which interlinks with Medical Association for the Prevention of War (MAPW) branches across Australia. Its WA President is Prof Peter Underwood, a well-known generalist academic.</td>
</tr>
<tr>
<td>1988</td>
<td>Doherty review of medical education and medical workforce future requirements</td>
</tr>
<tr>
<td>1988</td>
<td>GMC replaced by AAC who places greater emphasis on general practice in curriculum</td>
</tr>
<tr>
<td>1990</td>
<td>Sydney Medical Faculty closed and reorganized for new mature-age graduate intake</td>
</tr>
<tr>
<td>1993</td>
<td>National Health Act (1973) amended to reward general practice for continuing medical education (CME)</td>
</tr>
<tr>
<td>1995</td>
<td>WHO identifies poverty as the world’s deadliest disease and cited growing inequities between countries and between rich and poor within countries</td>
</tr>
<tr>
<td>1996</td>
<td>Doctors for health: a WHO global strategy for changing medical education and medical practice for health for all</td>
</tr>
<tr>
<td>1997</td>
<td>The Jakarta Declaration on leading health promotion into the 21st century. Cited as a key investment and a process of enabling people to increase control and improve their health with poverty as greatest threat. Other essential prerequisites for health were peace, shelter, education, social security, social relations, food, income, the empowerment of women, a stable eco-system, sustainable resource use, social justice, respect for human rights and equity.</td>
</tr>
<tr>
<td>2003-2004</td>
<td>Australian academic general practitioners begin to achieve respect and status.</td>
</tr>
<tr>
<td>2003-2004</td>
<td>Reform curriculum design across medical schools in Australia, UK and Canada.</td>
</tr>
<tr>
<td>2003-2004</td>
<td>New avenues opened for research and research training through the General Practice Evaluation Program. Master and Doctoral degrees available to those in departments of Community Practice. Now all medical school teaching funded through Commonwealth grants in Rural Undergraduate and Primary Health Care Research</td>
</tr>
<tr>
<td>2003-2004</td>
<td>No Health for All!! A medical system based on primary health care and the idea of empowering communities still has no place in the sun! Despite considerable gains, given the status and wealth behind the laboratory-oriented enterprise, generalists are still stereotyped as “only a GP”. They remain economically and intellectually outside the medical system dominated by hospitals and research institutes.</td>
</tr>
</tbody>
</table>
The umbrella under which administrators worked within the Whitlam government was one concerned with rights-based issues. In 1974, on the 26th anniversary of the Universal Declaration of Human Rights, Australia became a party to two significant conventions on the civil rights of women. These were the 1951 Equal Remuneration Convention, and the 1953 Convention on the Political Rights of Women. At the same time, Aboriginal and migrant issues were given attention. Ideas of assimilation and integration were disbanded and multiculturalism was promoted with a religious zeal by Whitlam’s Minister, Al Grassby, leading to the enactment of the Racial Discrimination Act (1975) and eventually the Land Rights Act (Northern Territory) (1976) which brought the central issue of land rights for Indigenous Australians into the public forum. Alongside these developments, substantial amounts of money were granted for new community initiatives, one being the Aboriginal Health Service and the other for Women’s Health Centres (Department of Media, 1975, Hunt, 1994, Saggers and Gray, 1991). At the same time, eight Royal Commissions were recommended. One, headed by Dr H.C. Coombs on Australian Government Administration, was the first comprehensive enquiry into the Australian Public Service for more than 50 years (Department of the Media, 1975, p.3). These initiatives should be seen as radical departures to previous practices by initially beginning to change the nature of government-decision making to “openness” (Verspaandonk and Holland, 2003). The opposite of “openness” is, of course, “secrecy”.

As far as health issues are concerned, one of the first steadfast advocates of community medicine and community health services was Dr Sydney Sax who was initially Director of the Division of Health Services Research and Planning in the Department of Public Health in NSW. When later offered the position of Chairman of the NHHSC by the Australian Government in 1972, Sax took the opportunity to pursue

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8 Grassby’s (1984) book, The Tyranny of Prejudice, was written as a challenge to the myth of a homogenous Australian society as part of his effort as Minister for Community Relations to begin to “lay the foundations of a more just and tolerant society”.


10 These authors give an extensive review and chronology of changes made to the Australian Public Service between 1975 and 2003.
these ideals by influencing policy direction (Hurley and Cummins, 1982, p.25).\textsuperscript{11} Firstly, Sax produced the report outlining a “Community Health Program” for Australia and recommended existing medical services be redesigned to provide a comprehensive community health care system where general medical practitioners and general nursing practitioners formed the mainstay of a primary health care system (NHHSC, 1973; Sax 1992, xiii). From this perspective, general medical practice, community health, community medicine and primary health care could become interchangeable concepts, the difference being in the emphasis (see Hurley and Cummins, 1982).

The ensuing directions in health policy appear to have resulted in the formation of two policy-making bodies which operated at two different levels within government and at which the different genres organized themselves. At the same time, while some initiatives were not formally coordinated, the generalists had a common objective. This was to bring back medical servicing and education to the needs of families and communities and make primary health care the backbone of the health care system (Hurley and Cummins, 1982; NHHSC, 1973). Possibly one reason some reforms got off the ground was because of the strategy used to incorporate community management into administration so as to avoid “centralist and bureaucratic obstacles by professional administrators” (Hurley and Cummins, 1982, p.24).\textsuperscript{12} However, by adopting this strategy, the generalist doctors would also have run the risk of institutionalising themselves even more into the subordinate structural position carved out for them by these new gatekeepers, setting themselves up once again for subordination or even “extinction”.

At the same time, as I will show below, the professional administrators did not appear to have any real understanding of the logic at work at the next policy-making level which centred around innovation in medical education and practice incorporating community health issues and “preventive” programs based on primary health care rather than eugenics. These new programs were quite different to the ideas of professional administrators and managers such as Everingham or Howells whose attitudes will be highlighted in the next chapter. So, only at this “second” level, a new social space was

\textsuperscript{11} One can only speculate on its impact on his rivals. The report shows that Dr Everingham was still Minister of Health when it was finalized. 
\textsuperscript{12} In the previous chapter, I have already pointed to the dominant structures which incorporated “higher level” management and “subordinate” administration within health organization.
opened up ready to receive those involved in what were called the “heady” days of the
groundswell of the wider reformist impetus. As Milio (1984, p.21) stated:

… those first involved say there was a “headiness” and spirit of innovation that
fostered another kind of “efficiency”, a calling forth of unusual personal
commitment and creative use of energy among the people directly involved
nationally and locally.

Like their counterparts elsewhere, the Australian generalists reached out to
others sharing the same interests and values regardless of disciplinary interests. In this
case, value was placed on the work of generalists within primary health care as “good
medicine” as well as on shaping medical education and practice to meet the needs of the
Australian communities they served. In keeping with the Whitlam government’s
actions, these values were based on principles of human rights contained in United
Nations charters. As Hurley and Cummins, (1982, p.23) point out, the key analytical
distinction was the focus on “wellness” rather than disease or injury. They state:

The principle of community health/wellness related to humans and creatures of
their environments reflecting and augmenting community standards, ideals and
aspirations. Every person had a right to total wellness equitable to his social and
intellectual potential. These are stated in WHO definitions of health, adopted
from the fundamental rights of human beings in the charter of the United Nations
Organization [italics added].

Apart from doctors like Sydney Sax who tried to influence policy direction, other
doctors worked within a number of different areas mainly focusing on medical
education. The most visible of those sharing this outlook worked within the RACGP
and the Family Medicine program (FMP). Others were community medicine or general
practice academics, and like-minded Deans and faculty staff working within new
innovative medical education programs also emphasising community medicine. These
all emerged within moves made for rapid social change at a time when health and
welfare were important components of social policy. The doctors worked with the
government which itself faced the resistant health profession who it would seem
remained on a plane remote from such community influences and who saw the present
in terms of the past. This even showed at times in their choice of language which made
one tend to speculate if their minds worked like those of lawyers who were often forced

13 For a detailed analysis of public policy in those years and later see Milio, (1984, 1992), Palmer and
14 One must keep in mind that before the 1970s, most of the older Australian general practitioners were
generalists who had worked in a variety of posts. One such example would be someone like Professor
Eric Saint mentioned above.
to operate on the basis of precedent. For example, the general practitioner emerging out of the FMP program was marketed as a “new breed” of general practitioner (“A new breed”, 1975). Such language mirrored 19th century terminology used when the entrepreneurial English apothecary/surgeon was dubbed as the “new breed” English general practitioner (see Loudon, 1995).

Neither the FMP nor the generalist genre as a whole can be considered as having the entrepreneurial characteristics of the 19th English apothecary/surgeons, as these battles were not primarily battles over market shares in the medical economy. They were battles over the control over knowledge and the diminished status and deskilling of the Australian generalists. The FMP program itself was designed to incorporate a longer-term outcome which was to educate future doctors about concepts of “family and community medicine” with a view to them cooperating with health institutions being established to distribute primary health services (Hurley and Cummins, 1982, p.23). The RACGP showed their resistance to extant practices pointing out:

Simplistically it was a revolt against the impersonal approach of medicine to personal illness by rational therapy with consequent neglect of human values. It was also in protest of changing structures of hospitals … from havens of solace to expensive and uncomfortable institutions of technical competence. Within their walls ministrations of medical science often result in disruption of human ethos, and even physical health, which were as devastating as the disease episodes for which admission and treatment had been sought (ibid).

In addition, developments should be understood as being set in motion within the social context of international and local trends and within some of the potentially radical aspects of Labor’s health policy at the time. As Whitlam, 1972 (cited in Milio, 1984, p.20) states:

Health insurance is only one aspect of our health proposals and in fact is not the most important. Health is a community affair. Communities must look beyond the person who is sick in bed or who needs medical attention…(We) will set up an Australian Hospitals’ Commission to promote the modernisation and regionalisation of hospitals. The Commonwealth will be concerned with more than just hospital services. Its concern and financial support will extend to the development of community-based health services and the sponsoring of preventative health programs… Far from restricting the choice of doctor or patients, our proposals will widen them.

However, in 1975, the Governor-General, Sir John Kerr, sacked the Whitlam Government and left the doctors to fight the good fight. John Kerr came from working-
class beginnings and did not have the patrician background of Menzies nor the doctors at the helm of the Order of St John (Pilger, 1992 p.215). Kerr was a Knight almost ten times over and an imperialist of the highest order. For example, Pilger (1992, p.215) asserts:

Almost everything Kerr pursued in his career denied his roots: from his passion for imperial pomp and ritual to his conspicuous consumption of Laurent-Perrier vintage champagne. In his black top hat and “Ruritanian flak jacket”, Sir John Kerr, Knight Grand Cross of the Order of St Michael and St George, Grand Cross of the Royal Victorian Order, Knight of the Order of Australia, Knight of the Most Venerable Order of the Hospital of St John of Jerusalem and so on, rivalled Menzies as the embodiment of imperium in Australia.

Prime Minister, Gough Whitlam, found out later, the Governor-General had extensive reserve powers under the Australian constitution. As stated earlier, as the Queen’s representative, he is commander of all military forces. These powers also reside over the Australian government and its constitution, its individual Ministers and its electors and, as far as I am aware, remain unchanged today. Pilger (1992, p.357) points out:

Few Australians, I believe, are aware of the existence of such despotic reserve powers, which are unheard of in any other advanced democracy and which are dangerous. To break free from them is imperative if Australia is ever to achieve independence from its imperial legacy and from the colonial state of mind that permeates its political life.15

So, while many Australian researchers have recognized qualitative and ideological differences within the medical profession, as well as within the politics guiding health policy16, few have recognized differences within the medical profession itself in such terms. Indeed, only at this time this wider vision tying in health insurance to health policy was embraced. It also became increasingly evident later in the decade, that the philosophy and actions of these doctors were in tandem with international trends to bring back the focus of medical education and practice to considerations of the link between health outcomes and human rights.

In light of the foregoing, as C. Wright Mills (1959) would argue, the story of the generalist genre of doctors needs to be recast to show the extent of such differences and

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15 Also, Encel (1976, p.157) quotes Horne in stating that any attack on Sir John Kerr and his institutional position symbolises an attack on a discredited power system which is in essence “monarchical in principle, repressive in practice and dishonest in public expression”.

16 See for example Davis and George (1988) for an examination of health policy and process as well as medical professionalism.
resultant effects in terms of structural constraints imposed upon them. Mills introduced the idea of the “sociological imagination.” Such an imagination focuses upon the place of the individual in the larger scheme of things, that is, the relationship between the individual and society, between the biography of individual members of any particular society and the broad history of that particular society.

A key distinctive characteristic of the “sociological imagination” is between “private or personal troubles and public issues” (Mills, 1959). For example, personal troubles which happen to an individual may be a private matter in which values or ideals are threatened, such as health, education or employment issues. Public issues occur within the wider context and have to do with the way society, particularly its social institutions are organised into a social structure, that is, if the “private troubles” of generalists are similar to those situated in the same way in terms of class, race or gender within the social structure, then they reflect public issues which need addressing (see Mills, 1959; Willis, 1993). We need to understand class here in Weberian terms and adopt insights from feminist sociological theory which chooses to integrate three aspects of social life, defined previously as “relations of ruling, local actualities of lived experience and texts” (see Ritzer, 1996, p.483)

So, with the above as background, I will discuss the RACGP and the FMP as, despite several changes in government between the 1972 and the year 2000, it was again really in the sphere of medical education the generalist genre could find some sort of meeting ground with like-minded colleagues in its anti-establishment stance and its community focus.

**Generalists and specialists within medical postgraduate and undergraduate education**

In the 1970s, even the Edinburgh medical curriculum had undergone changes from its traditional generalist orientation, with these changes calling for a redefinition of contemporary general practice and its academic status within a redefined medical system.\(^{17}\) For example, the first academic chair of General Practice was established at

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\(^{17}\) While I have acknowledged the cultural influences of the Scottish on Australian medical education, I have been more interested in how these influences impacted on Australian institutions. Because of this, I have not researched contemporary developments in Scotland, a subject which still holds a fascination. For those interested in Scottish medical history, there are now three contemporary texts, one on military influences in the first half of the 19th century leading to a Military Chair of Surgery being established at Edinburgh for that period only (Kaufman, 2003). In addition, two others recently published are by
In 1971, a leading article in *The Medical Journal of Australia* pointed to an international groundswell of educators who criticised the skewing of medical education towards science-based subjects, the isolation of the university teaching centre from its community and the need for “relevance” and “humanity” in medicine (“Curriculum development”, 1971, pp.1356-1358). The article gave evidence of changes already being undertaken within Australia and New Zealand. They pointed out Monash University as well as the University of Auckland had adopted significantly different curriculum patterns, while others at the Universities of Sydney, NSW, Brisbane and Adelaide were seen to be undergoing major revision. They also stated the Universities of WA and Tasmania were proposing a general examination of the curriculum in the immediate future, while the proposed new medical school at the ANU had planned a radically different scheme from the traditional pattern (ibid, p.1356). This article might have been written in the hope it would become a self-fulfilling prophecy rather than representing any sort of an overall reality of what was going on at the time.

As I will show below, although attempts at curriculum reform were made in the early 1970s, these apparently were changed back again to the old “Flexner model” some time later (see Australia Committee of Inquiry into Medical Education and Medical Workforce (ACIMEMW), 1988, p.83). What did happen was, after the 1960s, most of the medical faculties underwent a “scientific” (and militarised) “greening” wherein the structure of the faculty mirrored the interests of the Royal Colleges. This meant that, after graduation, students could carry on postgraduate work in any specialty field nominated by them linked to hospital or laboratory work. Although by this time general practitioners had their own Royal College, the idea that general practice was also a specialty and, as such, should be taught in medical schools, was one not favoured. Even today in the media and therefore in popular culture, the “front-line” of medicine is considered to be the hospital which has historically been the central establishment of doctors and nurses associated with military or “Hospitaller” traditions (see Howie-Dingwall (2003) whose work covers a period of 2,000 years of Scots medical history while Jenkinson (2002) has looked at Scottish health issues and developments in the period 1919 to 1947. As mentioned in the previous chapter, research conducted by Anderson and Western (1970) and others showed that medical schools were producing graduates who were conservative in outlook.
Willis, 1983; Summers, 1988; Seward, 1995). The media, which consistently reports on so-called impending crises, rarely questions the remuneration of specialists, but generally pursues discourses revolving around lack of adequate hospital funding or failure of general practitioners to bulk bill (see AMA, 2003). One only needs to look at the websites of the Commonwealth Department of Health and Ageing (CDOHA) to see the structural location of general practice still basically remains outside the existing medical system (CDOHA, 2002, 2002a).

While changes during the 1970s and the ensuing 30 or so years have indeed occurred within medical education, the full extent of these changes needs to cover both undergraduate and postgraduate medical education across Australia and look at the individual schools and corporations involved in such change. A summary of the direction of reforms occurring within undergraduate medical education has been outlined in both Australian and overseas medical journals (see Buckley, Marley, Robinson and Turnbull, 1998; Jones, Higgs, de Angelis, Prideaux, 2001; Lawson, Armstrong and Van Der Weyden, 1998). The topic of re-certification of specialists is one also receiving attention in the past decade because those at the “cutting edge” had no systems in place for continuing education and assessment (see Hamilton, 1995, p.87; Newble et al, 1994). The issues these reforms encompass need careful deliberation and they remain a topic for a longitudinal research project which would be necessary to gauge the extent of changes as well as the ensuing effects. As such, they remain outside the scope of the present thesis.

Returning to the main discussion, while those promoting community medicine had a shared philosophy with generalist doctors as a way of ordering a medical system based on primary health care, eventually, in its battle for survival, the idea of community medicine seemed to be set afloat from the broader perspectives it first encompassed. The only institution embracing the link between primary health and medical care and health policy has been the South Australian Health Commission (1988) (see McPherson, 1992, p.123). However, at the Federal level the interconnection between health insurance, health policy, medical education and medical and health servicing as an integrated health system is one still to be made.

Anyway, from the early 1970s, attitudes of the status quo towards curriculum reform seemed to be as inflexible as the idea of any changes to the definition given to “real” medicine. In 1973, an enquiry into expanding medical education was chaired by
Professor Peter Karmel, Professor of Economics and Foundation Vice-Chancellor of Flinders University of SA (Hamilton, 1992, p.168; Kamien, 2003, p.2). The other six members had backgrounds in neurology, medicine, obstetrics and hospital administration and also included a Commonwealth statistician and the Queensland Auditor-General (Kamien, 2003, p.2). While recommending “innovation” in the curriculum as well as a place for general practitioners within medical schools, the Committee did not appear to have embraced the philosophy behind the need for widespread changes.

The Karmel Committee not only reviewed general practice in Australia, but also was asked to “make recommendations to the Australian Universities Commission on the need for new expanded Medical Schools in the light of likely trends in the delivery of health care over the next 20 years” (cited in Hamilton, 1992, p.165). Submissions were made by the RACGP and the Newcastle Chamber of Commerce for a medical school. The Committee reported an exposure to general practice was essential as part of the training of medical students. However, they were not convinced general practice should be treated as an intellectual discipline in its own right. This greatly affected the future of general practice as well as the place of “community practice” in other medical schools. The Karmel Committee ended up making two recommendations. These were:

(a) medical schools be established at both Flinders and Newcastle to implement innovative programs;
(b) funding is made available to establish Community chairs of medicine within traditional universities (ACMS, 1973).

In response to such practices, from 1974 collaborative networks began to appear between the RACGP and those in the new medical faculties at Flinders University, the University of Newcastle, as well as the General Practice or Community chairs, the first established at Claremont, WA. While the older medical faculties remained steeped in tradition, it does seem the newer universities, such as the NSW Medical Faculty’s efforts to introduce a medical program to “humanise” the medical curriculum did have some impact. For example, counter-cultural figures at this faculty were doctors such as

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19 One should find it easy to recognise the checks put in place by the status quo by including these last two members on such a committee.
Kerr White and John Lawson whose work was in public health\textsuperscript{20}, while Peter Baume was in community medicine.

Whilst surgeons, as a body, generally remained resistant to collaboration, these networks included other doctors working in a number of areas, but not so enchanted with the system as it stood (see Hamilton, 1992; Maddison, 1977). For example, Miles Little (1995), who published a book entitled \textit{Humane Surgery}, was a colleague of John Hamilton referred to earlier (see Hamilton, 1992). Other critics were those like G.J.V. Nossal, the Director of the Walter and Eliza Hall Institute of Medical Research, Melbourne, who censures the displacement of the need for doctors to communicate with patients when he states:

Both science and medicine have a strong inward looking component. Illich exaggerates, but anyone attending a traditional grand round must concede he has a point. Similarly science is excessively concerned with its status symbols and its complex system of rewards and sanctions. Communication within science is so important it displaces the desire for communication between science and the rest of the world (Nossal, 1976, p 841).\textsuperscript{21}

Below I will explain these developments in more detail, as within a few years these ideas became aligned with new policy-directions established by WHO, whose Director-General, Dr Halfdan Mahler, visited Australia in 1977 stating his position, as follows:

(a) doctors were the most alienated group in society and they had to establish a dialogue with their patients and stop giving them “lollipops”;

(b) the rise in number of specialists was to be criticised, because it had been at the cost of general practice;

(c) medical science had pushed technology to the point where it had blurred the borderline between life and death;

(d) western medical schools were continuing to produce doctors who “addicted” patients to technology which had nothing to do with health (“W.H.O. Director-General”, 1977, pp.14-15).

These views were in keeping with WHO directives spelt out at the Alma-Ata Conference in 1978. This is especially because, under the Alma Ata Declaration of

\textsuperscript{20} Sometimes the term, the “new” public health is used to encompass health education and promotion as opposed to the “old” public health mainly concerned with immunization (see Fry and Baume, 1992 ).

\textsuperscript{21} For a fascinating anthropological study of the prestigious Walter and Eliza Hall Institute housing a distinctive sub-culture of the “life world of (a group of) scientists” engaged in the investigation of the immune system, see Charlesworth et al. (1989),
1978, WHO established a framework for medical care based on a primary health care approach and what came to be known as the Health for all Strategy (Owen and Lennie, 1992, p.6). As Hall and Taylor (2003, p.1) assert, the Conference also reframed the definition of health which was declared to be a fundamental human right, as follows:

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease and infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

Clearly, different sides of the medical profession would have responded to these views in different ways. Despite such statements from local and international leaders, even in 2002, the face of the Adelaide Medical Faculty, as well as others, reflect a linear progression of a universally organized medical system historically organized around these specialist interests. For example, similar to what Hughes (1967) had observed earlier about the social construction of a different view of medical history, a recent article reviewing Australian medical schools depicted the Adelaide school as being established in 1885 with its outstanding graduates as acclaimed culture-heroes of the scientific enterprise, namely, Howard Florey (Nobel laureate), Aubrey Lewis (first Professor of Psychiatry at London Institute of Psychiatry), and Hugh Cairns (First Nuffield Professor of Surgery at Oxford) (Lawson et al, 1998, p.5). These actions fit in with Foucault’s assertion that one should continually distrust any type of history which depicts a smooth and homogenous linear progression of its development. In this case, one such graduate, namely Howard Florey, was educated before the 1950s and before the medical faculty underwent structural change (see Lendon, c1935).

Such strategies, of course, have the effect of wiping Australian generalists off the historical map by destroying any sign of their influences on the outside world.22 One of the first to try and re-establish their status and value as doctors, as well try to re-skill their doctors was the Australian College of General Practitioners, becoming the RACGP, after being given its “Royal” prefix in 1969. Ironically this took place at the same time as national health insurance was being revised to reduce their status.

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22 Such strategies fall in line with those of scientific management, defined earlier as divorcing conception from execution. For example, as in the process of continual restructuring and renaming various government departments so that few are aware of their history which is kept a secret.
The RACGP and the FMP

The strongest contestation from the RACGP was firstly against the inequities in the National Health Act (1970) especially with respect to their rural practitioners, who remained experienced in obstetrics, anaesthesia as well as some minor surgical procedures. Even though the Whitlam government helped to fund the FMP as a postgraduate educational program, it took another two decades for them to receive financial recognition for doctors undertaking such training. In this instance, the RACGP conducted its own research on rural practice, arguing general practitioners were not “failed specialists” and presenting their evidence to governments. While, as shown below, the Doherty committee failed to support their efforts, in 1989 a Senate Select Committee considered their recommendations and, in 1992, the Labour Health Minister, Brian Howe, announced vocationally trained generalists would receive higher remuneration under Medicare schedules, becoming effective in 1993.

The key consideration in understanding tensions between general practitioners and specialists is to understand the way the “hospital” was central to both groups who utilized it in different ways and according to diverse perceptions about the way medicine should be practised. In the earlier system, the general practitioner was a generalist all-rounder who, especially in the hospital, would be at the bedside of the patient even when they had been given over to the care of another “specialist” or “consultant” doctor. However, although the idea of “personal trainers” in physical fitness is one that has caught on, the idea of a “personal” family physician has not been understood in this way. This is despite the fact both are in the business of keeping people well and healthy.23 This might be because the “new breed” general practitioner has been sold to the public discussing the FMP with no reference to history (“A new breed”, 1975, pp. 16-21).

Neither committees chaired by Karmel nor Doherty looked at general practice in this way, nor did they envisage general practitioners would be given a place in decision-making processes (ACMS, 1973; ACIMEMW, 1988). While at least Karmel was not averse to vocational training in general practice after graduation, as outlined below, the Doherty committee doctors considered the general practice workforce to be a

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23 For a wider discussion of this point see Winton (1983)
site for specialists to utilise and exploit for their benefit. One wonders whether such views would be held by other professionals in other areas!

The idea of vocational training for general practitioners was not new, but had previously lacked the support and the funding for its implementation (Winton, 1983). The RACGP first approached the Whitlam Government in 1973 and obtained a grant to establish the FMP which was a three year postgraduate educational program, with the option of a fourth year for those going into rural medicine. The program began with 250 trainees scattered across Australia along with a handful of educators. It was designed to make up for the shortfalls of the undergraduate medical programs which did not prepare students for general practice. The RACGP affiliated itself with The World Organization of Family Doctors (WONCA), more recently supported by WHO24 Competence was tested at the end through an RACGP Fellowship Examination (Fabb, 1994 cited in WHO-WONCA 1994, p. 85). For almost two decades after 1973, while specialists have been able to attract greater monetary rewards on the basis of receiving postgraduate training, general practitioners in Australia undertaking postgraduate training received neither social recognition nor economic reward.

The RACGP was not only involved in the postgraduate training of generalists, but also in reorganizing the general practitioner workforce into Divisions of General Practice. They wanted to abolish solo practice which they saw as a “relic of a cottage industry phase” and put general practitioners in competition with each other and they wanted their doctors to learn how to work together. At the same time, the RACGP also wanted some “reward” for the effort of taking on further education. In this respect, they were asked to come up with a set of “standards” which would be amenable to doctors so as to act as an incentive for undertaking vocational training. These “standards” were also to be amenable to state regulation and health insurance payments. (M. Bollen, personal communication, August 18, 1995).

They did not regard the traditional “time” based system for payment as equitable. This was because a young inexperienced doctor would need much more time to complete a diagnosis than a more experienced person. In the end the RACGP came up

24 This is the accepted name for the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians, an organization which comprises over 55 Member Organizations from more than 45 countries and has around 150,000 members worldwide (WHO-WONCA Conference, 1994).
with the idea the doctor needed to be paid to “listen to the patient”. In the mid-1980s, they put up another proposal to the government stipulating patient management as being multifaceted and “content-based” (ibid.).

Despite the objections documented above, the RACGP was finally successful in establishing vocational guidance for general practitioners linked to quality control and remunerative benefits. Vocational training of general practitioners linked to the payment system below was announced by the Health Minister, Brian Howe in 1992 (Howe, 1992). The details were published in a National Health Strategies publication entitled *The future of general practice and beyond*. This document established that the main considerations for vocational guidance of doctors were workforce regulation, training, qualifications, effective working relationships, establishment of standards and the means of measuring standards (National Health Strategy, 1992a). From that time, in terms of what it meant for practising general practitioners, the Medicare schedules now reflect four different levels of rebates for vocationally trained doctors which were justified and accepted for various medical reasons. These are:

- **Level A** Gives an injection or prescription
- **Level B** Records patient problem and gives a diagnosis
- **Level C** Takes full history and detailed examination and illustrates with full explanation.
- **Level D** Headache or “heart stoppers”
  
  I’m tired or I’ve got these headaches (M. Bollen, personal communication, 1995 (M. Bollen, personal communication, August 18, 2005).26

If one looks at the above details closely, in practice, this type of system does not reward the doctor for giving the patient a “quick fix”, a factor that has been criticised by both doctors and sociologists.27 Also, as shown in Level D, doctors are encouraged not to treat headaches or other such symptoms lightly. By 1994, the trainee numbers in the FMP had risen to 2,500 and the program has been looked upon as one of the largest family medicine vocational training programs in the world (Fabb, 1994 cited in WHO-WONCA, 1994, p.85).

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25 RACGP administrators believe that a nurse practitioner is fully capable of doing this work. Nevertheless for the moment it is still seen as the responsibility of doctors.
26 These details were the result of a personal interview with a senior RACGP administrator.
27 There will be further examples of doctors’ attitudes throughout this thesis. For a classic sociological critique see Silverman (1987).
The ritual blessing of the state to the validity of such a program took many years. Even in 1988, a year before the RACGP’s proposals were submitted to a Senate enquiry, an official enquiry (the “Doherty report” referred to earlier) was conducted on the topic of *Australian medical education and workforce issues into the 21st century* (ACIMEMW, 1988). Since the demise of the SPH & TM along with other changes in the areas of defence and public service, the new AIH had offered Masters Degrees in Public Health (MPH). However, while the Chairman and two committee members had chosen this route, most of this Committee seemed to have been members of a fairly new corporate entity who described themselves as physician/executives.

The Chairman of this Committee, Professor Ralph Doherty, was, at the time, Pro-Vice Chancellor (Health Sciences) at the University of Queensland. The Chairman and Committee comprised five male and two female members. These were a Vice-Chancellor, a senior hospital physician (known also be on a number of other elite workforce planning committees), a chief executive of a NSW local health service, and a Director in a Hospital Department of Community Medicine. Among them, four were medically qualified, the three with MPH degrees were also Fellows of the Australian College of Medical Administrators (FRACMA). The Vice-Chancellor was not a doctor, but a Fellow of the Australian Institute of Management (FAIM). The remaining two committee members were also not medical doctors, but were highly qualified academics outside of medicine, one being a Senior Lecturer in Community Medicine, and the other working as a Director of a Social Biology Resource Centre. In terms of status and therefore their ability to impact on decisions taken, they were no match for their committee colleagues. While the chivalric insignia had disappeared, the brotherhood symbols had not, as again most of the doctors boosted their status by distinguishing themselves by a vast array of letters after their names (see Table 6.2 below). As a source of comparison, one might take a look at another contemporary health manager and/or administrator James S. Lawson, MD, MHA with a degree in health administration rather than public health. This doctor was Head, School of Health Services Management as well as Director of the Centre for Public Health at the University of NSW. Even so, one should caution against over-generalizing in terms of individuals, as comparisons such as this, while useful, are sometimes not without contradictions.

These administrators seemed to particularly like the idea of themselves as “physician executives” and were also more comfortable in the authoritarian, “top
down”, and “we know best” approaches.\textsuperscript{28} As shown, these characteristics were distinguishing variables within the heroic genre as well as the generic attitude that the community owed them a considerable debt for their efforts.

Like the ACMS (1973) enquiry chaired by Karmel, this Committee was seen to generally encourage innovation in curriculum and training in undergraduate medical education. Nonetheless, the following statement of these new top dogs should remove any doubt about the use value they saw in general practice and of the way they evaluated workforce issues. In this case, it was not in terms of the general practitioner’s role and benefit to the community, but in terms of its benefit to those in a medical system designed and run by specialists for specialists alone. For example, the Committee thought vocational training for general practitioners would create a

\begin{table}[h]
\centering
\caption{Names of Chairman and Committee of ACIMEMW}
\begin{tabular}{ll}
\hline
Professor Ralph L. Doherty & MB, BS, MPH, MD, FRACP, FRCPA, FRACMA \\
Dr Bernard J. Amos & MB, BS, MPH, MD, FRACP, FRACMA \\
Dr Neville Hicks & BA., PhD \\
Professor Richard Larkins & MB, BS, PhD, MD, FRACP \\
Dr Sue P. Morey & MB, BS, MPH, FRACP, FRACMA \\
Mrs Delys Sargeant & B.Sc (Hons.), M.Ed. \\
Professor Robert H.T. Smith & BA, MA, PhD, FASSA, FAIM \\
\hline
\end{tabular}
\end{table}

(ACIMEMW, 1988)

\textsuperscript{28} These terms have been borrowed from those used by Metcalfe (1992) in Hamilton (1992, p.205). While many were also Fellows of the Royal Australian College of Physicians (FRACGP), this College could not be seen to nurture such sentiments.
barrier for specialist trainees who sometimes “moonlight” as locums or “shift into general practice at 65 after retiring from hospital work”. The report stated:

The Committee sees the mandatory concept (of vocational training) as potentially inflexible for several groups of practitioners, including specialists reverting to general practice, graduates switching from other specialist training programs and for those returning to the workforce after career interruption. It also believes that the mandatory concept would present difficulties for many graduates, for example, in hospital positions, wishing to undertake part-time general practice such as locum tenens appointments (ACIMEMW, 1988, p.xx).

As far as considerations of community health needs were concerned, those in the Committee showed their affinities to a system designed to meet the needs of the “expert”. Taking into account the submissions of consumer groups representing women’s health, the aged, the disabled, etc., the Committee was of the opinion that consumers would have to wait another decade for their concerns to be met until undergraduate medical education could be redesigned to accommodate their needs. They state:

The Committee, concludes, therefore, that the medical practitioners and profession of the coming century must be so educated, organised and compensated [italics added] for their work that they will regard the material discussed in this chapter – and the pressures for change which it represents – as requiring serious consideration (ibid., p.77).30

In summary, the most important factors in the above developments is at the time of the National Health Act (1970), when most Australian doctors were generalists and only part-time specialists, it seemed to have taken only a year to establish a new system which would reward those who registered themselves as specialists. In the above instance, it also seemed to take little time for the above medical elite to reorganize and establish themselves as a continuation of the culture of the self-declared elite or elect. Also, apart from the RACGP at that time, no other Royal College was asked to establish “standards”, or to find a means of measuring or evaluating standards amenable to state regulation and payment. In contrast, general practitioners were forced to undergo a process taking almost twenty years to formulate their own system which would be acceptable as amenable to state regulation. The RACGP collaborated with those in the

29 The relationship between these actions and the use they might make of the generalist workforce to suit their own needs is an issue that might be worthy of further exploration.
30 The submissions to this enquiry were supposed to be open to public scrutiny. However, in requesting access to these documents at the outset of my research which was within a decade of the enquiry, I was told that they were in archives in Canberra and, therefore, not easily accessible.
new medical schools, such as at Newcastle, Monash and, later James Cook, in the development of educational modules for general practice (Mudge, 2003, p.1).

The sociological significance of these developments was the emphasis given to “communication” in the doctor/patient relationship as well as challenging students to question the extant system. Some educators taught “experience is when you don’t get what you want” and the generalist had to teach the patient “not to always listen to the doctor” (M. Bollen, personal communication, August 18, 1995).

On the other hand, if Sydney medical faculty, and what one knows of its history, can be made an example, the synopsis below will give a picture of the effects of these traditions on the existing faculty as well as on their attitudes towards broader trends for curriculum reform (and inherent social change) at that particular point in time. Below I revisit Sydney Medical Faculty once again, this time from 1972 to 1974, when David Maddison attempted to implement curriculum reform. Maddison, who was a psychiatrist, believed one of the biggest mistakes of medicine had been the separation made between physical and mental illness (Maddison, 1977).

**Sydney Medical Faculty**

Between 1973 and 1975, the Government provided special grants to universities to establish or expand appropriate courses so as to increase the output of general medical practitioners, as well as special education teachers and social workers. Sydney Medical Faculty was caught up in these changes especially in the years between 1972 to 1974 when David Maddison became the Professor of Psychiatry and first Dean of Sydney Medical Faculty intent on reforming the curriculum. Maddison had come back to Australia from studying at Harvard University and became known for his interest in “preventive psychiatry” (“The death”, 1973, p.9). In his account of his experiences sub-titled a “tale of two cities” he firstly gave an insight into the power structure and attitudes of the status quo in the Faculty in terms of their age and their attitudes to medical education (Maddison, 1977).

During this period, he encountered “problems” at the Sydney Medical Faculty because of the power structures within the Faculty. Not only was the Faculty of

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31 I was given permission to access Maddison’s paper and other written articles from the Dean’s library at the Newcastle Medical School when I met with Dr Hamilton (J. Hamilton, personal communication, December 5, 1995).

32 It does seem that the word ‘preventive’ may have had many different interpretations.
Medicine organized in a rigid and inflexible way, but also the power wielded by Departmental Heads, albeit benevolent, was in fact formidable. The result was, despite the change in the composition of the Curriculum Committee, effective power was still concentrated in the hands of the professorial chiefs by virtue of their membership of the Faculty Standing Committee, the most important decision-making body within the faculty, over which they held almost unrestricted sway (ibid, p.3). For example, Maddison (1977, p.4) states:

Consulting my “Who’s who” made me realise that most of the senior and most powerful professors in the Faculty were getting close to retirement, an event however which was still far enough away for them to exercise their own form of influence for several years to come. I consider it a highly relevant circumstance that, through historical accident, six of the most influential persons in the Faculty were at that time aged 60 or over… none of them were interested in medical education as a process, and it was obvious they were not likely to do so now.

Practices which were surreptitious in the 1960s had since become blatantly visible when referring to each Head of Department insisting “on an unrestricted right of access to the Vice-Chancellor on all matters affecting his own discipline,… not intending to give this up when the first full-time Dean was appointed following (his) resignation” (ibid, p.3). What this meant was Dean as well as the Faculty as a whole had little or no control over major administrative matters relevant to the smooth running of the organization, such as staffing, sabbatical leave, provision of equipment, and so forth (ibid). In addition, educational reform was freely criticised and even the most modest change was likely to be labelled “eccentric” (ibid. p.4). However, Maddison (1977, p.5) did admit to undergoing his own process of enlightenment before this time when he states:

The view that the graduates were emerging with their heads stuffed with “scientific” facts (what Moran Campbell has recently called “the stories of science”), rather than an appreciation of the scientific method, was not regarded as acceptable, although it was one that I had found good reason to believe for many years.34

Also, as the history of Sydney Medical Faculty attests, like others of its kind, it placed excessive emphasis on research performance, the “case” approach in teaching

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33 Imagine the medical faculty at the University of Melbourne working along the same lines with the previous Prime Minister Robert Menzies undertaking the position of Vice-Chancellor after his retirement from politics.

34 This is a process referred to by Foucault (cited in Best and Kellner, 1991). One can visualise as a nucleus within a nucleus when knowledge turns in on itself to emerge on the side of humanist thinking.
hospitals, as well as medical experimentation. Such interests were not at all in tune with Maddison’s (1977) way of thinking, as his views quoted below on the topic of academic research would warm the heart of many academics. As I see a distinct relationship between the slogans of “populate or perish” and “publish or perish”, I for one can easily situate myself within the heterogenic “space” that opens up to Maddison’s (1975, p.5) views when he states:

… in my judgement the number of individual’s publications (their quality was sometimes not seriously questioned) was given undue weight in the process of appointment and, more obviously in promotion procedures. To doubt the usefulness or financial justification of some piece of repetitive, unoriginal, obviously derivative bench research, conducted by some junior academic or post-graduate student determined to “get on in the system” was to invite grave criticism of one’s own academic respectability!

Suffice to say Maddison, along with the Curriculum Committee, saw many shortfalls in traditional programs which contradicted their own educational philosophy and goals geared towards producing committed graduates who would take responsibility for their own learning and continuing self-evaluation as physicians. They wanted graduates to show a knowledge of Australian health problems, using more of an epidemiological approach. Maddison argued if one examined traditional programs against these standards, one would regularly see the extent medical education has moved away from addressing health and illness within the community (ibid, p.8).

During his period as Dean, Maddison attempted to make substantial changes to Sydney Medical Faculty’s traditional program. He successfully implemented a number of changes designed to meet the requirements of all graduates, including general practice, which he considered a specialty. Among these were the reduction of emphasis and time spent on Chemistry and Physics, as well as Anatomy. He also took biology away from its link to the Faculty of Science and introduced principles of human biology so as to make it relevant to medical education (ibid, p.1). In addition, he developed a course in the Behavioural and Social Sciences so all medical disciplines could appreciate the “major psychosocial issues affecting health and disease”. In short, he attempted to link medical students’ knowledge to the practice of “medicine in the community” (ibid, p. 2) 35. However, although he designed and implemented the new curriculum he doubted the full impact of these changes would be felt because of the

35 This will be clarified later when discussing the dynamics within the Newcastle Medical Faculty.
values held by the existing faculty staff. No doubt these innovations totally went
against the grain of the existing program which he regarded as severely flawed. For
example, Maddison (1977, p.10) states:

We believe that the traditional program has placed much too great an emphasis
on episodic exposure to patients in teaching hospitals; in the past such
institutions have tended to set up their own criteria of excellence, largely
unvalidated and perhaps unable to be validated, and have scoffed at people and
places who did not measure up to these internally derived standards.

It was on the above basis as well as other observations and experiences that
management plans for the new medical faculty at the University of Newcastle were
developed. However, before I explain these more fully, the ending of Maddison’s paper
gave a picture of him undergoing an intense ordeal and continual battle with those who
tried to turn the tide against him and his colleagues. For example, Maddison (1977,
p.12) concludes:

It is astonishing to note the amount of criticism, often of a most vitriolic kind,
which is attracted by an educational program which deliberately adopts a highly
innovative model. One cannot overestimate the importance for survival of a
relatively secure quantum of support from the Vice-Chancellor of the university,
from the senior officers of the health services, and from important opinion-
leaders in both health professional and lay communities [italics added].
Innovation is almost certainly not viable without security blankets of this kind. A
wide range of forces which bear upon us attempt to induce what we call
“regression towards the mean;”; the maintenance of our defensible differences,
and the avoidance of stultifying conformity, are tasks which cannot be
accomplished by a small band of dedicated medical academics on their own.

So, while community advocates in a number of contexts worked strenuously to
keep programs running and to a point succeeded, a factor mirroring Maddison’s
sentiments above was the extreme difficulty encountered in working against a tide intent
on trying to drown them. For example, Milio (1984, p.29) states:

… the tools of persuasion – size and financial strength of organization, media
penetration, lobbying resources, public opinion – and the nature of the policy
itself were no match for their counterparts who wanted Labor’s Community
Health program, like its other health policies, to disappear from the federal
scene.

David Maddison resigned from Sydney Medical Faculty in 1974. and accepted
the position as Founding Dean of the University of Newcastle consciously following an
educational philosophy and management style far removed from the one he criticised, as
well as ensuring the Vice-Chancellor of this University would be on his side (see
Hamilton, 1992). The new Vice-Chancellor, Don George, who had been Professor of Electrical Engineering at Sydney University, was a colleague who had been commissioned to report on academic structures and University governance in Australian universities (see ibid, p.168). Don George’s observations about rigidity and inflexibility in academic organization were very much the same as those found by David Maddison, who was offered his position as Dean at the same time George was offered the position of Vice-Chancellor.

Although in 1988, despite Maddison’s efforts, the Sydney Medical Faculty had reverted to the “1910 Flexner model” (see ACIMEMW, 1988, p. 83) this reversion was to be short lived. In 1990 this faculty was closed for refurbishing in more ways than one and, in 1998, Stephen Leeder, a founding professor of community medicine at Newcastle medical faculty, had become its Dean. As Hamilton (1992, p.188) points out:

By 1990, Sydney Medical Faculty became the first faculty to be completely dismantled and remodelled to adopt a graduate-entry program. In medical education generally, this has been the most dramatic change made not only at this medical faculty, but also at the University of Flinders and Queensland medical faculties. However, while this takes us away from the topic of the generalists for a minute, one now has to ask how dramatic have they been? Will these reforms change the attitudes of doctors in regard to the future of medical servicing? Once again if one looks behind the comment made by its Dean in 1998, Stephen Leeder, one will possibly rest assured to find that not only had he had been one of the founding professors of community medicine at Newcastle, he also played a major role in the Better Health Commission and the subsequent committee.

To understand Leeder’s outlook and his ongoing influence, one needs to tell the “tale” of Newcastle where, apart from the community focus, many other values of the generalist genre were incorporated. As I will show, some of these were empathy and compassion, respect for women and other cultures, as well as an intense dislike of mind/body dualisms.

**Newcastle Medical School**

Newcastle is a town situated in the picturesque Hunter Valley, and located about 40 minutes north from Sydney by plane. The city has a history of strong involvement of community groups in health schemes and had many projects in place even before the inception of the Newcastle Medical School. Both the medical profession, represented by the Central Northern Medical Association, as well as the Royal Newcastle Hospital,
were keen for innovation, the latter being in regular consultation with the RACGP (Hamilton, 1992, p.164-165).36

The aim of this section is therefore to relate some key aspects of Maddison’s experiences in establishing the new medical school, how he organized the faculty and how he integrated a community ethos into the new curriculum. As stated, one very important factor for Maddison was his relationship with the Vice-Chancellor and the reassurance and commitment made between Don George and David Maddison enabled the medical school to try such a “radically new approach” (Hamilton, 1992, p.168). After being appointed as Dean, Maddison underwent a two-month study tour of overseas medical schools involved in innovative programs in medical education.37

It goes without saying that Maddison and his foundation professors projected an entirely different life world to those within the Sydney Medical Faculty at that time, as well as for many years later in the picture projected by Doherty (ACIMEMW, 1988, pp.78-82). When these foundation professors were first recruited, they accepted Maddison’s views concerning medical education without too many reservations, ideas which surrounded the belief the medical school should be firmly locked into a community focus. This community focus was to be included in the development of its teaching programs, to a degree in the selection of research projects, as well as limited involvement in direct clinical service (Maddison, 1977, p.12).

As a psychiatrist, Maddison considered Behavioural Sciences’ academics should establish their own independent existence as they were considered to be “completely fundamental for the whole of medical practice” (cited from Hamilton, 1992, p.168). He stated the strategy of clearly outlining objectives guarded against “change without change” to ensure aims being transformed into a reality. He also considered student selection should be based partly on academic merit as well as having the capacity to be compassionate or empathic. For example, Maddison (1977, p.9) states:

36 The Newcastle Medical School was one I visited when I first began my research at the time John Hamilton was its Dean and who entrusted to me both his story of involvement, as well as that of Maddison. As well as Maddison’s (1977) paper cited above, most of the text is taken from Hamilton’s written accounts of developments following our meeting. As such, like other texts used in this thesis, I have no hesitation in putting these forward as representative of one account of such developments.

37 Subsequently, Newcastle as well as McMaster in Canada, Beersheva in Israel, Southampton in the United Kingdom and Maastricht in the Netherlands, along with others in developing countries, formed a global ‘Network of Community-Oriented Educational Institutions for Health Sciences’ – an organization committed to community orientation and innovation in health education (Hamilton, 1992, p.168).
While of course there is no evidence that intellectual ability is inversely correlated with compassion, it seemed … important to select at least a proportion of our students on that basis that, as well as showing a certain level of academic competence, they could be demonstrated to have certain characteristics which we saw as being required of our graduates – for example, the capacity for empathy, the capacity for creative thinking, and the ability to perceive the complexity of many of the ethical dilemmas which confront today’s doctor.

In regard to the calibre of new professorial staff, Maddison believed it was essential to recruit people who were personally and professionally stable. It was also important they had enough confidence in themselves to act independently in terms of the traditional philosophies and priorities held by colleagues in their own disciplines at other Australian universities. In terms of what eventuated, he states:

It has not, it might be noted, been too difficult to locate talented and scholarly persons who are to a greater or lesser extent disenchanted with the conventional forms of medical education, and who are therefore prepared to involve themselves in the innumerable developmental tasks which are essential for a school which is adopting progressive educational and assessment strategies (ibid., p.12).

The other important consideration was the management structure of the Faculty which took on the imagery of a hub around which everything else would revolve. A summarised version of what were seen as important elements is outlined below.

a) The Faculty was not divided into departments. Instead academics were organized around fields of interest such as social medicine, laboratory investigation or clinical medicine. At the same time, although individual professors retained a great deal of influence over research and educational developments in their own discipline, they had none of the authority they possessed in a traditional school (ibid, p.11).38

b) Budgetary control was not simply exercised by the professors by virtue of the fact that they were of professorial rank, but exercised by the Faculty through its various committees (ibid.). The various committees comprised both part-time and full-time academic staff at various levels of seniority as well as a small representation of students (ibid.).

c) The Faculty itself “owned” the curriculum and, with few exceptions “owned” the physical spaces. This was in opposition to traditional practices of gathering all (say) physiologists into one area (ibid.).

38 For example, what this meant was that when I visited Newcastle in the early 1990s, I found a Professor in Obstetrics and Gynaecology was head of the Division of Community Medicine with a special interest in epidemiology (Sandy Reid, personal communication, December 5, 1995).
d) The Faculty ethos allowed for management of the Faculty by the Faculty while not asking its members to forego their rights to go to higher administration on a matter of particular concern. (ibid.)

In light of the above and what I will show below, there seems to be some sort of mythology attached to the idea in today’s world that there is any real degree of professional autonomy. In cases such as these, there seems to be more theoretical sense in talking about what Foucault calls the “knowledge/power/truth” nexus or what Sandra Harding calls “situated knowledges” (Petersen, 1993; Harding, 1991). Even in Maddison’s case, being given a mandate to construct an innovative medical program did not give him absolute freedom. Reiterating earlier comments by others, he considered:

The most important constraints (were) the characteristics, attitudes and expectations of the parent university..., - the attitudes and expectations of the local medical profession ..., the level of funding provided, (and) the characteristics and qualities of...existing health services (cited in Hamilton, 1992, p.170).

One needs now to consider who exactly “the medical profession” was aligned to in non-Labour politics, given that there has generally been an intimate connection between Federal Liberal party politics and the evolution of the heroic genre. This is supported by Gray’s (1991, p.51) assertion that “Non-Labor preference for minimum government intervention in health and the support these parties give to the medical profession have been among the most important determinants of Australian health policy.”

Because the political climate both at national and state level had changed since the time of the Karmel report, the first years were made very difficult for innovative medical educators. This was due to the fact that the recommendations of the Karmel Committee as well as the orientation of the new medical school were regarded as not only ”being left-wing” but also as being “hostile to private medicine” (Hamilton, 1992, pp.170-171). This reinforces the continuity of the link between medical administrators and right-wing politics, a factor in itself that neatly disposes of the idea that “medicine” is a value-free enterprise and is apolitical. Especially as some experiences at Newcastle and Sydney would be reiterated by doctors in other medical schools, one should recognize that the power behind the scenes appears to lie with those who hold the purse strings in the upper echelons of the NHMRC referred to in the next chapter. For example, Hamilton (1992, p.171) points to the difficulties in regard to funding as follows:
Some Newcastle clinicians found that the startling innovations in this new school were not quite what they had anticipated, and there was some resentment when the first Professors were appointed from outside Newcastle. Foundation staff recall an atmosphere of substantial hostility, and practitioners in the City complained that the faculty, which started with open consultation, soon retreated into its castle. The state government failed to provide the health service with extra funds to support the hospitals in their involvement with the school and for the first 5 years there was a strong concern that the medical school would be closed or converted to a clinical school for another University.

However, after having provided leadership to the new faculty and recruited a number of Australian and overseas-trained educators into his team, the Newcastle Medical Faculty, had virtually just got off the ground when, in 1981, David Maddison suddenly passed away. The diplomatic skills of his successor, Geoffrey Kellerman, who was Professor of Medical Biochemistry and faculty leader for the next two years, paved the way for John Hamilton who took up the position of Dean at Newcastle in late 1984/early 1985 in a more receptive environment (see Hamilton, 1992). Hamilton was originally from London and had previously been involved in educational developments at the Universities of McMaster, Canada, and Iorin in Nigeria.39

Another relevant factor was the limitation placed on universities to carry on with its programs. For example, despite individual faculty staff being prominent in the supervision of postgraduate training, Australian universities have had no formal responsibility for postgraduate medical education. Including the RACGP, the further education of the graduate doctor is the responsibility of hospitals and specialty colleges. While the former has attended to some issues of population health, generally until 1992, this topic has been ignored by other postgraduate colleges (Hamilton 1992, p.186). In 1985, the GMC ceased to accredit the Australian medical schools and, in 1988, John Hamilton became founder of a new Australian Accreditation Committee (AAC) established as part of the Australian Medical Council (AMC) and whose members insisted on a greater emphasis on general practice in the curriculum (Hamilton, 1992; Mudge, 2003). However, these new developments did not resolve the issue of the non-recognition of overseas qualifications of doctors (see Farag, 1992).

There were other problems for, even within the medical profession, the idea community medicine and general practice could be interchangeable was one not easily embraced (see Copeman, 1992; Fry and Baume, 1992). As far as Karmel (ACMS, 1973)

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39See Hamilton and Ogunbode (1991) on experiences in ‘designing a doctor’ incorporating a community-medicine focus. At the beginning of my research I visited John Hamilton when he was Dean.
was concerned, general practice was only one discipline whose training was vocational, being one of others under the umbrella of community medicine. As Hamilton (1992, p.166) points out, Community Medicine was a new approach which was not confined to education for general practice but to the study of health and sickness of populations. He states even though this was clearly outlined in 1977 in the *Newcastle Morning Herald*, at the time of writing there were still many who had difficulty in grasping the broader scope of the curriculum and cites the newspaper article as follows:

> When Newcastle was chosen for the site of the third medical school . . . most people thought Community Medicine was basically the training for general practice…but…Community Medicine, by definition, is concerned with the study of health and sickness of populations. It uses the tools of epidemiology, demography, sociology, statistics, and other sophisticated methods to throw up a profile of a region’s health and its problems and even lifestyles (ibid, p.167).

The University was also responsible for formal degree and diploma courses, but not for vocational training. However, the community-based approach influenced postgraduate teaching and research within the faculty. Degree and diploma programs were conducted by the Centre for Clinical Epidemiology and Biostatistics for specialist clinicians and health professionals, in epidemiology, biostatistics, health social sciences, economics, pharmaco-epidemiology, occupational medicine, psychiatric epidemiology and health promotion (ibid., p.186).

In the early 1990s, with Paul Keating as Labour Prime Minister of Australia, a more favourable climate prevailed. At this time, the Minister for Health and Welfare Services, Brian Howe, established a National Health Strategy review. Howe was known to have a concern for social issues in terms of access to health and resources. Hamilton was again involved in assisting those in this project which was directed by Jenny Macklin. Again there was hope the review might reshape not only health care but also priorities for research and education (ibid, p.189). As highlighted earlier, one important consideration was the recognition of the causal relationship between socioeconomic status and health outcomes as well as the need to bring about structural change to address inequalities.
Hamilton’s influence inspired a new interest in the social determinants of health and the reformist spirit embedded in the first two National Health Strategy papers published in the 1990s. These were:


In the latter paper, the researchers concluded that, while Australians had a generally high level of health compared to world standards of mortality, they also found that levels of disability in the community were increasing rapidly without explanation. They argued for a more integrated health system and incorporated Sax’s expertise referred to earlier and who states

… to promote only a social model of health, or only a preventive model, or a biomedical model of health is childishly inadequate. A comprehensive model is required. It emphasises the interaction of social, physical and emotional aspects of health. A very strong case can be made for upgrading the social and physical environments of disadvantaged people…but until that has been achieved, victims of unsatisfactory environments, inadequate constitutions and other factors will demand and should receive comprehensive care (cited in Harvey (1991, p.57).

With a change to a Liberal government in 1996 hopes for reform were again dashed and, in a much more intensive way than in the Fraser years, a watering down or abolition of policies and practices began to occur to make critiques of health care delivery written in the early 1990s as relevant today as they were 15 years ago. The ensuing years have ensured that health benefits have not been effective. Not only health sociologists, but also the AMA, in some respects, have recently criticized the failure of governments to improve mortality rates of Indigenous Australians (AMA, 2001; Jackson-Pulver, 2003). Jackson-Pulver (2003, p.1) states:

One thing is clear … we have gone from being a culture believing that the needs of many far outweigh those of the few (to) one where we are barely serving the needs of “any”. This is most evident in the care delivered to the Aboriginal and Torres Strait Islander people of Australia

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40 Although publication dates are not in sequence because of the use of different publishers, research topics and titles must have been discussed at an earlier stage. In this series, there are approximately ten publications or discussion papers which are valuable resources for understanding Australian health servicing in the 1990s and today.

41 In the past decade or so, critiques of the Australian health care system have been written by Petersen (1994), Waddell and Petersen, (1994) among many other work on various aspects (see Willis and Broome, 2003).
For medical schools such as Newcastle to survive, the strategy was to maintain an international perspective to ensure being kept in touch with centres with similar educational approaches. It was also important to ensure a high profile within Australia, supported by participation of WHO networks and educational links. However, this could sometimes work against them because of the seductiveness of sending strong delegations to international meetings as against attending to the regular evaluations needed of their own programs (Hamilton, 1992).

The faculty also looked at sustaining a community orientation through the hope new graduates would establish their own dialogue with the community. At the end of the day, this would finally be the factor that matters because they found that, in the Australian health scene, it was much easier to develop projects in curative and technical field than in the public health and preventive fields (ibid.)42. Also at Newcastle, a strong program of health, law and ethics stretched across the whole five years to incorporate a “level of communication and understanding with patients that is rarely reached through … normal clinical encounters (ibid, p.86). There was also an Aboriginal Health program provided to gain better insight into the lives of others. As far as women were concerned, a joint student and staff initiative called the Committee for Women in Medicine was established to provide guidance for career development and continuing education (ibid, p.85).

As argued earlier by myself and other researchers, it remains clear theories of “male dominance” as well as “medical dominance” need some revision, especially in view of the inherent attitudes held by those at Newcastle towards women and Aboriginal people, as well as the social and behavioural sciences. As regards women, Hamilton, (1995, p. S85) states:

The best women students apply increasingly to Newcastle, and women are judged to be better at interview – the qualities we seek are, in retrospect, the feminine virtues! As interns across the State of New South Wales, women perform better than men, and that applies to graduates of all three of the schools. I believe the outcomes of this trend is that patients will be offered empathic and responsive health care. Women patients in particular will benefit, but so also will men, and my guess is that the dialogue on the priorities of health service will change for the better.

In sum, the first to institutionalise a community-orientation were those who founded the medical faculties at Newcastle and at Flinders Universities which to date

42 However, the public health and preventive fields can still engender conflicting definitions.
have been able to sustain their community ethos, albeit in different ways. While Newcastle has gained the reputation of encouraging women, employing Aboriginal lecturers and producing Aboriginal doctors, the medical faculty at Flinders University has gained the reputation of encouraging mature-age students. Both have experienced a lower drop-out rate than other universities. However, each has undergone different forms of reorganization. At Newcastle, the medical faculty is one among four faculties in the Division of Health Sciences. Medical students have integrated learning with nurses and other health care professionals in some subjects. On the other hand, along with the medical faculties at Queensland and Sydney Universities, Flinders has recently reorganized itself to take in graduates rather than school leavers (see Lawson et al. 1998, p.1).43

In light of the above, there is now more reason for Australian governments to support rather than hold back funding to medical schools. This is especially the case where “community-based” programs have been linked to labour market concerns, such as medical workforce issues to do with under-servicing of rural and remote communities (Norington cited in Jones et al. 2001, p.4). In this respect, Flinders as well as the new James Cook University in Townsville, Queensland have been involved in innovative changes to curriculum content and training. However, these innovations need close scrutiny, as Tropical Medicine has been reintroduced at James Cook (see Abbott 2006).

These changes are very much within the trends established by the GMC report Tomorrows Doctors which has emphasised the need for communication skills and public-health medicine within the medical curriculum. The GMC has also pointed out “clinical teaching should adapt to changing patterns in health care, and should provide an experience of primary care in the community, as well as hospital based services” (cited in Jones et al. 2001, p.4). For example, in a recent review article in The Lancet outlining changing international trends within medical education, Jones et al. (2001, p.4) make the following observations of these two Australian medical schools.

At Flinders University, students can opt for a whole year in rural general practice and associated hospitals to complete all their required clinical rotations. The new medical school at James Cook University, Townsville, has a brief to develop

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43 My first request to visit Flinders Medical Faculty was not acknowledged. I did not follow this up. In the end, I arranged to see some key informants in Sydney, Newcastle and Perth where my enquiries into generalist and community traditions raised my awareness of the need to delve deeper into the stories behind the historical evolution of Australian medical institutions.
rural and community-based programs in the north of Australia. Public-health medicine now comprises a large part of undergraduate teaching, especially in relation to clinical epidemiology, and the early contribution of behavioural sciences, including medical sociology and health psychology, is encouraged and welcomed and has been linked to increasing the medical workforce in rural and remote areas.

When the Deans of Australian medical schools were interviewed regarding the issue of graduate entry, a number were sceptical about the advantages. Others saw the program as not as important as clearly defining the sort of medical graduate the schools wished to produce (see Lawson et. al. 1998, pp. 2-3). The above issues and the effects of these changes would clearly be a project for further research. At that time, the fears expressed were that, after graduates enter hospital-based training programs, they would “unlearn the community orientation” taught within the undergraduate programs (ibid).44 However, once internalised, such values rarely change.

The last story to which I now turn needs to begin again in the 1970s to explain the outcomes of the other Karmel recommendation (ACMS, 1973). One of these was for general practice or community chairs to be established in the traditional medical schools where the dispositions of the faculty staff displayed exceedingly similar behaviour to those at Sydney Medical School.

**General Practice chairs and Community chairs: the “add-on” solution**

The effect of a medical system organized along craft-oriented lines is that in the last 50 years or so, this has resulted in a proliferation of over 50 medical specialisms which operate independently of each other and with no interconnection or communication with each other. Chew and Van Der Weyden, (2002, p.1) state:

> Sadly, the mitosis of medical specialties has not led to interconnecting, communicating cells. Instead, specialist and subspecialist “silos” have evolved which serve to contain and isolate. Each specialty has its own body of workers, is sustained by its own agenda, and drives its own research programs, the outcomes of which are discussed at specialist meetings and published in specialist journals

As there was no communication or collaboration among specialists themselves, it is not surprising there was solid resistance to incorporating community health subjects into the mainstream curriculum. Despite the fact Karmel (ACMS, 1973) had

44 More recent research on this topic has found this not to be the case and graduates more competent in professional and communication skills (Dean, Barratt, Henry and Lyon, 2003, p.1).
recommended that Chairs of General Practice or Community Medicine should be incorporated into all traditional medical schools, the resistance remained formidable. Although many have been successful, it has been largely due either to a more liberal ethos evident in some Faculties or to the political nous of the Chair and his/her ability to function in a potentially hostile environment. For example, the situation arose in the faculties where if a doctor in this position missed a committee meeting, the allocation of his/her resources would more likely be given to another “supposedly more worthy cause”\textsuperscript{45}.

Following Karmel’s (ACMS, 1973) recommendations, it was decided the first of the community projects was to take place at UWA. Subsequently, the planning of the Department of Community Practice began when a working party was established consisting of the RACGP, the AMA and UWA. The Department was to consist of a General Practice Teaching Unit which would have a research function as well as a teaching service which would use an existing group practice for its purposes. By the time approvals were obtain for planning and funding, land acquired and the building completed, it took until 1979 before the Centre was fully established. (“Teaching program”, 1980, pp.10-14). Kamien was appointed as the founding Chair of General Practice in 1977, a position which he retained until 2003.

Similar to Maddison’s (1977) experiences, these new developments occurred within a potentially hostile environment which viewed this medical education reform movement in terms of a threatening counter-culture (Kamien, 2003, p.8). Max Kamien was one of nine foundation professors in community medicine or general practice established within traditional medical schools across Australia. Except in the case of WA, other chairs came to be known by various titles, such as Community Medicine and Social and Behavioural Medicine.

As a result, until recently, general practitioners have continued to be thrown into a crisis milieu not of their own making but one created by others to continually reinforce the idea their practice behaviour is somewhat deviant. As such they are stereotyped as “undeserving” and are therefore placed in a subordinate status and minimal reward structure outside the health care system (see Del Mar, Freeman and van Well, 2003, Van Der Weyden, 2003). In fact, in light of historical events and the

\textsuperscript{45} I am grateful to Dr Geoffrey Gates for this insight.
structure of the medical system as it stands, one needs to consider why the media continues to report critiques about general practitioners, but not about specialists. In addition, one needs to also reflect on why the crisis around funding always centres around elective surgery in hospitals but rarely around the “taxpayers” money spent on laboratory research.

Neither Maddison nor Kamien appeared to be alone in their experiences, nor had various medical personalities lost the art of destabilising or “white anting” the work of the new professors. Neither sociologists, nor GPs, were innocent bystanders, nor did GPs easily embrace the idea of a counter-culture. For example, Kamien (2003, p.6) stated:

Four of the professors commented on departmental instability due to personalities “adept at the art of white-anting”. Also, three hybrid departments had structural difficulties that led to disagreement about aims and resources. One professor described his experiences as “cruelly caught between the sociologists on the left and the GPs on the right”

Kamien (2003, p.8) surveyed the Foundation professors in terms of their experiences and what they considered important enough to be passed down to their successors is outlined as follows.

* Understaffed community-based academics cannot be good at everything and therefore (need) to focus on two or three areas of activity. These activities were to maintain credibility as a clinician, pay serious attention to university politics, provide good leadership and role modelling, and facilitate a good research and teaching program.

* Their main role was one of leadership. They advised their successors that establishing a reputation as a good leader and manager was as important (if not more so) as establishing a reputation in research. They stressed that this leadership should include a role as an advocate for the weak, deprived and medically underserved people in communities, both in Australia and its near neighbours (ibid).

* They linked their academic work to community practice. Their opinion was that GP academics need to spend at least three sessions a week in medical practice [italics added]. This was to maintain credibility as a skilled GP and role model for students. It was also to maintain credibility with “the bag-carrying GP”. They stressed the need to do all they could to prevent a gulf between “working” and academic GPs and advised new professors to visit their GP teachers as often as possible, and to serve on various committees of their Division and State Faculty of the RACGP (ibid).
* They saw the need to pay attention to internal and external university politicking, and to attend all university meetings to avoid the risk of losing the department’s funds. Three of the professors advised “developing eyes in the back of one’s head, learning to recognise hostile academic colleagues, and developing the ability to deal with them” (ibid).

The first foundation professors, who had all retired by 2003, are shown in 6.3 below. You will see that as far as their credentials are concerned, in relation to their administrative colleagues, five held a university doctorate and most of their primary professional qualifications were a Fellow or Member of the Royal College of General Practitioners (FRACGP or MRACGP) or Fellow of the Royal Australian College of physicians (FRACP). As stated earlier, understanding their backgrounds is just as important as understanding those of their rivals. While one or two had an excessive array of medical credentials, most significantly absent was any type of military or chivalric insignia in front of their medical letters. The majority did not display excessive membership credentials from different colleges, and the most frequently stated reason for wanting to become an academic was they wanted to “make a difference”. For example, Kamien (2003, p.3) points out, these founding Professors’ outlook and that of their departments were mainly influenced by their personal history and whether or not their university already had an active Department of Public Health. He states:

Four of the nine came from a background of general practice, three from primary health care in developing countries and two were specialist physicians with experience and interest in public health. Six had held sub-professorial university appointments and one had been a full-time hospital administrator…. Three of the new professors had started their careers in general practice in New Guinea, and two had worked closely with Aboriginal communities in New South Wales. Four had been active in the politics, research committee or examination of the RACGP and two had been state presidents and federal councillors of the Australian Medical Association. (ibid.)

Below is a summary of some issues dealing with the wider impact and limitations of these developments over the last three decades (see Kamien, 2003; Mudge, 2003; Van Der Weyden, 2003).

* All medical schools now have a general practice division and the number of full-time professors has risen from 1 in 1977 to 15 in 2003. (Kamien, 2003);  

* A General Practice evaluation program became available in the 1990s, allowing opportunities for individuals to pursue Doctoral or Masters degrees. However opportunities for GPs in academic research and teaching are limited and difficult to achieve. Scholarship arrangements, such as those of the NHMRC,
are not appropriate either in terms of support or reimbursement (Mudge, 2003, p.3).

* A Primary Health Care Research Evaluation Development Unit has been established and funded by the Commonwealth government. Two of its aims are to support and develop a research culture for primary care researchers and practitioners (“Primary Health Care”, 2004, p.1).

* While general practice as a discipline is now represented on NHMRC Assessment panels, as well as on the Committee of Deans of Medical Schools it is not represented on the higher level or on the Council itself [italics added] (Mudge, 2003, p.3).

Table 6.3. *Foundation Professors in General Practice and Community Medicine in Australian Medical Schools -1975-2003*

<table>
<thead>
<tr>
<th>Name</th>
<th>Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Max Kamien</td>
<td>MD, FRACP, MRCP, FRACGP, DPM, DCH General Practice Western Australia, 1977– 2003</td>
</tr>
<tr>
<td>Jean Norelle Lickiss</td>
<td>MD, MRACP, FRCP, BMedSc, DTM &amp; H Community Health Tasmania 1975-1983</td>
</tr>
<tr>
<td>James Geoffrey Ryan</td>
<td>BSc, FRACGP Community Practice Queensland 1975-1986</td>
</tr>
<tr>
<td>Ian William Webster</td>
<td>MD, FRACP Community Medicine New South Wales 1975-2001</td>
</tr>
<tr>
<td>Ross Wharton Webster</td>
<td>FRACGP, MRACP Community Health Melbourne 1974-1989</td>
</tr>
</tbody>
</table>

(Kamien, 2003, pp.9-10)
Internationally, WHO has now defined generalists as being the new “Frontline Doctors of Tomorrow”. This is what they have called “The Five Star Doctor” who is care provider, decision maker, communicator, community leader and team member (see WHO-WONCA 1994 Conference, 1994, p. 43; WHO, 1996, p.1). The description of these roles is set out in Table 6.4 below. Hopefully, this vision of the new doctor of tomorrow will include a caution against doctors again seeing themselves as an elect.46 Again, a consideration of the ethics underpinning these practices needs to be documented.

Table 6.4  
WHO Doctors for Health: A global strategy

<table>
<thead>
<tr>
<th>The five-star doctor</th>
<th>* * * * *</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care provider</strong></td>
<td>who considers the patient holistically as an individual and as an integral part of a family and the community and provides high-quality, comprehensive, continuous and personalized care within a long-term relationship based on trust;</td>
</tr>
<tr>
<td><strong>Decision maker</strong></td>
<td>who chooses which technologies to apply ethically and cost-effectively while enhancing the care he or she provides;</td>
</tr>
<tr>
<td><strong>Communicator</strong></td>
<td>who is able to promote healthy lifestyles by effective explanation and advocacy, thereby empowering individuals and groups to enhance and protect their health;</td>
</tr>
<tr>
<td><strong>Community leader</strong></td>
<td>who, having won the trust of the people among whom he or she works, can reconcile individual and community health requirements and initiate action on behalf of the community;</td>
</tr>
<tr>
<td><strong>Manager</strong></td>
<td>who can work harmoniously with individuals and organizations inside and outside the health care system to meet the needs of patients and communities, making appropriate use of available health data.</td>
</tr>
</tbody>
</table>

(World Health Organization, 1996, p.8)

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46 I thank Mick Campion for his remarks on this issue.
A consideration of ethics

The concept of “rights” has again found a meeting ground with religious ethics as well as those sharing a liberal political philosophy (Veatch, 1989, pp.14-15). As shown above, it has been noted that, generalists who brought a humanist ethic with them, inspired an “Australian spirituality” and goodwill which was evident in the attitudes of doctors and politicians in the post-war period, but was severely constrained until the 1970s when the medical counter-cultural movement found political support.

As highlighted earlier, the first major interest in medical ethics in the English-speaking world appeared in the 18th century at the Edinburgh University medical faculty. At this time, John Gregory established an all-embracing medical ethics in his Lectures on the Duties and Qualifications of a Physician (ibid., p.9). These ideas were not as reliant on the Hippocratic tradition as they were on the broader philosophers, such as David Hume and Frances Hutchinson. The medical ethicist, Veatch (1989), has not related this event to what he calls the “Protestant” tradition, but because of the wider influence of John Gregory on the shaping of the Edinburgh University medical faculty and his close association with William Cullen, these ethics should actually be regarded as continuing the foundation of this essentially humanist tradition originally coming from the Universities of Salerno and Padua and continuing under Protestant influences.

The “patient rights” movement historically has had an affinity with such ethics, especially since the 1930s when there was a widening of Protestant thought regarding contraception, abortion and sterilization (Veatch, 1989, pp.15-16). For example, while until the 1960s, contraception was a forbidden practice in Australia, one general practitioner and his partner working in a rural practice used to encourage farmers to have vasectomies, convincing them their marital relations would not be affected (Gates, personal communication, September 9, 1994).

The difference between humanist ethics and the ethics of chivalric brotherhood in the following chapter is that in the latter the patient or community is an absent referent. It was the humanist ethic integrally related to the generalist tradition that essentially made doctor/patient relationship one between a “gaze and a face”, making patient rights to speak intrinsic to the medical encounter.

47 Veatch (1989) has not made this connection to the Protestant tradition which I later talk about. However, as far as I am concerned, these cannot be separated.
As shown above, the wider impact of these influences has been demonstrated in different ways. Sometimes, the association between the Scottish and Australian general practitioners has been used to bring home a point about the tradition of community or patient-centred practices. For example, the title of a book A’body’s body published by the RACGP stressed nobody was “too good” for such a job (see Winton, 1983). Perhaps another example is the emphasis on “communication” with the patient as well as in the ethics reflected in the College’s philosophy which guards against doctors entertaining notions of superiority and arrogance. They state:

It seemed to us that while structure is important in any enterprise it is the attitude of those involved that really counts. The humility in the “upper” echelons of College personnel is paramount – as distinct from arrogant (if unconscious) manipulation of friends and colleagues (sic.) (Anderson et al. 1990, p.5)

In sum, although there have been many changes within Australian medical schools, the generalists are still battling for a medical system supporting primary medical care which is integrated with hospitals and laboratories as well as the population. This is a battle still seen being fought on a number of intellectual fronts internationally as well as in Australia. Changes within the public health field in NSW were influenced by Kerr White who recommended multidisciplinary rather than purely medical approaches (see Palmer and Short, 1991, p.152). The trouble is the soldier tradition is still metaphorically speaking “set in stone”. As Kerr White (1991, p.xii) states:

Since the days of Robert Koch, medical research has been synonymous with wet bench laboratories. The owners of these laboratories have even arrogated the term “basic” for their particular approaches to understanding those manifestations of the human condition we call disease. What they do is assuredly of fundamental importance, but there are other approaches to knowledge and understanding that can be regarded as equally basic

As far as human rights are concerned, by 1988 it was clearly evident the goal of Health for all by the year 2000 was far from being attained. So in 1995, the Health for All slogan was reinforced by a resolution taken by the 48th World Health Assembly (WHA) calling for a reorientation of medical education and medical practice to meet community needs. The Director-General requested a report on the reorientation of education and practice of nurses, midwives, and other health providers. As pointed out earlier, WHO has also recommended that all research and discussion on any health issue should embrace the topic of human rights as a cross-cutting activity (WHO, 1996). It is
within these parameters that these reforms should be judged and within a framework which recognizes differences as being socially, ethically as well as medically motivated.

Maybe the most common denominator for assessing the effects such changes might bring is to ask where a future medical workforce will take us or where will we be taking them. Is there any value in reinventing the “family” doctor and reintroducing notions of ethics, compassion, empathy and human rights? Although there have been many changes within Australian medical schools, the community doctors and generalists are still battling for a medical system supporting primary medical care, a system which has always had the capacity to work with those specialists whose domains are the hospital and the laboratory. As Duckett, (2004), like many others before him, has pointed out, a state of affairs that is likely to increase the costs in the secondary and tertiary care sector, is having a weak primary care sector. It not only means health problems are not detected early, but also leads to unnecessary pain and suffering for individuals and their families. Foucault (1973, p.18-19) pointed to the criticism made by French economists of the hospital and its research foundations and the money they attracted through fund-raising which he called “assistance”.

Also, apart from human need for economic and social security, even in early civilizations, basic principles included the recognition of the fundamental relationship between health and social status together with the need for safe drinking water, sanitation and good food (Lawson, 1991, p.4).48

Other considerations

There could be much more said about other programs and policies produced by generalists, but it is important to end with a reassessment of what is happening in 2007. First of all the generalist workforce is being feminised by younger women doctors working in hospitals and in general practice mainly on a part-time basis (ABS, 2003). Secondly, the general practitioner workforce is currently being limited by minimising the number of provider numbers issued (ibid.). Thirdly, there is an increased emphasis by government bodies and other medical and health professionals for, once again,

48 There is no shortage of literature on the subject of Aboriginal health status, but some Ministers, such as Dr Michael Wooldridge, in the past have treated Indigenous health issues as victim-blaming behaviours such as ‘smoking’ (Zinn, 1997). Bartlett’s (1999) PhD thesis was on the history of Central Australia and specifically the development of the Northern Territory health services. He argues that there is a correlation between the persistent extant colonial relationship, poor health status and destructive behaviours.
limiting the generalist influence by reshaping the medical workforce using the new jargon of “task substitution” and promoting the “UK Skills Escalator” as a model of a new career framework for doctors (Ellis, Robinson and Brooks, 2006, p.1). It is not surprising that the hierarchical nature of this Skills Escalator is more like an army ranking. For example, the authors state:

The Skills Escalator is a nine-level career framework that starts with supporting roles then moves to assistants and senior assistants, assistant practitioners, qualified practitioners, senior or specialist practitioners, advanced practitioners, consultant practitioners and, finally, more senior posts. It provides a wide variety of entry points into health care careers, encourages and recognises lifelong learning and acquisition of new skills, and is used in an environment that seeks both job satisfaction and service efficiencies by “delegating roles, work and responsibilities down the escalator where appropriate” (ibid).

To justify their stance, the authors have used Adam Smith’s (an 18th century economist) argument that “all professions tended to form self-interest groups and generally “conspire against the laity” (ibid). They therefore see their job as reorganizing the “ego systems” so as to redesign (and test) a new health system that is “patient focused” and “provider friendly”. They are also actors involved in a process of meso-corporatism which will be explained in the next chapter.

Conclusion

In the above, I have shown that, since the 1950s, Australian generalists formed links with other reformists in the international sphere and were influential in translating their needs into political action in the early 1970s. This period marked the beginning of the fragmentation of the Australian medical profession into primary, secondary, or tertiary care physicians. This fragmentation was also reflected in differential access to resources, decision making bodies, international networks and goals in a system which valued the need for specialism and laboratory research over the needs of community.

The Whitlam government was committed to social reform and supported a counter-cultural movement involving doctors. In postgraduate education in 1973, the RACGP was given resources to establish the FMP for general practitioners and by 1994 were international leaders in this area. In Australia, these doctors battled for 20 years to

49 All these authors are from the University of Queensland. Ellis is Director of the Centre for Military and Veterans’ Health, Robinson, is Director for the Centre for Health Innovation and Solutions and Brooks (who has become the most vocal on these issues) is the Executive Dean of the Faculty of Health Sciences.
establish a Vocational Guidance program to encourage postgraduate training for general practitioners linked to financial incentives through the Medicare agreement. Also the RACOG was incorporated in 1979. Both these colleges introduced a mandatory goal of commitment to life-long learning and/or recertification examinations for practising doctors.

As far as undergraduate education was concerned, I have drawn on David Maddison’s “tale of two cities” as a parallel to my “tale of two archetypes” to show the essential differences particularly around Cartesian mind/body dualisms. I have also shown the reorganization of new medical faculties and divisions once again projected an egalitarian rather than an authoritarian/hierarchical structure as well as separating disciplinary interests of lecturers from the subject matter actually taught. Communication was considered a key element in the doctor/patient relationship. Changes were also made in the selection processes of students to make medicine more accessible to disadvantaged groups and to introduce notions of compassion and empathy. The virtues and strengths of Aboriginal as well as women’s knowledge were both elevated.

Also highlighted was that, until 1958, many WA doctors were educated in Adelaide and showed the effects of these influences on their outlook and practices, especially the leadership role played by those in the Department of General Practice in WA. In other medical schools, Chairs of Community medicine or General practice were “add on” models within extant medical faculties with seemingly the same attitudes to those at Sydney. These met with hostility and marginalisation from the established status quo. Now, about 15 years since their inception, definite inroads have been made to elevating general practice academically, linking it to patient-centred practices, as well as providing new postgraduate degrees and research streams.

The dismantling and restructuring of the Sydney Medical Faculty in the 1990s could be seen as symbolic retaliation to the treatment meted out to David Maddison, which has been somewhat similar to experiences of generalists in other medical faculties across Australia. More recently there have been waves of reform within medical education across Australia that need closer scrutiny as to the type of doctor each hopes to produce. However, despite reforms, medical faculties will be caught up within the dilemma of trying to produce a broadly-competent doctor who can
communicate with his/her patient, while at the same time, trying to create viable career options within the hegemonic medical system.

The previous ideal of a broadly-educated general practitioner with a “specialty of interest” and a commitment to life-long learning was one more attuned to attending to his/her own intellectual interests, while at the same time providing both rural and urban communities with services. This type of doctor can only re-emerge if there is once again a flattening of the constructed hierarchies and a broadening of options for flexible rather than narrowly defined career structures. A profound restructuring of the present health care system cannot be carried out in isolation from an acknowledgement that the type of doctor that emerges will be one meeting the needs of predominant medical, social, political and economic interests.

In assessing the present in terms of the past, the measure, of course, is how much of a role will reformers be able to play in trying to bring about structural change. Concerns for Indigenous health status, those of women, migrants, refugees and their children, as well as other marginalised or underprivileged groups will remain a critical measure. The key to understanding the resistance of the status quo to any notion of autonomy of general practitioners and also a resistance evident within much of the specialist workforce itself is to realise, as Willis (1989) stated, specialty interests arose alongside the rise of corporate interests in health in Australia.

The trouble is until people lose faith in the specialist as the “real” doctor and fully understand the implications of turning to generalists willing to promote primary health care and structural change as crucial to health outcomes, as in the past, such a doctor will remain situated outside positions of power and influence. Until the definition of a “real” doctor is changed, generalists, like others whose values and ideals do not sit well with right-wing political views, will remain continually marginalised.
CHAPTER SEVEN

The front-line sentinels of biomedicine: the heroic genre in contemporary Australia

The Committee concludes… that the medical practitioners and profession of the coming century must be so educated, organised and compensated for their work that they will regard (the lay submissions) and the pressures for change which it represents – as requiring serious attention [italics added] (Australian Committee of Inquiry into Medical Education and Medical Workforce (ACIMEMW), 1988, p.77).

Introduction

The text above associated with the heroic genre is taken from the report of the Committee of Enquiry into Medical Education and Medical Workforce (1988). This was chaired by a Professor R.L. Doherty, Emeritus Professor of Social and Preventive Medicine, University of Queensland. This Committee documented that the general practitioner workforce was considered as a site to be exploited by their trainee specialist locums, a practice which has earlier been shown to be found unsafe and unethical by their generalist counterparts. Leading doctors of this genre still consider themselves as operating on a distinctively higher social plane than others, including other doctors. They are looked upon as “experts” from their association with the “heroic” camp whose job it is to address medical research needs and/or “manpower” problems.

The heroic genre now associated with those who call themselves physician-executives or managers and administrators, stand as sentinels at the front line of the medico-industrial complex. As stated above, they remain convinced they are owed a debt by the community for their “life-saving” ventures and their “miracles” and look for medical responses to social problems.

The soldier influence on public health administration and management as well as on laboratory-research was reinforced by the fact between 1930 and 1968, most Directors of Health were soldier doctors. The effects have been that, in the contemporary period, the public health system still seems to be more than subtly influenced by Sutton’s ideas linking intelligence to heredity and genetic susceptibility to

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1 The word *locum* is a Latin word which in military circles is used to mean *lieutenant* (see Mills, 2000)
2 Details will be found in chapter five in regard to Adelaide practices.
3 This is similar to some recent strategies adopted in Australia, such as addressing the issue of youth suicide by providing more psychologists, rather than investigating the underlying cause.
class location. Even in the 1980s, the contribution of the school’s expertise was still regarded as invaluable in training the 1,745 medical officers in the armed services. Later the school trained administrators to be employed in government health facilities defined as “community health care”, covering such areas of drug use and abuse, controlling pollution, smoking and alcoholism (see “School”, 1980, pp.11-12).

In this chapter, I will concentrate specifically on explaining the extensions of the heroic genre and its influence from the 1970s onwards. Especially in the era of “new” genetics continuities as well as the discontinuities within national institutions and their extensions into other policy areas are highlighted. Some of these are immigration, mandatory detention, Aboriginal health and medical experimentation.

As shown from the outset, the medical system influenced by the soldier has never had a policy designed for meeting the needs of the Australian population other than those dictated along the lines of the authors of “social” and “preventive” medicine. Providing health care to the community was regarded as a burden rather than a duty. Although soldier surgeons moved forward with technological innovation and “life-saving drugs” to support them, the mental outlook of leaders reflected the atavistic bent of those in chivalric orders and other fraternities.

By the same token, I also argue the policy direction prevailing in the 20th and 21st century still promotes a “preventive” medicine underpinned by genetics. The partnership forged between those in the university, the laboratory and the hospital is central to its existence, an existence where community-oriented servicing generally, as well as empathy for the disabled, the mentally ill, the poor, the Indigenous, have no place. These actions might take on more meaning if one argues previous public health leaders have institutionalised Sutton’s three strategies for “human betterment” into the psyche of health administrators and managers. As mentioned in Chapter Five, these were:

* progressive improvement of the worthy;
* guarding against degeneration by getting rid of the “duds”; and
* attacking the enemies of “mankind” (sic.) (Sutton, 1944, p.25).

Also, many partnerships were originally influenced by other collaborative relations formed through association with Masonic and quasi-Masonic chivalric brotherhoods. In other words the system was designed to meet the aims and interests of

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4 This term has been used by Petersen and Bunton (2002) as well as Willis (2002).
its major-generals who are replaced by today’s modern-day physician executives and other appointed gatekeepers. As part of this heroic genre, these new sentinels are seen to be again strategically placed so as to influence a network of corporate bodies, some listed in Table 7.1 below.

Table 7.1. *Federal institutions and others aligned with a heroic genre*

<table>
<thead>
<tr>
<th>Commonwealth Department of Health (CDOH)⁵</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Specialist Qualification Advisory Committee of Australia (NSQACA)</td>
</tr>
<tr>
<td>Royal Australasian College of Surgeons (RACS) and its offshoots</td>
</tr>
<tr>
<td>National Health &amp; Medical Research Council (NHMRC)</td>
</tr>
<tr>
<td>“Traditional” or specialist-oriented Australian medical schools</td>
</tr>
<tr>
<td>Australian teaching hospitals</td>
</tr>
<tr>
<td>National research institutions and laboratories</td>
</tr>
<tr>
<td>Australian Defence Force (ADF)</td>
</tr>
<tr>
<td>Australian Priory of the British Order of St John</td>
</tr>
</tbody>
</table>

As such, the mindset remains frozen in the past, as if nothing has changed over hundreds of years. Over the past century where there have been periods of crisis, these have been accompanied by attempts to exert control over fertility through opposing contraception and abortion, and through taking coercive or aggressive actions showing an extreme insensitivity to more vulnerable sectors of the population. On such issues, the propagators seem to remain in the background by allowing others to take the frontline.

The vestiges of this legacy is seen to have continued on several fronts, the most important one in terms of this chapter is the way that, in the contemporary era, the control of medical knowledge has been maintained by a status quo which has formed a bridge across the hospital, the laboratory, the medical specialisms and research corporations. Apart from the specialist arena, the heroic genre has transformed eugenics into the “new genetics” where the colonisation quest has not only become hidden in the microscopic world of the laboratory but has also entered into discourses on “public health” (see Petersen and Bunton, 2002; Willis, 1998, 2002).

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⁵ This department periodically changes its name.
Apart from an abundance of sociological critiques about health policy, medical practices and inequalities (see Willis and Broom, 2003), the rationality, economics and science-fiction nature of Australian medical developments since World War II were also critiqued by reformist doctors returning to Australia in the 1970s (see Taylor, 1979, p.3). Even years later, the extension of science-fiction into medicine has not abated, but has been accompanied by a language of “total war” against “selfish genes” which has become part of the language inserted into medical text books in microbiology and immunology (see Waldby, 1996, p.1). As Waldby (1996, p.1) states, as far as those working in these disciplines are concerned:

The microscopic world is on a mission to colonise the human, to render the human body an extension of bacterial and viral interests. This apocalyptic mission, favourite theme of science-fiction cinema and horror fiction, also motivates the rhetoric of the most sober microbiological and immunological textbooks which … regularly evoke a vision of genetic colonisation in their opening paragraphs

In sum, the main characteristics of this heroic genre were that its actors evolved out of a tradition which not only taught them that they were owed a considerable debt by the community, but also that they had a shared ethic of chivalric brotherhood and saw themselves akin to gods creating a pure” and “white” Australia. This vision of them also created the medical “other” of doctors as the enemy which was defective in some way. These values shaped the organizational structure of the specialist division of labour, which excluded generalists and overseas-trained doctors completely, and limited the entry of women and trainee specialists. Such attitudes seem to be replicated in the way different sectors of the population were treated. In Table 7.2 below, some benchmarks of this era are also listed.

**The CDOH and its health generals and lieutenants**

Even during the Whitlam era, institutions shaped by the soldier tradition began to expand to reflect a medical system forged between surgeons and public health

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6 At the time, Dr Richard Taylor was an active member of the Doctors Reform Society which he joined in 1975.
Table 7.2. *Some benchmarks affecting the heroic genre of doctors associated with secondary and tertiary-oriented services, 1970 –2004*

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>National Health Act (1970) gives additional remuneration to specialists over generalists who carry out the same surgical procedure.</td>
</tr>
<tr>
<td>1972</td>
<td>National Specialist Qualification Advisory Committee of Australia (NSQACA) established as gatekeepers of Act and definers of what can be called a “specialism”</td>
</tr>
<tr>
<td>1971</td>
<td>50 years “flash-back” to inception of the CDOH quotes Dr Harry Allen’s eugenic sentiments about preventing the reproduction of the “unfit”.</td>
</tr>
<tr>
<td>1971</td>
<td>Era of Laboratory – National Health &amp; Research Medical Council (NHMRC) reassert act of faith that “real medicine” is laboratory-oriented</td>
</tr>
<tr>
<td>1971</td>
<td>Beginning of research on acoustics, ultrasound, and other technology related to needs of the Australian Defence Force (ADF)</td>
</tr>
<tr>
<td>1975</td>
<td>Pathologists begin to receive payments under Medicare</td>
</tr>
<tr>
<td>1975</td>
<td>Australian Association of Surgeons (AAS), a body representing political, financial and industrial interests of surgeons which is aggressive in nature. It challenged AMA leadership as it perceives AMA compromise interests of specialists in interest of negotiated peace. In 1985, a vigorous role negotiated with government: high profile.</td>
</tr>
<tr>
<td>1977</td>
<td>STM &amp; PH is changed to Australian Institute of Health (AIH) with seemingly more progressive ideas relating to national health policies.</td>
</tr>
<tr>
<td>1986</td>
<td>College of Pathologists gain “Royal” prefix (originally established 1956) Developments in CT Scanner, MRI technology and Ultrasound.</td>
</tr>
<tr>
<td>1996</td>
<td>Peter Doherty, Queensland veterinarian and experimental pathologist, shares Nobel Peace Prize with Swiss colleague.</td>
</tr>
<tr>
<td>1996</td>
<td>Production of the last “magic bullet”, Viagra.</td>
</tr>
<tr>
<td>1996</td>
<td>ADF’s need for doctors diminished with new need for experts in the field of Information Technology. Australia is still regarded by USA as “catching up”.</td>
</tr>
<tr>
<td>2000</td>
<td>The Australian Centre for International and Tropical Health and Nutrition (ACITHIN) becomes a new Federal body located in Queensland. Defines laboratory research trials as “primary health care”. Once again, issues such as alcoholism are seen to be connected to genetic predisposition.</td>
</tr>
<tr>
<td>2004</td>
<td>“Jewels in the Crown”: an evaluation made of the most popular research articles. The criteria for the Nobel Peace Prize have recently been questioned. There is a need for sociological research on this topic.</td>
</tr>
</tbody>
</table>

Administrators as recommended by Sutton (1944) earlier. This elite caste sustained historical proclivities which never lost their patriarchal, xenophobic and anti-feminist stamp. They also did not appear to lose their belief that eugenics was an instrument of social control. Such values informed the definitions they continued to give to “public health” and “social” and “preventive” medicine.

Again in the 1970s such values were reflected within the Commonwealth Department of Health (CDOH). The “speech” within such circles encompassed anthropomorphic ideas of “infection” controlled through practices of segregation, quarantine, immigration control, institutionalisation and other exclusionary practices inspired by the esoteric inclinations of a “secret” medicine. Such influences were not
lost on Foucault (1973), even though he was speaking of 18th century France. The 21st century emphasis is on social control of infection from disease as well as on surveillance of cells, viruses, germs, and genes. He states:

This … (medical) esotericism is different in structure, meaning and use from that which made…doctors speak in Latin: then it was simply a matter of not being understood and of preserving at the level of linguistic formulation the corporate privileges of a profession; now operational mastery over things is sought by accurate syntactic usage and a difficult semantic familiarity with language. Description, in clinical medicine, does not mean placing the hidden or invisible within the reach of those who have no direct access to them; what it means is to give speech to that which everyone sees without seeing – a speech that can be understood only by those initiated into true speech.” Whatever precepts are given about so delicate a matter, (they) will always remain beyond the reach of the multitude” (ibid, 1973, p.115).

This emphasis helps distinguish a shared ethos of a contemporary heroic genre whose medical specialties were linked to hospital and laboratory-based practices supported by legislation. The medicalization of the idea of “White Australia”, along with its patriarchal and military and imperial dimensions, not only affected the structure of the medical workforce, but also had a number of wider ramifications which continued to flow into the contemporary era.

Well into the 1980s, the CDOH status quo was maintained by the appointment by a heroic genre of executive officers. These physician-executives appeared as high ranking doctors of the “secret” service types again distinguished by their traditional practice of placing a conglomeration of initials after their names with their military and/or chivalric insignia taking a primary place. The “lieutenants” who manned the state offices were those with a medical or science degree and a Diploma from the SPH & TM. Especially during this period, the links between the army, navy and air force and research priorities were most visible and, as these were the years the biomedical corporate system began to take shape in Australia, one need to look at developments more closely.7

As shown in Table 7.3 below, Dr (Sir) William Refshauge, was a Knight of the Thistle (Kt or KT), a CBE, with an Efficiency Decoration (ED). His medical degree was the undergraduate degree of BM., BS, with other letters representing his election as a Fellow of several Royal Colleges, namely FROCG, FRACS, FRACP, and an Honorary

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7 As stated, apart from those mentioned previously, there has been little historical work on the shaping of Australian medical systems.
Fellow of the Royal Society of History, (Hon. FRSH). Sir William was also an officer of that year’s constituted World Health Assembly (WHA) and Chairman of the NHMRC (“People, 1971, p.34; “How the committees work”, 1972).\(^8\)

The person directly under Sir William was the Federal Director of Health, another doctor, a Dr R.H.C. Wells, also with an impressive array of letters. A proliferation of credentials displayed by chief executives may have been the symbolic continuation of some kind of ritual acceptance into membership of a selective caste. While Wells had no chivalric insignia, sometimes this is only received after passing through some ritual rite of passage which possibly had its analogy to initiation on the battlefield. In this instance, Sir William’s successor, Dr Gwyn Howells, was only awarded a CB after many years in the public service (“Director-General”, 1979, p.9).\(^9\)

In the decade between the 1970s to the 1980s, the journal of the CDOH entitled *Health* gave many illustrations of joint ventures between army, navy and air force and health research priorities, some of which are referred to later in this chapter.\(^10\) Even with changes from Liberal to Labor governments during this period, this department’s top executive positions appeared to remain linked to the soldier status quo, or at least to the continuity in training health administrators with a diploma from the SPH & TM. In addition, like the role of NSQACA as gatekeeper for funds expended under Medicare, there was a marked bias to funds meted out by the NHMRC,\(^11\) as well as a distinct reluctance to change the basic ethos of those who laid the foundations of their policies during the 1930s. As in the case of awards given to the post-war Liberal Prime Minister and imperialist, Sir Robert Menzies, it also seems these credentials were symbolic of some kind of ritual acceptance into membership of a selective caste.

Although these health officials took part in international health assemblies, such as the WHA, it should not come as a surprise the CDOH, reiterated its eugenic

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\(^8\) The women mostly depicted in the *Health* issues were unmarried mature women or veiled nuns. For an example, see “Health people” (1971, pp.34-35). As far as Aboriginal people were concerned, in 1973 they were depicted naked and referred to as “unsophisticated and primitive” (see “Co-operating with:”, 1973, pp.12-14).

\(^9\) As shown earlier Dr Howells joined the CDOH in 1966, first working in the Thoracic annexe of the Toowoomba General Hospital. The Thoracic Annexe was also the site of the first Federal laboratory which was established in 1927.

\(^10\) This appears to have been an “in-house” journal not available for purchase by the public.

\(^11\) In 1994 reviewers of the NHRMC, although stating that funds of $110 million were distributed reasonably well, they pointed out that its agenda remained based on the “old public health of chemicals, air and water quality, poisons, foodstuffs and waste management”. The “new public health” is based on issues of “inequality, housing and environment” (Ragg, 1994, p.591).
proclivities when it celebrated its 50th anniversary in 1973, a time when its journal articles reproduced some “fascinating extracts from its first issues” (“Fiftieth,” 1973, p.17).

Table 7.3. *Credentials of CDOH Executive Officers, 1970-1981*

<table>
<thead>
<tr>
<th>Position</th>
<th>Name, Title, Honours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director General of Health</td>
<td>Sir William Refshauge, Kt., CBE, ED, MB, BS, FROCG, FRACS, FRACP, Hon. FRSH</td>
</tr>
<tr>
<td>Deputy Director-General of Health</td>
<td>Dr R.H.C. Wells, MD, MB, BS, BSc, MRCP, MRACP, DTM &amp; H, DCTM, FRIPH.</td>
</tr>
<tr>
<td>Director General of Health</td>
<td>Dr Gwyn Howells, CB, MB, BS. FRCP (Lond.), FRACP, FRACMA.</td>
</tr>
</tbody>
</table>

(“Health People”, 1971, p.35)

For example, one text says as much about the authors whose decision it was to print these extracts as the extracts themselves. In this case, such views were articulated in a reprint of an inaugural speech given at the opening of the department in 1923 by a Professor Sir Harry Brookes Allen, Professor of Descriptive and Surgical Anatomy and Dean of the Melbourne Faculty of Medicine. As a well-known promoter of eugenic principles, like others of his time he saw alcoholism and sex as “two great social evils” and proposed the most important need was for research (Allen, 1923 cited in “Fiftieth”, 1973, p. 17). As far as the behaviour of people was concerned, his words reflected that of a monk rather than a doctor when he states:

A general awakening of the public conscience is necessary… *The essential remedy lies in purity of life, in discipline of the body, in self-restraint taught from the cradle, in the culture of true manliness and womanliness* [italics added]. Let warnings be given at appropriate times. Provide fully for the cure of the infected. But do not extend further the obsession of sex. Existing legislation is good, and may be strengthened, but the root of the matter lies with the individual (ibid, p.17).

Professor Allen, like other “soldiers”, also believed educational campaigns should be intensified so as to control infection and protect the “public health”. His following words place him in Lendon’s (c 1935) mould when he referred to Deans in those years as being “benevolent despots”. For example, Allen (1923) argues:
Give us better medical schools, build up institutes of research, popularise the theory and methods of preventive medicine. Teach the people to control typhoid, to avoid tubercle, to recognise the first stages of cancer. Finally, let us remember that all our health work may but insure the deterioration of the race, unless we find the means, with wisdom and kindness, to prevent the multiplication of the unfit [italics added] (cited in “Fiftieth”, 1973, pp.15-17)

The point to be made here is that not only was Allen one of Professor Harvey Sutton’s culture-heroes but also these words was reiterated in 1973 as something to be valued rather than hidden. The nature of esoteric influences on both Howells and Everingham, both CDOH officers, are outlined below.

In the 1960s, Howells’ colleague, Dr N.L. Everingham, had worked with the infamous Dr Cecil Cook in the NT. The Federal Minister for Aboriginal Affairs had previously accused Everingham of mounting a publicity campaign to get Aboriginal people to submit themselves to sterilization in order to reduce their numbers. Everingham denied this charge and claimed he only wanted to teach Aborigines “such things as hygiene” (Haebich, 2000, p.591). One can only assume, like most “service” types, these health officers had been affiliated in some way to esoteric and/or chivalric orders, but proof of involvement is elusive. Rather than leave certain details out for lack of tangible evidence, readers need to draw their own conclusions about the following observations.

In 1973 two new laboratories were opened at Toowoomba and Albury when Dr. Everingham was Minister of Health and Dr Gwyn Howells, Director-General of Health. Both these doctors were involved with WHO, namely they were part of the WHA Executive Board which had 24 members who met twice a year to direct policy (“W.H.O.”, 1975, p. 26). Both doctors shared an interest in pathology. In keeping with the characteristics of British military medical practices, as the guardians of the “secret”, the Federal laboratories, like the laboratory at Toowoomba, had been placed in geographical isolation from mainstream communities.

Toowoomba displayed a definitive insularity and secrecy about its research, previously shown in 1966 when a large-scale pilot diabetes survey was conducted there under the direction of the NHMRC, and where collection and analysis of all blood samples were carried out by solely by its own laboratory staff. At this time, two events occurred. Firstly, Dr Howells left Toowoomba to become a Commonwealth public servant and, secondly, the Toowoomba laboratory became recognised by the Royal
Australian College of Pathologists as a training laboratory (“Toowoomba”, 1975, pp. 33-34). While there is no such history pertaining to the Albury laboratory, it had been established in 1948, destroyed by fire in 1971 and temporarily set up at Albury Base Hospital until the new one was built (ibid.).

Anyway, for the CDOH, 1971 marked the era of “laboratory medicine” leading to these two laboratories being rebuilt, with Dr Everingham performing the opening ceremony for both. In carrying out this function, his apocalyptic sentiments became immediately discernible when he pointed to the analogy between the phoenix and the laboratory as both sharing an “immortality”. In this case, Everingham (cited in “Toowoomba”, 1975, p. 34) offered the following explanations:

* The phoenix was considered a sacred bird of the Egyptian sun worshippers, immortal and indestructible, resurrecting itself each lifetime from the ashes of its former body with increasing stature.

* The laboratory might not have arisen “from the ashes” but at least from the “burnt-out shell of its former shape”. It was “immortal” because pathology and medicine could never be divorced and this relationship therefore could never fade away.

From the above, one could surmise the shaping of this medical system has, for some, subtly left its covert esoteric stamp with the hidden belief the “secrets of nature” could be discovered from pathological investigations made in the laboratory. Doctors who shared Dr. Everingham’s sentiments were an inner circle called “the medical profession” by the CDOH.

While many of this “medical profession” selected as State Directors usually had “lesser” credentials, such as a medical or science degree and a Diploma, such as the DTM & PH, occasionally one could identify a state Director with chivalric insignia as well as postgraduate medical qualifications being appointed. This was especially true in the NT which, in 1978, began to take over responsibility for its own health services. The CDOH’s Director of the NT division was a Dr. C.H. Gurd, CBE, OStJ and MD and an elected Fellow of a number of Colleges (“Commonwealth”, 1978, back cover). Like many other former public service staff, he later was offered a position and became Secretary of Health in the new NT DOH in 1979. No doubt with the previous military

12 The presence of the United Masonic Orders in Australia up until the 1980s and its connections to the Order of St John has been documented (Smyth, 1991). However, no information is forthcoming about how strong the links remain between these Orders today and doctors are a minority group within Craft Freemasonry.
control of Royal Darwin Hospital and the aerial medical services in the RAAF, the Territory had a strategic role to play, as did the Order of St John. For example, a CDOH journal article states:

The Northern Territory Department of Health has exclusive policy and operational responsibilities for pathology laboratories in the Territory and has taken on the responsibility for disaster relief planning and the provision of relief in the Territory in the health field. It will keep the Federal Divisional Office informed of disaster relief plans so that the Federal (government) can maintain a national picture of possible requirements (“NT assumes”, 1979, p.1).

It was only years later with the Australian involvement in the Bali disaster that such factors came into play during a recent Federal election campaign when the Royal Darwin hospital staff’s exceptional handling of the tragedy was re-enacted in a televised report. At this time, the Liberal Prime Minister, John Howard, pledged just under $50 million to establish the Royal Darwin Hospital as a national centre which could respond to handling such “critical care” (Kirk, 2004, p.1). In the following I will show the different perspectives held by these soldier doctors to ideas of community medicine and primary medical or health care.

Community health, primary medical care and health promotion

The reformist impetus outlined in the last chapter became the catalyst for the establishment of the Community Health Program (CHP) within the wider agenda for social reform which continued to operate at state level (see Baum13, Fry and Lennie, 1992, pp. 1-3, Milio, 1984). One reason the CHP and Newcastle both struggled was because the newly elected Liberal Government not only completely disbanded the H & HSC but also dismantled most of Labor’s health policy implementations (see Milio, 1984). However, these “community” developments could not be completely ignored particularly because of the international focus placed on the benefits of widening health policy directions, especially after the Alma Ata Declaration of 1978 referred to earlier (see Owen and Lennie, 1992).

For this next government, the meaning of “innovation” did not have anything to do with a system of health and medical care based on primary health or medical care, but instead seemed to have something to do with a system which incorporated practices of an elite brotherhood. While, as shown, there was a severe political backlash at Newcastle, a backlash also occurred where doctors in CHP’s were seen to be successful,

13 This is F. Baum and is to be differentiated from P. Baume referred to earlier.
such as in Victoria, SA and the ACT (Copeman, 1992, pp.173). Both in Australia and overseas, it has been shown providing primary medical care reduces the stress on hospitals without any overall increases in health expenditure. However, until today this idea is still contested by the organized medical establishment, not really understood by general practitioners themselves and ignored completely by the present government (see Copeman, 1992; Duckett, 2004). Doctors who choose to provide primary medical care within community health centres were seen by some as threatening the survival of the hospitals (Copeman, 1992). Also, even though some reformist doctors themselves recognised the conservatism within the profession, they sometimes see themselves as being part of the same “system” of biomedicine, rather than as a counter-culture (ibid.).

On the one hand, at one point, the generalist genre was moving forward comfortable with new local and international trends and pressures for change, while, on the other hand, those in the upper echelons of the heroic genre remained uncomfortable with changing trends and reverted to their older networks and monastic proclivities. In turn, changes occurring within medical education and community health programs embodied new concepts and different interpretations on ideas about health and medical servicing, particularly those related to “community”, “primary health care” and “prevention”. The confusion this invoked enabled dominant voices to promote a sense of “moving with the times” so as to present a sense of homogeneity in outlook. For example, in terms of health promotion, Fry and Baum, (1992, p. 302) state:

The two dominant positions in the debate about (health promotion) have been . . . the view that individuals can be held responsible for their own health versus the role of the social and physical environments in shaping people’s actions that influence their own or others’ health.

To understand the dynamics at work at the time, one really needs to look at the different notion of “community” created at the Federal level where its Health managers appeared on the surface to be marching in tandem with WHO health policy towards Health for All. After all, these chiefs had an image to maintain as they were executive members of the WHA. Also, while the visit to Australia of the WHO Director-General had an immediate effect on the decision to dismantle the SPH & TM, on closer appraisal its new successor, the AIH, was still a Federal enterprise. So at the same time as the

14 As Copeman (1992, p. 179) has asserted a really enlightening article on the way ahead for a “community base general practitioner was published by Hart (1984) in the British Medical Journal with the title “The world turned upside down “.

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community-oriented generalists were struggling to survive politically, professionally and financially, the Federal government took up the discourse of “community” for itself. This is what appeared to happen.

Firstly, in 1978, the AIH was provided with funds to report on the latest developments in health promotion. Entitled *Health promotion in Australia 1978-79*, the report was tabled in Federal Parliament in 1979. At the same time two senior officers were sent overseas to gain first-hand information about trends from Canada, the USA and the UK (“Emergence”, 1980, p.19). As G. Gray (1991) has pointed out, while there have been variations to timing and types of government intervention, health policy developments have followed a similar pattern in most OECD countries. Blanpain (1978) is quoted by G. Gray (1991, p.6) who asserts: “All governments in a remarkably similar sequence made the same set of responses to similar problems guided by comparable issues and influenced by similar forces and events.”

So from the mid-1970s onwards, “health promotion” units or divisions were established within Australian Health as well as in other parts of the world. However, while using the broader term, many of these programs were designed to change individual behaviour and, of course, had the capacity to become victim-blaming exercises (Baum, 1992). For example, the Director-General of Health, Dr Gwyn Howells, looked upon health promotion and health education as historically associated with the work of the National Heart Foundation and the Anti-Cancer Councils (“Emergence”, 1978, p.18). Therefore, even though he agreed health could be defined in more positive terms, such as “a state of physical and mental well-being”, he saw health promotion both as a huge dilemma and challenge. This was because, like his military colleagues, he looked upon the masses as lacking self-control and discipline (see Wrigley, 1990). As far as he was concerned, the wider population were generally not “wise men or women” of the species. Instead, they were seen as continually subjecting themselves to self-destructive behaviour, indulging in excessive food intake, alcohol and substance abuse, and unwilling to exercise. He was quoted as stating:

It should be faced that *homo sapiens* will do to himself what he would not permit to be done to his dog or any other pet. One could imagine the outcry if it were discovered that a man was subjecting his dog to excessive intakes of food, particularly sugar, salt and fats, without ever walking the animal, that he was forcing tar, nicotine and other dangerous compounds into the dog’s lungs ten or more times every day; that he was regularly injecting excessive levels of alcohol
into the dog’s bloodstream; that he was continually frustrating the animal to keep it under a high level of stress (ibid, p.18).

Consequently between 1979 and 1980, while the earlier community health programs were struggling to survive at state and local levels, the first National Health Promotion program was launched by the CDOH. Entitled Help Yourself, this program was launched after research and consultation with State and Territory health officers, representatives of key organizations such as the AMA, the Pharmacy Guild of Australia, the Pharmaceutical Society and local governments. The main product was a booklet which taught about improving diet, giving up smoking, overcoming stress, and reducing alcohol intake. It was announced as being successful not because health programs were established to help people, but only because the book received a positive community response to the idea the road to health was through self-awareness (“Emergence”, 1980, p.18). Also, one needs to read into the meaning behind Gwyn Howells’ words, when he refers to the historical nature of national involvement in preventive medicine and public health in the following statement:

This Department has long had an interest in preventive medicine and health education. In fact the Order-in-Council which created the Department fifty-nine years ago specified among its functions the conduct of campaigns of prevention, the inspiration and co-ordination of public health measures and the conduct of health education (ibid, p.19).

This detail is important because one also needs to understand where victim-blaming attitudes or ideas about lifestyles or “risk”-taking behaviour in the Australian population emanated (see Owen and Lennie, 1992; Fry and Baum, 1992). For example, in the late 20th century, the poor state of Aboriginal health would be seen as a result of their own smoking, drinking or some such behaviour. The same can be said about notions “community health innovation” to which I now turn.

Several articles devoted to the topic of “community health” innovation were published in Health (1980) where one finds the “knights” at work in remarkable places and contradictory locations. Bearing in mind Whitlam had created hundreds of community centres; these were not directly controlled by the CDOH. As a result, the reporter was sent to find some examples of “innovation” in community health servicing directed by the government. Two were from Victoria, while the third was taken from information supplied by the W.A. Department of Health relating to the Karmel committee’s recommendations (“Teaching Program”, 1980).
In the case of Victoria, one was Sunbury Community Health Centre situated outside of Melbourne and the second was a new hospice movement established by the Melbourne City Mission which described itself “not as a preaching outfit, but a non-sectarian body providing health and welfare services from a Christian background” (“Support”, 1980, p.6). Neither, Sunbury nor the hospice movement appeared in any way linked to other innovative programs in community health as explained earlier.

As far as these projects were concerned, the Sunbury Community Health Centre operated as an employment agency and a welfare support centre for youth. It was connected to the Commonwealth Employment Services (CES) and to the Federal Government’s Community Youth Support Scheme (CYSS), employing health professionals (other than medical doctors) and social workers. The centre was also staffed by a Community Health Nurse, a Community Services Co-ordinator, a Family Day Care Coordinator and an Executive Officer whose background was in banking, having worked with the Papua New Guinea Development Bank giving financial counselling to Indigenous people (“Interaction”, 1980, pp. 1-5).

While there was nothing “wrong” with these ventures, they were not “new” in terms of the sheer numbers and variety of services established previously. It appears however, chivalric networks came together at a particular level and might not have been noticed if the Sunbury example was presented on its own. In regard to the Mission, it was regarded as “innovative” because it had been successful in attracting $367,000 from the American Kellogg Foundation and $180,000 from the Australian government to implement a “new type of care for dying people” based on ancient ideas about health servicing (“Support”, 1980, p.6). In this case, it was also stated this was linked to a strong modern hospice movement in the USA and the UK, its origins being in the Crusades. It then becomes clear to see where the connections might be when it was pointed out:

Hospice is an old word, originating from the Crusades, when religious groups or knighthoods (the Knights of St John and the Knights of the Cross) set up stations or hospices to care for the sick and dying going to and from the Holy Land…In modern day, the road is the course of terminal illness and the travellers are the dying patients and their families (ibid).

In terms of the Masonic link, one can only speculate the Sunbury executive officer might have belonged to a group such as the Knights Templar whose members were historically involved in accounting and banking (see Robinson, 1989). What the
government thought of “innovation” in other areas is clear from the lukewarm government support and funding in the case of Newcastle Medical Faculty and again, in the case of doctors in Departments of Community Practice (“Teaching Program”, 1980, p.10). Community health researchers have pointed out, public sector bureaucracies consistently destabilise (or white ant) their departmental staff through dramatically reorganizing themselves periodically (Laris, 1992, p. 65).

In sum, while other innovative community health programs and medical schools were forced to struggle, in the year after the acclaimed success of what was virtually a “do-it-yourself” health promotion initiative, Labor’s federal health policy initiatives were completely abolished, while at the same time the WHO guidelines were deftly side-stepped. The Liberal government did this by completely privatising health insurance, as well as returning responsibility to the states for most costs of hospital and Community Health Programs without any stipulation on how the allotted federal funds could be used in cost-sharing arrangements. As Fry and Baum (1992, p.302) point out, WHO published the shift away from such approaches in the Ottawa Charter for Health Promotion (1986). It was not until a new Labor government was elected in 1984 the present Medicare scheme was reconstituted and not until the 1990s when resistance from within the medical profession itself was, to a degree, breaking down.15 As far as the present Howard government is concerned, one can only quote Duckett (2004, 275) who states:

It is still extraordinary … that Australia does not have a comprehensive platform on which to build community-based health services. The brief flirtation with a national policy in this area, through the community health program initiation in the Whitlam years, was soon undone in the Fraser years. This is still a major gap in the Australian health care system. Dynamic efficiency16 then at the system level leaves much to be desired. Unlike the USA, Australian health policy culture does not emphasise systematic trials and experimentation in health policy innovation.

15 What was said to be new was some to the political right of Labor government are becoming more aligned with their political opponents over policies which support the private sector against Medicare. For example in 1991, the Health Minister, Senator Graham Richardson, was the first to tread this path (see Gray, 1991). While Medicare has survived between 1996 until 2004 through a period when a Federal Liberal Government has retained office, it has been subjected to controversies.

16 Dynamic efficiency is defined by Duckett (2004, p. 268) as “a concept which refers to the extent in which the health care system as a whole, as well as its constituent elements, adapt to change and innovation”.
The resistance to change in the culture of the medical workforce also seems to be evident in debates on changes needed to make the health care workforce more multi skilled and flexible, an idea which has some support from nurses, but does not go down well with some AMA leaders, who still today appear to view medicine as a craft and medical specialists as “masters of their trade”. For example, the Federal AMA President, Dr Mukesh Haikerwal (cited in Kruger, 2005, p.1), recently states:

What’s important is that we have highly skilled people who are proficient in their craft. So we need properly trained profession(als) who are masters in their trade. We don’t need people who are jack-of-all trades and masters of none. We don’t need a generic health worker that can do a little bit of everything. We need to make sure that the care we are delivering which currently is excellent, remains excellent.

Although such attitudes about craft-orientation and its Masonic links have become a force since the 19th century, in Australia surgeons began to reap their financial rewards under the National Health Act (1970). As stated earlier, these “masters” formed a body called NSQACA that became the gatekeeper for the specialties. In the following section some issues surrounding this development are elaborated.

The National Specialist Qualification Advisory Committee of Australia (NSQACA)

The National Health Act (1970) was the first piece of legislation enacted in Australia which rewarded specialists over generalists for the same surgical procedure. NSQACA, made up of representatives of the specialists’ colleges, was established in 1972 to make recommendations as to postgraduate qualifications accepted in Australia. While NSQACA’s was, in essence, an advisory body, its primary function was to ensure specialists who qualified for payments were only those medical or surgical specialties included in their handbook (Farag, 1992, p.65: NSQACA,1994). As a consequence, NSQACA refused to recognise general practice as a speciality, nor those undertaking “special interests” such as Aboriginal health, migrant health, and so forth (ibid.). The issue caused major schisms within the Australian Medical Association (Duckett, 1984, p.960). This process occurred earlier in the USA where general practitioners simply expanded their practices by referring to their own specialty interests. In contrast, Australia had gone the way of the UK where the specialist consultants refused general practitioners admitting privileges in hospitals (Bloom, 1989, p. 235).

17 NSQACA (1994) is the 22nd edition of the qualifications recommended for the Australian medical specialties
The first Australian handbook of medical and health professionals who were part of the new system was published in 1987 by the National Health and Medical Research Council (NHMRC). Most of those listed were aligned with “post-basic” medical occupations or specialities. The only one listed as undertaking a “basic” medical occupation was the general practitioner (NHMRC, 1987). This definition is somewhat of an anomaly in a system where the “basic” approach has been defined as being connected to the laboratory. In this handbook, a “Public Health and Preventive Medicine” specialist is dubbed a “Community Health Specialist”. In this case, preventive medicine remains associated with the idea of a “service” type or a specialist in salaried service outside of the hospital (ibid, p.120). The only postgraduate diploma in this area was then at the University of Sydney and the recommended “advanced” training was as a specialist in Infectious Diseases (ibid, p.121).

Another interesting factor in this handbook was the terms of reference for administrators trained to take charge of policy development at Federal and State levels. The fact that, before applying for such a position, these health service administrators were legally required to combine their “technical” knowledge with administrative knowledge has exclusionary connotations (ibid, p.1).

The relevance of understanding this type of bureaucratic organization as being divided into higher and subordinate levels, not only reflected the earlier Masonic structures, but also again reflected the divisions incorporated into scientific management. Such compartmentalisations existed in the psyche of the AIF military officers, who saw themselves as the jewels of the so-called “higher orders” of chivalric Masonry.

The effects of these influences appear to be more widespread than realised. For example, a recent study of neo-spiritual discourses within circles of human resources management points to a revival of evolutionary theories. The researcher found the language was one of the self as part of a “monistic unity” and ideas of otherness as those situated in some lower stage of the evolutionary ladder (Salamon, 1994). Such ideas about “higher civilisations” and evolutionary ladder stereotypes were greatly influenced by occult teachings.

Anyway, after the processes were set in motion to deskill and subjugate the Australian generalists, the specialist establishment began a process of dismantling the
reciprocal arrangements for medical practice established by GMC criteria for accepting doctors into specialist medical practice (see Farag, 1992). As stated earlier, the issue of the non-recognition of overseas qualifications was the topic of my earlier work on doctors but I had not considered military, religious or esoteric influences. At this time the processes put in place were totally in keeping with their atavistic and protectionist inclinations as well as the idea they were above the law. In this case, as it appeared their goal was to “purify” and “militarize” the specialities, they would have looked upon themselves in terms of a “higher order”. As a consequence, the resultant outcomes investigation by the Human Rights and Equal Opportunity Commission (HREOC) as a violation of human rights, were ignored (ibid).

While in my previous work I did not use the term “purification”, I did point to other research which drew parallels between the AMC examination set for overseas doctors and the infamous “language tests” used under the Immigration Restriction Act (1901) to keep Australia “pure” and “white”. I showed that in the 1970s, specialist doctors from the Indian sub-continent and Egypt were the first to be ostracised and excluded from practising in Australia (see Farag, 1992). These practices contradicted the ethos behind dismantling the Immigration Restriction Act (1901) which started to be unofficially dismantled during the 1960s, leading to the enactment of the Racial Discrimination Act (1975). A further support for my findings came from P. Baume (1994) who confirmed my argument that no overseas-trained specialist had been able to practice his/her medical specialty in Australia since the 1970s. I later realised such exclusionary practices also applied to both male and female Australian medical students and doctors, but especially female, who were excluded from membership in the more lucrative ranks (see Baume, 1994). These practices, of course, were also against the Sexual Discrimination Act (1985) enacted in Australia.

In other words, while Australian government policies began to reflect changes towards issues around land rights, multiculturalism and universal health care, both Liberal and Labor governments since that time have had completely different philosophies especially about health servicing. From the 1990s until the present, Liberal government politicians and medical administrators dominating the health sphere seem to

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18 As outlined in the previous chapter, the specialties beginning with the “operative” surgeons enjoyed an elevated economic and structural position after the time of the National Health act (1970). Their power and status was reinforced with the formation of NSQACA as well as the National Emergency Services giving them power to not only define the specialities but also ensure who should be excluded.
emphasise treating sick people, a position generally underpinned by a “blame the victim” approach or a notion that the “poor are undeserving” (see Farag 1992, p.4).

The support for the present militarization thesis of the specialist sector also seems to be reflected in Baume’s assertion although there has been almost a 50 percent increase in the female medical population, this is not reflected in the specialist workforce. He concluded both the overseas-trained and women were grossly under-represented and young surgical trainees were exploited (see Baume, 1994). In 1999 the excessive restrictions on overseas doctors as well as the extreme shortages within the specialist workforce drew a scathing critique from Dr Con Costa, the President of the Doctors Reform Society (Costa, 1999). It is only very recently such monopolistic practices are being challenged within.

As far as women are concerned, some years ago, research was conducted on attitudes to women’s involvement in Canadian army combat units. Although not specifically concerning doctors, parallels might be drawn between the above attitudes and the research findings below which showed that, within military circles, two groups differed in their outlook. As Cotton (cited in Wrigley, 1990, p.208), asserts:

For one group… it is a secular issue having to do with equal opportunity for qualified persons; for the other it is an emotional issue linked to military traditions and collective survival on the battlefield. …invoked (was) the term “beleaguered warrior syndrome” characterized by a dominant focus on battle and a sense of alienation from the military that is perceived as having become too civilianised to perform its essential function in combat.

As Willis (1989) has also argued, the beginning of Australian specialist training in the 1970s was accompanied by the rise in laboratory medicine and corporate interests. In this particular period, health issues which appealed to government and army interests centred around acoustics, pathology, the manufacture of CT scanners, ultrasound, and other sophisticated technology. Specialties and sub-specialities emerged as a solution to the belief they were incapable of providing a cure in all cases. Even Page, the Minister for Health in the Menzies government, believed any advances in surgery needed the

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19 Malcolm Fraser seems to have been one of the few contemporary Liberal Prime Ministers whose view diverged from others in the previous and ensuing years.
20 Medical sociologists might find a meeting ground with military sociologists such as Cotton (1981) who went into battle to try to redefine the military and move it away from its traditional practice of considering itself “a ‘higher calling whose institutional existence is crucial for the survival of society” (Wrigley, 1990, p.209)
support of drugs and technology to survive (Page, 1963). The following will highlight how the laboratory and research networks interacted with the CDOH.

The Australian “era of laboratory”

The laboratory quest to discover the “secrets of nature” was a job originally entrusted only to the military and Masonic doctors. Laboratory medicine, of course, became interrelated with the idea that finding a solution to this or that disorder was “just around the corner”. Investigating germs, viruses or genes became interrelated to ideas of defence and national security. As such, they were further transformed through new ventures which called for intelligence and surveillance measures to be adopted for disease problems as well as for supposedly life threatening events. In this regard, the Health journals published by the CDOH in the decade from 1971 to 1981, in particular, began to refer to the militarisation of the Department’s practices by linking it to military images, as well as to practices and to the values inherent in their medical system formed between the 1920s and 1930s. In this system, the medical bridge which later linked those in medical schools, universities, hospitals and laboratories into partnership was again the idea “real medicine” was laboratory-centred (“Era”, 1971, pp.18-22.).

In 1971, the CDOH announced the “Era of laboratory medicine” accompanied by the slogan the “medical profession demands the answers in advance” (ibid, p.18). Like other authors in this network, the significance of laboratory medicine was also shown as being part of the history of the CDOH, accompanied by an almost 50-year old article by Sawyers21 on the topic of “Commonwealth Health Laboratories” stating the “majority of great advances in alleviation and prevention of disease (were) due to the advent of laboratory medicine” (ibid). Regardless of the accuracy of the statement when first articulated, it gives the idea laboratory medicine was the real saviour of the masses.

Like in the 1950s, some research laboratories were connected with projects which were directly or indirectly related to defence and engineering interests. For example, in 1978, one specific project was planned between heads of the Departments of Transport and Defence who declared noise was a health risk which needed addressing. Department leaders expressed a need for assessment of the effects on hearing of aircraft and gunfire noise. Although the problem did not really affect the majority of the civilian population, it had flow-on advantages to produce hearing aids and other equipment to

assist the deaf. The researchers were employed by the CDOH’s National Acoustic Laboratories (NAL) in Sydney. Other research was into Ultrasound and resulted in the establishment of an Ultrasonics Institute (“Ultrasonics”, 1975, p.12), “Research”, 1979, pp.20-22). As stated, historically the STM & PH prioritized research projects funded by the NHMRC.

**The NHMRC**

The NHMRC was established in 1937 when NSW military doctors were influential. Like other institutions established between the 1920s and 1930s, until today, the NHMRC has been an important body recognized by the CDOH as having exerted a dominant influence for the pattern established for medical research in Australia (“How the committees work”, 1972, p.25). This Council’s function was to act in an advisory capacity to Federal and State bodies on public health legislation and administration, regarding any matters relating to health, medical and dental care and on related medical research (ibid.). Today, the NHMRC secretariat within the CDOH is seen to play a central role, even though it does not officially have a direct link to Federal policy formation (Duckett, 2004, pp.119-129). In terms of general policy direction, not only are its views regarded as influential, but also they are taken into account by health professionals and policy makers (ibid.). Their act of faith is that true research is also laboratory-oriented.

In reflecting on their achievements in 1987, the NHMRC maintained their efforts mirrored the goal first put forward in 1937 by the Minister of Health, William Morris Hughes, quoted by NHMRC (1987, p.3) as saying

> The functions of the Council are … to promote the health of the people of Australia, to protect them from disease and to advise, coordinate and direct research into the cause of, and cure for, those diseases which levy so heavy a toll upon the community and which have hitherto baffled medical science.

As late as 1987, the idea that health was the absence of disease and that the Council were gatekeepers in maintaining a first class health care system still held sway. Again because of their atavistic proclivities, when they spoke about their goals and aims, as above, they referred to past colleagues who held positions in different “health” portfolios during the 1920s and 1930s (ibid).

In their justification for NHMRC sponsored research, the Council claimed its primary medical research goal was to “underpin the nation’s health care system for the
benefit of the community” (ibid). They also claimed “the most spectacular contribution to medicine has come from the application to health problems of the advances made in biochemistry over the past 30 years, in cell biology and immunology over the past 20 years, and in molecular biology over the past decade” (ibid). Their yardstick of success of its health care system was the significant fall in mortality (40% over two decades) as well as reductions in morbidity, especially of those diagnosed with cardiovascular disorders and atherosclerosis (ibid).

The Council’s further influence was its link to university medical faculties and the prestige gained through the Research Fellowship Scheme which supports careers in biomedical research. NHMRC Research Fellows have the same status as a University Lecturer and a Senior Principal Research Fellow is equivalent to a Personal Chair. However, these are not permanent appointments and reviews are conducted once every four years (ibid, p.25). Best (1987) states these medical specialists/academics form “caucuses in the shadow of the NHMRC” which have a significant influence within government (cited in Palmer and Short, 1991, pp.133-134).

What is extremely significant is the Ministerial control of membership of the NHMRC which make it virtually an arm of government. For example, under Federal Statute since 1992, the Council comprises Ministerial appointees drawn from the health professions, together with appointees with knowledge in a range of non-health related areas such as business, trade unions, consumer issues and social welfare. They are all appointed by the Federal Minister for Health for a three-year period. Also on the Council is a representative of each state and territory. The Council has three broad functions, which are the provision of advice on policy, ethics and research funding (NHMRC, 1987).

All in all, the NHMRC today remains an important coordinating mechanism at national level and is a persuasive body in terms of general policy direction (Duckett, 2004, p.119-120). However, its act of faith is similar to the CDOH who are of the opinion “real” medicine is research-oriented “laboratory medicine” which has not shifted from the position it took in 1925. The story of the development of the Federal government’s research institutions and laboratories is briefly examined below.
The STM & PH and ACITHIN

The STM & PH remained the premier institution which set the research priorities alongside the Institute of Child Health until 1977, both situated within the grounds of the University of Sydney. The other laboratories were situated across Australia with the national pathological laboratories remaining mainly in their original locations. The Federal research institutions, schools and laboratories are listed in Table 7.4 below as they appeared in 1972. Except for two laboratories which had been relocated in Victoria, most national laboratories and research organizations were based in Sydney or Canberra. The federal pathology laboratories remained in many towns which were isolated from capital cities, the location of which had not significantly altered since 1926. Apart from the one in Rabaul, 13 laboratories were established with most of them situated in the premier combined military district of Queensland and the NT. In November, 1971, pathology services were added to the scheduled list of services payable under Medicare (see “Variations”, 1971, pp.7, 19).22

Sutton’s successor and Director of the STM & PH, Sir Edward Ford, retired in 1968, to be succeeded by a Professor R.K. MacPherson who remained until 1977. In 1980, the School’s name was officially changed to the Commonwealth Institute of Health after Professor Lindsay Davidson, several years after he became Director (“Institute”, 1980, p.10, “Towards”, 1979, p.11).23 The transformation was completed in 1979 only after the Government referred the recommendations of two Review Committees to the Tertiary Education Commission (ibid, pp.11-13). No doubt, the refusal to accept the recommendations of the first Committee of Review in 1975 may have been because this Committee was headed by Dr Sydney Sax who, as I have shown, has been part of the “community” camp.24 The latter Committee’s recommendations for sweeping reforms of the School were shelved until a further Task Force on Coordination in Welfare and Health in 1976 (the Bailey Report) was asked to make its recommendations (“School”,1980, pp.10-17).25

22 At this time oral surgery and obstetric services were also added (see “Variations, 1971, pp.6-7, 19”
23 Davidson, a Scottish doctor, appeared to be aligned with Sydney Sax and the NHHSC. It was stated that “he describes himself as “the sort of gardener who plants things, watches them grow and then moves on” (see “Towards”, 1979, p.13). This type of language could also be confused with those who used fascist terminology such as the “best seed” in the “best soil”.
24 Sax has published a number of books on Australian health care reform. For example, see Sax (1984, 1990).
25 As I will explain in the next section, the first Committee of Review recommended restructuring medical servicing to promote primary health care and generalist practitioner servicing as its basis (see HHSC, 1973).
Like the NHMRC, the School’s aim was to provide assistance and expert advice to a variety of organizations. This era really marked the expansion and sometimes relocation of National laboratories. For example, the National Biological Standards Laboratory established in 1958 on the grounds of the Australian National University was rebuilt at a cost of $26 million and relocated to Symonston, about 15 kms outside of Canberra.

Also, the projects on climatic chambers which began in the 1960s continued into the 1970s. One particular research priority coming under the category of “environmental health” as well as being experimental in nature was defined as “advancing physiological knowledge of thermal stress in cold climates and human responses to it especially in the Antarctic and sub-Antarctic, such as heart rate, blood pressure, changes to body weight, blood coagulation, skin-fold thickness and body temperature” (“Climatic Chamber”, 1979, p.7). While, like the Acoustics project, such research might have a flow-on effect to benefit the general population in some way, the general population were not primary considerations. Thus, meanings behind “public health” and “environmental health” appeared only to refer to simulated environments in which tests were devised and
applied. In this project, researchers undertook to design and build two climatic chambers, one to test hot conditions and the other to test cold conditions (ibid.).

Many such projects seemed to retain a collaborative link to the Australian Army’s malaria research unit as well as the investigation of the problems of exotic and tropical diseases. In addition, the national and international focus continued to support areas of defence and foreign relations, such as in the supportive role played to the Australian Army and to the South-East Asia and the Western Pacific region (“School of”, 1980, p.15-17). Research interests were also retained in relation to “various aspects of medical genetics”, environmental physiology and toxicology and occupational health (ibid, p.17). However more emphasis seemed to be placed on the Antarctic.

However from 1977, the new AIH began to reflect significant organizational and structural changes within teaching and academic programs and research directions. At this time, the postgraduate diplomas previously offered were replaced with others which effectively divorced Public Health from Tropical Medicine. This was achieved by offering a Masters degree in Public Health for those interested in development, analysis, design and implementation of health policy. The other new course offered was a Diploma in Tropical Public Health for those interested in specialising in this area (“Towards”, 1978, pp.11-13). More significantly, the person involved in pointing the Institute’s staff in these new directions was Professor Lindsay Davidson, a Scottish generalist doctor, who portrayed himself as “the sort of gardener who plants things, watches them grow and then moves on” (ibid, p.13). Not surprisingly, while the SPH & TM was replaced by the AIH at the University of Sydney, the linear descendant of this older school seems to have later emerged elsewhere within a medical environment more conducive to its ethos.26

This move appears to have occurred in 1995 when a new “Australian” research institute, The Australian Centre for International and Tropical Health and Nutrition (ACITHIN), emerged emphasising commitment to “public health and medical research”. While it is a federally funded institution, it now forms a part of the University of Queensland’s School of Population Health (University of Queensland, 2003, p.1). ACITHIN collaborates with the University of Queensland and The Queensland Institute

26 It seems this coincided with the timing of the election of Howard government, some of whom are extremely right-wing in sentiment and such eugenic sentiments still prevail in relation to people with disabilities, despite the enactment of the Disability Discrimination Act (1996) (see Hume, 1996).
of Medical Research (QIMR) and also makes special provision to train Aboriginal and Torres Strait Islander students in public health. QIMR undertake laboratory-based research on Indigenous people over a range of health issues, such as Malaria and Scabies, Rheumatic Fever and Rheumatic Heart Disease, Diabetes 2, among other things (QIMR, 2004, pp.1-4). However, one of QIMR’s special interests is in the area of Genetic Discovery and Genetic Disease and has revived the idea that the risk of developing alcohol related problems may be due to genetic predisposition, a mindset informed by eugenics which has not moved from that outlined by Sutton (1944). Also, much to the dismay of senior National Aboriginal Health executives, such institutions have concentrated on medicalizing Indigenous health issues through coopting communities to participate in laboratory-based research which they have defined as “primary” health care. For example, Naomi Mayers (2002, p.5) states:

Indeed, today’s government officials are like the “mission managers” of old and we are their blacks to be controlled… It is their agenda and their priorities to which we must submit.

As far as these programs are concerned, Mayers states that Aboriginal people are told “evidence-based medicine, computerisation and recall systems are tremendous advances in Aboriginal primary health care” (ibid). Not only is this a distortion of the meaning of “primary health care”, but also Mayers points out that if Aboriginal people ventured to state such research was of little benefit to addressing the overwhelmingly poor state of Aboriginal health, they were threatened with funding cuts. Mayers (2002, p.5) states:

Actually much of the thinking behind this technical approach came from the Aboriginal health sector but it was only conceived as a small part of an overall strategy. It was never intended to become the strategy. - the medical model has never had any legitimate currency in Aboriginal health – and it was certainly never intended that these so-called positive achievements should be used as a smokescreen to camouflage the fact that the structural determinants of our ill health have been influenced adversely as a consequence of the increased ascendancy of extreme right-wing policy in Australia.

27 Of course, many causes of health-related disorders in the Aboriginal population today have been caused by social structural determinants which have included the lack of adequate nutrition, among other things. This is not an issue for laboratory investigation. As shown in the previous chapter, diet was a key feature tied to an experiment conducted in New South Wales in the 1950s, supported by medical and dental practitioners and published in The Medical Journal of Australia (see Amberey, 2000, APS, 2004). It was also a well known fact then that lack of adequate nutrition would have far reaching effects in later life (see Sutton, 1944, Page, 1963)

More generally, as far as Indigenous health is concerned, the gap in the mortality rate between Indigenous and non-Indigenous Australians continues to be 20 years. The severity of this outcome can be gauged when compared to the gap of 3 years between Native Americans and others in the USA and 5 years between Maori and non-Maori people in New Zealand (De Costa, 2002; Neill, 2002).

The above demonstrates one of the ways the connection between basic research and advances in medicine has been understood and coined in the contemporary phrase, “from bench to bedside”. This time, however, the “speech” is not one of war but of semantics, but defines the medical system and its actors as participating in the “saving game”. For example, Van der Weyden (2003, p. 603) states:

During the 20th century Australians have benefited immensely from improvements in their general health and life expectancy. Our average life span has increased by 25 years, and even in the century’s dying decade we managed to gain another two years! As with many success stories, there have been numerous contributors, but there is no doubt that basic medical research has played a prominent part. Indeed the interplay between basic research and advances in medicine is succinctly captured by the phrase “from bench to bedside” or by the term “translational highway” – an autobahn for taking basic research advances and transferring these into clinical practices. [italics added].

Medical systems do not survive alone, but need support to “play the game”! The universities and the research institutes are kept afloat by the NHMRC, which is one of the major funding bodies. Apart from the Federal laboratories mentioned above, these medical research institutions are located across Australia and are listed in Table 7.5 below. The funds expended in this direction are substantial. As Van der Weyden (2003, p.603) again states:

The powerhouses of basic research in Australia are our universities and research institutes. Their financial underpinnings are the competitive grants provided by both government and non-government organisations. In 2002, for example, the NHMRC’s expenditure on health research and development was $276 million. Of this the universities received $190 million (69%) and the medical research institutes received $74 million (27%).\(^{29}\)

From the following table, one can see those in laboratory medicine and research are portrayed as the “miracle workers” and “saviours” of the wider Australian population. The new leaders are those behind the bench, rather than those at the bedside. Not only has a Divison of Public Health and Tropical Medicine been

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\(^{29}\) Presumably the missing 4% covered administrative costs.
established within the James Cook University, but other development should be understood as the beginning of a process of meso-corporatism referred to earlier by Coburn (2006). Another example is the establishment of the Australasian Faculty of Public Health Medicine (AFPHM) within The Royal Australasian College of Physicians (RACP) to foster specialisms in Public Health and Community medicine, while another is the establishment of Centre for Military and Veterans’ Health at both the University of Queensland and the University of Adelaide. (RACP, 2007). Again invoking the strategy of crisis, some of its members are pushing for the reforms of “task transfer” or “task substitution” mentioned in the previous chapter with a view to changing medical education to cater for such changes (Ellis, Robinson and Brooks, 2006). Neither the language nor the heroic imagery has disappeared.

**Heroic imagery in contemporary medical practices**

The strength of the inter-relationship between health and military issues and the degree of American involvement in this present era is beyond the scope of this thesis. However, until the early 1980s, this collaborative involvement was still important enough to be published in various issues of *Health*. For example, one article entitled *Defences against exotic diseases tested by Americans* reported an exercise involving quarantine, customs and military officers. This “invasion”, called *Exercise Kangaroo 3*, was the third in a series of joint allied military exercises which began in 1974 with the support of state and federal Health departments as well as the Department of Defence. During that same period another “war” was waged, this time this was a “war on encephalitis” which was part of a national campaign beginning in December 1980 involving a mobile field laboratory set up initially in the Murray Valley for this purpose (“Defences”, 1980, p.10-11, 21).

There are other examples of “seek and destroy missions” which are not confined to the human population, but to insects considered as having “a quarantinable disease”. For example, in 1977, a project was conducted to “intercept” the Giant African Snail which, like certain other insects, such as the Khapra beetle, the Oriental fruit fly, and others, are “enemies” considered an immediate threat to Australian agriculture (see

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30 See chapter two.
31 Ellis sees the role of physician assistant and medic interchangeable, making it easier for the medic to slip into a civilian job after retirement from the military. Brooks is Director of Health Sciences and the Royal Brisbane and Women’s Hospital University of Queensland and fellow of the AFPHM.
Table 7.5.  *The Australian medical research enterprise in 2003*

<table>
<thead>
<tr>
<th>Location</th>
<th>Corporation</th>
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<tbody>
<tr>
<td>Australian Capital Territory (ACT)</td>
<td>John Curtin School of Medical Research</td>
</tr>
<tr>
<td></td>
<td>Telethon Institute for Child Health Research</td>
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<tr>
<td></td>
<td>Lion’s Eye Institute</td>
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<tr>
<td>Western Australia</td>
<td>Walter and Eliza Hall Institute of Medical Research</td>
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<tr>
<td></td>
<td>Ludwig Institute for Cancer Research</td>
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<tr>
<td></td>
<td>Monash Institute of Reproduction and Development</td>
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<td></td>
<td>Baker Heart Research Institute</td>
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<td></td>
<td>Burnet Institute</td>
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<td></td>
<td>Peter McCallum Cancer Institute</td>
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<td></td>
<td>Howard Florey Institute</td>
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<tr>
<td></td>
<td>Prince Henry Institute of Medical Research</td>
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<tr>
<td></td>
<td>St Vincent’s Institute of Medical Research</td>
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<tr>
<td>Victoria</td>
<td>Menzies Research Institute</td>
</tr>
<tr>
<td></td>
<td>Institute of Medical and Veterinary Science</td>
</tr>
<tr>
<td>South Australia</td>
<td>Institute for Molecular Bioscience</td>
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<tr>
<td></td>
<td>Queensland Institute of Medical Research</td>
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<td>ACITHIN</td>
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<td>Tasmania</td>
<td>Menzies School of Health Research</td>
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<tr>
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<td>Institute for Molecular Bioscience</td>
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<td>Northern Territory</td>
<td>Menzies School of Health Research</td>
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<tr>
<td>New South Wales</td>
<td>Children’s Medical Research Institute</td>
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<td></td>
<td>Heart Research Institute</td>
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<tr>
<td></td>
<td>Garvin Institute of Medical Research</td>
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<td></td>
<td>Anzac Research Institute</td>
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<tr>
<td></td>
<td>Westmead Millennium Institute</td>
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<tr>
<td></td>
<td>(Van Der Weyden, 2003, p.603).</td>
</tr>
</tbody>
</table>

“Giant African”, 1977, p.19). Sometimes one wonders if even today any differentiation is made between the human, plant and insect environment. Under the Quarantine Act (1908), which remains virtually unchanged today, humans, plants and insects can at times be interchangeable with “things” (see Commonwealth, 2004, p.1). Such actions are mirrored within the contemporary research enterprise which continues to link the heroic imagery of the laboratory physician as a “miracle worker” who takes part in the wider “saving game” of the biomedical enterprise. This imagery is also reflected by
reference to the practitioner who goes on “search and destroy” missions to isolate and kill “the infectious enemy”.32

As the emergent biomedical system forged a link between research interests of those working in universities, hospitals and laboratories, presumably its needs were also multifaceted. However, RACS spokespersons have suggested that some of their traditional structures are crumbling. For example, they state university-based education for nurses has destroyed the esprit de corps and loyalties which existed in the hospital-based system which “went such a long way to maintain harmony and understanding with medical and para-medical staff” (Durham-Smith, 1987 cited in Palmer and Short 1989, p. 142). Other surgeons consider their history in terms of being aligned with a “trend” moving surgery from the hands of the generalists to the surgical specialties and, more recently, the surgical subspecialties (Maddern and Maddern, 2001, pp. 12-13).33 Willis (2000) has recently revisited Fordism and Taylorism in analysing some of the computerised hospital work with which doctors now need to deal. One example might be of Frank, a physician, who had undergone some coronary work, and who described the discussion with his cardiologist as follows:

We talked about my heart as if we were consulting about some computer that was producing errors in the output. “It” had a problem. Our talk was classier than the conversation that I have with the mechanic who fixes my car, but only because my doctor and I were being vague. He was not as specific as my mechanic usually is. I knew more about hearts than I know about cars, but this engine was inside me, so I was even more reluctant to hear about the scope of the damage (cited in Little, 1994, p.7)

Also, as far as patient care is concerned, one needs to regard the domination of surgeons over the hospital sector not as a trend but as a forced assault. Their monopoly over this “saving game” is maintained by waging a consistent battle against the “enemy”, a battle where military metaphors “invade” the whole language. For example, a physician’s wife wrote about her husband’s battle with cardiac disease in the following way:

They were trained … to anthropomorphise disease. Some diseases were enemies you could not vanquish: terminal cancers, inexorable progression downwards. Others were mischievous little bastards – sleepers, simple prostates and kidney

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32 For research on the link between quarantine, culture and imagery, see Bashford (1998) and Williams (1995).
33 Dr Guy Maddern, Head of Surgery at Adelaide University and current leader of the RACS, has in the past spoken out patient rights.
stones that should have been an easy win but might put up a hell of a fight, even to death…It was not a thing, not a germ, not a kidney stone, nor a cancer or an infection. It was simply this process … that he wanted to fight … aggressively, as he had been trained to do (ibid, p.6).

In the case of treatment of cardiac arrest, Bains (1998) has recently argued that in some cases the game has actually progressed from saving or “reviving the living” to that of “raising the dead”. As far as the monastic and esoteric inclinations go, we only have to look at the interpretations behind the Royal College’s coats of arms in England and Australasia extant before 2003, after which time the websites appear to have been transformed. The College’s motto is a heroic one. It is *Fax Mentis Incendium Gloriae* which, translated, means “the flame of glory is the torch of mind” (Royal, 2003). One can see the military symbolism at work in the idea force can be legitimately imposed on others.34 The parallels seen within the wider crisis milieu today is in the manifestation of violence or aggression which can be seen not only to be repeated in the stance taken by some doctors against smoking or eating behaviour, but can be seen in many other professional areas, such as administrators and politicians, especially in the policies which superimpose practices of mandatory detention (see Foschia, 2005).

As health legislation began to effectively reward specialists over generalists for carrying out the same surgical procedure, it also began the process of deskilling the generalist and stripping them of autonomy to define their own knowledge to service their patients. It also defined medicine as having little to do with patients. This meant that in new forms of medical education, the research-oriented model did nothing to prepare a medical student for general practice. So the surgeons became the “high priests of the organs” and dominated the hospital and the research institutions.35 The institutionalisation of the heroic or life-saving orientation was not only related to surgery, but the hospital also became an important site for mobilization in the event of

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34 In England, the Royal Charter was given to the Royal College of Surgeons in 1800. On its coat of arms, there is the Red Cross or St George cross, as well as a representation of Chiron the Centaur with a bow and Apollo shown bearing his harp. In Greek mythology, Apollo sired Asklepios, who was then taught by Chiron, Machaon and Podalirios, who support the arms of the Royal College who state they were surgeons to the Greek Army before Troy, in the siege where Chiron supported the Greek cause and Apollo the Trojan. The Curator has now discussed the various interpretations of both the College Motto and the Coat of Arms (RACS, 2003, 2003a).

35 One advantages of writing this thesis as a mature-age student is that I grew up in Marrickville, an inner-city Sydney suburb and remember what it was like in the 1970s when one went to the local family doctor there. In those days, family doctors were generally quite overworked, running a busy surgery, making house calls on sick children and adults, delivering babies and carrying out surgical procedures at the local district hospital, which also still had its very kind “honorary” orthopaedic surgeons who were called in to handle emergencies. During this decade and the next the whole system underwent immense change and these ways of doing things were fundamentally altered.
nuclear warfare. The monopolistic power enjoyed by surgeons since the post-war years, together with its acclaimed prestige and rewards, has, of course, had the effect of rating surgery as the pre-eminent medical career to which only the selected few should aspire.

It does seem these rewards could be more equitably shared. This is because leading surgeons themselves have stated advances made in surgery in the last fifty years or so have not been from any change in “manual dexterity”, but due to improved medication and technology (Maddern and Maddern, 2001, pp.12-13). The use of staplers rather than sutures has allowed surgeons without exceptional ability to perform procedures in previously inaccessible locations in the body (ibid.). Despite these factors, there continues to be a belief in both medical and lay circles a “specialist” is someone who has some sort of superior intelligence and ability. This belief, along with the restriction on numbers, enables the surgeon to retain an elitist status as well as a monopoly on public gratitude for cutting open bodies and “saving” lives and, according to Gearin, earning a “good quid” for doing so (Gearin, 2004, p.1).

The militarisation of medical institutions effectively replaced the military medical officer with executive managers and administrators who directed the hospital surgeon and the laboratory researcher, and retained the power not only to dominate medical schools and hospitals, but also to define who was a “specialist”. Nevertheless while, at times, the work of surgeons is recognised, in today’s social climate the gendered dimension of heroism has finally seen its day. One recent example is in the case of the Perth Plastic Surgeon, Dr Fiona Woods, who was awarded the Order of Australia (AM) for her work with Bali bombing victims. As a consequence, even though the archetypal dimensions of the soldier/saviour imagery lives on in parts of the ADF, as do culture heroes like Major-General Sir Neville Howse and Sir Edward (Weary) Dunlop, these culture-heroes now include women doctors. Smart (2003, p.1) states:

Most have played a vital role in Australia’s military history. Many have been decorated for their bravery and medical work on the front line, including Major General Neville Howse in the Boer War (awarded Australia’s first Victoria Cross), Sir Edward “Weary” Dunlop in WWII and, more recently, Captain Carol Vaughan-Evans, who was awarded the Medal of Gallantry for working during a massacre of Kibeho refugee camp in Rwanda in 1995. Others have made the ultimate sacrifice, dying in the service of their country – among them a personal hero of mine, Lieutenant (Dr) George Merz (who was killed by hostile Arabs in 1915, after working tirelessly as both an MO and pilot on many dangerous missions in WWI) and Major Susan Felsche (who died in a plane crash in 1993 while serving with the United Nations (UN) mission in the Western Sahara.
Today as the army, navy and air force have been amalgamated into the ADF, Smart, as the Commanding Officer of the RAAF Institute of Aviation Medicine, claims Medical Officers (MO’s) are multi-skilled and egalitarian. Unless they are in army reserves, these career MO’s do not alternate between military and civilian life except on retirement. She states they do not seem comfortable in the role of “playing God” when faced with the carnage visited on many war-torn countries in the world today. In some instances, she asserts “rather than feeling like Medicin sans frontiers or Doctors without Borders, like her NGO colleagues, she says they sometimes feel like Doctors without a Clue” [italics added] (ibid, p.8).

These doctors are no longer mainly surgeons nor men, but the MOs still have the same everlasting act of faith. For example, they look upon themselves as both warriors and healers, they feel they sacrifice their own needs for the good of humanity and they feel war is inevitable and their work on the battlefield has had a direct benefit to the advances of medical science (Smart, 2003, p.1). In other words, they still have their heroes and continue to regard themselves as “soldiers” and “saviours” of humanity. For example, Smart, (2003, p. 1) places this issue under scrutiny and then gives her answer:

Medical officers (MO’s) employed in the Armed Services are in a sense, both doctors and warriors. The concept of being both a doctor and a warrior is quite difficult to grasp. How can someone who has elected to dedicate his or her life to healing be part of an organization that may enter into armed conflict? How can healing and harming go hand in hand?

Nevertheless, they do. The idea of sending MOs to war is not new, as where there is war there is medical work to be done. Indeed, thousands of MOs around the world have shown a willingness to put their own needs aside to achieve a greater good. Furthermore, many advances in medical science that can benefit us all (eg. transfusion, ambulance services, and various surgical techniques) were first realised or developed in the theatres of war.

This state of affairs has remained very much the same even in 2004 when the RACS was criticised for retaining a virtual monopoly over its so-called elitist ranks in limiting surgical training positions. One could reiterate Willis’ (1989) assertion that any position of dominance is negotiated and is dependent on a whole range of other factors. In this case, there is somewhat of a culture shift, as the surgeons’ traditional authority over their own ranks is now being attacked by the surgical trainees themselves, as well as the Australian Competition and Consumer Commission (ACCC) and several state governments and the winds of change are blowing (Gearing 2004, Grimm, 2004). Even the mighty cannot continually gain by imposing force and even the mighty can fall!
A research study on crises situations in eight hospitals, including three Australian hospitals, found a key factor impeding better patient outcomes was that the “culture”, the fundamental ways of doing things, needed to change (Swan, 2005). Apart from the surgeon trainees, the winds of change may be slowly emerging in other areas, as a new Medical Emergency Team (MET) has pioneered an approach to prevent patients having cardiac arrests in hospital situations by not waiting for signs, but by actually listening and talking to the patients and their relatives (Swan, 2005a). I return now to the originators of the “saving” game, the St John doctors and their Knightly connections.

**St John doctors and other Knights**

Today, the Order of St John is an internationally affiliated organization sponsored by a British royal order of chivalry, now having two foundations, the St John’s Ambulance and the St John Ophthalmic hospital in Jerusalem. The conservative, atavistic and monastic attitudes of the knightly orders with whom the elite surgeons and physicians have been associated cannot be divorced from shared historical traditions which have consistently displayed an apocalyptic fervour as well as crusader zeal. Simultaneously, they have displayed both esoteric and mechanical leanings. The result was that until the Vietnam War and later, many AIF and RAAMC doctors drew on traditional chivalric values which did not move from the historic “expeditionary force” mentality, which, along with its feudal and ascetic form, has not totally disappeared today. As far as the Orders of St John are concerned, the St John Ambulance historian (Howie-Willis, 1983, pp. xxv-xxvi) has pointed out:

> The Orders of St John are remarkable for their incongruities. In a century where immense technological and social transformations have spawned a new science, futurology, to help humans understand that changes still to come are not fantasies from science fiction, they remain steeped in time-honoured tradition. In struggling to keep their medical knowledge, their publications, their computerized systems, telecommunications, transport and management practices abreast of the times they resemble any other organization endeavouring to keep up with the later 20th century. Yet they cleave to feudal monastic forms and

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36 In 2004, the Federal government also donated $50 million to the Royal Darwin hospital to become a “state of the art” establishment to treat wounded war veterans and accident victims using the Bali bombing incident as justification. In 2007, the Federal Government donated $7 million to Indonesia to establish an eye hospital in Bali said to be established in memory of the Bali bombings in 2002. The hospital is promoted as a “state of the art teaching and training centre”. These two hospitals are stamped with a military imprint as they will operate very much in professional isolation from the mainstream medical profession.

37 The imperial links between the United Masonic Orders and the Order of St John were severed in 1939. For a detailed discussion of the history and attitudes of Australian military personnel, and how both a warrior or crusader syndrome and an “expeditionary force” mentality still prevail, see Wrigley, (1990).
chivalric ideals which to some outsiders may seem quaint in the post-industrial era.

As issues of women’s reproductive rights have re-emerged today and have been generally associated with influences emanating from the heroic genre, one might compare the above words to that of an English doctor who was Director of an International Fertility Research program during the 1970s. For example, he states:

Most of the organised resistance to the spread of commonsense innovations in individual fertility control reflects not much more than the survival in our times, of ideas on biology and reproduction stemming from an era when the general belief was that the sun revolved around a flat earth. In most fields, knowledge has advanced, information is better and clearer, but belief remains entangled for many in ancient misconceptions (Davis, 1974, p.xix).

On the other hand, doctors involved with the Order of St John, such as Professor John Pearn, still view the idea of medical practice “at its best” as being associated with providing disaster relief or crisis-oriented servicing, a type of medical practice best shaped through the historical alliance forged between army doctors who continue to call for volunteers in the army reserves, as well as the St John’s Ambulance and the Red Cross (Pearn, 2004)38. While this alliance does not seem to be as strong as yesteryear, the medical roles played in the evacuation and treatment of the victims in crisis-situations such as the Bali bombing or the Tsunami disaster are clear examples of the roles for which these medical professionals are trained. However, while St John historians claim the former interest in voluntarism and practical chivalry has lost its magic for many doctors and was on the wane, in the eyes of politicians, the heroic genre is alive in its association with “life saving” events as well as developments in research. For example, in a speech to graduating students at James Cook University in Townsville, Queensland, the Australian Health Minister, Tony Abbott, honoured the city’s role in the development of “Australian medicine”.39 Therefore, ”the medical profession” is defined by him in the following way:

… I'm pleased to report that my contact with the medical profession provides ample reassurance that the age of heroes has not passed. Professor Paul Torzillo has sustained and led the medical services in the Pitjantjatjara Lands of central Australia for more than 20 years. Wing Commander Bill Grigg helped organise and lead the Australian medical team to tsunami-struck Aceh this year. Dr Peter

38 Pearn is the Surgeon-General of the ADF as well as being associated with the Royal Children’s Hospital in Brisbane. He also publishes widely on historical issues associated with Australian medicine and health. For example, see Pearn and O’Corrigan (1983); Pearn (1985).
39 Defined as being associated with its research centres, namely the Australian Institute of Tropical Medicine, Townsville and the Walter and Eliza Institute, Melbourne (Abbott 2005).
Hayward, the Westmead burns specialist, grafted my constituent Sophie Delezio from a 20 cent piece of unburnt skin. Dr Adam Frost, the Newcastle GP, helped to keep alive the injured Australian victims of the second Bali bomb through force of character and by getting others to lift their game. These inspiring but unassuming men are worthy to keep company with the Breinls, Weary Dunlops and Victor Changs of the celebrated past. (Abbott 2005, p. 3).40

An “expert” on the subject of these “monks at war” has asserted that while the military religious orders no longer go to war, most of them survive today in some form in many countries and exist as the final refuge for an ancient regime that preserves the mystique of rank and birth (Seward 1995, p. 399). He points out the first serving American President known to have formally acknowledged the presence of the American Order of Malta was Ronald Reagan and the Order’s Grand Master presented him with a collar for standing out against abortion. Later President George Bush invited the Grand Master to the White House (ibid, p. 332). Also in 1996, a Priory of the Order of St John was established in the USA. However, both Scotland and the USA do not make provision for first aid training or public duties. Figure 1 below shows the structure of The Order of St John as it exists today as an international organization.

One cannot help wondering whether these events have anything to do with President Bush’s apocalyptic fervour for “divine” missions to “save” Iraq and the world from terrorism. In the late 1990s in the USA, there has been an apparent revival of postmillennialism in the New Christian Right’s efforts to create a “Christian America” (Weber 2001, p. 2). As far as the Knights of Malta are concerned, Peyrefitte describes them as “The last aristocrats, men from a single social and even religious caste whose very existence is not suspected by the man on the street” (cited in Seward 1995, p.397).

Moving back to population health, another clear example of a nexus between military and health projects was in the way the National Trachoma and Eye Campaign was conducted by the Royal Australian College of Ophthalmologists in 1977. At that time, the Order of St John underwent a crisis because of mismanagement of funds. Consequently, as the order was a registered charity, it was strongly suggested any ophthalmologic work should be directed to Australian needs rather than to those of the

40 As far as the Masonic Knights are concerned, while they are known to be present in Australia, there is no information forthcoming about how strong the links remain between them and the Orders of St John. My enquires within Masonic and medical ranks have led me to believe while, no doubt, there must be doctors within the Knightly Orders of Freemasonry, if they are still present as members of military and religious orders of chivalry, then they must remain hidden.
Ophthalmic hospital in Jerusalem (see Howie-Willis, 1983, p.50). Some Ophthalmologists still travel to the Jerusalem hospital to gain experience which they

THE MOST VENERABLE ORDER OF ST JOHN

Sovereign head
(Her Majesty the Queen)

Grand Prior
The Duke of Gloucester

Grand Council
Consisting of
The Great Officers

Lord Prior
Mr Eric Barry (Canada) (Chairman)
Prelate
Bishop John Waine (England (ecclesiastical affairs)
Deputy Lord Prior
Professor Anthony Mellows (England
Sub-Prior
Mr John Strachan (New Zealand) (National Councils
Plus the senior representatives of each of the eight Priories

England    Scotland    Wales    South Africa    New Zealand
Canada      Australia    United States of America

They oversee

Priorities   Commanderies   St John Associations   Associated Bodies
(8 above) (Northern Ireland; Western Australia) (33) (Republic of Ireland)

(The Order of St John, 2007, p.1)

Figure 1.  The structure of The Most Venerable Order of St John
consider can be usefully applied to their work when returning to Australia (Khangure and Howie-Willis, 1997; Howie-Willis, 1983, p.51).

One vestige of these quasi-feudal systems that look for lifetime loyalty from its members has been sustained through the ethos of voluntarism. Even today many organizations are still sustained by the idea that they form part of a heroic “saving” game. Those organized into sharing some kind of a partnership or ethoses of collaboration are not only members of the ADF, but also the police, ambulance and fire brigade. These links are pulled together at the top through the fact that a prestigious National medal is awarded to members of any of these services who have completed 15 yrs of service. A clasp is added after a further 10 years of service. The award is given by State Governors on behalf of the Governor General (“Lorraine earns”, 2005, p.6). A recent example is of the previous Governor, Lieutenant General of Western Australia, John Sanderson, awarding such a medal to a St John’s Ambulance paramedic, Lorraine Graefling, who transferred to WA from the NT and who received many recommendations for her “professional, calm and efficient” attitude (ibid, p.6).

Returning to the medical enterprise, the last game players in the saving game are the aristocrats of the contemporary research enterprise who attract millions of dollars from the NHMRC for their services in keeping laboratory-based medicine alive and well. What is even more revealing is that as far as ministerial authority is concerned, there is a march backwards from being bureaucratic to feudal in character. For example, as Lennie (cited in Laris, 1992, p.65) has asserted “… increased ministerial authority, the abolition of seniority as a prerequisite for promotion and the professionalisation of management have led to a shift “from bureaucracy to feudalism rather than to greater democracy”.

Last but not least we come to some of the other gate keeping roles that are played in keeping disease and viruses under control. As well as the above discourses and practices fashioned to provide services of practical chivalry of saving people in crisis through hospital or laboratory services, yet another side of this medical system is the intelligence or “secret service” type of surveillance, or the more subtle “search and destroy” or “search and find” missions which are more likely to be caught up in the

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41 Sanderson as well as the present Australian Governor-General, Major General John Jeffries, were both career military men and Knights of St John.
rhetoric of “saving the nation”. Some instances where “secrets” and “security surveillance” become one and the same are outlined below.

**Disease intelligence and surveillance**

Apart from adopting an aggressive stance, the need for surveillance of “infection” or “contamination” is another key practice passed on by military doctors. Originally, in 1970s Australia, the language of these discourses was focussed on finding new types of secret intelligence work in surveillance and security. In some instances, the older language associated with “quarantine” and “wars on disease” began to take on sophistication when labelled “disease security”, “disease surveillance” or “disease intelligence”. Beginning with the idea of “disease security”, new projects and research developments undertaken were directly or indirectly underwritten by the CDOH.

In one instance, it was stated that the idea of quarantine was being transformed into “disease security” and surveillance of the patient was monitored by placing them in isolation chambers. These chambers were specially designed to be handled by a special Infectious Disease Hospital Staff of doctors and nurses who could transfer patients in isolation chambers from hospital, to ambulance and to aircraft (“Fairfield staff”, 1979, p.14). These new isolation chambers housed the patient “inside” while the medical staff attended the patient from “outside” (ibid. pp.14-15). However, it also seems that the generals did not like dealing with situations that they could not easily control. For example, earlier that year an unplanned influx of Indo-Chinese refugees from South-East Asia caused some concern when they arrived in large numbers in Darwin Harbour. The reason for this concern was that the various customs, immigration and quarantine officers had not been able to carry out their normal routine checks. Regardless of the fact that passengers were lucky to arrive safely and were fleeing from life-threatening situations, the Australian officers seemed immensely put out because it was implied that the refugees acted irrationally. That is, one sunny afternoon they decided to jump on a boat and set out on an adventurous voyage to find the Australian coastline without regard or fear of the consequences. This irregular and unregulated influx of people was unprecedented and as a result an immigration team was despatched to Malaysia to interrupt the passage of refugees and offer them an opportunity for “proper” migration (“Informal immigration”, 1978, p.2). These “boat people” became the “enemy” and were seen as presenting a possible threat to human, as well as plant and animal health. For example, at the time, it was stated that:
… the informal immigration of the “boat people” is a new phenomenon. Normally refugees, like other intending immigrants, are medically screened prior to their departure for Australia. They arrive, usually by air, at a predetermined point and undergo routine customs, immigration and quarantine clearance. The “boat people”, on the other hand, set sail at will, plot their own course and may land anywhere along Australia’s vast northern coastline, presenting a possible threat to human, plant and animal health (ibid. p.2).

Moving on from the service of “disease security” which dealt with the isolation of people in hospitals, aircraft, ambulances, etc., the next new life-saving service was called Communicable Disease Intelligence which was the brainchild of the Australian Society of Microbiology. The service provides pathological laboratories with up-to-date information on disease or virus outbreaks or trends which possibly might start some global epidemic (“Communicable”, 1978, p.12). Information sent to the laboratories is coded to comply with WHO requirements (ibid.).

At least up until 1981, another project of disease surveillance was in connection with the Australian Influenza Vaccine each year and a job performed by a group of people called the “flu watchers”. These observers were referred to as a “network of spies” and were recognized members of an intelligence service. Their terms of reference were to supply the CDOH with information about the various strains of influenza emergent each winter throughout the world so that a vaccine could be produced (“Flu Watchers”, 1981, pp. 1-3).

However, as Murphy (1999) recently concluded, many of those working in infection control in Australian health care settings have no clearly defined roles. Not surprisingly, Murphy also found that a limited relationship existed between surveillance duties, clinical decision making and policy development (Murphy, 1999). The basic surveillance of infection control comes from quarantine practices nurtured by ideas from laboratory-centred workers who are always on the look out for some impending crisis of a virus or epidemic nature. For example, the world today is seen to be struggling against three main infectious diseases, namely HIV/AIDS, tuberculosis and malaria. As Waldby, (1996, p.1) points out:

Declarations of epidemics are declarations of war. In the biomedical imagination, epidemics are crisis points in the Darwinian evolutionary struggle between the microscopic, inhuman world of bacteria and viruses, and human populations.
Waldby (1996) also asserts that the association with biomilitarism is strong when the punitive treatment of HIV/AIDS victims is compared to the treatment of women for Venereal Disease in the earlier part of 20th century Australia. Lupton (1999) has referred to media representations of people with HIV/AIDS in Australia as “archetypes of infection” (Lupton, 1999). Also, in some cases, a declaration of war can be directly waged by governments on its own citizens, or customs and immigration officials can be coopted to control an outbreak of “disease”. For example, in 2003 a series of articles were published on SARS and the Bush government decided to set up a training program for officials so as to isolate any suspect travellers (Aversa, 2003) As far as bird flu is concerned, the Australian Prime Minister John Howard recently expressed his intent to partner the USA in a multimillion dollar plan for defence of the region from “disease” (McLeod, 2005).42 Below is an example of an instance of virus warfare visited on a population.

**Media representations**

The following example, taken from a USA media article43, shows how influenza epidemics, like other viruses or diseases, can be presented as imminently likely to cause an impending crisis in an already explosive political environment. This example might demonstrate how a government can incite fear into a population by creating a real or imagined crisis and use this as an excuse to super-impose social control and place restrictions on civil liberties as if the crisis was one of real warfare. The article makes the impending disaster sound so great that it is shown to be in proportion to the sinking of the Titanic! It also cites the necessity for restrictions to be enforced, such as (a) restricting travel; (b) closing schools; (c) rationing scarce medications; (d) using quarantine and isolation measures; and (e) restricting public gatherings (“US Prepares”, 2004).

From the above, one might see that the measures that create fear and/or promote intelligence and surveillance belong to a discourse of biological warfare where “germs” and “viruses” might all of a sudden come out of hiding to devastate the population. This is still part of the same crisis-oriented medical system to which the more overt heroic life-saving genre belongs. This imagery is kept alive and explained by looking at some other media portrayals.

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42 See Appendix II.i and II.ii for these media reports.
43 A copy of this article has been placed in Appendix II.iii
Apart from the real dramas cited above, the other central sites of the heroic genre are the civilian battlefield of the hospital around which ambulances or aircraft usually hover. These dramas continued into the 1990s and beyond. For example, in 1995 there were at least four medical television dramas describing the surgeon’s heroic life-saving feats. Two, shown on Channel 9, were *RPA* and *ER*, while on Channel 10, there was *University Hospital* and *Chicago Hope*. These dramas all told their tales of crisis situations, some realistic and some not so realistic, but the end results were the same—the doctors were all portrayed as heroes and life-savers. These dramas were in contrast to another television series, *GP*, which ran on ABC, and which did not portray crisis scenes of accident or emergency situations. The stories were about the impact on illness on family life and how doctors and people managed to work together to deal with the effects (Browne, R, 1995, pp. 8-9). In this social space every-day heroes remain unsung! In addition, media images of laboratory researchers have been consistently referred to as working on “medical breakthroughs” which we are generally told are just around the corner, that corner sometimes being ten years or so away. But sometimes who should be saved becomes controversial. Again let’s have a look at some examples.

As shown above, others in the “saving game” are not confined to medical doctors or health professionals, but can include customs or immigration officers likely to be caught up in the more “secret service” type of surveillance or more subtle “search and destroy” missions, sometimes involved in a wider political rhetoric of “saving the nation” from some kind of impending doom. Their actions are affected by policies surrounding issues of quarantine regulation and infection control, not only through vaccination or immunisation, but also through monitoring movements at airports as well as laboratories and hospitals (see “Flu vaccine”, 1978).44

“Saving” associated with humanitarianism can be a selective process and, today, there are almost metamorphic re-enactments of events which occurred after the Vietnam War. For example, in 1975 a medical team was sent to “rescue” Vietnamese orphans who were brought back to Australia for medical treatment. This was presented in *Health* as a grand charitable venture with many offers of assistance given for the children accommodated at the North Head Quarantine Station (“Medical team”, 1975, p.3). In contrast, in the same journal a few years later other Vietnamese adults and children who

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44 Bashford (1998) has recently analysed the issue of quarantine and its relationship to the imaging of the Australian nation.
were also war victims made unscheduled landings and were looked upon as “aliens” or “invaders”. They became stigmatized as the “boat people” whose unscheduled landings became a “problem” for these same health authorities situated this time at the East Arm Quarantine Station at Darwin (“Immigration”, 1978, p.1). One might ask then, who should be saved?

Who should be saved

Despite the carnage visited on people whose countries have been thrown into chaos through political unrest and under-development, the actions can sometimes be also connected to treatment of immigrants and refugees in Australia, such as in the controversial “mandatory detention” policy adopted for “illegal” refugees. Again, such actions define who should be “saved” in exceedingly selective terms. For instance it was quite in order for “us” to do the “saving” as this shows the world that “we” are soldiers and humanitarians. However, if “others” ask to be “saved” this becomes a major problem because they are looked upon as viruses or germs to be quarantined. For example, the Democrats Deputy Leader, Senator Andrew Bartlett, has recently drawn attention to officials within the Department of Immigration and Multicultural Affairs (DIMA) whose role has been severely criticised for being seen to operate independently of law and public scrutiny with the Minister wielding “absolute power”. He argues that “major problems with the Immigration Department will continue unless the law and the Government's immigration policies are changed” (Bartlett, A, 2005, p.1).

So as not to throw the baby out with the bathwater, one must emphasise that this critique is not of the multitude of doctors, many of whom are dedicated professionals.45 The critique is of the culture ingrained in the medical system, the systemic ways of doing things which seems to have the key facets of the eugenic “human betterment” program built into it, such as attitudes which carry on the practice of quarantine or segregation by placing the mentally ill, orphans and juveniles, Indigenous people, refugees and significant “others” into institutions which isolate them from the mainstream community and treat them as criminals. For example, a recent study of the situation in the USA found that 500,000 mentally ill people, 10 times those in psychiatric hospitals, were locked up in prisons (Frontline, 2005). Also Australian researchers still raise the topic of “White Australia” as it is seen to re-emerge when civil

45 I will always be indebted to the surgeons responsible for being able to mend the shattered bones in my foot so I was able to walk again.
rights abuses occur regarding mandatory detention of refugees and the Tampa tragedy where refugees, including children, were drowned after going overboard (see McMaster, 2002).

**Other considerations**

As far as how doctors might further sustain political influence, one might take into account the views of a former physician and Tasmanian Labor senator, Don Grimes, whose comments seem to be as relevant today as yesterday. Firstly, Grimes asserted that, especially in the health portfolio, there was a tendency for policy advisers on ministerial staff to be drawn from those in health and related professions, rather than the medical profession (Best, 1988, p.211). This appears a distinct exclusionary strategy to block out influences of other doctors on such decision-making processes. Secondly, he complained about the “over weaning sense of superiority” of the medical profession as well as its isolation from the community and increasingly from the decision-making processes” (ibid, p.212). Thirdly, while their innate sense of superiority and isolation from the community are two characteristics that can be recognised as coming from military traditions, how did they maintain their influence without having to sit in Parliament? Grimes suggests that they did this through their membership in the contemporary “boys” clubs. As Best (1988, p.212) relates:

> (Grimes) wonders whether the fact that many of the political decisions have been made in exclusive male domains, such as the Melbourne Club or the Australian Club, had been the reason for much of the conservative decision making in health. In the past it was so easy for politicians and senior bureaucrats to come across the leaders of the profession in the Club. Therefore, by and large the medical profession felt secure, its opinions were sought, and through its ability to “minister to the Ministers in sickness and in convalescence” could exert the effect of maintaining medical suzerainty over the health area without having to sit in Parliament.

It does seem, however, that while these practices are probably still as alive today as yesterday, from the above one could also assert that these “boys’ clubs” are embedded within a network of institutions which sustain the system. For example, as I have shown wider notions of professionalism were related to defence and government. These included surgeons, sanitarians or hygienists, as well as engineers, lawyers and architects or builders, with many of these emerging out of their army connections.

Such “old boys” networks as well as the militarised relations and anti-feminist stance they invoke have not diminished today in some circles, especially as one can see
that the present Prime Minister, John Howard, and the makeup of some of his cabinet on the Federal Caucus are over-represented by lawyers from NSW, half of them being educated at Sydney University before the 1970s ("John Howard", 2005) when, as shown, medicine and law were particularly close co-partners. Since being elected in 1996, Howard has not only withdrawn his overall support for the Office of Women and Feminist Non-Government Organizations as well as the Aboriginal and Torres Strait Islanders Commission (ATSIC), but also denounced the use of non-sexist language in documentation associated with the Department of Prime Minister and Cabinet (Bulbeck, 2005, p.6).

In the year 2000, the government became a critic of UN conventions protecting human rights and has been criticised for refusing to adhere to protocols on discrimination against women and Indigenous people, among others (Reid, 2004, p.3, Dick and Donaldson, 2001). In 2002, attitudes towards human rights to health became visible when Australia, along with the USA, voted against a resolution put forward by the UN Commission on Human Rights. For example, Reid (2004, p.3) states that:

Only the United States and Australia voted against Resolution 2002/31 of the UN Commission on Human Rights, which appointed a Special Rapporteur on the human right to health. Australia also voted against the Draft Optional Protocol to the Convention of Torture, which enshrined the right of a Convention Subcommittee to visit any site where people are or may be deprived of their liberty, with a view to the protection of these people against torture.

More recently, Howard also openly affirmed that he is part of this soldier tradition by stating that "Australian patriotism and nationalism has always been strong", and that such expression was mainly found in "the nation’s soldiers, who … have not just been good at soldiering but ‘are also very good humanitarians’" (cited in Wright, 2005, p. 21). While Howard, himself, did not go to war, both his father and grandfather were army men (ibid). As stated, Howard’s culture hero was the last imperialist Prime Minister, Robert Menzies, who had no time for the Australian people. Pilger (1992, p.372) asserts that many conservative politicians today “are products of the Menzies years or the Great Australian Silence”.

As far as the relationship to the medical system or “sick care system” is concerned, this appears to remain sustained through its relationship to a military and

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46 In a recent media release, Howard spoke about “quarantining” welfare payments of parents who do monitor their children’s school attendance. .
religious status quo. For example, the present Governor-General appointed in 2003 by
the Prime Minister, is Major-General John Jeffery, who has previous experience in
counter-terrorism. After taking up this office, he was also appointed by the Queen, who
is Sovereign Head of the Order of St John, as “Prior for the Priory of Australia, and a
Knight of Justice of the Order” (Governor General, 2005a, pp.1-2). In keeping with
tradition, Jeffery is also head of the ADF and, like the previous Governor of WA,
Lieutenant John Sanderson, he was a career military officer and an active leader of the
Order of St John in WA (Khangure and Howie-Willis, 1997).

As such, like the armed forces, the current medical system is still bound up within
a feudal relationship and an international status quo associated with the Order of St John
whose executive officers swear allegiance to the Royal Sovereign. While the Order of St
John and the United Orders ceased to be intertwined under the same leadership, it is
highly unlikely that conservative medical army officers have dissolved traditional
relationships with the Masonic chivalric orders. In the early 1990s the specialist
medical workforce reflected that of an older defence force replicated within the
structures of the Order of St John where senior medical officers were an elite sector of
Anglo-Australian men, with women and non-English speaking migrant specialists
entirely excluded among the higher ranks (see Baume, 1994; Farag, 1992; Khangure
and Howie-Willis., 1997).

Another important factor relates to reactions to the tabling of reports and Senate
enquiries on issues of reparations to the treatment and abuse of children in state
institutions, mentioned in Chapter Six.47 In a recent speech on the issue, Democrats
Senator for Children’s and Youth Affairs, Andrew Murray, stated that while child abuse
was now recognised by many, including the AMA, as the most serious public health
issue within contemporary Australian society, the present government refused to
consider any kind of reparation. Murray stated that “there was a general shrugging of
shoulders of the coalition government at what the child migrant, Aboriginal and other
Australian survivors of institutional abuse suffered and continue to endure” (Murray,
2005, p.1).48 He further states:

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47 This issue has been closely led and monitored by the Democrats Senator for Children’s and Youth
Affairs, Andrew Murray, who was himself a child migrant.
48 The Federal government has recently called on the military to address child abuse in Northern Territory
Aboriginal communities.
Listen to the emotion of the government when it is shouting at the Labor Party and the unions! However, when it comes to what happened to children, their reaction is cold enough to make you shiver (ibid, p.2).

In addition, a recent review of clinical trials in children, researchers state that, because the bias of research priorities has been adult-focused, there has been a failure to recognise the equal rights of children to participate in such trials (Caldwell, Murphy, Butow and Craig, 2004, p.1). Although this issue is now recognised as being problematic, they also state that today “many prescribed treatments for children have not been adequately tested in children, sometimes resulting in harmful treatment being given and beneficial treatments being withheld.”(ibid)

In both the previous chapter as well as this one, it can be seen that the power is vested in the administrators and managers of the “esoteric” arm or the “higher order” medical executives who would consider themselves as the crème de la crème and who do not need to associate with the multitude. The existence of these two levels can be seen when looking at what medical ethicists such as Veatch (1989) say about the medical status quo.

**Medical ethics**

Many national medical bodies, such as the AMA, have their own ethical codes, the aims of which represent a guide to professional conduct (AMA, 2004). However, while the AMA is associated with the World Medical Association (WMA), it is not in itself originally representative of this heroic genre, initially the domain of the soldier surgeons and, only later, the hygienists. So at the time of the Nuremberg Code, which was drawn up by military doctors, there were two declarations of ethics. One was the Declaration of Geneva in 1948 and the other was the International Code of Medical Ethics in 1949 (Veatch, 1989, p.11). Encoded in the Declaration of Geneva are parallels to the ancient Hippocratic Oath which, contrary to “common sense” notions, had nothing to do with Hippocratic medicine, but more to do with military surgeons.\(^{49}\) It incorporates certain attitudes to teachers, as well as to “secrets” and ideas of “brotherhood” and has not been short of critics (see ibid, pp.7-9). As far as the Declaration of Geneva is concerned, Veatch (1989, pp.11-12) points out:

\(^{49}\) The Hippocratic Oath was constructed by a Pythagorean surgeon who was an Athenian general in order to regulate the Hippocratic physicians (see Davis, 1974, pp. 119-120).
The Declaration of Geneva is consciously patterned after the Hippocratic Oath. It is meant to be an updating. It retains a pledge to give teachers “respect and gratitude” (but no money). Reminiscent of the Hippocratic pledge, physicians will work for the benefit of the patient according to their ability and judgement, the Declaration of Geneva has the new physician pledge “The health of my patient will be my first consideration.” In contrast to the ambiguous provision in the Hippocratic Oath, it contains an apparently exceptional confidentiality clause: “I will respect the secrets confided in me.” It has the physician treat colleagues as brothers and “maintain… the honour and the noble traditions of the medical profession”

**Conclusion**

In summary, I have argued that the multifaceted nature of the heroic genre now spans the university, the hospital, the pathology laboratories and research institutions along with the Royal Colleges as a medical system spawning specialists and super-specialists emergent in Australia from the 1970s onwards. I have pointed to the militarised nature of these developments and how the discourses from the specialist and “scientific” circles have failed to move on from the idea that those working within disaster and emergency oriented situations and/or laboratory-centred medicine are the real “saviours” of the nation.

I have pointed to the fact that the heroic genre has remained alive by controlling the rewards for medical practice and research by replicating military practices meting out awards to the officer class, but these practices are now slowly shedding their gendered dimensions. Demilitarisation will only occur when one sees Indigenous and non-Indigenous men and women and overseas-trained in the ranks of the specialities previously closed to them. A process needs to occur when entrenched ways of doing things are called into question, as illustrated by the trainee surgeons as well as the METs.

It has been shown that, while the 1960s marked the soldier-surgeon’s influence on the Australian universities and hospitals, the 1970s brought with it the militarisation of the medical division of labour where the generalist was given a marginal place. The emergent status quo also forged a partnership with health administrators whose interests were in the expansion of the pathological laboratories and medical research institutes. I have shown that while many of the actors in this medical system are caught up in what I have called a “saving” game, in Australia ideas concerning disease remain caught up with issues surrounding immigration and refugee populations, as well as biological warfare and social control. So when we come to the issue of “saving”, who is saved can
sometimes become a selective enterprise when the idea of personal salvation has been transformed into personal protection, gain or profit.

This heroic genre that presently dominates the “sick care” system is still deontological or expert-centred and pathology-focussed in character, jettisoning or limiting other doctors’ ability to define their own knowledge and medical practices. Like the structure of the hospitals in terms of “national emergency” and “secrecy” attached to laboratory research, the medical system was designed by its military authors in terms of defence and foreign relations and, therefore, comprised only secondary and tertiary medical services or what has been called the “bench to bedside” type of medicine. Here neither social nor medical needs of the patient are considered. The glue that cemented the system together was the act of faith that “real” medicine was laboratory-oriented and “secrets” were waiting to be discovered. A factor worthy of further research might be an in depth study of the contradictory signals sent out by awards associated with the Nobel Peace Prize, an institution which should be regarded as the last bastion and the most prestigious “sacred cow” of the research-oriented scientific and medical establishment, which still rewards medicine for its exploration of cells and genes.

Last but not least, are concerns about the revival of the soldier tradition with the present Howard government and its refusal to take responsibility for child abuse, now considered to be a major Australian public health issue. In the case of clinical trials, the issue of children’s rights has still not been addressed. Also, alongside the USA, this government has refused to acknowledge UN conventions, especially with regard to human rights and health. These developments raise major concerns as well as the reversals of policies which divest women, Indigenous and migrant Australians, workers, students and other sectors of the population from asserting a collective front. I have argued that the three facets of eugenic programs for “human betterment” still underpins attitudes and practices that seek to prevent the reproduction of the “unfit” by looking for “defects” in the individual, such as genetic disposition or “risk-taking” behaviour as excuses for ignoring responsibility for their health and welfare. In addition, wars are consistently being waged on germs, viruses and diseases as the “enemy” within and without.

More importantly, unless the different genres are understood as comprising different forms of medical professionalism, there is a danger that those engaged in the
process of meso-corporatism will gain support to slowly change and reshape the nature of the medical workforce. Again, they will try to gain “consumer” support by using terminology that will be misunderstood as well as denigrating the integrity of medical professionals that do not share in their authoritarian and aggressive ways of doing things.
CHAPTER EIGHT
Conclusion

The location of ethical statements within the field of science is double edged. The right to health is an inclusive right, extending beyond healthcare to the determinants of health, such as access to drinking water, adequate sanitation, essential drugs and food; freedom from violence, torture, slavery, discrimination and harmful customary practices; and access to health-related information and education, including on sexual and reproductive health. It contains both freedoms and entitlements. Freedoms include the right to control one’s health, including the right to be free from non-consensual treatment and experimentation. Entitlements include the right to a system of healthcare that guarantees equity in access (Reid, 2004, p.2).

The aims of this thesis have been to document the background, historical development and contemporary manifestations of two archetypes, namely the soldier and the generalist who I have conceptualised as “ideal type” carriers or expediters of two rival systems of medical professionalism. This conclusion revisits the conceptual grid of the two archetypes in terms of the characteristics of rationalisation and reviews my findings in relation to the aims and research questions and to the current sociological work on medical professionalism. Reid’s (2004) above words reinforce her assertion that Australians today still have no legal right to health, nor any constitutional guarantee of human rights, while simultaneously reiterating Rose’s words quoted at the end of chapter two, that such issues become a matter of our own freedom (Rose, 1989, p 256).

I have shown how the soldier has exerted authority, taking up managerial and administrative roles within the Federal public service, while the generalist was influential within Australian medical education. I have also shown that eventual changes to medical education were accompanied by changes in public health policy and medical practices within frameworks which either acknowledged or rejected social issues. I have argued that it is at least as important today as it has ever been to understand the power relations supporting doctors and their colleagues, who have, in the past, either helped or hindered the formulation of policies surrounding rights-based issues. Therefore the final critique can only be made from the perspective of human rights.

In the preceding pages I have pointed to the various ways professionalism and specific professionalisation processes have been analysed in both international and
Australian contexts and have shown gaps in the data that can accommodate my thesis. I have explained the methodology used to analyse the medical archetypes. In chapter two, a conceptual grid has been tabled of the soldier and the generalist as “ideal type” carriers of rival systems of medical professionalism using Weberian characteristics of rationality. In considering the methodology used, I have argued that, while Foucault’s work is seductive, Weber provides a much more rigorous framework for organizing research material in such a way that it links history with sociology. This meant that one does not begin with any *a priori* theories or abstract ideas, but that concepts had to be empirically adequate, so that, in order to produce ideal types, one had to firstly immerse oneself in historical reality and then derive the types from that reality (Kalberg, 1980, pp. 1145-6; Ritzer, 1996, pp.117-119). I asserted that a methodology based on “ideal types” is perfectly compatible with such a methodology.

These “ideal types” have been used as heuristic devices to interpret the empirical reality. The characteristics outlined have been supported, partly by insights drawn from Weber, Foucault and Freidson, and partly from the empirical evidence documented. While, these “ideal types” have been used as heuristic devices to interpret the empirical reality, I have acknowledged that, as an “ideal types” is an exaggerated “pure” form based on a combination of rational characteristics, it very rarely meets up with what happens in the real world. However I believe it can form the basis for a conceptual model which might be used for comparative and historical purposes.

Throughout this thesis it has been shown that doctors’ ability to influence health, medical education and workforce policy areas is circumscribed by the wider dominant social relations that support them. As such the “ideal type” archetypes and their medical systems do not only become linked to doctors, but also represent an established set of social relations within which they operate. I have asserted that one needs to show the extent of political (and therefore social) convergence of ideas and practices; resulting in showing under what historical conditions and with what resultant consequences certain doctors and their medical practices become accepted, while others become excluded. Only then can one be in a position to develop a clear understanding so as to make an informed assessment of the present actions of doctors in our communities.

I have been conscious of WHO’s assertion that human rights violations have a direct impact on health outcomes, not only in regard to patient servicing, but also in the
way health policies or programs are designed. As stated above, the broader right to health involves a consideration of many specific rights which today are being violated. These especially include the ongoing refusal to consider the social determinants of health and to broaden the framework of health and medical workforce policies to embrace the wider vision of the interconnection between health and human rights established by the Alma Ata conference in 1978 (see Owen & Lennie, 1992). For these reasons, my research has taken into account WHO recommendations to treat research on health and medical issues and human rights as cross-cutting activities.

I have shown the soldier’s influence on the Australian Federal landscape mainly from the end of the 19th century adopting the career structure and knowledge base of those who previously formed the IMS. These developments were buttressed by a perception the army offered the advantage of a more critical training, a view which also nurtured notions of superiority towards civilian medical colleagues. In addition, notions of a nomadic existence were kept alive by associating army medical professionalism with professional isolation from colleagues (see Osler, 1906, p.117). This idea of professional isolation from colleagues has been seen by others as being the single most distinguishing factor of military professionalism (Hackett 1983). These soldiers also sometimes saw themselves as “gods” and as intellectually and morally superior to the broader population in their roles as protectors and defenders of Empire.

I have also shown that the soldier imprint has left its mark on specialisms involved with Surgery, Tropical medicine and Public Health as well as administrators and managers within the Commonwealth Public Service. Acting as advisers to the Federal government, by the 1930s the soldier surgeon and hygienists became visible as part of as bureaucratic framework dedicated to imperial service where an ethic of chivalric brotherhood and a “life-saving” ethos was sustained. Boundaries were established within and outside Australia for immigration control, quarantine, and segregation, making their mark on a number of institutions in Queensland and NSW especially in both military and civilian public service and playing a central role in cultural reproduction. Also foundations were laid for many of today’s federal institutions, such as the NHRMC, the Australian Intelligence Service Organization (ASIO) and the Commonwealth laboratories and there are parallels in yesterday’s quarantine sites and reserves for Indigenous people, and today’s mandatory detention centres for refugees.
The soldier internalised an ethic of chivalric brotherhood, as part of a wider hegemonic imperial relationship forged through the intersections created between imperial, chivalric and “scientific” institutions. In turn the soldier was the carrier of military medical professionalism and medical knowledge associated with biomedicine. I have shown the military map of Australia as a guide to understanding where the soldier’s cultural reproduction has been more prevalent and part of the reasoning why, in today’s crisis milieu, institutions such as Public Health and Tropical Medicine have been re-established in Queensland, where today’s “physician executive” and medical workforce planners are located.

Through association within either or both Masonic and British orders of chivalry, the internalised notions of “purity” were extended to embody ideas of “race” and “breed” and brought with them an inherent fear of others. In an anthropomorphizing sense, the alien “other” was equated with infection or disease. After Federation, their role as advisers to governments ensured that a “castle and fortress” model of defence was shaped to isolate people from within through segregation and quarantine and from without through Immigration policy. Disciplines such as Public Health and Tropical Medicine and legislation promoting the creation of a “White Australia” became underpinned by a “social” and “preventive” medicine guided by eugenics and social control of the population. Therefore, a collegiate relationship was not moulded with civilian doctors, but with clergy, engineers and especially with lawyers, establishing legislative foundations of punitive and coercive practices designed to further imperial aims and aspirations. These attitudes and practices entered into the political realm as well as the culture of the Commonwealth public service.

From 1925, the great act of faith that has persisted into the 21st century was that most of the great advances in medicine emerged out of laboratory research, the “secrets” of which are still waiting to be discovered. The other belief, that the soldier was owed a considerable debt by the civilian population, is also one that has remained prevalent, as well as their wish to assume a leadership role within the medical profession, subsuming generalist doctors under their mantle into a task-oriented medical workforce.

The soldier also had a dominant influence within the Order of St John, a military and religious chivalric order which today still sustains an international humanitarian organization in the Hospitaller tradition. Historically, its foundations were moulded to provide a reserve army of labour ready to be mobilised in times of war and for
humanitarian efforts outside of Australia rather than within. The soldier tradition today evolving into a heroic genre, still reflects the key tenets of medical positivism of viewing the body in terms of a normal/pathological dichotomy and as a passive object exhibiting a series of unrelated parts. This type of medicine not only incorporates a mind/body dualism and an esoteric/utilitarian or mechanical divide; but also defines health solely as the absence of disease.

The legacy of rights embedded in imperial institutions was mirrored in a legacy of reluctance to take responsibility for the Indigenous, the poor and the disabled. The volunteers or “workers” were encouraged to develop an ethos of voluntarism, but the social legacy left to those in the upper echelons were taught “not to acquire empathy for the masses” (Rich, 1989, p. 88). This resulted in exclusion from any social right or consideration and is reflected in treatment of such people, as well as women and children. As Weber has asserted, substantive values might lose their religious influences, but hardly ever change (see Kalberg, 1996, pp. 53-54).

Work patterns remain attached to authoritarian, hierarchical, patriarchal and xenophobic structures which are based on top-down or expert-oriented social relations that have little or no regard for the patient’s voice. Attitudes towards patients have always been interventionist and experimental and expressed in Foucault’s notion of the “glance and the silent body”.

Formal authority has always been based on the idea that they are somehow superior to others and have generally been given executive administrative or managerial roles. Their language resonates with the terms “task-orientation”, “efficiency”, “and calculability”. Therefore, ideas associated with task-substitution and efficiency in moves to reform the medical workforce using the model of the new UK Skills Escalator mirrors another hierarchical military model of professionalism, where some, from physician assistants to senior surgeons, could easily be mobilised for military purposes. As an addendum, I have added that the basis of this medical system works only between the secondary (hospital) and tertiary (laboratory) sectors. The meanings given to public health and community medicine as specialisms in this sector do not have a primary health care component.

Especially before the 1930s, there were sometimes meeting grounds among practitioners of all persuasions and it is difficult to show how rival medical traditions
work unless one juxtaposes hospital practices within different Australian social contexts. As I have shown, as a militarised or “police state”, Queensland allowed the soldier to dominate for many years while SA, as “the paradise of dissenters” was comfortable with the egalitarian ethos and practices of the generalist physician and surgeon. At the level of everyday practices, both generalist and soldier doctors coexisted for many years, sometimes laughing at each others eccentricities or idiosyncrasies. These practices were somewhat railroaded when the younger more aggressive doctors began to brandish their swords.

In contrast to the soldier, generalists who came to Australia were highly qualified medical practitioners whose knowledge and practices integrated the idea of doctor as scientist with the idea of the doctor as humanist. While the Edinburgh Medical Faculty was the first to introduce the “modern” medical curriculum, their idea of a generalist was based on the value placed on the family practitioner whose interests and practices were related to the needs of their communities. The influence of these doctors within the Australian medical faculties in South Australia and Victoria, but especially at Adelaide University, was often subordinated to wider social interests. These generalists held a real notion of stewardship and a professional interest in passing on their knowledge and experience to future generations of students. These doctors could integrate, among other things, general practice with sessional teaching and hospital care, as well as providing continuing care for the patient. Most of all, there was a significant emphasis on producing students as teachers who could carry on their traditions of conducting research that would add to medical knowledge to alleviate problems extant within their local communities. Medical practice was based on the knowledge of when to apply science and was therapeutic as well as curative.

The generalists were both anti-Cartesian and anti-Newtonian in outlook, drawing on the idea of the body as a vital force and adopting Hippocratic tenets to retain the idea of bodily balance. Their leaders helped produce a distinctive type of medical professionalism where the doctor was physician, surgeon and teacher who linked developments in medical knowledge to meet with the needs of the community it served. The early emphasis on botanical metaphors, to which Foucault (1973) also refers, were promoted as an intellectual exercise associated with showing the culture/nature interdependence as well as the complementarily of roles between men and women. Their idea of health was multi-faceted and not reduced to the absence of disease. As a
patient-centred tradition, they were non-interventionist, assessing their patients through history taking and observation. Foucault (1973) describes their clinical interaction as that between a “gaze and a face”, one capable of extension to the wider social milieu of the community.

In reasserting the dignity of the psyche in social and medical expression, Scottish doctors and their colleagues were the first to link ideas about health with notions of human rights. All in all, the deeply embedded nature of the cultural values associated with the generalist tradition were expressed in (a) the humanist secular and intellectual tradition passed on through medical education; (b) the patient and community centred focus; (c) the concern for both women’s and children’s health, and (d) the concern for peer review so that ethical and non-harmful practices in medical consultation rooms and in hospitals could be monitored. These values were part of their collegiate culture. As far as hospital practices were concerned, the result was that, especially in Adelaide “bedside medicine” was introduced into Australia at a time when other countries were moving away from such practices. Therefore, in the generalist tradition, there was little or no divorce between practice in the community, practice in hospitals and the type of medical knowledge taught in medical schools. This constituted an important facet of their practices sometimes extended into a speciality of interest linking educational aims and knowledge to the actual needs of the men, women and children they saw on a day-to-day basis in their communities.

My analysis has therefore pointed to the fact that this generalist physician and surgeon was, first and foremost, a family doctor, a patient advocate and an educator whose allegiance was to the community. However, while in times of war allegiance was also to the nation and Empire, they were doctors not soldiers. I have emphasised how the deeply embedded nature of cultural values work their way into contemporary social relationships and expressions of medical knowledge and practice. From those early times until the 1970s in Australia the term “general practitioner” carried with it a much broader definition and higher status than it carries today.

I have shown how today the generalist genre has been revived within medical education and the battles fought to reassert their status. The generalist is associated with medical professionalism reasserting the “social contract” and the use of terms such as “quality”, “transparency” and “public accountability”. Their authority is based on their knowledge as medical professionals. Again, as an addendum, the basis of such a health
care system revolves around primary health care with intervention at the secondary level when necessary. Of course these doctors are also involved with laboratory medicine but, for example, the type of work would most probably lean towards alleviating chronic afflictions, rather than towards genetic research.

I have asserted that, while some refer to a return to the “iron cage” of bureaucracy, the capability of the humanist professional project to counteract the task-oriented tendencies of the latter is one to be explored. So as to guard against equating professionalism with individualism, I have pointed to Freidson’s (2001) last work, *Professionalism, the Third Logic* (see Bosk, 2006). In this work, the diminishing autonomy of professionals was recognised because of the constraints imposed on them by others, but he provided three logics or heuristic devices to understand how “health care delivery as a commodity” was distributed (Bosk, 2006, p.645). In the third logic, professionalism has been transformed from its negative aspects to one where it has the capacity to serve the public interest (ibid.). Also my reading of Foucault’s (1973) *Birth of the Clinic* highlights its significance in understanding the dimensions of cognitive and practical rationality as well as power and human agency. From the above one can conclude that there are now two “ideal type” modes of professionalism, the heroic genre aligned with the corporate sector emphasising a task-orientation and the generalist genre aligned with the primary health care sector emphasising a socio-medical humanist orientation.

The implications of these findings has been that in Australia, despite concerted and repeated efforts by generalists over the past several decades to support community-oriented visions, the current medical system remains a “sick care” system and, as such, has no platform on which to build community-based services, nor to significantly improve the health status of Indigenous Australians, the mentally-ill, disabled and other vulnerable sectors of our society. Attempts to build such services have been consistently dismantled. I have pointed to the issue of medical experimentation on babies and children placed in institutional care before the 1970s and point to the need to conduct further research on the topic and to widen its focus to highlight the continuation of such patterns within present-day institutions. This is especially because the Howard government has further revived the soldier tradition by forming a recent partnership with the USA in refusing to sign special international conventions dealing with human rights to health and conventions on torture.
I drew on Foucault’s argument about the interconnection between military influences on politics and war and, by extension, the management of violence or the application of physical force to addressing social problems. I highlighted its extension into public health underpinned by eugenics. As shown, however, the soldier, although originally an army medical officer, while acting in advisory capacities to Federal governments, generally belonged to a wider network of chivalric orders bound into a feudal imperial relationship to royal sovereigns. I have shown that a “preventive medicine”, also reinforced by a negative eugenics, was constructed with the aim of shaping a “pure” and “white” Australia.

Weber (1930/1989, pp.121-122) argued that the ascetic rationalism shaping the ideals of a secular aristocracy caused an invisible gulf to invade the social fabric in a brutal manner. Such a feature is very much part of the imperial landscape into contemporary times. Therefore, rather than referring to the current re-engagement of the “religious right” in politics, one might turn to asserting a revival of the soldier tradition, and with it, the wider cultural trappings outlined. The metamorphic re-enactments of crisis milieux over time have been shown to signify an attachment to the rhetoric of “saving” which is bound to the idea of a personal salvation and which is generally apocalyptic and messianic in nature. This is aligned with Habermas’ (1975) assertion that within crisis milieux, a society experiences structural alterations which critically threaten its members’ security and freedom.

The outward effects of the soldier tradition led to punitive and coercive medical politics underpinned by eugenic ideas leading to social engineering and, for example, medical experimentation on both Indigenous and non-Indigenous children. At the same time, negative attitudes towards migrants and refugees, the mentally ill, the single parent, the disabled were systemically institutionalised. I have pointed out that such attitudes were institutionalised with the aim of “eliminating the unfit” from Australian society. The particular interest was children and the thinking was that, not only were poor children devoid of any intellectual ability, but those who were relegated to the so-called “defective” list needed life-time incarceration. Queensland authorities also tried to prove that there was a cause and effect relationship between infection and mental retardation of children. Recent reports have shown that the treatment of children in these institutions was similar to experiences in concentration camps and even babies were subjected to experimentation. Such attitudes did not die, but have remained embedded
in other practices after the 1970s, a time the CDOH declared to be the “Era of Laboratory” and a time when it followed its own agenda, rejecting incentives towards building community-health programs. I have argued that it is quite likely that resulting actions and practices in the contemporary era have the eugenic program of “human betterment” as their goal. While the influence of such doctors remains within the upper echelons of the Australian bastions of the Orders of St John, such bodies headed by vice-regal representatives still operate within a feudal relationship where the Duke of Gloucester is its imperial leader and the Queen is its Sovereign. The Order of St John is an international body, its humanitarian proclivities not generally concerned with the rights of the ordinary citizen.

These social relations and the medical system from which they emerged displayed an ethic of brotherhood combining a military, religious and philanthropic zeal. The focus of medical servicing and humanitarianism was mainly to those in disaster or “crowd” situations very often outside Australia. In contrast, I have shown that generalist family or community-oriented Australian and British doctors were influenced by the humanist generalist tradition which emerged from the Edinburgh Medical Faculty. This tradition was counter-hegemonic in its religious and scientific ideas and nurtured through Scottish/Presbyterian influences on generalist practitioners from Adelaide and Melbourne University Medical Faculties until the 1960s. To these practitioners, the primacy was given to the psyche or intellect as well to consideration given to the whole person as well as women’s reproductive choices. Working in consulting rooms and visiting families in their homes, these doctors were in opposition to “rational” medicine: a medicine seen to reflect a craft or specialist-oriented and experimental traditions concerning themselves with hospital and laboratory-centred practices and research on “infectious” diseases, rather than the needs of the community. When the soldier tradition became dominant, these generalists were unable to practice in hospitals, or even to consult with doctors who intended to operate on their patients. This effectively severed the relationship between the generalist as patient advocate and counsellor and his/her ability to monitor patients’ progress in hospital on an official basis. Also the generalist who was then a multi-skilled all-rounder underwent a process of deskilling and the “new breed” general practitioner became a referral agent to the specialist.
Coming to the contemporary era, it was emphasised that, within academic contexts, the aims of the generalist educator was to educate medical students to understand community needs. These humanist traditions are a world apart from some medical administrators who view the general practitioner workforce as a site for exploitation by retiring specialists. Such attitudes were reflected in the battle first waged by David Maddison at Sydney Medical Faculty in the 1970s and then as the first Dean of Newcastle Medical Faculty, where both he and his successor, John Hamilton, promoted an egalitarian type of faculty organization and structure as well as treating women and Indigenous students with far more respect and dignity than many other faculties of that period. Hamilton was also active in helping to frame a National Health Strategy to include the social determinants of health. While, during that period and later, many others endeavoured to influence health policy formation to create community-oriented policies and programs, these have consistently been dismantled.

With regard to the current literature on professionalism, Waters (1989) has referred to this type of medical professionalism as a collegiate culture. Also, both Lupton (1997) and Jones and Green (2006) have examined the impact of consumerism on the doctor/patient relationship in Australia and the United Kingdom respectively and put forward the notion of reprofessionalisation in their examination of doctors involved in catering to their patient’s needs.

However, in the past medical administrators, politicians and bureaucrats have silenced, excluded or ignored the voice of such doctors promoting generalist and community-oriented traditions and have continued to reverse policies which give more freedom of choice and voice to patients. Counter-hegemonic voices are rarely heard where the dominant influences of the wider soldier tradition have flowed through public service departments, hospitals, universities, research institutions and laboratories controlled by the Federal government in association with the corporate sector. These institutions have become covertly shaped to systemically discriminate against accepting responsibility for the social causes of ill health and to fit in with a definition that “real medicine” is laboratory-oriented. The association of the laboratory with esoteric influences such as the “Egyptian phoenix” should not be lost on the reader, along with the fact that a Division of Public Health with Tropical Medicine has once again been established, this time at James Cook University in Townsville.
Again in today’s crisis-oriented climate, managerial influences on the reshaping of the medical workforce are coming from the Productivity Commission and are especially supported by specific actors associated with the University of Queensland working in health sciences and military health. Through a process of meso-corporatism, defined as the “devolving of state powers onto civil institutions in society” (see Coburn, 2006. p.440), they have succeeded in establishing a Faculty for training Public health and Community specialists within the RACP, as well as trying to push for a new career structure for medical graduates based on a hierarchically organized one called the UK Skills Escalator which, although mirroring an army ranking type of organization, they justify as being “consumer-driven”. These medical and health bureaucrats are not part of a “collegiate culture” and show an enormous disrespect to other medical professionals as being “ego-driven” and “self-interested”. As stated earlier, corporatism as a process was examined by Hartley (2002) using the notion of “countervailing powers” to describe managed care in the USA. This entails the reshaping of medical services to become consumer-driven rather than provider-driven and involves a coalition of health professionals and others working together at one level so as to push both physicians and nurses into conflict with each other and therefore destabilise working relations which maintain physician dominance at another level. Such a strategy brings the practice of “divide and rule” to the workplace.

In addition, Freidson (1994) began to distinguish between a corporate sector and a service sector and stressed the importance of acknowledging Weber’s “ideal type model of rational-legal administration or bureaucracy” in understanding contemporary organizations, because the corporate sector exercised significant influence and control on shaping health policy. As regards formal rationalisation, he states that the single most important feature of this type of organization is a task-orientation described in formal written rules calculated to obtain maximum efficiency. It is within such organizations that individuals are employed solely on the basis of their competence to do one job alone and their work is limited to that job (ibid, p. 206-207).¹

In summary, I have shown that since the inception of the soldier tradition, the generalists have been immersed in counter-hegemonic politics, reaching out today to form international networks. Although internationally ideas of medical professionalism

¹ Of course, the military influence on administration and bureaucracy has been one that has been explored in-depth by Dandeker (1990).
embedded in the idea of a “5-star doctor” and the “social contract” have been introduced, these seem to be strategies for generalist family and community doctors to reassert their status in the medical world, rather than defining themselves as another elite caste and fit in with the idea of Freidson’s “third logic”. However, in the present crisis milieu, the soldier, as well as the authoritarian, punitive and coercive nature of the wider relations within which the archetype was embedded dominates the political landscape in Australia today.

The two traditions have been shown as not appearing in a vacuum, but as having emerged out of the social relations within which they were first institutionalised. The soldier tradition has reflected an attachment to a hospital and battlefield orientation nurtured by the Orders of St John, whose founders introduced the idea of “life saving” as a heroic and life-threatening pursuit. As such it has embraced a craft-oriented experimental medicine supported by the hospitals and laboratories and sustained through regal and vice-regal sovereignty. In contrast, the generalist tradition emerged out of social relations that revived the integrity of Scottish egalitarian traditions and institutionalised the “modern” medical curriculum to produce a humanist multi-skilled practitioner whose knowledge producing activities were rooted in meeting the needs of their communities. As the soldier tradition began to dominate the Australian medical workforce in the 1960s, the generalists began to lose control over their own knowledge and were excluded from universities and hospitals. As such, the important role of primary health care has been ignored as well as the capacity of these doctors to meet patient needs.

Not surprisingly today’s crisis milieu has seen a resurgence of the political, social and moral paraphernalia of the “ascetic rationalism” of the so-called “New” Right reflected in the resurgence of the soldier tradition. This is seen to be particularly prominent in the use of force or coercion to manage social problems underpinned by its vision of itself which sees itself as superior. I have asserted that, apart from AMA leaders, doctors are not visibly dominant in politics today, this soldier tradition is part of a broader culture which expresses a crusader zeal and messianic inclinations while ignoring broader definitions of health associated with human rights. As such it continues to marginalise and denigrate generalist educators and practitioners and exclude them from a system which has a laboratory and hospital-centred bias and is
craft and disease-oriented and secretive in nature. Soldier mindsets are still at work here especially in the idea that social problems can be resolved by force.

Before concluding, one must assert that the critique is not of many of the doctors working within each system but of the types of medical professionalism that have created the medical systems themselves. As far as the soldier tradition is concerned, there are surgeons and physicians who are still promoting aggressive strategies to combat risk or deviant behaviour, such as smoking or over-eating, as well as trying once again to “blame the victim” by linking alcoholism and other such addictions to genetic predisposition. Once again these doctors refuse to attribute any responsibility to social determinants of health. Children’s health and Indigenous health are just two examples cited, along with the issue of medical experimentation, still to be re-examined in much greater detail elsewhere. At the same time, there are several lights on the horizon, such as the reclaiming of medical education to produce doctors able to meet community needs, the questioning of the hospital training system by new surgical trainees, and the acknowledgement by new METs that the patient’s voice is vitally important in helping to alleviate cardiac arrests in hospitals.

All in all, it still remains to be seen if the generalist will become reinstated and reskilled so as to play a dominant role in a newly perceived health system and what this will look like. One wonders if the WHO directives to produce a new definition of medical professionalism enshrined in the notion of “The Five Star” doctor will have more success than the Health for all projects. Or will the future medical workforce be reshaped to reflect the task-orientation of the Skills Escalator and virtually destroy the input of humanist practitioners?

A future research project should explore what the impact has been on the outlook of newly graduated students who have been subjected to new changes to medical education and vocational training and, in turn, how these changes have affected nurse education. Will these new directions bring “change without change” or can these changes survive and augur well for the future? Will today’s medical students become new “saviours” in a world that moves towards peace rather than towards never-ending turmoil? This would really be an apocalypse for some!

In ending, nowhere do we see an integrated health system which will protect the integrity and dignity of the community, reinforce egalitarian attitudes towards women,
Indigenous people and others in the more disadvantaged sections of the population. Nor do we see the framing of policies by those who show compassion and empathy to produce a medical workforce prepared to listen to the patient rather than the pharmaceutical companies, research foundations and laboratories. One might assert that in order to have a just health care system, it is imperative that the dignity and respect of all Australians is preserved by upholding a medical system which sets aside its eugenic and utopian sentiments and begins to integrate health and human rights into its policies. Such policies not only need to address health and medical servicing, but also the social ramifications of policies which work to undermine intellectual, collective and women’s rights. It is important that, rather than following the USA, Australian governments need to turn-about and follow UN conventions and international directives related to human rights and health, as well as support doctors keen to help address the social as well as medical determinants of health. Only then would Australia throw off the shackles of the feudal “western medical system” and its militarised relations inherited from its British imperial leaders and only then would I agree that we have passed the “post” to really become an “advanced” and “modern” society.
Appendix I

Civilian, military and Aboriginal Australia: three different maps
Civilian Australia: boundaries of Australian Colonies and Territory, 1861-1863 onwards

(Australia’s Heritage, 1970, p.583)
Military Australia: boundaries and grading of military zones from approximately 1911

(Butler, 1930, p.11)
Appendix II

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Suspended due to Copyright
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