"THE HISTORY OF MEDICAL ORGANISATION IN AUSTRALIA

by

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F O R E W O R D

This thesis surveys the growth of medical organisation in Australia, and the emergence of the British Medical Association as an integrating force in medical politics.

It covers the six States and the Commonwealth. The problem of regional variations in evolution is discussed; and the influence these had in Australia towards the development of a different approach to the role of the profession in our community, and the ultimate establishment of a national health service. Certain episodes in that evolution are discussed in somewhat more detail than others; because records suggest that they had considerable influence beyond their locality.

The collation of material had an inherent difficulty in the breadth of the survey, and the lack of secondary material from which to attack research. Therefore I must express my gratitude to councillors and executives of the Australian Medical Association in all states for their advice, and for access to records held in Branches, and by the Federal Council; and to the many people who gave time in interviews to explain the complex problems of medical organisation.

The thesis could not be written without a close study of the evolution of medical organisation in Great Britain; and an adequate knowledge of the history of its national health service since developments in Australia were both by imitation, and rejection, of models in that country. For this background, some secondary sources were invaluable which are to be found in our excellent medical libraries. I am finally grateful to the librarians who work there.

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C H A P T E R 1

The British Medical Association as an Integrating Force

The history of the British Medical Association in Australia spans the years 1880-1962. The first Australian B.M.A. branch was founded in South Australia in 1880, followed in the same year by New South Wales and Victoria; by Queensland in 1894; by Western Australia in 1900, and finally Tasmania in 1911.

The Australian branches federated in 1912 as a Federal Committee, which became a Federal Council in 1931. 50 years after federation in 1962, an independent Australian Medical Association supplanted the former B.M.A.

The B.M.A. was not the first medical society in Australia. Several impermanent associations preceded it. The first recorded was the Medico-Chirurgical Association of Australia, founded in Sydney on May 15, 1855. Only one still existed of any size when the B.M.A. was first launched in Australia, namely, the Medical Society of Victoria. The latter was founded in 1855, but ultimately merged with the B.M.A. after a parallel existence for some years.

The B.M.A. was the only medical society to succeed in unifying the medical profession, both in Great Britain and in Australia. That this was no easy task was indicated by the medical editor's comment in one of Australia's first medical journals: the Australian Medical Journal issued in Sydney, January 1847:[1]

> "There is not any portion of the community so completely disunited, so thoroughly disorganised, So notorious is it that the squabbles of the doctors have become a standing jest to the non-medical public, much of our liberality to whom proceeds from our illiberality towards each other, and, who, while it reaps a rich harvest of benefits in innumerable ways consequent on our constant endeavour to outbid each other for its favours, laughs in our face and sets us down for a set of nincompoops".

The B.M.A. had been established in England some 15 years before on July 19, 1832, at Worcester, England, as merely one of a number of similar medical societies. Significant of its regional status at the time was its original name, the Provincial Medical and Surgical Association. Its founders did not, however, limit its ambitions to local affairs. They planned scientific

study, on a national basis, of all medical and allied sciences; and, towards this end, an annual meeting in a different town each year. Their growth, on a wider than provincial basis, was great enough to justify assuming such an encompassing name as that of British Medical Association in 1856. The name had belonged to another rival society, now defunct.

The B.M.A. took many years before it could exert the presiding influence over members of the profession, so sadly lacking at the time of its origin, and exercised in all other professions but medicine. Similarly, the creation of a general discipline was a slow and tedious task. The B.M.A. had to fight the speculation, underbidding, jobbing, canvassing, tendering and mutual denunciations that set doctor against doctor; and created the shameless public spectacles already referred to.

The rise of the B.M.A. to a position of overriding influence was hampered by the disunity flowing from the basic division of the hierarchy of the profession into four main groups. These groups possessed no common qualification, and boasted no statutory registration. They passed different examinations, and carried on different types of practics.

The first and highest prestige group were the physicians, who had received royal patronage since 1522, with the constitution of a Royal College of Physicians in that year. They had enjoyed the special status of their Royal Charter with the respect accorded to an elite, possible aspirations to the peerage, and the entree to the privileged and wealthy of the land. They claimed and were given professional pre-eminence. Family connection and money were both important to such a career, usually preceded by an arts degree at Oxford or Cambridge, to give them the obligatory classical education of the gentleman. Their ministrations at the beginning of the nineteenth century were only just ceasing to deserve the attack of Voltaire, who said: "A physician is one who pours drugs, of which he knows little, into a body of which he knows less." Massive bloodletting and prescribing were practices that were only gradually abandoned, as science introduced reason into physicking.

The second branch were the surgeons. They did not transform their lowly status from their origin of barbers- doing the bloodletting forbidden the mediaeval clergy - until 1745. They received a Royal Charter in 1800 as a Royal College of Surgeons. Access to this group was open to men of meagre, even no, fortune. They seldom had

the classical education of the physicians. Their training was by apprenticeship, and clinical attendance at teaching hospitals. An alternative, though not so highly regarded, route was by service in the Army or Navy. This was usually the resort of men with neither family connections, nor money, who could only look to future colonial service to make their fortunes. Even in 1800, the surgeons had not quite freed themselves from their origins in trade, and its lowlier social standing, despite their growing prestige with the work of great anatomists like John Hunter. The examinations to license surgical teachers led ultimately to the high standard of the Fellowship. Their prestige continued to rise throughout the nineteenth century as anaesthetics took the element of barbaric sacrifice out of their ministrations, new surgical techniques multiplied, and asepsis reduced their frightening patient mortality.

Distinctions between the two professional branches of physic and surgery, which had hitherto been clear, became in a state of transition during the nineteenth century. In his study of the period, W. Reader comments:[2]

> "The physicians watched the surgeons pretty narrowly especially as the surgeons' prestige rose in the latter part of the eighteenth century. In theory, there was a clearcut division between surgery, and physic. The one was a crude affair of the knife; the other was a recondite art. In fact, no clear distinction was possible.. many of the witnesses before the Select Committee of 1834 (On Medical Education) were ready to admit , or anxious to proclaim, that the supposed division of labour was nonsense".

The third order of doctors was the apothecaries, who were both retailers of drugs and prescribers. They were trained on an apprenticeship system, like other tradesmen, and their training was only as good as the efficiency of their master. In the words of Reader:

> "The physicians regarded the apothecaries with even greater contempt than the surgeons, and even the surgeons would not admit to their fellowship anyone who practised pharmacy".

The tide began to turn when the Society of Apothecaries established their licentiate in 1815 with the first organised compulsory five curriculum, a minimum standard for education for enrolment, and compulsory hospital attendance. Surgeons were obliged to take this course if they wished to conduct family practice. It became common to take both this and the surgeon's degree. This licentiate was to establish for the first time a proper level of competence for doctors. The new 'apothecaries' disengaged themselves from pharmacy, and assumed the new title general practitioner. The Society of Apothecaries

exercised its considerable new powers with great vigour and wisdom. From its work sprang the new well-educated, well-trained class of doctor, who generated the B.M.A., the medical reform movement, and the Medical Act of 1858.

The 'general practitioner' - at least till the nineteenth century - possessed few curative remedies, and hardly any drug which could be called a specific. There was a total lack of science in professional method, until well into the nineteenth century. Due to the infancy of such subjects asphysiology and bacteriology, doctors held such opposite opinions as to the causation of disease, as to make rival medical factions appear ridiculous to the lay public. Examples of this were the cholera epidemic of 1832, theories as to spontaneous generation of disease, the controversies of Pasteur's time from 1867 on, and the pro- and anti-Lister factions.

But a scientific attitude to medicine, encouraged by the Society of Apothecaries, and nurtured by the appearance of new provincial universities, as well as the reform of older medical colleges, led to the rapid transformation of the 'bottle of medicine' doctor into his modern prototype with multiple diagnostic aids at hand.

A fourth group of doctors - negligible in numbers in the early nineteenth century - were the salaried doctors. They worked with poor law infirmaries, and their status was the lowest of all. Salaried doctors grew in numbers, as the growth of 'clubs' and 'institutes' for cooperative medical insurance, increased the demand for them; and as the first public health doctors came to be employed. The independent doctor of the first three groups took the view that only the failures in medicine, or the incompetent, accepted employment - an attitude which has lingered on into modern times.

The B.M.A. from 1832 not only had to bridge the social gap between the professional branches, but to break down existing monopolies in practice. The Royal College of Physicians, for example, had special privileges in London. The Royal College of Surgeons in Ireland had a monopoly of all appointments in country hospitals there, and similar privileges also exsited in Scotland. The Royal College of Surgeons in England only failed by a margin in 1815 to secure rights from the House of Commons to the exclusive licence of all appointments in England. The Society of Apothecaries, however, in 1815, by a majority of one vote in the House of Commons, were given the exclusive right to licence doctors with the right to dispense outside London.

The Dublin Apothecaries Company in 1834 sought contrary legislation, aiming to limit prescribing to a handful of professional apothecaries - a right desired by the 6,000 physicians and surgeons of the country. The general practitioners of the Province of Ulster protested in a petition to the House of Commons, calling for[4]

> "An immediate inquiry into the present state of the medical profession in the United Kingdom, and for the removal of the several grievances which the profession suffer by the impositions of the medical corporate bodies of the country".

One of the special areas of inquiry, they said, should be the need for a different concept of what a 'doctor' should be in the future. The laws of the land should recognise a social trend already evident - towards a doctor basically qualified in all branches of medicine, allowed to practice anywhere. The petition urged this argument:[4]

> "That the wants of society in later years has created a demand for, and require the general medical practitioner who necessarily officiates in every department of the healing art, as physicians, surgeons and apothecaries, and therefore that all distinctions of grade and name are antiquated, unnecessary and injurious to the profession- introducing invidious grounds of fancied superiority among its members; and by varying the course of education are detrimental to the well-being of the community at large.
> "As 9/10 of the members of the profession are compelled from the circumstances of society to practice in all the branches, we believe their education should be uniform and equal, and that, for this purpose, all such institutions as the apothecaries hall where men are educated and examined in only one department of medical science should be abolished.

In 1832, a Parliamentary Committee was appointed to consider the state of medical education and practice. Its inquiries, and public agitation of issues of medical reform, stimulated the rise of many groups representative of the general practitioners, similar to the one in Ulster.

The B.M.A. emerged triumphant from the clash of colleges, corporations, and societies, during the era 1830-50. Led by its founder, Dr. Charles Hastings, it rejected other groups' agitation for radical reform of the Royal Colleges to assimilate the general practitioner, or total rejection of the Colleges with a third College of General Practitioners. Its moderate policy of compromise wanted respect for the Colleges, but more democratic control within them, towards acceptance of the general practitioner. This policy was endorsed by the famous Bedford referendum of the medical profession in 1850

This sought uniform and sufficient qualification in every branch of medical practice (finally achieved in 1886) , equal right for all so qualified to practice everywhere in Great Britain, and adoption of the representative principle in the formation of Councils or governing bodies of medical organisations. Approval of this policy led to the successful 1858 Act, which was the most important medical reform of the century. It prescribed a medical register, and approved portals of entry. Although the Act failed to punish the unqualified from preying on the gullible, and pleased noone, it proved successful. It was the first state tribunal of its kind with quasi-judicial powers over the whole profession in order to safeguard the public interest. Its failing at first was that it did not require compulsory qualification for doctors in all branches of medicine - obstetric, medicine and surgery; and the General Medical Council, created by it, only represented the Crown, the medical corporations and the Universities. But in 1886, this compulsion was introduced, and representation on the Council extended to include the profession at large.

The initial political struggle to secure these reforms , 1830-50, had helped to unite the profession nationally. Never before had the various sectors of the profession conferred so closely for a common object. The political sagacity of the B.M.A. leaders was put to the test, and, having been proved in open controversy, reinforced their claim to professional leadership.

The reason why so many rival medical societies failed, while the B.M.A. continued to grow, was not, however, solely due to its political policies. It was also inherent in doctors' very individualism. One of the greatest leaders of the B.M.A. attested to this in 1914, when Chairman of the B.M.A. Council in Great Britain, after years of service in its council through critical years of its evolution in 1902 and 1911. He complained:[5]

> "One of the most difficult bodies to lead in the world is a body of medical men. They are trained from the time when they enter the profession to independence of thought and action, trained to rely on their own judgement, and it is difficult to get them to give up their individual opinions and surrender their judgement to a few men at the head of affairs. It is the old story of a bundle of sticks".

Rival societies to the B.M.A. also failed, because good, consistent, and skilful organisers are always hard to find. The B.M.A.'s founder, Dr. Charles Hastings, was all of these. He was able to command attention and persuade allegiance. He also had the

perspicacity to use the kind of phrasing, in his call to membership, which struck the right note in the minds of prospective members.

Dr. Hastings, from the outset, described doctors, as members of what should not be regarded merely as a 'profession', but a 'liberal' profession, who must exhibit 'harmony and good feeling' and honourable behaviour, 'by reason of the obligations our profession imposes upon us'[6]

This call to a higher standard of behaviour met a ready response in a class of men, who sought to emancipate themselves from their earlier status as tradesmen; and to set themselves apart as men of education, as gentlemen with codes of professional deportment and ethics, as skilled practitioners far removed from the empirical quacks and charlatans who bought medical diplomas, and still widely infested Great Britain and its colonies. The description 'liberal' appealed to such men, whether used in its social sense, to describe a person who was an empirical thinker, or , in its political sense, of a person who, like the original Roman 'liberals' was a free man.

But Dr. Hasting's insistence that members of a 'liberal profession' should act with harmony, good feeling, and a sense of obligation towards each other, could not merely be left to the encouragement of feelings of pride, honour and virtue, such as might be felt to proceed from higher standards of education, and accordingly a higher status in society. By 1840, his society called for a higher tone of morality in the profession, and recommended a code of ethics to enforce such morality. Defaulters from the code of ethics would be expelled from membership. Such a committee on Ethics was not appointed until 1849, when a member was expelled for consulting with an unqualified 'doctor'.

From this date, a growing ethical code prescribed rules of conduct for all members of the B.M.A. Thus doctors, who did not conform, were either censured or expelled. Either could be a serious professional disadvantage in proportion to the number of doctors who belonged to the B.M.A., and used B.M.A. membership to determine whether they should associate professionally with the expelled doctor or not. By the turn of the century, B.M.A. membership was sufficiently wide to command almost universal professional respect for its codes of conduct - which was wider than that laid down by the British Parliament and administered by the General Medical Council.

The ethical code of the B.M.A. was seen by trade unionists as a disciplinary code similar to their own, which was punitive to non-members, and compulsive to members. Trade unionists in unions, whose rise paralled the B.M.A., commonly used the description of

the B.M.A., whose members continued to insist that theirs was a 'professional' association with many distinguishing features. Dr.D. Colquhoun's protest was one of many, when addressing the Australasian Medical Congress of 1905:[7]

> "We are sometimes told that our medical associations are great trade unions. I am afraid that those who use this phrase do not always mean it as a compliment- even when they are unionists themselves.
> "Many of us would be glad if our associations could emulate the virtues of the best of these great unions- the loyalty of their members to each other and mutual helpfulness.
> "Perhaps they might also learn some lessons from us, and we might then see the spectacle of one of these unions meeting as we do to discuss new ways of improving their work; trying to find out what other nations are doing - European, American, or Asiatic, and selecting the best of these methods for the improvement of their own work".

In fact, the B.M.A. by 1900 became what unionists called a strong 'trade union', not by compulsion, so much as a yielding by the profession of some freedom of action in the interest of general public reputation. Among the freedoms that clearly needed to be yielded between 1832 and 1900 - if the reputation of doctors in unseemly competition with each other were to improve were advertising, poaching, canvassing, secret commissions, press puffing, endorsement of remedies, and public attacks on colleagues.

An incentive to join medical societies - that outweighted any reluctance to accept a professional code of law- lay precisely in the are atressed by Dr. Colquhoun. Medical societies kept busy doctors up to date by the publication of journals, presentation of papers at meetings with exposure of doctors to controversial points of view. For over a hundred years, a meeting ground like the B.M.A. was the only post-graduate education available to the practising doctor. Thus, while their harmony and good feeling were nurtured by the fraternity of the B.M.A, and its concomitant rules of deportment, the 'professional' role of the doctor as a man whose continuing education was life-long was fostered by the instruction it offered.

The general acceptance of this view of medical life, aided in the rapid growth of the B.M.A. by men, who, perhaps, would not have accepted the view of Sir William Osler that membership of such an organisation was not simply valuable, but imperative. Sir William Osler, one of the most distinguished physicians of the late nineteenth century, reminded his students:[8]

> "The daily round of a busy practitioner tends to develop an egoism of an intense kind to which there is no antidote. The few setbacks are forgotten, the mistakes are often buried and ten years of successful work" tend to make a man touchy, dogmatic, intolerant of correction and abominably self-centred.
>
> "To this attitude, the medical society is the best corrective, and a man misses a good part of his education, who does not get knocked about a bit by his colleagues in discussion and criticism".

In addition, the practice of medicine had special difficulties, which differentiated it from other 'sciences' and led to its common description as an 'art';[8]

> "The problems of disease are more complicated and difficult than any other with which the trained mind has to grapple, the condition in any given case may be unlike those in any other. Each case may indeed have its own problem".

Egoism was in a sense a defence against the constant mental strain, created by the variations of diagnosis from one patient to the next in an exacting doctor-patient relationship. Every doctor must carry personal responsibility throughout his working day for far-reaching repercussions in the health and family of every patient- including responsibility for life and death - in proportion to the emotional demands and complexity of problems of every patient. The medical society was therefore, also, a necessary resort to reassure the doctor of the merits of his decisions, or the up-to-date adequacy of his knowledge during a century of extraordinary discoveries. The society also provided the stimulus of meeting new friends of like interests, and all the concomitant consolations of a professional fraternity. It was also a refuge from a society which always set the doctor apart, like the priest, and made social relaxation proportionately difficult for him.

Thus, the B.M.A. Councillors, succeeded from 1832 on, in organising a body of men - naturally difficult to organise by reason of their hierarchy of status, their egoism, their individualism - where many rival societies failed. They were able to do so, because they had able and diplomatic organisers of outstanding merit. They devised shrewd political policies. They struck the right note in their appeal to the profession to become one in every sense. They succeeded in gaining common acceptance of an ethical code where other societies failed. They encouraged the growth of an environment for a higher status for the doctor, with university medical school and research departments. They were able to offer meetings and a journal of sufficient scientific merit to attract and keep professional

attention. They were able to secure vital reforms in the organisation of the medical profession.

The B.M.A. also took up the banner of public health reform. Its general practitioner members were close to all the evils of the industrial revolution, which transformed Britain, post Napoleonic war: with breakdown of traditional village relief in parishes; massing of people in damp, unventilated, insanitary slums in the new industrial towns; the proliferation of unlit, insanitary, unpaved streets; the wildfire spread of mortal epidemics like the cholera outbreak of 1832; polluted water supplies; lack of drainage or rubbish disposal.

The doctor on his rounds was in a position to assess the deficiencies of reforms to the Poor Law (1835) not long after the historic Reform Bill of 1832. He had to tend the dead and dying, and the battle scarred. He had to risk his own life doing so, and often, in those days, lost it. He had to give charity, ~~wanting from the laisser faire morality that devised the~~ under a system designed poor law ~~in a form as~~ to deter all but the destitute and moribund; due to the belief that distress was the wages of sin, and thrift and virtue would reap their own reward. He had to carry the bad debts of society. He had to see the devastation of the unqualified doctor, who flourished for want of prosecution; and who even became poor law doctors for want of proper registration, ~~or~~ he had to tolerate the evil system of calling for tenders for medical service and accepting the lowest bidder.

The doctors clearly saw the need for collective action, and the need became an added incentive to strengthen their medical societies. They could see this would be difficult with the access of new power to local bodies of the municipal corporations for administering public health acts, and poor law unions- when such corporations were inexperienced and unused to initiative. But they did not so clearly see what action should be, except in the case of smallpox, which bore fruit in the Compulsory Vaccination Act of 1840; and in elementary sanitary engineering - a science yet in its infancy. The causes of major epidemics and diseases were still problems on which doctors themselves were heatedly divided for most of the century.

When the 1842 Report on Sanitary Conditions asserted Chadwick's view that filth, damp, bad drainage, and ventilation were all factors in ill-health, he was opposed by many, even by doctors. Perhaps this was due to the fact that he could only vaguely incriminate atmospheric impurities, though his view that defective supplies of water could transmit disease was upheld, not long after by Snow, whose brilliant deduction identified this source in the transmission of cholera. But the seed was sown, the theory of infection became more

popular. It was only twenty years before Pasteur in 1867 successfully asserted that minute germs were causes of disease, and these were identified over the following forty years.

The great sanitary reformers Southwood, Simon, and Chadwick - founders of the public health system- were opposed, in part, by Government, because their views, if correct, meant heavy expenditure on public works by qualified men, then in short supply. They were thwarted by the chaotic state of local government, as well as by inefficiency and apathy; and conservatism, even active opposition, of many vested interests. They suffered from the lack of a central department to take responsibility for the service as a whole and coordinate it. None the less, their work resulted in the first public health act of 1848, in which the British Government reluctantly, and halfheartedly, assumed responsibility for the health of the nation for the first time. Their hand had also been forced by the panic of the second cholera epidemic not long before . The 1848 Act was ultimately succeeded by a comprehensive public health act in 1875, which at last established environmental health service on a firm basis; but still in harness with poor law administration, with the spirit of the poor law predominant.

This was also the period of the first factory legislation, local government health regulations, and work on a scale that reduced the potential ravages which were lurking in the urban sprawls. The mortality statistics of Dr. W. Farr were the ammunition used in campaigns against diseases in the home and the factory.

But the sanitary reformers in control for a short time, initially in an unreformed civil service, could not singlehandedly have achieved this reform. It was the agitation of medical societies, particularly the B.M.A., who upheld their work; persuaded, exhorted and condemned local governments throughout the country; educated the people; and discussed detailed applications of theory to practice in their own meetings. It was the B.M.A., which was in the forefront of persuading a reluctant Parliament, and an equally reluctant people, to accept sanitary regulations which might, the latter thought, interfere grievously with the liberty of the subject in the interests of the vague and intangible entity - their own health. The B.M.A., in short, served to educate those who educated at large throughout the nation.

By the twentieth century, the State accepted responsibility for environmental health and the foundations were laid. The B.M.A. now sought a superstructure of personal services, and more detailed protection. Among the wide variety of reforms sought were training and

registration of nurses and midwives, infant and maternal mortality prevention, medical inspection of schoolchildren, control of milk supply , better care for inebriates, insane and V.D. sufferers. Their efforts tended to stimulate more sustained intervention by Government in community welfare. They had not succeeded in totally disqualifying the unqualified from medical practice. State activity still ended in policing unregistered men from signing death certificates, acting as witnesses in courts of law, sueing for payment , or getting prescriptions made up by chemists.

State intervention left undisturbed the status of the general practitioner. But the free competition, accepted as necessary to the independence of the profession, had not altogether worked in his favour, where the prevailing principle still was that medical service was bought for payment like other commodities. Many deserved the unflattering name of Sixpenny Doctor, and the service they tendered - whether in, or outside 'clubs', which tied them to contracts - was inferior both for doctor and patient alike.

In 1905, the British Government appointed a Royal Commission on the Poor Law to consider rationalising national health service with a new plan of a coherent nature. Two of its members, in their Minority Report issued in 1909, put the dilemna of such doctors:[9]

> "The medical profession in the United Kingdom stands at this moment in a position of grave danger. A very large proportion of its members earn incomes which can only be described as scandalously inadequate, whilst many of those who now enter its ranks after a long and expensive education fail altogether to secure a footing.
> "And for this evil, the unconsidered and piecemeal development of public policy in connection with the poor law medical service, isolation hospitals, midwifery, some of the action with regard to infant mortality, and the treatment of school children, together with the wholesale extension of voluntary hospitals and dispensaries may have been to blame. "What the private practitioner fears to put it bluntly is an extension of gratuitous doctoring, by which he will lose the poorer section of his paying patients."

The general practitioners had already demanded reform a decade before in 1899. They first had to gain the power they had lost in their own organisation. The constitution of the B.M.A. had remained unchanged since 1873, and government was in the hands of its Central Council. In a spirit of dissatisfaction with the B.M.A. , a number of local medical societies were springing up, including the Medical Guild of Manchester. This Guild in 1899

called a conference of delegates from societies and associations of general practitioners throughout the country - the first important conference of the kind since 1841. Chief of their aims were better organisation and adhesion for discussion, welfare, exertion of influence on public opinion, and democratic control of their affairs - particularly through an annual conference. The B.M.A. argued, through Dr. Cox, for reform within the B.M.A., instead of the threatened rival society and serious disunity in the profession. He asserted that the size, position, and wealth of the B.M.A. made it most suitable as a national medical organisation, and efforts should be directed into converting it into an energetic body, really representative of the majority of members of the profession. Dr. Cox later became secretary of the B.M.A.; and reforms - reorganising the B.M.A. in divisions, and vesting power of government in an annual representative meeting - were carried through in 1902. Branches were represented at this meeting, including those overseas. Thus the B.M.A. became, in effect, a federation of medical societies.

The reformed B.MA., shortly after, appointed a committee to study and remedy glaring abuses of contract practice, and the miserable salaries paid such posts as the parish doctor. This report declared the profession should, itself, prescribe the rules and conditions under which it would enter into agreements to give medical attendance by contract.

The B.M.A. produced the Bradford Rules of 1904 as 'model rules' for all branches to adopt for all contracts; while the fulminations of its report on the 'sweating', and exploitation, of doctors in contract practice led to a hardening of attitude in the profession to force 'clubs' to meet B.M.A. conditions of contract. Both the power of expulsion from the B.M.A., and boycott of doctors taking posts declared 'black' by the B.M.A., were enforced.

A signal example of such action occurred at Coventry. Five of seven doctors working at the Coventry Dispensary - one of the first of its type in Great Britain seventy years before - resigned in protest at several aspects of dispensary control. These were canvassing for members, lay control, and lack of a wage limit for membership in what was intended to be a concessional service for persons of limited means. The dispensary, at that time, had 20,000 members paying 4s a year for medical attendance.

With the resignation of the four B.M.A. doctors, four non-B.M.A. doctors took their jobs. The B.M.A. thereupon blacklisted the four.

All branches and divisions neighbouring Coventry refused to allow any doctor to associate with them. After 'sending to Coventry' had lasted eight years, the four doctors finally took out a writ against the B.M.A. for conspiracy to injure them in their profession, and to libel and slander. One of the grounds for libel was an article in the British Medical Journal for April 4, 1914, saying that medical officers who took such posts were of four classes - failures, men without initiative to succeed in private practice, men in financial difficulties, or unwitting juniors. They also took out a writ against certain members of the Coventry Division, who had taken the view that theirs came under the definition of Articles 9 and 10 of the B.M.A. Constitution as 'conduct detrimental to the honour and interests of the profession and calculated to bring the profession into disrepute."

Such collective action all over Great Britain acted as a trial run for the much bigger political struggle of 1911 with the British Government over national insurance. The reformed B.M.A. found it had emerged from the reorganisation and 'battle of the clubs' a much better fighting machine than before.

Indeed Mr. Justice McCardie, in finding against the B.M.A. in 1915 on the Coventry case, considered its power in the profession had been excessive and abused:[10]

> "These rules have behind them, not merely the local bodies but the weight and power of the B.M.A. It is clear, and it is admitted, that the aim of the defendants is to inflict professional ruin upon any medical man who breaks a rule of the local body or any rule which may be made by the head body itself.
>
> "This grave power is used not only against members of the defendant organisation, but also against those who have never belonged to it. The weapons of condemnation and punishment are employed against both. It follows that the defendants' claim to enforce by boycott, and by the infliction of ruin, their own standard of medical honour and interests throughout the country".

He utterly condemned the enforcement of 'honour' through the 'deliberately framed weapons of ostracism, intimidation and threat", particularly when a statutory body already existed to safeguard the profession's 'honour', and the dispensary had long since met the conditions the B.M.A. demanded. He questioned if the B.M.A. had no power to require its members to abstain from boycotting the individuals they had once boycotted.

The defence of Dr. Cox, now secretary of the B.M.A., was:[11]

> "The profession was forced into organising itself so as to form some other court which would fill up the hiatus or vacancy left by the limited powers

> "of the General Medical Council. Before they took up the question of ethics each man was a law unto himself".

The defence of rank and file doctors was in the terms expressed by a doctor in Australia in 1902:[12]

> "We are told it is all a matter of supply and demand. Strange to say the gentlemen who have engineered the Shops and Factories Act and the Anti-Sweating League, which surely have nothing to do with supply and demand, tell us this. In one capacity, they bitterly revile the principle of unlimited competition. As managers of contract medical companies, they approve of it, and so afford an interesting spectacle to gods and men".

The Royal Commission on the Poor Law condemned contract practice as a 'failure both for the patients and for the medical men' [13] It opposed any system of universal medical insurance as 'retrograde in policy'. The other Commissioners did not, however, agree with Sidney and Beatrice Webb, that there should be a unified public medical service; nor did many doctors. Doctors' opposition, according to the Webbs, was :[14]

> "either because they were, through long habit, not conscious of the defects in the existing arrangements, or because they could not see how a united service would work".

Prime Minister Lloyd George introduced legislation in 1911, which, in the words of a B.M.A. report of March 4, 1911, 'incorporated and perpetuated by law the bad features of club practice, and extended it to a wider segment of the population.'[15] It did nothing to establish the public health policy, which the Webbs had hoped would integrate and overhaul all medical services. A Ministry of Health was not created until 1919.

This legislation was based on the German scheme of national insurance of wage earners through existing insurance societies of all types, despite the fact that it had created considerable unrest in the medical profession there, and led to many strikes. But the Prime Minister had admired the scheme on a visit to Germany in 1908; and spent two years preparing details in conjunction with the insurance groups that were to be associated. He did not consult the B.MA. at all.

The scheme was for compulsory contributions from all manual workers and all workers below a certain income; to be complemented by contributions from employers and Government. The scheme would pay an annual capitation fee to doctors for all-in medical service, and sickness benefits while unemployed. The B.M.A. objected to details on amount of payment, inclusion of 'extras' in the service, representation on administration, and the mechanism of review of payment. Among their demands were more than the 6/- a year offered, exclusion of drugs

from the service, and representation at all levels of administration on committee. These demands were embodied in their charter of Six Cardinal Points, and fought over with the Prime Minister until he had conceded five of the six.

The profession looked to the B.M.A., as did the Government and the public at large, as spokesman and guardian of its interests - although the B.M.A. financial membership represented little more than 50% of the profession in Great Britain, compared to 90% in the largest Australian states. Many doctors outside the B.M.A. contributed to its special fighting fund, and agreed to sign pledges that they could not accept employment under the scheme on any other than B.M.A. terms. After some months, a stalemate was reached on Mr. Lloyd George's offer at 9/- a year capitation fee. On his threat to employ 'non-union' doctors, suddenly 10,000 doctors took fright and signed up with the Government. The B.M.A. battle was over. In the event, Government concessions to the B.M.A. had ensured that the general practitioner was better off under national insurance than before.

In 1945, the Labour Party won the elections with a mandate for a national health service, based on responsibility by the state for every citizens' welfare from the cradle to the grave. The inclination of the Labour Party towards a full-time salaried pensionable medical service was well-known. Doctors reacted with alarm, as Paul Vaughan wrote in his history of the B.M.A.:[16]

> "Large numbers of doctors seemed to belong to a section of society which regarded the advent of a Socialist Government as a national disaster, almost as catastrophic as defeat by Hitler. It was as though the rattle of tumbrils could already be heard in Harley St."

The Labour Party's tendency was to ignore the B.M.A. with some of the contempt of the traditional Labour politician that the B.M.A. was merely protecting encroachment on its privileges, which must be yielded in the interest of efficient national planning.

The intellectual rationale for this view was well expressed by the influential economist Professor Laski, in his "Reflections on the Revolution", when he argued that 'planned democracy' in the economic sphere would 'set a new context for freedom';[17]

> "Institutions which, like employers' associations or the trusts or the trade unions have been so predominantly concerned with safeguarding their members from the consequences of that subordination will operate in a new perspective, and be adapted to the performance of new functions.

> "Bodies like the Bar Council and the B.M.A. will find that their protective function becomes far less important than the contribution they can make to the improvement of the standard of legal and medical practice."

Whatever right the B.M.A. might demand to be heard, it had no right to prevent any Parliament passing and implementing legislatio no matter how unpalatable to the doctor. The 1946 National Health Act was passed by the ruling Labour Government, which the B.M.A. charged was 'grossly at variance with the essential principles of our profession'.[18]

The B.M.A. believed that the Act clearly left it in the Minister's power to develop the scheme into a full-time salaried service - and to do this by successive regulations under the Act, rather than further legislation.

Their own concept of a national health service had already been set out in a 'Report on a General Medical Service for the Nation' in 1930; and in a further report by a B.M.A. convened Medical Planning Commission (the most representative body ever called together of colleges and corporations) which met 1940-42.

Massive rank and file B.M.A. opposition hinged on several principles. These were expressed in a public statement of Seven Basic Points, reminiscent of the Six Cardinal Points 34 years before. They were opposition to a full-time salaried service; freedom to practice without state interference; freedom of choice by patient and doctor whether to take part in the service or not; freedom of choice by the doctor over the form and place of his work without state interference; freedom of every registered doctor to take part in the service if he wished; a planned hospital service divided into areas based on the teaching hospitals; and adequate medical representation on all administrative bodies connected with the service.

The B.M.A. Council at first found itself in the extraordinary situation, of having to advise the Minister it had no mandate from the profession to enter negotiations to carry out an Act, already the law of the land .64% of the 42,000 doctors, canvassed in a plebiscite, had declared against negotiations on the Act as it stood. Their leading objections were method of remuneration, working of tribunals, and liberty of movement of doctors. Discussion stagnated for months between six subcommittees, the relevant Government departments, and the B.M.A. with the presidents of the 3 Royal Colleges endeavouring to mediate.

Two special representative meetings of the B.M.A., and a further plebiscite disapproved (40,814 doctors against to 4,735 for). Yet more negotiations, and a further plebiscite later, the B.M.A. Council found itself in the opposite role to the one it had played in 1912- this time leading an unwilling profession into the scheme. The National Health Act took effect from July 5, 1948, on the promise of the Labour Government that there would be no immediate salaried service, and of the B.M.A. to its members that various questions would be ironed out later.

A mere 100 years had passed between the first public health act in Great Britain in 1848, and implementation of the British National Health Act in 1948. The role of the B.M.A. in that period had passed from that of an active social reform group taking the initiative with the Government, to that of a professional group on the defensive. The dominant fear grew to be loss of the independent status of their professional group, and the individual independence of each doctor.

The years 1911-46 had been especially years of transition. In the past lay the era of laisser faire in Government health policy. When the B.M.A. was founded in 1832, action by the state was still seen as interference with the liberty of the subject, and distress as the wages of sin. Charity was a matter for philanthropic individuals or the charnel house. The road to total acceptance by the state for all social security was by way of haphazard reform over many years. The end result, in Great Britain, was a free health scheme from the cradle to the grave, met from public taxation.

The years 1911-46 had been equally a period of transition in Australia, as they were in Great Britain. Prior to 1911, Australian medical and public health legislation always closely followed English models - though at variable stages in different states. The majority of Australian doctors - at least till World War 1- had their training in Great Britain, and frequently returned there. Their natural tendency to look to Great Britain, as an exemplar, was reinforced when the B.M.A. proved the only model of medical society to gain permanent acceptance throughout all states. Circulation of the British Medical Journal served to keep doctors up-to-date with all technical and political discussion from the Homeland.

The profession in Australia suffered similar crises to those in England over 'club ' practice from 1895-1914, with fear of depression of income, standards of medical practice, and status. They faced a similar intention from the Commonwealth Government in Australia to

introduce national insurance, and shared similar anxieties. The Government had sent the Statistician, Mr. Knibbs, to Europe to report on social security systems in 1909. National insurance was never put into practice in Australia, however, although legislation to that end was mooted in 1928, and finally passed in 1938. The 1938 Act led to a repetition of the English crisis of 1911 with the B.M.A. fighting a rearguard action against an Act already passed by Parliament.

The B.M.A. in Australia had unexpected support from non-medical vested interests. A Royal Commission inquiry, and unexpected political changes, brought postponement, and finally abandonment of the scheme in World War 2. A second violent dialogue between the B.M.A. and the Australian Government ensued after the Labour Party came to power in 1942. Their desire for a comprehensive health service - based, like the English, on the Beveridge White Paper of 1944 - was handicapped by the restricted powers possessed by the Commonwealth Government. Though ceded the power by referendum, B.M.A. intervention secured a qualifying provision that prevented conscription of medical manpower.

The spectre of a full-time salaried medical service did not, therefore, dominate negotiations between the B.M.A. and the Government 1946-9 as much as had been the case in Great Britain, where Parliament had unlimited power to nationalise. The Labour Party in Australia was unable to implement its 1948 legislation, before it lost power in 1949. The Australian health scheme finally came into operation in 1952 on a compromise, acceptable to the B.M.A., of voluntary insurance. This put an end to contract practice in Australia, and, being founded on the fee-for-service principle, inevitably meant greater average prosperity throughout the medical profession than they had ever known.

The divergence of fortunes of the Australian B.M.A. branches from their counterparts in Great Britain may be accountable to various differences. Chief of these was the higher status of the profession in Australia.

Doctors in the new colonies, from the earliest days, had social stature commensurate with their education. They did not have to move through a rigid class structure. Everywhere they became political and social leaders. Students from the first medical school in Melbourne founded in 1862, had to do a comprehensive compulsory five year course, 24 years before the standard applied in Great Britain.

This trend was consciously encouraged by men like Professor Anderson Stuart, first Professor of Anatomy at Sydney University in

1880. He himself came with the highest possible honours - gold medals at graduation from the University of Edinburgh in 1875, and for his M.D. In later years he claimed the medical profession occupied a leading position as to social influence in Australia, and claimed some of the credit:[19]

> "This is in great contrast to the position of the profession in the United Kingdom, where it plays a secondary part - a position which I personally would not tolerate for an instant. The causes of this are that, in the Old Country, until quite recently the medical man was not usually a University Graduate. In Australia, he has been a University Graduate from the very beginning, and there have been no colleges or corporations of secondary importance to mar the influence of the University".

Another factor was the proportionately higher membership of the B.M.A. among doctors by World War 1. In Great Britain, membership of the B.M.A. had risen from 4,000 to some 25,000 out of 40,000 doctors in 1911. In the Australian B.M.A. branches, membership had risen from a handful in the 1880's to 90% of membership in major branches like Victoria and N.S.W. Yet another factor was the different evolution of contract practice in the Australian states, compared to Great Britain. The major dissimilarity was the extensive enrolment of the entire family and dependents in the clubs, to which doctors gave concessional medical service on a capitation basis.

Finally, the profession in Australia found it somewhat easier to exert pressure on the Commonwealth Government, because its powers to legislate were restricted under the Constitution; and in some areas, dependent on cooperation with the State Governments. Health legislation had grown up haphazardly under seven separate Parliaments, and local governments, compared to the situation in Great Britain with one single dominating legislature.

In two major respects, evolution of the B.M.A. was the same in Australia as in Great Britain. Its status as a special interest group -as a profession- was seriously threatened by all proposals to engage the profession in a contractual relationship with the Government involving payment to the doctor from the Government. It had the same struggle to bargain, where the concentrated political strength of their antagonist left them little bargaining power, but where their own dominant situation gave them formidable lobbying strength.

It is of interest to recall that the B.M.A. began in the same era as Robert Owen's Grand Consolidated Trade Union. This was a fraternity of workmen half a million strong on a national scale unknown before, with ambitions towards a vast unifying force in the political process of the country. The more inflammatory aspects of the trade union movement caused apprehension in the highest councils of the land; wherein it breathed of economic revolution, secret oaths, and conspiracy,scarcely made legitimate by the repeal of the combination laws.

The trade union movement fragmented into less ambitious groups, but always remained the pasture not only of the moderate reformer, concerned with immediate wages and conditions, but the political revolutionary and radical who wanted total change in the industry, or even society itself. The emphasis of the B.M.A. that it was a 'professional' association always had political overtones.

In legal terms, the B.M.A. in 1873 dissociated itself from adopting the role of a trade union. It abandoned its original plan of seeking a Royal Charter like the Royal Colleges of Physicians and of Surgeons on the grounds of the great expense. It abdicated its independence to change its constituion as it saw fit,in order to incorporate under the Companies Act justifying the decision in that[20]

> "The Companies Act has been so modified as to enable scientific associations to obtain all the benefits of a charter at a comparatively slight cost."

The decision was a critical one, as in future years it created difficulties which prevented the B.M.A. acting as a strong 'trade union' when it wished to do so.

Implicit in the incorporation of the B.M.A. was the fact that it could only carry out those functions defined in its objects. In 1902, the B.M.A. Council sought to widen its stated objects to carry out some of the activities current in unions. These were benevolent provision for members and their families; promotion of candidature for any British Legislative Assembly;taking or defending legal proceedings for or on behalf of any member involved in his professional capacity; sale or transference of practices or partnerships and the undertaking of medical agency business; execution of any trusts which the B.M.A. might deem to be conducive in the interests of itself and the profession.

These problems were still unresolved when the B.M.A. applied for a Royal Charter in these terms in 1909, but was refused by the Privy Council owing to opposition from medical bodies, such as the existing Royal Colleges and some Branches.

After the political battles of 1911-1912 with the British Government, certain branches were seriously concerned with the weakness of the B.M.A. as a fighting organisation. A motion to this end, put to the Annual Representative Meeting of 1912, engendered heated controversy. One doctor admitted that the 'term trade union used to stick in his gizzard, but now he was in favour of it.'[21]

But the Chairman, Dr. MacDonald, counselled caution. He feared a split in the profession. If a union were contemplated, the B.M.A. as it now stood would have to be wound up with all its property and holdings. A fighting fund had already been created as a separate trust, to be registered under the Trade Union Act, and not to be used for anything but defence of the profession. He persuaded the meeting to refer the matter for Council to report to the 1913 meeting.

The B.M.A. Council report confirmed that the B.M.A. would have to be wound up in its present form. As it stood, an incorporated company under the Board of Trade, its authorisation depended on exclusion of anything which would impose any regulation, restriction or condition which, if an object of the Association, would make it a trade union. They added:[22]

> "Any actions, which were thought to be proper only to a trade union, would mean risk of loss of registration, forfeit the protection of the Companies Act, and the Charity Commissioners could step in and administer the funds".

As to the alternative, a trade union, they felt it was open to serious doubt if a trade union was a form of organisation suitable for the medical or any profession. They cited three arguments:[23]

> "1. The members of successful trade unions generally work together in large groups. Unions had always proved hard to organise among scattered workers.
> 2. A trade union drew strength from their offer of benefits and the loss of anticipated benefits involved in expulsion, helped to enforce loyalty. There was no evidence that the medical profession would be willing to subscribe to the same level as the unionist, to sustain him in the face of economic loss for refraining from work.
> 3. The weapon of the strike is not available to the medical profession, and the same remark applies to many of the most effective methods of the trade union which depend on what is euphemistically called moral suasion. Not only are they not available but they are repugnant to the great majority of the profession".

The Council doubted if the form of B.M.A. organisation had anything to do with the failure of loyalty among members in 1912. The real question at issue was whether the B.M.A. could ever command the loyalty of the members to the degree required of an effective trade union in a state of opposition. Even if the B.M.A. could have

given 'strike ' pay to doctors refusing service under the Act, they believed it likely that non-members, plus those who were not determined opponents of the Act, plus those who felt they would gain, would have been enough to man a British medical service without loyal B.M.A. doctors.

The Council was not enthusiastic about yet another alternative - a trade union to protect B.M.A. fighting funds. It raised the possibility of a serious rival that might eventually challenge the B.M.A. It would undoubtedly attract largely those doctors engaged in insurance and contract work. It might be looked on as a confession by the B.M.A. itself of inability to promote the interests of the whole profession, an object which had always been the B.M.A.'s prime claim to support from the profession. The Council prevailed at the 1913 Annual Representative Meeting. A motion for a trade union was defeated. The issue was traversed again in 1917. Sir. H. Slessor, K.C., then standing counsel to the Labour Party, told the B.M.A. it would have been in no better position as to liability to pay damages, in a case such as the Coventry libel case, if it registered as a trade union.

In 1924, the B.M.A. formed a new company. Its new constitution forbade it to attain any of its objects in a manner, or by means that would bring it under the definition of a trade union. It could not exercise compulsion on its members in connection with a dispute with employers; it had no power to levy funds; it could not organise a strike; and it could not employ its funds to compensate its members for pecuniary loss arising from obedience to a command of its executive to refuse to render service to any given employers.

The issue remained dormant in England, until the furore of the 1940's. Once again legal advice was that the B.M.A. could not engage in activities which would 'impose restrictive conditions' on medical practice, owing to its registration as a company not for profit. This did not allow it to do anything unspecified in its articles, such as organising a strike against the national health service, or collecting a fighting fund for organised action.

The solution adopted was to create a parallel body, the British Medical Guild, to collect and administer 'strike' funds. In his study of the B.M.A. as a 'pressure group', H. Eckstein adopts the view that there was a n emotional content to the rejection of trade union registration:[24]

> "Officially this was rejected because doctors, not standing legally in a masters and workmen' relation to the Minister of Health would not be protected under the Trade Disputes Act; actually it was

"rejected clearly because trade union status was normatively repulsive to the Association's leaders. "The other was to add the word Limited to the title British Medical Association, but that was also rejected, partly because it was thought to be indecorous to add such a frankly commercial form to the title of so pretentiously professional an association".

The B.M.A. Branches in Australia on at least two occasions also seriously considered registration as a trade union during critical debates on national health service. The proposals came from Queensland and Tasmania in 1938, and N.S.W. and Queensland in 1944. In N.S.W. the motive was to preclude the registration of any other medical body as a union. Some members feared that the Government might make membership compulsory, thus undermining the essential spirit of the .B.M.A. as a voluntary association. The Federal Secretary wrote to London to ask whether any recent consideration had been given to registration as a trade union. In fact, it had ceased to be a very live issue in the B.M.A. some years before. The B.M.A. Council continued to support the 1913 viewpoint, that the means to secure common action was not to change the legal status of the B.M.A. It was, rather, to pursue policies which could command loyalty.

As a large organisation of inherently dissident elements, the B.M.A. policies could only command loyalty to the degree that it was led by wise and seasoned councillors - whether in branch, division, or central councils and committees. Their experience, in the highly complex business of medical organisation covering all fields of medicine, was vital t o the policies of tactful compromise so often necessary to pacify rival factions. None the less the schisms sometimes became critical, as already exemplified in Great Britain, or in Victoria 1902-5, or N.S.W. in 1938 - to cite only a few among many instances. Then B.M.A. leaders needed to be not merely skilled in committee, but persuasive on the platform, and masterly in debate.

Sometimes schisms took the form of basic alignment into the original opposition the B.M.A. had from 1832 sought to bridge - of the general practitioner and the specialist. Having resisted the separatism of distinct College of General Practitioners, prior to 1800, the B.M.A. sought to represent all categories of doctor as its membership spread throughout the Empire. Its appeal lay in the open door to the whole profession. A B.M.A. member might go from the provinces, or from the colonies, and find himself on an equal footing with his confreres at all professional gatherings. He could use B.M.A. headquarters, its library and attend its scientific meetings

anywhere he might travel, thus enjoying its fraternity in any town he might enter. These were social and professional advantages by which doctors placed great store.

But the growth of specialisation, other than surgery and medicine, from 1850 on, accelerated within the twentieth century with the great technical advances in medicine. Up till World War 1, such specialists commonly spent some years in general practice first. Specialists from the early days had more limited hours of practice, and less neighbourhood visiting than general practitioners. Consequently, they had more time to spare to join B.M.A. Councils and Committees. They tended to dominate in these bodies both in Australia and Great Britain.

When the general practitioner member felt that B.M.A. policies were neglectful of their interest as in Great Britain in 1899, N.S.W. in 1895-9, Victoria in 1929, N.S.W. in 1938, the cry was usually raised that specialist preponderance on the councils was numerically disproportionate. In Australia, the general practitioners at times of maximum discontent have endeavoured to reduce any possible disbalance by running general practitioner tickets for Council, and adaptation of the constitution both federal and state. The existence of a latent 'opposition' in the B.M.A. democratic process at its most vehement turned on the difference of interest between the two predominant groups.

The period of maximum growth in B.M.A. membership from 1870 to 1938 was the period when conflicts of interest between the specialist and general practitioner sectors of medical organisation was least marked. In recent years, conflict of interest has become more obvious due to three factors. The first was the tendency for doctors to specialise immediately on graduation, instead of having a term in general practice. Specialists on B.M.A. Councils did not therefore have personal experience of problems, on which they might have to devise policies or arbitrate. Second was the change in the educational process with selection for University entrance, and concentration of clinical teaching in hospitals under specialists - again without general practitioner experience either for the teacher or the student. The assumption of an educational elite was reinforced by the orientation towards a preference - thought to be superior to general practice by virtue of longer study and senior degrees - for specialisation. In the newer establishment ' the student who entered medicine to follow his father into general practice was often unfavourably placed compared to the merely academically brilliant student.

Thirdly, national health service policies bore in different ways on the general practitioner and specialist sectors. General practitioners, rightly or wrongly, often said the specialists in Council, were insensitive to their problems and more susceptible to Government pressure to accept compromises in Government initiated schemes. These compromises then affected the basic abiding compromise between their factions.

Such charges were made amid considerable acrimony, and with more than a whiff of gunshot in Australia over national insurance in 1938. With threats of wholesale secession from the B.M.A., the Federal Council set up a general practitioner sub-committee to renegotiate terms with the Commonwealth Government so roundly opposed in the ranks as 'sell-out'. Another less major uproar arose over the pensioner medical service in the 1950's in Australia; while 'alarums and excursions' occur from time to time over fee payment levels under the national health scheme.

At less critical times, a sense of competing interest was often evident on policies of domestic interest to doctors, such as specialist registers, accreditation of specialists, hospital access, supersession, and regulation of fees.

The two sectors were also capable of solidly closing the ranks, as occurred in opposition to the Chifley Labour Government legislation for pharmaceutical benefits, and national health service from 1945-9 in Australia.

Fourth, the foundation of the Royal Australasian College of Surgeons, and the Royal Australasian College of Physicians before 1938, and the College of General Practitioners since 1938, has set up important new governing entities in the profession. In addition to these, a number of specialist medical societies or colleges scatter the attendance and interest of doctors with consequently less cross-fertilisation of knowledge through liaison between different branches of medicine.

Doctors were united also in their determination to preserve their autonomy as a professional group, and, through it, their high social status. They were politically astute enough to avoid any financial contractual relationship between. They realised the import of legal advice that this would place them beyond the protection of the limitation to the Commonwealth power in health matters, and that it could not be invoked for 'civil conscription'. They were aware that with loss of independence would come loss of bargaining power, and with it strength as a political machine to fight the 'nationalisation' into a salaried medical service which all dreaded. To be the employee of bureaucracy they saw as the deathknell of their wealth and status.

A contractual relationship with the Government was only conceded later in respect of pensioner medical service.

Doctors were also united in respect for professional ethics, community service, colleague solidarity in society, and their altruistic service ideals - ideas that had contributed so strongly to the high social status they enjoyed, second to none in the professions

Despite all dissension and storms within the B.M.A. in Australia, it survived until 1962 despite the fact that moves to found a purely Australian Medical Association extended intermittently over the 70 years from 1890. Majority sentiment - at least within Branch Councils - wished to preserve the connection, even after other Dominions such as South Africa and Canada, had replaced it with an alternative affiliation of an independent association; and even after the Empire in which it had evolved had disintegrated so that the very name of British Medical Association seemed archaic in Australia in the context of its modern relationship under the Statute of Westminster.

Tradition, the prestige of the name, considerable sentimental feeling for the attachment, and the desire to receive the British Medical Journal prevailed over the drawbacks of the link with Great Britain. These were the need to refer certain decisions and constitutional changes to the parent Council in Great Britain, and to remit sums of money home for the British Medical Journal which was a drain on the limited financial resources of the Australian membership.

With the federation of the six Australian B.M.A. Branches in 1912 in a Federal Committee of the B.M.A., Australian doctors had a national organisation with considerable autonomy from the Parent Council of the B.M.A. in England; although with very limited and defined powers. The Branches continued to remain direct Branches of the Council and to have direct representation at the Annual Representative Meeting in Great Britain. The Federal Committee was primarily a coordinating and advisory body, with power proportionate to the personal influence and strength of personality of those doctors who sat on both federal and state councils. This Federal Committee was replaced by a Federal Council in 1932 with little accession of power.

Major changes - post the 1939-45 war, both in Great Britain and in Australia, made dissociation between the B.M.A. in that country and its offshoots in Australia finally inevitable. The B.M.A. in Great Britain had agreed to national health services in 1948 in a form unacceptable in Australia. The voluntary insurance policies of the

Commonwealth Government in Australia from 1953 had no counterpart in England. The elders of the B.M.A. Councils in Great Britain could no longer offer counsel from equivalent experience as they had done for 70 years on issues like contract practice, public health legislation and national insurance. The influence, example, and help of the B.M.A. in Great Britain had been tremendous. But, by 1945, their aid in establishing sound and thriving medical societies had long ceased to be necessary. Constitutional procedures and ethical codes were well established with adaptation to local needs.

When the Australian Medical Association finally came into being in 1962, the B.M.A. in Australia ceased to exist. In this transformation to a wholly local constitution, the long experience of the B.M.A. with its precepts and precedents over a century proved valuable to the councillors concerned. The new federal body provided for representation from existing corporate interests, as well as membership and branch representation. It continued in the great tradition of the B.M.A. to be as widely representative of the whole profession as possible. But in one major respect, the emphasis in B.M.A. responsibility had radically changed from 1832-62; as expressed in the A.M.A. handbook for 1965, where it was said:

> "In recent times, medical politics have necessarily been in the forefront of the Associations' activities both centrally and locally".

Medical politics have been conducted on the principle that doctors have a moral right to manage their institutions, as they best know how to do this than anyone, and this in the end was best for the community advanatage; that doctors have a special trust to the community, and are held in special trust by the community - therefore they have a right to be consulted in the preparation of legislation. They have been more or less successful in pressing this viewpoint depending on the Government in power. They were always least successful with Labour Governments, with their distrust and hostility of social 'establishments' in which they customarily classified 'professionals' like the doctors.

The B.M.A. was often most hampered in medical politics by apathy and indifference among the profession, except when their pocket was touched. Both the causes for the apathy and the raison d'etre for the B.M.A. were succinctly described by Dr. Armit in 1927. He had a long experience in medical journalism in England and in Australia, being foundation editor of the Medical Journal of Australia in 1912, and asserted:[25]

> "Many members of the medical profession regard medical politics with disfavour. They are concerned with disease and its treatment. They hold that their obligations are restricted to their immediate duty to those persons who engage their service during periods of illness.
> "Others are occupied with the scientific investigation of disease processes, and imagine that, as their work brings them in contact with persons suffering from disease only in an indirect manner, they have no concern with the problems dealt with in the annual reports of the Branch Councils and in the addresses.
> "These views are just as narrow and untenable as the outlook of the practitioner who evaluates medico-political activity by the effect it has on his income. The profession is united in the B.M.A. for the purpose of exercising its influence to mould public opinion towards the establishment of means for the better carrying out of its work".

The ultimate compromise, satisfactory to all, of high and nomical standard of service to the public, with high standing of professional life, has not yet been worked out in Australia. The doctors' right to pre-eminence and prosperity on his own terms continues to be bitterly argued, against the harsh reality that vast sums of public money are involved. But the Australian Medical Association, successor to the British Medical Association, still dominates the majority of the medical population despite secessions, indifference, even open revolt. It still repairs the bridge first laid down so long before by the British Medical Association; and it still endeavours to preseve the status and independence of the profession that was the original care of the B.M.A.

NATIONAL MEDICAL ORGANISATION

Writing in 1870, the editor of the short-lived N.S.W. Medical Gazette complained of the disorganised state of medical practice in Australia:[1]

> "Many attempts have been made to remedy the mischievous state of medical ethics by the establishment of medical societies, but these have failed through the restrictions enforced by their rules, and by-laws both as to the election of members and the subjects admitted for discussion. The want is felt in every town, or district of town or country of a society founded on the broadest possible base both as to admission of members and subjects for discussion. The former should include all medical men, the latter all subjects not political nor sectarian."

Occasional advocates for a national medical society, which would fulfil the condition of the broadest possible base, and embrace all six Australian colonies, were to be found before the first three B.M.A. branches were founded in Australia 1879-80 in Adelaide, Melbourne and Sydney. But distances of up to 600 miles separates these capital cities from each other, while Perth and Hobart were even more remote. Although some large country centres were close to capital cities, others were considerable distances away particularly in Western Australia and Queensland.

Travel was awkward and slow. The first major railway links dates only from the 1870's with main trunk lines like the Sydney-Melbourne railway being opened in 1883. Sailing ships were giving place to steam, with faster and more regular schedules in coastal shipping; but most doctors had neither the time nor the money to spare away from practice for the lengthy interval required to travel interstate.

If a national medical society were to be of the slightest value in 19th century Australia, to doctors scattered widely through its vast territory, it would have to offer a national journal, and it would have to include topics of local medicine. Sufficient contributor would have to be found to discuss aspects of medicine created by the different climate and conditions of life, providing material that could not be found in British journals like the Lancet, and the British Medical Journal. Sufficient financial support from an adequate membership would be needed to keep it solvent.

The first group of doctors to found a society with a national name founded no journal, mor made any attempt to solicit interstate membership. This was the Australian Medical Association that lasted in Sydney 1859-69. A first attempt to found a national journal without a society was the Medical Practitioner published in Newcastle by Dr. S. Knaggs 1877-8. Despite the issue of 3,000 circulars to the entire profession, with an impassioned appeal for Australian

material and the liberal distribution of free copies, he found the profession just as apathetic as in his previous venture with the N.S.W. Medical Gazette 1870-5. The Australian Medical Journal in Victoria, organ of the Victorian Medical Society from 1856, met with an equally poor response in encouraging interstate contributions.

By 1880, the eastern states of Australia were entering an era where commerce with England was expanding; when great exhibition buildings were being built as in Sydney 1879, and commercial expositions held; and when the economy of the country was diversifying into manufacturing and primary industry other than sheepfarming and cattleraising. The rudimentary life of the pioneering community was no longer adequate even in newer towns. People were no longer satisfied with badly lit, ill-drained, squalid, unsewered and epidemic-ridden towns.

In this decade, during the International Exhibition in Melbourne 1881, a Social Science Congress projected an Australasian Science Union which would have a Health Section.[2] In 1884, Dr. MacKellar, medical adviser to the N.S.W. Government, was pioneering the idea of a federal quarantine system to hold at bay the periodic epidemics of cholera, and smallpox imported by overseas ships. He organised an Australasian Sanitary Conference, attended by one delegate from each state. The medical profession of Sydney entertained them to a banquet where Dr. Cox expressed the hope they would get better medical representation in Parliament.[3]

The N.S.W. B.M.A. Branch then put its resolutions to the Government which were for one uniform quarantine act for Australia, a uniform bill of health for all ships, medical inspection of vessels, federal quarantine outposts in the west and north, compulsory vaccination, and notification of infectious diseases. Such a system was introduced in 1900 with federation.

The beginnings of reform of public health legislation were set in train 1890-1920 , which led to increasingly detailed control of food preparation and handling, pure water and milk supply; sanitation and many of the minutiae that bear on individual health in crowded communities. Due to the efforts of great early hygienists such as Dr. Ashburton Thompson in Sydney, and Dr. Greswell; or Dr. H. Allen in Melbourne it ceased to be true, as was said of the 1858 Health Act, in Victoria:[4]

> "The legislative basis of the control of health was eminently unsatisfactory, and despite the strenuous efforts of many competent hygienists the administration failed to achieve even a modicum of success."

In 1888, the Royal Society of N.S.W. invited the Victorian and N.S.W. Branches to join in founding the Australian and New Zealand Association for the Advancement of Science for the centenary year of N.S.W., and doctors continued to take part in its meetings.

The year before, in 1887, an Intercolonial Medical Congress, was launched on a triennial basis. At the same time doctors continued to take part with other scientific disciplines, as they had done in earlier years in all states in Philosophical Societies. They founded a medical section of the Royal Society in N.S.W. 1876, and belonged to the Royal Society of Tasmania. They took part in an Australian Health Society in the 1880's, directed to pooling knowledge and to educating the public in public health. They participated in a sanitary section of the Royal Society 1886, and a Newcastle Sanitary Association; also in a Society for Medical Botanists, Pharmaceutical Societies, the Linnean Society, Microscopical Societies, a Geographical Society, and a Pathological Society.

As early as 1881, the Australian medical profession had looked even wider afield, accepting an invitation to be represented at the International Medical Congress in London in 1881, which Dr. J.W. Springthorpe attended for the Medical Society of Victoria and Mr. Rudall for the B.M.A..[5]

In the 1880's, a national outlook first began to triumph over parochialism of the states in politics. The first Federal Council of Australia began in 1883 which, though 'little more than a debating society', included quarantine among its proper fields of action. This council was the forerunner of the Federation Conventions 1890-8, and finally the Commonwealth of Australia 1900.

The first Colonial Conference gathered in Great Britain in 1887, (in spirit and fact an Imperial conference). Imperial federation was in vogue at the time, and found supporters in Australia and New Zealand to argue for imperial rather than Australian or even Australasian federation. By t he 1880's the integration of post and telegraph service with Great Britain, and of fast and reliable steamship services was fairly complete. Australians were wont to think in terms of Empire; their vision how to bring the Home Country physically, if not constitutionally, closer, because the growth in trade, on which the future expansion of the country rested, depended so vitally on that factor.

Medical men were no exception. Refuting a rather critical account in the Lancet in 1874 by a doctor who had spent 14 months in Dunedin, another doctor -16 years resident in Melbourne- wrote:[6]

> "When he refers to their great indifference to European news, their ignorance of medical topics, their being grossly ignorant of the practice of medicine and surgery, this is, in my opinion a great libel on the members of our profession at the antipodes.. numbers of the physicians and surgeons in the colonies are quite equal to the leading members of our profession in England, adopting every new mode of treatment or operation in surgery that will benefit their patients."

In 1878, Dr. Knaggs suggested in his journal, the Australian Practitioner, that the opening of the Sydney-Melbourne railway and the Sydney Exhibition 1879 should lead to medical federation and annual meetings in the colonies in rotation.[7]

In such a milieu, Dr. Louis Henry came to Melbourne from London in 1879 with a letter which he offered as authority to found B.M.A. Branches where he could in Australia.[8] He applied to belong to the existing Medical Society of Victoria, April 1879, but was refused, possibly because they were well aware that he had a charter from the B.M.A. though personal reasons as to religious exclusion were also later suggested.[8] He found a dissident faction in the M.S.V. due to clashes of personality, opposing points of view in litigation, efforts to enforce ethical rules, and criticism of the way in which the Editor had run the Society's journal, the Australian Medical Journal. He also found that several members had for some years contemplated forming a B.M.A. Branch.

The profession was not only beset at this time by factious litigation, but by competing 'quacks' of every description uncontrolled by the state, by the inroads of 'clubs' by hospital 'abuse', and by doctors' own quarrelsome rivalry for hospital appointments in the city. And, as the President of the M.S.V. said at a dinner that year, its 150 members represented almost every licensing body, every university in the United Kingdom and nearly every noted college on the Continent.

Dr. Henry found a ready response to his semi-formal invitation from the B.M.A. in England in Melbourne, where the ex-editor Dr. Neild and an ex-honorary secretary of the M.S.V. had recently resigned from both posts in a dudgeon; and now helped him to found a Victorian B.M.A. Branch. Similarly, when he wrote to South Australia and N.S.W., groups of doctors acted to take the necessary steps to form a Branch which included creating a number of B.M.A. members as nucleus. In both centres, three B.M.A. members had to nominate a number of others.

In both centres, also, earlier societies had failed to thrive, as had other rivals to the M.S.V. in Melbourne. Doctors were quick to perceive in 1879 that a medical society of British origin might succeed where Australian born equivalents had failed. A unifying force

being desperately needed, the one that might serve best was perhaps along already proven lines.

The B.M.A. had the prestige of its name, and its growing influence in Great Britain. There it was well known to have taken no small part in the formation of the General Medical Council 1858 which helped to control quackery, the tightening up of control of the friendly societies in Great Britain in 1875, improved public health legislation, and elevated standards of medical education - apart from other fields of scientific enquiry. It had a journal of known quality available free to all members and with an editor of considerable reputation. It had developed a body of ethical law, which every member was expected to act upon.

The major rock on which medical societies had come to grief in the past was ethical rules. The dilemna, clearly seen by those who founded such medical societies in the past, was seen to be that an organised medical profession should have ethical rules; and no medical society could fulfill all the functions its members might hope for it without them. Yet nothing more quickly led to factious argument among members of a small society than framing such rules.

A leading example was the conflict that had in part led to Dr. Neild's resignation from the M.S.V. This was an accusation brought by Mr. Rudall against Dr. Brownless, a most reputable citizen, a founder of the Medical School of Melbourne University, member of the Senate, of 'unprofessional conduct' in the Medical Defence Association The cause was evidence given by Dr. Brownless, along with two other doctors, in a case against Mr. Rudall in open court. Dr. Neild's provocative comment on this in the A.M.J. was:[9]

> "If these witnesses did not virtually declare that Mr. Rudall's operation was improper and unnecessary, and was really no operation at all, and that he charged too much, then it is equally difficult to explain how they came to be on all sides publicly reported to have done so, why they took no steps to contradict such a misstatement, and why Mr. Rudall thought it necessary to bring Dr. Brownless and Mr. Girdlestone before the Societies with which they were respectively connected."

An obvious solution in the small communities of Australian cities in 1879, where such public oppositions robbed the profession of considerable dignity, was to adopt the code devised in England with local modification, and thus bypass the kind of arguments that had flowed from attempts to create ethical rules in the past. It was also widely hoped that British experience in public legislation widely discussed in the British Medical Journal, might become known to B.M.A. membership

in Australia and prove useful in attacking legislative standards in Australia, then seriously lagging behind Great Britain in the control of all standards of public health and private medical practice. The single exception was the minimum standard of medical education, which was higher in Australia from the foundation of the Melbourne medical school in 1861, and Adelaide and Sydney 1880.

With travel no longer involving the nightmare three to four month journey of early colonial days, the prospect of returning to England for refresher study became more possible to a larger number of doctors, who would profit from the reciprocity of B.M.A. membership anywhere they might travel abroad.

Dr. Henry, and his confreres in Melbourne, were well aware of the one drawback to a British association - that the British Medical Journal could not spare space for topics of a local character. In 1880, they asked a Mr. L. Bruck of Melbourne to found an Australasian Medical Gazette to cater for the B.M.A. branches, and suggested the need to make his headquarters in Sydney, to secure the support of the N.S.W. branch. Mr. Bruck did this, opening a medical agency in Sydney. He secured the patronage of the N.S.W. branch who assured circulation, much as the M.S.V. had done for some years with L. Stilwell and Co, publishers of their Australian Medical Journal.

Doctors attributed the survival of the M.S.V. to having a journal to report their transactions, and the failure of all other ventures- journals or societies - ultimately to the lack of association between the two factors. Without a journal the preparation of a scientific paper went to waste, particularly as doctors were discouraged from publishing them in the daily press, on the grounds of personal advertising. The N.S.W. branch readily accepted the proposition, although the Victorian and South Australian branches did not lend their support at once. For a time South Australia published its own proceedings. When three B.M.A. branches were launched in 1880, the medical profession had the potential for a link to cut across state boundaries. The new branches drew on the experience of almost fifty years in England, and turned to the Parent Council of the B.M.A. for advice. They were entitled to representation in England, and consequently for many years looked to ex-patriate Australian doctors in practice in England, or local councillors returning for visits, to represent them among the other elders of the profession

The new B.M.A. branches in Australia at once adopted the ideals of the association, which embraced all that touched on the calling of medicine. At foundation, Dr. Hastings in 1832 had defined a fourfold function for the BM.A.- scientific, social ethical and medico-political

He had seen medical science in the broadest terms - not merely the individual case records compared on a local basis, but 'promotion of all medical and allied sciences' by study of medical topography on a national scale. He had conceived its social function as one which, by promoting friendship, would add to intellectual enlightenment and breakdown the natural insularity of medical practice. He had hoped for less public bartering and bickering in the market place, that had made the doctor so commonly a figure of satire. He wished for a profession working towards standards of etiquette that would uphold public respect for the medical vocation as one calling, no matter what the segments. Finally, he had foreseen that the profession as a whole would have to engage in politics to secure the intervention of the state to protect the health of its citizens. This must be done by the study of everything that bore on the health of every person in the community; the air he breathed, the water he drank, the food he ate, the way his houses and towns were built, the location of noxious trades, abbatoirs and rubbish dumps, the movement of epidemic whether through unvaccinated citizens, their wells, or ships coming from overseas.

The doctor himself must be properly licensed, and the public protected from his incompetence, and from those who forged or bought licenses, and impostors who claimed titles which they had never had.

The whole province of the profession, and the profession in the community, was claimed by the B.M.A. This commitment was knowingly accepted by the doctors who joined it to found the Australian branches. Its stated constitutional objects were wide. As the Chairman of the Council of the B.M.A. in England, Dr. Wand, said in England in 1960 when the Federal Council of the B.M.A. in Australia was planning, after seventy years, to become an Australian Medical Association of Australia:[10]

> "The objects of our Association are set out very briefly in a composite fashion, and they have by and large stood the test of time".

Over the years, a change in balance had gradually occurred until medical politics had predominated over science.

A common membership in the B.M.A., and a common name, were the only things in reality that united those in South Australia, N.S.W. and Victoria for some time after foundation in 1880 . Otherwise liaison between societies 1880-7 was limited to desultory correspondence and personal friendships. By 1886, relations with the B.M.A. in England had reached such a crisis in N.S.W. the Council of the N.S.W. Branch recommended March 29, 1887, the advisability of forming an independent medical association for the Australian colonies:[11]

The complaints were as follows: letters were disregarded, remittances of money were not acknowledged, lists of new members sent home were overlooked. Money transmitted in payment of subscriptions to the British Medical Journal received no attention. Journals were missing. Money already paid was redemanded by the Home Secretary in such a manner as to estrange many members. Chief grievance of many members was not receiving their journal, particularly country members who regarded the British Medical Journal as the oustanding benefit of membership, being unable to attend meetings.

Grievances were of long standing. Representatives of N.S.W. and Victoria had seen the British B.M.A. Secretary, as early as 1883, to complain. Three meetings of the N.S.W. Branch were called to discuss the advisability of severing the British connection, and indeed , on one occasion, voted for independence, but were overruled by a technical objection of the president:[12]

> "No meeting of any branch could be held with the object of altering its constitution or relation to the parent society".

13 members resigned in protest.

The British B.M.A. Secretary, Mr. Fowke, by chance read of the crisis, and cabled the N.S.W. Branch to stay its hand. At last he investigated the B.M.A. official who handled Australian correspondence who was found to have such a 'cerebral softening' that all the correspondence was disclosed unopened and forgotten in his drawers. The official was asked to retire, the B.M.A. branches decided not to do so, and the spectre of the Australian Medical Association once more receded. Although for the moment a dead issue, a notable gap was still left with the want of any permanent liaison between the Branches with particular attention to Australian problems in medicine.

Medical federation between the colonies had been mentioned from time to time in the M.S.V. or its journal. An Australian Medical Union was discussed in the Australian Medical Journal 1875-8, which recorded that doctors had suggested occasional meetings between different colonies to exchange experiences on climatic conditions of Australia, and local research relevant to their society. A science convention was mooted by the M.S.V. linked in the Melbourne Exhbition, which in fact was held.

The first intercolonial congress in Australia, wholly devoted to medicine, was held in Adelaide in 1887, to coincide with the International Exhbition in Adelaide celebrating fifty years history and the Jubilee of Queen Victoria's reign. Dr. Poulton of the South Australian B.M.A. Branch proposed it. A committee of seven

leading doctors cirularised members. These, having approved, a foundation committee of ten prepared a scheme and invited the cooperation of the profession throughout the colonies. As secretary, Dr. Poulton carried out the considerable work of organisation both before, and during, the conference; which was naturally onerous for lack of a precedent for such a congress. The second congress paid tribute to him with a purse of sovereigns, and a silver inkstand.

When an adequate number of South Australian doctors subscribed to Congress, they were called together in advance to elect a President and executive officers. A special appeal to attend Congress was also sent to all South Australian doctors, not then members of the B.M.A. Thus the B.M.A. did not itself run the Congress, but put it into the hands of the profession. The invitation, sent to all medical societies in Australasia, to India and many other centres, was to all legally qualified doctors- not merely B.M.A. members.

The presidents of all Australian medical societies were invited to be vice-presidents of the Congress. It was thought apt that a South Australian should be president as Adelaide was the venue. The Congress President, Dr. J.C. Veroc, distinguished in science as well as medicine, was a compromise appointment, as two rival factions were divided evenly as to two other contenders. At the inaugural meeting in the Councillors' Room, Adelaide Town Hall, on August 30, 1887, Dr. Verco greeted the 155 doctors- saying the large gathering testified that the Congress was not premature, nor small, in its expectation of ambitions. He referred to the introduction of old diseases into Australia by immigrants, and to the appearance of unknown complaints like the 'Barcoo', or the increased prevalence of others like hydatid disease. He was able to hail a unique contribution already made to world disease by an Australian, Dr. J. Bancroft, who had intended to be present as President of the Medical Society of Queensland:[13]

> "What an interesting field of observation has been opened up in connection with filaria disease. The story of its elucidation, with which the names of Bancroft(of Brisbane) and Manson (of Amoy) are inseparably associated reads more like fiction than fact, tracing to the insignificant mosquito a number of serious tropical diseases, and grouping them, despite their diverse forms, into one natural order".

He spoke of the peculiar difficulties and the heavier responsibility of the general practitioner in Australia, compared to England, which distinguished the nature of their work and problems from that of the Home Country. He justified the Congress in these

terms, and urged an intercolonial medical journal.

A special Congress meeting discussed the best method of federating the different medical societies in Australasia, the possibility of securing an inclusive Australasian medical journal and the frequency of Congress:[14] But neither federation nor the journal appears to have been discussed after Professor Allen's remarks at the outset. He spoke as honorary secretary of the oldest existing society in Australia, the Medical Society of Victoria:[15]

> "We must not forget that there are societies and journals now in existence which have histories in the past and which now do useful work. We must not hastily interfere with present organisations without sufficient security that our new and more ambitious projects will have equal power of continuous life".

The President of the section of medicine, Dr. J. Williams, president of the M.S.V., proposed the formation of an Australasian Branch of the Collective Investigation Committee of the B.M.A. (which already had 50 sub-committees in Great Britain linked with three continents) 'to give purpose and method to the observations of the general body of our practitioners'.[16]

From 1887 on, intercolonial medical conferences were well patronised. As Dr. E.S. Meyers said in later years, the Queensland men lost no opportunity to attend:[17]

> "In those times of relative isolation from the world centres of medicine, these meetings played an important part in the advance of all branches of medicine (but particularly surgery) in the various colonies".

They were also able to meet household names like Sir Alexander McCormick, surgeon of Sydney; and Sir Thomas Fitzgerald, surgeon of Melbourne.

But distances were too great in Australia to propose the kind of annual meeting in a different town each year that had done so much to prosper the B.M.A. in England. The 1887 conference elected for a meeting every three years, the president to be elected by Congress, and the sections of study to be continued as in 1887- medicine, surgery, state medicine, and gynaecology but with other sections added for E.N.T., pharmacology, psychology, pathology, anatomy and physiology. Skin and children were to be sub-sections.

But the Victorians suggested the next Congress should be held in two years time, not three, to coincide with the Victorian Centennial Exhibition 1889. The plan met with serious opposition from many who were generally foremost in support of any movement that tended to the advance of medicine, feeling that not enough time would have elapsed to gather fresh material of sufficient merit.[18] But, as the new President, Mr. T. N. Fitzgerald said the chance was 'too opportune to be missed', and the first Congress agreed to the second in 1889.

The new Congress Committee of 87 members represented not only all medical societies but the whole profession. 2,000 circulars went out throughout Australia in April, 1888, with a response confirming the decision for an early Congress. The Victorian Parliament voted money to cover the cost of printing transactions, to assist in entertainment and to provide Government shorthand writers. The railway departments and shipping companies offered travel concessions. The Premier, the Hon. D. Gillies, patronised the opening of Congress in Melbourne, and was joined by the Premier of N.S.W., Sir Henry Parkes. The Speaker of the Legislative Assembly gave a dinner to meet members of Parliament, and the Premier and Government invited doctors to an excursion by sea to Port Phillip Heads. The Chancellor of the University of Melbourne, Dr. Brownless, offered the use of University Buildings. Congress Committee had sent notices to the British and foreign medical press including France, Germany and India. 553 doctors came, 339 from Victoria, 5 from England, 1 each from the Northern Territory, New Guinea, India, the Dutch East Indies and even Finland. Dr. Verco, past president, said this 'gave hope of the firm establishment of the intercolonial congress as a permanent institution'.[19] At that time, Congresses were not the commonplace event they have now become.

The leaders of social life in what was then known as 'Marvellous Melbourne' assisted the committee in 'fitly entertaining the members of Congress' while the President and Commissioners of the International Exhibition staged a special concert.

The President, Mr. Fitzgerald, posed the question in his inaugural address as to what special advantages are to be looked for from an Australasian Medical Congress. While, he said, they could not bear comparison with the great medical gatherings of Europe, they did have 3,000 men in Australasia educated up to the same limits and in the same way as at home:[20] Yet, he added, some practices varied with those in Great Britain, while the environment of life in Australia was by no means identical with that in Europe.
For example, he added, it was taught that scrofula and tubercle were affected by squalor and dirt, and pthisis was favoured by close vitiated atmosphere and coldnight air. In Australia, doctors found that 'scrofulous impregnations' were occasionally excessively virulent and pthisis as common as in England, and more so than in Canada and Scotland, despite the lack of great squalor and dirt and cold. He also raised the problem that vexed the Australian profession for so long- why the mortality rate was so high in a land where the uncommon inheritance of sunshine, leisure and an outdoor life gave the

optimum environment for a health people. He named the three great scourges as alcohol, T.B. and typhoid fever - all preventable - with typhoid fever nearly twice as common as in England.

Typhoid fever was taken as one of the two themes for general meetings of full congress, and hydatid disease. The Congress voted that typhoid fever was a 'preventable disease, which owes its prevalence mainly to insanitary conditions'; that 'unsatisfactory conditions in Melbourne caused its excessive prevalence year after year' and that it was the imperative duty of the Government to take immediate steps. It called for:[21]

> "Fresh legislative enactments in all the colonies with a view to obviate the grave dangers to public health which everywhere prevail, and which in many cases are due to easily removable causes."

A progress 'Report on the Sanitary Conditions and Sanitary Administration of Melbourne' then current, had already disclosed frightening evidence:[22]

> "almost every watercourse or lagoon in the metropolitan area is stated to be used as a receptacle for sewage".

The Australian Medical Journal had inveighed against:[23]

> "infamous acts committed by land syndicates.. who consider drainage a prejudice, sunlight a delusion, ventilation a weakness to be treated with derision."

The final report of the Sanitary Royal Commission shortly after showed that the medical health officers were handicapped.[24] They were only paid part-time, and salaries were wholly inadequate (£20-£70 a year). They were liable to dismissal, and to be exposed to friction with other doctors if they tried to enforce public health codes, which could affect their private practice.

Dr. MacLaurin, President of the Section of State Medicine, called for public health laws, as well as laws on medical practice 'that the public might be in a position to protect themselves against the imposition of unqualified persons'.[25] He spoke not only as newly appointed President of the third Congress, Sydney 1892, but as medical advisor to the N.S.W. Government and President of the Board of Health in Sydney. Not so much support was evident for Dr. Mitchell of Port Adelaide when he argued that the doctor should be an officer of the State. Congress also called for Ministers of Public Health with portfolios in the State Cabinets, and for permanent Health Departments headed by Commissioners of Health. Certainly the influence of contact of Congress members with members of Parliament was a force in the achievement in Victoria in the next decade of a modern sewerage system in Melbourne, reform of local government, foundations of a modern health department, and reforms in public health laws.

In the interim between Congresses there was no real constitutional link. The only really tangible link was through circulation of the Australian Medical Gazette, which went far and wide, even to Central Africa and Russia. Nearly half the Australasian doctors subscribed, although the source of its news and articles was never as substantial from any other state, but N.S.W. where it was published. However, the topics dealt with, touched on problems common to all the colonies, and circulation was strong enough to ensure its survival from 1881 until 1914, when it was superseded by a genuinely national journal, the Medical Journal of Australia.

Its first number had appeared October 1, 1881. Its publisher, Mr. L. Bruck, had gone to Sydney on the advice of the Victorian Branch to secure the support of the N.S.W. Branch, and had offered to register the N.S.W. Branch as proprietors, but been refused.[26] The Branch referred him to Dr. F. Milford, who had edited the N.S.W. Medical Gazette during its life 1870-1875. Dr. Milford agreed to become surety under the newspaper act with Dr. Fortescue and to get transactions for it.[27]

Mr. Bruck's own account, in 1904, of the origin of the paper was that the Victorian Council of the B.M.A. had approached him to start a paper, on the lines of the British Medical Journal, after a quarrel with the Medical Society of Victoria over the propriety of the B.M.A. publishing its proceedings in the newspaper:[28]

> "The Council promised Mr. Bruck their cordial cooperation and moral support, and also granted him the right to announce the newly to be established journal as the official organ of the combined Australian branches of the B.M.A. , which were to be established throughout Australasia at the instigation of Dr. Hart, then editor of the British Medical Journal".

In the first year, Mr. Bruck had charged twelve shillings a year and received good support. When he wanted to enlarge the journal, and raise the subscription to £1 a year, the N.S.W. Branch threatened to start their own paper, unless he made over the Gazette to the Branch, as he had offered to do a year before. Branch members in fact subscribed £250 to buy him out, only half the price demanded. Instead, Dr. J. M. Creed, who became an active member of Parliament, took over as editor from Mr. Bruck 1882-92. The journal livened up so much that the chance of another journal succeeding was very slender, and the money was returned to the backers.[29]

Once again in 1894, the Branch Council debated buying the Gazette from Mr. Bruck, but the price was now higher - £1150. The Branch

incorporated to limit the liability of individual councillors for any loss the journal might incur; and to hold property for a library and meeting place, only to discover in 1915 that the form of incorporation was technically unconstitutional. The Branch had, in fact, ceased to be a branch of the B.M.A. in 1894. Blissfully unaware of its illegitimacy for more than twenty years, the error, when finally discovered, was quietly rectified.

The Gazette was a powerful force in transmitting news from one end of Australasia to the other of provincial battles on all the grievances that plagued the profession - most of all quackery, litigation by patients aginst doctors, clubs, epidemics, sanitation, and the inadequacies of state provision in many fields , including hospital and mental care. It made the profession aware that many problems were common to the whole continent, that similar grievances existed among their brethren not only in Great Britain but in Germany, Holland, and France; that common action by an organised profession was beginning in Australia to secure small gains locally, where the grievances bore most heavily. The Queensland Medical Society, for example, urged its new members in 1887 to support the Australian Medical Gazette as the organ of their society. It never had any lack of contributors, among them the most distinguished - such as Sir Alfred Roberts, Baron von Mueller, Dr. Bennett, Dr. Joseph Bancroft and others. In 1910, the President, Dr. R. Worrall said the rise of the N.S.W. Branch was synchronous with the purchase of the A.M.G. in 1894.[30]

In Victoria, the B.M.A. Branch was neither so vigorous nor so active in medical politics as its counterpart in N.S.W. It carried an overlapping membership with its parallel, M.S.V., which continued with its own monthly journal, the Australian Medical Journal, as it had done since 1856. The Melbourne Medical Association was formed in 1890 for Melbourne University graduates, and the Medical Defence Association was formed in 1896 for medical defence. Both were also active in medical politics in various ways. Until the M.S.V. amalgamated with the Victorian Branch of the B.M.A. in 1907 at a time when the Melbourne Medical Association was gradually declining into a social affair, the four groups dissipated the support of doctors.

From 1890 on, in all three eastern states, Victoria, N.S.W. and Queensland, local medical associations began consistently to appear, founded by doctors who often belonged to their state B.MA. Branch, but felt the need of a local group to exchange views - even in the suburbs where B.M.A. meetings were held at possible distances. But in a city like Sydney, for example, in the days of the horse and

carriage without paved roads, the journey from Strathfield or Parramatta was no mean one entailing up to 15 miles each way. No doctor, working evening surgeries and unlimited hours, could often be expected to patronise meetings so far removed. North Shore doctors in Sydney had the further division of the harbour and boat crossings.

In all three states, local associations bore appropriate local names, and, at first, had no attachment to the B.M.A. Such doctors might well ask what they would get out of the B.M.A. subscription apart from their journal, how it represented either their honour or their interests. In 1890, the Melbourne Medical Association had, as one of its objects, to correspond with bodies or individuals in the colonies, or elsewhere, on any matter touching the interests of its members.

When the Western Medical Association was founded in the western suburbs of Sydney, with medical defence against the pressure of clubs among its aims, and grew in its first year to a membership of 182 doctors, it was rapidly in correspondence not only with other suburban groups and coastal towns in its own state like Newcastle and Wollongong, but Victoria as well.[31] The Newcastle Medical Society of recent date asked for its cooperation in forming a Medical Defence Union, but the Western Medical Association suggested that Newcastle form not a branch of the W.M.A. , but an embryonic central association.

In September 1890, Dr. Poulton of Adelaide, had written to the A.M.G. recalling Dr. Verco's idea of an Australian Medical Association and reciting the advantages of the idea. At the annual meeting of the W.M.A. April 21, 1891, members resolved that existing medical associations, formed on particular lines, be amalgamated under the title A.M.A. with a central executive council of two members from the Council of each branch and bylaws be framed. Two delegates from the Eastern Suburbs Association and Northern Association spoke in support.

By 1892, the W.M.A. was encouraging other local groups with the example of the General Practitioners Union in Great Britain in mind, and were proud of their independent representation on the executive committee arranging the intercolonial congress in 1892.[32]

Meanwhile, in Victoria, the Ballarat doctors had sought to found a B.M.A. Branch there, quite distinct from that in Melbourne and directly affiliated with London. They feared to become involved with the latter's pecuniary liabilities, if any. The Melbourne Branch represented to the B.M.A. Council that it had jurisdiction over Victoria, and General Council refused the Ballarat application. Arising from this conflict, and correspondence with the W.M.A., the Ballarat

and Goulburn Valley Medical Association called a meeting of 'provincial' medical men in Melbourne on November 8, 1893. It affirmed the desirability of forming an Australasian Medical Association. It elected 2 joint honorary secretaries to organise it, and sent a circular Australia-wide calling for societies throughout the colonies, similar to theirs to unite to form 'a widespread association as far as Australia was concerned'.[34]

> "This organisation - while leaving each branch free to work in its own district, and untrammelled by any centralising power will exercise a controlling influence over all branches and be known as the Australasian Medical Association".

It mentioned the great value derived from congresses already held , and that this gain could have been much greater had they been banded together in a continuing parental association. Such union would make the profession a political force. It did not consider the B.M.A. adequate in medico-legal or medico-ethical matters. It was hoped that medical defence would have a meaning with a new A.M.A. to represent the general practitioner, and more vigorously protest 'against the wrongs that are daily being inflicted upon the profession'.[34]

Neither these hopes for a medical association in fourteen centres of Victoria, nor an A.M.A. materialised. The project was too ambitious for the day. Noone with the time, nor organising skill, to devote to such a mammoth task materialised. But one of the main handicaps, judging by the history of some of these early societies, was the fluidity of medical men from one centre to another. They would change their venue of practice, and a society would lapse.

Even the membership of the Ballarat Medical Society fell away, meetings becoming irregular. In 1898, it finally amalgamated with the Victorian B.M.A. after all, despite an alternative offer from the N.S.W., on a guarantee that it could conserve its financial interests. Under the banner of the B.M.A., it revived to flourish thereafter.

When the N.S.W. Branch bought out the A.M.G. in 1894, it tried to make the journal fully representative of all sections of the profession; the kind of journal the still-born A.M.A. had hoped for. Dr. Huxtable of N.S.W. had held out little hope of Victoria cooperating,[35] as they had long claimed publication for Melbourne. A concession of rights of editorship and representation were accepted by all branches on terms of equality in the A.M.G. An editorial committee of three, appointed for a short time, had one who exulted:[36]

> "The danger of becoming the exponent of narrow and illiberal views, and of falling into the hands of a set, a section or a clique of the profession is guarded against in the most complete manner possible."

This arrangement proved unsatisfactory, however, and Dr. Knaggs, once editor of his proprietary Medical Practitioner 1877-8, became sole editor until 1901.

From 1890 onwards, the B.M.A. became more strongly entrenched despite rival moves. The Queensland Medical Society founded 1887 amalgamated with the later arrival, the Queensland B.M.A. Branch of 1894, in 1900. The Western Australian Medical Society in Fremantle, within a few months of establishment, yielded place to a newly formed W.A. B.M.A. Branch. Both in 1887 and 1897, plans were made for a Tasmanian B.M.A. Branch in Hobart and Launceston respectively. The latter thrived for a few years as a sub-branch of the Victorian B.M.A.

The N.S.W. Branch took the lead by 1894 in seeking greater independence than existed for similar branches in Great Britain. As a newcomer to Australia, Dr. L. Huxtable, saw the problem of remote branches clearly:[37]

> "Sitting here separated by so many thousands of miles from their properties and activities, we feel our practical share in them is the shadow of a shade; that our representation on the Council, our participating in the library, our share in the advantages which result from the labours of the various committees and the money spent by them is practically nothing; and that, if we are to have a library, which we so sadly need.. we shall have to do these things for ourselves."

From changes made, the N.S.W. Branch rapidly built itself up into one of the largest in the Empire, and exhorted the other states to emulate it. The movement towards independent organisation outside the B.M.A. lingered on after 1890, despite the growing strength of the B.M.A. It mainly found expression at the periodic intercolonial congresses, where advocates of a wholly Australian organisation found their only non-partisan professional platform, and the only form of federation within the profession - the state B.M.A. Branches having no formal link.

The third Congress met in Sydney, September 1892. It was held on an even grander scale than that in Melbourne but on the same pattern - the panoply of State patronage, the loan of University premises, financial support from the State Government. It was impressively organised as to exhibits and demonstrations, and offered a conversazione in the Great Hall. The appointment of the joint honorary secretaries, Professor Anderson Stuart and Dr. Knaggs, had been made at a meeting of Sydney doctors present at the 1889 Congress. It initially caused some unpleasantness in N.S.W. A Dr. C.W. MacCarthy wrote to the Gazette of 'the very undignified rush for place and prominence'; while a meeting was reported of members of the future congress, instigated by a Dr. Tarrant, where nearly half the 90 doctors present voted against the two men being secretaries of the Congress, as not bona fide appointed. The

Still no changes were made, although all medical societies were invited to nominate representatives to the executive, and disunion and ill-feeling were said to exist between two sectors of the profession.[38] Chief grievance seemed to be that the staffs of principal hospitals and country doctors were not fully represented.

Resolutions at the 1892 Congress dealt with a proposed new test for insanity, need for early treatment of post-nasal growths, and the importance of compulsory vaccination in face of the growing danger of introducing smallpox into Australia. Among outstanding original contributions to these Congresses 1887-92 were Dr. John Gibsons work on worm nests in the cellular tissue of the brisket in cattle (1892); Dr. Joseph Bancroft on filaria in 1889; Dr. J. Verco, Dr. Davies Thomas and Dr.A.A. Lendon on hydatid disease in 1889.

In 1896, the Congress was first held in New Zealand at the invitation of the Otago Branch of the Medical Association of New Zealand, which had had its own journal since 1887. Prior to its meeting in Dunedin, 1896, an Intercolonial Quarterly Journal of Medicine and Surgery had been issued in Melbourne (1894) by Dr. W. Gardner, an ex-M.D. Gold Medallist from Glasgow, formerly in practice in Adelaide. The Australian Medical Journal by this time was 'showing symptoms of a failure of nutrition and circulation'[39] and amalgamated with it; a new title being adopted , namely the 'Intercolonial Medical Journal' aiming at a national circulation and identity with Dr. Syme, a leading Melbourne surgeon, as editor.

At the general meeting of Congress Feb. 3, 1896, Dr. Barnett of Dunedin reported to Congress that the New Zealand profession were very anxious to see an intercolonial journal, one strong representative magazine for the whole of the colonies instead of three. Dr. Colquhoun of Dunedin had proposed to the British B.M.A. Secretary in 1893, that the British Medical Journal publish an Australasian edition, but the idea was received coldly. Dr. Barnett had explored the idea of a New Zealand edition of an Australian medical journal, but believed:[40] 'that it was not in the least degree likely that the ideal could be realised'. The editors of both existing journals, Dr. Syme and Dr. Knaggs, reminded Congress of difficulties of editorial control, time of issue, literary form and postal regulations and postage. Dr. Syme thought a 'strong united journal was highly desirable, and it was:[41]

> ""a great pity that the material which, if collected, would go to make up that journal was scattered about over a number of comparatively poor journals".

The solution Dr. Syme put forward was for an Australasian Medical Association. He was backed by Dr. Colquhoun of Dunedin with a formal resolution for a committee to consider forming a union of Australasian

Medical Associations and reporting to the next Congress.[42] Dr. Worrall opposed this strongly, saying there were some who would never consent to severing their connection with the B.M.A., believing an A.M.A. would mean a multiplicity of societies and the disintegration of the profession. Professor Allen, with his habitual diplomacy, diverted the motion with an amendment that negotiations be continued for one Australian medical journal, to which Dr. W. Browan added that only the fittest of the existing journals would be surviving by next meeting of Congress.[43]

The special theme of Congress was T.B. in both man and animals. Resolutions were passed for use of doctors in their routine treatment of pthisis; for proper legislation for testing of vision of men employed at sea, or in railway service (prompted by a series of railway disasters in England as well as shipwrecks in Australasian waters; for elementary hygiene to be taught in state schools; and for Governments to study the scheme of sanitary administration to be introduced into British India.

The 1899 Congress in Brisbane had as president, Dr. John Thomson, and six sections instead of five, with eye, ear, nose and throat achieving the dignity of a full section. The Executive Committee's organisation went smoothly save for two secessions from the Committee by Drs. Jackson and Dr. Hardie over minor disputes; and a failure to obtain either papers or president for the anatomy section which was attributed to the absence of a school of medicine in Brisbane.[44] The Congress was notable for the attendance of three 'young lady medical students' including the youngest daughter of Dr. Thomson. The latter described the presidency of Congress as 'the blue ribbon of our profession here'[45] and the one in Brisbane who should properly have received it as the late Dr. J. Bancroft. Nothing had been done about the Australian Medical Journal, the Committee reporting laconically that the Executive Committee had not 'interfered' with the matter.[46] The State Government, having been asked to send delegates, Dr. Ashburton Thompson came from N.S.W. He was one of the new breed of qualified public health men who were to make public health a profession, and give impetus to long demanded reforms by the doctors for proper conditions in housing, town planning, epidemic and food control. He proposed to Congress an Advisory Board on the peace and war requirements of the Army Medical Corps; compulsory notification and isolation of infectious diseases, and a memorial to Governments:[47]

> ""setting for the abundant evidence available of abuses of the charitable institutions, and that, in the interests of the state, radical changes in the constitution, management and the maintenance of such is urgently indicated".

An interesting aspect of Congress was a more formal debate on whether Congress should advise the Premier of Queensland that the Queensland Government should adhere to the Venice Convention 1897, which involved notification of any outbreak of plague within the state, and subsequent progress of the disease, to all foreign governments which were parties to the Convention and to neighbouring countries. Not long after this Congress, Australia suffered a severe outbreak of bubonic plague, and it was Dr. Thompson who achieved international acclaim for determining that the rat-borne fleas were the vector of the plague.

Congresses placed little emphasis on medical politics except to call for specific legislation. The need to discuss medical politics on a national level led to convening of a special meeting in Melbourne 1898 on the subject of the relations of the medical profession with friendly societies. Summoned by the Medical Defence Association of Victoria, the President of the Victorian B.M.A. Dr.McAdam called it an unprecedented gathering in that it was the first to deal exclusively with political matters, and spoke of club practice as a species of white slavery. 55 delegates from most existin g medical groups were present. They agreed that present relations were unsatisfactory, explored ways to remedy them, and solidarity to combat them.

Its views were endorsed at the 1899 Congress - the need for union among medical men, for an income limit to members of clubs, for a model agreement for contracts with clubs, for determined ostractism of doctors who allied themselves ~~to~~ WITH the worst of clubs. Dr. Samuelson of N.S.W. called for an Australasian Medical Practitioners Association 'for the purpose of supervising and controlling the practice with regard to benefit societies and similar institutions saying 'the position of the profession was like that of Aesop's wagoner who had driven his wagon into the quagmire and could not get it out again.'[48] In later years, he deplored that Dr. Syme and Dr. Barnett caused him to withdraw his motion in favour of setting up merely medical defence associations like the Medical Defence Union of Great Britain - which would control relations between doctors and litigants, clubs etc, and leave medical societies to priority of scientific questions as Dr. Syme preferred.

Defence groups already existed in N.S.W. and South Australia, but were set up in all states by the end of 1900. The Medical Society of Victoria Committee reported in favour of such a body to act for medical defence, and 'polity', and to own a journal. Professor C. J. Martin, its President, said it would urge an Australasian Medical Association on the Hobart Congress with the right to retain self-government and property, though it felt that 'the question of the subscription made every scheme except that of amalgamation impracticable'.[49]

An M.S.V. report approved the views of its sub-committee September 1901:[50]

> "That the M.S.V. is of the opinion that the time is opportune for the formation of an Australasian Medical Association with the following objects
> (a) the control and management of congresses
> (b) the establishment of an Australian Medical Journal
> (c) the direction of medical polity
> (d) medical defence".

to be achieved by amalgamation of all existing societies in Australasia. The Victorian B.MA. adopted this report 'in globo' by a large majority. Its President, Dr. A.I. Kenny said that amalgamation of B.M.A. branches with membership totalling 1200 'had been constantly referred to when officials of the various branches have met at Congress or elsewhere for some years past"[51] The report was sent to Congress.

The W.A.B.M.A. proposed a special section of Congress of medical ethics and politics very soon after it was founded, but too late for the 1902 Congress; whose President, the Hon G.H. Butler approved the idea. He announced a change of name for Congress saying the term 'intercolonial' was no longer suitable since the inauguration of the Commonwealth of Australia in 1900, and a motion for an Australasian Medical Association which would give some permanency now lacking in Congress continuity. This had been endorsed by the Congress Executive Committee, which thought the time opportune for more representative and permanent asso ciation, and advised all societies of this prior to Congress.

Clearly the division of opinion in the profession was on the point whether they were all to amalgamate in a distinct A.M.A. or in some form of federation with the B.M.A., as favoured by a strong body of opinion in N.S.W. The case for the former was argued by Dr. McCall at the 1902 Congress. Not only would it replace the Congress, and have its own journal, but 'it would have a great influence towards having uniform legislation withe respect to the profession in the States' [52] He also referred to the failure of the B.M.A. in London in one case remitted to London for judgement, to act in a manner that was best. Dr. Worrell argued the opposition - for a Congress organised by the B.M.A., attachment to the B.M.A., and against 'unhealthy rivalry'. He exhorted the M.S.V. to follow the example already set in Queensland, where the Queensland Medical Society - though larger in property and membership - had merged in the Queensland Branch of the B.M.A. in 1899. He pointed to the fact that the profession was well organised in Queensland and N.S.W., by contrast with Victoria where organisation was weak due to two coexistent societies. Congress was not reminded of facts

familiar to all - that friction existed both between, and within, the rival groups.

Professor Allen of Victoria, who was finally to bring about, in 1907, the amalgamation urged in 1902, spoke up against pressing the issue for the moment, because of parochial problems:[53]

> "Recent events had so evolved that the B.M.A. was now comparatively feeble in Victoria, while the other was a strong and healthy society. It would be a policy of doubtful wisdom to put pressure upon the profession in Victoria to alter its society arrangements".

The Victorian B.M.A. Council , with Dr. G. Syme as President, had resigned in a body and no reconciliation had yet been possible with the succeeding Council. Professor Allen claimed the M.S.V. had made several attempts to unite with the B.M.A. in the past, from 1892 on (having almost converted into a B.M.A. Branch before there was one), but had been thwarted by the Branch due to the effect of one or two injudicious remarks made by two or three members of the M.S.V. The motion finally was not put to the vote, but dropped but in favour of an amendment to organise the Congress through the B.M.A. representative in each state , then finally lapsed. The view taken at this time was that the M.S.V. was a 'stumbling block in the way of a general amalgmation of the whole profession throughout Australasia';[54] seems hardly to have been justified; nor Professor Allen's fears that an A.M.A. depended on amalgamation of the two.

Failure to press through a vote for a national medical organisation in some form seems to have been due to uncertainty. The General Secretary of the 1902 Congress, Dr. Sprott, wrote to Dr. Rennie, editor of the Gazette, on his return, saying that he had sounded out the profession, but the proposal was not likely to be carried out by a sufficient majority to make the result a success.[55] Strong groups opposed it in South Australia and N.S.W. due to -in the words of Dr. Arthur-[56]

> "The failure to distinguish between federation and an Australasian Medical Association, and to the parochial spirit which views with distrust any suggestion of change coming from an outside source".

To resist the demand for an A.M.A., B.M.A. supporters worked to put their house in order. A B.M.A. Committee had been appointed to advise in reorganising the constitution. The N.S.W. Branch case was set out in a May 1901 resolution.[57]

> "That a letter be sent asking that special provision be made therein to the effect that the Australian branches of the association shall be autonomous; that is to say, shall have power to make their own rules and regulations subject only to the fundamental laws of the association... and that such law will not prohibit the Australasian branches from making rules and regulations for the admission and expulsion of members".

The Branch also objected that doctors could join the B.M.A as unattached members for a lower subscription without referring their names to the local branch as candidates for election; thus bypassing the need for local Branch approval. It deplored that the bylaws of the Parent Council demanded twelve months' residence and annual election for Branch representatives in England; the effect of this being to deprive the Colonial Branches of representation to the Council except at irregular intervals. The value of the latter was stressed by Dr. Kenny, for example, in[58]

> "the able and spirited action of the late C.F. Goodall in the famous Adelaide Hospital case, and in the passing of the regulation by which the Council of the Association agreed to refer to Branch Councils the names of all candidates for election as unattached members of the association within the British area".

The N.S.W. B.M.A. also wanted direct representation on the projected annual representative meeting, preferably by a doctor visiting the country who was up to date on Branch affairs. It also complained of the need to have an officer in the English B.M.A. office who was conversant with colonial affairs, thus creating greater precision, promptness and accuracy:[59]

> "Through mistakes in the London office during the past year considerable difficulty and friction have been occasioned at this end between the officers of the Branch and some of its members on account of the non-receipt of the Journal.. The want of some system of this kind has made the retention of certain members of the Branch a very difficult matter."

Dr. Rennie of the N.S.W. Branch tackled the Parent Council while in England. He was able to report that it had conceded the principle of direct representation.

Those in Australia, who favoured strengthening the B.M.A. as a national organisation, also looked to their laurels locally. The Australian Medical Gazette, official journal of the B.M.A. Branches in Australasia, came under fire. Dr. Clubbe led the attack by writing to the N.S.W. Branch Council July 2, 1901, by speaking of 'widespread dissatisfaction' with the Gazette management; in that it was 'almost universally condemned'; was an 'absolute failure' as a medical journal; and carried neither 'weight' nor 'influence'.[60] Dr. Knaggs, its editor of six years' standing, retorted that he had raised it from a doubtful financial venture to the position of a substantial paying concern, while receiving annual praise from the Branch Council for his effort. He complained he was charged with incompetence, and had been treated with base ingratitude.

A sub-committee unvestigated the charges, which asked Dr. Knaggs for a written answer to set questions, but gave him no personal hearing.

These make it abundantly clear that Knaggs had been ill with influenza for three months before, and unable to supervise the work directly; that there were no systematic means to obtain reports of medical or surgical work done in public hospitals in other states; that the functions of the editors in other states had never been clearly defined, and they often sent material in a disorganised state if at all.

Dr Knaggs had visited New Zealand and Victoria and written to editors and influential people to induce interest in the Gazette with indifferent success on the one hand, and no guidance from the Branch Council as to editorials or policy on the other. Dr. Knaggs thought the criticism a commentary on the contributors and the Branch Council rather than himself.

Sub-committee reported there were grounds for dissatisfaction. Dr. Knaggs promptly resigned. Council appointed Dr. Crago to carry on. Dr. Knaggs would not lie down quietly. He objected to the illegality of the Branch Council appointing an editor, rather than a general meeting. In calling for such an election, he declared his intention to stand in order to test the validity of Dr. Clubbe's assertion as to dissatisfaction among the B.M.A. members. He asked for voting by postal ballot. He circularised all members, saying he was standing not to solicit re-election, but to test the degree of confidence he retained with the membership. He was also aggrieved with the Council because of its proposal to take over the lease of his premises, which he had generously made available for some years as a library and reading room for the Branch together with access to all his reference books. This quarrel may well have been at the heart of the matter.

In fact, Dr. Crago had shared the role of building up the A.M.G.' with Dr. Knaggs, as manager from 1895. Dr. Rennie, a close friend and colleague of Dr. Crago, took Dr. Knagg's place and his partnership with Dr. Crago continued until 1914, when the Medical Journal of Australia succeeded the Gazette. By 1910, Dr. Knaggs ' contribution was quite forgotten when the then President spoke of the Gazette:[61]

> "It has undoubtedly proved, under the able direction of Drs. Crago and Rennie, the chief factor in attracting members to all the Branches of which it is the medical journal".

Although the controversies of 1899-1902 had not resolved the form of national medical organisation, national issues of a disinterested character were not neglected. For the first time , cancer was a special theme of Congress in 1902. Congress also heard a report from Dr. Goldsmith of Palmerston, Queensland, which was later laid before the South Australian Parliament.[62] As a result, it approved of a school of tropical medicine and research in Brisbane for the scientific and systematic investigation of tropical diseases in Australia on lines similar to the existing school in London.

The Congress urged approach to State and Commonwealth leaders, but failed however to approve a national society to be styled the Sanitary Institute of Australasia to collect and impart information on public health. In September, 1905, the Congress returned to Adelaide with Professor Stirling as President, and Dr. Poulton as Secretary, once more, as at the foundation congress. This Congress gave Dr. Poulton a service of plate for his great work. It was the first to record use of motor cars of medical men to transport guests on an inspection of sanatoria. A section on state medicine and medical ethics was added. Congress moved for epileptic colonies in all states, treatment of the insane, a naval and military section in Congress, for fulltime medical officers in state education departments, and proper training of children and teachers in hygiene, and for X-rays to be handled only by qualified doctors.

By far the most outstanding contribution was Dr. Lockhart Gibson's identification of paint used on verandahs as a cause of lead poisoning and blindness in children. Medical society federation was once more brought forward, moved by Dr. Rennie, for a committee to consider ways and means towards amalgamation. Two representatives were to be elected by all B.M.A. Branches and medical defence associations, as well as the Tasmanian Royal Society section of medicine, and the Medical Society of Victoria.

Western Australia had to reject its turn as host state in favour of Melbourne, as the Commonwealth had not yet agreed to build the vital trans-continental railway. In the 1908 Melbourne Congress, the exhibition of goods of interest continued to grow, while a new feature was a museum of the hobbies of doctors, antique instruments etc. The problem of hospital again came to the fore with moves for statutory bodies in all states to control hospitals; for enforcement of the rule that public hospitals or wards should be exclusively for the sick poor. Income limits for membership of clubs offering contract practice were agreed to, and a uniform system of medical inspection of school children again called for.

As well as hospitals, syphilis was a major topic of congress. Its President, Professor Allen, led a contentious discussion in a very large gathering of full congress, where his startling statistics on the incidence of V.D., particularly among children, were disputed, though all were agreed that V.D. was an increasing menace to the health of the nation. Committees were appointed on all such matters to report to the next Congress.

A special Committee on medical statistics had a less depressing

report. Working with the Commonwealth Statistician, it had found that uniformity of method of collection of statistics, had in recent years been reached throughout Australia, except as to classification of causes of death. It recommended changes in certification of death, statement of specific not general cuases, extending infant mortality statistical investigation to the second year. There was no investigation into the ratios of sickness and accidents, or to analyse causes of infant mortality, no way to distinguish if a child were murdered or died of natural causes. Grave suspicions were expressed as to various forms of malpractice with infant mortality.

The section of public health and state medicine demanded regular annual conferences between the professional heads of state departments of public health to secure, in the public interest, better coordination It secured approval of Congress for a deputation to the Prime Minister to request a Royal Commission to inquire into the possibility of the colonisation of tropical Australia by the Anglo-Saxon and other white races, particularly in view of the Commonwealth's intention to take over the area of the northern territory. In the interview with the Minister for Home Affairs, subsequently, the delegates- one from each State -mentioned how it had been thought that white people could live neither in Coolgardie on the goldfields of Western Australia, nor on the canefields of Queensland until a few years before; nor, for example, that yellow fever, as in Panama, could not be controlled. All were agreed that failure of health in the tropics was due to non-observance of the rules of personal hygiene, proper feeding or housing, rather than the tropical habitat itself as a striking change from beliefs of a generation before. The Minister reminded the deputation that the Commonwealth Government already subsidised the Tropical Diseases Institute at Townsville, along the lines of the similar institution in England.

All the foregoing discussions demonstrated the growing value of Congress in shaping policies of each state, not purely for the material environment of the profession, but also for the health and prosperity of the Australian nations. Many doctors saw an obvious need for some continuing federal association between triennial congresses, but the committee of 1905 had made no progress towards union. The Goulburn Valley B.M.A., the M.D.A. of Victoria failed to reply at all. The Victorian B.M.A. would not appoint representatives, nor the N.S.W. B.M.A., the N.S.W. Medical Union nor the Royal Society of Tasmania. Dr. Hamilton wrote to the 1908 Congress [62] "You will see that the desire for amalgamation does not seem to be either keen or universal". Dr. Rennie thought that some of the members of the Council of the N.S.W. Branch of the

B.M.A. feared the possible formation of an Australasian Medical Association, and therefore would not appoint representatives. A code for standing orders was adopted for Congress which gave birth to a debate as to who should be qualified to attend Congress. In Victoria, for example, only 400 of the 1,200 doctors were B.M.A. members, When Dr.Worrall of N.S.W. tried to limit eligibility to attend Congress to members of the B.M.A. , he said[63]

> "The time had come, when the sessions should become meetings of the Australian branches of the B.M.A."

to give effect to directions of the branches at national level not possible now. He found himself opposed by the President of the Congress, Professor Allen, and Dr. Syme, both of Victoria. The former referred to his own part in uniting the two Victorian medical groups in 1907:[64]

> "It would greatly impair the usefulness of the Congress for the very purposes which Dr. Worrall had so much at heart. Under the existing constitution the Congress served to bring together the great mass of reputable practitioners and to convince them of their common interests, and thus it acted as a most important feeder to the Branches of the B.M.A."

As an outcome of experience in Victoria, particularly the problem of having independent medical defence associations, Branches approached the Parent Council to ask them to concede autonomy in the matter of ethical rules and arrangements for consolidation either between Branches, or with outside medical societies, instead of being constrained to write for advice and approval to England.

By 1911, three compelling reasons for federation of the branches clearly existed: a more efficient approach to the B.M.A. Council in England, a more united and powerful profession in the community, and continuity between Australasian medical congresses to translate their motions into action.. On the first issue, Dr. Hayward said many matters referred to England could better have been decided by an Australian Council; on the second, it would unite the profession better to attack hospital abuses, coordinate medical defence, and administer medical benevolent societies; on the third, follow through Congress resolutions, which now lapsed for want of a permanent executive. The sentiments of a number of other leading Australian medical councillors was expressed by Dr. Dick in the N.S.W. Branch Council:[65]

> "If no special body like this is established for the next three years, a scheme might be put forward to the Commonwealth the Dominion, and the various State Parliaments, and we would have no large executive body to express our opinions, and to see that the great interests of the medical profession were properly safeguarded".

Two months before the 1911 Congress, Dr. T. W. Hayward of the South Australian Branch proposed that South Australia, as the first B.M.A. Branch in Australia, should take the initiative in calling for a union of B.M.A. Branches in Australia. The Executive Committee supported the idea, urging the need for a permanent federal committee to formulate in advance a concerted plan of action so that in the event of legislation being introduced in Australia affecting themedical profession, they might be ready for it. It referred to the matter:[66]

> "that has taken shape in Great Britain in the National Insurance and Invalidity Bill, and, under the name of nationalisation of hospitals and medical services generally is threatening us here...only by being prepared beforehand has the profession in Great Britain been able to so successfully compel recognition of its claims by the Chancellor of the Exchequer."

All Australian Branches immediately responded to the overtures of the S.A. B.M.A. Three delegates from each state and New Zealand, excepting Western Australia, were given authority to found such a body.[67] All were outstanding medical councillors of their day, as well as Branch councillors. A draft constitution was drawn up by Dr. Todd, N.S.W. Branch secretary, a qualified lawyer who took up and practised law after an injury to his hand during general practice in the country.

The constitution of the new federal committee was somewhat similar to the federal committee of South African Branches - its function to be:[68]

> Section 2
> "(a) a medium for communicating with and negotiating with the B.M.A. on behalf of the branches in Austral(as)ia in matters common to such branches.
> (b) it shall represent the members of the association in Austral(as)ia for the purpose of communicating with the Government of the Commonwealth (or of the Dominion) or of any state, in any matter affecting the relations between the Government and the medical profession.
> (c) it may consider any matter of medico-political or scientific importance."

Before the B.M.A. Federal Committee could have any constitutional validity, it had to go for approval through the cumbersome machinery of the B.M.A. - first to the Branches, then the Parent Council. New Zealand finally elected not to join.

The delegate chosen to represent the Australian interest at the Annual Representative Meeting in England, was Dr. Martin, who went to Liverpool July 1912 to sponsor the business:[69] He found it:

> " one of the most momentous assemblies of medical men that has ever occurred in the history of the profession. I presumed that, to bring our ideas of local autonomy for Australia before the representatives, would be a very simple matter. I had never heard of an insurance act for Great Britain and Ireland,(which was still creating a tremendous ferment)

> "None knew when the Australian business was to come on. I sat through four and a half days, long days lasting from 9.30 a.m. to sometimes 10 o'clock in the evening, and then on the last day during the final ten minutes of the session our business was rushed through".

The constitution, thus approved, was authorised by the Branches at a special meeting held concurrently with the 1911 Congress. There were those who would even then have seized the occasion to make Congress a B.M.A. preserve, but others who considered it should be open to any registered doctor, as many [redacted] still did not belong to the B.M.A.

At the 1911 Congress, a Commission of Congress was born as well as a Federal Committee to act in between one congress and the next, fill vacancies occurring in the future executive, and make such rules as necessary. Also it was to :[70]

> "2(b) not the course of medico-political events of importance in Australasia and where, in its opinion, intervention by it as representative of the medical profession in Australasia is urgently called for, to take such action as it may deem appropriate to safeguard the interest s of the profession.
> (c) to be at the service, as an advisory body in medico-political matters of the Government of the Commonwealth of Australia and the Dominion of New Zealand."

Some argued that the highest officers of Congress and the Commission should be B.M.A. members. Dr. Kenny objected saying that it was 'practically putting in the thin end of the wedge for insistence that membership of Congress shall be membership of the B.M.A.'[71] Dr. Todd in opposition claimed that the B.M.A. was the only one that was properly organised,[72] while Professor Allen added 'If there are persons in any state who are distinctly distasteful and impossible people they will be excluded'.

A Broken Hill doctor, Dr. James Booth, failed in a move for federation of all medical defence associations - the only support forthcoming, he said, for all B.M.A. Branches to work to overcome 'inadequate remuneration' in contract practice where it existed. To this end, the first steps should be to strengthen every branch, and form a fund to assist doctors who suffered financially through enforcement. Three other notable aspects of Congress were that the Commonwealth for the first time sent a representative, Dr. J. Cumpston; the International Congress of Medicine asked it to nominate men eligible for vice-presidents of sections; and Dr. Douglas Mawson informed Congress that several medical posts were still vacant for the Australasian Antarctic expedition.

Congress was also disturbed at the failure of the Federal Government to appoint a Royal Commission on tropical health, and

determined to press for more funds and staff for the Australian Institute for Tropical Medicine to make an organised enquiry into those matters likely to affect the permanent establishment of a working white race in tropical Australia. This was elected as the principal subject for the Brisbane Congress next to be held, Professor Anderson Stuart declaring 'there is no question so pressing as this, and it is nonsense to say it is political'.[73]

At the time, the Federal Committee was founded, all Branches agreed to join to found an Austalian Medical Publishing Company Ltd. which would produce one common journal for all Branches, and supersede the two existing journals in Victoria and N.S.W., the Intercolonial Journal now under the name of Australian Medical Journal once more, and the property of the Victorian B.M.A. since 1911; and the Australasian Medical Gazette.

As the constitution of the Branches made it impossible for them to own the new journal collectively, a new company limited by guarantee had to be set up with the various Branches as shareholders, and three members of each Branch to represent its interests in the Company. From the eighteen, seven directors were elected; two from N.S.W. as a local committee of directors - the journal being published in Sydney - and one from each of the other states.

The Medical Journal of Australia was thus not directly owned by the B.M.A. Branches, nor was literally their official organ. By general consent, however, B.M.A. Federal Committee policy was adopted in medico-political matters. Federal Committee had an agreement with the Company to supply B.M.A. members weekly with the journal. The B.M.A. Councillor with longest managerial experience, Dr. W. Crago became first Chairman of Directors 1913-24. The honorary editor, Dr. Rennie, retired in favour of a full-time editor, but on a note of warning that he could not always get assistance from other states. Dr. Rennie had been 13 years editor, nine years secretary of the branch, and eighteen years council member. A latter day tribute from medical historian, Dr. McDonald, reds:[74]

> "At night, and often from Monday to Friday, the older children could see the light in their father's study. When doctors complain of the increasing tempo of their activities, they might with salutary effect look on this picture of a medical scholar working on into the night with Churchillian energy".

He saw him as a skilled physician, a Puritan, an austere man.

The new editor, Dr. Armit, said at a welcoming dinner given in Sydney (as in other states he had passed through):[75]

> "He felt he had certain advantages in taking the position of editor; as he knew no one, he was at liberty to reject contributions which were not good".

Dr. Armit was extraordinarily well qualified to raise medical journalism in Australia from its amateur status, with part time editors, who were also busy medical men with the consequent uneven standards. He had studied medicine at St. Bart's in London, and science in Bonn, Germany. He had an immense range of experience: in general practice, with the Asylums Board, running a sanatorium, research at the Lister Institute under an Australian Dr. Martin , and work on the British Medical Journal. He was one of the earliest research workers on immunity, but his interest in medical politics took an increasingly dominant part. He had been a member of various committees of the B.M.A. (finance, medical, ethical, political), and reporter of international congresses both for the British Medical Journal and the Times; and a chairman of his division and representative in the Annual Representative Meeting for five years; finally secretary of the British Committee at the International Hygiene Exhibition in 1911. With this exceptional background, it is surprising that Dr. Armit chose Australia, unless by reason of innate restlessness or desire to command his own enterprise. On arrival he found a dearth of material, no publishing plant and no assistance. He threw his energy, resources and skill into the endeavour, and had acquired plant by 1921, and assistance by 1923. His ambition was no less than a journal equal to England or America. He also found the handicap of a directorate which suffered from lack of journalistic experience, as one of the directors, Dr. Hone, later recalled. Despite, all handicaps within a few short years the journal Dr. Armit produced was applauded as one of distinction.

The Tenth Congress was held at Auckland, February 1914, instead of Brisbane. The Chairman of the Central Council , Great Britain, for the first time visited Australia- namely, Dr. Mac Donald. As the Commonwealth Government favoured national insurance on the British model, inevitably he was asked to speak to the Congress on the subject. His speech could not have allayed any alarm felt by the profession: He stated that the need for such an Act in England had been very debatable, conditions in Australia were so different as to make it even more debatable in Australia. He warned them of what he called the 'scandalous' way Mr. Lloyd George had introduced national insurance in England, fostered a 'lamentable' press campaign when the doctors refused service under his terms, and threatened to mobilise other medical men to undermine them. Therefore, he exhorted Australian doctors to get thoroughly organised, to formulate their policy early, know what they wanted but not to be too rigid, and to keep all sections thoroughly informed.

As a measure to consolidate organisation the N.Z.B.M.A. Council recommended limiting Congress membership to B.M.A. members as there was considerable overlapping in the work of the two bodies and most Congress members were already B.M.A. members; while all questions, in any case, as on syphilis, were remitted to B.M.A. Branches for action. Approval was limited to asking the B.M.A. to run the Congresses. Few voices were now raised against this. One was Dr. Dixson, a N.S.W. Branch foundation member, who said resolutions from a B.M.A. Congress would have less influence, as it was already regarded as an 'exclusive' club

General feeling was that Governments would be more likely to heed the Congress if it was the expression of a united profession. The sort of matters they wished Governments to heed in 1914 were universal vaccination in view of the recent epidemic of smallpox; residential and day schools for the feebleminded child - the potential for most habitual drunkards, criminals, prostitutes and wastrels; education of girls to foster and safeguard allround development; control of V.D. by adequate legislation.

An unusual departure in 1914 was the appearance of the very kind of person such Congresses most wished to influence - no less than the Premier of N.S.W., the Hon.W. Holman, leader of the Labour Party. He commented on administrative aspects of public health from a Government point of view; announced a program of special maternity hospitals or wards; the supplement of school medical inspection with a travelling hospital for country areas, with specialist treatment for eye and teeth troubles fairly common in the country; preventive treatment for mental cases in incipience because of the disturbing increase in insanity and its great cost to the community; establishment of a special fever hospital and dispensaries for T.B., V.D. and appointment of a medical committee to report on V.D. In at least one sphere, he gave open credit to the profession[75]

> "The prevention of preventable diseases and the cure of curable diseases among the masses of the people - the working classes and the middle classes - who can ill afford to employ the best medical and surgical skill should be recognised, it would be imagined , as an imperative duty of the Government. This, however, has not been the case. For twenty years, successive N.S..W.Governments have been urged by the medical profession to systematically attack consumption. The present Government, profiting by such warnings, has seen its way to commence a national duty too long neglected."

Several months later, with the shadow of the outbreak of war looming, the British Association for the Advancement of Science held its annual meeting in Melbourne for the first time in its history. Founded in 1831, it was one year older than the B.M.A. Medicine had the dignity of a section. Dr. E. H. Embley of Melbourne took part. His original contribution to the study of the use of chloroform in

anaesthesis was already well known throughout the world. To the turn of the century, the incidence of death under anaesthesia had been a perplexing problem; and he, by careful statistical work and observation, was able to demonstrate the dangers in its use.

The Section President, Professor B. Moore, traversed the history of medical science in the nineteenth century to show the remarkable impetus given by discoveries to the transformation of medicine after 1850, and the time lag in application to circa 1880. No better summary exists in the record by a living witness of the medical revolution involved. He spoke of the doleful state of medical science in 1876, despite the disappearance of 'the heroic bleedings and leechings, and the scarcely less violent druggings with strong drugs'. If one were to practice medicine in 1876, he said:[79]

> "The whole of serum-vaccine and organo-therapy were unknown with the single exception of vaccination for variola. Enteric fever has been separated from typhus, but its etiology is still obscure, and, to a large extent, as a consequence, the mortality from it is 15% or quadruple present day figures, and is one of the commonest of diseases. The cause of diptheria is unknown, although it is recognised as a 'contagious disease, and as yet research in bacteriology has supplied no cure for it.
> "The unity of the various forms of tuberculosis is unsuspected, the infecting organism is unknown, and, as a result, it is not even recognised as an infectious disease and heredity figures most strongly in a dubious etiology leading up to a vacillating treatment. Pneumonia is not recognised as due to a micro-organism and is described as one of the ideopathic diseases. The cause of syphilis, and its relationship to tabes dorsalis, and general paralysis are unknown, and generally it may be said that the causes of disease are either entirely unknown, or erroneously given in at least three quarters of the very incomplete lists of diseases that are calssified and described."

In this short resume, Dr. Moore illuminates the staggering progress of medicine in the brief thirty four years since B.M.A. Branches began in Australia.

To which the comment of the President in 1911, Dr. Eockley, might be joined, as to the nineteen years since Sydney had been the venue of a Congress: That they had seen the appearance of microbiology and biochemistry as a fullfledged science, learnt something of heredity and immunity, modified therapeutics, and seen the birth of radiology and parasitology. His comment on surgery was more humorous, but underlined the fact that, over the same period, asepsis was now so reliable that surgeons could invade the abdomen and other critical areas of the human body without the desperate death rate they had incurred before:[80]

> "The President of the Royal College of Surgeons said recently that surgical operations are performed so well and so frequently that the public has come to regard them as a form of innocent recreation - whether for the patients, or the surgeons, he did not say".

So medicine stood, on the eve of World War 1 in 1914, with giant strides in technical achievement shortly ahead, and also with a concomitant responsiblity ahead of it; as enjoined by Dr. Moore in that disease was no longer merely a matter for the medical profession, but a national concern of vital importance.

The Federal Committee of the B.M.A. in 1913 had already called on the Commonwealth Government to endow medical research; had supported the Maternity Bonus (Allowance) Act; and appointments of government medical officers; requested the Commonwealth to consult the medical profession on bill s affecting them; dealt with warning notices on unethical practitioners; and issued broad principles of ethics to guide the Branches. On the latter, it found it impossible to draw up one code of ethics to suit all states. Four years later, at the end of the war, the range of topics had extended to uniformity of contract medical service in all states; fees for life insurance examination; federal medical officers' relief fund; relations of pharmacists with doctors, uniform medical registration; repatriation department contracts with local medical officers, the medical who's who, V.D. and the decline in the national birth rate. The Federal Committee was in contact with all Australian branches in the expectation that a scheme of national medical service - involving national-isation- would materialise early post-war. At the instance of the Commonwealth Statistician, it had circularised the profession in 1913 as to how to make the British scheme serviceable, in an attempt to adapt such a scheme to Australian conditions.[81]

This asked whether doctors should devise or launch their own insurance scheme, whether doctors should be nationalised as a work force in terms of more extreme socialist policy; whether they should develop a coherent national medical policy in areas other than purely insurance; or limit it merely to inclusive benefits under insurance; or finally establish a Ministry of Health. As a result, certain principles of improved medical service to the nation were developed in collaboration with branches, and a Ministry of Health urged to carry them out.

In none of these matters could the Federal Committee act as more than an advisory body to the state branches, having no power to initiate policy, but only to deal with matters recommended to it by the various Branches; and then only to persuade and influence. Its members were two delegates from each of the Branches elected by Branch Councils. During the war, Federal Council also dealt with aspects of its direct relationship with the Parent

Council. These included major changes in the ethical code 1915, and the constitutional relation of overseas branches, as well as the annual subscription of members.

An A.N.Z.A.C. Medical Association was formed during the war with the Gallipoli forces, led by men like Sir. N. Howse. It had many discussions on medical problems of army camps. An Australia and N.Z. Medical Association was formed in London just after the war to impart information to visiting doctors on appointments, post-graduate work, and common courses at Universities, as well as to hold two annual dinners.

The Congress, planned for 1917, was delayed until 1919 by war and then by the devastating 1919 influenza pandemic until August 1920, though planned for 1919. Theme of the Congress was to be the permanent settlement of a working white race in the tropics, so the Prime Minister of Australia invited two eminent world figures in tropical medicine as guests of honour. These were Sir Ronald Ross and Surgeon General Sir William Gorgas - the former noted for his work on the mosquito, the latter for eradicating yellow fever from the Panama Canal zone. Unfortunately neither could come, the latter dying shortly after. Due to the efforts of such men, the basis for enquiry in tropic medicine had changed vastly in the days before 1900. The President of Congress, the Hon W.F. Taylor, could point out that the causes of diseases like malaria, yellow fever, hookworm and plague were now well known. They were insect borne and the vectors could be attacked. He stressed however that work with local authorities in Queensland against malaria was less consistent against the mosquito - a fact made more alarming in that the type of mosquit which carried malaria and yellow fever bth existed in Queensland, while plague had in fact broken out there only a few years before.

A subcommittee had begun in 1914 collecting and analysing material from all doctors in Australian tropic areas. Work resumed in 1920 with a disappointing response. Doctors were mostly favourable to the suitability of North Queensland for continuted occupation by a 'working white race'. Neither fertility, infant mortality, physical energy, or notifiable defects in children, nor figures for rejects for army service showed material difference; while life insurance in tropic areas was on the same basis as for temperate areas. Dr. Breinl's work on physiology in Townsville bore out the conclusions. The sub-committee said:[82]

> "The whole question.. is fundamentally a question of applied public health in the modern sense, such as had been demonstrated and practised with success amongst civil populations under far more difficult conditions by the American authorities in th Phillipines prior to the Great War, and throughout the military forces of every allied power during the Great War."

They proposed certain measures,to effect which a Federal Ministry of

Health would be the most effective form of organisation. Congress adopted the report, including a number of fields of legislation and state government activity to educate the public, encourage tropi development and do more research. A judgement some years later by the Professor of Physiology at the new Medical School of the University of Queensland, Dr.D. Lee, was that:[83]

> "As affording an opportunity for the proper consideratio of all available data on their own merits, and for the formation of a sound conclusion, the congress seems to have been largely abortive.. The turmoil of war had interfered with the proper collection and consider- ation of requisite information".

Preventive medicine was another major subject of Congress. Dr. Taylor had recalled the figures of fitness for recruits that had shocked the government during the war. One quarter of the adult male population, unfit for military service by reasons of physical infirmity, congenital, or due to being reared in an unwholesome environment.

For the first time in an Australian medical Congress, the President raised the question of what form change in national medical service should take, and presumed that there would inevitably be such a service. He asked the question what effect would bear on the profession. With an equanimity, no President of Congress could conceivably essay forty years later, he suggested 'the service might be organised on the lines of the Royal Army Medical Corps' with doctors working on salary on shifts.[84] He said the well-ordered regulation of service life had reduced the incidence of typhoid, typhus, cholera, dysentery and smallpox to the lowest level in history, and the methods could be equally applied to the civilian community where diseases like scarlet fever, measles,influenza, meningitis remained without study or control. As many men in the services were infected with V.D. as died in the war- namely, sixty thousand. Pensions were given, but the public were not protected. An immediate Royal Commission on Health was imperative, as was a new concept, far removed from the original departure point of preventive medicine as 'sanitation of the drains and scavenging order'.[85]

Other sections lent point to the accusations: the absence of elementary regulations to prevent flyborne disease causing infant mortality; the use of lead in paint though causing blindness, paralysis or fatal kidney diseases in children; gonorrhea, invalidism, and mortality in women from puerpereal septicaemia. Other things needful were proper standards of eye testing for the services and public; a study on proclivity to cancer - particularly skin cancer - in certain people; education as to prophylaxis against V.D.

On the latter point, Dr. Stawell created interest by giving support for findings put forward by Sir Harry Allen at a Congress thirty years before as to signs of visceral syphilis, which

many contemporaries at the time had considered exaggerated. Very recent work in the U.S.A. 'had been a remarkable demonstration of every general statement made and taught by Professor Allen over thirty years ago'.[86]

Congress considered a proposal by Professor Barnett of the University of Chicago for a separate surgical association, offering a degree that would be the equivalent of the American Fellowship; but rejected it. In Melbourne that year, a Surgical Association had already been formed to overcome the insularity of the three medical clinical hospital schools and the tendency for graduates to develop in fixed lines and within narrow limits. Though independent, it had insisted that all members must be members of the B.M.A. The preceding Opthalmological Society and the Paediatric Society of Victoria were even closer to the B.M.A., being subsections of the Victorian Branch though with separate regulations and officers.

The fear of some B.M.A. members was on the one hand that surgical subsections would weaken the B.M.A. by diminishing interest in general medicine; on the other hand, that B.M.A. subsections would have to be open to all B.M.A. members and not simply surgeons. In the words of Mr. H.B. Devine, surgeons would be 'more likely to disclose their own difficulties and bad results in the privacy of a surgical association'.[87] As Universities in Australia offered higher surgical degrees at the time, there was no need to set up a new body to offer them as there had been in America. Dr. H. B. Newland of Adelaide, and a brilliant surgeon recently returned from England, where he had worked in plastic surgery, was in no doubt that separate bodies diverted the scientific effort of the B.M.A. in England. After war service in France, he found the old federated bodies such as the Royal Society of Medicine monopolised the scientific activities of its members, while the B.M.A. dominated politics.

From 1920, onward, Congresses were run by the B.M.A., though not limited to B.M.A. members. This change was not approved without some lingering opposition. The immediate obvious effect was that the emphasis returned in the next Congress to scientific discussion. While Congresses continued to provide a meeting place for informal exchanges in medical politics, they were no longer so often an open debating ground for controversial issues. The Federal Committee of the B.M.A. had assumed the function of organising Congress to give the continuity that was their weakness, but now seldom used such occasions as a sounding board for opinions.

In order to become a more effective body, the Committee had been involved in fairly exacerbating negotiations with the Parent Council in England. Constitutional problems had already proved so

irritating during the war that Dr. Verco and Dr Hone, both of Adelaide, had revived arguments for an Australian Medical Association in 1917. Dr. Todd replied from the state always most loyal to the B.M.A. - namely N.S.W.:[88]

> "I sincerely hope that no question of forming a separate association in Australia to be affiliated or not with the B.M.A. will be raised unless it is found that a modus vivendi cannot be established."

Their problem in South Australia was that it wished to incorporate its Branch as N.S.W. had done in 1894. As Dr. Hone had written to Dr. Todd:[89]

> "Our Branch is in exactly the same position as yourself in that we cannot advance without incorporation. Our solicitor has been arguing with them for incorporation since 1915 when they sent us Gore-Brown's opinion".

This, from a leading King's Counsel, was that an incorporated body was not, and could not be, a branch of the association, and that individual members of an incorporated branch, if they resigned from that branch, would remain members of the parent association.

In 1916, the N.S.W. Branch was forced to take more than an academic interest in the point made by the English K.C. One of their members, a doctor named only as Dr. X. in the file, had written to London asking if he might resign his membership in the N.S.W. Branch and still remain a member of the B.M.A. London for 25/- and receive the British Medical Journal, as he felt the subscription was too high during World War 1, with a proposed rise to £10.10.0.[90]

The 25/- mentioned was the amount payable by overseas members under Bylaw 11b. Any increase of subscription by overseas branches could only be by permission of the parent association under Bylaw 15 passed in 1910. But six overseas branches of the fourty four then existing had found a higher subscription necessary - N.S.W. for example then asking £4.4.0.

In considering the case of Dr. X, the Parent Council now made the startling discovery that the N.S.W. Branch was not in fact a Branch of the B.M.A. at all. It had incorporated in 1894 to own its own premises and journal without proper reference to the Parent Council. This contretemps was merely patched up with head office in 1897 in a way that postponed the problem.

The Parent Council was faced with a major dilemna. If Dr. X were told the truth it would place the incorporated branch in a difficult position. There would be a serious risk of members who objected to an increase of the local subscription as affecting themselves raising questions under that bylaw which might prove

awkward for the Branch, and do the Branch and Association much harm. It told Dr. X. that it was not possible for a member of the Association to remain a member and be unattached to the local Branch, though the Chairman of the Organisation Committee, Dr. Russell Coombs:[91]

> "had very considerable doubts as to whether he and the Committee were acting fairly towards Dr. X. and had some fear that the said Dr. might howl him out if he had sufficient brains".

As the larger question of incorporation was involved in this smaller question of the independence of branches in the matter of subscriptions, Dr. W. T. Hayward, the Chairman of the Federal Committee, was asked by South Australia and Victoria - both of whom wanted to incorporate - to represent their interests at these discussions. He was then in England on war service at the Australian Auxiliary Hospital in Middlesex. He wrote to Australia:[92]

> "Here was an opportunity of bringing under notice the relative positions of Parent Association and its Branches".

He was very concerned at what he thought a 'mere quibble' in the light of Gore-Brown K.C.'s report. He spoke most fervently to the Organisation Committee of the B.M.A. in London.

> "It would have the effect of causing the overseas branches to seriously consider their position. I drew attention to the change that had occurred in the personnel of members now, as compared with what it was in 1880. Then every member had a British qualification - now the vast majority had Australian degrees, and had not the personal relationship with England that the older members had.
> "I alluded to the absurdity that overseas branches could not decide as to the subscription that was necessary, that they could not as in the cases of incorporation take advantage of the laws of their own country...
> "I said that, anticipating the difficulties that might arise, I had endeavoured six years ago to get the Branches to make a radical change in their constitution, and, with the consent of the Parent Association, form an Australian Medical Association affiliated with the B.M.A., the only bond being one of sentiment. I warned them that now was the day of the young Australian."

Dr. Hayward had come, himself, as a young ship's surgeon to Australia in time to found the South Australian Branch - a man who never feared to speak his mind whether to the S.A. Government at the time of the Adelaide Hospital 'row', to doctors who excluded homeopaths, to the Parent Council. Like many others, his loyalty was to the new country not that of his birth, and he was disturbed that Australian interests had received 'scant consideration

The response was good. A proposed Council letter to overseas branches was withdrawn, and Parent Council, at first indifferent, now planned to change the B.M.A. Constitution. Early 1918, Dr. Cox, medical secretary, wrote to overseas branches asking for comments and suggestions 'as to the question of more effective cooperation.'[93] By now, Central Council were aware not merely that Australian Branches had at various times argued for incorporation, but that on four occasions they had asked for increased powers under the constitution - Victoria in 1893, N.S.W. 1895, S.A. 1913, and Queensland 1914, and currently the Federal Committee. Dr. Cox wrote that the Council recognised it might be possible to increase autonomy.

The war was not yet over. The feeling was abroad that the tasks facing the profession through the B.M.A. would be weightier for the welfare of the community than they had ever been before the war. All the Australian branches agreed, as embodied in the Federal Committee resolution August 7, 1918, they wished for the whole range of powers provided in the memorandum of the association - including power to establish subscriptions and incorporate. They desired a stronger Federal Council in Australia in place of a mere coordinating committee without initiative at federal level.[94] Out of 43 overseas branches and 17 divisions, only three replied besides Australia. Jan 2, 1919, the Organisation Committee considered the latter's case, together with the B.M.A.'s solicitor. It concluded one of the two burning questions was simple, the other was not. Australian Branches could be given power to raise their own subscriptions by simple change of Bylaw 15, but power to incorporate would require an entire reconstruction of the B.M.A. Instead of remaining one, it would become a federation or partly such.

Such a major change involved serious issues. First it was doubtful if such a change could be made in the constitution. Second, any such step, if attempted, might raise far-reaching issues as to the status of branches and divisions within the Association inside United Kingdom as well as overseas. The B.M.A. temporised by recommending the procedure already adopted by Tasmania and South Australia for a company composed of some or all members as trustees - witness the English Insurance Defence Fund 1911 and the Medical Journal of Australia. Its Branch Circular ended with a plea 'if the Federal Committee still regards the power of incorporation as an essential and indispensable requirement'.[95]

Federal Committee did learn that it had power to establish a Federal Council, to elect a representative body similar to the one in England, and to hold general meetings of the B.M.A. in Australia. A conference of overseas branches with the B.M.A. Central Council was proposed to time with the A.R. M. July 1921; though the Parent Council

[Annual Representative Meeting]

was still thinking along the lines of federation with former branches as independent bodies, as favoured by the legal counsel and first projected in 1914;[96] though to include non- medical bodies at the time. In 1920, Central Council made such a recommendation to the A.R.M. after checking legal advice that it could take further powers to become a federation without abandoning its present position as an ssociation of individual doctors. At this time, Dr. Hayward was about to retire as Chairman of the Federal Committee, and Dr. Todd to become Federal Secretary. Dr. Hayward wrote to Dr. Todd:[97]

> "Although the suggestion that the Australian Branches of the B.M.A. should be federated with the Parent Association has never been definitely dealt with, a very considerable number of members hold the view that such a consitution would be to the advantage of both parent and offspring, and that before very long it will be demanded."

The Federal Committee even glanced at the idea of forming an A.M.A., but Dr. G. Syme, who had spoken in favour at two medical congresses, now opposed it as a 'grave mistake' recalling the aid given the Australian B.M.A. by the British in the Victorian lodge disputes of 1917-18 to prevent doctors being recruited from England.

The Federal Committee, with universal Branch approval, chose Dr. Todd as the best possible man to go to London to represent Committee and Branches in London July 1921 . It was felt he had an unrivalled combination of council, secretarial and legal experience, an England and Australian background, and an acknowledged lucidity of intellect combined with determined strength of character. The Parent Council had written to say they strongly preferred the existing relationship if it could be preserved.[98] Dr.Todd had not left Sydney, when the B.MA. London solicitor, Mr. W.E. Hempson arrive April, 1921, ostensibly for his health, but equally on a sounding tour of the Branches in Australia and Canada. He found the N.S.W. Branch claimed the Parent Council's solution sidestepped all Australian requests. Dr. Todd's views on his London brief were so critical that Mr. Hempson asked him to write them down, which he did:[99]

> "the Council's proposals were not, and were not intended to be, a solution of the problem here, but merely directed to the general question of the affiliation of allied bodies, and that they had, in fact, no application to the branches in Australia unless such branches chose to dissolve and become bodies, corporate or otherwise composed of individuals not members of the B.M.A.... if the proposals are passed unaltered, the B.M.A. will be threatened with extinction in Australia, and, while the Association will lose its imperial character, the profession in Australia, although imperial in its instincts and traditions, will be impelled against its will and contrary to its inclinations to organise provincially".

In one precise paragraph, Dr. Todd played David to the Goliath of the B.M.A.

Next he was to prove inadequate five years of legal advice to the British B.MA. from what were presumably clever legal men in London. The whole basic misunderstanding seemed to rest on a failure to comprehend the difference between a branch in Australia, and a branch in England:[100] The former, Dr. Todd said were,

> "not comparable with the branches in England, seeing that they represent the profession of the whole state, so that the analogy is between a branch in Australia and the association in U.K. rather than between a branch in Australia and a branch in the U.K. As it is important, therefore, or even essential that the association in the U.K. should be incorporated, so it is important, if not essential, that a branch should be similarly constituted."

Dr. Todd's letter, when shown the Organisation Committee, prompted it to arrange a personal meeting with him when he arrived in London in June, with the proviso 'bearing in mind that it was primarily to meet the case of the Australian Branches that the suggested federal articles and by-laws were drafted'.[101] This Committee, after hearing Dr. Todd, directed him to conference with the standing counsel Mr. T.R. Colquhoun Dill; after its Chairman Mr. Coombs complained:[102]

> "this question had been going on for 27years, and had been one of increasing anxiety because they desired to meet the laudable and necessary requirements of the overseas bodies. Unfortunately they had been steadily met with legal difficulties."

Mr. Dill's conference with Dr. Todd produced a dramatic reversal of legal advice, either due to the force of his 'colonial' personality or his 'colonial' logic. Their joint opinion satisfied the special conference of July 25, 1921, to recommend the A.R.M. to abandon the idea of federation as a new situation had 'crystallised'.

Dr. Todd's own account leaves no doubt that his brilliant and incisive mind had enabled him to make sense where Council, Committee and legal men alike had failed.[103]

> "The Council had been confronted with certain legal opinions and administrative difficulties which hitherto they found it impossible to overcome But in looking back upon the history of legal opinions referred to, it had been found that at no time had the direct question of whether an overseas branch could remain a Branch although incorporated been and answered..."

The main opposition of the Parent Council to incorporation of Branches which remained branches, was that they might become liable for their debts; but it now decided that the dilemna could be resolved, and the B.M.A. protected from liability for any act of the incorporated branches. Dr. Todd had explained the need to incorporate as not only to own a journal, library and buildings,

but to have influence and authority with the profession, as well as powers, in view of the need to deal with Governments which Parent Council could not do by remote control. His visit was a triumph. All that had been sought for years, was won. The Parent Association honoured him with a vicepresidency in the world organisation, and contributed £700 to the cost of his visit. The degree of his success was also recognised in Australia. The M.J.A. editor, Dr. Armit, wrote:[104] " It may be assumed that the difficulties which Dr. Todd overcame during theconference were by no means small". For its part, the Parent Council kept to its promise that there was nothing within reason they were not prepared to do to keep them still a part of the old Association.[105] The policy was in keeping with political changes post-war in the British Empire, which favoured more self-government for the Dominions, and combined a relaxation of control with strengthening the bond of sentiment.

Another side issue, settled in 1921, was subscription to overseas branches... to be £1.11.6 with capitation grant rising to 6/-, compared to £3.3.0 for home members. Dr. Cox pointed out that the B.MA. in London was £11,000 overdrawn at the bank, and therefore it had not been ungenerous. An example of the good feeling that continued between Australia and London was the gesture made when the B.MA. was to enter a new house at Tavistock Square, London, in 1925. The Australian branches presented a President's Chair, designed by Sir Edwin Lutyens, architect of the new building. The inscription chosen was to include words 'in token of kinship, loyalty and goodwill'; and underwritten with the Edmund Burke quotation from his speech on 'Conciliation with America': 'Ties, which, though light as air, are strong as links of iron'.

Federal Committee, invited to send a delegate for the opening chose Dr. W.N. Robertson, Queensland representative on both the Committee and the Australasian Medical Publishing Company from foundation of both. He was a general practitioner, who became one of Brisbane's early E.N.T. specialists in 1899, and served many years on the state branch of the B.M..A and Medical Defence Society. Of him, Dr. Todd wrote to London that 'no one has done more for the profession in Australia, and few, if any, are better known to the profession'.[106] In 1935, he was honoured with a life vice-presidency of the B.M.A. at its first A.R.M. to be held in Australia in Melbouurne. In the late twenties, two issues remained unresolved between London and Australia. The first was uniformity of ethical rules, initiated by the B.M.A.; the second automatic membership, initiated by the Federal Committee.

A correspondence on ethics gave rise early 1927 to the B.M.A. London underlining the aim of the Association, which was to adopt uniformity of procedure. The A.R.M. in 1919 had adopted ethical rules as a guide to divisions and branches, though intending adaptation to local needs and autonomy in branches - particularly as to expulsion of members. Dr. Todd wrote to state branches, as federal secretary, stressing 'the great importance attached by the B.M.A. to the adoption by the branches of these ethical rules'. South Africa had recently done so, and, in 1927, the B.M.A. Medical Secretary wrote from London suggesting that the Federal Council in Australia might follow suit. This would mean dropping the intra-professional restriction regulations, which governed ethical procedure at that time in N.S.W. Passed in 1896 as a weapon against 'clubs', it provided that a doctor could not be met in consultation if 'guilty of conduct detrimental to the honor and interests of the profession'. This type of rule had been abandoned in London, after the Coventry case; and they felt N.S.W. might well follow their example after the Thompson case in that state.

The case referred to was that where Dr. Thompson, after his expulsion from the N.S.W. Branch in 1921, had fought a charge of conspiracy on five counts demanding £5,000 damages all the way to the Privy Council. Cause of his expulsion and 'derogatory' conduct, as alleged, was his agitation, on behalf of a Mrs Farr, that she was the victim of a conspiracy to detain her in the Hospital for the Insane, when, in his opinion, she was sane. He took her case to press and Parliament. The B.M.A. claimed he had insinuated himself between a doctor and his patient.[107] The case was a Pyrrhic victory for the B.M.A. It drained B.M.A. funds, and gave them much harmful publicity, while the vendetta followed the B.M.A. much later when Dr. Thompson gave evidence for a patient against her doctor in the even more famous case of Hocking-Bell in 1935. He never regained membership of the B.M.A. either in Australia or in England. The B.M.A. from that time on became very wary of invoking powers under their ethical regulations of this kind.

As the power to expel remained one, to which they no longer resorted, Australian Branches had no objection to the request of the Parent Council to have consistency in rules, and to abandoning the intra-professional restriction rules. Draft model rules were approved at federal level in 1928. At this time, the Federal Committee for its part wanted change to prevent 'automatic' membership on transfer of a doctor from one branch to another; and to make it ' 'subject to the approval of the Division'. Reasons given were

(1) members in some cases in one state accepted appointments in another which, according to the rules of the branch in that state, members were debarred from accepting (2) examples had occurred where a member had been questioned elsewhere, for example in South Africa, and had had to be accepted in Australia. If the Parent Council would not change the article, any Branch, concerned in being asked to accept a member it deeemed undesirable, would have to go through the process of expelling the member involved and incur the responsibility and consequent odium as happened in the case of Dr. Thompson.

Both the Organisation Committee and the Council in London, after considering its request, replied, taking the N.S.W. Branch to task for their wariness to expel-rather surprisingly after their Coventry experience:[109]

> "If your plans were adopted, and a man thought unfit to be a member of the Branch were still allowed to be a member of the Association, would not men of the type we now have under consideration fancy themselves to be favoured rather than penalised? They could still call themselves members of the B.M.A. They would still get the B.M.J. We could not refuse them the ordinary courtesies of membership if they came to this country; the annual meeting for example, and they could get off with a much smaller subscription.
>
> "It seems to the Central Council that the effect of a plan whereby offenders or persons of doubtful reputation went scot-free and unpunished or even financially benefited, would encourage black-legging and other misconduct on the part of members of other branches who thought of migrating".

This had been the position of the 'unattached' member until 1902, when ' it was deliberately abandoned for reasons which seemed to us to be very strong then and still seem so'. Indeed, the position of the 'unattached' member had been a grievance with the Australian Branches until 1902, who considered the effect of this on the influence of the association in the country to have been enormous But Dr. Cox believed that to go back to the old arrangement would be a retrograde step. The suggestion of N.S.W. would create a body of members in an inferior and anomalous position. He considered it better to have doubtfuls in the assocation than outside, as they would be more likely to receive education in medical ethics inside the Association.

Expulsions in Australia, after this date, appear to have only occurred in Victoria. But, in fact, membership still remained automatic and, if a member was unwanted, his exclusion had to be carried out by more subtle means than expulsion, if at all.

The slow and tedious process of consultation between the State Branches over such matters prompted the Branches to think once more of a Federal Council. During the years 1920-8, the responsibilities of the co-ordinating Federal Committee had been growing. From 1920, it was charged with attempting to carry out all resolutions of Branches and triennial congresses. Its problems grew and extended. They included advertising in the form of autobiographical notices of

doctors in the lay press, recognition of homeopaths, fee splitting, rules for procedure in ethical matters, the relative position of medical attendant and consultant in regard to fees, confidential list specialties on name plates, medical service in hospitals, deduction of cost of journals from income tax, travelling medical examiners for life insurance, industrial hygiene medical service contract, fees for attendance on naval personnel, revision of the British Pharmacopoeia, attendance on widows and orphans of servicemen, salaries of ship's surgeons, and medical officers in armed forces, conditions of service in the navy, tariff on medical and surgical instruments, status of unqualified clinical assistants, contract medical service, and a handbook for recently qualified doctors.

Most of these were direct problems of ethics and conditions of work. Others bore on the wider problem of the doctor in society- reorganisation of army medical services, medical services to natives in Central Australia, anticipation of epidemics, representation at th Royal Commission onPublic Health 1926, national insurance including conference with the Pharmaceutical Council, relations of pharmacists with the medical profession, a medical council for research, campaign against T.B. 1927, conference on venereal diseases 1922, and war emergency organisation.

The policy of the Federal Committee and branches constantly reiterated their wish to be consulted prior to legislation. The formal demand had begun with the N.S.W. Branch 1913.[110]

> "that, in the introduction of legislation, the success or otherwise of which may be dependent upon the work of members the medical profession, the representative body of the profession should be consulted from the inception of the proposed schemes in order, if possible, the success of the schemes may be secured, and there may be no difficulty."

With the approval of all branches, the Federal Committee approached Prime Minister Joseph Cook in 1913, who agreed to do so. This cordiality of cooperation with the Commonwealth Government continued post-war.

The exhortation of the General Medical Council and the B.M.A. in Great Britain to emphasise the preventive aspects of medicine throughout University training and medical practice was remarked throughout the Dominions. Dr. Armit , editor of the M.J.A. was a fervent apostle. In July 1919, the Federal Committee agreed:[111]

> "That a material advance will have been made in the practice of public health when the practising profession who come first into relationship with cases of illness and who can earliest take adequate measures, have become incorporated as an integral part of the machinery of health".

In February, 1920, it resolved further that it was highly desirable that a Commonwealth Department of Health should be created .[112]

It hoped that some scheme of practical cooperation with the profession through the state departments would then be forthcoming. Severe outbreaks of meningitis during the war, and lethal influenza post-war, had already led to emergency coordination. What could be done was already shown by the study on the causes of death and invalidity in the Commonwealth during the war 1915-17.

The Health Department, created in 1921, was operating by the time of the 1923 Congress. It had carried out a pilot anti-diphtheria campaign at Bendigo. It also had a considerable exhibit including hookworm, model ambulance,and mortality statistical displays. It also planned to establish health services in selected areas to exemplify what could be done in preventive medicine. The President of the 1923 Congress in Melbourne welcomed the idea, pointing to the weakness of local government as so many speakers had done for over a century.

The need was obvious to all. The reports at congress on diphtheria and T.B. still made depressing reading. Despite legislation in Australia to make diphtheria a notifiable disease, going back to 1880, it continued to flourish. The incidence of T.B. remained slightly higher in Australia than in Great Britain, though the cause and manner of its transition had long been known.

A combined session of all sections was held on T.B. as a top priority of Congress. Dr. Hone of Adelaide mentioned B.M.A. success after the Auckland Congress in 1914 in agitation for legislation against V.D. in every state. But he also reminded Congress as to T.B.;[113]

> "that in the past resolutions had been passed at Congresses at the final meetings and the majority of these had remained pious hopes."

Congress agreed to urge the Commonwealth to arrange for, and put into operation, a national investigation into the facts of T.B. in Australia, with special reference to the extent of infection in the community, the sources of infection, and the relative importance of these sources. As an aid to bring this about it reaffirmed a resolution of 1920 Congress; that laboratories be established at principal centres throughout the Commonwealth in the interests of public health on a concerted scheme.[114]

Before long, the Commonwealth Health Department had set these up in a number of large country centres like Launceston and Kalgoorlie; and had a T.B. division. Both the Acting Prime Minister Dr. Earle Page - a surgeon of standing - and Dr. S.S. Argyle, Minister for Health in Victoria, were there at the 1923 Congress to welcome

as guest of the Congress from Great Britain, the British surgeon, Sir William MacEwen, past president of the Parent B.M.A. , as did the surgical section of Congress. It was also the occasion for opening the new Anatomy Department, University of Melbourne, and the unveiling of the striking war memorial of the Victorian B.M.A. - a fine sculpture by Mr. Webb Gilbert.

In the four years until the Dunedin Congress, 1927, the Commonwealth freely invited the cooperation of the profession in two major matters - the Royal Commission on Public Health, 1926, and the Royal Commission on National Insurance 1924, together with its subsequent legislation, 1928. Dr. G. Syme and Dr. Hone were both Royal Commissioners on the former along with Dr. Todd. Their report naturally reflected their long experience with Branch Council, Federal Committee and Congresses. No men were more conversant with the viewpoints of doctors than they. They were against any national medical service based on national insurance, already canvassed in the Branches, believing the continental system unsuitable; but were for more extended development of preventive medicine.

An unexpected consequenceof the Royal Commission on Public Health was that Sir George Syme, when travelling Australia taking evidence, made approaches to surgeons in every state with the idea of establishing an Australasian College of Surgeons. At the 1920 Congress, he said he doubted if the time had yet arrived for such a College, and the division of opinion prompted caution. But the visit of some American surgeons not long after, including Dr. M. MacEarchen at the behest of the N.S.W. and Victorian Governments, was followed by invitations to the Australian profession to induce recognised surgeons to be given the advantage of membership, and 25 had accepted.[115] Sir George Syme secured the backing of senior surgeons in Sydney first, then others in all states. An initial meeting to organise the College was held in Sydney August 1926, while the first meeting of founders was held in Dunedin concurrently with the 1927 Congress.

Dr. L. E. Barnett, Congress President, told the Congress the objective of the new College was to:

> "combine the good points of the Royal College of Surgeons of the British Isles with those of the more recently founded American College. The aims are to raise the standard of surgical efficiency, surgical endeavour and surgical ethics in both hospital and private practice."

He pointed out that in Great Britain it was exceptional for anyone without special training to do major surgery, whereas in the newer countries there was no clear differentiation. Major operative work was commonly undertaken by men lacking knowledge and experience to decide critical questions as to necessity of operation, timing and complications 'though adequately equipped with what is popularly known as nerve'.

The new College borrowed some ideas from America in the belief that 'the obsolete and autocratic government of the English college would be impossible in this part of the Empire'.[117] Its objectives were named as (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 competence and are of high character. (c) to educate the public to recognise that the practice of surgery demands adequate and special training (d) to promote the practice of surgery under proper conditions by securing the improvement of hospitals and hospital methods (e) to arrange for adequate post graduate surgical training (f) to promote research, to bring together the surgeons of Australia and New Zealand periodically for scientific discussion and practical demonstration of surgical subjects. Its critics were many and vocal, not unexpectedly among general practitioners, who saw exclusion and monopoly, whether real or intended or not. Brisbane criticised the methods adopted by its founders, others the its syllabus, its effect in country towns, even to its being 'a self-laudatory private corporation or syndicate'. Its new secretary Dr. A L. Kenny wrote to the B.M.A. saying the College would work in the closest possible harmony with the B.M.A. Branches.

Papers were given at the 1927 Congress on the role of the doctor in the prevention of disease; national insurance, and the doctors' relationship to the state and hospitals. The Federal Committee had already reported that the service of the practising practitioner was not officially ultilised for the prevention of disease in any state consistent with his knowledge and opportunity.[118] Yet the Royal Commission on Public Health 1926 had reported;[119] that medical practitioners were the first to come into relation with those affected by illness, and have the best opportunity to advise for prevention, especially with infectious disease.

The great stumbling block to a national health policy of this kind appeared to be that state governments had no concerted policy as to health. On occasions, they consulted the profession in preparing legislation as with acts on V.D., training of nurses

and midwives; but on others , equally important, doctors were disregarded. Examples were the Health Act in Victoria, the Medical Registration Act in TAsmania 1919, and the Hospitals Act of 1926 in Queensland. The small gains of the B.M.A. up to 1929 were rather in the direction of hospital policy than public health legislation, while the Commonwealth Health Department could only exercise influence in the states indirectly. No matter how much was said on the platforms of Congresses or Branches, an obvious hiatus existed in comprehension of the health of the community.

At Congress general meeting 1927, a number of relevant measures for action were agreed to - for properly trained public health nurses in University medical schools; for hydatid disease to be made notifiable, and greater control of slaughter houses to prevent access by dogs who carried the disease; for chairs of bacteriology in all medical schools to include immunology; for councils of mental hygiene similar to the British Council, and work on toxic goitre increase particularly in New Zeland.

As predicted by the Jonahs of 1914, Congress now suffered financial difficulties, and debated a compulsory subscription from all doctors in the state where Congress was held. Transactions, once a heavy cost born by state governments, were now printed in the M.J.A. in series.

The M.J.A. had expanded during the 1920's after a difficult time during the First World War due to increased paper and labour costs, necessitating a reduction in size for a time. Publishing for the M.J.A. was done by the Shipping Newspapers until 1921, when the company purchased its own printing machine and transferred its office to the fifth floor of the Sydney B.M.A. building. Its first issue was October 8, 1921, but Dr. W. Robertson's prophecy to the Queensland Branch 1913 was not speedily fulfilled that 'profits on the paper will be so great that it shouldsoon become a valuable asset to the branches'.[120] The rate to members, initially 13.6 per member became £1 by 1915, and continued for many years at this rate except when Dr. Thompson won an award for damages against the company in 1923 for £5,000 for comments made on his expulsion from the N.S.W. Branch.

The articles of association of the Australasian Medical Publishing Co., as drawn up by Dr. Todd, were so wide as to include every possible business activity which could involve a printing and publishing house. Dr. Armit, on his appointment in 1913, foresaw that the Company might become a scientific printing

establishment for universities and scientific associations. As both manager and editor, he pioneered the purchase of ground opposite the University of Sydney, and the building of a three storey printing establishment in 1924 financed by debentures issued in all six states, and held by both members and branches.

One of the more ambitious early proposals, as made by the Defence Department, was that the B.M.A. organise and the A.M.P. Co. print 'a comprehensive popular book' on the work of the medical profession during the war (to include dentistry and nursing) - sales to be guaranteed by the profession. Both parties agreed in 1919, but asked for guarantee against loss in a deputation to the Minister in 1921. Eventually the history was written by Colonel Dr. Graham Butler, and completed in time to be announced at the 1929 Congress. In recognition of his work, Dr. Butler received the Gold Medal of the B.M.A.

Dr. W. H. Crago remained chairman of directors until 1924, and was also awarded a Gold Medal at the 1929 Congress for distinguished service. In presenting the medal, Congress President Dr. G. H. Abbott said 'the history of the N.S.W. Branch appeared to be practically the history of Dr. Crago's association with it'.[121]

A member of the B.M.A. from 1884 for a period of 45 years, Dr. Crago was Council member and Honorary Treasurer of the N.S.W. Branch from 1889, and manager of Chairman of Directors of the Journals (A.M.G. and M.J.A.) for 20 years. He had planned the finance of both homes of the Branch in Elizabeth and Macquarie St. He was honorary auditor of the Federal Committee from 1912, trustee of the N.S.W. Medical Union and the Medical Officers' Relief Fund, and Honorary Treasurer to the Congress which awarded him the Medal. None, in fact, in the history of the B.M.A. in Australia stood more fittingly as the highest example of the kind of medical man to which medical societies owed their development. The records and remarks, made from time to time in Council over the years, show that such men were by no means plentiful, particularly for the type of job Dr. Crago did, which brought little or no publicity or glory. He was also a doctor of considerable skill, being described both as a first-class family doctor and a surgeon skilful enough to be the only doctor known to have removed a hydatid cyst in the brain of a patient who lived thirty years after.

Prior to the awards to Dr. Crago and Dr. Butler, the Gold Medal had only been awarded twice to Australians, namely Dr . Hayward and Dr. Todd.

The N.S.W. Branch, as early as 1925, proposed a popular magazine to instruct the people in view of the constant reference to medicine in the paper, and a call for articles by doctors from time to time.[122] In 1926, the Royal Commission on Health recommended a publication to give information supplied by health departments and such sources. The Branches considered the idea practicable and advantageous. The Federal Committee invited the A.M.P. Co. to establish such a magazine, and the directors agreed, the intention being to produce something like the American journal Hygeia. The first issue was planned for January 1927, but , though it went to the verge of production, nothing transpired.

Not long after, a Public Medical Officers' Association was formed in Victoria in 1928, modelled on a similar group in N.S.W., with a committee representative of the several segments. Inactive during the depression, it revived in 1935, deciding to remain independent of the B.M.A.[123]

At the 1929 Congress in Sydney, the President Dr. Abbott described his appointment as a compliment to the Sydney University Medical School of which he was the first graduate. Thereafter he was the first to go on the Branch Council, and a foundation member of the Federal Committee. He recalled to Congress how his professional life had seen the introduction for the first time of operations for appendicitis, cancer of the stomach, gastroenterostomy and gall bladder. Sydney University was now to have its first full time Professors of Medicine and Surgery owing to the Bosch Bequest. Among prominent English visitors, he welcomed Dr. Janet Campbell in Australia. She was to advise the Commonwealth Government on maternity mortality and infant welfare, and to collaborate in post-graduate courses of instruction organised by B.M.A. Branches.

The 1929 Congress for the first time had a full section on anaesthesia, while also affording for the first time space to papers on medical literature and history. Pride of place went to a full meeting of Congress on cancer research work; a subject much agitated at Congresses from 1902-29. Sydney University had had a cancer research organisation, backed by public fundraising for seven years. Queensland began a cancer campaign in 1927 launched with the aid of the Public Health Association of Australasia, and the Queensland B.M.A. which led to a Cancer Trust in 1929 on which the B.M.A. was represented.

The Federal Government had assured approval from the Commonwealth for $100,000 for 10 grammes of radium for the states with the aid of the Federal Minister for Health, the former Orange general practitioner and wartime head of medical services in the forces, Dr. Sir Neville Howse. His dread of the diseases left this legacy to

the Commonwealth, but did not spare him from the family propensity, and death from cancer himself.

In other states, organisations were in process of establishment. January, 1928, the Federal Department of Health had sponsored an interstate cancer advisory committee to correlate all activities with cancer and allied conditions; to establish centres for treatment and research in each state capital - to which the Federal Government would loan radium on certain conditions. From this date, an annual Cancer Conference was held, convened by the Dept of Health, but attended by a representative gathering of all state organisations for the control of cancer, Universities and research institutions, Federal Council and Branches of the B.M.A. and the Royal Australasian College of Surgeons. It embodied the kind of cooperative consultation that earlier Congresses had hoped for in specified fields of disease. Other interstate congresses on special subjects had been convened but never on a regular basis. For example, congresses on ophthalmology and oto-rhino-larynogology were held in Melbourne 1918 Specialist groups had appeared from time to time, probably the earliest the Opthalmological Society, founded in 1899 by Dr. J.T. Rudall.

In 1930, an Association of Physicians was founded mainly by the leading physicians of Sydney and Melbourne. Sir Richard Stawell of Melbourne was the first Chairman, and it became a College in 1936. In 1938, it acquired a headquarters in Sydney, in which it housed the sister College of Surgeons, in return for similar privileges at the Royal Australasian College of Surgeons headquarters in Melbourne. This building in Macquarie St Sydney, was originally the home of John Fairfax, and a National Trust building.

The Association of Physicians, like its predecessor the Royal Australasian College of Surgeons, wished to raise the standard of education and qualification particularly of specialist physicians. One of the most highly respected physicians in Australia, Sir Charles Blackburn, said in 1951:[124]

> "With the rise of operative surgery, that followed the introduction of asepsis, internal medicine lost much of its appeal to the profession. Competition for appointments whether medical or surgical to the staffs of clinical schools, has, of course, always been keen, but in the first quarter of the century few graduates desired an honorary position as a physician in a hospital where medical students did not throng the wards.
> "In the late twenties and early thirties when most teaching hospitals divided the staffs for the first time into physicians and surgeons, competition was active only for surgical appointments."

He warned against the 'unhappy urge to win as many diplomas and degrees as possible, rather than gaining more clinical or laboratory experience'.

The Association of Physicians never provoked the initial antagonism incurred by the Royal Australasian College of Surgeons The Eastern Suburbs Division of the Victorian B.M.A. had called the latter 'inimical to the best interests of the profession'. The General Practitioner Section of the same Branch, formed 1929, was publicly sensitive to the possibility that Fellows of the College might undertake special pressure to obtain appointments, indirect advertising of competency and character, in a way that would bear adversely on the general practitioners. It openly condemned the press notices and photographs during the Congress of the College, early 1930 in Melbourne. A press statement on fee splitting - a topic already causing marked division in the branch was attributed to members of the College of Surgeons. A considerable body of opinion in Victoria objected to the possible political aspect of the College's activities. The College early had a hospital policy, issued a scale of fees, and, in the words of Dr. Fitchett-editor of the new journal of the section, the'General Practitioner', claimed to speak for the profession as a whole direct to the public, on matters concerning the relationship of the profession to the public. The President of the College, Sir Henry Newland, who had made the speech to which he was referring, was also Federal President of the B.M.A. at the time - due to the recent death of Sir George Syme. This very duality of role may well have been the cause of his speaking in such a way as to cause the hostility of those who demanded that the B.M.A. continue to be regarded as the sole intermediary of the profession with the public. The College accepted the demands of the General Practitioner Section that they delete from their constitution the principle of education of the public, and prohibit all press men from their meetings.

The General Practitioner Section, however, overlooked the central virtues of the Colleges, as defined by Sir C. Blackburn, t that their influence would be felt in overcoming a situation where clinical laboratories and workshops were few; rewards ppor; institutes chronically short of funds, and specialists working in isolation. It would eliminate parochialism, and create Commonwealth wide opportunities to meet regularly in a special discipline while working against a situationwhere the Floreys and Fairleys of Australia were being drawn from Australia by its intellectual isolation. And

indeed, the Colleges from foundation worked to raise practice to world wide standards and to promote research.

The Victorian B.M.A. did its best to discourage conflict over the College of Surgeons, objecting in its 1930 report that a position had been reached when the Council was embarrassed in its responsibility of administering the affairs of the Branch on behalf of its members. The storm in the teacup had given a rather more conspicuous flourish than usual to a latent conflict between specialist and general practitioner.

The Association of Physicians was more cautious in laying itself open to criticism. Its objects were not so lengthy or provocative, emphasising 'promotion of friendship among physicians and the advancement of internal medicine'. It banned both reporters and reports, and limited the association to seventy men.[125] The College of Surgeons (Royal in 1931) was heard of once again in 1934 as a target for criticism, owing to the occurrence in Adelaide of what was termed unnecessary publicity. At the heart of the matter also lay concern over the sovereign rights of the B.M.A., loyalty to the B.M.A. - whether new bodies would encroach on the B.M.A. and erode it in time - and the desirability of having no more than one body to speak for the profession in relation to Governments.

Even the B.M.A. itself in the period 1912-30 was scarcely equipped to speak as one body with a Commonwealth Government. The 1912 Federal Committee was purely a coordinating body formed, without even the Constitution of the Parent Association making proper provision for it until 1921, at the A.R.M. on a basis drafted by Dr. Todd.[126] From that time on, the Australian Branches had authority to form a Federal Council on their own initiative and to concede it such powers as they wished to forge for themselves; generally the powers and duties sought to be given by the Branches to the Federal Committee.

In 1927, the Victorian B.M.A. decided the time for a Federal Council with 'executive ' functions had come, with the power of initiative wanting in the existing Federal Committee. The Federal Committee was given a charter by the Parent Council to convert itself to a Federal Council . The Branches do not appear ever to have specified the area in which the Council was intended to act, as they were supposed to do, with the single exception that the Council could initiate business. But this meant little in a situation where all matters had first to be approved by Branches, or a majority of them, except for a right to introduce business. Moreover the Federal Council had no power to enforce any decision on the Branches if it should make one. The position stated by the N.S.W. Branch decisively in 1912, that no branch surrendered any function or duty or power to the Federal Committee, did not substantially change in 1933. The

only real change was its incorporation under the N.S.W.Companies Act as the 1921 reform enabled it to do.

The Federal Council became a reality in 1933, and was given a grant from the Parent Council towards expenses of foundation[12] The two men most responsible, Sir George Syme and Dr. R. Todd, were unfortunately neither of them alive to see it. The new President was Sir Henry Newland, and the new Secretary, Dr. John Hunter. Nor was the M.JA. Editor, Dr. Armit, on the scene to welcome thenew Council , having died suddenly of streptococcal infection in 1930; his successor being Dr.Archdall. The new Federal Secretary, Dr. John Hunter, like Dr. Todd before him, began as N.S.W. Branch Secretary, and continued in a dual capacity in both state and federal administration, while the new M.J.A. editor, Dr. Archdall had worked with Dr. Armit prior to his death.

Dr. John Hunter had begun as a scientist, and gone on Antarctic exploration, before going into medicine and general practice for a time. He was a man who was to give the same lifelong enthusiasm, energy and brilliant administrative skill to the B.M.A. as Dr. Todd had done with the advantage of training under Dr. Todd and the masterly legal foundations laid by him. In later years, Dr. Hunter said the two men who influenced him most were Dr. Todd and Dr. M. Archdall. Of Dr. Archdall himself, it was later said:[128] 'his influence on medical journalism in Australia in our time was far greater than that of anyone else'. He edited not only the M.JA. but a number of other journals like the A. and N.Z. Journal of Surgery, the Proceedings of the Royal Australasian College of Surgeons.

The members of the new Federal Council were only twelve in number - the number being limited deliberately first for lack of funds, second:[129]

> "stress was laid on the importance of having the committee as small as possible to allow of its travelling about from place to place to deal with particular matters as they arose".

The Council was sometimes even smaller in number due to the distance of Tasmania and W.A. from the usual place of meeting on the eastern coast prior to regular fast air travel, and the cost to the doctor of the time involved in being away. Then one delegate would hold a proxy vote for another. Council usually met twice a year. Representation was equal for all states as in the old Federal Committee, and N.S.W. often felt it could unfairly be outvoted by

a combination of the smaller states- unfairly because by far the larger proportion of doctors practised in N.S.W.

Although constitutionally the Federal Council could provide no real basis for change, the expectation that it would was real enough with both members of the Council and B.M.A. membership. The M.J.A. editor, Dr. Archdall, hailed the new Council with optimism:[130]

> "The Federal Council has arisen - a corporate body with power to initiate and to carry into effect measures advantageous to the Branches. The days of tedious reference to the Branches on matters of all kinds, the days of slow moving machinery are, or should be , done.. the Branches expect leadership.

All hoped the Federal Council was now more than a debating body and a secretarial office to channel the views of one Branch to another; and therefore armed with more than moral or persuasive powers on policy.

The issue was to become a highly important one in 1938. The Commonwealth Government had dealt with the Federal Council on the presumption that it was an executive body which could speak and decide for all the branches in Australia. The point was then hotly debated in every Branch in Australia, and the Branches accused the Federal Council of assuming 'plenary' power or powers of decision, vis a vis the Federal Treasurer, on behalf of the profession, during conferences in 1938, on conditions of service under the National Health and Pensions Insurance Bill.

The appearance to act may have been held to exist under Article 25 of the new constitution of the Federal Council which read:[131]

> "It may consider any matter affecting the medical profession in Australia, and may act in connection therewith on behalf of the Branches collectively."

But in truth any decisions it reached in this way were all conditional on Branch approval.

From the first, the Federal Council was handicapped by lack of money. Funds amounted to 2/- per head per member per year, and this was eaten up merely holding twice annual meetings. The Treasurer Dr. Dick warned members in 1934, they were not balancing the federal budget despite supplementary grants from the Branches.[133] Dr. J. Hunter was paid a token £150 as federal secretary, and assistant £40.

The chronic shortage of funds dictated the fate of the federal organisation. To overcome it, the president Sir Henry Newland and Dr. J.Newman Morris, Federal Council members and Chairman of Committees of the Victorian B.M.A., approached the Parent Council, when in London 1932. Along with Dr. T. Dunhill, Queen's Surgeon, an Australian famous for his work on thyroid surgery, and representative for three Australian Branches in London for many years, they saw the various B.M.A. bodies concerned, making two requests. The first was to reduce the amount of the Australian subscription remitted overseas from £1.5.6 to £1.1.0 'in view of the amount of work we did for ourselves in contrast to other branches (some 99%)".[134] The second was a change of rules so members would not be obliged to take the British Medical Journal in view of owning their own journal.

The Australians were told that most of the Australian money went to the British Medical Journal, little to administration. The Treasurer, Mr. Bishop Harman, was emphatic:[135]

> "It was, of course, impossible to alter the subscription rates, also fatal to stop the Journal, as then probably the American journal would take its place".

The 1932 Conferences suggested either the Parent Council support a fulltime secretary in Australia, as was done in Scotland and Ireland, or contribute the office expenses in Australia. The latter compromise was adopted - £1,000 being paid for three years running, with an additional grant in 1938, for B.M.A. representation at the Royal Commission on National Insurance.

The Federal Council still did not get a secretariat or full-time secretary. A sub-committee considered the cost in 1936 foreseeing that impending Commonwealth legislation would load administration heavily. Three suggestions were as follows - fist an assistant to release Dr. Hunter from Secretarial duties as required; second, that the Federal Secretary should be editor of the M.J.A. as in South Africa; third, the Council become an A.M.A. retaining in Australia the large sums now remitted to England as had been done in Canada. The first solution was adopted. Dr. John Hunter's brother, Dr. Hugh Hunter, was appointed, freeing Dr. J. Hunter to do organising work on occasion. April-June 1938 he travelled through Queensland at the request of the Queensland Branch to discuss difficulties arising from the Hospitals Act 1936, and to expound the Federal Council 1936 plan for a general medical service to the nation. In 1938, he went to Tasmania over

plans for a salaried medical service to outlying districts, and travelled the state. Both trips were the forerunner of similar sorties at critical times of change , which were eventually to include Canberra, New Zealand and Europe.

Even before the Federal Council in 1933 to strengthen federal cooperation, liaison was present other than through the B.M.A. Doctors attended Pan-Pacific Science Congresses begun in 1920 to correlate all scientific work in the Pacific area, which included medical studies, chiefly on hygiene, epidemiology, and community medicine. In 1926, a Dr. Decourt of Paris, at a gathering of doctors from many nations for the opening of B.M.A. House in London, used the occasion to try to enlist support for an international association of medical organisations. His vision was of a body , which would act as a centre of information, study the relations of doctors with the state in social medicine, and social hygiene, and the relations of doctors with each other. The B.M.A., London, after initial enthusiasm, decided against it, as meaning new responsibilities for the few medical leaders who were already overworked. It also felt existing liaison to be adequate. The Australian Federal Committee followed its lead.

Within Australia, a Federal Health Council of Departmental Health heads, created 1926, met every year. It sought to devise measures for cooperation of Commonwealth and States; States with States, and to promote uniformity of legislation and administration where advisable. Dr. Page, Commonwealth Treasurer, said in his Budget speech August 30, 1928:[136]

> "Some approach to a coherent national policy has been made possible by the creation of a National Health Counci

In the next ten years, it dealt with many of the matters on which action had been desired by past medical congresses. Such were control of V.D. and T.B., metropolitan milk supplies, uniformity of classification of vital statistics, school medical services, [redacted] of aboriginals, control of leprosy, maternal mortality, control of poisons and sale of drugs, and Commonwealth registration of doctors. During this era, the Commonwealth founded the School of Public Health and Tropical Medicine at Sydney University, and the Institute of Anatomy at Canberra, 1931.

After 1930, the number of specialist groups formed grew rapidly. By 1934, the radiologists and anaesthetists sought their own organisation. At the 1934 Congress, members of the section of X-ray and electrical therapy constituted themselves provisional members of a new Association of Radiology, and planned a Federal Council. Dr. G. Kaye of Melbourne urged a similar body for anaesthetists in a paper at the same Congress, emphasising the risks during major surgery from ineptitude of doctors given inadequate education.[137] A Federal

Section of Pediatrics was proposed in 1932, and an Australian Branch of the British Dermatological Association.

Immediately after the 1934 Congress, the Federal Council called for a report on the implications of specialist groups, fearing that they might 'tend to lessen the influence of the B.M.A. in Australia to the detriment of the profession as a whole.'. The report concluded that it would be best if they were formed within the ambit of the B.M.A., or, if this were not possible, they should confine themselves to clinical work, and insist on membership of the B.M.A. and cooperation with the B.M.A. especially where approach to governmental authority were involved. What was most feared, was disunity in the profession unless safeguards were provided and limitations defined.

Disunity could occur for at least five reasons. First, calls for subscriptions would be multipled. Second, independent meetings might affect attendance, as happened in 1934 and 1935 at the Australasian and the Commonwealth B.M.A. Congresses. Third, separate bodies might initiate different policies on matters like hospital policy, insurance etc. Fourth, they might take independent action on community matters. Fifth, they might have different rules on the division of fees.

In some cases, however, as with radiology, separate bodies might be necessary to allow members to join, who were not registered doctors, so the association could not be contained with the B.M.A. It was questionable whether the movement to set up independent bodies, drawing membership solely from registered doctors could, in fact, have been contained with the B.M.A. Those in B.M.A. Council, who were concerned at the fragmentation in 1935, believed that it could. The General Secretary, Dr. Hunter, wrote to London that many individuals agreed with the Federal Council that separate bodies would not have been formed if it had been possible to limit membership of sections of the association. The difficulty was that the Council could not form sections on its own initiative except under the object 'any matter of scientific importance". The Organisation Committee in London, on legal advice, now recommended that the Federal Council should have specific power to form Australia wide scientific sections. In 1938 a new Article 25 (a) was added to allow Council either alone, or jointly with Branches, to form special groups. The first of these was the Ophthalmological Society of Australia (B.M.A.) founded on the same day the rules were approved.

The distress,occasioned by the 1929 depression, precipitated the Commonwealth Government into fulfilling electoral promises, made monotonously at election time by both parties since 1913. Once the Commonwealth Government entered the arena of national medical service from 1924-8, then 1935 on, the only logical negotiating body was the Federal Council. This was the period when the Federal Council was being used by the Branches more freely as a clearing house, and to obtain an exchange of opinion with other branches. Its recorded business became multifarious.

It dealt with frontier medical service of the Australian Inland Mission (the flying doctor service), naval medical officers, the cost of Commonwealth Serum Laboratories biological products, the cost of drugs, curtailment of medical service by the Federal Health Department due to the depression, fees for various examinations in recruits in industrial insurance, postal regulations for X-ray films. Among its ethical considerations were liability of the surgeon for the anaesthetist's fee, gratuitous medical attendance on fellow practitioners, treatment in port of ships ' crews. It negotiated for registration of Australian graduates in Great Britain.

The Federal Council formulated a national hospital policy to present to the 1934 Congress. Discussion revealed just how difficult it was to formulate a simple common hospital policy for a continent presenting such varied conditions as Australia. Preparatory work had been done by Dr. E.S. Meyers of Brisbane, a surgeon who founded the first anatomy classes in Brisbane, and a founder of the Queensland University Medical School. He called for a national approach to hospital policy, and through it to a national medical service with the 1930 Report on a General Medical Service of the B.M.A. in Great Britain in mind.

In 1935, the Federal Council adopted principles for a general medical service to the nation, and a scheme of health insurance, described as the outcome ofyears of consultation with the Branches and the Parent Council in England. They were presented to the Commonwealth Prime Minister and Premier of every state in 1936. It had had an unparalleled opportunity to consult medical leaders of the Parent Council when the 103rd annual meeting of the world wide B.M.A. was held in Melbourne September 9-14 to coincide with centenary celebrations: as an outcome of a proposal by Sir James Barrett, who was the first Australian to be honoured by election as B.M.A. president for 1935-6.

1600 members came, 230 from Great Britain and elsewhere in the Empire, including seven leading officials of the Parent Council; 500 from other Australian states, and many foreign delegates. On the sidelines other conferences were held - an International Pacific Health Conference, a conference of the Deans of Faculties of Medicine, a conference between the Federal Council and the Parent Council, and affiliation of the medical women's organisation with the international federation. It also led to the first Australian conference on crippled children, 1935, to see how best to apply the Nuffield Gift of £50,000 for research on the subject.

The Rt. Hon. Lord Horder gave a public lecture on eugenics, as well as opening a joint meeting on thryotoxicosis of the sections of medicine and surgery, at which Sir Thomas Dunhill gave a paper.

At the B.M.A. annual dinner, Sir Earle Page, acting Prime Minister, in reply to the toast of the Commonwealth of Australia and the city of Melbourne, sprung upon the profession a momentous announcement:[139]

> "I am hopeful that a permanent memorial of your visit to Australia will be the inauguration of a federal medical research endowment fund in Australia".

The Federal Committee had first requested such a foundation in 1912, reiterated many times since. The model for such a fund was the Medical Research Council founded in Great Britain in 1911 to direct national endeavours not merely to curing the sick, but also towards prevention of disease. The 1926 Royal Commission on Health had called for a research fund of £30,000, as well as a Federal Council of Health with B.M.A. representation. But the latter, when established by a joint conference of state Ministers of Health, excluded the B.M.A. In 1933, the Federal Council had asked the Commonwealth to appoint the two B.M.A. represenatives originally envisaged. The current Minister for Health, Mr. Marr, preferred such liaison to be reinforced at state level. The Federal Health Council continued only to deal with administrative responsibilities of Commonwealth and State Governments.

Early 1935, the then acting Prime Minister Dr. E. Page, asked the Commonwealth Director General of Health, Dr. J. Cumpston, to confer with the Federal Council on the subject of a Medical Research Council. He had been instigator of the Commonwealth Scientific and Industrial Research Organisation ten years before. The Federal B.M.A. Council recommended one on the model of the Medical Research Council in England, with its autonomy and freedom

in research, divorced from departmental control, and with an independence of a judicial character. It was in doubt whether the Director General of Health should be an ex officio member, or act in advisory capacity as in England; but it was thought that the former might be of value in his ability to act as a liaison officer with the Ministry and give advice. It should advise as to research projects, initiate and supervise them, and expend the appropriation allotted by the Commonwealth.

The approval, first forecast by Dr. Page at the 103rd annual B.M.A. meeting, was confirmed in 1936, when the Federal Minister for Health, Mr. W.M. Hughes, announced Cabinet's decision to establish a National Health and Medical Research Council, which would combine the work of administering the new medical research fund with the functions of the Federal Health Council which it was to replace.[140] Federal Council reflected majority Branch opinion in writing the Minister urging their plan of April 1935 for a council limited solely to research,[141] but was ignored. The Federal Council perforce accepted the situation on the basis that something was better than nothing, and appointed Dr. J. Newman Morris as its representative- despite their objection that it would be dominated by permanent public health officials with the inclusion of six state departmental heads, and two officers of the Commonwealth Health Department.

The motivation of the Commonwealth in deciding on a Council in this form lay in the speech of the Chairman in his inaugural address, when he said:[142]

> "In no other country has an attempt been made to combine the preventive and curative aspects of medicine and the search for new knowledge in the science of medicine in one comprehensive scheme, and in no other country is there this happy combination of the official administrative agencies representing the social aspects of medicine and scientific and clinical workers."

When the Minister introduced the Medical Research Endowment Act 1937 into Parliament June 30, 1937, he remarked that some epidemic diseases had now been conquered like smallpox and typhus, and deaths from T.B. or diphtheria markedly reduced ((mass immunisation campaigns in diphtheria being undertaken in 1935; but heart diseases now caused more deaths than cancer, T.B. motor car accidents and diphtheria put together (40% due to infectious diseases in childhood or malnutrition in youth).[143] He added:

> "This is the first step the Parliament has been asked to take along a road which, willy-nilly, it will be compelled to travel sooner or later"..."The effect of sickness on economic output- to say nothing of the happiness, welfare and outlook of the people can hardly be exaggerated".

The functions of the N.H. and M.R.C. were broadly to advise the Commonwealth and State governments on all matters of public health legislation and administration, health of the public, medical research, and the expenditure of money appropriated for that purpose. B.M.A. Branch Councils almost at once became involved in its work on many matters referred by it. Examples in the first six months were prevention of blindness, maternal mortality, incidence of abortion, work of chiropracters, poliomylitis, and doctors giving public health addresses under their own names.

Emphasis was on the concept that Australia should no longer be considered a backwater in research; and the Commonwealth should no longer confine itself to simply handout subsidies to the States. The Commonwealth could play a valuable role as coordinator, and thus do more than merely find money for the States to spend without any control over the ultimate methods of its expenditure. The profession was enlisted by the N.H. and M.R.C. in four standing committees, to give the kind of consistency in research and social enquiry that Congresses had desired from their earliest days; as for example on tropical physiology and hygiene, T.B., dental research, obstetric research.

More consistent coordination of research had been going on from 1930 in the field of cancer, with annual conferences called by the Dept of Health and held in Canberra. These were attended by representatives of state cancer organisations, Australian universities, and research centres, the College of Surgeons, state branches of the B.M.A. as well as individuals working in the field. The need for some form of national organisation, discussed from time to time, had led the 1935 annual conference to urge support for a national medical research council, thus lending weight to Dr. Page's final decision.

With Government activity expanding rapidly in health administration, the Federal Council, in 1937, again returned to the idea-glanced at in 1935 - of conversion of the B.M.A. into an A.M.A., affiliated with the B.M.A, 'in view of the radical changes that are taking place in the practice of medicine:[144] But a subcommittee reported against it:[145]

> "a move in the direction of complete severance from the Parent Body is one that would be repugnant to most members entailing as it would the sacrifice of many things that are not calculable in pounds, shillings and pence".

The report proposed an extension of Branch autonomy, still limited only to executive acts. Such were decisions on subscriptions, elections meetings, eligibility and privileges, and excluded

ethical rules, on which referral could take up to two years, as the Queensland Branch had found not long before. Dr. Anderson's comment, as British medical secretary, was 'I have always felt these difficulties were magnified to a certain degree'.[146] The Federal Council could not, on request, give any recent examples in which the Federal Council had been hampered in its actions, by reason of its current constitutional relations.[147] The formal response of Branches was that they were opposed to any organic break with England, but, through the Federal Council, petitioned the Parent Council that it consider amending the constitutions to give branches more autonomy.[148] But legal opinion, secured by the Parent Council, insisted the Branches already had a full measure of autonomy under Bylaw 26:[149]

> "some of the difficulties which now confront the profession in Australia do not arise from any defect in the existing constitution of the Association, or to lack of autonomy under this constitution, but from the existing powers of the Federal Council inasmuch that the Council is mainly a coordinating and advisory body , the executive power being retained by the branches themselves."

The crux of the matter lay in the problem whether the State Branches were prepared to alter the status of the Federal Council they themselves had set up. The Parent Council, while willing to help by making alterations in their own articles, clearly thought each Branch should yield more power, if the purpose indeed was, as the Federal Council had represented to them, to enable the Federal Council to act more speedily, as well as more effectively, in any negotiations with the Commonwealth Government. The Federal Council, late 1938, sought the opinion of Branch Councils, with no great feeling of optimism that they would surrender any particle of their power for three dominant reaons. First was state separatism, manifest in most bfanches of government or private interest in Australia. Dr. Hunter explained to London:[150]

> 'In ordinary politics, State and Commonwealth rights are always a constant source of argument, and I am afraid th is much the same feeling even in medical politics."

Second, the Federal Council, by mid 1938, had fallen into active conflict with some sections of state branches over national insurance. These were with groups of general practitioners, who objected that the Federal Council had already assumed too much power in negotiations with the Federal Government; had committed the profession to an 11/- capitation fee, which the general practitioners considered inadequate; and had done so by exercising 'plenary' power which complainants said had neither been given them, nor were they entitled to it.

The danger was seen as twofold - too strong a representation of specialists in the Council, and the danger of a small group, indirectly selected by a procedure of appointment from Branch Councils, speaking for a large and diverse profession scattered over the whole of Australia.

In 1938, the Vice President of the Council was challenged for office and did not contest the next election, while the N.S.W. B.M.A. Branch nearly seceded. In view of feelings running high that year, Dr. Hunter wrote to London of the lack of confidence in State branches, with regard to making the Federal Council 'the supreme controlling body'.[151]
Third, the states were not at all satisfied with the balance of representation in the Council, and were not willing to entertain the thought of adding to its powers until this was rectified.

It is worth comment that Queensland, the state already the scene of fairly radical government policies, was the only branch not opposed to any severance of ties with the parent body; and also the Branch to propose formation of a trades union in taking action to secure recognition by governments.[152] The Queensland Branch, also in 1943, enquired of the Federal Council whether branches were bound by any decision the Federal Council might make, and legal opinion was sought. This decided there was nothing in the Federal Constitution which empowered it to bind the branches, who had merely a moral duty, not a legal duty, to cooperate with the Federal Council.[153] Although the Federal Council had not acquired formal power after 1933, it in fact played an increasingly authoritative role in relation to the Commonwealth Government. Precisely because of its lack of formal authority, it was difficult for the Federal Council to strike the right balance of power between the Branches. The events from 1938 on brought forward challenges from Branch Councils, or individual Councillors accusing the Federal Council, or specific members, of assuming powers to negotiate or agree that they did not possess.

A careful survey of the facts in 1938 tends to disclose that th Commonwealth spokesmen for the Treasurer virtually presented an executive committee of the B.MA. with a 'shotgun marriage'- an ultimatum as to the amount to be paid doctors, combined with an earlier failure to consult the profession, either on the principles, or the details, of the scheme at all. Some of the difficulty lay also in the swift march of such events, and the slow process of referral of problems to Branch Councils for consideration and approval, which could take months.

Another occasion was the presentation by the N.H. and M.R.C. of "Principles for a Salaried Medical Service for the Nation", November 1941. The background for this was the 1938-9 national insurance legislation; which, though proclaimed had never been put into operation. Too many objections by too many parties had been raised, and a Royal Commission as to the amount to be paid to the profession had never been reported. By the outbreak of war, August 1939, the legislation lapsed without regret from anyone. The attendant publicity, and innumerable conferences, had made it clear to all far-sighted individuals that some more comprehensive scheme of medical service would better serve the health of the nation.

The Federal Council expressed a consensus of the Branches in pressing the view that limited medical service to the breadwinner on the capitation system, derived from the old principles of friendly society voluntary insurance, neglected the interests of the chronic invalid, the family, the old, prevention of disease, and all forms of specialist treatment which usually imposed the worst financial burden on the family.

Both through the N.H. and M.R.C. in 1938, and independently, from 1935, the Federal Council pressed one of the most distressing problems- the destitution of the families of T.B. patients. For fifty years, B.M.A. doctors had said this prevented T.B. sufferers from seeking treatment in the early curable stages. In 1939, the B.M.A. sought family endowment to encourage patients to seek early treatment. The Minister for Health, the Hon. F.H. Stewart, replied the Commonwealth fully recognised the value of such a system, but could not add to its financial obligations. War at this juncture had already broken out.

The Federal Council had also, in November 1938, joined the N.H. and M.R. Council in support of a physical fitness campaign in Australia, and appointed a man to a National Fitness Council. At the same time, it asked the profession in the various states to interest themselves in this important national movement. As in the domain of V.D., cancer, maternal morbidity, medical inspection of school children, pre-natal and post-natal care, the general fitness of the citizen was now accepted by the state as its direct concern.

But these were only indirectly related efforts towards a consistently high standard of health for the Australian people. Some form of organised medical care was certain to emerge from the war. The mood of the day was for blueprints for a reconstructed society, where the state would accept responsibility to work for an optimum environment for its citizens from the cradle to the grave.. in shelter, clothing, food, and protection from the hazards of poverty, and illness and personal misfortune.

Two years after Australia's entry into the war, August, 1939, he Minister for Health told the tenth meeting of the N.H. and M.R.C. in May 1941, that he hoped to revive the national insurance scheme held in suspense in 1939. He invited the Council to submit its recommendations, as to this or other schemes, for providing for the health of the people. He approached the N.H. and M.R.C. presumably because the subject was within its charter, and because it was then the only representative body, at federal level, of a wide range of medical interests. The only other body was the Federal B.M.A. Council, or specialist groups such as the Royal Australasian College of Surgeons, or the Royal Australasian College of Physicians, who were represented on the N.H. and M.R.C.

The sequence of events was subsequently described by the Chairman of the N.H. and M.R.C. in an open letter to the profession[15]:

> "At a special meeting in July, 1941, the Council considered the position and adopted a report reviewing certain essential principles which would be met in any attempt at the improvement of public health. In this report appears the following passage:
>
> 'the logic of facts points, in the opinion of this Council to the need for critical and dispassionate examination in consultation with the medical professi of the place of the doctor in society before the insurance scheme is brought into operation, or before anyother national health scheme is considered'."[4]

The N.H. and M.R.C. appointed a sub-committee to report on the most effective organisation, which reported November 1941. Before this, however, the Federal B.M.A. Council debated the July recommendations. Its statement underlined problems, restated many times in medical congresses and meetings:[155] that health was determined by a complex of social conditions, that this obligation to the community could not be discharged if public health department budgets were inadequate. It added:

> "Hitherto it has been accepted as a principle that each individual had the personal duty of caring for his own health: the evolution of social organisation has produced conditions which now involve the principle that the care of personal health is a social duty and not an individual responsibility.

> "the rapid development of medical practice along lines of specialised work has produced a complex of uncoordinated activities all concerned with the care of individual health, and each having direct or indirect relations with the others. All of these are becoming more and more divorced from the principles of prevention of disease. It is important that a proper administrative organisation for bringing together all aspects of medical work be devised and incorporated in any system of social reform".

To overcome this, it proposed district health officers, district hospital systems, not inconsistent with the retention of private medical practice and private hospitals. It proposed a gradual continued infiltration by the Commonwealth. Among the Commonwealth' more recent innovations were mentioned the child endowment enactment, an enquiry into nutrition as a national problem, experimental pre-school centres in each capital, and a national fitness organisation of a permanent character.

The B.M.A. suggestions were so far-reaching as to completely alter the original basis of 1938-9 legislation; including provision for domiciliary service, specialist service, for unemployed and self-employed, better distribution of doctors, and integration of medical services. Meantime November 1941, the N.H. and M.R.C. approved the sub-committee report presented to it: in the form of an 'Outline for a possible scheme for a Salaried Medical Service' prepared in considerable detail as to cost and disposition of doctors. The Council approved with the rider: that it considered the present system of medical care capable of considerable improvement in some directions; and that the scheme outlined provided a basis for discussion with representative members of the practising medical profession in Australia. This scheme was then presented to a Joint Parliamentary Committee of Social Security, recently appointed by Parliament.

Dr. Morris, Federal B.M.A. representative on the N.H. and M.R.C. had put the views of the Federal Council at this November meeting: [1] that it was opposed to any scheme based on salaried medical service, that no scheme to alter medical service should be adopted for the duration of the war, and even then, only after submission to the Federal Council. He was outvoted 14 to 1, his being the only dissentient voice against the 'Outline', although 10 of the 15 members of N.H. and M.R.C. were B.M.A. members. His only gain was a discussion as to what form a conference with the profession should take creating considerable variance of opinion. He reported back to Federal Council that 'the difficulty felt was that of securing any group that can speak for the profession as a whole'.[157] The Chairman of the N.H. and M.R.C. Dr. Cumpston complained that the FederalCouncil could speak neither for the profession or even

the B.M.A. This criticism struck home, as witness Sir Henry Newland writing a week later:[158]

> "It is sheer impertinence of the N.H. and M.R.C. to say that the FederalCouncil cannot speak for the profession or even the B.M.A. The Federal Council has been recognised by the Federal Government and the B.M.A. in Australia, and more recently by the two Colleges as the senior medico-political body."

To the complaints of the W.A. Branch, he said he did not believe, as they did, that the N.H. and M.R.C. wanted 'to smash the B.M.A.' but rather to 'ignore' it, which was 'insulting and calculated to excite the resentment of your branch as it has also excited my own resentment.' The most shrewd estimate of the worth of Branch complaints was given by the man at the centre of it, Dr. Morris:[159]

> "The letter from W.A. and the action of members of the B.M.A. on the Council, together with quoted views of individual members of the profession indicated the usual difficulties experienced by the Federal Council".

-the difficulty of speaking as a general voice for many shades of opinion.

On another level, the profession was cooperating smoothly with the Commonwealth in plans for the conscription of medical men for home service up to the age of 60. A Central Medical Coordination Committee had been set up with the Director General of Health and State Health Officers charged to safeguard the interest of the civilian community and to organise hospitals, equipment and transport for civil needs in case of hostile attack.

The contretemps of 1941 with the N.H. and M.R.C. had served to provoke active discussion throughout Australia on the principles of future medical service, further stimulated by the enquiries of the Joint Parliamentary Committee on Social Security 1941-3, while taking evidence in the various Australian states. As its field of enquiry was all aspects of the human environment, the evidence on medical matters was fairly cursory for such a complex subject. A Medical Survey Committee, which toured Australia, endeavoured to give more specialised scrutiny to advise the larger body. In the course of publishing nine reports in all, the Labour Party succeeded the U.A.P. in office, and the composition of the Parliamentary Committee changed. During this period, the kind of conference desired by the Federal Council was called on several occasions at which the two Colleges were independently represented, and which were initially held in conjunction with the N.H. and M.R.C. until relations became markedly strained . At these conferences, a free, open and sometimes

aggravated debate was held on all aspects of post-war national medical service.

In the course of negotiations with the Commonwealth, the B.M.A. continued to object to the N.H. and M.R.C. having functions, other than those related to research. In February, 1943, Dr. W.J. Simmons, a general practitioner member of the Federal Council from 1938, and for some years N.S.W. Branch Councillor, became the B.M.A. Federal representative on that body, thus deciding the issue whether the representative should be a pure research man or one whose background lay in medical politics. His selection was recognition that the N.H. and M.R.C. had latterly become a medico-political body.

Not long afterwards the Federal Secretary, Dr. Hunter, pointed out in the M.J.A. the widespread objection in the profession to the Health Council performing functions other than research.[158] He had recalled the original B.M.A. letter to the Prime Minister in 1935, asking for a council entirely divorced from departmental control. At the August 1943 meeting, one Federal Councillor spoke of the N.H. and M.R.C. in the general opinioin as being 'discredited' and the Colleges both supported the B.M.A.

All were well aware that the list of functions for the N.H. and M.R.C., gazetted in 1936, were drawn up in such wide terms as to cover almost every activity in the field of medicine, but had not protested on foundation for fear of delaying any development that might extend medical research. As the 6th Interim Report of the Joint Parliamentary Committee on Social Security (par 159) recommended a permanent annual amount to be provided for the N.H. and M.R.C., and that its present advisory power in respect of research grant be made statutory, the Federal President thought it timely to write a private letter to the Minister for Health. This pressed the Federal Council's recent resolution in favour of detaching medical research from other activities of the N.H. and M.R.C., and placing it under a separate body,[159] more representative of men engaged in research projects. He urged the Government to seize the opportunity provided by Sir Howard Florey's visit to Australia to create a Medical Research Council, for which the B,M..A . had already sought support from the Deans of Faculties of Medicine, and the Colleges. The Cabinet asked Sir Howard Florey to submit a report on the needs of research to the Government, The latter recommended a medical institute in association with a national university as was then under discussion in Cabinet; but as a separate organisatio

with its own funds. He also recommended that funds for medical research be increased from £30,000 to £125,000, as the success of a national institute depended on the existence of active research in the medical schools and other institutes in Australia. Such an institute was generally considered to be dependent on the leadership of a man of Sir Howard Florey's calibre, and the Prime Minister offered him the first directorship.

The Federal B.M.A. made its own request to the Prime Minister for an increased grant for research, saying that Australia sadly lagged behind other countries.[160] It only secured an increase from £30,000 to £40,000, curtailed by 1947 to £32,000, and raised by Senator McKenna to £50,000 not long after. But 1949 found the B.M.A, along with the N.H. and M.R.C. periodically protesting about the inadequacy of the grant, insufficient funds to support deserving applications, and asking for a research foundation of £500,000. The major gain of this period was the creation of the John Curtin School of Medical Research in Canberra with established staff, and scholarship for work there and abroad.

On a change of government in 1950, the B.M.A. again renewed pressure on Sir Earle Page hoping for a sympathetic ear. He promised to take up the question with Cabinet, but four years later was testily responding:[161]

> "I would advise that the grant for the N.H. and M.R.C. which I brought into being myself in the 1930's has almost trebled since we have taken office, despite the fact that the financial position has been extraordinarily difficult."

From 1941 on, the B.M.A. had been apprehensive of the intention of the Labour Government, which had attained office - fearing 'Socialised' medicine. It read into the 'Outline of a Salaried Medical Service, passed by the N.H. and M.R.C. in that year, a portent of things to come. The Federal B.M.A. along with the Branches were unanimously against such a scheme, and advocated first a compulsory insurance scheme on a capitation basis, then a fee for service scheme.

At conferences with the Commonwealth 1941-4, many points of agreement were found, such as with outback medical service, but others of marked disagreement, as with experimental health centres. The B.M.A. fears of 'socialised' medicine were stimulated by the return of the Labour Party to office for a three year term in 1943, and the presence of avowed Socialists in the Labour Party cabinet, as well as by the example of a Labour Party in England determined to introduce a free medical scheme. These fears were not allayed by the promise made by the Minister of Health to

to introduce nothing for six months after the war, nor their knowledge that the Commonwealth Government had its hands tied by limitation of federal powers under the Commonwealth Constitution.

The problem of developing a consistent national policy of medical services, to which all sectors of the medical profession could reasonably assent, was a formidable one. The Federal B.M.A. President, Sir Henry Newland, shortly before his retirement after thirtyfive years in medical politics said:[162]

> ""The events of recent years have convinced me that the only way out of the present complicated situation is the foundation of an Australian Medical Association affiliated like the Canadian Medical Association with the British Medical Association".

The Committee of 1937 had reported the disadvantages of the English union even then to be: first, the limited autonomy possible under the B.M.A. constitution; second, the delay that must arise in giving effect to procedure deemed advisable for an organised profession in Australia; third, the ultimate decision on matters vitally affecting the interests of the profession in Australia lying with a body possessing little or no local knowledge; the drain on Branch finances in respect of the annual capitation fee of £1.5.6. For every member, a subscription of £1.11.6 was payable, only 6/- being allowed back in rebate.[163] Basically, the major limitations were the necessity to refer all rule changes back to London, and the demand that members of Branches pay a universal rate and receive the B.M.J. as well as the M.J.A. In the first matter, discrepancies had arisen in such issues as fees in border towns, workers' compensation laws in one state and not in another, differences in lodge rates between states.

The idea of an A.M.A. was raised briefly in 1943 in Federal Council once more. Dr. Hunter emphasised that the Chairman of the B.MA.. Sir Henry Brackenbury, on his Australian tour in 1937 had not been in favour, nor was the British medical secretary Dr. Anderson now. The N.S.W. Branch suggested a representative body like that in Great Britain 'in view of the great emergency'.[164] But shortage of funds, a situation also created by the remittance of funds to England, prevailed against extending federal representation in this way.

For the moment, the Federal Council sought the way of common consent: each branch to be asked to state whether the Federal Council statements represented their views, and whether the Federal Council was authorised therefore to express them.[165]

to involve nothing for six months after the most ordinary
The N.S.W. Branch Council, whose support was most critical, responded by agreeing that it was, as there could only be one body to present the views of the profession.

National policy questions had, by 1947, reached a point where the Federal Council was engaged in continual negotiation with the Commonwealth Government. The problems to settle were often urgent, and conducted in an acrimonious atmosphere, requiring decisions not only on details of policy, but as to public relations and press statements.

At this stage, the Branches agreed to give the Federal Council the moral sanction which legal counsel recommended in 1943:[166]

> "The Branches have all agreed to the principle that, in respect of questions on which the Branch Councils have made decisions and reported such decisions to the Federal Council, the Federal Council's decisions, made after consideration of such reports, shall become the policy of all the Branches, and that the Federal Council shall have the power to state these decisions to all interested bodies as the Associations policy."

In 1943, the Queensland Branch was led by Dr. Alan Lee, Federal Councillor and Brisbane surgeon of considerable intellect, forceful personality, and national vision. He moved to ask the Branches to do even more - create a strong Federal Council to negotiate directly with the Federal Government on behalf of the profession. This would obviate the tedious process of referral of all minutiae of decisions in all the Branches, in a process that proved a grave handicap 1937-43.
Two ways of giving Federal Council more power had been suggested in earlier years - possible transfer of power from the Parent Council to the Federal Council, or a concession of power from the Australian branches to their Federal Council. The legal niceties were enough to bemuse even the most seasoned councillors.

On the first alternative, Parent Council could transfer power over the branches to the Federal Council, but for the fact that it had already delegated to those branches essential disciplinary powers over their members which must be possessed, or at least shared by an Australian Federal Council, if it were to have governing authority.[167]

On the second, legal opinion was that Branches had constituted the Federal Council as having authority to act for them in matters by Article 25. This created only a moral obligation, but the objects of this article were only for the purposes for which the Federal Council was formed and did not of

themselves give the Council authority. The creation of the Council had in fact left Branch power unimpaired. The individual doctors, members of the State Branches, were not members of the Federal Council, nor bound by what it decided unless decisions were confirmed by their own branch. Indeed, the rules of the B.M.A. had not even properly defined the exact relation between a Branch and a Federal Council.

Sir Henry Newland, B.M.A.. President, expressed great surprise when he learned of the exact constitutional position of the Federal Council. He had shared misapprehension for ten years, with some other councillors, that the Federal Council was a more powerful body than its predecssor the Federal Committee, in view of the motive that led to its foundation - to secure greater powers than those possessed by the Federal Committee.[168]

Legal advice was that, if the Federal Council wished the power it imagined it had had, it could approach the Branches. There were no real difficulties as to the feasibility of such a tranfer, nor gross differences in the rules of the Branch. The Branches themselves were not totally resistant to a further access of power at the Federal level. Their leading objection was that the Federal Council was not consituted by proportional representation. Queensland, Western Australia, and Victoria all pressed this point. The criticism of N.S.W. and Victoria was also that the two largest states had only the same number of votes on council as each of the smaller states. Thus the four smaller states could dominate the two larger out of proportion to their numbers. The Branches were therefore unwilling to yield power in a situation, where the other states might outvote their point of view. Only the N.S.W. Branch asked for a statement of what federal powers would be necessary for the Federal Council to play a more effective role. In 1947, representation was changed with the consent of the Branches, but only slightly. N.S.W. was given two extra members, Victoria one. To the argument that N.S.W. might then have undue influence, the answer was that it only had four in fifteen members of Council.

Plainly, the role of the Federal Council in 1947 could also be strengthened without the access of formal power the Branches were still unwilling to give. This could be done by erecting a full-time Secretariat, instead of the standing arrangement, begun in 1921, whereby Dr. Hunter was sharing the office and staff with the N.S.W. Branch. He, like Dr. Todd, had acted as both

Federal and N.S.W. Secretary, which at times created a conflict of interest, as in 1938. Dr. Hunter was thought to be serving two masters, which could divide his loyalties. Interstate critics might also accuse him of giving undue predominance to the views of the N.S.W. Branch. A compromise allowed Dr. Hunter liberal terms of release from his obligations to the N.S.W. Branch for liaison work with profession and public, daily becoming more onerous. He had to be familiar with profoundly complex details of proposed national health service schemes, and the changing picture of projected ligislation. He had to act for a council who were all busy men by day at their profession. He had to keep in touch with Federal Presidents, who lived interstate, on many vitally urgent matters arising from Canberra and State Parliaments.

The words of Sir Henry Newland proved to be prophetic. The 'only way out' inevitably was an Australian Medical Association The existence of Australian Branches as part of an English based organisation, was, loose though its bond, becoming an anachronism in the 1950's. Sir Henry Brackenbury had been told that many Australians were restive with the arrangements in the 1930's. They were even more so in the 1950's. INsensibly with Britain's socialised medicine, and the increasing detachment of Australia politically from Great Britain, the ties of sentiment, formerly considered an argument to weigh in the balance of decision, ceased to be a force. Many of the younger doctors, graduating from Australian universities, found their ties did not rest solely with the B.M.A. as in the old days, but with alternative special groups both in England and Australia.

After the second world war, special groups servicing special interests sprang up both inside and outside the B.M.A.- the greater number outside. In the former between 1945-50 were founded the Federal Orthopaedic Group, the Australian Association of Physical Medicine, The Australian Society of Anaesthetists, the Section of Aviation Medicine, the Dermatological Association, the Australian Pediatric Association, and the Oto-Rhino-Laryngological Society of Australia. Of these , the anaesthetists and pediatricians withdrew from B.M.A. affiliation in 1951, believing their interests better served by independence. While affiliated with the B.M.A., they were limited only to scientific discussion. Those, affiliated to the B.M.A. , remained affiliated to the A.M.A. when it supplanted the B.M.A. in 1962. They were represented

in the A.M.A. Federal Assembly if their membership exceeded 200.

Among the numerous groups outside the B.M.A. , and later the A.M.A. , were the highly specialised areas of medicine such as the Thoracic Society of Australia, the Haemotology Society of Australia, the Endocrine Society of Australia. In recent years, a Public Health Officers' Association appeared, and was established on a national level: though a similar endeavour to link the Salaried Officers' Association of Western Australia and South Australia failed.

With all specialist groups outside the B.M.A., it maintained an ad hoc liaison, having political strength, resources, and contacts not always available to special societies. It served as a significant link between them all. The Royal Colleges had, by gentleman's agreement, left medical politics to the B.M.A.. This role was explicity defined , for example, by the Royal Australasian College of Surgeons in 1942, in regard to negotiations then current between the medical profession and the Commonwealth Government. The College had an 'important point of view' but the Federal Council was the proper body to represent the views of the whole profession on national medical service. The Colleges were, however, independently represented on important conferences, as on the N.H. and M.R.C. Ultimately when the A.M.A. was formed in 1962, the A.M.A. kept itself informed of their viewpoint by a settled procedure of twice yearly joint advisory committee conferences although no formal link was created. They also meet on other committees or on special fields of enquiry.

Over the years, various comments had been made as to the desirability of fragmentation of the profession into many specialist groups outside the orbit of one overriding medical society. The view adopted by the President of the Federal Committee, B.M.A., in 1920, Dr. Hayward was:[168]

> "Whereas every body of workmen and every other profession seems to see the necessity for consolidation we seem to be going in more than ever for new societies, which profess to speak for this, that, and the other special medical section. It is a fatal policy, and I have fought it with all the energy I can command".

The Medical Journal of Australia continued to be the only representative journal in Australia, speaking with editorial and news to the entire profession, and standing alone in dealing with medical politics on all aspects of health service. It also held pride of place by reason of the frequency of publication.

Several other bodies published, but these were only periodic- at the most monthly, more frequently quarterly or less. Offered until after the second world war for £1 a year, with a rebate during the war of 10/- to members on active service, the M.J.A. was becoming so profitable, it could consider a reduction of the per capita charge per year to 12.6d, but the difference was devoted to extension to the Printing House. At this time the editor, Dr. Archdall, suggested a half yearly or quarterly journal devoted to research in the medical sciences, but was vetoed. He spoke to the British Commonwealth Medical Conference in 1950 of the M.J.A. content: papers of meetings of the six Branches, research papers as well as clinical observations, book reviews, medical abstracts, medico-political debates. Australia joined the International Union of Medical Press in 1953.

Shortly before the first conference on medical journalism in Australasia, held October 1960, a survey showed that letters to the editor, and the leading article were the two most popular features of the journal. The conference , opened by Sir Henry Newland who had 48 years of service on the M.J.A. Board of Directors, was intended to form an association of editors, and to consider means to help contributors and staff improve their style of writing.

Education of the profession also took place through post-graduate committees, founded to provide an additional means of education to doctors other than provided by its normal meetings. Founded after the first world war to bring doctors returning from active service up to date, they ran courses and seminars on special topics, often within hospitals. The six committees, three still directly run by the B.M.A. in Victoria, W.A. and Tasmania, joined in a post-graduate federation of medicine in 1948 to correlate interstate programs. Its chairman, Dr. A. M. McIntosh, explained to the 1950 British Commonwealth Conference in Brisbane how post-graduate education had grown in Australia. It had been subsidised by state governments in some states, and been closely linked to universities and teaching hospitals, and to the Empire Medical Advisory Bureau of the B.M.A. and even to one post-graduate hospital in Australia, the Prince Henry in Melbourne. In addition, Australian Universities offered post-graduate diplomas as in public health, radiology, pathology, and others (as recommended in the 1923 Congress)

In 1955, the University of Sydney Post-Graduate Committee in Medicine held a conference in three sessions on the subject of training for general practice, specialists, and the practising doctors while the first Ausrralian conference on the subject was held November 1960 with five major groups of medical interest studied. It was no longer true, as was often said by B.M.A. members in the nineteenth century, that the very existence of medical societies provided adequate post-graduate education.

As a corollary to enquiries of this nature, and to the more diverse studies of the B.M.A. itself, an Australian College of General Practitioners was founded in Australia along the lines of a similar college in England in 1952, and the U.S. Academy of General Practice 1947. The N.S.W. Faculty was the first to be established overseas, followed not long afterwards by the other states. It was backed, as in Great Britain by the B.M.A., the Colleges, the Post-Graduate Committees and teaching hospitals who all saw the need for a specialised body in the one field of medicine that was <u>not</u> specialised- general practice.

The Australian College of General Practitioners was the fulfilment of a dream, the history of which went back to 1830 when a college of this type was first mooted in Great Britain. The object of several efforts to found over the intervening 130 years, it was brought successfully to a conclusion under the impact of the national health service, which many responsible doctors believed was having an adverse effect on general practice. The Australian enterprise was able to draw on various major studies on the subject made both in the U.K. and America, such as the B.M.A. report on training of the doctor in 1950, and a leading Australian Dr. V. M. Coppelson in Trends in Modern Medical Education. Thus, the 1950's saw the growth of locally born Australian medical organisations along with a rapidly reinforced conviction that Great Britain now acted as a model for Australia in matters of medicine rather than medical politics. Hard facts, no longer sentiment, became the dominating argument as to whether at last to cease to be an integral part of the B.M.A. organisation.

A federal secretariat in Australia needed to be strengthened administratively, and therefore financially , to cope with the expense and complexity of work spawned by Commonwealth legislation, and equally in the States. No one in England or in Australia was surprised that the trigger to change was the subscription to

England - already a bone of contention in 1921, 1932, 1935. The Parent Council had, since 1914, a differential rate for overseas subscribers, the latter by 1955 paying only 33/~~10~~-3 of England, and from Australia since 1932 not in sterling. Increasing cost of producing the Journal and of overall administration were giving the parent Council a financial headache. Finally, the Treasurer reported that the Parent Body was subsidising the profession in Australia to the extent of £25,000 a year.[170] When allowance was made for the capitation grant, and loss in exchange, the profit was 25/-, of which postage claimed 23/10, leaving a minute margin. It proposed a surcharge of £1.1.0 on the rate of £2.2.0 to meet its problems, this to be paid in sterling. Australia protested at reaching the decision first as to the B.M.J., second as to the cost

Sir Cecil Colville, Chairman of the Federal Council, found in London little or no insistence on preserving the old tie. He was told by the Chairman Dr. Wand that 'most of us realised that a time would come when you would feel that a separate Association should be launched.[171] Australia decided at last to leave the B.M.A.

By 1960, the Branches approved of an A.M.A., the plan for the Federal Council to draw up a constitution, and a convention to be held November 26-27, 1960 with representatives from specialised and salaried groups as well as the B.M.A. By October 20, 1961, the process was complete. The memo and articles of the new association were signed October 20, 1961, at the Brisbane meeting of the old Federal Council by the new provisional council. The Parent Council dissolved the Branches as from Dec.31, 1961. The last act of the Australian Council was a message to the Parent Council expressing appreciation and gratitude for assistance and cooperation extending over 80 years, hoping that it would continue, and thus assist in maintaining the standard and prestige of British medicine overseas.

The A.M.A. began January 1, 1962, its inaugural meeting being in Adelaide chosen because it was the scene not only of the first representative government in Australia, but the first B.M.A. Branch, the first Intercolonial Medical Congress, the first resolution for a B.M.A. Federal Committee, and the home of Dr. Hayward and Sir Henry Newland, who, as Chairman had been president for thirty years of his life. Its first President was Dr. C.O.F. Rieger of Adelaide.

Throughout the life of the Federal Council 1914-61, three major changes had been projected: a Federal Assembly with wider representation, optional arrangements for membership of the B.M.A. London, and increased authority at federal level. The first was accomplished in 1962 with a Federal Assembly as the policy making body. The objections of cost and distance, so cogent in 1933, were no longer so valid with frequent air service and extra income released by leaving the B.MA. the second was resolved by allowing members to subscribe on a new basis to the journal. The third was not given such a clearcut solution. The new A.M.A. was built around the existing branches of the B.M.A. These branches became autonomous when the tie was cut with Britain. All members of the branches, who had been members of the B.M.A., became ipso facto members of the new A.M.A. - of the Australian instead of the British organisation. But the branches as organisations were not branches of the new A.M.A., as they had been of the old B.M.A. Thus the administrative relationship of doctors to their organisation was changed. Before 1961, doctors had not been members of Federal Council, but of the branches.

The branches now in 1962 agreed to the constitution of the federal structure, nominated delegates to Assembly and Council, and agreed thereby implicitly to act as branches, and acted as the medium of the electoral machinery. But in their identity, for the first time, they were wholly autonomous bodies free to govern themselves, to alter their constitutions, and to make rules provided they did not conflict with articles of the A.M.A.

The tripartite relationship between branches, Assembly and Council still rested on common consent and negotiation as before with a change of emphasis, but not an obvious transfer of power. The change rested in the nature of the new Federal Assembly. The old, the Federal Council, had suggested policy which was modified or abandoned by the branches who might have alternative policies of their own. The new Federal Council became an executive body acting between Assembly meetings. The Assembly had a wide group representation, and was intended to consider suggestions from all sources whether Government, private organisations or the A.M.A.-Federal and State. It would be a source of authority for the Federal Council, independent of the branches.

The new 'Parliament' of the medical profession was analagous to the Annual Representative Meeting of the B.M.A., England, since

1902, but without a unified administrative system behind it. This division of authority in a federal system, as in the political system where states have always been jealous of their sovereign rights, means that the Federal Council is only as strong and unified a voice in national medical policy as the BRANCHES wish it to be. As the Federal Council is not itself directly in contact with the medical electorate, its capacity to act decisively with the Commonwealth Government is only equivalent to the mandate it is given. This built in inhibition is a factor rarely clearly understood by Parliaments, press or outside organisations- whohave frequently approached the Federal organs as if they were capable of speaking for the whole medical fraternity.

The Federal Assembly was created in the hope that in time more authority would rest at federal level: to militate against any accusation of oligarchic practice by a small Federal Council of elders who, by repeated election, might be open to the charge of medical establishment, and to create a forum accustomed to thinking exclusively in the national rather than parochial or special interest.

Election to the Federal Assembly and Council was partly a pyramid process- including officers and Council-elected representatives from the various states. But the aim was also to cover some of the spectrum of interests in the medical electorate hitherto with no formal place at federal level. Such groups had arisen since the original concept of the B.M.A. as a broad medical association in 1832.

Through most of its history until 1962, the B.M.A. Federal Council did not really acquire the initiative hoped for in its origin - except where persuasion or emergency prevailed. Its disappearance in 1961 did not guarantee any change in the role of Federal organisation. But it did in a very real sense act as a unifying and integrating force. The service of Councillors over long terms at Federal level, as well as State, has always been the decisive factor in the level of the achievement of such an organisation as this, where all the decisions are made by men giving honorary service in their spare time - often at financial and physical cost particularly for those travelling interstate. This waspossibly why it was easier to attract specialists than general practitioners onto medical councils, at least in earlier years.

The peculiar difficulties of running an organisation such as the B.M.A. or A.M.A. in this way are seldom appreciated except by those who have taken part; nor the scale of their decision where public money is such large sums is involved, particularly since post world war 2. In retrospect, the performance of the Federal Council and its general secretary, Dr. Hunter, was formidable, considering it rested on a tenuous power base, and a house with a tendency to divide against itself. It certainly was as divided as in England, while the formal negotiating power of theCouncil was a great deal less then in England.

If the B.M.A. case triumphed in 1951, it was as much that their case was consonant with the Australian tradition, as the undoubted quality of the personalities leading the Council, and their correct assessment of the temper of the medical electorate. It was not that the Council was itself an 'establishmen in the narrow sense, but they remained sensitive to the general 'establishment' of medical men throughout Australia.

In 1949, two important links of the Australian B.M.A. with doctors in other countries began - participation in the World Medical Association and the British Commonwealth Medical Conference. The second British Commonwealth conference was held in Australia, May, 1950, and provided theplatform for Sir Earle Page as Minister for Health to announce Australia's decision for a scheme of voluntary health insurance, or what he called ' the new conception of a national health service ' with eight basic principles. He was supported by two of the B.M.A.'s most dedicated leaders in N.S.W., Dr.H.R. Grieve and Dr. W. F' Simmons. As a member of the World Medical Association, [redacted]stralian B.M.A. also subscribed to their twelve principles of social security as adopted by the opening assembly.[172] These included one provison so important to the Australian profession that it was not in the public interest that physicians should be full-time salaried servants of the government or social security bodies. Distinguished Australians on its Council included two South Australians, Dr. E' P. Mallen, and Dr. C. Rieger - the latter becoming President on the occasion of its 1968 Assembly in Sydney.

Medical organisation in Australia had made a long progress from the days of the ill-paid, sometimes ill-trained ships' surgeons, and the intrepid immigrant doctor faced with a medical practice that would make many of their fraternity in England quail. The B.M.A. was a bridge that spanned that progress to the day when leading A.M.A. Councillors could join in an international gathering in Australia to decide the necessary 'definition of death' for the most sophisticated transplant surgery.

CHAPTER 3

(a) History of Medical Organisations in N.S.W. The 1945

The first colony in Australia was founded, Sydney 1788, with the arrival of Captain Phillip to set up a convict penal settlement. Nine doctors travelled with the fleet, including the first Principal Colonial Surgeon, Dr. White, and his successor, Dr. W. Balmain. Until 1815, such Government doctors - usually ex-naval surgeons- were responsible for the whole medical practice of the colony - but with the right to private practice.

The first doctor to go into private practice full time was Dr. W. Bland, an ex-convict sentenced for duelling- in 1815. Another well-known early doctor was Dr.W. Redfern, also an ex-convict sentenced for the naval mutiny of Nore in 1797. He had qualified with the Company of Surgeons, London; but, being without proof of qualification, a Board of Surgeons was created in 1808 to examine him. For thenext thirty years, until a Medical Board was founded in 1838, all persons who wished to practice in the colony had to pass a test before it. Dr. Redfern began the first training of medical apprentices in 1813. One of these early apprentices, W. Sherwin, became the first native born Australian student to go abroad to complete his medical studies, returning later as the first homeopathic doctor in Australia.

Both Dr. Redfern and Dr. Bland were on a committee of leading citizens who ran the first voluntary hospital in Australia on the English pattern, founded by the Benevolent Society of N.S.W. in 1821'for the poor, blind, aged and infirm'. Prior to this, the Government had established hospitals in Macquarie St. in 1816 (to succeed the Dawes Point Hospital, February, 1788) Parramatta, Windsor, Newcastle - but these were primarily for military personnel and convicts. The Macquarie St. Hospital, later became known as the Sydney Infirmary and then the Sydney Hospital. At first, its popular name was the Rum Hospital, as it was financed by giving its building contractors a monopoly on the import of rum for three years in order to conserve the meagre colonial budget. These were military institutions with a dominant surgeon superintendent, and were handed over to the N.S.W. Government in 1840.

In 1827, the service offered by the Sydney Infirmary was extended by the creation of a separate dispensary for the pauper sick which catered for outpatients and domestic visiting service, had an honorary consultant staff, and assigned doctors to prescribed districts. In 1836, the Government began to subsidise

the dispensary for £1 of voluntary contributions establishing a policy of conditional subsidy which was to obtain for nearly 100 years in respect of hospitals throughout the state. In 1839 Dr.F. MacKellar was appointed the first resident surgeon.

By 1820, settlement had begun to expand beyond the coastal strip and over the Blue Mountains. The early years were not merely a time when institutions were founded, and administration built up, but a time of scientific ferment. It is difficult today to appreciate the excitement of exploration and discovery - not merely the shape of the interior but what it held. The domains of science and medicine were by no means as exclusive as they are today. A number of early doctors became noted as botanists and zoologists. Many of them had their early training under the system of apprenticeship to doctors who studied for the Licentiate of the Society of Apothecaries, and were trained in pharmacy as well as medicine. Others had a natural bent for science and had origins similar to a notable colonist, Dr. Douglass. He was a graduate of the Royal College of Surgeons Ireland, elected to the Royal Irish Academy of Science for his work on typhus in Ireland. In 1821 he became civil surgeon to Parramatta hospital and a magistrate.[1]

Dr. George Bennett similarly arrived in N.S.W. as a ship's doctor after studying at the Hunterian School of Medicine with Dr. Owen, who one day became superintendent of the natural history department of the British Museum. On a journey to N.S.W., he studied the baby kangaroo and the platypus, then scientific mysteries. He became a fellow of the Royal Society, and received the Gold Medal of the Royal College of Surgeons, then only ever awarded six times. On their recommendation, he became curator of the N.S.W. Museum in1835.[2]

Dr. Douglass attempted to found a scientific society in NS.W. to encourage native Australian science as early as 1821, becoming Honorary Secretary and Treasurer at the first meeting of a Philosophical Society in the home of the Judge Advocate, Mr. Barron Field. Governor Brisbane arrived in the colony soon after, and agreed to be President. Members were fined £10 if they did not meet their monthly obligation in turn to produce a paper, and were fined if 15 minutes late. Polemical, divinity and party politics were excluded; but unfortunately participation of members in party politics outside the meetings brought the demise of the society by 1823. Dr. Douglass opposed Governor Darling's policy on

his arrival in 1825 and left the colony from 1828-48.

In the absence of any scientific society before 1850, local medical men, and men of science, like Dr. G. Bennett, kept surprisingly closely in touch with bodies at home, considering the distance. They also felt civic responsibility to the new colony. Dr. Bland, Dr. Bennett and Dr. Nicholson all joined, aiding a Reverend Carmichael to found a school of arts in 1833 to instruct emigrants in science, literature and the arts; Dr. Nicholson becoming curator of its museum for a time.

Many earlier doctors came to Australia as ship 's doctors either in convict or emigrant ships. Before 1814, the standard of medical care had become so bad that the mortality rates on convict ships had reached epidemic proportions from typhus fever, dysentery, scurvy and malnutrition. This was due not only to the capitation system whereby the captain collected his price per head for the cargo of convict whether dead of dying from carelessness, neglect, filth or starvation. It was also due to the standard of ship's doctors of the day.

Dr.W. Redfern, when commissioned by Governor Macquarie to report, condemned most of the convict ships' surgeons as incompetent. They were either not qualified, being merely students from the lecture rooms, or men who had failed in their profession or taken to drink. He recommended reforms that were adopted by the British Government, that doctors should not be under the command of either the captain or the shipowner, and this reform brought most abuses to an end.[3]

Many of Australia's early doctors, having come to Australia this way, liked what they saw- the challenge, the opportunity, the space, the freedom, and remained as settlers. Some like Dr. G. Bass in the earlier years went in for trade. Some gave up medicine for the land like Dr. D. Curdie, Dr. T. Braidwood Wilson, Dr. James Stuart. Others like Dr. Nicholson went in for politics. He became a member of the first representative Legislative Council 1843-51, was three times speaker, a knight and chancellor of the University of Sydney. Dr. Nicholson joined Dr. Douglass, when the latter returned to the colony in 1848, in [redacted]citating the Australian Philosophical Society in 1850.[4] He was its secretary for 15 years; and, when it became a Royal Society in 1866, honoured past interest in medicine by establishing a medical section in 1876.

For nearly fifty years, until 1838, no form of registration of doctors existed. Neither the Government nor the public had any way of distinguishing the qualified from the unqualified.

Though some 'quacks' or unqualified men were to be found in country areas, they were not numerous in the city prior to the goldrushes of 1851. In 1838, the N.S.W. Legislative Council followed the English Parliament in passing an act to register doctors and to give legal significance for the first time to the term 'legally qualified medical practitioner'. This merely distinguished for the procedure of justice those who were legally qualified, but did not prevent those who were not from practising medicine. Although it was an act to provide for attendance and remuneration of medical witnesses at coroners' inquests it did not prevent coroners from calling unqualified men as witnesses nor in any sense regulate the profession.

The act merely set up a medical board of not less than three to examine the credentials of those who wished to be registered, and to publish an annual register, to supersede the medical board already existing. By 1840, 172 doctors had registered. A fee for giving evidence was one guinea, for a post mortem two. A travelling allowance of one shilling a mile over ten miles was paid - penalty for failure to obey a summons was £3 to £20. These fees were to be the causeof complaint whenever medical societies and journals sprang up in the colony, as they were totally inadequate in many exigencies of early Australian settlement. Long distances and prolonged absences from practice often involved an economic loss to the doctor far more considerable than the amount the Government paid.

The problems of quacks and legal proceedings, however, were sufficient to be a leading cause for the formation of the first medical associations recorded in Australia. The announcement in full, appeared in the S.M.H. April 20, 1844:

> "An association is now in progress of formation under the name of a Medico-Chirurgical Association, the objects of which are to maintain and to secure the dignity and the privileges of the medical and surgical profession in this colony; to procure the passing of an Act by the Colonial Legislature to effect these objects; also to put down quackery; and put an end to the mischief which now too frequently results from the utter absence of any law to prevent the practising of unqualified persons. Another object is to take measures to procure that all coronerships should be vested in medical men; and lastly, the quarterly publication of the proceedings of the society, medical and surgical cases for the profession in this colony previously to their going to England to complete their education".

Its first meeting was 15th May at the Sydney Dispensary with Dr. Bland in the chair. Dr. McKellar moved it constitute itself the Medico-Chirurgical Association of Australia. They were chiefly men from the staff of the Sydney Dispensary and Sydney Hospital. Records are not extant to say how long it lasted, though it seems likely to have given rise to the subsequent Australian Medical Journal, and petition by five doctors to the Legislative Council for amendment of the law concerning evidence of medical witnesses.[5] Chief objection was that doctors could not examine bodies except with permission of the coroner, and, if given, often allowed too little time. The Australian Medical Journal appeared as a newsprint monthly in August 1846, edited by the Senior Colonial Surgeon Dr. G. Brooks. In December, Dr. I. Aaron took over until it ceased September 1847 for want of support, and an increase in his practice,[6] which made him too busy to continue the Australian Medical Gazette publication in

Dr. Aaron was typical of many doctors reaching the colony at this time, with excellent qualifications. Born in Birmingham, he studied at St. Bart's London, and gained both his R.C.S. and L.A.S. His editorial style was forcible when he pointed up the need for an ethical code and unity due to public quarrels in the profession. Among these was one between Dr. Nathan and Dr. McCrae which caused Dr. Nathan to retire from the Sydney Infirmary. As the Sydney Dispensary and Infirmary, the Old Sydney Dispenary had moved in 1845 into the Government Hospital in Macquarie Street which became available with the end of transportation 1840. They agreed with the Government to accept the sick poor, accidents, and acute and curable diseases in return for Government support of 1.9 a day. They abandoned their original plan of 1841 to acquire land from the Government to found a medical school. Medical students were accepted from 1849 at the Sydney Infirmary instead, where they were given two years' credit in clinical attendance towards the examination of the Royal College of Surgeons. First student was F. Milford who went to England in 1852, after being apprenticed to Mr. C. Nathan.

Dr. McCrae seems to have been a very contentious man as he was not only involved with Mr. Nathan and a successful action to recover £13.13.0 from a publican Mr. Toogood (for 26 visits at 10.6 to his wife) but in a most notorious squabble with Dr. W. Bland. As an ex-officer of the Inniskilling Dragoons, and 'hence quite contemptuous of a naval officer discharged in disgrace', he was prejudiced against Dr. Bland from the start. He wrote to the editor of the Sydney Morning Herald accusing

Dr. Bland of unethical conduct, after Dr. Bland had claimed Dr. McCrae's treatment of a patient they had seen together was wrong, and endangered his life. They both published pamphlets, abused each other in the press, and caused great loss of prestige in the profession.

The divided state of the profession was also reflected in the progress report of a Select Committee of the Legislative Council on the Medical Profession Bill in 1849, appointed on the petition of Dr. Nathan and Dr. Ewan, and certain chemists and druggists carrying on business in Sydney. It sought to required a certificate from the MedicalBoard for practice of pharmacy. Chemists objected, and even doctors like Dr. F. McKellar, to giving Board members powers of inspection in druggists' shops. The Committee commended no action be taken, in consequence of conflicting statements of witnesses. The records of evidence taken shows that there were no pure physicians or surgeons in Sydney at that time. Dr.F. McKellar, when asked what branch of medicine he practised, said proudly that he was a physician, surgeon , apothecary, and accoucheur, while he also kept a pharmacy shop with his brother. At this stage, chemists were beginning to demand that they be considered a body distinct from the medical profession, retaining a solicitor at the enquiry to put their point of view.

Just after the Sydney Dispensary moved in 1845, one of its first honorary physicians Dr. J. Macfarlane M.D. and M.L.C. founded an Australian Medical Subscription Library, housed with the early public library in Bent St. Unlike a parallel venture in Melbourne, or many in Great Britain, it did not give rise to a medical society. But the library in Melbourne did not outlive the Port Phillip Medical Association, whereas the Sydney library continued until 1960, when the Australian Medical Association formed in 1859 took it over, undertaking to spend at least £30 a year to buy further books. Membership was by election, subscription was considerable being £5.5.0 for the first year, and £2.2.0 thereafter. The catalogue for 1855 contained 200 volumes and many journals.

By 1850, Dr. Douglass was associated with a Legislative Committee of enquiry on a University of Sydney. On opening in 1852, the University was given power to give medical degrees upon a report of a medical faculty of eight examiners, thus becoming the first University in Australia to award medical degrees.

The Professor of Physics was Dean of the Medical Faculty. To gain a degree, a candidate had to possess a B.A. degree, or have been in practice ten years, and have further proof of four years' study in an approved medical school, and eighteen months in a hospital of more than eighty beds before being examined.

The goldrushes from 1851 on brought more qualified doctors, but also quacks, who usually scattered into the country areas, where it was harder to attract a qualified doctor. The Medical Practitioners' Act was altered in 1855 so that doctors with foreign degrees (outside the U.K.) were entitled to become registered by testifying before the Board.

In 1858, one of the newer immigrants found support among the surgeons for a medical society, namely Dr. J. Robertson. He planned a few conversational meetings 'experimentally', "hoping that out of these will arise the much to be wished for society".[8] At the first in his home in Wynyard Square, 40 were present to hear Dr. A.M.A'Beckett read a paper on scarlatina. A month later, the 22 present elected a chairman, and resolved to call a special meeting for December 20, 1858. This appointed a committee of five to form by-laws, and the first council was elected February 28, 1859. The list of 87 original Fellows was now declared closed, a fair proportion of the 230 doctors then registered. Members were very conscious of their status, being most anxious to gain permission from the Governor-General to be presented as a body at the levee on the Queen's Birthday, as were the lawyers, clergy and others.

Aware of the vital need for a code of ethics, they very early drew up a code based on the American Medical Association, with a few changes, and sent a copy to every doctor registered in N.S.W. At once the Sydney society was called on to play the incompatible roles of promoting fraternity, and of settling disputes between doctors which usually created opposing factions within the society. At its very first official meeting, Dr. West supported by seven fellows, accused Dr. Burgeon:[9]

> "[illegible]th on a late occasion having made statements of me which are unprofessional and calculated to injure my character as a professional man, and which I am prepared to prove are false".

Enquiry showed that in fact Dr. Burgeon had never been asked to meet Dr. West. The latter then withdrew his charges with an apology.

August 1859, Dr. A. Roberts and twelve others asked

for a special meeting to deal with publication of a paper on dysentery by Dr. J. Berncastle, in the 'Sydney Morning Herald' July 26, 'whereby it might be implied that such publication met with their sanction or was done at their request'.[10] A new rule was brought in to prevent it, whereon Dr. Berncastle, when censured by the A.M.A., resigned. A Dr. Foucart denied the same offence in the July 1861 'Empire'.

In 1859, the A.M.A. decided not to give insurance certificates free, as payment was made in England; and asked any fellow, finding another doing so, to report him to the A.M.A. provided there was no breach of confidence. Not long after, Dr. Williams protested at length over the constitutional procedure at stake, and the idea was abandoned, the insurance companies having refused anyway. October 1860, a Dr. McKay brought charges against a Dr. Mullen, and when these failed resigned in a huff. Early 1861, a Dr. Anderson of Balmain complained of unprofessional conduct by a fellow, but the Council would not receive the papers as he was no longer a member. The Council took an attitude of antagonism both to quacks and homeopathy, but there is no record to show if Dr. Nathan's resignation at that particular meeting had any relevance. There seems little ground for the enthusiasm of the 1860 report that 'the spirit manifested by the fellows leads the Council to indulge the highest hopes for the usefulness of the association both in its professional and ethical character'.[11] Ethical problems had in fact caused a disastrous decline in membership and interest, accelerated by the disappearance of Dr. Robertson as secretary after his death in 1863 of T.B., and the fact that a great many members lived in the country - in centres as far apart as Scone, Dubbo, Maryborough and Brisbane. After the A.M.A. decided against publication of proceedings, the latter could expect nothing for their £1.1.0 a year.

In its first two years, the A.M.A. had shared in drafting the Medical Bill 23 Vic., 1859, sponsored by Dr. Dougless; and the basis of legislation in 1869 and 1875. It provided that no certificate should be valid unless signed by a registered doctor, while fraudulent registration should be a misdemeanour with up to 12 months' imprisonment as penalty. An A.M.A. petition was 'numerously signed' supporting the Bill, withdrawn in face of undesirable amendments. The A.M.A. also failed in the case of Dr. Beamish, 1860, who was sentenced to 12 months' imprisonment for manslaughter, on the evidence of two medical witnesses against him - both young, and showing discrepancy on vital points.

In 1860-61, the A.M.A. made two payments to widows of doctors. Attendance fell away, and the society rapidly declined. Drs. William, Cox, Milford, Bowman and Aarons battled to keep it afloat. By 1865, the Council was reduced to six, the quorum to three. "The absence of excitement or dispute',[12] mentioned in the 1865 report of the Council, could not be taken as a measure of success. Two meetings had no quorum, while the author of the paper scheduled, Dr. Renwick, did not turn up to read it. By 1867, too few were present to elect office bearers; and by 1868, a meeting was called to consider the state and prospects of the association, and it was discontinued March 1, 1869, on account of the apathy of the profession. Dr. Milford wrote in 1871:[13]

> "These gentlemen tried all the means in their power to procure the attendance of fellows and to beat up for recruits but their efforts were not met with success. At last, they felt so disgusted that they discontinued meetings".

He himself believed failure largely due to lack of a medical journal with wastage of papers. Perhaps an equal factor was the nature of the profession itself, with the naturally divisive influence of a variety of degrees and backgrounds from the old country, and the problem of reconciling ideas of what a medical fraternity should be. The balance of £400 extant was retained to carry out the benevolent objects with Drs.Milford and Aaron as trustees.

Dr. F. Milford now started to fill the gap with Drs. Aaron and Ward through the creation of the Association of Medical Officers of the Volunteer Defence Force, which met quarterly and to which Dr. Aaron belonged. They circularised all hospitals and benevolent asylums in the colony, asking for reports of interesting cases or operations: and begged the profession to help them 'fix more definitely the characteristics of the diseases of N.S.W. and their treatment'.[14] Among contributors was Dr. G. Pringle of Parrammatta who had worked with Lister at the Edinburgh Royal Infirmary in 1854, and published reports of his work on antisepsis in the Lancet, the A.M.J., Victoria, and the daily press in N.S.W.- which annoyed some of his colleagues.

The Association of Medical Officers lost money on the N.S.W. Medical Gazette and Dr. Milford took over as proprietor and sole editor, out of a sense of duty, but was only able to continue for twelve months due to lack of support with papers.

This experience did not deter Dr. Milford from organising a medical society by 1880. In the meantime, Dr.S.T. Knaggs of Newcastle, one of the few men to support him in 1875, published an Australian Practitioner 1877-8, which he described as 'the fourth attempt at a medical journal in N.S.W.'[15] One record of a journal is therefore wanting. He experienced the same professional inertia as Dr. Milford which left him starved of contributors, money and support.

In 1872, a Medical Practitioners' Association had briefly existed to sustain the price of services of medical practitioners engaged in attending benefit societies, now reduced by competition to the smallest remuneration, and binding members not to attend under certain fixed prices. Medical benefit societies were now said to be entered not by the poor, but by people of wealth and standing to the injury of the general practitioner and depreciation of incomes.

A medical section of the Royal Society was founded in 1876. Its chairman was the Government Medical Officer, Dr. A Roberts, and it attracted some of the leading surgeons and physicians of the day , such as Sir Philip Sydney Jones and Sir Normand MacLaurin - the latter being the Chancellor of Sydney University; and acknowledged leader of the profession. A second medical society appeared by 1880, several factors contributing to its appearance: the building of Prince Alfred Hospital, the rebuilding of Sydney Hospital , and the foundation of a new medical school at the University of Sydney associated with both hospitals. The Sydney-Melbourne railway had just been built. Sydney was to be the scene of an international exhibition in 1879.

At this juncture, Dr. L. Henry arrived in Melbourne with a commission from the B.M.A. secretary in London to found Australian branches if possible, and was busy doing so in Melbourne. In Sydney, also, Dr. T. Storie Dixon, and Dr. Craig Dixon, had arrived from Edinburgh to find they, and Dr. W. H. Goode, were the only B.M.A. members they could find in Sydney. Dr. Goode had himself written to F. Fowke, the secretary in London, some time before on the subject, which may have led to Dr. Henry's charter.[16] They took the matter up with Dr. A. Renwick, and with Dr. Henry, who wrote Jan. 1880 to say any twenty members could form a branch under rule 40, and, if they thought it expedient, to have some special authority to make a commencement:[17]

> "I hereby as the accredited agent and correspondent of the B.M.A. for Australia, authorise you to form a branch in N.S.W."

The first meeting was held at Dr.F. Milford's house Feb.3, 1880, with eight present. As well as the instruction from Dr. Henry as to how to form the branch, a letter from the B.M.A. Council President, and the editor of the B.M.J., were read. The seven objects approved were quoted approvingly in the press.[18] As to the difficulty that there were not twenty members of the B.M.A. available, the three existing members nominated all the others for formal compliance with the rules. The N.S.W. Branch passed bylaws in February 'amidst considerable dissent' that membership approval should first be received from England. Dr. Renwick moved them on the basis that Victoria had done the same and were recognised by London. An eminent gynaecologist, he was the new President. The Branch began its meetings at the Sydney Infirmary. It touched on ethics, the Governor's levee, and the Medical Bill then before Parliament.

By midyear the B.M.A. Council in London ruled that no accredited agent could give the N.S.W. Branch power to form a branch, and that N.S.W. members should have received their acceptance as members before they could legally form a Branch. The Branch continued sending subscriptions to London, which decided to recognise it after all July 7, 1880. Dr. Renwick began efforts to found similar Branches in Queensland and New Zealand. By the end of the first year, its report referred to the 'severe struggle' to establish the Branch.[20]

~~The Australasian Medical Gazette began as a commercial venture shortly after~~ as and with Dr. F. Milford, now Branch Secretary, as editor. A member of the Medical Board since 1875, he became lecturer in surgery at the new medical school.

Dr. A. J. Brady, when President in 1903, recalled there were forty-three original B.M.A. members: saying one of their first actions was to draw up a scale of fees, following the Victorian example, to their material improvement.

The Australasian Medical Gazette was founded by the publisher L. Bruck with the support of the N.S.W. Branch in 1881, Mr Bruck who proposed the B.M.A. should buy the journal from him, but was refused. A move to get cooperation in management from South Australia and Victoria to own the journal failed.

Despite early congratulations from F. Fowke, the London secretary on the membership and usefulness of work in the Branch, by 1886 it held a special general meeting on the unsatisfactory relations with England, Council recommending an independent medical association. Before this came to pass, the London secretary

took action to heal the breach by reorganising the London office.

By 1882, a B.M.A. Committee had reported to, and given evidence at, a Royal Commission into the working of the friendly societies which had undergone rapid expansion in the 1870's.[21] This Commission found the Act insufficient, as it stood, for a sound actuarial basis for these societies. The N.S.W. Branch asserted that some uniform policy of medical contract was necessary. Other special subjects for study in the branch at this time were a report to the Marine Board on the need for normal vision in merchant marine officers; anaesthetics 1888, abuse of narcotics (1888) in relation to complaints such as neuralgia, phthisis, bronchitis, and womens' disorders.[22]

One of the major matters to engage the B.M.A. was control of medical practice. First, doctors who practised homeopathy were to be excluded. Second, many doctors, so-called, were frankly quacks. However, there were also those described by Professor Anderson Stuart, first Professor of Anatomy at Sydney University, who:[23]

> "had some medical education -possibly one year or two at one of the British medical schools, but had never obtained a diploma - had obtained considerable practises and even did good work especially in country districts to which more eminent men would not go".

By 1887, the problem of unqualified practice, noted by Professor Stuart, led to a Select Committee on the motion of the Hon. Dr. J.M. Creed to inquire into the state and operation of existing laws to regulate the practice of medicine and surgery. Dr. Creed, then an M.L.C. of two years' standing, had been an M.P. from 1872, an honorary surgeon at Sydney Hospital, secretary of the B.M.A. branch, an editor of the Gazette, and had already nursed through a bill on cremation.

The situation was summarised by Dr. H.N. MacLaurin, medical advisor to the Government, and president of the Board of Health, who said 'there is no law at all'.[24] He had found a quack who attended his own patient, then sat as coroner at the inquest; a quack who gave a crew pratique which caused much trouble; fifty cases of quacks who gave evidence before courts in twleve months (as Coroners could call anyone) since he had taken office. The secretary of the Medical Board quoted four recent glaring cases in law courts (three of quacks, one a doctor); and two cases of fraud on American diplomas, which, when discovered, could not be deregistered. Abortion was also a fruitful field for the quack

the N.S.W. Branch Council, having already reported on abortion cases then attracting a lot of attention due to death rates and doubtful inquests.

Supporting the profession, were letters such as that of John Maclean June 5, 1885, in the Sydney Morning Herald saying that he held a semi-public position, and could cite eighteen cases of surgical and medical malpractice, including a young man who on post mortem proved to have a slight fracture of the tibia, but who had died after tight bandaging caused gangrene, and amputation, at the hands of the quack involved.

Professor Smith, Dean of the Faculty of Medicine, had publicly attacked incompetence within the profession, and even published his speech in pamphlet form. A public meeting of protest, attended by forty doctors, protested against his views as unbecoming and unjustifiable, incorrect and calculated to do harm; that, holding such views, he could not with propriety continue as Dean. They appointed a committee to report to the General Medical Council in Great Britain. Despite the glaring publicity as to the scandals of quacks, their advertising and the damage they caused, no immediate law reform followed the Select Committee's hearings. A year before a press comment had read:[25]

> "This question, having been before the public so frequently, has now come to be viewed as a periodical one, without which no Parliamentary session is complete. No doubt this continued want of legislation in this colony appears remarkable, and, to the unitiated, probably reprehensible, but, on reflection, we shall see that the fault lay not so much with our legislators as with the class seeking protection, who, in attempting too much, overreach themselves by their extreme demands".

It was referring to their opposition to clauses which allowed unqualified men, who had been in practice for a certain term, to be registered on examination. Opposition also came from unregistered men who feared the examination would be used as a method of exclusion; and from doctors with American homeopathic degrees with only three years' training. Six attempts at legislation over medical practice failed from 1890-98 to pass the Lower House. The Hon. J.M. Creed said that a very strong letter had been sent to the Government after the Committee report, backed by all religious leaders the Mayor, the Chief Justice and the Lieutenant-Governor - 'yet, Sir Henry Parkes, then Premier, took no action, and everything continues just as it did when it was written in September, 1887'.[26]

When Chief Secretary, he also had failed to take action.

Numerous actions against medical men, scandals of coroners' courts, and alleged sweating of the profession brought other medical groups to light besides the B.M.A. A Newcastle Medical Society was founded in 1885, the President Dr.Crosby complaining that the Medical Witnesses Act was being disregarded, and that charlatans had the ear of many in positions of power andauthority. This was one of the earliest medical societies formed outside Sydney, although a Western Medical Association was formed in Bathurst with ten original members in April 1872, and Dr. Machattie first President - its first paper being on typhoid fever.[27] A Medico-Ethical Association was formed in 1888 to pursue some of the functions outside the scope of the B.M.A. Constitution, like medical defence; or to encourage attacks on other problems on which the B.M.A. was thought to be too inert such as clubs and'hospital abuse'. In 1890, the Western and Eastern Suburbs Associations were formed, and in 1891 the North Sydney and the Western Medical Association, the latter appearing to be a revival of that formed in 1872. The B.M.A. had members of the Western Medical Association to dinner, where Dr. Collingwood claimed with pride it was the first association in Australia on defensive lines.[28] Others began to appear further away - Moree, the Border Association in 1888. Annual social reunions of medical societies began in 1893, and they combined to organise the 1892 Australasian Congress in Sydney. A more serious meeting was held in 1898 of all medical societies in N.S.W. (which now included the Medical Union of 1895) to consider the need for an Indecent Advertisements Act, and a good Medical Act.[29]

By 1900, the B.M.A. Council had decided to establish sub-branches in large country towns, but a subcommittee report in 1901 said N.S.W. distribution of population made it difficult to organise divisions on the English plan as members were too disproportionate. Compared to 224 doctors in Sydney, and 21 in Newcastle, there were few other towns that would have more than four or five doctors.

In April, 1894, Dr. Huxtable,a young doctor recently arrived, read a report on the aims and policy of the Branch, shortly before it was incorporated to purchase the A.M.G. from Mr. Bruck. In 1907 Dr. Crago, a Council member for 13 years, traversed those of Dr. Huxtable's aims which had been realised in that time - namely an official publication, an increase in councillors from ten to fourteen, a library, and a doubled membership. Of the aims, not

realised, he mentioned formation of sub-branches with the right to each of electing a member to Council, and a reduction in the amount paid for the British Medical Journal. He then moved that Council secure rooms for an office, library, and meeting hall.

The A.M.G. belonged to the N.S.W. Branch from 1894, and became the organ of the South Australian and Queensland Medical Society by 1895. Edited by Dr. Knaggs until 1901, it proved a not so enviable job as Dr. Neild found in earlier years in Victoria with the A.M.J. In 1901, he became the target for attack on a charge that he had shown another doctor an article before publication. Having resigned, he was reelected editor in a general ballot. An extraordinary meeting was held to alter article 27 of the association to election of the editor by Council. Dr. Beeston attended from Newcastle with proxies from all parts of the state to oppose it, and secured a three quarter majority, considering the city had an undue balance of power. The row was resolved by Dr. Knaggs going to Japan, and Dr. Rennie and Dr. Crago becoming joint editors. Dr. Rennie was the first Australian ever to win the gold medal at the University of London.[30]

Despite the efforts of staunch Councillors like Dr. Crago, Dr. Rennie and Dr. Todd, who became the fist full-time secretary in 1908, their path was evidently a thorny one. Dr. E.T. Thring in his presidential address in 1900, after a year of combat with the friendly societie, lamented at the lack of appreciation:[31]

> "The Council and its work in relation to medical men generally and the members of the Branch in particular, has been subjected to much severe criticism. I have repeatedly heard it stated that the Council does little or nothing to help the general practitioner that his needs and difficulties are not understood, in fact the Council as a body is a useless and inert piece of machinery.
>
> "I might add that these criticisms have usually been made by junior members of the profession or those, who, never having been members of the Council, know very little of the work done or the difficulties met with in doing it."

Dr. Worrall in 1910 said the rise of the Branch was synchronous with the purchase of the A.M.G. in 1904.[32] Another factor, however, was also the economic depression of the 1890's which led to financial undercutting of prices in medical contracts, which formed a substantial part of medical practice for all but specialists. The only way of defeating the ensuing competition between doctors was to organise.

By the end of 1911, twelve local groups existed in different

parts of N.S.W. and proved of great use in the work of organising the growing membership. 714 out of 1052 on the register in 1910 belonged, making it one of the larges Branches outsides England. When negotiations with friendly societies on contracts were bogged down in 1910, the B.M.A. appointed a Mr. Barr Brown as organiser, who travelled throughout the state by train and bicycle, also becoming organiser to several local affiliated organisations. In 1912, Council asked them to appoint delegates to meet with Council once a year to consider 'matters of common interest to the local associations for the advice and assistance of the Council'. Their desire was to develop a vigorous corporate life, and to devise common policy on ethics, contract practice, medical politics, and organisation generally - uniform methods of procedure, and regulations. Model rules were put forward to overcome difficulties of administration caused by want of uniformity in the rules.

The U.K. Medical Secretary, Dr. Hankins, had, in 1907, proposed divisions for N.S.W. as in Victoria and England, but the N.S.W. Branch Council had already refused sanction for this in 1901, not being satisfied the constitution would allow it. The B.M.A. Council had first proposed a building in 1889, but the first meeting in its own building was not to be held until 1911 due largely to Dr. Crago, its treasurer, who raised the money in debentures. His wry comment was that many people, asked to subscribe, turned out to be buying either motor cars, or building houses. The building site, bought in Elizabeth St, cost £6,300; the building being completed for the 9th session of the Australasian Medical Congress in Sydney, September, 1911.

Behind the expansion of the N.S.W. Branch from 1900-11 was the exceptional intellect of Dr. R'H. Todd, graduate in arts, medicine and law, sparetime musician, once city coroner and chairman of several industrial boards, councillor of the B.M.A. from 1896 and honorary secretary from 1908. In a 1939 estimate, it was said:[33]

> "To say that Todd was honorary secretary to the N.S.W. Branch would not convey to an outsider any adequate idea of his activities. His capacity for work was enormous, and this, combined with his ethical outlook, his idealism, and the caution of his legal mind, had the only possible result in the progress of the branch and of the Association in Australia along every avenue.

He steered through model rules, a model lodge agreement, new ethical rules for disputes among members, founded an ethical committee, and many other matters.

Post-graduate courses were begun for the first time in Australia, authorised by the Senate of Sydney University. The B.M.A. was asked to advise, and R. F.P.Sandes 'who has long advocated

the extension of the academical privileges of the University Medical School to the practitioners' was appointed[34]. A 1912 committee of representatives of leading hospitals foreshadowed the post-war post-graduate committee of 1922.

All was not untroubled in the N.S.W. Branch despite the extremely smooth cooperation on contract practice. Protests came, for example, on the vaccination issue from the western medical association, and on handing over the Gazette to a company.

Medical defence remained outside the ambit of the B.M.A. The Medical Defence Union existed from 1893 to aid any doctor threatened with, or involved in, any action at law or prosecution. While Dr. Todd was still in legal practice, he had given the M.D.U. legal opinions on professional privilege, indemnities, and recovery of fees in court. In N.S.W., any doctor from 1858 could sue and recover fees in the District Court, but physicians could not do so in the Supreme Court. By 1898, the Medical Defence Union reported that its existence was sufficient to prevent blackmailing and litigation against doctors. In 1910, Dr. Dick proposed that no doctor could be a member of the M.D.U. unless he were first a member of the B.M.A. but was defeated. A further move to unite the two societies, to give B.M.A. membership an added attraction, failed.

Council proposed to start its own medical agency in 1914.[55] Annual dinners began in 1911, and the Council noted with satisfaction a year later that departments, both of the Commonwealth and State Governments, gave it increasing recognition by consulting it on medical matters such as a T.B. Advisory Board, increased accommodation for infectious diseases, a smallpox epidemic (1913), maternity wards in country public hospitals. The first baby clinics grew from 1914. An active public health policy finally led to a Ministry of Health in the State Cabinet by 1915. The Pure Foods Act and V.D. Control were strengthened, V.D. clinics being opened. The Poisons Act was reformed, considered very faulty in earlier days when drugs were sold without declaration on the label; and chlorodyne, containing opium and chloroform, could be sold freely for babies.

B.M.A. efforts were also directed toward maternity nursing, and against 'quack' abortion and untrained midwives. Doctors had begun courses in obstetrics in hospital, and assisted in legislation towards licensing midwives and private hospitals.

The work of the medico-political committee, continuous from [illegible], was held by 1914 to have increasing importance:[56]

> "We should take steps to protect our interests and rights in connection with the many and often hastily considered measures relating to our work which find their way into the statute book".

The B.M.A. asked the Government in 1913 that any Bill, to be presented to the N.S.W. Parliament affecting the medical profession should be first presented to them 'in order that, if possible, the success of the scheme may be secured'.[57]

Branch efficiency was increased by a change in the rules in 1914 to give Council power to appoint seven committees with powers and duties delegated to them. Such committees in the past, being powerless, had been unable to relieve an increasingly overburdened Council of business. These were now executive and finance, organisation and science, medical politics, ethics and contract practice. At this time, Council gave its treasurer of 25 years, Dr. Crago, a cheque on the eve of a visit to England in honour of his retirement, after almost 25 years, also as manager of the Australasian Medical Gazette. Dr. Todd also went to England in 1913 to attend the A.R.M. approving the new B.M.A. Australian Federal Committee, but arrived too late.

By the time the N.S.W. organiser, Mr. Barr Brown, resigned in August 1914, there were seventeen affiliated local associations meeting annually with the B.M.A. Council. The Branch adopted regulations for special branches of knowledge in 1915, and conferred with pharmacists in 1917. During the war the Branch was sensitive on the subject of 'encroachments on our interests' by a Labour administration in various ways- night V.D. clinics, doctors attached to baby clinics, medical attendance at state public schools by whole or part-time salaried officers. In 1916, they opposed medical men taking such jobs unless they only saw pupils after meanstesting.[58]

In 1918 two outstanding Councillors retired, Dr. F. Antill Pockley and Dr. G.H. Abbott, one in office for fourteen years, the other for nineteen. Both had played leading roles in the dramas of friendly society practice, and the considerable organisation had left the Branch a 90% membership of all doctors in the state. A less commendable chaper was the special meeting Dec.5, 1919, which protested against interned German doctors being allowed to resume practice, but called on the Federal Government to deport them; in particular a Dr. Max Hertz. The 1915 medical

act already provided that no German or Austrian subject could be registered. To his credit, the Prime Minister refused to see the B.M.A. deputation and Returned Medical Officers' Society. Post-war new sections appeared - eleven between 1921-1924. In 1923 a society of salaried medical officers of health was given representation on the B.M.A. Council, provided that medico-politics was left to the B.M.A.

The first meeting to be held in Canberra was that of the S.E. Medical Association Sep 11,1925 at the Hotel Canberra with doctors from Goulburn, Yass, Cooma, Gunning and Queanbeyan.[59] In 1926, a medical benevolent association of N.S.W. took over from the medical benefit fund of 1896 to extend its function to medical insurance. By 1924, the N.S.W. Branch had outgrown its Elizabeth St. building. The foundation stone of the new building in Macquarie St. was laid Sep 7, 1927 by Sir Ewen Maclean as President of the B.M.A. Great Britain. The new building design competition was won by Messrs K. McConnell and J.C. Fowell.

Many times over the years rules as to advertising were amended,while in 1926 the Council saw fit to define the relative position of general practitioners and specialists in respect to thepatients' fees. In 1929, the office of medical secretary was created and filled by Dr. J. Hunter, then in general practice, who thus had a two year apprenticsehip with Dr. Todd before his sudden death in 1931. The 50 year jubilee of the Branch in 1930 found a Branch completely different from that in 1880 catering for conditions of practice that had changed entirely.

The new building was opened June 1930 to celebrate the jubilee. With the depression, the branch found few of the suites taken, and they were running the building for some time at a loss. In 1931, the Branch founded the British Medical Agency to act as medical agents and insurance brokers, which proved a profitable business; and helped to found the Metropolitan Hospitals Contribution scheme which proved equally successful. Post-graduate teaching had continued post war as ancillary to the normal Branch meetings, and the B.M.A. now acted as midwife to the conversion of its post-graduate activities into the Permanent Post Graduate Committee in 1933 representing the B.M.A. Council, eight larger metropolitan hospitals, the Faculty of Medicine, and three coopted members. Clinical meetings were also held frequently in the hospitals. In 1935 the Branch prepared a handbook for members. In 1937, fifth and sixth year students

were first invited to attend ordinary and clinical meetings. The problem of the injured worker, and increasing stringency of ethical rules both occupied time. Negotiations took place with the Government for payment of subsidy on a basis similar to friendly societies to doctors till then treating unemployed for nothing. In 1936, the Branch urged and secured Government support for mass immunisation for diphtheria throughout the State. A committee reported on maternal and infant welfare, while the medical politics committee, by the time of the national insurance crisis of 1938, spent increasing time on the problem of future national medical service. By 1938, branch membership had risen to 1,741. After some apprehensive moments for the unity of the Branch mid-1938, the President was able to report April 1939, that the activities of the previous year had brought the profession together. The Branch was represented on thirty two bodies - even such as the Dept. of Information, the Free Library movement, the W.E.A., and the Refugees Emergency Council of the League of Nations.

The Branch acted on behalf of doctors in subsidised practices in outback areas to secure increases from £500 to £1,000 basic guarantee, and also in 1938 before the Public Service Board on behalf of the Public Medical Officers' Association. They approached the Minister for Health in 1938 to secure the right of doctors other than honorary medical staff to visit Gloucester House; to find positions for graduates who could not get posts as residents; and to secure a person with legal training to conduct any inquiry into any member of a public hospital staff with a doctor to assist in an advisory capacity with a right of appeal from the decisions of the Hospitals Commission. A British Medical Finance Ltd. was founded in 1937 to grant financial assistance to doctors to acquire, establish, or improve the equipment of practices, or to buy a residence or rooms.

With the outbreak of war, the Branch appealed to members to volunteer as medical officers to first aid posts and parties for national emergencies. They adopted the Federal Council model scheme for protection of practices. The shortage of doctors rapidly became acute with 475 serving full time in the services by 1942, and many more part-time. The Branch continued throughout the war planning for post-war, attending several conferences with Federal Council , and two planning convocations of national medical service; revising hospital

policy with local associations in 1940; creating a very active and successful department of medical sociology and research to educate the public in a wider appreciation of the principles of scientific medicine. This era saw the deaths of the last of the original founders and pioneers of the branch - Dr. Dick, Dr. Palmer, Dr. Sandes, Dr. Abbott, Dr. Crago, and Dr. Laves- whose long and devoted service had played such a vital part in the building of the branch.

The Branch began the post-war era with a charter declared at the planning convention of 1945, which remained its basic policy through the years of evolution in national health service to follow, and reported in its annual report 1944-5:

> "A free medical service to all is not in the public interest and not acceptable. Regimentation both of patients and practitioner is inseparable from, and essential to, any Government scheme of free curative medicine and health service departmentally controlled, and is inimical to maximum efficiency and public service"

(b) HISTORY OF MEDICAL ORGANISATION IN VICTORIA TILL 1945

Victoria had no permanent established settlement before 1835. With the first landing parties in Port Phillip Bay in 1835, settlement rushed in; and was further accelerated with the gold rushes of the 1850's. Dr. Cotter from Tasmania was the first medical man to arrive November 6, 1835, where, with Dr. McCurdy, he was to operate a drug and general store. Others were quick to follow, among them Dr. Alexander Thomsom- Tasmanian ship and landowner, who had sent fifty head of cattle with Batman's original party. He himself arrived in 1837 with formidable qualifications, a Master of Arts as well as surgeon. After a brief period as doctor and catechist to the settlement (giving services every Sunday in a tent to all denominations) and as Government Medical Officer, he went to Geelong. His career was the prototype for many other doctors who combined landowning, politics, civic responsibility and medicine: doctors like Dr. Palmer(soon to be Lord Mayor of Melbourne when Melbourne Hospital was founded), Dr. Haines (first Premier of Victoria) and others. He was followed by others with similarly high qualifications. The issue of why they had come to a pioneering primitive settlement was an intriguing one. A number were younger than Dr. Thomson on arrival, men in their twenties, who perhaps hoped for a more rapid career than the Old Country was likely to afford. Many were not unnaturally attracted to the security of landowning. By the time of separation from N.S.W. at least forty doctors held pastoral leases - some like Dr. J. Rowe having considerable landholdings.[1] Apart from being on the committee which started the Melbourne Medical School (1862) and an original member of the University Council, he was a breeder of the famous Saxony sheep. Some of these country doctors practised medicine, and all were doubtless called on in emergencies. The life was hard and demanding, thepractice in area sometimes quite enormous.

Other doctors were drawn in to politics-municipal, Legislative Council and Assembly, and member for Port Phillip district in the N.S.W. Legislative Council before separation[a] from N.S.W. Among these were Dr. Alex Thomson, who served in all four capacities(once editor of John Hunter's work) Dr. Wilkie, speaker of Victoria's first Legislative Assembly, Dr. Palmer, first president of the Legislative Council 1856-70, and Dr. D. J.

Thomas, who had studied under the famous Robert Liston in surgery in London. Several doctors were in the first club in Melbourne, the Melbourne Club (Jan 1, 1839) and the Melbourne Union Benefit Society (14.2.1839), which became the Melbourne Mechanics Institute and School of Arts, and through it the future National Museum. Dr. Wilkie was Treasurer 1856-78. The Institute was the home of various organisations, including medical and scientific bodies. Clearly, Victoria was lucky to attract from the first young doctors, who were highly qualified cultivated men. They did not come, as in other states, to serve military and convict establishments. Most were under 40, many in their twenties. One might wonder at their motives in apparently abandoning all their friends and connections to come to a totally unknown area in a recently colonised continent.

In 1846, twelve of these doctors joined for the first time to found their first official organisation. A Philosophical Society (later the Royal Society) was already flourishing, founded by Dr. D.E. Wilkie M.D., encouraged by the ~~Lieutenant-~~ SUPERINTENDENT OF THE PORT PHILLIP DISTRICT ~~Governor~~ Charles Latrobe, a man 'given to extolling science at the expense of the classics'.[2] The medical society had more of the character of a medical conversation on an informal basis, and sprang from a particularly active community which had already established a hospital and planned a University. They used to have 'capital dinners, and first rate social and intellectual evenings'.[3] One of its founders and first President was the Assistant Colonial Surgeon, Dr. P. Cussen, a man who 'was kept in a constant state of tribulation' between the immigration tents, the Government hospital, the goal and the press.[4] Others were Dr. Wilkie, Dr. Wilmot the coroner, and Dr. G. Howitt, leader of the doctors. It was intended to found a medical library, and museum; read original papers; introduce a code of ethics and more uniformity in medical charges. Its constitution predated those of the B.M.A. and the American Medical association.[5] The task of drawing up rules was 'troublesome and laborious' as reported by Dr. Wilkie, because they had no precedents to go on.[6] The only debt was to the scale of fees adopted by doctors in Aberdeen in 1829 to produce a 'greater uniformity' in charges. It had three scales of charge from 10.6d, 5s. and 3s, a consultation, whether at home or in the surgery, and £1 to £5 for midwifery. Bleeding and cupping were added at 2/6 ranging to £1.1.0

But Dr. Wilkie's hopes of a degree of harmony and friendly feeling among the members, not attained by other means, were doomed. Harmony was not attained by ethical rules such as:[7]

> "That no member of this association shall give any countenance whatever to disparaging reflectins or false reports affecting theprofessional character of other members."

They were to submit to judgement by the Association if they did. This was immediately put to the test with two cases. A Dr.J. Clark charged a Mr. F. Shaw, and A Dr. Turnbull, Dr. Greeves of such breaches of professional etiquette. Dr. Greeves failed to get the ethical rules repealed in August 1847, so turned his considerable influence to sabotaging the Association. He seceded along with Dr. Campbell and Dr. Mullane, thelatter ignoring request to return books from the library.

As well as a library, the Association produced for six months in 1846 a journal, and met in the board room of the Melbourne Hospital. Several valuable papers had been read, most important being one given by Dr. D. Thomas Aug 2, 1847, on the use of ether, only ten months after its first use in the U.S.A. He regarded it as'one of the greatest blessings bestowed on mankind'.[8] In 1848, the Port Phillip Medical Association P.P.M.A. found difficulty in securing attendance at meetings, but theefforts of Dr. Barker, and Dr. Sullivan kept it alive for two more years. Finally at a special general meeting Nov 20, 1851, the minutes record 'society dissolved, sold books, cleared up'.

Gold discoveries at this time disrupted the colony. The flood of population brought squalid canvas shanty towns. Nowhere was there plumbing, drainage, proper roads. Plague and disease followed. By 1856, there were nearly five hundred doctors, many coming as ship's surgeons, as emigrant ships by law had to carry a surgeon who had no guaranteed return passage. While a number were reputable men, this was a difficult standard to sustain:[9]

> "The private shipping companies in the 1850's were inundated with work, and their ships were compelled to carry a surgeon. They frequently took the cheapest available, and in their desperate need, according to James Backhouse they virtually'shanghaied' a number. Certainly they lowered the reputationof the profession proper by employing unqualified persons and those of poor character. Many of these men settled in Australia".

A London visitor of the day, W. Kelly , wrote:[10]

> "There were several doctors and surgeons in full practice about Melbourne who had never attended a lecture or smelt a subject and more than one who compounded his own medicine, because he could not write a prescription."

A death certificate did not require the signature of a doctor.

A quack in 1857 opened an artery in mistake for the median vein, and then by tourniquet lost the arm.[11]

Victoria was not long without a medical society. Within six months of the failure of the P.P.M.A. May 17, 1852, its former secretary called a public meeting of the medical profession in Melbourne at the Bull and Bush Hotel to form a Victoria Medical Association, with Dr. D. Wilkie as president. He took keen interest in the legislation required to attack dysentery, cholera, diphtheria and smallpox; having worked with two Glasgow doctors who distinguished between typhus fever and typhoid fever.[12] One of the first tasks of the V.M.A. was to systematically inspect the city of Melbourne and report on its insanitary conditions.[13] Attention was mainly directed to drains and privies, as the contagious nature of disease and the possible role of germs were not yet recognised, adequately.

In the drafting of the new society's rules, Dr. Wilkie 'steered the members clear of the difficulties which had wrecked the old one', namely the ethical rules.[14] By 1854 , there was a Bendigo Medical Association on the goldfield, asking for support of the V.M.A. for a crusade against 'quacks' including prescribing chemists. Dr. McCrea, an ex navy surgeon and assistant colonial surgeon on the goldfields, created a rival society- the Medico-Chirurgical Society June 6, 1854, many of whose members were on the professional staff of Melbourne Hospital. Of Dr. McCrea, it was said, he was extremely competent, industrious, clearheaded, and able to influence Latrobe's successor, Sir Charles Hotham, to bring all sections of the medical department under his control, after he became Colonial Surgeon.

The two rival societies amalgamated July 18, 1855, to form the Medical Society of Victoria, with the aid of Dr. Wilkie and Dr. W. Gilbee - ex-golddigger who became one of the first doctors to use Lister's methods. Dr. McCrae clashed with the M.S.V. in 1857 in his role as President of the Board of Health overstatements made against his Board during the course of M.S.V. pressures against a vaccination bill, which would allow 'any person' even a layman to vaccinate and register vaccination. The M.S.V. also lobbyed for a medical registration bill in 1858 (passed 1861). Dr. Gilbee started the first lasting medical journal in Australia in 1855 with Dr. Maund, a gynaecologist, who helped Dr. Tracy found the first lying-in hospital for women.

But the high tone and feeling hoped for did not eventuate, as instance a report in the Lancet of 1860; which spoke of 'the very disunited state' of the profession as evidenced from a mass of papers and reports in the Melbourne press, adding 'Melbourne and its hospital have certainly become famous in the annals of social medical warfare.'[14]

The M.S.V. from 1855 sought to bring together doctors of a wide range of personality and professional interest. Subjects discussed at the meetings had been of general appeal: midwifery, epidemic fevers, heart affections, dysentery, and lead poisoning from casks. Within a year, it had a journal, a rapidly growing membership, a library, and finances on the right side of the ledger. The early editors of the Journal were Dr. Maund, Dr. Black and Dr. W. Thomson 1859-61, who struggled with lagging subscriptions, financial crisis, and, in Dr. Thomson's case, a charge of misrepresentation of a lithotomy operation from Dr. Gilbee. The Journal from 1859 became independent of the M.S.V., though published under its auspices. From 1861-79, the editor was Dr. J. Neild, 'during which time his devotion to the journal was said to have been the sole factor in saving it from the fate that had so often overtaken medical journals.

For over twenty years, the M.S.V. had no home. It petitioned the Government for land in 1861, and was given an acre on condition of building. Failing to do so, it was sold, and an alternative site secured by Dr. A. Bowen, who found a piece of crown land at the corner of Brunswick St. South, and Albert St., E. Melbourne, and raised the money by debentures to build. At the first meeting in the new hall, Dr. T.I. McMillan recalled:[16]

> "It has dwelt in lodgings without paying any rent. It has been housed, under a kind of implied protest and as a matter of course, its elements have not cohered with a permanent force."

It was a wonder it survived despite this, and because of open quarrels aired in the Society. In 1859, Dr. Gilbee was involved in arguments over rejection of his nominee, Dr. Bowman, as member, as well as with Dr. Thomson. In 1860, Dr. Gilbee attacked a Dr. McKenna over press reports of evidence at a coroner's enquiry into the death of a G. Black, referred by Dr. McKenna to him for spasmodic stricture. The argument was one of malpractice, through delay; and the pros and cons, already thrashed out in the press, were debated in an open meeting of the society August 27, 1860.

Dr. McKenna was also attacked for advertising, on a charge of 'unprofessional conduct', because he advertised a reduced scale of charges in the press- a practice by no means

uncommon - and circulated cards into private houses by pushing them under doors and other means. Before the meeting ended, Dr. McKenna had resigned, as did Dr. Robertson, the secretary, and Dr. Barker, the President. The incident set a pattern for similar sorry affairs over the next twenty years, which were equally damaging to the harmony of the society. Yet, after a meeting, when only the president and secretary turned up Ocotber 1861, it was Dr. Gilbee the president who revived the society, aided by the creation of the Melbourne University Medical School. "There was a general influx of new blood, and, in particular, Dr. G.B. Halford arrived as professor of anatomy and physiology. On becoming a member of the society, Halford often contributed to, and undoubtedly helped to raise, the academic standards of discussion".[17]

Among the newcomers was Dr. Neild, who became honorary secretary 1862-79, lecturer in forensic medicine at the University, partner with his brother-in-law in a pharmacy business, librarian of the M.S.V., drama and music critic, editor of the A.M.J. and generally a prescence in Melbourne. Of him, it was said, on his death in 1906, that no doctor had ever been a man of wider interests or sympathies.

The University Medical School was the creation of Dr. Anthony Brownless, prominent physician who had become vice-chancellor. Two years after election to the council in 1857, he proposed a five year course when most British medical schools only offered three. He saw:[18]

> "the danger of copying the hospital schools of England, where there was good practical and poor theoretical training, or of imitating the old English universities which produced doctors who were cultured but inexperienced. He saw the wisdom of the blend of theory and practice in the Scottish and European medical schools where students studied theory in a University and practised medicine under the eye of experienced doctors in the hospitals".

The five other medical members of Council backed him, and between them they set a model which was followed thereafter in Australia, and set a very high standard for Australian medicine; although the course later required reforms to reduce the number of arts subjects, and improve hospital clinical teaching. The M.S.V. cooperated with the Council in working out details. By 1867, its degrees were recognised by many bodies in Great Britain.

Notable scientific work was done by M.S.V. members. Apart from Dr. W. Thomson's brilliantly deducted views that sources of contagion were other than drains, privies and miasma; there was Dr. John Day's work in physiolcgical chemistry and disinfectants

like hydrogen peroxide, which made him world famous. A new member, Dr.S Bird, in 1861 had been apprenticed to the King's Physician and had three Prime Ministers of England in his care, and demonstrated the laryngoscope (invented 1858). Dr. Tracy performed the new operation for vesico-vaginal fistula. Dr. Turnbull did a Caeserean section after a mother died suddenly when six months' pregnant. Dr. Thomas, after getting a senior degree in surgery in England, was the first to excise the upper jaw, the first to do a Syme's amputation, the first to ligate the radial femoral carotid and external ilian arteries for aneurism - all more hazardous to perform than today. Mr. Girdlestone was the first surgeon in Melbourne to establish the soundness of Listerian principles in surgery by securing union by first intention with something like unfailing regularity, and to use kangaroo tendon as suture material. Besides:[19]

> "the influence of the great James Young Simpson of Edinburgh on senior members of the society such as Wilkie, Tracy, and Thomas is revealed repeatedly by accounts of success in gynaecological operations, obstetrical manoeuvres and use of instruments devised by him".

Progress was not without stormy debate at times, as when differences of views drove Dr. Thomson to resign.

Doctors were on the eve of a scientific revolution of incredible proportion. Simple but vitally essential instruments were suddenly to hand to supplement the stethoscope and clinical thermometer, themselves not long in use. Such were the spyghnamometer, the laryngoscope, and microscope for use in cellular pathology, based on the work of Rudolf Virchow. It is strange to read in retrospect that vaseline was hailed as an important new antiseptic, plaster for fractures acclaimed, and the merits of alcohol for hospital patients discussed.

The M.S.V. was not without a rival. Such was the Medical Association of Victoria, which alleged that the M.S.V. represented only one third of the profession of 600, and that it and its journal had sought the welfare of the few rather than the many. It objected to 'the monstrously outrageous and hostile conduct of these gentlemen towards the great body of the profession.'[20] It was a fair sample of the torrid exchanges that enlivened medical journals as well as the columns of the daily papers. Antagonisms were aired publicly on anything from inquests, and cholera scares to asylums. In a libel suit against the publishers of the A.M.J., Lloyd vs Stilwell, Mr. Ireland said for Stilwell:[21]

> "There were two sections of medical men in the colony who were continually abusing each other, and they could not meet in consultation over a toothache without quarrelling"

Tact was not always to the fore, as witness the obituary of a Dr. MacKenzie in 1872:[22]

> "He had good abilities and excellent opportunities. He failed to use the former, and he wasted the latter. His life and death alike are warnings".

Even the most eminent, as Professor Halford, were not immune from charges within the M.S.V., as when he was 'tried' for advertising in 1878 by distributing a handbill. Others deserved censure more, as Dr. Blair for prescribing for sexual disorders by correspondence to a patient in New Zeland; and Dr. Barker (first lecturer in surgery at the University) for giving evidence in support of a notorious quack called 'Dr.' Jordan who ran an 'anthropological' museum of monsters, and had brought an unsuccessful action against Syme of the Age and Leader newspapers. He was censured for giving evidence which was considered exceedingly injudicious and imprudent and injurious to the interests of the profession and the public. Dr. Neild was decribed by Professor Halford in 1872 as 'long the chief prop of the society',[23] which was often threatened by wrangling and disorder.

But the internal quarrels of the M.S.V. were compounded by medical politics outside. The Coroner, Dr. Youl, had assigned the duty of making all post mortem examinations within his district to two men - Professor Halford and Dr. Neild: which was viewed with great hostility by doctors in practice.

The Medical Association of Victoria was founded Jan.30,1868, and published a journal, the Australian Medical Gazette from 1869-71 of which Dr. Neild said it was:[24]

> "a periodical ostensibly representing the profession, but in reality devoted to the gratification of personal hostility."

It survived a little longer than the preceding Medical Record of Australia 1861-3 dominated by Dr. Reeves and Dr. Beaney; the Medical and Surgical Review 1863-65; and the later Medical and Surgical Review 1873-5 with its wider range of contributors than its forerunners.[25] Dr. Neild's brand of forthright journalism and domination of the Australian Medical Journal inevitably created opposition within the M.S.V., as well as without. This came to a flashpoint in 1878 when eight members wrote to the Chairman asking for an investigation of the Journal in view of 'its extremely unsatisfactory state. This led to Dr. Neild's resignation as editor, secretary, and member of the M.S.V., not mourned by everyone it seems, as Dr. Cutts said in open meeting Sep.10,1879:[26]

> "He thought it was time for Dr. Neild to resign in consequence of a certain amount of ill-feeling expressed against him from time to time by certain members of the society".

In fact, he was caught up with a quarrel that had nothing to do with him in origin, springing from doctors being ranged on opposing sides in a court case in 1879. The chief protagonists, Dr.J. Rudall and Dr. T. M. Girdlestone, had already been in conflict in 1866 in another case (the Queen v. Beaney)- the former for the prosecution, the latter for the defence.[27] Dr. Beaney was acquitted of the charge of murder of a young woman through an abortion. Dr. Rudall had done the post mortem. Dr. Rudall took the reverse role successfully as witness for the defence when his friend, Mr. Barker, was sued by a patient in 1869 for maltreatment (failure to diagnose and treat a fracture of the femur in an elderly female). In 1879, Dr. Rudall undertook litigation himself sueing a patient successfully for his full fee for performing a laparotomy. The patient, Mr. Gilchrist, secured Dr. T. M. Girdlestone and R. A.C. Brownless for his defence which was that the operation was unjustifiable. In a summary, medical historian, Professor Gandevia, says:[28]

> "Whatever the merits of the case, it is clear that the small sum of six guineas for which Rudall sued, almost certainly on a matter of principle, was not in proportion to the strife which ensued."

It seems to have brought smouldering resentment from the past to a head, seeded in past court battles, and fanned by fights at the Royal Melbourne and other hospitals over the manner of elections of honorary staff.

Mr. Girdlestone, himself, appears to have been a contentious man. He had attacked Dr. Blair over a diagnosis in 1876; and had the name of a Dr. Lucas, wishing to join the M.S.V., withdrawn from a ballot in 1879 over an attack that he had practised homeopathy. This Dr. Lucas was most indignant that he had, as a newcomer, been libelled and excluded on mere rumour; while Dr. Girdlestone, also on rumour, had refused to meet him in consultation.

Dr. Rudall brought two charges, one against Dr. Girdlestone in the M.S.V., and one against Dr. Brownless in the Medical Defence Association,(founded November 1878 as a professional protection association) for'unprofessional conduct'in asserting his operation was unnecessary and improper. Dr. Brownless resigned from his presidency in protest against what he thought an amibguous decision which, though dismissing the charge, urged doctors to be circumspect in giving evidence against their fellows. Dr. Rudall's reason for laying the charge against Dr. Girdlestone is perhaps best explained by a contemporary account:

> "if these witnesses did not virtually declare that Dr. Rudall's operation was improper and unnecessary and was really no operation at all, and that he charged too much, then it is equally difficult to explain how they came to be on all sides publicly reported to have done so, why they took no steps to contradict such a misstatement".

A committee hearing acquitted Dr. Girdlestone, but his dissatisfaction with the way Dr. Neild reported the minuted in the Journal led to a special M.S.V. meeting, where Dr. Neild felt he had been accused of partiality and personal ill-feeling towards Dr.Girdlestone. On resignation after a trivial wrangle on the right of the general meeting to hear business already dealt with in committee, he refused to hear a deputation, which asked him to be editor of the Journal once more, while he rested under an implied vote of censure. He threw his reputation and considerable organising skill into founding a rival organisation, the Victorian B.M.A. Branch. A week before, refusing the peace offers of the M.S.W., he had already held a meeting at his house at 165 Collins St. to that end- the idea having been contemplated for some years by several members of the profession. These included Dr. Rudall, Dr. Graham and a Dr. L. Henry who had been refused membership of the M.S.V. in May, 1879. The refusal is difficult to account for as the minutes officially record that 'against him there was personally no cause for complaint'.[30] It could not have been his continental qualification of M.D. from Wurzburg, because he was a L.R.C.P. of London, 1878, and a Fellow of the Medical and Obstetrical Society, London. More likely they were aware that he had authority to found a rival society encouraged by E.Hart,then editor of the British Medical Journal, and the Parent Council.[31] Dr. Neild himself said in 1900 "Dr. Henry held a commission from the London Council to establish the Victorian Branch".[32]

The crisis in the M.S.V. gave a reasonable justification for a second society with thelogic of the influence to be commanded by linking with the B.M.A. in England; and the wisdom and experience of the larger group to call upon in medico-political matters, in which the local group had not been so effective as they would wish. There were thirty foundation members with Dr.W Gilbee first president, and almost all were members of both societies.[33]

> "It was conjectured that a differentiation of function could be defined, and that the old society would cater for scientific requirements, leaving the field of medical politics and ethical discipline to the new association".

This ideal was not sustained. The Victorian B.M.A. remained the smaller of the two bodies, despite growing enrolment, and mention was made that 'strife and disharmony arose out of the attempts of each body to assume the position of representative medical organisation.'[34] Rivalry continued until they amalgamated in 1907. Dr. Springthorpe is on record as saying that the [illegible]

to cliques which had views of ethics which varied with age, position and clash of ambition. Dr. Neild and Dr. Louis Henry between them ran the B.M.A. Branch for years. The M.S.V. finally offered the B.M.A. use of their hall, but earlier years relations were less amicable. At the end of 1830, the B.M.A. President Dr. Cutts attacked the editor of the A.M.J., organ of the M.S.V. for refusing to accept a report of the B.M.A. proceedings to print in the journal. The reply was:[35]

> "The bulk of the document in question had already appeared in extenso in the daily press. It seemed scarcely becoming that a medical organisation should send accounts of its meetings to a professional journal in the form of long columns clipped from a lay newspaper."

Dr. Cutts retorted, claiming that many subjects were of a kind in which the whole community was interested.[36]

The B.M.A. Branch was in touch with other colonies in its first year, although the Australasian Medical Gazette - launched by the Victorian Branch on the instigation of the editor of the British Medical Journal, did not become the vehicle of cooperation hoped for in its origin.

The M.S.V. found a strong and capable organiser to replace Dr. Neild in Dr. H. Allen, a Melbourne University graduate soon to become professor of anatomy and pathology at an early age, Dean of the Faculty by 1886, and member of the Central Board of Health. His pacifying influence and astuteness in debate was exercised not only in 1879 but ultimately in bringing about thefinal amalgamation of the two societies. In the decade 1880-90, many of the early founders faded out - among them Dr. Gill whose epitaph was an implied criticism of his profession ' no medical man occupying such a prominent position as he held ever had fewer quarrels or made few-r enemies'.[37]

Among achievements of this period were those recorded by Dr. Springthorpe:[38]

> "A new University Act, a new Board of Health, reforms in hospital elections and medical education, summaries of hospital defects, city sewerage beginnings, advances in public health, lunacy reform, a new pharmacopoeia, and the establishment of my own chair in therapeutics dietetics and hygiene. It was a time also for great discussion on typhoid, influenza and Koch's tuberculin'.

The two societies acted jointly in many matters over the years: in 1885 at a public meeting in the Town Hall for a Public Health Bill, and a change of site for Melbourne Hospital; and in 1888 in conference to get an amendment of the act to prevent doctors covering for quacks. Both acted for more stringent ethics, particularly forms of advertising. They also took joint action on

friendly societies, hospital abuse, training of midwives, V.D. and infectious disease isolation accommodation. These two societies were joined by others. First was the Melbourne University Students' Society 1883. Founded by Dr. Meyer, Dr. Willis and Dr. J.W. Barrett (who first represented the Victorian Government at the International Medical Congress, Rome, 1893). The M.U.S.S. had its own journal. In 1884, a Bendigo Medical Society appeared.[39] In 1887, several Ballarat doctors asked Dr. W. Morrison to convene a meeting to form a Ballarat District Medical Society; formed due to the opposition of Melbourne to a B.M.A. Branch there. Next came the Goulburn Valley Medical Association in 1893;[40] It issued a circular saying it wished to suggest similar societies, which would unite throughout Australia, as an Australasian Medical Association. As a result a meeting of provincial medical men was held in Melbourne November 8, 1893, for a society 'identical with the B.M.A. in Great Britain' and to further the work of congresses whose value to the medical profession had been so great. It would represent the general practitioner, and carry out a more active policy of protest. It did not mature. Both associations linked with the B.M.A. the former in 1898, and the latter in 1895. Launceston , TAsmania, established a subbranch in 1897 which survived until 1904.

A Melbourne Medical Association, founded in 1891, was the official organ of the graduates of Melbourne University with Dr. Springthorpe as president. Up till 1914, it joined in political and community work like the M.S.V. and the B.M.A., combining with them on deputations to Parliament. It founded the Medical Defence Association of 1894 with the approval of the other societies.

The M.D.A. was intended to deal with the continual evils that dogged the profession - defence in litigation, as for alleged malpractice, blackmailing etc. This body took a strong role from the first in ethical and political matters. In 1913, ethical matters again became the exclusive prerogative of the B.M.A. and amalgamation of the M.D.A. with the B.M.A. proposed. By this time, legal opinion was that amalgamation was not practicable because of the B.M.A. consitution, though held by the M.D.A. Council to be desirable.[41] Doctors continued as in England to subscribe separately to it, and to conduct all legal actions through it, while membership of the M.D.A. was not conditional on membership of the B.M.A. Considering the explosive effect of legal actions on the concord of the M.S.V. there was a cogent argument for keeping the two functions separate - though B.M.A. Councils at times would welcome attaching the protection offered doctors by the M.D.A to itself as an attraction to membership in theB.M.A. The opportunity was lost when the function was detached in 1914.

The Victorian Branch approached the London B.M.A. in 1891 to permit women to belong, the first branch to do so, with the ready support of South Australia and N.S.W. First admission of women resident surgeons was to Melbourne Hospital 1897 five in number, on merit in their courses. One of the earliest couses in post -graduate lectures in Australia was given at the Medical School in 1904 by Professor Osborne, the new Professor of Physiology.

The two major societies in Victoria, the M.S.V. and the B.M.A. 1880-1907, had considerable overlapping membership. They created a modus vivendi by the M.S.V. agreement to leave medical politics and ethics to the B.M.A. But the A.M.J. remained separate. In 1893 the M.S.V. began to supply the Lancet to members, instead to encourage membership and offer more for their subscription. In 1894, they began to publish the Intercolonial Quarterly in response to a proposal of the 1892 Congress. Amalgamation of the two societies was refused in 1891 by the M.S.V. on the terms suggested, believing it would destroy their work. The M.S.V. for its part took the initiative for amalgamation several times, but the attempt was always defeated by the B.M.A. Branch, who felt some members of the M.S.V. had made one or two injudicious remarks.[42] In 1900, the President Dr. A.L. Kenny referred to low attendance at meetings because of lack of a permanent meeting place, inefficiency in communication with the London office, and loss of membership.

Shortly after, the new PresidentDr. G.A. Syme was involved in a broil which led to the resignation of himself and his entire council. It began as an enquiry against the surgeon Mr O'Hara for unprofessional conduct in association as director with a company called Silenette, and his knowledge of a pink advertising circular on feminine hygiene, which in Dr.Springthorpe's letter of protest was said 'to be found in all its filthy suggestiveness in business offices, private homes and ladies' schools'.[43] The Victorian B.M.A. Council had recently expelled a member for a much lesser offence - advertising of a mouth wash. The Archbishop Carr had made a complaint in St. Georges Church, which it was difficult for the B.M.A. Council to ignore. Mr. O'Hara admitted the breach of ethics, denying he knew of the use of his name, but had merely taken a share in the company in return for the rights and trademark. The lawyer concerned admitted Mr. O'Hara had been used 'to get him associated at any cost'.[43] The Council, none the less, resolved to expel Mr. O'Hara but did not get the necessary 3/4 majority under the rules inopen meeting, so carried out their threat of resigning en masse. A new Council was elected with Dr. Neild, now an elderly man, as President. He himself had resigned from the M.S.V. on a similar

point of honour in 1879. As Dr. Neild had not been an active member for some time, he was reluctant to take over, deploring the issue which he said 'added nothing to its dignity, its reputation or its usefulness';[44] but he relented when told that, as one of the founders, he might be able to restore cohesion.[45] He failed and resigned due to ill-health by 1904. Dr. Neild's cofounder, Dr. Henry, tried to act as mediator to reconcile the 1900 Council. He wrote to Dr. Syme in a publicly conducted correspondence beginning May 18, 1904, saying one of the B.M.A. objects was to promote good feeling. The new Council believed disunion created grave disadvantages for medical men, and offered to resign. The late Council continued to object that 2 witnesses could not be trusted as to their evidence in defence of Mr. O'Hara's ignorance; evidence, which members of the Branch had accepted tacitly in exculpating Mr. O'Hara. The 1900 Council would accept nothing less than a bloc re-election to the 1900 status quo, with endorsement of regret from the entire branch, which refused such inflexible terms. They refused to accept majority vote of the 1900 meeting, and the qualified apology of the 1904 one.

Meanwhile Dr. Syme and Dr. Vance cabled London asking the Parent Council to defer acceptance of the resignation from the B.M.A., sent by Mr O'Hara, in order to put an end to the quarrel. They were told the Parent Council had no power to refuse to accept resignations, even when charges were pending against a member.

The 1900-1907 quarrel within the B.M.A. came to an end, finally, with amalgamation of the B.M.A. with the M.S.V., the new Council for the reformed B.M.A. Branch coming almost entirely from the M.S.V., with Professor Allen as the new President, and Dr. G. A. Syme as a vice president. This amalgamation was hastened by Australia wide opinion that the existence of two Victorian associations stood in the way of an independent Australasian Medical Association, or even a federal B.M.A. The method proposed was that the Branch should elect all members of the M.S.V. to be members of the Branch, all offices should be declared vacant, and a new Council elected at a joint meeting. The Hall, library and funds of both should become common property. The plan was negotiated with masterly diplomacy by Professor H.Allen, to wom committee member Dr. R. Stawell paid tribute at the enabling meeting of the M.S.V.[46]

> "the indebtedness of the committee to him for the immense amount of work he had brought to bear. Until Professor Allen had been brought into the negotiations all had been chaos."

It was carried out at simultaneous meetings of the M.S.V. and B.M.A. December 19,1906 - although the M.S.V. retained a formal title to land, and buildings, as these could not be transferred without a deed of trust.

The Intercolonial Medical Journal became the official organ of the reformed B.M.A. Branch. In the first year, the Branch had to consider the new draft constitution for the B.M.A. It asked for greater powers for branches outside the U.K.: to undertake financial responsibilities such as a local journal, medical defence, power to make rules consistent with the constitution, power to acquire, hold and dispose of property. The Branch was organised better, with divisions; and passed rules for sections for special branches of medical knowledge. A Victorian Branch of the British Medical Temperance Association was founded in 1907 with 23 members and Dr. W. Moore as President, who spoke on the declining use of alcohol in medicine as a drug especially for fevers.

By 1910, an accelerating membership had grown to 485, a large organising committee having approached all 'reputable' members of the profession by circular and personal letters. The Council felt its influence on legislation, already considerable, could only be effective if the B.M.A. could speak for the great majority of doctors in Victoria. Among most urgent matters were contract practice, hospital abuse, and medical inspection of schoolchildren. Meetings were very active by this time, Dr. R.R. Stawell, the President, receiving credit:[48]

> "He was the moving spirit in many of the innovations, especially the holding of clinical evenings, and making each ordinary meeting as far as possible a symposium upon some subject of special interest. In this way, the suburban and general practitioner were catered for more effectively than in past years, and they showed their appreciation by increased attendances."

In medical politics, discontent remained. Rates for contract practice remained lower in Victoria than anywhere in Australia, provoking such strictures as:[49]

> "The apparent extraordinary apathy (contrasted with N.S. of those managing the affairs of our society in Victoria can only be explained by the fact that they are individu without one or two exceptions not engaged in lodge pract

Dr. Worrall, N.S.W. President had alreaady been called in to address the Victorian Branch on the necessity for organistion in the profession, and dilated on the less than 50% of membership of doctors as a grave reflection on the public spirit of the professior and an incapacity to appreciate the importance of combination. The B.M.A.appointed an ethical committee in 1913, but could not follow the advice of the N.S.W. Branch in taking over the work of the Medical Defence Association due to the advice of counsel Mr. Lewers in 1912:[50]

> "The Victorian Branch could not apply any moneys to the defence of legal actions under existing regulations. It could not permit a special limited guarantee as the M.D.A. does. The Victorian Branch could not become a limited liability company limited by guarantee under its existing constitution and remain affiliated."

The M.D.A. would have to be wound up. This was not done.
The Intercolonial Medical Journal became the official organ
A Health Officers' Society had existed for some years, and was active enough for the M.D.A. to protest from time to time that it admitted men whom medical societies excluded.[51]

During the 1914-18 war, 232 members of the Branch were in whole-time military service. The Branch founded a medical agency in 1917, profits going to organisation. The 1922 report said it had fulfilled all expectations. It now had seven standing committees- organisation, press, ethical, house, scientific, war organisation and legislative. The latter was busy with the midwives bill, the nurses registration bill, the opticians bill, the medical act and the V.D. act. Owing to B.M.A. intervention with the leader of the Legislative Council, objectionable clauses in the last two acts were removed. The way was not always smooth, the Branch report for 1920 admitting that:

> "for many years, there has been recurring difficulty in having the views of the medical profession correctly laid before Parliament. This was found noticeable when attacks, based on false information, were made in the House on the B.M.A. by Mr. Snowball, Mr. Lemmon and other members."

The Branch became deeply involved, 1917-1918, in the 'battle of the lodges' which continued to occupy the Branch to the exclusion of almost all normal work.[52] However, the Branch still found time to join in a Royal Commission over an epidemic of cerebro-spinal meningitis; and a society for combating V.D. (1920) with 11 members of Council on it.

At the end of the war, a Returned Medical Officers' Association of Victoria was formed, and in 1920 a Melbourne Surgical Association - the latter with 50 members from doctors at Melbourne's three teaching hospitals. It was accused of being a closed corporation. Specialist societies began to appear, causing Dr. Syme to express alarm in a Council meeting;[53] that these societies left very little for the association to do, and they would kill the Branch . A move for integration with the B.M.A. was made, meeting a typical response in the Medical Club (open to University Staff) that they could not join the B.M.A. because the first rule of their own group was to exclude all medical ethics and politics.

The Branch appointed a Chairman of Committees, Dr. J. Newman Morris, in 1922 to organise and coordinate the work of Council and preserve continuity from year to year. Victoria was divided into seven country, and eight city, electoral divisions- all with representatives on the 35 man Council to reflect the views of the whole membership. The Branch now had some 95% membership of Victorian doctors; and began smoke socials for senior medical students and honorary associate membership. The Victorian Branch also sponsored a Post-Graduate Committee in 1919 on the prompting

of Sir Neville Howse, when Director-General Army Services, June 1918, that nothing existed for post-graduate needs of medical officers in the army.

Annual Branch conferences began August 1924, similar to N.S.W., but based on a wider conception of inviting any memberto attend, so as to cover individual as well as group interests. Expansion made a new building urgent. The standing building was pulled down, and a new two storey building put in its place, financed by debentures sold to members . The War Memorial, a fine sculpture, was housed in the foyer of the new building, opened in 1925.

The Victorian Branch Council also began conferences with the Charities Board, the Bar Committee of the Law Institute on medical evidence; while, in 1929, it sought a change of constitution to transfer initiative in policy from a general Branch meeting open to city members, to a Branch Convocation representing all divisions including the country. This was achieved in 1933, after considerable negotiation with England. But the general practitioners were still not effectively represented, according to Dr. W. H. Fitchett in 1929. Although 4 to 1 of practising doctors, they were not 4 to 1 on the Council, or on the Ethical Committee. The difficulty was to get them to vote in elections, as recently evidenced when only 300 of 1300 voted despite active canvassing.

December 1929, the Branch Council issued a circular on the subject of fees and fee splitting, just before the annual conference of the College of Surgeons in Melbourne, March 1930. At the same time, an article had appeared in the Melbourne Herald which was capable of being construed that the College of Surgeons aimed to restore ethical standards now being basely deserted in the general rank of the profession. At a very angry, vociferous, and crowded first annual meeting of the general practitioner section, Dr. Embleton was applauded when asserting,[54] 'it was an unwritten law that any dirty linen should be kept within the confines of the profession itself.' Branch Council was criticised for sitting back and failing to answer criticism in the press, or to comment on 'unethical methods adopted to secure publicity'.

The alleged defamatory article included the statement that unnecessary operations were advised to transfuse sick bank accounts as the outcome of fee splitting between physicians and surgeons.

Dr. Fitchett, editor of a separate journal, the 'General Practitioner', considered a separate General Practitioner Society but decided against detachment from the B.M.A. like the College of Surgeons. A medico-political section within the B.M.A. was formed instead, with separate funds to watch their interests.

The Victorian Branch Council was uneasy about this rebellious "loyalism", and was tempted to suppress the section. It issued a reprimand that the section had exceeded its approved objects in publishing a journal, which exhibited a rather spirited protest. The Victorian Branch, Council said, had an obligation to support the M.J.A. The 1930 Annual Report stated that is medico-political activities had embarrassed the Council's administration. The General Practitioner Section turned its energies to consider hospital and national insurance 1931-3; to elect more general practitioners to Branch Council, and to continue its journal. Fee-splitting continued a chronic issue- a special meeting behing held on the issue as late as December 1937.

Branch Council handled a variety of work 1931-8, and from 1930 included a woman doctor as delegate from the Victorian Womens' Medical Society. It represented doctors' interests in mileage for post-mortems; scale of fees for intermediate wards, workers' compensation payments; terms of appointment for public medical officers; payment for infectious disease cases; and for doctors under the comprehensive medical scheme at Yallcurn.

One of its greatest innovations was the Mallee doctor scheme in 1931. Doctors in the Mallee areas-Western Victoria's post-World War 1 closer settlement region-were finding practice uneconomic. The B.M.A. suggested a scheme to the Victorian Government of 60% guarantee of medical accounts - a medical coupon system up to £2 per month, acting like grocery accounts. The doctor became a preferential creditor on returns from the harvest.

The Branch had still two blacklisted organisations in 1935- the Ballarat United Friendly Societies Institute and Geelong Friendly Societies Medical Association and Dispensary. A confidential list of doctors still existed, one name being put on it. Doctors were also required to consult the Branch before buying the practice of an unethical practitioner. In 1938, such a request was refused, while an agreement between a member and an insurance company was disapproved.

The Branch acquired its first full time secretary in 1934, Dr. C. Dickson, when Mr. Stanton Crouch retired after 20 years' service. In 1946, the pathologist, Dr. Mollison, retired as Honorary Treasurer, both of the B.M.A. and the Victorian Medical Society after fifty three years' service. Dr. Dickson infused great vigour in the Branch. His work against unregistered medical practitioners, and in working with other branches to effect the transition to national health serv ice, made an immediate impact in branch affairs and public notice.

A publicity subcommittee was created to assist him in public relations, and began a medical radio session once a week, as part of a more practical program to educate the public in health care. The retiring president in 1938, Dr. J. Major, complained of lack of support from membership, as well as dissension:[55]

> "All is not well with our association. There is strong evidence that confidence is lacking, and that there are suspicion, distrust and not a little disloyalty"

He added that many doctors were ignorant of politics.

> "On such occasions, their ignorance of the problem before them is abysmal, apprehension becomes manifest, and, following this, one finds lack of faith in the ability of the elected council to safeguard the interests of the combined profession. It is not unknown for members of the Council to be disloyal to the Council itself and its decisions."

Among subjects that commanded more loyalty in 1938 was the shortage of doctors in country areas. A B.M.A. Council enquiry showed that practices were left, because they did not pay as in the Mallee. The alien doctors were not being denied an opportunity as many of the public accused, as only four of twentyfive alien doctors, registered in three years, had gone to the country. With the shortage of doctors during the war, many were given licences under national service regulations, and provisional membership of the branch without voting rights. Others, with foreign degrees, could be admitted to full membership, subject to inquiry beforehand.

The closing of the United Friendly Societies Institute at Bendigo brought the end of an era in 1942, though as recently as 1940, two bodies had been declared inimical to the profession. Negotiations with friendly societies for amended contracts, and with insuring bodies on schedules of fees, continued to take up a lot of time. Arrangements in outpatient and welfare centres, as in Footscray district, proved satisfactory to the Charities Board, and not to the B.M.A. The B.M.A. also refused to agree to subintermediate or service bed accommodation in public wards, as sought by the Charities Board. It acceded, however, to a concessional ear, nose and throat service by specialists. An insurance adjudication committee was set up in 1938; and a satisfactory schedule of fees finally drawn up.

The B.M.A. also sponsored two new special groups under new Branch rules -opthalmological and contract practitioner. A special subcommittee sought increased salaries for medical officers in the state public service, and increased salaries for medical officers of health (set at £0 a year twenty years before). In 1939, it established a revised hospital policy for the state, and deputations went unsuccessfully from branch council

for the Premier to avert increased hospital tax, and to propose a compulsory contribution as an alternative to hospital tax. It also failed over three years to secure a central admission bureau, though succeeding in setting up a subcommittee to notify the availability of obstetric beds, a committee to assist in hospital appointments for new graduates, and a hospital residents group.

It also drew up lists of doctors who could be spared for emergency work, shared fully in the war effort, and held prolonged deliberations on future National Health Services as well as rehabilitation of service doctors. It emphasised to the Premier the need for more hospital accommodation and formed a preventive medicine group. The Branch served on 25 public bodies in 1945.

100 years later, it had fulfilled the original hopes of the founder of the first Victorian society, Dr. Wilkie, that it would create a 'better state of things in the medical profession by fostering a degree of harmony and friendly feeling among the members which has never yet been attained by any other means'.[56]

(c) BRIEF HISTORY OF MEDICAL ORGANISATIONS IN SOUTH AUSTRALIA TILL 1945

South Australia from the first was a free settlers' colony settled by the South Australia Company with a well-defined policy of land purchase and immigration; proclaimed by Captain John Hindmarsh, the first Governor in 1836. One of the first arrivals on the eight immigrant vessels was Dr. J.T. Cotter, the Colonial Surgeon, He pressed the Government for a hospital. One of the first public controversies in the colony was over the incredible inadequacy of this hospital, despite Dr. Cotter's strenuous efforts. The two existing papers took opposing sides.[1] Dr. Litchfield on arrival as Inspector of Hospitals persuaded Colonel Gawler to build a better one in 1841, eventually replaced by an 8 ward hospital in 1857 on the site of the present Royal Adelaide. Finance for the 1841 hospital was in part from government funds, in part from the sale of flour and profits from a newspaper the "Egotist".

Politics were much more unbridled in those days. Dr. Litchfield, an energetic man was Chairman of the Board, but[2]

> "it appears that his energy was not always tempered with tact, and on one occasion he was forcibly ejected from the office of the Colonial Secretary, Robert Gouger, after he had attacked that gentleman with a horsewhip".

At one stage he thought to help hospital funds with the sale of leeches grown in the Botanic Gardens. Like many early doctors, he had other distinctions, as a Fellow of the Linnean Society of London.

In the year of conception of the South Australia Compnay, 1834, there appears to have been a South Australian Literary and Scientific Association. Dr. Wright M.D. and Dr. Corbett M.D. were among its members, the latter donating it with a book with an address he had given to the Worcester Literary and Scientific Institute, birthplace of the B.M.A. founded two years before. The Adelaide Philosophical Society, founded 1852, attracted men like Dr. Mayo, Sir John Verco, and Dr. C. Gosse. Dr. Gosse was an Adelaide born man, who studied medicine in England, and became a Fellow of the Royal Society. Sir John Verco was the paleontologist who restored a prehistoric skeleton and discovered the gigantic bird of Australia.[3] Dr. E. Stirling was noted for his work on the diprotodon. Others were botanists and scientists of merit. Other doctors were neither so skilled nor capable, many of them ships' surgeons. Dr. Duncan, Health Officer to the colony in 1849, complained that as many as three out of five doctors were unregistrable.

Two medical societies were known to have existed prior to the South Australian Branch, B.M.A., founded 1879. Dr. Lendon medical historian, wrote of the first that the records kept by Dr. Duncan had been completely lost. The second such society was

the South Australian Medical Association which also has no records extant, but five meetings were reported in interstate medical journals for 1872-3. Dr.Gosse was president in 1872. Dr. W.T. Hayward arrived in Australia at this time as ship's surgeon, and found an existing medical society when he came to the colony. In the words of Dr. Corbin:[4]

> "Its principal duties appeared to be to arbitrate in matters of dispute between individual members and between members and benefit societies. There was no time left at its meetings for discussion of professional and scientific subjects".

Eventually it wound up its affairs in 1881, and used the balance of £200 to found the Medical Benevolent Association of South Australia to assist medical men in distressed circumstances, or widows with families, or for bursaries.

In an account by Dr. Lendon, he says:[5]

> "The cause of the disbandment Sir J. Verco told me he believed to be the fact that the sedate seniors among the medical men were more concerned with petty disputes about medical etiquette and punctilio, whilst the ardent juniors vented a rather more scientific kind of meeting to read papers and discuss cases and specimens. It is probable that the collapse of the Medical Society and the want of unity was aggravated by the establishment of the homeopathic institutions, the dispensary and later the Childrens' Hospital, and by the difficulty the homeopath found in arranging consultations when they wished, or were requested by their patients to call in an orthodox surgeon or physician. Dr. D. Thomas would not touch them, nor would Dr.Gardner, but Dr. Way was the brother-in-law of Dr. Campbell, and Dr. Verco was the cousin of Dr. S. Magarey a Melbourne graduate, but all the same a disciple of Hahneman as well as of Harvey. Others again such as Dr. E. Wigg were eclectic and professed to treat patients by either method, whichever the patient preferred. This disunion then was probably the origin of the B.M.A."

Dr. Hayward's impression at this time was that the older doctors were more versed in the practice of the past than the present. They were not wealthy, could not take refresher trips to Europe if they had had the time, and had no university or medical school to keep them up to date. All were general practitioners according to a report of the day:[6]

> "The system at present in fashion in Adelaide is the one faculty system. There are no special consultants, although of course some of the more popular men get better fees than others... Every medical man is expected by the public to do his own work. I do not think there is a solitary assistant in Adelaide. There are numbers of high class men in the colony, and the tone of the profession is decidedly good".

Some dispensed with lodge practice, but there was no differentiation between physicians and surgeons. New ideas came mainly from young men

imported as house surgeons to the Royal Adelaide Hospital. Among 'new blood' arriving at this time were Drs. Corbin, Gardner, Poulton, Cleland, Davies Thomas and Gosse. Four were Australian born, and had done well in medical schools in England and Scotland Their arrival began a renaissance, which flowered into the S.A. B.M.A. Branch, a medical school 1885, the Intercolonial Congress 1887, and the Federal B.MA. Committee 1912. Both latter plans originated with the S.A. Branch.

In 1879, a letter from Dr. L. Henry in Melbourne urged the formation of a S.A.BM.A. Branch, an idea which was enthusiastically taken up. A preliminary meeting at the house of Dr.W. Gardner, already a leading surgeon, was held May 31, 1879. This invited doctors to form such a branch with Dr. Corbin as secretary. Nearly thirty came from all over Adelaide to the S.A. Club Hotel on June 19 to hear a motion from Dr. Corbin to that end. Dr. Hayward was the only doctor actually a member of the B.MA., and was called on to explain its aims and objects. He then had to nominate all those who wished to become members, along with three other B.M.A. members in the city. The new branch was launched with the ambitious program of a quarterly journal and a five man ethical committee, and Dr. Gosse as president of a seven man Council. In Dr. Hayward's opinion [7] "the founders did well to elect him as their leader, for, at a time when the brotherhood of man was not conspicuous among the members of the medical profession, he was universally respected". He was refined, gentle in manner, extremely courtecus, and almost the picture of a typical English gentleman.

The early meetings of the S.A. Branch were held in the Board Room of the Adelaide Hospital. It had a museum and custodian by 1884, and published proceedings of its own in the opening years, distributing them to its eighty or so members. It also at once became involved with contentious matters - a complaint in lodge practice, and the eligibility of a doctor for membership who was a homeopath. The proposed ethical code remained a proposal only, because members were too critical of the code.[8] Yet one was obviously needed. Discussions in 1880-1 were all too frequently devoted to personal questions. In 1883, an attempt was made to disqualify doctors who met with homeopaths from becoming members of the branch.

The S.A. Branch Council appointed a committee to investigate gross causes of irregular practice in 1885. It defended the city health officer, Dr. Robertson, who had been subjected to a campaign to get rid of him by having his salary lowered and other small indignities to appoint an analytical chemist instead. Council prepared charts in 1886 to show mortality within seven miles of Adelaide, and conducted deputations to the Commissioner of Public Works on Hope Valley Reservoir. It even sought introduction of a mortal

plague against rabbits on the Pasteur principle, they had become so bad.

The Medical School,founded in 1885, seemed a fitting incentive to propose Adelaide as a site for a first intercolonial medical congress in 1887 during the S.A' Jubilee Exhibition. Dr. Poulton, put the idea to the B.M.A. Council, and his organisation was widely acclaimed as leading to the fulfilment of the idea. As a compromise between Dr. Gardner, the leading surgeon, and Dr. Thomas the leading physician, the president became Dr. Verco; whose opening speech was considered a model of brevity and lucidity.

In 1887, the A.M.G. was supplied to members as official organ of the branch, and branch proceedings printed in it. Among early papers were some which clearly showed Adelaide doctors to be well to the fore. Dr. Hayward, house surgeon at Liverpool when the Thomas Splint was introduced, demonstrated it and evoked the condemnation of famous Melbourne surgeon, Mr. T. Fitzgerald visiting Adelaide at that date. Dr. Stirling suggested use of the electrc- magnet for removal of foreign body in the eye. Dr. Bailey introduced treatment for hydatid of the lung by incision and drainage. In 1889, Dr. Stirling, then president, suggested more papers on the new science of preventive medicine, saying all papers were almost entirely surgical. In 1890, Dr. W. L. Cleland, then at Parkside, called for more papers on everyday medical and surgical cases for country papers, In 1892, a Miss Laura Fowler applied to join the Branch, and Council found that no women could belong to the B.M.A. but that the Victorian Branch had already approached the B.M.A. Parent Council, and N.S.W. admitted a member. A circular to the Branch showed twenty of seventy five doctors against, fearing that women would disrupt their society. The Chairman ruled November 1892 that they must be eligible or S.A, would become a laughing stock to Victoria and N.S.W.

The S.A. B.M.A. Branch preferred to concentrate on scientific papers, so an Association of Registered Medical Practitioners of South Australia was formed 1888 for 'the mutual defence of interests of the profession in South Australia.[10] It tried to put lodge practice on a better footing. In 1890 it reimbursed members of the Medical Board in the case of Bollen vs the S.A. Medical Board. It revised the scale of fees to be charged. It set up a committee to report on medical advertising, and in 1892 condemned a canvassing society. But shortly after this, its work was disrupted by the Adelaide Hospital dispute, and it did not revive until 1902 under the name of Medical Defence Association.

The Adelaide Hospital dispute began with staff differences in the late 1880's and erupted again in 1893, leading finally to the resignation of the entire honorary staff, and boycott of the hospital by the B.MA.A.

Some of the worst hostility engendered in that dispute was directed against Dr. Ramsay Smith who had joined the hospital staff after the B.M.A. honorary staff resigned. Despite considerable prejudice against him by B.M.A. members, and charges of incompetence during his office, he had very high qualifications as surgeon to the Admiralty in Scotland, examiner for the Royal College of Physicians in Edinburgh, and its counterpartin Glasgow. The issue of homeopathy undoubtedly influenced some of the attitudes and antagonisms of that affair- by no means least that of the Premier himself. Sir John Verco in retrospect gave a view recorded by Dr. Lendon:[11]

> "Talking the matter over many years after with me, he agreed that, although our attitude was ethically correct, the course of resistance we adopted was a blunder, which was almost bound to fail".

The effect was that the clinical teaching of the medical school came to a standstill. Students had to go interstate with a loss to the state of men like Sir Charles Bickerton Blackburn who made his career in N.S.W. After the dispute was settled, and the B.M.A. Branch ceased to boycott the Adelaide Hospital, the branch was handicapped in its liaison with the Government by the Kingston' Government's appointment of Dr. Ramsay Smith in 1899 to take charge of the Dept of Public Health under the new Act. Public vendettas continued for some years.

In 1913, Dr. Hone of the Branch Council was to boast that the Government was now more cooperative, and consulted the branch before legislation such as the mental bill.[12] The annual general meeting of the S.A. Branch in 1911 on the motion of Dr.W' Hayward made the first move for the first federal organisation of doctors in Australia - a new Federal B.M.A. Committee to deal with contract practice, hospital abuse and medical defence as urged in the 1908 Adelaide Conference; for an organisation to speak nationally and unitedly and lead public opinion on public questions such as national control of consumption, treatment of the insane and feeble-minded, the questions of eugenics, venereal disease and uniform registration.

The Branch had variously met in the Adelaide Hospital boardroom the outpatient waiting room, later the University. Dr. Haywrad in 1911 secured a home for the S.A. Branch, a company being formed known as the British Medical Hall Co. Ltd. The first annual meeting was heldin the new building 1914. Many members, who purchased shares, later gave them to the Branch. It had no fulltime secretary until 1925. In that year, the Hindmarsh Square Building was to be sold, and a block of land owned by Dr. Newland bought at North Terrace at cost for $9,000

Branch membership rose rapidly during the war until a 92% membership could be claimed in 1924. In 1921, a Mr. R. Hodge had become lay secretary at £100 a year, and was appointed manager of a medical agency and insurance business to be established with the British Medical Hall Co.[14] In March, 1923, a company conducted by doctors known as the Hospital Electrical and Radium Co. Ltd. entered the field as a competitor. The directors of the B.M.H. Co. appealed to the Branch to ask the latter to discontinue, or failing that, to be allowed to retire. The B.M.A. asked the former to carry on, until they could do so themselves when they would shortly become incorporated.[15] These negotiations came to a puzzling end, as in 1925, the S.A. Branch transferred its right and interest in the medical agency to the B.M.H. Co. The Branch Council also sought a federal medical insurance agency and defnce union, along the lines of one formed by the British Medical Journal and Lancet in 1907. Later on, when the post World War 2 home of the Branch, Newland House on North Terrace, was bought at auction by the B.M.H.C. of which Sir Henry Newland was then Chairman, the condition placed on hading it over to the B.MA. was to promise to build the Memorial Hall at the back.[16] In 1958, B.M.A. Service Co. (now A.M.A. Services) took over the agency business, including insurance and locum tenens, the Branch holding 498 out of the 500 shares.

In the first world war, outstanding work was done by Sir John Verco as President for three years, and by Dr. Hone, on the Federal Committee. When the latter sought o resign in 1920, it was seen as a 'calamity'.[16] Dr. Hayward's distinguished service on the Federal Committee was recgnised by one of the earliest awards of the Gold Medal of the B.M.A. in 1924. Annual dinners became a feature of the Branch, one year a lady doctor asking that women members should not have to sit together. A Medical Sciences Club was formed in 1921 with its own journal by Professor Robertson and a Returned Medical Officers' Association as in Victoria.

The S.A. B.M.A. handled ethical problems. Among these were doctors setting up practice in someone elee's district or too close to another doctor; a scale of fees 1922; complaints by members against each other; giving anaesthetics for unregistered dentists; and, as late as 1943, the problem of some country doctors charging less than the minimum accepted fee.

The B.M.A. formed a committee in 1923 consisting of three members each, from faculty and council of the S.A.B.M.A. to arrange post-graduate courses. With two long standing Branch Councillors, Drs. Hone and Newland, on the 1926 Royal Commission on Public Health, the Branch was inevitably found to show an active interest in preventive medicine and national health policy. Two years

before, a special Branch meeting had resolved:[17]

> "while disagreeing with the necessity of any scheme of national contract practice under present Australian conditions, urges upon the government thepressing necessity of a national scheme of research in the cause of disease, for the prevention of disease, for the establishment of sanatoria and ante-natal clinics and similar measures".

Dr. Newland in 1929 proposed a Medical Association of Australia be formed to create a national policy. Dr. Hone's view was that he policy of parttime health officers had brokend down in all states.

At the Jubilee of the Branch in 1929 at the University of Adelaide, the founder's son was fittingly president Dr. J. Cobbin. Another founder gave a gift to the museum. The Branch, by this time, had subcommittees and rules for formation of sections - history of medicine as well as E.N.T., clinical and anaesthetics - the former due to the special interest of Dr. Hone.

On the State level:[18]

> "As far back as 1929, the Council approached the Government, and advocated a Ministry of Health under which the various health organisations of the state, although performing useful service as individual bodies, would become more effective by reason of their coordination. As the outcome of that deputation, the association at the request of the chief secretary of the day appointed a special committee of leading members to formulate a scheme forwarded to the Government".

The depression delayed this project, but in 1935, the Branch sent a report to the Government on the creation of a department of health together with a deputation to point out the defects of a system whereby the Chief Secretary under the 1898 Act was Minister for Health without a proper department. Health functions came under three departments, the system being inefficient and uneconomic.[19]

The B.M.A. remained on particularly close terms with Government agencies, particularly through the close liaison preserved by Dr.A.R. Southwood, Chairman of the Central Board of Health; but the Branch Secretary complained in 1941 that the Government was still not very sympathetic to reorganisation. At last the State Government in 1943 set up a special committee under Mr. Shannon M.P. to investigate how the services could best be coordinated of all organisations, official and voluntary.

The Branch had incorporated in 1935 with some 400 doctors; Local associations, as they grew, were affiliated with the B.M.A. Branch, eventually to have an annual meeting with Council as in N.S.W. It moved to its new Branch home in 1955. Outstanding Branch Councillors, as well as Drs. Hone, Newland and Hayward were Dr. Bronte Smeaton on both Federal and State Councils from 1924, as well as Drs. C. Rieger, and Dr. Mallen, presidents of the World Medical Association.

THEY, LIKE SIR HENRY NEWLAND
before them (1933-45), became Presidents of the national organisations of their day. All these men saw vast changes in medical practice, the disapperance of friendly society contract practice in favour of national voluntary insurance by 1951. All played a major part in the change.

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BRIEF HISTORY OF MEDICAL ORGANISATIONS IN QUEENSLAND TO 1945

In 1824, the N.S.W. Government founded a penal colony at Moreton Bay, six hundred miles north of Sydney. Dr. Henry Cowper was the first doctor there in 1826, Australia's first medical apprentice to Dr. Redfern in Sydney, who finished his studies in England. Free settlers were admitted in 1842. Doctors took a leading part in land settlement in towns like Ipswich on the Darling Downs, and a few years later the North Queensland coastal towns. A Dr. S. Simpson was Commissioner for Crown Lands. Doctors were also with early exploring parties - with Burke and Wills, Gregory, the search for Leichhardt.

They were among the most original pioneers of farming. Dr. Ballow, assistant colonial surgeon from 1839, remained later in private practice growing cotton. Dr. Hobbs, one of the Rev. Dr. J.D. Lang's immigrant party of 184?. exported dugong oil. Most remarkable of all was Dr. J. Bancroft, who arrived in 1864, and tackled the problem of failure of wheat crops on the Darling Downs. He grew rust free wheat in association with W. Farrer of N.S.W. (himself once a medical student) from specimens garnered from all over the world.

Doctors were usually represented in politics. Dr. Hobbs and Dr. Simpson were among the first members of the Queensland Legislative Council after separation in 1859. Dr. K. O'Doherty was for years a leading luminary of the Legislative Assembly, one of the few ex-convicts to achive political distinction. One of six Irish patriots tried for treason in 1848, he was transported to Tasmania, but practiced there on parole and studied at Hobart Hospital with Dr. E. Hall in the 1850's.

Brisbane had a hospital of sorts since inception under British Government control till 1848 - although its official status ended in 1843. Dr. Ballow was resident surgeon with no right of private practice, and managed to delay the final abdication for five years, securing a promise from the Colonial Government to donate £1 for £1 towards the project of founding a voluntary hospital, if local subscription should equal that amount. The Brisbane Benevolent Society founded 1844 came to their aid with their funds on the basis of combining the asylum function with hospital service.

For some years before Brisbane Hospital became a voluntary hospital, paying patients had been admitted. The migration of the sixties put undue pressure on the institution, and by 1879 it had divested itself of its asylum function, and moved to its

[illegible] [illegible] [illegible] [

Dr. Cannan had raised the question of chemists - either with no or with poor qualifications- prescribing drugs and often visiting patients. He proposed dispensaries. In doing so, he sowed the seeds of dissension which disrupted the society. Dr. Bancroft in 1888 said 'no agreement could be come to about certain usages; and 'the evil genius that presides over ethics again interferes'.[6] Another President, speaking from long experience in 1923, Dr. D. Cameron, remarked sadly:[7]

> "It seems strange that small differences of opinion on ethical questions should have wrecked the society, and that a number of men of such calibre could not continue to meet for discussion to their mutual advantage.
> "All through the records of the Medical Society of Queensland, and later medical associations, even up to the present time, I regret to say I find the same want of tolerance of each other's opinion and methods of ethical conduct."

In 1882, a Medical Society of Queensland was born on the inspiration of Dr. Smith and Dr. Rendle, which lasted only until the former went to England, It survived eleven months with Dr. K.L. O'Doherty as President and twentyseven members, but not long enough to use the £11.11.3 extant from 1871 to found a library. Among its members were three newer migrants to Queensland Dr. W. Taylor, Dr. C.Marks and Dr. E.S. Jackson(the latter a graduate of Melbourne). The first two became members of Parliament as well as prominent in medicine.

Dr. Taylor constantly brought forward motions that the Medical Society of Queensland should be a branch of the B.M.A., which were defeated or deferred. Members objected to subscribing to the British Medical Journal. Finally a letter was written to the B.M.A., asking if the Society could become a Branch without members taking the B.M.J. or by taking a limited number of copies. The B.M.A. refused. At its last meeting, Dr. Concannon moved that it become a branch of the B.M.A., the idea of joining the older Philosophical Society being dismissed. No record of scientific meetings were kept, if they were held. Adopting the ethics of the Victorian B.M.A. it dealt with medico-politics withconsiderable energy. A policy on the management and honorary system at Brisbane Hospital was purveyed to the Colonial Secretary, but revealed major disagreement. A draft medical bill was backed up with a circular to every member of Parliament and doctor in the colony, and a deputation to the Hon. S.W. Griffith. This resulted in amendments to the Bill in the Lower House, and referral to a select committee in the Upper House. Not all within the M.S.Q. were agreed on the reforms, the President, for example, not favouring any doctors on the Board. A Pharmacy

Board was set up with doctors. Chemists were forbidden to charge for medical advice. The question of relation of chemists to doctors had disrupted the 1871 society, and may well have contributed to the failure of the 1882 society.

An added factor was that they were also busy men. Many of them were interested in the arts, in science, and in music; and were office bearers of such societies. They were also men of strong individual personality who found it difficult to decide on a via media in an environment where the political and social life of a pioneer colony were in a state of rapid transition. They were agreed on at least one thing - of all their points of difference ethical matters were the most disruptive.

Dr. Rendle and Dr. Taylor decided to revive the M.S.Q. once more in 1886 under the presidency of that respected patriarch, Dr. Bancroft. The secretary Dr. Rendle recorded in the minutes:[8]

> "That, as the societies of 1871 and 1882 both became disorganised on consequence of the introduction of ethics and other matters not essential to the existence of a society, it was decided for the first few years of the present society that discussion should be purely scientific and that questions of ethics, legislation et cetera should not for the present be discussed at general meetings, unless they had previously been discussed and formulated in the shape of a definite resolution bya committee duly appointed for the purpose"

Moreover the press were to be banned from all meetings. Meeting in the School of Arts building, it concentrated on science, deciding to publish itsown proceedings rather than join either the B.M.A. and the Royal Society. Instead, however, it used the Australasian Medical Gazette as its official organ, this journal referring to the excellent and interesting papers.[9] By 1890, its secretary, Dr. W. Love was complaining of inertia, unwillingness to write papers, and non-payment of subscriptions. However, it discussed a committee report of its members into inebriates, the need for a University, the sale and use of poisons, registration of nurses, a medical bill and public health. One of the most outstanding members of the Queensland B.M.A. later wrote:[9]

> "It was evident some time before 1894 that the M.S.Q. was not altogether a happy family. Many of its members were men of outstanding personality, and held definite views on many subjects, views they were not slow to express. In those days, although the era of duelling was long past, quarrels were still conducted on a somewhat Homeric scale. At this date, so distant from the commencement of our history, like little Peterkin, just what they fought each other for, I cannot quite make out'."

In 1894, Dr. Bancroft died, and a contemporary said of him:[10]

> "There was no professional or scientific position of honour or trust which he had not held.. he was the recognised head of the medical profession there."

The Queensland Medico-Ethical Society was established by

the Queensland Medical Society in 1890 to deal with the vexatious field of contract practice and medical defence, and was active for three years. The latter was persuaded by a persistent member into a scale of fees in 1890 similar to that in Victoria and N.S.W.

The Queensland Medico-Ethical Society arose from a special meeting to consider a member distributing circulars, a scale of fees, and the action of the Friendly Society Dispensary in calling for tenders. It sent a circular to all other Australian medical societies to help in their stand against friendly societies and reduced conditions for doctors under contract to them, particularly at Institutes. It produced a brochure of social reform for all parliamentary candidates. It castigated the Medical Act as ' a useless piece of legislation' while the Health Act gave 'no executive power'.[11] It disappeared with the foundation of the Queensland Medical Association Jan.12, 1893, which became the Queensland B.M.A. in 1894.

In the meantime, a Maryborough Medical Society existed April 1888. A Rockhampton Medical Society was founded by Dr. Voss in 1890, and North Queensland Medical Society December 1889 in Townsville with Dr. Van Someren as secretary, lapsing when he left for Orange in 1891. The meetings of the latter alternated between Charters Towers and Townsville. At the first annual address, Dr.G. Browne painted a frightening picture of sanitation in Charters Towers and the supineness of municipal authorities in North Queensland on sanitary reform. Dr. J. Ahearne in Townsville surveyed the effect of residence in North Queensland on Europeans. An Ipswich Medical Society appeared before 1899.

The Queensland Medical Association, formed 1894, was the result of a visit from Dr. A.L.Kenny of Melbourne who sought a Queensland B.M.A. Branch. Three of the first thirty two members already belonged to the B.M.A. - the first President, the Hon. W.F. Taylor, and secretary, Dr. Peter Bancroft. Most of the members already belonged to the Queensland Medical Society, which remained the stronger group until they merged in 1900. The same membership was in both. As Dr. Meyers later said, it says much for the energy and keenness of the medical men of those days that they were able to keep two medical societies going for a period of six years.

The Queensland Medical Association was converted into the Queensland B.M.A. Branch May 30, 1894, in a more imposing manner than any other Australian Branch. The Governor and a large representative gathering of medical, scientific and political

[illegible] Nearly one third of the members were Australian born, [illegible] the Treasurer and Secretary, Dr. Duck [illegible] and Dr. E. Bancroft were both Australian educated.

The new society gave a sum of £7 to Dr.Bancroft in 1900 to study filaria embryophila, claiming that as "the first time a medical society in Australia had given money for scientific investigation." As in other states, the B.M.A. was preoccupied with out-browning Indoors, hospital charges, medical registration, low payment by Government for services such as lunacy and post-mortems, public health, facilities for training nurses, the insanitary condition of the capital, plumbing, deficiencies of the Health Act, the need for a Ministry of Health and a medical school. During the years 1894-1900, the coexistence of the B.M.A. Branch with the Queensland Medical Society led to several mutual deputations to the Government on questions such as T.B. and asylums. In 1899, Dr.W.F. Taylor became President for the occasion of the Intercolonial Medical Congress in Brisbane that year, which emphasised the absurdity of two societies in a city the size of Brisbane. The initiative to amalgamate came from the B.M.A. May 1899, being endorsed by both, effective from Jan.1, 1900. The Branch entered 1900 with a membership of 168, its annual report stating:[12]

> "it is well known that most of the credit at this juncture is due to the exertions of our President, Dr. Taylor."... "it has been the opinion of the members of the Branch that one scientific medical society was quite sufficient for all local requirements; also, that the interests of the profession were disturbed by the division of our forces, and where the voice of the profession in dealing with public affairs was desired that one society could speak and carry more weight than two."

Dr. Taylor was also responsible for launching the Medical Defence Society of Queensland, almost [illegible] advocated by the 1892 Congress for all states -- to deal with law suits for negligence etc.

The B.M.A. campaigned against adulterated liquor and foodstuffs including milk; and for uniform quality of medical advertising. Dr. Taylor in 1900 [illegible] to the question of [illegible] in the chase of advertisements [illegible] cure for [illegible]".[13] [illegible] is labelled as in France. The B.M.A. [illegible] deficiencies of children and [illegible] to the [illegible]

discovery by Drs. A. Jefferis Turner and Dr. J. Lockhart Gibson (on an observation by Dr. Hopkins) of the association of lead poisoning from flaking paint on verandah railings and nephritis in children.

The Branch formed a pathological committee, and in 1910 asked the Commissioner of Public Health for a fully equipped laboratory with a doctor in charge, which was granted, and housed pathological specimens of the Branch. Another deputation asked for systematic operations against mosquitoes in view of the prevalence of filariasis and future risks from yellow fever, which they dreaded might be yet imported from infested countries.[14]

A tradition of close cooperation between the Commissioner of Public Health and the B.M.A. began in these years, which was called into action in crisis eight times in the first decade with epidemic situations including dengue 1904-5, leading to a B.M.A. committee on the subject. Dr. J. Elkington, who became Commissioner of Public Health in 1910, was invited to read papers before the BM.A., and was elected to the B.M.A. Council 1911-13. He was already well known for his work in Tasmania, particularly during a smallpox epidemic in that state.

The B.M.A. enlisted the support of their medical governor, Sir William McGregor, an honorary member of the Branch, and former lieutenant-governor in New Guinea. He had several tours of duty in tropical countries to his credit, and attended a B.M.A. public meeting in 1911 in support of active steps towards mosquito destruction. The B.M.A. welcomed the first director of the Townsville institute founded to study tropic diseases, on the urging of Bishop Frodsham of North Queensland, Dr. Anton Breinl with a special meeting Dec.9, 1910. He pointed out that' tropical Australia affords a unique opportunity for studying the adaptability of the white race to tropical climate and conditions.'[15] The 1920 Australasian Medical Congress held in Brisbane 1920 affirmed overwhelmingly that the white race could colonise the tropics without loss of longevity, mentality, fertility health or physique.

In 1909, the Queensland B.M.A. established an organising committee as membership was too low, mainly due to lack of a home. Dr. Brockway, secretary from 1900-9,had performed prodigies in maintaining the Branch, winning tribute from a later President for 'the manner in which he kept the Branch and Library together in spite of many buffetings from place to place. His work was carried out under difficulties as the Branch had no fixed abode.'[16] Dr. Robertson, returned from the south impressed with the advantage of having premises, and founded the Medical Land Investment Co. with the B.M.A. holding some shares; a limited

liability company with a plan for a three storey building on land that had become available.

The President , Dr. F. W. Harlin, in 1910 suggested a circulating library as a means to coopt new graduates, the incorporation of medical defence with the B.MA., a medical agency and a paid organiser. Dr. Robertson even proposed in 1912 that interstate branches cooperate with Queensland to appoint a medical man as organiser ' to canvass every reputable practitioner in Australia so that complete cooperation may be obtained in all matters affecting the standing and interests of the profession. Replies were received from other branches approving the idea in principle, but nothing came of it. In 1913, a fulltime secretary, and organiser, Mr. Williams was employed, who had organised for the Victoria Branch. The 1914 report was enthusiastic about his success.

When the Federal Committee was launched in 1912, the Queensland Branch was more reserved in its support than some branches. A Dr. J. Thomson voiced this reluctance:[17]

> "The Branch should go slow before handing over important functions to a body which would consist chief of members of southern branches who might not all understand the conditions prevailing in Queensland".

Dr. Robertson, one of Queensland's first E.N.T. surgeons, was, however, by the distinction of his personality and intellect, to ensure for many years that Queensland's interests were not overshadowed. He was sixteen years on the Federal Committee, and Vice-Chairman for some years, being finally supremely honoured by being elected vice president of the B.M.A. Parent Council at its Melbourne meeting 1935. He was a director, and from 1923-9 chairman of directors of the A.M.P. Co. On foundation of the University of Queensland he was a senate member, and twelve years vice-chancellor.

The Queensland Branch itself was not always in harmony. Council reported in 1914:[18]

> "It is not infrequently difficult, or impossible, for the Council to fully meet the request of the member or members invoking their assistance either from conflicting local interests or opinions, or froma consideration of the effect of local action on the general policy of the association in Australia."

Dr. Butler complainedin 1912 that the clinical aspect of Branch meetings was far from satisfactory despite considerable efforts. Special meetings at Brisbane General Hospital had been tried and abandoned, but were resumed during the war. In 1914 the Council on the initiative of some members appointed a semi-official representative or correspondent in each town or centre 'to keep in touch with the feeling of the townor district' both for the Branch and the M.J.A. and to interview new doctors.

In 1917, the Branch drafted new rules based on the N.S.W. Branch, including advertising. With the outbreak of war, in 1914, the Branch cooperated in every aspect including circularising members as to whether they would agree to conscription in 1917. This referendum was overwhelmingly in favour/11 to 19 against. A special fund was established to support a 'yes' vote at the National Conscription Referendum. In 1917 in view of the harm brought from alcohol to the troops, a deputation pressed for legislation/to introduce prohibition; a referendum in 1920 still strongly in favour. A less commendable aspect of war zeal was the Branch proceeding against a German doctor to have him deported from the country, though once a B.M.A. Council and Medical Board member. Two other doctors of German origin fared a little better.

The Council had an active hospital sub-committee from a time of crisis at the Brisbane General in 1917. By 1921, it reported a considerable part of its time to be occupied with matters where its intervention was requested, particularly in respect of country hospitals:[18]

> "the assistance and advice of the Council has, indeed, on several occasions been solicited by hospital committees and others with a view to a satisfactory solution of difficulties."

Disputes occurred in twentyfour towns in 1922, and model rules for medical officers were drawn up. The Branch post-war also approved an advisory Board to the Government on hospital management to combine university, hospital and B.M.A. members with the possible function of approving honorary and resident staff appointments.

In 1923, the B.M.A. President deplored that none of the medical men at the head of state instrumentalities were B.M.A. members - namely Public Health, the Registration Board, Lunacy or the Federal Quarantine service, and were therefore out of touch with the profession. A Public Health subcommittee appointed 1922 sought a monthly meeting with the Commissioner, and the Branch affiliated with the Public Health Association. In 1923 a publicity subcommittee sought to educate the public on such public health issues as infantile diarrhoea. Both committees campaigned together over the question of a medical officer of health for Greater Brisbane in 1925. In 1924, a Brisbane General Hospital Clinical Society proposed a department of normal and morbid anatomy in association with the hospital, and the Branch secured approval from the Home Secretary. The museum specimens of the Branch were moved to the hospital pathological museum. Moving spirit was Dr.E.S. Meyers who was first to teach

anatomy at the Dental College, first to organise a post-graduate course, and became the first licensed teacher under the Medical Act of 1925, which provided for anatomical research - at a time when he was B.M.A. Branch Secretary. Together with Dr. J.V. Duhig, ~~Professor E.J. Goddard~~ PROFESSOR E.T. GODDARD [PROFESSOR OF BIOLOGY] AND leading B.M.A. members, he worked unremittingly for ten years to secure a medical school in the University of Queensland (its costs having been investigated as early as 1920). Labor Party Premier Mr. Forgan Smith agreed on the argument that only the sons of the rich could afford to go south for degrees, and on condition that it devoted particular attention to tropical diseases of men and animals and medico-social aspects.

The Branch, incorporated in 1926, did not acquire a new home on Wickham Terrace or medical agency business for another ten years. Meantime, special sections were founded, one of the first being surgical in 1927. Local associations increased, first on the Downs 1927, soon fifteen of them with representatives on Council. Eight were founded in the year 1926-7. The Branch weathered a major crisis with the friendly societies in 1928, and a Royal Commission on Hospitals in 1930. The course of Branch history diverged considerably from that of other branches during this decade 1928-38. Queensland had had a continuous Labour Government from the First World War 1 of which a historian has written:[19]

> ""The Labour movement in Queensland differed from that of other colonies in that it was decidedly and definitely socialistic from the jump."

Sir Raphael Cilento did little to allay B.M.A. fears of Socialisation of medicine, when he sent a circular to all doctors in Queensland in 1938, stating his purpose was to achieve better cooperation between state, public and profession: adding 'health being a national problem and an economic problem must be nationalised and rationalised'.[20] He asked doctors whether they would 'enrol with the Dept of Health and Home Affairs in Queensland ' subject to conditions of service being approved by the Branch. To which the B.M.A. President, Dr. R. Quinn gave reply that the BM.A. had been vainly trying for two or three years to effect the cooperation of which Sir Raphael spoke:[21]

> "Can he assure us that the persistent attitude of suspicion and obstruction hitherto manifested towards our profession by not only the present but past governments will be in any way abated?"

The issue remained unresolved due to the outbreak of war. By the end of the war, Sir R. Cilento had left the department. Health services had moved into the Commonwealth domain. The opposition of principle moved into the open forum of conferences with Parliamentary committees of enquiry - though, after basic

issues were settled, and the Commonwealth adopted a voluntary insurance scheme of national health, Queensland still persisted with a policy reflecting the dominance of Labour ideals in its free hospital bed system when other states, for financial reasons, abandoned it.

The B.M.A. Branch had joined the Labour Government in some innovations. The Brisbane General Hospital was the first in Australia to abandon the honorary system. The State was the first to make a compulsory provision for twelve months' residence in hospital before registration. It was given official representation on the Medical Board with three of seven members in 1934, and one assessor on the Medical Assessment Tribunal in 1939. It agreed to the specialist register in 1940.

Because of its unique conditions and isolation, the Queensland Branch had led in proposing autonomy and independence, in ideas for adopting policies to Australian conditions. Two Queensland members were honoured as vice-presidents of sections of the B.M.A. Centenary meeting in London in 1932, Dr. A Breinl and Dr. R.G. Broan. Dr. A.H.Lee was given the Fellowship of the B.M.A. by the Parent Council on Branch recommendation, in honour of twentyone years service on Branch Council and eighteen years as Federal Council representative. He also became founder of the Medical Benefits Fund in Queensland 1950 and president of its executive committee.

The Branch had called for an Australian representative body in 1932, and an Australian Medical Association in 1938. It revived the idea of a Commonwealth Health Insurance office in 1935. The stimulus of the Branch in Federal B.M.A. politicis was at all times felt.

BRIEF HISTORY OF MEDICAL ORGANISATIONS IN WESTERN AUSTRALIA TO 1[illegible]

The first settlement was in 1826 at King George's Sound- a shortlived penal settlement under Major Lockyer sent with some soldiers and convicts from Sydney. A Dr. Scott Nind was with the party. His studies of aborigines were among the earliest papers submitted to the Royal Geographical Society founded in London 1830. When Governor Captain Stirling was sent with free settlers to the Swan River in 1829, he carried doctors with him- army and naval surgeons though not a convict settlement. Dr. Charles Simmons as Colonial Surgeon built the first colonial hospital on Garden Island June 1829, while Dr. Milligan put up a marquee on the site of Perth. The first doctor in private practice was Dr. T. Harrison in Fremantle. The second Colonial Surgeon Dr. A. Collis was a famous naturalist, having been aboard H.M.S. Blossom in a scientific trip round the world.

The colony did not recover from the hazards of settlement in a hinterland area so remote from any other settlement, being neither so prosperous nor with such good harbours as New South Wales or Victoria. Medical attention was difficult to obtain at any time, except from the small number of medical men turned farmers and landowners.[1] The colony was depressed for some time, until the introduction of convict labour. IN 1850 ~~Shortly after~~ A medical Governor was appointed IN 1862 Governor Hampton AND REMAINED SIX YEARS. ~~1862-8~~. From Surgeon Superintendent on a convict transport to Tasmania, 1843, he became Comptroller of Convicts there, and introduced many land reforms. His term in W.A. saw vigorous public building, half the Legislative Council elective from 1867, pioneering development in the far north-west of the state, and the end of transportation in 1868. He left the colony for the first time without a deficit.

In 1869, the first act to regulate registration of doctors was passed, and the first medical board appointed. One of its original members was Dr. A. Waylen, Australian born son of one of the first emigrant doctors, drowned in the River Swan. He became Colonial Surgeon 1872-95.[2]

The goldrushes to the Kimberleys 1885-6, followed by those inland to Kalgoorlie and Coolgardie in the 1890's, gave impetus to immigration and inland settlement. A Dr. Lovegrove, who came in 1868, as ship's surgeon, and then took a job as Resident Medical Officer in the south at Bunbury, became Government Resident Chairman of the Quarter Session and Warden of Kimberley Goldfields. Other doctors played similar roles like Dr. Black in Southern Cross, Mayor 1892 and later magistrate.

Some of the worst hostility engendered in that dispute was directed against Dr. Ramsay Smith who had joined the hospital staff after the B.M.A. honorary staff resigned. Despite considerable prejudice against him by B.M.A. members, and charges of incompetence during his office, he had very high qualifications as surgeon to the Admiralty in Scotland, examiner for the Royal College of Physicians in Edinburgh, and its counterpartin Glasgow. The issue of homeopathy undoubtedly influenced some of the attitudes and antagonisms of that affair- by no means least that of the Premier himself. Sir John Verco in retrospect gave a view recorded by Dr. Lendon:[11]

> "Talking the matter over many years after with me, he agreed that, although our attitude was ethically correct, the course of resistance we adopted was a blunder, which was almost bound to fail".

The effect was that the clinical teaching of the medical school came to a standstill. Students had to go interstate with a loss to the state of men like Sir Charles Bickerton Blackburn who made his career in N.S.W. After the dispute was settled, and the B.M.A. Branch ceased to boycott the Adelaide Hospital, the branch was handicapped in its liaison with the Government by the Kingston' Government's appointment of Dr. Ramsay Smith in 1899 to take charge of the Dept of Public Health under the new Act. Public vendettas continued for some years.

In 1913, Dr. Hone of the Branch Council was to boast that the Government was now more cooperative, and consulted the branch before legislation such as the mental bill.[12] The annual general meeting of the S.A. Branch in 1911 on the motion of Dr.W' Hayward made the first move for the first federal organisation of doctors in Australia - a new Federal B.M.A. Committee to deal with contract practice, hospital abuse and medical defence as urged in the 1908 Adelaide Conference; for an organisation to speak nationally and unitedly and lead public opinion on public questions such as national control of consumption, treatment of the insane and feeble-minded, the questions of eugenics, venereal disease and uniform registration.

The Branch had variously met in the Adelaide Hospital boardroom the outpatient waiting room, later the University. Dr. Haywrad in 1911 secured a home for the S.A. Branch, a company being formed known as the British Medical Hall Co. Ltd. The first annual meeting was heldin the new building 1914. Many members, who purchased shares, later gave them to the Branch. It had no fulltime secretary until 1925. In that year, the Hindmarsh Square Building was to be sold, and a block of land owned by Dr. Newland bought at North Terrace at cost for $9,000

before, a special Branch meeting had resolved:[17]

> "while disagreeing with the necessity of any scheme of national contract practice under present Australian conditions, urges upon the government thepressing necessity of a national scheme of research in the cause of disease, for the prevention of disease, for the establishment of sanatoria and ante-natal clinics and similar measures".

Dr. Newland in 1929 proposed a Medical Association of Australia be formed to create a national policy. Dr. Hone's view was that he policy of parttime health officers had brokend down in all states.

At the Jubilee of the Branch in 1929 at the University of Adelaide, the founder's son was fittingly president Dr. J. Cobbin. Another founder gave a gift to the mseum. The Branch, by this time, had subcommittees and rules for formation of sections - history of medicine as well as E.N.T., clinical and anaesthetics - the former due to the special interest of Dr. Hone.

On the State level:[18]

> "As far back as 1929, the Council approached the Government, and advocated a Ministry of Health under which the various health organisations of the state, although performing useful service as individual bodies, would become more effective by reason of their coordination. As the outcome of that deputation, the association at the request of the chief secretary of the day appointed a special committee of leading members to formulate a scheme forwarded to the Government".

The depression delayed this project, but in 1935, the Branch sent a report to the Government on the creation of a department of health together with a deputation to point out the defects of a system whereby the Chief Secretary under the 1898 Act was Minister for Health without a proper department. Health functions came under three departments, the system being inefficient and uneconomic.[19]

The B.M.A. remained on particularly close terms with Government agencies, particularly through the close liaison preserved by Dr.A.R. Southwood, Chairman of the Central Board of Health; but the Branch Secretary complained in 1941 that the Government was still not very sympathetic to reorganisation. At last the State Government in 1943 set up a special committee under Mr. Shannon M.P. to investigate how the services could best be coordinated of all organisations, official and voluntary.

The Branch had incorporated in 1935 with some 400 doctors; Local associations, as they grew, were affiliated with the B.M.A. Branch, eventually to have an annual meeting with Council as in N.S.W. It moved to its new Branch home in 1955. Outstanding Branch Councillors, as well as Drs. Hone, Newland and Hayward were Dr. Bronte Smeaton on both Federal and State Councils from 1924, as well as Drs. C. Rieger, and Dr. Mallen, presidents of the World Medical Association.

THEY, LIKE SIR HENRY WELLCOME
before them (1933-45) became Presidents of the national organisations of their day. All these men saw vast changes in medical practice, the disapperance of friendly society contract practice in favour of national voluntary insurance by 1951. All played a major part in the change.

.....

(d) ~~BRIEF~~ HISTORY OF MEDICAL ORGANISATIONS IN QUEENSLAND TO 1945

In 1824, the N.S.W. Government founded a penal colony at Moreton Bay, six hundred miles north of Sydney. Dr. Henry Cowper was the first doctor there in 1826, Australia's first medical apprentice to Dr. Redfern in Sydney, who finished his studies in England. Free settlers were admitted in 1842. Doctors took a leading part in land settlement in towns like Ipswich on the Darling Downs, and a few years later the North Queensland coastal towns. A Dr. S. Simpson was Commissioner for Crown Lands. Doctors were also with early exploring parties - with Burke and Wills, Gregory, the search for Leichhardt.

They were among the most original pioneers of farming. Dr. Ballow, assistant colonial surgeon from 1839, remained later in private practice growing cotton. Dr. Hobbs, one of the Rev. Dr. J.D. Lang's immigrant party of 184?. exported dugong oil. Most remarkable of all was Dr. J. Bancroft, who arrived in 1864, and tackled the problem of failure of wheat crops on the Darling Downs. He grew rust free wheat in association with W. Farrer of N.S.W. (himself once a medical student) from specimens garnered from all over the world.

Doctors were usually represented in politics. Dr. Hobbs and Dr. Simpson were among the first members of the Queensland Legislative Council after separation in 1859. Dr. K. O'Doherty was for years a leading luminary of the Legislative Assembly, one of the few ex-convicts to achieve political distinction. One of six Irish patriots tried for treason in 1848, he was transported to Tasmania, but practiced there on parole and studied at Hobart Hospital with Dr. E. Hall in the 1850's.

Brisbane had a hospital of sorts since inception under British Government control till 1848 - although its official status ended in 1843. Dr. Ballow was resident surgeon with no right of private practice, and managed to delay the final abdication for five years, securing a promise from the Colonial Government to donate £1 for £1 towards the project of founding a voluntary hospital, if local subscription should equal that amount. The Brisbane Benevolent Society founded 1844 came to their aid with their funds on the basis of combining the asylum function with hospital service.

For some years before Brisbane Hospital became a voluntary hospital, paying patients had been admitted. The migration of the sixties put undue pressure on the institution, and by 1879 it had divested itself of its asylum function, and moved to its

[illegible] [illegible] [illegible] [

THE SOCIETY DID NOT PROMOTE THE FRIENDLY FEELINGS HOPED FOR.

Dr. Cannan had raised the question of chemists - either with no or with poor qualifications- prescribing drugs and often visiting patients. He proposed dispensaries. In doing so, he sowed the seeds of dissension which disrupted the society. Dr. Bancroft in 1888 said 'no agreement could be come to about certain usages; and 'the evil genius that presides over ethics again interferes'.[6] Another President, speaking from long experience in 1923, Dr. D. Cameron, remarked sadly:[7]

> "It seems strange that small differences of opinion on ethical questions should have wrecked the society, and that a number of men of such calibre could not continue to meet for discussion to their mutual advantage.
> "All through the records of the Medical Society of Queensland, and later medical associations, even up to the present time, I regret to say I find the same want of tolerance of each other's opinion and methods of ethical conduct."

In 1882, a Medical Society of Queensland was born on the inspiration of Dr. Smith and Dr. Rendle, which lasted only until the former went to England, It survived eleven months with Dr. K.L. O'Doherty as President and twentyseven members, but not long enough to use the £11.11.3 extant from 1871 to found a library. Among its members were three newer migrants to Queensland Dr. W. Taylor, Dr. C.Marks and Dr. E.S. Jackson(the latter a graduate of Melbourne). The first two became members of Parliament as well as prominent in medicine.

Dr. Taylor constantly brought forward motions that the Medical Society of Queensland should be a branch of the B.M.A., which were defeated or deferred. Members objected to subscribing to the British Medical Journal. Finally a letter was written to the B.M.A., asking if the Society could become a Branch without members taking the B.M.J. or by taking a limited number of copies. The B.M.A. refused. At its last meeting, Dr. Concannon moved that it become abranch of the B.M.A., the idea of joining the older Philosophical Society being dismissed. No record of scientific meetings were kept, if they were held. Adopting the ethics of the Victorian B.M.A. it dealt with medico-politics withconsiderable energy. A policy on the management and honorary system at Brisbane Hospital was purveyed to the Colonial Secretary, but revealed major disagreement. A draft medical bill was backed up with a circular to every member of Parliament and doctor in the colony, and a deputation to the Hon. S.W. Griffith. This resulted in amendments to the Bill in the Lower House, and referral to a select committee in the Upper House. Not all within the M.S.Q. were agreeon the reforms, the President, for example, not favouring any doctors on the Board. A Pharmacy

Board was set up with doctors. Chemists were forbidden to charge for medical advice. The question of relation of chemists to doctors had disrupted the 1871 society, and may well have contributed to the failure of the 1882 society.

An added factor was that they were also busy men. Many of them were interested in the arts, in science, and in music; and were office bearers of such societies. They were also men of strong individual personality who found it difficult to decide on a via media in an environment where the political and social life of a pioneer colony were in a state of rapid transition. They were agreed on at least one thing - of all their points of difference ethical matters were the most disruptive.

Dr. Rendle and Dr. Taylor decided to revive the M.S.Q. once more in 1886 under the presidency of that respected patriarch, Dr. Bancroft. The secretary Dr. Rendle recorded in the minutes:[8]

> "That, as the societies of 1871 and 1882 both became disorganised on consequence of the introduction of ethics and other matters not essential to the existence of a society, it was decided for the first few years of the present society that discussion should be purely scientific and that questions of ethics, legislation et cetera should not for the present be discussed at general meetings, unless they had previously been discussed and formulated in the shape of a definite resolution bya committee duly appointed for the purpose"

Moreover the press were to be banned from all meetings. Meeting in the School of Arts building, it concentrated on science, deciding to publish itsown proceedings rather than join either the B.M.A. and the Royal Society. Instead, however, it used the Australasian Medical Gazette as its official organ, this journal referring to the excellent and interesting papers.[9] By 1890, its secretary, Dr. W. Love was complaining of inertia, unwillingness to write papers, and non-payment of subscriptions. However, it discussed a committee report of its members into inebriates, the need for a University, the sale and use of poisons, registration of nurses, a medical bill and public health. One of the most outstanding members of the Queensland B.M.A. later wrote:[9]

> "It was evident some time before 1894 that the M.S.Q. was not altogether a happy family. Many of its members were men of outstanding personality, and held definite views on many subjects, views they were not slow to express. In those days, although the era of duelling was long past, quarrels were still conducted on a somewhat Homeric scale. At this date, so distant from the commencement of our history, like little Peterkin, just what they fought each other for, I cannot quite make out'."

In 1894, Dr. Bancroft died, and a contemporary said of him:[10]

> "There was no professional or scientific position of honour or trust which he had not held.. he was the recognised head of the medical profession there."

The Queensland Medico-Ethical Society was established by

the Queensland Medical Society in 1890 to deal with the vexatious field of contract practice and medical defence, and was active for three years. The latter was persuaded by a persistent member into a scale of fees in 1890 similar to that in Victoria and N.S.W.

The Queensland Medico-Ethical Society arose from a special meeting to consider a member distributing circulars, a scale of fees, and the action of the Friendly Society Dispensary in calling for tenders. It sent a circular to all other Australian medical societies to help in their stand against friendly societies and reduced conditions for doctors under contract to them, particularly at Institutes. It produced a brochure of social reform for all parliamentary candidates. It castigated the Medical Act as ' a useless piece of legislation' while the Health Act gave 'no executive power'.[11] It disappeared with the foundation of the Queensland Medical Association Jan.12, 1893, which became the Queensland B.M.A. in 1894.

In the meantime, a Maryborough Medical Society existed April 1888. A Rockhampton Medical Society was founded by Dr. Voss in 1890, and North Queensland Medical Society December 1889 in Townsville with Dr. Van Someren as secretary, lapsing when he left for Orange in 1891. The meetings of the latter alternated between Charters Towers and Townsville. At the first annual address, Dr.G. Browne painted a frightening picture of sanitation in Charters Towers and the supineness of municipal authorities in North Queensland on sanitary reform. Dr. J. Ahearne in Townsville surveyed the effect of residence in North Queensland on Europeans. An Ipswich Medical Society appeared before 1899.

The Queensland Medical Association, formed 1894, was the result of a visit from Dr. A.L.Kenny of Melbourne who sought a Queensland B.M.A. Branch. Three of the first thirty two members already belonged to the B.M.A. - the first President, the Hon. W.F. Taylor, and secretary, Dr. Peter Bancroft. Most of the members already belonged to the Queensland Medical Society, which remained the stronger group until they merged in 1900. The same membership was in both. As Dr. Meyers later said, it says much for the energy and keenness of the medical men of those days that they were able to keep two medical societies going for a period of six years.

The Queensland Medical Association was converted into the Queensland B.M.A. Branch May 30, 1894, in a more imposing manner than any other Australian Branch. The Governor and a large representative gathering of medical, scientific and political

gentlemen attended. There was a musical program and an ode specially written for the occasion by Brunton Stephens, set to music by Professor Allen and sung by five medical men. Nearly one third of the members were Australian born, while the Treasurer and Secretary, Dr. Jackson and Dr. P. Bancroft were both Australian graduated.

The new society gave a sum of £7 to Dr.Bancroft in 1900 to study filaria metamorphosis, claiming this as the first time a medical society in Australia had given money for scientific investigation. As in other states, the B.M.A. was preoccupied with mushrooming lodges , hospital abuse, medical registration, low payment by Government for services such as inquests and post-mortems, public health , facilities for training nurses, the insanitary condition of the capital, plague, deficiences of the Health Act, the need for a Ministry of Health and a medical school. During the years 1894-1900, the cooexistence of the B.M.A. Branch with the Queensland Medical Society led to several mutual deputations to the Government on questions such as T.B. and asylums. In 1899, Dr.W.F. Taylor became President for the occasion of the Intercolonial Medical Congress in Brisbane that year, which emphasised the absurdity of two societies in a city the size of Brisbane. The initiative to amalgamate came from the B.M.A. May 1899, being endorsed by both, effective from Jan.1, 1900. The Branch entered 1900 with a membership of 108, its annual report stating:[12]

> "it is well known that most of the credit at this juncture is due to the exertions of our President, Dr. Taylor.".. "it has been the opinion of many members of the Branch that one scientific medical society was quite sufficient for all local requirements; also, that the interests of the profession were diminished by the division of our forces, and where the voice of the profession in dealing with public affairs was desired that one society could speak and carry moreweight than two."

Dr. Taylor was also responsible for launching the Medical Defence Society of Queensland, along lines advocated by the 1899 Congress for all states - to deal with law suits for negligence etc.

The B.M.A. campaigned against adulterated liquors and foodstuffs including milk; and to enforce control of medical advertising. Dr. Taylor in 1900 complained that 'incentives to the commission of abortion are daily published in the press in the shape of advertisements of patent medicine guaranteed to cure female irregularities'.[13] He urged that medicines should be labelled as in France. The B.M.A. supported compulsory notification of phthisis and V.D.; exploited the 1900 bubonic plague to bring sanitary reform; and backed the impressive

discovery by Drs. A. Jefferis Turner and Dr. J. Lockhart Gibson (on an observation by Dr. Hopkins) of the association of lead poisoning from flaking paint on verandah railings and nephritis in children.

The Branch formed a pathological committee, and in 1910 asked the Commissioner of Public Health for a fully equipped laboratory with a doctor in charge, which was granted, and housed pathological specimens of the Branch. Another deputation asked for systematic operations against mosquitoes in view of the prevalence of filariasis and future risks from yellow fever, which they dreaded might be yet imported from infested countries.[14]

A tradition of close cooperation between the Commissioner of Public Health and the B.M.A. began in these years, which was called into action in crisis eight times in the first decade with epidemic situations including dengue 1904-5, leading to a B.M.A. committee on the subject. Dr. J. Elkington, who became Commissioner of Public Health in 1910, was invited to read papers before the BM.A., and was elected to the B.M.A. Council 1911-13. He was already well known for his work in Tasmania, particularly during a smallpox epidemic in that state.

The B.M.A. enlisted the support of their medical governor, Sir William McGregor, an honorary member of the Branch, and former lieutenant-governor in New Guinea. He had several tours of duty in tropical countries to his credit, and attended a B.M.A. public meeting in 1911 in support of active steps towards mosquito destruction. The B.M.A. welcomed the first director of the Townsville institute founded to study tropic diseases, on the urging of Bishop Frodsham of North Queensland, Dr. Anton Breinl with a special meeting Dec.9, 1910. He pointed out that' tropical Australia affords a unique opportunity for studying the adaptability of the white race to tropical climate and conditions.'[15] The 1920 Australasian Medical Congress held in Brisbane 1920 affirmed overwhelmingly that the white race could colonise the tropics without loss of longevity, mentality, fertility health or physique.

In 1909, the Queensland B.M.A. established an organising committee as membership was too low, mainly due to lack of a home. Dr. Brockway, secretary from 1900-9,had performed prodigies in maintaining the Branch, winning tribute from a later President for 'the manner in which he kept the Branch and Library together in spite of many buffetings from place to place. His work was carried out under difficulties as the Branch had no fixed abode.'[16] Dr. Robertson, returned from the south impressed with the advantage of having premises, and founded the Medical Land Investment Co. with the B.M.A. holding some shares; a limited

liability company with a plan for a three storey building on land that had become available.

The President , Dr. F. W. Harlin, in 1910 suggested a circulating library as a means to coopt new graduates, the incorporation of medical defence with the B.MA., a medical agency and a paid organiser. Dr. Robertson even proposed in 1912 that interstate branches cooperate with Queensland to appoint a medical man as organiser to canvass every reputable practitioner in Australia so that complete cooperation may be obtained in all matters affecting the standing and interests of the profession. Replies were received from other branches approving the idea in principle, but nothing came of it. In 1913, a fulltime secretary, and organiser, Mr. Williams was employed, who had organised for the Victoria Branch. The 1914 report was enthusiasti about his success.

When the Federal Committee was launched in 1912, the Queenslan Branch was more reserved in its support than some branches. A Dr. J. Thomson voiced this reluctance:[17]

> "The Branch should go slow before handing over important functions to a body which would consist chief of members of southern branches who might not all understand the conditions prevailing in Queensland".

Dr. Robertson, one of Queensland's first E.N.T. surgeons, was, however, by the distinction of his personality and intellect, to ensure for many years that Queensland's interests were not overshadowed. He was sixteen years on the Federal Committee, and Vice-Chairman for some years, being finally supremely honoured by being elected vice president of the B.M.A. Parent Council at its Melbourne meeting 1935. He was a director, and from 1923-9 chairman of directors of the A.M.P. Co. On foundation of the University of Queensland he was a senate member, and twelve years vice-chancellor.

The Queensland Branch itself was not always in harmony. Council reported in 1914:[18]

> "It is not infrequently difficult, or impossible, for the Council to fully meet the request of the member or members invoking their assistance either from conflicting local interests or opinions, or froma consideration of the effect of local action on the general policy of the association in Australia."

Dr. Butler complainedin 1912 that the clinical aspect of Branch meetings was far from satisfactory despite considerable efforts. Special meetings at Brisbane General Hospital had been tried and abandoned, but were resumed during the war. In 1914 the Council on the initiative of some members appointed a semi-official representative or correspondent in each town or centre 'to keep in touch with the feeling of the townor district' both for the Branch and the M.J.A. and to interview new doctors,

In 1917, the Branch drafted new rules based on the N.S.W. Branch, including advertising. With the outbreak of war, in 1914, the Branch cooperated in every aspect including circularising members as to whether they would agree to conscription in 1917. This referendum was overwhelmingly in favour/11 to 19 against. A special fund was established to support a 'yes' vote at the National Conscription Referendum. In 1917 in view of the harm brought from alcohol to the troops, a deputation pressed for legislation/o introduce prohibition: a referendum in 1920 still strongly in favour. A less commendable aspect of war zeal was the Branch proceeding against a German doctor to have him deported from the country, though once a B.M.A. Council and Medical Board member. Two other doctors of German origin fared a little better.

The Council had an active hospital sub-committee from a time of crisis at the Brisbane General in 1917. By 1921, it reported a considerable part of its time to be occupied with matters where its intervention was requested, particularly in respect of country hospitals:[18]

> "the assistance and advice of the Council has, indeed, on several occasions been solicited by hospital committees and others with a view to a satisfactory solution of difficulties."

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The Branch, incorporated in 1926, did not acquire a new home on Wickham Terrace or medical agency business for another ten years. Meantime, special sections were founded, one of the first being surgical in 1927. Local associations increased, first on the Downs 1927, soon fifteen of them with representatives on Council. Eight were founded in the year 1926-7. The Branch weathered a major crisis with the friendly societies in 1928, and a Royal Commission on Hospitals in 1930. The course of Branch history diverged considerably from that of other branches during this decade 1928-38. Queensland had had a continuous Labour Government from the First World War 1 of which a historian has written:[19]

> ""The Labour movement in Queensland differed from that of other colonies in that it was decidedly and definitely socialistic from the jump."

Sir Raphael Cilento did little to allay B.M.A. fears of Socialisation of medicine, when he sent a circular to all doctors in Queensland in 1938, stating his purpose was to achieve better cooperation between state, public and profession: adding 'health being a national problem and an economic problem must be nationalised and rationalised'.[20] He asked doctors whether they would 'enrol with the Dept of Health and Home Affairs in Queensland ' subject to conditions of service being approved by the Branch. To which the B.M.A. President, Dr. R. Quinn gave reply that the BM.A. had been vainly trying for two or three years to effect the cooperation of which Sir Raphael spoke:[21]

> "Can he assure us that the persistent attitude of suspicion and obstruction hitherto manifested towards our profession by not only the present but past governments will be in any way abated?"

The issue remained unresolved due to the outbreak of war. By the end of the war, Sir R. Cilento had left the department. Health services had moved into the Commonwealth domain. The opposition of principle moved into the open forum of conferences with Parliamentary committees of enquiry - though, after basic

issues were settled, and the Commonwealth adopted a voluntary insurance scheme of national health, Queensland still persisted with a policy reflecting the dominance of Labour ideals in its free hospital bed system when other states, for financial reasons, abandoned it.

The B.M.A. Branch had joined the Labour Government in some innovations. The Brisbane General Hospital was the first in Australia to abandon the honorary system. The State was the first to make a compulsory provision for twelve months' residence in hospital before registration. It was given official representation on the Medical Board with three of seven members in 1934, and one assessor on the Medical Assessment Tribunal in 1939. It agreed to the specialist register in 1940.

Because of its unique conditions and isolation, the Queensland Branch had led in proposing autonomy and independence, in ideas for adopting policies to Australian conditions. Two Queensland members were honoured as vice-presidents of sections of the B.M.A. Centenary meeting in London in 1932, Dr. A Breinl and Dr. R.G. Broan. Dr. A.H.Lee was given the Fellowship of the B.M.A. by the Parent Council on Branch recommendation, in honour of twentyone years service on Branch Council and eighteen years as Federal Council representative. He also became founder of the Medical Benefits Fund in Queensland 1950 and president of its executive committee.

The Branch had called for an Australian representative body in 1932, and an Australian Medical Association in 1938. It revived the idea of a Commonwealth Health Insurance office in 1935. The stimulus of the Branch in Federal B.M.A. politicis was at all times felt.

(c) [redacted] HISTORY OF [redacted], [redacted] [illegible] [illegible] [illegible]

The first settlement [illegible] Swan-a Church and [illegible] Perth. [illegible] Sydney. A Dr. [illegible] with the party. His [illegible] named [illegible] London [illegible] Church Catechist [illegible] Swan [illegible] Bunbury and [illegible] Dr. Charles Simmon, Colonial Surgeon, built the first civil hospital on Garden Island June 1829, while Dr. Millijan set up a practice on the site of Perth. The first doctor in private practice was Dr. T. Harrison of Fremantle. The second Colonial Surgeon Dr. A. Collin was a famous naturalist, having been aboard H.M.S. Blossom in a scientific trip round the world.

The colony did not recover from the hazards of settlement in a hinterland area so remote from any other settlement, being neither so prosperous nor with such good harbours as New South Wales or Victoria. Medical attention was difficult to obtain at any time, except from the small number of medical men turned farmers and landowners.[1] The colony was devastated for want of labour, until the introduction of convict labour. ~~Shortly after~~ A Medical Governor was appointed [illegible] Governor Hampton 1842-48. From Fremantle Superintendent on a convict transport to Tasmania, 1833, he later became Comptroller of Convicts there, and introduced many land reforms. His term in W.A. saw eleven new public buildings, half the Legislative Council elected from 1847, pioneering development of the far north-west of the State, and the end of transportation in 1868. He left the colony for Mt. Eliza in Victoria a disgraced man.

In 1844, the first act to regulate administration of affairs was passed, and the first Legislative Council established. One of the original members was Dr. A. Waylen, Australia's pioneer surgeon of the Great Western Railway, drowned in the River Swan. He became Colonial Surgeon 1842-[illegible].[2]

The [illegible] Inland [illegible] in 1848, [illegible] Dr. [illegible] in 1848, [illegible] Officer [illegible] of the Quarantine Service and [illegible] Dept. [illegible] Navy [illegible].

In 1895, Dr. Lovegrove became Principal Medical Officer, a title superseding that of Colonial Surgeon. In this capacity, with very little staff, he actively intervened to reorganise and build the hospitals on the Coolgardie fields, as the rushes set in, finding them little better than casualty clearing stations.[3]

As the number of doctors grew, so did the need for medical organisation. As early as 1886, the Victorian B.M.A. Council at the instigation of Baron von Mueller, had written to South Australia suggesting that branch write to the profession in W.A. and ask them to join. Nothing eventuated.[4] In 1895, further negotiations were reported direct with Melbourne.[5] A Dr. Haynes had complained to the A.M.G. about the urgent need for a medical society in Western Australia due to competitive practice.[6] A Dr. McWilliam physician at Perth Hospital contacted Melbourne , but when a Medical Association of Western Australia was founded in 1897, he was not in overt association. It met alternately at Perth and Fremantle Hospitals. A Coolgardie Medical Union also existed by 1898 with fourteen members. In 1898 Dr. Herbert Horrocks, recently arrived from London, called a meeting in the Board room of the Perth Hospital to found a branch of the B.M.A,, due to 'a generally expressed wish on the part of many of the medical men of this city'.[7] Only a short time before the Fremanle society had been revived after a dormant period, but immediately agreed to join the B.M.A.

One of the most notable facts about the first meetings was the presence of three doctors from one family Dr. J.M. Stewart, Dr. J.F. Stewart, and Dr. Robert Stewart. The latter married the same year, and, as Dr. Jull, led a distinguished career of public service in the state in health, welfare, and university life. The new Branch consulted the S.A. B.M.A. about the procedure of formation, and copied its bylaws. The twentyseven foundation members elected Dr. Waylen as first president, and excluded homepaths Their ambition was:[4]

> "to study the various questions of medical economics, hospital organisation, national and local sanitary obligations, the limitations of functions proper to friendly societies and the duties of the state and various sections of society to the sick and wounded and infirm."

One of the first acts of the Branch was to appoint a Parliamentary Bills Committee of three men to amend the public health bill concerning notification of infectious diseases in the colony., and to watch over all other Bills in theHouse. It also sent a deputation to the Government to protest at the wretched condition of many of the subsidised hospitals on the goldfields; and notified

other Branches of the dolusive advertisements promulgated by the assisted hospitals. By 1900 almost all had been brought under control of the Principal Medical Officer. The Government also approached the Branch. The Inspector General of Schools consulted it in 1899 on opthalmia and education of parents; and for comment on regulations for control of meat shops and dairies. A threatened plague epidemic led to a series of drastic regulations enforced by the the Central Board of Health.

In 1902 the Branch had a code of ethics, and proposed a section on politics and ethics for the Australasian Medical Congress, and a federated B.M.A. with freedom to admit and expel members. Some Branch members in 1903 moved to expel Dr. E. J. Haynes for his scandalous publications in the public newspapers of W.A. He resigned to become one of the two medical referees under the Workers Compensation Act of 1902, which doubtless was the cause of a B.M.A. resolution against medical referees who can give final opinions.

In 1900, the Branch became subscribers to the A.M.G. By 1905, it had a contract practice committee to deal with friendly societies. By 1907 it urged branches in country towns. Incorporation, considered in 1906, became a fact in 1911, as did an ethical committee. Dr. Jull of the Branch Council later recorded:[9]

> "After 1911, there was so much business to transact that most of the administrative, ethical and constitutional work devolved on the Council and was only reported briefly to the general meetings; these general meetings were chiefly concerned with medical and clinical matters. By 1915, there was so much secretarial work that it became necessary to appoint a part-time paid secretary to assist the honorary secretary.

The secretary had already recorded complaint to posterity in the 1911 Council report:[10]

> "The burden of work, whether it be reading papers or showing specimens or attending meetings, sub-committees etc falls on a willing few. Many others who might well take a lively interest in the welfare of the Branch are content to display what I can only describe as enthusiastic apathy. Owing to the amount of time taken up in dealing with the business of the Branch, there were not so many papers - only two being read."

The first decade had seen the Branch deal with workers' compensation, a midwives bill (1911) medical inspection of school children, foundation of a maternity hospital, formation of the Australian Traned Nurses Association in W.A. The advent of the Labour Party 1911-16 did not have the same impact as in N.S.W. and Queensland, possibly because the Government already played a far more extensive part in the hospital and medical practice of the State.

An amusing sidelight was a delegation to the Colonial Secretary and traffic department 'to ask if doctors driving their own motor cars could not be allowed a little more licence than ordinary drivers, and to point out the allowed rate of 12 miles per hour is absurd".[11] A few months later the new regulations were sent to them for comment. During the war, the branch cooperated in preparation of a V.D. bill with the aid of the Hon. Dr.A. Saw M.L.C. , which was not based on any legislation existing elsewhere, and was regarded as a model by other states. W.A. also had a medical act more stringent than any other states, but still could not deal, for example, with quacks who treated V.D.

In 1911, the W.A. Health Act had been amended, and the Central Board of Health abolished in favour of a Commissioner of Public Health with very wide power - wider than under the 1898 Act. The war created the same problems as in other states- medical care of dependants of lodge members on active service, safeguarding of practice of branch members on service, the care and rehabilitation of returned servicemen, and finally a medical officers' relief fund for members of the A.I.F. and dependents, a sum of £500 being raised. A circular to all district medical officers discovered their main grievance was inadequacy of post-mortem and court fees.

An incident in 1917 may well have led to the sowing of the seed of the idea for the Flying Doctor service in the mind of the Rev. John Flynn. A Dr.J.J. Holland had to direct the local magistrate and postmaster by morse code in an operation at Hall's Creek 1500 miles away on a stockman, whose pelvis was badly crushed. Dr. Holland sailed north on a cattle boat, only to arrive the day after the patient died. He told the story to the Rev. John Flynn, saying next time he would fly. With the advent of pedal radio, the Rev. Flynn made his hope a reality. This same Dr. Holland in 1917 asked Council to press for appointment of a licensed anatomist. With Dr. H. Gray and others, he started an anatomy dissection group in the dungeon cellars of the old Perth Hospital. But the medical school he and Dr. W. Hedly hoped for did not come till 1957. In 1934, they asked the Uniersity for accommodation in the new science building, when the Anatomy Act passed with coopertion between the B.M.A., the University and the Dental Association.

The site for a branch home was first taken up with the Premier in 1901, and perennially raised. The Perth Public Hosp-

ital housed Branch meetings in the Board room.

A medical defence union was founded in 1901, but lapsed from 1908-25, when it was revived as an entity separate from the B.M.A. A Medical Benevolent Fund was founded 1929. The first Australasian Medical Congress to be held in Perth was in 1932. A Post-Graduate Committee began in 1930, and was asked by the B.M.A. Council to undertake organisation of visits to country centres. Outstanding councillors during these early years were Dr. Trethowan, Dr. Dixie Clement, Dr.T.L.Anderson and Dr.E. Atkinson Commissioner for Public Health, who set a pattern of close liaison between that office and the B.M.A. in W.A. beginning in 1926 when Council had power to appoint him a member of Council ex officio.

The years 1920-40 saw a great deal of work on hospitals, workers compensation and lodge practice, involving policy and detail. In 1931, a general meeting appointed a vigilance committee to consist of council and certain members to report if the present honorary system in the hospitals should be amended - if so in what ways, and if a national insurance scheme was desirable.[12] In 1927, the Workers Compensation Act provided for medical expenses up to £100 to be paid by the employer. A special medical committee was set up to supervise medical accounts in view of the charge by insurance companies that medical accounts were too high. In 1932, they complained that the underwriters were not availing themselves of its decisions. Council's motive in joining in was 'to consider all medical accounts in dispute and to maintain the dignity of the profession by checking members who are inclined to be unreasonable in their charges'.[13] According to the B.M.A. President 1936, Dr. F Gill, of over 1,000 disputed cases from 1927, 90% were due to over-visiting, or charging the maximum. Some members resigned in 1932 when ethical decisions were not in their favour.

The Workers Compensation Act did not apply in Kalgoorlie or Boulder, where doctors worked under insurance agreements providing hospital and domestic care for a fixed amount. In some areas of country medical service, the Government and Roads Board had a guaranteed scheme for a minimum £750 a gross which included all expenses. The B.M.A. was represented on a ~~rather unique~~ committee to provide medical service to the great scantly settled tracts of N.W. Australia: the N.W. Medical Service Advisory Committee from the pastroalists association, the medical department and the B.M.A., born of a plan by Dr. Atkinson in 1933 to extend the older District Medical officer subsidy scheme, to major north west towns. This led in 1936 to the Australian aerial medical service.

All was not smooth either with hospitals (the Wiluna Hospital episode) friendly societies or with workers compensation. After Branch refusal to adopt the N.S.W. schedule of fees, as urged by the underwriters, because of widely divergent industrial conditions, a prolonged dispute on fees finally went to arbitration. In 1941, this subject was very active between the then Minister for Labour and the B.M.A. Council. The Minister warned that he was going to legislate to check 'abuse' alleged by certain doctors of 'the privilege' granted them under the Act. The Dept proposed a tribunal with power to conduct a register of doctors and remove names for misconduct. Members opposed this concept preferring adjudication by the Medical Board. Without further conference with the B.M.A., as Dr. Carter reported to the Branch:[14]

> "A Bill, which very greatly differed from the previous discussions had now been presented to Parliament, the differences among other things provided for a Board of Inquiry to include laymen and to consider complaints made by injured workers or their relations in purely medical matters and there was no provision for a court of appeal".

Among its more serious scientific enquiries are two more intriguing incidents. The first was a Hickson Spiritual Healing Mission which came to W.A., and led the Royal Society to suggest cooperation with the Branch in a scientific investigation of faith healing. The other was an investigation committee of specialists appointed to give facts and findings on the Koch treatment practised by Dr. Smallpage in the eastern states as a cancer cure (in reality a biochemical therapy)

The first meeting of the Branch held outside Perth was at Northam in 1936, while a joint meeting with the legal profession was held in 1934. Arising out of continual discussions on possible national medical service, - and the particular interest of other members like Dr. Leigh Cook, and Dr.D. Copping, then in Collie, the Council formed a planning committee of various branches and groups to inform the Council fully of the current views of the profession. These groups were increased in 1944-5, and the name of the planning committee altered to convocation. Its formation and meetings had meant a good deal of work and organisation, led chiefly by Dr. Cook.[15] This convocation became the body of control in the W.A. Branch instead of Council after a trial period. In 1948, Dr. C.E.Cook proposed to the Council that it cooperate in appointing an authoritative Health Council from the practising profession to advise the Minister and make public its findings and to sit in an advisory capacity, review the actions of the government and institute essential work in the interests of public health

This would give formal expression to one of the original objects of the Branch. Dr. Cook emphasised the present failing of health departments throughout the Commonwealth, which seemed divorced from the practice of medicine, while the average doctor was disinterested in matters of public health. This Health Council was created in 1950 after approval by the then Conservative Government.

In 1950, W.A. formed a general practitioner section, every such doctor in the Branch being a member of it. Its Council consisted of all general practitioner representatives in the Branch Convocation, and in the Branch Council. It was financed by the Branch funds, and any medico - political matters coming before Council were referredto it.

In 1954, the British Medical Agency Company bought Clarendon House in Kings Park Road for the Branch which had its own home for the first time. Mr. R.G. Hayward was chosen as first full time secretary to succeed those devoted part-time secretaries Mr. N. Hancock and his son Mr. H. Hancock, who had taken such a key part in the consistent growth of the Branch over many years. Dr. Le Souef had also been honorary secretary, during the time of the Branch's greatest expansion while still a young surgeon. There were Drs. Carter and Paton whose work on the Federal Council was continued by men like Dr. Leigh Cook, who had one of the longest terms on the Federal Council of more than twenty years.

W.A. did not get its medical school till long after the other mainland states. Recommended strongly by the Royal Commissioner, Mr. Justice Wooff in 1942, the Federal Government agreed to contribute £125,000 to the cost of building in 1947, but withdrew the offer in 1953. The Senate set up an Advisory Board in 1948 to include a number of B.M.A. members. When the University of Adelaide refused to admit any more W.A. Australian students, the Government at last heeded its approaches. The Labour Premier promised a B.M.A. and Advisory Board deputation to meet half the initial cost and all the administrative cost. £500,000 was subscribed; less than 600 B.M.A. members donating £40,000.

While acclaiming his own branch for this evidence of public spirit, its President Dr. Buttsworth in 1955 said the W.A. Branch was an expensive one to operate and onerous for its Council members, who were constantly pressed once more into servite each year on the grounds of experience. He added his formula for a Councillor 'drive, retentive memory and clear dissective thinking ' - all attributes of youth.

(P) [redacted]F HISTORY OF MEDICAL ORGANISATIONS IN TASMANIA TO 1945

Permanent settlement in Tasmania began with Lt. Col. D. Collin... in 1804 on the site of the present Hobart, and Colonel Paterson at Georgetown in the north. They brought doctors with them, all very young men and service trained. For twenty five years, Tasmania was served almost entirely by medical men in Government employ, looking after the bond and free, the control of Hobart Hospital, community health, and medical supplies from London and Sydney. They were allowed the right of private practice. Dr. J. Scott, the longest serving colonial surgeon 1824-37, was said to have made upwards of £2,000 a year. Between 1820-43, some thirty seven medical officers were added to the establishment including Dr. E. Bedford, Dr. D. Crowther, Dr. E.S. Hall, D. J. Lhotsky, and Dr. W. Pugh. All these men had distinguished careers. Dr. E. Bedford was an early Australian medical student, became assistant colonial surgeon, and founded St. Mary's Hospital on a subscription basis, the better to service his and other medical apprentices. He wrote to the Governor of Victoria and the Governor General of N.S.W. to this end, and to the Royal College of Surgeons for permission to allow students the remission of one year. Thus he was the first teacher to systematically attempt the foundation of a preparatory school of medicine in Australia.[1] His hospital was closed down in 1859 when the Government reorganised the hospital system, after the convict system ceased in 1853. By that time Dr. Bedford was able to claim that eight of his pupils had obtained diplomas in England (one as a Gold medallist).

Hobart Hospital had moved into its own premises as early as 1819. Dr. E. Warbreck Hall became the first to teach students there. He has fame today for his pioneer studies in epidemiology, in which Dr. Bedford had also taken an interest. Such men left invaluable records of early incidence of disease such as typhoid, measles, scarlet fever.

Dr.W. Crowther was owner of whaling ships, and anthropologist and zoologist of no mean stature, as well as a practising surgeon. Late 1837, he presented a long address to the Legislative Council urging the formation of a colonial school of medicine, and anatomical museum at the hospital with power to examine and grant diplomas, having already, five years before, sought to have pupils of surgeons admitted to the hospital to attend operations and dissect bodies. Dr. Crowther's son was one of his own apprentices, and completed studies in England, financed by a collection of five hundred skins and live animals and birds he took with him in 1839. He returned to lead a life of political distinction, and continue his father's

scientific interests, eventually gaining the Gold Medal of the Royal College of Surgeons for his services to its museum. Dr. Johann Lhotsky was a botanist and naturalist, contributing to the Linnean Society. He also found coal at Port Arthur. A number of early doctors did not confine themselves to medicine. Indeed, one of the first , Dr.T.W. Birch, a whaler surgeon wrecked at Hobart Town 1808, forsook medicine for ownership of a whaling fleet. Others were farmers and pastoralists,who took part in the foundation settlement of Victoria, which was colonised from Tasmania. A number served as magistrates, while Dr. J. Murdoch had a medicinal farm in 1822.[2]

A Board report in 1840 led to a bigger hospital, being erected in Hobart 1841-2. But, as in the past, only Government officers had entree to the hospital.[3]

> "During 1845, a controversy arose regarding the right of the medical staff of the institution to private practice, and local practitioners asked that they might be allowed to attend patients at the institution in order to gain hospital experience"
> "At the same time, the question of hospital fees became a problem, and from the regulations framed it may be noted that no servant of any person could be admitted into the institution until all arrears had been paid, nor could a free person be admitted unless he had paid the amount due for treatment on former occasions."

The hospital government remained an uneasy compromise between the traditions of the military type convict hospital with their dominant surgeon superintendent, and the voluntary system with its autonomous honorary staff. But the Board was appointed by the Governemnt and included the Colonial Secretary. The hospital was plagued by a series of Royal Commissions from the 1870's for the next fifty years.

Prior to self government in 1856, Tasmania had been fortunate to have the redoubtable Sir John Franklin as Governor. During his tenancy of Government House, he founded a Tasmanian Society meeting monthly there with its own journal. It attracted men like Dr. Bedford, who wrote on young marsupial animals. Dr. W. Crowther , medical historian, wrote that he believed no scientific society so remote had such a brilliant beginning, including, as it did, John Gould foremost ornithologist, Hooker the great botanist, and R. Jukes the geologist, and Count Strzelecki. The Royal Society of Tasmania resulted in 1843, housed in the new Tasmanian Museum, the first branch in Australia. An ardent supporter was the 1839 Colonial Surgeon, Dr. J. Agnew, secretary from 1861-93, who kept the importance of science before Parliament and public during his years in Parliament, and founded a medical section in the Royal Society in 1896 which thrived until a Tasmanian Branch of the B.M.A. was founded in 1911. By this time he had been twenty

years a Legislative Councillor and Premier of the State. At least four other leading doctors were Parliamentarians, Dr. H. Butler 1865-85, Speaker for eight years and M.L.C.; Dr. W. Crowther M.L.C. 1869-85, Dr. R. Officer Speaker 1861-77.

It is certain that Dr. Henry made some approach to Tasmania to form a B.M.A. Branch in 1880. But the first mention extant was a provisional committee to form a Branch in 1887, with Dr. Smart as President, as a medical society was said to be urgently needed;[4] Plans did not mature. The Medical Section of the Royal Society, formed in 1896, included medico-political affairs in its domain, and was represented in an interstate conference to discuss club practice. It discussed hospital abuse, government medical service, medical defence, homeopathy, quackery, prescribing by chemists, and even a request by the University Council of Tasmania to provide instruction in the first year of medicine acceptable by other universities.[5]

In 1897, a Launceston sub branch of the Victorian B.M.A. was formed with 29 members regarding the B.M.A. as offering benefits as a protective association, which the Royal Society could not. Currently, they had more marked quarrels with hospital and friendly socieities than Hobart did. This Branch became virtually defunct by 1904, and was urged to reform by Dr. Rennie, when on a visit from N.S.W. It revived in 1911, retaining its distinct identity in the role of a northern division co-existent with Hobart.

In 1902, in response to a request of the 1899 Australasian Medical Congress, a Medical Defence Association was formed both to consider legislation and promote honorable practice.

The 1897 Launceston B.M.A. sub branch had been absorbed primarily with hospital matters. Foundled in 1860, after the Joint Parliamentary Committee report of 1858, it was built to replace the defunct St. John's and the subscriber run Cornwall Hospital. One of the local doctors, Dr Crowther , suggested having only a junior resident surgeon, and an honorary staff.[6] History might have been different if the advice had been followed. Even, when a permanent Board of Management was established in 1878, the post of Surgeon Superintendent, dating from military days, remained a senior not a junior man, leaving the honoraries in a role difficult to maintain in the face of his dominating role. The B.M.A. approached the Launceston Hospital Board in 1898 to remove him, and widen the honorary system. The Board was not receptive, having tried such a system unsuccessfully 1878-81.[7] The B.M.A. approached Parliament in 1899, and conducted a well-publicised paper war with the Board. They proposed replacing the Government nominee Board with one elected by subscribers.

After a Select Committee enquiry, Parliament diminished the power of the Surgeon Superintendent to a status equal to that of the honorary staff. Dr. C. Craig, who took the post in 1926, commended the system as having made the hospital a 'community hospital in the full sense of the word'.[8] It did not, however, work so well at first, due to the fact that its incumbent Dr. Ramsay was an outstanding man attracting patients by repute. Hostility took the form of approaching the Chief Secretary to prevent Dr. Ramsay engaging in private practice, and a Bill to this effect passed in 1910. He went into private practice full time in 1912, and became himself an active member of the B.M.A. Launceston Branch after revival in 1911. Dr. Sweetnam, already a resident for five years, took over 1912-19, and his equally eminent reputation further exaggerated the contention. Many wealthy patients sought to enter a hospital primarily intended for the sick poor, thus increasing the 'unfair competition' with other doctors to which for years they had taken exception. The Launceston Division in 1917 asked the Hobart Division to take up their quarrel as a matter of principle to be fought by the Tasmanian B.M.A. in respect of both Hobart and Launceston Hospitals; even though the former had not a dominant surgeon superintendent, nor any but minor 'hospital abuse' with well-to-do patients of the kind complained of in the north. The results were disastrous for both Divisions. Parliament failed to support the B.M.A. who were excluded from the Hobart Hospital until 1930 and from the Launceston until 1925. The repercussions had deleterious effects on the outlook of both public and politicians to the B.M.A., with consequences which reached beyond state into federal politics as Tasmania was the cradle of leading figures both in the Commonwealth Parliament and public service. The high feelings of the day are also explicable in terms of the belief that all doctors were theoretically competent to do all things, and 'open' hospitals were important to the acquisition by the doctor of universal competence. Speaking in 1938, Dr. A. Pryde, then B.M.A.President, said:[9]

> "We have special conditions here that do not apply in other states. They are (1) a small population witha necessarily limited number of cases (2) absence of a large medical centre with its associated hospitals and teaching schools, (3) isolation geographically from the bigger medical centres".

Post-graduate courses were established twice a year to overcome this, with invited physicians and surgeons from the mainland who were teachers in medical schools there.

The Tasmanian B.M.A. Branch was founded in 1911 by a procedure of asking a selected list of doctors, eleven being excluded. It formed subcommittees on hospital and friendly society

practice; but with the intervention of war was to lose many of its most important members who enlisted. In 1916, the Branch excluded consultation with homeopathic doctors, and temporarily declared against meeting professionally a doctor disqualified by the Newnham Racing Club, the Dr. Ratten who was to make their ban on Hobart Hospital later ineffective by taking charge of it. The B.M.A. banned the hospital in 1917 until the Premier would give assurance that well-to-do patients would not be admitted. It is questionable whether any private professional group had any right to demand an assurance from an elected Government in regard to a Government supported and controlled institution; also whether its membership represented the well-considered opinion of their own electorate with so many B.M.A. doctors away at the war. Dr. T.H. Goddard, Medical Superintendent at the Hospital at the time recalled:[10]

> "I believe at the time of the celebrated quarrel between the Tasmanian Government and the B.M.A. in 1917, that, if there had been a little more sweet reasonableness on both sides, and perhaps particularly on the side of the B.M.A. there would have been a happier issue. However, the result was perhaps the most famous and damaging case in Australian medico-legal history....
> From the moment that the B.M.A. withdrew their services from the hospital, they were anathema to the Parliament (both sides Liberal and Labour) to the press and to a large section of the public. It was generally said that the B.M.A. put a pistol at the head of the Government, and when the Government would not surrender, the B.M.A. struck. The B.M.A. did not consider it a 'strike'; perhaps the word 'lock-out' was more to their liking".

The justification of one of the leading members of the Council at the time, Dr. Sprent, as recalled in 1928, was:[11]

> "It is absurd to expect men who have expended years of work, their money and their health in reaching their present position to give their services gratis to the well-to-do".

The Parent B.M.A. Council donated £100 to expenses occurring from the dispute in 1921. It dragged on until 1930; the B.M.A. returning to the hospital in that year, but Dr. Ratten remaining until 1935, not without further enquiries and Royal Commissions in which the B.M.A. was no longer directly involved. But the issue of means testing which had precipitated the crisis remained unsolved. The B.M.A. had legal representation on the 1935 Royal Commission on hospitals, and appointed committees to consider community hospital and contributory schemes. In 1937, it sought legal opinion as to lodge doctors who signed agreements with lodges, and their right to claim payment under the Workers'

Compensation Act. A schedule of fees was drawn up. Opinion was also sought as to professional secrecy on patients concerned in police enquiries. The Branch Council drew up rules for special groups in 1938, and formed a committee on national insurance in1936.

After a Department of Health was formed in 1934, the Director, Dr. B. Carruthers, invited the Branch Council April 1937 to cooperate in drawing up a scheme for medical service to remote country districts. It drew up a scheme after conference with other states and friendly societies, circulated it to all members with a questionnaire as to financial conditions of general practice to decide on acceptable financial terms; but it was contrary to the salaried medical service desired by the Labour Government for the outback areas, which caused the Branch such alarm they called on the Federal Secretary, Dr. J. Hunter to visit the Branch. He interviewed members of friendly societies, both B.M.A. Divisions, visited eight centres and interviewed men throughout the state, as well as the Premier. He reported:[12]

> "The B.M.A. viewed with a good deal of concern the proposal that these services should be available to rich and poor alike without charge, as it seemed that there would be a demand for similar services in other parts, and eventually the medical services of the whole state would be carried out by state medical officers that would be free to everybody. The Premier stated that that was, in effect, what he desired and his Government hoped that by the end of their term of office (another four years) the medical services of the state would be nationalised and administered by the Public Health Department".

The Premier had already threatened on return from London that if he could not recruit the first ten doctors for the service locally, he would get them in England or even from exiled European doctors:[13]

The B.M.A. was agreed that open hostility was unwise in view of past history with the Government, and it should concentrate on securing better terms for doctors in the service than those proposed in Western Australia and the Commonwealth service. But Dr. Hunter was aware of wider implications as he reported to the Federal Council:[14]

> "The position in Tasmania is a very serious one not only from the point of view of the local practitioners, but from the point of view of the profession in Australia, as there is no doubt that what is happening in Tasmania will be watched with a good deal of interest by other Governments in other states."

The upshot was appointment of twelve doctors, jointly paid by the State and the municipality with the right of private practice after 5 p.m. The Tasmanian Branch was to show a marked note of compromise in reaction to all plans for national medical service 1938-43. Suldo was open rejection of ideas put forward by

Tasmanian delegates in federal conference as other states, on issues like national insurance, national salaried medical service, payment of honoraries. The first legislative provision for foreign doctors was made post-war. Tasmania, being chronically short of doctors, was more liberal than any other state.

In 1939, Tasmania acquired a post-graduate committee, but waited nearly twenty years more for a medical school in the University of Tasmania; which became imperative with quotas in mainland medical schools. In 1943, three members formed a Journal Club to assist those studying for the Royal College of Physicians. Workers Compensation remained an active problem in hospitals with open admission of patients- the hospital not the doctor collecting the fee. The Tasmanian B.M.A. also sponsored a Medical Benefits Fund as in other states, but as a Branchof the Sydney body with voting rights.

The two Divisions of the Tasmanian Branch retained a marked identity, as noted by Dr. Hunter. He regarded the north as considering the south too radical, while the south considered the northern branch did not take enough interest in the B.M.A.'s work.[15] What remains indisputable is that both Divisions retained a high level of practice due to the high standard of cooperation between themselves and mainland Branches and Universities.

CHAPTER 4 THE BATTLE OF THE CLUBS * COMMONWEALTH STORY

None of the six colonies of Australia were to develop a satisfactory system of social welfare during the nineteenth century. 'Welfare' was limited to 'charity' for the destitute and deserving only, or the incapable like the insane. Hospitals and benevolent asylums were intended only for the very poor, or those hardy enough to risk the hazards and discomforts of their care. Most medical care was carried on in the home. The dangers of septic infection were enormous with regular outbreaks of erysipelas and septicaemia; while the standard of nursing was extremely low with illiterate or drunken attendants. For the great bulk of the population the only way to secure medical care was to pay the doctor a private fee for service, or enter a private hospital. But the vast category of the Australian population, from the earliest days of free settlement, was neither very poor, nor rich enough to afford to pay private fees at all times. They ranged from those at subsistence level, to those who could afford private care at normal times, but would be embarrassed by the illness of the breadwinner and thus his loss of capacity to meet the medical bills. In most of such families, the breadwinners' illness was an emergency to be dreaded without some insurance against such a crisis.

Workmen early thought of insuring against emergency by combination; at first to insure against the degradation of a pauper's burial, but to offer medical benefits as well by the nineteenth century. Even later, sickness benefits were offered to give the breadwinner family sustenance as well as medical care. Social reformers of the day encouraged the friendly society movement, subscribing to leading Victorian precepts that self-help and thrift were Christian virtues of the highest order.

But such societies were cooperative of workmen of very limited means, and had limited assets. They sought medical care on a concessional basis, compared to normal private medical practice, by way of an annual capitation fee of so much per year, in return for which the doctor would attend the lodge member all year round, irrespective of the number of calls for his service. The doctor, accepting concessional service, accepted the lottery, or gamble, that an excessive demand might be made by a member out of proportion to the capitation fee charged. The doctor entered into a contract with each friendly society lodge, so the service was commonly known as contract or club practice.

The lodge collected the capitation fee from the member by way of small sums paid each week; though these were often an overall sum to include funeral and sickness benefits as well. Many doctors entered such serviee because it suited both parties to the contract, for reasons explained by Dr. Mitchell in 1905:[1]

> "The notion of providing the poorer wage earners with skilled medical attention for a moderate fee, paid in the form of a regular premium, was a most excellent one.
> "It has brought comfort into thousands of homes where either the sick must otherwise have been denied medical attendance, or else, having availed themselves of it, the doctor must have received little or no remuneration for his services".

Many of the friendly societies, established from 1840 on in Australia, were branches bearing the same names as parent organisations in England. These were such as Grand United Order of Oddfellows, the Ancient Order of Druids, the Manchester Unity Independent Order of Oddfellows. Their original rituals and ceremonies were intended to promote high ideals of conduct and respect for the interests of other members; and through it honesty and care with members' funds. Mone the less insolvency and defalcation of funds was by no means uncommon. Ey the 1870's, Governments, both in Great Britain and in Australia, began to assume responsbilities to supervise the financial transactions of the lodges. The Registrars appointed at this time were given increased powers by the end of the century - sometimes after detailed enquiry by Parliamentary authority as in Victoria in 1875, and New South Wales in 1883. Registrars saw that payments to members were secured by adequate funds, and protected members from fraud; the societies being recognised as important social institutions in a field of social welfare Governments were not prepared to enter.

Contract practice in Australia deviated in several ways from its forerunner in England. First, medical benefits were extended at an early date to the entire family, whereas in Great Britain they remained for the breadwinner only. Thus contract practice encompassed a far larger proportion of the population, and made proportionately bigger inroads into private practice. Contract practice in Great Britain was usually confined to domestic service, but in Australia often included fractures, operations and confinements - even dressings and medicines, and attenadance at hospitals. The club of lodge doctors did not have the alternative sources of income often available in England, as poor law medical officers or dispensary doctors from the 1930's. A major variation in contract practice in Australia appeared in the form of subscription clubs that were based on a hospital; in country and outback areas in every

state, but particularly Queensland, and Western Australia, and in mining areas like Broken Hill, Lithgow and Newcastle. Hospital subscription clubs were formed on the same cooperative principle as the friendly society, with the additional purpose of establishing a hospital where there was none. They were very early subsidised by the Governments with a minimum £1 for £1, often more. Once the club built the hospital, it continued to run it, and employed a doctor either on full or part-time contract.

Doctors did not object to giving a concessional service to those for whom it was originally intended, the working class, particularly the family man with a growing family. They did not object if the lodge lists were not too extensive; the patients fairly considerate of their time, unless in emergency; the clerical work of the lodges honestly and accurately done so that lists were kept up to date; and the expectation to make night calls, and travel distances, not too burdensome. If they got a fair capitation fee, and were not overworked they did not complain. Many a young man of limited means was glad, in earlier years, to get club practice, with its guarantee of some payment, as a first step to private practice later. Nor did the medical profession object to the principle behind 'clubs' so long as Governments offered no alternative social security. Up to 1870 there was little opposition between clubs and doctors. From 1870-1900, however, they were completely to alter the relations between practitioners and patients in a generation. From 1900 on, a state of chronic warfare ensued between doctors and clubs, both in Australia and Great Britain, as the latter had become a powerful social force.

By 1878, the profession in Australia were well aware that lodge practice had grave drawbacks, in a free market where there was no shortage of doctors. The practice of calling for tenders for medical contracts to clubs had begun some years before, soon arousing opposition in N.S.W. and Victoria where the practice first appeared. A shortlived Medical Practitioners Association in N.S.W. 1872 brought a halt for a short time, but generally the practice continued unchecked. The evil, inherent in tendering, was that doctors were chosen by price and not by qualification. The clubs were more interested in 'cheap' medical service rather than good medical service. They regarded economy, and conservation of funds, as far more important than conservation of the health of their members.

Canvassing for patients had also become common by 1870, every method being used to tempt patients into a club, or to seduce them from other clubs - such as press advertisements

pamphlets in the shops (particularly the chemist), dodgers laid around a district, even door to door canvass by paid agents. Inevitably, the canvassing club tried to undercut its rivals, offering more benefits for less money with the doctor as the pawn in the game.

Doctors objected fiercely to both tendering and canvassing, regarding both as forms of economic jungle law, undignified and damaging to the profession; and creating conditions where it was manifestly impossible to give adequate medical service. Not all friendly societies and clubs indulged in such practices; chiefly the newer clubs, appearing after 1870 and known as medical aid societies, formed for that purpose only. However, in societies with a multiple function, while they did not have the outright profit-making aim of medical aid societies, they did have an interest in effecting economies at the expense of medical service for funeral and sickness benefits, or even for building amenities, and general funds to assure their solvency. The latter was a common complaint of club doctors 1880-1914. Where socities built hospitals= as they frequently did- club finance centred on the maintenance of the hospital, which then took priority before payment to the doctors, so that his prosperity depended on the efficiency of the hospital.

From 1870-1900, clubs in Australia began to attract membership not only from the poor but people of all classes. Even the most wealthy 'squatter' could often count his wealth back no more than a generation - the majority not being far removed from humble or modest origins. He did not have the same inflexibility about class distinction as the more rigid English society; and had no inhibition about rubbing shoulders in the Grand United Order of Oddfellows with the local stone-mason or bootmender. As early as 1878, the Medical Society of Victoria, was astonished and concerned at the turn of events and their journal recorded:[2]

> "The gentlemen farmers, merchants and all manner of well-to-do people enter into these societies, and very few are left outside them. Under such circumstances theunfortunate resident doctor is subjected to a species of coercion.
> "Under the new system he is expected to tender, and attend upon his wealthy neighbours as well as the labouring man for next to nothing. Should he demur and refuse to swallow the bitter pill, then immediately city newspapers are aflame with advertisements calling attention to this most desirable opening for a medical man."

What was a concessional service was becoming a community service. The effect on the doctors in some towns was described in a letter

from one country doctor in 1905:[3]

> "In this town, for instance, with hardly an exception all the wealthy inhabitants - some of them with incomes of more than four figures - belong to lodges. The leading lodge members form the hospital committee and thus half a dozen leading inhabitants rule the lodge, and through the lodge the hospital, and thus the doctor is at their mercy, unless he yields to their every wish, including giving them medical attendance for next to nothing. They harass him in every way until life is unendurable."

Where such social pressures existed, doctors obviously only had three ways in which to protect themselves. The first was by combining to exert counter pressure to ensure that their point of view, if not considered, would at least be heard. The second was to acquire representation in whatever form was necessary on hospital boards, in the community or in politics. The third was to ensure that lodge members had a choice of doctors, because the doctor who was monopolised by a lodge was in the most unfavourable position of all. He offered the other doctors in the town unfair competition, which they could not defend, while unable to defend himself against exploitation.

One of the chief incentives to expansion of medical societies 1870-1900, was to protect the 'interests' of the profession, vis a vis 'clubs'. Their Bill of Rights was to restore club practice to its original principle as a concessional service to the wage earner; to fight for a minimum capitation fee for the doctor; to resist such demands within the service as would 'sweat' the doctor - unlimited lists, unlimited services, unlimited hours. They would object to all conditions of monopoly of which the worst were to be found in combinations of lodges known as Institutes. They would oppose the practice of tendering to get the cheapest service irrespective of qualification.

Thus expansion of medical society membership, after foundation of B.M.A. Branches in Victoria, N.S.W. and S.A. in 1880, and Queensland and W.A. by 1900, was at a time when membership of lodges proliferated throughout Australia. Colonial depression, from the end of the land boom in 1890, promoted the demand for insurance in the only form then available - from the friendly societies.

B.M.A. Branches did not deal with 'club' practice with the single-mindedness its contract practitioners members desired, either in Great Britain or in Australia. The latter attributed inertia to the predominance of doctors on Branch Councils, not in contract practice. Such doctors, at various times, took an active part in promotion of other medical societies that might take a more special interest in what became known as the 'battle of the clubs'. Such were the medical defence

associations in the eastern states, and various country and suburban societies. The first recorded instance of such a society producing an actual increase in payment was that of the Western Suburbs Medical Association led by Dr. Walker Smith in Glebe in 1890, who went so far as to resign his lodges to force their hand. But such victories were at first local and limited. The profession proved difficult to organise, or at least those most concerned argued that it was.

Mr. Bruck, from whom the N.S.W. Branch purchased the Australasian Medical Gazette, remained owner of a medical agency, and brought out a pamphlet in 1895 as the outcome of a survey he had carried out throughout Australasia. His estimate was that nearly one quarter of the Australian population belonged to clubs, with a total membership of 245,000 in 3,064 branches involving nearly one million, if families of members were counted. At least one third of the doctors had lodges. He saw proprietary societies and institutes as most undesirable extensions of the system, and particularly condemned institutes:[4]

> "Mere sweating institutions.. and many of them are also the greatest curse to the affiliated friendly societies themselves.
>
> "These institutes, to enable them to produce a favourable balance sheet, not only engage their medical officers at starvation rates, but, with few exceptions, also buy their drugs in the cheapest market".

Such doctors might see fifty to one hundred patients a day, averaging 2-5 minutes a case; and have to fit in visits and confinements and emergencies as well.

He instanced the Medical Institute of the M.U.I.O.O. and the Balmain United Friendly Society Dispensary in Sydney among the worst. Equally so was the Brisbane Institute, formed to frustrate the efforts of the new Queensland Medico-Ethical Association, 1890, to secure £1 per member per year in the lodges. Club abuse, he considered, was at its lowest ebb in Australia with consequently deplorable medical service; although it undoubtedly achieved its aim of effecting economies, as with the Brisbane Institute, which had reduced the cost of medical service to its members by one third. Mr. Bruck considered that doctors would have to use the weapons of the trade unions to secure reform from friendly societies, as friendly negotiation had proved useless. Such weapons were - expulsion, blacklists, punitive action:[5]

> "Friendly societies would soon become disorganised, and financially crippled. The disreputable lodges and institutes would be effaced, and the more respectable ones come to terms with the profession".

But he doubted if the unity necessary to effect this was possible

The A.N.A. was singled out for condemnation on a federal scale, partly because it was notorious for offering the worst terms in Australia at 12/6 per year for a family; partly, because doctors believed its power ran so high, in social and political circles, that anyone who fell out with it would risk, not merely losing his lodge members, or even his private practice, but all hope of preferment if he wished to progress to specialising in larger hospitals. Such fears were apt to silence private opposition, and even quench organised action. Some were not silent as one speaker, who said:[9]

> "It was a power behind Ministers like the Tammany Hall in New York, where the Mayor was not the power. It was the head of the Tammany Hall organisation".

Until 1907, opposition to clubs was neither united nor determined in any state, because a high percentage of doctors remained outside the available medical societies. The B.M.A., however, was fairly effective in N.S.W. in preventing a number of profit-making medical aid societies from being established, as well as limiting the A.N.A.'s development within the state. Doctors in N.S.W. also founded the Sydney and Suburban Provident Insurance Society, as a doctors' cooperative, and established their own private medical lists in competition to lodges and institutes. By 1907, both N.S.W. and Victorian B.M.A. Branches laid the lines of a more efficient organisation.

Up to this date, the tendency was to condemn certain phases of contract practice, and certain institutions to which it gave birth, rather than the principle, or the mode of payment by way of capitation fee. In 1905, however, the report of the Contract Practice Committee of the B.M.A. in England could only give qualified approval to the system in principle:[10]

> "Contract medical practice is intrinsically injurious to the interest of the public and profession alike, and its acceptance by the medical profession can only be justified on the ground that it is necessary to meet the requirements of the wage earning classes or a certain part of those classes."

From 1907 on, B.M.A. Branches in Australia took a sterner line with contract practice. At the 1908 Australasian Medical Congress, all states joined in approving the need for an income limit for contract practice throughout Australia, set at £208 for enrolment, and £312 for entitlement; which meant that no member should be allowed to continue if he were known to earn more.[11] A subcommittee reported to the 1911 Congress, which met, already aware of the violent conflict in progress in England between Prime Minister Lloyd George and the medical profession there, over details of a national insurance scheme.

The 1911 Congress feared that Australia would adopt a similar system, based on the existing friendly society movement. Therefore it was vitally important to organise the profession strongly to allow it to bargain more forcefully with any government that might approach legislation with such determined pre-convictions as Lloyd George had done. Therefore Congress approved that all states carry out simultaneous enforcement of wage limits, and set up the first federal organisation of the B.M.A. with a Federal Committee, and a national Medical Journal of Australia to be owned corporately by the branches. Both served to reinforce common action against the lodges throughout Australia. Common action was not, however, successful in any state but N.S.W. till after World War 1. In all other states, doctors delayed asking for a universal minimum. In all states, they carried many dependants of servicemen free of charge on their lists.

The period of arbitration , however, that had lasted from 1890-1920 ended with a modus vivendi between doctors and societies; but not without many bitter episodes, and a legacy of attitudes and opinions about doctors, which can fairly be said to have influenced politics, both federal and state, for a generation afterwards. Many politicians, particularly labour, gained their first knowledge of doctors through their father's, or their own, membership of a lodge. The attitudes of public and politicians about the profession were not important until Governments began to plan national health services from 1910 onwards.

In Australia, national insurance on the German model, was an active issue from 1911-41. It was a scheme of compulsory insurance for all wage earners, the state supplementing workers' contributions in agreed proportions. Doctors taking part were still paid on the previous friendly society capitation basis of rendering all medical service for a fixed annual sum. Expecting a renewed demand for national insurance after World War 1, the Federal Committee shaped their policies to get a higher capitation rate in all states immediately the war ended, and to enforce the Common Form of Agreement, not later than three months after the war in all states, in view of inflation during the war.

From 1920 on, an era of mutual arbitration began with the old hostilities chastened, and only an occasional crisis. The B.M.A. Branches found it difficult to reach common consent on a uniform Model Lodge Agreement for the whole of Australia. Finally in 1927, the Federal Committee took that of the N.S.W. Branch as a foundation, and set margins of £312 to £416 as the maximum for entry to membership, and entitlement, with a minimum annual capitation fee of 30/- in the cities, leaving each Branch

to arrange its own rates in the country.

In 1924, a Royal Commission on National Insurance was taking evidence throughout Australia. The then Minister for Health, Sir Neville Howse, favoured the English system, although sceptical that the necessary legislation would pass in his lifetime. The Federal Committee canvassed Branch Councils before giving evidence to the Commission, and found none of them in favour of any known form of national insurance, after extensive conferences in each state. One of the most obvious objections, expressed in private meetings with the Commonwealth Treasurer, Dr. Earle Page in 1927, was the association of sickness benefit and medical benefit in the one legislation. 'Certification' had plagued British national insurance doctors; with the need to sign the patient first as sick, then as well, for entitlement to sickness benefit. Consequently, they could spend more time writing out certificates than examining patients. Doctors were also left with the burden of adjudication between genuine patients and malingerers. A lazy doctor could earn his money with less time and effort than an honest one; so the system encouraged the temptation to push the queue in and out the door with little more than a bottle of medicine. B.M.A. leaders believed national insurance merely perpetuated all the worst features of lodge practice; and was acceptable only in its original context of a very simplified service under primitive conditions to those, who otherwise would have possibly received none at all.

Dr. Page was sensitive to the dilemna presented by trying to adopt overseas models in Australia. As leader of the Country Party in a coalition Government, and Commonwealth Treasurer, he introduced national insurance legislation in the Commonwealth Parliament in September 1928. But he had abandoned the inclusion of medical benefit with sickness and pension benefits, although some requirements for certification for sickness insurance still affected the profession. The Bill was twice postponed, depression ensued, and the Government fell from office. The succeeding Labour Government did not revive it.

While the Bill was still under discussion, the B.M.A. Branch in Queensland, during the 1929 Australasian Medical Congress, called for an interstate conference on contract practice and national insurance, considering some of its features still unsatisfactory. A standing subcommittee for the new Federal B.M.A. Council was agreed on, instead; 'which could meet and act upon comparatively short notice in coordinating the activities of the several states', [13] deal with hospital and insurance benefits and problems affecting general practice.

This conference , not having the formal sanction of the Federal Committee, was, in a sense, a vote of no confidence in its capacity to speak for contract practitioners - a feeling already finding expression in the foundation of the General Practitioners' Section of the Victorian Branch in 1928. The Federal B.M.A. Council, succeeding the Committee, responded to the demand of the Branches for a more positive policy from the outset: a demand reinforced by the temper of the community that the national sufferings of the disastrous years 1929-32, with widespread unemployment and destitution, must be cushioned by community planning. In 1935, the Federal Council approved a general medical service for the nation, which accepted a contract medical service on a compulsory insurance basis. It insisted, however, on a definite income limit, and eligibility strictly governed within that limit.

By 1938, the Commonwealth Government had framed a bill of the composite character that Dr. Page had avoided in 1928; in accord with electoral promises made from 1935, and with the assistance of an administrative expert in national insurance from England, Sir Walter Kinnear. It combined pensions and sickness benefits with medical benefits, and ignored all the differences in the Australian environment, stressed by the medical profession in the years when the subject was alive from 1924-28. But the principles had not been discussed with the B.M.A. in 1938, as they had in 1928. In fact, however, neither Federal nor State Councils of the B.M.A. objected to the capitation system in principle at that time, or to contracts. The quarrel that ensued between them and the Government was limited to the amount to be paid; a quarrel that generated not from the Federal B.M.A. Council, but the ranks of the profession. This was proposed as 11/- a year for each wagecarner, whose contributions were to be matched by Government and employer in allotted amounts.

A surge of protest and votes of no confidence disturbed the normally peaceful Council halls of the Branches. The tranquillity of the Federal Council elections was shaken. Leaders from the general practitioners of all States conspired to send a delegation to Federal Council to urge that the 11/- capitation fee was wholly inadequate, based on Victorian figures which were the lowest in Australia and had not been revised for twenty years. Further the decision for 11/- had been reached by the Federal Council through an executive committee of six with the Treasurer without referral back to State Councils for approval.[14]

As the result of pressures from the rank and file, the Federal Council agreed to a consultative committee on contract practice to consist of one general practitioner from each state in concert with the Council, which continued to meet, throughout the life of the ensuing Royal Commission, on the amount to be paid from August-December 1938, and following debates on alternative legislation that continued until the outbreak of war in September 1939. Its influence was strongly felt, both on immediate policy making, and in emphasis, from that time, on the importance of adequate general practitioner representation in the Federal Council.[15]

A conspicuous feature of the 1938-9 wrangles, between the B.M.A. and the Government, had been that hostility to the B.M.A. seemed to have been transferred from the clubs to the political parties, while the B.M.A. was now on a very cordial basis with friendly societies. The one remaining reserve of the B.M.A. was towards the ambition of the friendly societies to become sole approved societies under the scheme. Both parties joined together in joint representation to the Commonwealth in 1939 to include dependants in any medical service, to make it more consonant with the traditions of Australian medical service in the past. By the outbreak of war August 1939, the principles of national insurance had been so thoroughly weighed and found wanting in some respect by various sections of the community that all political parties were rather thankful of the diversion of national emergency to drop the whole thing.

In 1941 and 1943, the B.M.A. Federal Council considered principles for a national medical service. A major difference between the two documents was the abandonment of the idea of a capitation system with an income limit. The initiative for the change came from Dr. C. Colville of Victoria, on grounds asserted as early as 1929, that no medical service could be regarded as national where large segments of the community were left outside its scope. Dr. Colville argued that there was nothing inherent in general medical service for a per capita payment.[16]

Negotiations continued with the Friendly Societies Association Consultative Committee, from 1940 onwards, for a Federal Model Lodge Agreement. Accepted in 1940 by the former, the B.M.A. sought amendments in 1945 at the end of the war. Price fixing had frozen the level in all states. Change was difficult. Special provision was made for enlisted men and dependants. When they finally met in 1945, they debated not only the M.L.A. but the practicability of some extended form of medial service, mutually advantageous to both parties. Mr. Best for the friendly societies

considered the time to be apt, the dispute , which had dragged on in Victoria, having been settled. Both bodies opposed the preferred principles of medical service of the Labour Party, then in office. Both were agreed on joining forces to extend medical services to those groups previously neglected by the voluntary insurance system- namely those too poor, or too ill, or ill for too long to belong to friendly societies. If some scheme could be devised, their hope was that the Government might abandon its stated intentions of national medical service in the form they opposed.[17] But, as the B.M.A's preference was for abandoning the friendly society system for voluntary insurance on a fee for service basis, the conference proved abortive. The negotiations with the F.S.A. on the M.L.A. were also indecisive.

Finally the Federal Council on November 14, 1946 decided to request Branch Councils to give formal notice to friendly society authorities throughout Australia of B.M.A. intention to terminate any agreements between the B.M.A. and the Friendly Society Councils or individual lodges in various states. New contract agreements were to be negotiated at rates varying from 36/- to 44/- capitation fee a year. The reactions of the Branches to this ultimatum were various. N.S.W. said their friendly societies had put up a good case for an intermediate rate. Queensland's rate was so close to the new one, they were loathe to change. Tasmania would have to ask for a 100% increase in rates. W.A. had the least difficulty. S.A. had no upper income limit, and did not wish to press the point,having been for many years, on very good terms with the societies. Victoria thought they might get some increase, but not so much, and even that would have to be secured from the lodges at'pistol point'. A circular to doctors showed they would not be likely to resign.[18]

By 1948, the B.M.A. President was to say that the attempt to implement a Federal agreement had failed, and the Federal common form of agreement hoped for could not be applied rigidly to every branch.[19] The reason for this was a decision of a conference of representatives of the friendly society movement in all states April 1947, which decided:[20]

> "That, in view of the opinions expressed by the respective state associations concerning the different conditions existing in states, this conference is unable to approve of the proposed Federal C.F.A. on a federal basis with the B.M.A."

The whole dilemna was thereupon referred back to the states for decision there. To which, Dr. Hunter, general secretary of the B.M.A. replied very testily:[21]

> "In view of the fact that discussions in regard to the federal C.F.A. were initiated in 1940, and actively carried on during the past two years between the two parties, it is difficult to understand why the friendly society representatives should now decide that a federal agreement is not possible because of varying conditions in the different states. An earlier decision in this regard would have saved much time and money".

By 1950, the return of the Liberal Government to power set in train a policy which was to carry out a bloodless revolution, abolishing contract practice as it had continued in Australia for over 100 years. During a period of transition, however, in 1951 the B.M.A. was negotiating a fee for service method of payment at concessional rates to members of friendly societies.[22] This was abandoned when it became clear that the Earle Page scheme of voluntary insurance would be based on existing friendly societies, with the Government paying refunds to patients on a fee for service basis. A few capitation schemes still remained in operation, on the Western coalfields at Lithgow, Portland, and Kalgoorlie for example.

Modern medicine by 1950 had demanded a more flexible system than the capitation system evolved in the medical environment of 1850- of which Sir George Syme had made the criticism in 1924 that it was 'based on a misconception of what medical practice is, viz lightning diagnosis and cure by a bottle of medicine'.[23] Four major evils had proved to be inherent in the system. First, doctors were chosen by the law of supply and demand, which meant that price, not qualification, was important. Doctors were in competition with each other. Where a lodge employed only one doctor, he could not protest if his lists were too heavy, excessive demands were made, in case the club should engage someone else. Second, cavassing for patients by societies made other doctors in the district suspicious of the lodge doctor. The prospect of being displaced, if he didn't toe the line, made the lodge doctor suspicious of them. Third, medical benefit was often not only the sole purpose of an organisation - where sickness and funeral benefits were offered. They had a vested interest in the solvency of all departments and better amenities for their administration. Where any club had a profit motive, which gave an incentive to cutting down the price of a doctors' services, the quality of medical practice ceased to be the only consideration. Fourth, people joined or remained in lodges who were not within the accepted income range. The onus was on the doctor to object to the terms of service with the lodge employing him, including

questioning on the bona fides of patients. He always found himself at a disadvantage in refusing patients on a frontier of eligibility, even in cases, by no means uncommon, where patients came to visit him in cars better than the doctor himself could afford, and still expect a low price treatment.

Overall, the B.M.A. Branches found that any situation in lodge practice which involved the employment of only one doctor, excluding others, was more likely to cause friction than one where an organisation or group employed several doctors, giving their members a choice of doctor. The ideal was one where every doctor in the district was allowed to participate, and every lodge member could choose from all the doctors in the district.

The worst evil in contract practice, from the patients' point of view, was that class distinction was very often emphasised; doctors having one waiting room for lodge patients and another for ordinary patients. This discrimination in quality and speed of service was all too common.

A feature trying to both lodges and doctors was the continual bickering over the cost of the capitation fee. The process of arbitration involved had led to much ill-feeling, public bitterness and recriminations against the profession with consequent loss of goodwill. It had made the profession guarded about any form of national medical service, which tied it to a contract with the government, without some safeguard for a mechanism of review of any original fees entered into. The history of arbitration with the lodges was such as to influence the BM.A. in Australia into adopting a vehement policy from 1948 that it would not participate in a Commonwealth medical service, which created a direct contractual relationship with the Government; thus instituting the kind of master servant relationship once familiar in dealings with some lodges and institutes. The B.M.A. insisted that no third party should be allowed to intervene in the direct doctor-patient relationship; and the present Commonwealth scheme of voluntary insurance respected this reservation - being only amended in respect of the pensioner medical service.

(a) CONTRACT PRACTICE IN N.S.W.

The first branch of Manchester Unity in Australia was opened in Sydney in March, 1840 by nine members, eight of whom had been members of the Order in England, established 1810.[1] Within a few years, it had extended to many other parts of N.S.W. The Grand United Order of Oddfellows was founded 1848 by Brother James Reid, who had arrived in 1844 with a dispensation to do so. At this date, welfare service was far more rudimentary than in England, under the pioneering conditions of a rapidly expanding settlement.

The Australian Medical Journal, published 1846-7 in Sydney, makes no mention of clubs, though vociferous on other issues. The Registrar General's return 1856-60 says there were only five, but these appear to have multiplied under the stimulus of the goldrushes to the point where the Australian Medical Association in 1866 could record that sick clubs and benefit societies were 'alike injurious to the profession and all connected with it.'[2] By 1870, the editor of the N.S.W. Gazette estimated that Sydney had about ninety societies, embracing a quarter of the population. Many of these were fairly new. Tenders for doctors ' services were being called 'like bread or meat or material sold by tradesmen. This is not the way to address professional men'.[3] He warned that many city doctors would have to reduce their fees to compete, as club patients were by no means poor. He quoted some who drove up to the druggist in carriages, and one who received his club doctor in a gorgeously furnished draving room. He said payment to club doctors could run as low as £150 a year to a surgeon, who gave 2,000 consultations, which worked out at 2d per consultation.

Aware of the denigration complained of in a letter to the NS.W. Medical Gazette, January 1872, that club doctors were called 'cheap' doctors, a Medical Practitioners' Association was formed about 1872 to invoke solidarity among club doctors with the aim of a minimum capitation fee, but no records survive. A letter to the Sydney Morning Herald March 1872, from a member of the Sons of Temperance Lodge, indicates that they had resolved in favour of increases in fees ranging from 25% to 50%.[4] It seemed to have succeeded in temporarily putting an end to incessant advertisements in the paper calling for doctors to tender for clubs.[5]

In 1875, the editor, Dr.S. T. Knaggs, who had had personal experience of this type of practice in Newcastle, fulminated:[6]

> ""The position of medical officer to a lodge is generally one of considerable trial and mortification, but it is sought after very eagerly by young men in the hope of making a connection and by the seniors as a means of

"subsistence".
He hoped to discard the club practice as he climbed the professional ladder; and was willing to accept poor pay and conditions as the means to this end. In general, clubs paid at this time 14/- to 18/- a year for the entire family, including all children to the age of 16. Midwifery was £1.1.0.

In 1875, after a Royal Commission, the British Government passed an act to regularise the financial operations of friendly societies. In 1881, the N.S.W. Government appointed a similar Royal Commission into the operation of friendly societies, and the security of their members. The N.S.W. Branch of the B.M.A., founded 1880, appointed a subcommittee of six to report to the Commission. It supported the 'provident principle' of the societies, their immmense value in encouraging thrift, independence and self-respect, and agreed with the Commissioners in their opinion that 'they relieve the Government of a considerable expenditure, and are doing much to prevent the increase of pauperism in our midst'.[7] But as there was great laxity in management and frequent defalcations - a serious matter with funds averaging £5 per head, and membership of 175,000 - there should be proper supervision through a Registrar, and an industrial bank. They asked that a medical examination be compulsory for entry to membership similar to life assurance, together with a fee for examination (usually free); and that medical benefits be confined to certain classes of the population. Moreover, that a uniform minimum payment of £1 be fixed by enactment; that medical and chemists' funds be kept separate from sickness and funeral funds; and general dispensaries be founded for drugs.

The Royal Commissioners only endorsed three of these requests - those for conditions for entry to membership, and for keeping medical and chemists funds separately. On confining membership and minimum payment, they took the attitude that this was not the province of the state, but doctors' services 'must be regulated by the law of supply and demand'.[8] The Commissioners were nine members of Parliament, and favoured the view that conscience would cause members, who joined lodges when poor, to refrain from using them in times of prosperity.

One B.M.A. witness, Dr. Belgrave, attacked the view, persistently expressed during the hearing, that club practice had a salutary influence on the prosperity and professional efficiency of medical men. He said it was debasing, neither to their pecuniary nor social advantage, nor likely to promote scientific practice,

The N.S.W. B.M.A. did not press the question of friendly societies till 1887, when Dr. Clubbe moved 'that the present system of payment ~~of~~ medical officers by the various friendly societies is very unsatisfactory";[9] adding he had never heard the subject discussed since arriving in N.S.W. in 1883, during which time 'an immense quantity of new blood had arrived' and should have 'the right to express themselves'. The 'new blood' had evidently created much more competition between doctors, if one can judge from the sixty three applications for post of medical officer to the benefit society of the Australian Agricultural Company Colliery.

Dr. Clubbe had been discouraged from raising the subject in the Branch on the grounds the subject had been 'worn threadbare and it was well nigh useless to bring it up again.'[11] He, none the less, circularised 160 doctors in lodge practice, receiving fifty replies, and finding the rate charged varied from 7/6 to 24/0 with an average 16s. The higher rates included all medicine. The majority of lodge members earned £3-£4 a week, yet paid only 3½d a week for medical service. The only area where doctors had established an understanding to preserve minimum standards was the northshore of Sydney.

The Branch called a general meeting of the profession May 6, 1887 in the Royal Society's rooms. Many there complained of low pay, needless calls, and people of means exploiting this concessional service. A committee was appointed to carry out the resolution for a standard agreement by all friendly societies with a minimum capitation fee, and to encourage doctors to observe them. One outcome was the establishment of a medico-ethical assocation in 1888, which in 1896 handed over its funds to the B.M.A. A number of regional associations sprang up in Sydney and the country. A consistent bargaining policy was gradually adopted in all of them.

At first the successes were limited. A warning in 1887, for example, led to the collapse of a body formed with the Premier, Sir Henry Parkes, as a director. In December 1889, a B.M.A circular outlining the desired model agreement went to all doctors newly arrived in the colony.

In 1890, Dr. MacGwinney of Petersham was the moving spirit in founding the Western Medical Association, which proved to be the first of its kind to survive more than a few months.[12] It arose from dissatisfaction with the B.M.A. He and his confreres thought it was;[13]

> "time to put aside old fashioned notions and prejudices about the dignity of the profession. There was nothing unprofessional in our banding ourselves together... at the outset of our career we were frequently taunted with being a Trade Union Society. We have never denied it, but we assert the need for our being so is very urgent."

The opening resolution of the W.M.A. was for a minimum tender of £1 per member, or 20/- with medicine; and for all doctors to give three months' notice of resignation of their contract to be renewed at this figure.[14] The general level of pay at this time was 12/- to 16/-. First to resign his clubs was Dr. Walker Smith in Glebe. When other Sydney doctors tendered in his place, the W.M.A. was successful in persuading them to withdraw their tenders, and Dr. Walker Smith was able to renew his 16/- contracts at a higher figure.

Affairs did not progress so smoothly at Parramatta, oddly enough due to seven doctors who held no lodges at all. They had agreed, before the W.M.A. was formed, to refuse to consult with the salaried doctors appointed to the Parramatta Institute at £250 a year. The W.M.A. itself advised the Institute that:[15]

> "Our association will inform any candidate of the position they will occupy in the town unrecognised by their professional brethren here or in Sydney, and unable to obtain their assistance in a case of doubt or emergency."

Despite this sabre rattling, a Dr. Waugh in fact consulted twice with an institute doctor, despite rebuke - whereupon the seven Parramatta doctors resigned from the W.M.A. in a body speaking of 'an evident disinclination to enforce our law number 3 and the primary object of the association having proved a failure'. The facts were rather the reverse. Under the stimulus of the W.M.A. , now 132 strong, and its successes, at least three other groups were formed within the year. The Newcastle Medical Association was revived as a Northern Medical Association, and talked of becoming a branch of the W.M.A. A Queensland Medico-Ethical Association, and an Eastern Suburbs Medical Association, both appeared during 1890, the latter September 23, 1890. A Broken Hill Society was in the making. The N.M.A. adopted the rules of the W.M.A., and soon had work to do when the Newcastle Friendly Society Dispensary dismissed one of its doctors, trying to intercept all applicants with a warning.[16]

The N.S.W. B.M.A. had been roused to lend its support to prevent a United Friendly Society Dispensary being founded at Petersham and Leichhardt, similar to those they were already fighting at Balmain and Parramatta. The Branch sent a warning

to the profession, criticising:[17]

> "the one-sidedness of the arrangement, the medical officer being practically in the hands of the Board with no appeal".

A move for a central A.M.A. to combine their joint endeavours as a fighting force may have hastened the B.M.A. to take up the cudgels seriously on their behalf. Moreover, ever increasing competition within the ranks of the profession for employment, and willingness to accept depreciating conditions, created by the depression of the 1890's, as well as graduation of young doctors from Sydney's new medical school, and continued immigration from overseas, were all factors militating against protection of working conditions in contract practice. The 1892 Branch President, Dr.S. Skirving a lively Scots physician, inveighed against the current amalgamation of clubs to secure cheaper medical service, and instanced one institute where the salary of the doctor was equivalent to 6s per family per year. In one which had issued 40,000 prescriptions in a year, this averaged 6d per consultation:[18]

> "I was often surprised that the committees of clubs do not more readily understand that the conditions of those contracts in a large number of instances negative the possibility of the best relations with the patient".

pointing out that 'the patients appraise us at our own valuation'.

In 1892, the W.M.A. had hopes of a body like the General Practitioners' Union of Great Britain, and were corresponding all over N.S.W. with a view to alliance in a purely Australian medical society. Faced with this embryonic challenge, the N.S.W. BRanch Council had to strengthen its own hand in attracting and keeping membership, or the new medical societies would erode its own primacy in the profession. Dr. Huxtable, recently arrived from the U.K., launched himself in Branch organisation with 'a tact, resource and energy truly remarkable' to quote a contemporary, Dr. Crago.[19] He increased membership over 50% from 192 to 325 , making it the largest Branch in the British Empire outside the U.K. He arranged incorporation of the Branch to allow it to buy the Australasian Medical Gazette, and enlarged the Council to allow representation of the new rival medical societies. The Gazette became the essential weapon in the fight over contract practice. The columns often ran editorials, letters of protest, words of doctors' rebellions, comparisons between states, and ultimately lists of prohibition of places where B.M.A. members could not work.

The prime target of the B.M.A. was the medical aid societies, which in the words of the B.M.A. President in 1896, Dr. Jenkins, were 'medical aid associations formed as trade speculations carried on by lay proprietors for the purpose of deriving pecuniary benefit from our earnings and pushed by means of advertisement, or by the employment of paid canvassers who tout and solicit the patients of other practitioners'.[20] These did not have the traditions or the public reputation of the older established friendly societies like the Druids, Foresters, G.U.O.O.F. and others.

In 1895 the W.M.A. asked the B.M.A. to condemn the Sydney Clerks' and Warehousemens' Benevolent Association as detrimental in six respects - no wage limit, no limit of age for family members, no consultation fee, no fee for midwifery, nor for operations. It called for united action against the Association despite its imposing patronage with the Lieut. Governor Sir. F.M. Darley and leading merchants and businessmen.[21] The B.M.A. Council called a general meeting of the profession Jan.10, 1896, under the presidency of the distinguished Dr. MacLaurin. It said the leading issue was that benefit societies were opening to a new class of people what was intended to be a concessional service for people of very limited means; and that they should be limited to those with incomes of £200 or less. The B.M.A. was instructed to send a circular to all doctors in the colony embodying a pledge to this effect, 305 being returned signed. The S.C.W.B.A. directors conceded all points demanded by the B.M.A., on this show of strength, except that of an income limit, which they set at £300. The Western, Eastern and North Sydney medical associations pressed the B.M.A. to insist on a £200 wage limit; and took a determined stand at a further meeting of the profession on May 8, 1896. Doctors now went further than condemning such societies, but urged boycott of them, and of doctors working for them: the ostracism to be not merely professional but social.

A B.M.A. rule was devised almost at once by a committee under the patronage of the B.M.A. Council, and were known as the Intra-Professional Restriction Rule, endorsed at a B.M.A. general meeting August 28, 1896, as rule 35a;[23]

> "No person pecuniarily interested in, or otherwise connected with such society, syndicate, or organisation shall be eligible for membership and may be expelled."

As a test of the new rule, a direct boycott of the S.C.W.B.A. was proposed, for refusing to meet the wage limit of £200.

Furthermore, this boycott was to be extended to all societies who ignored an intended demand for a similar wage limit, and lists of doctors working for them circularised to all Branch members. After 'repeated remonstrances' to such doctors, the BM.A. Council instructed the GAzette to publish a blacklist of their names in its pages - though the practice was not carried on regularly.

On the side of the friendly societies, they had difficulties of their own. The report of the Registrar of Cooperative Societies for 1893, for example, testified that keen competition among societies had led to inordinate raising of benefits, and cutting down of rates - up to 50% of what they should charge for solvency. Lodges opened unchecked in many parts of the colony without sufficient members. Management expenses were high compared to England (more than half the amount paid for medical attendance) and with undue ambition for building. Management was often actuarially unsound due to the principle of uniform cnntribution, and erroneous estimates of solvency. Finally there was an astonishing number of malversations, and peculation was rampant.

None the less, the medical professional demanded protection of their working conditions. Late 1898 the demand became imperative. The three Associations, Western, Eastern, and North Sydney met to demand that the B.M.A. Branch (1) recognise the minimum scale of fees fixed by them for lodges (2) to introduce an article of association to secure the failure to elect, or to expel doctors who cut rates established in different areas. They believed the 1896 rule too weak. Mere expulsion or refusal to admit was not sufficient deterrent. As the rules stood, doctors might take jobs with blacklisted societies while it suited them. Then, when they wanted to kick the ladder away, they were free to become respectable once more by joining their medical associations. The punishment had to be more severe - by extending beyond their period of employment with blacklisted societies into their professional life afterwards.

The B.M.A. Council was divided on the wisdom of inflicting such a drastic boycott, as was now proposed, but finally succumbed to the argument that:[24]

> "If men of such principles were to be received and treated as equals, it would mean whitewashing them, and so be a direct inducement for young men commencing practice to follow a similar course to the detriment of the whole profession".

The new rules provided that any doctor who held a post with an organisation declared 'inimical to the interests of the medical

profession', or holding a lodge at annual fees per member below those approved by the now existing local medical associations of the district, would not be eligible for membership of the B.M.A. for five years from the date of leaving such an appointment, nor be met in consultation for the whole of that period of disqualification'.[25] The period was curtailed to one year for those resigning before Jan 1, 1899.

The M.D.U. adopted a similar procedure for declaring a society 'prejudicial' in 1897, and excluding doctors working for such societies from membership- which had previously been open to any registered doctor irrespective of employment, or membership. The question of whether doctors could be informed as to which members were persona non grata came up, and legal advice indicated that a 'blacklist' could be sent out if marked confidential.[26] Thereafter, a printed card was approved by Council.

With all this 'relentless professional extremism', as Dr. Worrall described it, the B.M.A. was not able to do more than prevent new institutes being formed. The old ones continued. The B.M.A. Council Minutes still recorded some of their own members as carrying on the practice of canvassing personally with lodge members when applying for lodge appointments, and moved a motion that they be asked to discontinue the practice as objectionable. Opinion remained divided in the B.M.A. itself. Societies, condemned by the B.M.A., continued to function because B.M.A. policy was not retrospective. The worst of these were the Institutes.

The President Dr. Thring, in 1900, found a lack of appreciation among the very doctors for whom these efforts were intended:[27]

> "The Council and its work in relation to medical men generally and the members of the Branch in particular, has been subjected to much severe criticism. I have repeatedly heard it stated that the Council does little or nothing to help the general practitioner, that his needs and difficulties are not understood, in fact that the Council as a body is a useless and inert piece of machinery. I might add that these criticisms have usually been made by junior members of the profession, or those who, never having been members of the Council, know very little of the work done or the difficulties met with in doing it."

These difficulties were very real. If conditions obtained before 1896, Council hesitated to demand that doctors should resign, where no compensation could be offered.

In 1899, a new bill based on a recent British Act, revolutionised the law governing the 10,000 or so members of clubs. It required reregistration of rules, separate accounts, and remedied all difficulties.

In the period 1900-1902, the B.MA. entered into two major and very publicly conducted conflicts with the M.U.I.O.O.F and the A.N.A. The M.U.I.O.O.F Institute was the first medical aid society known as an 'Institute' in Australia. Its own medical board (of laymen) had conducted an inquiry as early as June 8, 1875, as to the reason why they had trouble getting or keeping doctors at the rate of £250 a year. The Board then reported the reason as being:[28]

> "The small amount of pay we offer for the vast amount of work required.. we are actually demanding from these gentlemen the same amount of attention for 6s as other kindred societies are paying from 14s to 16s for. This you will perceive is unreasonable, and conclusively answers at once the many inquiries why we cannot get good medical attendance."

In 1900, the salary paid was only a mere £50 higher than the amount condemned by the Institute's own Board. The dismissal of two of the Institute doctors led the B.M.A. to call a general meeting of the profession March 22, 1901, to consider relations with the Institute. The meeting gave unqualified support to the B.M.A. in any action against the M.U.I.O.O.F or any kindred institution, stating their objection to be the basic principle on which they were founded -namely, lodges combining to get service at a lower rate than the per capita fee by paying salaries, the doctor receiving the same pay no matter the work load;[29]

In the meantime the B.M.A. Council was at loggerheads with the Australian Natives Association, which was founding a Branch in N.S.W; an intensely patriotic body spurning any derivative connection from England, but not too proud to borrow the policies of English friendly societies. Founded in Victoria in 1871, open to Australian natives on the lines of a similar society founded in Sydney called the Australian Patriotic Society, originally its character was social and instructive. It was a debating forum and meeting ground, and inevitably became associated with politics. The A.N.A. then began to offer medical benefits to attract membership. The N.S.W. M.D.A. thwarted its first efforts to found a branch Nov 20, 1885. In 1900, the A.N.A. held a banquet attended by leading citizens including the Prime Minister, Mr. Barton, to open a Branch once more. But the Victorian B.M.A. had already declared it an organisation 'inimical to the interests of the medical profession', as their capitation fee was the lowest in Victoria.

A.N.A. policy in Victoria was said to be by way of a house to house canvass, a public meeting with parliamentary speakers of note, the conversion of private patients to benefit patients.

If a doctor in a town did not cooperate, threats were made to bring in a rival; and private practice was said, in some towns, almost to have disappeared. The A.N.A.'s declared policy for minimum wages for workers and overtime payments, doctors felt to be inconsistent with their statements to a deputation in 1897 of Victorian doctors, that they must be governed by the laws of supply and demand.

The N.S.W.B.M.A. Secretary, Dr. Hankins, went to see the A.N.A. President, Mr. Chanter M.P., and Mr. McGuire, Secretary, and asked them to establish a wage limit for people entitled to medical benefits; particularly as their membership was drawn from all levels of society in contrast to the ordinary friendly societies. The A.N.A. refused, the B.M.A. Council therefore declaring it 'prejudicial' to the profession in terms of Article 35a, notifying every doctor in N.S.W. The A.N.A. claimed the B.M.A. had tolerated other clubs with similar policies, and advertised for a doctor.[30] The B.M.A. called a general meeting of the profession, which approved what the Council had done, set an £200 income limit for membership, and set up a Permanent Investigation Committee of twelve, subject to the B.M.A. Branch Council. Doctors at the meeting were told by Dr. Jamieson that members in Victoria of the A.N.A. included:[31]

> "such people as the Chairman of the Stock Exchange, a vast number of well-paid civil servants, bank managers, a municipal and parliamentary magnates, landowners and businessmen who would not dream of associating with such people as Druids, Oddfellows, Foresters."

All of them, he added, paid the doctor less than they paid their barber.

The A.N.A. thereupon approached the Premier to legislate to compel doctors to consult with their lodge doctors; although at least one of their own officials disagreed - the vice president of the Newcastle Branch. Both the Herald and the Bulletin were critical of the A.N.A.[32] It was forced to negotiate Jan 7, 1902, and appeared to agree to the wage limit, while exacerbating feelings with public statements which led the B.M.A. in March to reaffirm its ban. It was to remain valid for another forty years, and effectively prevent the A.N.A. from becoming the political force it did in Victoria.

The B.M.A. was not making the progress desired in other quarters. The census, taken by the Investigation Committee, of 151 doctors (half in the city) revealed a number of disturbning facts: including the existence of 819 lodges with 300,000 members.

Only about one quarter of their income, in some cases like the M.U.I.O.O., was being spent for medical attendance and medicines, the rest being paid into accumulated funds. This was confirmed by the Report of the Registrar of Friendly Societies for 1902, that 'irregular and highly censurable practice of drawing on monies of one fund for subvention of another fund' was being followed. The profession felt, not without justification, that profit was made at their expense.

The Committee found that doctors were mostly not paid 'extras', and that the income limit was being observed nowhere. The B.M.A., afraid of the Committee's advice for an independent society of club practice doctors, took a stronger role in fighting the clubs. In 1901, for example, the Inverell Branch of the Manchester Unity asked the three doctors there to sign a new contract more onerous than the one they had worked under for twenty years. This would have included almost all fees for operations, and cut mileage payments by half. The doctors, supported by the B.M.A., resigned and opened their own patient lists, as in Newcastle. The Manchester Unity Grand Secretary of N.S.W. exhorted the local society not to give way on the £200 wage limit. Similarly, the I.O.O.F. lodge in Newtown tried to bind their doctors to a new agreement, requiring them to pay expenses for travelling to night calls, and dismissed those who refused. Trouble occurred in ~~other~~ country towns. Clubs would threaten to import doctors from Sydney to the country. Certain friendly societies in Broken Hill combined and advertised for a doctor, a member of the N.S.W. M.D.U. took the job. But the doctors united to oppose, it, as Inverell had done, with their own medical service and the institute languished.

A two year dispute occurred with the Balmain Dispensary, when it accepted A.N.A. as an affiliated lodge. But the years 1902-5 brought a lull described by the editor of the Gazette, Dr. Rennie, as 'a chronic state of ill-feeling and irritation,' culminating every now and then in acute disputes. He added that amicable settlement was becoming a matter of increasing difficulty. The B.M.A. was not yet a strong fighting force. It was slow to expel doctors who accepted contracts on terms less than they approved. It lacked money to compensate those who resigned their clubs in comformity with B.M.A. policy. It lacked consistent organisation in its want of any permanent officer until 1908.

There is little historical interest in reviving details

of many small episodes with the exception of Dr. Earle Page's trouble with the lodges in Grafton in 1905, in view of his subsequent career in Federal politics as leader of the Country Party, where he exercised an influence that is difficult to exaggerate. He influenced vital policy decisions in the periods 1924-8, 1937-9, and 1951 on. Throughout he used his influence against national insurance based on contract practice, and finally for a voluntary insurance policy adapting the old friendly societies to national medical service but without contracts. Personal experience of matters that become fields of legislation is not irrelevant to a politician's assessment of the form of legislation. His experience was gained in general practice in Grafton, his home town, after he returned there in 1903. In 1905, three doctors were being paid 25s per family, including medicine, of which five shillings went to the chemist, leaving twenty shillings net for the doctor. The friendly societies then decided to increase payment to the chemist, without increasing the doctor's payment, which would have the effect of reducing payment to the doctors from twenty shillings to seventeen shillings. Not unnaturally objecting, Dr. Page and Dr. Henry resigned, proposing certain alterations in their contract, which the lodges refused to discuss, accepting their resignations. The lodges then proposed to call for applications in all three eastern states - as lodges had done in many other centres - to import new doctors. The A.M.G. called on doctors in all states to refrain from applying.

Dr. Page's manifesto is worth quoting, as it shows early evidence of his political mettle; and willingness to assert a basic principle of importance to the profession which was not essential to his own dispute.[34] It demanded:

> "(1) recognition of the eligibility of every medical man of good repute and legally qualified, residing in Grafton to act as lodge doctors
> (2) the removal of the obligation (at present existing) of attending members' wives who have been refused medical certification of health.
> (3) the fixing of a schedule of fees for operation (the only operation at preent being paid for is curetting at £3.3.0.
> (4) power to limit each medical officer's list to 300 members if so desired.
> (5) the maintenance of the present rate of remuneration to the medical officer of twenty shillings per annum.

The statement stands out as a most explicit expression of the doctors' charter, among the speeches, addresses and editorials common in those years. He was in a far stronger position, however, to make such a statement than most country doctors. His father and grandfather had been outstanding citizens, helping found most of the leading local associations - school, hospital and even press.

Not long after Dr. Page's contretemps with the Grafton lodges in 1905, negotiations with friendly societies in N.S.W. entered a more orderly phase with the B.M.A. more widely organised in the State on one side; and a United Friendly Societies Association to speak for the numerous individual lodges on the other. These were years when the latter expanded throughout the state, with 180 new branches in 1910, and 155 in 1911 (though some were closed each year). In 1906, the B.M.A. took up the plan first urged in 1887 for a model lodge agreement. A joint committee of all Sydney associations 1907-1907 sent a draft M.L.A. first to Council, then to all N.S.W. doctors. Dr. F. Sandes made the call to concerted action in the Branch at a special meeting November 1906: that no member should sign any contract after Jan 1, 1907, which did not contain the terms of the M.L.A. as an irreducible minimum. Shortly afterwards, the punitive clauses of the B.M.A. ethical code were modified to meet much adverse criticism of their harsh character. Instead of a doctor being automatically excluded from B.M.A. membership for five years, after he had held a blacklisted appointment, he was to be excluded at the Council's discretion for a period ' not exceeding five years'.

Late 1906, the U'F.S.A. called for a conference with the B.M.A. held Dec. 23, 1906. The former were exceedingly conciliatory, agreeing to all including the wage limit - the first formal acceptance made of the principle after serious differences on the point for ten years. The U.F.S.A. had one qualification. It was not retrospective to existing membership.[35] Credit for this victory went to Dr. Antill Pockley. The undertaking made was kept in many medical contracts, although some lodges refused. Their refusal had some logic. They insisted that they imposed no income limit for sickness and funeral benefits, nor saw any reason to do so. They could not differentiate medical benefits, as only available to a special category of people. To do so, their constitutions would have to be rewritten. The U.F.S.A. could do nothing, as lodges were autonomous bodies.

February 1909, the B.M.A. Council reminded all lodge secretaries of the decisions of the 1907 conference, saying it intended to give effect to the 1908 Australasian Medical Congress resolutions, that income limit for new lodge members would be £208.[36] An emergency fund was created to absorb the Lodge Practitioner's Defence Fund 1902-3 for maintaining the interests of the profession against organised bodies in the country. Small payments of £90 were paid to two doctors who resigned their lodges. The Branch conducted a drive for 100% membership as essential to common action against lodges.

Disputes continued to occur. In Mudgee in 1909, for example, a doctor arrived, who had been working at the Balmain Institute, and blacklisted by the BM.A. When met by a local B.M.A. doctor in consultation, the other two local B.M.A. members resigned in protest. The W.M.A. , centred on Orange, sent Dr. Nevill Howse as committee member to speak to the B.M.A. Council. His mediation settled the dispute, and brought the B.M.A. resignees back into the fold. He later became a member of the Commonwealth Parliament and Cabinet.

Where lodges opposed doctors in N.S.W. 1908-12, they grew more adamant. A Northern District Medical Association, formed in Tamworth in 1911, in order to achieve a pay rise from 17s to £1, met a blank refusal. The lodges formed their own institute for their 800 members, and sought oustide doctors. In Sydney, the G.U.O.O. refused doctors' demands for the M.L.A. and instituted enquiry through the U.F.S.A. into the possibility oflodges combining to form a medical institute to cover the whole of N.S.W. , an idea still being propagated in 1913 by the Grand Secretary of the I.O.O. In 1912, the N.E. Medical Association on the northern rivers resigned in a body, and the lodges tried to import doctors.

The B.M.A. earned a bad press. Quotations would appear like that made by the President of the U.F.S.A. at its annual dinner 'that the doctors had climbed up on the back of the friendly society movement.[37] Brother Glasgow of the I.O.O., a leading U.F.S.A. official, was wont to assert, as he did in 1913, that the Macquarie St. doctors were causing the bother, the B.M.A. being governed by a caucus of four or five without marked support from the rank and file.[38]

Criticism could be just as vituperative from other doctors, who had either fallen foul of the B.M.A., or never agreed with them; or for personal reasons or misfortune had to accept appointments with lodges declared by the B.M.A. One of these was the M.U.I.O.O. medical institute - and one of its doctors, Dr. Beegley was refused a consultation by Dr. Clubbe, who thereupon published the letters with an attack on the B.M.A. as a professional trade union of the most bigoted and antediluvian type. Such doctors as he formed their own Australian Medical Association with more than 100 members. It sent a deputation to the Chief Secretary, Mr. Flowers, Labour Party minister in 1915, asking for the state to legislate to compel doctors to consult with them as registered doctors. The demand was renewed in 1913 by the S. and W. Sydney F.S.A. The Chief Secretary was, for once, on the side of the B.M.A.[39]

Hostility to the B.M.A. was not diminished by the extension of the intra-professional restriction rule in 1913 to include any doctor who 'shall have held any lodges at annual fees, below those approved of by the local medical association of the district in which such lodge is situated.'[40] It was kept alive by the existence of the confidential blacklist circulated among B.M.A. members.

Their point of view was nowhere advocated better than by a medical agency doctor in 1913, who dealt with both B.M.A. and non-B.M.A. doctors. He wrote in the A.M.G.[41]

> "As an onlooker with an intimate knowledge of the lodge question extending over many years, I cannot but feel that the B.M.A. has all along been working on wrong lines in their efforts to fight, blacklisting.
> "I have dealt with nearly all the unattached doctors that is men, who, owing to various reasons are desirous of getting settled in a practice, and I say most definitely that the number of such men who would in the first instance accept contract lodge practice (or openings) in opposition to B.M.A. ethics would be infinitesmal, if an opportunity was given them of securing a practice which was in accordance with B.M.A. association views... sometimes the alternative is to starve. Having once taken this step, they have nolens volens no other work there after open to them.
> "At present men take these regrettable positions solely under the stress of dire necessity (often brought about through sickness or misfortune)."

In 1913, a meeting spoke of the interminable wrangling that has long gone on, revolving around the adoption of the M.L.A. and the income limit. A new element had been injected with the growth of Friendly Society Dispensaries, encouraged by subsidy from the State Government for their buildings; a policy for which the Labour Government showed particular enthusiasm when it came to office in 1910.[42] The dispensing not merely of medicine, but free medical service, was put forward as a serious possibility, along with ideas for using them as free V.D. clinics, in an atmosphere of loose talk of 'nationalisation! Doctors felt much alarm, thinking any state sponsored scheme would be built on friendly society practice as in England.

By 1912, membership in N.S.W. was nearly 180,000, 17,000 joining in 1912 alone. One of the most rapidly expanding orders was the Grand United Order of Oddfellows, with 180 branches. In 1912, friction between the B.M.A. and lodges withstanding the B.M.A. was increasing. A B.M.A. leader complained:[43]

> "The lodges complain that the doctor is grasping; the doctor complains that the lodges are exacting and that some of their subscribers obtain cheap advice under false pretences."

The Chief Secretary, Mr. Flowers, an early and enthusiastic member of the first Labour Party, decided to intervene as mediator, calling both sides into conference September 18, 1912:[44]

> "knowing that the position required serious consideration and delicate handling due to the fact that tension for some years past had grown more and more acute".

The response to his invitation was beyond all expectation. Every order of friendly societies bar one, every Institute and Dispensary, and even lodges from all important country towns were represented. Sixteen Sydney doctors stood for the B.M.A., all but two being in contract practice. Both sides were conciliatory, but arguments were so strenuous as to lead to a second, unpremeditated session. The only point finally left undecided was the amount to be paid to country doctors. Agreement was reached on everything else- extras, income limit, mileage etc. On some points the B.M.A. won, on some points the societies. Agreement was won on all points dear to the B.M.A. - the principle of income limit, increase in remuneration, and a standard form of agreement throughout N.S.W. But the feeling of jubilation engendered by this comity was soon lost, as many lodges did not feel themselves bound by agreements made by delegates on behalf of the order as a whole.

The sort of situation that developed was exemplified by the Grand United Order of Oddfellows, then a rapidly expanding order. The Committee of Management decided to recommend acceptance of terms of the conference to all branches. Three B.M.A. Council members were invited to attend the annual meeting, April 1913, to explain the M.L.A. placed before the meeting for formal acceptance. Brother Ridley moved a successful Janus style amendment, that, though agreement with the B.M.A. was desirable, the C.F.A. should be amended as the increases proposed were 'unfair and inequitable'. The B.M.A. took umbrage at this change in the wind, insisting on standing by the M.L.A. and refusing to meet a deputation. The Committee of Management sent a questionnaire to 180 G.U.O.O. branches which revealed that fifty nine had accepted, others intended to do so, but a number would not. Nine of these had non-B.M.A. doctors. Those branches opposing tended to agree with the District Secretary of the Ancient Order of Druids, Mr. J. Cooksey, who objected to the 'stand and deliver' attitude of the BMA, and called for a medical institute for the whole state.[45]

The B.M.A. had indeed delivered an ultimatum that the new agreement should run from Jan 1, 1914, which provoked a conference of friendly societies, April 1913. Main objection was that benefits would be considerably curtailed, and they would get less on the new rate for 26s than they had for 18s in the past; while charges for certificates, night attendances and small operations included fees 100% higher. A subsequent conference of all grand executives of societies met in October 1913, to consider what they held to be demands for 'increased remuneration for a reduced service'.[46] Listed as demands were the 2/6 for examinations, a special fee of 5/6 at night, a reduced radius to two miles before qualifying for mileage rates. To concede these demands, they alleged, would prove a heavy tax on members, and in all probability lead to other increased demands at a later date. They decided to send a letter to every member of every lodge to secure united support in opposing them.

The B.M.A. saw this as a breach of faith from the 1912 promises, which had appeared then to give a 'favourable ending to the existing tension within measurable distance'.[47] The men, who had negotiated then, now offered a revised contract, saying the revision must form the basis for further negotiations. These included 'the best and brightest intellects of the friendly society organisation, and it may be inferred they were certainly competent to state the case for the friendly societies'.[48] The B.M.A. Council interpreted this as delaying tactics, if not virtually a declaration of war. They were already faced with a demand from state wide local medical associations for enforcing the agreement, in September 1913, and a plan devised then for all doctors throughout N.S.W. simultaneously to resign from their old contracts on the basis they would be prepared to renew them only in terms of the C.F.A. originally planned to begin January 1, 1914. But a number of lodges now planned to 'fight the B.M.A.', and even import European doctors, or advertise for doctors on a salary. The B.M.A. toyed with a plan to establish a provident medical association for people now in lodges, and warned that they would blacklist all imported or non B.M.A. doctors. The Sydney Morning Herald editor found it hard to assign the merits of the dispute to one side or another; saying it was hard to know whether it was a lockout or a strike that threatened. So much could be said on both sides, it was hard to condemn either. On the doctors' life in general, he commented:[49]

"The doctor, especially in the country, has not an easy life. His hours would horrify the artisan, his leisure is mostly conspicuous by its absence."

In December, Branch Council ruled that a member, who did not resign from his lodge, would have to resign from the B.M.A. forthwith - all were to be handed in simultaneously to take effect from Jan 1, 1914. In approving, the Branch membership subscribed to an Emergency Fund to aid doctors distressed by the loss of their lodges. Resignations were made. Early 1914, a deputation from the friendly societies waited on the Acting Premier, Mr. Cann, urging the Government to amend the State Arbitration Act to provide for arbitration of terms between themselves and the B.M.A., saying B.M.A. increases of up to 50% in the country were exorbitant Mr. Cann's reply was that the Government would have to get them registered as a trade union under the Act, and 'that perhaps would be a sacrifice of dignity on their part.' He would not import 25 'blackleg' doctors as requested by the mining lodges, addding that 'doctors could not be turned out like sausages in a butcher's shop'. The great majority of lodges accepted the Common Form of Agreement sought by the B.M.A. Some tried opposition, but found they could not get doctors, as in the Moss Vale and Blue Mountains districts, and had to capitulate. Dubbo, Orange and Wellington tried other doctors and found them unsatisfactory. Bathurst, after trying to get doctors from Queensland, agreed to B.M.A. terms. Maitland and Goulburn had non-B.M.A. doctors for some time after. The B.M.A. withdrew its mandate from Newcastle after a miners' deputation, January 1914, pointed out that they also paid 1½ a week to maintain the hospital. Local difficulties, including unemployment, made them different from other lodges.

The B.M.A. Council drew up regulations approved November, 1914, for combined action of all members in case of dispute. These were not to oppose any reappointment of a doctor to a lodge and not to take an appointment unless all in the area did so at once. By the end of 1915, some 85% of lodge appointments were under the C.F.A. The permanent relationship of mutual voluntary arbitration was not again seriously disturbed. Post-war common forms of agreement were written in every state on the N.S.W. model. In N.S.W. the number of changes in policy were few after 1916, and did not include recognition of the A.N.A., this having been refused once more in 1915 despite an offer to prohibit ''all participation in current politics or political movements, and to exclude from its membership all persons other than benefit members'.[51]

In 1920, the cost of living increase along with wages

led the F.S.A. to ask for amendment of the C.F.A. to allow a higher wage limit , and the B.M.A. to ask for higher rates. Mutual arbitration was amiable. A further change occurred after the Workers' Compensation Act, 1926. But, with the 1929 depression, the F.S.A. asked for a reduction of charges under the C.F.A. of 22½%, and carriage of unemployed members.[52] The annual delegate meeting refused, as Council had already asked doctors to take on their lists without pay a number of infirm and unemployed members not exceeding 10% of paying members.

A round table conference with the F.S.A., chaired by the Minister, Sep 4, 1933, came to no decision nor a follow up a year later, for various amendments to the agreement to expand the service in minor ways, for the same amount. By 1935, the Government was paying a subsidy for medical attendance to unemployed, and, by 1938, an agreement similar to the M.L.A. for their families. By this time, 728 members of the Branch out of 1700 were engaged in friendly society practice.

Federal

In September, 1940, the B.M.A./Council discussed the Federal C.F.A. with the grand lodges and contract practice for dependants of members of the services. During the war, some doctors were forced to close lists due to overwork and ill-health, thereby throwing further burdens on their neighbours. In 1942-4, the F.S.A. proposed abandoning the capitation for a fee-for-service system through a common pool into which all contributions should be paid; doctors being paid on a points value sytem The experience of the first two years was thought to enable determination of the value of the service. The B.M.A. Council told the F.S.A. it did not think any advantage would ensue. Moreover, if the contributions at the end of two years were inadequate to keep to the present level of payment, there was no guarantee it would increase. The F.S.A. also suggested a clinic to provide X-ray, pathological and cardiographic facilities, and asked for service to people earning £7-£12 a week. But, shortly after, the B.M.A. Council established its own medical benefits fund, which provided health insurance as an alternative policy to that of the F.S.A. In 1950, finally, after special meetings of Council and affiliated local associations, a majority of members by plebiscite voted to end capitation practice, though industrial practice continued in the areas of the S.E. Medical Association, Hunter Valley, Central Northern and Blue Mountains districts continued Thus a fee for service system on national, and not on F.S.A. lines, began.

(b) CONTRACT PRACTICE IN VICTORIA

One of the first friendly society lodges in Victoria was founded, September, 1849, - the Port Phillip District Lodge of the G.U.O.O., which separated from the N.S.W. Committee of Management in 1854. From 1846-70, there is little mention of clubs in medical society records, although the Medical Society of Victoria was said, by a critic, to be dominated by doctors from Collins St, the University, and Melbourne Hospital, who were not in club practice. However the problem was sufficient by 1862 to lead to a special meeting on the subject. In 1869, a new association appeared to represent the general practitioner with its own medical journal. The editor declared:[1]

> "Had the Australian Medical Journal and the Society sought the welfare of the many instead of the few, in all probability neither this Journal nor the Medical Association would at the present time have been in existence."

He then mentioned a Dr. Greaves who he claimed had 'the questionable distinction of having first introduced into Victoria the unprofessional and degrading practice of tendering for medical service to benefit clubs'.[2] The Medical Association called several meetings of club practitioners at Dr. Garrard's house in Collins St.[3]

> "to urge upon the friendly societies the propriety of adopting a more liberal policy towards their medical officers".

The hoped for unity of action did not flow from these meetings. Heated words indeed came in later weeks, when Dr. Garrard himself undermined the conditions the Association wished to improve, when he accepted election to the St. Patrick's Medical Benefit Society in place of a Dr. McCarthy, who had fought for two years against reduced contracts, which were now to include:[4]

> "all minor operations, providing all splints and bandages, and have another doctor act in his stead when he cannot attend".

Pressure on the doctor for extended service was by no means uncommon in the next decade. In 1872, a Dr. Iffla of Emerald Hill complained that the friendly societies were combining 'to reduce the very moderate rate of remuneration at present'.[5] A newly arrived doctor had, in fact, contracted by tender for a 16/- a year capitation fee. Some efforts to resist were tried, as at Bendigo, where all doctors tendered at the same price of 25/-, but their combination failed to prevent the Bendigo societies advertising for a doctor from Melbourne for £1, whereupon the Bendigo doctors signed up themselves for £1.[6]

Medical benefit clubs of Australian origin were now beginning

to appear with such pretentious titles as Australian Medical Benefit Assurance and Investment Association, which were blatantly commercial enterprises. In 1871, the Australian Natives Association began with both patriotic and benefit aims, and higher ideals and wider aims than either such medical aid societies or the friendly societies - including the promotion of federation.

A Royal Commission in 1876 found that societies had grown rapidly from 1864-74- parent societies 6-30, branches 186-819. The legislation of 1855, based on the Imperial Act, needed urgent revision. Audited accounts were badly needed, and model table rates for contribution to sickness. Only one doctor was called to give evidence, Dr. T. Serrell of the Medical Board. He said he could be paid better, averaging thirty society patients a day both home and visiting out of 1,000 members.

In November 1878, the M.S.V. called a public meeting of the profession to consider proposals by a provisional committee for union for defence purposes to include illegal practice, hospital elections, poor pay by Government and club practice. They were all well aware, he said, that:[7]

> "The clubs know very well that any resistance to their demands is only individual and will have no effect. If one medical man throws up a club half a dozen are immediately ready to take it, and no corporate feeling restrains them".

The new M.D.A. made little impact, its funds being turned over to the B.M.A. after its formation in1880. Neither the B.M.A. nor the M.S.V., however, had a firm policy against the clubs in the 1880's, nor did a special meeting called by the M.S.V. in 1890 create further action. Dissatisfied, a group of doctors in Ballarat formed a Ballarat Medical Association, which got in touch with similar groups in Australia fighting club practice, and tried to enlist their support for a new Australian Medical Association. In 1896, its President grumbled:[8]

> "Working men invite tenders from medical men, thus encouraging the neediest and least competent to undercut the other applicants by naming some absurd figure which is then considered to form a precedent for all time".

One of the first targets for negotiation by the M.D.A. when revived in 1894, was the A.N.A. thought now to be a unique social institution:[9]

> "no longer a struggling little friendly society

> "among many of its kind, but a powerful force in intercolonial politics, a forum for Queens Counsel, and ambitious members of Parliament, a workshop of constitutions, a nursery of Judges, of even a Prime Minister, a Governor General".

In Victoria, the profession called it a 'Medical Sweating Association'. It was said to have consistently refused to pay them as much as any other clubs, depressing their capitation fee lower than anywhere in Australia, to 12s a year. Doctors began to feel - not unjustly - that the A.N.A. was trying to ride to power on their backs; that it was undercutting other medical benefit societies, by offering potential members lower capitation fees as an inducement. In 1897, the M.D.A. organised a deputation representing 140 A.N.A. doctors, alleging injustice and dissatisfaction with the 1893 rules. The outcome was described to the N.S.W. Branch B.M.A. in 1900:[10] 'They were met with sympathetic smiles and the argument of the law of supply and demand'. The Victorian M.D.A. did not confine itself to broadsides in the two Victorian medical journals. It called for an intercolonial conference of all major medical societies in Australia to consider relations with friendly societies and other matters; and carried out a survey of members in its own state. 98% of all Victorian doctors complained of clubs - most of all of income limits, tendering and summary dismissal. None had any quarrel with the principle of friendly society practice; merely on the financial pressure brought to bear, creating conditions of overwork and inefficient medical practice.

The conference was held in Melbourne. Victorian delegates: ... agreed with those from other states to demand wage limits, a list of extras for which they should be paid, and a definition of dependants from societies in their state. The conference agreed:[11]

> "These abuses are of such a pronounced nature that it is a matter of astonishment that those concerned have tamely submitted to them for so long".

But support given the M.D.A. was poor. Less than 10% of doctors belonged to it, and the President of the M.D.A. lamented the lack of political sense in the profession:[12]

> "These abuses will not be rectified while there is so much disunion and apathy in our ranks. How great is that apathy in regard to our common good is evidenced by the feeble support given to the M.D.A. of Victoria."

It adopted a determined policy to canvass for new members, their number rising to 331 by 1900. Members were asked not to meet doctors in cavassing practices, and to demand fairer terms. In conjunction with the M.M.A., the B.M.A. and the M.S.V., it worked out a rule to be adopted by them all to boycott doctors working for medical aid societies, which were established merely to make a profit, declaring them ' as inimical to the best interests of the profession'. Doctors working for them would be considered as 'guilty of unprofessional conduct'. Yet little progress was made. In 1899, two conferences with friendly societies had led nowhere. Fresh institutes were established, while an institute such as the Bendigo Institute had not improved, having still in 1900 the lowest rate ruling in Australia. 25 lodges belonged with two doctors on £450 salary each, attending 10,328 patients, which worked out at 1.10d a head for medical treatment a year. When the Bendigo Institute advertised for a new doctor in 1904, the M.D.A. sent a warning notice throughout Australia.

A similar institute, planned in 1899 as an extension of a dispensary at Brunswick and Coburg, was to unite a number of local lodges and give medical treatment as well as medicine. It planned to employ one or more doctors at a salary of £450 to replace the previous contracts. Each member would then pay 12.6 a year. The A.N.A. was regarded as the brains behind the scheme: The two doctors were to provide their own rooms, and get no extra fees except for confinements. The A.M.G. castigated this contract:[14]

> "The duties that the medical officer has to perform certainly ought to qualify him for heaven if he can do them. He has to perform all operations, major and minor, to consult with anyone that the patient likes, but particularly with the other medical officer of the institute, and help him to perform any operations that may be deemed necessary. He must attend any urgent case when assured by a member of the institute that he cannot obtain the services of his own doctor.
> "There is no limit as to the number who may go on his list. He has also to provide all surgical instruments and other requirements, such as splints, bandages, anaesthetics and the like that may be necessary for the performance of his duties, except for a few things such as trusses, catheter, enema, syringes and such other appliances as cannot again be used with safety. There is no wage limit, and all sorts of inducements are held out to men in good positions to join lodges".

The A.N.A. promoted a medical institute in Carlton; which led to one of the largest lodges in Carlton reducing its fees from 23/- a year (including medicine as well as medical service) to 20/-.

The M.D.A. invoked action to boycott the new Institute, but one of its own members took one of the vacancies, along with others who broke the boycott,[15] and was expelled from the M.D.A.

The Victorian B.M.A. refused to discuss any rapprochement with the A.NA., charging it with not being a legitimate friendly society, and were even backed up by the U.F.S.A., saying its aims and interests were also inimical to their own.[16] The U.F.S.A. would not, however, agree to accept the model agreement sought by the M.D.A. However, with the growth of the M.D.A. in 1902 by yet 83 more members, progress in achieving higher rates was steadily recorded. In 8 centres in 1904, doctors successfully refused to work under 'undesirable' conditions. In Bendigo a Dr. Fullerton conversely refused to yield to pressure of local doctors to resign; being thereupon expelled from the M.D.A. and boycotted, despite his plea that he could not afford to resign. Other doctors were prepared to lose money for principle, such as one specialist who lost 100 patients by refusing to consult with the Brunswick Institute.[17]

To strengthen its hand, the M.D.A. in 1905 introduced a punitive rule more severe than any existing in Australia. It prevented any doctor, who was, or might, become a doctor to a medical institute anywhere in Australia from being eligible as a member; or prevented any member meeting any doctor in consultation who was not eligible to be a member, or had been expelled, or refused membership. To enforce the rule, the M.D.A. began a 'blacklist' with the scant courtesy that the victims of it were to be notified.[18] The 1908 Australasian Medical Congress records that it was 'much appreciated and resented'[19], but stressed its importance to young doctors ' who did not know where they were in such matters'. A Dr. Agnew objected on behalf of the men 'blacklisted' saying that they had often offended, only out of ignorance or necessity.[20]

But the M.D.A. in 1908 still complained that many 'reputable' doctors were outside its jurisdiction. In 1910, the N.S.W. B.M.A. President was asked to address the Victorian Branch on the problems of strengthening its organisation, and urged it to take over medico-political work from the M.D.A. A conference was held to define the functions of each, in the hope of achieving a similar strong position with the lodges as the N.S.W. B.M.A. A leading B.M.A. Councillor of the day, Dr. David Roseby, later wrote that the B.M.A. Council was then

divided between men who thought militant action was inevitable, and the moderates who thought a conference with the friendly societies would magically usher in an acceptable form of agreement. A meeting with the grand lodges in 1908 had proved the lodge delegates to be 'accomplished debaters, and procrastinators!'[21] They failed to reach finality, contending that they had no power to contract on behalf of their members.

Early 1913, the B.M.A. decided against amalgamation with the M.D.A. and took over all ethical matters from it including contract practice. Lodge membership was nearly as great as in N.S.W., with 1505 lodges, and 153,921 members, but they were considerably richer than in N.S.W., both in total funds and revenues, by reason of their lower average payment to the doctors: 14/- in the town, 18/0 in the country.[22] Late in the year, the B.M.A. called a conference with the friendly societies to ask for £1 per contract, a C.F.A. modelled on N.S.W., a charge for night calls, and a wage limit of £208. The lodge delegates would not commit themselves; but left with the vague promise of a round table conference when they had some authorisation from their lodges. Their attitude varied from rabid hostility to sympathy. Some of the sources of support were surprising. J. Lemmon M.L.A.' ex-chief president of the A.N.A., might have been expected to bear a grudge, but declared publicly:[23]

> "As one who believed in unionism, he could not join with those who decried the B.M.A. and advocated freedom of contract".

The past Grand Secretary of the I.O.O. , J.C. Smith, said to the Grand Lodge:[24]

> "They are entitled to more money. We have paid them too little in years past".

Others were vociferous against. The Grandmaster of the M.U.O.O. spoke in Ballart of forming a chain of medical institutes with doctors on salary to beat the BM.A. The Grand Secretary A.O.F. exhorted their annual meeting against:[25]

> "any attempt by the B.M.A. to dictate wages or the income that a member should be allowed to receive before being entitled to medical benefits".

and spoke of the doctors 'semi-pauperising' the friendly societies on the grounds that the funds could not bear the added burden proposed'. Even more intransigent was the M.U.I.O.O.F. conference which would not meet the B.M.A. at all.

The B.M.A. sent copies of the desired C.F.A. to every lodge doctor and secretary in Victoria., asserting that as this was the first occasion they had taken a determined stand 'it is only natural that considerable opposition has already been manifested by the friendly societies'.[26] The B.M.A.took six months to arrange the proposed round table conference, which transpired July 25, 1914, after much stalling and delay. 14 of19 orders were present; speeches of most delegates were unfavourable; and it was considered merely to have 'sustained the strained feeling' already existing.[27] A subcommittee of five from each side was to prepare a further conference, but, in the meantime, war broke out. The latter never met. The former met, with the B.M.A. subcommittee already having agreed (with what charter is not on record) to postpone everything as(it was impossible to estimate what effect the war might have upon the industrial classes'.[28] With this truce, there was no use for the £4,000 compensation and organisation fund which had been raised in anticipation of a fight.

By 1916, the war was clearly going on longer than anyone had foreseen, and the community far more prosperous than expected. Wage increases had occurred, and prices risen, but not the doctors' capitation fee. In 1916, two attempts to reopen the question of revised capitation fees failed, and discontent grew. The BM.A. Council finally yielded to pressure from members and criticism that the truce had been a mistake, and the secretary of the F.S.A. was asked to reconvene the subcommittee of ten to resume where it had left off August 8, 1914.[29] The reply was:[30]

> "All the reasons which existed in 1914, and which caused the postponement still exist in a more intensified form; the claims on the societies collectively and individual members are greater than they were in 1914, and we are unanimously of opinion that to reopen the conference at the present juncture is undesirable"."

The B.M.A. replied tersely that general dissatisfaction of members with conditions of contract medical practice was more pronounced than in 1914. It persuaded the lodges to a series of conferences June- August 1917, and held one of its own beforehand to gauge the divisions. At the former the delegates refused to consider an income limit, and the most they would yield was 17/- for the city, 24s for the country. Council refused this, claiming their rates had not gone up since before the bank crash of the 1890's.

What they were asking for was less than the worker paid his barber or his tobacconist a year, in fact less than a tramfare - 3½d to 5d more a week. Workers themselves had had increases. Doctors had had none, and in addition had had to carry dependants of men at the front lines.

The friendly societies argued that Victoria and N.S.W. were not comparable. In the latter state, the societies were not keeping members in the service financial while away; and they had a government endowment known as the subvention scheme, whereas in Victoria members had to keep a special levy ranging from 1/- to 2/9 a quarter to keep servicemen financial. There were 18,000 members at the war being kept on the books, of whom nearly 3/4 were single. Their absence was held to be compensation to the doctors.

The B.M.A. broke off negotiations and sent out a circular to all members, response to which was definite. Resignations would be sent in together with an ultimatum to lodges and a copy of the desired new C.F.A., to take effect from October 30, 1917 'without the exercise of moral suasion', but offering services under the new contract. How such effective organisation was accomplished was recorded by Dr. Roseby, then in general practice in the industrial inner area of Melbourne:[30]

> "The President of the B.M.A. was Professor Berry, the professor in anatomy , a short dark man of unbounded energy. An impending fight with the friendly societies was right into his basket. Within a week he gathered those with a flair for organisation, and presented the council with a plan of campaign that was immediately accepted.. For two years a subcommittee (of 3) met every night at 6 p.m.. The organisation subcommittee met 168 times in 1918 and 1919 and the full council every two weeks".

They fought for 100% membership of the B.M.A. through private canvassing, suburban meetings, and even by one more comic means - the aid of Mr. Williams, agent for antiphlogistine, who was given 5/- for every member he secured.

The reaction of some friendly societies was to expand institutes already existing, and to create others - advertising for non-B.M.A. doctors. The Premier of Victoria intervened early November to end a stalemate, by calling a conference on his own initiative. He lost the election soon after, but a new Premier pursued his intention Dec.7, 1917, despite the warning of the B.M.A. subcommittee chairman Dr. Boyd that:[31]

> "It was no use going on with another conference, unless the Premier would indicate the means by which the

"conference result could be enforced by the lodges". particularly as Mr. Mauger had told the Premier, Mr. Bowser:[32]

> "With regard to the income limit, there was no possible hope of their side yielding. Members of friendly societies must not be pauperised or put into classes.. Their association was united on that principle".

The Premier promised in Parliament to bring the parties before a Supreme Court judge. Council agreed to such arbitration only on the conditions decided December 8, that the judge should be satisfied that the Friendly Societies Association had power to enforce any agreement arrived at. The conference opened on a note of mishap, January 18, 1918, with Judge Mowle asking the parties to sign an agreement submitting to arbitration should conference fail, and then being astonished to learn that the B.M.A. had refused to submit to such an agreement at the conference with the Premier the month before. It said in the Annual Report 1918:

> "He was informed that he had mistaken the position.. and that the B.M.A. was not prepared to submit to arbitration in any form. The conference proceeded and the chairman very soon arbitrated on the subject of remuneration. He intimated at once that our delegates could not take any further part in the proceedings".

With time running out, the Premier Feb 1, 1918, asked B.M.A. delegates to wait upon himself and the Attorney-General. At this conference, February 6, Premier Mr. Bowser said:[33]

> "The wish of the Cabinet was that the B.M.A., having already secured a strategical advantage, would now be prepared to submit the question to arbitration. It was one thing to have the power of a giant, and another thing to attempt to exercise that power when you are dealing with a community of Australians. Powerful as your association is it is not for one instant to be believed that you will be able to drive the Australians with a threat."

The Premier pleaded for arbitration. Dr. Kilvington pointed out that 25% of the societies were not represented with delegates at the conference with Judge Mowle. Those, that were, had no power to bind their lodges, and certain societies were forming institutes. Before the B.M.A. would consider arbitration it had to be guaranteed that the result would be binding on both sides, the institutes given up, and there would be no victimisation.[34]

The B.M.A. Council then sent a statement to the Premier as to why it did not think the dispute to be one to which arbitration should apply. The essence of the service was a

concessional service at 1/- a service or visit. The only people who should be asked to consider how far such concessions should go should be the doctors themselves; the agreement they asked for had operated in N.S.W. for four years without complaint from societies there; and the Victorian B.M.A. Council was even contemplating a direct contract practice of its own.[35] The B.M.A. Council also secured legal opinion from the future Chief Justice Owen Dixon with the intention of 'declaring friendly society practice inethical in the event of negotiations absolutely failing by a certain date'.[36]

The Premier, at yet another meeting, offered £1 for the whole state, 5/- for night visits, and all other questions to be held over till the end of the war. The B.M.A. declined these terms and arbitration.[37] Notwithstanding, the Victorian Parliament passed an Act to appoint a Board to deal with the dispute - five from each side, and a Supreme Court judge as arbitrator. The Premier asked the B.M.A. to submit five names, but the latter refused, and stated the reasons why in a circular to every member of Parliament. The Bill was not enforced. Finally the Premier in desperation appointed a Royal Commission, chaired by Judge Wasley. His report in the B.M.A.'s estimate was 'a complete vindication of the claims of the association'.[38] The lodges were divided on accepting the verdict, some refusing. But the F.S.A. June 27, 1918, formally moved to accept the Commission's finding even with the 'noxious' income limit'. An essential condition of B.M.A. cooperation with the Royal Commission had been that the medical institutes founded after Nov.1, 1917, should be abolished, and the staffs of those existing prior to that date should be reduced to their original strength. But the friendly societies now made no move to fulfil that condition, claiming their abolition would mean a serious loss of money. The Premier again intervened, and legal counsel acted as mediators. A six point basis for allowing institutes to remain was at last devised, agreed to both by the F.S.A. and the B.M.A. in 1919: no institutes for five years, no reappointments or additions to medical staffs for five years, no filling of vacancies for five years, the lodges to pay Wasley rates whether B.M.A. or institute lists; reappointment of all B.M.A. members to lodges, and every lodge member to have the choice of going on either list.

In 1919, a clause was inserted in a pending Health Bill, at the instigation of some friendly societies (chiefly the M.U.I.O.O. and the A.O.F. who had withdrawn from the F.S.A.) to provide that the Governor may appoint doctors to give attendance to persons entitled under the Friendly Societies Act, 1915, and to have attendance upon members of friendly societies added to the duties of health officers.[39] The B.M.A., and the Returned Medical Officers' Association, resolved against allowing members to do so. The Associated Dispensaries sent a Mr. Falconer to England to recruit doctors, but the B.M.A. enlisted the support of the English B.M.A. to foil recruiting; and did the same through a warning notice in the A.M.A. Journal, U.S.A., when Mr. Mauger went to Canada to recruit doctors for the institutes there.

At least four doctors were expelled over institute positions in Victoria. The B.M.A. hoped that conditions under which the institutes remained open were such as to bring about their early dissolution, but still allow the lodges to meet the financial obligation involved in setting them up. The Annual Branch Report for 1919 recorded that B.M.A. hopes had not been realised, in that only half of the orders, representing something less than 50% of all members, had accepted the agreement The B.M.A. Council decided to make concessions no longer, but from that time on to deal only with individual orders, rather than the F.S.A. Gradually the B.M.A. was able to negotiate on a piecemeal basis the rate sought, and upheld by the Wasley Award, which was 20/- in the city, and 25/- in the country instead of the previous average 14/-. Additionally, an examination fee was allowed for new members, and a nominal charge for night calls. The B.M.A. by 1921 could say the dispute was 'now almost a thing of the past',[40] while the orders had gained what they had always desired, central control over their branches. The Manchester Unity alone held out, so Council decided that the standing offer of the agreement would be withdrawn by June 1, 1921. Peace did not follow till 1923. But the gains made did not bring equality with N.S.W. rates, as these were raised at the time to 26/-, a rate that Victoria did not secure for many years. In 1938, the Victorian rate remained the lowest in the Commonwealth.

The situation had not been without irony for the B.M.A. In 1924, Dr. J. Webb, ex-president of the Branch, when giving evidence to the National Insurance Commission said:[41]

> "If the dispute had commenced in 1919 or 1920, instead of finishing then, the claim of £1 per annum would certainly not have been made. It would have been very much more."

But the basis of settlement in 1921 had been an undertaking not to disturb the agreed on rate until 1926. Dr. Roseby, initiator of the 1916 referendum in the B.M.A. Branch which had begun the struggle, considered:[42]

> "It had been a staggering thing to see the terrible apathy that existed among lodge doctors... the lodge agreement was a most pitiable thing at the present time, and it was dreadful to think that work should be done, as it was done for so low a remuneration".

There were exceptions to the norm of contract practice in Victoria. The Yallourn Hospital and Medical Fund 1926 was organised on a unique basis without an income limit despite earlier insistence, and with an inclusive hospital and domestic service similar to the mining areas of other states with their very high accident ratio.[43] The B.M.A. also acted in private contracts by two doctors in the Mallee (1931) with timber workers (1932) forest workers and miners on a 6d per week basis deducted by employers (1933). In 1933, the grand lodges also proposed to add specialist services, a letter being sent to all the orders. The B.M.A. sections were to prepare a scale of fees, the patient being referred by the lodge doctors. The B.M.A. also proposed to see sustenance cases, referred by suburban public assistance committees, in groups on an organised time basis for 2/- an examination, but this was refused by the Minister for Labour.

The Branch still maintained a confidential list of black-listed doctors as late as 1935.[44] It issued warnings to other Branches, as in 1936, when interviews were being conducted in Sydney for a medical officer to the Ballarat United Friendly Societies Institute.[45] The Bendigo Institute, notorious in early days, lingered on until 1942. The Richmond and Singleton dispensaries caused an investigation as to salaries and conditions of employment in 1938.

The lodge agreement was altered in 1936 so that doctors could claim under the Workers Compensation Act for non-surgical treatment. In 1937, a standing consultative committee of representatives of lodges, and the B.M.A. Branch, was at last set up more belatedly than in other states. Doctors planned to ask for an increase,

now that prosperity had returned to the country. The new lodge agreement was presented by the B.M.A. April, 1938, and caused heated comments in the press that it was a tactical move to influence the result of the National Health and Pensions Insurance Bill, which the Commonwealth Parliament was to introduce in May. The Victorian rate in contract practice, universally considered by doctors in Australia to be too low, was to be taken as the model - therefore the higher it might be, the better. The Victorian medical secretary, Dr. Dickson, denied that Victoria had used 'pressure tactics', or that their action was intended to 'sabotage' the Commonwealth legislation.[46] The B.M.A. had for many years , he said, urged such legislation. The rate was not reviewed before war broke out in 1939.

The Federal Council contract practice committee in 1940 urged the Victorian Branch to take steps immediately to raise the Victorian capitation rate to that generally ruling throughout the Commonwealth,[47] realising that future plans for national health service might once more make the discrepancy important, and in view of its current negotiations with the Federal Consultative Council of the Friendly Societies for a Commonwealth C.F.A. The Victorian Branch thereupon asked for 26/- and 32/- without prejudice to negotiations for further increase at the end of the war. An impasse resulted with refusal by the societies, and the need to refer to the Prices Commissioner. After a long delay, the latter said he would approve a proposal of the F.S.A. that any increase should be determined by a member of the judiciary, assisted by ten assessors from both sides. The B.M.A. reacted as it had done in 1918, rejecting the idea as impracticable. In 1944, the F.S.A. agreed to the increase without conditions, but disagreement was not at an end. When the Federal Council B.M.A. finally approved its new C.F.A., after seven years of negotiations with the federal body of the F.S.A., the Victorian B.MA. said it was not acceptable. Finally in 1948, a new agreement was made for 36/- and 44/- providing for adjustment of those rates every three years, in line with variations to the cost of living index. At last in 1951, this long trail of conference was finally ended.

From September 1, 1951, a fee for service system became common to all friendly societies, who now became 'medical insurers' throughout Victoria in a totally new sense. The fee charged was to be the ordinary consultation fee prevailing in the community without income limit. Concessional service on an annual capitation basis, about which there had been so much haggling and bad feeling was gone, except for two or three defined categories - this service being policed by a Conjoint Committee. What legacy the system had left behind in bad feeling and misunderstanding - with an effect on the public attitudes of society in general, politicians in particular and through them, on the electoral policies of their party - is impossible to assess. What is beyond argument is that it provided almost the only form of social insurance until the national health service which replaced it.

(C) - FRIENDLY SOCIETIES IN SOUTH AUSTRALIA

The growth of friendly societies in South Australia, though less rapid than in states like Queensland, by 1892 represented 43% of the population. Of the two medical societies, prior to the B.M.A. in 1879, the Medical Association of South Australia circa 1872, spent most of its time arbitrating between members and clubs. Typical was a dispute at Moonta in 1873, when four doctors refused to sign new rules, and the company brought in another doctor from Victoria.[1] About 1886, several medical aid societies began to appear, managed by business men who kept the profits on reduced medical fees. When the B.M.A. Branch was founded in 1879, those responsible were more interested in science and learning than conditions of practice. They were not, however, oblivious of their responsibility At their first meeting, a complaint from a doctor at Willunga on underpayment was heard; but Council decided it had no power to act, as the arrangement was a private contract. On behalf of the B.M.A. Council, Dr. W.T. Hayward in 1888 sent out a circular saying many doctors felt an association of doctors to friendly societies should be formed to regulate fees, and consider relations. This led to the Registered Medical Practitioners of South Australia, March 1888, with as its object the 'mutual defence of the interests of the profession', and to attack the tendering for clubs which had brought about a reduction in fees. It held two conferences with lodge delegates in 1888 and 1889 to present claims, which got nowhere. The latter said they could not control their branches, and the suggestions were unsuitable. Among them was a major change of principle, in the aim to detach the provision of medicine by the doctor from the contract; abolition of tendering, and the limit of benefits to people who did not pay income tax. In 1890, the R.M.P.A. of S.A. heard at least 3 cases of lodge disputes.

During the nineties, medical institutes continued active, such as a canvassing society called the Mutual Provident Medical Institute of 1893. But doctors could do little more than pass a motion of disapproval and dissociation, and continue to complain. 1894 saw the beginning of the historic 'Adelaide Hospital row' which overshadowed all other issues, and created

further division in the profession, apart from the existence of two medical societies. When it was brought to settlement, in 1899, the R.M.P.A. was revived under the title of Medical Defence Association, but it made little more progress than in the past. Tendering was still common despite its efforts to'declare' certain organisations as 'not in the best interests of the profession';[2] and measures to divert doctors from taking such appointments by means of warning notices and blacklists. It did not,however, include the A.N.A. among these as in other states. When a Port Adelaide branch was proposed in 1904, it approved, being:[3]

> "satisfied that the A.N.A. in this state had always dealt fairly with the medical profession, and that there was no likelihood of their doing otherwise".

It agreed that lodge membership eligibility should cease with an income of £200 a year. The limited gains of the M.D.A. were also due to its limited membership.

A crisis in 1910 led to the transfer of lodge matters to the BM.A. from the M.D.A. in 1911. It began when a number of lodges united to form a United Friendly Society Dispensary, and appointed a committee to confer with the M.D.A. to estbalish a system of six to eight dispensaries.[4] Not all lodges were involved. The Rechabites, for example, publicly dissociated themselves. Up to that date, contracts had paid the doctor both for medical treatment and medicines; but now the contracts would be only for medical treatment, the medicines being provided seperately through the new dispensaries. The lodges claimed drugs would thereby be more. The doctors' payment would be 70% of the previous rate. The reduction involved was of the order of 10/- to 7/6, 25s to 17/6, and 30s in the country to 21s. The M.D.A. at a special general meeting resolved:[5]

> "The association is not opposed to the establishment of dispensaries upon an equitable financial basis, but the maximum reduction members are prepared to accept is 11½% on present fees.

In 1911, it based its figure on a circular, sent to all lodge surgeons, asking what percentage of their incomes was used to pay for the medicines and dressing necessary The lodges for their part based their figures on Victorian lodge practice - the worst paid state in Australia. Dr. Swift

pointed out the misleading nature of the figures tendered by the lodges. They had, for example, calculated an average of 70% married members in the lodges, whereas the figure was closer to 80%. Dr. J. Corbin had visited Ballarat, Geelong, and Melbourne in Victoria from S.A. and reported to the meeting that not one single advantage to medical men, or to lodge members, accrued from dispensaries there, except the ability of members to buy patent medicines, and all sundries, including instruments, from them at wholesale rates.

Therefore the M.D.A. decided that:[6]

> "the establishment of medical dispensaries in connection with lodge practice, on the terms proposed by the U.F.S. Dispensary Company would be inimical to the interests of the medical profession".

It circularised all doctors not only in their own state, but all states of Australia. Dr. Newland even moved to approach all lodge members as to the disadvantages of the proposed scheme.

During the dispute, eighty two doctors advertised in the press that they were determined to resist attempts to lower their pay, and agreed not to act as surgeons to any lodge affiliated with the dispensary scheme. Dr. Corbin sent a circular to all lay members of lodges calling on them to resign and join a lodge not affiliated with the dispensary, or unite with members to change the policy concerning doctors. The dispensary sent a counter circular to their members disowning Dr. Corbin. The argument seems to have dragged on for three years, when settlement was entirely in favour of B.M.A. conditions.[7]

In 1911 also, the M.D.A. of S.A. was called on to reply to the Standing Contract Practice Committee appointed at the 1908 Australasian Medical Congress. It said it felt it could not impose a wage limit clause in S.A. contracts, unless action against lodges were simultaneous by B.M.A. Branches throughout Australia, and called for a paid organiser travelling Australia. It also pointed out one of the difficulties most marked in South Australia, that country conditions varied widely in that state, as did the fees (30/- to 60/-). Doctors' lodge contracts were not bad, but did include all minor surgery. Their chief abuse was wealthy people in the clubs. The M.D.A. had no indemnity fund to support doctors who tried to resign lodges in protest.

The B.M.A. Council appointed a contract practice subcommittee in 1913, claiming that lodge issues had 'engrossed an immense amount of the Council's time and energy'.7

The B.M.A. objective was a C.F.A. similar to other states. The F.S.A. would not accept it at once. It deleted certain clauses - first, relieving the doctor of the necessity of meeting another doctor not approved by the B.MA.; second, payment of a doctor called in for consultation; third, releasing the doctor from the obligation of attending a member in arrears for payment. Then war broke out. The B.M.A Council wrote to the F.S.A. commenting favourably on the friendly manner of several past meetings, and suspending negoitations as 'we feel this is not the time when we should come to you with a request for increased remuneration'.[8] The B.M.A. expected war to bring economic depression; and offered to attend dependants of those on active service free of charge, if societies kept them good on their books. Incidents with lodges were few - one of these being the resignation of Dr. Abbott from the Denial Bay Farmers Medical Society because he was expected to run his car (800 miles a week) on his salary of £400.[9]

Another was the attempt of the Friendly Societies Medical Association Inc. to solicit the lodges to pass a resolution, empowering its members to become affiliated members of the F.S.M.A. Inc. By this, they would revive wholesale patent medicines, appliances etc, and offer reduced prices for dental work, optical work, massage etc. The B.M.A. banned the plan.

The F.M.S.A. was founded in 1914 and soon had a large membership of 11,000. It worked with salaried doctors. In 1921, the B.M.A. asked for an award equal to that paid by the other lodges. A series of abortive conferences led to the F.S.M.A. exercising their right under an agreement made in 1917 to have a dispute heard before a nominee of the President of the Industrial Court. The award gave the amount asked for by the B.M.A., but left other matters unsettled-particularly the amount for dispensing, age limit for families, and fees for childless families. Late 1921, the F.S.M.A. accepted the terms offered, but not long after was enquiring for doctors in England. Failing to secure an adequate response, the F.S.M.A. and Port Adelaide U.F.S. Dispensary Inc, ratified their agreements for further terms later that year.

Negotiations between the B.M.A. and the F.S.A. also resumed 1919-21. At first lodge delegates at their 1920 conference rejected an income limit, considered fees asked to be excessive, and preferred an agreement with the doctor to supply medicines and attendance, to separate agreements with doctors and chemists. They wanted an age limit of 16 instead of 14 as suggested by the B.M.A. and offered an advance of 25% on present fees. The B.M.A. wanted an income limit (already in force in Victoria and N.S.W.), an age limit of 14, and to exclude honorary members of lodges from medical benefits.[10]

After two conferences between the parties in a friendly spirit, the F.S.A. accepted almost all the B.M.A. conditions in metropolitan practice, but not in country practice. A special meeting on the subject late 1920 made it clear that conditions varied greatly, too much so for uniform rates. Lodge surgeons were advised to make their own contracts within limits to be fixed by the Council.

The 'settlement of the lodge question' seems to have occurred by August 25, 1921, as Dr. Hayward moved a vote of thanks in Council to Drs. Newland and Smeaton who had taken 'an immense amount of time and trouble.'[11] The only reform not carried through was for separate contracts between chemists and lodges, due to the refusal of the lodges on one hand, and the dislike of chemists for a flat rate on the other. The Pharmaceutical Society in 1921 tried to solicit the aid of the B.M.A. in opposing a Bill to enable the friendly societies to conduct open trading, but the B.M.A. could not do so.[12] A B.M.A. circular in June 1925 complained against lodges, late payments, inadequate and late lists, unfinancial patients, transfers on lists without members' consent. A new M.L.A. was proposed in 1926, the B.M.A. anxious for a separate agreement between lodges and chemists, and asking for a further increase of 50% to meet rising cost of living. The lodges, though still reluctant, by 1927 had agreed to dissociate the provision of medical treatment from that of medicines.

Other issues were not so readily settled. A letter August 4, 1927, from the F.S.A. proposed that the Chief Secretary should appoint an arbitrator, mutually satisfactory to both parties, to decide fees and mileage, both parties to abide by the results of such arbitration. To which the reply from the B.M.A. lodge subcommittee was:[13]

"Frequent meetings and conferences having been held, and the country members of this Association having submitted to the Committee their irreducible fees, no good purpose can be served by abmitting the matter to an arbitrator"

Both letters were sent to all doctors, with minimum rates suggested, and insistence that agreements must be subject to conditions of the new M.L.A. Despite twelve months' work and many meetings, and payment of increased fees by some lodges in 1927, the agreement was not signed until 1931, because of the difficulty involving country doctors. The scheme operated on a unit basis. In 1931, an agitation in Press and Parliament was aimed to have the unit reduced from 3.6d to 2.6d. This agitation appears to have been taken up generally, as the B.M.A. Council was given notice that from May 31, 1930, only 3s per unit would be paid in the metropolitan area, instead of the 3.6d agreed on in 1927. All doctors refused to reduce. The 1d per week, which appeared very little per member, meant a great deal to a medical man with a fair sized lodge practice.[14] Doctors felt that the rise from the original 2.6d per member (set by the M.D.A. in 1900 when the basic wage was 5s a day) to 3.6d. in 1927 (when the basic wage had risen to 14.3d a day) was a reasonable one in proportion; and reversal to a pre-war scale had not been justified.

During the thirties, however, adjustments with the friendly societies in general appeared to have been made cordially - though the state lagged behind other states in level of payment as laste as 1947. When new conditions for some 40% increase in capitation fee were served on friendly societies in that year, the argument given was that it was necessary to bring the level in line with the rest of Australia. The occasion evoked perhaps one of the nicest comments in the whole of the friendly society story with the B.M.A. in Australia. The Grand Secretary of the I.O.O., Mr. Parkinson, said his experience with the S.A. Branch of the B.M.A. was that it had always been sympathetic to the lodge practice business.[15] The 1948 agreement provided adjustment of payments in accordance with the rise or fall in the state basic wage. A 20% increase was negotiated by May 1950. In this year, however, the B.M.A. served notice to end all existing agreements on a fee for service basis with an upper limit of income entitlement, an increase in mileage rates and annual revision

of rates in accordance with State basic wage variations. This was intended as a concessional service to lodge members, but was ultimately superseded by the voluntary insurance scheme brought in by the Commonwealth Government in 1953.

(d) FRIENDLY SOCIETIES IN WESTERN AUSTRALIA

Major gold discoveries in Western Australia 1890-1900 brought spectacular social change, and a great rush of immigration. Among the migrants were many from the now depressed coal and goldfields of the east, who had been leading members of friendly societies there. The mining towns in the east, such as Newcastle and Lithgow, had given rise to types of medical contract different from the orthodox type of contract on the English pattern- based on the community hospital due to the lack of pre-existing hospitals when the towns sprang up, and the very high accident rate that made hospitals and continuing medical skill essential.

They were based on annual community subscriptions, ostensibly to found and maintain a hospital, which offered medical treatment, both in an out of hospital, as well as medicine. Doctors were not appointed by the group as lodge doctors, as they were in the friendly societies, but were appointed as hospital residents with the right of private practice. In fact, the private practice was usually illusory, as almost every one in the mining or timber communities were in the group as subscribers. Friendly societies did , also, exist. By 1894, there were 13 with 26 branches, and nearly 2,000 members paying an average 20s per member, including medicines, which worked out at an average 1s per visit. Mr. Bruck in his pamphlet on the 'Sweating of the Medical Profession' in 1896 wrote:[1]

> "The club system there is much more abused than perhaps in any other place in Australia. Really wealthy people in Perth belong to the clubs including the leading grocers and butchers of the town."

Clubs existed not only in Perth but Albany, Fremantle, Guildford and Geraldton. Those in Coolgardie were able to reach an amiable basis of work with doctors, for a standard fee of 7/6 per quarter on the principle:[2]

> "That no definite medical man should be appointed to any one society as had been the previous practice; but complete liberty of choice should be left to each individual member to select his own medical man".

Profiteering societies began to intrude where the more reputable ones were established, as in the eastern states; and hastened the formation of medical associations in both Perth and Fremantle.

One of the first resolutions of the W.A. Branch of the B.M.A. was disapproval of any member who accepted a post with a 'medical aid society, or any hospital carried on as such, August 5, 1899.[3] Action varied from deputations to the Colonial Secretary, warning advertisements, advice on contracts to doctors, and contact with other branches as to 'delusive advertisements'.[4] It received aid from unexpected quarters:[5]

> "The Pharmaceutical Society at Perth, the A.N.A. and the friendly societies generally have realised the situation and helped the Government arrest the free hospital and dispensary shopmovement, and hence several of these impostures have been suppressed notably at Bardoc, Goongarlie and elsewhere where contiguity to a railway and proximity to an already well-appointed hospital obtains. Bulong, however, although only about 20 miles from Kalgoorlie and Kanowa hospitals, backed by its opulent mine managers and greedy political bungs still successfully denies all ideas of honesty. Its dispensary is one of the best supplied in the colony and all comers rich or poor practically help themselves to its elegant contents, the only qualifying condition being the payment of 1s per week, the Government contributing an equivalent sum".

The B.M.A. adopted an avowed medico-political policy from the outset with a Parliamentary Committee, whose duties included the study of functions proper to friendly societies. It founded a Medical Defence Union in 1901, and urged power to admit and expel members, otherwise there would be a 'grave risk to the future usefulness of the B.M.A.'[5] In 1901, in Fremantle the societies failed to found a medical institute which would include all members of existing societies. The M.D.A. boasted in a circular to other states that the clubs had been unable to play off, as heretofore, one doctor against another,[6] because of the good feeling existing between doctors. It also called the A.NA. 'an association of sweaters' which tried to bring down the status of the profession. An A.N.A. conference at Perth heard a solicitor's opinion that the document was libellous, but decided not to risk the costs of a Supreme Court action against the M.D.U. Hard words were bandied against doctors, and only one man could be found to defend the doctors' right to unite.

In Coolgardie, the good relations between clubs and doctors, established in the 1890's did not last. A crisis occurred when the clubs began to admit a wealthier class of patient such as the Mayor. The local doctors objected, and the clubs sought a salaried doctor, deciding on a Dr. Erson.

The rest boycotted him, formed their own union in competition with the clubs with private lists. The clubs tried unsuccessfully to get a Bill to prevent any medical club being formed, unless incorporated under the Friendly Societies Act.

At Kalgoorlie, the neighbouring goldtown to Coolgardie, a friendly societies association had been formed early 1897 to make agreements with doctors, chemists and hospitals. A major incentive was the lack of any kind of workers' compensation legislation. In the twin city of Boulder, a similar Boulder United Friendly Society was founded. This scheme grew into the modern Goldfields Medical Fund Inc (jointly administered by trade unions, chamber of mines, and delegates from outside funds). Membership quite early became a compulsory condition of employment at the mines.

Rather unaccountably, as Coolgardie doctors close by had a working agreement with clubs there, the doctors in the Kalgoorlie region for some five years would not sign agreements or take list members. They also refused to consult with a young doctor, who, for a time, took list members. Finally the friendly societies, by offering guaranteed income, secured four doctors from Victoria. The Kalgoorlie doctors capitulated shortly after, being threatened otherwise with a major loss of practice. Only three did not, two were elderly, and one left in World War 1.[7] The only other boycott recorded January 1905 was equally unsuccessful - against a Dr. Cameron for meeting two abortionists in consultation.

From 1902-10, the hospital contract problem did not abate. After three years budget deficit, the Government by 1910 reduced the medical vote, asking districts, where population was not scattered, to take over responsibilities formerly carried on by doctors getting a stipend as district medical officers (£50 to £100). The new local committees, that took over the hospitals, no longer paid the doctors the fixed sum they could expect before. The doctor now only received what was left after administration, while the extras, which, in friendly society practice, gave him the butter on his bread as private fees, were expected as a free service with the club practice.

Enquiry throughout the state showed an urgent need for reform. Very few were like the timberworkers of Yarloop. When asked, subscribers voted the local doctor an increase

expressing delight with their 'union doctor' and the endeavour on his part to establish a 'minimum wage'.[8] But the general erosion of conditions elsewhere led to a subcommittee enquiry of Branch Council, and a call for revival of the M.D.A. which had lapsed in 1908. Its work led to a special meeting of lodge doctors in Perth in 1912. It complained many doctors were remiss in answering requests for information, and doctors in the goldfield areas did not take enough interest. A paid organiser was appointed for a time in 1913 to overcome the defect that not enough doctors belonged to the B.M.A. Membership rose from 121 to 152. An M.L.A. was secured by 1914 with a minimum capitation fee of 20s for the city, and an income limit clause. Country rates were decided locally. This was not done without innumerable letters, council meetings, subcommittee meetings and interviews with society delegates, as in other states. Unlike other states, it enjoyed good relations with the A.N.A. which signed the M.L.A.[9] Unlike other states, the income limit clause was to be retrospective. The Council Report of 1913 was able to state that many medical funds were anxious to have only B.M.A. members working for them. By 1915, many agreements had been brought up to standard. As in other states , the rates were reviewed in 1921, and the lodges asked for a 20% reduction of rates in 1932. This was refused, but a 10% provision for unemployed members continued until 1934.

In 1920, the friendly societies had asked that all agreements be made through the friendly society council. On the B.M.A. side, a committee of six was appointed, and the profession circularised as to acceptance. The Workers Compensation Act of 1926 raised a new problem in the employers' responsibility for cost of an injury at work. The injured worker was, by mutual agreement in 1927 between the B.M.A. and lodges, excluded from the M.L.A. for treatment up to the cost of £100 when he again came under its scope.

For many years timber mill, settlers' and mining agreements continued to figure on the business agenda of the B.M.A. because of the variable nature of conditions under which they were worked. The former proved the most difficult. By 1927 all but two were settled; one at Yarloop, formerly so well disposed to their doctor, had now sacked him and brought in a non-B.M.A. man. The three types of contract were

concluded by the B.M.A. on the four main B.M.A. principles: first, a per capita payment higher in mining districts (35/- in 1939 compared to 30/- elsewhere in the country); second, a wage limit- higher in the goldfields because of higher wages (£550 compared to £400); third, exclusion of fees under the Workers' Compensation Act (except at Kalgoorlie and Boulder which had special arrangements); and representation on the Board of Management of hospital contract systems.

In 1939 , the Council issued a warning notice to all members that they disapproved of any negotiations by individual members, or groups of members, with hospital committees or funds. It was then engaged in a crisis in Wiluna, the background to which had gone back many years. The Wiluna District Medical Fund had agreed to the B.M.A. agreement some years before, but friction between the Board and the doctors had been chronic ever since. In 1939, the Board proposed to pay the doctors a lesser salary than before (financed by capitation deducted by the Hospital from the miners' wages) and to charge the doctor for use of the hospital surgery and attending nurse. This was regarded by the W.A. Branch as 'an attempt by the Wiluna Medical Fund to make the hospital financial at the expense of the medical profession.'[11] The three doctors involved objected, and were given notice. In Wiluna, a B.M.A. deputation to the hospital committee, the mine and the unions was unsuccessful, and a deputation to the Minister of Public Health with a proposal for the Government to take over the hospital. The Wiluna Hospital Committee advertised for fulltime doctors on a salary basis. The BM.A. Council then blacklisted the Committee and invoked the support of other states. Two of the three doctors left, and the Council December 7, 1939 recorded 'the regret of the association for the want of cooperation of the Medical Department'.

Doctors in Kalgoorlie expressed the fear that, if Wiluna were successful, other goldfield centres, like their own, might seek a change of control. There was talk of a compensation fund. The row in Wiluna dragged on until 1942, when the B.M.A. conditions were finally accepted.

May 1947 the W.A. Branch signed an agreement with the Friendly Societies Council of W.A. to take the annual

variation in the basic wage, as declared in July, as the figure from which to establish the capitation rate. The Branch took the view that no increase had been expected during the war, and that friendly society members demanded, and got, far more in service than before. The old basis of contract practice was no longer satisfactory. Council in a circular to members said:[12]

> "The basing of the agreement on a flat rate without any provision for adjustments in the annual fee can hardly be regarded as equitable in these times of increased living costs and higher wages".

In 1953, as in other states, the system yielded to one of fees for services under voluntary insurance.

(e) FRIENDLY SOCIETIES IN QUEENSLAND

Friendly societies appeared from the first in Queensland increasing 1860-80, and began bargaining with doctors for lesser rates. A doctor in Rockhampton said, in 1887, that rates had fallen since their previous level, and a group of societies were combining to bargain yet further. Doctors responded by agreeing that only one doctor should tender, and he at the old rate of £1.1.0 for a single man; £1.5.0 for a married man. The societies in turn imported a new doctor, the local doctors trying to boycott him by refusal to consult, but failing. In 1890, the societies in Brisbane, after a series of bad years, reduced their rate from 20s to 15s. A number of lodges planned to extend the work of the friendly society dispensary in Brisbane, by combining to employ salaried doctors in place of the list doctors.

The Queensland Medical Society, revived in 1888 for the third time, was unwilling to prejudice its precarious existence by fighting this plan itself. It sponsored a meeting of medical men in Brisbane October 28, 1890, to discuss what action should be taken to oppose the Institute plan, and to overcome the considerable variation in fees in general. To the 22 doctors present, Dr. Booth proposed a similar association to the Medical Defence Union of Great Britain, and the Western Suburbs Medical Association of Sydney. A new Queensland Medico-Ethical Association was formed, with a policy that no member should tender for less than £1 per head, nor contest any vacancy declared, resolving:[1]

> "All members of this Association shall pledge themselves in every legitimate way to bring pressure professionally and socially to bear upon all members of the medical profession who contravene the principles of the Association and to induce all newcomers to join the Association".

A notice was sent to all lodge doctors, asking them to raise their fees; and another to all other states. A number of lodges actually gave the doctors the £1 asked for, or met them half way with 17.6d, being unable to levy members without sanction of their grand lodges until December 1891. A few lodges claimed themselves already pledged to the Institute, which was now advertising for three doctors at a salary of £550 a year each and £1.1.0 for confinements, but no right of private practice. The G.U.O.O. strongly opposed negotiation, advertising in a southern newspaper for a doctor.

It did not check the formation of medical institutes, not only in Brisbane but Warwick, Bundaberg, Toowoomba, Rockhampton and Townsville; nor their recruitment of doctors from other states. The Q.M.E.A.'s report for 1892 said that 'it is apparent from the figures supplied by our medical officers that their work is not altogether a bed of roses' with 17,447 consultations and visits, earning £697 or 9d a head for the doctor.[2] One doctor who tried to rebel at the workload, by taking a lodge member to court to recover fees for an operation, found himself punished by being starved for work. Their fees were considerably less than the condemned 15/-; only 2/5 of the lodge income, said to be for medical benefits, in fact going back to the doctors. There was no income limit, no list limit.

After a successful law suit conducted by Dr. Gerde of Toowoomba against Mr. Schmid, lodge members of M.U.I.OO. for £6.9.0 for an operation in 1894, the lodges in Toowoomba in 1895 planned an institute with 600members. They gave notice to the four doctors in lodge practice, who then enjoyed very fair terms. The new institute called for tenders to secure doctors for a fee, which now included all operations. Three doctors in three years were willing to take their terms. A new institute appeared at Rockhampton in 1900, which advertised for doctors. The A.M.G. warned doctors the post offered no private practice, and the conditions were intolerable.

The Queensland Medical Society had earlier joined the Queensland Medico-Ethical Association in declaring the terms of the Brisbane U.F.S.M.I. contract as 'derogatory to the profession, and degrading'. It said it viewed with dissatisfaction any members who met Institute doctors in consultation. The boycott failed for want of consistency. Some members still leaned to negotiation, even to the point of inviting friendly society members to dinner - to no avail. The spirit of compromise was expressed, for example, by Dr. Jackson, who opposed following the N.S.W. policy of total boycott, at a special B.M.A. branch meeting May 1898 to consider contract practice. A Committee formed at this meeting, therefore, proved ineffectual. A professional round robin collected views, which in general urged a wage limit for society membership. The 1896 resolution of the Q.M.S. was reinforced in 1902 against the B.U.F.S.I. by the B.M.A., which also boycotted the A.N.A.; despite their complaint that they were no worse than others not banned.

In 1905, a Dr. Fearnley wrote from Charters Towers that a new contract sought to cut doctors down a shilling, to require all operations to be included, and to charge the doctor for a consultation should his patient go to another doctor; while the dispensary operated at a handsome profit, and the lodge secretary got a bonus:[3]

> "We have mining magnates, managers, brokers, publicans, men who could buy and sell their doctor ten times over - all availing themselves of the lodges".

In 1908, a Dr. Booth Clarkson, near Townsville, pleaded for the B.M.A. to acquire the strength which would allow him to use the B.M.A. name as authority for a strong line with the lodges. The combined Townsville Friendly Society officials there opposed his complaints. The B.M.A. answer was:[4]

> "Our rank and file are very difficult to manage. They have little or no idea that such a society as the B.M.A. exists, especially in North Queensland. They take the attitude they are the payees, the doctors the servants; and many of them respect the doctor less than the navvy".

In May, 1900, the B.M.A. had formed a medical defence association, which was not as vigorous as its counterparts in other states. By 1910 there were nearly threehundred doctors, of whom 157 were members; when the B.M.A. approached them with a C.F.A. drawn up by the Branch Council on the N.S.W. model. After amendments, this was approved at a meeting July 1912, when the President and Secretary of the N.S.W. Branch were present. Though an income limit was decided, the scale of fees was left to each local association. The B.M.A. Branch Council then wrote to every friendly society in Queensland, except the A.N.A., asking for conference on the agreement; and this was sponsored by the Queensland United Friendly Societies Association November 1913. The B.M.A. accepted a wage limit of £260, with £2.2.0 for confinements and a capitation fee of 17.6d. One member expressed his disgust that they were really no better off than before:[5]

> "It is for this that we have wasted evening after evening in useless discussion, and our secretary and council have given their time and labour".

The M.U.I.O.O. had boycotted the conference, Brother Jack at their annual conference April 1914, saying:[6] 'Many members considered the doctors were trying to down them in every way they possibly could'. When war was declared soon after, the B.M.A. decided to abandon any plan to ask for increases in lodge rates for the duration.

In 1921, a B.M.A. subcommittee negotiated new terms. Bargaining took place, with 25/- proposed by the B.M.A. and 22/6 by the clubs. A mean was struck, and both sides remained on good terms until 1928. The A.N.A. was also accepted on B.M.A. conditions. But in 1928, relations deteriorated when the B.M.A. asked for the terms of the Federal M.L.A., and an increase from 24/- to 30/-. Conference led to deadlock.[7] The B.M.A. refused to negotiate further with the F.S.A. but only with individual societies. On the other side, the lodges proposed a pool scheme for fees, by which lodge members could call any doctor they wished at private fees, and get a refund from the pool. The scheme ran into debt by the end of the year, and had to be discontinued. Some members had done little to ensure success by doing the rounds of the doctors. One went to seven doctors for one illness. During 1928, the Brisbane U.F.S.M.I. had gained some 3,000 members as the result of the dispute, still offering services from three salaried doctors for £1.1.0 a year, plus the right to enter the Institute's hospital.

Finally, early 1929, a committee of lodge secretaries proposed a Friendly Societies Medical and Hospital Council to continue the pooling system, but on the old capitation basis, not fee for service. The B.M.A. relaxed several claims in return for the 30/- capitation fee demanded, including the income limit, which, at £416, was much higher than in N.S.W. (£364). The B.M.A. was able to negotiate with the new body without a legacy of past resentment, attaching to the F.S.A. The Council kept a central fund into which all fees were paid, and from which doctors were paid quarterly. It controlled the service of medical benefits, all doctors and all lists of members from all lodges of all societies being registered with the body. A joint committee of the Council and the BM.A. (which formed a special lodge section not long before) served as an arbitration body to deal with all applications for an increase of fees from doctors, and all complaints from either doctor or member. This Council existed from 1928-53 , ceasing with voluntary insurance by the Commonwealth. Its creation signified the right of the B.MA. to a fair and uniform contract. A schedule of fees for special services to lodge members was abandoned in 1931. Instead, a definite schedule of fees was laid down for private patients, doctors charging 25% less for lodge members.

The 1928 crisis led the B.M.A. to amend their rules to establish the principle of the open list in Queensland whereby all doctors would have the right to nominate to accept lodge members; and to allow treatment of lodge patients in hospital. The B.M.A. also tried to put the issue of capitation fee adjustment on an economic basis, particularly in view of erratic levels due to the depression. Professor Brigden worked out a scheme whereby it would be one third of the effective weekly wage. The 1929 rate of 30/- was taken as a base, and varied according to a set formula, covering the average weekly wage and the rate of unemployment. After initial difficulties, the system worked well from 1934, both parties accepting the figure tied to the Nominal Wage Index Number of the Commonwealth Statistician.

Further friction occurred with the Toowoomba A.F.S. M. Institute. When one of its three doctors, Dr. Brown, was dismissed, and the Institute would not accept an open panel, the B.M.A. declared it in 1929. Their boycott lapsed when Dr. Brown was reinstated. The other doctors were Drs David and Alexander Horn. Not long after, the B.M.A. realised in the course of negotiations to reduce the capitation fee 10%, that the Institute had not established an open list. By this time Dr. Brown had been replaced by Dr. Furness. The B.M.A. declared the Institute, and wrote to the three doctors, who worked for the Institute, asking them to resign within seven days. They refused. If the B.M.A. were to proceed to expel them under Bylaw 53A they had to distinguish between Dr. Furness and the two Drs Horn, as the former had joined the Institute after the bylaw had been introduced. The B.M.A. sought advice from the B.M.A. Council in London, who, in turn, consulted with their solicitors, The B.M.A. felt uncertain whether it had the power to expel, but equally that the inability to do so weakened the authority, not only of the Queensland Branch, but the Association as a whole.[8] London, in reply, pointed out the major difficulty in that the B.M.A. had not objected to the terms of appointment of either Dr. Horn when they had joined the Toowoomba Institute, but explicitly approved them; and there had been no alteration whatever in them since, nor in arrangements made by the Institute in treatment of their members. Moreover they had joined before introduction of the 1929 bylaw involved. Therefore they might well hope to succeed in a civil action for damages against the B.M.A. should it proceed to expel them; and the Queensland B.M.A. could not

look to London for financial aid. The Drs. Horn might find grounds in the assertion that the bylaw was framed in order to coerce them. In light of this advice, the Branch only proceeded against Dr. Furness , who had joined, after the bylaw was passed, without the consent of Council, and after the situation was pointed out to him; and asked the Central Council to adjudicate.

In Toowoomba, the B.M.A doctors of the Downs and S.W. Medical Association also took action by forming their own contract practice service, in conjunction with local chemists, and in competition with the Institute, calling for state wide support.[9] They felt an important principle to be at stake.

> "If it fails, it will mean that any local institute or friendly society anywhere in the state, will be able to decide what they consider is a fair and reasonable reumeration for medical service and we shall revert to the old system of each township making its own arrangements with the local medical men. This chaotic condition which was full of anomalies was in existence until a few years ago and was only terminated after a fight in the metropolitan area."

Even as late as 1941, trouble occurred in Bundaberg with the Institute there. Founded in 1919, it had some 2,000 members at the time. During the depression, both Brisbane and Bundaberg B.M.A. members agreed to reduce the capitation fee on the understanding that it would be restored when the economy revived. But an increase was refused in 1934 on the Brisbane formula. Finally, early 1941, lodge doctors there resigned unless it were adopted. The reaction of the Institute was to advertise for two fulltime doctors on salary. The B.M.A. established an independent medical service for a 27/- rate, though continuing efforts at compromise with the societies. The Institute established its own hospital in 1946. To this day the M.J.A. lists the Bundaberg A.F.S. Medical Centre under warning notices in the journal.

In 1952, lodge practice ceased in Queensland.

(f) FRIENDLY SOCIETIES IN TASMANIA

Tasmania was the home of the first branch of the Royal Society to be established outside Great Britain in 1843. It founded a special medical section in 1836, a unique feature of which was its deliberate concern with medico-political matters, normally eschewed by any Royal Society. Issues such as clubs, quacks , homeopathy and medical defence were raised, suggesting the real need for an active medical society.

The 'club' problem was evident in Hobart in 1898, when seven doctors sent out a circular to the lodges asking for reform as to fees, then 12s per head, and imposition of a wage limit. Some years before the doctors had tried to combine to charge higher fees, and the result was immediate competition from outside. In 1898, the lodges threatened to get two doctors on salary to do the lodge practice. There the matter rested until 1912 .

The Tasmanian Royal Society supported the special inter-colonial congress on friendly society practice called by the M.D.A. Victoria in 1898, and agreed to adopt any of its resolutions, though Dr. Crowther at the general medical congress 1899 objected to a 'stand and deliver' attitude, saying they should deal with the lodges by 'courteous and friendly discussion'. A Tasmanian M.D.A. was formed in 1902. This was precipitated by moves to form branches of the A.N.A. in Tasmania; and unfair treatment by lodges to the doctor at Queenstown. Alleged underpayment in club practice became one of the pressing issues that led to the eventual formation of the Tasmania B.M.A., as in other states.

Early 1912, the Tasmanian B.M.A. Council submitted a draft M.L.A. to every lodge in Tasmania, and invited negotiations on this basis. Societies, in most cases, accepted the justice of the demands, scale of fees for operations, reduction of ages for children from 18 to 16 for entrance, and a fee for certificates other than for lodge practice. On one point they would not yield, settling only for 15/- capitation fee - not the 20/- strenuously sought for. They may have had justice in their resistance, as Tasmania was not, relatively, a prosperous state. In Launceston, the North Tasmanian Friendly Societies Association tried to

negotiate for 13.6d, though at least two Druid lodges thought 13.6 insufficient. The Sherwood Court Ancient Order of Foresters A.O.F., with 1,000 members in Launceston, refused to pay more than 12.6d in spite of 'urgent representations'.' They brought in a doctor at a salary of £500 (or 4/- per head per year) who soon left; then tried to bring in another man paying him the 15s refused by the B.M.A. doctors, who said they would tell the new doctor that he was acting contrary to the policy of the association. The Court finally gave way and reinstated the old doctors. In 1913, the N.F.S.A. (North Tasmanian Friendly Societies Association) planned a combined medical institute with three salaried doctors, but the scheme lapsed with the outbreak of war.

July 11, 1916, a special general meeting decided to raise the rate to £1, the war notwithstanding. Notice was given the lodges that this would apply from Jan 1, 1917. Conferences with the F.S.A. from north and south ensued, both with the Council and then the B.M.A. Branch. The latter remained adamant despite fairly persuasive arguments from the lodges. These were that Queensland doctors had left fee increases in abeyance till after the war (they failed to cite Victoria which had not); that the service was below standard, as some doctors were on active service, and those left behind were overworked; increased costs of drugs had led to a special levy for the dispensary; and finally a new Act of Parliament - agreeing to pay the lodges half their losses through the war - had required insurance for which members would have again to be levied. The B.M.A., for its part, was already giving concessional service to dependants and widows of men on active service, as in Queensland. The F.S.A. believed:[2]

> "If, on top of this levy, the extra fees asked by the doctors were added- extras which would have to be passed on to the members, as the societies had not got the funds to pay them, it would inflict great hardship on a largenumber of members, more especially the older ones who had been in the societies many years, and the single girls".

The two friendly societies associations again toyed with the idea of a medical institute. Salaried doctors were employed in 'outlying'districts, like Queenstown and Zeehan, with a comprehensive service provided by two doctors, for example, in Queenstown through the Hospital Union. Pensioner services were free and maternity extra, the rest on a weekly contribution. Its 1700 members covered 97% and a specialist fund met expenses up to £20 a year. In 1920, the Zeehan

Medical Society registered as a friendly society and paid 9d a week to the doctor without salary limit. Its 1500 members were also covered for Hobart hospital as well. Similar schemes operated at Associated Pulp and Paper, and Rosbery Zeehan Hospital.

In 1936, a committee was appointed to consider community hospital and contributory schemes. Legal opinion was then sought as to the right to claim payment under workers' compensation, and as to the right of lodge doctors who had not signed agreements with lodges.

The friendly society movement in Tasmania never suffered the conflict that reached crisis point at various times and places in other states. The Tasmanian Councillors, at federal level, always tended to take a more moderate attitude to friendly societies - entertaining less exaggerated fears of their inroads on the standards of earnings of medical practice. As in other states, club practice disappeared in most areas in favour of the Commonwealth voluntary insurance scheme, but the hospital and medical contribution schemes continued unchanged where they existed, as they did in similar mining, or company communities, in other states.

CHAPTER 5

THE PARADISE OF QUACKS

When a General Medical Council was first set up in Great Britain in 1858, it was the first adequate state instrumentality to regulate the profession. It had three leading objects. The first was to keep some sort of register of what were recognisable qualifications for a doctor, and to keep a register of those who possessed them. The second object was to protect the public from qualified men who had been registered as competent, but for some reason had become incompetent. Such doctors might then be deregistered for 'infamous professional conduct' and forbidden to practice medicine. The third object was to see that the qualifications being registered were of the highest possible standard by maintaining proper standards of professional education.

Early state legislation did not establish any control over the not inconsiderable number of people who 'practised' as 'doctors' of one sort or another without any medical training at all; who were usually castigated by qualified doctors as 'quacks' and charlatans'. The vast majority of quacks, in the nineteenth century, defrauded the public by pretending to have qualifications in the form of letters after their name. Because of their trading on the wide variety of degrees, awarded by various training bodies in the United Kingdom, quacks were able to presume that the public would not know the difference.

Those , who wished to ban quacks from the community, had three courses open to them. The first was to ban them from the blatant advertising that was their stock in trade, particularly their generous claims to cure the incurable; the second was to prevent them from using false titles which deluded the public into thinking they were qualified; the third was to prohibit them from practising altogether, or even to limit them from offering to treat incurable diseases.

Governments were slow, both in the United Kingdom or Australia, to adopt any of these courses against quacks, not only in the nineteenth century, but up to the present day. Certainly none was willing to adopt the most severe

prohibition of all - that against practising medicine at all. Protagonists could always be found for practitioners of unorthodox medicine, particularly those who were not outright quacks in its derogatory sense with little pretence to formal knowledge; but those who considered themselves specialists of a kind with some formal training of their own, such as chiropracters of latterday.

Greater justification for tolerance of the quack, in competition with qualified doctors, could be found earlier in the nineteenth century than now. Early in the century, medicine was only just emerging from the excesses of bloodletting and complicated prescriptions with energetic drugging. The public were not unnaturally dubious that the profession really always knew what it was doing, or was able to cure very much at all. Then, any form of surgery often meant death from gangrene, gas or a gross infection including gross gangrene. Epidemics could not be controlled. None knew that infectious diseases were infectious but ascribed many other causes. The public still turned to the bone setter, the herb dealer, and the apothecary with his bottle of medicine and leeches.

As the skill of doctors increased through the century, and their armoury of knowledge, the public persisted in a conservatism towards the profession, in a critical attitude to the role of the body of the educated gentlemen that doctors now held themselves out to be - no longer the haphazardly trained apprentice- apothecary or surgeon. While roundly criticising doctors for their errors and mistakes, and their failures to cure, many a layman could be found to do the opposite with the many pretenders to medicine - to cite their cures, their wonders in healing, and to argue the case against banishing them from society. This inconsistency of attitude often was to be found reflected in the press and in parliamentary debate, whenever legislation concerning control of the profession was under fire. The doctors, for their part, were vocally and publicly very critical of the quacks. Doctors saw them as people under scarcely any restraint, except for the supposed limitation that they could not accept government employ, appear as medical witnesses or issue death certificates. By contrast, the doctor came increasingly under government supervision and restraint. The folly of such inconsistency was the theme of Dr. Barnett , when speaking as president of the 1927

Australasian Medical Congress:[1]

> "A sick man, or a man who thinks he is sick, is not bound to come to one of us for treatment. He can choose a layman if he wants to; he can have the drains of his own precious body, his stomach, his bowels, his kidneys, and what not, tinkered with by an ill-educated, self-styled healer who has not the haziest idea of the intricate mechanism of these essential organs. Yet if he wants the pipes, drains or sewers of his house looked to, the law insists that he must employ a man specially trained and certified for the job- paradoxial but true."

Consequently, the history of medical societies reveals the conduct of a crusade at two levels - the first to persuade Parliaments to enact medical legislation which would regulate the profession further - the qualified as well as the unqualified; the second to persuade doctors themselves to maintain the standard of morality demanded.

The attempts of medical societies to control the practice of medicine in Australia were conducted against the background of similar attempts in England, where Australians looked for a lead. Australia's earliest legislation in this field - in the colonies of Tasmania and N.S.W.- actually preceded legislation in the United Kingdom, however. Victoria was next, followed by S.A., Queensland and W.A.

The first Acts were those which set up a Court of Medical Examiners in Tasmania 1837, and a Medical Board in N.S.W. 1838. The Colonial Office set up these medical boards, before either colony had self-government in order to compile a register of qualified persons for coroners' inquest and inquiries held before Justices of the Peace. The N.S.W. Act recognised the category of a 'legally qualified medical practitioner; who had to prove he was qualified by submitting some proof of qualification to the Board. In 1844, this Act was extended to the Port Phillip district (later Victoria). A further Medical Practitioners' act in N.S.W. in 1855 gave the Medical Board there power to examine doctors who came before them or witnesses; to take declarations and to prescribe penalties for false presentation or forgery. The Medical Board, however, once it had put a name on the Register, had no power to remove the name, if it discovered the doctor's qualification was not of the standard presumed, nor if the doctor had committed any criminal offences. He could go on practising medicine. In short, the Board had no disciplinary power to impose penalties for 'infamous professional conduct."

The Tasmanian Court of Examiners had slightly different powers from those of the N.S.W. Medical Board. It could register doctors, if an applicant had degrees from specified colleges or institutions, or by its own examination of the applicant's 'Letters Testimonial'. The Medical Boards set up by such Acts were, and remained, independent of any medical societies formed by the doctors themselves, being statutory arms of the Government. In 1849 in N.S.W., Dr. Dickson introduced into the governing body of that state the first of many attempts 'to increase the responsibility of the medical practitioner and to afford additional security to the public'.[1] The Bill proposed a policy often put forward later in the Australian states, though seldom put into practice, of a medical board comprised only of doctors. The Bill also proposed to permit only properly certified people, acting either as doctors or druggists. Petitioners against it came forward, chiefly druggists and doctors who were also druggists, the evidence disclosing a laxity in practice of both professions and lack of clear definition between them.[2] The solicitor for the chemists and druggists argued for separation of the professions, a view that received support among doctors. The Bill itself lapsed.

In 1846, the shortlived Australian Medical Journal in Sydney had called for action by the profession of this kind:[3]

> "While the magnates of the profession are attempting its reformation in the United Kingdom and associated movements are made in almost every town towards the same object, it would surely facilitate measures of amelioration in the colonies, if the profession would consider collectively what legislative enactments are necessary for the prosperity of the body. We are encouraged in the colonies by the absence of inveterate local prejudices and opposing interests".

In 1847, the Port Phillip Medical Association petitioned the House of Commons where a Medical Registration Bill was being presented - that the same privileges and protection, therein proposed to be conferred on the members of the medical profession of the United Kingdom of Great Britain and Ireland, be extended to the members of the medical profession in the Australian colonies.[4]

During the evidence given the N.S.W. Legislative Council in 1849, it was said that quackery was not common as yet in N.S.W. One of the by-products of the gold rushes from 1851 on, both in Victoria and NS.W. , was the inrush of quacks, as well as many immigrant doctors with qualifications from Europe, whose qualifications were more difficult to check, both as to

quality and authenticity than those from Great Britain. By April 1854, the Bendigo Medical Association, in Victoria's largest goldfields town, wrote to ask the support of the Medical Association of Victoria for a crusade against unlicensed practitioners, including prescribing chemists. They said, of the Medical Practitioners Act of 1851, that that Act had long been pronounced quite unsuited for the present wants of the profession, no less than for the requirements of the public;[5] a view reiterated in 1877 when its reform was still wanting. An Act introduced into the Victorian Parliament in 1854 sought to require production of diplomas and degrees, on application for registration with the Medical Board, instead of affirmation under oath. This, and later efforts, failed to secure the passage of a draft Bill prepared by a Medical Society of Victoria subcommittee in 1856. This was despite having doctors in both Houses of Parliament. One knowledgeable observer blamed opposition from within, as well as without, the profession for the failure of the 1862 Act.[6]

> "To a less extent, than was the case in Great Britain, medical reform was delayed in Victoria by a want of unanimity among the medical practitioners themselves. "Homeopaths, hydropaths, mesmerists, and other septs wished to be protected from competition with unqualified practitioners , and in particular desired legislation to secure certification of qualified persons for the protection of the community. The Government of the day was in favour of liberal certification, and even of the acceptance of unqualified persons who had been plying their trade for a few years."

The Victorian Acts of 1854, 1862 and 1865, were largely inspired by Dr. Wilkie, a member of the Upper House, and leading member of the early Victorian medical societies, as well as editor of their first journal. However, neither the 1862 Act, nor the draft Acts of the M.S.V., included the powers given to the General Medical Council, when set up by the British Government in 1858, to deregister for 'infamous professional conduct'. A bill introduced by Dr. Douglas into the N.S.W. Upper House 1857 to prevent quacks using the title doctor, likewise did not seek disciplinary powers for the Board against doctors themselves. When an A.M.A. was formed in Sydney in 1858, one of its earliest acts was to support Dr. Douglas. It was consulted in preparation of this Bill, which, a later record said' was the precursor of many more of a similar character since consigned to the usual massacre of the innocents'.[7]

Quackery had its undoubted supporters, as one instance in South Australia in 1854 demonstrates. Locals gave testimonials to an unqualified man during an inquest at Thebarton causing a commentator in the Lancet to remark:[8]

> "Gentlemenly manners are not the right evidence of professional skill... the love of quackery, the pleasure of being cheated appears to be the same the world over. In Australia there is the same pigheaded advocacy of unqualified medical practice as in the centre of the British Empire."

In 1879, an attempt to pass a more adequate bill to decide who could be registered, and to fine unregistered persons, failed in South Australia, the South Australian Register commenting:[9]

> "One of the strongest arguments urged against the Medical Practitioners Bill of 1870 was that it was inconsistent with the principle of free trade".

A country doctor in South Australia in 1877 complained "north, east, south and west, quackery assumes its sway".[10]

Victoria and N.S.W. were both known as the 'Paradise of Quacks.' In Victoria in 1877 it was said that as many people were practising off the register as on. They called themselves herbalists, eclectics, hydropaths, galvanists, or simply specialists, or were even Hindoo or Chinese, or consulting chemists, or advertisers of nostrums. The Medical Society of Victoria in the 1870's made a consistent effort to tackle the problem by an alternative route to legislation.[11] They decided to pay a collector to raise funds with which to prosecute unlicensed practitioners; and to press the police to begin such prosecutions. One such was in 1872 of an A.W. Harris, fined in the Magistrate's Court at Sale for irregular practice, after he had signed the death certificate of a child. An A.W. Shaymes was charged with manslaughter and gaoled at Ararat for two weeks in 1873; but fines, the usual penalty, were ineffective as deterrents to quacks, particularly as they were usually discharged. Astonishingly few of the manslaughter cases were convicted. Two men were fined £25 in 1875 over deaths in childbed. A magistrate, while Mayor of Ballarat, discharged a 'Dr' Quoi Sang, accused of the needless death of a woman. A. W. Jackson, committed for the death of a child in 1872, was said to have used a gimlet and hook during childbirth. The requests of the M.S.V. to see the Solicitor General to complain were ignored. The President of the M.S.V. protested to a special meeting called to consider quackery that:[12]

> "Public sympathy in this colony was always in the direction of quackery... if he is hailed into court, the publicity does him no harm. He gets off nominally or is not fined at all".

Moreover, despite the prohibition in the pharmacy Act, 1876, a number of chemists continued to prescribe, and some to visit, in Victoria. Typical of the more flamboyant quacks was "Dr" Mohabeer of Emerald Hill, who claimed to be the late medical adviser to the rajahs and nabobs of India and professed 'to cure diseases given up by other doctors such as leprosy, cancer, consumption, paralysis, asthma, gout , rheumatism, dysentery, gravel and stone in the bladder'.[13]

His conviction was later quashed on appeal on the grounds that he had not said he was registered, when Judge Cope commented:[14]

> "The statute does not make it an offence to practise as a doctor without being licenced, but it is made a very serious crime to pretend to be a doctor."

The comment of the editor of the A.M.J. was :[15]

> "It is certainly anything but encouraging to the large number of students who are now attending the lectures in the medical school of the University, that the time and money they are spending, gives them no substantial advantage over any charlatan who chooses to assume the vocation of medicine".

A number of men the profession would consider 'quacks' at this time applied to the Medical Board of Victoria for registration. The Chinese community, much grown during the goldrushes, memorialised the Board asking that their doctors be registered, such as a Yee Quock Ping, who applied finally to the Supreme Court for a mandamus to compel the Board to register him, when they had refused the former's request to register Chinese doctors, on the ground that there were no medical schools in China. The M.S.V. openly supported the Board.

The question of American degrees had already become a problem. Dr. Neild, secretary of the M.S.V., wrote to the American Medical Association for some enlightenment, to be told that they had no list of colleges granting diplomas, nor any report as to qualifications.[16] A Mr. Bottrell, who claimed to have an M.D. of Edinburgh University, Chicago, had applied for registration in 1874 and been refused; proceeded to practice, was fined £10; moved for a mandamus to compel the Medical Board to register him and was refused by Mr. Justice Barry on the grounds that, while possessing a diploma, he had not stated details of his course of study.

The Medical Board of Victoria produced several drafts of amendments to the medical act without success, although also urged by the Medical Society of Victoria; except in the case of opposition to a proposal for compulsory vaccination to be carried out by unqualified medical men. In 1877 Melbourne degrees were recognised at last in England by the General Medical Council.

N.S.W. suffered a similar plague of quacks to Victoria. The N.S.W. Act was even less satisfactory. The limitation of the Act was notably demonstrated in 1872 in the case of Dr.J. F. Murray, once a member of the first Leichhardt expedition. Dr. Murray was a survivor of the infamous "Carl' kidnapping case, a blackbirding ship operating in the Pacific Islands to the north east of Australia. He was tried in Sydney for his misdeeds, which included having 'shot the slaves down, informed on his associates to save his own neck, did nothing for the slaves but ordered them thrown into the sea'.[17] Yet he could not be deregistered, and his name removed by the Medical Board. In 1871, the N.S.W. Medical Gazette reported:[18] 'From every section of the country we are constantly receiving intelligence of murders most foul having been committed by men calling themselves doctors'.[18] It added that the Act had been unsuccessfully tested a few years ~~age.~~ before In August 1872, the profession held a public meeting attended also by the only active medical association at that date, the Western Medical Association of Bathurst, founded April 1872. Leading the agitation for law reform was Dr. John MacFarlane,who had already drafted three bills 1858, 1861 and 1869, and was now drawing up a fourth. He was well equipped for the task, having been a Legislative Councillor 1858-70, and a member of the Medical Board from 1852 ~~on~~. He claimed his previous efforts to have failed due 'to factious opposition of some of the more prominent members of the profession'.[19]

The Colonial Secretary, the Hon. H. Parkes, agreed with a deputation 'that the law was at present in a most unsatisfactory state', and that he 'had no doubt that this or some similar Bill would be introduced by the Government'. But Dr. John MacFarlane died shortly after without seeing his long labours bear fruit. The W.M.A. protested against the Government's inertia. Another public meeting was called by advertisement, which organised a petition signed by every 'influential'

men in Sydney. 2,500 signed including the Chancellor and most of the University Senate, and legal men, clergymen, leading merchants and shopkeepers, as well as residents of the Bathurst district. When the petition was presented to Parliament, it asked that the colony should assimilate the laws to those of the United Kingdom and most dependencies. The Colonial Secretary, after a long silence, was roused by the agitation to declare that the Parliamentary draftsman considered the Bill drafted by the profession imperfect. When pressed, he said his objection primarily was:[20]

> "There was no clause allowing the so called homeopathic physicians or persons who had obtained degrees from the so-called homeopathic colleges to be deemed legally qualified practitioners".

Finally, in 1875, a Bill was brought into the N.S.W. House by Sir Alfred Stephens to regulate the practice of medicine, based on the English medical bill. It forbade false use of titles, allowed the Board to refuse noone on grounds of peculiarity of medical opinion or theory, and to give power of recovery of debts in a court of law to those holding degrees approved. Simultaneously a petition was presented to the legislative Council to assimilate the laws to those of the United Kingdom. The Bill provoked much controversy in the press, opponents taking the view that it was for the aggrandisement and protection of the medical profession. The editor of the Australian Practitioner, Dr. Knaggs, blamed in part a clause in the preamble which conveyed an impression of class legislation 'to protect educated and qualified persons' that could be offensive to some. A curious aspect was the opposition of the Dean of the Faculty of Medicine in Sydney University, the Professor of Natural Philosophy Dr. Smith, who was himself a qualified doctor. He opposed attempts to found a medical school, and now opposed the Bill. He argued that there was such an amount of ignorance, unskilfulness and intemperance amongst legally qualified doctors that human lives were daily endangered by them. But as unqualified practice, then rampant in N.S.W., was even more dangerous, his stand was difficult to justify. Editorial comment in England was that:[21]

> "There are plenty of ignorant people to point out the imperfections of our system of medical education and to ascertain the lessons of it without a Dean of the Faculty of Medicine coming to help them. Dr. Smith must know that the only reliable remedy for

> "incompetence in the profession is a better medical education of medical men and a more stringent examination. And these ends can only be secured by some such bill as that of which he has been the main and too successful opponent".

Quacks continued to flourish in N.S.W. to a degree exemplified by a case where a man sued a doctor who had called him a 'quack' (he, having an American diploma the Medical Board had refused to register) and successfully recovered damages for slander. The profession subscribed the doctor's costs, as it customarily did when doctors were sued by contentious litigants.[22] In Victoria, the M.S.V. President in 1881, Dr. J. Robertson, derided 'imperfect heresies and globulistic impostures' which continued to flourish despite a determined attempt to alter the Medical Act in 1878 there:[23] Such had grown to include psychopathologists, osychopathic practioners, magnetists, operating electricians, and Darmachardists. The M.S.V. editor moaned that the last Parliamentary Ministry was 'overgorged with that antipathy to the learned professions in general, but especially to the medical, which is part of the kit of the stump politician'.[24]

With the advent of three prosperous B.M.A. Branches in Victoria, N.S.W. and S.A. in 1880, the campaign against irregular practice of medicine quickened. The Councils had the experience and success of the British organisation before them. The older medical school of Melbourne, and the new medical school of Sydney, were anxious to protect their high standards of qualification (a five year medical course) The first Professor of Anatomy at Sydney University, the brilliant Professor Anderson Stuart, recalled in his memoirs:[25]

> "There was in 1884 among medical men, who wished to elevate the profession, a strong movement to place it under more definite control. In those days a large number of so-called doctors practising in N.S.W. were frequently quite unqualified in respect of academic degrees or training, and many more simply and frankly quacks.
> "In a number of cases, men of some medical education- possibly men who had had a year or two at one of the British medical schools but had never obtained a diploma - had obtained considerable practices and even did good work, especially in country districts to which more eminent men would not go".

Others did not do good work. One such, a Mr. Canne, was refused registration by the Medical Board when he returned after a five months visit with an M.D. degree from the Medico-Chirurgical College in Philadelphia, U.S.A. He had been

known as an irregular student at Melbourne Medical School for less than two years. When known as the Rev. Mr. Canne, he was involved in the death of a Mrs. Healy in 1888, and censured at the inquest.

When yet another Medical Practitioners' Bill was before the N.S.W. Parliament in 1886, one of the leading lay criticisms appeared to be failure to allow unqualified men, who had practised five years, to be registered. Men like Dr. Maclaurin pressed for Government action, saying, since he had become Government medical advisor, there had been fifty cases in twelve months where quacks gave medical evidence in coroners' courts. Judge Windeyer in his judgement in Jackson vs Goode had drawn attention to the reluctance of crown law officials to take action.

Finally in 1887, Dr. J.M.Creed M.L.C., moved successfully in the Legislative Council for a select committee to enquire into the state and operation of the laws existing for the regulation of the practice of medicine and surgery. The Royal Commission included two doctors in its eight members. Its report in 1888 showed that there were 183 unregistered men practising as doctors, many making fortunes. Almost all of these quoted dregrees, all advertised, and promised 'permanent' or 'infallible' cures. The Report said that almost no law existed, and the public were subject to an appalling amount of fraud from men who made use of titles which led the public to suppose they had gone through courses of study. The Report said the Medical Board should also be reformed without life appointments. The enquiry attracted great public attention, but produced no reform. A number of the most eminent citizens of the community sent a letter of protest to Sir Henry Parkes. Their petition read:[25]

> "The terrible evils consequent upon this state of the law have been so forcibly brought under our notice by the publication of the evidence given before the Select Committee of the Legislative Council that we feel it is but a duty incumbent on the occupants of the offices we hold to make representations of the urgent necessity for such prompt legislative action as will remedy them".

A Dr. W. R. Cortis moved in the Legislative Assembly for a bill, which was discharged a month later.

In 1890, as no progress had been made, Dr. Garran moved an address to the Governor in the Legislative Council asking him to cause the letter sent the Colonial Secretary in 1887 to be laid on the table. In 1891, after yet another Bill considered effective by the profession had lapsed, 86 doctors signed a letter to Sir Henry Parkes, asking him to consider the revelations of the Select Committee both in 1887 and October 1890. The latter concerned a Dr. Richards, questioned before the 1887 enquiry, registered in 1853. He had been 'covering' for two laymen, a bookkeeper and a wealthy racehorse owner, who ran a business diagnosing and prescribing by correspondence. One instance disclosed was prescribing for a diagnosis of spermatorrhoea in a woman. The Medical Board had no power to deregister Dr. Richards, although his diploma had been cancelled by the Royal College of Surgeons in England in 1887.

Another ten years passed without action. Quacks certainly lobbied against all parliamentary reform. Sir George Dibbs recorded his experience when Premier in an interview with a well-known quack, who was opposing a bill before the House, who said it cost him £1,600 every time it came forward to block it, complaining he could no longer afford it.[26]

The Medical Board made a limited gain in 1892 with the case of a 'Dr' Bourchier, who had been registered for several years. The Board discovered that he had bought his American diploma, and discontinued publishing his name in their list. Dr. Bourchier applied for writ of mandamus to compel the Board to continue publication, the Court holding that his proper remedy was by action and claim for a mandamus at common law.[27] He failed in his case. In 1898, the B.M.A., whose energies had hitherto been engaged contesting 'clubs', called a meeting of councillors of the combined medical societies of N.S.W. to consider the best means for persuading the government of the 'extreme necessity for a good medical act and indecent advertisements act'. The Act secured finally in 1900 (Act 33) made it an offence for untrained people to use medical titles. One of the chief stumbling blocks to prior legislation was removed with the compromise clause that certain doctors without qualification, long established in practice, were entitled to be put on a separate register if they had passed through a course of study at a regular

school and had practised for five years previously. Even this act did not prevent unqualified men from fraud. A quack who called himself a Chinese physician and surgeon was prosecuted, but it was held that he could not be convicted of using a title implying that he was legally qualified, only for using the name 'physician and surgeon'. In 1902, a registered dentist was held entitled to describe himself as Dr. Ormiston D.D.A. surgeon and mechanical dentist.[28]

During the equivalent years from 1880 in Victoria, the situation was scarcely any more satisfactory. Although prosecutions were at times launched by the police, the Act did not compel it, and the Chief Secretary could find a legal quibble to refuse. At least 11 doctors were known in 1888 to be 'covering' for quacks, but could not be deregistered. Matters came to a head, when the Chief Secretary Mr. Deakin, as head of police, refused to act on a report from Dr. Youl, as President of the Medical Board, to prosecute a quack, saying it was not the duty of the police, but the medical societies. The united medical societies met in Victoria November 28, 1888, and sought amendments to the Act to repress practice by unqualified people, on the lines proposed by the profession for nearly twenty years! declaring that the Act as it stood was not enforced, that illegal practice flourished to an alarming extent in Melbourne, and they should seek a policy to enforce the Act. Quackery appeared to be worse in Melbourne since the 1887 enquiry in Sydney, many exposed therein migrating to Melbourne. One man, when actually prosecuted for quackery, proved he was legally qualified saying it was more profitable to practise as a quack.

A bill introduced in 1891 gave the Medical Board additional power, not to prohibit quacks from practising, but to give the Board power to deal with persons guilty of infamous conduct in a professional respect. The evil appears to have continued unabated as the President of the M.S.V. in 1896 spoke of the 'shoals of vile charlatans who ever and anon infest our district'.[29]

All too rarely in either state were letters found in the press as from John MacLean writing in the S.M.H. June 4, 1886 of his experience in a semi-public position. He cited eighteen cases of surgical and medical malpractice by quacks, including a young man, who, on post-mortem - proved to have a slight fracture of the tibia. He had died after suffering

gangrene from tight bandaging and amputation at the hands of a quack:[30]

> "If the calamitous results of permitting unskilled practice were as frequent and open in the metropolis as in the provinces and in the backblocks, the remedy would have been applied long ago".

Matters fared even worse for doctors in South Australia. In 1884 the South Australian B.M.A. complained that unqualified practice was a greater grievance there than in Victoria, and discussed action against one man calling himself an M.D. A man called Klostmann had claimed to have studied at the University of Posen when giving evidence at an inquest, although it did not have a University. A nurse acted as a woman doctor and signed death certificates. When complaints were made to the Chief Secretary, he had replied 'there is nothing to prevent the person referred to practising in the manner mentioned'.[31]

A meeting called by the B.M.A. in 1888 deplored the change in the 1844 Medical Act in 1880 without consultation either with doctors or the Medical Board. The wording, intended to correct injustice to German doctors, was so loose that a person holding an American diploma, if once recognised in one state as a legal qualification, no matter how worthless, could claim to have it and himself registered. A Mr. Bollen presented his M.D. degree issued by the Hanemann College, Chicago, Illinois after a short course of study. The Medical Board would not register him, saying it was not recognised by the General Medical Council of the U.K., and that his degree was not a qualification with the Federal Government of the U.S.A. But Dr. Bollen in 1886 demanded registration, producing evidence that he was qualified to practise in all American states, and was supported by the Crown Solicitor as to the sufficiency of his evidence. The Medical Board appealed to the B.M.A. for support, which heard Dr. Bancroft, visiting from Queensland, tell them that the Queensland Government upheld the Medical Board there when it refused to register men there after 'such irregular and insufficient courses of study'.[32] The alternative facing the Medical Board was either to refuse to register him and then resign; or to register him first before resigning. They considered a precedent in the case of Regina v Medical Baord ex parte Thomas in 1872 in Victoria where the Supreme Court had refused a mandamus to oblige the Medical Board to register a Dr. Thomas. Dr. Thomas had a diploma of the Royal College of Physicians in England, but his name was

erased for advertising. The S.A. Medical Board finally refused to register Mr. Bollen. He sought a writ of mandamus in the Supreme Court, which decided that it was liable to register him in 1889. The Medical Board then resigned.

The S.A. doctors had formed an Association of Registered Medical Practitioners of S.A. to attack the evils of quackery as well as club practice. As the Medical Board had no funds, this association reimbursed members of the Medical Board for expenses incurred in the Supreme Court action. It also decided to do more to test the penal clauses of the S.A. Medical Act by a prosecution, as the Board itself had no power to summon a man to show his qualification. The subsequent case showed the kind of equivocation that daunted similar efforts to prosecute in Victoria. Dr. Corbin acted as complainant against 'Dr'. Bridgwater. At first convicted, 'Dr' Bridgwater appealed to the Supreme Court where his conviction was quashed on the grounds that the onus of proof that any person had been guilty of any of the offences in section 3 of the 1889 Act was on the informant Dr. Corbin. As 'Dr' Bridgwater had never called himself a 'registered' doctor, but simply said he was practising, he incurred no penalty, as merely advertising or assuming the title of doctor was not falsely pretending to be a legally qualified medical practitioner. The expense of such actions incapacitated the new medical society which lapsed till 1894, when it revived as a Medical Defence Association.

The Government in Queensland was far more sympathetic to the need for protecting the public from untrained medicine men, and to initiatives taken by the Queensland Medical Board, particularly after 1880, when more doctors were available in a huge territory chronically short of medical service. A Medical Board was set up in 1867, due to the strenuous efforts of Dr. O'Doherty, then in the House of Parliament; but it was merely a board of registration without power to erase a name. At first the shortage of doctors was too acute for anything but tolerance of unqualified men, particularly those who appeared to have some credentials. Such were Drs. Wuth and Smith, who petitioned against the refusal of the Board to register them on the grounds that it was 'an infringement upon the personal liberty of the subject and might involve persecution and gross injustice to himself'. Moreover some German degrees were already registered, such as Dr. Sachse from Berlin.

A Mr. Pugh M.P. introduced an act on their behalf into the House to enable the Governor in Council to overrule the Medical Board on issues of registration. The profession's case, aided by some members of the House, was that:[33]

> "The Queensland Board merely followed English practice. The test of the issue was whether or not a doctor was registrable in England. By that test Smith and Muth failed. Muth was at the time not even in possession of the certificate which would enable him to practice at home in Germany. Smith's College, though Smith had practiced in England, like many unregistered men, was not recognised by the General Medical Council of Great Britain".

Mr. Pugh believed the Board represented a vested interest in such matters as refusal to allow unregistered doctors to give evidence at inquests. The notion of the existence of a professional 'monopoly' was refuted by reference to the fact that while 32% of deaths in Brisbane were uncertified in 1865, there were no prosecutions under the Medical Act of 1861. An alleged prejudice against homeopathy was discounted; at least one homeopath, Dr. Waugh was registered.[34] A very large proportion of unqualified people were allowed to practice, and their death certificates were received officially. The Queensland Medical Board was only able to take firmer action after 1880, when the gold rushes brought more doctors to the state. In 1888, it refused to register one applicant with a diploma it doubted. It also found that two men it had already registered had equally dubious diplomas, but could do nothing for want of power to strike off a name once registered. The short-lived Queensland Medico-Ethical Association in 1891 complained of the inadequacy of the Medical Board to prosecute quacks; saying if the prosecutor was a doctor rather than an organisation, the public and magistrates were disposed to regard their action as personal jealousy, or pique, and not an honest attempt to stop unprincipled charlatans from preying on the credulity of people. Dr. Taylor complained in 1900 of lack of support from the profession in bringing legislation before the House, where a measure, sponsored by himself, was regarded 'as a personal grievance' and 'talked out of the House'.[35] He said opposition came from abortion mongers, pharmaceutical chemists fearing curtailment of their practice, and doctors engaged by medical institutes. He had more success with his campaign for an Indecent Advertisements Act, objecting

that ' our newspapers teemed with filthy advertisements',[36] of a kind not permitted in Europe, nor the sale of unidentified medicines. He secured an Act, partly because of publicity from the 1887 enquiry in N.S.W., before N.S.W. did; but it required someone to lay a charge. One of the hopes, in forming a Queensland Medical Defence Association in 1900, was to report to the Queensland Medical Board any registered doctor guilty of infamous conduct, as well as quacks. Almost at once, it informed the Medical Board of a Mr. le Hay or Marburg who was medical officer to a lodge with M.D. after his name, but unregistered. A test case in 1901 demonstrated that the Board was relatively powerless. When the Board removed the name of a Dr. Armitage Forbes from the register, he successfully obtained a mandamus from the Full Court ordering his name restored; this, despite the fact that the General Medical Council had removed his name from their register for advertising.

When yet another Bill came before the House in 1911, a Queensland B.M.A. Branch estimate of the problem was:[35]

> "For twenty years, the medical profession has called for a bill which would enable them (as much in the interests of the public as themselves) to put their house in order. At present the most evil criminal, who has once been registered as a medical practitioner, cannot be debarred from full right to practise with all the responsibility entailed and the opportunities for evil practices by evil men allowed by it. The Medical Board is obliged to register all and sundry who bring a certification however third rate, from the university of countries where the possessor of the highest degrees and qualifications from Australia could not order himself a bottle of medicine without undergoing a full course of training'.

One of the first committees formed by the W.A. B.M.A. in 1900 was to deal with Parliamentary Bills, including sterner terms of registration. Governor C. Hampton in 1870 introduced the first Act, forbidding anyone to recover fees or sign certificates unless registered, under penalty of £50. Quackery was not a problem until the goldrushes of the 1890's; and penalties acted as no deterrents in the prosecution of a Mr. Gill in 1902, wherein he was fined £2 for his activities as head of a Perth Health Institute. A Tawfik Raad, charged in 1906 with issuing a circular advertising medicines with the letters Phar M.S., M.C.S.S., won his appeal on the ground that he had committed no offence, as there was no 'unequivocal representation of professional qualification'. He was finally convicted in 1914

of advertisement, claiming to hold a university diploma, for a'blood specific! W.A. had led the other states with its 1894 Act, which forbade, in the most detailed terms, any pretence to medical qualification. It was the first whereby a doctor could be deregistered not only for felony but misdemeanour, and for infamous conduct in a professional respect. W.A. also led the other states in effective V.D. legislation to discourage the reprehensible practice of quacks in offering to cure V.D., and thereby diverting the public from proper medical attention, which alone could cure; its Act being followed in World War 1 by all other states.

In 1908, the N.S.W. B.M.A. Council organised a formal deputation of all doctors, members of either the Upper or Lower House, or the Medical Board of N.S.W., to ask for further amendments to bring the Acts more into line with those in other states of the Commonwealth. Not long before, the B.M.A. President, Dr. J.Mitchell, had expounded the reasons:

> "There is a general impression that we are a protected body of men in proof of which we are reminded of the many medical acts which have been passed by various Parliaments in our favour. It is almost vain for us to assert that the whole scope and tenor of the Acts is to protect the public and to show them clearly what men are qualified to practice physic and who are not so qualified, leaving the public perfectly free to drug itself in any way it pleases.
> "The Medical Acts certainly allow us to recover our fees for medical attendance, but the most arrant quack can also recover in common law if he can show he has not pretended he was legally qualified, and that the patients have placed themselves under his care knowing him to be unqualified. Here is a distinction without much difference in our privileges. In England, as in most states in the Commonwealth, we have to pay for the somewhat doubtful privilege of being placed on the Medical Register."

In 1904, the A.R.M. of the B.M.A. in England had discussed reciprocity of registration of medical men in Australia with Great Britain, resolving that only medical qualifications which could be registered in Great Britain and Ireland should be allowed in Australia and N.Z. This would mean insistence on a minimum training of four years in all Australian medical acts. Victoria accomplished some reforms in 1905, through formal deputations of all four Victorian medical societies. The Medical Board was able to deregister on conviction, and to insist on a five year course of study. This immediately excluded graduates from American diploma schools. In 1915, Victoria restricted recognition to countries offering reciprocity. An Act (no. 29) in 1913 gave the Medical Board of N.S.W., finally, the power to remove names from the register for

'infamous professional conduct'. In 1915 N.S.W. also provided that only graduates of Universities or schools could be registered, which gave the same or reciprocal privileges to graduates of N.S.W., and insisted on a minimum of five years training. This at once excluded not only American degrees, but many European countries. The legislation was not without opposition, even in 1915, as Dr. Worrall said: 'The debate in the N.S.W. Assembly shows that the medical profession has many powerful and unscrupulous enemies".[35]

In S.A. in 1913, the Medical Board was given added powers to introduce reciprocity, and to institute a procedure, by way of the Supreme Court, to strike off the name of a doctor guilty of infamous conduct in a professional respect, or misdemeanour or felony, or whose name was struck off by his graduating body. Dr. F.S. Hone, Branch Councillor, commented feelingly on the kind of difficulty in securing such Acts, when he said:[36]

> "It was seven years since our president spent many hours going through a medical bill, which was brought before Parliament that session, was quickly dropped, and we made no effort to resuscitate it till last year, when a deputation was assured that it would be introduced early last session. Some members spent much time again with no results".

In all states, cases continued to occur, not only of unregistered men, but also of doctors associated with them. An F. C. de Sylva of Hurstville was prosecuted, unsuccessfully, for implying qualifications in advertisements. He won as he did not imply he was legally qualified, although calling himself F.C. de Sylva, specialist, late University Paris, Berlin Royal College, St. Louis etc. specialist for eye, ear, throat, also diseases of women and children. In 1915, in N.S.W. there was a case against a doctor for improper conduct concerning a ladies college of health. One man signed a death certificate, and was convicted for doing so, and substituting the words medical practitioner on the document for registered qualifications. Three cases of covering by doctors were known in 1917. All Branches by this time had committees to deal with Parliamentary Bills, on this, and many other matters of poor medical practice or quackery - nurses registration, midwives bills, opticians bills.

In Queensland the profession saw the standards so long sought within their grasp when a Medical and other Practitioners'

Bill was brought into the House by a Labour Government in 1911. It gave doctors reciprocity of registration, the power to discipline and provision against indiscriminate advertising and practice by unqualified people; all strongly sought by the B.M.A. But it allowed registration to chemists, dentists, veterinarians, and opticians, and included a clause on faith healing and mental treatment - all opposed by the B.M.A. The B.M.A. was faced with the choice whether support for the first should arouse antagonism for the second; but joined the Medical Board in opposition, most of all to inclusion of the right of herbalists, hydropaths, and osteopaths to be registered as 'Other practitioners', and to advertise as registered under the act; and for the right of opticians to use drugs. The Medical Board threatened resignation if the Bill should become law, and it finally foundered.

In Tasmania, the opticians, as in the U.S.A., had been more successful, although defeated in Great Britain owing to the combined resources of the B.M.A. and the Ophthalmological Society. In Victoria in 1913, a Victorian Optical Association, representing a few large firms won the support of the Acting Premier, Mr. Murray - a man who had bought his presbyopic correction over the counter - for a bill to register opticians similar to Tasmania. But the Eye and Ear Section of the Victorian B.M.A. formed an active lobby so effectively that, when Mr. Murray introduced the Bill, he met 'hostile gibes from all parts of the House', and the Bill was discharged.[37]

The most famous and extraordinary instance of all in the story of medical registration in Australia was what was known as the Ratten Affair in Tasmania; which was to have an influence on demands in other states post world war 1 for tighter regulation. This affair will be detailed at the end of the chapter. In the World War 1 years, in other states control of medical practice was becoming already more effective. By 1917, the N.S.W. Medical Board was able to proceed successfully against a doctor for covering, and deregister him for infamous conduct in a professional respect. He had acted as manager of the business of a 'medical herbalist' and allowed his name to be advertised on the premises, and on pamphlets in which cures were advertised he knew to be useless.[38]

Pretenders could still escape conviction for misrepresentation

of a more subtle kind. In 1922, a man Watson was held not guilty of using a name implying that he was a legally qualified medical practitioner, when he advertised in the newspaper 'Dr. Watson, Eye specialist from Sydney' or similarly Dr. J. R. Ross, Doctor of Optometry.[39] A Victorian Court in 1927 took the view, under section 17 of the Medical Act, 1915, Victoria, that a Mr. Cully who practised as a 'doctor of osteopathy' was pretending to be a doctor.[40] Several similar cases occurred in South Australia. Police officers assisted in laying charges under the 1919 Act, Section 25, against four leading offenders. One of these, a Mr. Drew in 1926 escaped penalty because, as in other states, it was not unlawful to practice medicine simpliciter. Although he said he could cure the nerves and kidney trouble, and advertised rheumatic tablets, he had not represented himself as having medical qualification. Another advertised as a consulting herbal practitioner, capable of treating all chronic deepseated and supposed incurable diseases, who invited those, uncured by orthodox doctors, to consult. Others were convicted, such as a lady who claimed to tell people what was wrong with them merely by looking at them.

The list was a lengthy one, and the number of cases reported in the press 1920-40 showed that the temptation of 'quacks' to 'turn a quick quid' from the gullible public was a continual one. Both legislation and litigation merely taught quacks to use their titles and advertising more carefully. The former simply made it less likely that quacks would trap a public following by fraud, so much as individual credulity and despair. Not until the second world war and afterwards were at least two major fields of their endeavour removed by polio immunisation, and the discovery of effective treatments for V.D. and T.B. Cancer remained a field that invited their operations. Among the most contentious controversies on the merits of people without formal medical training were those surrounding Sister Kenny in the treatment of polio; and Mr. Fetherston in the treatment of cancer in Victoria, as well as the use of the Koch serum. Popular outcry led to formal medical investigations both with Sister Kenny and the Koch serum. Some of the publicity was unfavourable to the B.M.A.

Some public attack against the B.M.A. was associated over the years with limitation by the Medical Boards and the State

government of registration of alien doctors. During the First World War, in the height of patriotic feeling, exclusion of German or Austrian nationals was written into some acts. These clauses were to cause difficulty, when the Nazi regime in those countries drove many German Jewish doctors into exile. Reciprocity between Italy and Great Britain - which dated from the days when doctors went to Italy with rich patients for holidays- created an anomaly, also, as to recognising in Australian states all degrees recognised by the British Medical Council. Victoria and Queensland were two states which extended reciprocity to Italian doctors. This anomaly ended with World War 2, when Great Britain revoked the treaty with Italy.

In N.S.W. foreign doctors were entitled to be registered under legislation in 1930, if they did the last three years of the Sydney University medical course. An escape clause allowed the Medical Board to register, irrespective of the foreign quota of eight doctors written into the act per year, doctors with special qualifications, or such experience as would justify waiving compliance with the Act. In the first ten years, fourteen such were registered, compared to 22 under the study qualification. A further 22 were licenced to practice during the war under National Security Regulations in outback practices, before taking university courses.

The disparity in the quota situation meant that doctors, who completed the statutory requirement of study, would not necessarily receive registration. This bred discontent and misunderstanding, and directed blame towards a B.M.A. which post-war was very vocal on fears of overcrowding in the profession, due to the record number of rehabilitation students in the medical schools. Criticism of quotas was fed by the presence of fifty doctors in 1949 in migrant construction camps doing manual work under two years contract with the Government. The view taken by the B.M.A., however, was expressed by the Minister for Health when introducing the Bill in 1938:[41]

> "I refuse to accept the statement that the average practitioner in a suburb of Berlin, or in some provincial town in Germany is superior to the ordinary practitioner in this State. We don't want a man of this type, because he can contribute nothing to the welfare of the community".

A popular view was that exclusion was directly the work of

the B.M.A. as expressed by the Cessnock Eagle, October 3, 1947:[42]

> "In the Commonwealth today there are some brilliant professors of medical science who are not allowed to practice because of the objections of the B.M.A."

A correspondentin the Sunday Sun in 1948 tried to make the distinction plain:[43]

> "There is a widely held belief that a medical practitioner holds his charter to practise from the B.M.A. Nothing is further from the truth.. The B.M.A. has many useful functions, but has as much jurisdiction over the medical practitioners right to practise his profession as the Boilermakers Union"

A fact not well known to the public was that the basis for legislation of this order was the rule of reciprocity, which the State was not anxious to abandon, namely that the state would only recognise degrees and diplomas of those countries which granted reciprocal rights of registration. This not only applied in respect of the contentious issues of doctors with European degrees, but even to some doctors with English degrees or Empire degrees. Among those refused were men whose medical studies in Britain were reduced from five to three years during wartime.

Of all the Australian states, only Tasmania allowed aliens to practise without qualifying study, and the Commonwealth in Northern Territory and New Guinea. Some anxiety arose in the minds of some B.M.A. leaders in 1949 that the Commonwealth intended to promote the import of doctors. The Federal B.M.A. Secretary expressed the fear that such doctors would be of a low standard of medical education from inferior European universities. The Minister for Immigration, Mr. Calwell, immediately denied this, though calling on states to amend 'obstructive legislation' and saying he hoped state governments would allow qualified men to practice without Australian examinations.[44] The Federal Director General of Health, Dr. A.J. Metcalfe, supported the B.M.A.[45]

> "Most of the European doctors are not suitable to Australian conditions. They are generally specialists, and could not be used in country areas as general practitioners. Chief reasons for that is that European universities train doctors as specialists, whereas Australian Universities give them a general training first Australian doctors become specialists after serving as general practitioners. Our experience during the war was that alien doctors were not very successful".

The fears of the B.M.A. leaders had extra substance in that the Prime Minister himself admitted that he had discussed the use of 'displaced' doctors in N.S.W. with the N.S.W. Minister of Health, while the Victorian Government was relaxing its legislation along these lines..

The law in N.S.W. came under fire when sufficient doctors were graduating to require a ballot to decide the eight allowable under the quota. The President of the Medical Board, Dr. Poate, defended the principle of reciprocity by saying that Australian doctors who went to countries from which migrant doctors came: [45]

> "would have to conform to much more exacting conditions ... before he could practise he would have to go through the whole medical course, on top of his Australian degrees. Also he would have to become naturalised".

While it could be, and was argued, that the principle should equate to other countries with extensive professional immigration, where a single qualifying examination might be considered adequate as in some American states, it was also relevant that reciprocity was a principle established by the General Medical Council of Great Britain; and followed in Australia because it resolved an inherent difficulty in deciding the adequacy of qualification from multiple sources, without the exchange of information necessary to determine standards. A representative comment was that made by the Daily Telegraph editor, Sydney: [45]

> "The B.M.A. may be able to make a sound case for insisting on a thorough reeducation of foreign doctors in Australia. But the quota system smacks unpleasantly of the closed shop for Australian trained doctors."

Those, however, rejected in the 1950 ballot were employed by the Commonwealth Government in its territories.

Both the Senate and the Commonwealth disclaimed any power in the matter of registration, asserting the responsibility to legislate rested entirely with state governments. Even in the debate to amend the Act to do away with balloting for foreign doctors' registration, a N.S.W. member could be found to put the time-worn argument that 'the N.S.W. Medical Board was a prejudiced tribunal consisting of medical men only who do not want to have competition in their particular line'. [47] Meantime, the Continental Unregistered Doctors Association had been founded to advocate their cause.

In 1956, Dr. I.A. Listwan succeeded in an application to the Supreme Court [Full Court of the] of N.S.W. for the Court to make absolute a rule nisi for a writ of mandamus commanding the Medical Board to amend the Register of Medical Practitioners to include in his registration the qualification of M.D. Cracow, 1937. He wanted to become a member of the Australasian Association of Psychiatrists, but found that the formal registration of his Sydney degree was not adequate.[48]

With the growth of specialist associations and training, from 1930 onwards, Medical Board registers of specialists became a debatable question. Queensland had the first specialist register under a Medical Act from 1938. The majority of doctors in Queensland welcomed the Register, which provided, for legal purposes, some official basis for identifying those with skill, and a guide as to those to whom people might apply for special services. There were a number of doctors who had become specialists in a field to their taste after some years of general practice, and were allowed to continue. But, from Jan 1, 1941, a higher degree or diploma became imperative. One major problem arose due to the right of appeal by any doctor, refused specialist registration, to a Supreme Court judge, whose investigation amounted to a rehearing of the claim. His was the sole decision, and in practice he did not usually resort to the advice of the two medical assessors allowed for. The Medical Board was obliged to register those he approved as specialists; and in practice he always did approve. The Medical Board's right of rejection was therefore nullified.

In practice, the setting up of a Register could not prevent doctors practising as specialists if they wanted to. Some specialists refused to register, and the Board did nothing. For those who did register, an inherent advantage existed in that the specialist was protected, in case of litigation, from alleged unskilful treatment, where he wished to charge higher fees, or possible employment as specialists in a Government health scheme.

In 1946, the W.A. Government consulted the Queensland B.M.A. as to the effect that setting up a register had had in that state. The Medical Board drafted a set of rules; but it was opposed by the Commissioner of Health and the B.M.A. Branch, and disallowed in the Legislative Council. The reason given for opposition was the need to wait for a definition of a specialist by the

Under this clause, a Dr. Clarke of Franklin was registered with an American degree and a licence from the State of Massachusetts; and a Dr. Ratten of Sheffield who had an American degree from Harvey Medical College and Hospital, and an immediate prior registration in South Australia. In 1900, a Dr. E.C. Gould, M.D., graduate of Boston University, applied for registration - a homeopathic doctor already admitted in Victoria to practice at the homeopathic hospital there, Prince Henry. He was refused, and applied to the Supreme Court for a mandamus calling upon it to show cause why he should not be registered. Mr. Lodge, counsel for the Court Of Medical Examiners, argued that Dr. Clarke, unlike Dr. Gould, had a licence from the state in which he graduated. Defence counsel argued as to what was meant by 'some university' and the Court should recognise the principle of the comity of nations: The Chief Justice in giving judgement said:[50]

> "The British Statute must be considered as legislation for British subjects only unless a wider application was expressed.. Dr. Gould came with a degree from the University of Boston and it was not for the Court to appraise the value of it. They had to endeavour to find out what was the intention of the legislature in that third section of the Act, and they found that it was intended to operate as to a doctor of medicine of some university at that time English. They were not necessarily forced to the conclusion that the act had a universal application for then inconvenient results might follow."

On the latter point, the Chief Justice was curt, saying that the U.S. did not go on the principle. He recommended amendment of the Act and discharged the rule nisi with costs. A new Medical Act in 1907 specified that no American degrees were registerable. The Court of Medical Examiners put a black line over the names of those who were already registered and listed in the Gazette; which included Dr. Ratten. He was then practising in the north of Tasmania in Sheffield close to Devonport.

When the B.M.A. Branch was founded in 1911, all registered doctors were circularised soliciting their membership, and the names of eleven doctors were omitted, including Drs. Ratten and Clarke. In June 1910, Dr. Ratten wrote to the Secretary complaining his name was not on the list of Branch members. Shortly after he bought a practice in Hobart. The B.M.A. was disturbed by his suspension by the Newnham Racing Club on a charge of fixing races (by painting a horse) His suspension was

was removed and mention of his name expunged from the minutes. At this stage, the Launceston B.M.A. sought the support of the Hobart B.M.A. for a clause in the impending hospital legislation to prevent well-to-do patients, using public hospitals and expecting free service from the honoraries, when they could afford to pay. The Premier, Sir Walter Lee, refused the demand, saying that 'he was not opposed to the rich being admitted to the State aided hospitals provided the fees paid were on a basis equivalent to services rendered'.[51] Little of the alleged 'hospital abuse' had occurred at Hobart Hospital, and the Premier decided to ignore a B.M.A. boycott of the hospital which shortly ensued, and to appoint non-B.M.A. doctors there. He knew Dr. Ratten, when in practice in his own electorate of Sheffield, and offered the post of surgeon-superintendent of Hobart Hospital to him. Dr. Ratten accepted.

Already doubtful of Dr. Ratten's credentials, the Tasmanian B.M.A. Branch were not reassured when it found that Harvey Medical College (source of his degree) had been closed for some time, and its degrees were obtainable quickly. When the B.M.A. Secretary wrote to learn the status of this college, it learned that it had been a night school in which it would require 12 or 14 years to furnish the equivalent of a course given in a day college; and it had been closed since 1905. The B.M.A. Secretary wrote a second time, and found the Secretary of State advised that the charter of Harvey Medical College was terminated in 1902; it had merged with Jenner Medical College in 1905 - therefore Dr. Ratten could not have taken his M.D. there in 1907.[52] The B.M.A. did not at first know that a second Harvey Medical College had been given a charter by the State of Illinois under a slightly different name for three months before it was withdrawn; merely that Dr. Ratten's diploma could never have been issued for an adequate course of training. In fact Dr. Ratten's diploma had been issued during the three months charter, and was in a strictly legal sense valid.

In January 1918, the Court of Medical Examiners decided (with two members dissenting) to ask the four doctors holding American degrees to produce their diplomas for re-examination after legal advice that the Court had power to remove a name under certain circumstances. Dr. Clark and Dr. See complied, but not Dr. Gmelin nor Dr. Ratten. The two dissenting Court members were working as honoraries at the Hobart Hospital.

Concurrently the Government planned amendments to the Medical Practitioners' Act. Although some were commendable to the profession, such as removal from the register for felony, misdemeanour, fraudulent certification, and infamous professional conduct, another provision was condemned by the M.J.A. editor as likely to 'render the measure a disastrous one to the Tasmanian community' - namely, the third schedule to provide for registration of men with American degrees in three categories, including a doctor who 'has received a degree or diploma after due examination from the medical college'.[53] The B.M.A. protested vigorously[54] 'as mischievous a piece of legislation as could well be devised'. They held it was intended to widen the breach between the Government and the profession, to attract only the derelicts, failures and undesirables.

But the breach between the Premier and the B.M.A. was widened further when the Court pursued an enquiry into Dr. Ratten's credentials, set a date and notified Dr. Ratten. He appealed to the Premier for an 'independent inquiry' - in the Premier's words to the House 'to see that he gets a fair and impartial trial and should be given full and ample opportunity to answer every charge against him'. The Premier enlarged that the Medical Council was composed of some of the most militant members of the B.M.A., who, as Dr. Ratten's accusers, could not be expected to be impartial.[54]

The Premier had succeeded in securing agreement of the Council to suspend proceedings against Dr. Ratten in favour of a Royal Commission - on the grounds the Commission would consider whether his diploma was granted on some bona fide and regular course of instruction,[55] as well as to the actual existence of Harvey College in 1907. But he now announced that the Commission's terms of reference would be limited to inquire only into whether the Harvey Medical College existed or not in 1907, as 'the most serious question' He insisted no one had questioned Dr. Ratten's status or ability, or right to practice, during eleven years previously. The Medical Council tried to negotiate for wider terms of reference, but Dr. Ratten complained 'This delay is not fair to me and the strain of the situation on top of my work is becoming intolerable'.[56] He produced evidence that the Harvey Medical College in 1907 was a duly chartered institution, a fact not till then known to the B.M.A., who could see it would now be forced to make further enquiries in America to

but not without further turmoil involving his administration. A by-product of the 'Hatton affair' was a full scale enquiry by the American Medical Association on the subject of medical colleges after representation by Dr. Scott, President of the Medical Council of Tasmania, to the Council of Medical Education there in January 1919. This led to the prevention of issuing bogus medical diplomas without early discovery.

The medical acts of the six states of Australia developed without coordination up till the First World War in 1914. During the war, in the height of patriotic feeling, exclusion of German or Austrian nationals was written into some acts. These clauses were to cause difficulty when the Nazi regime in those countries drove many German-Jewish doctors into exile. Reciprocity between Italy and Great Britain by treaty created an anomaly as to recognising in Australian states all degrees recognised by the British Medical Council. Victoria and Queensland were two states which extended reciprocity to Italian doctors. This anomaly ended with World War 2, when Great Britain revoked the treaty with Italy.

By World War 2, the medical acts of the six states were no longer so defective by B.M.A. definition, either for the protection of the public or the profession. One problem that had not been cured, however, was that of uniform registration for Australia. Any doctor registered in one state was required to register in another state. This presented no difficulty other than inconvenience and expense for British or Australian graduates; but it created many difficulties for doctors of various categories due to variations in laws between states - e.g. if Tasmania registered doctors with American degrees in 1920, they could not be registered in other states that specified reciprocity. It also created anomalies in that doctors erased for professional misconduct in N.S.W. could, for example, practice in Victoria. Regional registration, and special licensing, were to introduce fresh complications.

The laws of the Commonwealth in 1900 did not allow for Commonwealth control of uniform medical registration. It could only be achieved by the states yielding the power to the Commonwealth by common consent. One of the first tasks of the Federal Committee B.M.A. in 1913 was to work towards this. It stated principles essential to an 'adequate' Commonwealth medical bill. It commended the S.A. Medical Bill 1913

'as the best detailed application of these that has come before our notice'.[67] The N.S.W. Branch was afraid that Commonwealth power would mean a risk of lower rather than higher standards of qualification. It urged rather pressure by branches in the states to bring their acts into uniformity with each other.

The Federal Council remained concerned that the existence of six Medical Boards (all Government appointed) made it 'easier for rogues and impersonators to gain entrance'.[68] In 1925, it deplored a situation where disciplinary powers varied from none to the Board acting as complainant only to the Supreme Court; while the power to warn, in most cases, did not exist at all; or to deregister in only some, and not in all, for all more serious offences. The Queensland Branch in 1917 had sought a body akin to the General Medical Council of Great Britain which would regulate Commonwealth standards, and act as a court of appeal for medical boards administering a federal act.

The functions of the Medical Boards had evolved in a basically distinct way from that of the General Medical Council in England, which sat as a Court. Not moving itself, it required some complainant. The B.M.A. in England often acted as complainant to lay the charge, then retired from the Court. In Australia, no B.M.A. Branch ever acted as complainant with the exception of the Tasmanian B.M.A. in the Ratten case. Usually the complaint sprang from an official source such as the police, or the Dept. of Health, as in an action against Dr. F. Zlotkowski in N.S.W. in 1922. He was an honorary physician in out-patients Royal Alexandra, and was soliciting patients for private practice by way of exaggerating the seriousness of an illness or alleging fatal disease.

In 1918, the Federal Committee sent a draft Commonwealth Medical Bill to all Branches. Queensland and Tasmania alone approved.[69] A further report prepared for the Royal Commission on Public Health 1924 said Commonwealth registration would be necessary for the proposed health scheme urged on the lines of the U.S. service. All branches now supported uniform registration. The Commissioners further claimed in their report that inconvenience in health administration flowed from the anomalies of six acts; and saw in the Federal Health Council a possible medium to arrange transfer of power to the Commonwealth.

The 103rd Annual meeting of the world-wide B.M.A. created an occasion for the meeting of delegates of Medical Boards, convened by the Medical Board of Victoria. This stressed the urgency of uniformity of law, but rejected the B.M.A.'s 1923 motion for Commonwealth legislation. The Federal Council appointed a committee in 1936 to consider the best means to bring about uniform registration. It proposed an Australian Medical Council, and drafted a fresh medical act, based on the Union of South Africa Act. It conceded that there was divergence of opinion as to how uniformity was to be attained, but insisted that uniformity of law by each state was not as rational a solution as one controlling law for the Commonwealth, as each state in the former case would be free to draw up its own by-laws to regulate medical practice.

The first session of the N.H. and M.R.C. in Hobart, 1937, resolved that 'either the Commonwalth be given constitutional authority of the kind embodied in state medical acts, or steps be taken by the authorities concerned to secure uniformity in the medical acts.' Among the kind of problem existing was the granting of licentiates to refugee doctors from Europe by Scottish Colleges after a prescribed short course of study and examination. Such doctors were registered by the General Medical Council of Great Britain, on condition that they would not practice in Great Britain. But the registration automatically carried the right of registration in Australia. The B.M.A. Federal Council asked the Commonwealth and State Governments to act to exclude such men from special treatment. But different states adopted different policies for these and other alien doctors which must have been most confusing to them. With the shortage of doctors in World War 2, modified policies of entitlement to registration, or licensing in outback areas with eventual registration or both, added to the confusion. During the war, state registration was suspended for all those serving in H.M. Forces.

The position in 1950 still showed considerable variation, as analysed at the British Commonwealth Conference by Sir John Newman Morris, who had been twenty years a member of the Victorian Medical Board.[79]

[illegible]

A conference of Medical Deans of Universities, in April 1940, deplored the lack of uniformity in medical acts as a matter 'seriously affecting the universities which are naturally jealous of the status of their degrees throughout the Commonwealth'.[71] This was enhanced by the advent of medical schools in Queensland (1938) W.A. (1950) and Tasmania (1960).

Impetus towards federal collaboration was given by the visit of the President of the General Medical Council in England, Sir David Campbell, to Australia in 1959 to certify as to the standard of medical education in the University of W.A. Medical School for reciprocal registration of graduates in the U.K. He stated that the time was ripe for Australians to have their own Medical Council, in order to accept responsibility for accreditation of medical standards of education in all its medical schools. They were still dependent on the General Medical Council of U.K. at considerable inconvenience to the latter.

In 1960 a provisional General Medical Council was set up with the approval of all State and Commonwealth Ministers of Health and Boards of Health, and in the presence of presidents of all state medical boards. The required common consent from existing authorities to give it power was forthcoming from all states except Victoria; which withheld consent due to the difference in their legislation controlling registration of foreign trained doctors.

In March 1962, the six state medical boards met in conference. They constituted an advisory board to the Commonwealth and State Governments on matters relating to medical practice, comprising the presidents of each state board and the chairman of the A.C.T. Board. Its objective was to achieve uniform registration, maintenance of standards of medical education, and the feasibility of defining conditions for the registration of medical specialists, as well as eventual conformity in admission of foreign graduates. The A.M.A. protested that it was not consulted, nor represented, nor noted as observer. The Federal Minister of Health replied the Council merely represented an extension of conferences already being held, which gave it no basis to include the A.M.A.[72] A.M.A. support was given conditionally that it should represent

the profession, the teaching bodies, and the state medical boards. Eventually early 1965 in conference, the Advisory Council explained it was merely a caretaker body, until the states agreed to give it a statutory basis. All Medical Boards now agreed that two representatives of the A.M.A. and the Universities respectively be joined to the Council, with Victoria dissenting. This Advisory Board could still act only as a referral centre. It could not of its own function harmonise the acts.

Negotiations had originally been approved by a conference of Ministers of Health, March 1962, forty years after another Ministers' conference had first moved for uniform registration. A further conference February 1964, however, showed reluctance to the actual transfer of power, chiefly due to the problem of specialist registration.

Despite the ever increasing intervention of the state to control medical practice since foundation of the B.M.A. in 1832, the practice of 'quackery' was still in 1964 in Australia not totally excluded by laws dealing with medical practice. No Australian Act, however, prevented entirely forms of medical practice, such as herbalists, naturopaths, osteopaths, chiropractors. Indeed, in W.A. in 1961 a Royal Commission seriously considered a form of registration for 'natural therapies'. Its report reiterated a principle usually adopted in Parliamentary deliberation of the problem of protection of the trained doctor, and prohibition of the untrained practitioners:[73]

> "It is not for the State to tell him (each individual member of the public) that he must go and go only to a certain class of registered practitioner. If the ordinary citizen in his own wisdom wishes to consult a person or persons who may not necessarily be properly qualified to give him the advice sought, then that is the concern of the individual and not the concern of the state".
>
> "The Commission feels that the interests of the public as a whole can, in many instances, override that particular human liberty. . There are occasions, and public health is definitely one of them, when the state owes a duty to its citizens that the public as a whole, or individuals in it, are not harmed by the activities of persons who have no particular qualifications to practice any particular profession or art"

Thus was expressed a change of governmental attitudes, encouraged in no small degree by the efforts of the B.M.A., over a century, so that no state in Australia could any longer be called 'the paradise of quacks'.

CHAPTER 6

ETHICS, FEES AND ADVERTISING

(a) ETHICS

The Hippocratic principle was restated in the code of ethics of the Australian Medical Association, when founded in 1962:

> "to command the respect of his patients, and of the public should be the aim of every doctor. The strict observance of basic ethical principles will enable the doctor to attain this end".

The A.M.A. code of ethics presented a consolidated statement of 'policy, definition and rules' devised over the whole period of Australian association with the B.M.A. 1832-62: to deal with good behaviour on the part of one doctor to another, and doctors towards their patients and the public. It was considered to be one of the most important functions of medical association. The code was governed and shaped by Great Britain, as the right to make an ethical code independent of the Parent Body did not lie with any branch of the B.M.A.

When the B.M.A. began in 1832, public estimate of the profession was very low, if we are to believe the Australian Medical Journal of 1846:[1]

> "The indifference, parsimony, and cruelty of society at large towards the profession of physic: the taunts, jokes and buffoonery with which those who rust in health are accustomed to salute the doctor or the mean chandler's shop advertisements of huckstering boards of guardians, and gruel-gauging Poor Law Commissioners, have never reduced the profession in public estimation, or their own, so much as their reckless and suicidal competition with each other".

In 1849 in England, expulsion of a member for consulting with an unqualified doctor led to the appointment of a first committee on medical ethics. In 1851, a further committee on quackery condemned homeopathy, a new theory of medical treatment, not recognised again until World War I. In 1853 and 1858, new ethical rules for B.M.A. members were issued; and added to from time to time. The code evolved, like the body of British common law, to meet contingencies over a period of time by a process of accretion; but, as it were, to deal with the rights of one citizen towards another, rather than as from the government prosecuting the citizen for offences.

Ethical rules were passed in the first instance by the Council of the B.M.A., and later, after 1904, by the Annual

Representative Meeting. They were adopted by B.M.A. Branches and Divisions as they thought necessary. The rules were mainly guides to procedure and etiquette or good manners, though punitive rules were added at times of agitation within the medical ranks; but never universally nor within all divisions. These were expulsion if already a member, and refusal to consult, or ostracism, if not. Over the whole history of the B.M.A. they were rarely invoked, predominantly during the 'battle of the clubs' 1890-1920. The pressure inherent in the code of ethics towards conformity was derived more from fear of loss of fraternity, and access to medical organisation, than loss of employment.

The first medical society founded in Melbourne - the Port Phillip Medical Association of 1846 - intended to introduce a code of ethics, even before the American Medical Association founded later the same year. Of these rules, Dr. H. B. Graham, medical historian, writes:[2]

> "Some of them turned out to be contentious and ultimately wrecked the Association; but many of them have been incorporated in all the subsequent medical charters".

Dr. Wilkie, its founder, spoke of 'the troublesome and laborious task of maturing the rules and regulations',[3] as there was no precedent. When the succeeding Victoria Medical Association began in 1852, ethics were deliberately omitted from its objects to avoid dissension; though provision was still made to expel or to rebuke members. This article was retained when it became the Medical Society of Victoria. A subcommittee in 1859 wished to revise the rules. Among ways to raise the prestige of the society, it proposed to adopt a code of ethics, and call it a faculty of medicine with fellows similar to the A.M.A. of N.S.W. Action under the new rules, approved January 1861, led to the expulsion of a Mr. MacKenna for advertising a reduced scale of charges, and circulating cards with these charges under doors of houses. His resignation had an immediate effect on attendance at meetings, and the M.S.V. was only revived by taking up the cause of medical tendering, and the arrival of two energetic personalities, Dr. Neild and Dr. Halford.

The A.M.A. in N.S.W. was more fatally affected than the M.S.V. by attempted hearings of charges against members, which caused membership to fall away rapidly, extinguishing it finally in 1869. The M.S.V. in Victoria survived various stormy 'trials' of members. Among these was an inquiry into Dr. E. Barker for

supporting a notorious quack named Gordon who kept an exhibition of anatomical monstrosities, and had brought an action against Syme of the Age. He was not expelled in 1870. The M.S.V. also proposed to try Dr. Thomson who wrote an article in the 'Medical and Surgical Review'. When he heard of it , he sent the article to the M.S.V. with "audacity" and "blackguards" written across it. Two ethical charges of intrusion, though proved, incurred no penalty in 1871; but a member who advertised too prominently resigned when called on to explain. Even Professor Halford, himself, was arraigned for advertising.[4]

The B.M.A. in Victoria emerged in 1879, in a year which had given rise to an unusual number of ethical disputes; one of the leading ones concerning refusal to consult with a newly arrived doctor suspected of homeopathy (which he denied). Dr. Henry, arriving with a charter to found a B.M.A. Branch, was refused M.S.V. membership, May 1879, for ethical reasons not specified. He attracted other doctors like Dr. Neild, already dissatisfied with the disruptive effects of disciplinary policies in the M.S.V., who founded the B.M.A. conjecturing that ethical disciplines and medical politics would become their function.[5] The first year's report said that 'several delicate questions of medical ethics have come before us during the year, in which some of our most valued members have been concerned'.[6] The B.M.A. soon decided that the hearing of ethical charges before the full society rapidly engendered quarrelsome episodes, and set up a committee to screen complaints. In the 1890's the B.M.A. established punitive rules to exclude doctors from membership who did not work under acceptable conditions - particularly with 'clubs'. A Medical Defence Association was founded in 1896 to conduct the burden of prosecution and a blacklist of doctors.

In S.A., the B.M.A. , founded 1879, almost at once drew up a code of ethics but , when these were put to the branch 'their remarks were not complimentary to the code'.[7] The B.M.A. concentrated on science, and ultimately ethics were taken up by a Medical Defence Association, from 1901-13 , when the B.M.A. at last actively assumed this function. The Queensland Medical Society in 1882 adopted ethical rules 'to promote fair and honourable practice;[8] which included those on consultation with unqualified men and advertising. Revived in 1886 with only general objects, it announced that prior societies of 1871 and 1882 had become disorganised over ethics, and it would confine itself to science.

A Medico-Ethical Association was formed in 1890 to deal with ethics and contract practice, its functions being assumed by the B.M.A. in 1892, and by the M.D.A. in 1900.

In N.A., the B.M.A. founded 1899, had an ethical function from the first, and it urged a section on medical ethics and politics should be included in the Australasian Medical Congress of 1902, which should advocate power being given to Australian Branches to make their own ethical rules - particularly for admission of members and expulsion.[9] In theory, the Branches could not, but in practice at least three did. The first was N.S.W., at the instance of three local associations in Sydney, which demanded what became known as 'intra-professional restriction rules', though Branch Council was not unanimous as to the wisdom of inflicting any penalty on doctors holding posts with organisations not approved of by the B.M.A. In theory, doctors holding such appointments were ineligible for membership for five years, or would not be met in consultation; but only one expulsion appears to have occurred before 1905 on these grounds. They became more common for a few years afterwards, but doctors, likely to incur B.M.A. condemnation, appear to have abstained from joining.

The Victorian B.M.A. adopted a similar rule July 1899, as did the Victorian M.D.A. in 1905. The latter underlined the difficulty of making such rules effective, despite circulation of a confidential blacklist and expulsions: due to the existence of a large percentage of reputable men outside the jurisdiction of the M.D.A.[10] By 1910, the N.S.W. M.D.A. had a confidential blacklist of 30 doctors and 10 organisations; these doctors being driven to approach the Premier to seek compulsion of B.M.A. doctors to meet them in consultation - unsuccessfully. S.A., W.A. and Queensland all , also , had blacklists, while the Tasmanian Branch on foundation in 1911 - when taking over ethics from the M.D.A. - examined lists for eligibility and refrained from asking certain doctors to join.

From 1900, not only did the branches intensify action on their punitive rules against doctors who diminished their working conditions; but they were more vigilant as to professional advertising. The N.S.W Branch , for example, in 1909 adjudicated 16 ethical disputes. These included 12 cases of irregular advertising, two cases of medical articles in the lay press, one case of commendation by a doctor of a proprietary medical

appliance, paragraphs in newspapers thanking medical men for services, paragraphs extolling the merits of practitioners and other problems. As late as 1918, it was necessary to rule at a meeting with country associations against hanging directories in Bakers' and Barbers shops, or having consulting rooms in chemist's shops. Such annual meetings between the B.M.A. and country associations, begun in 1912, had been mainly to achieve alignment of ethical rules.

One of the most spectacular ethical disputes on record in the branches in this era was the Silenette affair of 1900 in the Victorian Branch. A B.M.A. meeting, March 21, 1900, had sought to expel a surgeon, Mr. O'Hara, from the Branch for his connection with Silenette Proprietary Company Ltd. on a complaint laid by a member, on the basis of a circular issued by Silenette, dealing with birth prevention, after complaint by Archbishop Carr that it had gone to homes, businesses, and girls' schools 'in all its filthy suggestiveness'[11] A 3/4 majority of the Council agreed to expulsion, as another member had recently been expelled for a much lesser offence- advertising a mouth wash. Mr. O'Hara protested that he merely held shares in the company, and was ignorant of the circular. Expulsion was put to the Branch to seek the necessary 3/4 majority with the Council's threat, that, if it were not forthcoming, they would resign. It was not, and they did.[12] The intransigence of the old Council for four years delayed healing of the breach, as it demanded complete reinstatement and full apology. This seems to have been somewhat pointless, as Mr. O'Hara resolved the dilemma by resigning; as did an appeal to the Central Ethical Council in Great Britain, by virtue of the fact that the B.M.A. had only powers to deal with its own membership, and Mr.O'Hara had passed out of its jurisdiction by resigning.

A contrasting situation occurred in 1909 when the Central Ethical Council did hear the case of Fox vs Moore, without a request from the Branch Council, on the mere lodging of a protest by the doctor involved from the Branch's decision. The former varied the Victorian decision with a finding that appeared to suggest the need for punitive action as to professional conduct. The Victorian Branch objected that they were not told the decision first, and disallowance of local decisions would greatly hamper their work in organising the profession; moreover, the C.E.C. could scarcely be in possession of adequate facts where personal examination of witnesses was involved.[12]

The B.M.A. Branches in Australia assigned the task of a coordinated body of ethics, as one of the first of the new Federal Committee in 1912. This proved to be possible only in broad terms, because of the varying conditions in the six states. All states, however, had rules similar to Article 13 of the 1904 Constitution, which allowed expulsion for 'conduct of the member detrimental to the honour and interests of the profession or of the association, or calculated to bring the profession into disrepute, or on the ground that the member has wilfully and persistently refused to comply with the regulations of the Association, or the rules of any Division or Branchof which he may be a member.'

In 1915 and 1919, the A.R.M. (Annual Representative Meeting) of the B.M.A. approved new rules after the celebrated Coventry Case had thrown doubt on Rule 7 and the powers of the association as regards non-members; and desired that all branches and divisions within the British Isles should adopt them. After Dec. 31, 1919, the B.M.A. would not accept responsibility for any ethical proceedings undertaken or conducted by a branch or division otherwise;[14] and after 1921 would not accept any new group of members, as a branch or division, until they adopted the new ethical rules.

The N.S.W. Branch had not followed the 1919 decision, when, in 1921, it brought the expulsion rule into operation against Dr. G.T. Thompson. He had been expelled by the due procedure of vote of 3/4 of the Branch Council vote, the Branch Ethics Committee and a general meeting. The charge against him was his action on behalf of a Mrs. Farr, then a patient of a Dr. Davidson. He said, when she consulted him for a chest complaint, that she had been wrongly confined in a lunatic asylum. To secure her liberation, he published a letter in a Sydney newspaper, and approached influential people for an enquiry into the case and the lunacy administration. An adverse judgement by the judge in lunacy led to comment in the M.J.A. which incensed Dr. Thompson who then released to the press the whole correspondence with the B.M.A. The B.M.A. complaint ensuing was[15] his letter tothe State Premier, insinuating that the detention of Mrs. Farr was effected by improper action of doctors; to public statements in derogation of professional honour, and publication of letters presumed confidential.

Dr. Thompson sought an injunction to restrain the association from maintaining the expulsion, saying it had:[15]

> "with undue influence wrongfully, maliciously and unjustifiably induced and procured large numbers of medical practitioners practising in this state, members of the association to refuse to meet the plaintiff in consultation or to accord him professional recognition in any other form"."

He claimed £5,000 damages for intra-professional restriction. He won before a jury in the Supreme Court 1922, but lost in two subsequent appeals to the Full Court 1923 and the Privy Council 1925. He won £1,000 for libel against the Australasian Medical Publishing Company, the libel consisting of the words:[16]

> "Dr. G.S. Thompson, on his own showing, has followed a course which would have resulted in the removal of his name from the Register of Medical Practitioners had the incident happened in Great Britain. According to the evidence given in the Court he first of all insinuated himself between a medical practitioner and his patient."

The Privy Council found that the intra-professional restriction regulations existed before his expulsion, and were framed before he became a member and were not specifically directed against him, but their very existence amounted to proof of intimidation, coercion: that this was the foundation of the case for damages. They considered the argument of counsel for Dr. Thompson that this regulation operated in restraint of trade, and was therefore void, to be a misuse of language. Their finding added:[17]

> "The object of the rule is in their lordship's view not to penalise or impoverish or injure Dr. Thompson or any former member, but solely to keep up the discipline of and morale of the members of the Association, to protect and promote its interest, though indirectly and as an entirely undesigned result some injury may incidentally be sustained by an expelled member in the practice of his profession. The difference between two such intentions is well established in trade competition".

In 1924, the South African Ethical Committee asked the B.M.A. for powers in respect of expulsion as possessed by the B.M.A. under Article 10a. The B.M.A. Secretary in London asked the Federal Committee to assume the same power saying "The Council feels that the recent case heard by the Privy Council has a distinct bearing on the above proposals".[18] Meantime, some uneasiness had been expressed as to the proper way to distribute confidential lists to branches, and Federal Committee decided to get legal advice as to their legality and

on the intra-professional restriction regulations.[19] Sir Edward Mitchell K.C. recommended minor changes, but London wanted Australia to drop them altogether, to bring their ethical rules in line with Branches overseas, particularly Great Britain; to establish the desired uniformity of constitution, powers and procedures everywhere. London believed their view fortified by the events of the Thompson case. However autonomy of overseas branches in ethics was preferred, and the Central Ethical Committee urged them to adopt rules on the British pattern - a view endorsed by the Australian Federal Committee. The Federal Secretary, Dr. Todd, followed the 1919 B.M.A. ruling that it would not take responsibility for any proceedings not consonant with the new ethical rules; and drafted a new rule which would avoid fear of legal reprisal as England had already done.[20]

The Federal Committee had only one query to make to London as to Article 17 on 'automatic' membership - whereby members, coming from other states or countries took up appointments, which members were 'debarred from accepting' and were thus put to the 'consequent odium of expelling or otherwise dealing with the appointee'. Butthe Central Council would not depart from the essential principle of the B.M.A. that graduates might go anywhere 'under the British flag' with full reliance on their welcome by a local branch of the B.M.A. If members had to ask local 'approval' the Council believed this would affect membership.

In 1936, the Federal Council sought approval from branches for amendments to the original 1914 code of ethics: further to restrict advertising by way of broadcasting, lay press, through interview or personal photograph, or appointments to sporting clubs or charitable institutions. The N.S.W. Branch also suggested adding ethical rules for supersession and consultation, and by 1938 the Victorian Branch saw fit to add them to its own Branch rules. It had already indicted the practice in 1929 after great turbulence in the Branch, leading to two expulsions from the Branch, and the deregistration of a doctor by the Medical Board for the practice of fee-splitting. A new code of ethics was later approved in March 1948, and a further occasion for change presented by the formation of the Australian Medical Association in 1962: a much more elaborate document being approved than that of the B.M.A. Federal Council. It included the declaration of Geneva by the

World Medical Association launched in 1948, and the International Code of Medical Ethics of 1949. Two of the latter were of particular importance in reference to contemporary events. One was directed against human experimentation as had been seen in Nazi Europe; the other a commentary on political viewpoints towards state control of medicine - that unethical practice included 'taking part in any plan of medical care in which the doctor does not have professional independence'. The Code emphasised its raison d'etre:

> "problems will always arise in the course of his professional work on which he needs specific guidance. They may occur, for example, in the setting up of practice, in his relationship with colleagues, in dealings with official bodies, in contact with the general public and in numerous other ways".

Each Branch Council retained a standing committee, such as had existed from World War 1, to deal with disputed points and to advise on points of enquiry not covered by the code's explicit comments. It claimed that the decisions of the General Medical Council were generally accepted as the basis of 'infamous professional conduct' and enumerated them. The code was expanded to recognise such new areas of practice as medical inspectors, industrial medical officers, and group practice. The old rules as to 'unethical medical appointments' were still carried on, though the article providing for a society or institution to be declared 'inimical to the interests of the profession' does not seem to have been invoked for many years. The last instances on record were expulsions of members by the Victorian Branch in 1931 and 1932, when it still circulated a confidential 'blacklist'.

Perhaps the most striking feature of the whole code is the picture it presents of the doctor in the twentieth century as a man hedged about with a multitude of ethical rules, fortified by both professional and community law. The doctor no longer appears as the simple dispenser of a bottle of medicine, but a man occupying a role of extremely complex and delicate balance both to other doctors and to patients. One can only wonder at the first years of the young graduate in medical practice; and how often this code must be in his hand to meet the many variations of problems for which it is meant to be a guide. Even then,

it does not mention the considerable number of state laws, with which every doctor is expected to be familiar and conform.

A significant addition to the A.M.A. 1962 Code of Ethics was the prelude, which acknowledged the status the doctor had achieved in little more than 100 years, since its progenitor the B.M.A. was born, and the role of the code of ethics in maintaining that status:[21]

> "The medical profession occupies a position of privilege in society because of the understanding that a doctors' calling is to serve humanity, and because members of the profession have built up a tradition of placing the needs of the patient before all else.
> "On admission to the brotherhood of medicine, every new member not only succeeds to the benefit of its special place in society, but also takes upon himself the duty of maintaining this high position. The justification for the freedom of medicine lies in the hands of those who practise it."

(b) FEES

The belief that medical men made a lot of money was not the prerogative of the twentieth century, witness the editor of the M.J.J. 1873.[1]

> "There prevails a fallacy that the medical profession is rich, and that because it is necessary for a medical man to maintain a good deal of external show. While some few practitioners make fortunes, the bulk of them do little more than exist, and the records of the Medical Benevolent Association show that some of them find it very difficult to do this".

A correspondent, somewhat soured, seems to have done a little research in Collins St., the medical stomping ground:[2]

> "Out of the thirty medical men residing there, who are theoretically supposed to live in houses of £300 a year rent, and to visit their patients in expensive vehicles, drawn by thoroughbred horses, driven by fat coachmen in gay livery, seven have no carriages at all, and three drive but one horse, and their coachmen are certainly not in livery... the incomes of most do not reach more than £760, not an extravagant income for a professional man when you reckon the expenses which are a necessary part of his outlay. Three or four medical men in highly varnished carriages drive through the city every day as if every minute were worth a guinea to them, and on the evidence all the rest of the five hundred are declared to be wealthy. Bitterly do I say I only wish it were so".

The Port Phillip Medical Association in 1849 drew up a schedule of fees for doctors based on an Aberdeen Society scale of 1829.[3] It aimed to introduce uniformity of charge, but still with three classes of charge ranging from 3s to 10.6d; or double out of hours. The charges for consultations at home and visits were the same with a 'discretionary deviation' in chronic cases. Midwifery ranged from £5.5.0 to £2.2.0. Specialist consultations had only two classes, first and second for a guinea and half guinea. The remarkable fact is that for the best part of a century these charges remained unchanged.

In 1872, Dr. Gilbee in the M.S.V. said this scale was now unsuitable to present conditions in Victoria. A revised scale was issued based on a minimum 10/6. A contemporary comment objected, saying 7/6 was the fee of many, not a few took 5/6, some 2/6, others whatever they could get. The writer claimed that a medico-ethical society he had tried to establish some years before, had found fees a difficult subject. Somewhat similar fees seem to have been charged in the other states. The A.M.A. in N.S.W. in 1859 had a similar scale of charges. In South Australia, the lowest fee was said to be 5s in Adelaide in 1873, while midwifery varied from two to five guineas.

society lodges and charges acceptable to both sides.

Workers compensation introduced a further aspect of medical practice, requiring voluntary arbitration. In N.S.W. in 1927, after the 1926 Act extended the scope of compensation, the Associated Licensed Insurers and the Government Insurance Office approached the B.M.A. to draw up a suitable schedule of fees and charges, which was done after protracted negotiations. The B.M.A. explained to members that the schedule applied only where the doctor chose of his own free will to look to the insurance adjudication committee. In W.A., a special medical committee was set up to consider all medical accounts in dispute 'and to maintain the dignity of the profession by checking members who are inclined to be unreasonable in their charges'. A Victorian Insurance Adjudication Committeein 1937 dealt with disputed accounts for services rendered.

In Queensland and N.S.W. administrative machinery was set up to hear appeals against private fees charged by doctors. The Queensland Medical Assessment Tribunal consisted of a Judge sitting with Government and B.M.A. representatives - its purpose for the 'better control and discipline of medical practitioners'.[10]

In special circumstances, governments intervened to assist as in the Mallee in 1931, when Parliament agreed medical expenses incurred by settlers should have preferential status, and assisted from harvest proceeds. In 1937, the B.M.A and the Pharmaceutical society arranged with the Government to give free medical treatment to 15,000 families on food relief as a social service. The B.M.A. had carried unemployed patients up to 10% of their practice without charge during the depression.

From time to time, the scale of fees in private practice came under attack, but not often by so highly placed a personage as the Inspector of Charities, or so publicly as the press. In 1937, the former complained the B.M.A. had refused to establish a scale of fees for medical attention, hospital accommodation and nursing service within the reachof most wage earners. He referred to a scheme submitted by himself to the B.M.A. with subintermediate accommodation at public hospitals on low fees with a fixed scale of medical and surgical fees. The B.M.A.'s answer was that at least 75 % of surgical work in Victoria was already done at intermediate fees, and the fee problem was not the solution of the hospital problem which rested in:[11]

> "attention to excessive extravagant costs of hospital building, the institution of proper systems of assessment closer supervision of hospital managements, and the support of contributory schemes".

Fees were also attacked in Parliament in Victoria at the time as a result of a move from the B.M.A. and the Medical Board to prohibit the issue of composite accounts on behalf of two or more doctors for the treatment of one patient for one complaint. 500 doctors attended a special meeting in 1937 objecting to the Bill as likely to undermine patient confidence in doctors, until amendments were made.

Fee schedules had never remained uniform as between city and country, or as between states. The need for a loading for country practice had always been recognised in lodge practice; while Queensland with a higher cost of living had a higher rate than Victoria for example. Such variations caused discrepancies in border towns, or even between adjoining streets, if local association rates varied. These variations caused no problem until national medical service was projected in 1938 with the Commonwealth plan for national insurance. The undue prominence given to haggling about payment to the doctors tended to feed any public reputation the doctors had for being profit hungry. The haggling in practice rose rather from the Commonwealth endeavour to strike a simplified rate, for actuarial purposes, in a country of many territorial differences, which had never been able to arrive at simplified solutions.

A major cause for caution by the profession in 1938 was the lack of any review mechanism provided by the original legislation, despite the belief that the amount proposed was a bare minimum - a minimum that could only be changed by further Act of Parliament. In all further discussions of national medical service, the problem of review mechanism remained a contentious one. In 1948, doctors feared that any contract entered into with the Government for direct payment would lose the profession the constitutional clause protection 'not for industrial conscription'. The voluntary insurance scheme agreed to in 1952 only provided for direct contract in the form of pensioner medical service.

Doctors' fees were still subject to voluntary arbitration, as in the days of contract practice, but between three parties instead of two - the doctor, insurer and Government. Although doctors still continued to decide their own fees in consort for a given area, they now became subject to the very real and effective force of public protest and pressure, by both the voluntary insurance organisations and the Government, which was now the ultimate paymaster.

common law rights or freedom of contract. It could also be construed as restraint of trade and unenforceable. On the other hand, if a local association were to reach mutual agreement as to fee levels, there appeared no power in the N.S.W. Branch to overrule it.[14]

The A.M.A. , federal and state, from 1952 had the responsibility for preserving public goodwill in a national health service, therefore, with a debatable power to constrain their members on the most crucial factor of fees. The factor was crucial because public acceptance of voluntary insurance, as a viable scheme of national health service, depended on the patient's ability to recoup the major part of his fee; and the insurance company's ability to keep its gap small, without considerably increasing the patient's annual contribution to insurance funds. The insurer had to retain a balance between the call on its funds and the size of its reserves; and in any case could not increase the patients' benefit payment without Government consent.

The A.M.A. was forced to rely on rallying goodwill in the profession for voluntary regulation of fees. Arriving at what was an acceptable table of fees proved in practice no easier than it had done in the past under other forms of medical service. In practice it earned the doctor more odium than it ever had in the past. It engaged the time of the Councils of his medical organisations more than it had ever done. It required enlisting expert advice from outside, special subcommittees of Council to analyse such advice, public relations counsel, endless conferences with the Commonwealth and the insurers outside the close and regular liaison existing by virtue of the existence of the national health service. It was not the kind of arbitration involved between employer and employee, resorting to an independent court for wage determinations. The Commonwealth was both the employer and the judge. But the A.M.A. , joined as it was to the Arbitration process, did not control the employee for whom it was acting, the individual doctor. The procedure was fraught with difficulties for the A.M.A. Councils, and an unenviable and thankless task for those who engaged in it. The A.M.A. walked a tightrope in defence of the freedom of the individual doctor, in particular his right to establish his own rewards, and in defence of voluntary insurance, harassed by a Labour Party

that wishes to rationalise the scheme economically and to control the financial aspects directly. The A.M.A. was further handicapped in the loose federal structure of the organisation, and in that many of its members thought only of their individual self-interest in terms of what they had to pay: therefore demands for increases were periodic and variable.

The viewpoint of the Government was expressed by the Federal Minister for Health, Dr. A.J. Forbes to the Australasian Medical Student's Association Convention in 1968:[15]

> "Increases in fees might endanger the future of the medical benefits scheme. The point could be reached where the scheme was no longer worth subscribing to because of the disparity between the fees charged and the refunds made.
> "Alternatively increased fees could force an increase in weekly contributions to the point where they became more expensive than they were worth or could not be afforded.
> "The medical benefits scheme was vulnerable to cost pressures - and its principal alternative was nationalisation".

The A.M.A. saw some of the fault as lying in the refusal of the Commonwealth to allow larger funds to pay the larger benefits they could afford in order to protect the smaller funds - a multiplicity which the Labour Party condemned.

The difficulty of the A.M.A., in acting for the body of the profession at large, was accentuated post World War 2 by the dissatisfaction of many doctors in specialist groups, and particularly doctors in salaried groups, with the B.M.A. method of bargaining and its outcome : as in the case of the Dillon report in Victoria, and the resident medical officers in Brisbane, and salaried officers in N.S.W. - who went to arbitration outside the orbit of the A.M.A. The decision of the N.S.W. B.M.A. branch in 1958 to become registered with the Arbitration Act as an employers' union in respect of doctors employing staff, then excluded the Branch from acting as it had done in past years for salaried doctors, who formed their own Salaried Doctors' Association.

One thing throughout was clear - that doctors' fees were no longer simply a matter of what the market would bear. Fees were always a vexed question, but they did not - in pre-national health service - create any more difficult problem than resistance to undercutting prices of one doctor by another. With national health service, two new tangled problems arose:

relationship of general practitioner charges to those of specialists and the pressures of Government control on each; and the problem of general practitioners charging too much rather than too little- as in contract practice days- which endangered the stabilisation of the national scheme. Neither of these problems were satisfactorily solved to the content of all parties under the voluntary health insurance scheme.

(c) ADVERTISING

Advertising was the bane of the profession in the nineteenth century, both of the qualified and the unqualified. Medical societies in time gained power to control advertising by the qualified - at least among their own members. But they had eventually to look to state legislation to prevent advertising by the unqualified. In this, they had only limited success, even to the present day.

In the 1840's and 1850's , doctors customarily advertised when setting up in business, when going on holiday; even the performance of particular operations. Doctors would send medical papers to the public press, conduct controversies in the newspaper columns as to their rival theories; invite the press to medical society meetings. All these activities of course tended to promote business for the doctor whose name was mentioned, if not too unfavourably.

The first cases of use of ether in Australia in 1847 were fully reported in local papers - by Dr. Pugh in Launceston, by Dr. Thomas in Melbourne, and Dr. Nathan, Dr. Farquahar and Dr. McCrae in Sydney. We read of objections to the press being associated with meetings of medical societies in 1869 , and a special meeting on medical advertising being called in 1875 at which the M.S.V. adopted a stricter policy, It carpeted a Mr. John Williams for public announcements that he was commencing practice, as 'unprofessional conduct'. Mr. Williams justifiably replied that a great many others were doing the same, and was excused.

Public medical controversies in the press on issues such as diptheria commissions, water supply, viewpoints on antisepsis etc. worried doctors less than what was known as 'newspaper puffery'. A rival medical journal to the A.M.J. in 1869 in a personal exchange with Dr. Tracy over an editorial of theirs, reprinted as a circular to a hospital subscribers Meeting said:[1]

> "They recall when the advertising columns of the daily press groaned under the repeated announcements of Dr. Tracy on ovariotomy".

Complaint was made in 1872[2]

> "The professional indecency of advertising by a kind of semi-direct proclamation of superior competency appears to be on the increase in the country districts, especially those in the north east of the colony."

Circulars or pamphlets were common in that day. Most famous exponent was Dr. J.G. Beaney, honorary surgeon to Melbourne Hospital 1852-76, who figured in two trials: one for murder of a young unmarried woman by abortion in 1866, and the other an issue of negligence in lithotomy in 1875.[3] When a Mr. Bailliere, publisher, sued Dr. Beaney in 1878 for money owing, the most remarkable revelations occurred in court. He had acted for years as Dr. Beaney's publicity agent and promotor. Lectures were written and printed for him for distribution; Bailliere saying 'the lectures were for advertising', and that copies of the book on lithotomy were printed as advertisement at the cost of £700, the whole being distributed free. He had made £2,000 from Dr. Beaney. One would like to say that Bailliere won his case, and Dr. Beaney did not get away with the £400 debt too; but he did, and became wealthy and famous into the bargain.

Some of the leading members of the M.S.V. were asked to account for themselves during the 1870's. One member who advertised too prominently was allowed to resign. Dr. Blair disowned an advertisement for a compound of cod liver oil and iron, which claimed it had the approval of the M.S.V. But he later left the society over advertising and prescribing by letter for sex problems to a N.Z. patient. In his defence he said:[4]

> "He did not think they differed materially in character from those so extensively put forth by Dr. Churchill in connexion with the hypophosphites, or Sir James Murray in association with his fluid magnesia, or Dr. Richardson with the anaesthetic ether, or Dr. Dover with his powder, or by Dr. Gregory with his. Instruments were called by the names of the inventors who were often practising surgeons."

So notable a personage as Professor Halford was even hauled up to account for advertising private practice hours by lithographed circular, along with a Dr. Bulmer. The latter was told his advertising was 'improper in any part of the world'. A heated controversy in the press involved Dr. Jamieson and Professor Allen in 1879, when the former charged that puerperal deaths were much higher in Melbourne, as many of the doctors at the Women's Hospital, where the deaths occurred, were doing work at Melbourne Hospital also.

With the 1890's and the advent of B.M.A. branches in Australia, control of advertising became more specific, and not the mere laying of complaints. Medical societies had more success in discipline than in earlier days. The Queensland Medico Ethical Society dealt with a member for an advertising circular, and he apologised and withdrew it. The N.S.W. B.M.A. resolved

against any advertisement in the lay press, but above to a special policy concerning the profession and the press was defeated in 1902; such as signed articles on medical subject. Many forms of advertising still occurred, such as 'a very conspicuous advertisement opposite the Coogee tramshed that Drs. Freeman and Wallace treated nervous and private diseases.'[5] Other doctors had their names appear as honorary surgeons to rowing, football, athletic, racing clubs, fire brigades, agricultural societies etc, and their names figure in annual reports. Advertising in its many variations was a hardy perennial in all branch discussions.

The N.S.W. Branch report for 1909 records twelve cases of regular advertising; two cases of publishing medical articles in the lay press, one case of commendation by a doctor of a proprietary medical appliance, paragraphs in newspapers thanking medical men for services, paragraphs extolling the merits of practitioners and others. Apart from this it was claimed that advertising in newspapers was becoming comparatively rare.[6] In 1915, two doctors were found to be touting for custom; one with an agent meeting trains at Sydney railway, the other with an agent in Macquarie St. near Sydney Hospital. N.S.W. Branch rules on advertising in 1895, and 1907 (re press interviews) had been reinforced by regulations on advertising, 1911, dealt with by the Ethics Committee.

Victorian Branch discipline was not quite so effective, their ethical committee reporting in 1916 'numerous cases of advertising in the lay press, but request for discontinuance met with a response'.

The B.M.A. adopted British B.M.A. rules forbidding members to use secret formulas, or to arrange for dispensing or supply of any medicine or appliance at any one place. In 1921 the Victorian Branch said advertising came up in various forms; names in circulars, in papers, testimonials in trade advertisements, while a few doctors in the country were not complying, mainly with notices as to visiting days in certain districts. Generally, when reminded, doctors discontinued; while notices in personal columns of attendance on prominent citizens were not so much in evidence.

In the 1920's, advertising was not of the blatant order of the nineteenth century. The Central Ethical Committee of the B.M.A. in England laid down rules in 1925, which were a guide in Australia. The subject cropped up frequently in medical journals, and was dealt with in the 1927-8 B.M.A. Handbook. In 1927, however, the M.J.A. editor found fault with the profession none the less:[7]

> "There is too much advertising by medical practitioners at the present time in the Commonwealth. Many sail close to the wind and adopt expedients whereby they can bring their names before the public without infringing any rule. Others are less crafty and risk being called to account. They think it is a safe gamble."

"Brazen nameplates" came up for comment in 1926, the N.S.W. Branch having failed to get endorsement from the Federal Committee in 1922 to ban the practice of doctors putting their specialty on their nameplate, as the precedent was already established. In 1928, the foundation of the Royal College of Surgeons led to accusations of advertising against the worthy founders who were photographed in the press. In N.S.W. the Branch Council issued a reprimand in 1930 over publication of pictures of new appointments to Sydney University, and an ironic critic said:[8]

> "We must remember that if we and the dentists put forth a doctrine to which 95% of the community refuse to subscribe, we have no divine right to enforce it on them".

In 1930, the Branch did away with all advertising of resumption of practice, as was already the case in England and the U.S.A.

The 1936 Federal Council revision of ethics touched on recommended ethics of advertising. By the post war period there is no doubt that the control over this aspect of medical practice was most direct and pervasive. Bylaws unequivocally prevented a member inserting an advertisement concerning his profession, or the practice of it. The increasing stringency of rules on advertising in the 1930's quite often made the B.M.A. the butt of press criticism.

Nowhere was regulation of medical practice prescribed in such minutiae, as with advertising. The post war handbook issued by the S.A. B.M.A. has for example six pages devoted to detailed rules on the subject. Branch power to control advertising is so considerable, that, while it may not have so direct control over the scale of charges of a doctor, it can prevent him inserting an advertisement as to what the scale might be. In N.S.W., the state, by virtue of the medical act, acquired the power to prevent 'competitive' advertising, and the Medical Board to direct inspection to see that it does not happen. Thereby the state has sanctioned the sanctions of the profession against this practice. This innovation was introduced by the Labour Party.

This form of intra-professional restriction, was regarded as not only creating conditions of fair competition, one doctor to another, but also as protection to the public from being lured to one doctor, in preference to another, by prominence of exposure of his name or reputation. Just what advantage freedom from ethics as to advertising might give a doctor was nowhere more obvious

than in Tasmania with Dr. Hatton after 1937 in his work at the Hobart Hospital, where he felt no inhibition to silence on his work or giving information to the press - and indeed kept a press room at the hospital.

Strangely, modern society has not been persuaded of the equal importance of restraining unqualified men from advertising. Society is ambiguous in its attitude, recognising the need to protect the public from medical advertising, while refusing to legislate, to more than a limited degree, to protect the public from fraudulent advertising. Thus "quacks" may still advertise treatment except for certain serious diseases, where doctors may not. One is reminded of the words of Dr. G. Fullerton to the Select Committee on the Medical Profession in N.S.W. 1849:[9]

> "I do not think it would be worth the trouble to bring in a bill merely for the object of protecting medical men, duly qualified, from the encroachment of unqualified persons, but I consider it would be one of the kindest acts you could do to the uneducated part of society, as the best protection against injury".

Advertising by the profession at large on its own behalf was a different matter. After World War 1, publicity became recognised as an adjunct to medical societies. In 1924, the South Sydney Medical Association brought up in annual conference the need to establish machinery for an active publicity movement as 'the interests of the profession suffer from the lack of organised publicity'.[10] Active publicity committees were created by the 1920's, and among its work were radio broadcasts on public health education, efforts to prevent unqualified broadcasting as in the Northior case in N.S.W. and Victoria, and ultimately presentation of the profession's case during negotiations with the Commonwealth as to forms of national health service. This became more intensive post-war. During the elections for the Commonwealth, late 1949, the publicity campaign became a highly organised affair to present a consistent view throughout the Commonwealth.

B.M.A. representatives attended the first Australian seminar on health education, held in Canberra January 1955, on the initiative of the Commonwealth Dept of Health. Thirty years before Dr. Hone, a member of the Royal Commission on Public Health, had said the Department should have a division of publicity and health education. The S.A. Branch was represented by Dr.C.Jungfer, also a South Australian, who was also a member of the S.A. Branch Council, which asked Federal Council to consider the advisability of appointing a Public Relations Officer 'for the purpose of replying to unfavourable press criticism

and to publicly reply to any controversial medical questions as they affect the profession as a whole'.[11] Dr. John Hunter, Federal Secretary, and Mr. C. V. Crockett, director of the N.S.W. Branch department of medical sociology and research, jointly prepared a statement on the principle of public relations:[12]

> "Traditionally doctors have themselves conducted public relations for their profession, since by the nature of their work, they are familiar or even intimate relations with members of the public. Until recent times this sufficed for a group, which met no organised challenge to its independence.
> "It does not however suffice under modern social conditions and against strong trends towards state regulation or complete state control of medical practice
> "Though the medical profession has always been a theme for criticism, satirists in the past dealt mainly with the physician's lack of knowledge or dangerous methods. Nowadays the lines of criticism correspond to a society where most respect the science, but many are opposed to the form of medical practice. With this goes much cynical commentary on medical tradition and the Hippocratic ideal.
> ".... Organised criticism is chiefly an expression of modern philosophies. Its interest is less in advancing medical science than in elaborating state control".

They added that social planners tended to capitalise on the existence of dissatisfaction towards the profession amongst the public. Public relations was needed to counteract adverse personal reports and criticial reporting. Finance however deferred the decision to have a public relations representative for another ten years.

The policy of reluctance for personal advertisement in the profession had long delayed common acceptance within the profession of the need for a reverse policy as to the problems of the profession as a whole. This policy could not merely be defensive, point by point, as pressures were set up by the Commonwealth, with new changes in national health service: with doctors presuming they should be judged by their long record of public and humanitarian service. Doctors must set out to educate the public as to possible inefficiencies in the health service likely to be created in offsetting old ones. Undoubtedly, the need for a public relations spokesman was a significant indicia that medical organisation had moved a long way from its original spontaneous amateur status, to a form of organisation that could no longer improvise for crisis, nor treat medico-political policy as a haphazard affair, that did not have to work for goodwill both within the profession and throughout the public.

CHAPTER 7

The Hospital Problem defined

Debates on the 'hospital problem' were very frequent in early medical societies. The 'problem' consisted of admission of patients who could afford to pay something into hospitals for the poor, where the doctors had to treat them for nothing. This was called 'hospital abuse'.

Doctors advocated two policies - the first to means test to select those who might pay the doctor something as well as the hospital, or to exclude them from entering the hospital at all; the second to secure more efficient hospital management so that hospitals would not, by reason of shortage of money, be driven to encourage such patients in order to get income.

In 1900, the so-called problem of 'hospital abuse' was of long standing. It was sufficiently pressing to warrant the President of the Intercolonial Congress of 1899, Dr. A. L. Kenny saying:[1]

> "The grossest abuses exist in many of our charitable institutions. Imposition, fraudulent or ignorant is continuous, and maintenance, owing to decentralisation, is the reverse of economical. The check for imposition would be such legislation as would allow the hospital managers and the medical man concerned to recover fees from patients found guilty of imposition - a copy of such law to be posted in larger type in the common outpatient and other rooms of the hospitals".

Writing on the 'Uses and Abuses of Hospitals in 1899, Mr. Bruck , medical agency owner, said after surveying 364 hospitals and sending out 3,000 questionnaires:[2]

> "My long connection with the medical profession in Australia (extending over the last 26 years) enables me to speak with authority on the vexed hospital question which is of far greater importance than the sweating of medical men by friendly societies"

A motion was passed at the 1899 Congress to memorialise the Governments of the respective colonies as to abuses in charitable institutions, and demanding reforms.

It is difficult to assess just when 'hospital abuse' became common enough to put pressure on the medical profession for reform

It seems likely that the principles on which hospital endowment were based encouraged its development over the period 1850-1900, after the disappearance of the office of colonial surgeon with his direct responsibility for hospitals. These principles were encouragement of philanthropy among private citizens by way of donation by matching every £1 privately raised with Government subsidy of £1 or more. In Victoria, the matching grant went as high as £3 for £1. Hospital Saturday and Sunday schemes began in the 1870's as alternative ways to raise money for hospital support.

Popular philanthropy was founded on the principle that public hospitals were for the deserving poor, as they had traditionally been in England. But the demand to enter such hospitals by other than the pauper class of patient was a perennial problem, and had, indeed, led in England to the creation of provident dispensaries for the 'intermediate' class of patient from the earliest in Coventry in the 1830's. Hospitals such as the Melbourne in Australia in their earlier days admitted paying patients, but tried to limit their patients later to the 'deserving' poor.[3] The success of such policies appears to have been variable: according to the finding of the Royal Commission on Charitable Institutions of 1871:[4]

> "It does not appear that the charities are much abused so far as relates to inmates, but the funds of most of the hospitals, more particularly those within populous towns or districts are unduly expended in affording outdoor relief to persons well able to pay for medical treatment themselves, and who should be ashamed to burden the resources of a charity intended for the relief of the poor only".

The N.S.W. Inspector of Hospitals' report for 1878-9 asked for similar powers to similar officials in Victoria, Tasmania, and South Australia; adding that the Colonial Secretary's office had neither the machinery nor time to prevent a widespread system of imposition, while an almost uniform concession to all demands was given; many buttressed by political influences.

Governments of the day did not advocate increased Government support of social welfare - the policy preferred being to encourage greater philanthropic contribution and to decrease the government grant which was thought to encourage extravagance in hospital management. The 1871 Victorian Royal Commission wanted to reduce state grants from £3 for every £1 raised to the N.S.W. principle of £1 for £1. The N.S.W. Government at this time was contributing approximately 50% of hospital maintenance, most of the cost of building, and money grants for payment of 'Government patients' of 3/- and later even more per day.

Governments were reminded, however, of the need for rationalisation of expenditure by men like Dr. Alfred Roberts, Government Medical Officer of N.S.W., who went on an official tour of all states. In his 1878 report, he said the difference in annual cost of each occupied bed in various hospitals of an individual colony was very remarkable. In N.S.W., it was £36 to £156, in Victoria £31 to £122; the proportion of payments by patients ranging from 1/14 th in N.S.W. to 1/57 in Victoria. He reiterated also the importance of Government rule as to accounting and approval of hospital construction, already stressed in Royal Commissions.

Government control of hospital systems varied greatly from state to state. In N.S.W. the Government exercised neither supervision nor control of the 38 hospitals, despite providing ½ to ¾ the cost of running them. Government maintenance in Victoria's 34 hospitals varied from 1/3 to 2/3. In Queensland 2/3 of the income in 25 hospitals was provided by the Government with little Government control being exercised at all. In South Australia, the six hospitals were government, except for the Adelaide Hospital to which it contributed 1/6th. In Tasmania, the three leading hospitals were fully controlled.

Hospital reform was one of the two burning reasons for founding B.M.A. branches in Victoria and N.S.W. in 1879, as for the M.S.V. founding a Medical Defence Association in 1879 also. Dr. Brownless, as Chairman at the latter's foundation meeting, claimed that medical charities had been abused for 26 years past. Dr. Graham blamed the medical profession themselves for some of their problems, saying that professional fees were too high at half a guinea and several shillings for medicine. An editorial in the A.M.J., however, spoke of doctors' determination to make a 'stand against continual demands to give our services for nothing'.[5]

Policies on admission of paying patients into public hospitals varied. Royal Melbourne rejected the attempt of one group to establish paying wards, as incompatible with its charter. Another group of doctors permitted the introduction of paywards in the Alfred Hospital in 1886 for people who either had part, or all the means, to pay hospital expenses. The Alfred Hospital Secretary told the Victorian 1890 Royal Commission that the two classes of patient, who did pay, paid a 'ridiculously low' fee which went into a staff fund.[6] Dr. Girdlestone stated to the Commission that many doctors would not object to paying

patients in public hospitals if a system of strict discrimination could be maintained between those who did, and those who did not. Dr. Reid's opinion was that half the cases in seven years at the Melbourne were 'entirely undeserving of charitable relief'.[8] but many complaints made to the committee and secretary had proved ineffective:

> "The Committee declared that it was, if not impossible at any rate very difficult to make such an inspection"

The 1890 Royal Commissioners came down heavily for means testing and against separate paywards: They found a certain percentage of imposition:[9]

> "people getting tickets from a subscriber imagine they have a right to relief. Subscribers do not make sufficient enquiry into the needs of those whom they furnish with tickets, and suppose that their annual subscription of £1 entitles them to send any number of patients to the charitable institutions".

They also criticised the use of country hospitals, as had Dr. Roberts in N.S.W., as benevolent asylums for chronic and infirm care, as well as alcoholism and other community problem patients.

Professor H.D. Allen in his final general report on Hospital Construction and Management in 1891 agreed that paying patients in the full sense of the term should not be admitted to public hospitals, as this might discourage private charity.[10] But he thought that payment might be made according to means, as was the practice in the great German hospitals.

The view of the medical fraternity at the time was that the community was ceasing to regard public hospitals as institutions for paupers and benevolence, but rather as places for the benefit of anybody who could secure admission. This view was underlined by the report of the Royal Commission on Hospitals in N.S.W. in 1897 which found that public hospitals were regarded as 'public' in a literal sense:[11]

> "The charity of the hospital is taken advantage of by a number of persons who have no claims upon it whatever. The class of people seeking hospital care is said to be altogether different to that in Great Britain, and the charity of hospitals is abused first by those who obtain admission without making any payment at all, but are well able to do so; and second by those who pay small amounts, but are easily able to pay much larger ones".

As to whether hospitals, faced with 'abuse', should charge or not charge patients, the 1890 Commissioners gave arguments for and against the pay or part pay systems, pointing out that the five doctors who were in favour of the pay system were all hospital directors; those against were not. They reached no

conclusion other than that:[12]

> "We find the subject bristling with difficulties, out of which there is no royal road. It seems impossible to lay down any law for the guidance of hospital authorities, and each case must be left to the discretion of the management".

The Report added that it thought the hospitals competed unfairly with doctors, using the free services of their honoraries to attend on cases 'from which they or other medical practitioners would, under other circumstances, receive fees'. However, it commented on the great problems in administering means testing in hospitals, in the difficulty of arriving at the circumstances of patients. The hospitals, in general, also admitted country patients with little question, and were lax in outpatient departments.[13] In many of the 95 hospitals in N.S.W. considered public, doctors were in fact allowed to charge private patients, and in 85 of these a doctor was allowed a small salary or retaining fee with right of private practice.

The problem that most exercised medical societies was that hospitals, by admitting paying patients, in effect often excluded the utterly destitute for which the institutions were originally founded and endowed with Government money and philanthropic donation. Indeed, the desire to obtain income to run the hospital could act unfavourably to the destitute. Therefore, a strong faction in medical societies favoured vigilance to restore public hospitals to their original concept of the voluntary hospital for the pauper class. Such policies were put firmly into operation in certain hospitals such as the Ballarat, the Royal Melbourne and the Royal Adelaide. But in others hospital authorities were more inclined to temporise in view of the existence of a large class of intermediate patients for whom neither intermediate wards or hospitals existed. These could afford to pay something, but not the whole cost of hospital confinement. As an article in the Age, September 10, 1912 explained the dilemma, it was:[14]

> "Unable to harden their hearts to suffering humanity (although it may not be completely indigent) they have sanctioned the custom of admitting between class patients and as, an offset, they charge such cases as much as they can extract from them. Thereby they have to no small extent victimised the doctors in attendance; for the hospital doctors get no such part of their fees".

Those doctors, who wanted to put down 'abuse' or the admission of paying patients with a firm hand, were fighting a rearguard action. By 1899, the admission of

paying patients was fairly general throughout the hospital system of Australia, as shown by L. Bruck's survey of that year.[15] All major hospitals in all six states had had paying patients at some time. Sydney, Perth and Adelaide hospitals had at that time less than others. Royal Melbourne began charging in-patients once more due to pressure from an unexpected source. This was the threat from Sir George Turner, Premier and Treasurer in 1899, that the hospital might not get its annual grant from the public treasury unless it charged patients according to means. When the hospital committee of management debated the matter they [16]

> "described it variously as a concession to the not-quite-poor, a defence against impostors, and an expedient dictated wholly by the low condition of hospital finances".

Thus, in the end, the argument was inexorably resolved in most hospitals by the perennial and urgent need for funds, and the reluctance of Governments to yield from public benevolence what private benevolence was inadequate to render.

In Tasmania, for example, Dr. Butler described at the 1908 Australasian Medical Congress, how the need for money had led to competition between two hospitals in seeking finance, and therefore in charging patients:[17]

> "Gradually the two boards got into competition as to who would collect most money, and by saying who found the government most would get into most favour with the government.".

At this Congress, Dr. Thomson of Brisbane spoke on the difficulty of following policies of exclusion of paying patients in country towns:[18]

> "In bush and mining towns it would be well nigh impossible. There are many in both places, who while actually homeless are very far from being penniless, and are compelled to seek and willing to pay for the aid which can only be obtained at the district hospital. In larger centres, some departments, police, defence, railway etc and some employers, shipmasters and others have to find medical attendance for their employees and they do this by arranging with the hospital to pay a daily stated sum-in the case of Brisbane 3s.

By 1908, hospital policy for Australia had moved to the front of the stage of Australasian medical congresses. It was agreed that 'abuse of hospitals' had been a burning question for at least thirty years, but , despite many deliberations, no solution had been found. Abolition of the honorary system had been proposed at least as early as 1881,[19] by the President of the M.C.V. Dr. J. Robertson, who said:

> "In a matter of principle, I think we are generally agreed that these honorary services are wrong. It is useless to tell the public so, because we go to a

> " great deal of trouble to obtain them, and it is very naturally concluded that, if they were not of value, they would not be sought".

However, at this time, the concept of philanthropy still pervaded hospital attitudes from both sides to inhibit any establishment of a paid partnership; while governments simply could not have afforded to pay the doctors for their services, and the doctors knew protest was useless.

Sentiment of the 1908 Congress was that,under conditions of honorary service, no payment should be taken from patients treated at public hospitals; and, that, except in cases of accident and emergency, every patient should, before being treated, be required to sign a declaration of inability to pay. This view was adopted because of majority opinion that any attempt to means test patients in major hospitals was a farce. If a patient lied and was found out, no one could prosecute them for their fees. A Dr. O'Sullivan, who had tried to sue for fees in Melbourne, had lost one of his two cases, it being claimed the onus was on him to prove there was a contract.[20]

All were agreed that public benevolence was slowing down. Too many charities were competing for funds. Government support acted as a deterrent for private philanthropy. Hospitals were coming to be regarded as 'medical boarding houses' and not charities. Public demands to use public hospitals as of right, whether poor or not, were growing rapidly Doctors who wanted to exclude paying patients from them were sensitive to the need for an alternative policy, for intermediate hospitals for those who could pay small amounts. In 1908, delegates from Melbourne's three leading medical societies met to decide conditions for such hospitals: which were that they should be open to any doctor, there should be no outpatients, and all those admitted should have a medical certificate for suitability. The 1908 Congress approved the policy, and rationalisation of the hospital system as a whole, to operate more efficiently. The resolutions foreshadowed the Hospitals Commissions set up in Victoria and N.S.W. within twenty years: for an executive statutory body, independent of any hospital which might administer the government grant, classify hospitals, prevent overlapping, insist on uniform accounting, close unnecessary hospitals, or prevent new ones being founded, foster economy in administration, and insist on enquiry to prevent imposition.

Fears of 'nationalisation' of hospitals began to be heard at this time. And a standing committee from the 1908 congress reported to its successor in 1911 that intermediate hospitals should be sought by B.M.A. Branches (absolutely controlled by the profession) to prevent it.[21] Dr. R. Worrall, leading member of N.S.W. Branch Council asserted.

> "Their absence is the one weak spot in the case of the profession in defending itself against the schemes for nationalised hospitals admitting rich as well as poor"

Some even foresaw the day when governments might offer free universal medical service as they did education.
At least in Victoria, the B.M.A. was accused by the Victorian Charities Inspector, in his 1907-8 report, of opposing intermediate hospitals; based on their opposition to a Friendly Society hospital at Carlton which proposed to operate on a capitation system, so that treatment would cost patients less than equivalent private hospital care. The N.S.W. Branch had opposed a similar proposal as doctors would only be paid the balance left over after hospital expenses, and would have to attend all cases for an inclusive weekly charge irrespective of their nature and severity, whether medical or surgical. In fact the Victorian B.M.A. approved the Salvation Army Training Hospital in 1904, the intermediate Bethesda(5) established on their principles with the further allowance that fees would be arranged between doctor and patient. The 1911 Australasian Medical Congress upheld the Victorian B.M.A. opposition to an inclusive weekly charge, saying it would mean contract practice in another form.

The Victorian Government in 1912 proposed establishing intermediate hospitals, and the B.M.A. assisted in drawing up a scale of intermediate fees, heeding comments such as that made in the 'Age':[22]

> "As doctors generally dislike the increasingly popular notion of health nationalisation, the profession is most unwise not to have stood forth long since in support of the intermediate hospital proposals."

In the same year, the Chief Secretary of the newly elected N.S.W. Labour Government, Mr. Flowers, advocated opening public hospitals to those who could pay as did his counterparts in Queensland and Tasmania. Such men saw in the continued existence of the 'public' hospital the stigma of pauperism, already repugnant to twentieth century notions of social democracy. Some doctors, as they did, began to look to the public hospital as a general community hospital rather than simply for the deserving poor.

The W.A. Branch encouraged it to bring 'club' hospitals under Government control. South Australian and Tasmanian hospitals were already largely departmentally controlled. The Victorian and N.S.W. Branches had begun to seek the controlling authority that Victoria secured in 1922, and N.S.W. in 1929. Similar trends in Queensland were accelerated by the failure of the Brisbane Hospital to carry on financially as an independent body in 1917, and their appeal to the Government to take control.

A conflict of opinion continued in the medical profession for some years after foundation of the Federal Committee in 1912, one of the chief motives for foundation being fear of 'nationalisation of hospitals'.[25] This Committee took a census of branches on the choice of policy, and resolved against intermediate hospitals as a result. The 1914 Australasian Medical Congress resolved public hospitals should be confined to the sick poor; a view put into practice in Queensland and Tasmania where the Branches wanted exclusion written into the relevant public hospital acts; and in South Australia where the honorary staff at Royal Adelaide refused to countenance admission of paying staff. In Tasmania , such refusal took the extreme order of all honoraries resigning in a body from both Launceston and Hobart hospitals. Exclusion, as a policy, was restated in 1917.

With the end of World War 1, wartime inflation had had impact on hospital finances. In the next decade, at least four states undertook fresh hospital legislation designed to do three things - for the first time, to make hospitals directly responsible to the Government for their efficiency and management; to create sources of income to offset the burden of hospitals on the public purse, and to introduce some rationalisation into the overall system.

Four ways of bringing in finance were considered prior to 1930. The first was by way of direct taxation, the second by increase of payment of patients, the third hospital contribution funds, the fourth indirect financing as through lottery. Of these, the first two were embodied in hospital legislation; the third was encouraged by public bodies like the Melbourne City Council and private groups of citizens; the fourth by various bodies including the hospitals themselves, the B.M.A. and friendly societies.

Direct taxation of all incomes over £52 a year was put forward in Western Australia, and the principle finally endorsed there with a hospitals tax in 1930. It created the difficulties predicted by the B.M.A. from the first - that it would lead to a demand for treatment as of right by taxpayers, irrespective of financial position, and would practically abolish voluntary contributions. Queensland introduced a similar tax. The totalisator tax, adopted in Victoria, did not create expectancy of use of the service, being a concealed tax.

Both Victoria and N.S.W., when their governing bodies were set up in 1922 and 1929, provided for the principle of payment by patients in hospitals, and their liability. Thus the two largest states recognised legally the basic change in the concept of public hospitals, and the BM.A. was forced to adapt its policies to the fait accompli.

Subscription schemes to hospitals, from the twenties onwards, were intended to create a more flexible system of hospital insurance, extending it through the community irrespective of the hospital; and thereby a flow of assured revenue into the hospital system from people of limited means who could afford to pay, provided they did not have to meet a large bill at any one time. One of the most important was the Metropolitan Hospitals Fund of 1932- a joint venture of hospitals and the B.M.A.

The hospital lottery was advocated as a way of yielding large sums rapidly - a method adopted in Queensland and N.S.W. by their respective governments.

All four solutions to hospital finances brought pressures to bear on the profession which demanded a definite hospital policy, and a clear choice betwen the opposing schools of thought evident in the profession prior to 1914. In Great Britain, the B.M.A. in 1922 gave a lead by announcing a policy of support for intermediate accommodation, whether in separate hospitals or in established public hospitals; and for encouragement of contributory schemes to save hospitals from overwhelming debts then facing them. In Australia, advocates of the exclusive public hospital were more rarely heard. 25 As the B.M.A. Federal President, Sir George Syme, said in 1926:

> "In Victoria, it is the large amount paid by patients that is causing a change of view by the profession as regards their attitude to public hospitals".

This changed viewpoint was evident when the Federal Committee canvassed all branches in the process of drawing up a policy on hospitals for uniform conditions of medical service. B.M.A. Branches no longer objected to admission of paying patients in public hospitals, but rather to treating paying patients free as honoraries.[26] Its report in 1926 emphasised the lack of uniformity due to different hospital systems, which made classification difficult except in the one point that generally honorary or visiting staffs to public hospitals did not receive any payments. Some public hospitals then admitted intermediate and private patients, now defined as such (who did pay their doctors), but only in Victoria were there intermediate hospitals as such. In no state was there as yet a community hospital.

In 1925, Dr. M.T. MacEachern, Associate Director of the American College of Surgeons, visited Victoria at the invitation of that Government to survey their hospital system, and agreed to extend his study to N.S.W. at the invitation of the N.S.W. Government. He was a very strong advocate for the community hospital as the most efficient, economical and satisfactory system, besides being the most commonly found the world over. He found that in three years, the Victorian system had been remodelled with considerable administrative changes, headed by a Charities Board of 14. For N.S.W. he recommended a similar board representative of the government, the committee of management of the hospitals and the B.M.A., More intermediate accommodation was needed, and rigid means investigation to limit public wards and outpatients to needy cases, which was not then the case.[27] The Hospitals Commission in N.S.W. from 1929 followed the policy advocated by Dr. MacEachern of developing public into community hospitals on the American system, as enunciated:[28]

> "As the modern public hospital stands alone in the range and efficiency of the services it provides, it is only proper that these services should be made available to all members of the community."

In Queensland, evolution had been such as to make the community hospital an accomplished fact without a clear moment of legislation. Subscription schemes throughout the country promised hospital rights to all irrespective of income, and without further charge. In Tasmania, South Australia and Western Australia, evolution was slower.

[illegible]

> "At least 50% of the people have neither reserves nor income to support them without suffering in time of serious sickness... A breadwinner's wage may stop when sickness comes, and family bills [illegible] and convalescence his dependents may be reduced upon his savings".

In Victoria, the B.H.A. in 1930-31 levied a scheme to join the Charities Board and the combined public hospitals in founding a voluntary insurance plan with an income limit, a [illegible] and strict control of hospitals' admissions, except for [illegible]. The B.H.A. repudiated an alternative scheme of the Charities Board as making no allowance to pay either doctors or nurses.[30] The B.M.A. further registered opposition when schemes launched by the Lord Mayor's Fund in 1932, on the grounds that government was only ready for half maintenance, yet contributors would expect for their contributions free treatment in public hospitals.[31] The scaled benefits contemplated were far below the cost of treatment. Directors of the scheme spoke out on the secret of the B.H.A.'s uncompromising obstinacy, and dictatorial ways. The B.M.A. complained to the B.M. B.H.A. of their bad sense, which included resolutions that the letters had appeared in Hospitals Benefit Fund in their stead. The B.H.A. [illegible] to their request with a stern and chiding[32]

> "The hospitals in B.H.A. are not like shops of [illegible] Any body in a [illegible] public hospital can be operated [illegible] and in any [illegible] in the public institutions. If they were [illegible] than they [illegible] of the [illegible] the [illegible] which have to [illegible] with [illegible] and which [illegible]
>
> "[illegible]

> "hospitals where medical treatment is free has led to the hospitals becoming overcrowded, and some members of the medical profession being unable to live... The Kaiser system has been quoted, but conditions in Britain are entirely different. There, under the national insurance scheme, doctors are paid for their services".

One voice was raised in the Melbourne press in support of B.M.A. opposition:[33]

> "It is not surprising that the medical profession should desire a deciding voice in the terms upon which it is expected to give free service. It has declared, broadly that it will continue to treat the sick poor, free of charge in public hospitals, but that any scheme of relieving the burden of hospital treatment upon persons of moderate means must be upon a business basis, and divorced from control of charitable organisations".

The B.M.A. in Victoria in 1932 had stated the basic principles on which it would accept a contribution scheme - namely that a proportion of subscribers' contribution should be used solely for medical benefits in the form of a cash benefit towards the cost of the patient's treatment.[34] That the B.M.A. was not averse to contributory schemes as such, was seen by their unqualified support at this time for a scheme launched by Colonial Mutual Life Ansurance throughout Australia.

The Hospital Benefits Fund grew apace in N.S.W. in the 1930 and included the medical benefits sought by the B.M.A. It absorbed the industrial section of the Hospital Saturday Fund, and rapidly reached out into the country, The Hospitals Commission welcomed this expansion, arbitrated where it came in conflict with established country schemes, and sought uniformity of conditions throughout the state. The B.M.A. had imposed conditions that a machinery should be established to enable doctors to charge and recover fees, that no outpatient treatment be offered, and for a uniform system of classification of the three categories of patient. It enunciated the principle that in regard to public hospitals 'the Association insists on the right of medical practitioners to remuneration for services rendered in such hospitals'.[35] When W.A. sought the advice of the N.S.W. B.M.A. on their schemes, at the instance of the Under-Secretary, Dept of Health, the N.S.W. secretary, Dr. J. Hunter wrote, 1934, saying that the scheme had succeeded in relieving some of the congestion in public hospitals - in that 20% of payments had gone to private hospitals, for patients normally public hospital patients.

Early 1933, the Federal Council had a hospital policy subcommittee which reported in favour of hospital policy being part of a national medical service on the lines of the British B.M.A. plan for a general medical service of 1930. Clear differences of opinion were obvious from the six states,

reflecting their divergent hospital problems. Tasmania was in the process of restoring the honorary system, retrenched during the Hobart Hospital row of 1917. Queensland was in the process of doing away with it. South Australia supported hospitals from local rates, Queensland in part from local rates, Western Australia from Government revenue under alleged hospital tax. Only N.S.W. and Victoria had substantial hospitals contribution schemes. One problem only was common to all states - that every Government had to provide large sums from Consolidated Revenue. Therefore, the subcommittee urged conferences between B.M.A., hospitals and state authorities in each state; and compulsory insurance for patients. It raised the question of doctors' unwillingness to continue honorary service to all but pauper patients, as did the following Hobart Australasian Medical Congress of 1934.

By 1935, the hospital problem was seen as but one part of the total problem of national insurance, which had become the predominant issue in Federal Council deliberations. The 1925 plan for a Commonwealth Health Insurance Department was revived, and endorsed by all branches as part of the revised B.M.A. plan circulated to the Prime Minister and all state Premiers - for a part capitation, part fee for service scheme. The 1938 Act however did not include hospital benefits.

July 1941, the Commonwealth Parliament appointed a Joint Parliamentary Committee on Social Security with a charter to enquire into community medical service including hospitalisation Early 1943, a Medical Survey Subcommittee - five of its seven members being doctors - carried out a three months survey of the Commonwealth, including visits to 370 hospitals or 1/5 of those in the Commonwealth: the first of its type ever carried out. Its report June 1943 dealt with its terms of reference:[36]

> "The practicability of introducing a Commonwealth wide hospital benefit scheme, in grant-in-aid or subsidy under existing hospital facilities, or alternatively what additional facilities would be necessary,
> "the practicability of establishing such clinics (outpatient district clinics) as an adjunct to our hospital system and whether or not they should, and could, be established in particular localities, for example, industrial areas".

The report had drastic things to say about standards of hospitals in general, unsuitability of design, bed shortages, lack of statistics, and maternity provision. It recommended extension of intermediate accommodation in hospitals, and decentralisation of outpatient departments. In none of these

areas, however, did the Commonwealth have any power to carry out the Committee's advice:[37]

> "The Government of the Commonwealth has no power to intervene in respect of hospital care within the states of Australia, except insofar as its activities are covered by the term 'insurance' (Commonwealth Constitution Act 1901 s.51 xiv) or with the consent of the states concerned (loc cit s 51 xxxvii). No benefit may be distributed to the undue or unequal advantage of a state as against other states (loc cit s99)."

Of all the recommendations, the one, neither State Governments nor the B.M.A. would cavil at, was that for exercising Commonwealth financial powers to give a hospital subsidy. This appeared possible, subject to the above limitations. The purpose of the subsidy was stated to be to give a direct financial benefit to patients, relieving them of part or all of hospital expenses. The committee had worked out that the average collection of fees from patients in Australia was 4/11, the range being from 3/9½ in Victoria to 5/9 in N.S.W.; and nothing from some patients to full fees from others. A Commonwealth subsidy of 6/- a day would cover patients' fees actually collected by public hospitals in all states; and, if extended, would enable all inpatients in public hospitals to receive free treatment there. In private hospitals, the subsidy would work as a reduction of the bill.

The committee advocated outpatient clinics to relieve congestion in larger public hospitals, and the uneconomic load carried by them; as well as to restore general practice to the local doctor which unjustifiably went to the hospital. The committee proposed to pay the latter on a sessional basis to man the decentralised clinics, otherwise retaining the means test, and adding a Commonwealth subsidy of 2/- per patient.

The J. P. C.S.S. , now chaired by H.C. Earnard, drew heavily on these findings in making its sixth interim report, July 1,1943 endorsing the recommendation for health clinics, and uniform standards and system of control for hospitals. By the former it was hoped to close the growing gap between general practice and the hospitals, and to stop the public drift into outpatients' departments which concerned everyone. The B.M.A. was not at odds with any of these ideas, provided that a leading principle was always observed -- that the services be based on a family doctor of the patients' own choice.

In the Bell-Simmons report of 1941, the B.M.A. Federal Council, with the concurence of all branches, advocated that hospitals should be developed on a regional basis grouped around a base hospital:[37] Such a hospital, if not associated with a medical school, should have staff and equipment to undertake more specialised methods of treatment. It found a part-time basis ideal for staffing to allow general practitioners continued access to hospitals, for their continued efficiency, promoted through hospital association, was vital to the community. On the payment of hospitals' staffs, it was vehement:[37]

> "Consideration of the change in clientele and of the change in the law inevitably leads to certain conclusions. The strictly charitable basis of the public hospital now exists only to the extent that some of the poor are still treated gratuitously: the majority of persons obtaining treatment are those who can pay, desire to pay, and do in fact pay, directly or indirectly towards their maintenance and treatment. Although the medical profession will gladly give, as always, its services gratuitously to those who cannot afford to pay for them, it is inequitable to require it to give its services without remuneration in public hospitals which treat persons able to pay, and, which, in practice collect payments from a large number of their patients. " The field of private practice has inevitably contracted with the result, that consultants, and in particularly, the younger consultants, are finding it increasingly difficult to secure and maintain a standard of living which represents a reasonable reward for their services, and which enables them to maintain the highest possible standard of professional efficiency of the medical staff in respect of all medical services in hospital for which payment is made, directly or indirectly, by contributory scheme, by staff authority, by employer, or by patient".

This Declaration of Rights for the doctor was reiterated without change in 1943 except for one cri de coeur:[38]

> "Although it has been assumed to be a responsibility of the medical profession, the medical care of the indigent is a communal one. There is no reason why the medical profession should alone bear the burden of providing one of the necessities of life".

After two referenda seeking power to legislate for hospital and other benefits - the latter successful - the Chifley Government was able to establish the hospital benefit scheme of 6/- per bed per day as recommended by the Medical Survey Committee in 1943. A condition was attached - that no patient in a public ward be means tested, whether he be accident case, worker's injur insured or not. In Queensland, where the hospital board paid per session for attendance in public wards, no principle was at

stake; nor in various hospitals where public patients were the responsibility of resident medical staff, or a doctor or doctors financed by some local contribution scheme as at Lithgow coal mines.

The recommendation for hospital subsidy on this principle was justified in the 7th interim report of the Joint Parliamentary Committee on Social Security Feb. 15, 1944, on the surprsing ground that it might promote the much needed uniformity in existing systems of hospital finance. At the same time, it conferred an equal benefit upon all without discrimination against any state or individual. It was feared that if existing differential debts against public bed patients continued - as low as 7s to 9s in Queensland, or as high as 15s in parts of Western Australia, patients might be required to pay any balance over and above the amount of the subsidy, and thus the object of the Commonwealth benefit be defeated. As to the dilemna of the doctor servicing public wards, the rather naive belief was expressed that public demand and hospital management would combine to encourage the flow of patients toward paying accommodation; as had happened after payment of increased maternity benefits, especially in Queensland. To create extra bed accommodation to meet the expected increased demand, payment of hospital benefit was to be deferred for one year.

The Joint Parliamentary Committee set up a Medical Planning Committee which included seven representatives from the B.M.A. and two from the Colleges. The 8th Interim Report of the former was largely based on its findings, there being no fundamental disagreement with the B.M.A. on leading principles. These included the need for a Commonwealth expert advisory body to give advice to hospitals on planning construction and equipment - acceptance of its advice to be a condition of subsidy. A hospital administrators course of training was seen to be needed; and a redistribution in the use of beds. The report endorsed the earlier plan of regional rationalisation of hospitals as a basis for further study. In Dr. Simmon's words to the December 1943 conference, at which these principles were discussed - its policy was that of the hospitals' committee of the N.S.W. Branch B.M.A. for many years past.

It also suggested that the Commonwealth might not be putting first things first if it were not to question how the patient was using the hospital, rather than merely how the hospital could service the patient.[38]

It was useless to make grants to patients for hospital benefits free medicine etc, if there were no provision for patients to use them by getting admission to hospitals when needed.

> "We feel that the first and most urgent call on any fund should be the making good of all deficiencies in hospital accommodation; that the immediate and cheapest solution lies in overcoming the glaring deficiencies in accommodation for subacute and chronic diseases, and for the evacuation of these patients from acute hospitals with resultant lowering of maintenance costs."

The Commonwealth Hospital Benefit Act of 1945 could not be brought into action without enabling legislation in each state. Interstate conferences of Premiers and Health Ministers agreed to accept the act, including the contentious Clause 8 requiring abandonment of meanstesting. Sir Earle Page, leader of the Country Party, claimed in Parliamentary debate that some of the Premiers accepted because they were given no alternative.[39] They might well have also been influenced by provision for the Commonwealth to contribute to hospital building and possible payment of doctors; as well as the overall intention of the Commonwealth to accept financial responsibility towards hospitals for the first time.

This Act immediately cut across B.M.A. policy to protect the honorary from possible 'abuse', by abandoning any classification of public patients. The states with the most extensive honorary system were Victoria and N.S.W. - the figures for the latter being 1500 in 200 hospitals, working 500,000 hours of free honorary service.[40]

Late 1944 the Victorian B.M.A. endorsed principles asserted by honorary medical officers of the larger Melbourne hospitals: protesting against radical alterations in hospital service advanced without previous consultation with the medical profession - particularly abandonment of the means test. They stressed that they should not give honorary service to patients in public wards and outpatients who could afford to pay, except in emergency. This view was echoed March 1945, by the honorary staffs of major hospitals in N.S.W,[41] and that of Perth Hospital in Western Australia. All were backed by the B.M.A. Federal Council. Queensland and Tasmania were less vocal, as the former had already abolished the honorary system, and the latter was thinking of doing so. In fact, the Queensland B.M.A. Council urged N.S.W. against fighting abolition of the means test, and for preference for a policy for part time paid hospital staff as in Queensland.

[illegible] Council [illegible] Medical services. Their report [illegible] the [illegible] thus:[42]

> "The tendency of the honorary system is [illegible] to the hospital which has not [illegible] the good will, the quality of the staff, the standing of members, and there is no doubt a big part of the profession to return to it."

In N.S.W., the Branch executive continued to support the view that doctors could not become employees in any way, in reference to the sentiment of the majority of honorary staffs in Sydney hospitals. In reporting to the Federal Council, Dr. A. Collins explained that heart of their objection was not the fear for a difference in status, but that it was a definite step from a part-time to a full-time salaried service; adding that the profession in N.S.W. was afraid of an unpredictable future'.[43] Federal Council decided each state should be left free to decide its own conditions of honorary service. After five of the six states passed the necessary enabling acts to begin payment of hospital benefits January 1, 1946, the B.M.A. learned that the Prime Minister had acted in confidence that he would have no difficulty with the profession as they would continue to give honorary service as before;[44] and had, indeed, said as much to the State Premiers. The B.M.A. for its part protested, March 1945, that legislation had been pushed through hastily; and the Federal Council had little more than initiated intermittent discussions with the profession.[45]

The Victorian Branch held a referendum, June 1945, on whether the honorary system should continue or not. The results showed that doctors were by no means as unanimous as they had been fifty years before. 612 doctors voted, of whom 242 held honorary appointments. Of these 313 did not favour abolition, 171 did. Of those who were honorary 166 did not vote for, 71 did. Many the important reasons cited for the honorary system were that only doctors could participate, an honorary is not a servant of the [illegible] consists of the hospital and therefore [illegible] view of professional [illegible] policy in a way they would [illegible] Among reasons cited against, was the fact that [illegible] years past a few doctors had [illegible] whole or part time; public hospitals were [illegible] but community wide in which the community would [illegible] should unduly encroach [illegible] profession be asked to give [illegible]

In the scales 'for' the honorary system were thrown fears of nationalisation, and 'against' the obvious difficulty of demanding payment if the hospitals had no means test. The reaction of doctors, particularly in N.S.W. 1945-7, was influenced by the known predilections of some of the Labour Party Cabinet in office, including the Prime Minister himself. Right or wrong, many doctors presumed that part-time payment was intended only as a first instalment of socialisation with an overriding principle of finally employing all doctors on salary. The Victorian and W.A.[45] Branches said so directly.

In 1948, when the National Health Service Bill was pending, the Federal Council asked the Branches once again to define their view on hospital policy, as to abolition of honorary staffs and amount of remuneration of visiting staffs.[46] W.A. voted the honorary system should continue under protest until a better system could be devised because Queensland had found payment for sessional service grossly inadequate. N.S.W. agreed. S.A. and Victoria said the time was not opportune to open up the matter. It was impossible to generalise because of differences of organisation and staffing of country and metropolitan hospitals, and the problems peculiar to teaching hospitals. Tasmania voted the honorary system should be abolished. S.A. thought also the honorary system should be but at a time to be decided on by the Federal Council. Federal Council policy, February 1949, in the end reiterated views frequently put before as to the 'community' principle in hospitals for patients and administration, and the importance of medical representation on all advisory committees and boards.

The Chifley Labour Government went out of office in 1949. The major changes feared had not taken place. A survey undertaken in 1957 revealed that all states but Queensland retained the honorary system. Tasmania, after a short trial of sessional payment for larger centres, had restored the honorary system for certain categories on the grounds of costs.[47] In all states, teaching hospitals were 'closed' to all but staff residents and honoraries, the rest mostly 'open' to general practitioners who ought to practise there, to a greater or less degree, except in Queensland the large base hospitals. At least three major hospitals, Sydney, Hobart, and Royal Adelaide still had virtually all public beds. The 'community' principle was not yet fully recognised in all large metropolitan Australian hospitals.

The era when all general practitioners were considered theoretically qualified to give unlimited hospital service to

patients had come to an end with World War 2. It was widely accepted in all B.M.A. branches that the principle of 'open' hospitals so often asserted by the B.M.A. as desirable, had now to be qualified by ensuring 'classified' staff particularly in larger hospitals - that is staff with further specialised training in which they elected to practice. The N.S.W Hospital Commission, and the Queensland Dept of Health, both required classified staff at large base hospitals. Victorian staff was classified when the hospital was of sufficient size, and there were adequately trained medical practitioners in the area to justify classification. In order to preserve some general practitioner association with hospitals, and to encourage further qualification on their part, both W.A. and N.S.W. adopted policies to this end. In Perth, W.A. they were appointed 'clinical assistants' in a number of departments for annual terms. In N.S.W., the newer Sydney district hospitals provided for an associate honorary staff to work with the classified specialists, a N.S.W. Branch policy approved by the Hospitals Commission.

Certain categories were also paid in all states- highly specialisted fields like thoracic surgery and neurology- with the approval of the B.M.A. In one hospital, the Childrens' Hospital in Melbourne, the whole staff were paid from 1951. In all cases, special arguments applied.

The honorary system may not have changed radically 1945-55, but the relationship of the other parties to the process of hospital care did - namely, the government, the hospital and the patient. The change was as drastic as a complete reversal of the principle of the Hospitals Benefit Act 1945, after the Labour Government went out of office in favour of a Liberal Government 1949. The Labour Party had abolished the means test, and offered 'free' beds in 1949. The Liberal Government restored the means test, and made it an essential condition of the bed subsidy that a charge should be made. Architect of the new scheme was the political veteran, Minister for Health, Dr. Sir Earle Page, who offered it January 1951 for inauguration in 1952. To encourage hospital insurance, the Commonwealth now paid only 8/- a day, but an extra 4/- a day if the patient were insured. Pensioner patients were given the same subsidy without contribution.

In offering thisscheme, Sir Earle Page brought more skill and experience to bear than possessed by any other man in Australia. Veteran of all debates on national health for over 30 years, and some yearsof Cabinet service both in Treasury and Health, he said:[48]

> "As part of its efforts to nationalise all health services, the Federal Government then in powerOffered to turn over to the states for five years an amount equal to that received by them from patients in all public hospital beds , with the proviso that all ward beds in these hospitals be made completely free. "Inevitably and logically this led large numbers of people to drop their contracts with and contributions to the voluntary insurance societies. Free hospital service could be had for the asking, so what point was there in paying for it? One thing led to another, and the hospitals soon found themselves caring for an unreasonable number of ward patients and losing money on each of them. The whole hospital system drifted rapidly towards bankruptcy. The Commonwealth tried to turn the tide by increasing its per-bed or per-patient contribution, but the damage was already done, and it took us years to undo it".

As some Premiers had feared, non-Governmental revenue had decreased from 50% to 20% of hospital income. In the words of the Information Bulletin of the Dept of Health in 1955:[49]

> "Falling non-Government revenues forced the states to divert substantial funds to current hospital upkeep instead of devoting them to programmes of improved accommodation and equipment."

It reported that the 1952 scheme:

> "Exerted an immediate effect on state hospital revenues. Since 1950 in consequence, non-governmental revenue has more than doubled, there has been a considerable increment in Commonwealth aid, and a notable increase in state government contributions."

Dr. Lee, Queensland member of the Federal Council later recalled what Sir Earle Page had to say when he met the Federal Council Jan 16, 1950 to explain his plans:[50]

> "The public of Australia must be made to realise that free handouts are demoralising, and that the individual had a responsibility beyond that met in the mere payment of taxes for the health care of himself and his dependents. These additional benefits would be available only to those who accepted the responsibility, and the measure of their acceptance would be that they had voluntarily insured against medical and hospital costs".

All States, except Queensland and South Australia reimposed the charge. The Premier of South Australia, Mr. Playford, maintained free hospitals five years longer on the grounds of electoral appeal. In Queensland, Dr. Lee - Chairman of the Medical Benefits Fund in that state - deplored the effect of the continued free

hospital scheme in that state. Where insurance rapidly rose in all other states, it was difficult to reach a 50% level in Queensland. Those, who did insure, were likely to create a higher claims ratio, and necessitate charges of higher premiums than in other states. He believed that the free public hospital acted in absolute opposition to the method of hospital finance whereby Commonwealth additional benefit subsidies existed to provide a mechanism by which the patient could reimburse the hospital through the medium of charges. In all other states than Queensland, the level of insurance arose rapidly to levels as high as 90%; and Australia was given an opportunity over the next fifteen years of unbroken Liberal Government of determining the wisdom of prophecy made by the Federal Hospital Sub-Committee B.M.A., 1934, that the crux of the hospital problem hinged upon the proportion of the community who could be brought to pay by insuring themselves against the risk.

Bed shortage had been stressed during the deliberations of the nineteen forties as a priority problem over all else. Sir Earle Page had seen the need to overcome it by stimulating the demand for private and intermediate beds via voluntary insurance. Sir Earle Page suggested to the Federal B.M.A. Council that their influence be used to declare an increasing number of public hospital beds private beds, citing the case of a Queensland maternity hospital, which had become 80% private through a hospital benefits scheme.[52] That this did indeed happen in N.S.W. is evidenced by the Report of the Hospital Services Committee in 1965 appointed by the N.S.W. Cabinet in 1963.[52]

> "The present system of financing hospitals and medical services in N.S.W. partly by organised insurance, and partly by government subsidy, has altered the pattern of medical practice. There is a marked diminution in the number of public beds, and especially in industrial and rural areas, a marked increase in intermediate beds".

In certain cases, Government opposition had to be overcome. In Tasmania, the B.M.A. asked the Minister for Health on a number of occasions to instal intermediate beds, but were told this was against government policy of 'free beds for all irrespective of means'.

By 1960, the entire concept of hospitals in Australia had finally changed along lines totally different from their origins and traditions. Australia, after a decade of prosperity and high employment, had large hospitals with public patients of whom 70% were insured. The old definition of public beds for the sick poor had become farcical, and with it free service by doctors to those beds even more questionable than in 1900, when it

began to be so strongly agitated.

A Medical Service Review Committee appointed by the A.M.A. October 1962 exposed two problems. It was illegal for doctors to charge fees to public patients in all states, except ~~Canberra~~ the Australian Capital Territory. The Committee itself was unable to recommend one course to follow as to a possible method of payment-whether by session or by fee to insured patients in public beds who might be national health, workers' compensation, or third party cases. The pros and cons of both were set out in their report. Policy as to non-teaching hospitals was to be left to Branch Councils. Only as to teaching hospitals was the Committee's national hospital policy more specific:[53]

> "Where it is desired, there should be some method of payment for patient care of public ward patients by members of visiting staffs of teaching hospitals.
> "It is desirable that there should be adequate payment by universities for members of visiting staffs engaged in teaching".

The rest of the section dealt with extension of principles asserted in prior years. The first question was the hardy perennial - whether any part of the honorary system should still be preserved.

The dilemma of the honorary system now rested for the most part not on whether honoraries should be paid, but how they should be paid. The Commonwealth Government, anxious to pay in 1945, resisted payment in 1965. The State Governments claimed lack of funds. The B.M.A., which generally resisted payment in 1945, now, as the A.M.A., claimed right of payment in many areas.

The sessional payment methods attracted a majority of votes from some honorary staffs, but the Medical Services Review Committee was aware of the old quandary of some mechanism of review which would ensure that the initial contracts would not become relatively 'frozen'. In the words of the Committee:[54]

> "From experience, it is visualised that difficulties also will be encountered in obtaining improved condition of service and salary".

Top priority was given to payment for all services in teaching hospitals. At the instance of the Branches, the Federal Council A.M.A. October 1966 asked for the barest minimum - payment for teaching medical students - from the Australian Universities Commission. Yet the Australian Universities Commission Committee on Teaching Costs of Medical Hospitals said:[55]

> "Such payment would not of itself jeopardise the present system of hospital appointments' and 'such unpaid teaching takes place in no other category in the university and is an anachronism".

Senator Gorton, on the subject, answered a petition on the ground that it had 'very wide implications which are not confined to teaching hospitals', and which were of concern to both State and Commonwealth.[56]

The 'implications' referred to were the problem of whether state or federal governments could afford to pay to abolish honorary service in hospitals in general. As the Medical Services Committee pointed out:[57]

> "Such a scheme would require a reassessment of the real cost of medical care in hospitals to the medical benefits funds and could not be recommended without complete examination and consideration of its effect on the voluntary health insurance principle of the national health service".

One guess at the cost of paying the doctor for service to insured patients in public beds on a fee for service basis was £5,500,000 of which the funds would have to meet £3,000,000, thus causing a rate increase of 1/6d a week to the contributor.[58]

The Federal Assembly A.M.A. was well aware that payment had been discussed for years by staffs of hospitals in all states. In 1962, it was stated:[59]

> "As far as we can ascertain the several Australian states which still retain the honorary medical system are unique. It has been abandoned in all other parts of the world. The system was established when there was great economic inequality in the community, and when the medical care of the poor was largely left to charitable organisations".

But the gap in the insurance system remained, that the Commonwealth made no contribution to the cost of medical care of patients covered by insurance who occupied public beds in public hospitals. Yet the N.S.W. Branch Council's definition of 'indigence' was now 'financial inability to join a medical insurance fund'.[60] The honorary staffs of eleven teaching hospitals - particularly the three obstetric hospitals - preferred that any system of payment should be by way of federal insurance benefits for payment for patient care in this type of accommodation in hospital. Despite the A.M.A.'s reminder, in 1965, of the deleterious effect of the honorary system, and the fact that its maintenance had become a serious financial burden to the profession, governments continued to claim lack of funds as the reason why the profession must go on subsidising the hospital system with their time and effort.

After sixty years of striving for a 'fair deal', doctors in hospitals often remained unpaid workers, and the 'hospital problem' remained unsolved. As such they presented a social anomaly in a modern age of being the only group of people

expected to work for nothing in time when a man is presumed to work for a living.

1900-65 had seen a vast change in the attitude of government responsibility. 1920-40 had seen an increasing assumption of state responsibility to coordinate, direct and finance hospital systems; 1945-65 the direct intervention of the Commonwealth with financial aid. In all states, the hospital systems had on record at one time or another quite serious conflicts and major enquiries, the history of which makes illustrative reading.

(a) ASPECTS OF HOSPITAL HISTORY IN N.S.W.

The British Government established military hospitals in Sydney and inland centres of N.S.W. such as Goulburn, Bathurst and Windsor. It relinquished direct control of these when transportation ceased in 1840, and they were taken over by committees of local citizens, which often included doctors. Such citizens regarded the responsibility as an act of Christian charity, traditional in British society. ~~The prevailing system became the pattern of~~ the voluntary hospital, where honoraries serviced the hospital, became almost universal. Only in two hospitals did a feature, peculiar to the military hospitals, linger on in the role of the full-time paid medical superintendent - namely in Goulburn and Newcastle.

Subscription from the public was necessary to maintain such hospitals. The colonial government provided some limited financial support for hospitals from 1836 onwards, strictly on the basis of stimulating fundraising from the public with £1 for £1 of public money raised, sometimes more. But this was not enough to keep the hospitals open, nor for the most part of the nineteenth century were Governments ever anxious to extend their responsibility. Indeed, even the Boards of a hospital like the Sydney Hospital saw at times, in increased Government finance, an active deterrent of public donation in which they saw their most important source of livelihood.

The first voluntary hospital as such, in N.S.W., was the Benevolent Society's hospital, founded in 1821 'for the poor, blind aged and infirm' as an extension of ~~their~~ the Society's work of Christian succour since 1813. Honorary service to the public was extended with the creation of a dispensary in 1827, as an adjunct to the Sydney Infirmary. This dispensary provided an outpatient and domestic visiting service, conducted by doctors on a district basis. Its management committee took over Sydney hospital in 1840. The third hospital to offer 'charity' to the sickpoor was St. Vincent 's Hospital founded in 1857. Its first honorary surgeon was the Dr. James Robertson who founded the A.M.A. in Sydney in 1858, and the two most common diseases he treated in the first year were consumption and leadpoisoning. Dr. Robertson was followed by Dr. F. Milford, the first medical student to study at the Sydney Infirmary for a course of preliminary training recognised in Great Britain.

The public hospital system in Sydney was not considerably expanded till three new organisations appeared in short compass with the Coast Hospital (Prince Henry) in 1881 (due to a smallpox epidemic); the Prince Alfred Hospital 1882 (from a fund raised by

by the Sydney public as gratitude for the escape of the Duke of Edinburgh from assassination by an Irish fanatic in 1868; and the Sydney Hospital for Sick Children (The Royal Alexandra) in 1880 from the efforts of a ladies' citizens' committee. These were all born of a momentum in the community, which also saw the foundation of the B.M.A. in 1880.

By this time N.S.W. had 38 hospitals, which provided 1 bed to 527 people. Of these, three were wholly Government hospitals, four wholly public. In the remainder, the Government contributed half to three quarters of the cost, and its share in contributing to building had risen above the original £1 for £1. Although an Inspector of Public Charities had been appointed in 1866, the Government exercised no supervision or control . Statistics were difficult to secure, records often not properly kept. The annual cost of each bed varied from £36 to £156. The nature of hospital construction was scarcely checked at all as to economy or to suitability, either of building, site, or need in a particular area. Country hospitals were called upon to act as benevolent asylums, as there were no institutions for the sick poor in the country, and one of the prime conditions of their annual subsidy was that they had to admit anyone on an order from the local magistrate or police whether chronically ill, vagrant, or alcoholic. Dr. A. Roberts, medical advisor to the Government, in 1870 had spoken of the depressing and injurious effect of such a policy on everyone in country hospitals, and urged the need for greater Government control of expenditure on them, saying they were in a highly unsatisfactory condition.

A Royal Commission into the Working and Management of Public Charities, 1873,[1] found there was sufficient evidence of neglect and mismanagement to justify that the Commissioner of Public Charities should have powers of inspection and action.[2] It found statistics so bad it could not make a proper inquiry, while hospitals should not be allowed within 25 miles of each other. No action was taken, and the Inspector, in 1878, was demanding that it should be. He complained that there was widespread 'imposition', and no power to stop it, with an 'almost uniform concession to all demands, many buttressed by political influence'.[3] Public charities were increasing 'beyond all bounds' despite ample employment; and the public were looking to Government care as of right. Two major acts followed in 1881, the Hospitals Acts Amendments Bill 1881, and an Act to incorporate the Sydney Infirmary and Dispensary following a crisis in its affairs in 1878, when the entire medical staff resigned.

The doctors returned on promise of action from the Board, which led to the rebuilding of the hospital which they claimed insanitary and unsuitable. Sydney Hospital's 1881 act gave it power to institute proceedings to recover costs for treatment, although it remained a hospital primarily for the sick poor. Its President from 1883-1903 Sir Arthur Renwick, also helped to found the Royal Hospital for Women, Paddington.

Yet another Royal Commission on Public Charities 1897 found little change.[4] Hospitals had grown to 106 in number, all state subsidised, including the Royal North Shore, Balmain and other. Authority to control them was divided between the Chief Secretary and the Medical Adviser, without any voice in management conditional on subsidy, or the Government offering advice on administration. The Commission felt that the hospitals with most shortcomings were those with the least public subscription - a reflection that community pride was related to grassroots financial support. The Chief Secretary could instigate special inquiries only when charges of neglect and mismanagement occurred, or quarrels between officials impaired the 'good government' of the hospital. Otherwise the Medical Adviser could visit and comment on obvious defects only. Inquiries were held from time to time, such as in 1890, when a Dr. Goode of Orange was in gaol for eight months as a debtor for £1,000 damages and costs, because he had made charges against the matron and committee of Orange Hospital, had been dismissed and successfully sued for damages. The B.M.A. defended Dr. Goode by waiting upon the Premier Sir Henry Parkes to urge a select committee of inquiry. Orange Hospital subscribers protested against B.M.A. interference. Sir Henry Parkes declined to act. The A.M.G. reported:[5]

> "These charges laid by Dr. Goode before the hospital committee gave rise to one of those squabbles and angry party divisions that only those who have lived in a small country town can imagine".

In nearby Bathurst, a hospital dispute with variations occurred the same year. The honorary staff, matron and nurses resigned, refusing to work with Dr. Garrett, the resident. When taxed by the Board, they refused to give reasons, pointing to the awful example of Dr. Goode, who had done so, and met continued libel actions, severe financial loss and imprisonment. The staff would only declare it was impossible to work with him. In 1899, a similar situation occurred at Lewisham over the appointment of a certain doctor to the honorary staff. In 1892, the honoraries and committee of Newcastle Hospital were ranged against the resident, Dr. Doyle, but the Premier refused Dr. Doyle a Royal Commission to investigate charges made against him, threatening to stop the subsidy if the committee

did not 'settle its little differences'. The honorary medical staff resigned. Years later, Newcastle Hospital was once more the scene of major differences between the honoraries and the superintendent.

Disputes with matrons were not uncommon, and the 1897 Royal Commission commented that often they had not the thorough training essential for the post. Moreover, although the Medical Adviser had drafted a code of model rules for hospitals, they did not have to adopt them, and most had not. It said the 'pay' system existed in all but two hospitals, had grown up with them, been thoroughly thrashed out for years, and existed because of an acknowledged gap in hospital accommodation. There was a class of patient - not eligible by reason of health for friendly society or provident medical association - who, not being able to afford fully private treatment, were forced to look to outpatient and public hospitals for treatment. The Commissioners saw the proper solution not to load the honorary system of the free public hospitals, but to create provident dispensaries. The medical professions' own organisation , the City and Suburban Provident Medical Association, established 1895 in Bathurst St. gave a concessional service from over seventy doctors to patients - many sent from the hospitals.

The N.S.W. Government, from 1900, encouraged the friendly societies in building dispensaries for medicine, which, by 1910, became the centre of an argument with the B.M.A., because the Chief Secretary toyed with the idea of extending dispensary service to include medical treatment. Neither dispensaries on the English model, nor intermediate bed accommodation on any scale developed at this time. But Mr. Flowers publicly expressed the ambition to 'nationalise' hospitals when public finances would permit, when replying to a deputation from the Political Labor Conference who were concerned with congestion and lack of money in the hospitals His predecessor, Mr. McDonell, Labour's first Chief Secretary in 1911. had circularised all subsidised hospitals, threatening to withdraw subsidy unless they placed every medical man in the town or district on the hospital staff. A B.M.A. deputation had protested, saying they could not then refuse to work with non-B.M.A. doctors; and arguing further that too many doctors would cause chaos, committees being left with no discretion as to admission of doctors on their honorary staffs, and with impaired authority. To which Mr. Flowers replied:[7]

> "He could not share the deputation's confidence in the present control of country hospitals, for there had been cases where things were not at all that they might be, and in some country towns much trouble had arisen with regard to the medical staffs. If a medical man was qualified to practice outside, why should he not be qualified to practice in a hospital?"

The principle of the 'open ' hospital gave trouble to the B.M.A. in two disputes of a very different character - at Wyalong Hospital and Kurri Kurri Hospital in 1912. The B.M.A. had a blacklist of thirty seven doctors with whom they would not meet. Some hundred non-B.M.A. doctors had an association of their own, the A.M.A. One A.M.A. doctor was appointed to Kurri Kurri Hospital whereupon the whole B.M.A. medical staff resigned, and the nurses gave notice. The BM.A. agreed to vist the hospital in emergencies. A deputation from the hospital committee to the Premier protested against the B.M.A. boycott, to which the B.M.A. comment was:[8]

> "The miners of Kurri Kurri believe in trade unionism and fair conditions of work and remuneration for themselves, but not for the doctors whom they employ".

The State Premier Mr. McGowen lent a willing ear to the miners saying 'no body of men should take up an attitude which is detrimental to human suffering', but said he had no power to act. Commenting on the Premier's remarks against the B.M.A. for 'striking' a S.M.H. correspondent said that his sentiments were:[9]

> "quite inconsistent with the tacit or open approval of the Premier and his friends of the gas strike, the coal strike, the wharf labourers' strike or Brisbane tramway strike".

The inconsistency was certainly there. The B.MA. was striking against 'non-union' doctors. Yet a meeting of combined miners' lodges voted to withdraw their support from the hospital unless two A.M.A. (non-B.M.A.) doctors were appointed to the medical staff. The hospital committee were faced with an ultimatum from the Chief Secretary, having failed to get the Government to appoint a resident medical officer as in West Wyalong; who for once sympathised with the B.M.A., that, if they could not make satisfactory arrangements, the Committee must resign. On a visit to the hospital, Mr. Flowers told them:[10]

> "He could not deny to the members of the B.M.A. the right to refuse to work with men who had no sympathy with their ideals."

Mr. Flowers took the same attitude to the Nepean Cottage Hospital where a non-B.M.A. doctor wanted to send patients and the hospital committee refused as at Kurri Kurri.

The dispute at West Wyalong Hospital was quite the reverse. There a non-B.M.A. man, Dr. J. Maloney applied to go on the staff

as an honorary, but the hospital committee refused. The Chief Secretary then said the subsidy of £700 would not be paid. The Hospital Committee would not accept that it should be an open hospital, aware that other hospitals had not acquiesced in the 1911 directive. It claimed the sole right of election of staff doctors under the Act (No. 16, 1898) and retaliated by saying their funds were exhausted, and they would close the hospital except for emergency cases. They gave notice of dismissal to doctors and staff, when the Government intervened by requiring the Inspector of Hospitals to hold an inquiry, as in other cases in dispute.

The N.S.W. B.M.A. Branch sent a deputation to the Chief Secretary proposing a way out of the difficulty of 'open' hospitals in cases like West Wyalong, Coonabrarabran - that the Inspector General of Hospitals should be given the function of certifying that appointments of the type were necessary and advisable with the right to speak at hospital committee meetings as in New Zealand. Mr. Flowers' reply was that this officer was going to report. He sent an instruction, May 1912, which made it impossible for a doctor practising in a hospital, also to sit on its board, on the grounds that doctors who were on committee had vacated their positions as medical officers:[9]

> "It being a well-established principle of law that the holding of a public or quasi public office is incompatible with membership of the public or quasi public body to which the holder of that office is answerable".

The B.M.A. Council asked that the Act allow medical staff to be represented, as in the Acts of Sydney and Royal North Shore Hospitals. The dispute is of interest, because doctors had often sat on the boards of hospitals in the past, but it set a tradition in train that doctors should not be on hospital boards, except in advisory capacities. The B.M.A. Annual report, March 1912, asserted the rule of the B.M.A. that doctors could not apply for appointment unless a hospital had declared the office vacant, and invited applications. From saying that 'the Government has acted with discretion' the B.M.A. report next year said the instruction 'has continued to give trouble, and during the year has brought a certain number of hospitals in the country into conflict with the department', referring to 'judicious administration' warding off the serious consequences which would have been inevitable under a literal enforcement of the instruction'.

At this time Mr. Flowers issued a widely distributed pamphlet on hospitals, which indicated his preference for opening public hospitals to all classes irrespective of financial status. In his view nationalisation was the only course fitted to meet requirements as with education. The hospitals were kept from consolidated revenue, and the taxpayer had to pay. It was wrong, he argued, to raise class distinctions and admit one section, refusing another. He believed that doctors got their quid pro quo:[10]

> "as a means of advertising to a great extent, most medical men desire to have the opportunity of giving publicservice in a public hospital".

Dr. Arthur in the Legislative Assembly asked if the Government approved of Mr. Flowers' policy, to which reply was given that it required 'the most mature deliberation'. The B.M.A.'s reaction to press controversy was to reaffirm the principle that public hospitals should be reserved for the sick poor; and spoke of the imperative need for a federal B.M.A. committee in view of impending nationalisation of hospitals. At a B.M.A. meeting, Dr. Pockley sought support for a referendum of members to oppose medical men giving honorary service in state hospitals, such as Waterfall, Rookwood, Liverpool. He argued:[11] 'We are thus aiding the Government in nationalising the hospitals by making it possible for them to do so at an infinitesmal expense, as far as medical expense is concerned'. He claimed that in England the B.M.A. would not countenance free service to patients maintained by state funds. He lost his motion.

As a step to nationalisation, the BM.A. opposed free dispensaries in 1912, saying that public hospitals, ~~and~~ clubs and doctors privately, all made concessional, or free, medical services available, and dispensaries were unnecessary therefore, unless for T.B. clinics. It opposed paid residents in hospitals bbing allowed private practice outside, and supported the 1914 scheme to guarantee income of doctors in centres more than twenty miles from district hospitals, conditional on having two beds for urgent cases.

The B.M.A.'s alarm continued into 1915, when its report read

> "Following the conversion, some two years ago, into state general hospitals of three institutions, conducted previously as asylums of destitute persons, and the encouragement of Bush Nursing schemes, and of Tuberculin Dispensaries, the programme of the Government has recently been extended by the introduction of several special public services, including baby clinics and hospitals, convalescent homes, venereal clinics, further development in bush nursing and tuberculin dispensaries, and schemes for subsidising resident medical practitioners at remote country place, and for adding maternity wards in such public hospitals".

The B.M.A. interpreted these developments as diverting medical attendance from the private doctor to the government service, a tendency bad for both public and profession. Such fears seems strange today. Taken in the context of the times, it was difficult to foresee the limitation of such services in view of the ambitions of Labour Governments. A strong meeting of protest was held for example against themove to give Government employees free treatment in public hospitals, if injured in the course of duty ~~of~~ honorary medical staffs in 1916. Mr. Flowers, since 1915, a Minister for Health with his own Ministry spoke of his intention, at some future date, to introduce paid medical staffs in public hospitals.

In 1915 the Branch Council carried out a survey of methods of financing, managing and controlling hospitals; and, in 1918, rejected the idea that they should be controlled by municipal councils, preferring a statutory hospitals commission. The same issue was under debate still in 1923, with the Branch offering the same solution of a hospitals board, free from political control, which should decide the number, nature and equipment of hospitals in each district of the state, and prescribe the method of administration and management. Early 1925, the N.S.W. Government convened a conference (including B.M.A. delegates) to modernise hospital legislation in the state - after the visit of the Director of the American College of Surgeons, Dr. F. Martin with one of its founders Dr. W. Mayo to lecture on hospital standardisation. The latter said the medical profession in N.S.W. had allowed itself to be exploited by free hospital service. In the same year, Dr. M. MacEachern, Associate Director of the same College, and Director of its Hospital Activities was asked by the N.S.W. Government to report on its hospitals. He recommended a state hospital board, similar to the Board of Charities of Victoria, and representative of Government, hospitals, and the B.M.A., specific grants secured from the general budget of both municipality and state, rather than through a definite tax rate; payment of a per diem allowance to meet free and part-pay work; and hospitals to provide for all sections of the public. Public wards and outpatients were to be limited to needy cases and more rigid means testing carried out. Hospitals should have uniform policies of staffing to embrace as many as possible of the doctors in the community. Everyone should have a complete honorary staff - being differentiated into various services or specialties in metropolitan and base hospitals. In small hospitals medical and surgical work should go to local men.

For the first time the Public Hospitals Act of 1929 established a Hospitals Commission of five members, the Chairman being full-time, and the B.M.A. directly represented.[11] At last the Government had power and machinery to deal with the hospital system, Further changes were made to the Act in 1934 and 1943. It laid down uniform principles relating to hospital finance and administration, provided for regular inspections, and power to give directions on administration or management, though only after a properly constituted enquiry It provided no really effective penalty for non-observance other than withdraval of subsidy. Post World War 2, the Hospitals Commission had 250 public hospitals within its orbit ranging from Royal Prince Alfred with 1,400 beds, to hospitals of under ten beds.

The N.S.W. B.MA., in 1929, set up a standing Hospital Policy Subcommittee, which acted as a permanent liaison body with the Hospitals Commission, was frequently consulted, and aided in the foundation of the Metropolitan Hospitals Contribution Fund in 1932. The latter took over from the Hospital Saturday Fund, and twentyfive hospitals approved of its policy. The N.S.W. Government gave it a foundation grant of £2,000. Its principle was one of weekly contribution, 6d per week, which entitled, up to twelve weeks in a year, hospital treatment in any hospital. It grew rapidly from 3,000 opening contributors, gradually displacing local subscription schemes tied to a particular hospital, except in certain localities such as Broken Hill, Lithgow, Cessnock, Wollongong where the schemes already existing were much more comprehensive and retained their local appeal.

The edict of 1912, forbidding doctors from sitting on hospital boards, had not always been strongly policed. A U.A.P. Minister of Health, Mr. Weaver, in 1934, amended the Act to prevent any practising doctor in the hospital sitting on its board, except in those hospitals with their own act. As Minister, he also sat as Chairman of the Hospitals Commission, a situation changed by the Labour Government in 1944. The B.M.A. has not been able to alter this state of affairs substantially since. Generally, doctors were confined to a nonvoting right of attendance at board meetings, or to medical advisory committees to the boards.

The problem of how and where to charge patients continued to grow in the 1930's with the rapid conversion of public into community hospitals. The Workers Compensation Act ~~amendment~~ in 1926 allowing of medical and nursing services up to £50 had created problems; resolved by deciding to charge such cases

if admitted to casualty, and pay the money into a fund controlled by the honoraries as in England. The Hospitals Act 1929 provided for intermediate patients to have free choice of doctor. May 1939, a Joint Parliamentary Committee was appointed by the U.A.P. Government to inquire into the appointment of honorary doctors and graduands to hospitals, the treatment of and charges to patients in private, intermediate and public hospitals. A progress report was issued December 1939, but, due to the war, its task was never completed. Dr. Hunter, as N.S.W. Branch Secretary, attended all sessions. Sir Charles Bickerton Blackburn represented the BM.A. in tendering a formal statement of B.M.A. policy, which contended the system of honorary medical service caused the doctor to attain and maintain excellence, though conceding that financial reward might follow only after some years on the staff. Moreover it only worked efficiently as a teaching service if it attracted the best brains. The Committee was faced with a virtual crisis in the hospital system to which it equated the Queensland crisis which had precipitated major changes in the systems of that state:[12]

> "Whilst your Committee does not suggest that the N.S.W. situation is yet in anything like the above described position, it is definitely of the opinion that the position of our hospitals indicates a definite drift in that direction".

Pressure on hospitals had increased due to depression patients continuing to patronise them in better times for the quality of their service, including many who could have been treated at home.

> "Many of our citizens are inclined to look upon them as something they should receive free of cost in the same way that they receive free education. This must eventually result in a very heavy burden being imposed upon the taxpayer".

A zoning scheme was recommended which had as a basic principle a triple responsibility for patient, hospital and government. It was thought desirable that all hospitals should prepare budgets to be approved in advance by the Hospitals Commission. One novel suggestion was made that a tax on all alcohol from the Main Roads Fund take care of the growing hospital load from alcoholism and road accidents.

The Joint Parliamentary Committee was reappointed late 1940 to consider the Progress Report without taking further evidence, and various amendments were made. It had found little public appreciation of the modern importance of the 'public' hospital:[13]

"It is to be regretted that so few of the public realise the very real need and very great value of our large modern public hospitals. They still regard them as homes for the sick poor, which admittedly was their original purpose. What they do not realise however is that during the present century these hospitals - particularly teaching hospitals - have become our chief source of medical knowledge, and as such have given a tremendous contribution to the progress of medicine and consequently to the well being of all"..

"It has been stated in evidence that these hospitals 'attract' our best medical men, but rather is your Committee of the opinion that they 'create' our best medical men".

It is surprising to find the report covering ground covered by equivalent enquiries many years before in this and other states. The Committee found once again that subsidies to hospitals did little to encourage economy and efficiency; rather they encouraged inefficiency as the hospital with the greatest deficit invariably succeeded in obtaining the largest subsidy; although the deficit might result from local apathy and poor administration. New and expensive techniques, diminishing number of donors to hospitals, and general overall rise in costs of running hospitals meant that even the highest charge made to patients was well below the cost of maintenance, apart from the tendency of patients to 'evade their obligations'.

The Committee's comments on the honorary medical system makes interesting reading, in that it found that all systems had disadvantages, whether honorary, part pay or full pay. The fulltime paid system was undoubtedly the cheapest, but other factors were of overriding importance; of which the chief was the need to give the greatest opportunities for medical and surgical proficiency to the greatest number of doctors. The limitation of the paid full time service was that it excluded a very large proportion of doctors, whose standards must thereby be lowered. Chief reform proposed was regulation of the honorary system to remove 'inequality of opportunity' where it existed and to demand more punctuality, efficiency from honorary doctors.

In recent years, the system had not been without its dramas. The best known incident involved the Royal North Shore Hospital in 1937. A change in status for the secretary, in office since 1912, was predicated by a subcommittee proposal to make changes in the principal executive officers of the hospital. Hospital Board elections had been a routine procedure for 24 years; but a technical point was taken by the secretary on election procedure to cause a major change in Board personnel. On applying for re-election to the honorary staff, ten members found they had lost their jobs, and applied for aid to the

Medical Union, which bore the costs of a lengthy inquiry, won to the extent that all honoraries bar one were reinstated. A Parliamentary Inquiry also took place under the aegis of the Hospitals Commission, the hospital having been brought under its control February 1938. This inquiry proposed that the Chairman and all directors be removed as 'public confidence must have been shaken' and the hospital be controlled for a period by a Commission nominee (a by no means uncommon practice). Appointment of honoraries was brought under the Medical Appointments Advisory Committee for Teaching Hospitals, which included representatives of the Colleges, the Dean of the Faculty of Medicine, the Medical Board as well as the B.M.A. The inquiry did not hedge as to where to sheet the blame for the 'row'.[14]

> "These happenings were the result of a conspiracy between Mr. Russell and certain directors to exclude fr the Board the directors who favoured medical control of the hospital, and to replace them with directors who favoured lay control".

Pre World War 2, the Minister for Health set up a base hospital system , approved by the B.M.A. where it was intended to congreg certain specialist skills, to provide a pool of expert advice on special problems within reasonable distance of towns well away from Sydney. This led to problems of classification of staff, already looming also in Sydney's non-teaching hospitals with the growing complexity of medical practice. A process of selection for tasks, for which each was best fitted and trained, was envisaged.

N.S.W. Branch hospital policy in 1948 accepted finally the principle of the community hospital, and adapted policy to its requirements - that doctors should 'refuse' to give free treatment in public beds to patients who could afford other accommodation except in emergency; and try to classify patients where possible for admission as to the best point of reference; that all hospitals should be open to all doctors, and all vacancies of 'visiting medical staff' should be advertised. In the next decade, country medical associations were vocal on the principle of charging fees in public wards where justified, from which they were precluded.

Country hospital policy in 1958 forecast a process of evolution with senior and junior members of staff:[15]

> "In determining seniority in a hospital, senior qualifications should be the determining factor, if all other factors are equal.. it is desirable that the stimulus for classification of staff should come from the honorary medical staff of a hospital when such hospital attains sufficient size and facilities".

A Hospital Services Committee was appointed by Parliament in 1963

to enquire into measures necessary to integrate and rationalise existing public health services throughout N.S.W. Its views were not at one with the A.M.A.[16]

> "The policy with regard to the staffing of country, including base, hospitals favoured by the A.M.A., was not uniformly approved by the Committee and differenceof opinion might well provide an early agenda item for the committee on patient care".

This Hospital Service Committee was representative of all relevant organisations, and included the Chairman of the Hospitals Committee of the N.S.W. A.M.A., Dr. T. Y.Nelson. The Minister of Health, the Hon. W.F. Sheahan, thought the new inquiry necessary 'because of undesirable competition between the various boards for developments within their hospitals which are not always related to their community needs'.[17]

A new concept, not apparent before, entered into this inquiry The modern concept of the hospital was recognised for the first time in the call for 'modern patient care' as the'prime concern' of theCommittee to the 'highest possible standards'. Apart from allconsiderations of ancillary services, technical services, coordinated administration within the hospital and hospitals with each other, the most vital one involved policy on what sort of medical staff would serve the various categories of hospital best. As to one doctor towns there could be no argument. There was nochoice. Next in scale were the smaller country towns, which did not attract specialists; then the large towns, often with base hospitals; finally thecapital city with large teaching and non-teaching hospitals. The Committee's report recommended yet a further professional committee of fourteen to represent all relevant medical organisations to advise the Hospitals Commission on hospital care. One of the earliest items of agenda of such an advisory body, the Committee thought might be policy with regard to staffing country hospitals including base hospitals. As a clue as to how dissident members thought was the item:[18]

> "For optimum patient care, the introduction of service on a sessional basis or by full time staff specialists might become increasingly necessary".

The Committee on Patient Care was appointed in 1965 from fourteen related organisations.

The long controversy on honorary service finally came to an end in 1969,with a N.S.W Branch resolution in favour of its abolition. It was now held to be an anachronism ~~no longer~~

no longer consistent with the complex demands of modern medicine and surgery, and the modern economic structure of medical practice particularly in teaching hospitals. ' The honorary in such hospitals was torn between the need to earn a living outside them, and the importance of spending more time within them for greatest medical competence.
Within less than a hundred years, the changes in the hospital systemof N.S.W. symbolised a great social revolution both within the profession and the community.

....

(b) ASPECTS OF ~~THE~~ HOSPITAL ~~SYSTEM~~ HISTORY IN QUEENSLAND

The Brisbane Hospital was a convict hospital until 1848 when it came under a committee of management. It early encountered a forceful Colonial Secretary, R. Herbert. Wrangles included both responsibility for finance, and the site of a new hospital which the Government built:[1]

> "In Queensland.. the Colonial Secretary's department evolved directly into the Dept of Health and Home Affairs (now the Health Dept). One may speculate upon the extent of the influence of the authoritarian Herbert tradition, exerting itself through an uninterrupted chain of descent, upon the subsequent unique development of the Queensland hospital service".

Undoubtedly he was responsible for an act, the Hospitals Act of 1865 (not implemented at the time, and arising from disputes at the Toowoomba Hospital) which was an uncanny prognosis of what was to happen with a Labour Government; but , at the same time, underlined the point that the tendency for a bureaucracy to take over was by no means confined to Labour politicians.[2]

> "It empowered the Government to nominate a proportionat number of the committee when its annual grant amounted to one half or more of the hospital revenue, and to take over the total management if the proportion reache 2/3".

Well before 1900, the situation had been reached whereby the Government endowed hospitals throughout Queensland with £2 for every £1 raised by voluntary effort to found a hospital and maintain it; though the Government did not yet demand the right to direct administrative responsibility to ensure that the money was wisely spent, nor adopt a coherent hospital policy. Queensland first medical society urged district dispensaries to relieve the unnecessary pressure of the sick on Brisbane Hospital. The first Queensland Medical Society in 1883 publicly called for a committee of medical management in the Brisbane Hospital.[3] The second Queensland Medical Society deliberately held itself aloof from political matters. The demand that the Government should exercise greater responsibility came from the Queensland B.M.A. At the 5th intercolonial congress in Brisbane 1899, Dr. A. I. Kenny's resolution called on the governments of the colonies for more active policies:[4]

> "That, in the interests of the state, radical changes in the constitution, the management and the maintenance of such is urgently indicated."

As the President of the B.M.A., Dr. W.F. Taylor said in 1901, the cost of maintaining 76 hospitals was 4/10 per head of population,

of which the Government gave 3.3d.[5] Dr. Taylor wanted charges in hospitals, then about 3s per day to be abolished, with the aim of restoring the public hospital to the sick and needy, and keeping the rest of the community out of them. In many country towns, a subscription system had developed for 10/- or £1 a year, which many people began to presume gave them the right to free entry to the hospital, an impression which was not always discouraged. Free beds were in principle only for the sickpoor, and charges were made in them on a meanstest basis both for in and outpatients. When, however, Mackay Hospital passed a regulation guaranteeing subscribers free treatment, the Government ordered them to remove it.[6] In 1904 voluntary contributions were to a large extent the result of begging letters, circulars, and collectors, and not the voluntary gifts of the charitably disposed. But meanstesting met with differing success, and could be downright unpopular. In Charters Towers, for example, the use of an inspector in outpatients, while proving that abuse existed, had to be abandoned. Abuse did not appear to be as common at a city hospital like the Brisbane General.

Doctors were concerned with abuse because it reduced their expectancy of income from private practice. This was wont to happen in country towns where most of the residents had bought subscriptions in their community hospitals. Doctors were induced to take up resident appointments on salary with promises of private practice that often appeared illusory. In 1899, 128 hospital surgeons were paid an average retainer of £130 each. The B.M.A. occasionally received complaints from members. In 1908, Gympie hospital was transformed, for example, into a mutual benefit organisation, and, after protesting to no effect, the BM.A. informed the Government of the dangerous precedent it was condoning.[6A]

In 1911, a dispute occurred between the Mackay doctors and the hospital, which amply demonstrated the growing strength of the B.M.A. or, as the A.MG. said its 'moral force and power'.[7] The committee, faced with dwindling finances asked the local doctors to prepare a scheme to run the hospital with a junior resident, based on the Sydney Hospital rules. The honoraries rejected the plan, resigning in a body, and invoking the aid of the B.M.A., which issued warning notices when the hospital advertised for doctors. The hospital capitulated. A letter at this date indicated that Rockhampton and Townsville doctors had similar troubles:[8]

> "It is regrettable that many towns of greater importance and larger populations than Mackay, still adhere to a system of medical administration in their hospitals... a relic of primeval conditions. Where medical men give honorary service to such hospitals, they have actually to compete with them, and be exploited by them, an untenable state of affairs, inimical to our profession and the public as well."

By 1904, Government grant to charities was reduced, and ways of raising money by tax began to be discussed. The wages tax proposed by the Government in 1905 caused unfavourable comment in friendly society circles. The Grand Master of M.U.I.O.O.F. said that, if this tax were imposed, then all hospitals should be made free to everyone.[9] Dr. Halford had made proposals at the 1899 medical congress for an inspector general of public charities who should see to a uniform system of accounting, and approval of new hospitals, and even hospital support from local taxes rather than general Government finance. By 1917 the need for uniformity of rules had become imperative. The Branch Council set up a subcommittee to form a scheme whereby medical appointments - honoraries and superintendents and residents - should be made. Common rules were formulated for country hospitals' appointments, or cases of disputes between doctors and boards. Such disputes were by no means uncommon, there being 24 in 1922 for example.

This commitee condemned the collection of weekly amounts from subscribers to country hospitals on the grounds that it encouraged universal use; and about funds in mining districts that they offered inclusive service, domiciliary as well as hospital at a cost of 6d to 1s per week. The B.M.A. complained that such schemes were intended to keep the hospital, rather than the doctor, solvent.

The B.M.A. also recommended an advisory medical board to the Government not only on appointments but also hospital management. This idea was not quite the same in intention as similar policies in other states for an independent Hospitals Commission; and pressing it, was to lead to a major clash between the B.M.A. and departmental leadership by 1930. In the interim, the Home Secretary, Mr. Stopford, was on excellent terms with the B.M.A. meeting them halfway on almost all immediate issues. B.M.A. leader, Dr. Meyers, said in 1928 he had 'always been most considerate to the profession in Queensland'.[9]

The Queensland Government did not assume active direction of hospitals until the Hospitals Act of 1923, despite an active period of socialisation in other fields of state enterprise, particularly industrial - a period which revealed

strongly divided opinions in their own ranks. The hospital system, that the Labour Party inherited in 1915, was an uneasy compromise between the voluntary hospital system of England, and the habit of looking to the state for developmental aid- beginning with its origins as a penal colony- in an environment naturally hostile to private enterprise.

Its 1923 Hospital Act provided for hospital maintenance throughout the state on a 60/40 basis, the former from the state, the latter from local councils - the system to be organised in six districts to which settlement naturally lent itself. Brisbane Hospital had already been brought directly under the Home Secretary in 1917 by Government proclamation after a financial crisis, and was now included in the Brisbane and South Coast Hospitals Board, embracing the greater Brisbane district and six former public hospitals. A major result was that hospital policy became largely dictated by the Health Dept, as remarked by Dr. A. Lee , B.M.A. Councillor. Hospitals Boards were to be of nine members, three nominated by the Government, three from local authorities, three from subscribers. In country areas, the Chairman was usually a Government nominee, often the stipendiary magistrate. Frequently, the hospital management was now in the hands of civil servants and trade union officials, instead of charitably disposed people and doctors, as in the past. Certainly, no boards permitted representation of any doctors on the staff. The B.M.A. pressed to have some - in the case of the B.S.C.H. Board in 1925, two members, but was refused by the Home Secretary. The Labour Cabinet of the day thought it was not desirable to have men sitting in judgement on their own interests.[10]

The Royal Commission on Hospitals in 1930 made this comment on the issue:[11]

> "The evidence given by representatives of country hospitals was generally adverse to such representation, whilst that submitted by the medical practitioners- supported by a few lay witnesses some of whom represented local authorities and hospitals, was naturally in favour. It must be understood that the position in the country districts in this matter differs materially from that in the cities.
> A fear has been expressed in some quarters that the medical representatives if appointed would dominate the Board, but as they will seldom, if ever, have more than one member out of nine, such a fear must be baseless. If one member should succeed in dominating eight others he should be commended. Those who entertain ideas of that nature pay the doctors an unwarranted tribute, and conversely, place the other members of the board on an exceedingly low mental plane. However, if such an unlikely situation did arise, the Government, and, or local authority, could easily rectify the position by

> " selecting men of stronger intellectual calibre to represent them".

Only two of the three commissioners found in favour, proposing one representative on boards of all hospitals over a hundred beds, but the chairman dissented that boards, committees and local authorities were all against it, while the medical superintendents sat in on all the meetings, and this channel sufficed. The B.M.A.'s view was that where a superintendent was a servant of the Board, he was not so free to express an opposition point of view.

The Home Secretary however upheld the B.M.A. in another matter, when it complained as to laxity of means testing in several country centres. He insisted on the policy being enforced in the 'offending' hospitals, and endorsed the Council view that these were:[12] public hospitals established primarily for people who could not afford private medical treatment, although private patients might be admitted provided they paid their doctors their proper fees. Despite his continued support, disputes continued to occur on the points. Failure to cure the problem was evident in the Royal Commissioners' comment 1930:[13]

> "There is considerable laxity by Boards and committees in the collection of fees from patients, and many well able to pay all or part of the fees incurred have been allowed to escape their liabilities. Fear of alienating public support was the reason advanced by some of the representatives of voluntary hospitals for not insisting on the payment of fees; but such reasoning cannot be accepted by your Commissioners".

They pointed out the Home Secretary's rules to all public hospitals included one highly contentious clause in rule 8, requiring doctors, who had private patients admitted, to be responsible for payment of the accounts of defaulting patients. The B.M.A.'s vigilance appeared to have prevented insistence on this rather highhanded provision. The chances of patients defaulting were lessened by increasing provision of three categories of accommodation, a process assisted by friendly socities. The representatives of 16,000 members outside the the Institute in Brisbane approached the B.M.A. to discuss hospital facilities for lodge patients in 1925, and agreed for doctors to attend the latter in public or intermediate wards by arrangement. Before the Commission in 1930 the President of the Friendly Societies Hospital and Medical Council urged that members should be given intermediate accommodation with the right to their own doctor.

In general, over the period 1917-30, the Queensland B.M.A. Branch did not object to state control. It welcomed the reforms of 1923. It approved of greater use of the 'excellent facilities of personnel and equipment provided by public hospitals' when giving evidence to the Commonwealth Royal Commission on National Insurance in 1924. The Branch President had only praise for the amalgamation of the Brisbane and South Coast Hospitals Board; as a move 'which should greatly add to the efficiency of our public hospitals, and to the value of the training received therein by nurses and resident medical officers'.[14] The clash between the administration and the B.M.A., which began in 1927, occurred, not, as one might expect over the state's assumption of control, nor any interference with medical administration and its status quo, but over a question which had never properly been in the traditional jurisdiction of doctors - the building extension of the hospital. Plans for five new blocks, begun in 1924, were approved in March 1927. Many honoraries were uneasy that the blocks were sited wrongly for Brisbane's climate, as well as efficiency of layout, but they were not represented on the Board. At the request of the B.M.A., a general conference of concerned authorities was called, and recommended a technical advisory board not only on this but future hospital facilities; which was refused by the Home Secretary's Dept. The B.M.A. then sought enlarged powers for the medical advisory board to the Brisbane and South Coast Hospitals Board, which were conceded with the proviso that the latter was not to be bound by any of its recommendations. Hospital plans were sent to the Medical Advisory Board in 1928, and their criticisms sent back to the architects. As these were ignored, the B.M.A. wrote to the Home Secretary asking for the opportunity to discuss the problems of the Brisbane Hospital extensions with the architect. Mr. Chuter in reply claimed that the plans had been approved before the Advisory Board had enlarged functions that financing of extensions had been arranged, and delay was prejudicial as the hospital was overcrowded. This statement was published in the press. The 1930 Royal Commission commented on this clash saying that the Board was justified in continuing with the building 'but consider it displayed a lamentable lack of courtesy in not advising the medical staff of its reasons for proceeding'.[15]

The B.M.A. would not retire gracefully from the fray. A letter got into the press with a leading article, which Mr. Chuter in reply said was based 'on erroneous assumptions'.[16] His reply left no doubt that he had taken serious umbrage against the B.M.A., and makes it obvious that the serious decline in his relations with the B.M.A. dated from that point He declared the Board had never agreed to what would be a complete surrender of its statutory powers, by agreeing to accept recommendations of the medical advisory board; adding ' it is a position in which the B.M.A. would no doubt like the Board to be'.[17] From a policy of formal cooperation, Mr. Chuter now adopted a policy of open hostility to the honorary medical staff, and withdrew the concessions made already He now criticised the honorary system in principle, alleging it had failed, that they were 'in control', and the Board could not control medical affairs. In 1929, the medical advisory committee called for a public enquiry into the administration of the hospitals, and criticism of its inability to control its fellow members to the misfortune of the general public. The Board's quarrel with the advisory committee was conducted partly in the public press. In the concurrent elections, the conservative party promised a Royal Commission on Hospitals in his electioneering, and, having won power, proceeded to appoint it, and include many of the points raised by the B.M.A. for enquiry.

A Commission was duly appointed May 1930, the delay being due to efforts to secure Mr. R. J. Love, Chairman of the N.S.W. Hospitals Commission. Failing this the Chairman became the Police Magistrate for Queensland, Mr. W. Harris, the Auditor General Mr. Glassey, and Dr. Sandford Jackson , medical superintendent of the Brisbane General from 1883-98. The Commission made some rather startling comments:[17]

> "Investigation has disclosed the unpleasant truth that the relationship existing between the Brisbane and South Coast Hospitals Board and the honorary medical staff of the Brisbane Hospital has degenerated into a state of open hostility. This was made manifest quite early in the proceedings... The language that the Chairman of the Board permitted himself to use with respect to the principal witness for the honorary medical staff and the profession generally when giving evidence before the commission was reprehensible, and his demeanour did not command itself to your Commissioners"

They condemned the appearance of Mr. Chuter both as assistant secretary and Chairman of the Board, as a case of the judge sitting in judgement on thejudged - 'his position is somewhat

akin to that of an auditor of a company writing up the books of account of the company, and then auditing and reporting to the shareholders on his own work."
The Royal Commission proposed an independent Hospitals Commission as almost unanimously approved by witnesses, and hospital finance to be drawn from a direct hospitals tax on wages and income. Neither of these suggestions were carried out. It also proposed medical representation on all hospitals boards of 100 beds or more. For a time Dr. W.N. Robertson was appointed to the B.S.C.H. Board, but this was cancelled when Labour returned to power in 1932. As to Mr. Chuter's Chairmanship of the Board, a Mr. T. L. Jones, Labour polician and successful business man was appointed.

The Commission also recommended intermediate wards; doctors being made no longer liable for the bills of other than public patients; and the onus of proof of inability to pay the 9s a day in public wards being placed on the patient. The first two were not ignored. The Labour Party on their return to power were not adverse to developing paying accommodation in the hospitals, while allowing public preference for such beds to be met in what had begun as primarily a public hospital such as Lady Bowen. The new Minister, Mr. Hanlon, recommended further increases,[18] emphasising that doctors' fees were not excessive. In public wards, the 'considerable laxity' noted by the Commission in collecting fees, continued to be the rule rather than the exception. It was against all Labour morality to act as inquisitor as to means, or to dun the patient. But in principle until the inception of Chifley's Commonwealth subsidy scheme in 1945, public beds were not theoretically free.

The Royal Commission had served a vital purpose in causing a thorough public examination of all the problems left in the wake of the 'districting' system, created by the Hospitals Act of 1923. This airing process not only exerted a restraining influence on all participants when the next major confrontation occurred over the abolition of the honorary system. It also bore fruit in the full consultation that occurred between the Government and the B.M.A. before the alternative scheme was finalised.

Although the Government did not set up a Hospitals Commission, it did create a Dept of Public Health under a medical man in 1934 to meet some of the prior criticism as to

lay interference incurred by the Under Secretary, Mr. Chuter, despite his acknowledged skill as an administrator, and the vision he had shown in transforming an improvised system into a coherent regional organisation. The department still remained under his formal control, though he was to have serious differences on occasion with his new head, Dr. Cilento: as for example over his support of Sister Kenny in the mid 30's. The B.M.A. wrote to him on appointment, promising full cooperation.

The Royal Commission did not mention abolition of the honorary system in their report. B.M.A. leaders had discussed it in the twenties, and Dr. Myers revived the issue in 1931, questioning whether a paid resident and consulting staff might not be preferable as in some municipal hospitals in England (19). The Hospital Act in 1936 provided for part-time medical officers instead of honoraries; the B.M.A. Council having approved Feb. 1935. Approval was based on three grounds; first, that honorary service was an anachronism in a hospital service offering free treatment to the whole community; second, the alleged weaknesses of honorary service were being constantly preached to the public by the Minister for Health Mr. Hanlon, and Mr. Chuter; third, the early advent of medical students into the hospital would require the review of a staff that had not been appointed with any consideration to its teaching ability. Among the weaknesses were alleged unpunctuality, failure to attend, and conflict between private and public interest by doctors with the bias to the former. There was some truth in the first two of this trio, as many of the honoraries were also busy general practitioners; while increased use of hospitals by patients overtaxed all available doctors (inpatients by 84% and outpatients 212% in a decade post World War 1).

Early 1939, the honorary staff of the Brisbane Hospital, with B.M.A. support, asked the Board for reorganisation, complaining of repeated breakdowns in the full time staff, throwing extra duties on the visiting staff; and that the bulk of insured patients were taken into public beds where the doctor could claim no fee. They deplored the attitude of the Home Office to doctors, the B.M.A. and the Brisbane Hospital (19). At the request of the Board, they submitted four possible schemes for staffing the hospital including Mr. Chuter's preferred scheme for a salaried service and their own for a part-time payment, supported by the Chairman Mr. Jones. At this stage ,

feelings were running high, and Mr. Chuter even attacked Mr. Jones in the press. The latter issued a writ, and he was obliged to apologise. He then disappeared from the Hospital Board, and the Dept of Health no longer remained under his aegis. A new Dean of the Faculty of Medicine was appointed in place of Professor Wilkinson who had supported a fulltime scheme as an adjunct to the new University medical school. The part-time scheme was decided on by a committee of six on a basis satisfactory to all parties to begin Nov 1, 1938. The change was regarded as fairly dramatic by all other states, but worked smoothly. The Medical Advisory Board was given a considerable part in applications for vacancies to the visiting staff, and Dr. Quinn, former medical superintendent at the hospital, when asked, said 'the only difference has been that there are now fewer visiting members of the staff.. and they work at the hospital longer hours than they did before. Doctors, when questioned, always said that they have never regretted the change, nor noticed a change in status. Cooperation remained harmonious - new terms and conditions were worked out at intervals - though not always in future years to satisfaction.

Outside the Brisbane Hospital in the rest of the state, the same trend away from the honorary system occurred. It extended a feature of hospital service always more marked than in any other state - the employment of full or part-time superintendents, either with or without the right to private practice. The N.S.W. Joint Parliamentary Committee on hospitals went to Brisbane December 1939 to survey a system now in contrast to their own. Sir Raphael Cilento said of the Queensland system:

> "The tendency towards fulltime staffing is growing, but there is also growing with it a cooperative relationship in many instances, where local practising medical men are seeking and obtaining part-time relationship with hospital boards on a basis far more satisfactory to all parties and far more conducive to efficiency than the former haphazard honorary arrangements".

He explained that departmental power to appoint honoraries was based on a system of record keeping built in by reference to co-workers and members of the B.M.A. Council.; B.M.A. policy was to lay down a minimum salary of £750 for a hospital doctor.

The Labour Government from 1932 were known to wish to extend public medical service beyond the mere reorganisation of administration and hospital building. The B.M.A. was anxious to be allowed to participate in planning, and prepared a medical service plan for the state December 1934.

In a circular to all doctors, Dr.T. Price, the President, expressed the B.M.A. Council's concern that the new Dept of Health and its director would follow a 'definitely inspired policy of the encouragement of a drift towards the public hospitals'.[22]

> "The reduction not only of general practice, but also of lodge practice is threatened in many parts of Queensland, and in some country districts even their existence is threatened.. to gain legislative sanction to stem this drift by limiting patients to the poor only, or even to more or less small income limits is not practicable, as no political party would risk its prestige in championing such a cause."

The B.M.A. plan hoped to keep the patient out of hospitals through a compulsory insurance scheme. The Minister of Health dismissed the scheme as too vague and general. Mid 1937, the B.M.A. enlisted the aid of the Federal Secretary, Dr. H. Hunter, in a tour of Queensland to explain their viewpoint to trade unions, hospital boards and friendly societies; namely, to point out the disadvantages of centralising the whole of medical care in institutions, with loss of choice of doctor etc.[23] He detailed the type of problem in country hospitals which concerned the Queensland Branch Council. Maryborough, a town of 11,000 with a 100 bed hospital, had recently appointed a superintendent, and two other junior medical officers on salary. Charges were made in public and private beds, the hospital being open to everyone, including outpatient service. It was considering a domiciliary service. Its contribution scheme gave a service in return for 2d in the £1 on wages. The problem for the local doctors in Maryborough was that doctors in private practice could not use the hospital, following their patients there, ~~and the practice also affecting friendly society membership.~~ This meant loss of friendly society patients to them. Although the ~~latter~~ friendly societies could solve some of their problems by creating their own hospitals, a few of which still exist, the doctors' problem could not be so readily relieved.

The B.M.A. Council approved the right of doctors to charge where taxes were used for the support of the necessitous sick, except in public beds; but was wary that the Socialist Labour Government proposed to introduce a full salaried system in all Queensland hospitals. This fear was not allayed by an open letter sent by Sir Raphael Cilento in January 1938 to all medical men in the state, in the form of a questionnaire to determine whether each doctor would express his willingness to cooperate with the Government for the health of the people;[24] 'to analyse the present relationships between the state, the public and the profession,' and to work out a plan for the 4/5 of the population who could not afford medical care. To which Dr. Quinn tersely replied in the press that 'the BM.A. had been vainly trying for two or three years to effect the cooperation of which Sir Raphael spoke'.[25]

A new Health Act was projected in 1939, and one aspect was bitterly opposed by the B.M.A. This was the plan to keep central statistical records of details of patients' illness in hospital files throughout Queensland. Depsite whatever value these might have had for scientific study, the B.M.A. regarded them as a trespass on privacy.

In 1945, the Government abolished the local government tax for financing the hospitals, along with establishing a base hospital system. With the disappearance of local liability, it became even harder to interest the local citizen in his obligation to the hospital. The B.M.A. issued a state hospital statement August 1945, which said:

> "In Queensland, public hospitals are largely used by the whole community. In Victoria, 50% of hospital patients use private hospitals. In Queensland only 20%. Their organisation should be altered accordingly and they should become to a large extent self-supporting."

It asked that hospitals should be open to all doctors in each town, and there be four base hospitals with attached specialist staff specified. It urged the abolition of the large open public wards, and voluntary insurance, assisted by government funds, for those quite unable to pay for any hospital care.

About the time, salaried doctors formed their own union and went to the Arbitration Court. The visiting staff at Brisbane General also claimed an increase, partly provoked by criticism of their rates from other parts of Australia.[26]

> "Few of our members would have complained of this rate, seeing that at the most only four hospital sessions were worked weekly, were it not that, as staffs in other states considered a change to paid status, the Commonwealth Labour Government insisted on using the Brisbane figure as their standard."

The B.M.A. Federal Council moved that terms of remuneration in the Brisbane General were quite inadequate.[27]

Mr. Chuter testified before the Joint Parliamentary Committee on Social Security thet the process of maanstesting operated against the patient, because there was an arbitrary wage limitation.[28] In 1945, the condition of the Commonwealth 6/- a day subsidy was that Queensland should cease to means test in public beds. When the Earle Page Government in 1950 made additional subsidy conditionon a charge being made for public beds, the Queensland Government was alone in refusing to reimpose a means test. It did not however abolish private and intermediate beds. By, however, tending to build public rather than private

beds, the shortage of the latter tended to create a pressure for the former. The new 650 bed Princess Alexandra Hospital did not reverse the anomaly. The B.M.A. continued to be dissatisfied with the amount of private and intermediate beds offered, accusing the Government of a bias towards building public ward accommodation as first priority. The chief effect of the free bed policy was on voluntary insurance in Queensland, which has remained at a far lower level than anywhere in Australia of 50% in the public knowledge that in emergency any citizen could always get a free bed.

In the refusal of the Queensland Government to restore charges for public beds in 1950, special factors operated in that state. The hospital system had in later years been more solvent, due to determined government support from 1923, and the Golden Casket lotteries. Even during the depression, building had continued. Furthermore, lipservice had always been rendered by the Labour Party that the public had a right to free treatment as their birthright.

Clearly the Queensland hospital story 1917-67 had an intemperate beginning with strong overtones of personality. An ex-Cabinet minister from those halycon days of early Socialism, Mm F. Bulcock, expressed his retrospective view that the Labour politicians were generally working class men who thought of the doctor as the 'establishment', the theoretical enemy, and believed that a medical dictatorship was inherent in the profession. Such views bore fruit in a deliberate failure to consult or to allow representation to the doctor as a 'vested interest' who could not be allowed to sit in judgemmnt on his own interests. Nor were those interests in the hospital always distinguished from those of any nurse or laundryman also serving the patient. Despite the inflammatory effects of such policies and views well flavoured with personalities, and the growth of a system whose civil service control fairly steadily ignored hospital policies enacted by the B.M.A., or its advice, it is remarkable in Queensland how much the Government did achieve in conjunction with the B.M.A. For a number of the achievements, Queensland was well ahead of other states with changes:[27]

> "now being regarded as bright new ideas elsewhere. The close coordination of preventive, clinical and mental services under one directorate, 'McKeown's balanced hospital community, of which the General is a modified example, the payment of part-time staff and the registration of specialists - the last three of which are positively supported by the Queensland A.M.A., are examples. The flying surgeon, a well-organised system of health education, a state-wide well-coordinated radi therapy service, and a well supported state Institute of Medical Research are others. Another is the collection and compilation of detailed statistics from all public hospitals in the state; a very good and relatively

"cheap public health service is another".

The power of the Director General of Health over the whole range of service, including advice on hospital appointments, is acknowledged to be very great; but, with the liberal exercise of this power, and frequent consultations with the B.M.A. Council from 1937 on to ensure a free flow of opinion, post-war relations have been marred with none of the in-fighting of earlier years.

The Labour Party became more sophisticated, and abandoned its doctrinaire socialism. The role of the educated man such as the doctor was re-estimated:[28]

> "The present government appears to be not so much anti-professional as short of cash. It has freely appointed medical practitioners to hospital boards, and in many ways, has shown itself ready to listen to medical representation".

But the story of fifty years remains a rather baffling study of how a democratic party, with a majority in the Parliament over a long reign of power, responded to an interpretation between the conflicting needs of the total electorate, and a section within it.

...

(c) ASPECTS OF ~~THE~~ HOSPITAL ~~PROBLEM~~ HISTORY IN VICTORIA

By 1861 in Victoria, there were eighteen hospitals chiefly for the sick poor, and three combined hospitals and benevolent asylums. The largest of these was the Melbourne Hospital. Founded by private effort in 1841, Governor Gipps offered it £1,000 and a block of land, if the citizens matched the contribution with a like amount. It very early ceased to confine itself to the sick poor, taking paying patients and those nominated by subscribers. Although the latter were not large, they were numerous enough for the committee of management in 1856 to appoint a subcommittee of medical offiers to enquire into the best means of preventing people receiving benefit at the Melbourne Hospital, who ' from their circumstances and appearances' are not fit objects of charity.[1] Medical men in Melbourne argued over this problem for the next two decades, over the extent of imposition, the principles of exclusion, the causes of 'imposition'. The causes were said to be four - charges by doctors outside, lack of other than expensive private hospitals, large government subscription, and inadequate scrutiny.

A Royal Commission on Charitable Institutions was appointed in 1862.[2] It found that costs could be much lower. The Government's high contribution to building new hospitals had caused too many unnecessary hospitals. As local people and authorities were asked for little, there was small inhibition on their building ambitions. The cost of collecting private money towards the hospital was too high - the paid collectors receiving 10 to 20%. Hospitals carried far too many benevolent and non-charitable patients for economy. The Commission wanted a municipal rating scheme to support hospitals, to increase the sense of local responsibility. But the municipalities strongly opposed the scheme, and nothing was done. Nor did any but medical society speakers continue to advocate it.

A further Royal Commission endorsed a similar policy of economy by charging 1/10 of 1d in the £1 on the normal rateable value of all property in a municipality; the money to be used both for hospitals and benevolent asylums, and hospital districts created for the purpose. It insisted that state grants both for building and maintenance were too high. Those for building should be 'at once and altogether discontinued'.[3] Those for maintenance should be reduced to £1 for £1 local subscription. The number of charities receiving state aid had increased in 18 years, and

certain of these should be discontinued. Above all, an inspector of charities should be appointed to audit accounts of subsidised hospitals. None of these recommendations were adopted, due chiefly to municipal opposition. The only instance of local support of hospitals was in 1885, when the Borough Council of Horsham with four shire councils contributed 3½% of their gross revenue for local hospitals.

An Inspector of Charities was not appointed until 1860. He was charged with the impossible task of improving the system and reducing the annual grant of the legislature at the same time. Dr. Alfred Roberts, N.S.W. Government Medical Adviser in 1875, found that the costs of running hospitals in Victoria had varied enormously from £31 to £122 a bed. Victoria by this time had 34 hospitals with a lower bed ratio per head of population than N.S.W. , and three special hospitals where N.S.W. had none. These included the Eye and Ear Hospital, and the Women's Hospital founded by leading members of the Medical Society of Victoria. All hospitals had subscriber boards of management, and all received subsidies from the Government, varying from less than half to more than 2/3 of their maintenance. All this money was given without any effective Government supervision, while discrepancies in running costs were obviously not due to local costs.

In 1873, the Ballarat Hospital Committee held an inquiry into the circumstances of patients, which indicated that of 200 called on, nearly half could afford to pay.[4] Doctors in the N.S.V. believed hospital 'abuse' was tolerably common in the country, and the subject was raised in the Parliament on the grounds that Government money was never intended to subsidise people who could afford to pay for treatment. Many doctors wished to discourage such patients on the grounds 'that these half-paying patients are very exacting and never satisfied'.[5] Most opposed the move of a minority for pay-wards in the hospitals. The point was raised in both the Melbourne and the Alfred Hospitals in 1875. A subcommittee reported against it in the former, country subscribers had asked for it in the latter, but the constitution would have first to be changed to allow for it.

Hospital Sunday was launched in 1873 by the Mayor of Melbourne on the English plan for collection of money in churches for use jointly by hospitals. A subcommittee of the Alfred Hospital Committee in 1877 as an experiment proposed a payward of 32 beds with fees on a fixed scale to be divided at the end of each quarter. Dr. Blair in a letter to the Argus publicly claimed credit for the

wisdom of the project'. This plan did not however appear to have been the first of its kind, The A.M.J. for January 1875 spoke of paywards in several hospitals.

The Melbourne Hospital appears to have been by no means the only hospital with a chequered history of dispute between doctors and boards. In 1873 for example, a dispute in the Geelong Hospital over the appointment of a nurse led to a breach between the hospital committee, which supported the matron, and the senior house surgeon. Like most episodes of the day, it boiled over into the press with vituperation from both sides, and comments of the order: 'the unexampled deference so long paid to the remarkable gentleman who has hitherto ruled the Geelong Hospital is just a little less profound that it used to be'. A move for a similar strong senior medical superintendent in Melbourne Hospital in 1874, on the model of Geelong Hospital with honoraries limited to consultations only, was defeated in the belief that it would be[7] 'an arrangement which entrusts one man with the duties of a dozen, and in effect exempts him from all supervision'. In Ballarat Hospital in 1885, the rules were altered to make the honoraries 'consultants' whose opposition to the change led to a local medical society. Many doctors urged dispensaries, but a possible reason why they did lies in a comment made at a meeting of the provisional medical defence association June 1879 on the fear of friendly societies that dispensaries would act deleteriously against them. Dispensaries were urged once more by yet another Royal Commission in 1870.

The Victorian B.M.A. discussions on hospitals ranged through many aspects, building sites and constructions, the need for consumptive hospitals, and the need for reform in the two hospitals where the honorary staff were elected by subscribers (Melbourne and Womens') The Royal Commission of 1890 interviewed many doctors from both the B.M.A. and the M.S.V., and covered all the ground of the 1862 and 1871 Commissions plus the limitation of benefits, pay wards, female nursing etc. After eighteen months, the Royal Commission reported:[8]

> "no principle whatever has been adopted in the allocation of the Government grant. Allocation has grown up on political influence, and continued without reference to the special need of such institutions, and is a source of annoyance and a drag upon each Treasurer".

It was neither in proportion to local effort, nor proportionate for equivalent institutions. It believed at least half the money should be locally borne, as was the system in most parts of the world. Collectors expenses varied from 15 to 50%. Two Commissioners dissented from the principle of local taxing, saying 'it would be

the thrifty who have joined friendly societies'. A supplementary report in 1895 regretted that no action had been taken. A Bill recently drafted failed to secure any approval as did a later measure in 1897. But the Commissioners insisted:[9] "at the present time, the great need of charity in Victoria is organisation and the establishment of adequate authority". They agreed with Professor Allen in his report on hospital construction and management 1891 that patients should be charged according to their means. Both reports wanted Melbourne Hospital removed to a new site, a change often urged in both existing medical societies.

In 1899, Mr. L. Bruck in a pamphlet on Australian hospitals estimated that Victoria had 59 public hospitals, only three with less than thirty patients a year. Victorian hospitals had nearly as many beds and number of patients as ~~the~~ N.S.W with a higher average of bed days. Outpatient attendances were higher than in Sydney. Of 228 doctors, the average paid was £39 each, much lower than any state but N.S.W. The report also said the pressure on the honorary medical service was possibly higher than anywhere in Australia. It was not surprising that the strongest initiative came from Victoria to the Australasian Medical Congress to cut down the pressure on public hospitals by preventing paying patients using them. But the Government had already elected in 1895 to recognise the fact that paying patients were using the hospitals by charging them. An irreversible tide was already setting in. Alleged 'abuse' of outpatients in 1899 was also high in Melbourne, despite the frequent records of long queues and waiting times up to six hours with the prospect of seeing a busy surgeon perhaps for two minutes in order 'to get medical advice for 1/- with a bottle of physic thrown in'.[10]

At the Women's Hospital, Melbourne, in 1901, a crisis occurred over the death of a woman from septicaemia. Action by the honorary staff to isolate cases and treat the wards was though to have removed further danger. But, because the honoraries refused to 'guarantee' that no further outbreak of sepsis would occur, the committee of management closed the hospital. The residents defied the committee and were dismissed.[11]

Melbourne Hospital had always been a playground of dissension. Rivalries, created by the system of electing honoraries, continually impaired harmony on the staff. Finally some, led by Dr. Moore and Dr. Stawell, decided to put an end to the unseemly four year public elections which for so long had led to buying of votes, dummy subscribers and undignified elect-

ioneering. Allotted by the Government in 1910, they promoted candidates of their own on the committee of management of the hospital to put an end to the system.

The Victorian B.M.A. were much concerned with the lack of intermediate accommodation in hospitals. Bills were brought forward annually for a Charities Board 1911-14, but all failed. During the 1912 debate, the Minister spoke of B.M.A. support for intermediate hospitals, and B.M.A. conditions on which such hospitals should be based. Provision for them was made at last with the Hospital and Charities Bill in 1922, which at last created the long sought Charities Board, to cure the chaotic state of affairs, the Treasurer, Mr. McPherson said he had inherited.[12] In a preliminary run in 1920, the Treasurer, had sought the support of the B.M.A. who had laid down conditions for approval. Hospitals were classified, adequate records were to be a condition of subsidy, and work done the basis of grant. By setting a minimum standard, the Charities Board rapidly influenced hospitals, particularly in the country, to a higher standard. Commenting on the long abortive history of prior legislation, Mr. Ronaldson says:[12]

> "Anyone who considers the number of unsuccessful attempts during the last century and the first decades of this century to establish a central, coordinating body, may wonder why Victoria was so slow to introduce this reform, yet here is an interesting point.
> "In 1929, the Inspector of Charities visited America, Great Britain, New Zealand and other states of the Commonwealth, and made a survey of philanthropic activities of the world. He found that in no other country was there a central controlling and advisory body such as the Charities Board for the systematising and perfecting of hospitals and charities. The Hospitals and Charities Act of Victoria was regarded in other places as 'one of the most progressive pieces of philanthropic legislation enacted anywhere'."

In 1924, the B.M.A. Branch accepted a policy of intermediate wards in all country hospitals, except Ballarat, Bendigo, and Geelong; and asked for a policy of payment to an honorary where patients recovered damages, or well-to-do patients were admitted in an emergency. The Branch foresaw that national insurance, then expected, might necessarily involve a complete revision of relations of medical officers to patients in hospitals. The Victorian Branch of the A.R.U. approached the B.M.A. with a scheme for organised payment to hospitals as in Queensland and S.A. Although the A.R.M. B.M.A. in Great Britain had agreed that year that staffs might be paid where boards took contributions from employees, the Branch Council were not in favour while public hospital policy remained inflexible, urging the Federal Committee to a federal hospital policy in terms of national health service.

The homeopathic hospital in Melbourne, Prince Henry, continued to occupy an uneasy place of half-acceptance, as homeopathic doctors were still not allowed to be B.M.A. members. This prohbition was finally abandoned, and eventually Prince Henry' ceased to be a 'Homeopathic hospital'. The intermediate hospitals, discussed in 1920 with the B.M.A., did not transpire. The Hon W. McPherson had made a provision in the 1922 Bill for their establishment, agreeing with the Victorian Premier in debate when he said 'one of the most conspicuous defects of the present system was the absence of facilities between the expensive private institutions and the public charitable hospitals, but they must be separate."[13] The Hon Dr. Argyle, Minister for Health and President of the Victorican B.MA. in 1924, agreed with the B.M.A. that doctors would prefer such hospitals to be not managed directly by the Government, all medical men to have access to them, and without a senior paid staff. The B.M.A. was prepared to charge an intermediate scale of fees, as in the 500 beds in the three private intermediate hospitals already existing. The Legislative Council would not pass the provision, partly because of reservations that the Government would be attracting paying patients away from charity hospitals, which would then be an even greater drain on the public purse than they already were. The Act made the collection of fees in public hospitals legal. The Branch President in 1926 complained that people rushed public hospitals. Nearly 250,000 were treated free each year, the percentage of the population doubling to nearly 15% since 1901. A hospital committee was formed consisting of the medical advisory committee to the Charities Board with power to coopt other members.

When Dr. MacEachern visited Victoria at government invitation in 1925, he found the system completely remodelled; all with an income of more than £5 were being required to pay in public hospitals although no direct tax as yet was imposed on their upkeep. The Councils, that levied 1d in the £1 towards local hospitals, were exceptional. Following his advice for community hospitals, the Board was given power in 1929 to provide grades of accommodation in existing hospitals in lieu of enough separate private and intermediate hospitals. Committees would make full enquiries as to means, The Board would prescribe standard payment, and the categories other than public were to be open to all doctors. The Board expected to increase income 50% as against 13% from this source.[14]

For solvency of the hospitals, however, during the depression the Totalisator Act 1930 brought additional revenue.

Throughout the changes of the 1920's, the B.M.A. had been fully consulted. The Inspector of Charities, Mr. R.J. Love, addressed the branch on his policy. With the consent of the B.M.A. in 1926 the Yallourn Hospital scheme of the Electricty Commission was devised, for a contract service for employees receiving income higher than the limit, and to include hospital treatment owing to exceptional circumstances. From this time on, contribution schemes caused the Council much concern to prevent schemes, which conferred greater privilege at hospitals on contributors than non-contributors, being founded. In 1930 the Council arranged a conference between the hospitals sub-committee and medical superintendents of public hospitals to coordinate the work of providing beds for patients, and to consider the question of outpatients getting attention only on receipt of a doctor's certificate. In 1929, Mr. Love had commended the establishment of consulting clinics as clearing houses prior to attendance at hospitals.

Changes in the Act 1929 permitted pay beds to be established in public wards in Victorian hospitals.[15] The Branch refused to endorse this, on the basis that the patient had no choice of doctor, and a more satisfactory solution could be devised for hospital solvency. They pointed to the fact that intermediate beds at Epsworth and Bethesda were not fully used.[16] The Hospitals committee on the basis of 3 prior years of research and enquiry believed that it was only possible to reduce the demand for free beds by stimulating insurance. Otherwise, a situation would continue as indeed occurred in 1933:[17]

> "Metropolitan hospitals, the Charities Board told Parliament in 1933, were in danger of collapsing altogether unless their debts were somehow reduced, the board predicted demands for acceptance of state responsibility demands not from socialist politicans but from despairing hospital committees".

September 1930, the Victorian branch launched an enquiry into all existing schemes of medical and hospital insurance, including one proposed by the Charities Board. After a special conference of delegates from all Victorian divisions April 1930, its standing insurance committee reported:[18]

> "In 1922, the Charities Act was passed in Victoria, and it gave public sanction to the evident appropriation of the public hospital to the service of an increasing number of the industrial population as well as to the

> "indigent. This fortified the stand now taken by the Charities Board that people are entitled to treatment for what they can afford at the time of their illness, and thus exempted an increasing number from the necessity of saving for this contingency of sickness.
> "During the past twenty years, the investigations and medical work undertaken on behalf of each patient in his illness have very much increased, and this has likewise contributed to increase the difficulty of providing from the patient's own resources those services regarded as adequate.
> For these reasons, there is an ever increasing demand for more free or cheap hospital, nursing and medical service both inpatient and outpatient. These demands will be made more urgent by the introduction of any national insurance scheme. The solvency of the funds which pay sickness benefit in any insurance scheme depends on the incidence of sickness. Maintenance of health and cure of sickness depend on adequate medical and nursing facilities being within easy reach of the insured".

The B.M.A. put forward a plan for compulsory insurance (below a certain income) for both hospital and medical treatment to encourage saving among the young and healthy against maturity and sickness. It rejected a capitation fee, as a system which had caused 1,000 medical strikes in Germany in thirty years, where economy in the scheme was usually effected at the expense of the doctors.

It also opposed the scheme currently sponsored by the Charities Board to convert the Lord Mayor's Fund into a hospitals contribution insurance scheme for payments of 6d per week, along lines successful in England. Under this scheme, the doctor was not to be paid, and the B.M.A. viewed the idea as a step in conversion of public hospitals into public utilities, and towards socialisation of the profession.[18] As an alternative, the B.M.A. in 1931 now preferred a scheme of voluntary insurance effected through a company to provide medical and nursing services and pharmaceutical supplies; and to include investigations and specialist work. Reasons for the change given were:[19]

> "It is recognised that a compulsory scheme to provide for medical, nursing, and hospital service would be preferable to a voluntary scheme. A compulsory scheme would ensure the enrolment of a higher percentage of choice risks, a lower incidence of poor risks, a continuity of subscriptions, and, therefore, a lower subscription rate would be required to establish and maintain the same funds and services. The present economic condition of the Commonwealth renders legislation for such a scheme impracticable."

A five member Board, nominated by the B.M.A. Council, was put forward on the grounds of the long standing experience of the profession, five years investigation of the problems in light of worldwide experience, and the profession's sense of special responsibility to the community.

The Council plan pointed out the amount of free or cheap conditional service already existing, which did not satisfy the demand. Public hospitals treated 50% of Melbourne's population in time of sickness: outpatients 25%. Honorary service was rendered by 60% of Melbourne doctors, some giving as much as three days a week. 25% of the population were in friendly societies at £1 a year for the whole family. Other services were given by district nursing societies, childrens' welfare departments, dental and V.D. clinics, free dispensaries and T.B. bureaux and other agencies. The problems were not a legacy of the depression, as many thought:

> "The present national financial crisis has not created, but has only accentuated the need for revision of the methods adopted in the provision of medical care, and nursing requirements".

By 1933 the scheme was in abeyance, being ahead of its time. The Lord Mayor's Metropolitan Fund Council had still not got underway. An expert Committee appointed by the Victorian Premier failed to agree on vital questions of policy.

November 1931, the B.M.A. invited the Lord Mayor's Fund, and the Charities Board to a conference. A 2/3 majority felt the 9d a week contribution too high, and the conference disbanded. The Lord Mayor's Fund and the Charities Board met separately, and May 1932 submitted to the B.M.A. a scheme based on 6d a week for married men, and 3d a week for single men and women; 25% of revenue to be allocated to pay hospital and medical fees. This provision would have required Parliament to amend the Lord Mayor's Fund Charter. The B.M.A. refused to agree. The Fund went ahead with its 1d in the £1 scheme on wages. The B.M.A. throughout received unfavourable press publicity, the secretary of the Lord Mayor's Fund, Mr. Gibson claiming in a large public meeting that 'the delay in putting into operation was almost entirely due to the 'unreasonable obstinacy of the B.M.A.' "[21], comparing the Victorian B.M.A. unfavourably with their counterpart in N.S.W. and cooperation in the Metropolitan Hospitals Contribution scheme. But the B.M.A. contended that hospital contribution schemes, should as the latter was, be divorced from charity and charitable organisations. To justify its attitude the Branch Council issued a circular to all members after its representative, Dr. Morris , resigned from the joint committee early 1934:[22]

> "The Council's representative on the Lord Mayor's Fund (Dr. Newman Morris) was authorised to inform that body that the right to determine who should receive gratuitous service at the hand of the profession could not be resigned to contributory scheme executives or other lay bodies. In other words that the charitable services of the profession could not be sold to any person who became eligible under their scheme by contributing 1d in the pound of wages received".

A conference was held under the aegis of the State Attorney General,

then Mr. R. G. Menzies, and the argument resolved by the launching of the Hospitals Benefit Association. It was founded by a loan of £1,175 from the British Medical Insurance Company and £1,000 from the Lord Mayor's Fund. By the end of 1935, it had 10,000 contributors. In evidence given by the secretary of the Charities Board, Mr. C. L. McVilly in 1943, before the Social Security Committee, he said:[23]

> "The hospitals benefits scheme in Victoria is not nearly so successful as that operating in N.S.W. The cause of the comparative failure of the Victorian system are, I think, initial errors in launching the scheme, and an outlook among the medical profession of Victoria different from that of the profession in NS.W."

Mr. H. C. Gibson, a director of the H.B.A. and ex-member of the Trades Hall Council described the scheme as a 'compromise' saying 'how it lived is the miracle of the age'. In N.S.W., the Government had given a £2,000 grant to the equivalent M.H.C. Fund, but the Victorian Government refused a similar request, although the B.M.A. sent one of the most representative deputations in its history to the Treasurer. The B.M.A. had been unable to meet its condition that country schemes be amalgamated with the H.B.A. first, because Mr. McVilly, secretary of the Charities Board, had offered a subsidy to all country hospitals if they dissociated themselves from the H.B.A. The latter was therefore confined to Melbourne, despite 11,000 country subscribers then on its books.
During these years of controversy, the Victorian B.M.A. twice formulated hospital policy, first on subscription schemes, second on paying beds in public hospitals - mainly , restatements of principles already well known. In 1937, the B.M.A. sought payment for third party cases both in and out of hospital; and for allowance for payment under the Workers' Compensation Act. Legislation on third party was pending in 1934, so the B.M.A. Council sent a deputation to the Chief Secretary May 23 with little hope of success. A circular was sent to members of both Houses, and to all hospitals, followed by another deputation on the 'shortcomings of the Bill', complaining that the limitation of the provision for hospital expenses to public hospital treatment would prompt a desire to be treated in public hospitals, where the profession would have to keep giving free service to those not entitled to it.[24]
Doctors were not in fact paid for third party work in hospitals till 1952. Opposition to conceding the right from insurers included complaints as to careless and false certification by doctors, charging of fees out of proportion to the service, inappropriate treatment delaying recovery and leading to excessive claims.

Hospital finances continued to show increasing deficits, despite unemployment relief fund money, increased grants from the Government and totalistor tax. In 1936, finding the raising of private money

increasingly difficult, the Victorian Premier examined a report from New Zealand on their hospital tax. A State Cabinet sub-committee of ministers also looked at hospital maintenance experience with the hospital tax in W.A. and Queensland, but their report was not heartening.

When the Commonwealth Government proposed its Hospitals Benefits Act in 1944 to aid the States financially with a 6/- per bed per day subsidy, the Victorian Branch was not slow to prepare a memorandum for the Premier of Victoria:[25]

> "It is respectfully requested that the Government of Victoria seriously consider all the implications of the proposals of the Commonwealth Government before these proposals are accepted".

The B.M.A. predicted that the flow of voluntary finance would cease along with honorary medical service, further decreasing outside sources of support while demand increased for beds. It would do nothing to create extra beds to cope with the demand, yet the 1945-6 annual report of the Charities Board showed a bed shortage of 2215 beds for the state, created by the war. It would also prejudice such valuable voluntary organisations as the Bush Nursing Association with its 67 hospitals. As events transpired, the Victorian Branch did not press for abolition of the honorary system at a cost which they had told the Premier might be reckoned at £294,178 if calculated at 17.6 a head.[26] It confined itself to resolutions of protest, and further statement in 1949 that no blanket decision could be reached on such a subject.

In 1926, Dr. MacEachern had said that the Board's policy was most sound and efficient, and one of the most logical so far evolved in any part of the world'.[27] Its troubles by 1940 had mainly to do with the problems of conversion of the original voluntary system in a traditional framework.[28]

> "The Charities Board was interpreting the will of electors, hospital committees, and the medical profession in believing that, although the charity system had created too many abuses and left too many gaps, the voluntary principle should remain. Most Victorians, with an opinion on the matter, seemed to think that the state should support public hospitals and police them; that it should encourage them to accept intermediate and private patients, but that it should leave their management in the hands of committees which were theoretically elected by contributors."

The Chifley Legislation of 1945 was undoubtedly the end of an era, bringing major changes in social policy. By 1953, the Victorian B.M.A. proposed that medical benefit payments should be extended to honoraries. The Labour Party, on taking office in December 1952, had to approve an enabling act to accept Sir Earle Page's legislation out of sheer financial necessity, such as it had rejected when in coalition. Sir Earle Page had reimposed the means test abolished in public hospital wards by the Commonwealth Labour Government in 1945, demanding that its abolition was a

condition of subsidy. But deficits were soaring even worse, and the Royal Melbourne was threatening to close wards down, so the Labour Party had no choice but to bow to the Committee's ultimatum:[29]

> "The Committee does not subscribe to the principle that all hospital treatment should be free, irrespective of the patient's ability to pay".

The Royal Melbourne itself changed its traditional policy by introducing private and intermediate beds in 1952. The Charities Commission in 1946 became a fulltime body with even greater power over the autonomy of the hospitals. The demand for extra state responsibility had come from both hospitals and the B.M.A. over the years.

The 1948 Act gave the Commission comprehensive powers to inspect, allocate types of beds, even to close institutions and to determine the raising of funds by way of appeal to the public (unlike N.S.W.):[30]

> "A curious aspect of the legislation is the extent to which the Act determines the liability of outpatients at public hospitals and secures methods of enforcing such liability against the outpatients."

The Australian Hospitals Association, founded shortly after, persuaded the Federal, the N.S.W. and Victorian Governments to bring Dr. MacEachern to Australia once again to report on hospitals-particularly teaching hospitals. His report did nothing to allay concern already expressed in these terms:[31]

> "The ten parent clinical factories in the Commonwealth are in most part poorly equipped, badly housed, and have too few paid teachers. The result will be that the professional practice of every city and every country town will gradually but surely sink to a level of which all good Australians will be ashamed".

The way of the Hospital Committee of the Victorian Branch continued to be paved with reports on how best to resolve such dilemmas as this, and the discontinuance of the honorary system, the level of payment of doctors within the hospital system, and the permanent problem of how to offer greater efficiency against escalating costs.

The Victorian hospital system's evolution had reflected a state of affairs where the Labour Party had been in office far less than in other states, where there had been an incredible number of changes in the persons holding the office of Minister for Health, and an enlightened policy introduced at a time when a doctor held the Ministry, had early introduced acceptable reform.

(d) ASPECTS OF ~~THE~~ HOSPITAL HISTORY IN SOUTH AUSTRALIA

South Australia was a large colony territorially, but small in population. It did not experience a sudden surge of prosperity like the eastern states, and lacked, from the first, a wealthy community to lend philanthropic support to a voluntary hospital system. Hospitals from the first were largely supported by the Government. Government policy is best exemplified by a study of the history of its first hospital, the Adelaide Hospital. Built as an alternative to the Infirmary, with Government financial aid, it was born to turbulence. The first Board of Management, appointed by the Governor in April 1841, failed to include any one of the four honorary medical officers including Dr. Wyatt, board member of the old Infirmary. The Board refused their doctor's request to be represented unanimously:[1]

> "it being completely at variance with the practice of all well-regulated hospitals they could hear of, and involving many great objections which must be obvious on the most casual examination".

After a second request was refused by both Hospital Board and Governor of the colony, the honorary medical staff resigned, not to return on a regular basis until 1867. Before long, the Government dismissed the Board and put the hospital in charge of the Colonial Surgeon who ran it till 1867, though not without incident. After the honorary medical staff was restored to the hospital, in 1849, Colonial Surgeon Nash protested at interference in 'internal managment' by the honorary staff, and was backed up by the Government. Finally in 1867, a new Hospital Act recreated a Board of Management despite the fact that a Royal Commission of five in 1864 (including Dr. Wyatt) had recommended against it. No limitation on medical representation on the Board was set. Nine of the twelve members of the new Board were doctors. One was Dr. Wyatt, who became Chairman from 1870-86. A further Act of 1884 limited the number of doctors to eight of its sixteen members, of which only three were practising members of the staff.

From 1867-94, the principle for which Dr. Wyatt had once resigned prevailed.[2] Doctors sat on the board and the honorary medical system was reinforced, despite a report against it by a Royal Commission in 1883 on the management of the hospital (the majority of medical witnesses were in favour).

In 1884, an Act was passed which laid
~~The 80's brought a specific act as to management of the hospital~~
~~to lay~~ the foundation for the future career of the Melbourne Hospital
~~in 1885.~~ as a teaching hospital. It also brought an official enquiry into the future staff management after a difference between nurses and an officer in 1886, with rearrangement of ward management; and a differentiation between physicians and surgeons. This Committee recommended changes in nursing staff, as a result of which four nurses were brought from England to train an enlarged staff in what was called a 'new era in the nursing services'.[3] Two of these in the most senior posts lasted two years; and their replacements for one and three years respectively. The new Matron wished to remain, but the Board regarded her as unsatisfactory.

The determination of the Board not to renew the appointment of the Matron in 1894 was the immediate precipitant of the 'hospital row' as it became known. The method of filling the vacancies became the battleground in such a public way as to cast doubt in the mind of every citizen, whether the improvement in nursing services hoped for in 1888 had in fact transpired. Certainly stability had not, with two matrons in six years.

After visitingother states, a second Government appointed Committee in 1888 had made a further proposal for the appointment of a medical superintendent, since the Colonial Surgeon had dropped out of the picture in 1869. A Dr. Perks from England was appointed, who became a key figure in the hospital row.

In 1894, the honorary staff had a medical committee of three - Dr. Way, Dr. Stirling and Dr. Corbin (all B.M.A. founders and well qualified men) - who were also on the Board of Management, and, together with the new superintendent Dr. Perks, most directly advised the Board. Dr. Hayward, chairman of the honorary staff, was also a leading B.M.A. figure. These men were thus deeply involved in the 'hospital row' first as Board members, next as honorary staff representatives, finally as B.M.A. Councillors, while Dr. Hayward was honorary secretary of the B.M.A. In retrospect in 1901, a contemporary Dr. L. Bickle was to say:[4]

> "The real cause of the trouble still exists, viz a dual control of the hospital, a system that allows of political influence being brought to bear. We have a Board of Management nominally responsible for the control, but behind this the Ministry of the day which can override all actions of the Board. The occasion came, a question of discipline occurred and the Board's action was overriden by the Government. The staff unfortunately took up the Board's quarrel and resigned. "Now after upwards of five years, a portion of the old staff have returned, but the point on which they went out still remains. The hospital is still as much under a dual control as ever. The whole of this vast expenditure of good will, and bad feeling has been absolutely useless."

To summarise, Dr. Bickle blamed dual control as the bugbear, a question of discipline the immediate cause, and the resignation of

that Miss Annie Gordon was the most competent and this should be the prevailing consideration, a view asserted by Dr. Perks. An exchange between the Premier and the Board next involved an independent appeal from Nurse Hawkins to the Premier, and the Board simply refusing to alter its decision - with the Premier at one point insisting that their stand 'raised the whole question of the competence of the nursing staff'.[9] In January 1895, he added that one of the most senior nurses, Miss Fairclough had been recommended by Dr. Way himself as Night Superintendent in 1892; and the Senior Charge Nurse, Davoren highly recommended by the Matron and three honoraries for the post of matron for the Home for Incurables in 1890. Notwithstanding his misgivings, Premier Kingston confirmed Miss Gordon's appointment on February 1. The events of the four months had consisted of an effort by the Premier to advise the Board to reconsider a decision which he regarded as injudicious, and which had already caused discontent among the nurses. The principle at stake was not a minor one in any civil service - the degree to which seniority might count in promotion. The Premier had not at this stage in any sense 'interfered'; he had merely delayed and now considered the matter closed. Over a year later Mr. Booker M.P. claimed that the mistake was made by Dr. Perks, who came to regret it in light of consequences in the hospital.[10]

For the matter was not in fact closed. 6 charge nurses [including Nurses Fairclough and a fourth-year probationer Nurse Graham] protested, ~~alleging~~ THAT they had been treated unjustly,[11] both to press and political friends.[12] The Board unfortunately considered protest insubordination, and decided to 'deal with the nurses' on a 'question of discipline'. The Board appointed a special committee, which secured apologies from five of the six nurses. Only Nurse Graham refused to apologise, and as the Board thought she had been impertinent and rebellious, it withdrew her nomination for the post of charge nurse. It was clear that the Board were not going to retain either Miss Hawkins or Miss Graham in their service. The latter wrote to the Chief Secretary, the letter finding its way into the press. Public excitement was such that a Royal Commission was most necessary 'to enquire into the management and condition of the hospital'.

Its interim report said the claims of other nurses should have been brought forward, but the Board had acted in good faith on the strength of advice from the Chairman and Dr. Perks. It believed that Miss Gordon should retain her post. In its final report, some months later, it also generously praised the general conduct of the hospital. It was clear very early that the Commission however believed that Miss Hawkins and Miss Graham were acting on behalf of the senior nurses in pressing for an enquiry, and that their protests were 'justified' even if the terms were not 'properly chosen'. It recommended reinstatement on apology, consisting of 'withdrawal of the

offensive expressions against the government and the hospital'.

Both Nurse Hawking and Nurse Graham apologised twice, the second time in stronger terms on advice from the Chief Secretary. The Government insisted on the Board's acceptance of the compromise recommended by the Royal Commission - reinstatement on apology. The Board and the honorary staff, however, believed they could not take the chance of trying to reinstate the nurses on probation. They refused to do so in lengthy and courteous terms, standing now on the principle of their right to appoint or dismiss hospital staff; and the belief that the harmony of the hospital would be too seriously prejudiced. In view of the fact that Miss Graham was later Matron of the hospital from 1899, their stand in 1895 ~~on that the prejudice of her~~ her presence would prejudice discipline in the hospital makes rather strange reading. The S.A. B.M.A. backed up the Board, resolving that reinstatement of the nurses was prejudicial to good order and discipline.

Miss Graham refused to resign despite all overtures, and the honoraries then refused to work with her. The Government then had to run the hospital with Government medical officers seconded for duty, five non-B.M.A. doctors and recruits from abroad. The old Board went out of office, and a new one was appointed February 1896. By this time all the principals had resigned, Dr. Perks, the new Matron Miss McLeod, Miss Gordon, Nurses Fairclough and Davoren. On Miss McLeod's resignation Miss Gordon was appointed Matron while on leave, but never took the post, going to W.A. to become Matron of the Perth Hospital. March 1896 the Government appointed Nurse Graham once more charge nurse, and omitted to appoint any member of the honorary staff to the Board for the first time since 1867. A Dr. Hynes, expelled from the B.M.A. was given a seat.[12]

> "These two factors, added to Miss Graham's reinstatement and promotion , led to the most unfortunate result of of the whole quarrel, namely the resignation of the honorary staff, which at that time numbered only 17".

The S.A.F.M.A. supported the honoraries in boycotting the hospital. and the new staff working there; a boycott supported by every branch of the B.M.A. and the Central Association in Great Britain.

The Government brought Dr. Leith Napier and Dr. Ramsay Smith from England to run the hospital, and immediately these two men clashed with the four house surgeons, all of whom left the hospital. In 1899 Dr. Ramsay Smith became Coroner and Chairman of the Central Board of Health, and only retained his connection as honorary physician with the hospital till 1901, and physician to the infectious diseases ward till 1903. After a severe accident, January 1900, Dr. Napier was mainly absent from the hospital, resigning in 1903. Both men were there long enough for the B.M.A. to have to swallow its pride, and agree to go back to the hospital while they still worked there, although regarding them as 'scab' labour.

[illegible]

c. Returning [illegible] delayed by Dr. Harvey Smith's [illegible] the opening [illegible] attack [illegible] by Dr. Taylor who [illegible] he was quickly aided by Dr. [illegible]:[12]

> "There were no [illegible] method, and my duty [illegible]
>
> The hon[illegible] a failure as [illegible] inefficient [illegible]

Many things had been said that might well be better left unsaid, as Mr. Kingston's public attack on Dr. Way [illegible] or Mr. Gibson's remarks on 'medical crisis' on the staff.[13]

One is left to wonder if Bromley and Staindrop were [illegible] better by the 'merits' than suffering his rude entry and of the rumour, from which they had [illegible] the hospital would suffer, or if Messrs Kingston had really been so unreasonable in first offering a compromise, and then, when refused, standing by his own Board Commission, appointed only because friction had failed to be contained within by the Board. Perhaps the core of the dispute was the power of Parliament's agents to approve or disapprove of [illegible] within the hospitals. With this view a very recent [illegible] appointist, Mr. R. F Olgin, is [illegible]:[14]

> "It is very doubtful if this [illegible] anything. Miss Graham, [illegible] objected, to [illegible] such and the lady [illegible] Miss Graham. [illegible] Matron after the [illegible] .. It is very unlikely [illegible] may be quoted to Mr. Wynne, and that [illegible] the resignation of the staff

Dr. Ronnar Smith [illegible] dismissal from his [illegible] disturbance against the decision of the A.H.A. [illegible] direct no action had [illegible] [illegible] permission of certain [illegible] of Enquiry the nature of his [illegible]

[illegible]

[illegible] Beyond, who [illegible] [illegible] [illegible]

...

...

...

survey of the B.M.A. federal hospital policy committee 1933 found that the S.A. country doctor thought conditions satisfactory. This S.A. background was reflected in a cautious approach to 'national medical services'. The S.A. branch considered that the big hospitals were already government controlled with such resultant disadvantages, that they would not welcome future government control of general medical service.

In evidence given by the Director General of Medical Services May 17, 1943 to the Joint Parliamentary Committee on Social Security, Dr. L. Jeffries revealed there was no basic change in the state hospital system, nor objection to it; that the rating system originally opposed by many, was now universally accepted as the fairest means of supporting the hospitals. A S.A. Mutual Hospital Association had also come into being on lines similar to the eastern states.

When the Commonwealth hospital benefit scheme came into operation, the S.A. Branch Council decided the honorary system should continue, because the time was not opportune to change but considered the system was outmoded and should be superseded by paid service at a time to be decided by the Federal Council. It wanted a rate of payment on lines already put by the Federal Council for sessions similar to the Queensland system, and private and intermediate wards in community hospitals.

Opinion in the next decade was by no means clearcut - as was brought out by a somewhat inconclusive interhospitals committee which stated it had encountered some difficulty in interpreting differing wishes of hospitals staffs in relation to methods of payment. A request for sessional payment at the two leading hospitals was tactfully refused owing to lack of money. The problem of honorary service applied rather to these and the six government hospitals still existing outside Adelaide, rather than in the forty-nine government subsidised hospitals where honoraries had the right to charge private patients and recently for service rendered pensioners as well. B.M.A. Branch report June 1955 showed little evidence of progress to change conditions as to 'abuse'. Two conferences had been held with representatives of the four leading public hospitals in Adelaide during the year to urge financial assessment for persons seeking admittance to public hospitals, a large proportion of whom it was well known could afford to pay for private treatment' also to restate their conviction that they should not be required to treat free people who were covered by voluntary insurance, workers compensation or third party. In the 1960s doctors were still being paid neither by the patient nor the Government, and demands on Government finance were such that sessional payment was refused.

The Branch had appointed a standing committee on hospitals 1955 to

investigate 'hospitalisation' and increasing beds to the community, particularly private beds, as those in the Adelaide were still all public . The question of whether the Elizabeth should be a 'cloned' hospital and the rebuilding of the Adelaide, were both contentious matters. Once again in 1961, the B.M.A. supported the honorary staff of the latter in their protest that 'after years of discussions, meetin and deputations the rebuilding project seemed to be hopelessly bogged down by indecision and procrastination'.[22]

The Council made a statement criticising the administrative structure of the teaching hospitals, by implication suggesting that direct Government control was responsible for the ills the hospitals were heir to. The B.M.A. called for removal from direct Government control with a larger and more independent Board of Management to include representatives of the University and community as well as the Government. It also asked that the Boards control their own funds and staff. Rebuilding finally proceeded without any such concessions being made. An immediate post-war report, the Sharmon report, had put forward a plan for coordination of health and hospital services on a less haphazard basis.

Throughout its development, South Australia had exemplified close departmental control, unlike N.S.W. and Victoria, due to the failure of a pioneer community in a less favourable environment to sustain a system by subscription and endowment.

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(e) ASPECTS OF THE HOSPITAL SYSTEM IN WESTERN AUSTRALIA

The distinctive nature of W.A. settlement placed distinct limitations on the voluntary and local system of hospitals. The population was scattered in small groups along the relatively fertile southwest coastal strip and into its semi-desert hinterland. Government paternalism was often a necessary condition of survival. This was most true east of Perth in the goldfields. In the capital Perth, the major hospitals at Perth and the adjoining seaport, Fremantle, had their own Acts, but were always closely directed by the Government. Elsewhere hospitals were under committees, which received £1 for every £1 subscription raised, a policy which creat an incentive to raise as much money as possible, irrespective of method. The hospitals, founded thus, often advertised in the eastern states for doctors offering a salary of £200 to £350 with the right of private practice. Those joining, which usually included most of the residents, received all medical attendance and medicine, both indoor and outdoor for 1/- a week. The temptation to save at the expense of the doctor was at odds with the original purpose of such contribution schemes - to combine to make a guaranteed income which would attract a doctor to districts inherently unattractive because of the social and physical milieu - isolation, trying conditions, higher cost of living. The whole of the subsidised hospitals of the colony were by 1900 under the direct control of the Principal Medical Officer; and were the highest ratio of hospitals to persons in the whole of Australia: 1 to every 4,100 people compared to Victoria with 1 to every 20,267.

Private practice proved mainly illusory for the doctor. He was in no position to rebel, as the managing committee consisted of the workers, while he often had to live in the hotel owned by the hospital president or treasurer.[1] Opposition was led by friendly societies, who found their membership affected by the more liberal privileges offered by the hospitals.[2]

> "The Pharmaceutical Society at Perth, the A.N.A. and the friendly societies generally have realised the situation and helped the Government to arrest the free hospital and dispensary shop movement, and hence several of these impostures have been suppressed, notably at Bardo, Goongarrie and elsewhere, where continguity to a railway and proximity to an already well appointed hospital exists".

Previously the Government had been unwilling to interfere, as criticised by L. Bruck in his pamphlet on Australian hospitals issued in 1899 'from fear of losing the support of one or the other goldfield members in Parliament';[3] despite the fact that unnecessary hospitals were being founded - as at Bulong only 25 miles from Kalgoorlie with:[4]

> "a great waste of pecuniary resources, much local ill-feeling and finally a most imperfectly constructed, dank, draughty, dismal and badly appointed microbe breeding place being the outcome.

The theme of hospitals was not the first [illegible] when founded in 1911, [illegible] recurred in later years [illegible]:

> "[illegible] the [illegible] the [illegible] the [

fees might be charged well-to-do patients using free public beds in the three major hospitals, Perth, Children's and King Edward; but the B.M.A. decided against charges, approving the principle of intermediate hospitals for such patients instead. The then B.M.A. President, Dr. Atkinson, was also head of the Government Health Dept, and therefore responsible, and claimed he did not know of any cases, although on the lookout for them. His remarks were 'cordially and unanimously disagreed with'. A further B.M.A. report in 1918 however recorded that enquiry now upheld Dr. Atkinson.

Doctors were themselves not always cooperative in achieving their own protection in country districts. The B.M.A. Council in 1914 complained it could not make headway on a model agreement for state assisted hospitals 'owing to the difficulty of getting the doctors concerned to supply any information'.[10] But medical practice suffered considerable turnover. The A.M.G. in 1914 gave a graphic picture of conditions in some towns:[11]

> "The pay was £400 to £450 often with quarters (which means in fact a poorly furnished frame tent covered with hessian) and the right of private practice. These terms may or may not be liberal, but the fact remains that the average tenure of these posts can hardly exceed a year. One had three doctors, and a locum in twelve months".

In 1921, the Government appointed a Parliamentary Select Committee to consider a new Hospital Bill to amend the Hospital Act of 1894. The B.M.A. sent copies to all members of the branch 'at great expense; but said the secretary 'I regret to say not one reply was received, nor a single suggestion made;[12] On request from the Government, B.M.A. members appeared before the Parliamentary Committee to present B.M.A. policy and objections, as a result of which the Bill failed; as did a second, which the B.M.A. thought fair and equitable. The B.M.A. had opposed abolition of voluntary contribution schemes, a plan for direct hospital taxation, the power of the minister to dismiss honoraries, and contracts between hospitals and friendly societies. Their own proposals included payment for visiting medical staff if all ratepayers were admitted, and coordination between hospital districts so patients could transfer from one to the other.

In 1931, a B.M.A. hospital committee debated the relation of honorary service to changing conditions, including national insurance. Objection was taken to giving such service to workers' compensation cases,[12] on the principle that no scheme offering benefits should make their scheme solvent by exploiting the altruism of the profession. A general meeting August 1932 called for an intermediate hospital to be built out of the surplus of the hospital tax, now paid into general revenue; for all doctors to be allowed to follow paying patients into

such hospitals; and declared the B.M.A. opposed to all contributory schemes which did not make provision for paying the doctor. It also deplored the increasing tendency towards state control of hospital medical staffs. The Minister of Health was receptive to their ideas, and for a plan to import an expert like Mr . Love to advise on how the community principle in hospitals should be extended - both in a new hospital to relieve pressure on Perth Hospital and in the adaptation of Perth Hospital itself.[13] The B.M.A. was supported by the secretary of the Friendly Societies Council of W.A. in that community hospitals would allow the doctor to follow his patient into hospital.[14] The B.M.A. also advocated an independent statutory hospitals commission to give a continuity of policy they believed otherwise difficult to attain.

In 1933, the B.M.A. reported to the Federal Council that the Hospitals Tax (1930) encouraged all taxpayers in W.A. to expect free medical treatment at a public hospital as of right, believing that hospital charges were paid in part to their doctor.

By 1937, no changes had been made. A B.M.A. deputation, representing every phase of medical and surgical practice, went to the Minister to revive their representations of 1932 and 1933. It complained of existing conditions in the Perth Hospital due to neglect by the administration of professional advice; a view reinforced by an expert Mr. Stephenson called in by the Board at the urging of the honorary medical staff who said it fell far short of a desirable standard as training hospital for junior doctors. The deputation also deplored:[15]

> "that the present tendency to general decentralisation of hospital work is dangerous, in that it tends to throw the burden of difficult treatment on to the smaller country hospitals, which must be inadequately equipped and staffed for such a purpose".

It spoke of the uneconomic ambitions of many country hospitals, which installed X-ray ~~patients~~ PLANTS, where a few in base hospitals would be sounder practice. 25 of these hospitals were directly controlled by the Dept of Health, and as the assistant under secretary of health, Mr. Wilson said in 1943: 'The efficiency or otherwise of the Board hospitals is eventually a department responsibility:[16]

The B.M.A. worked for years to ensure that doctors in such towns would get a minimum standard under a model contract. All but urgent operations and industrial accident cases under the workers compensation act had come to be excluded from the combined hospital/ medical service rendered by the doctor. By 1938, conditions of service had come to be fair and equitable by B.M.A. standards. Workers compensation owing to a fairly high accident rate, provided an additional private income, such as had been illusory in earlier days.

But trouble over contracts was not altogether over. In 1938, the hospital board of Wiluna (400 miles N. of Perth) conceived the plan of replacing the 1933 contracts with three doctors by employment on salary in order to reduce its debts. The doctors affected were greatly distressed saying [17]

> "they rendered worthless the saleable value of the practices- an asset built up through years of practice in a district offering no social or educational amenities to an educated man".

As to the principle involved, the M.J.A. made this comment: [18]

> "the avowed object being to utilise the difference between what they will pay the medical practitioner, and the amount which they compute is at present being earned by the practitioners in the town to finance the hos ital which is sorely in need of funds... all services will be included, together with work which at present comes under workers compensation acts. It is arguable whether this can be done without infringement of an act of parliament or coercion of the worker".

The local doctors were fully supported in the dispute that ensued by the B.M.A., and declared a boycott of the Wiluna Hospital. Nevertheless the Board engaged salaried doctors, and the local doctors left defeated. The doctors engaged proved to be unsatisfactory, being described by a partisan in evidence before the Joint Parliamentary Committee on Social Security in 1943 as 'idealists or charlatans'. The B.M.A. received no support from either the Under Secretary of the Health Dept. of the Minister. The official attitude was rather one of hostility, as was clear in evidence before the committee already cited, when Mr. Wilson spoke in such strong terms against the B.M.A. that the Committee invited the B.M.A. to reply, in view of its 'very strong terms'.

Kalgoorlie doctors became worried enough about Wiluna to support the formation of a compensation fund at a general B.M.A. meeting in Kalgoorlie in September 1939 to anticipate a similar turn of events. From 1918-38 , doctors had run their own funds for those who did not belong to friendly societies by mutual agreement with unions, and the Chamber of Mines, to include both domiciliary and hospital treatment. By 1938, both doctors and the Mines Medical Fund were losing money owing to rising medical and hospital costs (they had to pay the Governme to use the hospital) From 1938-42, the Chamber of Mines took over the whole of hospitalisation of employees paying the government at a higher rate.

The B.M..A. was involved in 1938 in asking for an enquiry into the administration of Heathcote Hospital, but objected to the terms of reference when the Premier appointed a stipendiary magistrate, Mr. H.D. Moseley to carry out the enquiry. The cause was the dismissal of a Dr. Bentley and reinstatement; and opposition of the B.M.A. to the manner in which the Under-Secretary, Mr Huelin had handled the affair considering,as they did, that the integrity and honor of Dr. Bentley

had been unfairly impugned, and public confidence in the state medical service damaged. B.M.A. objection to terms of reference were stated thus:[19]

> "The Association felt it had been perhaps unwittingly placed in the position of accuser, and, although the need for an enquiry was obvious, of justifying its request to you for an enquiry."

Legal counsel was engaged. The B.M.A. asked for some of its costs to be met, particularly as B.M.A. charges were, in the upshot, vindicated by the Commissioner;[20] particularly the need to remove the matron, as Dr. Bentley had tried to do.

The war introduced new issues - the Hospital Benefit Scheme bringing hospital policy to a head. In 1944, with the legislation pending, the honorary staffs of the three major hospitals decided that they:[21]

> "did not consider it apart of their duties, or a condition of their appointment to treat patients in these hospitals unless they have satisfied the means test in current use in them, except in cases of emergency."

W.A. B.M.A. sought advice interstate, including the N.S.W. decision to continue honorary service. A further B.M.A. meeting decided that 'under this Act the honorary system automatically ceases'. B.M.A. doctors said they would not contest the coming Perth Hospital elections unless the Board agreed to the principle. They sought conversion into a community hospital as a solution, with the support of the entire profession. In a public statement, the President, a distinguished surgeon who had been Branch secretary for some years, Dr. Le Souef said:[22]

> "while the medical profession is proud of its record of honorary medical service, it cannot be expected to continue this under the circumstances at present forced upon it".

Mr. Panton, the Minister, claimed to have pointed out to Mr. Chifley that doctors could not be expected to treat everyone without a means test, adding that Mr. Chifley promised the states would not suffer, whatever cost was brought about by the change.

The Premier August 16, 1946, asked a B.M.A. deputation to prepare a scheme for a part-time paid sessional service. This was referred back to Council and Convocation. The Premier was then told the scheme would be delayed as it had become obvious the implications to the profession were of much greater significance than had seemed possible at the outset. In 1947, the Convocation decided to continue the honorary system a further three years owing to the state of uncertainty as to future conditions of medical service in Australia and the staffing requirements of the projected medical school.

They sought, however, medical advisory committees at each hospital, a medical committee of review for all honorary appointments, and that all insured patients should be allotted to 'community beds'. This was a question of great urgency due to the sharp decrease in private hospitals, and the fact that not all public hospitals offered intermediate accommodation. On the subject of shortage of beds, a further deputation to the Minister of Health, December 1947, represented Colleges, B.M.A. Council and two major hospitals:[23]

> "We believe that the difficulties in this state would not be so marked had the whole question of an adequate and well-balanced hospital scheme received in the past the attention it deserved".

They referred to their own repeated requests since 1932 to Health Ministers for a Hospital Commission; though they acknowledged the advance made by appointment of a Hospital Planning Committee in 1946, (which included two members of the B.M.A.) in the Dept of Public Health to formulate a regional hospitals program.

In 1949, Dr. Hislop moved in the Legislative Council for a Royal Commission to inquire into the administration of all hospitals in the state including the effect of Commonwealth legislation to prevent means testing in hospitals, and price fixation on hospital finances and maintenance.[24] Like other States, W.A. found their hospital problem desperate as a result, and gladly restored means testing in 1952. In 1952, both in Perth and Fremantle Hospitals, public beds could be declared private or intermediate beds according to demand, and in principle in all but Royal Perth, doctors could follow their patients into hospital. The honorary system remained, but staffs became classified in metropolitan hospitals. Shortly after, Perth at last got a medical school, and the leading hospitals of Perth became teaching hospitals.

Throughout the history of hospitals in W.A., the effect of dependence on Government finance and control made a clear differentiation in its evolution from those of the eastern states.

5) ASPECTS OF HOSPITAL HISTORY IN TASMANIA

Tasmania, being neither rich nor large in size or population, did not produce the large voluntary hospital of the mainland. Hobart Hospital was Government from the first, Imperial then state owned; founded for military and convict personnel. Launceston Hospital onthe north coast began privately 1841-54, needed Government donation to supplement public appeal, and continued Government support for a permanent building. Among others were the Devon in Latrobe, company hospitals on the west coast, and others.

The early management of the Hobart Hospital was on the military service model. A Joint Parliamentary Committee recommended an independent Board of Management (1859) and that the Government should match all voluntary contributions. But the Surgeon Superintendent continued to have the overriding authority he had originally possessed when it was a military hospital. In 1874, the Board was suspended for four years. The new matron (an original Florence Nightingale trainee) and properly trained nurses from Sydney Hospital demanded certain reforms, which led to a Royal Commission report 1877 that:[1]

> "the entire management of the hospital (with all its complicated arrangements, medical, economical and financial) are in the hands of a single officer, the surgeon-superintendent".

The Royal Commission recommended reinstatement of a Board 'with duties and responsibilities properly defined and full statutory powers for the administration'.[2] The new Board 1879 was Government nominated, with honorary representation. A new Government nominated board was also constituted for the Launceston Hospital by Act of Parliament in 1878, responsible to the Dept of Public Works, and later the Dept of Health.[3] Honoraries were purely consultative without any rights to enter the Hospital unless requested. For a brief time 1879-81, a fuller honorary system was introduced, but considered a failure due to lax attendance. In 1897, three local doctors protested at the closed character of the hospital, and approached the Board to do away with the dominating role of post of surgeon superintendent; supported by the existing three honoraries who had all held that post themselves. The Board had had a succession of excellent men in the post, and was unwilling to make a change. The B.M.A. then approached Parliament to seek a change in the Act which governed the hospital. Two successive Premiers proved willing to introduce an enabling bill of the kind sought, the first S. E Braddon the second the Hon. Lewis; the first to include Hobart Hospital, the second not. A Select Committee approved the B.M.A. reforms, despite further Board protests of their preference for a senior surgeon on the spot for emergencies.

The new Bill gave the Board power to appoint 4-6 honoraries as distinct from consultants, with equal status to the superintendent, and the same number of beds. Dr. Craig , a highly qualified surgeon who joined the hospital later, wrote in retrospect:[4]

> "It would be pleasant to be able to report that the new system was an unqualified success. All went well for a while, but in 1903 Dr. Clemons quarrelled with Dr. Ramsay and resigned. Ramsay had many splendid qualities but certainly he was dominating and intensely individualistic.. His reputation as a surgeon created difficulties in this way. A patient would enter the hospital under an honorary doctor, but would then hear of Ramsay's skill and would ask to be transferred to him. This is the difficulty that Dr. Pardey encountered in 1903 and he resigned forthwith."

A Royal Commission of three appointed in 1905 investigated the efficiency and economy of the hospitals, which reported that the conditions of appointment of surgeon superintendent should be 'materially modified' when Dr. Ramsay should leave; that his successors should be allowed no outside work whether as consultant or otherwise as he had been a serious competitor while in office; and that the Board of the Launceston Hospital should be reorganised to make it more representative; and that the standard of these public hospitals had attracted patients who could afford to pay.[5] Furthermore some Board members and hospital officials had actually touted for custom. These reforms were not instituted. In 1907, at the Launceston Board's July meeting the Chief Secretary promised to recommend an increased salary for Dr. Ramsay, and predicted new hospital legislation in Parliament.[6] The Board at this meeting refused to limit Dr. Ramsay's practice to the hospital; and were backed by a petition from 45 centres in northern Tasmania signed by 8041 people. A further such petition countered an intended bill in 1910, requesting exemption for Dr. Ramsay, but passed on the principle that no other public servants such as school teachers were allowed to enter into competition with private individuals. Dr. Ramsay retired 10 years later. Dr. Sweetnam, his successor, was restricted in practice to the hospital. But in this victory, the B.M.A. sowed the seeds of the crisis of 1917 to come.

July 1914, the Chief Health Officer, Dr. S.A. McClintock was made sole Royal Commissioner 'to survey present unsatisfactory conditions affecting hospitals throughout the state'.[7] He advised a central hospital authority, and community hospitals. The B.M.A. President protested that throwing public hospitals open to all classes of patients opened the whole question of a state medical service prematurely.[8] The Branch voted against intermediate hospitals

Dr. McClintock had also attacked the inbred system of appointment of honoraries to hospitals through patronage of those on the boards, which did not always produce those best qualified. Of the smaller hospitals like Latrobe, Strahan, and Zeehan he had nothing but praise; Latrobe, for example, being open to all doctors. The Hobart Hospital he found to be 'the worst conducted institution of its class I have ever visited'. He found it strange the Government was responsible for the Board's actions with its employees, and yet not for the Board's financing in these hospitals.

Malaise raised by this report was allayed by the almost immediate appointment of an enlarged commission to consider the Hobart Hospital. It included Dr. Mc Clintock, and confirmed all his charges, including that as to the honorary staff: considering appointment should be by advertisement, rather than the existing system through being persona grata with a member of the Medical Committee. The Chief Secretary shortly after introduced a new Hospital Bill on the lines recommended. The B.M.A. then approached the Premier to ask that provision be included in the legislation to prevent well-to-do persons being admitted either in to the Hobart Hospital, or the Launceston General, on the grounds that it was contrary to the use of government general hospitals and seriously affected the interests of the medical profession.[9] Initiative came from the Launceston branch of the B.M.A. on the complaints of Drs. Hogg and Dr. Clemons that concession of beds to honoraries in Launceston Hospital was a gesture, and opportunities to get experience were still a monopoly of the surgeon superintendent; and that they had failed to move the Launceston Hospital Board to reform. They received unexpected support from Dr. Ramsay, now a B.M.A. member, who now said he felt all local doctors should be allowed to follow patients into the hospital A B.M.A. meeting November 25, 1916 leaned to the view of Dr. Clemons in the chair that it was a serious matter for the whole profession in Australia as an example of nationalisation. It decided unanimously that the honorayy system in Hobart Hospital must cease if the Premier persisted in refusing an assurance to them that he would cease to permit well-to-do patients to be admitted to state aided hospitals. The Branch thereupon made urgent and repeated representations along these lines to the Premier, who delayed for some weeks. The Branch in February delivered an ultimatum for decision by March 1, which was not forthcoming, and then decided:

> ""that the Branch call on all honorary medical officers of state aided hospitals to handin their resignations to the secretary of the Branch, who shall withhold such resignations pending a reply from the Premier .. In the event of the Premier not giving the assurance asked for the resignations to be forwarded to the secretary of the various hospitals forthwith".

The Premier, Hon W. Lee, gave his version of events May 15, 1917;[11]

> "The genesis of the trouble was the question of admission of well-to-do patients to state aided hospita particularly as it applied to the Launceston institutio Pressure was brought to bear on me to stop the practice although I had no power to do so under the existing legislation, while the number of cases treated that cou be counted well-to-do was ridiculously small. The threa was held out that unless definite action was taken in the direction of preventing admission of these patients all the honorary medical officers would be withdrawn. "As far back as November 1916, I promised a deputation from the association that I would introduce a Hospital Bill during the coming session dealing with the whole question. This assurance was repeated on more than one occasion, and the cooperation of the association as for by me in drafting the Bill. To this reasonable request, the Association has at every turn met me with the demand that I should guarantee to insert in the Bil a clause to prevent the admission of what the Associati indefinitely terms well-to-do patients. This demand I have refused on the ground that it is almost difficult thing to determine a definition of what is well-to-do and further because, in my opinion, it is a very extreme step to take to say to any citizen of the state, who, for special reasons may desire hospital attendance, tha he shall be disqualified from admission on financial grounds."

Further, he felt that the in between class of people neither indigent nor rich could not properly be denied access, and forced into privat hospitals which they might not be able to afford.

The B.M.A.'s quarrel was that the system, particularly in Launceston worked against them both ways - no means testing and an almost 'closed ' hospital. Whether they argued the latter issue adequately with the Premier at the time is not clear from the records The M.J.A. editor perceived the interconnexion between the two, while clearly seeing that the Premier was inheriting the harvest of many years of irritation:[12]

> "The question at issue at present is limited to that of hospital 'abuse' by well-to-do persons and does not include the expediency of the appointment of an active honorary staff. We are, however, inclined to the opinio that unless the demands of the profession are acceded to without loss of time and qualification, the two questions will gradually merge into one another, and some striking reforms in hospital administration will be witnessed in Tasmania before long".

The demands were not acceded to , nor did reforms follow.

In resigning from the Hobart Hospital, the B.M.A. assured the Board they had no complaint against the management, their grievance being against the Launceston Hospital.[13] When asked to reconsider, the B.M.A. Council insisted this was conditional on the clause of assurance asked for being included in the Hospital Bill. The B.M.A.' admission gave the Premier much ammunition, and turned the Hobart Mercury against the B.M.A. from its former sympathetic standpoint. The Mercury at first felt the doctors to be in the right, but objected to the B.M.A. trying to force the hand of the Premier.[14] The Premier , May 7,1917, said:[15]

> "If this were the Board's quarrel, we might be inclined to advise it to give way, rather than fight so powerful a union as the B.M.A. But the grim humour of the thing is that the Board cannot give way, because no demands have been made which it has power to grant".

When the Hospital Board met April 16, 1917, the B.M.A. secretary was insisting still that the honoraries would continue as long as they were wanted.[15] But despite a promise from the Premier in conference with the Board and the B.M.A. to submit the draft hospital bill to both before it went to the Parliament, the resignations went forward. The Premier wrote to the B.M.A. Council to call a full meeting of members, April 12, to reconsider the resignations and assist in drafting the Bill. The Council did not do so, but notified the Board without reference to the Branch. When the next Branch meeting came up May 8, the Premier had engaged Dr. Ratten as Surgeon Superintende the day before; so agreement to cooperate in framing the bill at this meeting came too late to be acceptable to the Premier, who now charged the meeting with being neither full nor representative; and was supported by Dr. E. L. Crowther who resigned from the BM.A. on these grounds, and the fact that the Council had always been the preserve of a coterie. No voices were raised now to defend the B.M.A. amid all the cries of desertion of the suffering and sick, bar one anonymous correspondent signed 'not well to do', who alleged that the difficulty had been laid before the Premier over two years before. One fact scarcely mentioned was the B.M.A. demand April 1, 1917, for 33% to 50% increase in lodge fees, involving a large part of the population, on top of wartime levies already imposed on members; which made the timing of the hospital 'strike' even more disastrous.[15a]

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In the first weeks of Dr. Ratten's office, he gave anaesthetics for him, and testified that he was an extraordinary man, and a remarkable technician despite misgivings as to his qualifications. These were so great as to cause long proceedings by the B.M.A. against Dr. Ratten for fraudulent registration on evidence that he had purchased his degree in America. Dr. Craig's estimate of the man when he met him some years later, was that he had a very strong personality, and extraordinary skill in the handling of patients soliciting implicit trust; while his standing was aided by a hostile press and personal attacks by the B.M.A. to the B.M.A.[17]

In accepting the contract from the Premier, Dr. Ratten had extended the scope of the offer to allow him right of private practice outside the hospital, and control of all surgery within, with the same administrative powers of the same position in the Launceston Hospital.

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In accepting the contract from the Premier, Dr. Ratten had extended the scope of the offer to allow him right of private practice outside the hospital, and control of all surgery within, with the same administrative powers of the same position in the Launceston Hospital.

October 1917, the Hospital Bill went to Parliament, and left the

the principle that hospitals were open to any member of the public untouched. In October 1918, the Federal Committee of the B.M.A. sent the M.J.A. editor Dr. Armit to Hobart to act as an intermediary in the dispute. He conferred with the Premier and the Minister. On consultation with the B.M.A. he agreed to attend a round table conference on condition that the five non-B.M.A. doctors be removed from the hospital, particularly Dr. Ratten whose presence was held to be an insuperable difficulty in the way of settlement.[18] The Premier countered by calling the B.M.A. demand an insuperable difficulty, as to which Dr. Armit's comment was:[19]

> "The Premier sought to influence public opinion by suggesting that the condition asked for was extraordinary and by implication irrational".

A 1920 Act prevented enquiry into a doctor's credentials after seven years' registration; and prohibited anyone from preventing doctors consulting with those employed at Hobart Hospital (fine £1,000) This clause prevented the B.M.A. persisting with their advertised public boycott of Hobart Hospital.

When Dr. Sweetnam resigned as surgeon superintendent from Launceston Hospital late 1918, the Premier remarked in the House that the B.M.A. had brought it about . The B.M.A. denied this saying he wanted to act fairly with them. In 1918, both the Wynyard and Latrobe hospitals offered to pay doctors' fees.

Dr. Ratten in 1922 quarrelled with the House Surgeon of the Hobart Hospital, who was dismissed and successfully proceeded against the Board for wrongful dismissal. In view of remarks made, Dr. Ratten asked for a Board of Inquiry into the administration of the hospital; and the Board itself for a Royal Commission into charges of insubordination alleged against the House Surgeon by Dr. Ratten. The first was held, but not the second. The Inquiry report was never published, and was by no means favourable to Dr. Ratten.

On matters cogent to the B.M.A., there were two major points. The first was the controversy as to the extent of Dr. Ratten's right to 'engage in consultations'; abetted by his associates in the hospital covering for him. The second was the Board regulation 1920 which made the hospital an open one to all doctors. The report held there was nothing to stop B.M.A. doctors entering the hospital, bar their objection to Dr. Ratten. The Inquiry recommended that Dr. Ratten's right to all medical and surgical practice should be modified. When his contract was renewed in 1923, he was given the right to see private patients for two hours a day.

On the initiative of the Chief Secretary, the Board consulted with the B.M.A. as to a possible compromiee. The conditions were not accepted, nor further ones in 1925. The stumbling block appeared to be my intention of B.M.A. doctors not to cooperate with non B.M.A. doctors involved outside as well as inside the hospital.

In 1928, the Government asked the former Inspector of Hospitals in Victoria to hold an independent inquiry into the Hobart Hospital administration. He made some very caustic remarks about the standard of the hospital; the quality of its equipment and treatment, the total insufficiency of staff, lack of modern X-ray or pathology, diagnostic methods or proper statistics. He reported that staff appointments should be advertised, and made by an advisory board; and that a return to a full honorary system was preferable to salaried staff for clinical work in order to secure a much wider ranger of service than was being offered with the present limited staff. Leading B.M.A. doctors were not silent about the deficiencies of work done at the hospital. Dr. C. Hogg in 1928, when President of the Branch, said:[20]

> "Long past is the day when at a hospital a man was general physician and surgeon treating all and every form of disease.. nowhere is specialisation, not only of examination but of research and of treatment, needed more than in a large general hospital. Commonsense, if nothing else, demands the appointment of a proper medical staff in the Hobart Hospital".

Dr. Frank Fay, a senior man in surgery trained at the Royal Melbourne, had come to Hobart in 1923. To resolve the impasse, he got on the Board as medical representative , determined to see a settlement. He quoted Dr. Hogg's comments at length, and added his own. Royal Melbourne, he said, was only twice the size of Hobart Hospital with 400 beds. Yet it had a full-time superintendent and 23 residents with 79 honoraries or 100 doctors. Hobart with 200 beds and a large outpatient department had only five doctors, only three resident, and one of these part-time.[21]

> "I say emphatically that this hospital is hopelessly understaffed. However competent these doctors may be, they cannot possibly give the time necessary for the complete preliminary examination and investigation of the ailments of patients".

There was no record in the hospital of X-ray diagnosis for stones in the ureter or of pyelogramphotos; nor was there deep X-ray treatment for cancer. The inference was obvious. His plan for a round table conference with three board members and three B.M.A. members was taken up. The Board carried a motion 'that the Board realises the advantages that a fully staffed B.M.A. hospital would give to the community'[22] and appointed a sub-committee at last to approach the B.M.A. to end the impasse of 13 years. Dr. Ratten told the Board in his opinion the hospital was fully staffed; and the Fay proposals meant the present staff being sacked, while he would not accept an honorary post. Dr. Fay moved the Government seek the opinion of an expert on hospital management. Mr. Love reported June 1929. As a result, agreement was finally secured on the recommended basis that Dr. Ratten confined himself wholly to the hospital without right of private practice, and conceded reintroduction of an approved honorary system. For its part, the B.M.A. Branch yielded the point they had refused so long, to work with the non-B.M.A. doctors they had boycotted so long both inside and

outside the hospital. Dr. Fay was undoubtedly a conspicuous figure in bringing about a most difficult reconciliation, where everyone else had failed; due to his tact, discretion and lucidity. The story must stand as an exemplar of a large hospital run without any of the usual safeguards from the errors of centralised medical and political responsibility; or from the evils of political patronage which protected dubious qualifications and poor management.

In 1931, a Royal Commission was appointed because of the 'dire financial straits of the hospital', comprising the medical superintendent of the Melbourne Hospital, secretary of the N.S.W. Hospitals Commission and Magistrate E.L. Hall. Dr. Ratten came in for much unflattering comment in their report.[22]

> "The unvarying opposition and obstruction to the whole of the report prepared in 1927 by Mr. R. J. Love is a further illustration of the manner in which the Surgeon Superintendent has adversely influenced the conduct of the hospital. Many of Mr. Love's recommendati could have been carried out without expense, and would certainly have resulted in savings to the hospital but the Board preferred the opinion of the Surgeon Superintendent to that of a recognised specialist in hospital administration"."

They urged abolition of his post in favour of a medical superintendent with a different status and lower salary which was all the hospital could afford. Launceston was frequently quoted as an example of greater efficiency. As to the point which had caused the original dispute:[23]

> "The hospital labours under the disability of being regarded by the public as a government institution in which service may be demanded as of right".

Three classes of patient were suggested including private who would pay the doctors ' full fee.

Incredibly the Hobart Hospital was the subject of two more major enquiries in 1933 and 1935. One was by the Board into public criticisms by the Hon A.G. Ogilvie as to certain incidents mentioned in Parliament;[24] and one by the Royal Commission into the Board itself after resignations late 1935.[25] These revealed three changes of Board with radical changes of personnel, major dissension between Dr. Ratten and the new matron over the entire period, failure to reorganis Dr. Ratten's duties in terms of previous Royal Commissions, failure to define clear limits of executive functions leading to conflict of authority. The Premier Mr. Ogilvie resisted efforts to appoint a fulltime administrator, reducing Dr. Ratten to a part-time specialis but this was finally accomplished by Mr. Ogilvie's new appointee to chairman of the Board, Father O'Donnell, while Mr. Ogilvie was overseas Thus a stormy chapter in the hospital history was finally closed. The Board was reduced to five, with the Director of Health as Chairman and a highly qualified surgeon from Sydney replaced Dr. Ratten in 1936

One marvels in retrospect at the survival of Dr. Ratten in the face of public criticism by public enquiry so often, and the unmoving support of certain politicians, whether from fear of popular support for Dr. Ratten in the electorate; or from personal commitment.

In Launceston, Dr. Ramsay had become a leading B.M.A. figure, and first member of the Hospital Board there, and then Chairman from 1933-44. The hospial introduced more modern methods of specialisation in 1929, encouraged high calibre ~~of~~ men and clinical meetings, and a post-graduate link with the mainland that flowered into recognition of the hospital as a post-graduate school in 1947. The B.M.A. Branch participated in the growth.

By wartime, the southern half was served outside Hobart by bush nursing and private hospitals. In the north with closer settlement and less mountainous terrain, there were ten public hospitals besides Launceston, nearly all with maternity accommodation, and some bush nursing hospitals.[26]

Special arrangements catered for the westcoast mining communities. One of the oldest was the Queenstown Hospital Union, created from local contributions with a small state subsidy. After a fire in 1939 the Government built a large new hospital. Salaried doctors were paid by subscribers; all hospital and dispensary treatment was free, except for maternity, specified diseases and chronic illness. The Zeehan hospital came under the state health scheme. The Mount Lyell Employees Sick and Accident Fund by agreement with the Queenstown Hospital Union in 1941 each contributed towards a specialist fund. By agreement with major hospitals, such patients were sent there. Burnie Mills also had a medical and hospital fund in the north.

The B.M.A. attitude on the honorary system in 1945 was that it should be replaced by parttime payment as in Queensland. Advice to the federal B.M.A. Council was given by the Honorary Secretary, Dr. J. Walsh:[27]

> "The Tasmanian Branch will very soon be faced with the alternative of either accepting parttime paid service in public hospitals or putting up with closed hospitals run by a fulltime salaried staff. The Branch is very anxious to avoid the latter alternative, and therefore hopes that the Federal Council will do nothing to prevent acceptance of partime positions after its next meeting."

In Federal Council, Dr. Craig said doctors did not want to return to the 'closed' system. Tasmania consulted Queensland as to the effect of the sessional payment system on a state where the Government assumed the kind of direct control always evident in Tasmania. Their reply was not altogether reassuring:[28]

> "Desirable increases in the size of the hospital staff, which might have readily been acceded to under the honorary system have not taken place, and the restricted parttime visiting staff is grossly overworked (speaking of Brisbane General)"

Free attention in Queensland had led to many more people getting free service, who could afford private fees:

> "the coincidence of the abolition of the means test and the payment of parttime staff are difficult to disentangle in their effects".

In 1948, the Commonwealth gave financial aid to the Tasmanian Government to back the scheme, but the B.M.A. objected that the Queensland rate which the Commonwealth nominated was lower than that desired by both the Federal and Branch B.M.A. Councils of £5.5.0 per three hours session.

When the Eagle Page scheme came in in 1952, the State Government said it could no longer afford it. The B.M.A. subsequently pressed for payment of doctors, and for intermediate and private beds as in other states - but made little headway until 1965 when the personal patient bed system was introduced for the first time - namely, to allow honoraries to charge fees to patients in public hospitals who also paid extra for their bed. They succeeded owing to the view of the Commonwealth Grants Commission that some attempt should be made to make the hospitals pay their way.

1934

Dr. Meyers proposition to the/Hobart Congress is worth recalling in this context:

> "What means should the B.M.A. take to enlighten our various Governments that it is economically unsound for such Governments to undertake the wholesale treatment of all and sundry whether they be rich or poor?"

The history of Tasmanian Branch, vis a vis Launceston and Hobart Hospitals, show them to be singularly unsuccessful in pressing this point of view on their own behalf; while many of the problems of the government arose from their attempt to do so.

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CHAPTER 8 NATIONAL MEDICAL SERVICE

Significant accession of power by Parliament in England sprang from ~~the demand of the people that their elected representatives should~~ its demand ~~have~~ no longer the power of the purse, ~~not the Crown~~. ~~This included the decision as to be~~ particularly the form and purpose of taxation; and the mode of expenditure of tax money when collected. At first, the demands of the individual citizen were modest - that some of the benefits of government money should accrue to them by way of law and order, or defence. During the nineteenth century, the demands widened to questions of convenience - water supply, good roads, postal service and added functions of local government.

In the process, the citizens began to broaden their access to Parliament, by making the roles both of electing and elected to the House more widely representative. An alternative route was also broadened: the role of the petitioner, which in the eighteenth century had still flourished in the form from which it originally derived - the petition of the individual to the crown. The role was now adopted by groups rather than individuals. These groups were of educated and informed citizens, who petitioned Parliament in various ways to express the needs of the community on questions which could not be resolved by individuals, or on which individuals might find it difficult either to approach their member or get a hearing. They were usually questions which could not effectively be resolved in areas of local government, but only on a nationwide basis.

A prime example of this was medical relief. The Crown's policy, as far back as 1601, required the local parish from poor rates 'to provide relief for those who were lame, impotent, old, blind and such among them being poor and not able to work'. The Crown did not provide for medical treatment. Parishes everywhere by custom offered treatment and medicine through a parish doctor. By the 1830's the accelerating industrial revolution created large crowded urban areas overnight; and a population movement that caused the old system of parish relief to be outgrown. At the same time, epidemics of all kinds ravaged people far more widely and rapidly than every before - promoted both by the difficulty of control in large groups of people, and lack of town planning or sanitation. Control on a national basis could ultimately be the only solution. Responsibility was not rapidly accepted by Parliament, neither for proper relief of the sick breadwinner before he became destitute, and incurably sick, with the consequence that both he and his family were a community burden; nor for the elementary control of sanitation and water supply to prevent the spread of diseases like typhoid, cholera or gastro-enteritis - with their even greater economic loss to the community.

The original shortlived B.M.A. and , what was to become its nominal successor, the Provincial Medical and Surgical Association (1832) occupied themselves with these issues, as did other medical groups - and, from the first, devised many petitions to Parliament. Their object was to prompt Parliament to act on a national scale for poor law reform and public health reform to reduce disease among the pauper class, and initiate for the first time a study of the economics of national health. Efforts were directed chiefly to attaching a public health service to local government bodies, and requiring that poor law medical men were properly qualified, for which the State was to keep a medical register so qualification could be determined. These measures, however, represented a very limited concept of preventive medicine that health was an individual not a national matter. The temper of the times was that a man was victim to the faults in his own character, rather than a helpless victim of society. Charity was for the destitute. If charity was readily available, people would be encouraged to abuse it- which led to the 'workhouse test' or'means test' to establish eligibility.[1]

> "It was the fond hope of some of the most ardent of the reformers of 1834 that the universal adoption of the 'workhouse test'would eventually lead to the complete disappearance of the pauper class".

Rather it created a notion of a pauper class.

The stamp of the 1830's remained on English national health policy over 80 years. England had no Ministry of Health until as late as 1919, despite a report of a Royal Commission in 1869 in favour of one to consolidate ' the present fragmentary and confused sanitary legislation' which in the interim was merely extended.[2] Despite another Royal Commission on the Poor Law in 1834, there remained in the poor law medical service a lack of rationalisation, and overlapping and duplication of authorities, The emphasis of its work was on institutional treatment in the hospital systems it created. It was a service for the poor and the hopeless, the destitute and incurably ill; who did not count as destitute until they were.

There was little or no coordination between the two mainstreams of development - the poor law medical service and public health medicine. The reform movement in preventive medicine began to take shape in the popular mind as 'tinkering with drains', losing some of the force of its visionary idea as promoted by early medical societies. They were not issues readily presented in electoral programs to buy votes and voters on the level of statistics of infant and maternal mortality, V. D. control , alcoholism, and a dozen other aspects debated by B.M.A. branches[4] everywhere over the years.

During the nineteenth century, both in England and Australia,

government took place by shifting coalitions. Changing allegiances were not uncommon. Electoral programs were not hard and fast - though the practice of offering them at election time began to be usual. The advent of the Labour Party in 1900 in Australia brought forward a party whose members did not change allegiance, and who offered their own members, and their voters, a pre-determined program of reform of a fairly simple type readily comprehensible to a fairly medically illiterate electorate. The rudimentary notions of planned economics in a planned society was the mental environment for projecting specific reforms. These included blueprint schemes for health, offering something tangible to voters in the realm of treating the sick, no longer as an individual but a national matter. Inevitably twentieth century policy came down on the side of extending medical relief outside the scope of the much-castigated poor law medical service. The Royal Commission on the Poor Law 1905 emphasised the inherent waste of public money of the latter.

Mr. Lloyd George, the then Prime Minister, in 1911, offered the British Parliament a national insurance scheme on the German model. Bismarck's Government had, in 1880, merely taken over the already existing private schemes that originated with the late mediaeval guilds. Lloyd George visited Germany to study their scheme, and decided on an amalgam of its principles and the majority report of the Royal Commission on the Poor Law. The new British scheme of national insurance was then prepared with the almost singlehanded advice of a Mr. Braithwaite seconded from the Board of Inland Revenue to the Treasury. A contemporary associate recorded:[2]

> "He had much of the same quality of reckless enthusiasm as Lloyd George, and more than a touch of genius. In a few months, Braithwaite had , with practically no help at all, made a hurried study of the German scheme, visited various parts of the globe and collected materials enabling Lloyd George to produce his tremendous scheme without a previous investigation by a Royal Commission."

The new scheme offered a centrally organised system of medical relief based on an extension of the pre-existing system of capitation service, and linked to a weekly payment of sickness benefit to help maintain a minimum income level during sickness. It was administered through pre-existing insurance groups and friendly societies and unions. It offered no service to unemployed, bad risks or chronically ill; and was for the wage-earner only.

The B.M.A. in 1911 protested that it had not been consulted, whereas intended approved societies had been. It was confronted with service under a scheme which represented to most of doctors a major revolution in the conditions of medical service. The B.M.A. reacted strongly - considering the legislation to be hasty

and ill-advised; and demanded some of the acceptable principles of contract practice the B.M.A. had defined in 1903, and which were now elaborated as the six cardinal points - of which Lloyd George was finally obliged to accept five. They were:[3]

"1. An incomelimit of £2 a week, nobody earning more should qualify for benefit.

2. Free choice of doctor by the patient, subject to the doctors consenting to act.

3. That medical and maternity benefits should be administered by Insurance Committees, not the Friendly Societies, and that all questions of medical discipline should be settled by local medical committees to be composed entirely of doctors.

4. That the exact method of payment adopted by each Insurance Committee should be decided by the preference of the majority of local doctors.

5. That payment should be adequate; this was later defined as 8.6d per head, excluding the cost of medicines and any other extras.

6. Adequate medical representation among the various administrative bodies working the Act, and statutory recognition of the local medical committee which the BM.A. proposed in point 3.

Chief in the demands of 1911 was that the B.M.A. should have as large a share as possible in the guidance, if not the control of the administration in any scheme affecting doctors' livelihood. The B.M.A. perceived that the State was, for the first time, offering social service not simply in money or cash benefit, but in kind. In such a treaty, limits had to be set to the bargain, to preserve the doctors from a grosslyone-sided contract with all the limitations set on the doctor - none on the patient nor the government administration. Concessions by Lloyd George saved an unseemly public wrangle degenerating into a complete refusal to serve under the scheme by a majority of British doctors.

The national insurance scheme remained in force in Great Britain with modifications until its replacement in 1948 by a comprehensive family service - offered free to every taxpayer from general revenue. It was simply a limited compulsory contributi scheme by employers and employees with the option to other breadwinne to join if they wished.

By the time it came into being, the state had accepted responsibility also for a healthy environment for its citizens both at home and through factory legislation; as a foundation to the superstructure of personal services which began to be laid through national insurance. The same process had gone on in the Australian colonies prior to 1900, due, as in Great Britain, to the efforts first of individual doctors and later medical societies.

Australian public health legislation, put on a more systematic basis from 1850 onwards, was at first modelled on English legislatio

Gradually a dissociation took place, as legislation became adapted to local conditions. But, for a long time, this was haphazard, by additions rather than omissions leaving many provisions inapplicable in theory. Dissociation was due to four major differences in the social development of the Australian states from Great Britain. First, the Australian states had no equivalent to the poor law medical service of Great Britain with its poor law hospitals based on local government areas. Second, in the absence of such a public medical service, the friendly society movement was more comprehensive offering medical service not only to the breadwinner, but to all his dependents. Thirdly, local government developed in the reverse manner to England, as offshoots to central colonial administration. Fourth, local government often tended to cover great areas of country with scattered population, meagre income, little administrative experience. These bodies had to begin building up the most rudimentary sanitation with water supply, roads, etc.

Epidemic continued to play a vital role in community demand for extension of public health service 1850-1900 - epidemics of typhoid, smallpox, cholera, gastro-enteritis among others. The plague outbreaks annually 1900-09 were a signal example in inducing reform in sanitation; while the smallpox epidemic of 1913, influenza in 1919, and plague in 1921, each played an important part in defining the relative functions of Commonwealth, states and municipalities and in developing and strengthening legislation and administration.[4] Further impetus to reform was given by the findings of various official enquiries such as the Causes of Invalidity and Death by the Commonwealth 1915-16, recruiting figures showing unfitness in World War 1, the Royal Commission on Pure Foods 1912, the Royal Commission on the Decline in the Birth Rate in N.S.W. 1903.

During this era 1900-21 in Australia, came the beginnings of personal service in public health - special services for maternal and infant welfare, T.B., V.D., industrial hygiene, inspection of school children, and uniformity in interstate pure food laws. In some of these, the Commonwealth began to play a role of offering technical advice and financial subsidy. On every issue that engaged the attention of Parliaments, the records disclose that the medical societies had something to say. B.M.A. branches were vociferous from the first by way of resolutions, meetings, deputations, lobbying with members on protection of public welfare. Leading members of the B.MA. were often members of bodies like the Central Board of Health in South Australia. Others often played a

part in founding public medical services, like Dr. R. Jull in W.A. Members of Parliament and local government Councillors were not always receptive to new public health measures, any more than they had been in England. When D.A. Campbell, for example, battled as Legislative Councillor in the S.A.Parliament in 1898 to establish modern public health laws on a basis suited to that state, he not only failed, but was opposed on the grounds that 'it would let loose a horde of bloodhounds who would have their noses in everyone's backyard'.

A report on public health services in the country in N.S.W. in 1926 emphasised this:[5]

> "The medical officer of health in country towns and rural areas is commonly a partime official. He is poorly paid for his services in this capacity. He is given no special facilities to aid him in this work. His daily round of work as a medical practitioner dominates his view and leaves him but limited time to devote to official duties.
> " The local board of health frequently is not fired with the spirit of progress. It has the primary responsibility, but in the complex problem of public health there are many phases in which the local board has had no training or experience, and if left to itself it has simply to muddle through.
> "In many places, there is no fulltime health inspector with proper qualifications. The Town Clerk in a small community is frequently designated as health inspector in addition to his other duties. .. although he may be a most excellent executive, he is not technically qualified to deal in a sound and logical manner with all the questions which arise in public health administration".

In brief, doctors had to serve as government public health officers because councils could not afford to pay anyone to carry out the duties; nor, if they could, was trained personnel available. This was emphasised to the Royal Commission on Health in 1926:[6]

> "Sydney and Melbourne are the only two municipalities which employ a whole time health officer. In all states except N.S.W. within municipalities and in country districts, a partime health officer is employed, who as a rule is also in general practice."

In Australia, as in England, B.M.A. Branches were early calling for health matters, that might be covered by various authorities, to be brought under the one control, preferably a separate Cabinet portfolio for health in all states. They did not want health relegated to a potpourri of administration covering a dozen matters under a lay departmental head, not a doctor. A layman usually knew little of health matters, and served under a lay Cabinet minister who often knew even less. Continuity has been sadly lacking at most times; and even when a Ministry of Health was set up, administrative reconstruction did not necessarily follow, for they could not readily cure the legislative disorganisation that preceded them.

A Commonwealth Health Ministry, when set up in 1921, could not readily impose a brand new health policy successfully on on the incoherent state medical services, public and private. The service, that existed, tended to stultify rather than expand endeavour for the benefit of the community, as emphasised by the Royal Commission on Public Health 1926:[7]

> "In all the states, the private practitioner notifies to local or central authorities cases of certain prescribed diseases, but beyond this his activities generally cease. This limitation of activities not only results in a lack of coordination between public health administrators and general practitioners, with a consequent atmosphere of distrust on both sides, but fails to utilise and develop the interest and activities of the bulk of medical practitioners in any public health scheme.
> "In order to avoid a clash with non-medical administrativ officers (e.g. sanitary inspectors and nursing inspectors the practitioner often feels compelled to maintain an attitude of passivity towards preventive measures and to limit his interest to curative methods. The medical administration consequently thinks he is uninterested".

These words were written by two leading B.M.A. members Dr.Hone and Dr. Newland, both practising doctors. The failures and faults of lack of health planning were deplorable and obvious to them. As they knew, health policies had merely been improvsied to meet crisis.

When coherent planning began, it occurred rather at Commonwealth level, after creation of the first federal government in 1900. At first the latter had no health policy other than quarantine until 1910. But the demand for more and better social services was of long standing, and could not long go unheeded - particularly with the ferment of reform in Great Britain suggesting similar courses of action in Australia. The Deakin Liberal Government consequently sent the Commonwealth Statistician G. Knibbs abroad to Europe to study schemes of social welfare in operation there. His report in 1910 was in the estimate of economist W. Ince:[8]

> "probably one of the best essays on social insurance that has been written. It contains a precise statement of fundamental principles, such as is not to be found in any other report yet published in Australia. His thesis appears to have been that it is the duty of Government to care for needy citizens, not only for humanitarian reasons, but also for reasons of state policy."

The principle of state responsibility had already been accepted during debates on old age and invalid pensions 1898-1908 both in States and in the Commonwealth.

G. Knibbs was exceedingly enthusiastic about the German scheme of compulsory contributions, and even to its presumed effect on the prosperity of Germany.[9] Australian Liberal and Labour Parties both favoured comprehensive social insurance of this type, although Labour was already becoming divided on the issue whether it should be contributory or not. G. Knibbs recommended following the German law, but said remarkably little about medical benefit

except that:[10]

> "the act should also prescribe the conditions under which medical and surgical attendance may be rendered, and should provide for the construction and equipment of sanatoria".

The Federal Committee of the B.M.A., formed in 1912, asked the Australian Government in a deputation to the Prime Minister, Sir Joseph Cook, July 19, 1913, that the Federal Committee be consulted before any legislation was introduced affecting the doctors ' relations with the public. Sir J. Cook agreed to do so.[11] G. Knibbs late 1913 sent a circular to the Committee asking them for their views. Their response was twofold: to prepare a statement of principles for a national health service, and to ask the N.S.W. Branch to commission three doctors currently in England to report on the working of the Act there. Asked by G. Knibbs to comment how the British scheme might be adapted to local conditions, the B.M.A. emphasised the essential differences between the two countries: ~~particularly, that dependents were included in~~ all medical benefits then conferred by friendly societies in Australia, compared to Great Britain where they were not. The report also stressed that in Great Britain, a large number of the very poor received medical benefits through poor law authorities, which did not exist in Australia, and such essential differences could add greatly to the difficulties of a new administration in Australia ~~found to be by no means small in Great Britain~~. The B.M.A. commented on its preference for an ideal scheme, paying by attendance.

The B.M.A. was not alone in its critical approach. The Prime Minister at Parramatta July 15, 1914, said he hoped for a system in cooperation with the B.M.A. and friendly societies. But the latter feared for the effect national insurance on the British model might have on their own role or funds, as for example:[12]

> "an entirely different act will be required to meet the needs of the Commonwealth, to that which is in force in Great Britain. We therefore suggest that a Royal Commission be appointed to inquire into the whole question before any legislation is introduced."

An equal desire for caution was apparent at the Australasian Medical Congress 1914, when Dr. J.A. MacDonald, Chairman of the Central Council of the B.M.A., spoke on the subject. He had been the presiding figure during negotiations between Lloyd George and the BM.A. He confirmed that the B.M.A. could get neither a copy of the Act, nor a definition of medical benefit, during drafting - other than, payment was for treatment by any medical man of average skill and ability.[13]

> "The Bill was introduced in a way which we considered scandalous, After two years' discussion with the friendly societies. Originally it was drafted on friendly society lines, and that was what we, as medical men, considered was the fundamental error.
> "We were an untried body and had never entered into a contract of the kind before. We did not know how

> "far we could trust each other. We were up against the most powerful body in the world, the British Govern-ment."

His advice to the B.M.A. in Australia was to formulate policy early and to organise thoroughly. He warned that conditions were quite different in Australia.

At this time, Commonwealth health came under the Department of Trade and Customs, administered by a Director of Quarantine. The authority of the post was difficult to exercise as the Commonwealth had responsibility, but no executive machinery. The states had executive machinery, but no responsibility. The Director of Quarantine, appointed in 1911, was Dr. Cumpston who had joined the B.M.A. in W.A. and remained a member of the Victorian Branch Council for some years. He was already familiar with problems of state administration and now found a jealous defence of 'state rights' as well as a dual authority and lack of assured legal basis for Commonwealth action - at a time when Australia during the first world war had for the first time to see itself as a national entity. The Commonwealth had the responsibility for troops, international traffic, protection from infectious disease and many other matters. A Victorian Royal Commission had already emphasised the excessive prevalence of V.D.; and Professor Allen at the 1914 Australasian Medical Congress called for legislation in other states, based on the W.A. model. The Commonwealth offered a 50% subsidy for expenses by states taking part.

The Committee on the Causes of Death and Invalidity 1916 reported in favour of an ideal scheme for a state public health service, regionally organised with whole time medical officers of health. In 1918, the N.S.W. Branch endorsed this wholeheartedly, as one they had already seen allowed for, in theoretical terms, in the N.S.W. Public Health Act of 1902. The Federal B.M.A. Committee in 1918 asked the Branches to draw up schemes of national medical service in view of its belief that some scheme 'involving nationalisation of the medical profession... to some extent' could be expected at no distant date. It urged Branches to examine the B.M.A.'s proposals in Great Britain for a Ministry of Health as 'most appropriate in the public interest'.[14] A collation of replies from the Branches was reported by the Committee back to the Branches in these terms:[15]

> "In favour of closer cooperation between the Commonwealth and the States in public health matters, and unanimous in recommending an immediate extension of local activities in various states. It is considered by all that an extension in different directions of Commonwealth assistance to the states is desirable.

> "Victoria recommends a standardising of methods and reports, and N.S.W. considers that attempts should be made by the Commonwealth Government to standardise, as far as practicable, public health legislation in all the states".
>
> "All Branches are in favour of education of the public to a higher conception of the importance of preventive medicine, and Victoria has gone into details as to how this should be secured. It would appear that the local government system is the best instrument to secure this object. Better health administration in cities and outlying districts; more competent and better paid personnel; the appointment of a district medical officer and of a large number of whole time and parttime medical officers, and the provision of better trained sanitary experts than we have at present are eminently desirable.
>
> "Cooperation of health societies, the formation of various clinics in different districts, and the utilisation of the practitioner to a greater extent in preventive work are also advocated..
>
> "The establishment of institutes for medical research is eminently desired by all the branches. These might be endowed by the Federal Government alone, or acting with the state governments. It should be considered whether or not it is advisable to keep separate these institutes from the public health laboratories, where much routine work is necessarily done to the detriment of more valuable work.
>
> "In any case, existing public health laboratories will need to be extended, and more officers employed. In districts outside the cities, other subsidiary laboratories should be established at certain hospitals to meet local requirements."

The Victorian Branch issued a warning that was seldom to be heeded in future national policy planning.

> "Disappointments and disillusion are frequent. The histories of infectious disease hospitals, of sanitoria, of anti-venereal campaigns, of liquor prohibitions, are full of warnings against excessive trust in machinery. Enduring progress is usually gradual, and at its root has education rather than compulsion".

It was also prophetic in its approval of Dr. J. Newman Morris' plan for district diagnostic clinics, enlisting doctors in the teamwork of a form of medical cooperative, on the grounds that curative medicine had in certain respects outgrown the old detached activities of individual practitioners, and this even in 1918. The B.M.A. in the process had fulfilled its desire that the Association should be prepared with a constructive policy, and not be content merely to offer destructive criticism of schemes not in accord with its view.

At this stage, the Prime Minister at the Premiers' Conference January, 1918, offered to back common schemes with the states by Commonwealth subsidy. He expressed the view that the Commonwealth should concern itself with investigation into causes of disease and death, prophylactic measures, collection of sanitary details, and institution of campaigns having the object of public education. An urgent crisis, provoking Commonwealth-State collaboration, loomed with Spanish flu from Europe. While the B.M.A. was approached

by all governments to enlist their cooperation in preventing its spread, April 1919, the acting Prime Minister was chiding the governments of four states for the failure to state their attitude on the more abstract question of disease prevention.

July 31, 1919, the B.M.A. waited on the Acting Prime Minister the Hon E.D. Millen with BM.A. proposals for urgent extension of the public health service on a Commonwealth-state co-operative basis with uniformity of legislation throughout the Commonwealth; facilities for scientific research; district organisation of state health services on a local government basis with fulltime medical officers; a 'sanitary' unit; extension of medical inspection of schoolchildren. The Prime Minister, the Hon W.M. Hughes, in his policy speech October 30, 1919, promised to carry them out. The B.M.A., encouraged, asked for a Commonwealth Dept of Public Health with its own permanent head and minister. It was also concerned at this time that 'nationalisation' was a platform of both political parties. The Victorian Branch had waxed on the subject:[17]

> "Nationalisation would involve the concentration of enormous power in the hands of a few, possibly in the hands of one supreme administrative head, and the few or the one would not be chosen by the profession, but by the politicians. The grave dangers that would ensue leap to the mind and need no further exposition. Consultants, and sanitary chiefs, members of the practising profession, and health officers, would all be more or less in bondage. Let all concerned consider their present lot, and note the security that the independence of the profession gives. But the whole profession should remember that its independence and all its privileges are conditioned by efficient, progressive general discharge of duty. A policy of laisser faire will not suffice"

Dr. Cumpston, speaking at the Public Questions Society, Melbourne University, referred to the four leading theoretical advocates of nationalisation of health of the day, whose ideas on health were currency among the progressives in medical organisation reform, namely B. Moore, Havelock Ellis, B. Shaw and B. and S. Webb.[18]

> "Certain sections of the daily press in Australia , most notably the 'Age', have taken up the idea very warmly. The term, now under discussion, the 'nationalisation of medicine', is not used by any of the above writers, and, though extensively used in the Australian daily press, is not, so far as I know, used elsewhere. Some appreciation of the motives underlying the demand for nationalisation will assist materially to a comprehens of the exact nature of the demand. The motives are mainly twofold; firstly, dissatisfaction with certain phases of individual medical treatment, and, secondly, the conviction that much more might be done in the preventio of disease.
> "The defects of medical practice, as it is today, are stated to be firstly that considerations of financial interest must intrude forcibly into all relationships between the doctor and his patient.. secondly, that no medical man can have even a working knowledge of all branches of medicine.
> thirdly, the anomalous position of public hospitals..the advocates visualise a stage of development at which all

> public hospitals will be entirely state controlled and the hospital will gradually evolve into something in the nature of a health institute".

The remedy suggested by all four writers was to do away with the defects of private practice by making medical men paid servants of the state:

> "It is significant that none of the authors makes any attempt to discuss in a practical way the actual accomplishment of the proposal to make the treatment of all patients a state controlled department administered by a large body of medical public servants".

The conclusion of the speaker was that the proposal to nationalise was an impracticable and doubtfully advantageous suggestion; and, although it would mean shorter hours of work and a longer expectation of life for the profession, no striking advantage to the community suggested itself. The prevention of disease was the only idea receiving universal support, and the only practicable working suggestion in the final analysis put forward.

After the Prime Minister announced his intention to effect the B.M.A. Federal Committee 1919 recommendations, the latter submitted additional resolutions originating from the Victorian Branch for a full Commonwealth Health Department with a permanent head and an exclusive Minister. Further there should be an advisory council of members of the profession outside the public service, a central establishment to investigate preventible diseases working with existing institutions in each state, diagnostic laboratories in selected centres, and field and laboratory research staffs in public health departments. It was emphasised that this policy was identical with that followed successfully in the United States for a federal health department working in conjunction with the states.

Mr. Hughes was true to his promise. A Federal Department of Health was created March 7, 1921 - though for some years the Ministry of Health remained a combined portfolio, sometimes with Defence and sometimes with Repatriation. The Federal B.M.A. Chairman Dr. Hayward, called the new department 'an epoch-making event' and the Federal Committee expressed its 'gratification at the course events have taken'.[19] The new Director-General of Health, Dr. Cumpston, wrote to the B.M.A. proposing informal meetings linked to the biennial meetings of the Federal Committee, emphasising that the policy of the department would be as recommended by the B.M.A., and that its work could not be accomplished without the active cooperation of the profession since the work would emphasise preventive medicine.[20] The B.M.A. replied, saying:[21]

> "It is a step of great significance that the chief permanent official of the department should seek the collaboration of the medical profession through the agency of the federal committee. Hitherto the Federal Committee has been compelled to approach the Government departments with requests or demands. Often the Minister

> "being influenced by political considerations, have not understood the professional aspect of the problems under discussion and the committee has pleaded in vain for departmental action".

The Prime Minister in his policy speech of 1922 promised a Royal Commission 'to consider and report upon the best means to coordinate the various activities and improve the nation's health' in cooperation with the states, saying:[22]

> "Great progress has already been made in the investigatic of diseases which directly or indirectly affect the efficiency of the nation, and are responsible annually for an appalling loss of life and wealth. The Government feels that no question is more important and has determined to extend its efforts to a much wider field".

Five years of Bruce-Page administration followed. Dr. Earle Page was leader of the infant Country Party. He had begun in general practice in the country as had a colleague , Sir Neville Howse in Orange, he inGrafton. Dr.Earle Page was Commonwealth Treasurer, and at times Acting Prime Minister. Sir Neville Howse served as Minister for Health in 1925-6 and 1923, and had formerly been Director of Medical Service in World War 1. During their terms of office, their comprehension of medical matters at grass roots level bore fruit in at least two Royal Commissions of value in assessing the future course of national medical service in Australia. Of the period of Government, Sir Earle Page, as he became, was to recall in his book 'Truant Surgeon',[23]

> "The basic problem inhibiting all effective Federal Government, the unsatisfactory relationship between the Commonwealth and the States, demanded our first attention. The Governor-General's speech had indicated that his Ministers had under consideration 'subjects of a national character' in which the Commonwealth and States are jointly concerned'.

Coordination in health matters was set in a general context of improved coordination, and Dr. Page claimed that their administratior showed that even the most intricate problems could be solved with mutual satisfaction , given cordial cooperation between the Commonwealth and States, including national health. At the Premiers' Conference June 9, 1923, at which much agreement was accomplished, the Premiers would not however agree that a Royal Commission on Public Health was necessary. They agreed instead on interstate conference between representatives of Commonwealth and State Health Departments July 23, 1923 (to revise the whole health policy of Australia) and the B.M.A. was asked to submit subjects. The B.M.A. Federal Committee appointed Dr.F.S. Hone and Dr.S.H. Newland as a subcommittee to propose how the professionand administration could cooperate. They were both longstanding members of B.M.A. Councils in South Australia; Dr. Hone an outstanding exponent of preventive medicine; and Dr. Newland as a plastic surgeon in Great Britain and FLanders in World War 1.

Their report went forward with Branch approval. The Victorian Minister for Health, Dr. Stanley Argyle, (himself a B.M.A. Councillor) said it did not differ fundamentally from the administrative methods advocated by a Victorian Royal Commission in 1919, which proposed reorganisation of health administration with district medical officers instead of parttime medical officers with only partial control of health. Based on this, the Federal Committee again approached the Prime Minister, the Hon S.M. Bruce, seeking the promised Royal Commission, which was announced shortly after 'to consist entirely of experts'.[24] The Chairman was Chairman of the B.M.A. Federal Committee, Melbourne surgeon Sir George Syme, and its members included Dr. F.S. Hone, and Dr. R.H. Todd, Federal Committee Secretary. Dr. Jane Greig was a doctor 'well known as a frank critic of existing departmental methods'.[25] Mr. Innis Noad was a member of the Legislative Council of N.S.W. The M.J.A. editor said:[26]

> "It is significant that three of the Commissioners have taken part in the formulation and adoption of the policy of the Association in this particular connection".

Dr. Page stated the purpose of the Royal Commission to be:[27]

> "to provide for greater uniformity and coordination of the services of the Commonwealth and the States in the administration of the laws relating to health".

The report was submitted November 30, 1925. Many of its recommendations sought to overcome the leading problems admitted by all - of apathy and lack of progress. Probably its most important recommendation was the principle of health administration to be followed. The unit of administration was to be the local authority in a state wide organisation of health districts, officered by properly trained men with adequate staff to control all government services and voluntary organisations connected with health. The duty of such officers would include possibly other Commonwealth functions (examinations for public service etc). The permanent head of the department, Commonwealth or State, was to be a doctor 'highly trained in preventive medicine'. No lay official should be interposed between him and the Minister. State Health Councils were to act in an advisory capacity.

The intention was to overcome a state of affairs created by the original emphasis of health departments on control of the environment rather than prevention of disease; so their activities were mainly directed to sanitation of premises and food. Supervision of the individual life was held to be a proper function of health departments, which had been assumed by voluntary bodies free from any supervision, and controlled by laymen without medical training, so that health administration had often been made subservient to political, municipal and vested interests.[27a]

The aim of the policy was not only efficiency of administration, but research and education to raise standards of public health practice. It was also economic efficiency - to cut down on the cost of invalid pensions by avoiding people becoming invalid pensioners; to cut down on the numbers in hospital by cutting down epidemic diseases like dysentery that put them there; to use the investment in maternity allowance money better to lower the mother and child death rate. Dominating the report was the pervasive suggestion that the Commonwealth might use its financial power as a force for the good, as had occurred with campaigns in V.D., pure foods, T.B. and hookworm control.

The final note struck by the Royal Commission was that any resolution must be on a basis of voluntary cooperation. A permanent Federal Health Council was proposed (as by the B.M.A. in 1919) to include two B.M.A. representatives and a permanent Health Research Council: both to coordinate Commonwealth and state endeavours. Complaints had been made in evidence before it by departmental heads from ~~N.S.W., Dr. Atkinson, and N.S.W., Dr. Norris~~ Dr Dick NSW and Dr Ibry SA, respectively, as to 'overlordship' by the Commonwealth, and 'the old state feeling';[28] while emphasising that money was hard to secure and insufficient to run decent state health services.

Little flowed from the report to cure the defects in health administration exposed during its preceding enquiries. Its gains remained piecemeal. Dr. Cumpston, then Director General of Health, however, wrote after retirement in 1945 that:[29]

> "Royal Commissions are frequently criticised on grounds that they produce no result. This Commission did produce results. There were positive results, and the policy which had been followed by the Commonwealth Department of Health was confirmed. But the greatest result was indirect, the full discussion and questioning analysis had clarified the issues, and removed much confusion of thought which had arisen during the sixteen years since the quarantine act came into force. It was a notable stage in the progress of social evolution".

As early as 1920, the B.M.A. had also seen the necessity for equivalent enquiry in depth on national insurance, and had asked for a Royal Commission on the issue of 'necessity'. Begun earlier than the Royal Commission on Health, it lasted longer, producing four reports 1923-7. It comprised six Parliamentarians, three senate, three Assembly but no doctors. As the Commonwealth had power to legislate in the field of insurance, its findings were not constrained by limitations in Commonwealth power as was the other Commission's. Its Chairman, Senator J.D. Millen, admitted 'the inquiry is most staggering in the magnitude of its ramifications'.[30] It covered the whole field of 'social insurance' including unemployment, old age, invalidity, casual sickness, accidents and maternity, and proposed to hear witnesses including friendly societies, trade unions, medical and

pharmaceutical societies. The Commission raised two vital issues for the B.M.A. - the major one whether a national insurance scheme would offer medical treatment as did the German one, and the English which initated it: the minor one, medical certification for sickness benefit. On the major issue, evidence was taken in the opening hearings of the Commission 1923-4 in every state from B.M.A. members. The process of collecting the official views of B.M.A. branches was more tardy. This was partly due to the desire of the Federal Committee to 'prepare the brief' properly for the branches'with an authoritative report on the working of the scheme in England and its effect on the medical profession';[31] partly, the desire to carry out a referendum of members as to their response to the principle of national insurance in general, adaptation of the British scheme to Australia in particular, and the conditions under which Australian doctors would serve if faced with such a scheme. The B.M.A. had for reference the supplement to the British Medical Journal Jan. 5, 1924, reporting on the subject; and articles by Dr. Cox, London secretary of the B.M.A. and Dr. Newman Morris of Melbourne - the latter highly praised by Dr. Cox. Dr. Morris' article made it clear there was currently a crisis over national insurance in Great Britain:[32]

> "With regard to the administration of medical benefits, the bill as originally introduced, provided for the administration of approved societies, but this was not agreed to by Parliament. Only 15 voted for it. According to Carr, Garnet and Taylor, arguments carrying the greatest weight were the insistent demand of the medical profession, the urgent public need for uniformity in the medical service which could not have been obtained if each approved society had adopted its own methods, and the obvious fact that the withdrawal of the administration from the societies could not possibly harm them, but would be advantageous as the insurance committees, if funds were insufficient, could have recourse to the Treasury.
>
> ""The medical profession' says Cox (B.M.A. secretary) 'were determined after its experience of club practice that it would not put itself under the control of the approved societies or similar bodies, though it had no objection to the control of a public body on which the profession, as well as the approved societies was represented.
>
> "The revision by the Minister of Health of the amount of remuneration for 1924 has been taken advantage of by the representatives of the approved societies to attempt to gain control of medical benefits. So united was the opposition of the 13,000 panel doctors that over 94% of them placed their resignations in the hands of the Insurance Acts Committee of the B.M.A. rather than submit to this control".

The B.M.A. was faced with the likelihood that the Royal Commission would recommend medical benefits on a compulsory basis on the English model based on approved societies. The question raised in all states was whether national insurance on the British model was necessary, or whether the English scheme was the best one to follow.

Early 1924, the B.M.A. became alarmed that the Royal Commission might report in favour of medical benefits. Their reactions were official and unofficial. On the official level the B.M.A. wrote to the Prime Minister, the Hon. S.M. Bruce:[33]

> "It is understood that legislation is contemplated establishing new relations between the medical profession and the public. In this connection, the committee request that I inform you of a promise made by the Hon Sir J. Cook on July 18, 1913, when he was Prime Minister of the Commonwealth, that the Government would consult the medical profession in regard to any proposals for legislation on national insurance."

On the unofficial level, Sir G. Syme approached the Minister, Sir N. Howse, who promised to write to the Chairman to ask him to defer his report to allow the B.M.A. to formulate its views.[34] Sir G. Syme recorded that Howse was not really in favour of national insurance with medical benefits for wage earners on the British model himself. Dr. Todd also reported that Sir. N. Howse would prefer to abolish all charitable and benevolent institutions and substitute payment for all services by the Government, where it could not be given by the individual - for, in his experience, he had found that the number of people who could not pay exceeded those who could, through friendly societies, in twenty years practice in Orange.

A B.M.A. survey of branches in 1924 caused the Federal Secretary, Dr. Todd, to report to H.C Green, Royal Commission Secretary, that the profession generally was opposed to medical benfit in the form of domiciliary medical atendance, as at present provided under the English or any other known scheme, being included as part of any compulsory individual insurance.[35] The B.M.A. was asked to offer an alternative scheme. It proposed a completely new system without contract practice, aiming at uniformity of medical service moving away from the role of the doctor as a glorified ambulance man. The basis of opposition was best expressed in a submission from the Queensland Branch:[36]

> "Contract practice evidently predicates the idea of medical treatment as a commodity which it is not, any more than it is even a series of experiments on a dead level of pure science. Contract must therefore inevitably lead to deterioration of service, and, that this is so, is universally admitted.
> "The idea of introducing that form of insurance into Australia is indeed founded on various fallacies, the chief being the assumed existence of an analogy between English and Australian conditions".

The Victorian Branch took the view that ordinary medical treatment was available throughout the community except in scattered rural districts, where no scheme of insurance could solve their special problems. Contract practice, or national insurance was thought to be based on an entire misconception of what contract practice should be,

or was. It only provided for elementary medical treatment and could not be expanded to provide the desideratum of proper investigation of complaints.

The B.M.A. scheme proposed a Commonwealth Health Insurance Department under the Minister for Health, which would offer insurance against sickness and accident, similar to that offered by insurance companies. It would offer the type of treatment excluded by friendly and other societies to people such as the unemployed ~~and unemployed~~, those with T.B. , V.D., acloholism and malignant diseases. It would also cover employees whose incomes were not below a certain amount; and for all methods of diagnosis and treatment; and provide choice of doctor and payment to the doctor be fee recoverable from the department on a scale of fees agreed upon. Extension of the service to institutional and specialised treatment was envisaged, even maternity and dentistry benefit.

The Royal Commission abandoned the recommendation of medical benefit, and , in its Fourth Report March 11, 1927, came out strongly in favour of detaching medical from sickness benefit, and coordination of the former in a national health scheme. For the latter, it favoured a National Insurance Fund, reporting that experience had proved that national schemes which provided for administration through approved organisations were cumbercome, complex, and led to unnecessary competition, overlapping, and high administrative expenditure. George Knibbs had already said in 1910 that 'as a system they constitute by themselves a crude, inadequate, and wasteful method of supplying a great social need'.[37] The B.M.A. had already been assured of the omission of medical benefit, as reported by Dr. Todd of a conversation with the Royal Commission secretary, Mr. Green:[38]

> ""There was no intention to import into Australia the troubles which had arisen in England in connection with this benefit, and the medical profession. He told me for my own information that the suggestion was to adopt the Repatriation Commission method of arranging in every locality medical men to attend beneficiaries and to pay them fees for their service, but he thought the scale would not be so high as the Repatriation Scale which was arranged with the Federal Committee viz 10/- for the first visit etc."

The Federal Government pledged itself to introduce national insurance if returned in the 1925 election, and did so when re-electe with a National Insurance Bill Sep 14, 1928. It involved the medical profession, in that it required certification for sickness benefit. The Treasurer, Dr. Page, justified the final choice of the English model when he presented the Bill, saying that he had been guided by a Royal Commission on Health Insurance in Great Britain in 1926, and that institutions which, in the past, had done valuable work should

be conserved. This concession to the friendly society movement did not save the Bruce-Page Government from attack by the friendly societies, who wanted to be sole approved societies, a state of affairs greatly disapproved of by the B.M.A. In their opposition, the societies were abetted by worker and general electorate apathy. Dr Page expatiated on the reasoning behind the decision in his second reading speech launching the Bill in 1928; in that he believed that insurance against sickness,and prevention from sickness, were two different concepts, often confused in the public mind. The first only began to operate when the second had failed. The object of the bill was merely to furnish relief in case of sickness when it had occurred. The B.M.A.'s objection was that the societies insisted upon seven forms of certificates, intended to safeguard funds against abuse; but so elaborate that they were oppressive to the medical profession without ensuring any better treatment to the sick.

In any event, the Bill was allowed to lapse by the Labour Government which replaced the Bruce-Page Government in November 1928 elections, in the crisis of the depression. A point of interest, when plans for similar legislation were to be revived 1937-8, was the assumption made,during negotiations between the B.M.A. and the Government over sickness certification, that the Federal Committee of the B.M.A. could speak for the profession in general. Sir George Syme, then President, was careful to explain:[39]

> "We are not an executive body. The branches consider matters which are brought before them, and then they send on their resolutions to this Committee. This committee,.. then arrives at certain resolutions, but it has no power to carry them out".

A marked feature of all negotiations was the cordiality and respect for the need for continual collaboration - that was to be in some contrast to 1937-8 when Dr. Page was no longer Treasurer, although still leader of the Country Party. None of the experience he had acquired 1925-8 was adequately called on by his successors at the Treasury. Nor did any of the lessons learned at that time by anyone appear to have been remembered by others than the leaders of the B.M.A., or even by all of these. Perhaps the most apt epitaph for the National Insurance Bill of 1928 was that of Dr. Todd: 'It all suggests the fable of the mountain that brought forth the mouse'[40] 1938 by contrast was to become more of a runaway leviathan.

The major outcome of this era was the Health Council to coordinate state activities in health, and to bring about uniformity in legislation and administration. Its first meeting was in January 1927. But a deviation between the two realms of Commonwealth endeavour - insurance and public health - was already setting in.

The onset of the world-wide economic depression , 1929, left the Commonwalth with such an impoverished economy, that national insurance was a dead issue for seven years until 1935. Despite the depression, however, a civil service recession, and consequent curtailment both of the budget and staff of the Commonwealth Health Department,work in public health went on, including the Federal Health Council meetings. Dr. Page in 1928 had said:[41] 'Some approach to a coherent national policy has been made possible by the creation of a National Health Council'. But its scope was more limited than proposed by the Royal Commission on Public Health that suggested it. It was merely a regular association of Federal and State departmental heads, and did not extend to creation of a Medical Research Council. Research was financed by the Government on an ad hoc basis - for hydatids, snake venoms, polio and cancer. The Government also established an annual cancer conference, purchased radium for all states, founded a school of tropic medicine and public health at Sydney University (not without opposition from Queensland), and a national museum of national zoology at Canberra (The Institute of Anatomy).

None the less, the record of the Federal Health Council's work was surprisingly wide during its ten years of life 1927-37. It enlisted doctors from other areas of public health (education medical officers) and laymen (statisticians). It dealt with matters on which B.M.A. branches had always had active policies, such as V.D., leprosy, poisons and drugs, maternal mortality, school medical service, purity of milk supply, medical control of migration, T.B., cancer, uniform medical registration, classification of statistics, child health, industrial accidents, endemic typhus, control of broadcasting, diabetes, food inspection, and, in 1933, systematic diptheria immunisation. The latter for example was an Australia wide campaign conducted jointly with the B.M.A.

Direct B.M.A. association with the Federal Health Council had been recommended in 1925; and the demand was renewed by the Queensland Branch in 1933. The new Federal B.M.A. Council approached the Minister for Health to ask that it be reconstituted to promote the closer association between the Government and B.M.A. desired. He replied that the state Governments would have to be consulted first. In 1936, the B.M.A. was still petitioning for such a change - to include an annual subsidy for research. The new Minister for Health, the Hon W.M. Hughes, was receptive to the idea - having created the highly successful C.S.I.R.O. (Commonwealth Scientific & Industrial Research Organisation) for scientific research a decade before. The form now proposed was a combination of the ideas of the Royal Commission 1926 for a Federal Health Council and a Research Council. The existing Federal Health Council was expanded - representatives from the College of Surgeons, the College of Physicians, the BM.A. and the medical schools of the Universities

being added. Thus it brought the B.M.A. for the first time into an official relationship with the Commonwealth Government.[42] Although the B.M.A. was consulted in its creation, the final form was not as desired by the B.M.A. The B.M.A. preference was for an independent medical research council on specified terms:[43]

> "The medical research Council must, in no sense, be regarded as a departmental committee of the Ministry of Health. It should be entirely divorced from departmental control and exercise an independence of a judicial character."

This view had been put to the acting Prime Minister Dr. Page, as early as 1935; and he had announced at the inaugural dinner of the first world B.M.A. conference in that year that he intended a federal medical research endowment fund as a permanent memorial of the event. The composite council that emerged in 1937 was designed to overcome the political objection that an independent research council would consist of people who would possibly be the chief beneficiaries of the endowment. An annual fund of £30,000 was authorised by Parliament in the same year.

The new Council was called the National Health and Medical Research Council. Its Chairman was the Director General of Health, Dr. J. Cumpston, who testified to the value of the Federal Health Council which preceded it, 1927-37.[44]

> "The condition of suspicion, distrust, conflict and friction disappeared. To some extent, this was due to the passing from the stage of the older pre-federal residuals among the higher executives in the state public services - to some extent it was part of a general smoothing of political relationships; but, above all, it was the result of open discussion; of the realisation of the ideals and of the difficulties of other members; each learned something from the others but, above all, came the general realisation that each state was no longer a separate unit, but a partner with a national as well as a local responsibility".

The Commonwealth once more took up its national responsibility for health in the form of insurance. The alarm of the B.M.A., as to the form the scheme might take, had never been quite dormant. An incident concerned with Canberra in 1931 even had a touch of absurdity. The Federal Honorary Secretary, Dr. W.B. Wade wrote to Dr. Cumpston saying that several Branches had heard the Commonwealth intended to 'nationalise' the profession in the A.C.T. and sought to be consulted. The latter assured him that all he had done was to call a meeting of Canberra associations to devise some plan to overcome the gross deficit.[45] The plan was for some contributory scheme decided on by the community, without change to the open policy of allowing doctors to charge fees in all wards if the patient could pay.

In anticipation of Commonwealth action, the Victorian Branch

Council as early as 1929 had begun systematic study of national medical service, which emphasised that the leading theoretical problem in national medical service was whether the principle should be one of voluntary or compulsory insurance. Voluntary insurance was the 'Provident Principle' beloved of the nineteenth century theorists, who thought to encourage those principles of thrift and prudence that had produced the friendly societies, and hospital contribution insurance. Compulsory insurance was the principle of national insurance schemes - action by a 'benevolent' state to offer security to its citizens. The Victorian scheme of voluntary insurance to cover every phase of medical service for the first time formalised a concept, which was finally to predominate in B.M.A. policy post World War 2; and to extinguish B.M.A. policies for compulsory insurance through a National Insurance Commission still receiving support till the end of that war. The Victorian B.M.A. had not ignored the study of compulsory insurance, and indeed said they preferred such a scheme. However they considered the economic condition of the Commonwealth rendered legislation for such a scheme impracticable. Voluntary insurance had the merit that it would ensure the enrolment of a higher percentage of choice risks, a lower incidence of poor risks, a continuity of subscriptions, and therefore a lower subscription rate. Plan 1 of the scheme was the basis of the Hospitals Benefits Fund in Victoria in a limited form - for an enlistment of all bodies engaged in hospitals for a weekly subscription scheme to cover the cost of subscribers so they could support themselves without anxiety in time of serious sickness. Plan 2 of the scheme was for cover for domiciliary, pharmaceutical and investigation service on a mixed capitation and visitation fee basis. In a limited form, and without the income limit, it became the basis of the Medical Benefits Fund of Australia, a B.M.A. sponsored group founded in NS.W. 1945. The Victorian B.M.A. was explicit that their motivation was self-protection; that the profession must promote some policy attractive to the public or public opinion would force others to take action possibly undesirable to the profession - such as expansion of free service by honorary staffs in all departments.

The 'Proposals for a General Medical Service to the Nation', published by the B.M.A. Great Britain in 1930, showed a general concordance of principle with the Victorian approach. But voluntary insurance already appeared to be a local variation.[46] Indeed, such a scheme was initiated by the Colonial Mutual Life Assurance Society Limited throughout Australia in 1933, prompted by Victoria, but proved a failure.

As early as 1932, the Commonwealth Government revived its interest in social service schemes. Economist, Mr. Kewley records that :[47]

> "During 1934, his government instituted enquiries into the possibility of reviving the national insurance scheme proposed by the Bruce-Page Government in 1928. However, it reached the view that action to this end should be delayed until the economy was in a more prosperous condition, when opposition to compulsory contributions on the part of both employees and employers was likely to be less strong".

In 1935, a committee of actuarial experts reported to Federal Cabinet on the probable cost of adopting various kinds of insurance.[48] The U.A.P. had promised some scheme in the elections of 1931 and 1934, as had the Labour Party. May, 1936, the Australian Government requested the British Government to provide an expert to guide them,[49] on the advice of Sir Frederick Stewart who had just returned from a private investigation abroad on social insurance, and was publicly advocating the British system. He said to the Press at the time of the U.A. P. convention a month before:[50]

> "in Britain the worker paid 1/8 a week for health pensions and unemploment insurance' whereas ' men in N.S.W. had to prove they had dissipated all their earnings and then perhaps they might receive some cold charity'.

He hoped "to see the Australian system of social insurance with its stigma of public charity totally disappear in favour of a just scheme, under which the workers would receive their benefits as of right".

Sir Frederick Stewart was at the time Under Secretary for Employment, a humanitarian with friends among leaders of the friendly society movement. He, like other ministers in that Cabinet, such as J. Lyons and R.G. Casey, had not been in Federal politics in 1928 with experience of the arguments for dissociating medical benefit from cash benefits and pensions. Dr. Page, who had, in his policy speech at the 1935 election, ~~had~~ advocated revival of the 1928 legislation, excluding medical benefit.[51]

The B.M..A Federal Council had already appointed a subcommittee to draft a complete scheme of health insurance applicable to Australian conditions, adopted Sep. 7, 1935,[52] and calling for a Commonwealth Health Insurance Department as in 1926:[53]

> "The purpose of the proposal was to ensure freedom of medical benefit from friendly society control in any shape or form. This of course does not apply to sickness benefits. Your Committee is satisfied this principle is the same now as ten years ago.. it is now generally accepted that the voluntary system of health insurance is impotent to achieve the desired results. We are in agreement with this attitude".

They said it should include treatment for families and hospital benefits. They were adamant for the need to coordinate health insurance with public health services; continuing public and post graduate education

on preventive medicine, and a national research council.

The Committee showed a far more unqualified acceptance of national insurance than in 1924 - based partly on a report by a Dr. Kaye Le Fleming, Councillor of the B.M.A. in Great Britain. His opinion was it had not only improved national health all round, and applied preventive medicine to general practice, but that, in the opinion of most competent judges, its result had exceeded the most optimistic hopes of those who helped to place it on the Statute Book. The fear of the profession, who had at first opposed it, had been falsified.[53]

The Australian B.M.A. report came down on the side of an equitable flat rate method of payment if the British model were followed. In 1936, the Federal Council wrote to the Premiers of every state, and the Prime Minister, saying that after very careful consideration by Branch Councils during the past few years in consultation with the Parent Council in Great Britain, they would offer wholehearted cooperation in bringing in such a scheme.[54] But they now asked for one major difference in principle to the concept of 1924. Instead of all doctors being paid by fee, recoverable from the Department in accordance with an agreed scale, they recommended payment by capitation fee to general practitioners. Payment for special services should be by partial or full payment for each service rendered, with the patient possibly paying part of the cost of the special service. Thus a discrimination was made in procedure for the general practitioner and the specialist, and in the nautre of their mode of practice, which had been avoided both in the reports of 1924 and 1931. The Federal Secretary, Dr. Hunter asserted in a letter to Dr. Morris that:[55]

> "many of the medical practitioners during the last few years have changed their views regarding national insurance, and would welcome any scheme that would lessen the amount of gratuitous work that they at present have to do".

Queensland, however, dissociated itself from the report on the comment as to the desire of the B.M.A. to be free from 'friendly society control in any shape or form'. This Branch had adopted a policy for general medical service based on an expansion of the friendly society movement and subsidised by the Government.

In 1936, the British Government loaned the services of Sir Walter Kinnear, Controller of the Insurance Dept, Ministry of Health, to advise the Australian Government. He, together with G. H. Innes, reported in June 1937, after a bare three months in Australia late 1936, and consulting only with the Treasury, not even the Dept of Health.[56] He claimed to have consulted representatives of all interested parties in all states, but left behind a general impression that he had preconceived ideas and a recorded statement that his only concern with doctors was to police them.[56]

His report was based entirely on the English scheme. It offered medical benefit only to the breadwinner, not the family; and was based on approved societies, including the friendly societies. Its administration had some regard to representation from the doctors, but was conceived as a Treasury function with the emphasis on the self-sufficient economics of social insurance as a whole. It had carried out none of the statistical enquiry into lodge practice, sought for by the N.S.W. Medical Political Committee of the B.M.A. It had no regard to public health considerations, though Sir W. Kinnear was at pains to speak of the need for willing cooperation of the medical profession, and to detail subsequent concessions made to medical opinion in Great Britain. His scheme also excluded maternity benefit. The estimate of the Director General of Health was that it was:[57]

> "drafted in slavish imitation of the insurance system in force in Great Britain, and with an almost cynical disregard of Australian social and geographical conditions

As soon as the report was tabled June 1937, Dr. Page advised the B.M.A. that a Bill would be brought down in the near future with an income limit of £350 for contributors. The B.M.A. accepted the income limit, and asserted its desire for a capitation rate of £1 to insured only , or £2 if for the family, - with a maximum number of 1,500 on any one doctor's panel. Medical treatment within the capitation rate would include 'all proper and necessary medical services'. This excluded confinements, and treatment involving special skill of a degree which the general practitioner could not be expected to possess.

A new election was held August 1937, with both the U.A.P. and Country Party promising immediate national insurance legislation. A coalition government of the two parties was returned, and at once implemented their promise. The Prime Minister left the responsibility chiefly in the hands of the Attorney-General Mr. R. G. Menzies, and the Treasurer Mr. R. G. Casey. In the six months of preparation, Sir Walter Kinnear was brought back to Australia February 1938. The B.M.A. was not consulted either before, or during the drafting of the Bill. Only two months before the legislation was introduced, did the Treasurer move to consult the B.M.A. March 1938.

A month before, the Federal B.M.A. Secretary, Dr. Hunter, was already aware that the terms to be offered were a good deal worse than the B.M.A hoped for. In writing to the British Secretary, Dr. Anderson Feb. 16, he said[58]

> "Kinnear has apparently come to Australia with a fixed idea that a 9/- capitation rate is more than enough - in fact he believes that 8/- is adequate payment. Any such offer, of course, would be strongly resisted by the profession. Nothing less than 15/- would be considered".

To which Dr. Anderson replied March 7:[59]

> "I think I warned you some time ago to be wary of Kinnear

> "I know that he has always felt that the doctors in this country are overpaid, and he would gladly have reduced the present capitation fee of 9/- had it been possible for him to do so. He is not a bad chap in many ways, but he is a typical Irishman in many others. Watch him very carefully. I am perfectly certain that you will probably have a fight with the Government, if he is to advise them on the pay question".

This was a most accurate prediction. The fight that followed was to do the medical profession much damage in the public eyes, and to reveal serious differences in the government, and alignments of the profession.

The account of the Federal Treasurer's approach to the profession has been left on record by his friend, Dr. J. Newman Morris - a Melbourne surgeon with a long term of service as Chairman of Committees on the Victorian Branch Council, and as a Federal Council member, and vice president of the Council. His account was:[60]

> "About the beginning of March, 1938, Mr. Casey asked me how he should go about such a consultation (with the B.M.A.) Mr. Casey was informed of the Federal Council and its powers, and referred to the President, Sir Henry Newland. The executive was summoned to Melbourne at the invitation of the Commonwealth Government and met the Treasurer and his advisors."

This included Mr. Brigden, Mr. Green and Mr. Lindsay as well as Sir Walter Kinnear. Mr. Green had been secretary to the earlier Royal Commission on National Insurance. Mr. Brigden had been an economist in Queensland, where he worked out the formula used in B.M.A. Contract practice. Two conferences were held in March witha fortnight's interval, because an impasse had been reached on financial terms. None of the principles of the Bill were under discussion, merely the amount to be paid.

The B.M.A. Executive of Federal Council at the first conference were conscious that the Council's own resolution six months before was for a capitation rate of £1 for a single person. This amount had been reiterated by a special meeting of the N.S.W. Branch Council March 1, 1938, with the President and Secretary of each local Association (to be higher in the country at 26/8 with a 3/- mileage rate). At once the Commonwealth made it clear that this figure would not be met. Dr. Morris' report stated:[61]

> "We were definitely informed that there was only a certain amount of money available for medical benefit, but we were never told what this amount was. We wereinformed too that the 11/- capitation and 2/- mileage exhausted the funds available'.

The B.M.A. countered with the view that a capitation fee of between 12/- and 15/- was justified depending on the scope of the service.

The source of the figure 11/- was later something of a mystery, when under fierce dispute between the Government and the BM.A.

Dr. Carter, of the W.A. Branch, said:[62]

> "This figure appeared to be nobody's baby. Mr. Brigden appeared to be under the impression that it had emanated from Dr. Hunter, the Federal Secretary, and Sir. W. Kinnear was of the opinion that it had originated from the Victorian representatives of the friendly societies, but the undeniable fact was that these financial experts whose duty it had been, and is, to advise the Federal Treasurer in all matters relating to actuarial factors operating under the scheme were (a) unwilling to accept the responsibility for this figure (b) were anxious to pass the responsibility onto other people".

It was agreed that the figure was based on a 3.2 average for insured persons which Dr. Hunter later claimed he had given as the figure for the number of visits a year under the model lodge agreement, but not as a basis for attendance.

The Treasurer, Mr. Casey, asked the Executive Committee to treat discussions as confidential, but the latter got permission from Mr. Casey to report to their Branch Councils - who left the Committee to continue negotiations. They went into the second conference March 28-9 resolved to insist on a capitation rate of 14/-, a mileage rate of 3/- and a radius of two miles, as well as differential rates for country practice. The capitation rate was to include fractures and anaesthetics only, and to allow for clerking fee and loss of private practice. The B.M.A. capitation rate was struck by averaging rates in contract practice in the four states, ~~with better rates~~ whose rates were highest.

At this stage the Government was still arguing at figures lower than 11/-, their maximum after two days of debate. The argument was that the average per capita fee for lodge practice on an average of 2.2 dependents per member was 9/-. The consultation ended with no further concession to the B.M.A., and even these terms, recorded Dr. Hunter, were 'not obtained with ease'.[63] Sir Walter Kinnear and Mr. Casey asked the B.M.A. to keep the agreement confidential until the Treasurer, Mr. Casey, should announce it to the public which he did on April 16 - agreeing only that Branch Councils might be informed in confidence. Thus the profession at large was presented with a fait accompli.

The B.M.A. Executive Committee of four that negotiated this compromise had been elected a month before at the Federal President's prompting (Sir Henry Newland) considering some body was needed to act for the Council that could, in an emergency, be consulted by the Government. Its creation was approved by all Branches by February 1938, though just how much plenary power was conceded to it was by no means clear, when the Branches challenged the commitment made by it to the Commonwealth Government. Its minutes show that all members believed they had been given full power to negotiate by their respective Branch Councils. Three of the four men concerned were surgeons, and only the Queenslander, Dr. T. Price, was a

was a general practitioner. All four man knew that the Councils of certain Branches held views different from those of the Federal Council in regard to income limit, terms of service etc; and were reminded of this by Dr. Hunter. But power to negotiate was not 'plenary' power or executive power, consistent with past practice in B.M.A. procedures, where all past decisions had had to be referred back to Branches for confirmation. But the most powerful Branches, N.S.W. and Victoria, did temporarily give their delegates fuller authority. The N.S.W. Branch Council at a special meeting, March 28, 1939, gave 'plenary' power to Dr. Bell. The Victorian Branch Council and Convocation authorised Dr. Morris to obtain the best terms possible within the principles laid down - having said 12/- would be acceptable. However the S.A. delegate, Sir Henry Newland, said afterwards that acceptance was depedent on referral to B.M.A. members, and this was made clear at the time to Mr. Casey. But the Executive Committee, by accepting the demand of Mr. Casey to keep the terms in confidence , would seem to have abdicated their right to refer the terms back to Branches for approval prior to public announcement. Consequently, the profession, all unaware, was confronted with a public announcement by Mr. Casey on April 16, 1938, that the Commonwealth had reached an agreement with the B.M.A. for a capitation service for 11/- a head for all wage earners to include all minor fractures and dislocations for five years. The comment of the W.A. Branch reflected a general reaction when it charged it was a specified capitation fee for unspecified service to be determined later by the Insurance Commission - and thus a negation of orindary business principles.[64]

The truth appears to be that the Victorian Branch Council at a special meeting April 6 had endorsed the arrangement; and that the Federal Secretary, Dr. Hunter, had sent a letter April 2 to Sir Walter Kinnear confirming the terms of the agreement. The records do not disclose what authority Dr. Hunter had for this letter in any formal meeting with written minutes. Dr. R. Grieve, a member of the N.S.W. Branch Council at this date, later wrote:[65]

> "The Federal Council had been advised by those believed to be competent judges that the profession would be wise to cooperate in this scheme, as the alternative would be a salaried medical service introduced by a socialist government at some later date. This advice was at least plausible, because national insurance is the best possible prevention of nationalisation".

but in actual fact

> "The profession had been manouevred at the outset of what was to become the most acutely critical public dispute which had until then confronted it, into an entirely false position. It had indeed been forced to take up the defensive".

Thus the profession found, that only three weeks before the Bill

was due in Parliament, they were faced with a fait accompli which they had not debated at all. Critics at once said the Federal Council should not have accepted the demand for confidence, should not have agreed to the terms, should not have confined the debate only to narrow details. The members of the Executive Committee found themselves attacked and abused as having exceeded their authority, and, as specialists, of being out of touch with general practitioner interests, even of 'selling' the latter out. One of their most public critics, Dr. F.W. Carter of the W.A. Branch - who became for a time a full time organiser for the Branch, also spoke out most strongly in their defence. He acknowledged the just choice of these men for their high personal qualities and professional distinction for the Federal Council, and the many years of honorary service they had given to all matters relating to collective policy and professional repute scarcely regarded at all by the profession. The Federal Council went its way 'undisturbed' so that when national insurance was upon them, they had no support or research behind them for an event that had been anticipated for years, and was known ultimately to bear on every doctor in Australia. The members of the Federal Council might have been ill-equipped to deal with the assembly of trained economists, and mathematicians at the command of the Commonwealth Government, but they were seasoned politicians. They knew the Commonwealth Government had the right to legislate as it thought fit, without reference to the B.M.A. at all. They had been warned about Kinnear, as an inflexible man.

April 1938, doctors throughout Australia began to speak out. One of the most vocal was Dr. R. Grieve, a member of the N.S.W. Parliament. Later he described the reaction of the general practitioner in 1938, when speaking to the British Medical Conference:[66]

> "All the well-experienced evils were there; the vast bureaucratic organisation; the medical director to be subordinate to non-medical personnel; the complexity of relations between doctor, patient, approved society and government; the control of prescribing; penalties; committees ad nauseam and ad infinitum; a niggardly per capita payment; in short, the hotch-potch of interference by the untrained in the work of the trained".

Two general practitioners, Dr. Byrne and Dr. Gowland became leaders of the opposition in Victoria. Dr. Byrne's estimate was:[67]

> "The opposition of the harassed general practitioner was based on their realisation that, under the national health insurance act, they would have to work harder for less money. This is not as mercenary as it would appear on first sight; as it was also realised that such conditions would inevitably result in a lowering of professional standards disastrous to both doctors and patient. I nevertheless feel sure that the early offer of generous financial terms would have resulted in a settlement. Fortunately, for the profession, the Treasury was too concerned with saving pennies."

Before the groundswell of opposition from the doctors had reached a climax, the National Health and Pensions Insurance Bill was introduced into the Commonwealth Parliament by Mr. Casey on May 5, in the same terms as Dr. Page ten years before:[68]

> "one of the most far-reaching schemes of social reform presented to the Federal Parliament".

It would not only consolidate much prior legislation, but would extend to 1,850,000 wage earners, of whom only one quarter were previously covered by friendly societies (all manual workers and nonmanual) up to £365 a year income. The scheme was later to be supplemented by voluntary insurance. The philosophy of the Government concerning the doctors was shown to be essentially the same as the friendly societies by certain revealing statements: that the government regarded itself as a trustee for the contributions paid by both employers and employees, and therefore its duty was to see the money was carefully invested, and the insured person would get full value for his money.

The Labour Party, led by Mr. J. Curtin, did not support the Bill. Objections to the principle of contributory insurance by the Labour Party had been predicted as soon as the Kinnear report was published in 1937 in the press.[69] A Labour Premier in Tasmania, Mr. Ogilvie, stated publicly his government's opposition to contributions by the State Government as well as employee. The Labour Party did not merely oppose details of the Bill as in 1928, but the very principle of it.[70] Mr. Curtin said in debate that, by partially overlapping the field of friendly societies, it threatened them without providing in full the services which they now rendered to wives and children; while pensions for old age, invalids, and widows should be a matter of right from consolidated revenue without exaction of individual contributions.

Mr. Chifley, who became Labour's first post-war Prime Minister, was at that time not a member of Parliament, having previously been in the State House. He dissented from the view of the Labour Party in Parliament and campaigned in support of the Bill, giving his reason a decade later as:[71]

> "I supported that scheme, not because it was complete, but because it would have provided a foundation for the establishment of a scheme such as this government proposed to introduce. I would not have hesitated to support that scheme on any platform in any country. Indeed, I wrote to the Chairman of the Commission controlling that scheme, and offered him my services in a voluntary capacity to address trade unions and advocate the adoption of the plan".

His disappointment in its ultimate failure to be implemented was reflected in his attack:

> "The medical profession and the Australian Country Party torpedoed it..principally by Sir Earle Page, who was the agent in this Parliament of the B.M.A."

His conclusions as to the role of the B.M.A. undoubtedly influenced him towards the intransigent attitude he took with the B.M.A. in negotiations for a national health service 1945-9.

On reconstruction of the history of the legislation, his conclusion scarcely seems valid. Not only did the Labour Party to which he belonged oppose it, but also the friendly societies to a degree. The latter feared loss of their own membership, if workers had to pay into two schemes. They sought to strengthen their position by seeking B.M.A. support for a policy that they should be the only approved societies,[72] and issued a brochure through the 1938 Consultative Committee of the Friendly Societies Association. The Commonwealth Government refused, insisting that insurance companies, trade unions, and any new body organised for that purpose be allowed to participate. This last proviso created violent opposition from both Labour and U.A.P. members, as creating competition with existing organisations; while the B.M.A. also opposed it as they had always done to any scheme increasing friendly society power.

The Country Party opposed the measure, not merely to support the BMA but on behalf of the small farmers and the casual worker in seasonal employment. Either would find regular contributions onerous. But opposition to the measure came not only from outside the U.A.P., but within, for many employers were critical of having to pay compulsory contributions on behalf of employees. The day before the Bill went to the House, the Sydney Morning Herald said:[73]

> "The government will face strong criticism from a number of its own members. Mr. Lyons admitted late tonight that the Ministry expected criticism of aspects of the Bill, but he scouted suggestions of revolt".

Even the Premiers of the States had reservations about their role as employers of Labour, which would demand a further load on state revenue. The workers themselves were not keen on making contributions. The principle was new to them. Many would be brought into tax, who had never been taxed before. The Treasurer, Mr. Casey, also admitted in conference with the BMA. March 1939 that 'one of the horrors of last year was the difference of opinion between dispensaries and chemists.'

Attack on the legislation was likely to come from many quarters. An economist of the day, Professor R. Walker, confirms this:[74]

> "It is worthy of note that the scheme has come under attack from many angles, and that sectional groups have not hesitated to misrepresent it in the course of propaganda against it. There is singularly little interest in the general principles of social insurance, and still less understanding among the public of the problems it is intended to deal with".

The policy of both the Prime Minister, the Hon J. Lyons, and the Treasurer, was to get something on the floor of the House and argue after. The

Prime Minister had had little concern with the Bill, but all concerned hoped that difficulties could be ironed out later:[75]

> "It was to be expected that a complicated scheme such as national health insurance would require adjustment and alteration after it had been examined in protracted debate".

The debate was protracted, the lobbying fierce and prolonged. During seven days debate, every member spoke. Seldom in the history of the Commonwealth Parliament had a Bill caused such heat and variance, certainly not since conscription and industrial arbitration. Four Country Party members voted with Labour on one amendment, and eleven Government members with Labour on another (to exclude life insurance offices). It finally passed in an emasculated form, and with a rider requiring a vote of both Houses to make it effective.

The Leader of the Country Party, Dr. Page, and the Attorney-General, Mr. Menzies, were both overseas during the rumpus, occupied with trade and defence, and shortly to return disturbed by trends in Europe. Dr. Page's own account of this was:[76]

> "Before my departure for London in 1938, I conferred with Casey and his British advisers and urged them to avoid the sort of complications and delays which had confounded my own efforts ten years previously. I believed that, if the new measure attempted to cover all the suggestions and safeguards that Kinnear proposed the Government would be burdened with a child of such size that only a Caesarean section would permit its parliamentary delivery and both the offspring might be killed in the process. My predictions proved exact. The controversies, that surrounded the proposal created a considerable bitterness among parliamentary members, especially on the government side... many amendments were carried against the government in committee which seriously emasculated the Bill. Because of these circumstances, and the financial emergency that attended the approach of war, cabinet deferred the proclamation date of its operation which had been fixed for January 1, 1939."

Mr. U. Ellis, secretary to Dr. Page at the time, made his own comment in the history of the Country Party:[77]

> "While national insurance was the measure which brought to light the ominous cracks in the fabric of the government, there were, as in all similar political situations, quite a number of other contributory causes. Personal feelings and ambitions, individual antagonisms, and political disagreements aggravated the landslide, which, beginning as a fall of rock in the government backyard, held for a moment when the Bill was passed, became a shower of colliding boulders and ended in an avalanche".

During the debate, before any landslide was guessed at, the B.M.A. Federal Council was in serious trouble with B.M.A. members, first in N.S.W. and S.A. , shortly in all states, despite efforts of the M.J.A. to present a reasoned case on behalf of the Federal Council, as on May 28: 'it did not appear that the Commonwealth Government

representatives would agree to a higher capitation fee'.

A 'general practitioner revolution' rapidly developed against the predominance of specialists on state and federal councils. This had occurred, both because the latter had had more time, and because the ordinary membership generally took fleeting interest in B.M.A. affairs. Normally Branch affairs were left to the willing few with little new blood to spread the burden, as Dr. Byrne, one of the leaders of the Victorian revolt, was first to admit. Speaking of criticism against Victoria's delegate on the Federal Council, and Chairman of the Victorian Branch Council, Dr. Newman Morris, Dr. Byrne said:[78]

> "I always admired him before, during and after the 'revolution'. To say that he was out of touch with the views of the general practitioners was not quite fair. Up to that time they had none".

The opening day of debate in the Commonwealth Parliament was the signal for the 'revolt' to begin in N.S.W. and, for a brief time, talk of a General Practitioners' Association. An extraordinary meeting of the N.S.W. Branch was held to which doctors flocked from all over N.S.W.: reported in the Sun, May 6, as 'the meeting was one of disturbance and heated interjection unheard of in B.M.A. records'. Motions carried were reported widely in the press, as amounting to severe censure of the B.M.A. Council for agreeing to 11s a year, or 2½d a week capitation fee. The meeting was divided as to whether 15s or £1 would be a fair alternative. The country doctors were for £1 , considering they stood to lose more than the city men, £500 in every £1,500 income as against £300 for the city docctor. One country doctor stated the conviction held by many, which had led to their immediate public protest:[79]

> "The chief objection is that they will have to increase the number of their patients to a great extent which will be difficult in view of the great distances they have to cover, and the amount of night work which they perform. they fear that excessive calls on them at night, often for trivial cases, by people who benefit under the scheme, will mean a deterioration in their normal work".

They were not opposed to the principle of national insurance, but demanded protection for themselves as well as for the patient. Under the scheme, they would get nothing for night calls as a deterrent to abuse, and 2s a mile outside three miles one way only, for one journey a year to all patients - no more. Income limit had been raised from £260 to £365 for eligibility for the scheme.

A majority of district associations in N.S.W. met and joined the N.S.W. Branch in voting against the 11s capitation fee, and other clauses of the Bill. Some doctors spoke of refusing to work under the scheme as they had in England in 1911.[80] Speculation led to denial that questions of threat or ultimatums had arisen at any meeting of state or federal executive, with the assertion that the N.S.W. Branch was working through ordinary official channels. In fact they were also through unofficial ones - contacts privately with members of Parliament to put their case for removing the major stumbling block

to cooperation - the higher capitation fee.

S.A. joined N.S.W. in opposition with an emergency general meeting May 18, 1939, of lodge practitioners, which called for the Council to urge postponement of the bill owing to general uneasiness about it. They called for 14/-, night fees and mileage rates. Queensland pressed the the same, while W.A. general practitioners called a meeting independently of their Council, alarmed that the lack of income limit in goldfield practice could be a major threat. In Victoria, two general meetings were very well attended, with similar criticisms and grave doubt as to 'the quality of the service it will be necessary to render'.[81] The Federal B.M.A. President took the rather ambiguous view that, although agreeing to the scheme presented to them 'the Association in no way expresses its approval of the Bill as a desirable scheme of national insurance'.[82]

The Commonwealth Parliament was due to begin debate again May 24. The Federal Council B.M.A., sensitive to Branch protest, prepared its oblique assault on the Government. As yet, this executive did not believe that objections were sufficiently widespread to justify abandoning the basic agreement with the Commonwealth while there was hope of amendment, particularly Clause 115 as to the amount allocated. A Federal Council meeting May 21 had endorsed a statement sent to every member of Cabinet and Parliament as well as the Press. The B.M.A. called attention in this to their long study on the problem of the health of the people and inclusive medical service:[83]

> "It is contrary to the policy of the Association to provide a service of different quality for the rich and poor, or to adopt any proposal which would deteriorate the quality of medical service or deter the best class of medical practitioners from practising in the Commonwealth. No plan is economically sound which does not safeguard standards since efficient service is, in the long run, the most economical".

After detailing principles as to preventive medicine, research, choice of doctor and the need for a 'complete' service, and their support for insurance as conducive to self-reliance and thrift, they recalled the view of the Royal Commission on National Insurance that it is impossible to include in one measure a huge financial system of cash benefits, and an equally vast organisation of purely professional men. Having attacked the whole basis of the bill, the B.M.A. report detailed:[83]

> "Sickness and similar benefits are self-contained cash benefits based merely on actuarial science, and logically capable of restriction to persons paying contributions for them. But medical or treatment benefit is quite a different matter. From the community point of view, there is only one thing to be considered, and that is to prevent the incidence of illness as far as possible wherever it may occur. That the Commonwealth Government is aware of this necessity, is shown by the recent creation of the

> "National Health and Medical Research Council after repeated requests had been made by the B.M.A. for the establishment of this body."

The B.M.A. believed that the national insurance scheme did not have regard to this, being slavishly copied from England, nor to the need for early diagnosis of disease, nor for a complete service to everyone. Poverty still remained a bar to medical benefit, and many persons were still dependent on the charity of the community. Finally the scheme was merely an extension of contract practice, whose weakness was its incompletness and inadequacy.

The Federal Council was charged by Mr. Casey and Mr. Brigden with being guilty of a deliberate attack on the Bill, because of this statement; particularly the closing remarks of the B.M.A.'s submission that the incompleteness of the scheme was not the fault of the profession, but that the low rate of remuneration proposed to be paid by the Commonwealth made full investigation and treatment impossible. Dr. Morris, one of the Council members, denied that this was an attack:[84]

> "No such attack was in their minds, but they did not wish the public or Parliament to assume that the Federal Executive was in agreement with the health provisions of the Bill, or of the manner of their inclusion in what was actually a financial measure. They informed the Government that they claimed and exercised the right to restate their views in this regard".

To Mr. Casey himself, the Federal Council made formal representations of the terms acceptable to the B.M.A.: a 14/- capitation fee in the city, with 25% loading in the country; a mileage rate of 2/6, 6d to be paid by the patient, 2/6 night call fee, amendment of section 50 to exclude alcoholism and V.D. and others already mentioned and a specialist service pool. The Council insisted that the Federal Council Executive had 'distinctly stated that it was not in a position to bind the profession to accept the terms of the agreement,' when discussing it with the Commonwealth representatives.[85] Conditions were not satisfactory, insofar as they departed so far from existing conditions of contract practice throughout Australia. Mr. Casey and his advisers denounced this as a repudiation by the Executive of the agreement entered into, and much feeling was aroused. The Federal Executive were called in to support the Federal Secretary at Canberra, together with a general practitioner representative from N.S.W., Dr.W. Simmons, a N.S.W. Branch Councillor of long standing.[86]

> "At the end of the discussion and explanation, the Treasurer and his advisers withdrew all charges of repudiation and attack, but rather unwillingly, and he later made this withdrawal more or less publicly and in the House".

In retrospect, Sir Henry Newland, was later to say to Dr. Hunter that they should never have accepted lodge rates as a basis when they first met Kinnear. A Labour M.P., Rosevear, publicly accused the Government of 'double-crossing' the profession. Whether this was true or not, the Government certainly would not yield on the 11/- capitation fee, though prepared to make minor concessions on other points. Cabinet was adamant that it had every right to insist that the Federal Executive should honour its agreement, although admission was made at a U.A.P. meeting that the B.M.A. had originally asked for a higher figure. Official Cabinet statement in the Press was that:[87]

> "The Ministry had acted in good faith, and as the supreme governing body of the association in Australia, the Federal Council was the logical and the only authority representing the Association with which the Ministry could treat".

The Prime Minister himself stated the same day May 25, 1938:[88]

> "Careful calculations made during the progress of the negotiations between the Government and the B.M.A. executive indicated that 11s represented the equivalent of the payments now made to doctors under the friendly society services".

The B.M.A. countered by saying that the figures had been based on the Victorian contract practice, which had the lowest rates in Australia, and had always been regarded as seriously inadequate.

In the hubbub over the issue, doctors addressed informal meetings of members at Parliament House, saw members in their own electorates, and sent a flood of telegrams. Typical of basic objections were those voiced at a Western Medical Association meeting June 5, 1938, N.S.W., when Dr. Mulvey read Professor Brigdens reply to their protest. They said lodge service was partly charitable; 1/3 of lodge rates for one person was neither equitable nor fair; the upper limits of lodge terms were taken as the limit in national insurance,[88a] and the average of all states was not weighted: The comment of Sir F. Stewart, in a sense instigator of the Bill, was:

> "Reduced to simply understood terms, the issue between the Government and the doctors was a matter of 1½d per week per insured persons, and he would be sorry to find that sufficient wit was lacking to end such an impasse".."I feel bound to suggest that the Government representatives were better negotiators and mathematicians than were the representatives of the medical profession".

The issue was really more than 1½d per week. It was that the capitation fee could not be reviewed for five years, and then only by a special Act of Parliament. As the President of the Queensland Branch, Dr. R. Quinn, said in justification of the hostility of the branch:[89]

> "We know the fee was too low, but, as we were aware of the financial difficulties, we were prepared to accept it for the time being to get the scheme going. As the fee will not be subject to review, we must now have the correct figure."

The Federal B.M.A. President, Sir H. Newland, had the day before stated his dissent in a joint statement with Mr. Casey, and his view that it should be given a trial. Mr. Casey in the House also claimed that Sir H. Newland had said he had plenary power.[90] Mr. Casey himself had made an appeal to general practitioners throughout Australia:[91]

> "The increasing opposition of members of the medical profession is seriously embarrassing the Ministry. It is confronted with the knowledge that, unless the dispute is adjusted, the medical benefits section of the measure will be virtually unworkable".

Meanwhile the B.M.A. Federal Council, under pressure, had accepted the creation of a Federal Contract Practice Committee with a majority of general practitioners to which all states sent delegates, and to which Federal Council delegated all negotiations with the Government. This overcame a strong move for an independent general practitioners association, and answered the charge of the Editor of the 'General Practitioner' Dr. Fitchett that 'a division of interests between surgeons and general practitioners, which had existed for years had been brought to a head by the national insurance bill'.[92]

Plebiscites were held in all states among the membership of 4,300 doctors, representing 90% of doctors, as to whether they would accept service under the ACt. They were overwhelmingly against. The N.S.W. Branch had refused already to recommend members to serve. Dr. Carter found Mr. Casey unconvinced of the strength of the opposition, on a visit to Canberra June 6;[93] characterising it 'as being merely the noisy protest of a small minority in N.S.W.' He had already said in the press the agreement was not lavish, but fair. Dr. Carter tried to prove to him he had been labouring under misapprehension.

The Government by June 11, 1938, made concessions on all points, bar the capitation fee and the mileage rate, with assurances by the Government that this would be dealt with in the detailed drafting of the Bill. The Prime Minister's attitude was 'We must get the Bill passed. That's the first thing'. In Queensland, W.A. and Victoria, general practitioner groups had been set up within the B.M.A. - that in Victoria having been warned against 'political action'.[94] Branch Insurance Committees had been set up within every state, and confidence in the B.M.A. restored. Dr. Grieve, elected from N.S.W. to the new Federal Contract Practice Committee, asserts in his resume of the episode:[95]

> "The profession at large quickly regained confidence in its leadership, and opposition became at once compact and coherent."

The fracas within the B.M.A. had repercussions all over Australia, while the object lesson learned was not forgotten for the next

decade. The B.M.A. remembered the danger of being rushed into a scheme by allowing debate to be forced on details, and not on general principles - and in yielding to alleged political necessities of speed, or philosophical argument, or moral priorities as to the general welfare of the community.

The general practitioner representatives asked its delegates to the Federal Council each for a pledge of loyalty to the state policies including possible refusal of service to the Commonwealth. General practitioner representation from that time on was conserved both on state and federal councils, and general practitioners have been conscious of the need for it. Neither Federal nor State councillors, nor the Medical Secretary, Dr. Hunter over the next ten years ever forgot the vital importance of invoking the federal machinery of the B.M.A. however slow and cumbersome, if they were to secure the general cooperation of the profession. Even Sir Henry Newland, who had persisted in his view, defended the right of the profession to criticise its leaders, and, in later negotiations with the Commonwealth Government, never again committed the profession without precise attention to administrative reference, except on the occasion of the amendment to the constitutional power of the Federal Government in respect of health (in 1946 ~~with~~ when the clause 'not for civil conscription' was included). Even the M.J.A. came in for severe censure for its article of May 14, 1938, and was more aware of the groundswell of opinion from the profession in ensuing months.

Before the famous affair of national insurance was finished, it dragged on for over a year after the Bill was finally pushed through the House. In the closing stages, the Federal Council repudiated its agreement with Mr. Casey in March, due to the 'united opposition of B.M.A. members' as the Federal Secretary, Dr. Hunter, said in a public statement in the Daily Telegraph and other papers June 13, 1938. It asked for fresh negotiations on the basis of 14/-. National insurance became law during scenes that included the suspension of the Acting Minister of Health ; a public rebuke by the Treasurer to the B.M.A. over an alleged disclosure of an intended interview; defeat of the government on an amendment to exclude life insurance offices, and a personal appeal by the Prime Minister to avert a deadlock with the doctors as an alternative to reopening negotiations direct.

The B.M.A. representatives in Canberra pressed for an interview with the Treasurer, who refused to see them again. They wrote a resume of events , climaxing in the 'general rejection of members of the terms of agreement but intention to work under terms offered by them.[96] Otherwise cooperation of general practitioners could not be assured. The Treasurer, harassed and overworked for months past, closed the chapter:[97]

> "I regret I can see no useful purpose in meeting your members on the basis of your declaration, and requests, and in the light of recent experience".

He announced appointment of a Royal Commission to advise on the proper payment to be made, and to investigate the financial aspec of the voluntary provision of medical treatment for wives and children of insured persons.[98] The Commission consisted of the Chief Judge of the Commonwealth Arbitration Court, MR JUSTICE Dethridge; Sir G.M. Allard, President of the Institute of Chartered Accountants; and Dr. R.D. Mulvey, president of the Western Medical Association. Dr. Mulvey was well known to both Dr. Page and Mr. Casey, and was of high reputation in the B.M.A. The Hon. J. Lyons, the Prime Minister, had commended him as a general practitioner with a wide knowledge of contract practice in country districts. He was already familiar with the debates of 1938, having chaired a meeting where the comments of Professor Brigden, Chairman of the National Insurance Commission, had been dissected by the W.M.A. There a Dr. Bamber, for example, in practice in Lithgow, had asserted that medical service in that area would suffer - this, being a district where almost no private practice existed, the workers being already on a 10½ a week subscription scheme, which yielded doctors 44/- a year for medical service and medicines.

Mr.W. Dovey, a leading K.C from Sydney, was to assist the Commission. Mr. Lyons said that neither the Government nor the doctors would perforce be bound by the recommendations, but its personnel would be such as to command respect. A decision was hoped for to allow insurance to begin early 1939. As the Royal Commission was to take evidence in all states, the Federal B.M.A. National Health Insurance Committee at its first meeting, June 30, was occupied with preparation of its case, including sending a questionnaire out to members; selecting legal counsel who were Mr. N. Cowper, solicitor, and Mr. L. Abrahams, and Mr. A.C Gain, barristers. They anticipated the extra cost by foundation of an emergency fund by member contribution (e.g. £10.10.0 over five years was sked in W.A.). They secured legal opinion as to the legality of the Bill. On the former issue, the B.M.A. London gave a grant of £1,000 to the Federal Council to aid costs. On the latter, Sir Robert Garran, draftsman of the Australian Constitution, told the N.S.W. Branch the law was intra vires - although another legal opinion from S.A. differed on this point.

Sittings of the Commission with eight terms of reference began in Sydney August 8, 1938. The B.M.A. meanwhile was still negotiating with the National Insurance Commission. They succeeded in securing a narrower scope of medical service to be offered by doctors to patients to exclude minor operations, confinements, all anaesthetics, and fractures needing special skill. But the

Commissioners would not vary their belief that the original capitation rate of 10/6 was sufficient. They believed that the aggregate income it would offer doctors would 'place the practitioners on a better economic basis than was available in other professions, and upon that foundation it might be expected that many younger members would establish their careers;[99]

The B.M.A. decided to frame its case primarily to illustrate the effect of transference of private practice to insurance practice, and the loss of gross income sustained at the level recommended by the Commonwealth, to procure that the rate be such as to provide the doctors with an income not less in proportion to the time spent earning it, than that approved by the Federal Arbitration Act No. 23 of 1926. The B.M.A. continued to express regret that the Royal Commission provided no chance to discuss the principles of national health service; and their opposition to Clause 115 of the Bill, which allowed of no alteration to the capitation rate without an amending Act of Parliament.

The M.J.A. warned that the kind of proof of their case as to incomes, required by the Commission, would be difficult. They decided to produce actuarial cases based on statistics, and evidence from individual doctors. The latter was heard by the Royal Commissioners in confidence. An immense amount of travail and time by the special committees of the B.M.A. Branches went into the task of preparation of the B.M.A. case, which, unlike that of their five legal counsel, was in their spare time. Two members of the Federal National Health Insurance Committees were appointed full-time coordinating officers, Dr. D. Embleton and Dr. T. Price.- the latter travelling interstate to S.A. and W.A. to organise. Extra staff was engaged everywhere. The work done in W.A., where Dr. Carter was seconded full-time, was of special interest, as the W.A Government Statistician, Mr. H. Goodes, assisted the W.A. BMA. Branch, and was later to be leading adviser to the Commonwealth in the Treasury during the controversies on national health policy of the 1940's under a Labour Party Government. He was influential in the work of the Medical Advisory Sub-Committee whose recommendations led to the 6/- a day hospital subsidy introduced in 1946, and other Commonwealth policies. In 1938, the W.A. Branch reported that he'was able to show that the original figures supplied by the Commonwealth were not correct' after 'elaborate returns were prepared from questionnaires, lodge returns and miners' wage sheets which all indicated that thefamily unit was 2.5 not 3.2."[100] A large number of miners earned more than £365. Counsel, Mr. Abrahams was to say that W.A. produced some of his best evidence for use before the Commission.

Some of the medical witnesses to appear were selected because of their panel practice experience in England, and said that it was not better there than 'first aid attention in Queensland' (Dr. Parer) or 'snap diagnosis' (Dr. Hillier).[101] It was vital to the B.M.A. case that the proposed rate 'would necessarily lower the quality of service and would reduce efficiency',[101] as stated by L.S. Abrahams K.C; whereas Mr. Casey had asserted quality to be the very essence of the service on May 6. Alternatively, if a doctor gave quality of service, he would not be able to make a reasonable standard of living.[102]

> "It would be shown that the panel doctor in England was merely a clearing station for hospitals, and in hardly any case in England was a panel doctor on the staff of a hospital.
> The panel doctor in England was almost a mere hack. Geographical conditions in Australia and England were different. In Australia, great distances had to be travelled in the country. There were no specialists outside the capital cities. In England, when a case showed the slightest sign of difficulty, it was sent to a hospital where it could be received and treated. In Australia, hospital accommodation was not so adequate".

It also demonstrated that patients accepted a lower standard of practice in England, and doctors lower fees; while on the other hand costs of living were higher in Australia, as in different parts of Australia.

The Royal Commissioners took evidence in all states accompanied by the National Insurance Commission who worked on details of administration. Public criticism was not wanting of various aspects, but first outright opposition was contained in a booklet issued by the Hon. Mr. Curtin, Labour Leader of the Opposition August 1938. He firmly expressed what was to become a cardinal principle of Labour policy; social service from taxation not from contribution; that those in the best position to pay should bear the cost. Those with incomes from property and investment, and higher wage earners not exempt should be included. The workers could not pass it on, while the employers could. Mr. Curtin also allied himself with the B.M.A. point of view in saying the Bill did not cover pre-natal, post-natal or infant health, families, dental or hospital treatment, nor the unemployed; and was therefore unsatisfactory as a medical service. His opposition was reinforced in October by a decision of the N.S.W. Trades and Labour Council to launch an intensive scheme against national insurance. At this moment, the Royal Commissioners Party was on its way back from the west to Melbourne for B.M.A. counsel's ~~cross-examination of~~ summing up of the Commissioners, after having taken evidence in all states but Tasmania. A terrible tragedy intervened.

The A.N.A. airliner, carrying all five B.M.A. counsel crashed in fog in the mountains outside Melbourne, and all were killed. The Royal Commissioners and their assisting counsel Mr. W. Dovey K.C. owed their lives to public service practice of travelling by Government railways. New legal counsel had the task in short order of arguing a highly complex case from rushed studies of transcripts. Not long after hearings were completed in November, 1938, the Royal Commission Chairman, Mr. ~~Judge~~ Justice Dethbridge died suddenly after a short illness. The Royal Commission report was neither written, nor its decisions intimated, if they had been foreshadowed. All the turmoil and work had been for nothing. The only clue extant, as to what the Royal Commission findings might have been, lies in the statement of Dr. J. Hunter to the special meeting of the W.M.A. April 19, 1939, that it was possible that the Royal Commission might have brought in 15/- capitation fee in the city, 18/- in the country, and 3/8 to 4/- per service per person based on a figure of 2.5 per insurer.[103]

Both Commonwealth and the B.M.A. had acquired enormous experience on the subject of national medical service during 1938, which was perhaps later of negative profit; the unwisdom of interfering with extensive health insurance arrangements - even if haphazardly organised - unless offering something better to displace them.

In England, the Political and Economic Planning Report on British Health Service of December 1937 had exposed the glaring defects of national insurance there. Of its general place in English society it concluded:[104]

> "Millions of pounds are spent in looking after and trying to cure the victims of accidents and illnesses which need never have occurred if a fraction of this amount of intelligence and money had been devoted to tracing the social and economic causes of the trouble and making the necessary adjustments".

The B.M.A. Federal Council, conscious of the extremely limited terms of reference of the Commission, had not neglected to reiterate its proposals sent to the Prime Minister in 1936 for a general medical service under a separate Commonwealth Insurance Department and Minister for Health.[105] It was deeply concerned that national insurance would do nothing to cure the defects exposed by the P.E.P. report while aware that it might indeed indefinitely, and perhaps permanently hinder a proper overhauling and integration of all the medical services. This latter report was compiled by an independent non-party group which was a cross-section of party and profession. Dr. Grieve and Dr. Embleton, both of the Federal Insurance Committee, now reported on an alternative compulsory health scheme. This took serious objection to the whole structure as currently visualised by the Commonwealth, the regulation making power of the National Insurance Commission, and absence of a court of appeal from its decisions. It also quoted a comment of the Lord Chief Justice of England

over appeal from dismissal by a doctor there;[106]

> "As an example of present despotic bureaucracy consider the treatment of panel doctors under the National Health Insurance Acts which is pure despotism."

This report was adopted as tentative policy.

Long sessions with the Royal Commission had created a wary mood in the Federal Council National Health Insurance Committee. Considering various objections raised, on Dr. Grieve's motion it accepted 'that representatives from this Committee confer with the Prime Minister and inform him that the Act in its present form is unacceptable'.[107] It asked for separation of medical benefits from sickness, invalidity and pensions; and that no act be brought to the House without time to refer terms of service to the Branches. A statement by the N.S.W. Branch detailing objections to the Act, was to be sent to every Branch in Australia. Also on the motion of both Dr. Morris and Dr. Bell, it agreed that the present act shoul not be the basis for calculation for any new or amending act. As a final symptom of the hardening attitude, it drew up a form of pledge, such as Branches had been urging- not to consider service under the Act until the terms and conditions were considered by a plebiscite (70% majority being considered necessary). Legal opinion on the merits of a pledge had been in Victoria that the B.M.A. had no power to enforce it; in N.S.W. that it involved the Federal Council in no liability at common law, although Dr. Hunter expressed the view that it could be an act of conspiracy against the Parliament if carried out. A pamphlet issued by the N.S.W. Branch October 1938 made trenchant criticism of Sir Walter Kinnear, ' who made the important error of assuming that the standard of medical service in Australia 1938 was similar to the standard in Great Britain in 1911, which all competent authorities know is manifestly incorrect'.[108]

At a meeting of this Federal Council Committee at the end of 1938, it refused to hear the Chairman of the National Insurance Commission, although invited to speak by its own Chairman as to how regulations should be drawn up. It further refused the Chairman's written request for aid of this order, on the grounds that they wished to refer to the profession whether service would be accepted under the act. The Committee already knew privately from the Prime Minister, and the leader of the Country Party, that neither would press to save the legislation; moreover, that the U.A.P.- Country Party coalition faced a crisis, harassed by what appeared to be an organised campaign to seek ~~repeal~~ abortion of the legislation (letters and circulars by the thousand). A majority of Ministers were alleged in the S.M.H. (8.12.1938) to be disposed to yield to their party pressures and shelve the scheme. The Country Party wanted small farmers excluded, but the U.A.P. thought this concession should not be made to one grou p

and the small employers in the city might equally claim to be excluded. Thus the Ministry faced three awkward problems, one section wanted concession to rural industries, another was opposed to concession, and a group from both sections wanted to shelve the scheme altogether. The Country Party belonged to the first group; the Attorney General Mr. Menzies and Mr. Casey the second; the Prime Minister vainly trying to bridge the hiatus. If he gave way to the former, the resignation of both Mr. Menzies and Mr. Casey was likely. Yet well over half the Parliamentary members were said to favour postponing and reviewing the measure, due as well to falling prices and defence burdens. Due to strenuous efforts by the two Ministers, the scheme was temporarily saved to operate Sep. 4, 1939, and was proclaimed January 1939. With the prevalent uncertainty, the Royal Commissioners' work was in abeyance for a time until ~~Judge~~ Mr Justice Beeby was appointed in March 1939. If, as th[ey] seemed likely, they reported in favour of the higher capitation fee sought by the doctors, basic review of the legislation would have been necessary in any case. The Queensland Branch, October 1938 had already stated the alternative, which was for a complete health service. The Treasurer, by March 1939, was widely reported to have modified even his views due to the profound change in the economic outlook (fires, drought, falling export prices) and deteriorating international problems. Mr. Lyons had said December 9, 1938, 'I would that you knew while yet there is time on what a slender thread Australia's peace depends'. Mr. Curtin reported in the Argus March 3, 1939, that the Government had already recognised the Labour principle that pensions should not be contributory.

At this stage, the Country Party at a meeting in Parliament House initiated a move for the Commonwealth Government to call a joint conference of friendly societies and the B.M.A. to evolve a comprehensive scheme. A joint Country Party- U.A.P. meeting heard Mr. Lyons, s[ta]g, that a Cabinet majority now favoured abandonment of the 1938 Bill as they could not afford 'liberalisation (which would cost some £1,000,000 extra) and they could not command the numbers in the House to enforce regulations under the Act. He was opposed by some members, led by Mr. Menzies, Cabinet, after two weeks of public speculation and private conflict, and finally accepted the Page plan, rather than repeal the 1938 Act, on the same day as they reappointed a Chairman of the Royal Commission ~~Judge~~ Mr Justice Beeby. The Page plan was to exclude old age and widows' pensions, to halve the contribution from 1/6 each worker and employed person to 9d, and to retain a family medical service with added dental benefits, along with funeral, sickness and disablement pay. The N.I.C. reported that the Page scheme was ill-advised; that the 1938 scheme was voluntary , whereas this would be compulsory. When Mr. Lyons announced this plan March 14, Mr. Menzies resigned as Attorney

General saying that he had more than once found himself 'at variance with the Cabinet for six months;[109]

> "The decision of the Cabinet on national insurance is the last but weighty straw".

His views had been best expressed in an article in the Kew Advertiser for the benefit of his electors in February, 'explaining and defending the scheme', as he was under attack in his own electorate;[110]

> "My own views on this great subject would perhaps be summed up in a few succinct paragraphs:
> (1) the enormous burden of free pensions in Australia cannot be indefinitely increased.
> (2) there is a great moral principle in the proposition that, if we desire to obtain benefits from the community we must be prepared to contribute towards the cost of those benefits.
> (3) we have a great opportunity today by putting national insurance into operation to arrest the trend towards pauperisation in Australia, and to strike a real blow for that rugged spirit of independence which characterised the Australian pioneers.
> (4) Personally I am so utterly convinced of the essential quality of national insurance that I am quite prepared to incur any quantity of temporary unpopularity in order to see it made effective".

His views are of interest, as he was to have the opportunity in 1952 as Australian Prime Minister himself to introduce Australia's individual scheme of voluntary insurance on the principles he commended in 1938.

Sir Earle Page in later years recalled the ambiguous position in which he found himself despite the plan he put forward in March, his views at that time being more consonant with a speech made at Kempsey February 21, 1939, in favour of postponing the Bill indefinitely due to the likelihood of war.[111]

> "In the last few months of 1938 not only were the portents on the international front grave and menacing, but Australia's domestic politics were overcast with uncertainty and disaffection. The Country Party at the time felt in some doubt whether it could afford to continue in partnership with a party so clearly split on so many issues personal as well as political. Menzies felt that, for some reason, he was out of step in the Cabinet finding himself voting frequently in opposition to all other Ministers."

The B.M.A. itself had been engaged in a review of the situation until the Royal Commission was supposed to resume in March. The two largest states were now opposed to any of their members accepting service of any kind under the Act, despite the fact that conference of legal counsel with Mr. Dovey representing the Commissioners had disclosed as early as November 9, 1938, that he would recommend proposals similar to ones originally put forward by the B.M.A. on matters such as mileage, night calls and scope of service. There was continued resistance to meeting the Chairman of the National Insurance Commission as keenly sought by him; those opposing being motivated in the words of Dr. Gowland of Victoria to Dr.Hunter.112

> "The possibility is not absent from my mind that Mr. Brigden is attempting to advance the organisation of the medical benefit to such a stage that to alter the administration of these benefits later in the year would present the greatest difficulty."

The Federal Council was asked to revive the Consultative Committee of Pharmacists appointed in 1926.

National Insurance however never really recovered after December 1938. Just before Dr. Page's speech, Dr. Hunter had written to London:[113]

> "It seems extremely unlikely, in fact practically conclusive, that the Government will postpone indefinitely the whole scheme, the scheme is not welcomed by many elements in the community."

The Federal President, Sir. H. Newland, who had survived a challenge to his leadership, added:[114]

> "If the Government drops national insurance, it will be revived, if not by this Government, by the next, a Labour Government. I hold very strongly that we must organise our forces, and devise a medical service for the nation".

The Prime Minister had been advised of the B.M.A.'s desire for a separate Health Commission, and to be consulted on any amendments of the old or new Act, and their preference for the latter.

When Mr. Menzies' resignation precipitated a crisis in March, 1939, a curious series of events began. A month later, by one of those strange turns of fate which had overtaken the Bill from first to last, Mr. Lyons was dead, after a short and utterly unexpected illness. Mr. Menzies entered the election for Prime Minister, and now had to retreat from his stand a month before by giving an undertaking on national insurance.[115]

> "He promised that the existing scheme would be suspended and that before a new scheme was introduced, a parliamentary select committee would review the whole situation. He insisted however, and the party agreed with him, that the principle of national insurance must be preserved."

The Select Committee would operate with members of the medical profession, friendly societies, unions, and the National Insurance Commission. This led to a bitter attack in the House by Sir Earle Page, who refused to join the coalition under his leadership, charging him with lack of courage, loyalty and judgement. He attempted to lure S.M.Bruce back from London without success.

Mr. Menzies became Prime Minister , notwithstanding, and appointed Sir F. Stewart, Minister for Health and Social Services, He thus tacitly conceded a point dear to the B.M.A. by appointing the chief protagonist of a comprehensive family service, and one evolved in harmony with existing institutions. The B.M.A. had already met in conference with the friendly societies. Their request for the Royal Commission, in which they had invested £20,000, to complete its sessions, was met with the reply that the

whole basis for discussion had altered.[76]

> "The chief subject of the Royal Commission enquiry is the appropriate payment for the treatment of insured individuals in relation to the payment made under contract practice for the treatment of families, and in respect of each insured person whether he or she was attached for treatment to any medical practitioner or not".
> "The present purpose is quite different, and I am not clear as to how, within its terms of reference a report from the Royal Commission can assist your deliberations. I had hoped that the parties on whose behalf you have written would have had no need for such a procedure"

The proposals of 1939 were so vague as to make it difficult to ground any recommendation from Federal Council to the Branches, They had one cardinal difference from friendly society practice. They proposed to introduce people in all conditions of health. In the absence of the findings of the Royal Commission to guide the B.M.A.'s deliberations, the proposed Select Committee was to assist them, or even give the Royal Commissioners new terms of reference.

By May, the BMA. had a consensus of opinion from its Branches. When the new Minister, Sir F. Stewart, reopened negotiations May 17, 1939, with the Contract Practice Committee, it told him of the general wish throughout Australia for compulsory insurance and for the Royal Commission to make its findings as essential to deducing a capitation figure. They preferred a compulsory scheme administered by a Board, representative of the bodies providing the service - as the consistent B.M.A. policy for some years past. The general view was best expressed by the N.S.W. Branch that compulsory insurance was preferred, because it was more economically administered, and the risk, being more universally spread, better conformed to the fundamental principles of insurance. In no sense, was there a refusal to work with a voluntary service, but they foresaw certain difficulties such as selection of risk.

June 1939, however, saw the end of national insurance. The Country Party voted with Labour to defeat the proposals for a Parliamentary Select Committee, along with Labour's move to have the proclamation of the 1938 Bill annulled. Before this occurred, the Government had followed the course it had failed to take in 1938, full discussion with the B.M.A. prior to drafting legislation. Mr. Casey and Sir Earle Page had both attended a conference convened by the Government to consider conditions, cost and administration of the new scheme. Present were seven members of the Approved Societies Consultative Committee, the B.M.A. and the Pharmaceutical Guild and members of the National Insurance Commission. Mr. Casey explained the plan as one which would extend to all manual workers under Commonwealth and State awards up to the limits of the M.L.A.

in N.S.W. of £365. It would in effect subsidise friendly societies and similar bodies, and act as an extension of friendly society contract practice with an increased number of contributors. the cost of such services being a matter for negotiation. It was hoped to keep cost within £1,000,000 a year, and to attract voluntary insurance on a decentralised basis allowing of different scopes of medical services, and of arrangements to suit local employees and other special groups.

Up till the last moment before the war, the National Insurance Commission was trying to delay dissolution of all its endeavours. FAced with collapse of the scheme by June, 1939, the Chairman Professor Brigden sought to salvage some benefit to the B.M.A. by way of advice from his experience of long association with the B.M.A. both in Queensland and in the Commonwealth. No one was more fit to analyse the shortcomings of their approach than he, according to his lights; nor to point out the dilemmas that beat them in the national health services; as real thirty years later as in 1938. He appealed to the B.M.A. to 'think more deeply and thoroughly; declaring:[117]

> "A distinction must be made between the procedures of control and the extent of control.... it may be that most of the objections to the British system are directed to procedures rather than extent.
> "Both of these can be discussed if the way can be cleared for that discussion. The way has been blocked for twelve months, and the sole purpose of these notes is to help towards a clearance".

He attempted to diagnose the troubles that beset the relations between the profession and the Commonwealth in their joint effort to found a system of national health service. These troubles, he said, were not superficial, and had arisen in all countries where systems of the kind had been attempted.

The real trouble, in Professor Brigden's view was not, in fact, remuneration, but where "the responsibilities of the financial authority impinge on the professional functions of practitioners as they do in certification and prescribing." He expounded:[117]

> "The professional aspect is quite clear. The judgement of the practitioner is involved, and all his personal and intimate relations with his patients. He advises, prescribes, certifies; all in the exercise of the same judgement. His authority and success require that nothing whatever should interfere with him in the exercise of his judgement. His private practice is established on that basis, and he demands that the same basis should be continued.
> "The financial aspect is equally simple in its essentials. The profession finds that about half of the community is unable or unwilling to pay the customary fees and to secure the medical treatment it needs. It suggests that these people should be compelled to contribute for an adequate service, or that the Government should provide the money in some way. The Government's function is to become a trustee for the contributors. The provision of the taxation required will limit welfare expenditure in other

that the profession had done little more than lay down certain principles without looking at the problem from any point of view but its own; and that, if it did not have more definite proposals, and a Labour Government came into office, it might have reason for regret.

War broke out three months later September 3, 1939, and lasted 1939-45. The amendments to the 1938 Act, approved by the Government in August on the lines of the March Page plan remained in abeyance. The war brought a profound change in the Government approach to the problem of national health service - due chiefly to the unbroken term in office of a Labour Government for eight years both during the war, and for four years immediately after. The change derived from official Labour policy, personal attitudes of Labour politicians, and trends in ecnomic thought. Certain schools of thought were the derivation of any philosophic content that gave a bulwark of logic to Labour concepts. The leaders of the Labour Party were chiefly declared Socialists, who believed they had a mandate from the people for Socialist planning.

In England, a Medical Planning Commission was set up in August 1940: seventy-three members from all leading sectors of the profession. In Australia, the B.M.A. Federal Council affirmed February, 1940, that its policy was now nothing short of a complete medical service, and appointed Dr. Bell and Dr. Simmons to consider its principles. Their report, adopted September 1941, marked the last official occasion when compulsory health insurance with an income limit (£416) was asserted. The idea of an income limit was abandoned and the B.M.A. became committed for the first time to the principle of a contribution scheme without income limit.[120] This statement, and a following one early 1943, were both confined[121] largely to principles. There was no disagreement on the fundamental: that the several parts of the complete medical service should be closely coordinated and developed by the application of a planned national health policy.

The Commonwealth took the same view, and national insurance was allowed to lapse without regret from any section of the community.[122] The Commonwealth Parliament appointed a Joint Parliamentary Committee on Social Security with a much wider charter than ever before, July 3, 1941. It was to consider a national housing scheme, a comprehensive health scheme (to include child and maternal welfare, nutrition, hospitalisation and community medical service) and pensions and unemployment insurance. Of its nine reports issued 1941-6, the last four were directly concerned with health. The first was issued July 1, 1943, the last in 1946. Sir F. Stewart, Minister for Social Services was the original instigator, but was not associated with it after March 30, 1944. Its sessions lasted for

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two years 1941-3 all over Australia.

The National Health and Medical Research Council met in May, 1941, and Sir F. Stewart invited it to submit constructive suggestions, saying he hoped national insurance would be revived, although not necessarily in its past form. In this, he was supported by the Director-General of Health, Dr. Cumpston, who advised the B.M.A. that it would be wise for their views to be known, and that he would like to be advised by the Federal Council.[123] Therefore, a small committee of the N.H. and M.R.C. reported July, 1941 in fairly general terms - on the ideals operative in a health program, the possible administrative division of the Commonwealth into health and hospital districts, and filtration by the Commonwealth. Its content was in agreement with traditional B.M.A. policy in many vital respects; particularly in its reiteration of the emphasis on preventive medicine and seeing the individual not merely as a vehicle of disease process, but as a living organism adapting itself to the environment. It condemned national insurance, proposed an administrative scheme of health districts put forward by the B.M.A. in 1926, and pointed out two major problems of the doctor in society. These were the personal burden on the doctor created by the concessional service of the capitation principle, and the honorary system. On the first, the only incentive to the doctor was to increase income by adding to numbers at the expense of professional efficiency; on the second, the doctor was asked by organised society to accept two great burdens no other trade or profession would any longer tolerate - namely a 24 hour 7 day service, and considerable service for nothing.[123]

The July 1941 report of the N.H. and M.R.C. did not offer any policy, but merely as precedent for policy the following:[124]

> "The logic of facts points, in the opinion of this Council, to the need for critical and dispassionate examination in consultation with the medical profession of the place of the doctor in society before the Insurance scheme is brought into operation, or before any other national health scheme is considered.

The new Labour Minister for Health, Mr. E. J. Holloway - appointed in the interim- addressed the November 1941 meeting of the N.H. and M.R.C. Council in much more explicit terms:[125]

> "I hope that attention will be given to the need of a national salaried medical profession to better serve our nation and to build up our national fitness".

Of which Dr. Cumpston said in 1954[126]

> "In these few words was declared the Labour Party's objective of socialised medicine".

The Government had already asked the N.H. and M.R.C. to submit a plan on a salaried basis, which was done with great length and a wealth of detail as an elaboration of the district principle: regional organisation of all health and hospital services manned by Commonwealth salaried staff aided by local personnel. It presented to advocates of socialised medicine - of whom there were many at that time in the Government, and even in the N.H. and M.R.C. itself- an exposition in practical terms of the issues involved. The Director General in retirement wrote of this scheme in his 'Health of the People'[127]

> "There were some grave objections to the scheme as proposed. 1. a service in which all the professional officers were subject to the public service act would contain elements of rigidity which might seriously prejudice the harmony and efficiency of professional work.
>
> 2. the intimate personal relationship between the doctor and his patient would be very adversely affected.
>
> 3. the opportunities for, and the reasonable certainty of nepotism, could not be ignored."

As a civil servant he could not express his views at the time, and became identified with the policy of the Labour Government in preparation of this report in the minds of many B.M.A. state and federal Councillors. The coolness and suspicion that set in with the B.M.A. extended to the civil service for some years.

"The Outline of a Salaried Medical Service" was a vital turning point in the history of national health policy. The weight of its comment against national insurance and capitation systems was reflected in the abandonment of these ideas in the deliberations of the B.M.A. and of the Joint Parliamentary Committee on Social Security; though reinforced by the Labour Party's preference for social service by taxation and not by contribution.

In the first report, it had revived ideas that had given common ground for policy in the past between the Commonwealth and the B.M.A. If the second report was intended to force detailed discussion on the problem of arbitrary alternatives to current medical practice, it certainly did so. The W.A. Branch called for discussion on the Federal Council which initiated a move to report to Branches on a full time national salaried service.

By the end of 1942, planning conventions were called in every state - that, in N.S.W., to include representatives of a number of non-medical bodies: for a conference between the Federal Council and the Royal Colleges; and for conference with the Federal Consultative Committee of the Friendly Societies Association. If, as a by-product the N.H. and M.R.C. plan aroused the hostility of the B.M.A., this would have been inevitable sooner or later

with the Socialist outlook predominating in the Labour Party. The Council's plan made it a case of 'sooner' and the B.M.A, being forewarned, saw to it that they were forearmed. The N.S.W. Branch had noted that the representatives of the Royal College of Surgeons and the Royal College of Physicians on the N.H. and M.R.C. had voted for the 'Outline', though as a personal not an official vote; whereas the B.M.A. member on instruction from Federal Council had refrained from voting (Dr. Morris). It realised that these members had done so, knowing the report was a basis for discussion, However, looking to the future, it was alarmed:[128]

> "Recent happenings in connection with the N.H. and M.R.C. tend to the belief that the Commonwealth Government would be justified in assuming that
> 1. a section of the profession as represented by the R. A.C. of Physicians and the R.A.C. of Surgeons is in favour of a nationalised medical service.
> 2. The Federal Council of the B.M.A. does not represent the medical profession as a whole in Australia.
> "The Council of the N.S.W. Branch, being seized with the importance and seriousness of the whole matter, is of the opinion that there should be but one body to speak for the profession on important medico-political problems such as this, and that body with its long experience and representing as it does all sections of the profession in the Federal Council".

It asked that the Colleges ask their representatives not to discuss medical politics on the N.H. and M.R.C., and that, if discussion were necessary, they should confine themselves only to problems of consultants

The Royal College of Surgeons formally stated the position of the College:[129]

> "As the R.A.C.S.is an educational body, the Executive Committee thinks that the Federal Council of the B.M.A. is the proper body to represent the views of the whole profession in regard to national service, but appoints a subcommittee to confer with the B.M.A."

At the Federal Council meeting March 16, 1943, the Presidents of both Colleges attended, and a separate conference, with representatives of all three, led to Dr. Colville of Victoria reporting that they had views which coincided with those of the Federal Council, and expected to be able to devise a common policy. The B.M.A. also sought a formal assurance from the Minister of Health that no national health service would be introduced during the war; believing too many doctors were away, manpower disorganised, and the profession without proper time to deliberate the issues.

Mr. Holloway, Minister of Health, gave the equivocal reply, November 21, 1942:[130]

> "I wish to say that I have not broken my promise, and have no intention of breaking it in the future, but however this does not mean that unorthodox methods have not already been introduced, or might be necessary during the war period".

Discussions with the Commonwealth continued during 1943 and 1944 with major divergence that the B.M.A. Federal Council was not in favour of salaried medical service, except in outback areas unattractive to private practice; and increasing espousal of fee for service in some contractual form with the Government. Whereas the Commonwealth Government ceased to consider insurance schemes - the J. P.C. on S.S. condemning national insurance as falling far short of any satisfactory concept of social service- the B.M.A. never quite abandoned its interest in the subject. It began to see it as an extension of existing forms of medical practice. The form it would take began to emerge at the Federal Council meeting March, 1943, and the opinions expressed there by Federal Councillors had already been thrashed out in Councils of all Branches. It was resolved that the existing services should be modified by encouraging private group practice among doctors, and they should build on the principle that:[130]

> "Whilst the health of the community is a national matter, there is a duty on every individual to accept a moral and social responsibility for his own health and that of his dependents."

A Mr. Milne of the Bankers' Health Society was invited to address the Federal Council on a scheme of voluntary health insurance, begun by that society in Victoria July 1939. Other professional bodies had approached them to extend the scheme. From this meeting, dated the reawakened interest in voluntary insurance, which led to foundation of the Medical Benefits Fund in N.S.W. two years later.

The events of 1941-2 had also reminded the Federal Council of the weakness exposed in 1938 as to its power to act as intermediary for the profession with the Commonwealth Government. Mindful that the 'coming year would be a year very probably of grave decisions' as Dr. Simmons expressed it,[131] the Council in 1943 discussed various aspects of its powers and the need for a fulltime secretariat. Dr. John Hunter, by arrangement with the N.S.W. Branch, was allowed to give more attention to federal matters, while the Branches were asked to give the Federal Council power to negotiate with the Commonwealth Government. This became urgent when the Joint Parliamentary Committee asked the B.M.A. to nominate six members to meet with it, along with six from the N.H. and M.R.C. This meeting took place December 8-9, 1943, and was the first official conference of any kind held between the Commonwealth and the BM.A. on the principles of national medical service.

At this point, the J.P.C. on S.S. had taken evidence all over Australia 1941-3 and had presented its sixth report to Parliament July 1, 1943 on a comprehensive health scheme after prior reports on unemployment, housing and reconstruction planning as well as the scope of enquiry. It could not have been said to have interviewed an extensive list of doctors in private practice, ranging, as it had, over such an enormous field of enquiry. It had, in fact, delegated the special field of enquiry on health for the Sixth Report to a Medical Survey Committee in order to establish a factual basis upon which it might continue discussions with representatives of the N.H. and M.R.C. and the medical profession. Part of its charter was to keep in view the integration of preventive and personal health services and the subdivision of the Commonwealth, state by state, in effectively coordinated and workable health units.

Members of this Committee had made a hardworking three month tour of the Commonwealth. Its personnel was not designed to give fair representation to those in private practice, whether general practitioner or consultant, as neither were represented. Its Chairman was Dr.A.B. Lilley, General Superintendent at Royal Prince Alfred Hospital; deputy Chairman was Dr.F. McCallum Senior Medical Officer of the Commonwealth Department of Health. Of its four members, two were doctors who had already declared their support for a salaried medical service, Dr. A.E. Brown of Colac, Victoria; and Sir. R. Cilento. The others were Mrs. A.M.Walsh, matron of the King Edward Hospital for women, Perth, and a personal friend of the Prime Minister; and an economist, Mr. H.J. Goodes, Dept of Treasury, and formerly W.A. Govt. Statistician. Its work was to form the basis for three successive reports, not only the sixth but the seventh on hospital benefit, but the ~~eighth~~ eighth on health service.

The commitment of the J.P.C. on S.S. was apparent as early as September, 1941, in its interim report on the overall structure to be created. Dr. Cumpston left on record his opinion of this mode of attack:[131]

> "The form of administration under a colossal Ministry for Social Security was prescribed before even the for m of organisation with its complex problems had been studied.
> "The whole medical and health functions of the Commonwealth were to be placed under lay control, the Dept of Health with its very patient and successful work of thirty three years was to vanish and finally the Committee recommended the immediate enactment of a statute covering fields of legislation which, as the Committee well knew, were far beyond the constitutional powers of the Commonwealth Parliament".

The form of organisation was in opposition also to B.M.A. policy for thirty years past.

The commitment of the J.P.C. on S..S. was implicit in its fifth report October 8, 1942:

> "The Social Security Act should also include a national scheme of medical health, maternal and child welfare services for all irrespective of circumstances. Proposals for such a scheme drafted by the N.H. and M.R. Council are before the Committee. These proposals will be fully investigated and a Report thereon submitted to Parliament".

It was implicit in the report of the Medical Survey Committee June 30, 1943 on the question of health districts:

> "The vesting of the executive authority for the area in a district personnel comprising the local medical officer, and forming part of an Australian medical health service introduces questions of considerable difficulty. To render a scheme, such as that proposed, practicable, would seem to require either the separation of environmental and personal service to the public which is considered entirely reactionary; or the establishment of control of the medical men in each district by the present health authorities in a full or part-time salaried service which is opposed strongly by the Federal Council of the B.M.A. or major changes in existing legislation".
> "It is too often forgotten that , in all medical and health services supplied to the public either privately or otherwise there are two parties - the public which demands and pays for the service, and the medical practitioner who provides the service for a 'fee or a salary'."

After dealing with the B.M.A. view that all medical service should be correlated, and this usually occurred through local government authorities, the report pointed out that private medical control of such a service in terms of responsibility would be 'inchoate and entirely contrary to accepted principle'.

> "if the medical men concerned were paid officers of an Australian medical health service, the situation as to responsibility might be better defined, but the protection of the equal interests of the local authority (as representing the people) would not be improved. It is a familiar maxim of political economy that , when the public provides funds to pay for a service to the public, public supervision through agencies responsible to the people is obligatory"

The report pointed out that legal provision for districting existed in several states, whereby control would be in the hands of a medical officer of health responsible to the state director for the adequate exercise of his duties.

The commitment of the J.P.C. on S.S. was explicit in its Sixth Report:

> "In view of the comprehensive nature of the services, we have carefully deliberated upon the 'capitation fee and panel' and the 'fee for service's systems for the payment of general medical services, but are unable to agree that either would, if adopted, be anything more than an expedient, and we feel that neither is likely

"to provide a permanent and satisfactory solution. Moreover both these systems are open to abuses against which no adequate protection has been suggested.

".. We believe that the ultimate solution will probably be found in a full time salaried medical service with standardised uniform hospital provision, within which complete medical hospital and public health services will be available to all and will be financed by a tax on incomes for this purpose.

"Within such a service, promotion should be purely on merit. Such solution, however, must be regarded as the long range objective, since apart from the insuperabl obstacles to its introduction at this stage, or until after the war, it is opposed by a large majority of the medical profession, whose cooperation is vital to the success of any plan. So drastic a change would be considered revolutionary, and therfore should not be introduced except by evolutionary developments over a period of years".

The advice of the committee in detail on the attitude of the medical profession to full time salaried service gave the impression that, despite this opposition, there was a substantial body of opinion among doctors that did not share it, by men undoubtedly inspired by the highest motives and a sense of public duty. While this opposition would be less if control was vested largely in an independent body with statutory authority and removed from political control. This advice may have contributed in no small measure to the later misjdugement of the Parliamentary Labour Party as to the doctors' likely response, and scale of opposition, to proposed legislation to attach them more closely to the state.

Despite these publicly declared opinions, the B.M.A. agreed to meet the J.P.C. on S.S. in conference. It had proposed many things on which they had common agreement-such as T.B., V.D., uniform registration, mental hygiene, foods, drugs and poisons, nursing and ancillary services, research, group practice: all of which had aroused undivided support for many years in the B.M.A. They were also agreed that the N.H.I. Act of 1939 should remain a dead letter. There was no doubt of the truth of the assertion in the Sixth Report of the J.P.C. on S.S. that:

"The experience of national health insurance, and the prolonged but inconclusive negotiations to arrive at a basis of payment for medical services under the 1938 Act, have unquestionably influenced the attitude of the medical profession generally to any national health service.. Nothwithstanding this, good relations have been established between the committee and the Federal and State Councils of the BM.A., and with medical practitioners generally including non-members of the Association".

The B.M.A. also knew the Committee had done much valuable detailed study, necessary to planning (some of its work providing the statistical basis for the Hospital Benefits Act 1945).

The Canberra conference of December, 1943, was attended by

eleven members of the Parliamentary Committee and its Medical Survey Committee: three medical service heads, seven B.M.A. members - two representing the major colleges- and the Chairman of the N.H. and M.R.C. Two of the B.M.A. were general practitioners. The conference opened on a note of protest, not from the B.M.A. but from the N.H. and M.R.C., in its failure to send the six delegates requested. The latter had decided to send only the Chairman as observer without power to commit them. The B.M.A. President, Sir Henry Newland, expressed his disapproval that the balance of the conference would be thereby upset,[132] and would not be as envisaged by the BM.A. as one of conference between medical men across the table. Furthermore, the conference was intended to have occured before the Joint Parliamentary Committee report went to Parliament, and delegates accepted in that belief; only to find it took place after the Report was presented. Mr. Barnard, M.H.R., gave as reason the necessity to report before the dissolution of Parliament, which meant the termination of the Committee. The Committee itself had suffered internal dissension, its secretary having resigned and its composition changed.

The December 1943 conference basically discussed the Sixth Interim Report, and a number of its recommendations were accepted. Dr. Simmons challenged the Committee on two grounds - first, that the fee for service system would be nothing more than an expedient; second, that the B.M.A. definition of diagnostic centres of group practice was the same as that of the official reports. First, he offered the compelling criticism that the Repatriation Dept throughout Australia, and Workers' Compensation in N.S.W. and W.A. were conducted in that manner - the former where men could not be taken to hospital for treatment, adding:[133]

> "I resent the remark of the Committee that both of these systems are open to abuses against which no adequate protection has been suggested".

He instanced the panel of doctors in both states, which acted as tribunal in all cases of disputed fees. Second, he said:

> "the idea of the B.M.A. was that the clinics should not be of the kind described by Sir Raphael Cilento, but that they should be diagnostic centres to which patients should go on the recommendation of their medical advisors".

The B.M.A., he asserted, was in favour of an experimental system of group practice being established within the control of the association, and was backed up by Dr. Carter of W.A.[134]

> "The B.M.A. considers that a period of experimentation during the next few years would enable the profession to develop the clinic idea and be able to advise the government as to the best type of clinic".

At this time, clinics in private practice existed at Colac, Thebarton, and Horsham in Victoria, and in Brisbane at the Nye Clinic. The latter was the first in Australia, and had aroused some resentment and hostility on its foundation prior to 1930, but gained acceptance. Dr. Simmons also pointed out that para. 145 dealing with uniform hospital services and standards had ideas which had been the policy of the Hospitals Committee of the N.S.W. B.M.A. for many years.

With little effort at all on the part of the delegates to continue the challenge on these two vitally important problems of ways and means - financial and organisational- the conference adjourned with the B.M.A. representatives agreeing:[135]

> "that consideration be given to the provision of a general medical service through a system of group clinics, staffed by private medical practitioners, as a part-time or per session basis, subject to adequate trial being made by the establishment of an experimental clinic in each state - under conditions to be considered by a representative sub-committee of this conference, and later considered by the conference".

This subcommittee was duly appointed, meeting January 24-27. Of its nine members, only three represented the B.M.A.

Prior to the conference, Cabinet had already discussed the problem of administration of a national medical service - whether entirely by the Commonwealth or through co-operation by the states with the Commonwealth. The Ministers of Health in conference had decided that the states would administer such a scheme, and the Commonwealth would finance it, but their pronouncement of government policy from the states differed very materially from the tenor of the sixth interim report, and was at odds with the purport of the conference to throw everything open once more for discussion. Dr. Cumpston, representing the N.H. and M.R.C., had also thrown doubt on the validity of future discussions by such a subcommittee, having told the December 1943 conference that:[136]

> "The Council has never regarded the 'outline' as being the only or necessarily the best plan for future medical service.. the famous outline presented by our council is now dead and we must make a new start. That is largely true of the report of the Social Security Committee."

The view of the N.H. and M.R.C. was that it had a responsibility to Parliament on the same plane and not less than that of the Joint Parliamentary Committee, and that further conferences with the B.M.A. could not profitably be held by the J.P.C. on S.S. until major questions of policy were decided.

Neverless the medical planning committee, created by the December conference, went on to report March 1. 1944.

It covered nearly all the same ground as previous reports, making many similar recommendations and some valuable new ones, such as for chairs of social medicine and health, and on education. It went well beyond its terms of reference. It reached a compromise suggestion that experimental group practice centres should be established at selected places and different sets of conditions, types of practice and methods of payment be studied. There was virtually no contentious material. It was sent to be endorsed by the Federal B.M.A. Council without reference back to any conference. There matters stood early 1944.

So great a measure of agreement existed on at least sixteen major aspects of health that little necessity for further discussion existed. In the administrative field, there were no differences on these, which could not be removed by consultation. The two remaining subjects for serious discussion were hospital services and medical services. On the general principles to be followed on hospital service, there was no serious disagreement, not even on the possibility of payment for services of honoraries. On medical services, there was agreement as to the need for subsidised or salaried medical practice in all remote areas (extensive in all states but Victoria).

By early 1944, it was also clear that any extension of Commonwealth power in health would be in cooperation with the states only (of the type approved for a T.B. campaign June , 1943) , and that the Committee could no longer plan, as it had been doing, in contemplation of a uniform scheme for the whole of Australia. Administrative experience had always demonstrated the practical difficulty of doing just that.

In no sense could the B.M.A. at any time 1941-4 have been said to have failed to have offered cooperation; nor , despite provocative declarations, to have been unduly provoked; nor, despite their awareness of Labour Party admiration of the New Zealand scheme, unduly alarmed. The N.S.W. Planning Convention Feb. 6, 1943, was by far the most widely representative conference held by the B.M.A. in wartime. It included representatives and motions from every medical organisation in N.S.W. This convention expressed the opinion of the majority of doctors, city and country, that a whole time salaried basis for a nationwide medical service was not in the best interests of the community. This was consonant with the view of the Victorian Branch which had also held a convention of representatives of various organisations with the Council of the Victorian Branch in June 1943, that medical services were already to some extent nationalised on a salaried basis; as with mental disease, T.B., V.D. various branches of preventive medicine, country localities; and there was no justification for complete nationalisation as a matter of urgency.

As an alternative, the N.S.W. Planning Convention proposed that the profession support a contributory health insurance scheme, although already informed that the Government was not disposed to such a scheme.[137] Shortly after, the N.S.W. B.M.A. invited the Metropolitan Hospitals Contribution Fund to meet a committee of Council to discuss establishment of a non-profit-making corporate body, funds being raised by contribution from doctors to found it. The Federal Council endorsed the scheme:[138]

> "That it be a recommendation to the Branches that schemes on a voluntary basis be developed for the provision of medical service to the middle income group".

The Federal Council appointed its own medical planning committee August 23, 1943, to collate all Branch recommendations. It proposed voluntary insurance for the middle income group, and a fee for service scheme to the indigent. The B.M.A. was highly sensitive at this juncture to past suggestions that the profession had been uncooperative to Commonwealth planning for national medical service - as witness the statement of Sir C. Bickerton Blackburn to the Medical Planning Convention of 1943; that the public in 1938 were led to believe that negotiations had broken down because of extortionate demands of the profession. Furthermore, Sir. H.Newland had told the December 1943 conference, that a casual reader of the Sixth Report of the J.P.C. on S.S. might form the opinion that implementation of a satisfactory scheme for medical service was prevented by the selfish attitude of doctors. The profession felt it had, in good part, accepted civil conscription during the war, worked on Commonwealth coordination committees for rationalisation of practice - but doubted if professional opinion on future health service could be accurately canvassed with so many doctors away in the armed services.

Feb. 15, 1944, the Joint Parliamentary Committee brought out its Seventh Report on a Hospital Benefit scheme. At this juncture the Commonwealth called a joint conference between the B.M.A. and the N.H. and M.R.C. without Committee representation for an informal discussion. This was intended to arrive at some agreement on future principles of medical service. The Committee took umbrage at not being asked, held that they had been passed over, and insulted, and resigned in a body. This view was scarcely consistent with its support for the idea in 1941.

In its Eighth Report, published 1945, the Committee said:[139]

> "The action of the Minister of Health.. was taken without prior consultation of the committee, and indeed without even informing it of what was taking place. The action has side-tracked the work of the Committee while the matter is being handled by the Government directly with the profession. It is clearly impossible for the profession to

"carry on discussions concurrently with the Commonwealth". The Committee thus abdicated from the role it had elected for itself - of sole authoritative source of national medical policy rather than as an advisory body, its original purpose.

National health service ultimately did not come; as the J.P. C on S.S. advised under a comprehensive social service department, but under the Health Department, as desired by the B.M.A. From the disappearance of the Committee, all negotiations with the B.M.A. were carried on through the Health Department. As the Sun reported, June 30, 1944,

> "A difficult situation has been intensified by jockeying between the Department of Health and the Department of Social Services for control... at the moment the Department of Health appears to have been successful".

When the Labour Government called the joint conference, June, 1944, it already planned to appeal to the people by referendum for additional powers to carry out post-war reconstruction including health. Only two states had agreed to give them powers for five years after the war. It had passed a Pharmacy Benefits Act, April 1944, and made enquiries as to the effect on friendly societies of a social security scheme like that of New Zealand. The White Paper on National Health had been tabled in the House of Commons positing a health service free to all.

The June 1944 conference was authorised by a Cabinet thirsting for action. Labour had waited a decade to govern, and to express the ideal of Labour of a better society for every man, to which poverty would ~~be no bar~~ cause no social discrimination. A number of Labour ministers and members had known poverty and struggle; and, if they had prejudice against what they held to be vested interests, their prejudices had been born in bitter strikes and the depression. The notion of a planned society ~~of~~ a welfare state had special emotional appeal for such men. The preference was for the kind of complete plan put foward by Lord Beveridge in England in his 'White Paper on Social Security'.

With such an approach, it was difficult to see in B.M.A. policy that many solutions could go a long way to redressing areas of grievance, which proposed only limited government intervention. That this was not the Labour Government's intention was made clear when Senator Fraser opened the 1940 conference on a note of ultimatum (as Minister of Health); that the government intended that every citizen should have medical service without cost other than general contribution through general revenue; and that it would do so whether the service were accepted or not. Mr. Chifley, the Prime Minister, in one short speech made before opening the conference leaving shortly after his speech prejudiced the goodwill built in three years previous between the B.M.A. and the Commonwealth.

He claimed that the medical profession were reluctant to cooperate with the Government, and thus held up implementation of plans to date. He warned the Government would go ahead with its plans, and, if cooperation were not given, would go ahead with its objects looking to the pool of doctors in the defence service - who had never practiced - to provide doctors pledged to the Government.

The B.M.A. view was that largely a measure of agreement had been reached; but the disagreement referred to the order in which proposals for service should be adopted - in that the enactment of the Pharmaceutical Benefits Bill was beginning at the wrong end. Mr. Chifley's own cabinet was not in absolute agreement with the wisdom of this point of attack; but yielded to this view that they were going to have opposition from the profession anyway, that they had to start somewhere, even if it was - as some said- in the middle.

The 1944 Conference discussion was based upon the Medical Planning Committee's report March 1, 1944. The first part was accepted without debate, as 'the government is entirely in accord with the medical profession'. The second part, the relationship of the profession to this organised system, held the contentious matter:[140]

> "The discussion which have taken place over the last four years must now be brought down to practical terms. The Medical Planning Committee has progressed no further than fee for service, capitation, sessional salaried basis or a combination of any, or all of these'. This is too vague for practical administration".

But discussion could only take place with certain limitations on which the Government was definite, first the service was to be a free medical service of the type current in remote areas of N.S.W. (which precluded subsidised policies). Whether this was a sound principle was not open for discussion. Second, payment to the doctor would be by direct contract between the Government and the doctor, and administration by a department would be necessary as a part of the general system of the public service. This excluded any system independent of departmental control. As to who would make the ultimate decision, little doubt was left that the form of contract and the method of payment of doctors would be decided through Parliament. Sir Charles Eickerton Blackburn protested:[141]

> "I stress the point that you more or less indicated that cooperation meant following in line with the particular policy already laid down".

In fact, the B.M.A. was to be allowed to debate only the form of payment. From Dr. Grieve's attempt to get assurance on the three reservations contemplated in the Medical Planning Committee's report degenerated into the type of inconclusive argument, that is created by any attempt to establish validity

in an abstract concept such as free choice of doctor, quality of service of a doctor under a salary etc. The form of administration was not debated at all.

The heart of the matter was, to what degree was the domain of curative medicine to be invaded by the principle of payment by way of salary outside the agreed areas of public health, flying doctor service, outback areas, and area medical officers. The conference broke up with the Government clear as to the decided preference of the B.M.A. for a fee for service system, undiminished by the Government case for salary. The only profit of the conference was to appoint a fresh small consultative committee, proposed by the Minister, to do what the December conference had expected of the Medical Planning Committee six months before, and which it had avoided doing, to work out details. The Federal Council consulted with the Branches further on possible schems, control and conditions. Finally, a convention early September determined:[142]

> "The Government policy, having been stated to be a free medical service to all, with control by Government department and a contract for service between the Government and the doctor, this Convention is agreed that such a policy is not in the public interest, and is not acceptable to members of this Association.
> "The main basis of the objection is that the regimentation both of patients and practitioners, inseparable from and essential to, any Government scheme of free curative medical and hospital service departmentally controlled, is inimical to maximum efficiency and public confidence."

A conference September 29, 1944, attended by a Federal Council committee, and Dr. Cumpston and Mr. Goodes, was inconclusive. Planning was handicapped by lack of constitutional powers, but principles were defined. The Committee went into the conference to enter an emphatic protest against the formulation by the government of a scheme involving drastic alteration of medical service to the community during the war, or for one year afterwards; further that a free medical service to all under a Government department was not in the public interest or acceptable to the B.M.A. The B.M.A. would only discuss a fee for service scheme with payment by patient direct to doctor of a fixed percentage of the scheduled fee.

~~After~~ the war, in fact, ended shortly after, Planning continued 1946-9, traversing many of the same issues in more long, earnest, and doubtless tedious conferences to those who had already survived ~~their~~ their wartime ~~predecessors~~ DISCUSSIONS. The major change in the context of post-war conferences, however, proved to be the acquisition by the Commonwealth of power to legislate for medical services by a referendum of 1946. The Pharmacy Benefits Scheme, however, had been

possible to institute with the acquisition of Constitutional power. As soon as the Government acquired funds under the National Welfare Act, it gave notice to the friendly society movement of its intention to introduce a sickness and pharmacy benefit scheme - despite the promise of the Minister for Health, Mr. Holloway, not to introduce medical schemes until after the war. But he had also said 'unorthodox methods.. might be necessary during the war period".[143] Mr. Chifley favoured the N.Z. scheme, and sought a conference with the B.M.A. in August 1943 to have a 'viewpoint consistent with the B.M.A.'.

The B.M.A. expected that private pharmaceutical service would be heavily curtailed, and the principles set might set a precedent for future medical service. It feared that friendly society dispensary service might be taken as a model, which was felt to offer lower standards of service from a limited formulary, in a service controlled by non-technical men whose advice of ideal standards of service had qualified value. In short, the B.M.A. questioned the wisdom of elevating a concessional scheme with a lower standard of service to a national program - thus extending a lower standard to a far greater number of people. One of the Pharmaceutical Guild representatives told the Federal Council, B.M.A., that Mr. Chifley gave them the impression the Government was more concerned about the price of medicines than the quality; and referred to the parallel of friendly society service where the sum of 1/1d flat rate per bottle was struck irrespective of what was in it - while the friendly societies had already proposed to the government to provide a service at a lower rate than the pharmacists could do. Mr. Bennett expanded on the defects of concessional service in pharmacy, apart from the fact that dispensary pharmacists were not always fully qualified.[144]

> "The standard method of achieving economy in any service was to provide a limit. Public hospitals had to reduce costs and to do this by limiting prescribing. It was the custom of some contract services to desire a formula and the object of that formula was not to help the doctor at all, but to make certain the doctor could not prescribe high priced drugs. The doctor was restricted in his choice of prescribing. The patient would have to pay extra for the more expensive drugs which are outside the services. A formulary was unsound if the doctor was restricted. The inavitability of a formulary was advocated. The pharmacists raised the question as to whether a formulary was necessary.. an adequate formulary had never been prepared. Experience showed that formularies in existence cover 4.8 at the highest 20% of drugs actually prescribed by the medical profession.
> "Very few medicines could be kept in stock without deterioration of their therapeutic value. In cheap services and contract services, the methods of compounding are often not sound. A formulary enables a service to

> "make up mixtures in bulk, and these were often stored. It would be detrimental to public health, if that system was brought into being. It should be made wholly illegal to keep stocks of therapeutic mixtures. Very few mixtures could be made in bulk, and kept for more than 24 hours.
> "The friendly society pharmaceutical service was cut to the bone. Such a service was as good as the price paid for it. It would be a national tragedy if that type of service was accepted as the basis of a medical service, as was done in England".

The Labour Cabinet approved the scheme December 7, 1943, despite some disagreement from the pharmacists, and announced that the Bill to provide for the dispensing of doctors' prescriptions without charge would be one of the first steps in a long range medical and health program provided without costs (including hospital services). The public was not explicitly told that pharmacy benefits were a partial service, based on a formulary. In fact, if a doctor added any one ingredient to listed formulas in the formulary, the patient would have to pay. He could only subtract an ingredient.

The Federal President of the Pharmaceutical Guild, Mr. McGibbony, sought to remove the impression that this body had approved the scheme in the form endorsed by Cabinet. In the S.M.H. December 17, 1943, he was reported as saying it would:

> "lower the standard of service to the public and reduce the efficiency established by pharmacists.. the public would receive a restricted range of medicines dispensed from bulk produced stocks. The ideal system of prescribing and dispensing, according to the individual needs of each person, was not possible with a cheap standardised formulary service".

The B.M.A. was not officially informed by letter of the basis of the scheme, until a week before the Cabinet decision, and not consulted until the day after. The Minister advised IN CONFERENCE WITH THE B.M.A. REPRESENTATIVES that the Australian War Pharmacopeia of 1942 would be expanded by regulation, in collaboration with the B.M.A. and chemists, with the aim of a permanent formulary committee of review. Although he HE realised the B.M.A. would regard this as a 'main drawback' a formulary was necessary 'because it considerably reduces the cost of administration'. The B.M.A. President HAD had no time to secure authority from the Federal Council or the Branches prior to THIS conference with the Minister, but expressed the opinion that the B.M.A. would only support the kind of scheme the Labour Party claimed to be offering to the public - a comprehensive pharmacy benefits scheme which the limited service now being offered by the Labour Party was not in reality. The STates were to put the matter in stronger language, the W.A. President in 1944 saying the B.M.A. would not be a party to a confidence trick played on the country.

The B.M.A. did not consider the formulary as the main drawback, so much as the total drawback; so long as the patient was required to pay the full cost of any prescription where any single item was altered, and the onus of the decision was on the doctor.

The Pharmaceutical Guild also complained of the marginal costing, their Executive Officer saying it was based on eight prescriptions dispensed an hour, the fee being insufficient to cover labour and costs:[145]

> "To earn a bare living wage under the Government's free medicine plan, chemists would have to exceed the safety margin of time in dispensing prescriptions".

By the end of January, problems of costs had been resolved by concessions to the Guild; and the Pharmaceutical Guild had an understanding that the status quo re dispensaries would be preserved. ~~They~~ ITS MEMBERS had been alarmed at the request by the Labour Government to State and Federal Ministers of Health, November 1943, to amend state laws to allow friendly society dispensaries to supply benefits where ~~they~~ ITS MEMBERS could not do so; and to supply the public at large if they were not members of friendly societies. All States except Victoria had agreed to ~~do so~~ AMEND THEIR LAWS

The B.M.A. Federal Council had not yet had a chance to endorse the President's stand on December 8, 1943. The Branches supported him. He conveyed the official B.M.A. point of view to the Minister in conference Jan, 30, 1944. The N.S.W. Branch view from a committee of representatives of Council , Local Associations, and special groups was:[146]

> "The sums proposed to be spent by the government on such a scheme would be spent with greater benefit to the community on the construction, equipping and maintenance of pathological and radiological diagnostic centres throughout Australia.
> "The profession cannot agree on the grounds of efficiency to cooperate in any scheme of pharmacy benefits which ~~must~~ does not permit of unrestricted prescribing".

Queensland, W.A. South Australia and Victoria agreed; only Tasmania did not. Accordingly the B.M.A. Federal Council did not feel justified in nominating B.M.A. representatives on the formulary committee. This refusal became more positive after the Pharmacy Benefits Act became law, April, 1944, when B.M.A. cooperation in the formulary committee was again sought:[147] The B.M.A. stated with all respect to the Government that rigid adhesion to a formulary, if enforced by contract, violated the first great principle of medical practice - that doctors must remain free to direct their clinical knowledge and skill to the patient in the way they felt best. They must retain 'the priceless assets of individual freedom and enterprise'.

This unyielding attitude was undoubtedly influenced by recent legal advice, suggesting that a challenge to the validity of the

legislation
~~If~~ the High Court under Section 81 might succeed, the question had never ~~having~~ been decided by the High Court, remaining the most important of the large questions still open under the Constitution. Advice was to persuade the Attorney General of a state to take action as an invasion of state power. The attitude was also born of antagonism to provisions of the Act (16 and 22), which conferred wide regulation making power; and 15a whereby the Director General could appoint a medical man in any area on a salary basis for the purpose of writing prescriptions so the public might get free medicine. The B.M.A. saw in this a consciously planned loophole to allow the Commonwealth Government to establish a salaried service by a 'backdoor method'. This view was reinforced when the Labour Party defeated, on the floor of the House, an amendment to limit its application to remote areas only.

These factors caused more hostility than the failure to consult the medical profession at all, or the direct departmental control planned. Exception was taken to two further details. These were heavy penalties for offences under the Act (£50 or imprisonment three months) and insistence that prescription could only be made by personal examination of the patient (excluding emergency telephone service). Sir Earle Page, Leader of the Country Party, had expressed a view commonly held among the profession:[148]

> "The Free Medicine Bill was an extrordinary beginning to a national health programme.. if ever a measure came back into the Federal Parliament upside down, feet first, and back to front, it was this measure".

At the conference, June 29, the B.M.A. expressed the desire of the profession to cooperate provided certain objectionable features in the Act were removed. But the Government would make no concession on the principles causing B.M.A. opposition. July 19, the Government advertised for doctors willing to act on the formulary committee and were able to secure them. The B.M.A. refused to nominate members for the formulary committee, and the Federal Council decided that the profession should be advised not to cooperate with the Government in the use of the Formulary or the prescribed forms. Members were told there was no legal obligation to use either.

Press editorial comment generally adopted a very qualified view of the value of the Commonwealth scheme. The Argus, for example, June 5, 1945:

> "Normally political action is taken, usually belatedly, to meet a long-felt public need. The reverse happened in this case. There was no long-felt public need for free medicine for any considerable section of the people. On the contrary, the community as a whole was fairly well catered for in this respect.

The Sun News Pictorial had written when the Bill was passed, April 1, 1944:

> "Sweeping aside the advice of the country's best medical brains, the Government blunders into a costly, half-baked scheme under which it proposes to 'shout' pills for all and sundry and invites hypochondriacs to stagger to chemists' counters and quaff black draughts 'on the house'."

They questioned whether the scheme would give proportionate benefit to the health of the community for the cost, quoting Sir Earle Page that the only further backward step would be to provide free coffins before free medicine, and asserting that expense would be better applied to preventive and scientific health services. Many commentators doubted if the cost could be confined to £3,000,000 a year, as the Government confidently alleged, on the figures for New Zealand.

During the next few months of 1944, the formulary committee began work with a majority of laymen (only two doctors of seven members). The start of the scheme was postponed from January 1 to July 1, 1945. A Commonwealth referendum for additional powers, including health, was defeated. After the June Conference 1944 with the B.M.A., both on pharmacy benefits and the national medical service, a marked decline of goodwill occurred; and it should be noted that the decision of the B.M.A. not to cooperate on the former was known to Mr. Chifley before his influential speech at the June Conference. Among the leading reasons for loss of goodwill were not only his speech at the conference, but refusal to make the slightest concession on pharmacy benefit objections at the same conference, including the clause giving most concern, clause 15a, as to the Government's ultimate intentions towards the medical profession.

The B.M.A. was not absolutely unanimous in its own ranks. Criticism was found even with one of its own Federal Councillors during the visit of the Federal Secretary, Dr. Hunter's visit to Queensland July 1944. Dr. T. Price publicly, at a Queensland Branch meeting, dissented in the belief that the formulary would be widened, and Dr. A. J.Collins, leading member of the N.S.W. Branch, retaliated[149]

> "It is strange to find that some of our members still ask why we will not cooperate in what should be described as the Government Pharmaceutical Benefits scheme. They ask further why, if we insist on a complete scheme, we will not cooperate in a partial scheme, on the principle that half a loaf is better than no bread.
> "The reason is an important one. To cooperate in a partial scheme would involve the sacrifice of our freedom in prescribing. The partial scheme must of necessity mean that pressure will be exercised upon us, by our patients and the Government alike to confine our prescribing to the formulary. The principle is involved, no matter how wide

"the formulary may be".

The N.S.W. Branch, prior to a joint meeting of all State wide associations, sent a newsletter to its membership. It said that nothing had happened to change the B.M.A. decision not to cooperate:[150]

> "The measure purports to provide a benefit to every member of the community, but in fact does not do so. Under the provisions of the Act, the community will be divided into two sections
> (a) the individual whose pharmaceutical requirements come within the limits of the official formulary and who will be entitled to the benefits of the act.
> (b) the individuals whose pharmaceutical requirements do not come ~~within~~ the limits of the formulary and who will not be entitled to the benefits of the act.
>
> "The Federal Council considers that this discrimination between individuals through circumstances over which they have no control is unfair to the public and entirely unjustifiable, and it is not prepared to accept the responsibility of making, for every individual patient, the decision as to whether he is entitled to benefits or not."

The Federal Council also reiterated its objections to the provision of benefits only on personal examination, to a penalty , the form of administration, and the possibility of introducing a national service.

The Commonwealth had further postponed pharmaceutical benefit till 1945, and introduced an amending act, 1945, to overcome difficulties apparent with the Pharmaceutical Guild particularly in respect to friendly society dispensaries. The only concession made to the B.M.A. in this was to Section 22 that the doctors could satisfy themselves in some sufficient manner before prescribing. They had also, for the first time in over a year, sought a conference with the B.M.A. October 16, 1945. This conference was held at B.M.A. insistence after a politely hostile exchange of letters, in which the B.M.A. President insisted that they had never had a conference with the Minister on the Bill.[151]

> "The members of the Federal Council were not invited to discuss with you the proposed Bill , but to discuss the formulary with your departmental officers. As a result of that discussion, certain important suggestions made by members of the Federal Council have been adopted"

Two of the main objections still existing were limitation of pharmacy benefits to a restricted formulary - rather than simply providing free medicine - and to Clause 15, which provided for employment of doctors to prescribe pharmaceutical benefits 'should the necessity arise'. Federal Council were firm that cooperation could only be envisaged if these objections were removed.

At the time of the conference October 16, 1945, the new Director General of Health, Dr. MacCallum, was in office for a short term before his death, to be succeeded by Dr. J. Metcalf. Mr. G. G. Jewkes, director of Pharmaceutical Services in the Department, stated the official Government view that the Government would not take the responsibility of financing an unlimited scheme. It was essential to determine the benefits to be provided, as it was not possible to control the prescriber under the Act; in contrast to existing schemes which controlled the prescriber, but not the benefit.

By early 1945, the Treasury was concerned that the original estimate of £2,100,000 would bear no relation to the likely costs under the Formulary and were haggling over the costing system accepted in 1944: for a cost plus basis for supply of medicine. Two leading advisers were an ex-dispenser of the Melbourne Hospital, and an ex-dispenser of the friendly societies. The Treasurer's support for friendly society dispensaries being given open trading rights was common knowledge; and in fact was openly stated in the N.S.W. Parliament (in debate on the Friendly Society Dispensaries Enabling Act) when enabling state legislation was under discussion. This meant that twenty two dispensaries would be given full trading rights; and the pharmacists saw in this unfair competition, as the dispensaries were in a position to offer special inducements to attract custom. The 1945 Act was held to have broken faith with the pharmacists once again in failing to limit the number of approved dispensaries. In a history written by Mr. Holloway of the Dept of Health, who participated in these events, he said:[152]

> "These two powers permitted the dispensaries, almost without check to expand into open competition in the practice of pharmacy with the legitimate pharmacists. The Guild believed that the amendment was an encouragement and an incentive to the establishment of additional dispensaries, and that, once these were established, they would clamour for approval to supply the public generally; and there was no guarantee that such demands would be resisted for any appreciable length of time. The Guild visualised as a result of the enactment the utilisation by the friendly societies of the large capital funds held by them of a large increase in membership, and in the provision of financial inducements to their members to patronsie the dispensaries to the detriment of private pharmacists."

The Guild then recommended its members to cooperate with the Government no further; the Prime Minister intervening to say that opposition would not deter the Government who would use the dispensaries and other agencies if the pharmacists continued to oppose them. At this critical stage:[153]

> "it became known that serious opposition to certain aspects of the Labour administration's social services' program was likely to be encountered by sources other than the B.M.A. At least one state government was in

> "no wise convinced that the introduction of the Pharmaceutical Benefits scheme, if not the first step towards the assumption by the Commonwealth of the state powers to control local health matters, did not involve several direct trespasses upon state legislative powers".

The Attorney General of Victoria joined with certain members of the Medical Society of Victoria in November 1945 (which now had a merely formal existence in alliance with the Victorian B.M.A.) in seeking an injunction from the High Court of Australia, to restrain the Federal Minister and Director General of Health from carrying out any provisions of the Act, and to declare the Act invalid and void. The Commonwealth entered a demurrer which was dismissed by a 5 to 1 majority, November 18, 1945. The High Court did not accept the Commonwealth case that the legislation fell within Section 81 of the Constitution. They held that the effect of the Act not only authorised expenditure of Commonwealth revenue to provide free medicine, but it also contained provision for the expenditure of money for purposes which could only be described as legislation upon a subject of public health; a subject upon which there was no express power in the Constitution for the Commonwealth Government to legislate, its powers being limited to quarantine.

This decision was immensely important. In passing the Pharmacy Benefits Act of 1944, the Labour Government had had legal advice similar to that given the B.M.A. by its own counsel; and were well aware that their sole authority rested on the appropriation power contained in Section 81. However, it was also known that a Commonwealth Statute, even if unconstitutional, could continue in operation until its validity had been challenged, and it had been declared ultra vires in the courts. This had been the case with the maternity bonus. Because it did not aggrieve any individual, or group of individuals, it had not been challenged. The Labour Attorney General, Dr. H.V. Evatt, in his referendum campaign of 1944 had explicity said there was no authority in the Constitution for the Commonwealth to undertake either pharmacy benefit or national medical service.[153]

The successful 1945 challenge to the Pharmacy Benefits Act had far wider implications. The whole of the Commonwealth Social Service program had a precarious legal base; not only phases of it, like hospital benefits, widows' pensions etc, but the national welfare fund itself. Both past and future legislation were in jeopardy. Thus was precipitated within the Labour Party the demand for a further referendum for specific powers in this field; but a referendum which would avoid what were considered to be the mistakes of the unsuccessful 1944 referendum to the people in asking for too much added power for the Commonwealth, and couched in too general terms.

In the event, the Victorian Government did not proceed in the High Court to challenge the validity of the Act. A Labour Government came into office in Victoria, and the Commonwealth had decided to hold a further referendum in 1946. The Pharmacy Benefits Act remained in abeyance for two years 1945-7, awaiting reinforcement of Commonwealth power in the field of health. The 1946 referendum was successful, and the Constitutional Alteration (Social Services) Act received assent September 1946; giving the Commonwealth powers to legislate 'for the provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorice any form of civil conscription), benefits to students and family allowances'.

In July 1946, Senator McKenna took over the portfolio of Minister of Health - a lawyer and accountant, formerly in practice in Tasmania with the Labour Premier, Mr. Ogilvie. Mr. Chifley, the Prime Minister, retained the key portfolio of Treasurer. Four years of highly publicised antagonism were to occur between the Labour Government and the B.M.A. Although the natural bias of the Labour Party was towards nationalised medical service as a cardinal principle of Socialism, the personalities and beliefs of Mr. Chifley and Mr. McKenna gave the program driving force, particularly those of Mr. Chifley. He was fairly blunt about his viewpoint: being quoted in the Sydney Morning Herald of July 14, 1947, as saying:

> "The B.M.A. was not attuned to modern ideasof public service. I am convinced the B.M.A. is hopelessly conservative, but we have to recognise that it is the doctors' union, and is entitled to its point of view".

This view was becoming more vehement by the second reading debate of the Pharmaceutical Benefits Bill March 17, 1949, when he declared:[154]

> "All I can say concerning the officers who control the Federal Council of the B.M.A. is that they have museum minds that refuse to move with the times".

Veteran of many years as Cabinet Minister, Sir Earle Page is on record as saying:[155]

> "Students of political history are apt to divorce events from the personalities of the time. But history is in truth the impact of individuals on forces and influences which they seek to free or restrain, or by which they are submerged or conquered".

In the public wrangle with the B.M.A., Mr. Chifley was finally conquered; but not before lasting damage had been done to the public reputation of both the B.M.A. and the Labour Party before he went out of office in 1949. The judgement of subsequent writers has been that

he and his colleagues of the Cabinet misjudged the temper of the people towards Socialism in their attempt to translate a political theory into Australian society. In national medical service, they had been encouraged by the success of Aneurin Bevan in bringing it about in England: where, however, constitutional and social conditions were rather different.

Mr. Chifley was undoubtedly a strong Prime Minister, who generally dominated his Cabinet, partly because he had the necessary mystique of a working class and trade union background, seasoned in bitter industrial strife, and state politics over many years, since his origin as a traindriver. Those most close to him, McKenna, Dedman, and Dr. Evatt had not.[156]

> "None of them had in significant degree the basic Labour background and instincts which were Chifley's strength. Nor would they stand out strongly against him once his mind was made up". Professor L. Crisp

This was the assessment of his biographer,/ In any case, the demands of post-war reconstruction were so heavy that all were overworked, while Dr. Evatt also played a role in the United Nations. Senator McKenna, Minister of Health 1946-9, had 'a special position at Chifley's elbow after acting for some two years as an unofficial assistant.'[157] Furthermore, the Cabinet under Mr. Chifley dominated the non-Parliamentary Labour Party. This did not mean that Mr. Chifley was altogether an autocrat; ministers like Dr. Evatt (ex-state politician, barrister, High Court Judge of considerable intellectual reputation) having a great deal of say within their own portfolio. These were the men, who, in April 1946, brought down a Bill seeking enlarged powers for the Commonwealth, despite an election pending later that year.

An important amendment met the objections of the Liberal Party opposition in the 1944 referendum campaign, mainly in respect of industry. This was in the words ('not so as to authorise any form of industrial conscription') In Senator McKenna's word:[158]

> "For this qualification I pay tribute to the Opposition which stressed the point during the last referendum campaign".

Mr. Spender tackled the Attorney General with the crucial question whether the power to legislate in respect of medical and dental services, if granted, would enable the Parliament to nationalise these services. To which Dr. Evatt's reply was unequivocal that it would authorise the Commonwealth to do everything incidental to providing those services, but not to enable the Commonwealth to say that all practitioners must become members of the service. He admitted that it was a very wide power.

The Commonwealth would not be able to control registration, or the right of the States to lay down the qualifications necessary to practice medicine.

The response of the Leader of the Opposition, Mr. R. G. Menzies, was:[159]

> "Very little doubt exists that not only the words of the proposed amendment, but also the decision of the High Court will mean that under these words the medical and dental profession could be nationalised by making all doctors and dentists members of one government service which had a monopoly of medical and dental treatment. In that sense, this power includes a power to nationalise medicine and dentistry."

As to the outlook of the Attorney-General, Dr. Evatt, if such a point ever came to issue, Mr. Abbott evidenced Dr. Evatt's statement, given at an Australian Institute of Political Science summer school:[160]

> "The taking away of the right of the individual to choose his own vocation and employer was only one of the freedoms which the Australian people must forego in the interests of the State".

Senator McKenna argued at this time that doctors were subject to industrial conscription during the war, but Sir Henry Newland replied that it was 'voluntary', adding this was:[161]

> "a poor reward for the medical profession's patriotism and unselfishness if its acceptance of conscription during the war were to be used as a reason for its conscription during peace".

He was astute in realising the threat to the medical profession. He had not failed to examine the Bill in detail, and acted to create some safeguard. He wrote to Dr. Hunter:[162]

> "The referendum proposals are now being debated in the House of Representatives and I have written to Mr. Menzies, Sir Earle Page and Mr. Turnbull pointing out that the retention of the word 'industrial' in the terms 'industrial conscription' in one of the referendum sections would permit conscription of the medical profession, or of any other profession or body of associated persons. I have suggested that the word 'industrial' should be replaced by the word 'civil'. I think every effort should be made by your Branch Council to secure such an amendment. The Labour Party cannot logically oppose such an amendment, but party spirit tends to annihilate logic."

Indeed, Labour was in a sense hoist[ed] on its own petard, having originated the phrase themselves to prevent control of the employer-employee relation under the National Security Act, 1939, and conceded to them by Mr. Menzies when he was Prime Minister. Dr. Evatt now accepted the amendment from Mr. Menzies from 'industrial' to 'civil' conscription to prevent the state, as employer, drafting peopleinto vocations in a relationship of employment. With this small, but vital, change, the B.M.A., thanks to its President, was

presented with an opportunity, albeit a limited one, to challenge unacceptable phases of nationalisation.

Although the referendum was not passed until September, 1946, the Prime Minister, Mr. J.B. Chifley had embarked on his cherished program of national medical service before the Bill had even reached the House in April, 1946. With his Hospital Benefits program already launched, March, 1946, he sent a letter to State Premiers in anticipation of a conference of Federal and State Ministers of Health May 6, 1946. The basis of the scheme was to be the establishment of diagnostic and X-ray centres throughout Australia, which would offer a 'complete medical service' and whose services would be free and available to everyone without means test. The medical staff would be the responsibility of the Commonwealth. The last Commonwealth Conference with the B.M.A. June, 1944, had appointed an advisory committee to the Government, which had lapsed. The state of negotiations then had been that the B.M.A. had expressed itself in favour of a general fee-for-service scheme ; of a salaried service in remote areas; of diagnostic centres in principle at several conferences with certain provisos and of many areas of government intervention which would occur at the same time such as T.B. programs etc.

The understanding in 1944 was that the Government should proceed with no program for at least one year after the war, to allow doctors returning from service to readjust to civilian life, and have some basis of comparison before deciding which type of medical service they preferred. In March, 1946, in fact the Prime Minister ignored the undertaking, announcing his policy to the Premiers without any notice at all to the B.M.A.: despite their continued cooperation 1941-6, and the lack of any major point of conflict except on the issue of a fulltime salaried service without qualification. The conflict on the Pharmacy Bill had not been on questions of principle. Mr. Chifley now told the Premiers he would use the existing state hospital systems wherever possible; medical centres being established where it was not. In May, 1946, the Ministers were assured the Commonwealth did not intend to take control of hospitals.

The B.M.A. was alert to one new declaration in Mr. Chifley's announcement that the Commonwealth would, if necessary, use the expanding control by the Commonwealth over University education to train doctors who would guarantee to work under the scheme; and training schools would be established for certain categories like biochemists, pathologists etc. Doctors already in practice

would be given the chance to join the scheme either on a fulltime or a part-time salary. Simultaneously, the Labour Government in Great Britain was debating a National Health Service Bill, May, 1946, which was to satisfy the ideal desired by the Australian Labour Government - that it should be complete and free to every citizen who wished to avail himself.

The May Conference of Ministers decided to appoint two committees to work to the principles laid down already by the Prime Minister, comprising Commonwealth and State officers. The first was to establish a basis on matters of policy. The second was to work out detailed location of centres, allocation of general and specialised treatment facilities and extenion of flying doctor services. The B.M.A. was invited to elect a representative to the second committee in each state, but not the first, on the grounds that:[163]

> "as the first departmental committee, which is to consider the practical aspects of the scheme has not yet established a basis upon matters of policy, and reported thereupon to a conference of ministers of health".

The Commonwealth was not prepared to discuss principles, only details of administration and remuneration. The B.M.A. were aware that the Ministers of Health, in both the Churchill and Atlee Ministries in England, had conferred with B.M.A. men there. They would not nominate a representative saying it would be premature until the first committee had reported on policy.

The B.M.A. had made no formal statement. The President unofficially reminded the Press that the B.M.A. had no alternative plan December, 1945, and were planning voluntary insurance or prepayment schemes for medical and hospital benefits. Public opinion polls had seemed to show there was a demand for such a service. They desired expansion of existing service, among the most urgent of which were the safeguarding and improvement of educational, nutritional and housing standards, extension of the present maternity and child welfare services, and extension of hospital construction and equipment. The Prime Minister, late 1946, took the rostrum in a dual campaign both for re-election and the referendum, the former being fought on the leading issue of the latter. In his September policy speech, he said:[164]

> "By carrying the social services question at the referendum, the Government will push on with a national medical scheme providing clinical, pathological, X-ray and specialist services throughout Australia. Special attention will first be given to areas which at present lack these facilities.
> "There cannot be, and will not be, any compulsion on doctors to achieve this. Those who wish to do so may continue in private practice. The doctor who joins the

> "Government service will take pride in rendering disinterested community service. He will have an adequate and regular income, recreation leave, superannuation rights, and opportunities for post-graduate study".

In this speech, he foreshadowed a salaried service. In an earlier speech at Fremantle, he declared that if doctors would not cooperate in the medical scheme, the Government would train its own doctors. He seasoned his manifestos both with persuasion and threat. Only a year before, his Minister for Health in a public article in answer to Sir Hugh Devine on the futility of nationalisation, pointed to Army medicine as a successful example of 'free medicine'. His successor as Minister, Senator McKenna, now said the Government planned to introduce the scheme by stages, with the objective of a complete service in 10-15 years, adding in a letter to the B.MA. President that:[165]

> "The Government's plans for a national medical service will, of course, be conditioned by events to take place later this year".

With the referendum successful by the end of the year, the Labour Government planned to make a serious beginning with both a national medical service in 1947, and revival of the pharmacy benefits scheme of 1944-45. For the next two years, 1947-9, B.M.A. negotiations were to be a counterpoint of these two themes with the more serious and irreconcilable antagonism manifest over pharmacy benefits as it had been 1944-5. Critics of Labour Party policy were not wanting among journalists, as for example the Argus News Editor, writing June 2, 1945:

> "Nationalisation of medicine they call it. It aims to abolish the private medical practitioner, substituting a departmental medical officer whose boss will be a bureaucrat and whose master will be the government of the day. In plain English, it means that the health of the community will become a political bargaining point like coalmining... The nationalisation of medicine has been proposed and planned by a handful of Government officials in the Treasury and Public Health Department. They include medical officers in a salaried service; experts in epidemiology, in the policing of pure food regulations, the quarantining of people. They have been away from clinical medicine and active medical practice."

In January 1947, the Director General of Health, Dr. Metcalf, had visited all states; and the committee of health officers, February 3-4, compiled an extensive report of recommendations, which were then discussed by a conference of Ministers in May, and brought before the first official conference held between the Minister, Departmental officials and the B.M.A. July 21, 1947. Up till this time, the Minister had made no recommendations to Cabinet - though the Labour Government hoped for legislation and some form of administration to be set up by the end of 1947.

From the BM.A. side, they offered principles essential to any national medical service. From the Government side, the B.M.A. were told that the principles laid down by the Prime Minister must be kept in sight; that a free medical service was to be offered; and the basis of discussion was to include the committee's February report. The Minister declared that it would be a complete service , free, and of the highest technical excellence. Over sixty resolutions were dealt with in relation to the four Government principles.

This comprehensive official report included some ideas implemented twenty years later (N.S.W. country practice scheme 1968); others with which the B.M.A. had little quarrel; but some contentious suggestions such as recommendations that staff of many hospitals should be fulltime, and that remuneration in the city and large towns should be either fully salary, or basic salary plus a capitation fee plus hospital sessions; and that medical centres in metropolitan areas should be staffed by fulltime salaried men as well as general practitioner services.

The Minister and the B.M.A. were most politely at loggerheads from the first; the Minister, anxious to confine the discussion to details, but the B.M.A. as a conscious policy insisting on discussion of principles. The principle on which they were most anxious for definition was the extent to which the Government planned to extend the salaried service which they had gathered to discuss. They were not satisfied with statements from Mr. Chifley and Mr. McKenna that private practice would continue. They believed that the scheme might not introduce political compulsion, but it would introduce economic compulsion. Twice the Minister was asked in effect the question to which the B.M.A. had as yet had no answer - whether the Government intended, or hoped for, the complete elimination of private practice. As yet the Government had avoided acommitment.

On being pressed in conference yet a third time by Victorian delegate, Dr. C. Colville, the Minister made a commitment which was to have a vital effect on the B.M.A.'s attitude in all further negotiations with the Labour Government. Dr. Colville asked whether, although the Minister kept on emphasising the development would be gradual and some would prefer private practice, ~~whether~~, in fact, the ultimate object was admittedly that private practice would be eliminated. To which Senator McKenna replied:[166]

> "That is so. There is no dispute as to that"

evoking further comment from Dr. Colville

> "That is the answer I want. Do you understand that this expert body which has come toconfer with you today considers that it is a bad thing and advises against it?"

Although the Minister tried to recover ground by saying he would consider Council's views and put them to his government, the damage was done.

For the Senator's part, he gained no converts to his view that the Government was given a mandate for a free service by the referendum; and was acting in response to popular pressure. He had claimed the identity of the Government with the people in his opening phrase to the conference "The Government is in effect the people, and the mouthpiece of the people". Therefore there were not two parties to the conference but three, the Government, the patients, and the doctors. For the B.M.A.'s part, they failed to convince the Senator that doctors might also be competent to represent patient interests:[167]

> "Where is to be found the urge to bring about this great upheaval? Certainly not in the minds of the medical profession, and I venture to say if all its implications could be made clear, not in the minds of the public either."

As to their own doubts, Dr. Colville was spokesman for the B.M.A. Federal Council:[168]

> "Turning to socialised medicine, we are immediately brought face to face with the fact that it is an unknown quantity, since no such system in its entirety is in use anywhere in the world today. We can therefore only speculate on some of its aspects, but it seems reasonable to assume that under it most of the advantages of the existing system would be adversely affected or destroyed.
> "In their place, would emerge the one outstanding feature that medical service would be free of direct cost to the patient; but it is an elementary fact that, as everything has to be paid for in the long run, he would have to provide the cost indirectly through social service contributions".

The patient would find medicine trammelled with forms, permits, certificates, and service; not from his family doctor, but from whoever happened to be on duty. He quoted from existing hospital and public service systems as to the kind of problems in promotion and economies that could afflict government service. In short, the B.M.A. argued, the free service was only 'free' in the sense that it was freely available to those who wished to use it, but not free in the sense that it was not to be paid for by somebody, somehow.

For the first time, the Federal Council formally proposed to the Commonwealth that fee-for-service should be paid rather than capitation. The Minister promised consideration of the idea, although honest about the attitude of both himself and the Cabinet; that it was not the type of thing he would be disposed to recommend, while the general feeling of members of the government and the party was entirely opposed to the principle. The B.M.A.'s case rested on the Government's use of the practice in repatriation work, invalid and old pensioners, and the emergency medical service;

and on the fact that the N.Z. Government had found fee for service had cost them very little more than capitation; that doctors had worked under workers' compensation on agreed fee for service schedules for years-with tribunals to arbitrate on all disputes in Queensland, W.A. and N.S.W. Moreover the principle was recognised in legal practice by the Government, which paid fees for service to lawyers.

The two major objections to fee for service were known to be the cost factor (proved not as great as expected in New Zealand) and the fact that it was open to abuse by doctors. But it was felt that tribunals such as in W.A. and N.S.W. for workers' compensation had reduced abuse to 'an absolute minimum'. Capitation was believed to be also open to abuse:[169]

> "We have always felt that we should not be paid a fixed fee for what is really an unlimited service. We do not know the nature or extent of that service. What we do know is that, under a per capita fee, we would have to attend our patients considerably more frequently than we have done in the past. The old 'something for nothing' idea is one which gets hold of the public, and there is no question there would be abuse along these lines".

They were not confident that the public, being told the service was free, would realise that they would have to pay for it by way of tax, and their use of it reflected in the incidence of tax. Nor were they confident that Ministerial control would offer sufficient protection to the profession. Therefore a secondary demand from the B.M.A. was that there should be no direct contract between the Government and the B.M.A.

Both at the conference, and afterwards, Senator McKenna was definite that the conference was exploratory, that no concrete proposals had been put to the B.M.A. In the Minister's words to the Press:[170]

> "Although no decision was reached, the Commonwealth and the B.M.A. now have a feeling of certitude regarding matters that are common ground".

The only decision sought or given was to confer further before legislation went to the House. The most apt comment was that the first conference had yielded no guarantee of the collaboration the Government needed.[171] The Melbourne Herald, July 31, 1947 added:

> 'The profession hesitates to fall in with the purely voluntary scheme proposed by Senator McKenna because doctors regard it as a first step towards nationalisation of medicine. It claims that if the Government were to get even quarter of what it proposed from the profession, an organisation would be created with enough momentum to carry on until nationalisation was complete."

The diplomacy exercised by Senator McKenna was at odds with that of his Prime Minister a scant week before. With little regard to the history of negotiations in any field but pharmacy benefits, he had addressed the Macquarie A.L.P. Assembly in his own electorate saying the Parliamentary Labour Party had been more ambitious than the trade unions and the Labour movement, in its social services policy. He believed the B.M.A. to be hopelessly conservative, and not attuned to modern ideas of public service. However he admitted their right to act as a trade union, and instruct its members if it opposed a certain policy to do likewise. If a belief prevailed with Mr. Chifley or his associates that the B.M.A. was 'instructing' its members, rather than expressing the demand of the membership, the events of the next two years were to prove the latter to be the case.

By September 1947, the profession believed they were being asked to indulge in 'professional euthanasia'. The Press tended at first to support the B.M.A. The Daily Mirror, for example, wrote September 30, 1947:

> "It is felt that it would be foolish to take part in any consultation which would amount to assisting in the virtual extermination of medical practitioners. Emerging from the gigantic task of nationalising doctors, dentists and chemists will be yet another bureaucracy to be added to the already huge army of civilians employed by the Government.
> "A majority of the public will prefer that the present system of choosing one 's own doctor should not be abandoned or encroached upon in any way. This is another of our liberties which we should insist with the medical profession must not be filched from us".. "To suggest for one moment there will be no conscription of the medical profession is puerile".

The N.S.W. Branch of the B.M.A. certainly anticipated the hard line apparent after the July Conference. In reporting to their membership the Branch said it had not, at any time, agreed with the Minister to form a service along the lines proposed:[172]

> "It speakers indicated that, just as the Government considered it had a mandate from the people for providing a free service, so the Federal Council had a mandate from its constituents, embracing the principles that the control of any service must be by a corporate body, that any service should be based upon the existing type of private practice, that remuneration should be based upon fee for service, and that the Government activities should be restricted to coordination only".

The Federal Council now sought a mandate from members, as to whether to negotiate with the Government in the formation of such a service, now there was no doubt:[173]

1. "that the Government desires the disappearance of private practice
2. that medical practitioners in the service will be controlled
3. that, whatever the form of central control, there will be overriding ministerial control.
4. that the Government will not agree to accept nominations from the B.M.A. for appointment to the central controlling body
5. that a fee-for-service method of payment is definitely not favoured by the Government".

Shortly after, the B.M.A. regarded the truce of silence with Senator McKenna as broken, due to publicity on points where the B.M.A. had failed to agree. It advised Senator McKenna, in view of unilateral publication of proceedings it was absolved from maintaining the silence which has hitherto, to the disservice of the nation, prevented the public presentation of the case of the B.M.A.[174] Although the Minister disowned the publicity, the B.M.A. proceeded with a formal statement issued by the Publicity Committee to the nation September 10, 1947- though not without protest from the W.A. Council that by so doing they closed the door against further negotiations.[175]

> "If it is said, as indeed it is by the Government that doctors surrender their traditional freedom of practice because the Government has a mandate from the people conferring powers over various 'social services' including 'free medical treatment' they reply that that mandate was asked for in very general terms. It was not asked for as a specific mandate to do what is now proposed, to set up a large new Government department, to destroy a long cherished social freedom - the patient's right to choose his doctor, the doctor's right to practice his art in the way most to the patient's advantage; and the right, which transcends all his other rights, to see the light of medical truth wherever it appears to him, and not where he is directed by an official to see it.
> "Whether or not a mandate was given to establish a new bureaucracy without which no scheme of state controlled medicine could be organised, may be considered beside the point. But the medical profession believes it has an implied mandate to preserve a social freedom which the Government wants to take away.
> "Free medical service is not what it might seem, since it must be paid for and that very expensively, out of people's taxes. But if medical service is to be free, why should not the still more primary needs of life first be free - food, clothing, shelter? Free bread? Free clothing? Free housing?"

Senator McKenna's defence was that no doctor could be compelled to enter the scheme. The Press joined the Chief Justice of Victoria, Sir Edmund Herring by and large in warning of the dangers of bureaucratic government, such as might be raised by national medical service. Onthe right of choice of doctor, the S.M.H. editorial September 11, 1947, said that whoever proposed to revolutionise or abolish the system of private practice was under a tremendous obligation to prove equal or superior benefits

from its alternative.

On September 23, 1947, the Cabinet approved plans for the national medical service in principle. By November, differences were public enough to include statements like that of the President of the N.S.W. Branch, Dr. R. Grieve, that the Government intended to 'blackmail' doctors into entering the scheme. He referred to the intention to pay doctors compensation who entered the scheme by a given date; and challenged [the Minister Senator McKenna] ~~him~~ to publish the transcript of the July conference. Patients were also said to be going to lose their tax benefit if they attended doctors privately.

Although doubts were expressed from at least two branches, Tasmania and Western Australia, about the wisdom of such an attack on the principles of the Government scheme while still under negotiation, the N.S.W. Branch Council had already said it was unwilling to cooperate in forming a service whose ultimate intention was to replace private practice. Councillors, both Federal and State, also remembered acutely the results of a similar truce of silence in 1938. The sense of antagonism between the Labour Government and the B.M.A. was fortified during the first half of this critical year, 1947, by parallel negotiations on pharmacy benefits. Knowing that the Government intended to revive the 1945 legislation whose validity had been imperilled by the High Court action, the B.M.A. Federal Council had met on March 5, 1947, to prepare policy, should the Commonwealth revive negotiations with the B.M.A. These had lapsed after the conference October 16, 1945, when the Council resolution had been made known to the Minister that, if the Minister refused to meet the Council's objection to the Pharmaceutical Benefits Act, it would discuss no other aspect, and would continue its policy of non-cooperation. The B.M.A. now planned to put forward a new alternative policy, already approved by the Branches, that free medicines should be limited to costly life-saving and disease-preventing drugs on the grounds that this would lessen the cost of the scheme, simplify administration, take the emphasis away from the bottle of medicine and get away from the greatest difficulty - freedom of prescribing. The drugs left out of such a program were not costly, used mainly to treat symptoms, and could be obtained already through friendly societies, and hospitals.

Summoned to a conference with the Minister for Health, April 21, 1947, as legislation was intended in a matter of weeks, the B.M.A. Councillors had submitted this plan to Senator McKenna

who declared himself to have no preconceived notions. He promised to consider it, and asked for the B.M.A.'s comment on the formulary. He asked for its deficiencies and the amplifications necessary; and to have a definition of what constituted an examination for the disputed Clause 22. The only concession in fact made was the appointment of one more doctor to the formulary committee, and a promise to consider the penalty clause. The Minister refused outright to omit Clause 16 from the Bill (permitting the Commonwealth to enter into agreements with doctors) nor was he amenable to the idea of offences against the Act being dealt with under the penal code.

A week before legislation, the B.M.A. reported to the Minister its criticisms of the Formulary. As to the formulary, if used, they said first the provision for individual prescribing was too inadequate. Allowed variations were cumbersome and quite impracticable. Second, the range of drugs was not a fair coverage of those in use. Third, allowance for repeat prescriptions was inadequate, particularly for chronic conditions. Three major criticisms of the use of the formulary at all were reiterated. First was that the doctor would not be able to prescribe uncompounded medicines, or to vary the formula by so much as one addition. It would no longer rate as a free benefit. The necessity to stick to the formula could only have one result:[176]

> "Slavish reference to the formulary at the end of every consultation would prove irksome, time consuming and humiliating to the doctor and would undermine the confidence of the patient."

Secondly, the doctor would have to write out the prescription on a government form. He might conceivably forget in an emergency at night either his form book, or his formulary. Thirdly, he could only write one prescription to each form. Hence for a patient requiring a mixture, powders or pills and a liniment, the doctor would have to write three separate forms in duplicate; a procedure considered vexatious and time-consuming. The Sydney Sun reported a Caucus meeting where the Minister was said to have explained the Act to the Labour Party, and said thereat that doctors and chemists who prescribed outside the scope of the Bill would be questioned, warned, and then 'lose their meal tickets'. When tackled about this, the Senator said the news story was a distortion. Such episodes, however, did nothing to create confidence between the sides.

June 6, 1947, the Pharmaceutical Benefits Act, 1947, was introduced into the Federal House to repeal the Acts of 1944 and 1945. It, however, retained the main provisions of these acts. The Commonwealth, now having power to do so, gave friendly society

dispensaries the right to engage in trading, to which the Pharmaceutical Guild had already expressed disagreement, and which its Federal President Mr. Scott now called an 'outrageous piece of legislation'. It included all the principles to which the B.M.A. had taken exception in 1945, including the principle of discrimination involved in the formulary, of penal clauses, of control by a government department. It still provided, in the opinion of the BM.A. in Clause 16, an opportunity for the introduction of a nationalised medical service by means of an act not drawn up for that purpose. Though purporting to have dropped the principle of penalties in deference to the profession, their fears were not allayed onevhit, as it was replaced by a clause conferring on the Minister the power to determine offences and penalties by simple regulation - a power that appeared more, rather than less, arbitrary than before. The only question in fact left open for debate with the B.M.A. was the actual contents of the formulary.

The Act No. 33 of 1947 came before the Parliament an hour before Parliament rose at 5.45 a.m. in the morning, after two consecutive all night sessions; members had had 5 ½ hours respite in 48 hours, But Mr. Menzies, Leader of the Opposition, summoned enough energy to protest: that for the third time the measure had been brought in in the wee hours of the night. The revival of the Bill in the same form as before belied any suggestion that the Minister had no pre-conceived ideas. The B.M.A.'s own plan for 'costly and life-saving drugs' was relegated by letter July 7,1947 from the Minister;[177]

> "Your Council will appreciate the difficulty in which the Government will be placed to explain the exclusion of pharmaceutical benefits providing for the cure or amelioration of the maladies and minor ailments already mentioned".

The B.M.A.'s reply was to say that, as the four obnoxious principles were still in the new act, the Council could not advise members of the profession to use the Government prescription forms and formulary. It is important to note that this letter was dated July 18, four days after Mr. Chifley's Macquarie Assembly speech, so that the charge of conservatism or failure to agree could not have referred even to progress on the pharmacy benefits bill. It could only have influenced the July 21 conference on national medical service, while the rigid attitude of the Government on pharmacy benefits must have contributed to their desire on July 21 to push the Minister on the point of whether socialisation was intended or not.

A further long and painstaking exchange of letters with the

Minister claimed on his side that their objections were without substance, while it was not proposed to include it in the regulations; on the B.M..A's side the Government had failed to grasp the decisive importance of the doctor being required to decide by his prescription if the patient should get free medicine or not. They pointed out that:[178]

> "no process of reasoning or argument could convince patients that the doctor is not responsible, especially if government statements continue to inform the public as they have already done on an impressive scale, that all modern remedies will be included in the formulary".

while relegation of this power (i.e. to impose penalties) to 'future and undefined regulations' is infinitely more pernicious than its inclusion in a special section of the Act.'

Finally, the Minister promised in September to put the objections of the Federal Council to Cabinet, but was not able to advise them that this had been done until six months had passed, until April, 1948; or of Cabinet decision to use the Formulary, and Cabinet viewpoint expressed as follows-that it had met the BM.A. by reconstituting the Formulary Committee; abandoning penalties for doctors for unnecessary prescribing; by agreeing to consult Council as to the form of sanction re prescribing; and by specific assurances as to the use made of Section 16(that the Government did not intend to introduce a national health service under the Act). The Minister thereupon asked for cooperation from the profession, only a week before the Government planned to launch the Act by gazetting the regulations.

Writing of the six months' interregnum late 1947 - due to attempts to bring to finality an agreement with the Guild including some guarantee of review, Mr. Holloway wrote:[179]

> "It is doubtful whether the results of these attempts to incite public opinion justified the efforts of either party. A limited amount of support was given to both sides, but this came mainly from those bodies whose affiliations or political leanings had under all circumstances favoured one particular side.
> "However the support of the general public, which was the real goal of each side in this publicity campaign was singularly lacking and thereby created the impression that the government in the insistent and inflexible pursuit of its policies might have sacrificed the substance for the shadow".

These remarks remained true of the whole episode until the dispute was settled by Labour's fall from office, late 1949.

The dispute dragged on through 1948 and 1949. On May 2, 1948, the Minister, Senator McKenna, had broadcast to the nation that the scheme would operate from June 1, 1948, on a formulary that included 300 more prescriptions than originally (now 650), but not one that the B.M.A. had proposed. Senator McKenna said:[180]

> "The Government had dropped at the request of the B.M.A its original proposal to provide penalties against doctors who prescribe unnecessarily under the pharmaceutical benefits scheme. Instead, the regulations would give a code of 'proper prescribing' with no penalty for breach. The Government placed its trust in the honour of the profession to observe the code".

The Secretary of the B.M.A. repeated in the national press the claim that the BM.A. had for four years been urging a complete free medicine scheme on the Government; which resisted this with the formulary scheme offering 650 prescriptions 'to squeeze the nation's medicine bill into limits that fitted the budget! He also denied that penalties were deleted from the Act. Doctors still had to produce formularies and Government prescription forms intact or suffer £50 fine, with no right of appeal against penalty.

The Guild had, by plebiscite, agreed to cooperate with the scheme after the Government had accepted certain principles (involving 3,000 chemists); and the friendly society dispensaries also supported it (though claiming that only 50% of their prescriptions in 155 dispensaries would be benefits).

The Federal Council, their policy fully endorsed by the Branches, once more presented to the Minister the terms under which they would cooperate - either in a totally free medicine scheme paid on all doctors' prescriptions (claimed this only some 15% more), or on their own plan of a 'costly and life-saving drugs' scheme;[181]

> "Throughout discussions with the Government from 1943 until today, the Council has stated that it would recommend members of the profession to cooperate in the working of the Pharmaceutical Benefits Act if a prescription written by a doctor on his own prescription form was free to the patient."

They objected to Regulation 34, as 'a new form of iniquity, intimidation and cooercion';[181]

> "The Council is satisfied that the regulations already introduced are much more rigorous and comprehensive than any contemplated by you in your conversations or correspondence with the Council and the medical profession generally takes strong exception to them. Further, the Council cannot be assured that the present or any future Government may not make further more stringent regulations".

The Council had already decided and published in the M.J.A. advice to members that, when the formularies and forms arrived, they were to refuse delivery - acceptance would expose them to penalty. A printed statement was to be available to all patients stating the doctors' objections, and declaring 'I have no objection to the Government paying the chemist for dispensing any prescription I might give you - that is supplying you with free medicine'. In offering this advice the Federal Council had sought legal advice, among others from G. Barwick, K.C., which indicated that, while

the Government had power to provide services, it had no power to compel the doctors to render the service. Out of 7,000 doctors in Australia, less than 200 failed to follow the advice, and refused to accept the formulary from the postman.

If the Government had hoped for a demand from patients, and younger and socialistically minded doctors, they were to prove wrong. If they hoped that the Federal Council had not reflected the general sentiment of the profession they were also wrong. The battle with the B.M.A. became a paper warfare of statements in the press, revealing official letters between the two protagonists. On the Council's appeal for loyalty from doctors throughout Australia, Senator McKenna did not mince words:[182]

> "Your action seeks to deny to a doctor any opportunity to exercise his personal medical judgement as to the merits and demerits of the formulary and the Government's plan... This attempt to interpose an iron curtain between medical practitioners and full knowledge of the Government's proposals, indicates to me that your Council lacks faith in the merits of its objections to the Commonwealth Pharmaceutical Benefits scheme".

To which the B.M.A.'s reply was:[183]

> "You state the doctor is completely free to take part or to refrain from taking part in the scheme. The doctors almost to a man have exercised that freedom and have refrained. Having decided this, surely the logical course to adopt was to refuse to take delivery of the Commonwealth formulary and prescription forms".

A conference with Senator McKenna advanced matters little on July 3, 1948. Amendments proposed by McKenna proved unacceptable, as he would not withdraw either formulary or Government form. He further appealed to Council to withdraw their non-cooperation 'having regard to the absence of merit in the objections put forward by your Council', and asking if they had others not yet disclosed:[184] The profession stood firm on the view published the day the Act commenced:[185]

> "No valid reason has ever been advanced by the Government for this insistence on regimenting the medical profession under a scheme which properly concerns only the Government the chemists and the public. The Federal Council of the B.M.A. during four years of correspondence, conference and negotiation with the Government has consistently opposed this entirely unnecessary and unfair involvement of the medical profession in the working of the Pharmaceutical Benefit Act, but to no purpose".

By the end of 1948, the six months' wait and see period adopted by the Government, the professional boycott had been almost unanimous, although the B.M.A. from the first had declared it had no intention of acting against those doctors who did cooperate with the scheme.

The Government was faced with an absolute stalemate created by

its political decision to begin with pharmacy benefits, as a result of pledges made in the 1946 referendum. Unquestionably if it had begun its program for the first time in 1947, it would have begun with the national health services, and allowed benefits to develop gradually as an incidental of the service. The five years of the 'battle of the bottle' by the end of 1948 had turned into a grave political embarrassment, and gave Labour's political opponents fresh ammunition to that, already created by Labour's plans to nationalise banking, shipping, airlines and other enterprises.

Plans for national health service had proceeded as well during 1948. Cabinet had approved plans for a medical service, September 1947, while the B.M.A. had publicly declared opposition to any plan for a salaried service. Ina press release, September 10, 1947 they said:

> "This suppression of freedom, according to Government statement, will not be by one swift stroke, but slow, deliberate and ruthless. It is to be made in the name of the people, and in the name of 'freedom'. That is both the irony and the danger of it."

The B.M.A. sought a date to meet the Government early 1948, Legislation had been postponed. Pressure on Cabinet members meant Senator McKenna had to act in other capacities. The Director General of Health, Dr. Metcalf, was also abroad examining other health services. A memorandum on the merits of fee for service had been prepared at the request of the Victorian Branch by its secretary Dr.C. H. Dickson and its leading exponent of the problem, Dr. C. Byrne. This was redrafted to incorporate the various amendments suggested by the Branches, and after further referral to the Branches, sent to the Minister, February 1948. It examined the four alternatives put up to the B.M..A by the Minister July 1946, and asserted that the fourth - fee-for-service- was the only one consonant with their principles: It was felt this would be more efficient and with a minimum of administrative machinery Three criticisms were dealt with in terms of New Zealand experience, which Dr. Hunter, and the Victorian Secretary, Dr. Dickson , had been sent to study. These were that the liabiality was unlimited; it would be abused by patient and doctor; and there would be no provision for night and weekend service. Their report showed that fee for service cost after two years as at March, 1943, was less than if a capitation fee had been universal; that abuse in N.Z. had proved to be more relative to pharmacy benefits which had soared from a base 4/- to 13/6d per head. Part payment by the patient had been recommended to check such patient abuse.

In support of the viewpoint of all B.N.A. Councils, a plebiscite had been held, late 1947, of the total membership stating the principles asserted by either side to decide whether to keep aloof from these proceedings or continue to negotiate; and, if the latter, on what basis. Perhaps the most interesting of these statistics were those from Queensland and Tasmania; the latter state having been the most kindly disposed towards the Government during negotiations. In Queensland, a very large majority of the 400 replies favoured continuing negotiations, the majority preferring fee for service. In Tasmania, almost all believed negotiations should continue, ~~and~~ (a number would accept capitation fee) ~~though~~ the majority preferred fee for service. In both states almost 90% were prepared to accept decisions of their Councils.

Months passed by before the occasion arose, which was finally October 26, 1948, once more only a month before legislation was to be brought down, ~~and with~~ the intention of only stating broad principles, details to be laid down by regulation. The B.M.A. were to be invited to discuss pay and administration, not principles. In the interim, the Director General had spent three months examining schemes abroad, and returned in April saying that nationalised schemes in England, Ireland and France were not a success; that he had found nothing that could be adapted from them to help the proposed Australian scheme. To the Press he said:[186] 'In Australia, we have different geographical and social conditions and we will have to work out our own system'.

In these months also, the news from England had changed drastically. From an overwhelming opposition to the Bevan health service, and Lord Horder exhorting the profession to stop the march to totalitarianism, the B.M.A. suddenly decided to cooperate with the Government. The London Secretary explained to Dr.Hunter by radio telephone May 7, 1948, the reasons for this - that it would not be possible to introduce a salaried service which had been the outstanding point at issue, and on which the B.M.A. considered they had won a signal victory. Finally, the joint committee of B.M.A. and Government representatives in New Zealand had reported on the scheme there. Lord Beveridge had visited Australia in May, and recommended waiting for this report. The Labour Cabinet put a revised plan to the Federal Council on October 26, before submitting it to their own Federal Parliamentary Labour Party. Confidence was asked for, until this had taken place.

The Labour Cabinet had now decided on an abdication from its overriding principle that the medical service should be free:

that such an ambition might be achieved by a process of evolution, both for a complete and a free service.

The B.M.A. boycott of the Pharmaceutical Benefits Bill begun four months before, may have had some influence on their decision, for the 'inevitability of gradualness' of which they spoke. On the one hand, the Commonwealth would not disturb state institutions - its role would be financial aid, standardisation, coordination, and securing an even approach along the lines recommended by the Royal Commission on Public Health in 1926. On the other hand, the Government would adopt fee for service for the general practitioner with a schedule of fees, the fees to be claimed for by the doctor on behalf of the patients for the 50% the Government was prepared to contribute. A doctor who came into the scheme would be obliged to keep to the agreed schedule of fees.

With regard to the original plan for diagnostic centres, the idea had not been abandoned but was presented in the form in which recommended in 1943, for experimental health centres to determine the best method of payment (originally supported by the B.M.A.) The Bill would give power for payment but on no fixed principle. The Minister anticipated B.M.A. cooperation, in view of their former support. But in fact his scheme was not the same as before, as he proposed the very thing the profession asseverated they most wanted to avoid- a direct contractual relationship with the Government which would intervene in the doctor-patient relationship. By proposing that a doctor's clinical records of patients should be produced for adjudication committees, and for inspection to check accounts; and that the doctor should have to get the refund direct himself from the government; and by erecting categories of doctors who were either in or outside the scheme; he was once more preparing the ground for dispute that would militate against the cooperation he believed he was now able to secure. Either the Minister could not comprehend the profession, or he hoped to cajole their acceptance.

After dealing with progress on all points raised by the B.M.A. in 1947, such as T.B. (a Commonwealth T.B. scheme had been launched by Mr. Chifley in February welcomed by all parties) measures including a chair of child health, division of child welfare, unit of industrial hygiene at the School of Public Health, he admitted the basis of payment to be that of the New Zealand scheme with one major difference; the N.Z. Joint Committee had not proposed any schedule of fees;[187]

> "It is obvious that, if there is to be a real benefit to the patient there must be a ceiling of fees. Otherwise the amount contributed by the Government could be a benefit purely to the doctor, and no advantage to the patient, leaving the doctor free to charge over and above the amount of the Government contribution whatever he likes, puts the doctor in the position where he may if he likes require the patient to pay the normal fee and have the Government contribution to boot".

The Government bias for collection from the doctor was largely influenced by the ease of collecting from a few thousand doctors compared to millions of individuals. The additional work, given the doctor, was held to be compensated by lack of bad debts. And yet the cost of collection in New Zealand at that date was said to be as high as 11%.

At the October Conference, Dr. Colville pressed the Minister for definition whether a doctor would have to 'belong' to the scheme, to register in any way, and thereby institute an arrangement which would control the doctors' method of practice, to which the Minister agreed that once a doctor 'elected' to belong, he could not charge his patients in excess of the schedule; precluding any variation to pay more if the patient wished to do so. While it did not appear to create a contract, it did create sanctions. More time was occupied at this conference on the old stumbling blocks of departmental control and disciplinary powers flowing from the Minister; a point that had caused serious concern in England - because the denial of the right for a doctor to continue in the scheme could be a major punishment in itself. At the end of the conference, Senator McKenna again took it that the principles of the proposed legislation were the same as those supported by the B.M.A.; and that the details, for which he was trying to solicit support, such as nomination of B.M.A. men for a committee, need not be resolved before the Bill went through.

The Federal Conference, having remained uncommitted, then sought Branch views after the October 1948 conference, particularly as to appointment of such a joint committee to consider details of the scheme. The Minister had also asked the Council to extend the period of secrecy on their discussions, until after the Bill went to Parliament. The N.S.W. Branch Council objected strenuously to this extension to the original promise in Conference to observe confidence only until the ~~the~~ Parliamentary Labour Party had approved, which they had done October 28. This Branch had bitterly objected to such a condition being imposed in 1938 with serious public consequences for the B.M.A.

The Minister had done no more than announce publicly October 29 that the Government had approved the Bill, that they would not

'nationalise' the medical or dental professions, and , in any case, nationalisation was not possible under the Constitution. He introduced the National Health Service Bill in the Senate November 24, and repeated this reassurance:[188]

> "The Government does not contemplate, nor does the Constitutional amendment permit, nationalisation".

He said the scheme would not involve any disturbance of the doctor-patient relationship. His was no more than an enabling bill setting out the broad purpose of the Government, the details to be filled out in collaboration with the B.M.A. and dental profession.

Branches had already taken the view that the obligation to secrecy was discharged when Labour Caucus had approved. The scheme had been disclosed to the press, and widely discussed at meetings in all states and all N.S.W. associations. The reaction was generally adverse to doctors collecting parts of their fees from the Government, though there was general agreement for cooperating on the Joint Committee proposed by the Minister. Sternest opposition came from N.S.W. throughout the State, local associations and from the B.M.A. Branch Council, which saw in all its details that the Bill would violate all the principles they defended. They felt, however, that negotiations should continue on the lines approved by the Federal Council March 11, 1947 , until the three principles laid down then were rejected by the Government outright: namely, control in a corporate body, no contract and payment on fee for service principles. The general tenor of a mass meeting at B.M.A. House November 27, for example, was that it was a sickness scheme, not a 'health' sheme.

The day before the S.M.H. editor was sympathetic to the medical profession's point of view:[189]

> "The Director General of Health will be very much of an autocrat, even to deciding what doctors and dentists shall be recognised as specialists; but behind or over him will stand the Minister, to whose directions he will be subject in 'the exercise of any power or function'. "Ministerial responsibility for broad policy is necessary but the present Bill opens the gates to endless political manipulation and meddling. On the other hand, the medical profession will have no effective representation. A huge, new bureaucracy, tending to the gradual supersession of private practice, appears to be envisaged".

Some clue as to the attitude of the Minister at the time might have been seen in his address to a weekend conference, the week before, of union delegates on free medicine:[190]

> "He believed the doctors had not yet made up their minds about cooperating with the government scheme, but had blindly followed the Federal Council of the B.M.A... He had concentrated his fire in the matter on the Federal Council and had not attacked the doctors as individuals or as a profession".

Another report, the day before the doctors' mass meeting, that he had also said the Government could carry out civil conscription, right or wrong, did nothing for goodwill - while the Prime Minister himself did nothing to relive the suspicion with his contribution in Parliament, on December 8:

> "He had read of a meeting of 350 doctors recently. He did not know how many of them were ordinary practitioners, but he strongly suspected most of them were Macquarie St. specialists".

Sir Earle Page's comment was:[191]

> " Subtle attack was possible, if not intended, on doctors and their traditional methods of dealing with patients. If the attack was not immediately successful, the Bill would enable the Government to use new specially subsidised graduates to break down the long established practice of the medical profession, and to evade the constitutional limitations on conscripting the medical and dental professions.
> "Every move by the government showed more and more clearly that the only satisfactory way to deal with the whole problem was by a comprehensive scheme of national insurance."

In this speech in the House on December 8, he asked why not turn to the voluntary organisations, hitherto ignored, if he wished to cut the cost of administration. As for the Government promises to have a complete, free and comprehensive medical scheme, he said 'we have a scheme which is incomplete, half-free and technically inefficient' and the Government had 'lost the people's cooperation'. He attacked Federal ideas of regimentation which had, for example, in federal hospital aid, in operation since 1946 (the 6/- per bed per day Commonwealth subsidy) 'wiped out the hospital insurance societies and largely destroyed local interest in the well-being of the hospitals', and gave several major reasons for public apathy on this much vaunted national health service.

> "Perhaps the vocations of the two chief inspirers of the Labor plan are responsible for the lack of appeal of their proposals. The Prime Minister has been associated with trains and locomotives all his life - with immense power that is controlled by a small valve- with trains that move regardless of human whims or human wishes or human obstacles. If the passenger is on time, he catches the train; if he is not, he misses it and it is just too bad.
> "The Minister of Health is a lawyer. His problem is to deal with generalised laws, with fusty documents, and with meticulous points of law about which no one knows much and whose relationship to life no one really senses".

If Senator McKenna had hoped to keep the door open, Mr. Chifley in his speech closed it half way with the words 'All doctors were asked to do was to send in a return showing the people whom they had attended and why." The Bill passed through all stages in the House in nine hours, which seemed scant time to give to a service that would touch every citizen in the nation, and the Government suffered strong criticism fro m the opposition

to the 'rush debate'.

For the Government's side, it should be said they were motivated by high principle of belief in the virtue of the scheme they offered; and conviction that both the public and the medical profession, in the long run, would agree with its merits. The Labour paper, the Standard Weekly, expressed Labour's desire that medical service should give equal opportunity to everyone rich or poor, in writing November 26, 1948:

> "Very few pieces of legislation brought before Parliament have been more important than the National Health Service Bill. It is expected that there will be opposition from the old brigade of the B.M.A. and we will be told the old story of interference between doctor and patient. But the scope of the Bill indicates that the Government has planned a new deal in health on the widest possible scope.. It is only under such a plan that the best in scientific methods for preventing and fighting disease can be made available to the whole community..... the scheme will open up careers to brilliant students, many of whom have found, because of financial limitatons, the door to specialism closed after their preliminary training. It is to be hoped that the medical profession will fall into line behind the scheme".

These hopes were far too sanguine. On December 18, the B.M.A. issued a statement containing nine reasons why the BM.A. would not cooperate in the scheme, until the Government had agreed on general principles acceptable to them. They would join a Joint Committee for this purpose. Chief of these was departmental control, and regulation making provisions of Section 22 of the Act.[192] They knew that Aneurin Bevan, Minister for Health in Great Britain had passed additional regulations, which violated the spirit of the undertakings made by him with the B.M.A. The B.M.A. felt these powers would enable the Government to bring the whole profession , both present, and future, under its complete control; while no doctor who took part would be secure against unlilateral variation at any time by the Government of the condition under which cooperation had been offered. The B.M.A. considered it reasonable to ask that all essential conditions of the service should be stated in the Act, before professional cooperation was requested. It would not accept a fee for service scheme where it acted as Government agent; by entering into any contractual relationship with the Government. The moment any doctor accepted the first half of the first fee, a contract was established, and he forfeited any protection the referendum clause might give him.

In a press release December 24, the B.M.A. reminded the public that the Government had always refused to make public

the transcript of the July 1947 conference, where the Minister for Health had admitted the ultimate aim to be the abolition of private practice:[193]

> "Let the Minister make public the official report of the conference of July 1947, from which it will be evident that the B.M.A. pressed on the Government those very measures of preventive and curative medicine, which the Minister now implies has been disregarded by the Association. The Minister should know that every measure of preventive medicine carried out hitherto in Australia e.g. diptheria immunisation has been suggested by the profession and delayed by Governments to be ultimately carried out with the full cooperation of the profession. The profession will not hesitate to compare its record in public service, either in peace or in war, with that of this or any government".

By Xmas deterioration set in in its relations with the Government. The Minister wrote to the B.M.A. December 22, 1948:[194]

> "Your intimation that your Council insists that the Government makes its contribution to the hundreds of thousands of individual patients per month instead of to a few thousand doctors, as a condition precedent to its participation in a Joint Committee is a presumptuous prerequisite, and is accepted by the Government as an express rejection of its proposal for the establishment of a Joint Committee".

After saying that the Government had exhausted every endeavour to secure cooperation, and that the Association was 'grievously lacking in a sense of responsibility', the challenge was issued:

> "I have to convey to you the decision of the government that, within the limits of constitutional power, it will proceed to put its plans into operation".

1949 opened with a deadlock on national health service, and a doctors' boycott on pharmacy benefits with all the exchanges of correspondence published freely in the press. The Labour Party did not always secure backing where expected. The President of the A.N.A. at the Dandenong Branch Jubilee celebration said ' the whole thing was windowdressing'.

Antagonism between the B.M.A. and the Labour Government from the opening days of 1949 was to mount into a state of open political warfare, using the twofold instruments of judicial appeal with amendment to the Pharmacy Benefits Act 1949 as a test case; and of open electoral agitation to unseat the Government itself at the November 1949 election.

The opening skirmish had begun June 1, 1948, when the Federal Council circulated the regulations recently gazetted to doctors throughout Australia, and asked all doctors to refuse delivery of the Formulary and prescription documents sent to them by the Commonwealth. Senator McKenna claimed that the Federal Council had denied the doctors the opportunity to judge for them-

selves the value and virtues of the Formulary. The B.M.A. had warned doctors that acceptance of the Formulary would bring the doctor concerned under the provisions of the Act.

Senator McKenna's speech in the Senate June 15, 1948, had argued the case against the B.M.A. with the competence of a man who held the brief for the Commonwealth; its chief concern to show the sweet reasonableness of the latter and the unreasonableness of the B.M.A. In all these long negotiations to which he referred on which they had not conceded, as he said, one point, little had been said to counter their objection to the leading principle of the scheme- the Formulary, other than the cost factor;[195]

> "It will be remembered that, on the occasion of our first meeting with the Minister and his officers at Canberra on December 8, 1943, and on many subsequent occasions it was clearly stated that cost was a predominant factor in the Government refusal to recognise independent prescribing and that it was the Government intention to standardise prescriptions and so avoid the added cost incidental to pricing separately those that did not conform to a laid down standard".

Senator McKenna now also cited the use of a Formulary as being established practice in every responsible medical sphere; mentioning friendly societies, public hospitals and the Australian War Pharmacopoeia. Apart from the fact that these were limited and special services;[196]

> "The B.M.A. is opposed to penal clauses which have never been imposed on the prescription of free medicine in and outside formularies of public hospitals for over a century."

As to Government prescription forms, 2,000 doctors had used such government forms in Repatriation Commission work since the 1914-18 war, so the B.M.A.'s objection to its use was as baseless as its objection to the Formulary. As to penalties, he claimed that penalties were imposed and accepted by the doctors without protest under the Dangerous Drug Acts of every state - in three states including imprisonment. As to the comprehensive nature of the Formulary, the Government had done a survey, the results of which were markedly at odds with one done by the B.M.A. itself. His claim was that 90% of prescribing would come within the Formulary, the B.M.A, from a survey, said in N.S.W. 50% or less. The Government claimed that the only drugs excluded from the Commonwealth Formulary were those which had fallen into disuse or served no useful purpose; and new drugs whose worth in the treatment of disease had yet to be proved.

Therefore, the B.M.A. said in riposte, why not extend free medicine to the small range of prescribing the Government said was left outside the Formulary. Mr. Holloway records:[197]

> "With little hope of any successful outcome, a conference with the Association was held in July 1948 in the course of which much old and little new ground was traversed. The point was, however, conceded by the Minister that provision should be made to permit the writing of more than one prescription for a benefit on the same prescription form, and to remove as far as possible any objection to the format and printed particulars of the Commonwealth prescription form. It was suggested by the Minister that the form should be quite plain , except for a number for recording purposes and a reference in small print to the Act. In this way, two prescriptions which was the number proposed to be allowed could be printed on one form, and it would also be within the discretion of each doctor to add in the way he thought most suitable his name and address as a heading to the form".

No amount of change in the form itself could remove the fundamental objection at the time of using a Government form at all, particularly of forms numbered in series.

But the Government would not yield over use of a form as an entitlement to free medicine - saying that these forms were like blank cheques. There had to be control of the number and to prevent unauthorised people using them; and to reduce the staff and the checking in processing them; and to prevent medicines that were free and not free appearing on the one form. They said they had not settled on forms for the love of forms, but for lack of any practical alternative. In 1948, they had yielded only on details.

On the major principles of both formulary and Government forms, they had been as rigid as the B.M.A. While the penal clauses had been modified, a severe monetary penalty still remained for any person who parted with possession of, mutilated or destroyed any copy of the Formulary, rules or forms supplied to him except by direction. Surrender of these could be required within a certain time specified, and doctors were forbidden from transferring any unused forms, or using them for other purposes than the Act:[198]

> "These penalties directed against the medical profession not only in the foregoing provisions but elsewhere in the regulations were inserted in the legislation; notwithstanding the assurance given by the Government to the B.M.A. that it did not contemplate the inclusion in the regulations of penalties directed to the doctors".

Apart from fundamental difference in policy, the B.M.A. felt it could not trust the Labour Government despite public assurances on nationalisation, and a specific statement in writing to the B.MA. by the Minister September 9,1948. All state branches and

all members by plebiscite had rejected the Minister's amendments proposed shortly before.

The National Health Service Act, December, 1948, had provided further grounds for conflict. At its inception January 18, 1949, the Government had abandoned further attempts to secure the 'cooperation' of the B.M.A. Once more the B.M.A. had been asked to submit nominations to the Formulary Committee and refused, so doctors were advertised for.

The Government now drafted amendments to the Pharmacy Benfits Act 1947 to accomplish two major objects. The Pharmaceutical Service Guild's objections to the absence of any right of appeal from the decisions of the Director General as to suspension or revocation of approval to dispense free medicine. The approved chemist, doctor or hospital authority were given the right of appeal to the Supreme Court of his state or territory. The other amendment was the new section 7A subclause 1 which made it an offence to prescribe any medicines in the Commonwealth Formulary other than on a Government form, unless the patient specifically requested that the doctor prescribe on his own form: the alternative a fine. Parliamentary Labour Caucus passed this amending legislation after Mr. Chifley had told them 'the Government would not withdraw or lie down. The Federal Government had a fight on its hands'.[199]

Senator McKenna was alleged in the Sunday Herald, March 27, to have 'lost prestige', claiming to have been at one time considered the 'most likely successor' to Mr. Chifley as Prime Minister. The Canberra correspondent alleged that a considerable section of Caucus at the time was opposed to 'pulling on a direct fight with the doctors' but that he had been a 'fall-guy' for Mr. Chifley:

> "They assert that while Senator McKenna has stood out for moderation, Mr. Chifley has pushed him on to extreme action".

By March, 1949, the Government was faced with a dilemna of its own making. The public was paying 1/6d in the £ social service tax, of which £2,000,000 a year had been earmarked for free medicine. Yet over more than six months, with the doctors' boycott, only some £27,000 had been spent. In short, the public were paying both for the tax, and for the medicine.

Mr. Chifley made it clear that the lawyers had advised that the Commonwealth power to impose penalties by regulation had doubtful validity; and the amendment was intended to reinforce that power. The Federal Council B.M.A. announced the doctors would not

yield to Government coercion in the free medicine scheme and would 'take all necessary steps, including legal action to preserve the freedom of its members.[200]

> "The Government has repeatedly stated it could not and would not compel doctors to prescribe medicines from the Government list. It now reversed that policy. It now proposes to force doctors to sign prescriptions, which happen to be within the Government list on Government forms".

At the same time, the Council wrote to the Prime Minister, while Sir Earle Page moved unsuccessfully three times to secure an adjournment of the House to discuss national health service schemes. Sir Victor Hurley, successor to Sir Henry Newland as Federal B.M.A. President, and a vice-President of the Royal Australasian College of Surgeons, stated to Mr. Chifley that the B.M.A. deprecated the summary rejection by the Government of principles sought by the profession.[201] These were subjection of doctors to the power of regulation by the Department of Health under the legislation in the framing of which they would have no vote; Second, intrusion by the department into the confidential patient-doctor relationship; Third, establishment of a contract with doctors denying them the right to practice outside the scheme and their patients choice of doctor without forfeiting medical benefits; Fourth, imposition of burdensome clerical work not required in an alternative scheme; Fifth, establishment of government controlled experimental health centres using government employed doctors. Mr. Chifley's answer was:[202]

> "The Government cannot permit the introduction of the medical benefits scheme to be delayed by interminable discussions. It is the Government that must accept responsibility to the community for whatever scheme is adopted. Your Council's views seems to be that the B.M.A. and not the Government, decide the conditions under which the national health service should operate".

He insisted the relationship between patient and doctor would remain precisely the same as it was.

The Minister introduced the amending Bill March 10, 1949, accusing the B.M.A. of denial of freedom of judgement to its members. The B.M.A. opened a fighting fund to help fight it. Newspaper reports continued to suggest that personal intervention of the Prime Minister had served to sidestep the undercurrent of criticism within the party. Already the Labour Government had some five judicial arguments on its hands over aspects of its government on matters other than medicine without inviting another one from the B.M.A. Senator McKenna assured Caucus the Government had the necessary powers to enforce the proposals of the Government against the B.M.A.[203]

There were comic aspects in the opening debate with Labour senators referring to the B.M.A. as the Beast McKenna

Association with the Federal Secretary as the high priest of the old witch doctors, and the Council itself as Drug House Addicts. But Mr. Chifley himself in the House could not maintain the more temperate quality of the Minister's speech in the Senate. Mr. Menzies had charged that the Bill turned out to be one intended finally to shackle the profession. Mr. Chifley made his famous 'museum minds' speech:[204]

> "The B.M.A. Federal Council officers have museum minds which refuse to move with the times. It will find if it continues its attitude it will be swept away, and replaced by people prepared to give a proper service to the people.
> "... The B.M.A's talk of service to the people is so much bunkum... The B.M.A. through its own conservatism and pigheadedness believes it can be the judges of what is to be done for the people and the government".

One is tempted to wonder if Mr. Chifley ever really understood the nature of the B.M.A. organisation with its loose federal structure, or saw beyond his insistence that doctors always opposed national health schemes, as they had with Lloyd George in England, Lyons in Australia and Truman in America. There was no question that the schemes might have been ill-advised, simply the doctors.

Not only did he brand the B.M.A. as conservative, he said they had been on strike for four years 'not only against the law but against the expressed will of the people of this country'. It was his claim to express the will of the people that the B.M.A. were to challenge in the next election. He could not remember the coalminers being on strike, he said, for four years. It was a most damaging speech to the B.M.A. The whole weight of his prestige and high office was thrown into the ring to charge non-cooperation from the B.M.A. Despite counter publicity from the B.M.A., much of the mud stuck, and, to an extent, the statements have not only become part of the public myth of our society, but also serious representations in academic restrospects of the events. Counter attacks to Mr. Chifley receive less credence, such as that he would not fine striking unionists, but would fine doctors.

Sir Earle Page asked why the Government was bringing in the amendment at all; or for that matter the Bill itself:[205]

> "If the Government really desires to give free medicine, it can get in five minutes an agreement with the chemists which does not involve nationalisation of the medical profession".

The B.M.A.' stand was endorsed by a state conference of sixty-two delegates, representing 3,000 doctors, nearly half the number in Australia. They authorised the Federal Council to continue to

fight the Act. Similarly, a meeting in Brisbane attended by 422 doctors from all parts of Queensland had only one dissentient and likewise opened an independence fund, at which the Queensland President Dr. Clarke said:[206]

> "The B.M.A. is not opposed to the people having free medicine, or having fifty per cent of their medical fees paid, but it does object to the manner in which these two acts are to be enforced".

He dealt with both Acts, as if they were interlocked and the national health service was to come up again when Parliament resumed. West Australia took exception to the criticism of Federal officials by the Prime Minister, praising their representatives as men who were general practitioners. One was also a chemist, Dr. Carter, and the other Dr. Cook, a B.A., for ten years a school teacher. Two hundred doctors in South Australia were reported as 'more hostile than ever'.[207]

By mid 1949, there could no longer be any confusion from either side. The Government had broken off negotiations after months of verbal exchanges fully aired in the press. The Labour Prime Minister had declared in the House, there could only be one end to the dispute. The Government was faced with what it took to be, in the words of a future Labour member, Dr. J. Cairns 'one of the most effective refusals to carry out the law that has ever taken place in Australia'.[208]

The BM.A. did not want to sell its birthright for a possible 'mess of potage'. In the Government's plan for health service they saw a policy copied from Great Britain, married to elements of the New Zealand scheme; with departmental control, and the head both employer and judge. They saw the Government demanding the right to fix fees for doctors, a form of price-fixing abandoned for every other section of the community. In the Government's plan for pharmacy benefits, by contrast, they saw a failure to copy from Great Britain, which paid for all doctors' prescriptions without a formulary.

They believed the draft in Great Britain was such as to command caution to the doctors in Australia; a "wait and see" policy to judge how matters were turning out in that country. By the end of June, the Chairman of the B.M.A. in England, Dr. Guy Dain, presided at a meeting which called for machinery to organise a mass withdrawal of doctors from the National Health Service at any time, unless they had some means to take their grievances to arbitration.

Many had said that no scheme could succeed without the enthusiastic cooperation of the doctors, and the Australian Government had to decide whether to enforce its scheme without willing cooperation. The decision could only be made to enforce it, if the Government believed they could derive popular support for such action. But, as the year wore on, this seemed doubtful. But the B.M.A. had throughout rested its case on the Government's reiterated assertion that no doctor would be forced to participate in either scheme. Their association would be entirely voluntary. They had been careful never to challenge the Government's right to pass legislation on either subject, and had confined bargaining to the principles on which their cooperation would be secured. The turning of the tide came when the Government introduced compulsions in the amending act of March, 1949. The Government made no secret that these were intended to bring the B.M.A. to heel. While the B.M.A. began to plan an intensive publicity campaign to present its case to the public, the Minister for Post War Reconstruction, Mr. Dedman, was quoted at the Victorian Labour Party conference on the possibility of enlisting trade union aid, offered before, to insist that family doctors prescribe free medicine. The Minister was quoted as saying at a meeting in Parramatta that the Government would press both schemes to the limit of its constitutional power, while the B.M.A. should overhaul its election machinery to make it more democratic.[209]

May, 1949, for the first time in B.M.A. history, doctors mounted the public platform in Parramatta also to give the B.M.A. point of view as precursor to a series of such public meetings. The N.S.W. Branch Secretary, Dr. R. Grieve had already announced the B.M.A. would test the validity of the Act, the moment it was proclaimed. He claimed that the Minister for Health had always been more moderate in negotiations than the Prime Minister. The amendments became effective July 25, making it compulsory for doctors to write prescriptions covered by the Government formulary on free medicine forms, except at the patients' request, which evoked from Mr. Menzies, leader of the Opposition, the ironic picture of a doctor prescribing for a very sick person, asking if it should be prescribed on a government form or not. The BM.A. filed a writ in the High Court issued July 25, the day the Act became effective, and the Commonwealth Crown Solicitor engaged not to prosecute any doctor until the High Court decided on the validity of the Act.

The Commonwealth in reply filed a demurrer to the writ on the grounds that the Act was valid, and the regulations validly made. The Victorian Attorney General had stated his Government intended to intervene, also as it had done in 1944, so a writ was issued against the Victorian Attorney General also. The Commonwealth asked for an injunction to restrain the B.M.A. counselling any registered medical practitioner to commit any offence against the Act and its regulations, or not to comply with its provisions. The Attorney General, Dr. Evatt, formerly a High Court judge himself, appeared for the Commonwealth, and asserted no compulsion; that there was no obligation on a doctor to use a Government form if the patient did not desire it. The BM.A. Counsel A.R. Taylor K.C. alleged compulsion to the degree of conscription. The High Court reserved its judgement on August 12, which was not made until October only six weeks before the national election. The B.M.A. had taken the case because of consistent legal advice that the Act in certain important respects, infringed the constitutional safeguards written into the clause. The judgement, made October 7, 1948, justified this legal advice.

The demurrer of the Commonwealth was overruled with costs by a majority of four to two; the dissenting Judges being Mr. Justice Dixon and Mr. Justice McTiernan, of whom Mr. Justice Dixon also had dissented in 1945. The judgement was that Section 7a affected the freedom of doctors and their means of living, unless they subscribed to the benefits scheme whereby they were subject to control as to the form of treatment and the drugs they might provide for their patients; and thus was a form of civil conscription within the meaning of Section 51 (23A) of the Constitution. The dissenting judgement held that the prohibition 'but not so as to authorise civil conscription applied only to medical and dental services. The difference between the two judgements rested largely on the precise phrasing of Section 51; that the Commonwealth could make laws for certain specified purposes including medical services. The Chief Justice, Sir J. Latham, dealt at length with the definition of conscription, believing:[210]

> "The words 'any form' are important. They show that the Parliament intended that any service to which the limitation applied should be completely voluntary and not procured by compulsion of law."

As to whether the phrase dealing with conscription applied to the whole or only part of the clause, he had this to say:

> "An important constitutional question should only, in the last resort, be decided upon the presence or absence of a comma.
> "No reason has been suggested, other than the absence of a comma after the words "(medical and dental services)"

> "Why civil conscription of doctors or dentists passed under the power to make provision for 'medical and dental services' but that doctors and dentists should be compellable to service in a particular way in relation to the provision of pharmaceutical benefits or sickness or hospital benefits."

As to 7a in particular, his view was:

> "if laws imposing such requirements were held not to be civil conscription the result would be that, without infringing the prohibition of civil conscription the whole practice of a doctor could be completely controlled, not merely by negative provisions, but also by positive provisions requiring him to do certain acts in his practice."

The Minister announced that the scheme would continue on a voluntary basis.

The general significance of the overall decision was not lost on Party members. The Attorney General, Dr. Evatt, incurred party criticism on two counts. First, he had persuaded Cabinet from its decision not to appoint three new judges in the High Court in 1946, and limited it to one; second, for accepting the amendment on civil conscription put forward by Mr. Menzies on the floor of the House. The Sunday Herald reported:[211]

> "Most embarrassed man in the Government is Dr. Evatt. It was he who accepted Mr. Menzies' amendment on civil conscription and thereby earned the strong criticism of Mr. Chifley".

Labour now opened its election campaign for the December, 1949, election with a High Court decision that made its Pharmaceutical Benefits Act impossible to enforce; that seriously threw question on other aspects of its nationalisation program such as banking; with adverse news of the British health scheme-that it cost twice as much as budgeted for; and harassed on the flank not only by the B.M.A. launching on an active political campaign, but by the officers and staff of the private banks doing likewise to avert bank nationalisation.

The publicity campaign of the B.M..A. against the Government was planned some months before the election. In conjunction with the states, Federal and State B.M.A. publicity committees were co-ordinated; the Federal Independence Fund allocated £5,000 for publicity. The Victorian Branch brought out a brochure of its own, analysing the two controversial Acts, and circulated it very widely in the state. The Federal Council issued its socialised medicine bedside book as a compilation of statements on the subject.

The Federal Publicity Committee's pronouncements did not always go without criticism from the state branches, but gradually a consistent policy was hammered out. Experience in Great Britain had shown that public relations was best conducted at the general practitioner level. It's slogan was followed with the preparation of literature to go into surgeries throughout the Commonwealth, as well as press and radio advertising. Furthermore, the Victorian Branch Publicity Committee suggested an Australia wide broadcasting campaign, which, despite extra cost, was approved by the Federal Council to coopt five hundred practising doctors, three times a day, for one minute on sixty-nine stations throughout Australia from November 14 to December 8, or election day. The traditional professional anonymity was discarded to give these broadcasts more force. All doctors gave their name and address; 5,000 broadcasts paid for by voluntary donation from the profession. A number of sample scripts were prepared for doctors to choose from - to widen the propaganda offered.

The Council had predicted April, 1949, that the campaign would be fought partly by the Government as The People v the B.M.A.;[212] and their campaign was on a scale that was the largest ever undertaken by a professional organisation in Australia defending the 'family doctor'. Indeed, Mr. Chifley in Ballarat castigated the B.M.A. as 'callous and inhumane', saying it was not the ordinary doctor but the Council of the B.M.A. causing the opposition.[213] Senator McKenna likewise in Adelaide spoke of 'their callous indifference to the sick and suffering of the community',[214] saying they were 'regimented' by the B.M.A. fearing 'social ostracism which was vicious and cruel', and 'ultra-conservatives are in power'.

Advertisements by the B.M.A. warned that similar plans had been tragic failures in Britain and New Zealand. 'Your family doctor warns you'; 'Socialisation or Freedom, you can't have both'; while Labour Party posters declared 'The Doctors Won't Cooperate' 'You are being robbed of your social service benefits because of the attitude of the B.M.A.'. In such a brawling atmosphere, the Government made further moves to advance national health services. Senator McKenna introduced an amending National Health Service Bill October 26, 1949, to extend the flexibility of Section 6, and to enable the Minister to make special arrangements, if he desired, where agreements existed between doctors and particular groups such as friendly societies, and industrial and other medical schemes.

The Government had to give three months' notice of any intention to reduce a fee. It would also allow exclusion of workers' compensation cases, and patients who were provided for with other classes of services; to allow a mileage allowance to be paid etc. Some of the strain Senator McKenna had suffered, standing at the front line of party and public exposure for years, showed in the attack he made on a Federal Councillor for a 2CA broadcast which showed abysmal ignorance, or was a deliberate misstatement.

Senator Cooper, in the debate, referred to a handbook produced by the B.M.A., which suggested that a national health service could be conducted by the existing friendly society and other organisations, and proposed the adoption of a system similar to the medical benefits schemes which were now operating in three states, Queensland, N.S.W. and South Australia. That, in Queensland, was being planned for January 1950 with a capital of £3,000 contributed by doctors at £10 each. The Hon H.C. Barnard, Labour Party member, added in the House that some of the proposals submitted were identical with those of the Joint Parliamentary Committee on Social Security 1943.

The B.M.A. had submitted the handbook to the Federal Government, just prior to the debate. As well as contributory schemes for the middle income group, it suggested a service for pensioners and unemployed as proposed by the NS.W. Branch in 1948; and extension of lodge service for lower income earners to be comprehensive. Among provisions it said were urgent necessities were £500,000 a year for research; expansion of public health departments - Commonwealth and State; large scale increase in hospital accommodation and equipment to overcome the bedlag of 18,000 beds; nationwide immunisation facilities; vast expansion of industrial hygiene sections; regular large scale T.B. examinations; full living wage for T.B. sufferers, expansion of school medical service. Government subsidy was to be paid according to a scale of benefits as operated with old age, invalid, war and service pensioners, and child endowment beneficiaries. On October 9, Sir Earle Page, in his speech on the Budget, had already said that opposition parties would introduce a national health scheme based on one the B.M.A. submitted to the Government in 1947, of which this now represented an expansion.

At the eleventh hour, November 25, two weeks before election day, the Government, ignoring the B.M.A. proposals, gazetted regulations under the Act, with a table of fees covering 192 items to be paid to any doctor who applied to work under the Government scheme of refunding half the patient's fee. The B.M.A.

castigated this scheme as an act of bribery:[215]

> "A final example of the Federal Government's readiness to make a political plaything out of the people's health services".

The Minister in his turn said Dr.Hunter was 'playing politics'.[216]

On election day, December 8, 1949, the issue of The People vs the B.M.A. was decided. The Labour Party lost the election. The Liberal Party returned to power in coalition with the Country Party. Sir Earle Page became Minister for Health, bringing an unparalleled knowledge of politics in various Cabinet posts; and as Leaderof the Country Party began to negotiate a national health service on the principles he preferred. In his memoirs, he said:[216]

> "When I was sworn in as Minister for Health on December 19, 1949, this program became my specific duty (the five point program). On the same afternoon, I issued telegrams seeking separate as well as joint conferences with the Federal Executives of the B.M.A., the Pharmaceutical Guild, and the Friendly Societies."

The essence of his policy, presented to Cabinet January 9, 1950, was as he had advocated for years to build on existing services, insurance groups, friendly societies, nursing and hospitals:

> "I believed that by subsidising voluntary efforts, many of the pitfalls inherent in universal compulsory medical schemes could be avoided. At the same time, a definite control could be established over the amount of money to which official subsidies committed the Government and taxpayer".

The Cabinet approved of changing the basis of attack on both national health service and pharmacy benefits; of the former by a voluntary insurance program on a fee for service basis; of the latter by confining 'free medicine' to life-saving drugs, and disease preventing drugs. Both these involved abandonment and repeal of prior Labour legislation.

In another record, "What Price Medical Care:" Sir Earle Page recalled:[217]

> "Having been in the Australian Parliament for over forty years, I have witnessed every attempt made in that time to have government take over medicine and many other things, and I was on the scheme when attempts to socialise medical and hospital practice reached a crisis of confusion a little over ten years ago.
> "During the years immediately before 1950, the Government made a terrific effort to nationalise all major activities. The desperate conditions of war had demanded large scale Governmental activities, and these were regarded as psychological opportunities to nationalise banking, shipping, aviation, medicine, and nearly everything else."

As a political veteran, Sir Earle Page knew that:[218]

> "in the realm of politics belong the adroit strategies, the bargainings and compromises which get things done by legislative bodies in lands of the free".

He went to the conference he had invoked on January 19, 1950, far more closely allied to the B.M.A. in objectives and the method of reaching them, than had ever been the case with Labour. But, even so, as Dr. C. Byrne, Federal Councillor for over ten years, records:[219]

> "Contrary to the popular impression that all was now plain sailing, the atmosphere in the early stages of negotiations between the explosive Earle and the Federal Council was far more heated than in the days when the more self-controlled McKenna was politely fencing with it. Page had inherited the advisors of the previous Government, who were all very nice fellows, but unchangeable as the Bourbons".

The bone of contention arose over the predictable issue of the role of friendly societies in the scheme, which had plagued both the B.M.A. and the Pharmaceutical Guild for many years. Though no one now pressed that they should be excluded, the problem was chiefly as to how they were to be included. The Federal Council had acknowledged this mid-1949:[220]

> "That the Federal Council is of the opinion that lodge practice within the present income limit should be encouraged, and Branch Councils are recommended to explore the possibility of providing a more complete service, including ancillary and specialist services under these auspices."

Sir Earle Page had told the B.M.A. from the first that he would be repealing preceding acts, and would not renew the agreement with the States made under the Hospital Benefits Act for the five years ending June 1950. He proposed, among other things, a Commonwealth Health Council combining all health departments and the profession to handle finance, and that subsidies to the friendly societies would go towards meeting the costs of their excluded service, and reduce the amount of contribution paid. He analysed the four groups of the population: the first, a million in number, including old age pensioners, unemployed and servicemen and their dependents (The Commonwealth to take complete care with the B.M.A.); the second, nearly four million with family incomes between £250 and £450, or some 1,300,000 families of whom the friendly societies looked after 800,000; the third group of old people not taking the pension with policy open; the fourth group over the friendly societies' income limit, who could be catered for by extending the range and scope of voluntary insurance benefits.

He hoped to stimulate hospital insurance once more by subsidising all patients carrying hospital insurance, the 1945 Act having discouraged insurance heavily by insisting that

Commonwealth subsidy was dependent only on no charge being made for public beds:[221]

> "The whole scheme is dependent on the full functioning of voluntary organisations. The success of the scheme will depend on the rapid expansion of those voluntary organisations especially in the higher group."

Such organisations had laboured under a disability over the five years of the Chifley Hospital subsidy. Friendly societies had lost subscribers who saw no reason to insure if the Government guaranteed them free medical and hospital care. In 1950, there were 150 hospital funds for 3/4 million members; 53 industrial unions for sickness, accident and hospital; 420 by certain firms for employees; 97 by employers, while 13 life assurance companies had nearly 6 million current policies. Thirty other insurance offices covered accident and sickness, medical benefit clubs etc; apart from friendly societies.

The Government met the B.M.A. in conference January 17, 1950, the first tri-partite conference ever held between the Government, the B.M.A. and the friendly societies. The Minister gave a vitally important statement of his conception of the role of Government in modern society:[222]

> "Our object is to reconcile and coordinate the responsibilities of both the Government and the private individual. It is fundamentally wrong to throw the whole responsibility of private medical and hospital services on the Government. That robs the community of its independence, makes for inefficient administration, creates a pyramiding of bureaucratic control and increases costs. "Under such conditions, there develops quickly in the community a cynical indifference. 'Everything is on the government, so why worry?' is an insidious doctrine. It not only affects the patients, but it also affects the administration".

He declared for decentralisation, for cherishing the voluntary movements that had sustained hospitals, bush nursing, even medical research long before governments were willing. The four points of the Government program were nutrition of the mother and child to give a start in life; prevention of disease to preserve health when established; curative means to control disease especially through hospitals; the cost of medical care- preventive, diagnostic, and curative - within the means of the people. Of these, the last was the only one the Commonwealth would carry out alone. The others could only be carried out in cooperation with the states; such cooperation already proved as in the T.B. program. Nothing in the scheme would be free, except milk for children up to 12 years of age, life saving drugs, and certain drugs for chronic disease.

The scheme would secure free choice of doctor, would not standardise fees, would restore control of hospitals to their local management, while use of voluntary organisations would obviate the need of government intervention to discipline doctors. As to free medicine, this would be on the doctors' own prescription forms, and discipline against abuse would be left to bodies brought into being by medical and pharmaceutical bodies. The B.M.A. agreed to nominate members to a Formulary Committee, asked that the hospital problem should have first priority and agreed with the Ministers' policy, while asking for an increase of hospital subsidy from 8/- to £1 a day.

Sir Earle Page believed there was no difference with the B.M.A. on principle, only on methods. He asked for a Committee of three to help prepare detailed plans. The question of whether a capitation system should continue in any form was debated vigorously, being at first a point of insistence by the friendly societies. The consensus of B.M.A. Branches was against doing so; that it had failed to meet the needs of those who did not choose to insure themselves ; who could not afford to do so; fathers of large families on low income; people who were temporarily unfinancial; and old people who were not pensioners. April 2, 1950, a joint meeting of the B.M.A. with the Minister led to agreement to approach friendly societies for a fee for service system; and to plans for a concessional fee for service for pensioners. The Government would pay refunds to the patient for each service in accord with a scale of benefit, whether specialist or general practitioner service. Patients would be insured with voluntary insurance societies, and could expect to be compensated to a level of 80-90% of their expenses. When a contributor exhausted his insurance benefits, he would not exhaust government aid. Sir Earle Page announced this plan in a national broadcast April 30, 1950.

The British Commonwealth conference was held in Brisbane May 23, 1950. The Chairman of the British B.M.A. Council, Dr.E.A.Gregg attended and warned Australians:[223]

> "The best lesson Australia can take from Britain's national health scheme is to avoid introducing one here in a single stage. We believe that most of the trouble in England arises from the haste with which the scheme was introduced and insufficient personnel to carry it out".

Sir Earle Page told the conference voluntary insurance against sickness was an established principle in Australia; and by adopting it the Government would conserve the best elements of medical practice built up over the centuries, as well as employing the standard method of dealing with various risks such as theft and fire. He detailed six advantages in voluntary

insurance - flexibility, avoidance of setting up costly Government machinery, a range of premiums to suit all classes of income, and stimulus of a sense of responsibility in the patient by asking for payment of a small amount. No fresh problems of variation of practice would be raised. The concept was one of 'evolution' and a partnership between the Government and the individual through union of governmental aid with voluntary effort.

Sir Earle Page had one problem- an Opposition majority in the Senate. His own account of how he surmounted this hurdle was:[224]

> "We were fortunately able to avail ourselves of Labour's own methods of ensuring for the Government a measure of freedom outside the bounds of Parliament. For, during its period of office the Labour administration had passed legislation which gave very wide powers to the executive in the making of regulations under the law."

As soon as Parliament adjourned in July 1950, he used this power to bring in his own regulations, knowing the House was in recess for over three months. Although Parliament had the power of veto of such regulations within 15 sitting days after they were tabled in the House, he foresaw that public response would be such as to make it difficult for the Labour Party to use its Senate majority to disallow the regulations. This proved to be the case. The B.M.A. was aware none the less that there was a future danger in the possibility of such exercise of Ministerial power.

In September 1950, the free drug scheme began with a limited list of 135 life-saving and disease-preventing drugs. The doctor could write the prescription on his own or the Government form, which was to be standardised in size to simplify accounting. The list was drawn up by a Pharmaceutical Benefits Committee which continued to advise on matters such as maximum quantities, the number of repeats and which drugs were to be included; the Committee including members of both the B.M.A. and Pharmaceutical Guild. Regulations also authorised the supply of medicines to pensioners and their dependents with special benefits additional to the list available for them. The Labour Party accused the Government of a scheme that would help only 5% of the people. Details were finally negotiated by mid 1951. On July 13, 1950, the Commonwealth provided generous T.B. allowances to give security to families of T.B. sufferers and induce T.B. patients to offer themselves for treatment early.

The Commonwealth reversed the policy of subsidising hospitals so much per day provided the bed was free. Unless a patient was insured, he could not now be eligible for a benefit. The purpose was to stimulate hospital insurance to increase hospital income - by reinforcing private insurance by Commonwealth contributions, to increase the value of the return from the premium paid. When the scheme finally went into operation Jan 1, 1952, the Commonwealth supplemented the existing 8/- a day by an additional benefit of 4/- where the patient was a contributer to a registered hospital organisation; not payable unless the hospital charged a minimum of 18/- a day.[225]

At a conference of Ministers of Health, August 1950, all war and postwar problems were reviewed- cessation of hospital building over ten years, big influx of migrants, war disabilities, acute staff shortage, acute beds in use for chronic cases. As an immediate measure of relief, the Minister removed the limiting condition of hospital grants to enable private hospitals to join in, and restored to hospitals thereby control of their own policy. Overall it was hoped to restore a situation where £6,000,000 a year revenue had been lost to hospitals, voluntary donations had dried up, the rapidly growing insurance system been discouraged, and government contribution increased 80%. Moreover, conditions were such that doctors in most states were refusing to continue honorary service in public wards; salaries already being paid to doctors in two states. In one state, the fees thus paid exceeded ten per cent of the Federal Government's subsidy to hospital maintenance.

When the hospital scheme was offered to the states January 1950, reaction was varied. Ministers pushed legislation through in N.S.W., Tasmania, and W.A. and S.A. In Victoria, the Labour Party in the coalition government refused support until taking office December 1952. Queensland, already committed to a free hospital bed system, was only able to accept the scheme after some delay in a limited form, thus denying itself the full subsidy. By 1951 most of the major problems had been resolved, and cooperation of the states was secure. By this time also, the friendly societies had agreed to cooperate fully in a national medical service based on a fee for service principle - as announced by the President of the Friendly Societies Council, Mr.A. J. Eades mid 1950. Thus contract practice, which had caused contention with the B.M.A. for a century came to an end.

In January 1951, the Government completed negotiations for a free medical service to pensioners with the B.M.A., launched February 21, 1951, and extended July 1951 to special pharmaceutical benefits. It was to be free during ordinary hours, with a small

deterrent fee outside hours (for aged, invalid, widows, T.B. or service pensioners). Doctors would indicate their desire to participate, and patients could choose any doctor who had done so. A committee of enquiry with wide powers was also set up with a medical membership. In December, 1950, the Minister had introduced the promised free milk scheme, which required state agreement (Queensland delaying two years).

In July, 1951, Sir Earle Page went to Canada and the U.S. to study their health programmes, a trip which confirmed his faith in the policy of voluntary insurance. Final approval of the scheme took another two years until July 1953 (Act No 95, 1953). In one consolidating National Health Act, operative from July 1, were embraced all prior regulations; plus the machinery for administration necessary by a system of committees from the various interests. The newest feature was the offer of 850 different services, for which the Government would double the amount paid by the insurance organisation e.g. for general practitioner attendance 6/- where the insurer paid 6/- . The Minister sought the help of his former secretary, Mr. Ulrich Ellis, who gave members of Parliament bulletins, and prepared a booklet which went into every home in Australia. He said that:[226]

> "The Act's final acceptance by Parliament was the culmination of a long series of processes, not the least of which was the publicity with which the Health Dept. presented the scheme to the politicians and the public."

October 1955, the Minister considered his work was done, and resigned the portfolio in January 1956 after the Federal elections. In the Senate, December 2, 1953, Senator McKenna, the former Minister, had criticised the scheme for lack of administrative control; in that there was no prohibition to the doctor raising his fee. He also asserted that the B.M.A. itself were apprehensive that this might happen, having appealed to members not to raise their fees.

In 1955, the Victorian Branch Council approved an idea that all future increases of fees should be determined by actuarial investigation, an idea later accepted by the Federal Council. The Labour Party also attacked the role of the B.M.A. in founding the Medical Benefits Fund, saying 18 of its 23 directors in N.S.W. were B.M.A. members; and it was unethical for the B.M.A. to be running an approved fund which was doing business with its own members under government subsidy in three states. The fund was said to be also to be used as a lever to increase doctors' fees.[227]

Senator McKenna did not lay down the cudgels without saying that the B.M.A., in accepting the pensioner medical service were doing exactly what they had refused to do with the Government, when the Labour Party was in office; dealing directly with the Government in lodging claims and collecting money.

The one gap, not initially met by the scheme, was with people with pre-existing or long-term illness. This was closed in 1959, when the Government introduced a Special Account plan for hospital and medical benefit, guaranteeing to meet funds' deficiencies from the insurance of such patients (these being likely to be a drain on the funds). On March 1, 1960, the Government altered the basis of pharmacy benefits by charging 5s for each prescription except to pensioners; and widening the list to include almost all drugs available to pensioners: virtually all listed in the British Pharmacopeia. The imposition of a charge was not enough to halt the mounting cost, which had risen from £3,000,000 in 1951 to just over £19,000,000 1958-9 and over £35,000,000 by 1964-5. At an early date, a committee had been set up to investigate the unnecessary use of drugs, either by malpractice or wasteful prescribing (expensive drugs for minor ailments); short measure dispensing by some chemists; supply of substandard drugs by some drug houses. Penalties for offences were fairly severe in respect of false or misleading claims.

As voluntary insurance rested on the principle of an absolute minimum of interference by the Government in the doctor-patient relationship, the Commonwealth had sought no power to control the level of doctors' fees for patients. Doctors remained free to charge what they felt appropriate. The freedom of action , sought by the profession, had been preserved; but only on a basis of responsibility of action.[228] The only member of the triumvirate involved in hospital and medical benefit funds without a self-limiting factor was the doctor. The Government's was in relation to the budget; the funds in relation to reserves and a reasonable contribution from the member. The limitation of the doctor could come from direction of his professional organisation, as to what was reasonable for the professional body as a whole; or from his individual judgement as to what was proper for the community and his own reward for effort, time and skill.

In the first regard, control of the doctor by his own organisation- this was not nearly so effective as popular

belief held. Neither the Federal Assembly, nor the Federal Council, had any power of direction over the branches. They could only reach common decisions which had persuasive power, as reflecting the broad spectrum of opinion - particularly after the B.M.A. became the A.M.A. in 1962.

The State structure of the A.M.A., as when it was the B.M.A., varied from state to state. In N.S.W., with the largest number of doctors, there was a dualism existing with state wide local medical organisations constitutionally independent of the A.M.A. While the doctors were also members of the A.M.A. state branch, it was a separate membership- and any decisions made in local associations were independent of anything decided by the N.S.W. Branch Council. The procedure varied in other states - either by a process of convocation as in W.A.; or local medical societies, as in Victoria, being directly represented by a delegate on the Branch Council. Thus the A.M.A functioned as a federation of autonomous or semi-autonomous medical societies. The difficulty of securing common action was intrinsic to this form of organisation.

To planners and Prime Ministers, it has at times proved an exasperating state of affairs; and even to the officers of the organisation itself, who must often wish for a more efficient instrument for negotiation at Commonwealth level. A procedure has evolved whereby committees of consultation are held between the Commonwealth, medical insurance funds and the profession. Recognising the need for stabilisation of fees, the A.M.A. in 1963 voluntarily entered an Australia wide period of stabilisation for two years to give a period of review- aiming at higher benefits from the funds. They proposed to give notice if higher fees were found to be necessary at the end. In fact the funds made no increased benefit until just before the end of the period, making it appear as if the rise in professional fees sought provoked the increase in benefit. The A.M.A. reacted with resentment. The controversies of 1965-8, which followed, were in some respects damaging to the profession. This was commented on by Mr. A. J. Eade, secretary of Manchester Unity, who had seen thirty years of negotiation on national medical service. At the Dublin conference on voluntary health insurance, he said September 1966

> "Continuous close cooperation between the insurance organisations and the medical profession is essential, if the organisations are to retain the favourable public acceptance upon which their future depends"

In August 1967, the A.M.A. Executive Committee met with a special committee of representatives of the state funds, and agreed to periodic meetings to consult continuously between both, and the Commonwealth Health Department to maintain the proportion of medical fees paid by the patient at a reasonable level. This issue continues to remain one of the headaches of voluntary insurance. A point of interest in this context was the remark of Lord Beveridge, whose report was the foundation of the British health service, that the nation had failed to keep voluntary organisations alive, which had been a cardinal point of his recommendations. Yet, he believed, this was the only way to keep costs in bounds.[230]

An A.M.A. report in 1965 reiterated that ten years' experience of voluntary insurance in Australia showed it to be in the best interests of the Australian community - after considering the advantages and disadvantages of a salaried or capitation system. The report believed the pensioner medical service functioned smoothly, as did hospital benefits; but suggested minor reforms. It proposed a higher schedule of benefits for specialists and essential ancillary service, in the medical benefit scheme. Only on pharmaceutical benefits did the A.M.A. find some serious complaints from doctors and patients; and many minor irritations that demanded constant negotiation between the A.M.A. and the Commonwealth Government. The report also restated health education and preventive medicine in modern terms, such as preventive psychiatry, rehabilitation and geriatric medicine. The question of how to increase a sense of responsibility in the patient as to utilisation of service -particularly with pensioners- remained an unsolved one, except by imposing penalties on service extended by doctors.

Anyone, who reads fifty years of dialogue on national health service and community medicine, can be pardoned for wondering at the vast labours of paper and wisdom expended for nothing, before any scheme, acceptable to all, came into being. It is also obvious ~~and for noticing~~ that curative medicine finally predominated over preventive medicine in welfare state medical programs. ~~Nor has the~~ Although rationalisation of service was always intended and sought in Australia through nationalisation, it has not necessarily followed. ~~But~~ the words of Sidney and Beatrice Webb were still as relevant as they were when first written:[231]

> "It is necessary for the welfare of the community that there should be a strong, competent and adequately remunerated medical profession".

As to how this is to be achieved in the changing concept of medicine and social welfare is still just as much a matter of contentious debate as it was then.

C O N C L U S I O N

The B.M.A. was founded in England in 1832, and branches existed in Australia from 1838-1962, when they were superseded by an Australian Medical Association - the impetus for which had been intermittent over 70 years. At the time of its foundation in 1832, the profession was a house divided against itself with four main branches; the physicians, the surgeons, the apothecaries and the salaried doctors with varying levels of status, and professional competence.

The B.M.A. was the only medical society - out of many rival starters - to succeed in unifying these groups to any degree, both in England and Australia; and to create a world-wide fraternity. This task took many years of growth, and was hampered by the disunity flowing from the basic division of the hierarchy of the profession into four main groups without common qualification. It succeeded because it followed a moderate policy of compromise with existing colleges and institutions; and asserted an acceptable policy of morality, ethics and legislation to the majority of the profession: particularly the rising class of general practitioner who sought a high standard of personal and professional conduct. National unity of the profession was aided by the initial political struggle in Great Britain to secure reforms 1830-1850 to acquire the standards of registration, of regulation, and medical education to achieve the professional status and standing sought in the community. It was also aided by the struggle for reforms for better sanitation and public health for the community.

The B.M.A. was able to build a bridge successfully between these four professional groups with their different, and sometimes dissident, demands. It was able to do so, despite the strong individualism of the doctors; frequent conservatism leading to continual contention; occasional tendency to arrogant dogma, susceptibility to irascible personal dispute; at times surprisingly slow adaptation to significant medical discovery; and egoism encouraged by the isolation of practice, and the semi-sacerdotal attitude many of the lay public in modern times have grown to adopt towards them.

Public disputes and counter accusations of doctors in the press and courts ultimately yielded to the ethical codes of the B.M.A. devised gradually to this end, which worked by common consent rather than compulsion. An element of discipline was introduced into these codes by the end of the century, which helped to feed charges that the B.M.A. was the strongest trade union in the world. Such discipline was not used simply to persuade doctors to better public and private behaviour in the common interest of professional standing; but also to compel conformity to minimum employment conditions or fees, with the power of expulsion from the B.M.A. as the threat to intimidate the member to fall in line. But condemnation of this form of punishment by boycott, creating ruin to an individual doctor, was made in the judgement in the Coventry case in England in 1915; and discouraged further use of such boycott in England. In Australia, expulsion was a weapon almost exclusively used to present a united front against friendly societies between 1890-1920; at that time considered by doctors to be depressing their conditions of contract practice. Sanctions in fact proved difficult to apply against those not observing ethics, and only partly effective at the best of times, either in Australia or in England.

Enlistment of doctors in the B.M.A. as their preeminent professional association reached a higher level in Australia than in England; partly because there were no pre-existing institutions such as the Royal Colleges; partly because there were different and urgent social problems arising from a pioneering environment; partly because the recruitment was more vigorous and successful in the period 1890-1920 when friendly society practice created pressing problems of conditions of medical service in the community; partly because the failure to introduce national insurance in 1911 at the same time as Great Britain, or indeed till post World War 2, left B.M.A. Branch Councils in a materially stronger bargaining position in the community. The period of maximum growth in BM.A. membership from 1870-1938 in Australia was the period also when conflicts of interest between the specialist, salaried, and general practitioner sectors of medical organisation were least marked.

The major issues concerning B.M.A. Branches in Australia, from foundation 1880 till 1962, were the most effective organisation of their own societies; friendly society practice; hospital organisation and the work of doctors in them; ethical codes to which fees and advertising were related; the state regulation of all phases of the practice of medicine; and the organisation of private medical practice in the community.

One issue came to be considered of paramount importance, namely the rationalisation of medical services. The nineteenth century was the era of haphazard, ill-coordinated, ad hoc policies of public health, and minimum control of the profession to ensure a basic standard, but without proper exclusion of the unqualified from medical practice, or proper protection of the public on whom they preyed. It was therefore also the era of demand for rationalisation of improvised legislation; and, by the doctors, that the state assume some of their load of private charity for distress, other than the poorhouse.

B.M.A. leaders saw that to rationalise would unify medical service and practice in every sense: first, the states with the Commonwealth in Australia (registration, education, hospital standards, industrial medicine etc); second, the services within each state (hospitals, public health etc); third, the profession by giving all sectors a common interest in community medicine; fourth, groups within the profession by way of pooling technical resources that weighed heavily on the individual purse as the necessary technology of medicine expanded.

By the twentieth century, it was commonly accepted that the cost of proper medical service in the community was so great, as to be a national responsibility pursued through state instrumentalities by virtue of government legislation. Every citizen came to be regarded as entitled to proper medical care whatever his misfortune; and this should be rendered to him no longer merely by private philanthropy, but through a comprehensive medical service financed from the public purse.

Schemes of nationalisation were widely discussed in Australia over the years 1911-52. These were initially a policy for national insurance on the model of the British legislation introduced in 1911; and later for the Social blueprint for cradle to the grave

The initial fear of B.M.A. leaders towards nationalisation in this era was a reaction to ideas then relatively unfamiliar, and associated with radical intellectualism, and the rising Socialist groups of Great Britain and Australia. These were ideas also propagated by early Labour Governments in the State and Commonwealth; and linked with reform programs whose novelty aroused some apprehension.

The B.M.A. Federal Committee pronouncement of February 6, 1918, was representative of the determined majority view for professional independence at that time. It asserted:[1]

> "Generally speaking, the interests of the public are best served by the members of the profession continuing, as at present, to conduct their practices as free individual citizens in competition with one another, subject to the traditional customs and rules of the profession, and under the laws generally governing medical practice in British communities".

Medical departments of the public service were excepted, and defined. Third party intervention between doctor and patient was deplored,(whether individual, corporate or Government), in these terms:[1]

> "As a general principle, third party intervention between medical attendant and patient, whether such third party be an individual, a corporate body or a Government Department, is likely to destroy that relationship, essential to medical treatment, which is based upon that attendant's sense of his personal responsibility for the proper performance of his duty and the patient's confidence in his attendant's skill and honour".

The fears of the B.M.A. at this time were not to association with Governments as such. Such association had been necessary and sought in many domains of practice as asserted by Professor Truman in his study of the professions:[2]

> "The professions of medicine and law have in all ages been close to the institutions of government in the sense that almost invariably they have been subject to a considerable measure of regulation to ensure effective and scrupulous discharge of their public interest".

The B.M.A.'s fear was that association with Governments would not be as desired - consultation with a free, independent professional group to create a service of voluntary association (such as honorary service in hospitals was); but to create a master-servant relationship on a contractual basis which would make medical practice a compulsory service where

the Government, as paymaster, would dictate the terms and amount of service to a profession shorn of its bargaining power. They feared this might destroy the quality of public service in medicine by changing the attitude of the doctor to his work and his patients. They feared also that the plans put forward might not offer the best possible solution towards an ideal medical service to the public.

The B.M.A. was constantly mindful in its discussions from 1911-52 of a criticism as to the bias of national health programs towards the economics of sickness. This view was reinforced by the comment of the Royal Commission on Health in 1926:[3]

> "Under the existing system a very undue proportion of money spent on the health of the people is devoted to the care of the sick, and there is little or any attempt to utilise the knowledge in the possession of hospital staffs, and of Health Department staffs, for the common purpose of reducing the total quantity of disease and disability".

A similar argument, against the limited view of health service that prevailed in political planning, was put forward by a report by an independent non-party expert group in Great Britain in 1937, called "The P.E.P. Report on Health Services in Great Britain. It said:[4]

> "It is important to outgrow the attitude of confining the term health services to what are really sickness services. The nation needs sickness services, but a nation which regards them as a substitute for health services is going to find the confusion expensive in money and suffering".

But public health does not buy votes. It does not have the glamour of research, or even dramatic surgery. The social conscience of the individual voter is far stronger on the right to a free bottle of medicine, than the alcoholic in the gutter. Parliaments are more willing to legislate for those injured in expensive motor car accident injuries, than to reduce their rate by safety features in vehicles, stringent licencing requirements etc. Consequently, the emphasis remained on blueprint planning for 'sickness ' services, or subsidising hospital care, after earlier national insurance schemes had proved their inadequacy to offer more than an unsatsfactory compromise on earlier contract practice in medicine.

The B.M.A. was first promised by the Prime Minister of Australia in 1913 that it would be consulted before any national health planning was drafted; which had not occurred in the preceding two years in Great Britain

This promise was carried out 1913, 1924-8, but not to a satisfactory degree 1936-8, and only perfunctorily 1944-9 by a Government already committed to a concept of national health service not acceptable to the B.M.A. The form of consultation varied as to whether on basic principles, or details only. On the wide range of legislation affecting the doctors, (~~and~~ of concern to the B.M.A., both in State and in Federal spheres) consultation, and the sympathy and sincerity with which it was conducted, varied greatly both with conservative and radical government; but, on the whole, was greater with conservative governments. Very frequently the prescence of a medical man in the Cabinet, particularly if either Premier, Cabinet Minister, or holding the portfolio of health-as with Sir Stanley Argyle in Victoria, or Sir Earle Page in the Commonwealth,- was a most telling factor in the creation of harmony, and productive of acceptable legislation, or desired legislation.

The national health service that finally emerged in Australia in 1951-2, after long and often acrimonious dialogue with the Commonwealth Government that proved damaging to the medical profession in public regard, was not the scheme preferred by the Labour Government during its term of office 1944-9. It was a scheme of voluntary insurance , based on traditional insurance organisation in an evolutionary framework of traditional medical practice. It largely retained the prior contract practice organisations, although on a basis of fee for service, instead of annual capitation payment. It was evolved with full consultation with the B.M.A. and full acceptance by them,

The Liberal Government then in office leaned to the view expressed by its Prime Minister, the Hon.R. G. Menzies:[5]

> "any activity in which choice and personal confidence are essential is not an activity for which the socialist solution is appropriate... Our family doctor knows us, our history and our oddities, so sees us as individuals, and evokes a high degree of frankness which is based on actual confidence. There is no substitute for the diagnosis and therapy so produced".

The voluntary insurance scheme was one which, by requiring the patient to continue payment direct to his doctor, was considered to remind him of regard to the amount of his financial responsibility, and thus still to have an incentive to keep demands within bounds. This was a responsibility said to be forfeited in a compulsory/free scheme, where the doctor rendered his patients' bills direct to the Government; and the patient had no bookkeeping to do himself, nor process of recovery from an insuring organisation for a fee to which he still had to make a contribution.

Since the voluntary insurance scheme began, the B.M.A. (the A.M.A. since 1962) has been on the defensive in respect to it, against continuing Labour party calls for reform; extension of the pensioner or free service area of the scheme in which a contract exists between the doctor and the Government; embarrasment caused within its own membership by failing to observe voluntary agreements to peg fees on which the viability of the scheme depends; on types of arbitration between itself and the Government to prevent abuse of the scheme either by patient or doctor, and to decide on necessary deterrents and penalties. A further continual problem is that of an adequate process of review of the basis of payment to doctors, satisfactory to all, which will allow for rising costs of practice, and reward commensurate with long years of study. This aspect of adjustment is one which always arouses most public notoriety for the profession, often to their disadvantage. The profession is widely, and not unjustly, regarded as being more prosperous than it was in pre World War 2 days of practice; and enjoying a higher level of status than at any time in its history. Its right ~~to continue~~ to continue to enjoy the reward and status is at issue; its argument, that both are necessary to the highest standard of medical practice, challenged.

However, it is dubious that any argument for a service that did not provide for a competent, and adequately rewarded medical profession could be sustained. Beatrice and Sidney Webb in 1909 insisted that any unified medical service on a planned basis should have regard to this as necessary for the welfare of the community: therefore[6]

> "that any change which was likely to injure a profession of so much value to the public must be, to say the least of it, very critically scrutinised".

These words are as true as they ever were.

But every citizen's relationship with his doctor is a continuing one, and any national health scheme bears on everyone in the entire community. Medical practice can no longer be carried out in primitive hospitals and the home; but requires elaborate laboratory and diagnostic aids, advanced specialist skills, and the large expensive institutions, which hospitals have become, for proper treatment of the sick. Therefore the task of the B.M.A. by 1962 has become increasingly more complex, as medicine has, and the deliberations of its councils far more dominated by medical politics than at the time of its origin. Its advantage, as one representative voice for the majority of the profession, was even greater than a century before; for a Government administering a national health scheme obviously found negotiation with one, rather than a multiplicity of bodies, desirable.

But creation of wide representation of affiliated bodies in Federal or State Councils did not altogether solve the problem of the B.MA. adequately sustaining its role of speaking for the profession at large. The latent conflict of interest between the general practitioner and specialist sectors of the profession continued to cause periodic crisis, and chronic exacerbation. In recent years, this conflict of interest has become more marked due to the tendency of doctors to specialise immediately on graduation; to the change in selection for university entrance, and the nature of university education; and to the differential effect national health service has on the two sectors and the competing interest engendered by modern reorganisation of hospital systems.

In addition, membership of the B.M.A. began to recede from its pre-war high water mark. Many doctors began to join merely the specialist group, in which they could find fraternity and post-graduate education more suited to their professional needs, and to assert that the B.MA. could do nothing for them. Salaried doctors multiplied in number either as research workers, industrial medicine as specialists of exotic skill, or administrators. They had new status, and different demands. Looking to careers in the modern technology of medicine they could not support an argument for professional independence financially, being already employees; while the inability of the B.M.A. to go to arbitration for review of salary on their behalf was a positive disadvantage in belonging.

None the less, despite secessions from membership, recurrent rebellion within its ranks, and a much more complex task of political administration, the B.M.A. (and now the A.M.A.) is still regarded as the major form of self-government within the profession, and representative of the common voice of the majority,

Its task remains the same, as always since foundation, of reconciling the great natural individualism of the doctor with the collectivism of his organisation; of reconciling the individuality of the organisation with the planned collectivism of national health service. It is still concerned with the fear that blueprints for sickness services will cause escalated financial demands on the public purse, and social demands for more and more service without a correlation to the standard of that service. It dreads erosion of professional standards, so painfully acquired, ethical , moral and social as well as economic; and equates this with loss of professional independence and destruction of the patient-doctor relationship by intervention of the state.

Critics can be found within the ranks of the profession, and always have been, and, without, to charge it as pursuing self-interest, and acting as a pressure group to that end. Others have charged it with doing too little. Perhaps the answer to the last is that the record is not too little, but too little known. The words of the B.M.A. President in Queensland in 1923 may, therefore, be a fitting epitaph to this record of the B.M.A. in Australia in the period 1880-1962. He answered the question "What does the B.M.A. do for its members?" in these words:[7]

> "To those I would say look over the minute books, and see what a fine record is written therein not only for the benefit of its members, but, what is far more important, for the benefit of the public, and the common weal of all classes".

Its successor, the Australian Medical Association, still, as the B.M.A. did, dominates the majority of the medical population despite secessions, indifference, even open revolt. It still repairs the bridge laid down so long before by the British Medical Association; and it still endeavours to preserve the status and independence of the profession that was the original care of the B.M.A.

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D.H. Borchchardt:	Checklist of Royal Commissions, Select Committees of Parliaments and Boards of Inquiry 1. Commonwealth of Australia 2. Queensland 1860-1958	Dept of Political Science-University of Sydney

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Australian Medical Journal 1846-7	Sydney
Australian and New Zealand General Practitioner 1952-	Sydney
The Australian Practitioner 1877-8	Sydney
Australasian Medical Gazette 1880-1914	Sydney
Australian Medical Journal 1856-	Melbourne
Bulletin of Post Graduate Committee of Medicine 1945-	Sydney
Bulletin of the History of Medicine 1934-	London
British Medical Journal 1871-	London
General Practitioner of Australia 1930-	Melbourne
Intercolonial Medical Journal of Australia 1894-1914	Melbourne
Journal of the History of Medicine and Allied Sciences 1946-	London
Journal of the Royal Historical Society of Queensland	Brisbane
Journal of the Royal Australian Historical Society	Sydney
Medical History 1957-	London
The N.S.W. Medical Gazette 1871-4	Sydney
Medical Journal of Australia 1914-	Sydney
Royal Melbourne Hospital Clinical Reports	Melbourne

ARTICLES IN JOURNALS

Articles , too numerous to list, were found occasionally in other journals such as:

Annals of General Practice
Australian Hospital
Australian Law Journal
Australian Quarterly
Economic Record
Health
Health and Building
Hospital Administration
Pharmaceutical Journal
Public Administration Journal
Royal Perth Hospital Journal
Sydney University Medical Journal

NEWSPAPERS

Recourse was had to major dailies in all states, and also to press cutting books for certain periods held in branch and federal offices of the Australian Medical Association.

MINUTE BOOKS

Those extant were read in all branch offices, and the federal office of the Australian Medical Association.

These were complete for the history of the British Medical Association until it ceased in 1962, and was replaced by the Australian Medical Association.

Records of preceding medical societies were fairly complete; and, where they were not, is mentioned in the text of the thesis.

CORRESPONDENCE

Past correspondence has not been preserved to the same degree in various branches.

Correspondence for the B.M.A. is lacking in Tasmania, Victoria and South Australia in any volume prior to 1939. It is well-collated in Western Australia ; and held in Queensland and New South Wales.

A great bulk of correspondence is held in the Federal Office for the history of the Federal

Council of the B.M.A. and its predecessor, the Federal Committee 1913-33. This correspondence was not sorted, being held in boxes under general headings correlated to the minute books.

INTERVIEWS

Interviews were held with branch councillors and officers in all states; with those who had served as councillors in past years or officers; with politicians concerned in significant events or legislation; with departmental heads, state and Commonwealth, past or present; with executive officers of friendly societies past and present; with individual doctors and medical historians; and with members of the Joint Parliamentary Committee on Social Security including its secretary and other officers concerned with it.

These interviews were of great importance in reconstructing past events, particularly in relation to the emergence of our national health service.

Among such interviews were:

Sir Henry Newland	Adelaide	23.11.66/25.11.66
Dr. Mallen	Adelaide	24.11.66
Dr Le Souef	Perth	29.12.67
Mr. Hancock	Perth	5.1.68
Dr. Atkins	Perth	29.12.67
Dr. Leigh Cook	Perth	29.12.67/1.1.68
Dr. Coppin	Pert	1.1.68
Dr. G. Newman Morris	Melbourne	14.4.67
Dr. Leembrugger	Melbourne	29.7.68
Sir Cecil Colville	Melbourne	30.7.68
Mr. A. Calwell	Canberra	7.2.67
Professor Crisp	Canberra	26.5.67
Lord Casey	Canberra	8.2.67
H. Goodes	Canberra	26.5.67
Mr.J.Dedman	Canberra	8.2.67
Mr. R. Rowe	Canberra	8.2.67
Sir W. Refschauge	Canberra	8.2.67
Dr. Nye	Brisbane	19.5.67
Dr Pye	Brisbane	19.5.67
Dr. Wagner	Brisbane	18.5.67
Dr. Freyberg	Brisbane	15.5.67
Miss M. Spooner	Brisbane	19.5.67
Dr. J. Lee	Brisbane	16.5.67
Sir R. Cilento	Brisbane	19.5.67/15/5/67
Professor Gordon	Brisbane	16.5.67

INTERVIEWS

Sir R. Grieve	Sydney	4.10.66
Jack Lang	Sydney	16.2.67
Gus Kelly	Sydney	16.3.67
Dr. A. Larkins	Sydney	3.4.67
Dr. G. Howe	Sydney	4.4.67
Dr. T.Y.Nelson	Sydney	11.4.67/7/7/67
Mr. Sheehan	Sydney	10.4.67
Mr.F. Daley	Sydney	4.12.66
Dr. Simmons	Sydney	1.9.66/15.11.66
Dr. Lilley	Sydney	20.11.66
Mr. Eades	Sydney	19.12.66
Dr. Metcalf	Sydney	26.10.66/6.11.66
Mr. J. Doyle	Sydney	13.8.67
Mr. Justice Dovey	Sydney	27.6.67
Mr. Ridley	Sydney	7.6.67
Sir Robert Cosgrove	Hobart	28.6.67
Dr. F. Fay	Hobart	30.6.67 /4/7/67
Dr. C. Craig	Launceston	25.6.67

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9.	B. and S. Webb-"The State and the Doctor"	p.218
10.	British Medical Journal-26.10.1918	p.58
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12.	Intercolonial Medical Journal of Australia 20.8.1902	p.405
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7.	Australian Practitioner 1877-78 Vol.1	p.239
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