

**THE CHALLENGE TO MEDICAL
AUTONOMY AND PEER REVIEW EMBODIED
IN THE COMPLAINTS UNIT/HEALTH CARE
COMPLAINTS COMMISSION
OF NEW SOUTH WALES**

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ABSTRACT

The exercise of autonomy and self-regulation is seen in the literature as one of the basic criteria of professionalism. Since in modern states Medicine has generally been the occupational grouping which has most completely attained that status, it is seen as the model or archetype of professionalism. This study focuses on just one aspect of medical autonomy, that relating to the right of medical professionals to be accountable only to their fellow professionals as far as the maintenance of practice standards are concerned. In this thesis, the theory underlying this system of "peer review" is examined and then its application during the course of the 20th century is traced in one particular jurisdiction, that of the State of New South Wales in Australia. The reason for the focus on NSW is that in this jurisdiction, medical autonomy existed and was exercised in a particularly pure and powerful form after it was instituted in 1900. However, it was also in NSW that for the first time anywhere in the world, an institutional challenge to medical disciplinary autonomy emerged with the establishment in 1984 of the "Complaints Unit" of the Department for Health. The thesis of this study is that as a result of this development, which within a comparatively short space of time led to the emergence of a system of "co-regulation" of medical discipline, medical disciplinary autonomy and peer review had within a decade, been so severely challenged as to be almost extinct in this State.

In the light of theoretical frameworks provided by Weber, Habermas and the American scholar Robert Alford, the study examines the long drawn out struggle to institute medical autonomy in NSW in the 19th century, its entrenchment by subsequent legislation over the next eight decades and the "counter-attack" staged by the emergent forces of consumerism, supported by the forces of the ideology of "Public Interest Law, in the last two decades of the century. The study concludes with a discussion of the implications for definitions of professionalism which might result from the loss by Medicine in NSW, of its right to exclusive control of medical discipline and the consequent disappearance of medical peer review.

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KEY TO ACRONYMS USED

AMA	Australian Medical Association
BMA	British Medical Association
CAB	Consumer Affairs Bureau
CU	Complaints Unit
HCCC	Health Care Complaints Commission
MCA	Medical Consumers Association
MRB	Medical Registration Board
NSWPD	New South Wales Parliamentary Debates
PIAC	Public Interest Advocacy Centre
PIL	Public Interest Law

CHAPTER ONE

INTRODUCTION

The medical profession featured strongly in the "indemnity crisis" in Australia in 2002. Perhaps because such a wide range of activities were affected by that crisis, including even iconic pastimes such as swimming at Bondi beach and horseracing, the novelty of the situation with regard to medical practice was little remarked on. The extent of the threat was well canvassed however. For instance under a banner headline "Patients now face risks, say surgeons" the *Sydney Morning Herald* on Monday, June 17, 2002 carried a front-page article which reported: "Surgeons are calling for a national medical insurance scheme to fix the indemnity crisis, warning that advanced medical techniques may be shunned and many doctors forced out, with no young people willing to take their place." At the other end of the spectrum, a visit to a local surgery revealed a state of more than mild panic among general practitioners who as a result of the collapse of a major insurance company faced the prospect of financial ruin if they were successfully sued for the smallest error in their practice. Even an undertaking by the Commonwealth Government that it would meet all claims until the situation was sorted out, failed to calm the apprehension.

In historical terms, the vulnerability of the medical profession to litigation constituted a new situation. Practitioners have of course, always been open to being sued by dissatisfied patients. But by the turn of the 21st century, not only was there a new spirit of litigiousness abroad, but conventions such as medical autonomy and peer review, which had always sheltered practitioners from the harsher winds of litigation, had either

disappeared or been emasculated. The indemnity crisis of 2002 was particularly acute in New South Wales, where actions by the State government and consumer advocates have gone perhaps further than anywhere else towards breaking down the system which, for most of the 20th century, had largely exempted the medical profession from accountability to its clientele.

The way this had happened forms the subject matter of this thesis. The methodology adopted is to trace general developments through those in two particular institutions, these being the Medical Registration Board and the New South Wales Health Care Complaints Commission. A momentous although little remarked development, occurred on July 1, 1994 when the two bodies officially began sharing responsibility for the discipline of the medical profession. In fact, that sharing had been taking place on an unofficial basis over the best part of a decade, during which time the system known as "co-regulation" or "collaborative regulation", had emerged. In historical terms this was unprecedented, bringing into question some of the most deep-rooted and fundamental aspects of the professional status medicine had always enjoyed, namely autonomy and peer review. The thesis being argued in this study is that the legislative introduction of "co-regulation" in 1994, meant that both medical autonomy and peer review had been severely challenged if not altogether extinguished in this State of New South Wales (NSW).

An in-depth discussion of medical autonomy and peer review occurs in Chapter Two. At this point it can be noted that the peer review principle is an old one in the English-speaking world. One of the earliest recognitions by the state that the medical profession

possessed "such an unusual degree of skill and knowledge ... that non-professionals are not equipped to evaluate or regulate it" (Freidson, 1970 p137) was evident in the royal charter granted to the College of Physicians in 1523 in England. The word "royal" signified a crucial condition for the entrenchment of peer review: it can exist only where the state officially grants a profession exclusive rights to control its field of work. Such control is two-faceted; on the one hand "external control" empowers the profession to exclude anyone but its own members from that field of work; on the other hand, "internal control" gives to the profession in Freidson's words, exclusive rights to take "proper regulatory action", against those of its members found guilty of "deviant performance" (Freidson, 1970 p137). It logically follows that if anyone or any agency outside the profession is given the right to monitor or control the actions of professionals, not only does this bring the autonomy of the profession into question, but the principle of peer review ceases to apply. The postulation of this thesis is that the system of "co-regulation" described above, brought about exactly that situation in NSW.

In arguing that point, this study is structured around several major themes. These are:

1. Theoretical considerations related to the notion of medical peer review and medical autonomy (Chapter Two).
2. The origins and institution of medical autonomy and peer review in New South Wales (Chapters Three and Four).
3. The results of the exercise of autonomy and medical peer review in practice (Chapter Six).
4. Changes in societal thinking affecting the standing of professions (Chapter Seven).

5. Challenges by government and consumer advocates to medical autonomy and peer review (Chapter 8).

Rationale

There are a number of issues which justify the investigations undertaken in this thesis. For instance, while the origins and institution of medical autonomy in NSW (point 2 above), has received a good deal of attention from researchers, they left much scope for the postulation of broader understandings of the developments they dealt with. The earliest of these researchers were Hilder (1959) and Cummins (1969). Their work appeared in published form, as did that of Lewis & MacLeod (1988). Two unpublished but thorough and comprehensive accounts are the Masters thesis of Davis (1983) entitled *The Professionalisation of Medicine in N.S.W. 1870-1900* and the doctoral thesis of Lloyd (1993) *Medical Professionalisation in New South Wales, 1788-1950*. The work of Hilder (1959) and Cummins (1969) are semi-official histories and are almost purely descriptive, containing very little either political or sociological analysis. Lewis and MacLeod's (1993) work is much more scholarly and well researched and they, together with Davis (1984) and Lloyd (1993) have provided the most analytical and in-depth studies of this field. However, using aspects of the theories of Weber and Habermas, I believe I have been able to highlight aspects of the attainment of medical autonomy in NSW which have not been covered so far. Moreover, on the purely empirical level, I have made use of primary research material, particularly the record of parliamentary debates in Hansard which received only passing attention in earlier studies. This material throws new and important light on the historical developments which contributed to

medicine's professionalisation process in NSW and which will I believe, significantly add to the understanding of that process.

It might also be remarked that this thesis was written at a time when attitudes to traditional or alternative medicine were changing. Writing at an earlier date the authors mentioned above, along with others such as Pensabene (1980) tended to see anything outside of the scientific paradigm of medical practice as mere charlatantry or, in colloquial terms as "quackery". However, I have thought it important to extend a more sympathetic treatment to non-scientific medicine. An indication that societal attitudes on this point are changing emerged while this study was being written; early in 2002 the Australian Medical Association issued a position paper which reversed their former total opposition to alternative or complementary medicine (Australian Medical Association, 2002). That move, which attracted a good deal of attention, is discussed more fully in Chapter Four, where I argue that only when serious attention is given to non-scientific epistemologies, can a full understanding of the processes and the shape of medical autonomy in NSW in the 19th century be fully understood. This issue will also be discussed more fully later in this chapter.

Apart from new interpretations about developments in the period before 1900, by looking fairly closely at developments in the State's health care system after that date, this thesis moves into little explored if not altogether unexplored research territory. Although the title of Lloyd's 1993 thesis sets out an intention to cover the professionalisation of medicine in NSW up to 1950, his focus moves away from NSW after the 1920s and on to developments at the national and federal level. Thus for instance, he makes no mention of

the landmark 1938 Medical Practitioners' Act in NSW, his omission being indicative of the fact that this Act and the important 1963 Amendment Act, constitute a *terra nullius* as far as research is concerned. The account of the development of medical regulation and the exercise of medical autonomy and peer review in NSW I believe will add useful information on the medical history of this period.

Coming to a more recent period, particularly the last two decades of the 20th century, it can be said that to date no author or authority has attempted to assess the importance of the system of co-regulation in NSW, covered in the last section of the thesis. This is understandable; NSW constitutes a fairly small jurisdiction in global terms, and those outside Australia may have difficulty in appreciating the unique nature of developments in each State to which the country's federal structure gives rise. None the less, as is explained in Chapter 7, the NSW system of co-regulation is unique within Australia; while all other States and Territories (with the exception of South Australia) have developed health complaints mechanisms of their own, none have been given the co-regulatory powers over medical discipline exercised by the NSW HCCC. Moreover, while systems of co-regulation have been developed in a small number of American States (Feinstein, 1985) no other jurisdictions outside of Australia apart from New Zealand, have developed independent and statutory health complaints bodies like those in Australia. Thus the system of co-regulation may well be unique anywhere in the world and in purely administrative terms, that provides reason enough for the particular attention given to it in this study.

Moreover, in sociological terms the system of co-regulation constitutes a development which I would argue ranks not far behind the significance of the issues of deprofessionalisation, corporatisation and proletarianisation which have attracted a good deal of scholarly attention. According to Burnham in his compendium on medical professionalisation, *How the Idea of Profession Changed the Writing of Medical History* (1998 pp116-7), the deprofessionalisation argument grew out of fears that the undermining of the autonomy and knowledge-claims of professional workers would reduce them to the performance of "controlled tasks - dependent on others - so that they would end up just like workers within the bureaucratic society" (pp116-17). This possibility had been advanced a quarter of a century earlier by writers such as Oppenheimer (1973), who postulated that any loss of autonomy and status would mean that the medical profession was being "proletarianised", provoking "defensive reactions which can be considered the beginnings of a working-class consciousness". In a similar vein, although using different terminology, Haug (1975,) (1976), (1988) argued that the loss of medical autonomy was a result of increasing numbers of doctors being employed by large corporations in the private sector, and thus being subject to managerial direction just like other employees. Her argument was supported by McKinlay & Stoeckle (1988) and Wolinsky (1993).

From this point of view, the situation of co-regulation in NSW described above can be seen as a more serious challenge to medical autonomy than any of the arguments about deprofessionalisation because it has deprived Medicine of the sole right to discipline erring or miscreant practitioners, which constitutes the essence of peer review. However, the word "challenge" is used advisedly, because it is not being argued that co-regulation

betokens the end of the medical autonomy in NSW. The exercise of discipline is only one aspect of the operations of the State MRB, which continues to operate autonomously in that it is a self-funding statutory corporation which is independent not only of government but also of the medical profession. (Medical Registration Board NSW, 2000 p6). However, whatever the legal position, the thesis of this study is that the situation which has been in place since 1994 when co-regulation was officially instituted, signals a significant aberration from the notion of autonomy as set out in the texts comprising the vast corpus of writing on the professions and on professionalisation.

Literature review and original research

The overall conceptual framework of this thesis is derived from the literature on professionalism in general and the medical profession in particular. This is important because while the present study does not focus on professionalism as such, autonomy is generally agreed to be a distinguishing mark of the professions. Burnham (1998) has rightly pointed out that in any account of the history of Medicine, it is always a mistake not to deal with professionalism and professional development. As far as professionalism in its more general sense is concerned, I have paid limited attention to the literature of earlier functionalists such as Carr Saunders & Wilson (1932), Parsons (1939) and Durkheim (1957) since they fall into what Brante (1988) describes as the naïve school, in that they gave to professionalism "an image of a largely autonomous self-regulating and self-perpetuating institution, the altruistic members of which are filled with a desire to work for the common good in the most effective way" (p122). It might be remarked that whatever the shortcomings of his "naïvist" approach, Parsons (1939) was right in seeing that higher education was and is a central factor in professionalism, since "[e]ducation

and competence justify demands for influence and power, and demands for occupational monopoly within certain sectors" (p123). Parsons' conclusions are supported by Larson (1977) one of the chief proponents of what Brante described as the "cynical" school, i.e. those to whom "doctors appeared as the wielders of power, not servants of the public good" (Macdonald, 1988 p4).

Supreme among such writers of course is the American sociologist Eliot Freidson, who turned the tide against functionalism with his *Profession of Medicine* in 1970, although as Macdonald points out "Freidson himself makes very little use of the word "power", preferring the term "organized autonomy" (1995, p5). I find it useful to link the views of Freidson and Larson with those of Weber, relating to his concept of economic or social closure, referred to later. Freidson's work was particularly valuable because of its focus on the phenomenon of medical autonomy. The studies of the Australian sociologist Ann Daniel, particularly her *Medicine and the State; Professional Autonomy and Public Accountability* (1995) are also important in this regard.

On the other hand, for my purposes neither Daniel's nor Freidson's analyses go far enough, since they deal with professionalism and professional autonomy in a general and theoretical sense and do not look closely enough at the "mechanics" of autonomy - how it is (or was) realised and embodied in the day-to-practices of both the medical profession as a whole and of individual doctors. The same can be said of the work of others who have focused on autonomy, particularly Boreham (1983; Wolinsky 1993; Southon, 1992 and Southon & Braithwaite 1998). While Wolinsky (1993, p12) sees that professional autonomy does not exist as a self-evident or self-enforcing theory and that it has to be

legally instituted, he too does not go on to describe or investigate how this is concretely embodied in the form of regulatory bodies established by legislation and which operate as statutory authorities. Not only the institution, but also the functioning of these bodies is crucial to understanding the challenges to autonomy investigated in this study, and therefore I have paid particular attention to this issue.

Another issue which these authors did not consider in sufficient depth is that of the historical roots of medical autonomy which reach back a surprisingly long way. In the English-speaking world, the first body which was charged by the State with enforcing medical regulation and which operated on an autonomous basis, was the Royal College of Physicians, founded in 1518. While there may be doubts as to whether such an institution had any bearing on modern medical practice, it is interesting to note that over 350 years later, one MP in the NSW parliament quoted the 1518 regulations in support of an attempt to institute medical regulation in NSW in 1886! (NSWPD, 1:23 19/10/1886, p5861)¹ As will be demonstrated, arguments in favour of medical regulation remained basically the same over the space of three and a half centuries. Moreover, recent works by Pelling (1998) and Holmes (1982) indicate that not only the traditions but also the forms that medical autonomy took in the 16th century, were clung to until well into the 20th century, something confirmed by Berlant (1975) in his study of the Royal College of Physicians.

¹ See p 13 for an explanation of the reference system adopted for citations from “Hansard”.

Medical autonomy (discussed later in more detail) has to be seen on two levels: firstly, there is the institutional autonomy exercised by those bodies charged with the maintenance and enforcement of medical regulation, the Medical Regulation Boards (referred to as MRBs from this point). Secondly, as Southon and Braithwaite (1998) argue, individual practitioners are also seen to be, and indeed regard themselves as, autonomous as far as their practice issues are concerned. The existence of this second type of autonomy it is further argued, is dependent on the existence of institutional autonomy in the first place. Thus, in examining medical professional autonomy, both of these dimensions need to be investigated. To do so entails an investigation of the operation of MRBs, which are the institutional expressions of medical autonomy. My examination of MRBs was grounded in the fact that these bodies are statutory or corporate authorities - that form of governance which accompanied and indeed characterised the enormous growth of government in the late 19th and early 20th centuries. It therefore seemed worthwhile to examine the work of Australian scholars in the field of public administration who specialise in the analysis of statutory authorities.

There was a great burst of such writing in the late 1970s and early 1980s by Spann (1979), Corbett (1975) and particularly Wettenhall (1963), 1981, 1983, 1988) which proved useful in providing an understanding of the origins and operational context of statutory authorities. That in turn helps with the understanding of how MRBs were established and how they operated. However, as specialists in public administration, none of these authors were particularly interested in medical regulation and none made more than passing references to MRBs themselves. What they probably would have found extraordinary had they paid more attention to the MRBs, was the degree of their

autonomy, particularly in the early years of the 20th century, in which they appear not even to have reported to parliaments on their activities.

As far as literature relating to the MRBs themselves is concerned, the most fruitful area for research is that relating to the early model for these types of body, the British General Medical Council, established by an Act of the British parliament in 1858. Although it was not the first, it forms the archetypal model of such bodies. However, while there is a fair corpus of literature on the General Medical Council (the GMC from this point onwards), ranging from scholarly accounts such as those of Parry and Parry (1976) and Stacey (1992), to the semi-official histories of Heseltine (1949) and Pyke-Lees (1958), there is very little analytical and scholarly literature on the MRBs of Australia. The only published histories of Australian MRBs are those of Frankael and Wilde (1994) on the MRB of South Australia and the semi-official histories of Hilder (1959) and Cummins (1969) referred to earlier. However, as noted earlier, these works tend to be wholly descriptive and make no attempt to set their data in the context of social, political or administrative developments. While Lloyd (1993) examines the establishment of the NSW MRB in some detail, he says little about its later operations. Only very recently has more attention been paid to the workings of MRBs in edited volumes such as that of Smith's *Health Care, Crime and Regulatory Control*, (1998). Even here attention is focused on contemporaneous developments, little or no attention being paid to the history of MRBs, while there is no attempt to see them in the comparative context of other statutory authorities.

For the purposes of this study, one shortcoming of the work of Davis (1984) Lewis & MacLeod (1988) and Lloyd (1993), is that they focused very narrowly on the activities of the medical profession in attempting to achieve their goal of professional autonomy and did not pay attention to the broader processes and contexts of bureaucratisation discussed in Chapter Two. I contend that a complete understanding of this process means that it is crucial to understand what those in government were thinking and doing, and that governments should not be treated, as they are in even the work of Freidson, as distant and shadowy entities which merely reacted to the push and pull of outside forces. Freidson tends to see governments as "neutral referees" in the way they were depicted by Dahl (1962) in his work on pluralism, rather than being extremely proactive players in administrative as much as in party politics.

On that score however, documentation which could throw light on thinking and politicking on medical issues within governments at the time medical professionalism was being instituted, such as cabinet briefings and minutes or ministerial correspondence, is non-existent. All too often the researcher simply finds the dreaded word "culled" when searching for such documentation in the State archives. Thus the nearest one can get to the "inside story" of what was happening in the inner sanctums of government is provided by the NSWPD reports of debates in the two houses of the NSW parliament. Obviously Lloyd (1993) and Lewis & MacLeod (1988) did use these sources but were possibly daunted by the tediousness of perusing debates in detail. This is particularly true of the period before the first NSWPD reports were published in 1880; up until then only near-verbatim reports of parliamentary proceedings were printed in the *Sydney Morning Herald*, which although indexed in a separate government publication, are much less

easily accessible than are NSWPD reports. However, I did consider it worthwhile to read all the debates relating to Medical Practice Acts from 1873 onwards, an exercise which yielded rich rewards in terms of hitherto hidden knowledge and understanding of issues related to the regulation of Medicine in NSW for well over a century.²

Coming to actual historical developments, the subject matter has demanded that the bulk of the research be based on original documentation, since there are very few secondary sources apart from those of Hilder (1959) and Cummins (1969) covering developments in medical regulation in NSW after 1900. Lloyd's (1993) thesis on the professionalisation of medicine in NSW up to 1950 is of course, strongly analytical, but his focus moves away from NSW to the national scene after the 1920s. In attempting to fill the gaps in the medical history of NSW after that point, I investigated the original papers of the NSW branch of the Australian Medical Association (referred to from this point as the AMA) and the NSW MRB. Both proved somewhat problematic; the AMA papers, stored in the Mitchell Library, Sydney, have not yet been classified or catalogued, only rough guides to their subject matter being available. Thus although I believe I was able to do some useful original research here, finding information was a somewhat hit-and-miss affair. It is to be hoped that resources will be made available at some stage to finance the sorting and cataloguing of this valuable material.

² The usual method of referencing Hansard (NSWPD) as set out for instance, in *The Australian Guide to Legal Citation* (Melbourne University Law Review Association, 1998) seemed to be to be somewhat clumsy. I have therefore used an "in-text" system. The first element of each NSWPD reference indicates the series and volume number in which it appears. Thus 1:10 denotes Series 1, Volume 10; 2:10 denotes Series 2 Volume 10 and 3:10 Series 3 Volume 10 and so on. (Series 1 comprises the sequence of volumes between 1879 and 1900, Series 2 that between 1900 and 1952 and Series 3, from 1952 to the present. Each reference also contains a date and a page number Thus a typical reference appears as NSWPD, 1:3 14/5/1880, p1234, which denotes Series 1 Volume 3, May 14 1880, page 1234.

As far as the MRB is concerned, its "institutional memory" does not go back much further than 1987, when it was wholly reconstituted. While its earlier records, dating back to 1838, are stored by the State Archives Authority, it proved impossible to obtain documentation of more recent times.³ This was also true of the records of the Medical Tribunal, actually a court of law which has the task of hearing cases relating to medical discipline and imposing sentences on practitioners found guilty of breaking the law as set down in Medical Practitioners' Acts. Here again the short institutional memory among the staff of the Tribunal (it too, was wholly reconstituted in 1992) gave rise to an insuperable problem since officials claimed not to have any idea of where older records could be found and there is no trace of them in the State Archives catalogues. I do not believe that had these records been accessible to me, they would have had any major effects on the conclusions of the thesis since the broad outline of developments discussed is clear enough from the research sources which were accessible. However the recent MRB documentation and also that of the Medical Tribunal documentation would undoubtedly have enriched my research. It is to be hoped that these records will become available if and when the request of the MRB for larger premises is granted by the State government.

In contrast, I had enjoyed free access to the archives of the Health Care Complaints Commission during the course of a research project in which I was involved in 1993. This was at the time when after a prolonged and bitter political battle, the status of the

³ This was because since while the officials of the MRB had no objection to this being used, they would not allow it to be taken off their premises. As they are "bursting out of the seams" of their present headquarters, they could offer no space for an examination of documents and would not allow these to be studied in their offices after hours. This physical problem proved an insurmountable obstacle. While MRB staff offered to photocopy any documentation needed, it was impossible to tell without examining the documents in the first place, to say what I wanted photocopied - a classic "Catch-22" situation.

Complaints Unit, which forms a central focus of research especially for the later chapters of this thesis, was being transformed into that of an independent statutory authority. At the time the worth of the project seemingly lay in the fact that the Complaints Unit (referred to as the CU from this point on) was the first body of its kind anywhere in the world and its transformation into the Health Care Complaints Commission (referred to as the HCCC from this point on) was seen as giving the study further interest.⁴ At the time, as now, there was no major published history of the CU, the only in-depth study of the subject being the unpublished Masters' thesis of Donnelly (1990) a former official of the CU, which had examined the circumstances of the formation of the CU at the time of its establishment in 1984.

Finally it should be said in relation to my original research that in addition to the documentation, it was also possible to gather oral accounts from people who were involved in the events, both within the CU and also other bodies involved in that development, such as the Medical Consumers Association and the Pensioners and Superannuants Federation. Among those who were interviewed were the first director of the CU, Ms Philippa Smith, as well as her successor, Ms Merrylin Walton, and who remained director for the next 15 years. Those interviewed in relation to the conflict over the Health Care Complaints Commission Bill in 1993 included Ms Claire Petre of the Public Interest Advocacy Centre, who was deeply involved in the political struggle to

⁴ Although the results of my initial study were written up, for various reasons no attempt was made to publish them until 2002, when they were included a work I was responsible for writing and editing, *Medicine Called to Account: Health Complaints Mechanisms in Australia*. It was in the process of being published by the School of Public Health and Medicine at the time this thesis was being completed.

transform the CU into a statutory authority as well as Dr Bernard (universally known as “Bernie”) Amos, who was both president of the MRB and and Director-General of the NSW Department of Health in the period covered by Chapter 7 in this study. One important “player” in the events recounted in the last two chapters whom I tried but failed to interview, was Mr Laurie Brereton, who held various cabinet posts in the government of NSW, including that of Minister for Health in at the time of the establishment of CU, before moving into Federal politics.

Theoretical frameworks

The empirical data of the thesis has been couched against the postulations of the major sociological theorists, Max Weber and Jurgen Habermas and also the much less well known American scholar, Robert Alford, who is a political rather than a sociological analyst. The way the theories of each has been used, will be discussed separately.

Weber and bureaucratisation

The use of the work of Weber was indispensable because so much of this study is concerned with the processes of the bureaucratisation of the medical profession in NSW, which was happening at exactly the same period that he was making his observations of the rapidly spreading processes of bureaucratisation in Europe and the United States and formulating the theories which appear in his work *Economy and Society* (Weber, 1978 [1922]). Not surprisingly, in the approximately 100 years since Weber's analyses were first published, they have been subjected to comment and criticism by numerous authors. The critiques of Talcott Parsons (1939), Reinhard Bendix (1947), Alvin Gouldner (1955)

and Peter Blau (1956) were well summed up thirty years ago by Martin Albrow (1970), one of the greatest contemporary commentators on the phenomenon of bureaucratisation.

He pointed out that the basic criticisms of Weber arose from the observation that he

...believed that the growth of bureaucracy was inevitable. Its 'rationality' ensured it a place in the general process of rationalization. Clearly this belief becomes questionable when, as with the authors just cited, the very 'rationality' of bureaucracy itself is disputed (Albrow, 1970 pp54-61).

In his most recent work Albrow (1996) elaborates on this theme, stating that when he first wrote on the concept of bureaucracy in 1970, it was still seen as the necessary shape of any organisation. However, the "test of time" between that date and his next book on the subject, published in 1996, "was to show its rootedness in eighteenth- and nineteenth-century discourse, and what is now ... a common recognition, is that it was ... a passing phenomenon" (Albrow, 1996 p117). Albrow none the less affirms that Weber is still seen to be the greatest observer of this "passing phenomenon"; despite the numerous and wide-ranging critiques his work, "... the classic account of the overall developments of ...[bureaucratic] institutions remains Max Weber's rationalization process" (p112).

Australian scholars, Colebatch and Larmour (1993), supply a simple, yet very useful definition of bureaucracy when they state: "[A]ny organisation in which all transactions [are] governed by the hierarchical application of rules may be called a bureaucracy" (1993 p20). The application of such "hierarchical rules", in other words regulations, is designed to create order and predictability and thus to rationalise activity in a particular sphere or the activities of a particular group. Reiger succinctly sums up the core element of Weberian thinking when she states: "For Weber, the rational accounting and calculation of the capitalist enterprise is the hallmark of modern society" (1985 p25).

Martin Albrow, one of the greatest international scholars in the field of bureaucracy states that Weber's outstanding contribution to the study of this phenomenon was "his analysis of the idea of authority and the way he located the notion of legitimacy at the centre of the problems of social order, social control and the state..." (1996 p104). It is these questions of authority and legitimacy which comprise the most important aspect of the discussion of bureaucracy in this study. Little or no attention is paid to questions relating to bureaucratic structure as set out by Weber, since the bureaucracy on which attention is focused, the NSW MRB, for most of the period under study, had no full-time bureaucrats. Its activities were instead controlled by a part-time unpaid or minimally-paid members who earned their living from private medical practice.

But while it was unusual in this respect, the MRB none the less was a typical Weberian bureaucracy. Despite itself having little formal hierarchy or structure, it had been established by government as the legitimate agency for the exercise of the hierarchical authority by means of which the activities of the medical profession in NSW were regulated. In terms of acts of parliament, the MRB was endowed with the "legal-rational authority" (to use Weber's term) to specify who would be permitted to practice medicine, the educational and training they would be required to have, and the disciplinary processes by which their standards of practice were to be maintained.

The purpose of imposing these bureaucratic controls was, as noted above, the creation of order, stability and predictability in the practice of Medicine. The drive to create that situation in NSW constituted a typical example of the forces which, according to Weber,

were leading to the enormous expansion of bureaucracy in industrialised and industrialising states in the late 19th and early 20th centuries. In such states, he asserted, the increasing complexity of civilisation was

... a function of the increasing possession of consumption goods, and of an increasingly sophisticated technique of fashioning external life - a technique which corresponds to the opportunities provided by such wealth. This reacts upon the standard of living and makes for an increasing subjective indispensability of public, inter-local, and thus bureaucratic provision for the most varied wants which previously were either unknown or were satisfied locally by the private economy. Among the purely political factors, the increasing need felt by a society grown accustomed to stable and absolute peace, for order and protection ("police") in all fields, exerts an especially persevering influence in the direction of bureaucratisation. (1978, [1922] p972).

The postulation that the advance of bureaucratic organisation is rooted in demands for "order and protection" is also put forward by contemporary Australian authors Petersen and Lupton (1996) in their treatment of "risk discourse". Drawing on the work of Rutherford (1994) and Beck (1992; 1996), the "risk" they discuss in the late 20th century context is that posed by environmental degradation. While they do not refer to Weber, they come to similar conclusions when they state:

Given the assumed pervasive and insidious nature of health risks, the identification of such risks has come to be viewed as beyond the capacity of most individuals. Risk identification is increasingly regarded as the preserve of those who have access to technology and expert knowledge, for example scientists and members of the medical profession (Petersen & Lupton, 1996 p98).

However, as fellow Australian scholars Colebatch & Larmour (1993) might point out, technology and expert knowledge by themselves are an inadequate means of controlling

risk and need to be enshrined in law and enforced by "rational/legal organisational structures", in other words, bureaucratic agencies. Petersen and Lupton (1996) agree, asserting: "The environment has become represented by a set of physical resources that requires the rationalised strategies of governmentality, including continual surveillance, monitoring and regulation on the part of experts" (p90). That "principle" applies not only to environmental issues, but to an enormous range of societal activities, especially those related to health.

Of course, as post-structuralists, Petersen & Lupton (1996) are critical of the very strong perception, which has scarcely waned over the last two centuries, that the type of rational organisation embodied in bureaucracy is "natural", arguing along with Albrow (1970, 1996), that rationality is a time-bound social construct. That certainly does not undermine the overall value of Weber's observations and theories. As Colebatch & Larmour (1993) explicitly state and Peterson & Lupton (1996) implicitly, Weber's perception of the origins of the enormous spread of bureaucratisation in the modern era has stood the test of time.

However, there is more to the process of bureaucratisation than general calls for government to create "order and protection". Particular note needs also to be taken of Weber's postulations about what he calls social or economic closure. In these terms, bureaucratisation also results from the demands of specific interest groups which lead to the establishment "of a legal order that limits competition through formal monopolies" (1978 [1922], p342). Such group demands are often difficult to resist because they come as requests for government to impose "order and protection" on a particular field in order

to benefit society as a whole and moreover, yielding to them often results in electoral advantage to political parties occupying government benches. This "Weberian" observation was made by Mr Gary Sturgess, a senior public servant in NSW, who noted in a special report he was commissioned to write on "red tape" in government in the 1990s, that its "excessive accumulation" was the

... inevitable result of interest-group politics. The accretion of regulatory agencies over the decades has happened, to some extent, because of the attempts by politicians to meet the demands of new constituencies (Sturgess, 1994 p45).

When politicians do meet these demands, the outcome is the creation according to Weber, of a "legally privileged group (*Rechtsgemeinschaft*)" in which participants become "legally privileged members (*Rechtsgenossen*)". Governmental legitimation not only gives them control over their particular sphere of work, but also enables them to limit and even eliminate competition from outsiders and thus help create conditions of scarcity which improve their economic status. The moves made by the medical profession before 1900 to obtain governmental legislation which would ensure social closure through the creation the MRB, so closely followed the processes of bureaucratisation described by Weber that it almost seems as if his work (published more than two decades later) was being used as a blueprint! For these reasons, the work of Weber on bureaucratisation forms the analytical fountainhead of particularly the first few chapters of this thesis, although as will be noted in the concluding chapter, some important caveats about his theories also need to be kept in mind.

Habermas and the "lifeworld"

The theories and terminology of Habermas have also been used as analytical tools not only because they are related to and complement the Weber's theories, but because they are useful in discussions of the non-scientific medical epistemologies and therapies mentioned earlier. The adherents of these beliefs and practices played a major role shaping the way that the bureaucratisation of Medicine occurred in NSW. They were vehemently opposed to that development and the conflict between the two epistemologies in many ways constitutes a classic example of what Habermas calls the struggle between the "lifeworld" and the "system" in his *Theory of Communicative Action* (Habermas, 1987b). In the words of Pusey (1987), Habermas "invites us to look at our own modern condition as a kind of tug-of-war between the lifeworld and the system" (p72) and in doing so Habermas expands on Weber's theories about bureaucratisation. According to White (1988) Habermas was concerned with

[t]he provision of a richer account of what he saw as the costs of modernization or rationalization: the loss of freedom in an increasingly bureaucratized society and the loss of meaning or unity in a fully disenchanted world. (pp92-3).

That "disenchanted world" was one in which "the system" was triumphant. Over against that, the "lifeworld" is rooted in what Habermas calls "communicative action", that is action based on consensual norms, intuitively shared meanings and understandings of the world, or as he puts it, "a culturally transmitted and linguistically organised stock of interpretive patterns" (Habermas, 1987b p124). Communication in this context, reflects understandings "which define reciprocal expectations about behaviour" (p124). This makes possible *cultural reproduction* (the "continuity of tradition and a coherency of

knowledge sufficient of the consensus needs of everyday practice"), *social integration* (which "lends constancy to the identity of groups") and *socialisation* (which "secures the capacity for action for future generations") (Habermas, 1987a pp341-2).

"The system," in contrast, is characterised by purposive-rational action in which "the actor is primarily orientated to attaining an end", or in other words, to the attainment of success. (Habermas, 1987b). In communicative action in contrast, participants are not primarily oriented to their own individual success; but "pursue their plans on the basis of a shared definition of a situation" (Habermas, 1987b p126). However, when action is purposive-rational, it becomes "uncoupled" from communicative experience, and instead is co-ordinated through what Habermas calls "steering media", chiefly money and power (Habermas, 1987b p154). This in turn leads to his postulation about the "colonisation of the lifeworld by the system" (Habermas, 1987a p354). In this process, "[e]conomy and state penetrate, via money and power, into the Lifeworld and destroy communicative processes in areas where these remain necessary, namely those of cultural reproduction, social integration and socialisation" (Brand, 1965).

Habermas of course, has written little directly applicable to medicine or health care. None the less, his theories have been taken up by a number of sociological analysts working in the health sphere. One of these, Scambler (1987), equates "the system" with the professional and institutional manifestations of modern scientific medicine, arguing that "...system rationalisation in the sphere of health and illness has indeed led to a medical colonization of the lifeworld". He uses as his prime example the "medicalisation" of childbirth during the 20th century. This is epitomised by "the switch

from the home to the hospital as the typical location for childbirth (that is, the growth of territorial power), and the increasing emphasis on the active management of labour and childbirth (that is, the growth of technological power" (p175). On this analysis, the advance of scientific medicine in conjunction with the process of bureaucratisation which were necessary to entrench its power, can be equated with "the system", and non-scientific medical epistemologies with the "lifeworld". This is not to say that Habermas idealised the "lifeworld" and held it up as morally superior to "the system". In the words of White, (1988) Habermas raises the question of "whether purposive rationalization is only *one* possible way of developing that broader *potential* for the rationalization of action which is made available with the culture of modernity" (p97). In other words, Habermas does not decry rationalisation or modernity as such, although he regrets the way in which both have developed as a result of the processes of bureaucratisation.

Habermas is criticised on this point by Albrow (1996) who argues that he fails "... to take forward the possibility that the encroachments of the modern state on everyday life actually assisted in the empowerment of people, through education of course, but also in requiring participation in everyday bureaucracy." He further argues that

...colonization also involves the expansion of competence on the part of individuals without which the modern state could not operate through their lives. To this extent the consequences of colonization of the lifeworld are the same as territorial colonization: the eventual acquisition of an independence, but one which depends on assimilating the colonial culture (p177).

Supporting that point, I would argue that in examining the emergence of those movements which challenged the bureaucratic status quo in many fields in the late 20th

century, the Habermasian "lifeworld" vs "the system" typology constitutes too broad an analytical brush. While it is true, as we shall see, that the challenge to medical autonomy in NSW originated in the consumer movement, this study will show that it is unlikely that on its own, that movement would have had the power to make any impression on medical autonomy, entrenched as it was in and by the bureaucratic State apparatus of the MRB. The most effective assault on that kind of bureaucratic power was launched by governmental "counter-bureaucracies" which, using the terms of Albrow (1996), placed in the hands of the "colonised" subjects of bureaucratisation, instruments which could be used to undermine the dominance of the "colonisers".

The emergence of "counter-bureaucracies" in the second half of the 20th century was a result of the introduction of what became known as "administrative law" in public sector governance. That development is fully discussed in Chapter 6, but here it can be noted that through the establishment of "counter-bureaucratic" instruments such as ombudsperson's offices, administrative appeals tribunals and freedom of information legislation, the proponents of administrative law aimed to create a much higher degree of "open government" and bureaucratic accountability than had existed up to then. Of course it could be argued that counter-bureaucratic instruments of the kind mentioned represented merely an extension of bureaucratic hegemony or of "the system". However, people were very often selected to staff these agencies precisely on the basis of their anti-systemic values and once installed in "counter-bureaucracies", they used their power to challenge and undermine "the system" from within. It will be argued particularly in Chapter 7, that the CU/HCCC represented a typical example of this phenomenon.

Although he was encouraged by the emergence of what he called "the alternative movements", more fully discussed shortly, Habermas seems not to have realised that in order to combat "the system", adherents of those movements would themselves enter it. But while as noted above, his failure to see that possibility attracted criticism from writers such as Albrow (1996), those critiques by no means invalidate his postulations about the struggle between "the system" and the "lifeworld". Although these are very broad categories and as suggested, need some qualification, the concept of "lifeworld" in particular has proved very useful terminologically. While the scientific epistemology taught in universities was commonly described as "allopathic medicine" during the 19th century and in the 20th century as "scientific medicine", until the 1960s there was no common descriptor for non-scientific epistemologies. I have therefore chosen to borrow Habermasian terminology and refer to these epistemologies as "lifeworld" medicine, and not only because the word "lifeworld" constitutes a convenient adjective. I would also argue that the epistemologies which it will denote in this study formed the basis of a societal phenomenon with strong class associations. On those grounds the bare technical term "non-scientific epistemologies", besides being clumsy, is not an adequate descriptor because it fails to convey the social and political connotations of this movement.

The modern term, the "alternative health movement" does help to convey such connotations, and might have been used particularly because this movement can be seen as the spiritual descendant of 19th century lifeworld medicine. However, the adjective "alternative" appears only to have come into widespread usage after the emergence in the 1960s of the "alternative culture", led by figures such as Dr Timothy Leary with his mantra of "tune in, turn on and drop out". Since this particular view of the world

embodied a reaction against what was seen to be the excessive rationality and materialism of the mid-20th century, the word "alternative" was also attached to those therapeutic treatments which did not base themselves on scientific rationality. Still, it would be something of a reverse anachronism to apply a late 20th century term to the non-scientific medical epistemologies which were powerfully entrenched among the populace of NSW a hundred years earlier. Nor, I would argue, would an application of the terms "traditional" or "folk" to these epistemologies suffice, because at that time they encompassed emergent therapies which attracted a widespread following, particularly homeopathy and hydrotherapy which could not be called traditional nor were they rooted in folkways.

The use of the term "lifeworld" medicine also means that the terms "quacks" and "quackery" can be avoided. As is detailed in Chapter Four, these terms were freely employed by the proponents of allopathic medicine, particularly the British Medical Association (BMA), in the late 19th century when referring to lifeworld medicine and its practitioners. A century later Lewis and MacLeod (1989) and Lloyd (1993) were also using the terms, the latter for instance noting that in the second half of the 19th century "... quackery was flourishing in New South Wales" (p149). The problem with this terminology as Lloyd himself notes, is that it "carries with it the connotations of deceit and questionable efficacy" (p142). In less euphemistic terms, to speak of "quacks" is to speak of charlatans.

However, as mentioned above, these "quacks" or charlatans had a broad public following. The widespread faith in and preference for traditional medicine is evident from a host of

sources (Peterson, 1978); (Pensabene, 1980) (Hicks, 1982) (Allen, 1982) Lewis & MacLeod 1988; Willis, 1989; Lloyd, 1993) and that was coupled with an equal scepticism about the claims of allopathic medicine, a point acknowledged by Lloyd when he asserts that belief in "quacks" remained strong because the treatment offered by allopathic practitioners was not seen as any more efficacious than that of the "quacks" for most of the 19th century (p142). This was understandable, given that medical training in universities could hardly be called scientific in the modern sense of the term, being based on "humoral" theories which located the cause of disease as imbalances of "humors" in the body and led to the use of practices such as bleeding, blistering, purging, vomiting and heavy sweating, to effect cures (Holloway, 1964 p301).

Despite their seeming outlandishness today, such treatments obviously did produce cures in some cases; had they proved universally non-efficacious or even fatal, they simply would not have been used. It may be that while some human constitutions were robust enough to withstand harsh allopathic treatments and able to revert to a state of full or partial health by themselves, none the less the treatment would have been *believed* to be the source of the cure. In other words, the application of even misconceived therapies could none the less bring about cures by means of the placebo effect. But if this was true of allopathic medicine, it would also have been true of lifeworld medicine. That means there was more to the following of non-scientific medicine than mere mass deception of the public by charlatans and that a good deal of non-scientific treatment was found, or at least believed by its clientele, to be efficacious, as is the case with alternative medicine today.

Whatever the explanation, it was because of the flourishing state of lifeworld medicine that there was such stubborn resistance to medical bureaucratisation and regulation in the NSW parliament before 1900. That resistance in turn was motivated in part by fear that regulation would make the practice of lifeworld medicine illegal. As is demonstrated in Chapter Four, moves in that direction faced such passionate opposition that governments abandoned any attempt to control "quacks" for the first four decades of the 20th century. For these reasons, I would argue that the terms "quacks" and "quackery" are not appropriate descriptors of what was a mass movement. And it is because that movement encompassed so many of the features of cultural reproduction, social integration and socialisation used by Habermas to define the "lifeworld" (Habermas, 1987a pp349-50) , that I have chosen to use the term in this study.

Habermas's theoretical formulations on the "lifeworld" and "the system" are also useful because of his postulation that the "lifeworld" staged a revival in 1960s in the form of what he calls "the alternative movement (which encompasses the urban scene with its squatters and alternative projects, as well as the rural communes)" and the women's movement among others (Habermas, 1987a p393). He saw hope in this "alternative movement" because it was actively challenging the rationalistic underpinnings of bureaucratisation imposed on society in the later 19th and early 20th centuries. While he does not mention it, he would no doubt agree that the alternative medicine movement could also be seen as part of his overall "alternative movement". Moreover, it could even be argued that while it was strongly rooted in the assumptions of bureaucratic rationality, the counter-bureaucratic impulses of "administrative law" mean that it could also be seen as one of the "alternative movements" of the 1960s.

It is important to emphasise that the "lifeworld" is not being idealised in this study. In the case of medicine, the non-scientific and very often irrational bases of lifeworld therapies means that they indeed were and are open to exploitation by charlatans, imposters and others who frankly seem to be on the borders of sanity. This was vividly illustrated in the evidence given to a parliamentary select committee as far back as 1887, described in detail in Chapter Four (pp113-5). But charges of charlatanry or semi-lunacy cannot be applied to many and perhaps most of the practitioners or followers of lifeworld medicine whose epistemologies not only survived the onslaught of bureaucratic rationality in the later 19th early 20th centuries, but staged a remarkable resurgence from the 1960s onwards. The endless debates over whether lifeworld medicine is "good" medicine is not at issue in this thesis; what is an issue is the "brute fact" of its existence and the wide ranging effects that had on the bureaucratisation of medicine and the resultant effects on the exercise of medical autonomy and peer review in NSW.

Alford and structural interests

Both Weber and Habermas can be described as "grand theorists". The same cannot be said of the American Robert Alford (1975), whose theories were based on his observations in a limited geographical area in the United States (New York) and in a limited field, that of health care. But precisely for that very reason, Alford's theories are useful for analysing the interplay of social and political forces in localised areas such as that under investigation in this present study. The theory put forward in his work, *Health Care Politics; Ideological and Interest Group Barriers to Reform* (1975) has already

been found to be useful and applicable to the local Australian situations by health care analysts such as Steven Duckett (Duckett, 1984). He argued that changes in the Australian health care system which were often depicted as being a result of the need to contain costs, in fact represented the outcome of struggles and alliances between different structural interest groups, while he attributes the emergence of the Community Health Program during the Whitlam government's period in office (1972-75) to "a co-incidence of interest" between two structural interests (Duckett, 1984 p960). Gardner (1995) and Palmer & Short (2000) also point to the usefulness of Alford's theories not only in the Australian context but also, as demonstrated in the work of Allsop (1995) and Ham (1992), in analyses of the British health care system.

Alford proposed that the shape of health care systems could be seen as an outcome of struggles between three major "structural interest groups". These, he stated

... are interests which are more than potential interest groups ... which are merely waiting for the opportunity or the necessity of organising to present demands or grievances to the appropriate authorities. Rather, structural interests either do not have to be organized in order to have their interests served or cannot be organized without great difficulty" (1975, p14).

Structural interests are broad, inchoate groupings, their commonality not being immediately visible even to those who are within them. This characteristic differentiates them from interest groups as such, and it is because they represent underlying patterns of interests that they are called "structural". He further asserted that while there may be conflict between various sectors of a particular structural interest, "[n]one of the conflicts

of this type challenges the *principle* of professional monopoly" (1975, p14). This point is elaborated on shortly in relation to NSW.

While Alford (1975) postulated the existence of three structural interest groupings, which he entitled the "professional monopolists," the "corporate rationalisers" and the "community population" (pp9-17), I have added a fourth, the "government interest", for reasons given below. Each of the structural interests proposed by Alford will be will be examined separately.

The professional monopolists

The "professional monopolists" constitute what Alford describes as the "dominating interest" (1975, p14). The membership of this group is broadly comprised of the medical profession but also "bio-medical researchers, general practitioners, surgeons [and] dentists" and also those industries with interests in supplying them, such as the manufacturers of medical equipment and the pharmaceutical industry. In his words, this grouping constitutes a "professional monopoly, in which existing institutions protect and reinforce the logic and principle of professional monopoly over the production and distribution of health services" (1975, p14). Duckett supplements this by stating: "In Australia, the major voice of the professional monopolist interest is the Australian Medical Association" (1984, p959).

The corporate rationalists

The "corporate rationalist" structural interest is composed of people in bureaucratic organisations which according to Alford, include "hospital administrators, medical

schools, government health planners, and public health agencies and researchers". In the Australian context, to these should be added especially the bureaucracies within government health departments. Alford stated that all have "a common relationship to the underlying changes in the technology and organization of health care" and that one of the chief forces in their "common relationship" is that of "breaking the professional monopoly of physicians over the production and distribution of health care" (p15). Palmer and Short (2000) see the interests of the corporate rationalisers as lying in the promotion of greater efficiency, effectiveness and equity in the provision of the health services (p42). Alford describes this group as the "rising interest", because in historical terms, health bureaucracies are a recent phenomenon, and having emerged only in the last century or so, their lineage is nothing like as old or as honoured as that of the professional monopolists. None the less, as the guardians of the public purse and the allocators of resources, they have become increasingly powerful, particularly since the 1960s.

The "community population" structural interest

Those in the "community population" structural interest are, in Alford's definition, the poorer and politically weak sector of health consumers. He described them as a repressed interest "because no social institutions or political mechanisms in the society ensure that these interests are served" (1975, p14). However, those who comprise this structural interest benefit from and are represented by what he called "equal-health advocates", in other words activists who are responsible for initiating actions, very often successfully, to improve the health care available to the community population. The activities of equal-health advocates in New South Wales can be perceived in pressure groups described in this thesis, such as the Medical Consumers Association, the Australian Consumer

Association and the Public Interest Advocacy Centre. However, some of the most effective actions of the equal-health advocates have been achieved from within the public sector through counter-bureaucratic agencies such as the Office of the Ombudsperson and more particularly through the CU/HCCC. As will appear in Chapter 7, it was equal-health advocates who, inspired by the ideology of the "Public Interest Law" movement, used the CU to launch the attacks on medical autonomy and the peer review system which forms the subject of this thesis.

The government structural interest

This is not one of the structural interests originally described by Alford, and my reason for creating it is that, as Palmer & Short (2000) point out, the roles of government and political parties are almost non-existent in his work (p43). This probably reflects the fact that he was living and writing in the USA, where the Congressional system of government with its constitutionally entrenched separation of powers between the executive and legislature, ensures that governments and political parties play a much weaker role in the formulation of policy than they do in political systems, including that of Australia, based on the "Westminster system". Under that this system, government executives (comprised of the ministers who sit in the cabinet) are not only required by law to be part of the legislature, but exercise almost total control of legislatures through the application of party discipline - that convention which requires all members of a party, on pain of expulsion, to vote as directed by the executive regardless of their own

feelings, opinions or even interests.⁵ As a result of the power placed in the hands of the executive by party discipline, governments in Australia,

⁵ Refusal to obey the executive amounts to political suicide, since expulsion from a party means losing its support and resources, which are generally crucial to the individual's ability to retain their seat in future elections.

unlike those involved in the struggles in the USA analysed by Alford, are major players in the formulation of policy.

Governmental executives however, comprise only a small part of the government structural interest, which needs some definition because it does not easily fit into Alford's characterisations given above. Firstly, it should be said that the government structural interest will not normally include the bureaucracy, even though in popular parlance, the executive and the bureaucracy are generally lumped together as “the government”. As affirmed by numbers of authoritative writers on public administration, (Corbett, 1992; Davis, 1993; Wilenski, 1986), and as will appear at various points in this thesis, bureaucrats or corporate rationalists have interests which often clash or at least are not congruent, with those of government executives. That point was of course, also illustrated with hilarious accuracy in the *Yes Minister* television series.

Although the executive may be interested in the promotion of efficiency, equity and effectiveness in the health system, which Palmer & Short (2000) aver are the chief concern to the corporate rationalists (p42), the interests of executives go far beyond that. They encompass the fortunes of the political parties of which they form a part, both within and outside of legislatures as well the need to retain the favour of those who habitually vote for the party without being members of it. It can also be said that since in political systems such as Australia, major parties represent very broad sets of capital vs labour economic and social interests, when they are in power governing parties may act to defend or extend the interests which they claim to represent. In short, although its parliamentary manifestation is highly visible, the government structural interest is as

broad and inchoate as the other three, but there can be no doubt that in the Australian context, it has to be treated as equally real and equally important

Retrospective use of structural interests

Alford evolved his theories on the basis of conditions in health care systems in the second half of the 20th century. What will be seen is that I have applied his analysis retrospectively to the situation in NSW practically from the beginning of the period under review, namely the second half of the 19th century. My justification for doing so is based on the fact that the structural interests he defined were present and detectable from the outset of the formation of the health system in NSW. The "professional monopolists" for example, can be said to have arrived in the persons of the surgeons such as William Balmain who were part of the First Fleet which established the colony of NSW in 1788. Although until the passing of the Medical Practitioners' Act of 1900 they were neither "professionals" in the strict sense of the term nor exercised a monopoly over allopathic medical practice, it will be seen both from this thesis and earlier studies such as those of Lewis and MacLeod (1988) and Lloyd (1993), that the actions of their leaders in the second half of the 19th century were aimed at establishing the dominance of a "professional monopolistic" interest. On those grounds, I would argue, it is perfectly valid to use Alford's term to describe them as such during this period. In similar vein it can be said that the "corporate rationalist" structural interest had emerged in the form of embryonic health bureaucracy of the colonial administration in the early 19th century. While it was very small to begin with, by the 1890s that bureaucracy had become large and mature enough to constitute what was described in annual reports as a Department of Health (New South Wales, 1899). By that stage, as will be argued in Chapter Four, the

health bureaucracy can certainly be said to have developed as a separate "corporate rational" structural interest. And even though there was never any reference to and no consciousness within the "community population" structural group of its interests in health care until the mid-20th century, this does not mean to say that those interests were non-existent before then. As is demonstrated in Chapter 5, proto-typical equal-health advocates were active as early as the 1930s (see pp161-3). Finally, it can be said that a governmental structural interest existed from the moment the NSW legislature was transformed from an appointed to an elected legislature in 1856 and politicians in government had to act and form policies in ways that would be productive of votes.

Conflict within and alliances between structural interest groupings

The period examined in the latter part of this thesis was congruent with the time period covered by Alford in his *Health Care Politics* (1975) so here the retrospectivity issue falls away. It will be seen that during that period, Alford's assertion that the boundaries between the structural interests are fluid and that very often there are conflicts between different sectors within the same structural interest, are valid in the case of NSW. Conflict of this kind was present in the community population structural interest in NSW in 1992/93 over moves to transform the CU into a statutory authority, the HCCC (see Chapter 7). That struggle however, did not change the basic commonality of interest between the conflicting groups of "equal health advocates" representing the community interest. .

The four structural groupings are not necessarily always in conflict. Besides the example given by Duckett (1984) above relating to the establishment of Community Health

program, it will be seen from the present study that an alliance between the government and the community population interest led to the establishment of CU in NSW in 1984. This alliance has held firm for almost two decades since then in the face of strong and sometimes strident opposition by the professional monopolisers, as represented by the Australian Medical Association.

Conclusion: “dynamic stasis” or structural change?

Alford’s purpose in suggesting structural interests as an analytical tool was to demonstrate that their effect on health systems was the creation of what he called “dynamics without change” (1975, p284), which has also been labelled as “dynamic stasis”. That oxymoronic term denotes that despite constant interaction between the structural interest groupings involving conflict, contest, negotiation, alliance-making and alliance-breaking, the strength of each structural interest group ensures that the balance of power between them remains stable, or at least changes very slowly. That in turn means that the overall shape of the health system does not change despite the victories or defeats of the different structural interests in contests across a wide range of issues. In other words, in terms of dynamic stasis, the on-going interaction between the structural interests is merely a surface phenomenon which does not affect the underlying structural characteristics of the system.

One example of the effects of dynamic stasis would be the failure on a national level in the USA, of numerous attempts to introduce a universal health insurance schemes, which would be to the benefit of the community population structural grouping. The most recent of these attempts was made by the then presidential couple, Bill and Hillary Clinton,

during their first term in office between 1992 and 1996. In that situation, the Clintons were representative not only of the government executive, but also of the community population interest and as such they were acting as typical albeit very high profile “equal health advocates”. In terms of Alford’s theory, the defeat of their efforts can be attributed to the interests of the private health insurance industry being congruent with those of the professional monopolists . Invoking the support of their allies in the Congress, who because of the lack of party discipline could not be controlled by the government executive, the professional monopolists were easily able to fend off the Clinton-led government executive/community interest attempts to change the health insurance system, which remains in place to the present.

Although Alford probably did not envisage his theory being used and applied outside the USA, as mentioned above, it has been found a very effective analytical tool in several other industrialised countries, including Australia. But if the structural interests approach is used, it logically follows that the health systems of these countries are also characterised by dynamic stasis. The materials set out in this thesis should form a good “test-bed” of that proposition since the following chapters portray a great deal of conflict both between and within these structural interest groupings over the period under review which ends in 1994 with the formal establishment of the HCCC. One feature which stands out is that while in conformity with Alford’s propositions, the professional monopolists were indeed the “dominant interest” for most the 20th century, the loss of their exclusive control of the disciplining of the medical profession towards the end of the century, constituted a major diminution of their power. If the thesis of this study is proven, viz that the challenge to medical autonomy was serious enough to ensure its

virtual extinction, it raises the question: does the change in the power balance between the structural interests amount to a mere adjustment of the *status quo ante*, or does it constitute real structural change? These issues are discussed further in the concluding chapter.

CHAPTER TWO

THE THEORY AND PRACTICE OF MEDICAL AUTONOMY

Very broadly, autonomy means that professions and professionals are not subject to *control* by any other body or authority, and also that they are not *accountable* to any other body or authority. Freidson (1970) provided one of the best rationales for peer review when he stated that "professional people have the special privilege of freedom control of outsiders". That privilege, he argued, is justified by three claims.

First, the claim is that there is such an unusual degree of skill and knowledge involved in professional work that nonprofessionals are not equipped to evaluate or regulate it. Second, it is claimed that professionals are responsible - that they may be trusted to work conscientiously without supervision. Third, the claim is that the profession itself may be trusted to undertake the proper regulatory action on those occasions when an individual does not perform his work competently or ethically. The profession is the sole source of competence to recognize deviant performance, and it is also ethical enough to control deviant performance and to regulate itself in general. Its autonomy is justified and tested by its self-regulation (p137).

That autonomy is generally enshrined in and exercised by statutory authorities, which in Australia are known Medical Registration Boards. Such Boards represent the recognition by government and society of the right of Medicine to self-regulation, in terms of which the medical profession provides its own quality control and self-management

There has been a great deal of theorising about autonomy (Freidson, 1970); (Johnson, 1972); (Boreham, 1983); (Rueschmeyer, 1983); (Willis, 1989); (Southon, 1998). Perhaps not surprisingly the concept is subject to different interpretations. Willis for instance, sees medical professional autonomy as consisting in the fact that "Medicine is not subject to direction and evaluation by other health occupations." He sharpens that concept by arguing: "Not only has medicine gained the right to deny the legitimacy of evaluation by others, but it has also gained control over the work of other health occupations. This ... denotes a relation of *authority* over other health occupations" (1989 p88). In this light Medicine can be seen to be "supremely autonomous" among those health occupations which are regulated and have their own Registration Boards.⁶

The definition put forward by Willis however, is rather limited in that it defines autonomy only insofar as it determines relationships between occupational groups in the health care field. A more comprehensive definition of professional autonomy is that of Daniel (1990) who widens the concept and gives autonomy a power dimension. She states:

Autonomy, based on knowledge claims, definitively expresses the power of a profession to control its field of work and its own reproduction. Professions control the criteria for entry, the lengthy educational training, registration, and standards of practice conduct within the profession (p63).

⁶ As at 1993, there were nine other such boards in New South Wales, these covering chiropodists, chiropractors, dental technicians, dentists, nurses, optical dispensers, optometrists, pharmacists, physiotherapists,

The power which flows from professional autonomy will be extensively discussed later in this thesis. The peer review principle supplements and complements autonomy: while autonomy means professionals are not accountable to anyone or any body outside their profession, in terms of "peer review" professionals are accountable to their fellow professionals. If they fall short of either the ethical or the technical standards laid down by the profession for itself, they are judged and disciplined by their peers. This form of self-regulation, in terms of which a profession provides its own quality control, "represents a significant departure from the formal, hierarchical control by lay individuals to which mere occupations are subject" states Wolinsky (1993, p13).

The application of the peer review principle however, raises the dangerous possibility that a profession, in Wolinsky's words, will "misuse autonomy and abuse its clientele - both the public and other workers in the health care industry" (1993, p13). Such abuse would contradict one of the bases of the claim to autonomy made by a profession as set out by Freidson viz. that it is "ethical enough to control deviant performance" (1970, p137). It should be noted that the whole functionalist view of professions, as supremely set out by Durkheim (1957) and Parsons (1939) rested on the assumption that professions not only embodied ethical ideals, but that these formed one of the *raison d'etre* of professionalism. Rosenthal notes that "the strong standards of autonomy" which characterise professions "emphasize self-regulation and altruism that submerge self-interest and emphasize service..." (1995 p3) while Gouldner paints professions "as a paradigm of virtuous legitimate authority, performing with technical skills and with dedicated concern for society at large" (1955 p19).

But "virtuous and legitimate authority" does not exist simply as an ideal; all professions have a controlling body which derives its legitimacy from the state. Such controlling bodies are established by legislation and generally operate as statutory authorities. In the case of the legal profession, the controlling body is the Law Council, the Law Society performs the same function for solicitors and the Medical Registration Boards (MRBs) for the medical profession. In the words of Rosenthal, such bodies have in their empowering legislation "regulations governing disciplinary procedures and ... stated codes of professional behaviour and etiquette," and as such constitute "the recognized mechanisms of professional self-regulation..." (1995 p4). In turn, their ability to regulate themselves, in other words, to operate in terms of peer review, represents the materialisation of professional autonomy.

That autonomy is exercised on an institutional level through bodies such as MRBs; but institutional autonomy represents only one dimension of medical autonomy. The other dimension is that exercised by *individual* professionals. Southon and Braithwaite (1998) for instance, define professional autonomy as consisting in the freedom given to each individual professional "to control the management of each task" (p23). Such autonomy is necessitated by the high levels of uncertainty and complexity in the work professionals do; people such as engineers, lawyers, academics, accountants academics or doctors "continually face new situations which require individual assessment and often the application of a sophisticated set of skills". Those with the skills for assessing and engaging with these tasks "must ... be given the freedom or autonomy to act according to the demands presented" (p23). Matheson postulates a further rationale for this kind of individual autonomy and the freedom from hierarchical control enjoyed by professionals

when he argues that "the imposition of such controls would limit their initiative and creativity" (1998p17). This view is complemented by Boreham's argument that professionals and medical professionals in particular, deliberately set out to create "an aura of *indetermination* [original emphases] about their activities that denies the possibility of rationalization and codification" (1983 p697). Both Johnson (1972) and Rueschmeyer (1986), argue that the indeterminacy of the tasks carried out by medical practitioners is a reflection of the "competence gap" between professionals and their clientele. But in terms of this reasoning, the indeterminacy of medical practice also makes it undesirable for professionals to supervise the work of their follow practitioners lest that stifle their "initiative and creativity". Thus Southon and Braithwaite (1998) see medical autonomy as consisting in the autonomy not only of the profession as a whole, but in the autonomy of individual professionals. Medical professionals themselves strongly supported this view, and as will be demonstrated shortly, they used the law to entrench the autonomy and indeed the virtual untouchability of individual practitioners.

Professional autonomy then, is exercised in two spheres - the institutional and the individual. These are interdependent; they are strong only if both are intact; if one is undermined, both are weakened. This study will show that while it was the autonomy and consequent non-accountability of individual practitioners which became an ever-greater cause of complaint in NSW, it was not possible to introduce greater individual accountability until the institutional autonomy of the profession, as embodied in the State's MRB, was changed. Therefore it is important to investigate the functioning of that MRB.

Institutional autonomy; the functioning of MRBs

One of the most important points about MRBs is that they are executors not only of state power, but also of professional power. Daniel is both mistaken and correct when she asserts, as cited above, that "professions control..." In fact, unless empowered by legislation, professions have limited control over their occupational sphere, as is evident from the history of the medical profession in Australia before the introduction of legislatively-based medical regulation. Thus before 1900 the medical profession in NSW had no power even over so basic an issue as who was entitled to call themselves a "Doctor of Medicine". As is outlined in Chapter Four, anyone, no matter what their background or training or lack thereof, was free to adopt this title and could practice without any fear of retribution. This had economic consequences for the profession, which faced competition from a large number of practitioners of lifeworld medicine who, despite their lack of formal medical education, did not scruple to style themselves as doctors. While bodies such as local State branches of the British Medical Association were formed to increase the influence of the profession, for most of the 19th century, their drive to secure recognition by and regulatory powers from governments, went largely unheeded. (Pensabene, 1980).

Yet Daniel's assertion that the profession controls its sphere of work is correct from the point of view that once Medicine was granted the legitimating authority it was seeking in the form of MRBs, these bodies became the executors not only of delegated state power, but also of professional power. That was because, as will be more fully explained shortly, in terms of a long-standing tradition and precedent going back to the establishment of the

Royal College of Physicians in the 16th century, members of the medical profession always staffed regulatory bodies. Moreover, the practitioners who served on the MRBs were also invariably members of professional associations, in the case of NSW, the British Medical Association (BMA) which was later to become the Australian Medical Association (AMA). That body was of course, the major vehicle of Medicine's economic and political aspirations as well as of its efforts to give practical expression to professional collegiality.

The way in which MRBs embody and execute professional control, is evident in their functioning. In terms of their empowering legislation, they exercise two basic functions. In the words of Salter (2000 p1), they firstly "provide explicit standards, ... certification [and] registration" for the medical profession. The "explicit standards" are those which set out the qualifications required of anyone who wishes to become a medical practitioner. MRBs not only assess and certify the qualifications of aspirant practitioners, but also have a major input into determining the content of the education and training required of them. The names of those who qualify in terms of the assessment criteria and become practitioners, are recorded in a Medical Register; anyone whose name is not on that Register may not use the title of "doctor" and is prohibited from practising allopathic/scientific medicine, under pain of severe legal penalties.

Secondly, as Salter points out, MRBs "wield ... disciplinary procedures to ensure the maintenance of high standards of medical practice." Practitioners who fall short of the required standards may be referred to a quasi-judicial body, often a Tribunal, which operates as a court of law. Such bodies in turn have the power to order that a practitioner

found guilty of a misdemeanour be subject either to punitive or remedial measures or in extreme cases, have their names struck off the Medical Register. Through the exercise of these disciplinary functions, the MRB becomes the supreme arbiter of the practice of allopathic/scientific medicine and that makes the question of the control of the MRB a crucial one. Although in terms of law, MRBs are in the final analysis controlled by and responsible to government, their autonomy on both an individual and institutional level for a great deal of the 20th century meant that governmental control was weak to non-existent. That in turn meant the informal control exercised by bodies such as the BMA/AMA through their overlapping membership with the MRBs, put immense and virtually untouchable power in the hands of these associations. Their autonomy also meant that the MRBs became the embodiment of the peer review principle, particularly with regard to the disciplining of miscreant medical practitioners, a point that will be discussed in more detail shortly.

MRBs as instruments of public administration

Peer review is a principle or a convention which is observed in practice, even though it is seldom or never enshrined in law. The autonomy of MRBs however, does have a legal foundation, in that they constitute what is known in public administration parlance as "statutory authorities," or "corporate authorities". Such bodies, while established by government to perform governmental functions, are not part of any ministerial department and are given freedom, in varying degrees, to operate independently and autonomously. The reasons for using these administrative devices will be set out in more detail shortly. Here we may note that the number and permutation of statutory authorities is vast, so much so that in Australia according to Wettenhall, writing in 1983, nobody

was sure just how many there were in existence (1983, p18). Since then, while the number of statutory authorities has very probably grown, no attempt has been made either to list them or to enumerate them. They are extensively used in the both Commonwealth and State spheres; in NSW, their range of functions range from those of the Sydney Opera House Trust to that of the Wild Dog Destruction Board which maintains a dingo-fence on the borders of the State. They form the hidden bulk of what may be described as the iceberg of government, in which parliaments and departments constitute the much smaller, visible sector.

However, while MRBs are statutory authorities, they together with a small number of bodies controlling the professions such as the Bar Council, are exceptional in their degree of autonomy in relation to government. For instance, despite the passage of over 30 Acts relating to the NSW MRB between 1838 and 1984,⁷ there was never anything in the legislation which required it to account for its actions to a Minister or to parliament and thereby to the public. This may be compared to the first legislation regulating other health-related occupations. The Act (1897, No. 7) which set up the Pharmacy Board as a statutory authority laid down that:

The Board shall in the month of January in each year prepare and send to the Colonial Treasurer a reports of its proceedings during the last preceding year, and shall also, at the request of the said Treasurer, made at any time, forthwith prepare and send to him a special report of its proceedings. A copy of every annual report furnished under this section

⁷ Despite the lack of any legislative direction, as is detailed in Chapter Five, the MRB began to compile annual reports to be laid before the parliament between 1958 and 1972 when it was nominally brought within the jurisdiction of Health Commission which had replaced the Department of Health. After that there was a hiatus until until the passing of the 1984 Annual Reports (Statutory Authorities) Act onwards.

shall be laid before both Houses of Parliament without delay. (New South Wales, 1898 p407)

The Board reported to the Colonial Treasurer because there was no Minister for Health or health ministry at the time. After such a ministry was established in 1913, the Board was required to report to the Minister and the reporting requirement was also laid down in subsequent Pharmacy Acts passed over the course of the next century.

Direct reporting to government requirements were lacking in the first Dentists' Act passed in 1900 (No. 45, 1900), although it was laid down that the Dental Board was keep a register of legally qualified dentists and "shall transmit in the month of January in each year a certified copy of such register to the Colonial Secretary, who shall cause the same thereupon to be

published in the Government Gazette" (New South Wales, 1901 p472). While the MRB was also required to publish a list of qualified practitioners in the Government Gazette every year in terms of the 1838 Medical Practitioners' Act, this did not have to be through the agency of the Colonial Secretary. The more restricted autonomy of the Dentists' Board compared to the MRB, was reflected in the fact that while all members of the MRB had to be qualified doctors, the Dentists' Act laid down that only four of the eight members of Dental Board were to be qualified dentists, the other four being comprised of two doctors and "two persons not being either medical practitioners or dentists", in other words, lay people (New South Wales, 1901 p471). Dentists therefore were not allowed to dominate the Dental Board in the same way that doctors dominated the MRB.

The significance of the non-accountability of the MRB is most evident in terms of the concept of "responsible government" which came into general use in public administration after the introduction of the Northcott/Trevelyan reforms in Britain in the 1850s. In terms of these reforms, the civil or public service was no longer appointed on the basis of patronage, under which the appointee was accountable only to their patron and the patron ultimately accountable to the monarch. Under the new system, public servants' appointments were made on the basis of competitive examination and promotions were made on merit. Instead of having an "upward" responsibility to the monarch, responsible government meant that all parts of government were and are considered to be responsible to the people through the agency of parliament (Silberman, 1993 p356-7). Such responsibility was enforced through parliamentary scrutiny of budgetary submissions and also of annual reports. The MRB had no budget however,

since especially in its earlier years, its members, including those who performed secretarial duties, acted in an honorary capacity⁸ while meetings were held in rent-free governmental offices. The monies collected from the annual registration fees paid by doctors went directly into general revenue. Not having a budget or being required to produce annual reports, the MRB's links with parliament were tenuous to non-existent. Thus, even though its powers were derived from parliament, the MRB was tacitly placed outside of this system of responsible government. That situation constituted not just a governmental, but also a societal recognition of the principle of peer review; if the medical profession was not seen to be accountable to government, that meant it was accountable only to itself.

Moreover, in addition to its high degree of autonomy in relation to government, we may add Willis's setting out of the medical profession's autonomy in relation to other health care professions; while as noted above, doctors were members of the Dental Board, no dentists or member of any other health-related profession ever sat on the MRB. On that basis it may be concluded that the institutional autonomy of the NSW MRB and hence of the medical profession in NSW, was almost total in NSW for the greater part of the 20th century.

But this of course, raises the question of why any MRB should have exercised this level of peer review-based autonomy which made it exceptional among statutory authorities.

⁸ As will appear in Chapter Five, the members of the NSW MRB were not paid for their services until 1955. Even after that date there is no evidence of any MRB budgets and that situation did not change until the

One answer lies in the history of these bodies which in fact came into existence long before the

Medical Practitioners (Amendment) Act of 1987 put the body onto an entirely different footing in terms of which it became self-financing (see Chapter 7).

statutory authority first began to be employed on a large scale either in Australia or in fact, in any part of the world. Perhaps the earliest MRB was established in Ontario as far back as 1818 (Goulet, 1997). In this country, the first MRB was set up in 1837 in Tasmania, followed by NSW a year later. This was not only before the era of responsible government, but also pre-dated the advent of statutory authorities which emerged only in the 1880s when the Victorian government set up the first Board for Railways (Spann, 1979p115).

The establishment of NSW MRB also took place well before the advent of self-government, when the Australian colonies were under the direct administration of the British Crown. At that time there were no government departments as such, the whole administration being nominally controlled by the governor. However, as the colonies developed, there was an increasing need for the administration of areas about which the governor and his staff had little knowledge and in which they had no administrative expertise. These included land, education, health and Aboriginal affairs. Thus specialised boards were established "as a convenient way of getting special jobs done where there were interested parties willing to act" according to Spann (p115), these boards being run by non-paid appointees who worked on a part-time basis. The MRBs, particularly those of Tasmania, NSW and Victoria were typical examples of such bodies. One significant point about them was that, having been created in the pre-responsible government era, they were accountable only to the governor for their actions, and precisely because they were seen as being specialised and therefore best left to specialists, it is likely that little accountability was expected from them. After the attainment of self-government and the implementation of the doctrines of responsible government in the colonies, most of these

boards were absorbed into governmental departments (Davis, 1983 pp3-4). Significantly however, the MRBs were excepted from this process and in NSW, for particular reasons set out in Chapter Three, continued to exist on an extra-departmental and virtually non-accountable basis.

The advent of the era of statutory authorities from the 1880s onwards resulted from the same reasons which had called the specialised boards into existence in the pre-responsible government era, viz. the need for the specialised administration of particular areas. It had also become clear that the administration of these areas needed to be buffered from the hurly-burly of parliamentary politics which strongly affected the working of departments under the control of a Minister (Spann, 1979, p118).

Although pre-dating them, MRBs had been set up in exactly the same way and for the same reasons as statutory authorities and therefore fitted easily into the new administrative scheme of things. However, they were also significantly different in that their autonomous status, to all intents and purposes outside the system of responsible government, did not change after the commencement of the era of statutory authorities. To understand why the MRBs retained this anomalously autonomous position, it is necessary to understand their place in the history of medicine.

MRBs as part of the history of medicine

In considering this topic, it is necessary to range more deeply and widely into history than I have done so far. The first point to make here is that of course, the advent and operation of MRBs is due to much more than simply the administrative needs of government. In

fact, when one examines statutory authorities as a whole, as was noted in Chapter One, this is very often due to the opportunistic advocacy of special interest groups seeking control over their sphere of economic activity, the medical profession being an archetypal example of such groups.

In the English-speaking world, the MRBs reflect both the societal demand for "order and protection" (Weber, 1978 [1922] p972) and the medical profession's demand for social closure. This process can be traced to the time when a species of industrial organisation by doctors led to the founding of the London College of Physicians in 1518. At that time, the College had only six members, all of whom were wealthy (Cooke, 1964-72 pp62-3) and whose main motivation was to ensure their exclusive access to attending the Royal family (Berlant, 1975 p124). In other words, they comprised a typical Weberian *rechtsgemeinschaft* who were spurred into action by the failure of the first piece of medical regulatory legislation passed in 1511 entitled "An Act Concerning the Approbation of Physicians and Surgeons". Its preamble fascinatingly encapsulates Weber's twin drives, stating:

Forasmuch as the science and cunning of physic and surgery to perfect knowledge whereof, be requisite both great learning and ripe experience is daily within the realm exercised by a great multitude of ignorant persons, of whom the great part have no manner of insight in the same, nor in any kind of learning, some also cannot read letters on the book, so far forth than common artificers, as smiths, weavers and women, boldly and costumably take upon them great cures of things of great difficulty; in which they partly use sorcery and witchcraft, partly apply such medicines unto the disease as to be very noxious, and afford great infamy to the faculties, and the grievous hurt, damage and destruction of many of the

king's liege people most especially of them that cannot discern the uncunning from the cunning. Be it therefore, to the surety and comfort of all manner of people, by authority of this present Parliament enacted, that no persons within the city of London, nor within seven miles of the same, take upon him to exercise and occupy as a physician and surgeon, except that he first be examined by the bishop of London, the Dean of St. Paul's for the time being, calling to him four doctors of physic and surgery, other expert persons in the faculty, and for the first examination, such as they think convenient, and afterward always four of them that have been so approved, upon pain of forfeiture, for every month that they occupy as physicians and surgeons, not admitted, nor examined after the tenor of this act ... (cited in (Gottfried, 1986 p288).

In the above we might note the argument for control based on the public interest (to eliminate the "grievous hurt and destruction of many of the king's liege people") as well as limitation of practice to those possessed of "great learning and ripe experience", who would have unquestionably have benefited from the elimination of the "great multitude of ignorant persons" from medical practice. The Act failed because of a lack of any machinery to enforce its provisions, and a group of six doctors set out to remedy this situation through the establishment of the College of Physicians (Cooke, 1964-72 pp63-4).

Although it was not a government instrumentality as such, in many ways the College prefigured the modern statutory authority in that its aims were the same as those of the abortive act of 1511 while its authority was derived from the state. Initially it was granted a Royal Charter reinforced by an Act of Parliament passed in 1523, which empowered the College to lay down the educational training required of its members and giving it the power to prosecute anyone outside its ranks who set themselves up as a

practitioner (Berlant, 1975, p139). In other words, the College was established to exercise exactly the same functions as a modern MRB as set out by Salter above.

The College can also be seen as perhaps the earliest attempt to apply social closure to the medical field. That concept, was nothing new in other fields; the guilds and craft guilds had existed for exactly that purpose for several hundred years. The College of Physicians however, represented an entirely new development; unlike the guilds which owed their status to the granting of charters by city authorities who exercised close control over them, the College was virtually autonomous. Its strongest obligations seem to have been to the Crown according to Pelling, who adds that "its relations even with the universities were limited and often negative, and it was not subordinated to the City authorities" (1998 p239).⁹ While prosecutions of non-licensed practitioners did take place, they were "far from exhaustive" says Pelling (1998 p239); evidence suggests that only a small proportion of those practising without official permission were caught in the prosecutorial net even in the limited area to which it applied, namely London and its surrounds. Although it was made by "Royal" College by Charles II, during the 17th century its status shrank to that of simply a gentlemen's club, the chief aim of its members (*rechtsgenossen*) being to maintain their own exclusive status rather than to assert any monopolistic rights over medical practice.

Whatever its weaknesses as a regulatory mechanism, the importance of the College from the point of view of this study is that it enshrined the principle of, and contributed

powerfully to, the convention of medical autonomy. Thus when the MRBs began to appear in the 19th century, that convention was applied to them without question. When the British General Medical Council was established in 1858 after 18 years of action and debate in the British

⁹ This actually proved to be a weakness, since its autonomous status deprived the College of the authority it might have had if it was seen to be acting as an agent of city authorities or of the Crown

parliament, it was made accountable only to the Privy Council, not the parliament (Berlant, 1975, p155). In this way it was placed outside the evolving system of responsible government and since its responsibility to the Privy Council was purely formal, it was *de facto* a totally autonomous body. In NSW the process of establishing the first State MRB with regulatory "teeth" was even longer, taking over forty years between 1859 and 1900. But while as will be shown in the next chapter, multiple Bills were brought before the parliament during that period and the membership of the proposed MRB was debated at length, that it would enjoy autonomous status seems to have been wholly taken for granted.

This is not surprising; the doctrine of medical autonomy was already well entrenched even in NSW. As Cummins (1969 p82) points out, boards composed of medical practitioners who had decisive powers over the recognition of the qualifications of aspirant practitioners, had been in place in the British armed forces from the 18th century onwards. Following this precedent, similar boards had been set up by the NSW Colonial government on an adhoc basis to test the qualifications of aspirant medical practitioners at least from 1801, when John Redfern "was examined by a Board comprising Thomas Jamison, John Harris and William Behan as a pre-requisite to entry into the medical service" (Cummins 1979, p82). The first Medical Board established in 1838 was merely a permanent and more systematised extension of these earlier boards and enjoyed the same autonomy, even though its powers were rudimentary. For reasons which will appear in Chapter Four, the structure of this Board was not changed for another century and even after the passing of the first "modern" Medical Practitioners' Act in 1938, the Board had no reporting obligations to parliament and therefore enjoyed almost complete autonomy.

The exercise of medical discipline

What is of particular concern in this study is the way autonomous medical regulatory bodies exercised discipline over the profession. In terms of recent history, a good place to begin an investigation of the regulation of the medical profession is by looking at the British General Medical Council (referred to as the GMC from this point) since that body set the precedents which were followed by MRBs in Australasia and particularly that of NSW.

The GMC was established by the British Medical Act of 1858 (21 and 22 Vict. Cap 90), which introduced state-sponsored regulation of the medical profession on a national basis for the first time. That regulation empowered the GMC, in Daniel's terms, to "...control the criteria for entry, the lengthy educational training, registration, and standards of practice and conduct..." (1990, p.63) of the medical profession in Britain. As far as standards of practice and conduct are concerned, it is significant that out of the 55 clauses which comprised that Act, only one (Clause 29) related to discipline. It laid down the following grounds for taking action against erring practitioners.

If any registered medical practitioner shall be convicted in England or Ireland of any felony of misdemeanour, or in Scotland of any crime or offence, or shall after inquiry to be judged by the General Council to have been guilty of infamous conduct in any professional respect, the General Council may, if they see fit, direct the registrar to erase the name of such medical practitioner from the register.

This wording was duplicated in successive NSW Medical Practitioners' Amendment Acts passed between 1900 and 1972, when it was superseded by the equally vague term "misconduct in professional respect". Of particular note is the wording of the

disciplinary clause in the Medical Practitioners' Further Amendment Act of 1900 (No. 70):

If it appears to the satisfaction of the New South Wales Medical Board that any person registered as a legally qualified medical practitioner within the meaning of the Medical Practice Act ... has been guilty of infamous conduct in any professional respect, it shall be lawful for the Board to remove such person's name from the register, and thereupon he shall cease to be a legally qualified medical practitioner within the meaning of the Act.

“Felony or misdemeanour” had also been made a ground for deregistration in NSW by an Act passed a few weeks before. Thus here, as in Britain, there were two reasons for deregistration of erring doctors; but since very few were likely to be struck off the role for felony or misdemeanour, the major ground for deregistration was that a doctor had been guilty of "infamous conduct in professional respect".

This archaic and obscure wording had in fact been taken directly from the statutes of the Royal College of Physicians, founded as we have seen, several centuries before. Berlant provides a key to the understanding of this clause when he points out that such conduct "did not include mistakes or incompetence short of gross malpractice and gross incompetence" (1975, p161). The long-lasting and worldwide influence of the precedents set by the Royal College Of Physicians and GMC in this respect, are noted by Maley who asserts that the Code of Ethics of the NSW Branch of the Australian Medical Association (AMA)

... is derived from the rulings of the General Medical Council of Great Britain on what constitutes "infamous conduct in a professional respect". The Code is therefore directly linked with the English tradition of medical

ethics and is thus a codification of "professional common law" in medicine (1974 p400).

That the Medical Practice Acts of both Britain and NSW were so closely aligned to "professional common law", is indicative of the way in which it was incorporated into legislation in the respective jurisdictions. However, as will be made clear in Chapter Four, it was not legal draftspeople but members of the local branch of the British Medical Association (forerunner of the AMA) who played the major role in having the "infamous conduct" wording included in the crucial Medical Practitioners' Further Amendment Act of 1900. In fact, six years before that Act was passed, it was laid down in the first Articles of Association of the BMA in NSW that:

Any member of the Association ...whose name shall have been erased from the Medical Register ... on account of infamous conduct in any professional respect shall *ipso facto* cease to a member of the Association ... (1894 p35).

This wording was obviously taken directly from that of the parent British Medical Association since in 1894 there was no law in NSW under which any doctor's name could be "erased from the Medical Register".

Not only the wording, but the interpretation of "infamous conduct" noted by Berlant (1975) above, was faithfully followed both by the GMC and the MRB in NSW. Here too, during the eighty-odd years during which it was incorporated in law, "infamous conduct" did not include practice issues. This was an inevitable consequence of the idea of individual medical autonomy; if individual practitioners were given freedom to practice without reference to any agency outside of themselves other than their peers, those peers acting through the regulatory body, also granted individual practitioners freedom from

any accountability for the way they practiced. Thus while a gentle reprimand might be given in private to a negligent or incompetent doctor by fellow doctors, it was extremely unlikely that the GMC or the MRB would take legal action against the doctor on the grounds of their negligent or incompetent practice.

The freedom and indeed the right of regulatory bodies such as the GMC to interpret “infamous conduct“ in this way was affirmed most famously in the *Allinson v the General Council of Medical Education and Registration* ([1894] 1 QB 750)¹⁰ case of 1894 heard in the British Court of Appeal. Allinson was a medical practitioner who had been deregistered by the GMC for publishing advertisements in which he disparagingly compared his own curative record with that of his fellow medical practitioners. His appeal against the GMC's action was dismissed by the Court and in his judgement which set a long-standing precedent, Lord Justice L.J. Lopes provided the following definition of "infamous conduct":

If a medical man in the pursuit of his profession has done something ... which will be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency, then it is open to the General Medical Council, if that be shown, to say that he has been guilty of infamous conduct in a professional respect. (p763).

While he referred to the GMC in this judgement, Lopes was in fact affirming that only the medical profession could pronounce on what constituted "infamous conduct", which in fact meant that the judgements of the profession as expressed through bodies such as the GMC and the MRB in NSW, fell outside the jurisdiction of the courts. In other words, the Lopes judgement affirmed and entrenched the institutional autonomy of medicine.

That this view was closely followed in NSW is apparent for instance in the case, *Clune v. The Medical Board* ([1917] 34), in which a medical practitioner who had been deregistered by the MRB for "infamous conduct" appealed to the Supreme Court. In dismissing the appeal, Mr Justice Pring observed that while the court was not bound by the finding of the MRB, none the less "this court is very loath to disturb the finding of a Board of professional men whose knowledge of what may be termed professional misconduct must be very much greater than the Court can possess" ([1917] 34 *Weekly Notes* pp127-29). That statement of the pre-eminence of the peer review principle as exercised by medical regulatory institutions continued to be supported in law up to as recently as 1984, when it was re-stated in another important case, *Quidwai v Brown* ([1984] NSWLR 100) heard in the NSW Court of Appeal.

That the institutional autonomy of medicine also guaranteed the individual autonomy of physicians as far as their practice standards were concerned, is clear from the disciplinary record of the GMC as set out in a publication commemorating its centenary in 1958 written by its then registrar, W. Pyke-Lees. He reported that among the 200 doctors who had been disciplined and de-registered in the 50-odd years since 1900, "77 have been erased for adultery or improper conduct with a patient, 53 for procuring or attempting to procure abortion or miscarriage, and 45 for offences connected with drink or drugs" (1958 p27). Notably missing from that list were anything relating to professional practice

¹⁰ Legal cases are references separately after the main list of References (see p307)

standards, which led Klein, one of the best-known writer/commentators in Britain on medical autonomy, to ask 25 years later:

Does the official machinery of accountability actually ensure that the public can rely on getting "satisfactory treatment" from members of the medical profession? The answer is, almost certainly, no. Once a doctor has graduated on to the medical register, the GMC's role is essentially negative. ... Its role is to drum convicted sinners out of the profession, not to ensure continued professional virtue..... Its machinery is not designed to deal with the doctor who is neither psychiatrically ill nor dishonest, who does not touch drink or drugs, who does not sleep with his patients or break the law... who is a good and sane citizen but a poor doctor (1984 P162).

As will be demonstrated particularly in Chapter Five, this was also true of NSW, where right up to the 1980s, the "infamous conduct" of most practitioners deregistered by the MRB related to improper advertising, financial fraud and addiction to alcohol or drugs.

In 1972 "infamous conduct" was replaced in the NSW Medical Practitioners' Act with the words "misconduct in any professional respect". This may have been in response to a statement made by a learned judge in a Supreme Court case of 1965, *Ex parte Meehan; re Medical Practitioners' Act* ([1965] NSWLR 30). This case resulted from an appeal by a practitioner who had been suspended for 12 months by the Medical Tribunal which had adjudged him guilty of "infamous conduct" for performing operations in which he himself had administered the anaesthetic instead of engaging the services of an anaesthetist. The practitioner appealed to the Supreme Court against the judgement. While all three judges of that Court agreed with each other that in terms of the precedent set by the Lopes judgement in the *Allinson* case of 1894 and followed in numerous other

cases, only medical peers could define and decide on "infamous conduct", Justice J. Wallace stated: "... I cannot leave the case without expressing the view that the phrase 'infamous conduct' which derives from an English provision enacted over a century ago (and I would think, was inspired by a somewhat different legislative intendment) is antiquated and attracts legislative review" ([1965] NSWLR 30).¹¹

The suggested "legislative review" took place in 1972 when the Medical Practitioners' Amendment Act of that year was passed. However, the replacement of "infamous conduct" with "misconduct in professional respect" in that Act, had been preceded long before this in regard to the Dental Practice Act when it was amended in 1934. When the original Dental Act was passed in 1900, it included "infamous conduct" as the main ground for deregistration, but this was changed to "misconduct" by the 1934 amendments which, "without limiting the meaning of the expression 'misconduct in a professional respect'," laid down that a dentist would be guilty of such misconduct if he was addicted to alcohol or drugs or if, in the words of the Amendment Act, he

- carries on the practice of dentistry under a name other than his own name except whilst he is acting as duly appointed locum tenens of another registered dentist; or
- allows the use of his name in connection with the practice of dentistry at premises at which he or his duly appointed locum tenens is not in regular attendance for the purposes of practice and supervision during the hours in which such premises are open for the practice of dentistry; or

¹¹ While it agreed with the Medical Tribunal's finding of "infamous conduct", the Supreme Court overturned the penalty of a year's suspension from practice and substituted that of a reprimand to the practitioner.

- advertises otherwise than in accordance with the regulations or advertises in contravention of the regulations; or
- for fee, salary or other reward is employed by or associates himself with a person who is not a registered dentist in carrying on the practice of dentistry.

Obviously these clauses were designed to protect the economic interests of practising dentists and evidenced no concern for the maintenance of practice standards. That situation remained essentially unchanged for the next fifty years, which led Dr J. Jago, who taught in the dentistry school at the University of Queensland, to remark in an article in *New Doctor*, (the journal of the Doctors' Reform Society) in 1980:

The dental practice acts of the various states and territories, which are the ultimate symbols and enforcers of professionalism, lay down no specific standards of competent practice, no means of testing them, and no provision for deregistering a dentist on the basis of assessed incompetence or obsolescence.

Thus, argued Jago, while the profession had "successfully obtained the right to autonomy as the only fit body to assess its performance collectively," it none the less had never made any real attempt to do so (Jago, 1980, p21).

The situation in dentistry closely paralleled that in Medicine, but that was of no concern to either medical professionals or lawmakers for a long time. For example, in the GMC centenary publication, Pyke-Lees praised the Lopes judgement of 1894, stating that it had "proved of great value" since the great majority of complaints registered by the GMC raised no questions of infamous conduct on the part of the doctor concerned. "Rudeness is not infamy; and many minor lapses of judgement or etiquette, although liable to cause anger or pain, fall far short of constituting infamous conduct" (p24). Patients who had

suffered "anger or pain" would probably have disagreed, but with their position reinforced by the Lopes judgement, the "usual answer" of GMC to complainants said Pyke-Lees, was that "the Council is not empowered by the Medical Acts to intervene in the matters about which they write" (p25). Both he and the medical profession as whole might have taken warning from the fact that, as he himself stated, "to the general public, and to the Press ... the Council is concerned above all with discipline" (p25) and as Daniel argues, "discipline, or rather the perception of discipline, is the basis of trust in a profession" (Daniel, 1994 p198).

In any case the disciplinary instrument created first in the British and later in the NSW Acts, was a blunt and crude one. It specified only a single sanction for a practitioner guilty of "felony or misdemeanor" or "infamous conduct", and that was de-registration. This was an extreme penalty imposing what could amount to an occupational death sentence. Being deprived of their means of earning a livelihood could financially ruin anyone found guilty of the offences set out in the clause. Not until the passing of the Medical Practitioners' Act of 1938, were lesser penalties, including suspension from practice and reprimand incorporated into the law for what were adjudged to be less serious misdemeanours.

Without these lighter penalties the situation pertaining to the exercise of medical discipline before 1938 in NSW was analogous to that of a jurisdiction in which the only penalty for any crime was death, which probably has never been the case in any society anywhere in the world. Pursuing the extreme penalty analogy, it is evident that whether this involves capital punishment or a life sentence, such a penalty is generally applied

only to the most blatant and extreme cases and then with great care. The tendency to err on the side of caution was likely to be magnified in Medicine, which like most other professions is characterised by a strong sense of collegiality. In the words of Johnson: "Professionalism creates a high degree of self-consciousness and complete identity" (Johnson, 1972 p57) and that in turn creates a situation in which professionals tend to close ranks around a colleague whose conduct is being questioned, as was demonstrated in Rosenthal's study of the behaviour of doctors in the United Kingdom carried out within a decade of this thesis being written. That study showed, she wrote, that the inexact nature of medical treatment means that doctors work under "a sense of permanent uncertainty" and have an "overwhelming feeling of personal vulnerability". Thus she reported, "interviewees express a strong impulse to understand their colleagues' situation when an accident occurs and are quick to forgive" (Rosenthal, 1995 p21).

That this is by no means a new phenomenon in Medicine appears from an anecdote recounted by a member of the NSW parliament, Mr Alexander Brown (Progressive, Newcastle) in the debate over the Medical Practitioners' Bill of 1900. He told the House that while certain surgeon was performing an operation with several other doctors present, it was "manifest to the others that he had made a mull of it." One of the attending doctors

stood out against the others, and did not hesitate to say what he thought of the matter. The other half-dozen however, stuck to their friend at the operating table, with the result that they tabooed the man who had not hesitated to express his opinion with regard to the matter. ... One of the medical men to whom I spoke in connection with the matter said: "There can be no doubt my friend made a mistake; but that was not the place to

declare it; it was our business to stand by him (NSWPD 1:107 1/11/1900 p4634).

Hiding the shortcomings of individual practitioners in this way was made easier by the fact that because this was a practice issue, the MRB would not have adjudged the surgeon's actions to be "infamous conduct".

Finally, it might be remarked that for over a century after the passing of the British Medical Practice Act 1858 (which was the model for later Australian legislation) its disciplinary functions were not seen to be a major feature of medical regulatory bodies. As noted above, only one clause out of 55 in the 1858 British Medical Practice Act related to discipline, while in NSW only two out of the dozen clauses 1900 Medical Practitioners' Acts were concerned with discipline. Moreover as will appear in Chapter 7, even today MRBs are not equipped with anything but the most elementary machinery to investigate disciplinary matters.

Conclusion

This chapter has sought to demonstrate that the recognition of the peer review principle meant that as far as the application of medical discipline in NSW was concerned, the interests of medical professionals on both the institutional and individual level, were deeply entrenched by the "infamous conduct" wording of the disciplinary clauses of Medical Practitioners' Acts. The peer review principle was embodied in the high, almost total degree of institutional autonomy of MRBs which in turn ensured the individual autonomy of practitioners, since no other agency outside the MRBs including the courts was seen to be competent to judge their professional performance. Since MRBs were not

willing to hold individual practitioners accountable for their standards of practice, medical professionals appeared to be unaccountable to anyone on this score. It is this situation of non-accountability and the way in which it was reversed, which forms a core issue in this study.

CHAPTER THREE

THE ESTABLISHMENT OF MEDICAL AUTONOMY IN NSW

As noted in the previous chapter medical autonomy is exercised not only on an individual, but also on an institutional level. When authorities such as Freidson (1970) and Willis (1989) write about "the medical profession" as being autonomous and exercising control over other health-related professions, they do so in a general sense; but in a more specific sense, as Wolinsky notes, "...autonomy is always granted through legal process" (1993, p12). In concrete terms, this means that autonomy is embodied in a parliamentary or legislative act which establishes an institution i.e. an MRB or its

equivalent. Those institutions also make it possible for the full force and range of professional status to be attained. There are of course, a plethora of other conditions for professionalisation which have to be fulfilled and these, in the words of Lloyd (1993),

... involve: generating and sustaining group solidarity; establishing codes of professional conduct; standardising initial and continuing education training and work practices; restricting access to such educational opportunities; maintaining the barrier between powerful expert and dependent clients principally by emphasising the indeterminate or interpretive quality of professional knowledge; establishing and extending access to a clientele by excluding or subordinating adjacent and competing occupational groups (in large part through exclusive alignment with major institutional settings within which professional practice occurs); jostling with third party providers (for example, in the health sector, with organisations such as friendly societies and hospital contribution funds) for control over the terms of the expert-client encounter; and lobbying government to provide legislative support for the group's monopolistic position (p44).

The major part of the theses of Davis (1983) and Lloyd (1993), as well as the work of Lewis & MacLeod (1989), is devoted to describing how the professional monopolisers in NSW acted to achieve these aims although their success remained very partial until the passing of the Medical Practitioners' Acts of 1900. That legislation not only provided the foundation for Medicine's dominant position in law, but also provided it with the legitimation which enabled it to dominate the discourse of health care in a Foucauldian sense during the 20th century. That domination, it should be said, was attained despite its almost complete failure to exclude or subordinate "adjacent and competing groups". On this latter score, the conclusions of Lewis and MacLeod (1988) are mistaken while Lloyd

(1993) also underestimates the power and influence of the lifeworld medicine, as will be demonstrated later in this text.

The 1838 Act and the expansion of government in NSW

Since legislation occupies such a crucial position in the process of professionalisation, all studies pay attention to the Act of 1838 which established the first MRB in NSW. A plaque on the headquarters of the current MRB in Sydney proudly records its lineage in this regard. However, the Board which existed between 1838 and 1900 was not a regulatory body; its function was set out in the title of the legislation under which it was established, viz: "An Act to provide for the attendance of Medical Witnesses at Coroners' Inquests and Inquiries held by Justices of the Peace" (1 Victoria No. 3)¹². In other words, its sole purpose was to provide governments with a list of medical practitioners whose testimony could be accepted at coronial inquests. That Act therefore might seem to have had little direct significance as far as the processes of medical professionalisation and autonomy are concerned. Much more significant in that regard was a Medical Practitioners' Bill which came before the NSW Colonial Legislature, also in 1838, which would have regulated the medical profession as far as the training and qualifications of medical practitioners was concerned, although it did not include any disciplinary clauses. This Bill however, like all of those which came before the NSW legislature over the next 60 years, failed to pass and lapsed for reasons which will be more fully discussed shortly. Willis chooses to ignore it because it did not affect the division of labour in health (1989, p48), but however limited its direct impact on the processes of professionalisation, the

¹² The "Victoria" in this title, was Queen Victoria, not the colony of Victoria. All Acts at that time were dated in terms of the name of the current monarch.

1838 Act is a marker of some very significant trends and developments which deserve fuller consideration with regard to the subject of this study. One of those trends was the growth of the bureaucratisation of public life, described by Weber when, as noted in Chapter One, he pointed to "...the increasing need felt by a society grown accustomed to stable and absolute peace, for order and protection ('police') in all fields..." (1978 [1922], p.972). This felt societal need in fact led to one of the most significant but little remarked developments in public life during the 19th and 20th centuries. This is reflected in the figures quoted by Howard (1995 pp87-8):

... there has been a massive increase in the relative size of the public sector in advanced capitalist nations. From 1890 to 1980, total public

expenditure as a percentage of gross national product (GNP) increased from 15 per cent to 47 per cent in the United Kingdom, 10 per cent to 45 per cent in Germany and 5 per cent to 34 per cent in the United States." ... In Australia public sector employment as a percentage of the total workforce increased from 9 per cent in 1900 to 23 percent in 1981 (pp. 81-2).

As is evident from the above quotation, no economic figures comparable to those of the USA, UK and Germany are available for Australia as a whole. However, Knight who in his Masters' Thesis of 1955 traced the growth of the public service in NSW in the late 19th century, demonstrated that that the expansion of government bureaucracy in this State was probably even faster than that in the economically developed countries mentioned by Howard above. Thus, while between 1860 and 1895 the population of NSW grew by 262% (from 348,546 to 1,262,270), according to Knight (1955):

In the same length of time, but taking the period 1859 to 1894, we find that the number of Civil Servants, (including Railway employees and Police) increased from 843 to 32,722 - giving the astounding result of a rise of 3,793 per cent! (p38)

Knight's asserts that this growth was "much faster ... than was warranted" because "a great deal ... was attributable to the recruitment of large numbers of unqualified and generally unsuitable officers, appointed mainly because they were able to command some influence on their behalf" (p38). Whether that is so or not, Knight's statistics can be taken as confirmation of the observation made by Drucker, quoted below, that at that time populations in economically developed countries had "fallen in love with government" and saw it as panacea for all kinds of societal ills.

Also illustrative of this trend is that the number of ministerial portfolios in NSW doubled from six to twelve in the 50 years after the granting of responsible government in 1856. By 1916 the number of portfolios had risen to 14 and included in these for the first time in that year was a health portfolio, known as the Department for Public Health (New South Wales, 1998 p258). In 1920 this became the Department for Public Health and Motherhood, the last word reflecting Australian concern about what was seen as the small size of the population at the time and the need to ensure its increase through natural growth. "Motherhood" was dropped from this ministry's title in 1925, and the word "Public" ten years later (NSW 1998, pp263, 267). That there was no Health Ministry for 60 years after the coming of responsible government indicates that at that stage, health was seen only as a peripheral government responsibility and even though as outlined in Chapter Four, this changed in the later 19th century; the Australian Commonwealth government established in 1901 did not include a Ministry for Health until 1921.

The size and scope of government continued to expand exponentially throughout the 20th century. In 1956, 100 years after the introduction of responsible government in NSW, the number of portfolios stood at 29 (NSW 1998, p274), while today (2002) they number 39.

This enormous expansion of government indicates a Kuhnian paradigm shift in thinking about the functions and scope of government which has taken place during the last 150 years. The five ministerial portfolios in NSW in 1856¹³ were reflective of the minimalist and liberal *laissez faire* thinking about the functions of government at the time, but as

¹³ Those of the Colonial Secretary, Colonial Treasurer, Attorney-General, Solicitor-General and Auditor-General.

Drucker (1969) stated in his influential article, *The Sickness of Government*, attitudes changed radically in the later 19th century. Rather than being a source of societal problems and therefore needing to be kept within bounds, government began to be seen as the chief source of societal redemption. "For seventy years or so - from the 1890's to the 1960's," wrote Drucker:

[M]ankind, especially in the developed countries, was hypnotized by government. We were in love with and saw no limits to its abilities, or to its good intentions. ... Anything that anyone felt needed doing during this period was to be turned over to government - and this, everyone seemed to believe, made sure that the job was already done. (p5)

The phenomenon of governmental expansion has been discussed at some length because it was at this time and in this context that the bureaucratisation or regulation of medicine in NSW was taking place. The result of that development was that while the medical profession encountered great opposition from the adherents of lifeworld medicine as it sought "legislative support ... for its monopolistic position" in Lloyd's words (p.45) on the other hand there was in the later 19th century in NSW "increasing State interest and support for medical activity both private and public, curative and preventative" (1983, p.2). That reflected the wholehearted support for the processes of bureaucratisation in public life noted by Knight (1955), which meant that both the government and corporate rationalist structural interests looked favourably on the drive for medical regulation by the professional monopolists. Indeed it will be argued, without the help of the representatives of these structural interests, the professional monopolists would have found it virtually impossible to obtain the regulatory regime they needed to entrench their claims to legal institutional and individual professional autonomy.

The “expert co-optation” principle

One problem governments faced as they sought to respond to demands for regulation and bureaucratisation, was that of staffing the newly established bureaucracies, particularly statutory authorities. As noted in the previous chapter, these bodies were operating in fields in which the existing governmental personnel had little or no knowledge let alone expertise. The solution was to apply the principle of “expert co-optation”, in terms of which experts from the private sector are recruited to administer new bureaucratic agencies. That principle, as noted above, was extensively used in the era preceding that of responsible government in NSW, when administrative boards were established to oversee special areas, including that of health. Indeed, in no instance was the "expert co-optation principle" more likely to be applied than in the case of Medicine, particularly because of the historical precedents already cited. As noted above, ever since the 16th century governments had accepted that doctors were the best administrators of the state-related issues of doctoring. As will be argued more fully, this arrangement contained an additional benefit, in that the societal legitimacy which professions such as Medicine had won for themselves in turn legitimated the activities of the governments which co-opted them.

All of this provides a context for the 1838 Medical Witnesses Act, the instigation of which is taken by all who have written about it (Hilder, 1959; Cummins, 1969; Davis, 1983; Lewis & MacLeod, 1988; Willis, 1989; Lloyd, 1993) as a piece of legislation remarkable only for being the first of its kind. However, they make no attempt to see it against the background broader societal developments at the time, particularly the

changing paradigm of government. This Act represented the incoming tide of bureaucratisation based on societal demands for "absolute peace" and "order and protection" noted by Weber (1978 [1922]), although the origin of those demands in this case lay not so much in NSW as in the United Kingdom, where the first Births, Deaths and Marriages Act had been passed by the British Parliament in 1836. That Act, which came into force on July 1, 1837, had two main purposes: "first, to facilitate legal proof of death, and, secondly, to produce more accurate mortality statistics" (Great Britain, 1972 p9). As was the custom of colonial dependencies at the time, this Act was adopted by the NSW Legislative Council and incorporated into the law of the colony. In the view of Foucault (1975), the statistical concerns of the drafters of the Act would have represented a sinister example of the expansion of "surveillance" by the state, another building block of the Panopticon. However, the necessity of recording the causes of death, and particularly of unexplained death, would certainly have been seen at the time (as it is now) as an important contribution to societal stability and support for the rule of law.

The contest for societal legitimacy

One of the weaknesses of the British Act recognised from the outset was that "the particulars of the cause of death to be recorded in the register were not required to be obtained from a medical practitioner but were merely part of the information to be given by the informant [the person giving information about the death] or, in inquest cases, by the coroner" (Great Britain, 1972 p9). This remained a flaw in the British Act for many years and the passing of the Medical Witnesses Act in NSW in 1838 was probably an attempt to remedy that. However, it must soon have become apparent that although the Act specified that "legally qualified Medical Practitioners' should be required give

evidence at coroners' inquests", it did not define what constituted a "legally qualified Medical Practitioner".

While today that definition may seem obvious, this was not so before the rise and dominance of scientific medicine. During the whole of the 19th century, lifeworld medicine was not only widely used, but as argued earlier, was seen by possibly the majority of the population to be just as efficacious, if not more so than the treatments offered by doctors. Thus it would by no means have been obvious as to who was best qualified to practice medicine. The wide array of traditional practitioners is evident from testimony given to a Select Committee of the Legislative Council in 1838, which mentioned "Midwives, Herbalists, Cuppers, Barbers, Electricians, Galvanisers, Dentists, Farriers, Veterinary Surgeons, Village Wisemen and Cow Leeches" (New South Wales, 1838 p19). As is argued in Chapter Four, all of these would have been accepted and used particularly by the lower socio-economic strata of society as bona fide medical practitioners.

None the less, it would no doubt have seemed to the NSW legislators drawn from the elite classes who preferred to use allopathic medicine, that there could be no question of regarding uneducated traditional healers as qualified medical practitioners; to allow for instance, a "village wiseman" or a "cow leech" to give official testimony in the newly established coronial courts, would be an affront to the Majesty of the Law. Therefore, three months after the passing of the Medical Witnesses Act in June 1838, the Legislative Council passed "An Act to define the qualifications of Medical Witnesses at Coroners' Inquests and Inquiries held before Justices of the Peace in the Colony of NSW" (2 Victoria No. 22).

This second Act was of seminal importance, since it set the precedents for the institutional autonomy of the medical profession in NSW. This Act established the first MRB, specifying that it should be composed of not less than three members, all of whom had to be legally qualified medical practitioners. A legally qualified practitioner was defined to be one who

...is a Doctor or Bachelor of Medicine of some University or a Physician or Surgeon licensed or admitted as such by some College of Physicians or Surgeons in Great Britain or Ireland or is a Member of the Company of Apothecaries of London or who is or has been a Medical Officer duly appointed and confirmed of Her Majesty's land or sea service.¹⁴

The MRB had as its basic function the compilation and maintenance of a Medical Register, published annually in the Government Gazette, which contained the names of practitioners who were adjudged to be "legally qualified". Those who wished to be so recognised were obliged under the Act to present evidence of their credentials to the MRB, which had the power either to certify or reject them.

While it was probably not obvious at the time and indeed is not so even today, this Act can be seen as it were, as a "starter's gun" in a race for societal legitimacy between allopathic and lifeworld medicine, the outcome of which would by no means have been certain in 1838. However, whatever its shortcomings at the time (as described in Chapter One) allopathic medicine started the race with a huge advantage in that it was based on university education. As Jackson (1970) states, the university,

¹⁴ This last stipulation remained on the NSW Statute Book right up to 1938.

...with its emphasis on teaching and research provides both the training and the intellectual tradition itself but also, in some measure, incorporates the legitimating structure of authority and competence. (1970 p2).

While particularly the medical knowledge taught in universities, based as noted in the previous chapter on humoral theories, was very often misconceived and from today's perspectives, often not very apposite (heavy emphasis was placed on learning Latin and ancient Greek), it was none the less, systematic and testable for qualification purposes. It could therefore be regarded as both "scientific" and rational in a Weberian sense. On these grounds university medical education provided the foundation for the societal legitimation of allopathic medicine, and that in turn indicates how education provided and still provides the bedrock of legitimacy for a great range of societal activity performed by an equally wide range of groups. Larson also makes a salutary point when she points to "the role that educational systems play in different structures of social inequality" (1977 pxvii).

That assertion certainly supports the point made by Davis (1983) that the epistemological race for legitimacy between allopathic and traditional medicine in NSW had a strong class-based dynamic. He demonstrated that the chief proponents of allopathic medicine were "elite practitioners [who] moved in circles which were mutually reinforcing and exclusive" and this produced "a medical practitioner whose social, political and economic interests lay with the people who employed and paid him, and who shared with them a social status and reputation" (pp. 10-11).

Although this trend became much more fully developed in the later 19th century, none the less it is clear that it was very much present in 1838 when the MRB was constituted on the

basis of the “expert co-optation” principle. The first appointed president was Dr J.V. Thomson, who was already Deputy Inspector-General of Hospitals. The other members were Dr J. Dobie, a surgeon with the Royal Navy who was to become a member of the legislature, Dr J. Robertson who was later to join the staff of the University of Sydney, as did Dr C. Nicholson and who was also a member of the legislature. Finally there was a Dr. F. Wallace who had been trained in Edinburgh and after having been in Sydney for six years, was obviously close enough to the local medical establishment to be asked to give evidence before the Select Committee investigating the Medical Practitioners' Bill in 1838 (Hilder, 1959 p16).

These practitioners not only provided the NSW government with expertise in the field in which they were working, but also imparted their education-based legitimacy to that government as its activities expanded into their field. As such the MRB illustrated a developing principle - that governments needed specialised occupational groupings such as Medicine for the successful conduct of administrative activities in specialised areas. This is the other side of the coin to that discussed above when it was pointed out that the occupational groups such as Medicine themselves need legislative support from governments in order to complete their professionalisation. This would support Johnson's (1982) view that "... the relationship of state to professions presents itself as one of constant struggle and seeming hostility, while at the same time constituting an interdependent structure". It also constitutes the ground for his critique of Carr Saunders & Wilson as well as Durkheim for "viewing state regulation as, in many instances, an undesirable incursion into matters best left to the autonomous professions" and for asserting

that there was a choice between "intervention leading to loss of autonomy or non-intervention allowing autonomy" (Johnson, 1982 pp206-7).

Autonomy and the functioning of the MRB

The MRB established in 1838 had no regulatory powers. As such it gave the medical profession few obvious advantages and if anything, its activities were irksome for doctors. Despite being remunerated for giving evidence before Coroner' s Courts when summoned to do so, they very often found themselves out of pocket through having to travel long distances and also lost income because of the time that could take (New South Wales, 1887 p18). The members of the MRB were unpaid and as outlined in the next chapter, their ability even to perform so basic a function as checking the qualifications of those who presented themselves for accreditation, was non-existent.

Still, the fact of the Board's existence and its maintenance of the medical register, did hold advantages of the profession. That as Hilder (1972, p.35) shows, the numbers requesting accreditation rose from 6 in 1839 to 1,906 in 1889, indicates that getting their name on the register benefited practitioners in the longer term. Even though the register maintained by the MRB was meant to be simply a reference source for magistrates and coroners and was not drawn up for any wider public interest, none the less doctors who had their name on the register could expect to reap commercial benefits from the fact that their qualifications had received official legitimation.

Finally, it is important to note that since it was entrusted to a body composed entirely of medical practitioners, this first exercise in medical credentialling in NSW signalled the institution of legislatively-supported peer review. Furthermore, that other than the

maintenance of the register, the 1838 Act specified no reporting or accountability requirements by the MRB, meant not only that it was free to act autonomously, but that in fact it was expected to do so. As such, it set precedents for institutional autonomy which would be followed by legislators and MRBs themselves in NSW for the next century-and-a-half.

CHAPTER FOUR

MEDICAL EPISTEMOLOGICAL STRUGGLES IN nsw

For reasons that will be outlined in this Chapter, the high degree of institutional medical autonomy in NSW established in 1838 lasted well over a century. Institutional autonomy was complemented and reinforced by the individual medical autonomy introduced in 1900 by the Medical Practitioners' Further Amendment Act (No. 70, 1900) in terms of which "infamous conduct in professional respect" became the main ground for medical discipline. The strongly entrenched nature of professional medical autonomy in NSW for such a long period was a result of a major conflict between allopathic and lifeworld medicine which also had a major impact on the way the legislative framework for that autonomy came into existence.

The paradox is that while the proponents of lifeworld medicine were more successful in NSW than in any other Australian jurisdiction in delaying the legislative entrenchment of allopathic medicine, the very ferocity with which they resisted that development in the final result actually strengthened the position of allopathic medicine and also the

autonomy of the medical profession in this State. This Chapter thus deals extensively with the conflict between the two epistemologies in NSW and the way this shaped the legislative developments which gave rise to the form that medical autonomy took for most of the 20th century.

The weakness of the Medical Witnesses Act

The 1838 Medical Witnesses Act was the only legislation affecting the medical profession in NSW for the next sixty years. Amendments to this Act did not affect its substance,¹⁵ although it was given "teeth" by the "Medical Practitioners' Registration" Act (Victoria 17) of 1855 which laid down a three-year jail term for anyone convicted of giving false testimony to the MRB or using forged documents to secure legal registration. However that both this and the 1838 Act were inadequate as regulatory instruments is evident from the strenuous efforts made to bring in more comprehensive legislation after 1859. That these proved consistently unsuccessful meant that because of its lack of medical regulation, NSW was increasingly isolated in the later 19th century. While the model for regulatory legislation was the British Medical Practice Act of 1858, in fact embryonic legislation of a similar kind had been passed in Tasmania as far back as 1838 (Tasmania, 1884` pp1405-1408).¹⁶ Medical Acts had also been passed in Victoria in 1862, (Willis, 1989 pp52-3), New Zealand in 1866 (New Zealand, 1867, pp407-14),¹⁷ South Australia in 1880 (Fraenkel & Wilde, 1994), Queensland in 1867 (Queensland,

¹⁵ The 1844 amendment allowed for the establishment of a MRB in Melbourne (Victoria No 7, 23rd August 1844). In 1855 the Medical Practitioners' Registration Act added the newly established University of Sydney to the list of institutions whose qualifications could be accepted by the MRB. The purpose of this Act set out in its preamble, was simply to "amend the law relating to the qualifications of Medical Witness on Coroners' Inquests and other Inquiries" (NSW Statutes, 1879, p1419).

¹⁶ 1 Victoria, No 17. 7th November, 1837

¹⁷ 30 Victoria No. 30, 10th October 1867

1911 pp2108-2122)¹⁸ and Western Australia in 1894 (Western Australia, 1984pp1-9).¹⁹

Similar medical regulation was also advancing apace in the United States, where according to Starr, every State had passed the necessary legislation by 1901 (1982 p131).

The NSW 1838 Act stood in sharp contrast to what was happening elsewhere in this sphere. While it did specify criteria for entry and registration into the medical profession²⁰, there was little or no attempt to enforce those criteria even after the passing of the 1855 Act with its punitive provisions. Moreover both the 1838 and 1855 Acts failed to specify any disciplinary measures to maintain standards of practice and conduct. While NSW did finally get a "Medical Practitioners' Act" in 1898, it merely tidied up the wording of the 1838 and 1855 Acts and their amendments and did nothing to remedy their glaring weaknesses. Those weaknesses were first and foremost that while the legislation provided for the registration of doctors, it did not prohibit the use of that title by those whose names did not appear on the Medical Register. That point was forcibly made to the Select Committee inquiring into the "Law Respecting the Practice of Medicine and Surgery" in 1887 by Dr Henry McLaurin, chancellor of the University of Sydney and also a member of the MRB. "Any person" he told the committee, including those who had had no medical training whatsoever, could practice medicine in NSW and advertise themselves as a doctor of medicine or as the holder of other medical qualifications (New South Wales, 1887 p16).

¹⁸ 31 Victoria No. 33, 28th December 1867

¹⁹ 58 Victoria No 36, 28th November 1894

²⁰ Those criteria, as we have seen, were based on educational qualifications or service in the British armed forces.

Moreover, the powers given by the Act to the MRB were extremely weak, a point continually made by members of the MRB and others who were also serving in the NSW parliament in the late 19th century. As the chairman of the Board, Sir Arthur Renwick, pointed out in 1880, while the Board had power to certify the qualifications of anyone presenting themselves for certification as a registered practitioner,

... the powers of the board were confined to that special purpose, and did not admit of a determination whether any gentlemen who presented themselves for registration, were really and properly the possessors of the documents they showed, or qualified to practice. No other step could be taken than to demand an affidavit. Several applicants for registration had no doubt forsworn themselves and were now practising in the colony. Although different Attorneys General had been consulted on this matter ... it was found that the power of the law could not be brought to bear on such cases (NSWPD 1:1 12/3/1880 pp1530-31).

Thus it was difficult to say who were duly qualified doctors even when they were certified by the MRB. Those who did "forswear" themselves before the Board by presenting false credentials were, in terms of the 1855 Act, running the risk of a three year jail term. However, confirming Renwick's point about the lack of state support, the 1887 Select Committee reported that while the Board had from time to time made requests "for assistance in prosecuting cases of fraud", these had without exception, been refused by Crown law officers (New South Wales, 1887 p5).

Nor did the Act confer on the Board any powers to control or discipline doctors once they had received certification; no legally qualified practitioner could be de-registered or barred from practising, however miscreant they had proved themselves (New South Wales, 1887 p21). Worse still, the Board had no alternative but to accept the credentials

of and certificate a doctor who had been deregistered in another jurisdiction (NSWPD 1: 93 21/9/1898, p733).

Thus NSW, the most populous of the Australian colonies²¹, constituted a model of chaotic unregulated medical practice in the late 19th century. Not until late 1900 was some elementary regulation introduced in the form of the Medical Practitioners' Amendment Act

(No.33, 1900) and the Medical Practitioners' Further Amendment (No. 70, 1900), which were passed within weeks of each other. Compared to the legislation of other Australasian colonies, these were extremely brief measures. The Medical Practitioners' Amendment Act consisted of only five clauses including the one which set out its name. The Further Amendment Act, which was rushed through the parliament a few weeks later had only six clauses, one of which again contained nothing but its name. When the two Acts were consolidated in 1912, the new Act had a mere 12 working clauses.²² This contrasts sharply with the model on which they were based, the British Act of 1858, which had 55 clauses and also with the 35 clauses of the Victorian Act passed in 1862. That the Medical Acts of the other Australian colonies as well New Zealand were similarly all very much more extensive than that of NSW is a point which has not been remarked on by any of the authors who have dealt with the history of the medical professionalisation in NSW and the reasons behind it certainly invite more in-depth investigations.

²¹ According to the census of 1901, the population of NSW was 1,359,133, its nearest competitor being Victoria, with 1,201,506 (NSW, 1901, p935).

Attempts to introduce medical regulation

As mentioned above, the 1858 British Medical Practice Act (the world's first comprehensive legislation applied on a national basis) provided a model for medical regulation. Only one

²² This Act has been reproduced in Appendix B rather than the Acts of 1838 and 1855 because in consolidating those, it very closely followed their content and format.

year after its passing, Dr Henry Douglass, a member of the Legislative Council (the Upper House of the NSW parliament), attempted to have a similar Medical Bill passed. This failed, as did further attempts during the 1860s (Lewis & MacLeod, 1988 p77) but in 1875 a more concerted campaign was launched which could on the surface, provide a good illustration of Weber's point that bureaucratisation arises from "the increasing need felt by a society grown accustomed to stable and absolute peace, for order and protection ('police') in all fields..." (Weber, 1978 [1922]). The strong and prolonged resistance of a significant sector of the population to medical regulation in NSW over the next 25 years demonstrates that demands for bureaucratisation are not necessarily always universal.

Still, in 1875 the medical profession attempted to show that the society of NSW, desirous of "order and protection" in the medical field, did indeed support the introduction of regulation and policing by means of the establishment of a bureaucratic apparatus. Thus in December of that year, 17 petitions requesting the introduction of a Medical Practitioners' Act were laid before the parliament. Containing 2,878 signatures from both urban and rural areas across the colony, these petitions were used to launch yet another attempt to have such an Act passed (New South Wales, 1876 pp135-157).

Yet while they were presumably willingly signed, whether the petitions represented any strong grass-roots popular feeling is questionable. Although they came from widely separated parts of the colony, their wording and content bore a close similarity (some were identical) and were obviously based on the same basic template. That indicates that in all likelihood their compilation had been orchestrated by the medical profession or probably more accurately, by the medical elite who will feature extensively in this

Chapter. The nature of the petitions can be appreciated by quoting from that received in March 1876 from "the inhabitants of Sydney" and which contained 1,360 signatures. It claimed that the petitioners

...have hitherto been deprived of legal protection from injury and maltreatment in sickness, in consequence of there not being any Statute to restrain the fraud and imposture which is now extensively carried on throughout New South Wales by a class of persons professing to be duly qualified practitioners in the art and science of medicine and surgery, but who are in reality impostors, possessing no recognized qualifications whatever.

That, in consequence of there being at present no such Act of Parliament in this Colony, we, your Petitioners, would respectfully pray a Medical Bill be brought before Parliament which would assimilate the laws with regard to the medical profession to those now in force in the United Kingdom (New South Wales, 1876 p281).

It was a classic statement of the demands for "order and protection" to which, as noted in Chapter One, Weber as well as present-day commentators (Colebatch & Larmour, 1993); (Albrow, 1996); (Petersen & Lupton, 1996) attribute the emergence of bureaucracy as the chief and indeed the only method of managing risk. In this regard, it is interesting that the 1875 petitions put forward much the same arguments in favour of regulation as those contained in the preamble to the Act which established the College of Surgeons in England in 1523. This is not surprising seeing, as argued in Chapter One (pp20-23) the basic reasons advanced for the regulation in any particular sphere do not vary, whatever the place or time.

On the one hand, there is the argument for regulation in terms of the public good. Thus in NSW in the 19th century, leaders of the medical profession always argued that they

themselves had no personal interests at stake in the regulation of medical practice. In introducing a medical bill into the Lower House in 1880, Dr Richard Bowker (who served in both the Lower and Upper Houses of parliament) claimed he had no other motive "than that of having the honor [sic] of doing good service to the people" (NSWPD 1:2 16/3/1880 p2158). In 1886 Dr Harmon Tarrant claimed he was acting "solely in the public interest", and in this he was supported by Dr John Creed, who said he "no purpose but to serve the good of the colony" (NSWPD 1:23 12/10/1886 p5596). Such claims were mostly, but not altogether disingenuous; state-licensure does undoubtedly provide "order and protection" in the medical field, as experience during the 20th century increasingly confirmed.

Their opponents however, saw Medicine's demands for regulation simply as crude attempts at economic closure, particularly because in the 19th century Medicine could offer little evidence, let alone any guarantees, that its practices were superior to those of competing lifeworld medical epistemologies. Pensabene (1980 p16) points out that for

... all the major diseases confronting late nineteenth century society - consumption, diphtheria, typhoid, measles, pneumonia and heart disease - the registered doctor had no established cures, nor did he fully understand the causes of these diseases (p16).

Thus it was much more difficult to argue that allopathic medicine did indeed embody the public good as far as health care was concerned. Suspicions that economic closure was the real, underlying motive of allopathic practitioners were sharpened by their attacks on lifeworld medicine such as those in the petitions cited above, which were typical of the way Medicine argued its case in favour of regulation.

Between 1876 and 1900, there were no fewer than 13 separate attempts to have Medical Practitioners' bills passed through the NSW parliament, but all failed because, with two exceptions (those of 1886 and 1894-5) they were rejected by the Legislative Assembly, or the Lower House of the parliament.²³ The significance of that is to be understood in terms of the composition of the legislature. When it was established in 1856 after the granting of responsible government, the NSW parliament was constituted as a bi-cameral legislature in which the function of the Upper House (the Legislative Council), although not its composition, was modeled on that of the House of Lords in Britain. The Upper House consisted of members nominated by the Governor, who were mostly drawn from the elite sectors of the society. The purpose of this nominated chamber was to interpose "a safe, revising, deliberative and conservative element between the Lower House and Her Majesty's representatives" (New South Wales, 1853 p119). In other words, the Upper House was established as a "House of Review". Parker asserts that "the nominee Council was conservative in practice, and generally in political complexion and action" (1978 p197).

The Lower House (the House of Assembly) in contrast was an elected body and therefore far more populist in its composition. While in its earlier years, the members of this House were mostly drawn from the *petit bourgeoisie* (Davis, 1983 Ch.4, p.7), after 1889 the payment of members made it possible for more working class representatives to enter the parliament.²⁴ It is significant in this regard, that the great majority of attempts to pass a

²³ A full list of these Bills and the reasons for their failure, appears in Appendix A.

²⁴ According to Davis (1983): "The largest occupational groups represented from 1856 to 1900 were Pastoralists (between 42% and 10%), Traders, Shopkeepers, and Professions and, only from 1891 onwards,

Medical Practitioners' Act were not only launched in the Upper House, but were also invariably passed through all their stages in that House.

The free play of expression of the views and in voting patterns was made possible by the political situation in the NSW parliament in the 19th century, which was very different to that of 20th. Although there were two loose oppositional forces based on free-trade and protectionism (Parker, 1978 p.40), there were no political parties as such until the emergence of the Australian Labor Party (ALP). Formed in 1891, the ALP (which became the official opposition in 1904 and the government for the first time 1910 (Parker, 1978, p.53)), was responsible for introducing party discipline into the NSW parliament.²⁵ The lack of party discipline before 1900 meant that individual members were free to vote according to their conscience and opinions. The consequent inability of 19th century executives to command automatic majorities greatly weakened their position, and ensured that fully two thirds of all legislation presented to the parliament was rejected (Lloyd, 1993 p.197) Thus the Lower House rejection of the Medical Practitioners' Bills would not have been seen as anything unusual at the time, although in resisting the onset of regulation and bureaucratisation in medicine, it was the Lower House which showed itself to be “conservative in practice and ... in political complexion and action”.

Artisans. Between 1856 and 1900 the middle class groups had the largest representation, as the Pastoralists were on the decline both in influence and numbers”(Ch 3, p7).

²⁵ The system of party discipline had been in existence long before this in the British parliament. As far back as 1867 the famed constitutional lawyer, Walter Bagehot, had observed that without party discipline in the House of Commons “there would be 657 amendments to every motion [there being 657 MPs at the time] and none of them will be carried, nor the motion either” (Bagehot, 1964, [1867] p158).

Socio-economic status and medical epistemology

The long resistance to medical regulation by the Lower House affords the firmest pointer to

what has been argued as the class basis for the clash between allopathic and lifeworld medicine in NSW. As noted in previous Chapters, while the higher socio-economic groups

in NSW tended to favour allopathic medicine, the opposition to medical regulation by middle-class representatives in the parliament indicated that its support was nothing like as strong among this group, and was probably even smaller among the lower socio-economic groups. That the medical epistemological divide ran along class lines was often unconsciously conceded by members of the Upper House, who were much given to lamenting about the way the poor were preyed upon by lifeworld practitioners. For example, in introducing the second reading of the Medical Practitioners' Amendment Bill in 1900, Mr T.M. Slattery declared that

[T]hese men have been allowed to practise on the poor classes of the community. Of course they do not get their fees from the educated or rich classes, but from the poorer classes.... these men have cruelly and heartlessly taken away - and no doubt continue to take away - hardly earned money from a large number of the poorer classes, not only destroying their health, but also robbing them of their money (NSWPD 1:106 4/11/1900 p3533).

It might have been pointed out that given the meagre curative record of allopathic practitioners at the time, the same might have been said of them, and since their services were more expensive than those of lifeworld practitioners, it is not surprising they were not well patronised by the poor.

But if the stalemate between the two parliamentary Houses which developed over the Medical Practice Bills was a reflection of the divide between higher and lower socio-economic groups in NSW, it was by no means a neat and definite one. That is reflected in the fact that the support for or opposition to the Medical Acts was never total in either House. There were always a minority who disagreed with the majority in their particular

House. Thus there were some members of the Upper House (for example Thomas Holt who had been Colonial Treasurer in 1856 and was appointed as a life member in 1868) who consistently expressed strong and sometimes vehement support for the anti-regulatory stands of lifeworld medicine. Similarly in the Lower House some such as John Norton, who was also editor of the sensationalist *Truth* newspaper, strongly favoured Medicine's call for regulation. Another was R.A. Price, who played a leading role in securing the passage of medical regulatory legislation in 1900.

Reasons for resistance to medical regulation

One of the chief reasons for the resistance of the majority in the Lower House to successive Medical Practitioners' Bills was that they were seen as attempts to implement "class legislation" (or in Weber's terms, social closure). More specifically, in the words of Mr Francis Abigail (West Sydney), the parliament was being asked to pass a measure "giving the greatest possible protection to the medical profession" (NSWPD 1:20 4/6/1886 p2433). In May 1880, Mr John Lucas (Canterbury), told the House that he had "a great objection to class legislation of any description, and he looked upon the Bill as the worst form of class legislation he had ever seen introduced into the House. ... The Bill was a monstrous attempt to protect a few individuals, and the most amusing feature in connection with it was that it was advocated by gentlemen who professed to be free traders" (NSWPD 1:3 14/5/1880 p2327).

Widespread bribery of members of the Lower House has been also been advanced a reason for its resistance to the Medical Practitioners' Bills (Lloyd, 1993 pp263-4); (Lewis & MacLeod, 1988 p78) This allegation was based on a speech made in the parliament in

1895 by a former Premier Sir George Dibbs, in which he stated that a lifeworld practitioner, who he refused to name, had not only offered him a bribe to prevent the passage of a Medical Act but boasted that his bribery of other parliamentarians had achieved that purpose on several previous occasions (NSWPD 1:76 21/3/1895 pp4700-01). This was a serious charge, and as members indignantly pointed out, it impugned the integrity of everyone who voted against the Bill. They challenged Dibbs to call the practitioner to the Bar of the House to answer the allegations. Dibbs never did so. That however, did not prevent his story from being repeated by John Norton, who as mentioned above, was also was also the owner of the *Truth* newspaper. His speeches in the Parliament tended to reflect its sensationalist content. He named the practitioner in question as E.H. Botterell, who he said, had done so well out of his "quackery" that he had "added house to house and field to field, drove about with a gorgeous equipage, had a beautiful suburban villa and a house on the mountains, station property in the country" (NSWPD 1:105 18/9/1900 p2987). These charges were repeated by Dr Creed both in the Parliament (NSWPD 1:105 4/10/1900 p3538) and in the *Australasian Medical Gazette*, although there, not being protected by parliamentary privilege, he was careful not to mention Botterell's name, referring only to "a well-known man". Nor did he make an outright accusation of bribery, stating:

Of course, I do not venture to connect the expenditure of the money with the failure of the numerous other Medical Bills which passed the Council but failed in another place to become law, but still it is a subject which readers ... may like to consider in their leisure moments (March 20, 1900, pp113-14).

That hardly indicates that Creed was sure enough of his facts to challenge Botterell to sue him. In the light of the failure of Dibbs or anyone else to instigate action against Botterell

for what after all was a blatant attempt to induce impermissible parliamentary behaviour, the charge of bribery must remain, in the Scottish legal term, "not proven". Whatever bribery may have occurred, it failed to prevent Medical Practitioners' Acts being passed by the Lower House in 1886 and 1894-95 as well as in 1900.

Lifeworld medicine in NSW

Moreover, it can be argued that no bribery was necessary because the majority of the members of the Lower House had no doubts about the rightness of the cause of lifeworld medicine over against allopathic medicine. The views of those in the lifeworld medicine camp were very often held and stated with great passion. The wide support for lifeworld medicine was lamented in an editorial in the *Australian Medical Journal*, of March 1873 which stated:

It should not be forgotten ... that the sympathy both of the average public and more discreditable still, of the authorities, is on the side of quackery. ... there is a well-understood feeling in the public mind - and it extends to all classes - that medical knowledge, like poetry, is born with the professor, and that quacks are natural geniuses, whom to foster is a duty, and to prosecute is base vindictiveness (p89).

Lloyd (1993 p263) notes that "Some of the more prominent quacks and irregular healers enjoyed a level of patronage and popularity of which many of their qualified counterparts would have been envious." Willis (1989 p58) points to the fierceness of the struggle between lifeworld and allopathic medicine when he states: "The homeopaths saw themselves as pioneers, as founders of a new paradigm of medicine..." and that "[t]hrough the 1870s and 1880s the controversy between homeopathy and allopathy raged in newspapers and journals".

In Victoria, lifeworld practitioners (who included "Chinese and and Indian medical men, magnetists, clairvoyants, homeopaths [sic] herbalists, galvanists, botanists, hydropathists and psychopathists") comprised only 4.5% of the medical workforce. None the less in urban areas where the bulk practised, "their numbers equalled one-third of the number of urban registered practitioners", which represented "a major competitive threat" (Pensabene, 1980 p16). The situation in NSW seems to have been rather different. In 1886 there were 1,275 legally qualified practitioners in the colony (Hilder, 1959 p.34) compared to the figure of 183 "unqualified men" practising in NSW cited in the Upper House in the same year by Creed, who served as president of the BMA and editor of the *Australasian Medical Gazette*. Of these, 83 (45%) were located in Sydney and its suburbs (NSWPD 1:23 12/10/1886 pp5597). While this may hardly have seemed to pose a threat to allopathic practitioners, Creed thought the number in NSW scandalous because in the whole of the other five colonies there were only 74 unqualified practitioners.

The fervour with which he and other proponents of allopathy attacked the 183 "unqualified men" indicated that they were indeed seen to constitute a major threat. That may have been because even if they represented only a small proportion of total medical practice, the "unqualified men" attracted a devoted following and exercised an influence that was much greater than their numbers might have suggested. While medical doctors constituted by far the great majority of practitioners in the colony, this was not the case as far as their clientele were concerned. This is suggested by comparing the 2,878 signatures on the 1875 petitions cited above with an 1879 petition containing over 2,000 signatures of "landed proprietors in Sydney and suburbs, and in Bathurst, Maitland, Morpeth and

other parts of the colony" who opposed the passing of a Medical Bill (NSWPD 1:1 15/3/1879).

The strength of homeopathy and another treatment, hydrotherapy, were evident in debates even in the Upper House in 1876. Here Thomas Holt charged that the Medical Practitioners Bill of that year would not only disadvantage homeopaths and the practitioners of hydrotherapy, but that favouring allopathy would "tend to put a stop to all improvements in the healing art, and to foster monopoly". He also expressed the over-optimistic opinion that "The allopathic practitioners were, in fact, gradually changing their views and coming around to the principles of homeopathy and hydrotherapy" (*Sydney Morning Herald*, 24/2/1876).

The passion of supporters of lifeworld medicine is also evident from what was said by the member for Northumberland, Mr Ninian Melville, in the 1880 debate in the Lower House on the Medical Practitioners' Bill of that year:

The object of the Bill was stated to be to save suffering humanity from those whom a certain portion of the community were pleased to call quacks. The term 'quack' could only be legitimately applied to a person who pretended to be able to do a certain thing and proved by his action that he was incapable of performing it, and he maintained that if legally qualified men had failed to do what they professed to be able to do they were in every sense quacks as much as persons who were certified to be legally qualified. It was unfortunate that only in a very few cases could the specific result of certain treatment be discovered. If we looked at the prescriptions of the legally qualified men, we should find that they comprised a variety of drugs of such a nature that if the patients for whom they were prescribed knew what they were expected to take they would die from sheer fright (NSWPD 1:3 14/5/1880 p2325).

Melville also sang the praises of hydrotherapy. It was, he said, "specially applicable to certain diseases, and that hydropathic treatment left behind it none of the bad effects which frequently resulted from the doses of the allopathist" (NSWPD 1:3 14/5/1880 p2325).

While recounting the struggle between allopathic and lifeworld medicine, the more serious studies of medical professionalisation i.e. those of Pensabene, (1980) Lewis & McCleod (1989) and Lloyd (1993), pay no more attention to lifeworld medicine after the passing of the 1900 Acts, as if those endorsements of allopathy by the State brought the struggle to a close. This was by no means the case as far as NSW was concerned; as will be made clear shortly, the Lower House only agreed to pass the 1900 legislation on the express understanding that it would not affect the position of lifeworld practitioners. They continued to flourish until well into the 20th century and, it could be argued, were in a more flourishing condition than ever at the end of the century, in the form of the alternative health movement (Siapush, 1999p.265) Indeed, early in the 21st century the AMA, successor to the BMA, officially made its peace with the lifeworld movement, as is related in more detail below.

Nothing illustrates the longevity and continuing strength of lifeworld medicine more than the reaction of its supporters to the introduction of the Medical Practitioners' Act of 1938, the first comprehensive measure of its kind to be passed in NSW. In contrast to the 1900 Acts and the consolidated Medical Practitioners' Acts of 1912 and of 1915, the 1938 Act represented the kind of major legislation which supporters of allopathic medicine had tried and consistently failed to have introduced in the last half of the 19th century. It was

three years in the making and its seven sections and 53 clauses covered a wide range of issues pertaining to the regulation of medicine. Its aims, said the Minister for Health at the time, Mr Herbert FitzSimons, could be summed up as the control of the medical profession, control of "lay practitioners" and control of the manufacturers of patent medicine (NSWPD 2:105 4/8/1938 p823). The "lay practitioners" (i.e. those who did not have university degrees) to whom he referred, were the practitioners of lifeworld medicine and this was the first time that a NSW government had attempted to act against them. However the "control" did not involve their freedom to practice, but simply prohibited them from advertising. This would have put them on the same level as doctors who had always been prohibited from advertising by their professional ethics and who from 1938 in NSW, were also bound in that respect by Section 27 (2)(b) of the Act of that year, which gave the MRB power to control advertising.

Both before and during its passage through the parliament, the 1938 Bill generated enormous controversy. Not only was the mechanism for controlling medicine queried (this will be discussed in more depth in the next Chapter) but even more so was the prohibition of advertising by lifeworld practitioners. The attacks on that move, both in newspapers and in the parliament, were no less fierce and well-supported than were the attacks on allopathic medicine in the last three decades of the 19th century. The strength of the feeling of opponents of the Bill is evident in the way they opposed its introduction into the parliament (NSWPD 2:105 14/7/1938 pp407-415) and not surprisingly that opposition was fiercely re-iterated during the Bill's second reading. In this respect, NSW seems to have differed sharply from Victoria where, in quoting remarks favourable to

allopathic medicine made in its parliament in the 1930s, Pensabene states: "Gone was the old hostility shown to the medical practitioner in the previous century" (1980 p48).

In NSW, very little other than the "old hostility" was in evidence in the Lower House in 1938. During the first reading debate Mr Christopher Kelly (Labor, Bathurst), told the House that ever since the Bill had been mooted, he had

received quite a sheaf of letters from people who ... generally point out the value of the lay practitioner and what wonderful, and in some cases, miraculous cures have been performed. One gentleman wrote to me the other day and said he had no faith in doctors at all. It may be an open question as to whether they are any better than the lay practitioner (NSWPD 2:105 14/7/1938 p408).

To illustrate that, his correspondent recounted an anecdote in which he told of how his wife, he himself and the doctor on a ship on which they were travelling, had all contracted influenza. The captain gave the writer a bottle of rum as a remedy and having drunk the rum,

I sent for the doctor for my wife. The doctor prescribed a certain medicine, the prescription being written in Latin. Then the doctor told me he himself had influenza. I asked him what he was taking himself and he said he was just drinking water and plenty of it. I drank the rum, my wife took the doctor's medicine and the doctor drank water and we all got better around the same time.

More serious evidence of continuing scepticism about the claims of allopathic medicine is evident in a statement by Mr James Heffron, (Labor, Botany), who told the House that the medical profession had always been extremely conservative and that its members had consistently resisted the discoveries of laymen. This theme of the conservatism of Medicine over against the "cutting edge" innovatory nature of lifeworld medicine was

taken up again and again by speakers in both the first and second reading debates on the bill. In the words of Mr James Arkins, (United Australia Party, Dulwich Hill), "As one delves into the history of medicine, one finds that generally the discoveries have been made by the unorthodox medical man" (NSWPD 2:105 14/7/1938 p414). The names of Jenner, Lister, Pasteur and Simpson (the inventor of chloroform) were all mentioned as being among those whose discoveries had been initially rejected and scorned by the medical profession.

It was not only Medicine in general but the NSW branch of the British Medical Association (BMA) which was a particular target of attack since it was seen to be the *eminence grise* behind the Bill. Mr Arthur Tonge (Labor, Canterbury) charged that "this was not a doctor's bill, it was a BMA bill" (NSWPD 2:105 17/8/1938 p411). In debates in the Upper House, the BMA was described as "the greatest union that Australia possesses" by one speaker (NSWPD 2:106 30/11/1938 p3061). So fierce were the accusations against the BMA for being behind the Bill that it felt constrained to deny them in an editorial in the *Medical Journal of Australia* (7/7/1938, p170), which the Minister also felt constrained to quote in parliament to support his assertion that "any suggestion ... that this bill is the product of the British Medical Association is without foundation, and untrue" (NSWPD 2:105 4/8/1938 P823).

Had the situation in the Lower House been the same as it was in the later 19th century, no doubt this Bill would have been blocked by its opponents by means of filibusters or by ensuring that there was no quorum present or simply ignoring it and letting it lapse. By

1938 however, government executives had acquired an invincible weapon for controlling the legislature, namely party discipline (the operation and effect of which is discussed in Chapter One (see p 35). This device had been in use in the British House of Commons long before it was introduced into the parliament of NSW after 1900 by the Labor Party, the lead of which was soon followed after by their conservative opponents. Party discipline also provided governments with an effective weapon for cutting debates short. Called “the guillotine”, it could be used at any time by a member of the government proposing “that the question now be put” and invoking the disciplined majority to ensure that it was agreed to.

One of the most telling illustrations of the effect of the imposition of discipline is the fact that Mr James Arkins, the member for Canterbury referred to above, who was one of the most bitter critics of the Bill, none the less consistently voted for it in the divisions. The reason for that seems to have been that having been elected as a Labor representative in 1915, he had defected to the National Party twelve years later and in 1938 he was listed as a representative of the conservative United Australia Party, which was part of the ruling Coalition (NSW, 1998, p74). No doubt he needed its support to hold his seat in the next election and probably was given the freedom to express his opposition to the legislation as long as he voted for it.

Thus, even though there was practically no support for either the Bill or the medical profession among speakers during the debates in the Lower House, where it was criticised even by members of the ruling Coalition government, the guillotine was applied and it was passed on party lines in August 1938 (NSWPD 2:105 18/8/1938 p1166).

However, in line with the situation of the 19th century when the earlier Medical Practitioners' bills were invariably passed by the Upper House, the Bill had a much smoother passage through that Chamber, finding plentiful support from the floor. Here the second reading debate was completed in one day without a division (NSWPD 2:106 30/11/1938 p3076).²⁶

The Bill was assented to in December 1938, but perhaps in reaction to what was said in Lower House debates, the *Medical Journal of Australia* published an editorial in the same month which expressed concern about the "Public Esteem of the Medical Profession". It attempted to answer the question : "... how are we to account for the fact, which is becoming more and more evident, that whilst the individual medical practitioner is usually esteemed and respected, the profession collectively is regarded with suspicion and distrust?" by stating:

The most outstanding cause of public antagonism is the collective organization of the profession. ... Organization of medical men is essential for their own and the public's welfare; but such organization is seriously resented because of suspicion that public interests are thereby subordinated to professional advantage" (3/12/1938, p954).

That scenario would certainly have applied in the second half of the 19th century. In that era it was not only the weak and embryonic organisational embodiments of scientific/allopathic medicine but, as is evident in Melville's 1880 speech quoted above, its epistemology also

²⁶ This means that the measure was approved "on the voices" without a vote. Only when one party or another other feels strongly enough will it demand that a vote be recorded on the basis of a time-consuming "division" in which members leave their seats to record their votes.

evoked "suspicion and distrust". During the debates on the 1938 legislation in the Lower House, the accusations of conservative obscurantism made by the supporters of lifeworld medicine against the practitioners of allopathic/scientific medicine, indicates the persistence and power of this strain of thinking.

The defeat of the adherents of lifeworld medicine in the NSW parliament 1938 was a precursor to the eclipse of these epistemologies in the State. The ban on advertising by lifeworld practitioners imposed by the 1938 Act was certainly one reason for this outcome, but another was very probably the outbreak of the Second World War less than a year after the passing of the Act. The solid and real progress made by allopathic medicine in the first four decades of the 20th century, particularly in surgery (Pensabene, 1980, pp39-47), could be immediately and highly visibly transferred to battlefields, where conditions hardly suited the application of lifeworld therapies like homeopathy, hydrotherapy and herbalism. Moreover, the exploitation of the antibiotic discoveries of Alexander Fleming by the Australian-born Howard Florey in the 1930s, produced seemingly miraculous cures²⁷ especially among troops serving in the Pacific theatre during the Second World War. Rapidly transposed into routine medical treatments, they helped to raise the reputation of allopathic medicine and its practitioners to unprecedented heights.

²⁷ As is testified by one of the people interviewed during the course of writing this thesis, Dr Fran Hausfeld. She recounts how as a schoolgirl in the early 1940s, she was one of the first beneficiaries of an antibiotic known simply as "M&B" which was used to treat her after she contracted pneumonia. Without it she states, she would have been dead in a week. Instead, after taking the medication, she was back at school a week after being diagnosed with the previously invariably fatal condition.

And yet it should be remembered that only 15 years separated the end of the Second World War from the 1960s, during which era non-scientific epistemologies staged a resurgence in the form of "alternative medicine" or "complementary medicine" as it later became known. While not as visible as it was before the 1938 ban on advertising, that lifeworld medicine continued in vigorous existence during the 1940s and 1950s is evident from the fact that as late as 1956 a Labor government felt constrained to introduce a Bill to control lifeworld medicine. The Minister for Health, Mr Bill Sheahan, explained that this was because the activities of unqualified medical practitioners were receiving widespread newspaper publicity. In introducing the Bill he stated:

Strangely enough, whenever the activities of these so-called "quacks" have been exposed and demands made that their activities be restricted or banned, the Health Department has received numerous protests that they should not be interfered with. It is felt that a complete prohibition of the activities of numerous unregistered persons who claim to be able to treat diseases would be difficult to enforce and would result probably in the adoption of various subterfuges to defeat it (NSWPD 3:20 12/7/1956 p922).

The Bill he was introducing therefore targeted only those unregistered practitioners who claimed to be able to treat "prescribed" deadly diseases such as cancer and poliomyelitis. In restricting official action against lifeworld practitioners in this way, both the executive government and the corporate rationalisers were admitting defeat in such attempts as they had made to eliminate lifeworld medicine. Those attempts would be abandoned altogether after the rise of "alternative medicine" from the 1960s onwards and even the professional monopolisers were in time to accept not only its existence, but also its validity. Thus the AMA created headlines in March 2002 when it issued a statement which, while it called for greater regulation and testing of non-scientific-based

"complementary" therapies, none the less recognised "that evidence based aspects of Complementary Medicine are part of the repertoire of patient care and may have a role in mainstream medical practice" (Australian Medical Association, 2002).

The epistemological struggles over medicine will receive little further attention since after 1970 the challenges to allopathic/scientific medicine and its organisational embodiments which form the subject matter of this study, came not from lifeworld medicine but from Alford's third structural interest, the consumer interest represented by "equal health advocates", who emerged in the 1970s. None the less, even though driven underground for over two decades after 1938, the existence of lifeworld medicine had created a continuing sub-textual critique of scientific medicine which provided a seedbed for the work of the equal health advocates, even though they were not as critical of the scientific medical epistemology. All of this points to the fact that lifeworld medicine deserves serious attention in any account of developments in health care over the last two centuries. It is certainly the case that the strength of the lifeworld medicine movement over the century between the passing of the 1838 and the 1938 Acts, was to have a crucially important effect in shaping the way medical regulation was introduced and operated in NSW. That in turn also had major effects on the functioning of medical autonomy in NSW for most of the 20th century.

CHAPTER FIVE

THE EFFECT OF THE LEIFEWORLD/ALLOPATHIC MEDICINE CONTEST ON MEDICAL AUTONOMY IN NSW

While the BMA was accused of being the force behind the 1938 Act, there can be no doubt that the government executive of the day was the major player in driving that Act through the parliament. Here again, the situation stood in sharp contrast to most of the 19th century, when not only the NSW parliament but also governments were extremely reluctant to support medical regulation. As reported by Lewis & MacLeod (1988), when deputations of doctors saw the Premier, Sir Henry Parkes, and requested him to advocate the introduction of a Medical Practitioners' Act, he told them "that the Government would not support sectional interests, however, learned and respectable" (p77). The sharply changed governmental attitudes towards medical regulation in the later 19th century were due to a number of factors, including the political failure of the parliamentary representatives of the professional monopolists, the emergence and rise of the NSW health bureaucracy and most of all to what I have described as the "bureaucratic imperative", the call of which was being heard and heeded in NSW to an extent which surpassed that of most other jurisdictions in industrialised countries.

The political failure of the medical elite

For the best part of four decades after the coming of responsible government to NSW in 1856, the professional monopolists or more accurately, an elite coterie of doctors, were the driving force behind attempts to introduce medical regulation into NSW.

H.G.Douglass, who as noted earlier made the first attempt in the Upper House in 1859, was a doctor by profession and as we have seen, it is very likely that doctors orchestrated the petitions of 1875, even though the initiator of the Medical Practitioners' Bill of that year was a lawyer, Sir Alfred Stephen (who later became the Lieutenant Governor of colony). Later Bills were invariably introduced by doctors, these including Dr Richard Bowker (both when he was an elected member of the Lower and House and later, as a nominated member of the Upper House), Dr Harmon Tarrant, Dr Sir Henry McLaurin, Dr John Creed and Dr Sir Arthur Renwick.

The names of two of these, McLaurin and Creed are listed by Davis (1983 Ch 4, p7)²⁸ as being among the "medical elite", as is Sir Arthur Renwick, who combined his duties as an elected member of the Lower House and later as a nominated member of the Upper House, with those of Chancellor of the University of Sydney and as president of the MRB. This elite, according to Davis, were set apart from the general run of medical practitioners, their status being reflected by their appointments to the MRB, as honoraries to major hospitals, to advisory positions to government, and through their connections to the University of Sydney, either as members or the Faculty of Medicine or as examiners. Davis also notes that "a high proportion of them were ... active in Professional [sic] politics and a surprisingly large number active in State politics either as elected or nominated members of State legislatures" (Ch.4. p4).

²⁸ Each of the Chapters in Davis's work has separate page numbers.

The political as well as the professional activities of these figures would have been boosted by the formation of the local branch of the British Medical Association (BMA) in 1880, with Renwick as its first chairman. As Weber so accurately observed, interest groups will show "a growing tendency to set up some kind of association with rational regulations" (1978 [1921], p342). This had been true of Medicine in NSW although earlier attempts to found a medical association had failed; these included the Australian Medical Association (founded 1858) and the Medical Practitioners' Association, founded in 1872. These however, were racked by disputes among the members and were poorly organised and financed (Davis,1983, Ch 3, pp 27-32; Lloyd pp238-240) and had respectively gone out of existence in 1868 and 1877. The BMA flourished because, says Davis, it had success in struggles such as those with the Friendly Societies, which the previous medical associations had never been able to achieve (1983, pp32-3). On the other hand those struggles tended to absorb all its energies and it took little part in efforts to secure the passing of a Medical Practitioners' Act. The minutes of its Council meetings make no reference to this issue at all before 1900 while what became its official mouthpiece after 1894, the monthly *Australasian Medical Gazette (AMG)*, carried only two editorials on the subject over the next six years. The main justification for introducing medical regulation advanced in the first of these, entitled "Wanted - a Medical Act", was the need to suppress

the unqualified men or women calling themselves doctors - and appropriating to themselves bogus titles - who are allowed to ... flaunt their filthy advertisements in the press, and imperil the safety of the community by suggesting easy escapes from the results of immoral practices (Vol. 14, Nov 20 1895, p262).

The second editorial was devoted mainly to praising the introduction of the West Australian Medical Act in 1896, comparing that favourably to "the mother colony" which had not been able "to frame any adequate law for the protection of the public from untrained medical practitioners" (Vol. 15, April 20, 1896, pp151-52).

While the members of the medical elite were also all members of the BMA²⁹ apart from Renwick and Creed who served single-year presidencies³⁰, the names of the elite do not figure among those of the office bearers of the Association. Despite the BMA's lack of active participation in the struggle to secure medical regulation, its editorials and constant attacks on lifeworld practitioners demonstrated, the *AMG* and therefore the BMA were fully behind the efforts of the medical elite. But on that score the record of the professional monopolisers for 20 years after the foundation of the BMA was one of failure since they were never able to "establish a legal order that limits competition through formal monopolies" in the words of Weber (1978 [1921] p342). As the survival and resurgence of lifeworld medicine indicates, the proponents of scientific/allopathic medicine, despite all their advantages starting with those conferred by the state in 1838 and later scientific advances which allowed them to dominate medical discourse later in the 20th century, were only very partially successful in establishing the monopolistic legal order referred to by Weber.

²⁹ As appears in its membership list published in *The Australian Medical Gazette* of March 20, 1897 (pp105-58).

³⁰ Renwick in 1880 and Creed in 1887 and 1892 (*Medical Journal of Australia*, December 6, 1930, p773).

This was not from want of trying and on this score it is again useful to refer to what Weber wrote about "Open and Closed Economic Relationships," particularly because, as noted in Chapter One, he was writing and analysing developments in Europe and America at around the same time which paralleled those in NSW. He noted that when in any field, "the numbers of competitors increases in relation to the profit span, the participants become interested in curbing competition." As a result, "[u]sually one group of competitors takes some externally identifiable characteristic of another group of (actual or potential) competitors ... as a pretext for attempting their exclusion. It does not matter which characteristic is chosen in the individual case; whatever suggests itself most easily is seized upon" (Weber, 1978 [1922] pp341-2). As far as the number of competitors in the medical field was concerned, Davis (Davis, 1983 Ch 3 p27) shows that while in absolute terms, the number of doctors in NSW may have seemed small in the second half of the 19th century, in terms of their ratio to the total population, there were actually more doctors in NSW per head of population than there were in England. That "crowding in the market place" would very likely have led to their being interested in the curbing of competition.

Another factor here which is present in Weber's analysis was the existence of a group of competitors with "some externally identifiable characteristic" against whom an interest group would want to move. As might be evident from the petition quoted above, lifeworld practitioners constituted exactly this kind of group by virtue of their lack of formal university training as well as their non-scientific and almost mystical approach to healing. There were some among the medical elite who saw one of the chief purposes of a Medical Practitioners' Act as being to effect the kind of exclusion of lifeworld

practitioners from the market as delineated by Weber. In the colloquial terms of the day, they constantly called on government to "put down quackery". One of the chief spokesmen for that view was Dr Richard Bowker, who in his speeches was much given to quoting instances of people being killed by "quacks" which proved he said, how urgently they needed to be prevented from practising.

Another proponent of this view was Creed, who as noted above, was also editor of what was later to become the BMA's national journal, *The Australasian Medical Gazette*, in which, as Lloyd (1993, p251) points out, "quackery was one of the more frequently occurring issues (together with antipathy towards homeopathy)". In 1887 Creed convened and chaired a Select Committee appointed by the Upper House "to inquire into the state and operation of the laws existing for the regulation of the practice of Medicine and Surgery in New South Wales". That title however, only very partially described the aims of this Select Committee, which were quite transparent and could be simply described as "an exposure of quackery". Besides taking evidence from witnesses such as McLaurin, then Chancellor of the University of Sydney, about the uncontrolled state of even allopathic medical practice referred to above, the Select Committee also subpoenaed a good number of lifeworld practitioners, requiring them to give evidence about their epistemologies and administration of their therapies. This was probably designed as a shock tactic because it exposed some outlandish practices and practitioners, apparently in the hope that this would jolt the government executive into action.

Among those called was the notorious E.H. Botterell, who proved to be a master of obfuscation. It turned out that his assumption of the title of "doctor" rested on his having

received a diploma from "Edinburgh University" in Chicago, USA. This was one of the numerous "diploma mills" which created great difficulties in the attempts of American States to introduce medical regulation. Botterell however professed to support a Medical Practitioners' Bill because "within the last five years Sydney has been inundated with a class of men with no qualifications at all" (NSW 1887(a), pp39-43). Given his own lack of real qualifications, that statement constituted little more than one example of his effrontery, although it also demonstrated that when it came to eliminating economic competition, he was as pro-regulation as any member of the medical elite. Among others examined was a herbalist, Mr Michael Green, whose medical epistemology may be judged by the following exchange with the Creed, president of the committee:

Q. When did you study medicine?

A. About twenty-five years ago..

Q. Under whom?

A. My own; as it came into my head.

Q. You never had any teachers?

A. No; only the AlmightyThe Bible I study is my guide to botany, and Almighty God is my physician, my teacher, and my guide in every shape and form (NSW 1887(a), p63).

Some evidence of a homeopathic practitioner, William Moore, was considered so obscene that it was deleted from the record of the committee (NSW 1887(a), p52). However, in 1886 Creed had referred extensively to Moore in a speech to the Upper House. After noting that there were no ladies present (he seems to have ignored the fact that "ladies" could and did read NSWPD), Creed quoted from a pamphlet published by Moore in which he claimed he could provide a means by which men could protect themselves from being "copper-blown" by a woman who, during sexual intercourse, held a deep breath "while the semen is passing from the male; wind from the female has been

known in many instance to pass under these circumstances, into the male, and to inflate him like a bladder."

For the supporters of lifeworld medicine as well as for government politicians, the hilarity and shock effect of such anecdotes was probably counteracted by Creed's statement that while Moore had a large practice, "I think I must have convinced hon. members that he is so grossly ignorant that he should not be allowed to practice at all" (NSWPD 1:23 12/10/1886 p5956). But that, his opponents in the lifeworld camp might have reasoned, would be a classic case of spoiling the ship for a ha'porth of tar. The banning of even one outrageous "quack" could set a precedent for the banning of all lifeworld practitioners.

Fears on that score would have been strengthened for supporters of homeopathy by Creed's equally vigorous attacks on their beliefs and practice earlier in his speech and also because homeopaths figured prominently among the "quacks" summoned by his Select Committee in the following year. Although in its report the committee stated: "We are not prepared to recommend that any person should be prohibited from practising medicine..." (NSW(b), 1887, p6) and Creed himself repeated this in the parliament, there appears to have been some ambivalence in his position. While himself giving evidence to the Select Committee, he was asked: "Do you think that disease would be more under control if there were no unauthorised practitioners who did not understand their business," he simply replied "Yes" (NSW, 1887(a), p78). And while his committee may not have called for the banning of lifeworld practice, it did recommend that all lifeworld practitioners be legislatively forced to add the words "Unregistered by the MRB." to their

advertisements³¹ and also to display them on plates "in some conspicuous place open to public view" (NSW, 1887(b), p7). Such public branding of themselves as unqualified, even if it was true, was unlikely to be welcomed by lifeworld practitioners and their supporters.

The fevered attempts by the proponents of allopathic medicine to impose controls on lifeworld medicine were probably counter-productive and actually delayed the introduction of full medical regulation. As Weber asserted, when action against an identifiable group is taken by another group seeking to defend and extend its own interests, this could "provoke a corresponding reaction on the part of those against whom [the action] is directed" (1978 [1922] p342). The reaction of the lifeworld camp probably explains why Creed's committee failed to make any impression on government. The *Australasian Medical Gazette* lamented in an editorial of February 1898 that while the Select Committee had exposed "the danger to the public and the urgent necessity for legislation", it was "almost impossible to realize that no action was taken, the then Premier, Sir Henry Parkes, quietly ignoring it" (21/2/1898, p80). That was just one example of the way in which the medical elite proved incapable of bringing successive governments in NSW "on side" in the three decades between 1860 and 1890. The continuing hostility of these representatives of Medicine to lifeworld medicine and the insistence by some among them on the need for governments to "put down quackery", in

³¹ Unlike medical practitioners, there was no code of ethics among lifeworld practitioners forbidding the use of advertising in printed media, a situation which continued, as has been outlined earlier, until the passing of the 1938 Medical Practitioners' Act.

all likelihood merely succeeded in increasing the intransigence of the Lower House on the score of medical regulation.

The rise of the corporate rationalists

However, during the 1890s it became clear that that intransigence suited the government executive interest group less and less and eventually between 1898 and 1900 the objections of the Lower House to medical regulation were overcome. While as noted above, the lack of party discipline in the NSW parliament in the 19th century meant that the government executive structural interest was weak, the corporate rationalist group in the early phases of responsible government, was also weak to non-existent. In 1856 the *Journal of the Legislative Council* carried only two reports relating to health issues, these being those of the Medical Adviser to government which was exclusively concerned with vaccination activities and that of the Health Officer who likewise was exclusively concerned with quarantine issues (pp249-50;663-4). These two officials, along with some clerical and field staff, comprised the entire health bureaucracy at that stage.

That situation changed rapidly, both to cope with and to cater for a population which more than quadrupled from 357,978 in 1861 to 1,364,590 in 1900 (New South Wales, 1902). As Davis notes: "The second half of the century was marked by increasing State interest and support for medical activity both private and public, curative and preventative" (Ch. 4, p2). In this regard, NSW followed the precedents set in Britain, where from the middle of the 19th century, "[o]fficial services ... included the work of public vaccinators, coroners, and medical witnesses. ... The private practitioner also acted as an agent of the state in the registration of deaths and in the notification of

infectious diseases” (Brand, 1965 p149). Brand quotes a speech made to the British Medical Association by a Dr Henry Rumsey who noted in 1870 how government services were by then evident in "medical relief of the destitute, in medical care to inmates of asylums and prisons, in medical services to the police, civil service, and labourers in public work, in medical care of soldiers and sailors." Furthermore, stated Rumsey, "by medical agency again, the State protects the children and youth of the working classes in factories, workshops and mines, where the keenly contested race between labour and capital requires constant and vigilant supervision" (1965 p9).

Rising public pressure in NSW for more governmental involvement in health meant that it was difficult for successive governments "to resist the demands made upon them for funds for such charitable purposes as hospitals" (Dickey, 1976 p35). Thus thirty years after the attainment of self-government, the *Journal of the Legislative Council* carried reports about a large number of "Charitable Institutions", i.e. government subsidised hospitals, including four in Sydney and 68 in country areas as well as eight government asylums for the "infirm and destitute". The Inspector of Public Charities noted in that year:

A comprehensive view of the Charities makes it apparent that the Government is most generous and constant in its endeavour to supply aid to all forms of distress; and that year by year improvements are being introduced in the appliances and administration of the institutions it supports or subsidises for that purpose (New South Wales, 1887(a) p394).

Besides the 131 vaccinators reported to be active in that 1887, there were also 96 medical officers serving in institutions such as jails, asylums and special schools as well as in country towns (NSW, 1887(c), pp 405-423). By 1900 the number of hospitals had risen

to 121 (Lloyd, 1993, p281) and these hospitals "were operating within a web of regulation" (Dickey & B, 1977 p49).

Not only was governmental activity expanding in the sphere of curative services. In 1896 with the passing of a Public Health Act, a "Department of Public Health" was brought into being which operated under the under the aegis of a statutory body, the Board of Health, founded almost two decades earlier. That Board had

... accumulated powers over matters of public health and played an important role in the regulation of conditions of life in Sydney and throughout the colony... in examining the responsibility of the government in the general field of medical and health care, this great extension of its work through the Board into such matters as dairies, ewers, water, cattle slaughtering, diseased meat must be noted (Dickey, 1976 p50).

Although there was no Minister of Public Health until 1913, none the less from 1896 this department had a bureaucrat, Dr Ashburton Thompson, as its permanent head (New South Wales, 1900 p1). This was in contrast to the previous period when Board of Health presidents such as McLaurin and other officials such as Dr Anderson Stuart, Professor of Physiology and Anatomy in the Medical School of the University of Sydney, were part-time incumbents who generally combined their duties on the Board with numerous others public offices. The full-time bureaucrats who replaced them were also medical practitioners: Ashburton Thompson was a medical practitioner, as was Dr Frank Tidswell who headed the other major arm of the Department, the Bureau of Microbiology. That indicates that in NSW, as in Britain, "[i]t was clearly apparent that the state and the doctor were increasingly linked together in the expanding society" (Brand, 1965 p149).

That the bureaucracy responsible for health issues was coordinated by the Premier's Department meant that these officials had more direct access to the head of government than had there been a Minister for Health. Their reports to parliament printed in the *Journal of the Legislative Council* contained not simply reporting but also a good deal of advocacy,

indicating that these appointed officials were as active in the making of policy as were elected politicians.³² The notion of bureaucrats acting in this way of course, contradicts the received wisdom of the Westminster tradition, which is that in proffering advice to ministers, public servants are always neutral in a party-political sense and that their advice is always objective and impartial.

However, as one of the greatest observers of the Australian public service, Dr Peter Wilenski, pointed out:

[T]he policy advice that officials tender (and that they may go to extremes to see adopted) cannot be objective and impartial but is inherently value-laden. ... Many of the most important issues on which senior policy-makers are required to advise - are all issues in which values play a larger part in guiding a public servant to advocate a particular position (Wilenski, 1986 p53).

Wilenski of course, was not the first observer to come to this kind of conclusion. When during debates on the 1938 Medical Practice Act, the Health Minister FitzSimons as noted earlier, denied that he had been unduly influenced by the BMA in drafting the Bill and claimed that he had been wholly guided by senior bureaucrats in this task, the critics immediately pointed out that the Director General of the Health Department was a member of the BMA (NSWPD 1:105 4/8/1938 p823). His indignant assertion that of course that bureaucrat had acted with proper political impartiality might have evoked

³² As for instance, evident in a statement by Inspector of Public Charities in his 1887 report that "some of the evils at present connected with the distribution of State Charities may disappear, consequent on the application of regulations more stringent than those any central government has hitherto been inclined to enforce" NSW 1887 (b). p395). The Inspector obviously believed that the government needed to change its policy in this field, and was saying so in no uncertain terms

sceptical smiles not only from the Minister's opponents, but also had he ever heard about it, from Wilenski himself

In the earlier period before the turn of the century, in the lack of a Health Minister, senior bureaucrats were not only advising on the drafting of legislation, they were actually doing the drafting themselves. A pioneer of NSW medical history, Cyril Cummins, states that after Ashburton Thompson became the first Director-General of the Public Health Department and set about organising its administration:

He was co-author with Berbard [sic] Wise Q.C., of the first Public Health Act; sole draftsman of public health legislation to control leprosy; hygiene of dairies and noxious trades, [and] innovator of pure food laws on a system of uniformity between the States (New South Wales, 1973 p5).

Nor did bureaucrats hesitate to enter the policy field. In 1894, Dr Anderson Stuart, Medical Advisor to the Government, reported to the Legislative Council:

The question has arisen during the year as to whether unqualified medical practitioners should be appointed to medical officerships of subsidised hospitals; and it has been decided that in no case shall a hospital subsidised by Government employ either as a paid or an honorary medical officer any person who is not a legally qualified medical practitioner according to the law of New South Wales (New South Wales, 1897 p1061).

A major problem with that policy (which did not become law until 1938) was that before 1900 in NSW, it was difficult to know who were indeed legally qualified medical practitioners. As the Government Medical Officer, Anderson Stuart would have had no difficulty in bringing that problem to the attention of politicians in government like Creed, Renwick and McLaurin because like them, he was a member of select coterie of

doctors who comprised Davis' medical elite (Ch. 3, p14). Although not a parliamentarian he was just as effectively "in government" as other members of the elite and as a member of bureaucracy was probably just as effective, if not more so, in the making of policy and law.

Even after Anderson Stuart was replaced by a full-time official in 1896, the doctor/bureaucrats, in other words the corporate rationalists in the Public Health Department, would no doubt have constantly pointed out to those in the government structural interest group that the lack of medical regulation left NSW in an isolated position in Australasia and the economically developed world. It also left Medicine in a bureaucratically anomalous position within the colony itself, particularly since ancillary health occupations were beginning to be regulated. This applied to pharmacy in 1897 (Haines, 1997) and dentistry in 1900 (New South Wales, 1901 pp471-5). Moves were also under way to regulate nursing, although these did not finally come to fruition until 1924 (Anonymous, 1990)

Since under the Westminster tradition, one of the important duties of the bureaucracy is to advise politicians in government, it can be assumed that the governmental drive for medical regulation which emerged in the 1890s was due to pressure from the corporate rationalists, not least because their leading lights were either members of, or had close relationships with, the medical elite.

The “bureaucratic imperative”

That factor is not taken into account by Lewis & MacLeod (1988, p81), who attribute the changed climate of opinion which produced the Medical Practitioners Acts of 1898-1900 to the notion that

... medicine had gained prestige from greater effectiveness [and] ... also from the advance of science. The cultural authority of medicine improved immeasurably in a society epistemologically and practically dominated by science and technology (p.81).

The continuing strength of lifeworld medicine and scepticism towards allopathic/scientific medicine described above in relation to the 1938 Medical Practitioners' Act, indicates that these authors overestimate the domination of science and technology at the time as does Pensabene (1980). That is probably because they, as well as Lloyd (1993), tended to focus, as argued in Chapter One, on the actions of the professional monopolists and not to give adequate consideration to those of the government executive and the corporate rationalisers. The same is true of Davis (1983), who while he notes the "encroachment" (Ch.4, p36) of the state on the medical sphere in NSW, none the less in his final Chapter deals exclusively with the way this benefited the medical profession, hardly making any reference to, let alone investigating, the actions of government.³³

³³ Davis's lack of interest in the actions of government is evident in the fact that he pays minimal attention to the legislative regulation of Medicine. He states nothing more than that "doctors got a ... modest registration Bill passed in 1898" (Ch 5, 24), making no mention of the much more important Amendment Acts of 1900, which is more than strange seeing that the topic of his thesis was *The Professionalisation of Medicine in N.S.W. 1870-1900*.

Over against the view that it was solely the influence of the medical elite and its organisational embodiment in the BMA which led to the passing of medical regulatory

legislation, as has been argued, of equal, if not more importance were developments among the corporate rationalisers. This applied not only to the bureaucracy, but also to the government executive interest group. In this regard, political changes in government played an important role. It is significant that having been Premier for 12 of the 20 years after he first attained the office in 1872, the influential but also anti-allopathic Sir Henry Parkes, finally lost power in 1891. He was replaced by the Protectionist Premier Dibbs, whose accusations against Botterell mentioned above indicated that he was no friend of lifeworld medicine. His successor Reid who was Premier between 1894 and 1899, shared Dibbs' views on this issue, even though he was of the Free Trade persuasion.

A changed climate of thinking in the government executive about medical regulation was evident from the fact that during the 1894-95 session of parliament, an attempt to pass a Medical Practitioners' Bill was launched by members of the government executive, in contrast to previous Bills which had invariably been introduced by members of the medical elite. In the Upper House the Bill was introduced by the Attorney General and in the Lower by no less a figure than the Premier Sir George Reid, who was to become one of the main architects of Australian Federation. Possibly because of this august backing, this Bill was passed not only by the Upper but also by the Lower House. It only failed to become law because the Upper House refused to accept an amendment (introduced by Reid himself) which made the courts rather than the MRB, the final arbiter of an individual practitioner's qualifications (NSWPD 1:78 6/6/1895 p6944). In 1898 the introduction of another Medical Practitioners' Bill by Dr Andrew Garran, the government representative in the Upper House, once again signalled the Reid ministry's determination to have the legislation passed.

The outcome of the votes on the Bill of 1894-95 also points to a changing climate of opinion among ordinary members of parliament. One reason for that was a perception of the increasing urgency of what may be termed "the bureaucratic imperative", in other words the need for the "order and protection" created by bureaucratisation. As noted in Chapter Two (p73-4), the governmental bureaucratisation which was advancing at a rapid pace in NSW involved not simply the expansion of public service, but also the regulation of a wide number of activities and occupations. It was pointed out in the NSW parliament over a good number of years that occupations ranging from conveyancing to cab-driving had been subject to regulation and it was ridiculous that so crucial a service as that provided by doctors remained unregulated (NSWPD 1:1 12/3/1880 p1525; 1:67 4/10/1893 p286). The most eloquent statement of this point was made by Norton, referred to above, who declaimed in the Lower House debate on the Medical Practitioners' Further Amendment Act in 1900:

How readily we handed great state interests over to the Railway Commissioners. How readily we handed over the whole body of our civil servants, depriving them of the right to trial by jury or an appeal to the court of the country against the decision of the Public Service Board! We handed our settlers over to the land boards and land courts, but here - where the health ... and the very lives of the people and the children of the people ... were at stake ... some hon. members said that they did not think we ought to pass this bill (NSWPD 1:105 18/9/1900 p2987).

The lack of adequate regulation empowered by a genuine Medical Practitioners' Act, meant there was no reliable system for accrediting doctors, or of ensuring that the standards of their training were adequate, or of maintaining those standards. The strength of health care provision was thus being compromised at the heart of the system and

besides being bureaucratically untidy, this situation could also have had deleterious legal implications. As was pointed out by Creed's Select Committee of 1887, practitioners who were not legally qualified in terms of the law were being called to give expert witness at inquests and in medical cases since it was as difficult for the courts as for anyone else, to know who was qualified to give evidence and who was not (NSW, 1887(b), P4). Again, the only remedy for that situation lay in the introduction of medical regulation. This was just one example of the "bureaucratic imperative" which probably persuaded legislators in NSW, who had actively resisted and continued to resist "the cultural authority of medicine", to agree to the passing of the Medical Practitioners' Acts of 1898-1900.

While corporate rationalists in all probability, as suggested earlier, argued strongly for medical regulation on the grounds of "the bureaucratic imperative", in the end they had to rely on the skills of the government executive to put the necessary legislation into place. In this regard, the professional monopolisers as represented by the medical elite, who had initiated and for a long time been the main driving force in moves to effect medical regulation, had proved themselves to be the opposite of skilled. For instance, when introducing an extensive Medical Practitioners' Bill into the Upper House in August 1897, Sir Arthur Renwick began by giving an assurance, on the basis of his personal contacts, that the BMA "entirely approve of the provisions of the bill". He also argued that the findings of Creed's Select Committee ("an exposure of the most extraordinary character ... of the prevalence of quackery") demonstrated the necessity of the legislation (NSWPD 1:89 5/8/1897 p2618). He seems not to have appreciated that both issues were likely to be a "red-rag-to-a-bull" to the Lower House, as were Bowker's statements that "a

girl was killed and a man was hanged because [a 'quack'] was not prevented from practising" (NSWPD 1:89 5/8/1897 pp2619).

Renwick showed similar non-perspicacity when he stated that his one reservation about the Bill was its proposals on the constitution of a new MRB. The twelve current members he said, felt slighted by the fact that their services would not be automatically continued once the legislation went through. In deference to the sensibilities of these members, whose high status had been recognised by the appointment to the MRB in the first place, the House devoted most of the committee stage to trying to devise a complicated formulae to enable the current members to continue in membership, but gradually to be replaced over time (NSWPD 1:90 7/10/1897 pp3658-3660). The record of these deliberations is impressive only in its tedium and of course, in their ultimate futility, because the Lower House refused to consider the Bill. However, one effect of these discussions may have had was to sound a warning that any attempt to reconstitute the MRB would be fraught with controversy. Since the introduction of medical regulation had proved to be so highly contentious over so many years, the Reid ministry might have concluded that the introduction of yet another controversial item into the process was something to be avoided if the legislation was ever to be passed. Thus there were no more attempts to change the composition of the MRB, which in fact remained unaltered until 1938.

The government strategy

In 1898 a Medical Practitioners' Act (No. 26) was passed which at first sight, is a baffling piece of legislation. As mentioned earlier, it contained nothing new, its title being belied by the preamble, which almost exactly duplicated the 1838 Act and only referred to

medical witnesses at coronial inquests. There were no debates on this legislation, which was passed through all its stages in one fell swoop in the Lower House in July 1898 along with a long list of other “consolidation” Acts received from the Upper House (NSWPD 1: 92 6/7/1898 p531). This Act seems so inconsequential that it receives no mention from Lewis and MacLeod (1989) while Lloyd (1993) simply refers to it in a footnote (p264).

It may be asked: What was the purpose of this legislation? The answer probably is that the government was determined to have a Medical Practitioners' Act on its statute books, no matter in what form. However, there could also have been some "method in the madness" of the government executive. Whatever their other weaknesses, the 1838 and 1855 Acts had put into place two of Daniel's criteria for professionalisation, viz. those for controlling entry to the medical profession and the registration of medical practitioners by means of specifying the length of their educational training. Only the laxity and *laissez-faire* attitudes of governments towards the enforcement of these instruments for the external control of the medical profession had prevented their being effective. A change of thinking in government about the necessity for the enforcement of the law would certainly have remedied some weakness of the Acts and the passing of the 1898 Act signaled that such a change had taken place. While the weight of sixty years of non-enforcement would have made it difficult immediately to invoke the punitive provisions that Act, none the less it contained the groundwork for the regulation of medicine which would bring NSW into line with other jurisdictions the world over.

More was needed however, to put the basics of full external control of the medical profession in place and thus a Medical Practitioners' Amendment Bill was introduced

into the Upper House later in 1898 by Dr A. Garran as a member of the government executive (he was not a medical doctor, but a Doctor of Laws). Even though this Bill never got beyond the Upper House, none the less in the debate Garran revealed new thinking on the tactics the Reid ministry would employ as they attempted to finesse the legislation through the parliament. These tactics necessitated outmanoeuvring the medical elite as well as the supporters of lifeworld medicine.

However desirous they now were to obey the bureaucratic imperative with regard to medicine, government executives in the pre-party discipline era found themselves between the Scylla of the Lower House and the Charbydis of the political ineptitude of the medical elite with their "put-down-quackery" demands. Thus the government executive began to develop a strategy for steering between these forces, as was evident in the Reid ministry's attempts to pass a medical Bill in 1894-95. Its "whole scope", Reid told the Lower House, was simply to prevent unqualified practitioners from using medical titles, adding "I would not push it further than that" (NSWPD 1:76 21/3/1895 p4699). In other words, the Bill was a "barebones" measure which sought to impose only minimalist medical regulation and in this respect, contrasted notably with the much more comprehensive Medical Acts of the other Australasian colonies and also those of pharmacy and dentistry which as noted above, were regulated in 1897 and 1900 respectively. That approach was vehemently rejected by Bowker in the Upper House. He declared that when the Bill was first introduced "to my surprise I found it was so short and inadequate that I thought it an absurdity to oppose it," although he said, his non-opposition did not mean that he acquiesced in the Bill either. His rather novel position was based on the belief, held with varying degrees of conviction by all members of the

medical elite, that the objective of any Medical Act should be to "put down quackery" (NSWPD 1:69 27/9/1894 p805).

However, for the government executive, that demand by the professional monopolisers represented an issue best left severely alone since it merely raised the ire and opposition of the majority in the Lower House. What was much more important, in terms of "the bureaucratic imperative", was simply to get some basic medical regulation in place. Thus echoing Reid's thoughts if not his exact words, Garran stated the "great purpose" of his Amendment Bill was simply to prevent the fraudulent use of titles and that "[i]n order for it to pass the Government have not encumbered it with anything that is not absolutely necessary." In other words, the Bill too, contained nothing that would "put down quackery". On that score, he said, while he knew there were some members of both the Upper and Lower Houses, "medical men", who wanted a great deal more to be included in the Bill, none the less "...it is best to pass what we can pass, and leave further matters to further experience" (NSWPD 1:93 21/9/1898 p732).

The government's minimalist approach evident in this Bill (its length was probably much the same as that of the Bills which were passed in 1900) contrasted sharply with full-blown legislative instruments introduced in previous years by members of the medical elite. The brevity of Garran's Amendment Bill of 1898 was cause for it to be immediately attacked by Renwick, who said that although he sympathised with the government executive "in their desire not to meet with obstruction in connection with this particular kind of legislation", it none the less was a piecemeal measure and therefore totally inadequate. None the less, both he and Creed (who also deplored the brevity of the Bill)

supported it because, said Creed, while it failed "to do everything that was required, it would do a great deal".

Creed even opposed amendments put forward by Renwick on the grounds that "the Government have determined that they will have this particular bill and nothing more" (NSWPD 1:93 21/9/1898 p734). As his speech indicated, not only had the initiative for the passing of medical regulatory legislation moved firmly into the hands of the government executive, but the medical elite was divided about the best strategy for introducing medical regulation. Bowker did not share the pragmatic approach of Creed and Renwick and as usual argued that a "proper" medical bill was needed "because there are a number of unqualified practitioners who are continually causing deaths in this country" (p736). That point was strongly supported by another member of the Upper House, Mr Henry Dangar, who called "for a stop to be put to the nefarious practices of men who have been allowed to carry on their atrocious business without any interference on the part of the Government". Instead of calling it a bill to regulate the practice of medicine, he said, its failure to suppress lifeworld medicine meant that "it ought to be called a bill for the encouragement of quacks" (p737).

Although this 1898 Amendment Bill was passed by the Upper House in a division by 17 votes to 9, it was again ignored by the Lower House. This probably convinced the government executive that it was useless attempting to launch the legislation from the Upper House. Moreover, if its introduction even by a non-medical member of government had failed to make it acceptable, to have a Bill introduced by a member of the medical elite was to give it the "kiss of death". It might therefore have been reasoned

by those in the government executive that further attempts to put a Medical Practitioners' Act in place would need to be launched from the Lower House, which as the "near miss" of 1895 had demonstrated, was not impossible. However, it would take some careful strategising to effect that, and the time taken in working out and implementing the strategy might account for the fact that, in contrast to the previous decade in which attempts to have Medical Practitioners' Bills passed had occurred virtually on an annual basis, nothing further happened for another two years.

However, the Protectionist Lyne ministry which had come to power only a week before the 1898 bill was introduced, proved as determined as the Reid ministry to get a genuine, albeit minimalist Medical Practitioners' Act on to the statute book. One reason for that was no doubt that while the government executive had changed, the corporate rationalists in the bureaucracy had not. Eventually, an elementary form of medical regulation was achieved in December, 1900.

The Medical Practice Amendment Acts

As already noted, the way in which the two Amendment Acts of 1900 were passed was to have a crucial effect on the way medical autonomy was entrenched and institutionalised in NSW. Before considering that, it is first of all necessary to outline and discuss the content of the two Acts in some detail. Clause 1 of the first, the Medical Practitioners' Amendment Act (No 33, 1900), made it an offence for anyone who was not a legally qualified practitioner in terms of the Act of 1898 to assume "the name or title of a physician, doctor of medicine, licentiate in medicine and surgery, bachelor of medicine, or surgeon, or any name, title, addition or description implying that he is legally

qualified". The penalty was severe: a fine of £50 and £5 for each day during which the offence was committed or alternatively a jail term of 12 months. While the criminalisation of fraudulent titles dated back to the Act of 1855 and thus was nothing new, the eagerness of the government executive to have this legislation in place signalled that the law would be strictly enforced in the future. In other words, the practice of allopathic medicine, with the equally eager concurrence of the professional monopolists, had been subjected to state-supported "external control".

The first Medical Practitioners' Amendment Act of 1900 also for the first time, introduced a system of medical professional discipline through the medium of its second major clause. As we have seen, that there were no disciplinary provisions in the 1838, the 1855 or the 1898 Acts meant that it was not possible to remove anyone's name from the medical register. The Amendment Act in contrast, provided for the deregistration by the MRB of firstly anyone who, even though previously legally qualified, turned out not to have the requisite educational qualifications and secondly, of any practitioner who had been *convicted* (my emphasis) of "felony or misdemeanour". The inclusion of the word "convicted" in this sentence gave the state complete control of medical discipline. Since the MRB was given no powers to deregister *unconvicted* practitioners its power of internal discipline over the profession remained practically non-existent. That in turn denied the notion of peer review since the legislation made the courts primarily responsible for acting against miscreant practitioners rather than the profession itself.

While this might have suited the government executive and the corporate rationalisers, it would have been a glaring weakness from the point of view of the professional

monopolisers. That weakness was remedied by the second Amendment Act, the full title of which was the Medical Practitioners' Further Amendment Act (No 70, 1900). Crucially, the first clause of this measure specified "infamous conduct in any professional respect" as the ground for deregistration. The importance of that may be appreciated from the discussion on this topic in Chapter Two (see pp 59-63). Since there was no reference to the judicial process, the enforcement of the "infamous conduct" clause became the responsibility of the MRB, which as we have seen, constituted the legislative embodiment of the power of the medical profession. If the first Act had given the MRB full external control of the medical profession, this second Act complemented and consolidated that by ensuring the establishment of full "internal control" by the MRB of the profession. The second Act therefore constituted the legal institution of peer review in NSW.

The passage of the two Amendment Acts of 1900, together with the 1898 Act, meant that all the conditions for the full regulation of allopathic medical practice in NSW and the attainment of full professional status by Medicine in NSW had been attained. With the backing of the state, the MRB had been given full control of "the criteria for entry, the lengthy educational training, registration, and standards of practice and conduct within the profession" (Daniel, 1994) However, this had been accomplished in an extremely messy legislative fashion. The "criteria for entry" were specified by Clause 3 of the 1898 Act and Clauses 1 and 3 of the first Amendment Act of 1900, those for "the lengthy educational training" by Clause 1 of the 1898 Act and Clause 1 of the Further Amendment Act of 1900 while the control of the "standards of practice and conduct" was specified in the clauses relating to professional discipline in the two Amendment Acts of

1900.³⁴ That piecemeal situation remained in place until 1912, when the three Acts were consolidated into a single Medical Practitioners' Act (Act 29, 1912).

But it was the very messiness of the process which also produced a high degree of medical autonomy, something which calls for a closer examination of the passing of the two Amendment Acts. Neither Lewis & MacLeod (1989) nor Lloyd (1993) deal adequately with this issue. The former note simply that in 1900 "an Act passed surprisingly quickly" and was strengthened by a second piece of legislation, which implies the two acts represented a logical legislative progression. Lloyd (1993) echoes this view in his statement that "Given the level of previous opposition," the passage of the first Act "occurred with little fuss" (p264) while the second Act consolidated the gains made by the profession. Moreover, it seems that in the view of these authors, the two Acts embodied the complete triumph of allopathic over lifeworld medicine. Lewis & MacCleod state for instance that the passing of the 1900 Acts meant that: "At last, the profession had secured legal support in its attempt to suppress unorthodox practice" (1993,p78). As demonstrated by the speeches of Reid in 1895, of Garran in 1898 and also that of Price in 1900 recorded below, the Acts of that year strictly avoided any attempt to "suppress unorthodox practice" or to "put down quackery".

³⁴ The untidiness of the legislative situation confused even Lloyd (1993) who states that the MRB's power to regulate the behaviour of registered practitioners remained limited after 1900. Despite having been given "the power ... to deregister doctors for serious breaches of professional conduct" he states, it was not until the passing of the Medical Practitioners' Acts of 1912 and 1915 that the Board had the power "to remove from the register the name of any doctor 'convicted of felony or misdemeanour' ..." (p267). Lloyd seems to assume that the second Amendment Act passed in November had over-ridden the first, but this was not the case, as was pointed out in the Lower House during the committee stage of the Bill (NSWPD 1:106 27/11/1900 p5831).

The differing origins of the Medical Practitioners Acts.

It has earlier been suggested that government executive had realised that if proper medical regulation was to be put in place, there was no alternative but to take the Lower House bull by the horns and to push the legislation through there. As suggested above, that was not such a hopeless proceeding as might have appeared. The debates in 1886 and 1894 which resulted in the Bills being passed, had revealed there were a good number who supported medical regulation in the Lower House both because their views on lifeworld medicine were not very different from those of the medical elite in the Upper House and also because they understood the urgency of the "bureaucratic imperative." An extreme example of such members would have been that of Norton and while the colourful vehemence of his views would have made them suspect, they were shared by Mr Richard Price (Independent, Gloucester), who introduced the first Amendment Act in September 1900. The shrewd political manoeuvring described below ensured its passage through the Lower House. Upper House acceptance followed shortly afterwards, and once the Act was assented to in October, the basic criteria for the regulation and full professionalisation of medicine had been put in place.

This raises the question of why there was a second Amendment Act. As suggested above, this Act did not represent a mere logical progression from the first Act, since while that had been fashioned and sponsored by the government executive, the second was the work of the professional monopolisers. That they were determined to have an Act of their own can be deduced from what was said during the debates and also from the fact that in its original form, this Act contained the "infamous conduct" clause as well as the that

providing for a longer training period for doctors,³⁵ both very much to advantage of the profession. In Willis' view, the lengthening of the training requirements can be seen as "part of the attempt to improve the status of doctors in early Australian society by professionalisation" (1989, 54), which had in fact had been accomplished in Victoria in 1862. In this regard, Willis cites a statement by Freidson which is worth repeating because it is so apposite to the theme of this study:

[T]he content and length of training of an occupation including abstract knowledge or theory, is frequently a product of a deliberate action of those who are trying to show that their occupation is a profession and should therefore be given autonomy (1970, pp77-80).

On the basis of evidence cited below, it seems the reason for the introduction of the second Bill was that it has been prepared, quite separately from the first government executive-sponsored Bill, by members of the medical elite. They appear to have come to the same conclusions as the government about the best way of securing the passage of an Act and had also found a Lower House champion in the person Mr Richard Meagher (Independent, The Tweed). His credibility in the Lower House was indicated by the fact that while he was originally elected as an independent in 1895, in 1907 he won his seat as a Labor candidate (NSW, 1998, p157).

That his was a rival Bill to the government's is evident from the fact that while it was read for the first time on June 19, it was "upstaged" by Price's Bill which, although introduced two weeks later, went through all its stages in both the Lower and Upper Houses and

³⁵ In its original form, this Bill did not include the provisions for establishing a separate register for unqualified practitioners, which was included in the final Act. This was introduced against the strong opposition of the medical elite. See p 147.

passed into law two-and-a-half weeks before Meagher's Bill received its second reading. Further evidence that the two Bills came from different sources is indicated by the fact that initially each bore exactly the same title, something which confused even the compilers of the contents list of NSWPD!³⁶

The passage of the Acts

Further contrasts between the two Acts are provided by the way they were passed. As far as the first or what may be termed the government executive Act is concerned, political wisdom might have dictated that it should not be introduced "cold" into the Lower House. Therefore members like Price might have prepared the way by arguing the case for the Bill to their colleagues in informal arenas before it was introduced. The flavour of such arguments can be seen from points advanced by Price when he moved the second reading. He assured the House that the Bill would "... take away none of the rights possessed at the present by persons who may be practising ... ". He contrasted this approach to that of the medical elite in the Upper House, stating that "the main objection to the bill introduced in another place by Dr Bowker and also to previous medical bills ... was that they attempted to interfere with persons who were practising ..." (NSWPD 1:105 18/9/1900 p2978). Those "other persons" were of course, lifeworld practitioners. Although Price was as hostile to them as the medical elite, in terms of the government's minimalist strategy, he had distanced himself from any attempt to "put down quackery".

³⁶ According to that list, Price was responsible for the second reading of Meagher's Bill, which was nothing like the case.

Price would also have ensured a more favourable hearing from Lower House members by arguing that the bill was confined to a "broad principle which is ... recognised among trade unions. They insist that a man shall not use a term signifying that he possesses a certain qualification that he does not possess" (NSWPD 1:105 18/9/1900 p2978). That point disarmed opposition to the prohibition contained in the first clause of this Act which prevented the assumption of medical titles by practitioners who did not have academic training.³⁷ This seems to have been readily accepted in the House; however, in conceding that only allopathically trained practitioners could use the title of "doctor", the proponents of lifeworld medicine were allowing their opponents to take a giant stride towards the domination of the discourse of medical practice which they established during the 20th century.

It might also be remarked that Price's "trade-union" argument was unlikely to have been used in the Upper House by the medical elite. Moreover he would not have appeared as disingenuous as they when he argued: "The bill is not in the interests of the medical profession, nor in the interests of any special class" ...[but] of the public who are victimised by quacks" (NSWPD 1:105 18/9/1900 pp2978-80). While in the ensuing debate one member Mr William Hughes³⁸ (Labor, Sydney-Lang) [sic] deplored the failure of the Bill to "put down quackery", Price found support from others on the grounds of the bureaucratic imperative. Among these was Mr John Neild (Independent,

³⁷ This point had been disputed in 1894 by the Labor member for Waratah, A. Griffith, who argued that anyone practising as medicine should be able to prefix the title of "doctor" to their names, so long as those not legally qualified added the words "not registered". (NSWPD 1:78 14/5/1895 p6103).

³⁸ This was the famous (or infamous, depending on various points of view) Billy Hughes, later to be Prime Minister of Australia.

Paddington). who pointed out that auctioneers, tobacconists and omnibus drivers all had to be licenced and that "[i]n the interests of the men, women, and children of the community, no man should be allowed to tamper with their lives and limbs unless his competency is guaranteed by some form of state supervision" (NSWPD 1:105, 18/9/1900, p2985).

The lack of opposition to the Bill as a whole during the comparatively short debate was reflected in the way that its second reading and committee stages were passed without a division. In technical terms, the Bill had indeed been accepted with "little fuss", but that may also have been due to a deal having been made by government with the members of the Lower House, who in return for an assurance that the position of lifeworld medicine would not be touched, agreed to pass the Bill. It had an even quicker passage through the Upper House but as argued above, the disciplinary provisions of this Act notably failed to accomplish the complete professionalisation of Medicine in NSW, something which had to wait for the passage of the second Act.

This second Act, the Medical Practitioners' Further Amendment Act, was of crucial importance because it contained the "infamous conduct" clause, which in terms of the *Allinson* judgement of 1894 (see Chapter Two p62) gave Medicine complete control over medical discipline. However, to judge by the very short speech Meagher made in introducing the second reading on October 30, he was either half-hearted about this Bill or simply did not understand it. He appears to have been aggrieved by the passage of the first Amendment Act, stating that while Price had "introduced a medical bill" (ignoring the fact that it had already passed into law), the medical profession was dissatisfied with

it since it was "only a titles bill". His reference to the medical profession was a clear pointer to the source of this Bill.

More evidence that Meagher's Bill had been prepared quite separately from that of the government executive, is that its first two clauses were identical to those in the first Amendment Act. Had there been any communication between the drafters of the two measures, they would not have allowed this duplication to occur. That apart, Meagher charged that what the medical profession found most unsatisfactory about the government Bill was that it did not do "what is very important shall be done. It does not prevent quacks and alleged medical men from advertising in the newspapers" (NSWPD 1:105 18/9/1900 p2978). Had his Bill sought to prohibit such advertising, it would have provoked an even bigger storm than it did in 1938; in fact it merely contained a provision that practitioners who placed advertisements in newspapers, should include their names and home addresses. This had also been specified in the 1894 Bill and was aimed at unqualified practitioners who were being allowed to use the premises of doctors to offer treatment to an unsuspecting public. None the less, Meagher's statement quite possibly reflected the true feelings of the medical elite about the advertising of lifeworld medicine. That "Freudian slip" of 1900 of course became a reality in 1938.

Other than this Meagher said nothing more about the content of his Bill. It seems extraordinary that he failed to mention the "infamous conduct" clause or the provision for extending the training period for doctors. That may have been either because he did not want to draw attention to these clauses, or because both he and the other members present simply did not grasp their significance. The Bill was introduced after 10 pm., which may

account for the fact that it evoked no debate, the second reading as well as the committee stage being approved without a division. The whole process, according to NSWPD, took eleven minutes, the record filling less than one page (NSWPD 1:105 18/9/1900 p4524).

There could have been more than simply the moderate lateness of the hour to account for the lack of opposition to the Bill. If, as suggested above, there had been a deal between the government and supporters of lifeworld medicine in the Lower House, there was little or no suggestion that the government was reneging on it. Apart from its mild advertising provision, the Bill left the position of lifeworld medical practitioners untouched. The terminology of "infamous conduct" clause may well have seemed incomprehensible mumbo-jumbo to members of the Lower House, who were obviously also unaware of the sophisticated arguments such as those of Willis and Freidson cited above, about the significance of the extension of the training period for medical practitioners.

The institution of individual medical autonomy

The swift passage of the Bill through the Lower House was not duplicated in the Upper House. Here it was introduced only two days later by Creed, the unusually short time after its passage through the Lower House being indicative of a sense of urgency among its sponsors in the Upper House. That the Bill had not emanated from the government executive is clear from the fact that the representative of the government in the Upper House, Sir Francis Suttor, immediately protested that since its first clauses duplicated those of the earlier Bill, the House was being asked to pass the same legislation twice (NSWPD 1:106 1/11/1900 p4635). Creed admitted this did pose a problem and was due to an "oversight" on his part, but argued that despite its overlap with the previous

Amendment Act, it was essential to pass the second reading. His urgency on that score was echoed by Dr William Cullen³⁹ who declared:.

I think we ought to take what the gods send us, and be thankful. We have been trying to legislate in this direction for a very long time, and now, when we find two bills passed through the Assembly in one week each giving us an instalment of what has long been desired by the people, I think we should accept them (NSWPD 1:106, 1/11/1900 p 4636).

The House heeded his plea and passed the second reading without a division.⁴⁰ However, during the committee stage, the "infamous conduct" clause was queried by Dr John Nash who had been appointed to the Upper House less than six months beforehand (NSW 1998, p39) and who, although a medical practitioner, obviously did not feel himself to be a member of the medical elite. Nash said "he would like to be informed of the meaning of the words 'infamous conduct'. This was a subject that had given rise to a great deal of trouble, and had been before the English courts on many occasions during the last ten years."⁴¹ His worry, however, was not that of critics of the term in the late 20th century, who saw it as providing a convenient shield against accountability by individual doctors, but that "the use of the words had been found to be fraught with grievous consequences to medical men who had been registered in England". In other words, Nash's fear about the vagueness of this clause was that it could be used as a weapon in the endless squabbles within the medical profession. On this point he was supported by Mr Alexander Brown (Progressive, Newcastle), who as detailed in Chapter Two (see p68), had cited the case of the surgeon whose incompetence had been covered up by his fellow surgeons. Brown's

³⁹ He was a Doctor of Laws, not a medical doctor (NSW 1998, p32).

⁴⁰ The difficulty posed by the duplication of clauses in the second Bill was dealt with by deleting them at the committee stage

point however, was not that the infamous conduct clause would protect incompetent practitioners, but rather that it could be used to silence the "whistleblower" in this and other cases.

In other words, Nash and Brown opposed the clause not because of the way it might affect the rights of patients, but because of the way it could affect the interests of doctors. In response to their fears, McLaurin claimed that the MRB was composed of men of "high standing, respectability, and honesty of purpose" and could be trusted to administer the clause fairly. Moreover he said, anyone deregistered on these grounds had the right, in terms of the Bill, to appeal to the Supreme Court. Both he and Creed asserted that the clause had been in operation in Britain since 1858 and had raised no problems, which of course ignored the *Allinson* case, although they also had reason not to draw the attention of the non-medical members of the House to that case.

Nash asked Creed to reconsider the clause, especially because the low attendance in the House posed the danger that the debate would be halted and the Bill possibly lapse because of a lack of a quorum. The medical elite would have none of that and it was when Nash reiterated that "it ought to be stated what was meant by infamous conduct", Creed replied: "It is impossible to define it!" (NSWPD Vol 106, 1/11/1900, p 4637) In that statement is to be found the basis for the non-accountable practice of Medicine for most of the 20th century. As will appear later in this thesis, Creed was not expressing an individual opinion here. He was expressing the view of Medicine as a whole, and that

⁴¹ Nash was guilty of hyperbole here, because the only case which had occurred in "the last ten years" was that

view was supported both by governments and by the legal system. Today the logic which produced such thinking seems incomprehensible, because it was allowing Medicine the sole prerogative of defining a term which medical practitioners themselves claimed to be non-definable or to be definable only in their terms. Those terms, as pointed out by Berlant (1975) and Klein (1984) among others, did not include issues relating to practice. But this ultimate claim to medical peer review contained the seeds of its own destruction because it was based on the assumption that those in the community population would forever tolerate what was the blatant over-riding and ignoring of their interests.

But obviously any such thoughts would not have been near to anyone's minds that day in the Upper House. What was clear was that the medical elite were in a hurry to get the Bill passed. In appealing to Nash to drop his opposition to the clause, Creed argued "there was an evident need for a provision which would enable a man to be struck off the roll without it being proved that he had actually committed a crime" (NSWPD 1:106 1/11/1900 p4638). Later in the debate McLaurin expanded on this argument, claiming that while habitual drunkenness or sexual assault of a female patient could constitute "infamous conduct," the law could not touch anyone for these offences. The profession should therefore be empowered to take action against someone whose conduct was "so gross, glaring, and shameless, that it could fairly and properly be described as infamous" (NSWPD 1:1061/11/1900 p4640). This was a reasonable enough point, but there can be no doubt that seeing Nash knew about the *Allinson* case, that Creed and McLaurin were

of *Allinson*.

also very familiar with it and with the implications of the Lopes judgement with regard to the autonomy of the medical profession.

Although Nash said that in his view no satisfactory definition of "infamous conduct" had been forthcoming, under sustained pressure he withdrew his opposition to the clause (NSWPD 1:106 1/11/1900 p4642). The pressure by the medical elite on Nash, as well as the haste in which the Bill was brought into the Upper House, indicates the eagerness of its sponsors to rubber stamp the Bill as quickly as possible. Any changes would mean the measure would have to be re-submitted to the Lower House and as Cullen had implied, there was no guarantee that its amendable mood would continue.

However, hopes for a quick passage of the Bill were again dashed by Nash, who introduced a new clause (it became Clause 3 of the final Act) which stipulated that a practitioner not possessed of the qualifications laid down in the previous Act but who none the less had passed through "a due course of study at a recognised school of medicine and surgery" and had "practised in a reputable manner" for 15 years, could have his name placed on a separate register by the MRB. This move to legitimate non-qualified practitioners was fiercely opposed by the medical elite, but was passed on the casting vote of the Speaker (NSWPD 1:106 27/11/1900 p5840). In the Lower House it was opposed with equal vehemence by Norton (he said it would "encourage the most diabolical quacks") and also by Price, who had introduced the first government executive-sponsored Bill. None the less, the clause was not only accepted without a division, but the period of "reputable service" was reduced from 15 to 5 years (NSWPD 1:106, 27/11/1900 p5843). That indicated that despite the belated acceptance of the

necessity for medical regulation, there was still a great reservoir of sympathy in the Lower House, for practitioners who fell outside its boundaries (and these would have included lifeworld practitioners).

The change meant that the Bill had to be re-submitted to the Upper House, where again it was considered only one day after it was passed by the Lower House. Despite protests by McLaurin about the reduction in the period of "reputable service", Creed's plea that Lower House amendments be accepted without change was heeded; he might have had in mind the way the 1895 Bill had been stymied "at the winning post" by the Upper House's refusal to accept Lower House amendments (NSWPD 1:106 28/11/1900 p5854). Thus the Bill, the title of which on the basis of the expert legal advice of Cullen, had been amended to "The Medical Practitioners' Further Amendment Act" (NSWPD 1:106 1/12/1900 p4643) was at last ready to pass into law, being assented to in December, 1900.

The passage of the Act represented a double victory for the professional monopolisers. Not only had they successfully staked a claim to share "internal control" of the medical profession itself with the state and reasserted the legality of peer review, but the entrenchment of individual practitioner autonomy had been enshrined in the law by the adoption of the "infamous conduct" clause. The significance of that can be appreciated by a comparison with the situation in Victoria, where a fairly complete regulatory regime had been installed by its parliament as long ago as 1862. However, the Victorian legislation had never included an infamous conduct clause and as Lewis & MacLeod

(1989, p78) point out, it was not until 1933 that a similar clause was included in the Victorian Medical Practitioners' Act.

In this regard, what is strongly evident from the NSW debate about "infamous conduct" is that the question of the actual practice standards of individual doctors was not a disciplinary issue even for Nash. Patients' rights were simply not a part of medical discourse at the time. Instead McLaurin put forward the notion that "infamous conduct" related mainly to addiction to alcohol or drugs and sexual misconduct, particularly extra-marital sex. In the light of what Creed had earlier said about the "indefinability" of "infamous conduct", he might have deprecated McLaurin's attempts to give the term even limited definitions such as these. As pointed out in Chapter Two, it was precisely the non-definability of "infamous conduct" that made it infinitely valuable to Medicine. As affirmed by Mr Justice Lopes in 1894, the non-definability of "infamous conduct" in either everyday speech or in legal terminology meant the interpretation of the term was left solely the medical profession. That gave the profession as embodied in the MRB, the power to exclude matters relating to medical practice from consideration under its disciplinary procedures. Thus was the individual autonomy of practitioners entrenched in NSW for the almost 90 years, with results that will be discussed in the next Chapter.

The entrenchment of institutional autonomy

As was argued in Chapter Two, the first line of defence for individual medical professional autonomy is always that constituted by the institutional autonomy of their controlling body, in this case, the NSW MRB. As we have seen, the 1838 Act had established it as a strongly autonomous body and the passing of the 1900 Acts not only

left that autonomy intact, but probably strengthened it. Had earlier attempts to pass a Medical Practitioners' Act succeeded, the autonomy of the MRB might not have been anything like as complete. Most of the abortive Bills between 1876 and 1897 were comprehensive measures which envisaged reconstituting the MRB in such a way that the majority of its members would be drawn from outside the ranks of practising doctors.

In this, the proposals followed the precedent set by the 1858 British Medical Act, which had established "The General Council of Education and Registration of the United Kingdom," better known simply as the General Medical Council (GMC). That body had 24 members, nine representing the Royal Colleges and other medical licensing bodies which had emerged in the course of time in the United Kingdom, another ten representing the universities which trained doctors, and six members nominated by the Privy Council, the body to which the GMC was responsible (Pyke-Lees, 1958 p3) Since there were no licensing bodies in NSW, the composition of the proposed MRBs was necessarily different here, although the model of having a mix of representation was followed. Thus in many of the abortive Bills and also in the recommendations of Creed's Select Committee (NSW, 1887, p6) it was proposed that besides members of the medical profession, the Board should include representatives from the University of Sydney (because of its medical school) as well as government nominees.

Ideas about the size and the balance of representation of these elements differed over time, but what is notable is that in every one of these Bills, the numbers which it was proposed would be nominated or elected by the medical profession were in the minority, while in some Bills, notably those of in 1876 and 1884, were eliminated altogether. There

were obviously strong feelings even in the Upper House about allowing the medical profession to control the proposed MRB. Holt for instance, expressed agreement with what had been "justly said", that the establishment of the MRB would result in "the appointment of a body of men to regulate their own affairs, and for the protection of themselves and not of the public" (*Sydney Morning Herald*, 3/3/1876). One hundred years later, feelings in the consumer structural interest group about the MRB almost exactly mirrored those of Holt in 1876. In that year another member of the Upper House, Mr Bourne Russell, averred that unless the Board contained a strong lay element, "it would very soon dwindle into a close borough that would be very oppressive.... no body of medical men ought to be trusted with the powers proposed to be given by this Bill" (*Sydney Morning Herald*, 24/10/1876).

As will be seen from the table below, the extreme position which altogether eliminated the appointment of medical practitioners to the MRB, was not maintained in the later proposals.

Some examples of the proposed membership of the MRB in various Medical Practitioners' Bills can be seen from the Table.

TABLE 1. Proposals for the composition of the MRB contained in the abortive Medical Practitioners Acts for the years specified.

	University of Sydney appointees	Government appointees	Medical profession appointees	Source
1876	3	6	0	(<i>SMH</i> 24/2/1876).

1884	3	6	0	(NSWPD 1:1 1/2/1880 p1597).
1886	3	3	3	(NSWPD 1:20 4/6/1886 p2432).
1893	2	4	4	(NSWPD 1:67 11/10/1893 p284)

It is also possible that even with the addition of nominees from outside the medical profession, it probably would still have been dominant since appointees from University of Sydney would undoubtedly have been drawn from the medical faculty. It is also possible that government appointees would simply have been more medical practitioners.

However, the attempts to make the composition less dominated by the medical profession came to nothing. The minimalist, little-or-no-change strategy adopted to get the Acts through the Lower House dictated that any issues which might generate controversy and opposition, were to be avoided. The composition of the MRB was one such issue, and therefore it was left unaltered. Since the MRB had originally been appointed before the era of responsible government and that over the next century it was regarded as simply a continuation of that body, it is not surprising that, as noted in Chapter Two, no Medical Practitioners' Act or Amendment Act passed between 1838 and 1987 laid down any reporting provisions for the MRB. Nor did they specify any mechanisms through which the MRB could be made directly responsible for its actions either to a minister or to the parliament.

In short both before and after 1900, the MRB enjoyed almost complete institutional autonomy in terms of which as remarked in the previous Chapter, although empowered by government, in a *de jure* sense it was not responsible to government. Thus the minimalist strategy enforced on government by the power of lifeworld medicine, in the final result had actually increased the power of its allopathic rival by entrenching the autonomy and non-accountability of the MRB.

Conclusion

This chapter has sought to demonstrate that what emerged from the messy production of medical regulation and the consequential full professionalisation of Medicine in NSW, was a very high degree of both institutional and individual medical autonomy. That degree of autonomy was due to accident as much as design, one of the chief "accidents" being the persistence of lifeworld medicine and the political power of its adherents. Their power was evident in many ways in the society, but from the point of view of this study, most evident in the resistance of the Lower House of the parliament to the introduction of medical regulation.

The power of lifeworld medicine proved too great for the professional monopolisers as embodied in the medical elite in the Upper House and the BMA to overcome in the parliament. It was thus left to the government executive to finesse the necessary legislation through. However, this could only be achieved by keeping that legislation as minimalist as possible in order to back assurances given both in the open forums of the parliament and very probably in private arenas, that it would contain nothing to suppress lifeworld medicine. The success of this strategy allowed the professional monopolisers to

"piggy-back" their own desired legislation, contained in the Further Amendment Act of 1900, through the parliament. Yet here again their fear of the power of lifeworld medicine in the Lower House gave them a good excuse to suppress the Upper House debate on the "infamous conduct" clause which so deeply entrenched individual medical autonomy,

Thus we return to the point made earlier: in the final result the attempts of lifeworld medicine to block the advance of allopathic medicine actually contributed to its power. That indicates that of course, the attempt by the proponents of lifeworld medicine to contain the onward march of bureaucratisation constituted a "mission impossible". They were at a double disadvantage because as far back as 1838, it had become clear that their lack of a scientific epistemological foundation deprived the many and varied strains of lifeworld medicine of any hope of recognition or legitimation by the state and they therefore had no hope of joining the onward march of bureaucratisation.

In contrast, as far as allopathic medicine was concerned, the increasing dominance of societies by rationalistic/scientific epistemologies made the advent of bureaucratisation seem welcome because it held out the promise of "order and protection" in Weber's terms. Thus "the system" in Habermasian terms, not only colonises, but is often willingly invited in by inhabitants of the lifeworld. However, as stated in Chapter One (p18) in the words of Albrow (1996 p177), "assimilating the colonial culture" can lead the colonised to the eventual acquisition if not total independence, then at least to a position of power equal to that of the colonisers. It is suggested that the attainment of that position was

accomplished in NSW by the consumer structural interest group in NSW in the late 20th century.

CHAPTER SIX

THE DOMINANCE OF MEDICAL PEER REVIEW IN NSW

1900-1972

The long time-period under review in this chapter marked the apogee of medical autonomy in NSW. 1900 and 1972 are the dates of the Medical Practitioners' Acts and Amendment Acts which provided the framework for the exercise of that autonomy over the first seven decades of the 20th century. That legislation in turn ensured that peer review remained the supreme and exclusive instrument for the enforcement of medical accountability during the period under review. While there are indications that medical autonomy had begun to be questioned in the late 1960s and early 1970s, its force was not checked in any significant way even as late as 1972, which forms the cut-off point of this chapter.

The investigation of the nature of medical autonomy between the dates specified is concerned with firstly the constitution of the MRB and its relationship to government, since those are indicators of the degree of institutional autonomy enjoyed by the medical profession. Secondly, the chapter investigates the way in which medical discipline was applied, since that had a vital bearing on the individual autonomy of practitioners and more to the point of this thesis, the operation of peer review. It should be said that the evolution of both institutional and individual autonomy was a slow one; for long periods, what was *not* happening was just as significant as what was happening. As will be seen

from the content, what was not happening in the period under review, was any change to the principle of peer review.

Medical autonomy and discipline, 1900-1938

It was pointed out in the previous chapter that the initial medical regulatory Acts, viz. those of 1898-1900 were of an extremely elementary nature. As has been stated, when these were consolidated and amended slightly in 1912, they shared the "barebones" nature of the original Acts. Both these Acts and that of 1912 specified nothing more than that the MRB should consist of not less than three medical practitioners nominated by government (there was no specification of the maximum number). The duties of the MRB were simply to maintain a register of the names of those who it had adjudged on the basis of their education and training, to be legally qualified medical practitioners, and to remove from the register any found to have been guilty of "felony or misdemeanour" or of "infamous conduct in any professional respect". The 1912 Act specified no reporting requirements for the MRB and thus the high degree of autonomy and its essentially unaccountable nature dating back to 1838, remained intact.

The records of the MRB indicate that there was no application of any disciplinary action against practitioners between 1900 and the passing of the 1912 Act. Although it seems unlikely that there were no cases calling for discipline, especially since the number of legally qualified practitioners had risen by 33% during that period⁴², the lack of action may have been because the Acts of 1898-1900 simply stated the grounds for acting

⁴² The exact number of legally qualified practitioners according to Hilder (1959) was 1,225 in 1897 and 1,825 in 1912. He states that the figures for 1898-1904 are unavailable (p34).

against a practitioner without specifying who could register complaints or how they would be dealt with once they were made. The assumption was probably that the MRB would initiate and deal with disciplinary cases in the course of its ordinary business. Although the problems of acting on that basis are not recorded anywhere, it is easy to see what they might be. Simply to strike a doctor's name from the register without hearing the accused would have left the MRB open to a charge of acting without due process. On the other hand, if accused doctors were allowed to defend themselves in an ordinary meeting, that raised the question of whether they had the right to legal representation. If so, the MRB itself would be entitled to have a legal representative. This in turn would raise questions about the procedures to be used in hearing the case since the MRB did not constitute a court of law.

To deal with these issues, a clause was included in the 1912 Act stipulating that for disciplinary hearings the MRB would transform itself into an open court in which the normal rules of evidence would apply, including the cross examination of witnesses and the right of legal representation by the accused. That system had already been in use for disciplinary proceedings in the dental profession in terms of the Dentists Act of 1900 (New South Wales, 1901 p472). Although the open court principle represented an advance on the 1900 Medical Practitioners' Act, its application to the MRB meant that its members, who were unlikely to have had any legal training, were expected to act as both judge and jury in cases brought before them. This situation probably seemed of no great consequence since the MRB dealt only with medical matters in which its members could be expected to be expert, a view which seems to have been accepted in the *Clune vs the MRB of New South Wales* ([1917] 34) case cited in Chapter 2 (see p62).

While the minutes of the MRB demonstrate that after 1912 disciplinary actions did begin to be taken, leading in most cases to the deregistration of practitioners, these were few and far between. The first happened only in 1915 and between that date and 1938 only 12 such actions are recorded, an average of one action every two years. During this period there was only deregistration on the grounds of "felony or misdemeanour", this being that of a doctor convicted of a crime in a court of law and sentenced to a year-long jail term (Medical Registration Board NSW (1838-1972), Vol 4, 1924, p325). All other deregistrations were as a result of practitioners being found guilty of "infamous conduct", although most cases were concerned with financial fraud, not practice issues. The emphasis on fraud is evident from an item of 1916 in the minutes of the MRB, which record that one of its members, Dr R.H. Todd "drew attention to disciplinary cases before the [British] General Medical Council, particularly the case of Dr William Herbert Fawcett summarised as the charge of having improperly used undue influence in the making of a will. Dr Todd said he mentioned the case as it appeared to him similar to one that occurred in this State" (Medical Board, 1916, Vol 4, p91).

Other cases over the years involved the deregistration of practitioners who had deliberately given wrong diagnoses apparently in the hope of financial gain from the misdiagnosed patients. For instance in 1932 a practitioner was charged with having wrongly diagnosed three men with gonorrhoea and advising them they required "special private treatment" which only he could give them, "by means of which representation [he attempted] to obtain ... various large sums of money" (Medical Registration Board NSW (1838-1972), Vol 6, pp352-3). A second charge was that this practitioner had published

and was selling a book called *Sex and Disease* and was also selling a preparation called "San-o-Sex". The misdiagnosis charge was dismissed on the grounds that the practitioner had been misled by the three men: in its judgement the MRB told the practitioner that

[T]he evidence clearly indicates that in each of three cases there was a deliberate attempt to deceive you by wilful misstatement of symptoms and of the medical history, and in all the cases the misstatements were so misleading that the Board considers that they might have influenced your judgement, and led you to give a diagnosis which the Board cannot, in the face of the evidence, believe was correct (Medical Registration Board NSW (1838-1972), p352-3).

It might be remarked that it is difficult to see why the practitioner would have relied on statements rather than on physical examinations to make his diagnosis, although of course, the three complainants might have been attempting to entrap him (which in turn would indicate that he had already developed a reputation for exploiting victims of sexually transmitted disease). While the practice issue involving misdiagnosis was rejected by the MRB, the second charge involving improper financial gain was found to constitute "infamous conduct". On this score, the deregistration sentence was suspended for six months on condition that the practitioner desisted from his commercial activities, which he promised to do. It is perhaps a significant pointer to the thinking of the MRB members at that time that they seemed to consider financial impropriety a more heinous offence than a practice issue.

While the 1912 Act made provision for the enforcement of discipline, it made no provision for policing the behaviour and actions of the members of the profession. In terms of the notion of peer review, the assumption was probably that the profession itself

and the MRB in particular would be responsible for this function. If they failed to perform it, there was no official "complaints pathway" by means of which aggrieved patients could register their grievances.

However, an unofficial pathway does appear to have been developed over time. When Mrs Kathleen Flynn of Sofala in 1934 approached the MRB with a complaint about what a local practitioner had said "concerning the nature of her illness," she was informed that

...the MRB is a judicial body, and can only conduct inquiries when sitting as a Court: the usual procedure followed to initiate an inquiry is for the complainant to acquaint the Director-General of Public Health with the substance of the complaint. The Director-General then has a preliminary investigation made by his officers, and if he considers that the matter is one that should be enquired into, he takes the necessary steps to have it brought before the Board (Medical Registration Board NSW (1838-1972), Vol 6, p51).

Since it was not specified by law, this would have been a purely ad hoc arrangement. In the same ad hoc fashion, some aggrieved patients had earlier established an alternative complaints pathway by directly approaching the office of the Crown Solicitor. This is evident from a response by the Crown Solicitor to a complaint made by Mrs Augusta Smith against a doctor in 1930. She was told that if she signed a form of complaint ("a draft of which is submitted herewith"), the MRB could serve a summons on the practitioner concerned (Medical Registration Board NSW (1838-1972), Vol 6, pp284-5). This would certainly have short-circuited the process set out by the MRB when it told Mrs Flynn that it could only launch investigations when it was sitting as a court (the Catch-22 being that it would not sit as a court until it had the results of an investigation in front of it). The use of the office of the Director-General of Public Health to conduct

initial investigations might have been introduced to deflect direct complainants' approaches to the Crown Solicitor.

This early system for dealing with patient complaints by requiring that they first be screened by the office of the Director-General for Public Health before being passed on to the MRB, set a precedent in that it required complainants to prove their case before two different bodies. That double hurdle, which was written into the Medical Practitioners' Acts after 1938, remained in place in different forms right up until 1987. The second hurdle, that comprised by the MRB sitting as a court, was the more formidable one, because here complainants were faced with having to prove their case under court-room conditions in which expert legal knowledge and probably the employment of legal counsel was required if the complainant was to have any chance of success. Evidence for this appears in the later history of the case brought by Mrs Smith in 1930 referred to above, who had taken her complaint directly to the Crown Solicitor. In a letter to the firm of solicitors engaged by the doctor in question to defend him, the Crown Solicitor stated that the MRB would hear Mrs Smith's evidence and that of any witnesses she chose to present, and would also hear evidence in answer to the charge "whether the parties are represented by Solicitor or Counsel or not" (Medical Registration Board NSW (1838-1972), Vol 6, pp284-5). Having already engaged a firm of solicitors, the doctor was obviously going to be legally represented at the hearing. The Crown Solicitor informed Mrs Smith that if she wanted to be similarly represented, "she must make her own arrangements ... and must bear any expense in connection therewith". That nothing more about this case appeared in the MRB records indicates that Mrs Smith did not pursue the matter, even though the Crown Solicitor had told her that in his opinion, if her charges against the practitioner were proved, they "might be found as justification for

removing his name from the roll of Medical Practitioners" (Medical Registration Board NSW (1838-1972), Vol 4, pp284-5). Very probably Mrs Smith simply did not have the financial means to use the services of a solicitor.

More evidence of the difficulties faced by complainants appears in the MRB minutes for 1936, which record a charge brought by Miss Sylvia Welsh, a nurse, against Dr Percival Homer, who she alleged, "performed an illegal operation on the late Eileen Verna Clint Smith, and did criminally neglect her, the result of which caused her death" (Medical Registration Board NSW (1838-1972), pp133-4). This complaint was made directly to the MRB, which sent her the complaints form drawn up by the Crown Solicitor "with a suggestion that she should consult her solicitor". The case was brought before the MRB sitting as a court on June 22, 1936. What followed is best related in the minutes of the proceedings.

The President read the Complaint, and after waiting for ten minutes for Miss Welsh or for any one to appear on her behalf, was about to dismiss the complaint, when she presented herself and requested an adjournment on the ground that she had no legal consultation on the matter. Also that there had been interference by public officials (not named). The President pointed out to Miss Welsh that notice had been served on her on 18th May of the date fixed for the hearing, which should have afforded her sufficient time for legal consultation; and that official interference - of which there was no evidence - was a matter into which inquiry could not be made by the MRB: He asked Miss Welsh to proceed with the charge.

Miss Welsh said she must insist on an adjournment. Mr Bradley [the barrister appearing on behalf of the accused doctor] opposed an adjournment. The President after consultation with other members of the Board informed Miss Welsh that the request for an adjournment could not

be granted and that if she would not proceed with the charge, the Board had no alternative but to dismiss the case.

Miss Welsh said she must consider for a while as she must communicate by telephone with a certain official (stated later by Miss Welsh to be the Minister for Health).

The President informed Miss Welsh that the Board wished to give what assistance it could within reason; but it appeared to members that no good purpose could be served by adjourning the Court. He must ask her quite definitely to proceed at once with the charge; or the case would be dismissed.

Miss Welsh stated that she had relied on the Minister to provide legal assistance. There was a definite official leakage and she must know why. Everything had been done to suppress the matter (Medical Registration Board NSW (1838-1972), Vol 7, pp133-4).

The MRB ignored Welsh's pleas for an adjournment and dismissed the case. It is difficult to disagree with her view that there had been, in modern terms, a "cover-up". Despite her strong feelings about the case (as a nurse she had no doubt been an eye-witness of the events leading to Smith's death), she obviously did not have the means to employ the services of solicitor. Thus this proto-typical "equal health advocate" found herself powerless against the alliance which existed at that time between the government, corporate rationalist and professional monopolists interest groups.

The chief representative of the government was the Minister for Health, Mr Herbert FitzSimons, who as related in the previous chapter, was responsible for piloting the 1938 Medical Practitioners' Act through the parliament. Welsh's hopes for help from him were misplaced; his thinking on the meaning of "infamous conduct" is evident from a case cited in parliament by Mr John Hawkins (Labor, Newcastle), during the committee stage

of the 1938 Medical Practitioners' Bill (NSWPD 2:153 18/8/1938 pp1143-4). Hawkins related how, through negligence and failure to act quickly, a doctor at the Buladelah hospital directly contributed to the death of an injured 19-year old youth from a forestry camp in the district. When the man's workmates, who had carried him three miles over bush tracks on an improvised stretcher, brought him to the hospital, the doctor on duty adopted a truculent attitude and wanted to know how the costs of treatment would be covered. The workmates said they would pay whatever was necessary, but when they said that the youth urgently needed to be taken to Newcastle hospital, the doctor had asked who would pay for the 'phone call. He did nothing more than examine the youth and diagnose blood poisoning, leaving him in a bed outside on a verandah for the rest of the night and next day without treatment. When his workmates visiting him the following evening and found him semi-comatose, they protested to the doctor, who ordered them out of the hospital. He also said that in future there would be no treatment to patients who did not pay for it in advance. Although the youth was eventually taken by ambulance to Newcastle hospital, he died there.

So outraged were the workmates by the doctor's actions that they took the case to Hawkins as their local MP and he in turn raised it with the Minister. While obviously the MP and the workmates thought the doctor had been guilty of "infamous conduct", the Minister claimed that under the 1912 legislation, he had had no power to act against the doctor. That judgement of course, was based on the interpretation of "infamous conduct" which confined its purview to moral turpitude and obviously in the Minister's view that did not encompass the allegations of negligence made against the doctor. The best the Minister could think of was to refer the case to the BMA, but since the doctor

was not a member of that organisation, it had no grounds for taking action . No doubt the doctor in question would have had his own version of the events but he was never called to account for his behaviour.

The case was indicative of how little ideas about peer review and "infamous conduct" had changed since 1900 in official and medical circles. The record of the MRB over the first four decades of the 20th century further indicates that the interpretation of "infamous conduct" was not even particularly focused on issues of "sex-and-booze" which characterised those of the late 19th century, but rather on unfair financial gain by individual practitioners. The lack of any disciplinary cases at all between 1900 and 1915 and the small number of such cases between that date and 1938 also indicates that exercise of medical discipline was not seen to be of high priority by the MRB even after the passing of the 1912 Act. However, the development of the non-official complaints pathways by aggrieved patients described above, and cases such as those presented by Nurse Welsh and the Buledelah loggers, also indicate that there was a slow but steadily rising demand for greater medical accountability among patients.

The effects of the 1938 Act on institutional autonomy

One point which stands out with regard to the constitution of the MRB, is how slowly it changed. As noted above, not until 1912 was there any attempt to alter the chaotic nature of the legislation of 1898/1900. Although updated Medical Practitioners' Acts were considered in the 25 years after 1912, it was not until 1938 that a new, much more

comprehensive Act was passed.⁴³ The need for that Act would have been made ever more pressing by the continuing expansion of the population of the State from 1,777,534 in 1912 to 2,735,695 in 1938 (35%), while according to Hilder (1959), the rise in the numbers of registered medical practitioners from 3,213 in 1912 to 6,035 (53%) in 1938, was even faster (p34).

During this period regulation of other health occupations was also expanding; besides pharmacy and dentistry regulated in 1897 (Haines, 1997) and 1900 (New South Wales, 1901 pp471-5) respectively, nursing was regulated in 1924 (Anonymous, 1990 1990, p23) and optometry in 1930 (New South Wales, 1938 pp643-53), while physiotherapy was moving towards being regulated, something which eventuated in 1945. The more comprehensive nature of the Acts which established the regulatory bodies for these health occupations, stood in sharp contrast to minimalist nature of the 1912 Medical Practitioners' Act.

That Act would also have seemed increasingly inappropriate in the light of the rapid expansion of governmental activity in the health field. As noted in the previous chapter, health became a full portfolio with its own Minister in 1913. Annual reports of the Department of Health indicate a steady expansion of the bureaucracy and the activities in which it was involved. Whereas in 1913, the number of staff running the various sections of the Department for Public Health amounted to a little over 100 (New South Wales, 1915 pp12-14) by 1938 that number had grown to close on 1,400 working in 25 sub-

⁴³ An Amendment Act was passed in 1915. However, this did nothing more than prohibit the registration of any

divisions (New South Wales, 1940b pviii). While the number of hospitals grew from 342 in 1913 to 549 in 1938, efforts in the field of public health (i.e. that sector concerned with the control and elimination of disease) were becoming a central concern.

In the face of this expansion of activity and interest in the health field as the 20th century progressed, the failure of governments to change the elementary nature of the 1912 Act meant that in many ways, the history of the pre-1898/1900 period as far as medical regulation was concerned, was repeating itself, even though unlike in the earlier period, there was an Act in place. However, the struggles to pass the 1900 legislation had left a long institutional memory which seems to have discouraged any attempts to pass another Act. This can be deduced from an anecdote told by Mr Herbert FitzSimons (Coalition, Lane Cove). In the later stages of his long parliamentary career, he moved to the Upper House where during debate on the Medical Practitioners' Act of 1963, he stated:

I well recall that in 1936 I first discussed proposals for the new Medical practitioners Act with the Crown Solicitor, Mr Clarke, and the Parliamentary Draftsman, Mr. McCrae. I remember Mr. Clarke looking at me quizzically in my office in the Department of Health and saying: "Are you really serious about attempting a new Medical Practitioners Act?" I said, "Yes, Cabinet has directed it." He said: "I shall just tell you this. In the department somewhere there are probably the remains of twenty six previous drafts of Medical Practitioners Acts, some of which were taken only to the rough draft stage, some of which were printed and some of which were actually introduced, but as far as I know none ever succeeded in getting approval" (NSWPD, 3:46, 3/4/1963, p4063).

doctors of German or Austrian registration.

However sceptical the "Sir Humphrey" of his day was about the possibility of passing a new Act, it is evident both from what he said about the 26 drafts of putative Acts and also from FitzSimons' report about the directive from Cabinet, that there had been a growing realisation during the 1930s of the necessity for passing of such an Act.

FitzSimons had been appointed Minister for Health in the conservative Coalition government which, having first come to power in 1932, had been re-elected in 1935. Although, as he recalled in his 1963 speech, moves to introduce a new Medical Practitioners' Act began the following year, these were not implemented until after another Coalition election victory in February, 1938. That cleared the way for FitzSimons to introduce the Act in July 1938, and as we have seen in Chapter Four, the effects of party discipline ensured that it had passed into law by the end of the year.

The 1938 Act was the most extensive and sophisticated medical regulatory legislation adopted in NSW to that date and brought this State into line with legislation in other Australian States and overseas jurisdictions. It might also be remarked in passing that this Act enormously strengthened the position of the medical profession. Not only did it extend and tighten the provisions relating to the admission of candidates to the profession, but it also laid down that only registered practitioners would in future be permitted to hold appointments, honorary or non-honorary, as medical officers in public hospitals and medical officers of health, to sign death certificates or to sign any legal certificates. Although these stipulations had been applied since 1894 (see Chapter 4, p120) in terms of policy, this was the first time they had been given legal force. That constituted a major reinforcement of allopathic medicine's dominance of medical

discourse since it decisively confirmed the exclusive recognition of the legitimacy of allopathic medicine by government.

In line with the general recasting of medical regulation, the Act also made extensive changes to the constitution of the MRB. For instance, rather than merely specifying as had the previous Acts, that it should consist of not less than three members, the 1938 Act set the number at nine. One of these was to be appointed by the Senate of the University of Sydney, another to represent the interests of physicians outside of Sydney, while the remainder was appointed by the government. However, the fundamental composition of the MRB was left essentially unaltered in that the Act specified that all members had to be medical practitioners. In other words, there was no attempt to bring in "lay" or non-medical representation as had been suggested in the 1870s and in fact there was no such representation until 1963.

Still, the total domination of the MRB by medical practitioners was only half the story. It was pointed out during debates in the Upper House that all government appointees to the MRB were also likely to be members of the BMA (NSWPD, 2:157, 6/12/1938, p3281). In the Lower House, the leader of the Industrial Labor Party, Mr James. Heffron, (who later became State Premier), raised an interesting point when he asked: "Would the Premier allow any board that was established to deal with the mining industry to be comprised of three members of the Miners' Federation, and give them authority to determine wages and conditions to govern the industry?" (NSWPD, 2:155, 14/7/1938). The flaw in that argument was of course, that the miners were just one of the stakeholders in the mining industry and thus hardly deserved to be given exclusive control of it. This

highlights the fact that in 1938 the medical profession was seen to be the only stakeholder worthy of any recognition in Medicine's controlling body. Government-nominated members to the MRB were appointed as representatives of the medical profession, not of the State. In fact, as will be outlined shortly, government came under pressure to allow the BMA to have direct representation on the Board, a demand that was at least partly successful.

The continuance of the institutional autonomy of Medicine was assured by the fact that, as in previous legislation, the 1938 Act laid down no reporting requirements for the MRB. Moreover, while for administrative purposes, it was included in the purview of the Department for Public Health, which provided it with office accommodation and administrative services, there were no official lines of communication with the Department. When Mr Charles Kelly (Labor, Bathurst) charged in the debate on the Act that "The board will be altogether distinct from the Department of Public Health" and that the Minister was therefore "creating something that will be outside his jurisdiction," the Minister did not deny the accusation. Nor did he make any response to Kelly's statement that he was giving "to an outside body power unequalled in the history of responsible government in New South Wales" (NSWPD, 2:155, 10/8/1938, p327). But in fact this had always been the case; at that stage it was not seen to be part of the operations of the Department for Health, as is indicated by the fact that there was never any reference to the MRB in the annual reports of the Department either before or after 1913, when a separate ministerial health portfolio was established.

Even had they agreed with Kelly, the government at this point were in a weak position over against the professional monopolisers, who found powerful support in the Upper House of the parliament. Although it had ceased to be a purely nominated body in 1934,⁴⁴ the Upper House continued to differ sharply from the Lower House on questions of medical regulation. Thus, while as we saw in Chapter Four, the BMA was the subject of harsh criticism in the Lower House during the debates on the 1938 Act, the opposite was true of the Upper House, where members not only heaped adulation on the BMA, but also demanded that it be given direct representation on the MRB. When even the conservative Minister piloting the Bill balked at the recognition of what he called "sectional interests", he none the less was forced to compromise and to accept an amendment which gave the BMA the power to appoint the Board member representing the interests of doctors outside Sydney (NSWPD, 2:157, 6/12/1938, pp3279-84).

The financial arrangements of the Board would have bolstered its independence. While it produced revenues from the registration fees of doctors⁴⁵ which went directly into consolidated revenue, its operations involved practically no financial outlays for government. Particularly in its earlier years, it met once a month in offices provided by the government (NSWPD,3:7 11/11/1953 p1866) so there were no accommodation expenses and moreover until 1955 its members acted in an honorary capacity.⁴⁶ If it is

⁴⁴ Although it had become "elective", it was elected only by the members of parliament. It became a popularly elected chamber only in 1978 (NSW Parliamentary Archives, 1991, p.30).

⁴⁵ As from 1950 these fees had to be paid annually and not simply when the doctor first applied for registration (NSWPD, 5/10/1950, p563).

⁴⁶ Also until 1938, secretarial services were provided by a member of the MRB. One reflection of the "amateur" status of secretaries is that its minutes were handwritten until 1932, a good half-century after the invention of the typewriter and its widespread employment in office work.

true that "he who pays the piper calls the tune", then it is also true that non-paid pipers have much more freedom to play their own tunes and to act autonomously.

Even though members of the MRB had been officially requesting government since 1946 that they be paid for their services (New South Wales, 1938 Vol 8 unp), what they received once their request had been granted in 1955 would hardly have formed a major portion of their income. Initially these payments amounted only to £6 per monthly meeting for the first hour and £2 for every subsequent hour. In 1967 their fees the corresponding payments were \$25 and \$20 respectively (New South Wales, 1938 8/9/1967 unp). Not only did government therefore largely lack any grounds for demanding "value-for-money" from the MRB, but the fact that those who served on it were seen as leaders in the profession and the community would have inhibited any inclination to call the MRB to account for its actions or inaction with regard to the enforcement of discipline of or anything else, for that matter.

The effects of the 1938 Act on medical discipline

The 1938 Act brought about extensive changes in the MRB's disciplinary machinery. In place of the open court system set up in 1912, the new Act established an official Medical Tribunal for the hearing of disciplinary cases, consisting of the members of the MRB but with a judge of the District Court as its president, which ensured that its deliberations were conducted under competent legal supervision. Emphasising the distinction between this Tribunal and the MRB itself was a provision that its members would be paid, which meant that for the first time in 100 years, members were given some remuneration for

their work, although somewhat anomalously, as mentioned earlier, they were not paid for their work on the MRB until 1955.

The Act also widened the scope of the grounds on which the discipline of medical practitioners could be based. While the main grounds of "felony or misdemeanour" and "infamous conduct in any professional respect" remained intact, addiction to alcohol or drugs was incorporated as a new legal ground for deregistration. Moreover, there was some sophistication of the penalties which could be imposed, in that besides deregistration, it was now possible for the Medical Tribunal either to suspend an erring practitioner from practice for a set period of time, or simply to issue them with a reprimand. This seems to have arisen out of a case in which the MRB had found itself impaled on the old "death-or-nothing" provision when a doctor was found guilty in a court of law of causing injury while driving a car under the influence of alcohol. He was then hailed before the MRB which found him guilty of "infamous conduct" and struck his name from the register. It did so with reluctance however, stating: "Had we power to suspend him we would have suspended him. Finding him guilty of professional misconduct. we could punish him only in the way provided by the Act..." (NSWPD, 2:157 6/12/1938 p.3283).

Another major innovation of the 1938 Act was that for the first time it created an official pathway for the registration of complaints against practitioners by members of the public. Now however, instead of the Department for Public Health constituting the complaints-screening body, this function was put in the hands of the Board of Health, the statutory body which had originally been called into existence in 1881 to contain a smallpox

epidemic and which ever since was responsible for general oversight of health care in the State. Reflecting the fact that the containment of the 1881 epidemic was seen to be a community-wide concern, this nine-member Board had been set up with a majority of "lay" members, the remainder being medical practitioners. Placing the preliminary screening of health care complaints in the hands of this lay-dominated body might have seemed to represent a small diminution of the control of disciplinary processes by the professional monopolisers. However, it is unlikely that this was a conscious attack on their power or autonomy. As is evident from the Minutes of the MRB(New South Wales, 1938 Vol 7, pp51-2) the Minister had been consulting with it long before the 1938 legislation was introduced, and while this admittedly was not about the new disciplinary machinery, there can be no doubt that the members of the MRB, and therefore the BMA, would have been well aware of what was proposed. They registered no objections, nor did the supporters of the BMA in the Upper House.

There may well have been second thoughts on this issue once the new system was put into place. In April 1941 it was reported by the secretary of the MRB "that the Crown Solicitor's Office and the Board of Health were ready to proceed with the charges pending against 8 medical practitioners" (New South Wales, 1938 Vol 7, p287). This was just a little over two years after the 1938 Act had been passed and the number of eight cases reported here can be compared to the 12 cases instituted by the MRB itself between 1912 and 1938. That seven of the eight cases related to practitioners being addicted to drugs or alcohol is indicative of the effects of the 1938 Act, which as noted, had included such addiction as a ground for deregistration. On the other hand, that there were only eight more such cases between 1940 and 1963 (four of them in one year,

1961), is one pointer to the somewhat erratic record of the Board of Health in dealing with complaints (Board of Health, 1897-1973).

Indeed, the choice of the Board of Health as the channel for complaints seems somewhat odd. This Board, which only met once a month and therefore had a very part-time membership, had always been concerned with public health matters such as the licensing of food outlets and the control of infectious disease rather than curative medical practice. And unlike the Medical Tribunal, it did not have a member of the judiciary to guide its deliberations. When a complaint was laid, the Board used its own officials to investigate and report. Either because of or in spite of the predominantly "amateur" nature of the Board of Health, it referred an average of close on three disciplinary cases a year to the Medical Tribunal compared to the average of one case every two years in the 1912-1938 period. Altogether between 1938 and 1963 the Board considered 106 cases (32 of them were rejected and therefore not passed on to the Medical Tribunal) and in line with the 53% increase in the number of registered medical practitioners, there was a corresponding rise in the number of cases. Thus while during the period from 1938 to 1951 the Board considered 26 cases, in the period 1952-1963 the number of cases totalled 81 (which means that during this period, it was considering an average of close on seven cases a year). The following is a breakdown of the grounds on which the Board referred cases to the Medical Tribunal:

Infamous conduct	26
Misdemeanour	20
Drugs/alcohol	24
TOTAL	70

The minutes of the Board of Health detailing these cases only rarely stated the reasons for the charges laid against practitioners or the origins of the complaints. It is notable however, that practically all the cases in which the name of the complainant was given, were dismissed by the Board since they were adjudged not to contain sufficient *prima facie* evidence against the practitioner. This would seem to mean that the majority non-medical representation on the Board did not necessarily make it more sympathetic to individual complainants.

That in turn indicates that opportunities provided to aggrieved patients to register their complaints under the new system introduced in 1938, were extremely limited. As in the era between 1912 and 1938, in terms of the new Act they also had to prove their case twice, first before the Board of Health, and then before the Medical Tribunal, which was of course, merely the MRB with another name. Thus while the 1938 Act did make some slight obeisance to the interests of health consumers, it remained heavily weighted in favour of those of the medical profession.

However, in the view of the BMA (which changed its name to the Australian Medical Association in 1962) the weighting was not heavy enough. Although there were no open challenges to peer review after 1938, none the less it appears from a letter in the correspondence columns of the *Medical Journal of Australia* (MJA the official journal of the BMA) that there was unease in the ranks of the BMA about the role of the Board of Health. In a letter of August 14, 1954, Dr Douglas Anderson, who gave his address as Macquarie Street, Sydney, argued that a weakness of the system of complaints investigation established by the Medical Practitioners' Act lay in "... the curious

circumstance that it is possible for medical practitioners to be in a minority on the Board of Health". He argued that whereas "it is in the public interest that medical discipline and the preservation of the profession's good name should be the responsibility of the profession itself" (*MJA* Vol 2, No. 7, p272)⁴⁷ this peer review principle was not being observed in the current system. He repeated his points in another letter to the *MJA*. In 1960, in which he again asserted that because the majority of the members of the Board of Health "may not be medical practitioners", it was "a very unsuitable body" for the processing of complaints. He charged that the Board had made "serious errors of judgement in the past in referring to the Tribunal matters which ought to have gone no further" and asserted that the time had come for the disciplinary provisions of the Act to be amended (March 19, 1960, p.478).

The thinking of the NSW branch of the BMA/AMA on this issue was set out in a position statement which appeared in the *MJA* in June 1960. This repeated Anderson's point that the Board of Health was not the body to which complaints should be made; instead it stated, the

screening of complaints should be referred in the first place to MRB and that their final adjudication placed in the hands of a Disciplinary Tribunal consisting of a member of the legal profession and two medical practitioners, one appointed by the Minister, the other by the NSW branch of the BMA. (June 4, 1960, p902). Such a system would have totally excluded any "lay" participation in the disciplinary process apart from that of the member

⁴⁷ Anderson also made the interesting observation that "the law distinguishes between the wrongdoings of doctors and their unskilful or negligent acts, which are dealt with by the ordinary legal processes". While there

of the legal profession, who could be expected to defer to the opinions of the medical representatives on the interpretation of "infamous conduct". Whatever the Minister for Health thought of this proposal, he was to be impelled to act on medical discipline within the next 18 months not by the professional monopolists, but by what was to become an unfailing champion of the community population structural interest group, the media. The catalyst was the Windsor Hospital incident of December 1961 (see p178), which brought the era introduced by the 1938 Act to an abrupt close.

In summing up developments with regard to peer review during the era between 1938 and 1963, the most significant feature seems to have been the effect of placing the screening of complaints in the hands of the part-time Board of Health with its majority of non-medical members. From the figures given on on p192-3, it can be seen that even though the Board did not prove to be particularly sympathetic to individual complainants, none the less the number of disciplinary cases it sent to the Medical Tribunal increased at a rapid rate, especially towards the end of the period. The resentment this aroused in the ranks of the AMA indicates that the 1938 system which used the Board of Health as the first stage of the complaints pathway, represented what the AMA anyway, regarded as a rising challenge to peer review.

It might also be remarked that even the increased volume of cases sent to Medical Tribunal probably did not represent anything like the full number of health complaints being made at the time. As will appear from the next section, members of the public were

is no evidence that that view was widespread, Anderson's opinion could indicate why the medical profession at

actively seeking alternative complaints pathways to those laid down in the 1938 Act, particularly through use of media.

Media becomes a player

The part media played in bringing about change in the Medical Practitioners' Act of 1963 represented a new development in the health care field which deserves particular noting because it was to have major effects on questions of medical discipline. Mass media's interest in health issues was spurred not only by its unending quest for news, but by government and in particular by the Department for Public Health. As the 20th century progressed, as Baum points out in *The New Public Health*, (Baum, 1998 pp20-28) governments increasingly abandoned the old *laissez-faire* attitudes to public health which left it to individuals and individual households to maintain hygiene and healthy environments. Instead, the Department for Public Health began actively to propagandise the population about health issues and to promote what in modern parlance would be called "healthy lifestyles". The first indication of that new drive was a statement in the annual report of the Director-General for Public Health in 1915 that "steps will be taken at an early date with a view to arranging for the delivery of courses of lectures on health matters at centres in the metropolitan and suburban country schools of art" (New South Wales, 1915 p13).

Over the next two decades these propaganda efforts expanded enormously, the Department for Public Health moving from mere lectures in "country schools of art" to increasing use of mass media including both newspapers and "the wireless" which created its own far-flung audiences from the 1920s onwards. The Report of the Director-

the time interpreted "disgraceful conduct in any professional respect" as not including practice issues.

General of Public Health for 1938 shows that by that time a full-time Publicity Officer had been employed and his report filled several pages. Among other things, he stated that in terms of a long-term plan drawn up some years before, provision had been made "for the issue of attractive posters, show cards, and booklets; the use of health motion pictures; press propaganda, photographs and stereos, broadcasting of health talks, lectures and addresses, effective window displays and exhibits, promotion of Health Weeks and exploitation of other avenues"(New South Wales, 1940a p67).

Public consciousness of the importance of health care issues was also boosted by the professional monopolists, as represented by the AMA, entering the media arena. Although the AMA did so much later than the corporate rationalisers, after its NSW branch established a Public Relations Committee (PRC) in 1956, it began to play a major role in public health education and promotion. Of course it was not doing this in a wholly disinterested way, its aims also embracing the protection and enhancement of the image of the AMA. In pursuit of that brief, the PRC began to place material in both print and electronic media and in the following year, it engaged the services of a firm of public relations consultants, J. Walter Thompson, at a cost of £2,000 a year, possibly the equivalent of \$200,000 in 2002 (Australian Medical Association, 1956-62 25/6/1957, Minute 41b p17). In 1958 it was reported that the PRC had been responsible for sending material to over 150 newspapers in both urban and rural areas, had sponsored a 48-page supplement to *Women's Weekly* and had provided a series of talks, such as "Keeping Your Family Healthy", to radio stations (Australian Medical Association, 1956-62 Minute 197, Appendix). The new medium of television had not been used to any great extent, but this was to change in the 1960s.

Just how active the PRC became in that decade can be appreciated from an item in its minutes of 1962, which stated:

It was noted that the Secretariat was considerably occupied in answering the day to day members' queries, holding Press Conferences and issuing press statements, writing letters to answer to correspondence [sic] of all variety, providing articles and radio material to guide the public on community health matters, assisting radio and television interviewers to obtain the Association's views, assisting individual journalists and feature writers to obtain medical data and checking afterwards prior to publication (Australian Medical Association, 1956-62 8/4/1965, Minute 481, p7).

The AMA was of course, simply duplicating the drive to use media for health promotion purposes started by the corporate rationalists, but that drive probably produced unintended consequences for both structural interests. Since so much of the effort to make the population more health conscious emanated from authoritative sources, it would have naturally followed that in the eyes of the populace, those authorities in both the public and private sector were as responsible for the maintenance of health standards as was the individual citizen. Very probably this was one factor which spurred the mobilisation of the community population/equal health advocate structural interest in the second half of the 20th century.

Cases such as that of the Buledelah hospital and that raised by Nurse Welsh cited above, indicate that the populace began increasingly to expect government to be responsible not only for public health on the macro-level, but also to intervene on the micro-level when the provision of health care by individual medical practitioners and health institutions

was sub-standard. While governments were initially unresponsive to these demands, the situation began to change in the 1950s and 1960s after mass media had been alerted to the potential of health care as a source of news and sensation by the favourable public response to the governmental and AMA health promotion campaigns. The powerful impact of media interest in health care issues, especially those containing a hint of scandal, was demonstrated by the role played by media in the events which occurred at the Windsor Hospital in December 1961.

The Windsor Hospital incident

Those events were set in train by a visiting medical officer or VMO (i.e. a doctor appointed to work in the hospital an honorary capacity), Dr J.F. Boag, who was seeing private patients in his surgery at the time he was supposed to be on duty at the Windsor District Hospital. When a six-year old boy with an arm fractured in two places by a fall from a horse was brought into the hospital for treatment, Boag directed that the boy be brought to his surgery. When that was done, he demanded a fee of £10. Had the treatment been undertaken at the hospital, it would have been gratis.

That story was unnoticed by media, but it was considered serious enough for the Windsor Hospital Board to ask Boag to attend an inquiry on December 18, 1961. When he refused, claiming he had not been given enough notice, he was suspended from his VMO position. In reaction, all the other nine VMO doctors withdrew their services from the hospital. The outcome of that action was summed up in a large headline in the *Sydney Morning Herald* on December 26: "No doctor available. Man dies". The newsworthiness of the story was enhanced by the fact that the man who died had been injured in a water skiing

accident. He was taken by his friends by car to the Windsor Hospital where, with no doctors on duty, they were directed to the surgery of one of the "striking" VMOs, but could get no response when they knocked on the door (it was a Sunday). They then tried to take the injured man to Parramatta hospital, but he died in their car on the way there.

The story caused a great public outcry and that the "striking" doctors realised just how serious it was is indicated by the fact that after being contacted by the Hospitals Commission (the body which had oversight of all hospitals in the State), the VMOs agreed they would treat emergency cases at the hospital. The following day the *Sydney Morning Herald* again carried a major article under the headline "Doctor Dispute: Sheahan Sees Need for Ethics Review" (Sheahan being the Minister for Health at the time). It also ran an editorial entitled "The Duty of Doctors" in which it attacked the "striking" VMOs for their "false sense of loyalty to a colleague". The editorial stated:

Such an extreme decision by a group of doctors virtually to boycott their own hospital is rare, if not unprecedented, in the annals of the medical profession. But the fact that it could occur at all, points to a lowering of former professional standards. Many complaints received by the Department of Health... show that there is a more extensive withholding of services and relaxation of diligence than this extreme case would suggest.

Newspapers for days on end ran major stories on the incident and the subsequent four-day long inquiry by the Hospital Board in January, 1962. On January 11, the main front-page headline of the *Sydney Morning Herald* read: "Board Dismisses Doctor: New Angry Clashes at Inquiry". Boag's dismissal was described as a "Hitler regime tactic" by Boag's counsel, Clive Evatt QC. Confrontations of this kind made excellent news material for

media, something which increased pressure on the both the government and corporate rationalists, as well as on the professional monopolists. Government executives in particular had much more to lose from consumer discontent than did the professional monopolists and this factor began to drive a steadily widening wedge between the two structural interests which would widen into a chasm when the equal health advocates, with the enthusiastic support of media, emerged as a political force

The 1963 Medical Practitioners' Act

The enormous publicity and press coverage left the Labor administration of the time with no political alternative but to take swift action. The Minister for Health, Mr Bill Sheahan, thus set about a major revision of the legislation which, when it was incorporated in the Medical Practitioners' Amendment Act of 1963, was the most important of the long series of amendments to the 1938 Act which had been legislated during the 1940s and 1950s.⁴⁸

In constructing the new Amendment Act the Minister proceeded carefully. His first move was to call the "ethics conference" alluded to by the *Sydney Morning Herald* headline quoted above, on January 23, 1962. It was attended by representatives from his Health Department, the MRB and the Australian Medical Association⁴⁹ (AMA) and also a lecturer in medical ethics from the University of Sydney. The conference appears to have been a stormy one; Sheehan later told the parliament that there had been a "frank" discussion and "differences of opinion" (NSWPD, 3:46 2/4/1963 p4007), a typical political euphemism for "a blazing row". Although he did not specify the main points of

⁴⁸ Those amendments were concerned with the qualifications of doctors and therefore are not of direct concern to the present thesis.

difference, the medical representatives were probably reacting against his argument that the definition of "infamous conduct" should be extended to include refusal by a doctor to see patients in an emergency.

Despite the objections, just such a clause was incorporated into the 1963 Act. This was the first time that there had been any specification or definition of "infamous conduct" in NSW legislation. While that represented a diminution of the peer review principle in that it infringed on the profession's sole right to define "infamous conduct", a year later in parliament Sheahan claimed that it had been agreed to by all parties, including the representatives of the AMA (NSWPD, 3:45, 27/3/63, p3807). This indicates that despite the initial resistance, as the *Sydney Morning Herald* remarked in an editorial: "...it is a fair inference that [the AMA] felt no enthusiasm for the recent behaviour of the nine Windsor honoraries" (26/1/1962). In its editorial on the same day, the *Daily Telegraph* expressed the view:

The proposals for State legislation to force doctors to obey their own code of ethics seems moderate, sensible and just. The legislation should ensure that members of the public in genuine need will never be denied medical care; it should safeguard hospitals - and consequently the public - from actions like the recent walkout of honorary staff of Hawkesbury District Hospital. (26/1/1962)

What is clear from these editorials is that the newspapers in question constituted a powerful ally for the Minister on this issue. However, as already suggested, although the 1963 Act was designed to rein in the medical profession, in the final analysis it had exactly the opposite effect.

⁴⁹ It had changed its name from the "British Medical Association" in 1962.

Medicine resumes control of health complaints processes

The AMA had been very concerned about the proposed changes to the Act on its national level as well as on the NSW branch level. This is evident from an editorial on the subject in the *MJA*, which ordinarily paid little attention to issues within individual State jurisdictions. This editorial noted that in the Governor's speech at the opening of the 1962 NSW parliamentary session, it had been indicated that an alteration was to be made to the provisions of the Medical Practitioners' Act "relating to the investigation of complaints against doctors for unprofessional conduct, such as 'failure to attend in an emergency...'" (2:2, 25/9/1962, p513). That the Windsor Hospital incident was neither the first nor the only incident of its kind was confirmed by the editorial when it reported that at the January conference mentioned above, the Minister had expressed concern about "the number of complaints being made against the Department of Health in regard to the failure on the part of members of the profession to answer what were said to be emergency calls".

The *MJA* did not mention the confrontations at the conference and reported that the Minister had later had a meeting with AMA deputation at which several matters were discussed, "one of which was a submission that the Association itself be given statutory power to investigate complaints made to it against doctors". Obviously in line with its 1960s statement given above, the AMA was trying to seize control of the health complaints process. The Minister's resistance to this idea may have been the reason for his refusal to meet another deputation from the AMA, which was regrettable, said the *MJA*, since "they might have been able to help him to steer a safe course between the

Scylla of the ineffectual and the Charbydis of the intolerable". The meaning of that resounding phrase was not set out in the editorial and it concluded with the hope that the Minister would change his mind

Although the Minister did not do so, he was doubtless wary of alienating the AMA too far, since at this point in time it had become enormously powerful. In her examination of the rise and decline of the AMA, McKay remarks that the political influence of the BMA/AMA on the Federal government was probably at its peak in the period of Coalition dominance between 1949 and 1972 (McKay, 1995). In NSW the power and influence of the BMA had peaked much earlier according to Lloyd (1993), who asserts that in this State:

[D]octors had become adept at negotiating with government, and in using the political system in general well before the beginning of World War II. Even following the establishment of the BMA Federal Council [in 1933], and despite that body's independence from state branch directives, power remained with the state councils ... The state branches, particularly in New South Wales, Victoria and Queensland, where the level of political debate had always been much greater than in the smaller states, continued to take the leading role in dealing with medico-political issues (Lloyd, 1993 p349).

However, although as suggested by the records of the Public Relations Committee, the AMA was not as powerful as it seemed, its political skills described by Lloyd may well have been sharpened by the fact that for 45 of the 62 years between 1910 and 1972, it had to contend with hostile Labor administrations in NSW. That Labor was much less favourably disposed to the BMA/AMA than its conservative Coalition opponents was evident among other things, in the critiques of that body made by its members during

Lower House debates on the 1938 Medical Practitioners' Act in contrast to its much smoother passage through the Coalition-dominated Upper House (see Chapter Four p105).

However, reflecting a complete change in the climate of thinking, among politicians anyway, since 1938, was that Labor's hostility to Medicine in general and the AMA in particular, had all but disappeared. In debates on the 1963 Amendment Bill, references to both were made in the most fulsome and complimentary terms. When introducing the Bill, Sheahan found it unexceptionable that "the doctors who will be members of the board constituted by this bill are, for all practical purposes, members of the Australian Medical Association" (NSWPD 3:46 2/4/1963). And in contrast to 1938, when the responsible Upper House Minister in the conservative Coalition government had been reluctant to grant any direct representation to the AMA on the MRB, in 1963 Sheahan as Labor Minister for Health, for reasons given below, allowed the AMA three representatives.

Moreover, while he had refused to capitulate to AMA demands that it be given complete control of the complaints investigation process, it had little reason to be displeased with what was specified in the Act. For one thing, in establishing a new pathway for the registration of complaints, the Act abolished the role of the Board of Health as the screening agency and replaced it with a three-person "Investigating Committee", one of whom had to be an AMA representative. The other members were a stipendiary magistrate, who headed the Committee, and the Director-General of Public Health or his nominee. The structure of this Committee could only strengthen medical dominance. Lay

influence been almost completely eliminated from the complaints screening process since the magistrate was likely to defer to the opinions of the two medically orientated members (the Director-General was usually a medical practitioner) when it came to judging matters of medical ethics and practice.

Like the previous system, if a complainant convinced this Committee that their case had a *prima facie* validity, it would be passed on to the Medical Tribunal. There however, the case had to be argued *ab initio*, while complainants themselves had to bear the cost of any legal representation. The Act also stipulated that the hearings of the Investigating Committee were to be held *in camera* and that anyone registering a complaint with this Committee had to put down a deposit of £5 (the equivalent of at least \$50 in 2002) and support their complaint with a statutory declaration. If the Investigating Committee decided that a complaint was "vexatious or frivolous" or contained false information, the complainant would not only lose their deposit, but could also be fined £100 for making false statements under oath (NSWPD, 3:99 7/9/1972 p791). These stipulations (which were absent from the 1938 Act) resulted from amendments passed in the Upper House, and meant that obstacles in the way of complainants had been made much higher than they had ever been before.

The MRB reconstituted

The 1963 Act brought about a wholesale reconstitution of the MRB. The expansion of its membership from 9 to 13 reflected developments in Medicine since 1938, one of these having been the emergence of the specialist colleges, or "Royal Colleges" as they were known. Thus, the new Act made provision, for the first time, for representation of the

Royal Colleges of Physicians, Surgeons and General Practitioners.⁵⁰ This however, prompted protests from the supporters of the AMA in parliament that while it was a much larger organisation than any of the Royal Colleges, the AMA has been given only one representative in the original draft Bill. It was because of this protest that the representation of the AMA, as noted above, was raised to three. Another significant innovation was the inclusion of two members from outside the ranks of practising doctors, these being a barrister or solicitor nominated by the Minister and also the Under-Secretary of the Department for Health (or his nominee). The Minister noted that the latter appointment would provide a "nexus between the profession and the Department". The Minister's reference to the "profession" rather than to the MRB seems to reflect a view that the MRB was a professional rather than a governmental body; in any case, this was the first time since 1838 that there had been a "nexus" of any kind between governmental administration and the MRB.

These changes however, represented no inroad into the autonomy or power of the profession as expressed in the MRB. The nominated barrister was the only member from outside the medical profession, while the Minister himself, who up to then had nominated all members other than those representing the University of Sydney and the AMA, was given the right to nominate only one representative. The Council of the University of New South Wales which by then had developed a medical faculty, was also given the right to nominate one representative, but it was specified that this person too had to be a

⁵⁰ Both the Federal and the NSW branches of the Colleges of Physicians and Surgeons were given representation. The recognition of the Colleges through their representation on the MRB reflected not only their advent since the passing of the 1912 legislation, but also their rising power.

medical practitioner. Since the Departmental representative was also likely to be a qualified medical practitioner, it is clear that the dominance of the MRB by the profession was strengthened by the 1963 Act. That dominance was reinforced by changes to the disciplinary and complaints pathways.

The closure of complaints pathways

When he introduced the 1963 Bill into the parliament, the Minister advanced several reasons for bringing in the new system, one of which was that, in his opinion, dealing with complaints should not be the function of a statutory body such as the Board of Health. Another more likely explanation was that the Minister had found himself under growing pressure from consumers who found the old system less than satisfactory and who, as argued above, were increasingly looking to government to intervene and correct substandard health care delivery. In speaking to the second reading debate, the Minister stated:

I have received letters of complaint against medical practitioners and I have been forced to make my own investigations and findings on the facts, although I do not think that that is part of my duties. One such complaint was first made to the medical association, which took no action, and then the person concerned went to the newspapers. I had to make my own investigations into that matter, and the resultant finding was in favour of the doctor, notwithstanding what had been published in the newspapers (NSWPD 3:45 27/3/1963 p3807).

Sheahan's report of how newspapers were being used as a non-official but highly effective complaints pathway is indicative of an emergent alliance between media and consumers which as remarked above, worked to the disadvantage the professional rationalists over against the government executive and corporate rationalisers.

While the Minister stated that the government had no desire to "build up a Maginot Line or an East Berlin wall between the public and the medical profession" (NSWPD, 3:45 26/3/1963,p3719), the management of complaints as laid down in the 1963 Act was hedged about with such careful conditions and so dominated by the medical profession that, as the table below indicates, this is exactly what happened. Compiled on the basis of figures given in the annual reports of the MRB between 1963 and 1972, Table 2 below indicates that the flow of complaints passed on to the Medical Tribunal by the Investigating Committee, underwent a drastic fall as compared to the 1938-1963 period.

TABLE 2. Medical disciplinary cases dealt with by the Medical Tribunal, 1962-72

Year	Number of cases	Penalties Imposed			
		Reprimand	Suspension	Deregistration	Not guilty
1962-65	3	0	2	0	1
1966	0	0	0	0	0
1967	0	2	2	0	0
1968	4	0	0	2	2
1969	1	0	0	1	0
1970	3 (one case adjourned)	0	0	0	2
1971	2	1	1	0	0
1972	0	0	0	0	0
TOTAL	13	2	3	3	5

(Medical Registration Board NSW, 1963-72)

The figures indicate an average of only a little over one disciplinary case a year, less than half that in the previous period. Another figure of some significance is that while the number of registered doctors rose from 6,658 (Medical Registration Board NSW, 1967 p5) to 9,878 in 1972 (Medical Registration Board NSW, 1967 p9), i.e. by 32%, there is very little year-on-year variation in the number of actions over the period under review. That the number of disciplinary cases was extremely low can be appreciated by contrasting it to statistics produced by the Complaints Unit of the Department for Health established in 1984. This was a little over a decade later, and it is unlikely that conditions would have altered dramatically over that time period. In 1984-85, its first year of operation, the Complaints Unit received no fewer than 500 written complaints and 200 telephone inquiries (Department for Health NSW, 1984 p3). Once the Medical Practitioners' Act of 1987 enabled the Complaints Unit to investigate and refer cases directly to the Medical Tribunal, in the following year alone, 1988, it sent no fewer than 15 cases to that body as well as another 12 cases to the newly established Professional Standards Committee. These figures can be compared to the 13 cases sent to the Medical Tribunal for the whole of the period between 1963 and 1972 (Department for Health NSW, 1990).

The sophistication of medical discipline

Other than extending the definition of "infamous conduct" to include failure to render emergency treatment, the disciplinary provisions of the 1963 Act were the same as those of 1938. Thus, as far as penalties for "infamous conduct" were concerned, besides deregistration, the 1963 Act also made provision for reprimanding and suspending practitioners who were adjudged to have erred in less serious ways. An analysis of the

penalties imposed by the Medical Tribunal for "infamous conduct" between 1963 and 1972 (Medical Registration Board NSW, 1963-72) shows the following:

TABLE 3: Penalties imposed by the NSW Medical Tribunal for "infamous conduct in professional respect", 1963-72

1962	Unprofessional conduct (nature not specified)	Suspension for six months
	Unprofessional conduct (nature not specified)	Suspension for twelve months
1967	Charging exorbitant fees	Reprimand
	Unprofessional conduct (criminal charge)	Deregistration
	Unprofessional conduct (addiction to drugs)	Deregistration
1968	Criminal conviction (including drug addiction)	Deregistration
1971	"Complaint proved" (no details given)	Reprimand
	"Complaint proved" (no details given)	Suspension for three months

(Medical Registration Board NSW, 1963-72).

What will be seen from the above is that none of the cases in which the nature of the "infamous conduct" was specified concerned issues of medical practice. This clearly demonstrates that the individual autonomy and non-accountability of doctors as far as their practice was concerned, was virtually unquestioned in both the MRB and in governmental circles in the period under review. That the interpretation of "infamous conduct" had not changed since 1900 is evident for instance, in the debate on the 1963 Bill, Health Minister Sheahan stated: "Nobody can attempt to define infamous conduct. To try to do so would be like Mr Speaker, trying to define improper conduct in this

House" (NSWPD, 3:45 27/3/1963 p.3807). It was a not a good analogy; the Standing Orders of parliament define improper conduct very closely (e.g. loud and persistent interjections) and there are a range of prescribed penalties for such conduct - loud and persistent interjectors may be suspended or ejected from the House. But possibly because they so completely agreed with the Minister on the score of the non-definability of "infamous conduct", neither the Speaker nor anyone one else contradicted him on this point.

The minutes of the MRB show that its members were at this time, actually thinking of extending their control over the medical profession by widening the scope of "infamous conduct". In June 1964 the MRB discussed "the implications of the ... decision to recommend that the powers of the Investigation Committee be extended to cover moral turpitude or misconduct of a non-professional kind..." Its ambitions on that score however, were checked by its barrister-member, G.H. Kerr who

... stated that had he been present at the discussion of this matter ... he would have urged the Board to be very circumspect about altering the longstanding position that infamous conduct, to imperil registration, must be "in a professional respect". He said that the policing of general conduct would be a very big change and should be introduced only if the Board felt there was strong case for it (Medical Registration Board NSW, 1963-72 Minute 5).

Exactly what was being proposed and what the members of the Board considered to be "moral turpitude or misconduct of a non-professional kind" is not evident from the often frustratingly cryptic minutes of the MRB. But obviously the barrister Kerr thought the

changes constituted a "bridge too far" and the Board seems to have heeded his advice, because nothing more was heard of this matter. .

One significant development as far as the institutional autonomy of the MRB is concerned which should be mentioned here, is that between 1958 and 1972, printed annual reports were included in the *Parliamentary Papers*, which were comprised of the documents tabled in the parliament during each of its sessions (Medical Registration Board NSW, 1963-72). This was the first time since 1838 that such reports had been made and indicated that in this respect, the necessity for public accountability was being realised either by the MRB itself or more likely, by the corporate rationalisers and governmental executives in the parliament. That development should be seen against the background of and be coupled with what is dealt with in the next chapter, i.e. the advent of the consumer movement in Australia, and also of the much less well-known, but none the less vital development of administrative law, which was transforming ideas of the accountability of all sectors of government. However, in 1972 the Health Department was transformed into a statutory authority, the Health Commission and since the MRB was considered to fall under the jurisdiction of that entity, its annual reports ceased to be published over the next 12 years and there was no mention of its activities in the annual reports of the Commission itself. This situation continued even after the Commission was re-converted into a Department in 1982.

The beginning of the end of medical dominance

The total dominance of the professional monopolisers in NSW was relatively short-lived and did not last much longer than a decade. For the sake of chronological convenience, I

have marked the end of this era by the passing of the next Medical Practitioners' Amendment Act, that of 1972. That legislation changed very little, merely adding the College of Obstetricians and Gynaecologists to the bodies represented on the MRB, as well as a representative of the NSW Universities Board, while withdrawing the representation of federal bodies of Royal Colleges. None of these tinkering with the membership of the MRB made any difference to its dominance by the professional monopolists. Nor, as noted in Chapter 2 (pp59-60), did the discarding of the "infamous conduct" terminology in favour of "misconduct in professional respect" make any difference to the exercise of unchallenged peer review in the medical profession.

None the less, despite Medicine's dominance, there was a growing groundswell of protest about its non-accountability among health consumers during this period. One indication of that was the way in which as we have seen, the establishment of the Investigating Committee in 1963 came about as stated earlier, as a result of the Minister for Health wanting to avoid having to deal with an increasing stream of consumer complaints which were coming directly to him.

However, the Investigations Committee established in 1963 proved to be anything but an ideal complaints pathway. It had no investigatory powers and worked on a part-time basis. As its chairman noted with regard to a particular case "The members of the Committee apart from myself, have busy professional practices and its most difficult of course, for them look to the possibility of having a full week away from their ordinary duties." In a Green Paper produced by the Department of Health in 1985 and to which extensive reference will be made in the next chapter, it was noted:

In practice, the [Investigating] Committee does not actively investigate complaints. The Committee writes to the medical practitioner, forwards details of the complaint and provides an opportunity for the medical practitioner to respond. The Committee then conducts a hearing at which it reviews the material placed before it. ... The cost and responsibility of preparing in support of the complaint however, rests entirely with the complainant (Department for Health NSW, 1985 p21).

The Green Paper further noted that “this approach to investigation has been widely criticised on the grounds that generally, an individual has neither the financial resources nor the medical knowledge required to assemble and present the necessary evidence” (p21).

Under these circumstances, there was very little scope for complainants to pursue their cases successfully. There may have been some realisation of growing consumer discontent in government circles. Thus it is perhaps significant that in the 1972 Amendment Act, the stipulations that complainants put down a £5 deposit and make a statutory declaration to support their complaint, was abolished. The "Maginot line" constituted by these provisions and also by the way the Investigating Committee operated, had proved unhealthily impenetrable.

It is interesting that while these provisions were incorporated into the Act at the insistence of the Liberal/National Party Coalition when it was in opposition in 1963, they were dismantled by that same Coalition when it was in government in 1972. This point was seized on by Mr Kevin Stewart (Labor, Canterbury) later to be Minister for Health, when he spoke in the Lower House debate on the 1972 Bill. The 1963 insistence of

Coalition members on the £5 deposit and the statutory declaration was, he charged, merely a result of their

jumping on the band waggon [sic] and making as loud a noise in as hysterical manner as they could in order to alarm medical practitioners of New South Wales about the big bad wolf that was going to devour them - the Labor Government... (NSWPD, 3:99 17/9/1972 p793)

While his typical parliamentary polemic need not be taken too seriously, Stewart was right in pointing to a notable Coalition policy somersault on this issue. It can be speculated that the change did not originate from within the government executive, but resulted from reports by the corporate rationalisers to the Minister about the volume of consumer complaints. The Coalition government Minister, like the Labor Minister Sheahan before him, would also have been the recipient of a constant stream of such complaints, particularly because the official channel through the Investigating Committee, had proved to be so unresponsive.

Conclusion

While the way in which the original Medical Practitioners' Acts were passed between 1898 and 1900 indicated the weakness rather than the power of the professional monopolisers, they gave this interest group a platform on which it could consolidate its strength over the next four decades. In the process, the professional monopolists showed themselves to be highly resistant to calls from the members of the nascent community population structural interest group for greater medical accountability. The position of the professional monopolists was immensely strengthened by the support for the medical peer review principle given by the courts, both in Britain and in NSW, starting with the *Allinson* case of 1894. Through the failure of the professional monopolists to recognise

the low-grade threat to peer review posed by the "complaints management" system instituted by the 1938 Medical Practitioners' Act, their grip on medical disciplinary procedures was weakened over the next 25 years. However, this position was reversed by the victories of the AMA over the government structural interest enshrined in the 1963 Medical Practitioners' Act.

In assessing the developments which led to the passage of that Act, it is obvious that the losers in the contest over control of the MRB and the complaints management processes were the government executive and the community population structural interest groups. Even though they were supported by media in their drive to curb the power of the professional monopolists, in 1963 the government interest, as represented by Sheahan, found itself isolated in the parliament. While the position of the corporate rationalists in the central Health Department bureaucracy on this issue is not very evident, they certainly would have supported the moves by the Windsor Hospital Board against Boag and the nine VMOs who withdrew their services. To have done otherwise would have undermined the whole system of medical practice in public hospitals. However, as had been proved by events between 1898 and 1900, the corporate rationalists are dependent on the power and skill of the government executive to get measures they favour through the parliament. Because the government executive lacked power seriously to challenge the support for the AMA, the corporate rationalists were helpless to achieve whatever reforms they might have had hoped for.

Since the community population structural interest group was still so unformed and inchoate, it is not surprising that it was also a big loser in this contest. However, one new

factor was the role played by media which, since they are dependent on consumers to purchase their products, invariably favour consumers in any clash with professional monopolists or government structural interests. Those among the latter who aspire to power, are of course, also dependent on consumers for votes and thus, as it became clear later in the 1960s that the AMA had failed in its attempts to secure unconditional media support for Medicine, government executives as noted above, abandoned the alliance they had perforce to enter with the professional monopolisers in 1963. Thus, while the 1963 Act undoubtedly constituted the "high water mark" for the influence of the professional monopolisers as represented by the AMA, their position was not as strong as it appeared and in fact was crumbling rapidly.

CHAPTER SEVEN

CHALLENGES TO MEDICAL AUTONOMY AND PEER REVIEW

1972-93

The previous chapter has demonstrated that medical autonomy and the peer review principle was at its apogee during the 1960s and the 1970s. The legislative embodiment of supreme professional power evident in the Medical Practitioners' Acts and their amendments from 1960 onwards, remained intact right up until 1987. This meant that the cumbersome medical disciplinary procedures outlined in the previous chapter, remained in place during that period and that in turn meant that the medical peer review principle was cocooned from the impact of the major social and political developments of the 1960s and 1970s.

However, it was precisely in that decade that new social and political forces, anithetical to professional privilege and autonomy, began to make themselves felt. In writing about this phenomenon, Habermas argued that the "new conflicts" which emerged in that era were not about distributive issues and no longer concerned the sphere of material reproduction.

Rather these new conflicts arise in domains of cultural reproduction, social integration, and socialization. They are carried out in subinstitutional - or at least extra-parliamentary - forms of protest; and the underlying deficits reflect a reification of communicatively structured domains of action that will not respond to the media of money and power.

...This new type of conflict is an expression of the "silent revolution" in values and attitudes ... (Habermas, 1968 p388)

He cites the antinuclear and environmental movements, the peace movement the alternative movement and the women's movement as examples of the "new movements" which emerged to challenge "the system" in West Germany. In Australia similar phenomena were evident in the anti-Vietnam war movement while social movements with origins that went much further back in time, moved to the forefront of public consciousness. Some of these, such as the women's movement and the movements concerned with the preservation of the environment, duplicated those of Germany; others such as the Aboriginal land rights movement were unique to this country.

One movement not mentioned by Habermas was that of lifeworld medicine, which became known as alternative medicine. It has been argued earlier that alternative medicine did not spring spontaneously into life in the 1960s, but was based on and rooted in lifeworld medicine which had been weakened, but never extinguished, during the previous two decades of the 20th century. The critiques of scientific medicine and its institutional embodiments which, as described in Chapter Four, played such a notable role in the issue of medical regulation before 1900, had not been diminished by the successes of scientific medicine in the intervening period.

Those critiques began to be broadened and made more formidable through being taken up academic sociologists. In the words of Canadian defenders of the medical profession, Cruess & Creuss: "The concept of professionalism came under intense scrutiny during the 1960s and 1970s. The belief that physicians would be altruistic was greeted with

scepticism by social scientists, and medicine was accused of putting its own welfare above that of society". They also note that: "The intellectual basis for the criticism was articulated largely in the sociology literature, not readily available to physicians" (2000 p688). A leader in this regard on the international scene was the American Professor Eliot Freidson of New York University, while in Australia Evan Willis of Monash University stands as a typical and towering example. As can be seen from the preface, his book *Medical Dominance* (1989) based on his PhD thesis, was the culmination of more than a decade of thinking and theorising together with many others at the university. In the preface to the second edition he remarked on "the way that the concept of medical dominance has become part of the discourse of health care policy analysis in Australia" (unpaginated).

Another "new social movement" not mentioned by Habermas, but which is of particular relevance to this study, was the consumer movement. The word "consumer" is a loaded one, implying that the buyer of goods and services has rights which need to be respected and which, if they are violated, merit legal redress. That notion was evident in the speech by the NSW Minister of Labour Mr Eric Willis when he introduced the first Consumer Protection Bill into the NSW parliament in 1969. He quoted an article in the *Boston Law Review*, (NSWPD 3:78 12/3/1969, p4447) which stated:

Caveat emptor, according to both celebrants and mourners, is dead - buried by the vast flood of new consumer protection status. Indeed, changes wrought in the substantive law of the marketplace have defined and established new consumer rights and merchant duties in recognition of the fact that mass advertising, distribution and merchandising have

radically differentiated modern consumer transactions from the feudal antecedents up which so many common law principles are based.

That development was to have important consequences for power relationships in the health sphere when the word "consumer", with its connotations of the active participation and the power of buyers in commercial transactions, began to be used to describe patients. Taking up the point made by Willis above, the word "consumer" also helped to change the discourse of health care policy and in itself constituted a challenge to the principle of peer review.

Since "consumerism" played such an important part in that challenge, it is important to examine the origin and growth of the consumer movement in Australia. That movement had begun to emerge in institutional form in the United States as far back as 1929, and three decades later the Australian Consumers Association (ACA) was established in 1959. But rather than being the generating force behind the wave of consumerist sentiment which burgeoned over the next ten years, the ACA like a surfer, merely rode that wave, which had obviously been in powerful although inchoate and unorganised existence for a long time. The initial membership of the ACA, garnered from public meetings and other activities, was 500 and these members were the recipients of the first edition of *Choice* published early in 1960. Writing about that event 25 years later, one of the founder-leaders of the ACA, Dr Roland Thorp of the School of Pharmacology at the University of Sydney, stated:

When those magazines were delivered ... subscriptions started to pour in, and our initial print-run of 5000 was soon exhausted and another 15,000 were ordered. Offers of help came from all sides – we could see that ACA was going to be a huge success (Halpin, 1974).

Strangely, no records of the early growth of the ACA other than that given above, seem to have survived. The first firm indication of the number of subscribers to *Choice* (who automatically became members of the Association) appeared in its Annual Report for 1980, in which a graph illustrated the rise in membership since 1969. In that year, a decade after the establishment of the ACA, there were 60,000 subscribers. That figure rose to a peak of just under 200,000 but thereafter underwent some major fluctuations, falling away to 100,000 in 1979 (Australian Consumers' Association, 1980 p2). Even so, the ACA ranked as a major organisation.

Supporting Habermas's contention that this "new social movement" was not based on distributive issues is the statement by Professor Thorp (Halpin, 1974) that the strongest support came from "teachers, academic staff, public servants etc." but that "unfortunately the less affluent workers and their unions took little interest in us...". In other words, this was a middle class movement; according to Thorp, its best recruiting ground was among the membership of Rotary, Lions and the Apex clubs, which in many ways epitomise the ethos of middle class suburbia.

Government takes up the consumerist cause.

From the point of view of this study, the most important result of the consumer movement was not so much its effects on commercial transactions in the private sector, but the way in which it influenced both government and also governance in the public sector. Of crucial importance in the latter regard was the emergence and implementation of "administrative law" which will be more fully dealt with shortly. At this point we should note that like mass media, governments became aware of the popularity of the

consumer cause in fairly short space of time. The first governmental response to the consumer movement in NSW was the passing of the Consumers' Protection Act of 1969 which established a "Consumer Affairs Council" composed of consumer representatives who acted in an advisory capacity to government. The Act also set up a "Consumer Affairs Bureau" as a unit within the Department of Labour and Industry, to give advice to consumers and to receive complaints about sub-standard goods and services.

In introducing the Act, the Minister of that Department, Mr Eric Willis, explained that NSW was following the lead of Britain, Western Europe, the USA, Canada, Japan and New Zealand, all of which by that time had fully established government-sponsored agencies to look after the interests of consumers. Expressing a significant new governmental attitude towards the issue of consumer rights, he declared: "Consumers need help and this is a government responsibility" (NSWPD 3:78 12/3/1969, p4447). It could be cynically observed that the NSW government had come to that conclusion only after seeing the successes of the ACA and realising that there were electoral rewards to be gained from jumping on the consumer bandwagon. None the less, that government had made the move indicated that consumer rights had entered into societal discourse.

This first foray into the field of consumer rights was a limited one. The function of the newly established Consumer Affairs Bureau was simply to give advice to consumers and to receive complaints about the quality of mainly foodstuffs and everyday commodities (NSWPD 3:78 12/3/1969, p4485). Moreover, the CAB had no regulatory or punitive powers. However, like the Australian Consumers' Association, its activities evoked an enormous public response. After the first year of its operation, the Consumer Affairs

Bureau (CAB) reported that "complaints continue to be received in ever increasing numbers and rate of intake tends to outstrip the growth in staff resources..." (p11). The Annual Report of 1972-73 noted that the 6,658 complaints received during the year represented a 63% increase over those of the year before. After a Labor administration replaced that of the Coalition in 1976, the work of the CAB was transmuted into that of a fully fledged department with Mr Sydney Einfeld as its Minister. By then its staff had grown from the eight people operating a single office in Sydney to 92, many of them working in the nine regional branch offices which had been established around the State. By 1980 the Department was dealing with 250,000 complaints per annum (NSWPD, 3:160 24/2/1981, p3996).

The advent of "administrative law"

While it signaled the beginning of a new approach by government to consumer rights, the Department of Consumer Affairs was solely concerned with interactions between consumers and providers in the private sector. However, the consumer movement also had another much less visible but in many ways profoundly more important effect on government, in that it spurred the adoption from the 1970s onwards, of the notion of administrative law. In the very simple terms of Davis et al administrative law "...is designed to ensure external review and checks on the individual actions of officials" (Davis, 1993) . The adoption of administrative law, in Wilenski's words "brought judicial power into administration in order to redress the balance of bureaucratic power" (Wilenski, 1986).

The idea of administrative review was not new. According to Corbett "... common law processes for seeking redress against wrongful administrative decisions are so ancient as to be archaic ...". The problem was that these processes could only be invoked by using legal means and going through the courts. Law reformers in Australia in the 1960s and 1970s, "like their British counterparts in the 1920s and 1930s, were convinced that these ancient remedies were too expensive, complex and technical to serve the needs of modern societies ..." (Corbett, 1992). In Australia that thinking led, in both the Federal and State spheres, to the establishment of government-sponsored and financed agencies such as Ombudsperson's offices, the institution of freedom of information legislation and the establishment of Administrative Appeals Tribunals. Such devices were designed to make it possible for individual citizens to have their complaints and concerns about bureaucratic actions and decisions taken up and investigated at little or no cost. Freedom of information, in principle anyway, gave individual citizens the complete right of access to hitherto closed bureaucratic records.

The results of the introduction of administrative law were set out by Ms Pat Brazil, secretary of the Commonwealth Attorney General's Department, in 1987.

Never before have administrators and government decision-making been so exposed to public scrutiny and criticism, particularly when increased parliamentary scrutiny is taken into account. It is a major aspect of the new climate of accountability within which administrators must work and which is also reflected in the Government's initiatives for public sector reforms (Brazil, 1989 p13).

Brazil also expressed the view that the process of opening up the bureaucracy to public scrutiny was probably irreversible "given the demands of fairness and of an ever more

articulate and sophisticated community". As noted above, that development was to have far-reaching consequences for governance since one of its chief characteristics was its demand for accountability and "open government". That applied not only to visible sector of governmental bureaucracies working in Ministerial departments, but also to statutory authorities such as MRBs which under the banner of professional autonomy and peer review, had for over a century been operating in the non-accountable fashion described elsewhere in this thesis.

That administrative law was bound to affect such agencies became clear after the establishment of the NSW Ombudspersons' Office in 1975 (a year before the establishment of a similar office in the Federal sphere). This made it possible, for the first time, for members of the public and also of the health workforce, to have their complaints about health care institutions investigated. From 1976 onwards, around 30 such complaints were taken up annually, and while that number is minute, none the less that an entirely new in-principle situation had been created within the State bureaucracy is clear from the first annual report of the Ombudsperson. In the section dealing with investigations affecting the NSW Health Commission, the Ombudsperson cited the case of a long-term patient who had been denied access to his hospital records. When the Ombudsperson put the patients' request to the Health Commission, officials replied that patient records had always been kept confidential on the grounds that:

Medical records often contain important subjective observations of the patient, his [sic] attitudes and behaviour which is important that the medical officer should record for his [sic] own future guidance or for the guidance of other members of the therapeutic team. This would be particularly so in the case of psychiatric records. It would not be

conducive to the maintenance of rapport between the doctor and patients if such observations were to be shown to the patient, and it would have an undesirable inhibiting effect on the medical officer in his compilation of the records if he knew that this was likely to happen (New South Wales, 1976b p39).

The Ombudsperson replied by pointing out that "the position is different in my case as under the provisions of the Ombudsman Act ... I am entitled, in investigating a complaint, to obtain the production of such records". While no finality was reported in this case, it illustrated the way in which individuals had been provided with a state-sponsored champion in their encounters with bureaucracy. In any case, the reasons advanced by the Health Commission for denying patients access to their records were soon to be swept aside by the introduction of freedom of information legislation (FOI). While in many ways FOI is honoured in the breach rather than in practice and bureaucrats have found new ways of keeping information to themselves, none the less FOI has created a convention in terms of which nothing appears in governmental records which cannot stand public scrutiny.

It is significant that when, in an interview with the NSW Labor Minister for Health, Mr Laurie Brereton, sometime in the early 1980s, a delegation from the Pensioners and Superannuants Federation raised their difficulties in obtaining redress from doctors with whom they were dissatisfied. They told him that what was needed was "something like a health Ombudsman" (Hewitt, 1993). That indicates two things: firstly, these consumers believed that accountability in health care needed to extend beyond public institutions and into the sphere of private medical practice. Secondly, this incident indicates that the discourse of administrative law had moved beyond governmental and bureaucratic circles

and had been taken up by consumers. And when that happened, as has been noted above, those in government, in pursuit of their own electoral interests, were invariably inclined not only to listen, but also to act.

The stage was being set for the formation of the Complaints Unit as a typically "counter-bureaucratic" bureaucracy. As such, it exemplified the way in which administrative law was making it possible to fight the fire of Weberian bureaucracy with a counter-bureaucratic fire and as Wilenski, said, was helping "to redress the balance of bureaucratic power" (Wilenski, 1986). In doing so it provided both those in the community population/equal-health advocate and those in the government structural interest, now eager to please voters in the light of the rise of the consumer movement, with a new weapon in struggles to prise open the bastions of bureaucratic non-accountability. On that score, as the incident related in the Ombudsperson's Annual Report noted above indicated, the interests of those in the government structural interest, tended to diverge markedly on this point, from the those of the corporate rationalists. The opinions of the latter on this issue are probably best encapsulated by the reactions of "Sir Arnold", the Cabinet Secretary in the *Yes Minister* series, to demands for open government. Constituted "a contradiction in terms. You can either be open or you can have government". The growing insistence that all of government should indeed be open (and *Yes Minister* was probably one of the deftest weapons fashioned by proponents of that demand) was obviously going to affect the MRB. This was not only an old (in fact the oldest) corporate rationalist agency in the NSW government, but because it was comprised of co-opted experts, i.e. medical practitioners, also formed one of the strongest power bastions of the professional monopolisers.

The health consumer "movement"

The ferment created by the growth of the consumer movement in the 1960s inevitably spread to the field of health care. Baldry (Halpin, 1974) points out that "consumer consciousness" here was stimulated by the growth of the women's movement. A major concern among feminists was birth control and also to secure legalised abortion but this soon broadened to other health issues. Baldry quotes the case of a Sydney-based group known as "Control", in which the "initial focus on birth control and abortion expanded rapidly as the group became aware of the deep and widespread dissatisfaction amongst women with medical services" (p124). That in turn led to the establishment of the Leichhardt Women's Community Health Centre in Sydney. "It and the many similar centres which opened around Australia in the following decade, emphasised the right of women to be fully informed about their physical health and to have access to counselling and support in their social settings" (p.125).

Still, it took almost two decades after the advent of the consumer movement in Australia for the first health-specific consumer body to emerge in NSW, this being the Medical Consumers' Association (MCA) formed in 1976. It is significant, in the light of what has been said above about the emergence of the academic sociological critique of scientific medicine, that the leading lights in the MCA were just such academics. The first president was Dr Erica Bates of the School of Health Services Management at the University of New South Wales and a widely published author of sociological texts on health care. Another figure was Dr Fran Hausfeld, who became its second president. Hausfeld had begun her academic career late in life, but having obtained her PhD, she was appointed to the staff of the Department of Administrative, Sociological and Political

Affairs in the new Kuring-gai College of Advanced Education. Here she soon developed a reputation as a leading activist in the field of health care and was frequently consulted by government, especially after the more radical Wran administration gained power in NSW in 1976. Among other things, she was appointed by the Minister for Health, Mr Kevin Stewart, to the Health Advisory Council of NSW.

Hausfeld decries the idea that the formation of the MCA was due to the irresistible rise of health consumer power (1993, 2002). She states that the main motivation for the establishment of the MCA was instead provided by a group of members of the Health and Research Employees Association whose jobs in the community health programs set up under the Labor Whitlam government in the Federal sphere, were being threatened by cuts under the Liberal/National Fraser administration which came to power in 1976.⁵¹ There was a heavy presence of these unionists and members of the left faction of the Labor Party at the "wild and woolly" inaugural meeting of the MCA, reports Hausfeld (1993, 2002). Also prominent among those present, were a group of what she calls "crazies, whose main objective seemed to be to lynch doctors". These were people who having suffered injury or harm during the course of treatment, and whose efforts to obtain redress from either the medical profession or from government having proved fruitless, saw the MCA as vehicle for pursuing their ongoing vendettas against the medical profession. Hausfeld states that it was always difficult to control the members of this

⁵¹ Their hopes of being able to use the MCA as a front for the advocacy of their interests were thwarted by a clause in its constitution which prohibited anyone who derived their income from institutions or activities concerned with health care delivery, from being office-bearers. This stipulation, according to Hausfeld, was included at the insistence of Bates, who feared that it would be taken over by the AMA. In fact she states, the AMA remained supremely indifferent to the MCA.

group whose activities and demands were in time to cause the resignation from the presidency of Dr Bates.

Despite that, wrote Bates in her book *Health Systems and Public Scrutiny* (1983), this body was "the most active of consumer groups in Australia and between 1976 and 1978 obtained a great deal of media coverage for its exposure of doctors' high incomes and its complaints at the gradual erosion of the protection afforded to consumers by health insurance" (p137). In 1978 the MCA published a Charter of Patients' Rights and Responsibilities which Bates noted, was praised by the *AMA Gazette* and adopted in a modified form by the Australian Hospital Association.

However, the MCA appears never to have duplicated the success of the ACA in recruiting

members. While few of the records of its early period survive, one pointer to the size of the MCA was a membership survey carried out through the medium of its newsletter in 1978. This evoked 72 responses, which the authors calculated to be about 15% of those surveyed. While that would mean that around 1,000 people were surveyed, these would have included all the recipients of the newsletter rather than simply the actual membership and no doubt for public relations purposes, the newsletter was being circulated much more widely than to the membership. The survey indicated that a little over half of those surveyed comprised people either involved in or who had been involved in the past, in health care occupations (four were medical practitioners.) This indicates that despite being given good coverage in the media, the MCA was not attracting large numbers of the general public.

Hausfeld states that in their dealings with media and figures in government, "we were careful never to let them know how small our membership actually was". The newsletters of the MCA, which consisted of poorly produced cyclostyled sheets, confirms Hausfeld's statements about the weakness of the organisation. In a passage of the article assessing the results of the membership survey referred to above, the authors stated in response to suggestions as to where the MCA might direct its activities:

Unfortunately the Association, given its present membership, financial resources and lack of volunteers, cannot undertake any activity which is costly, time consuming or labour intensive. We lack human and financial resources; and we lack basic facilities such as a desk, chair, typewriter and telephone. (Medical Consumers Association, 1978 pp2-5)

These weaknesses were remedied to some extent when the MCA merged its activities with those of the ACA in 1980, which says Bates, allowed the MCA to benefit from the

administrative and public relations resources of the ACA. This does not appear to have led to any significant increase in either the membership or activities of the MCA, although Bates (1983, p138) asserted that its lobbying led to the establishment of a special section in the Department of Consumer Affairs to investigate health consumer complaints. This was soon being fairly well-used by health consumers. As Donnelly (1992) states:

The Annual Reports from the Department of Consumer Affairs for the years 1978/81 all comment on the increasing number of complaints against doctors particularly in regard to incompetence, unskilled treatment and inadequate services. For those three years a total of 265 complaints against doctors were received ...(p51).

That development probably resulted from the fact that soon after its establishment, the MCA found that besides the "crazies", other aggrieved patients also saw it as a channel for registering their complaints against doctors and the health system. However, given its organisational weaknesses, it was powerless either to investigate or to pursue these complaints and could do nothing little more than refer them to other bodies such as the Consumer Affairs Bureau which in turn however, did little other than settle financial disputes between doctors and patients.

Hausfeld states that to the best of her recollection the MCA never did any lobbying and certainly there are no reports any lobbying activities in its newsletters. The one time the MCA did approach government as a group was when its leaders visited Einfeld, who became Minister for Consumer Affairs after the election of the Wran government in 1976, to ask him for financial support for the MCA.. He said he was unable to help because his Department was new and because it was "at the bottom of the governmental

heap", was itself short funds. However, Hausfeld is fairly certain that that the special health complaints section of the Consumer Affairs Bureau referred to above, resulted from this encounter, which confirms the point made by Bates above in this regard. Both Hausfeld and Bates, as respected academics, served on bodies such as the government's Health Advisory Committee; in August 1982, Hausfeld was selected by Brereton after he became Minister for Health in 1981, to join a team of three to review the planning, development and co-ordination of Community Health Services in NSW (Medical Consumers Association, 1982 p1). Appointments such as these gave Bates and Hausfeld privileged access to the Minister, with whom they could raise issues thrown up by the MCA as well as their other more generalised sociological critiques of the medical profession.

In Brereton, they found a sympathetic audience. After the accession of the Wran Labor government to power in 1976, the NSW legislature had in many ways reverted to type with Labor Party members in the Lower House in particular, being much more critical of Medicine than had been its members at the time of the passing of the 1963 Medical Practitioners Act, when Sheahan was Minister. The ancient enmity between Labor and organised Medicine had burst into the open at the Federal level when the AMA mounted a million-dollar fighting fund to block the introduction of Medibank, Australia's first universal health insurance scheme. As detailed in their book *The Making of Medibank* by Scotton & Macdonald (1993) the resistance generated by the forced the Whitlam government into a double dissolution and fresh elections in order to get the legislation passed.

In the State sphere in NSW, a new willingness on the part of government to attack the privileged and exclusive position claimed for themselves by the professions was embodied in a clause of the 1980 Consumer Protection Amendment Act which enabled the Consumer Commissioner "to receive complaints about fraudulent or unfair practices by professional persons" in the words of Minister Einfeld (NSWPD, 3:159 19/11/1980 p3160). This evoked some heated opposition both outside and also inside the parliament, where Mr K. Rozzoli (Coalition, Hawkesbury) argued that the proposal had been opposed unanimously by the professions, and in particular by the Law Society of New South Wales, the AMA, the Australian Hospital Association and the Dental Association and by organizations such as the Council for Civil Liberties" (NSWPD, 3:160 24/2/1981 p3973). He further argued that: "No matter how strongly the Minister may assert that there is no difference between going to the doctor and ... going to the butcher and buying a pound of sausages, there is a considerable difference". That statement was contested by the Brereton when he said: "One is compelled to ask oneself what is so sacrosanct about the so-called professions. Are not consumers entitled to every protection from professionals?" (NSWPD, 3:160 24/2/1981, p3975).

Another participant in the debate, Mr John Hatton (Independent, South Coast) argued:

In the past ten to fifteen years the professions have come under great scrutiny. Experience has revealed that merely because a person is a professional does not mean that improper practices are beneath him [sic]. This has been made quite clear in the professions of medicine and law. In many instances the improper practices have been evident to an extent that could be described only as shocking. (NSWPD, 3:160 26/2/1981, p4203)

That these parliamentary critics of professional immunity from investigation did not stand alone was evident from the report of the NSW Law Reform Commission which had averred that "The ... proposition that professionals can be trusted always to put the public interest ahead of sectional professional interests, is one which few people will accept today" (New South Wales, 1982 p122)

Brereton was certainly aware of the lack of effective pathways for the registration of patient, or as they can now be termed, health consumer complaints. Donnelly (1992) states that

Health Dept records reveal that in 1977 there was concern in the senior levels of the Dept. about the difficulties the then Health Commission was having in investigating and dealing with complaints about medical services. At the direction of the Minister, internal procedures for dealing with complaints referred direct either to him or the Commission were drawn up (p48).

It may be that in their encounters in other capacities with Brereton, the leaders of the MCA helped to make him aware of the difficulties faced by health complainants. Whatever the case, the shared attitudes of the Minister and the academics who led the MCA, was yet another pointer to the alliance being forged between the government and the community population/equal-health advocates structural interests.

There were pragmatic as well as ideological reasons for this. As was argued in the previous Chapter and will be argued much more fully shortly, a very powerful factor was simply that of electoral arithmetic. The popularity of the consumer movement made it much more attractive to politicians than the cause of providers of goods and services. From the point of view of the equal health advocates, the pragmatic advantage of an

alliance with corporate rationalisers was that the consumer interest groups, in the words of Palmer and Short (2000, p42-3) were "diffuse, not well organised, poorly financed, and generally lacking in bargaining power in the political arena" and therefore any alliance with government was bound to help their cause. This applied even to organisations that were much stronger than the MCA, such as Australian Community Health Association and the Victorian-based Health Issues Centre. Among the myriad issues of health care, challenges to medical autonomy and peer review from groups such as these were unlikely to succeed; what was needed in the terms of Albrow (1998, p177) cited in Chapter One, was "participation in everyday bureaucracy". It will be argued that attaining such participation depended not so much on the efforts of those in the community population structural interest, but on the willingness of members of the government executive such as Brereton, to enable that to happen.

Mass media perceptions of the consumer movement

The driving force of the consumer movement swept governments along with it in a comparatively short space of time. This no doubt was due to some elements and personalities, such as Einfeld, among the ranks of politicians. Equally important however, was the mass following behind the consumer movement, evident for instance, in the growth figures of the ACA and the CAB cited above. An even more telling indicator of the popularity of the movement was the way it was taken up by mass media. The 1975-76 Annual Report of the Department of Consumer Affairs noted for instance:

Consumer protection has become a fashionable subject with the Australian media recently. Business malpractices are valued as scoops while advice regarding consumer law and wise buying is sought after as a good programme content. Consequently, the demand on the Bureau for

such publicity is considerable and has increased since the annual report of 1974-75 (New South Wales, 1976a p26).

In fact, the CAB was being "a bit slow on the uptake" on this score; in 1969 during the debate on the first Consumer Protection Act, Einfeld, then in opposition, had noted in the parliament that "In September 1966, the *Sun* newspaper commenced its Hot Line service and since that time it has received about 80,000 complaints from consumers. (NSWPD 3:78 12/3/1969 p4450). That was one indication that those in media had quickly perceived that the enormous popularity of consumer issues was a very useful means of boosting audience size in both print and electronic media. Thus an alliance based on the mutual interests of media and consumer organisations including those in government, quickly emerged. In the CAB's Annual Report for 1971-72 for instance, it was stated:

Mention should be made of the public media and its representatives which have been most helpful and co-operative. The Bureau's policy is to make as much time as possible available to journalists and other media representatives and, within the limits of discretion, to be frank and open in its discussions. Virtually without exception, press, and other media have responded in similar fashion and the Bureau's confidences - necessary at times - have been respected (New South Wales, 1976a p33).

The report acknowledged the "substantial contribution to consumer education" by columns and features in media. The 1975-76 Annual Report noted that "with regard to adult consumer education, top priority has been given to publicity through television, radio and newspapers..." The heavy schedule of media activities was reported as follows:

Television appearances apart from news items included a regular weekly spot on the programme "Eleven a.m." on Channel 7, weekly segments on Channel 2's teenage pop programme "Flashez", a monthly appearance on "The Mike Walsh Show" on channel 10, and a guest spot in Don Lane's "Tonight Show" on Channel 9. In November 1976, with the advent of the

"Willesee at 7" programme, the Extension Services officer began regular participation in this national evening show as an integral part of her consumer education activities with the Bureau (p26-7).

There had also been a variety of radio programs in which the Bureau had participated while in the print media, with whom daily contact was maintained, "some weekly and monthly magazines, in particular, *Woman's Day* have featured regular consumer articles for the shopper's or homemaker's information" (New South Wales, 1976a pp26-7).

Importantly, the newspaper space and electronic airtime given to the Bureau had been provided free. In other terms, consumer affairs constituted a public relations "dream run" for the Bureau and certainly the readiness of government executives to take up the consumer cause would have resulted from their realisation that its popularity meant it was a vote winner.

Mass media perceptions of the AMA

This phenomenon might be compared to the difficulties faced by the AMA in its public relations efforts. As noted in the previous chapter, the NSW branch of the AMA had established a "Public Relations Committee" (PRC) in 1956. The minutes of this Committee⁵² reveals that public and particularly mass media perceptions of the medical profession remained deeply ambivalent, even during the profession's heyday of power and prestige between the 1940s and 1970s. While educational and instructional material provided by the AMA's public relations efforts was readily accepted, both print and electronic media maintained a critical stance towards Medicine which led to constant

⁵² Held in the AMA Records Archive in the Mitchell Library, Sydney (in Bay2E12 of Level 2). Accessible only with the permission of the president of the NSW branch of the AMA.

complaints within the profession about its poor public image. In notes presented to the PRC in 1965, the branch Director of Communications, Mr C.V. Crockett, stated:

When I joined the staff in 1940, I was asked to suggest some means of countering Press criticism of the profession. I suggested radio talks on "health and medical " subjects and newspaper and other articles because these would be given as written and approved by the Branch, whereas there could be no control over newspapers' use of contributed articles, in respect of headings and shortening or alteration of text" (Australian Medical Association, 1965).

The acceptance by the Australian Broadcasting Corporation of this proposal gave an added benefit to the AMA in that it received £4,000 (on the basis of the calculation made in the previous chapter, the equivalent of \$400,000 in 2002) in payment for its contributions.

Such publicity successes and the much more extensive efforts launched after 1956 by the PRC did little to change media ambivalence towards the medical profession in general and the AMA in particular. While on the one hand, the ever-increasing technical expertise and successes of Medicine called forth praise, the mass media proved more than willing to carry strong critiques of the profession⁵³. The PRC was criticised on more than occasion for this "bad press" by regional sub-branches of the AMA. In 1962 for instance,

⁵³ At the PRC meeting of 14/6/1962, the following typical examples of hostile articles were considered: *The Sun* "Death of a Child" (editorial) "Boy's death report" (29/5/1962); "Ethics legislation. A code for doctors" (5/6/1962) "The scandal of American doctors" (7/6/1962); *Daily Mirror* "Sheahan to push bill on doctors" (31/5/1962); *Sunday Mirror* "Medicine men talk gibberish" (10/6/1962).

the Eastern District Medical Association, reacting to the Windsor Hospital incident, expressed regret "at the lack of active steps taken by the Council in the interests of the profession and the lack of publicity in this and similar disputes in the daily press". In response the Director of Communications prepared a submission to the PRC which is worth quoting at length because it so well encapsulates the public relations dilemmas in which the AMA found itself.

It may be useful to point out how Public Relations policy differs from direct publicity, used on particular occasions. Publicity for the most part has to be conducted through statements to the Press, which naturally finds much more "news value" in criticism of the medical professional profession than in the Association's replies. For these, necessarily

temperate, must seem by comparison merely *defensive* [original emphasis].

The Association has very friendly relations with the press. Whenever strong criticisms are made (as on several occasions recently), they usually come, not from the Press, but from members of the public, who, whether rightly or wrongly, feel they have some cause for resentment against an individual doctor. But the Press, then, will always feature their complaints; not in the least because is hostile to the profession, (for it is not), but purely because such occasions are specially rich in what it calls, "human interest". ...Direct publicity, if it is forceful, tends to produce controversy from which the profession never gains advantage (Australian Medical Association, 1962 pp3-4).

While the publicity director was correct in stating that there was no hostility to the AMA on the part of individual journalists, he was of course, also underlining the fact that in pursuit of expanded readership and audience, mass media ruthlessly pursues its own interests by carrying material which owners and journalists sense has popular appeal. As has been demonstrated above, the cause of consumers was enormously popular because of course, as consumers themselves, the great bulk of media audiences had and still have infinite sympathy for fellow consumers subject to unjust treatment or incompetent service by providers. Against that and the "human interest" value of stories of people with grievances against doctors, the very considerable publicity efforts of the AMA were bound none the less, to seem ineffective.

One illustration of that was a letter sent in 1966 by the General Secretary of the AMA to its sub-branches advising them on ways of dealing with media statements which "are unjustifiably critical of and derogatory to the Association or its members..." He reported that efforts to refute or correct "undesirable publicity on a variety of contentious subjects

have met with scant success" and were mostly ignored by media. One method which did seem to work however, was getting statements into the "Letters to the Editor" columns of newspapers (Australian Medical Association, 1966 pp1-2). That amounted to a counsel of desperation since the material appearing in correspondence columns generally represents individual rather than official views and therefore lacks the authority of official statements.

In short, the records of the PRC indicate that during the 1950s and 1960s when the AMA was seemingly at the height of its power, in terms of public perception its position was not strong compared to the growing force of the consumer movement. Nothing illustrates that better than the difficulties and criticism the AMA and Medicine encountered in dealing with the media compared to the uncritical and almost adulatory way with which even so weak an organisation as the MCA was treated.

That the overall position of medicine was in fact weakening during this period is most evident from the fact that from the mid-1960s onwards, the PRC found it necessary to open a "second front" to try to boost the image of the AMA within the medical profession itself due to falling membership and particularly, its failure to attract young recently qualified doctors into its ranks. A table presented to the PRC in 1964 showed that the proportion of graduates from the University of Sydney who entered its membership had shrunk from 58% (110 out of 192 graduates) in 1958 to 11% (21 out of 197 graduates) in 1963. Thus the PRC proposed to send a newsletter to hospital boards decrying the fact that honorary medical staff of major hospitals "are not impressed by the necessity for unity in the profession as expressed by membership of the Association, nor are they

aware of the considerable advantage to be derived by membership of this Association" (Australian Medical Association, 1964 pp2-3).

The most obvious indicator of even professional disenchantment with the AMA appeared in 1973 when the Doctors' Reform Society was founded in Victoria, followed by branches in NSW and the ACT in the following year. This organisation tended to share the sociological critiques of traditional scientific medicine in that it "sought to improve the health of populations, recognising the social components in health maintenance ... It therefore not only strongly supported and fought to save the redistributive economic decisions taken by the Whitlam Government to provide universal health insurance but also those which aimed to improve housing, pollution, control, food standards and citizen participation in health policy" (Baldry, 1992 , p127). Its membership, which reached 1,000 in 1981, never approached that of the AMA, but none the less, as stated by Baldry, it was big enough "to be listened to by government".

Yet while the public prestige of that section of the medical profession represented by the AMA was in decline during the 1960s and 1970s, none the less its grip on the controlling body of Medicine, the MRB, remained untouched and that meant that whatever else happened, the power of the MRB remained untouched as well. That would not have surprised Weber; bureaucracy, he had pointed out "is a power instrument of the first order for the one who controls the bureaucratic apparatus" (Weber, 1978 [1922] p987).

The Chelmsford "deep sleep" scandal

The far-reaching consequences of the pure application of peer review under which the MRB operated made themselves felt in the case of the Chelmsford Private Hospital in Sydney, where from the 1963 onwards, Dr Harry Bailey and his colleagues began to apply "deep sleep therapy" to patients with various psychiatric disorders. The "therapy" consisted of administering large doses of barbituates, rendering the recipients unconscious for periods of up to a fortnight, during which time they were drip-fed and also subjected to electro-convulsive treatment. Patients were kept naked and often chained to beds to prevent them from falling out, while their bodily excretions were simply emptied on the sheets. The treatment was not new, but according to Walton (Walton, 1990 p283) in her Masters thesis⁵⁴: "Most psychiatrists had rejected deep sleep therapy as a mode of treatment in the 1930s." Twenty five of the 1,430 patients subjected to deep sleep in Chelmsford between 1963 up to the time when it was stopped in 1979, died as a direct result, while large numbers suffered varying degrees of trauma and brain damage.

The situation first came to light as a result of an inquest into the death of a Chelmsford patient in 1967 while investigative work by the Church of Scientology also resulted in major media coverage from that date onwards, the nature of which was set out by Walton (1992)

The material generated by the print and electronic media tended to show one side of the story, repeating anecdotal information and building on the

⁵⁴ She had also, since 1985, been the director of the Complaints Unit of the NSW Department of Health, which figures prominently in the next chapter.

previous layer of chronicles of a horrific and ugly treatment. Everything associated with Chelmsford Hospital became exotic. Dr. Bailey became the 'mad doctor', the sleep ward became the 'zombie ward' (p8).

In other words, the story provided the kind of sensationalist material which media typically uses to boost its audience sizes, its one-sidedness not being readily apparent to anyone who did not read or see the reports analytically or critically.

Despite the storm generated, it was not until 1985 that official action against anyone involved in the deep sleep therapy was taken, when the newly-formed Complaints Unit of the NSW Health Department brought actions against three Chelmsford doctors before the Investigating Committee of the MRB (Bailey, having become a semi-alcoholic, committed suicide in 1985). The Committee found that strong enough *prima facie* evidence existed for the matter to be referred to the Medical Tribunal. The actions of the Tribunal were however, halted by a successful appeal by the doctors in question to the Court of Appeal, which ruled that the case was *ultra vires* because of an excessive delay in the submission of the complaints (Complaints Unit, 1988 p10). Finally, in 1988 a newly elected Coalition government appointed a Royal Commission under Mr Justice J.P Slattery, to investigate the Chelmsford case. It sat for 288 days, examined 258 witnesses and produced more than 18,000 pages of transcript (Complaints Unit, 1990b p15). In his findings the Commissioner not only condemned the Chelmsford deep sleep treatment and the doctors responsible for it, but also expressed especial disapproval of the Health Department's "failure to investigate complaints" (New South Wales, 1990 Vol 1 p23) in the period before 1985.

There was never any official explanation for this failure, although as recounted in the next chapter, in his Chelmsford Royal Commission Report of 1990, Mr Justice Slattery speculated that it was due to sheer bureaucratic inertia within the Department of Health. The fact that even so powerful a Minister as Brereton was not able to overcome that inertia, is indicative of the way in which corporate rationalists are on occasion, able to thwart the government executive. On this score however, the power of the corporate rationalisers was reinforced by that of the professional monopolists who dominated the MRB. As the chief custodian of medical discipline and in terms of peer review, responsibility for taking action against the Chelmsford doctors rested with them. However, the interpretation of “infamous conduct” or “misconduct in any professional respect”, bolstered by legal precedent, as not applying to practice issues, meant that the Chelmsford doctors were safe from being called to account for their actions. In other words, the Chelmsford case constituted perhaps the starkest example of how the institutional autonomy of the medical profession as realised through the MRB, guaranteed the non-accountability of individual practitioners. It is significant that when the “counter-bureaucratic” CU did initiate action at the behest of Brereton, even the Investigating Committee, which had proved notoriously unresponsive to health consumer concerns, found there were strong grounds for putting the issue before the Medical Tribunal. That the case never got to that stage meant that the Chelmsford doctors were never formally called to account for their actions. But while they escaped any legal investigation and possible retribution, Chelmsford immeasurably strengthened the arguments of the representatives of the community structural interest that there was a prevailing ethos among the providers of health care which made it acceptable and even imperative, to cover up and deny medical error.

The appointment of the Royal Commission in 1988, which even if it was powerless to inflict retribution, at least damningly exposed and condemned the Chelmsford happenings, indicated that those in the government, regardless of political affiliation, were very aware of public reactions, were increasingly of the same view. None of this boded well for the survival of the peer review principle in NSW.

Conclusion

At the beginning of the period under review, i.e. in the early 1960s, an alliance between the professional monopolist, government and corporate rationalist structural interests had almost totally closed the pathways which could be used by people in the community population interest wanting to register their grievances by means of the Investigating Committee and the MRB. However, it has been demonstrated that mass media in general and Wran's Labor Administration in particular, reflected changing societal attitudes which questioned the authority of the professions, including Medicine, and this led to the breakdown of the alliance between the governmental and the professional monopolist structural interests groups. The impact of "new social movements", particularly the women's movement and the consumer movement, as well as the development of administrative law, had by the end of the period created several alternative pathways for health complaints in the form of the Ombudsperson's Office and also the special section of the Department of Consumer Affairs dealing with health matters. In fact, by the end of the period under review, the scope for the registration of grievances had become much wider than this, as was pointed out in a speech to the national conference of the AMA in 1990 by Ian Siggins, the Health Commissioner in Victoria: "Consumers could voice their

complaints to MPs, Health Ministers and Departments, Consumer Affairs, the AMA, MRBs, Hinch⁵⁵, or lawyers”. However, said Siggins, the lack of a coherent complaints pathway meant that for complainants, the results of their efforts to register their grievances were both inconsistent and frustrating. It was that feeling which at least partially accounted for the “energy of medical consumerism” (Siggins, 1990 p1). The dawning of a new era of health “complaints coherence” not only in NSW but in each State and Territory in Australia, was signalled by the establishment of the CU in NSW in 1984. When that was transmuted into the Health Care Complaints Commission in 1993 it brought to an end the system of medical peer review which had prevailed in this State for almost a century.

⁵⁵ Derryn Hinch the abrasive presenter of a current affairs program on Channel 7 TV at the time, was a typical media personality who made the most of the “human interest” hostility voiced by aggrieved patients about both health institutions and individual doctors.

CHAPTER EIGHT

THE TWIN ASSAULT ON MEDICAL AUTONOMY

1983-1994

The final section of this thesis discusses the two-pronged assault on medical autonomy which resulted from the impact of the social and political forces described in the previous chapter. On the one hand government executives, both Labor and Coalition, mounted an attack which destroyed the type of the institutional autonomy of Medicine which had been embodied in the MRB since 1838, i.e. autonomy exercised outside the parameters of responsible government. On the other, there was an equally destructive attack on the individual autonomy of physicians led by the equal health advocates from the community population structural interest group. They had ensconced themselves in the “counter-bureaucratic” organisation, which forms one of the central foci of this study, the Complaints Unit of the NSW Health Department.

The attacks on both institutional and individual autonomy developed simultaneously and for that reason, the chapter considers events in each sphere separately, although as will be demonstrated, they were closely interlinked. The chapter is thus not presented in a linear chronological fashion. It concludes with a separate section which examines the ongoing

linkages between the drives of both the corporate rationalists and the equal health advocates in the Complaints Unit (CU) which led to the establishment of the "co-regulation" or collaborative regulation of medical discipline.

That system, it is argued, constituted a *coup de grace* for the autonomy of medicine in NSW in terms of which it had exercised exclusive control of medical discipline. There is also an examination of the attempts by the chief protagonist of the professional monopolist structural interest group, the AMA, to defend that autonomy. The reverses it suffered in the process probably negated any attempts to reconstruct that autonomy in the near future. This closes the argument of this thesis that not only medical autonomy but also medical peer review in matters of discipline, ceased to exist in NSW after 1993.

The assault on individual medical professional autonomy

In the study of this issue, attention is focused on the CU since it was the establishment of this organisation that set in train events which, during the course of the next decade, were to bring to an end not only individual medical autonomy but also the type of institutional autonomy of which the MRB had enjoyed since 1838. It should be stressed that this process cannot be seen as the result of far-reaching strategies based on theoretical models of medical autonomy as advanced in the literature and in this thesis. Instead the process was one of ad hoc advance which, far from representing the flight of an arrow aimed at a target, should rather be compared to a stream of water finding its way around whatever obstacles it finds in its path.

Thus at the time of its establishment, there was no thought that the (CU) would have such far-reaching effects. When it began functioning in January 1984, it was the first body of its kind in the world. Not surprisingly no one, including Brereton who decreed its formation, knew exactly how it would operate. Thus the form it was to take by the time it was transformed into the Health Care Complaints Commission (HCCC) in 1993, was not the result of forethought or planning. That it did reach that point represented the close-run victory of one particular group which, over the course of a decade had engaged in major ideological and political struggles with proponents of competing philosophies. Before embarking on an investigation of those philosophies, described as "agendas", some historical issues need to be dealt with, particularly the circumstances surrounding the formation of the CU.

The establishment of the Complaints Unit

It could be said of the CU that while its formation was unexpected, it was not a surprise. The announcement by Brereton in April, 1983 that he was establishing the CU as a unit within the Health Department, seems not to have been preceded by any consultation with stakeholders, such as the MRB, in the health care field (Donnelly, 1990 p56). From that point of view, it was unexpected. However, given factors such as the rise of the consumer movement, the emergence of administrative law and the lobbying by health consumer groups described in the previous chapter, the emergence of the CU was not surprising. Long before Brereton became Minister in 1981, there had been concern about the rising level of complaints in the health care system. In her Masters thesis on the CU, Donnelly (1990) (who was one of its Investigations Officers at the time) reports that:

Health Dept [sic] records reveal that in 1977 there was concern in the senior levels of the Dept. about the difficulties the then Health Commission was having in investigating and dealing with complaints about medical services. At the direction of the Minister⁵⁶, internal procedures for dealing with complaints were...drawn up (1990 p56) .

That Brereton shared these concerns after becoming Minister was indicated by his institution of a second Medical Tribunal, as mentioned in the previous chapter, in an attempt to speed up the processing of complaints. The Chelmsford case was one of the first tasks he delegated to the CU, which indicates that the need to remedy the failures of the Health Department in this regard, loomed large in his thinking (New South Wales, 1990 p289).

Although there were no precedents for an agency specifically devoted to handling health care complaints, Brereton was probably aware of the work of the NSW Law Reform Commission, which in 1982 had recommended that "Lay persons should participate in the investigation and resolution of complaints and in the work of the Professional Standards Boards and of the Disciplinary Tribunal" (New South Wales, 1982 p53). Brereton did not envisage similar lay participation in the complaints-handling processes of either the MRB or the Medical Tribunal. Instead he chose to establish the CU as an entirely lay body to investigate and pronounce on medical professional conduct. He may also have been aware of the moves being made towards the formation of a health complaints body in Victoria which had commenced in 1982 (Barraclough, 2002 356p). But precisely because there was so much forethought, planning and consultation with

⁵⁶ At that time, Mr Kevin Stewart (Labor, Canterbury)

stakeholders in that State, it took much longer for the process to be finalised there. However, when that happened in 1988, the Victorian "Office of the Health Commissioner" had the great advantage of being established as a statutory authority with its own legislative base. The CU had no such base and those who worked in it were always uneasily aware that having been established simply by Ministerial fiat, it could be just as easily disbanded by a less sympathetic Minister.

The immediate issue which provided Brereton with a reason for bringing the CU into existence was not the level of complaints about medical practice issues, but medical fraud. When he announced the formation of the CU on April 26, 1983, he stated that it had become necessary "because of the growing number of complaints about fraud and overservicing...". In a press release on the same day, he quoted the report of the Joint Public Accounts Committee of the Federal parliament (the Georges Committee) which had found that "between 1975 and 1982 more than \$100 million a year in medical benefits had been 'ripped off' in fraud and overservicing by doctors". There was a high public consciousness of what was known as "medifraud" at the time (Crichton, 1990 pp82-6); (Hicks, 1982 pp46-7), something which leads Donnelly (1990) to conclude that Brereton was acting opportunistically in order to gain electoral advantage for his party (p56). Medifraud however was not his sole concern. In his letter to the Public Service Board announcing the formation of the CU, he stated that it would also "enable the investigation of the many incidents within the health care field which cannot be encompassed with the present resources and expertise in the Department [of Health]" (Department for Health NSW, 1984 p2). And in his press release of April 26, he identified "the standard of care provided in institutions governed by state legislation" as

another major justification for the formation of the CU. This could only have been a reference to Chelmsford. In other words, as an astute politician Brereton probably believed that the medifraud issue constituted the best launching pad for a "counter-bureaucratic" agency to deal with health complaints.

Still, the way in which it was created made for uncertainty and ambivalence about the direction and purpose of the CU, and there was conflict on this issue between the time of its formation right up until 1993, the cut-off point of this thesis. Because the outcome of that conflict had such a vital bearing on the issue of medical accountability and the way it was to be enforced, it is necessary to investigate competing philosophies or "agendas" within the CU and the wider issues they raised, under the following headings:

1. The fraud agenda.
 - 1.1 The "prosecutorial" vs the "conciliation" approach to dealing with health complaints.
2. The consumer/victim agenda.
 - 2.1 Individual redress or public interest?
3. The professional monopolist/AMA agenda.
 - 3.1 The continuity of government support for the CU.
4. The "public interest" agenda.

The fraud agenda

While he did have concerns about health complaints issues, medifraud was Brereton's priority and in fact he can be characterised as the chief proponent of the "fraud agenda" which figured prominently in the early stages of the CU's existence. This was somewhat

anomalous, since the financing and administration of Australia's public health insurance system, which even before it became a universal system in 1984 under the name of Medicare, was the responsibility of the Commonwealth Department of Health and more specifically, of the Health Insurance Commission. As was pointed out by the *Sydney Morning Herald* in an editorial, the pursuit of medical practitioners who defrauded the system was a Commonwealth and not a State responsibility (27/4/1983). Brereton appears not to have set down any guidelines on this issue and the role of the CU had to be negotiated by the newly appointed manager of the CU, Ms Philippa Smith. One of her first meetings was with senior officials of the Investigation Section of the Commonwealth Department of Health, which had responsibility for policing medifraud. It was agreed at that meeting that a letter be sent to the Commonwealth Minister of Health requesting that the CU be included on the Co-ordinating Committee on Medifraud, which included representatives from the Federal Police, Crown Solicitors, the Health Insurance Commission and the Commonwealth Department of Health. It was also agreed that "liaison ... be maintained on fraud matters" (Department for Health NSW, 1984p6).

Whatever the niceties regarding the division of responsibilities between Commonwealth and States, as noted in the Chelmsford Royal Commission report, Brereton was "quite insistent" that he wanted the NSW State police to be involved in CU investigations related to fraud (New South Wales, 1990 p296). Thus a police officer, Detective Sergeant Bruce Coates, was appointed to the CU as one of its first four staff members. (Later another police constable was appointed to help with the investigations into Chelmsford). Coates was very active in the first year of the CU's existence. In a report he wrote in 1984, he recommended the appointment of six more police officers to the CU stating that

10-15% of the 800 complaints received to that date by the CU, required legal/police attention and interpretation. These were "mainly allegations of fraud committed by medical practitioners". There were also some cases which related to "services performed by persons on the periphery of the medical profession and their actions which require investigation by police". For instance he had instigated a major case against five doctors who were accused of defrauding the Macksville District Hospital of large sums of money (Complaints Unit, 1984? p1).

The fraud agenda did not last long within the CU. For one thing, there was no obvious proponent of this approach among those who were qualified or willing to direct the CU. Indicative of the impulsive and ad hoc way in which the CU was brought into existence, was that Brereton was still casting around for a director seven months after he made the announcement about its formation (New South Wales, 1990 p280). Eventually he appointed Ms Philippa Smith, who at the time was acting as a consultant to the Health Department and before that had played a prominent role in consumer-oriented organisations such as the Australian Council for Social Service (ACOSS). This was as a result of her, when she heard about the imminent formation of the CU, sending him a memorandum making suggestions as to how it should operate. After interviewing her, Brereton decided she was the right person for the job. That circumstance constituted a classical illustration of the working of the "expert co-optation principle" as set out in Chapter 2 (see p75-8), in terms of which government brings in non-government experts not only to staff but also to set directions for newly-created governmental agencies. This was of course, the basis on which the MRB had been established and had run ever since, the co-opted experts in that case being members of the medical profession.

Although Brereton did not realise it, Smith posed a major threat to his fraud agenda. She was a typical "equal health advocate" and for her the question of medifraud was an issue between government and doctors and therefore was not a consumer issue. Moreover, as noted above, the government in question was that of the Commonwealth and not of the State. Much more important to Smith was the question of redressing individual consumer complaints, and in fact this was the issue which prompted her to draw up the memorandum mentioned above, in which she urged that the CU be based on "a much broader perspective of consumer perspective as opposed to the criminal view " and that it "look at broader issues of quality of care, matters of administration and matters of policy, as they affected consumers" (New South Wales, 1990 pp279-80).

Once she had been installed as director of the CU, Smith set about downgrading the medifraud agenda. Her task in this respect was made easier by Brereton ceasing to be Minister of Health in February 1984, one month after the CU commenced operations. His successor, Mr Ron Mulock, was never as concerned about medifraud and obviously had not been involved in the issues which led to the formation of the CU. Smith's success in imposing new priorities on the CU is evident from a document of 14 May, 1984, in which it was reported that during discussions between her, the new Minister and the Secretary and senior officers of the Department, it was agreed that the CU would become much more focused on health issues. Among its main functions it would:

- (a) Examine and monitor complaints
- (b) Provide recommendations regarding the implications for the ongoing policy and practices of the Department

- (c) Liaison [sic] with major 'community' interests, and develop projects and actively seek 'feedback' on the quality and availability of services (Department for Health NSW, 1984 pp1-2).

As will be seen, these were very much consumer concerns, which from that time onwards moved to the forefront of the work of the CU. While as can be seen from the reports of Coates, fraud investigations continued to form a prominent part of its operations, the police presence proved increasingly problematic. The police officers saw themselves as being responsible to their superiors in the Police Service rather than to the CU itself, which therefore lacked the power to control their actions. Justice Slattery called some of the police investigations into question in his Chelmsford report, particularly because they had diverted resources and time from the CU's work on the Chelmsford case. As an example he cited the "goats' milk case" which arose out of a complaint by a farmer "who took the view that the Health Inspector was 'on his back' as to the quality of his goats' milk ... because a competitor was 'getting some corrupt advantage'." The inquiry, which took up some time and led to nothing, "highlighted my concern about the priorities within the unit", stated Justice Slattery. Later, the case against the Macksville doctors went disastrously wrong and ended up with the police having to pay \$500,000 in compensation for wrongful charges (NSW 1990, Vol 8, p300).

For ideological reasons which will be set out shortly, Ms Merrilyn Walton, who became Director of the CU in April 1985, was even more impatient than Smith of the fraud agenda, which without Brereton, had no champion in government. In 1986, the police officer's secondment to the CU was terminated at Walton's request (Walton, 1993). That fraud had been moved from the purview of the CU is evident from its first Annual Report

of 1987, which stated that "Cases of fraud and overservicing are referred to the Commonwealth Department of Health and the Health Insurance Commission" (Complaints Unit, 1990bp10). None the less, the fraud agenda left a crucial legacy within the CU; fraud of course, is a criminal offence and the pursuit of fraud is usually undertaken by police acting through the courts. Brereton's intention was plainly to prosecute miscreant doctors by legal means and to expose them to the full force of punitive law. This was emphasised by the fact that a lawyer was also among the first appointees to the CU and had the task of the legal investigation of health complaints. Thus, from the outset, the CU adopted what is termed a "prosecutorial" approach which it has retained up to the present day.

The "prosecutorial" vs the "conciliation" approach

Its prosecutorial approach means that the CU and later the HCCC, have occupied a unique position in Australia. None of the other States and Territories, which by now have all set up health care complaints mechanisms of their own, followed its "prosecutorial" lead (Thomas, 2002). Instead they adopted the model of the Victorian Health Commissioner's Office, which is based on "conciliation" and which in contrast to adversarial legal processes, uses the techniques of "alternative dispute resolution". In terms of this approach, complainants and practitioners against whom a complaint has been made are brought together on a face-to-face basis and attempt, with the help of a trained conciliator, to come to mutual understandings and acceptance of the circumstance which prompted the complaints in the first place. The first Victorian Commissioner, Mr Ian Siggins, was a champion of conciliation, as is the current Commissioner, Ms Beth Wilson. In one of the few articles on the topic, conciliation is lauded by Wilson and co-authors precisely on the grounds that it "operates as an alternative to litigation" (Wilson

& Punshon, 1998 p59). The rationale quoted is that of a joint submission made by the National Association of Specialist Obstetricians and Gynaecologists and the Royal College of Obstetricians to the Law Reform Commission: “Liability is arrived at by consensus, and theoretically, both parties should be satisfied with the result.” This, say Wilson & Punshon, , is the opposite outcome to the adversarial (read “prosecutorial”) system, in which “the notion that ... there are winners and losers is not always true - all too often there are losers and losers...” (Wilson & Punshon, 1998 p59). They concede however, that not “all cases in which medical negligence is alleged, or where damage has occurred as a result of medical procedures, are suitable for conciliation...” (p61). This applies to a very small minority of cases and these are referred to MRBs. If those bodies adjudge disciplinary action to be necessary, they in turn refer the cases to Medical Tribunals.

In contrast to that model (which prevails in all other jurisdictions in Australia), ever since the passing of the Medical Practitioners' Amendment Act of 1987, first the CU and later the NSW Health Care Complaints (HCCC) Commission themselves undertook the investigation and also directed the prosecution of accused practitioners before the local Medical Tribunal. Because of their emphasis on recourse to law and the prosecution of offenders, the CU/HCCC always maintained a strong legal section; as already noted, one of the first four staff members of the CU was a lawyer and ever since, its legal section,

although small in number (five out of a total staff of 44 in 1993) has formed one of its core operating divisions.⁵⁷

The unique prosecutorial powers of this body are to some extent an expression of a particular ideology known as “Public Interest Law” which will be dealt with more extensively shortly. However, it can also be argued that the groundwork for the prosecutorial approach was laid by Brereton’s long-forgotten fraud agenda which from the outset involved the CU in legal and punitive action against not only individual doctors charged with medifraud, but also the Chelmsford doctors. I will further argue that without the legal and investigatory resources and expertise it accumulated as a result of its prosecutorial approach, the CU/HCCC would never have been equipped to become co-regulator of medical discipline along with the MRB. Thus, while it was discarded after a relatively short period of time, the fraud agenda played an historically formative role in the history of the CU/HCCC by setting it on the prosecutorial path.

The “consumer/victim” agenda

The "consumer/victim" agenda is so-called because its spokespeople, while describing themselves as "consumers", were also the victims of medical and other types of misadventure, for which they demanded financial compensation from government. Prominent among these were the Chelmsford Victims Action Group, the Vietnam Veterans’ Association of Australia and also the MCA. The members of the first two groups mentioned were aggrieved because they had been denied financial compensation

⁵⁷ This is not to say that the concept of conciliation is rejected in NSW. In terms of the 1993 Health Care Complaints Act, a "Conciliation Registry" was established as a separate statutory authority attached to the

for injury. In the case of the Chelmsford victims this was because of the Supreme Court judgement which prevented any action being taken against the doctors involved in deep-sleep therapy (see pp225-30). The Vietnam Veterans' Association was particularly concerned about the fate of ex-soldiers who had been exposed to the effects of the "Agent Orange" defoliant used during the Vietnam War. A Royal Commission found their claims for compensation had no basis since at that stage, the case against Agent Orange had never been medically proven.

The coalition of the MCA with these groups at first sight, seems somewhat incongruous. As was pointed out in the previous chapter, in its earlier years the MCA was not particularly concerned with the issue of consumer complaints, let alone consumer compensation. Its stance on this issue changed when Mr Andrew Allan, one of its earliest members, became general secretary in 1991. However weak the MCA was in terms of numbers and resources, it had in Allan a formidable and combative intellect. He had formerly been an engineer, his interest in the MCA arising out of having suffered medical injury for which his attempts to obtain recompense had proved fruitless. Their demands for financial compensation created a common interest between the Chelmsford victims and also the Vietnam veterans and those in the MCA like Allen.

However, their compensation-focused agenda brought them into sharp conflict with the CU because in terms of its prevailing "public interest" agenda, which will be described shortly, it refused to support their claims for compensation. As pointed out by Alford

newly formed Health Care Complaints Commission and complainants can make use of its services, if they so choose, rather than following the normal complaints process.

(1975, p14), conflicts within structural interest groups can be just as fierce as those between structural interests themselves. There was in fact, a tectonic fault-line in the consumer movement between the drive on the one hand, to secure individual consumer satisfaction and redress, and on the other, to serve a much broader “public interest” by making the supply and production of goods and services, more reliable and safer. The way this dichotomy affected the issues arising from health complaints, were summed up in the Phillips Fox *Review of the Complaints Unit* commissioned by the NSW Health Department and published in January, 1988.

Handling concerns and complaints about the provision of health services can be primarily directed at keeping consumers happy, or primarily be concerned with protection of the public interest. Sometimes it can be difficult to pursue both objectives at the same time.

Although there are many occasions on which individual and public interest co-incide, they can diverge when a complaint about the manner of delivery of a professional service is considered. If individual consumers and providers have difficulties, these can be resolved to their individual satisfaction without the public interest necessarily being protected. The immediate problem between two people may be solved, but the fault remains with the system (New South Wales, 1989 p6).⁵⁸

The dichotomy between the “individual redress” and the “public interest” approaches was at the root of the conflict between the consumer/victim groups and the CU, which under the leadership of Smith and her successor Walton, became wholly committed to the

⁵⁸ It might be remarked in passing that this passage also contains one of the main critiques of the conciliation approach. Proponents of the prosecutorial approach argue that while conciliation may restore trust between provider and consumer, it is a weak instrument for dealing with systemic faults and thus fails adequately to serve the public interest Newby (2002). On the other hand, supporters of conciliation argue that the proponents of the public interest approach are often more concerned about complaints as indicators of systemic pathology, than they are about the fate of complainants.

"public interest" approach. This was not so much the case as far as Smith was concerned. While as we have seen above, she quickly moved to de-prioritise Brereton's fraud agenda, there is little evidence to suggest that she had thought through the individual redress vs. public interest issue, and most of the time, simply failed to differentiate between them. Thus in a paper entitled: "Consumerism – how to cope with the Publics [sic] need and wants" dated August 24, 1984, she stated:

The Complaints Unit should play an important role in providing a consumer window into the standards of care provided (and whether they meet consumer needs). Over time the Complaints Unit should also assist in the developments of procedures which meet the needs of the consumer (Complaints Unit, 1984 p2).

While this statement includes some concern for public interest issues, she also went on to say that "in some ways, the Complaints Unit role is one of an internal Ombudsman", which suggests that she also saw it as an organ of consumer redress. However Walton, who

replaced her when she resigned after having been director for little over a year, was much more strongly and definitely committed to the public interest approach.

The consequent refusal of the CU to take up the cause of individual redress, led the members of the consumer/victim group to see it as part of a "bureaucratic/medical conspiracy" to deprive them of their compensatory rights. Their suspicion of the CU is evident from Allan's accusation that its actions were "cosmetic" and "... designed not to upset the power holders, and not able to provide compensation for poor service to what is a largely alienated segment of the total health customer base" (Allan, 1993 p6).

The activities of the consumer/victim group were to cause immense difficulties when in the late 1980s and early 1990s, Walton initiated moves to upgrade its status to that of a statutory authority, the "Health Care Complaints Commission". While that move was supported by the government of the day, the MCA in response took the lead in the formation of a coalition entitled "Community Organisations Concerned with the Health Care Complaints Bill," which claimed to have recruited 40 member organisations representing some 300,000 people (Coalition of Community Organisations Concerned with the Health Care Complaints Bill, 1993 p2). These organisations were not merely "concerned" with the Bill, they furiously opposed it, not so much because they were against upgrading the status of the CU to that of a statutory authority, but rather because they believed (rightly) that that would entrench the public interest approach behind virtually insurmountable barriers.

The critique of the CU by this coalition was set out in a long and closely argued document prepared by Allan and published by the MCA in April 1993 in which it was stated:

When you see a document saying that something is being operated “in the Public Interest” (as the cover the Complaints Unit Annual Report proudly proclaims) you may feel that it is automatically a good thing. But just stop and think[:] is the public interest always congruent with your own personal interest? The surviving victims of Chelmsford hospital found a government adopting the view that payment of compensation to them was not in the public interest as it would be too costly. ... Millions of dollars have been absorbed by the extended governmental-legal system in order to protect the “public interest”. This does not demonstrate the essential need in a democracy for personal access to action law as a final right ... (Allan, 1993 p6).

The consumer/victim coalition was given strong support by at least one NSW Labor M.P., Mr Paul Gibson, and also elements of the media, particularly the *Sun-Herald* weekly newspaper which had a circulation of over two million. It was used by the maverick columnist/commentator, Alan Jones, to attack the CU in typically strongly worded views (*Sunday Telegraph*, 21/11/1993). This was the first time the CU had experienced any media hostility; like the MCA, its consumerist credentials had up to that time always ensured that it received favourable treatment from mass media.

The consumer/victim-led coalition posed the most formidable threat to the public interest agenda approach of the CU to that date. As will be related in the final section of this chapter, it came very close to defeating the CU and government in the struggle to transform the CU into a statutory authority. That would also have constituted a defeat for the public interest approach which might possibly have followed the fraud agenda into

oblivion. Strangely enough, one likely effect of that development would have been the survival of medical disciplinary autonomy since neither governments nor the MRB, the other major stakeholder in that field, would have been prepared to work with any organisation dominated by the consumer/victim approach.

As far as governments were concerned, recognition of the compensatory demands of this group threatened to make enormous demands on the public purse. Medicine would have felt equally threatened because the consumer/victims agenda was even more fiercely "prosecutorial" than that of the CU; its proponents were spiritual descendants of those who, as Dr Fran Hausfeld had noted, wanted to "lynch doctors" if not physically then through legal processes in the courts. This resort to law held out the prospect of the complaints process being mired in incessant and long-drawn out legal wrangling. Both Medicine and government refused to contemplate that situation, which accounts for the "rock solid" support accorded to the CU throughout the struggle with the consumer/victim group. Thus in the 1992 annual report of the CU, the then Minister for Health, Mr Ron Phillips, stated in his introduction:

[S]ome complainants have viewed the Complaints Unit as the official body to assist them with civil claims and as a result some have had expectations of the Unit (Complaints Unit, 1992 p7).

Their mutual agreement on this point cemented a growing alliance between the equal health advocates as represented by the CU and both government executives and bureaucrats in the corporate rationalist structural interest group.

The AMA agenda

Although they strongly rejected the consumer/victims' agenda, those professional monopolists represented by the AMA and the specialists' Royal Colleges, were just as hostile to the CU's public interest approach. While there was a recognition in this group of the need for change in the structural instruments used to enforce medical accountability, they did not see the CU as an appropriate body to achieve this end. Not surprisingly, their agenda was very much based on peer review principles. Those principles had been defined during a three-day conference on the subject of peer review staged by the AMA in 1977. In the following year the Federal Assembly of the AMA "endorsed the progressive introduction of formal methods of the evaluation of medical care under the general term 'peer review'" (Anderson, 1983 p7). In reporting the general conclusions, Anderson said that in fact a definition of peer review had been difficult to find since peer review "meant different things to different people in different places at different times and in different contexts". It was easier to say what it was not:

It is not centralised, nor is it controlled by either the government or the AMA. The AMA Federal Assembly made this abundantly clear in 1978 when it rejected the creation of any centralised bureaucratic organisations to run peer review (Anderson, 1983 p9).

The CU of course, was exactly this kind of "centralised bureaucratic organisation" and the AMA in NSW expressed strong opposition to the establishment of the CU after Brereton made his announcement of April 1983 (Donnelly, 1990 p). However Walton states that when she first became Managing Director the AMA tended to ignore the CU since "they saw it as small and not really a player" (Walton, 1993). This was true as long as the CU was able to investigate only complaints relating to public health institutions

and could take no action against private practitioners. The situation changed drastically when this provision was swept away by the watershed 1987 Medical Practitioners' Amendment Act, which is fully discussed in the next section.

Even before the passing of the 1987 Act, the case against the Chelmsford doctors, although eventually unsuccessful, demonstrated the investigatory potential of the CU. Another example of that was an investigation undertaken by the CU into the Cumberland psychiatric hospital,⁵⁹ the results of which led to the Minister for Health to appoint an Advisory Committee to review standards of care in all 25 psychiatric hospitals in NSW (Complaints Unit, 1987 p19).

The unease these activities might have caused the AMA could only have been magnified by a passage in the CU's annual report of 1987 which noted that that year had been a remarkable one, in that the 1,946 new complaints registered constituted a 47% increase over the previous year. The report noted that 80% of these complaints were against the medical profession, two-thirds of them doctors in private practice (Complaints Unit, 1987, p13). Whereas between 1966 and 1979 only eight cases went before the old Medical Tribunal, in 1988 alone the CU brought 15 matters before the Tribunal and another 12 before newly constituted "Professional Standards Committees" (Department for Health NSW, 1990 p1).

⁵⁹ On the basis an abnormally high number of complaints identified by the CU "which gave cause for concern about the standard of patient health care and safety" (Complaints Unit. 1987, p19).

Even though when introducing the 1987 Act, the Health Minister, Mr Ron Anderson, asserted that the AMA had been consulted about and had assented to the proposed changes, documentary evidence does not support his claim. In its submissions to government before the passing of the Act, the AMA argued: “If complaints are made to the Department, then the Department should pass these on to the [Medical] Board for investigation and action.” It further stated that the role and function of the CU had never been made clear to the medical profession and therefore constituted “a source of deep and lingering suspicion” (Australian Medical Association, 1986 p4).

After the passing of the 1987 Act, the AMA began stridently to demand of government that the CU be terminated, or at least restructured so that its powers were limited to investigating complaints against the Health Department only. In a letter to the NSW Premier in October, 1989, the AMA State president, Dr Bruce Shepherd, charged that the CU had proved itself unfit to deal with complaints referred to it directly, since it was pursuing trivia with “excessive zeal” and showed “a grave lack of understanding of the practice of medicine and how doctors are required to work and what matters are in the best interests of patients” (Australian Medical Association, 1989 p3). The continuity of this thinking is evident in yet another letter to the Minister for Health dated 17th February 1992, in which the AMA submitted that “all complaints should initially be referred to the MRB for consideration” (Australian Medical Association, 1992)]. Even though, as will be made clear shortly, it had lost control of the MRB by that stage the AMA clearly saw the MRB as a lesser evil than the CU.

The AMA had several professional allies in its campaign against the CU. The Royal Australasian College of Surgeons for instance, called for the CU to be shut down (*Sydney Morning Herald* 24/3/1989) while the local AMA magazine, *The New South Wales Doctor* had earlier noted that a hope that the CU would disappear “is the only thing the doctors and nurses throughout NSW have in common” (20/8/1988 pp8-9). In a letter to the Minister for Health of April 10, 1989, the AMA went so far as to state that “members of the medical profession insist on a mechanism whereby elected representatives (say A.M.A. branch Councillors) could overview the workings of the Unit from time to time in order to create confidence that the Unit was conducted on equitable lines”(Australian Medical Association, 1992 p3).

Government support for the CU

The AMA however, had largely failed to take into account the huge societal changes in thinking about the professions and on questions of accountability which had occurred from the 1960s onwards. Among others, these changes had also affected its traditional allies in the Coalition parties, who gained power in a landslide victory in the State election of 1988. They proved just as resistant to the AMA’s peer review agenda as had Labor administrations. This came as something of a surprise; there were fears in the CU that the new Coalition administration would follow the traditional support its predecessors had given to Medicine in general, and the AMA in particular. However, the administration of the young new Premier, Mr Nick Greiner, was driven by a “market liberal reform strategy” (Laffin & Painter, 1995 p9). As representatives of that novel phenomenon, the radical right, perhaps best embodied on the global scene by the British Prime Minister Margaret Thatcher, the Greiner government was characterised by a

strongly reformist bent. For that reason, the new administration did not attempt to reverse the reforms introduced under Brereton and his successors in the health portfolio.

According to Degeling and Thomas,

[T]he Liberal record in health care between 1988 and 1995 was characterised by continuity as much as by change and ... rather than being reformist in its own right, much of the Liberal program consisted of fleshing out the reforms introduced by the previous Labor administration (p202).

That assertion is supported by the way the Coalition continued government's unstinting support for the CU, which it had enjoyed since its inception. The expansion of CU activities is reflected in the fact that in comparison to its initial staff establishment of four, by 1987, Labor's last full year in power, the CU was employing 33 staff while its expenditure totaled just over \$1m (Complaints Unit, 1987 pp27-8). By 1993, after five years of Coalition government, staff numbers had risen to 44 and expenditure to \$2,639,971 (Complaints Unit, 1994 ppA-1, A-2).

One major contrast between the old Liberal leadership and those in Coalition governments between 1988 and 1993, was that they had far less sympathy for Medicine and very little for the AMA.⁶⁰ This is evident in the way the first Coalition Minister for health, Mr Peter Collins, vigorously defended the CU when it was attacked by the AMA. In a letter written to Collins, the AMA president, Dr Bruce Shepherd, claimed that the CU had been established as a deliberately provocative move by an "antagonistic Labor

⁶⁰ Nothing illustrates that better than the way Collins and his successor in the Health portfolio, Mr Ron Phillips, reversed the disastrous losses to the public purse incurred by the previous Labor administration's poor handling of the "doctors' dispute" of the early 1980s. The Coalition did not hesitate challenge on the AMA in a series of

government” that Coalition backing for it could only “reflect badly on the Government and its Health Minister in the minds of all members of the profession” (Australian Medical Association, 1992).

In response, Collins asserted that the CU “was established after many years of inactivity, on

actions in industrial courts which it won, leaving the AMA to pay a \$1m in costs (Degeling and Thomas, 1995, pp199-202).

the part of the Department of Health, in dealing with complaints about health professions” and that the CU had developed “considerable expertise in assessing complaints, undertaking investigation, and initiating disciplinary action where necessary.” Contrary to Shepherd’s assertions, wrote Collins, “the Unit does not pursue frivolous or vexatious complaints” (Department for Health NSW, 1990). That response made it clear that gone were whatever hopes the AMA had of imposing its own agenda on the CU and the health complaints process, as was any chance of re-vitalising the alliance between the professional monopolists and the government executive under the Coalition administrations.

The Public Interest Agenda

That the public interest agenda had as its chief proponent Ms Merrilyn Walton, director of the CU and later the HCCC between 1985 and 2000, is a major reason for its eventual success in dictating the direction of the CU. Walton however, did not merely follow the "public interest" approach; she was also a devotee of one of its most powerful embodiments, the "Public Interest Law" (PIL) movement. She had started her career as a social worker, but by the time she joined the CU she had been working in legal advocacy circles for some time. As a member of the Legal Aid Commission, she had been appointed to the Board of the Public Interest Advocacy Centre (PIAC) (NSW 1990 Vol 8 p298) which betokened that she had become a convinced supporter of the PIL movement.

Here she met Smith, the first director of the CU. Smith informed Walton early in 1985 that she was resigning from the CU and suggested that Walton apply for the post (NSW 1990 Vol 8 p298). That Walton successfully did so meant that the emphasis on the public

interest approach over against that of individual redress, was entrenched even more strongly in the CU, since as mentioned above, Walton was a strong proponent of the "Public Interest Law" movement. Because the philosophy of that movement had such a decisive influence in prompting the assaults on medical autonomy described later in this chapter, it deserves calls for some special attention.

While proponents of the PIL movement constitute a typical interest or pressure group, they do not seek to act by garnering mass membership or through use of the media. Instead, as its name implies, the PIL movement operates through the legal system and its proponents, all of whom are lawyers, use the courts as their chief means of attaining their objectives. While the term "public interest" is a vague one, PIL has been given strong and definite connotations by its advocates, who encapsulate its aims and objectives by means of the aphorism "representation of the under-represented". Like the consumer movement, this particular movement has its origins in the United States, where, as explained by Aron (1989):

Public interest law is the outgrowth of diverse efforts stretching deep into American history to secure legal representation for the powerless and disenfranchised. The legal aid movement of the 1800s, Progressive Era reformers ... the civil liberties activities of the American Civil Liberties Union (ACLU) in the early 1900s, the watershed civil rights cases of the 1950s – these are some of the roots of public interest law (p86).

Aron points out that the immediate antecedents of the contemporary PIL movement in the USA are evident in the efforts of the National Association for the Advancement of Colored People (NAACP) to assert the rights of and counter the disadvantages suffered by Afro-American people through the courts. The advent of PIL in a later form dates

from 1970 when the Ford Foundation began financially to support advocacy bodies practicing PIL principles in the legal arena.

Australia was not far behind; Professor Ben Slade (1992), Principal Solicitor of the Redfern Legal Centre in Sydney, dates the official institutionalisation of PIL here to 1972 when the first community legal centre was opened in Fitzroy, Victoria. Since then a large number of legal centres have come into existence, “some with a general service aim and others with a specific brief such as the Communications Law Centre or the Consumer Credit Legal Centre”. The impetus for these centres, according to Slade, was “the desire by lawyers and others to provide representation for a class of people who were otherwise being denied access to legal services” (1992 p1).

One of the bodies referred to by Slade included the Queensland Aboriginal Legal Service, in which Walton served before moving to Sydney. As its name suggests, the Aboriginal Legal Service constituted an archetypal PIL institution, seeking to represent in the legal arena, one of Australia’s most under-represented groups. Before that, Walton had been a social worker among psychiatrically ill people and prisoners, and in that situation had seen and experienced at first hand the powerlessness of these groups in the face of a largely non-accountable medical profession and governmental bureaucracy. In the health care field, she saw the patients as a disadvantaged and under-represented group. This is clear from her Masters thesis in Social Work presented in the University of Sydney in 1989. In a discussion of the power implications of doctor/patient relationships she wrote: "The relative powerlessness of patients is also reflected by the fact the medical profession has been largely free from lay control and remains publicly unaccountable" (Walton, 1990 p5). She saw the Complaints Unit as a major means of remedying this situation. By

making Medicine more accountable through the use of legal, prosecutorial powers, the CU would help redress the doctor/patient imbalance. In Walton's words: "The trend towards public accountability will ultimately change the way doctors and patients relate" (p105).

The PIL agenda differs significantly from that of the consumer movement in that its focus is on the rights of disadvantaged and disempowered groups rather than on those of injured individuals. This also differentiates PIL from administrative law in that

... a public interest legal issue [is] one where the results have ramifications which go beyond the immediate parties and affect a broad community of interest either immediately or in the foreseeable future" (Selby, 1992 p12).

In terms of this reasoning, the ramifications of the injury or harm suffered by an individual at the hands of the provider of goods and services sound a warning that the community at large may be at risk. In other words, individual injury is indicative of systemic pathology and this in turn means that in terms of PIL, systemic reform is more important than individual redress.

It is in this context that the words: "In the Public Interest" appearing on publications of the CU during the period under review, must be understood. In its first published annual report, the rationale of the CU was described as "a philosophical commitment to a complaints mechanism focusing on accountability and the public interest" (Complaints Unit, 1987 p6). The systemic implications of the complaints mechanism referred to are evident from the fact that in terms of the Medical Practitioners' Act of 1987, these included more than simply the complaints made by individuals. The CU was empowered

to launch its own investigations without waiting for complaints to be made, on issues raised by a wide range of both governmental and non-governmental institutions and significantly, also those raised by the media. This was in terms of defending the “public interest”. Perhaps the most famous case undertaken by the CU under that brief in its early years, was the prosecution for professional fraud launched against Dr McBride of thalidomide fame, after a program attacking him had been broadcast by ABC radio.

The other dimension of the PIL philosophy of course, consisted in the utilisation of legal processes to promote the interests of “under-represented” groups. Having been equipped with a legal section and the resources to use prosecutorial legal processes in terms of Brereton’s fraud agenda, the CU constituted an ideal, ready-made instrument for the implementation of the PIL agenda. It was used to the full particularly after Walton was appointed its director in 1985. It is interesting that while only a very small minority of health complaints⁶¹ were ever adjudged to be serious enough to require legal remedies, the prosecution of medical practitioners accused of serious offences became one of the distinguishing characteristics of the CU. Its “prosecutorial” activities also made it unique among health complaints bodies in Australia, which as we have seen, based their operations on conciliation or alternative dispute resolution process. While they were obliged to refer cases which they adjudged to be worthy of prosecution to their State MRBs, they had no control of, or share in, the conduct of cases once they had been referred on.

The 1987 annual report of the CU showed that by that stage it had four qualified solicitors on its staff, one of their tasks being to support the prosecution of cases brought before the Medical Tribunal. The annual report stated that while the prosecution of some complex and time-consuming cases required the briefing of a barrister, and that the services of the Crown Solicitor were used for this purpose

the Complaints Unit has a view that in some cases it would be more efficient to have the capacity to brief Counsel directly itself. In many cases, the legal officer from the Unit has prepared all the material and has intimate knowledge of the case, making it unnecessary to duplicate this exercise" (Complaints Unit, 1987 p12).

That indicated that the CU was accumulating a significant and unique store of legal knowledge and expertise. That expertise was to prove of crucial importance in the relationships which were developing between the CU and MRB. While only the MRB had the power directly to refer disciplinary cases to the Medical Tribunal, it lacked the investigatory and legal resources of the CU, and therefore came to rely increasingly on the CU to undertake the prosecution of cases it did refer to the Medical Tribunal. Their complementary of capacity thus created a symbiotic relationship between the two bodies which constituted the foundation of the co-regulation of medical discipline in NSW which will be discussed in more detail later in this chapter. What needs to be noted here is that this system developed as a result of the application of the PIL agenda to the operations of the CU. However, it was only as a result of changes and developments in overall mechanisms of medical discipline between 1983 and 1993 that co-regulation became possible, and it is to these that we now turn our attention.

⁶¹ In 1989 the Phillips Fox Report on the CU noted that 86% of complaints were resolved without any special

The assault on individual practitioner autonomy

Although they had to devote much energy to defeating attempts by the proponents of other agendas to take over the CU, neither Smith nor Walton allowed this to divert them from their primary objective, which was to obtain for the CU the power to investigate cases against individual medical practitioners. This was not possible during the first stages of the CU's existence because it was allowed only to investigate complaints made against public institutions and their staff. This prohibition against the investigation of doctors in private practice, constituted one of several lines of defence of individual medical autonomy. Any hope of making individual practitioners more accountable would also involve changing the deliberate "indefinability" of the disciplinary clauses of Medical Practitioners' Acts which had applied ever since 1900 and so strip away any latitude allowed for the interpretation of "misconduct in professional respect".

From the outset of their respective tenures of office, both Smith and Walton stressed in memoranda and other submissions to government that the CU could never be fully effective until it was able to investigate and take action against individual medical practitioners. The needs here were evident from the statistical records which began to be accumulated by the CU; as early as February 1985 (one year after its establishment) Smith reported that the largest category of the 1,800 complaints registered to that date were in the area of "what patients perceive to be alleged negligence, incompetence or inadequate treatment" by doctors in private practice (Complaints Unit, 1985 p2).

action other than explanations from providers being required, while only 2.7% went to the prosecution stage

In an earlier memorandum, Smith pointed out in November 1984 that this number of cases indicated that the current legislation and complaints-handling mechanisms were inadequate. She stated:

They cannot effectively deal with certain circumstances which reflect on standards of care. The Act should cover a wider range of professional conduct such as incompetence or negligence; and should do more to improve the performance of practitioners providing inadequate services. (Complaints Unit, 1984 p1).

She thus recommended a wide array of changes to the Act, and it is significant that the first of these was that the term “misconduct in professional respect” should be replaced by “unprofessional conduct” which would include improper or unethical conduct as well as incompetence or negligence (p3). This proposed change was a radical one in that it was proposed for the first time, to bring hard and fast definitions of professional misconduct into the law of NSW.

Smith’s recommendations were circulated widely to other bodies, and according to Dr Bernie Amos, then the president of the MRB who will figure prominently later in this chapter, they provoked major discussions within the Department of Health, about change in the system of medical governance (Amos, 2002). In November 1985 the Department produced a Green Paper containing “Proposals for Amendment to the Medical Practitioners Act”, many of which were based on those put forward by Smith. That in turn within a short space of time, resulted in other bodies including the Australian Consumers Association, the Combined Pensioners Association, the MCA, the Public

Interest Advocacy Centre, the NSW Council for Civil Liberties, the Doctors Reform Society and the NSW Consumer, also putting forward requests and submissions to government about the reform of the Act. Most significantly they were joined by the MRB for reasons which will be set out shortly.

The representations made by these bodies were accepted by the Labor Administration and in 1987 it introduced amendments to the Medical Practitioners' Act which were not only the most extensive since 1963, but also brought about the most radical change to the system of medical regulation since 1900. The Act created an entirely new disciplinary system in which "professional misconduct" was even more closely defined than in the original recommendations made by Smith; Section 27 of this Act among other things, defined professional misconduct as including "any conduct that demonstrates a lack of adequate (i) knowledge (ii) experience (iii) skill (iv) judgement; or (v) care". In other words, incompetence and negligence on the part of individual physicians now constituted punishable offences in terms of the law.

In his doctoral thesis *The Disciplining of Doctors Under the Medical Practitioners Act 1938 (NSW)* presented to the Faculty of Law at the University of Sydney, Francis Smith (Smith, 1994) notes that the new definition of professional misconduct under s.27 of the Act occupied three pages and asserts that this definition was "far wider than that deriving from common law" (p47). He was highly critical of it on those grounds, stating in his conclusion that the definition "... exceeds the justifiable limits of disciplinary control of the medical profession" and also that the Act had been "changed in ways which far exceed established norms of professional discipline" (p110). Whether Smith's view is

valid is an argument for lawyers to sort out. It is quoted here to illustrate how far the 1987 Act went towards extinguishing the individual non-accountability and therefore autonomy of medical practitioners as far as their practice standards were concerned.

The discarding of the old wording of the disciplinary clauses of Medical Practitioners' Acts, also imperiled the whole philosophy of peer review which had been entrenched by the *Allinson* judgement of 1894. But in fact, according to Francis Smith, under s.27, "bare transgression" of the Act would result in a conviction whether or not there was "peer disapproval" of the action in question. On this point he notes an *obiter dictum* made by the Medical Tribunal that "s.27(1) (a) does not depend upon proof that conduct would meet with the reprobation of fellow practitioners" (p108). However, he also noted that while the issue had been before the Court of Appeal a number of times "no authoritative determination of the question has yet been made" (p108). It seems strange in this regard, that Smith makes no reference to the *Rogers vs. Whittaker* case determined by the High Court of Australia in 1992, in which as was argued in Chapter Two, had rejected the peer review principle. In the words of Whitelaw (1995), "The present Australian position is that the final determination of the applicable standard is the task of the law and the courts, not the medical profession" (p83). While that judgement was made in a Federal Court, it reflected radically changed thinking in the State sphere as well about the autonomy and non-accountability of individual physicians. The legal manifestation in NSW had been the 1987 Medical Practitioners' Amendment Act, but of course that Act itself represented the result of a multi-rooted movement which from the mid-1970s had mounted an increasingly fierce assault on the legal barriers which had sheltered individual medical autonomy. The CU from 1984 took the initiative in the developments that resulted in the

destruction by the 1987 Act, of the deliberately vague concept of “misconduct” based, as we have seen, on the older “infamous conduct in professional respect”.

Not only were the concepts relating to individual professional discipline changed. The 1987 Act also brought about major changes in the mechanisms used to enforce discipline, again in line with the recommendations originally made by Philippa Smith.⁶² In terms of the new legislation, the prohibition on the CU investigating private practitioners was abolished. Now it was empowered to investigate on behalf of the Department of Health and also the MRB, all complaints against medical practitioners from whatever source they came, including media. And in carrying out those investigations, it was also given new powers which included those of subpoena and search. The Investigating Committee was abolished, and a two-tier system of applying discipline was introduced. In the words of the MRB’s annual report for 1987-88, “Complaints which would prima facie justify suspension or deregistration are required to be referred to the Medical Tribunal”, while complaints “of a lesser gravity” were to be referred to newly constituted Professional Standards Committees composed of two medical practitioners and a lay person appointed by the MRB. The powers of these Committees

... are to caution, reprimand, require counselling or treatment, impose conditions, or completion of an educational course, require reporting on the practice or the seeking of management advice or to impose a fine of up to \$5,000 (Medical Registration Board NSW, 1988 p7).

In other words, the principle of making the punishment fit the crime was greatly extended and the creation of softer sentencing options had made the taking of disciplinary action

more likely, since it no longer would constitute an occupational death sentence for those found guilty of less serious offences.

In narrowing the definitions of medical professional misconduct, the 1987 Act also made the instruments of discipline much more widely applicable. Thus the Act can be said to have greatly limited if not altogether extinguished individual professional autonomy in NSW and it should be clear that the CU had played a major role in bringing that about.

The challenge to institutional medical autonomy

The assault on individual medical autonomy ran in tandem with the assault on the institutional embodiment of Medicine's autonomy, the NSW MRB. In Chapter Six it was demonstrated that the AMA had established what seemed to be an immovable dominance of the MRB as a result of the provisions of the 1963 Medical Practitioners' Amendment Act. Almost immediately on becoming Minister for Health, Brereton launched moves to break that dominance. One of the people he used to achieve this aim was Dr Bernie Amos. He states that after he was appointed to the MRB as the representative of the Royal Australian College of Medical Administrators in 1981, he was very conscious of AMA dominance. Amos also states that although he was a member of the AMA, he often used to wonder why. In other words he was far from being an AMA activist, let alone a member of its controlling establishment. He had developed a reputation as a reformist "do-er" in the planning of the major new hospital at Westmead, erected to meet the hitherto neglected needs of the Western suburbs of Sydney and served as its Chief

⁶² She and those who colluded with her in the drawing up of the recommendations, had in turn relied heavily on the disciplinary model for the legal profession put forward by the Law Reform Commission in 1982.

Executive Officer once it became operational. He speaks disparagingly of the general ethos of the MRB as he experienced it when he became a member. Then in his mid-40s, he was told only half-jokingly that his appointment to the MRB had reduced the mean age of its members by half. One of its priorities, it seemed to him, was embodied in its Advertising Committee, “which spent a lot of time talking about things like the wattage of bulbs doctors used in the red lights outside their surgeries” (Amos, 2002).

In 1982, only 18 months after first joining the MRB, he was appointed as its president in a move which he says took him by surprise and was badly received by the AMA; it had its own preferred successor to the current president who was retiring on reaching the age of 75. Brereton had probably selected Amos for the presidency not only because of his relatively young age, but also because he appeared to be reform-minded. This was the first installment of major changes which were to impact the activities of the MRB over the next three years.

Also betokening the onset of a new era was that from 1986 onwards, the MRB began once again to publish annual reports, although this was not so much due to the reformist spirit imported by Amos as to the passing of the Annual Reports (Statutory Bodies) Act of 1984 which as its name implies, required all statutory authorities to produce annual reports to be laid before parliament. That legislation was a typical example of the application of the efforts being made in terms of administrative law, to render all parts of government more transparent and accountable.

Brereton’s next step to break the AMA’s grip on the MRB occurred when in 1983 he piloted through the parliament an amendment to the Medical Practitioners’ Act (No. 177,

1983). This legislation brought to an end the convention in terms which the Minister simply rubber-stamped the nominations of MRB members by the AMA and the Royal Colleges. From that time onwards, whenever a vacancy occurred, they were required to submit panels of three names to the Minister, from which he would nominate one for membership of the MRB. The aim of that requirement, charged the Deputy Leader of the Opposition, Ms Rosemary Foot in the debate on the Bill in the Lower House, was “obviously ... to allow the Minister greater control over the MRB by being able to determine its membership”. (NSWPD, 3:174 23/3/1983, p4991). Mr Bob Debus (Labor, Blue Mountains) in response said he was “inclined to the view that that is true. The government has every right to ensure that its policies are implemented by the MRB” (NSWPD, 3:174 23/3/1983, p4995). In another significant move, Brereton increased the membership of the MRB from 9 to 11 and specified that the two extra members would be nominated by himself on the grounds that they were “conversant with the interests of patients as consumers of medical services”. Among those he appointed under this heading was Philippa Smith, who at the time was managing director of the newly constituted Complaints Unit while he appointed Dr Marcus Einfeld, an outspoken champion of human rights, as the legal representative.

The AMA reaction to these moves was expressed in a resolution taken by its NSW Council in response to the 1985 Green Paper on the Health Department’s proposal for reforms to the Medical Practitioners’ Act mentioned above.. The Council resolved that it had “no confidence in the mechanism for appointments” to the MRB and demanded that “the Board be reconstituted as it was prior to ...1983” (Australian Medical Association, 1986 p1). In its comments on the Green Paper, the Branch Council noted that:

The composition of the MRB was significantly changed by legislation in 1983, and while it might be argued that 7 out of 11 board members are required to be registered medical practitioners, it is the strong view of the profession that the nomination procedures and the fact that the ultimate selection is a political matter mean that there is a significant lack of representation from the practising profession. It is the practising profession which is, generally speaking, the subject of the Board's attention, and on the principle of judgement by one's peers, this current situation is far from satisfactory (Australian Medical Association, 1986 p2).

While the statement did not spell out the differences the Council saw between "medical practitioners" and the "practising profession", it is clear that the latter term applied to the AMA. With Amos as its president, the MRB was unlikely to support this call for a reversion to the pre-1983 situation. In any case, the AMA's demands fell on deaf ears at governmental level, where the preparation of the watershed amendments to the Medical Practitioners' Act, based on the Green Paper, were in full swing. The Labor administration also ignored vociferous protests against the Green Paper proposals put forward by numbers of other medical professional associations (Smith, 1994, p46).

The dilution of AMA influence was extended as a result of the 1987 legislation. The Act expanded the number of MRB members to 18, and although two of these were to be nominated by the AMA and another eight by the Royal Colleges, the Act also specified that there be four "general nominees of whom not less than 2 shall be conversant with the interests of patients as consumers of medical services" (Medical Registration Board NSW, 1988 p3). Signifying that a new era had commenced was that only three of the 10 medical representatives on this new MRB had been members prior to 1987.

Moreover, the structure of the MRB had been completely changed by the passing of the Act. Up to that time, it had occupied an anomalous position, in that while it was a statutory authority established by its own Act, it was also seen to be part of the Department for Health and its income and expenditure continued to be administered under the general accounts of the State. Despite being included in the Department, as its long inaction on the Chelmsford case indicated, it was left to its own devices and there was little or no attempt to make it subject to outside control. In other words, its high degree of autonomy as described earlier in this thesis, remained intact. That situation was drastically changed by the 1987 Act in terms of which, for the first time since its establishment in 1838, the status of the MRB was clearly spelled out in law. Its new legal status set out in its annual report for 1987-1988 was as follows:

... the Board has been established as a corporation consisting of 18 members appointed by the Governor, with the ability to appoint its own staff and a Registrar. It is required to collect its own revenue which is generated by fees payable under the Regulations; and to meet expenses in accordance with the Act (Medical Registration Board NSW, 1988 p6).

In other words, the MRB was for the first time, established as a regular statutory authority, which while empowered to act autonomously, like all similar governmental agencies, was directly accountable to a Minister and through him/her, to the parliament. Thus, after almost 150 years, the MRB had been finally brought within the ambit of the system of responsible government. While it enjoyed a legislatively defined autonomy in those terms, the special and high degree of autonomy which had characterised its existence since its establishment, had been terminated.

The operations of the MRB were also radically altered after 1987 in that for the first time, it developed an internal bureaucracy since the administration of the regulatory affairs of the 20,000 doctors in NSW required the appointment of a growing number of full-time staff. After the passing of the 1987 Act, it immediately engaged nine employees, including a Registrar and Deputy Registrar, and by 1993 that number had grown to 17. Significantly its first Registrar, Mr Andrew Dix, appointed in 1988, was a lawyer, not a medical practitioner, and in fact there were no other medical practitioners on the staff at that stage at the cut-off point of this thesis.

In noting that the registration boards of other health occupations adopted the organisational model laid down for the MRB, Smith (1994) states that as a result of this "deliberate policy ...the role of the professional Boards ... has been waning since the 1987 watershed" (p286). This however, was certainly not true of the MRB, which by no means became just one more administrative body run by bureaucrats. According to Amos, although the dominance of the AMA had been broken and it was left with only two out of 18 members, the other medical representatives jealously guarded their role as the legal supervisors of their profession and there was never any suggestion that they had been reduced to ciphers in that process.

From this point of view, the institutional autonomy remained intact. However, the MRB had lost its autonomy in one crucial respect, that of control over medical disciplinary processes. In place of the old system in terms of which it was the exclusive arbiter in this field, by 1993 it had been legislatively compelled to share its disciplinary processes with the HCCC and it is to that development that attention is now turned.

The emergence of co-regulation

It has been remarked in the introduction to this chapter, that while the developments undermining medical autonomy in NSW are best considered separately, they were continuously interlinked among other things, by informal and personal contacts between the leaders of the MRB and the CU. While Amos states that the members of the MRB were initially suspicious of the CU, seeing it as “some kind of star chamber”, none the less he knew and respected both Smith and Walton. The latter especially, established what she describes as “professional and cordial” relationships with the MRB and states that “we were able to persuade them to use us as their investigatory agency”. This function was extremely useful as far as the MRB was concerned, because while it was empowered to receive consumer complaints, it lacked the capacity, resources and knowledge to deal with them (Walton, 1993). Amos in any case was critical of the MRB’s complaints mechanisms dating back to 1961; the Investigating Committee he said, did very little investigation of anything as far as he could see. Thus he was open to changes to the complaints procedures recommended in the Green Paper issued by the Department of Health in 1985 (even though he was critical of that document) and incorporated into law in the 1987 Act.

Formal links between the MRB and the CU were strengthened by the stipulation of the 1987 Act which laid down (s.28(4)) that they should inform each other of the complaints each received.⁶³ Moreover, the MRB had perforce to hand to the CU any complaints which it believed to be worthy of investigation, since as noted above it had no

investigative resources of its own (Medical Registration Board NSW, 1989 p17). However, there was much more than simply the exchange of information. More direct CU participation in the Board's affairs is evident from the fact that the 1988 annual report of the CU listed among the duties of Walton, its director, was that of "attending Medical Board meetings and taking appropriate action on matters raised" (Complaints Unit, 1988 p3).

The meetings she attended included not only those of the MRB itself, but also of its "Screening Committee" set up in terms of the 1987 Act, which had the task of reviewing complaints received by both the MRB and CU and deciding how they should be dealt with. The large majority of the members on this Committee, which met monthly, were doctors (Medical Registration Board NSW, 1992 p11). But while the MRB seems to have been the senior partner in this process, that the CU was having significant inputs into it is denoted by a statement in its 1988 annual report that the CU had "established protocols for referring and consulting with the MRB on complaint matters" (p7). These kinds of linkages were adding to the symbiosis between the two bodies.

However, the status of the CU as a mere administrative unit with the Department for Health, meant it was a somewhat weak and unstable partner, as was spelled out by Walton in a memorandum sent to government in 1989.

The bottom line is that the Unit with clearly defined functions and roles has no basis for implementing and carrying out those functions except by the good grace of the Secretary of the Department of Health and the

⁶³ The same applied to all the other nine health occupational registration boards in the State.

Minister of the Day. There is some protection from the negative effects of an unsympathetic Secretary because the current Minister has directed that the Manager of the Unit report to him directly on any matters not being resolved. This though again depends on the Minister and his/her commitment to a Unit such as this (Complaints Unit, 1990a p2)

This remained Walton's chief motivation for her view that the CU needed to be transformed into a statutory authority based on its own legislation. That view had been supported by both Mr Justice Slattery in his Chelmsford Report and also by the Phillips Fox report. Moreover, all the other health complaints commissions which had been or were being established in Australia to that date were constituted as statutory authorities. Even the MRB had put forward a proposal to establish a "Health Standards Commission" which Walton noted in a letter to the Registrar Mr Andrew Dix "is not too dissimilar from the model the Complaints Unit has suggested" (Complaints Unit, 1990a p1).

Walton's pleas for the transformation of the CU into a statutory authority were eventually taken up by the government executive. On September 14, 1991, the Minister for Health and Community Services, Mr John Hannaford, sent a Cabinet Minute to the Premier Mr Nick Greiner, "setting out proposals to establish a Health Care Complaints Commission" (Department for Health NSW, 1991). This was approved in March 1992 and in November of that year, without any consultation with interested parties or stakeholders outside the health care sphere, a Health Care Complaints Commission Bill was brought into the parliament.

This was obviously seen by the government executive as a tandem measure to the 1992 Medical Practitioners' Act. Although this Act did not do much more than refine and

update the 1987 Act,⁶⁴ one point of significance was that it explicitly established the co-regulatory system in law. Instead of the CU and MRB being merely required to inform each other of complaints received, the new Act laid down that before any action was taken on a complaint, the MRB and the new HCCC were to “consult to see if agreement can be reached between them as to the course of action to be taken concerning the complaint”. That such consultation had already been taking place is evident from what was stated by the Minister, Mr Ron Phillips, when moving the second reading debate on the Bill: “In practice the board and the complaints unit – the commission – have been able to reach consensus regarding the handling of complaints” (NSWPD 3:232, 24/9/1992, p6501).

That it seemed to contain no important new principles was reflected in the effortless passing of the Act with bi-partisan support. However, the co-regulation of medical discipline could not officially be put into place until the HCCC had been established by its own Act. The process of getting that Act passed contrasted starkly with the smooth passage of the Medical Practice Act. Although the initial HCCC Bill got as far as the second reading stage in the parliament, even groups which supported the Bill in principle charged that it was badly drafted and their protests were vociferously supported by the consumer/victim groups. As a result, the Bill was withdrawn for redrafting at the end of

⁶⁴ One point worth noting in passing was that following the precedent set by the Nurses Registration Act of 1991, this Act introduced a distinction in its disciplinary provisions between “unsatisfactory professional conduct” to cover less serious complaints and “professional misconduct” which was applied to complaints serious enough to be brought before the Medical Tribunal. However this was simply a refinement of the way complaints were assessed rather than any change of the grounds on which discipline was to be applied and therefore is not of great concern to the argument of this thesis.

1992.⁶⁵ The legislative hiatus gave the MCA time to organise the anti-Bill coalition mentioned earlier, which in its submissions charged that

The Government is set upon making the present Complaints Unit into an unaccountable Commission despite a massive report concerning delay, inefficiency and corrupt investigations (Coalition of Community Organisations Concerned with the Health Care Complaints Bill, 1993 p2).

This was a reference to a report about to be published by the office of the Ombudsperson, the contents of which can be appreciated from its title: *Report of Investigation into Unnecessary and Excessive Delays in the Handling of Complaints by the Complaints Department of the Department of Health*. These had been leaked to media outlets and that in turn increased the pressure on the Coalition administration which was in an extremely weak position at the time. Its landslide majority won in 1988 was reversed by the State election of 1991 and in order to hold on to power, it had to govern as a minority administration. This made it a hostage to four independent MPs who held the balance of power in the Lower House. Among other expedients it adopted in order to get its legislative program enacted, was the avoidance of any kind of controversy which had the potential to alienate the independents. The HCCC Bill of course, held out the prospect of exactly this kind of controversy and thus, even after it was re-drafted in the light of submissions from no fewer than 70 different organisations and re-introduced into the parliament, the government made no moves to advance it to the second reading stage.

The government might have found it even more difficult to pass the Bill had it not had an ally equally as vocal, articulate and probably more politically skilled than bodies like the

⁶⁵ The immediate cause of the withdrawal was not the objections in general but rather the unwillingness of

MCA and other groups in the consumer coalition. This was the Public Interest Advocacy Centre (PIAC), founded ten years earlier by the Law Foundation of NSW to embody and act as an executor of the principles of the PIL movement. In the word's PIAC's Principal Policy Officer, Clare Petre, who was to become its leading activist in the HCCC Bill struggle:

PIAC's charter is to pursue matters in the public interest through advocacy and representation of citizens, consumers and communities, and in particular those people disadvantaged in asserting their rights (Petre, 1993.).

The major public interest issues for PIAC in 1993, declared Petre, were "access to information and the community's right to know". In pursuit of these objectives, it had set "health products and services" as one of its main target areas for action and on that basis became closely interested in the HCCC Bill. Professing itself to be disappointed with the Bill, PIAC proceeded to discuss the legislation with 10 other consumer and social welfare groups whose interests were affected, or who took an interest in it. These groups, which included important peak organisations such as the Australian Consumers' Association and the New South Wales Council of Social Services, were able to come to a consensus about the Bill and how they thought it should be amended, and thus called themselves the "Consensus Group". PIAC, as well as Petre proved very adept at lobbying and "reticulating" with interested parties, including the Labor Opposition's Shadow Minister for Health, and as will appear in a moment, the four independent MPs.

government to risk industrial action being taken by the NSW Nurses' Association, which favoured a conciliation model for the complaints process and therefore opposed the Bill *in toto* (1:301192; 14/12/92).

Backed by the Consensus group, PIAC made a submission to the Minister for Health in October 1992 suggesting an extensive range of amendments, the most important being "in relation to issues of independence, access, public accountability, and the role of the Commission" (Public Interest Advocacy Centre, 1992 p1). Not surprisingly, all were aimed at aligning the Bill more closely with the PIL agenda. For instance PIAC argued that the functions of the proposed HCCC were too narrowly defined and that while it was vital to offer a means of redress for complaints by individual consumers

... this is not enough, unless the complaints are recognised and acted upon as a valuable source of information to the Commission about trends in complaints, significant areas of problems, suggestions for change and reform on a broad level in areas such as health training, ethics, and operations or health facilities (Public Interest Advocacy Centre, 1992 p4).

This was the heart of the PI agenda and the government proved amenable to this and other suggested amendments. That representatives of both the government and corporate rationalist structural interests had become advocates of the public interest approach indicates just how close an alliance they had established with the equal health advocates, among whom PIAC now figured prominently. This is also evident from a letter to PIAC sent by Amos, who by then had become Director-General of the Department for Health, in which he thanked the organisation for co-ordinating community views. "I understand that this has been a most successful means of obtaining the input of a large number of community groups within a short timeframe on what is clearly an important initiative" (Department for Health NSW, 1993). The Department professed to be so impressed by the way PIAC had fulfilled its role that in March 1993 it was asked to act as an "honest broker" and adviser as far as community responses were concerned. It might be remarked that however "honest" it was, PIAC was not an impartial broker and this must obviously

have been realised by corporate rationalists like Amos. Equally obviously these corporate rationalisers were also willing to adopt a partisan position and on that score, their role in shaping the HCCC Act is reminiscent of that played by the health bureaucracy in getting the 1900 Medical Practitioners' Acts passed.

As to why the corporate rationalisers supported the Consensus Group, one answer may be simply that they knew its proponents better. As noted above, both Smith and Walton established good personal and working relationships with Amos in the MRB which would have persisted once he was appointed as Director-General of the Health Department in 1988. Another powerful factor was probably that to the corporate rationalisers, the PIL agenda was a much more palatable than that of the consumer/victims' groups. As already mentioned, the adoption of the views of these groups on compensation would have been hugely expensive for government, while governments would also have been reluctant to adopt the confrontational stand against the medical profession demanded by the proponents of this consumer/victims agenda. In any case, while mounting strong attacks on the HCCC Bill, the consumer/victim groups never put forward any comprehensive or well-thought out alternative.

Still, the force of these groups and the support they found in media would have made the government cautious, particularly because after an internal coup, one of the leading bodies in the Consensus Group, the Combined Pensioners' Association, defected to the consumer/victim coalition. The government had not brought the HCCC Bill forward in the main parliamentary session of 1993 and there was no indication that it would be raised in the short, end-of-year parliamentary session which commenced in November. In

this situation, the imminent publication of the Ombudsperson's report referred to above might have acted as a catalyst. The report, compiled in response to 19 complaints about "inordinate delays" in CU procedures, contained a damning assessment of the management of the CU which thereby had of course, itself been burned by "counter-bureaucratic fire".

The report was due to be tabled in the Lower House on December 13, 1993, but as mentioned earlier, its contents had been widely leaked before that and had been used among others, by media commentator Alan Jones, to attack the CU. The Ombudsman's report would not only in all likelihood have prevented the passage of the HCCC Bill because of its effect on the independents, but could also have threatened the survival of the government itself by inviting a censure motion. While there is no evidence that these considerations were a major motivating factor, it seems more than co-incidental that the second reading of the HCCC Bill was introduced, unannounced, into the Lower House in late October, 1993, probably the last occasion on which it could be launched with any hope of getting it through both Houses through before the Ombudsperson's report was published.

In the Lower House the passage of the HCCC Bill was hotly debated, since the opposition Labor party, while not opposing it outright, none the less argued that it should be referred to a parliamentary inquiry before it was finally considered. Obviously the government could not afford that, but in order to have the Bill passed, needed the support of the independents, and here the lobbying by PIAC proved crucial. For instance, in a

letter to one of their number, Dr Peter Macdonald, Petre had urged the importance of getting the Bill through the short session of parliament, stating:

We are fearful that if the Bill is put off to a Parliamentary enquiry or elsewhere, then it will not come back. It has been up twice and it would have to be a dedicated Minister to bring it back a third time. We also fear that further debate would bring out the health provider lobby, particularly the doctors, and that the result might be an outcome far worse than the current Bill. ... we do not have the faith in a parliamentary enquiry that some groups seem to have (Public Interest Advocacy Centre, 1993).

The independents were persuaded by these arguments and gave their support to the Bill. However, just how close the issue was in the Lower House is clear from the fact that it was passed only on the casting vote of the Speaker, while some clauses which one or other of the independent MPs opposed, were lost (NSWPD 3:239 16/11/1993 pp5429-5454). However, the Bill emerged virtually intact and had a quick and much more peaceful passage through the Upper House in the proverbial “nick of time” before the publication of the Ombudsperson's report. By the time that document was officially published, the major issue at stake, namely the continuance of the PIL agenda as the guiding principle of the newly established Health Care Complaints Commission, had been settled. More importantly from the point of view of this thesis, the passing of the HCCC Act signalled that at last the co-regulation of medical discipline by the MRB and the new HCCC had been recognised in law.

That the application of medical discipline had legally ceased to be the exclusive province of the MRB, meant that the institutional autonomy of Medicine in this sphere had been extinguished. That development, coupled with the extinction of individual practitioner

autonomy as outlined earlier, closes the argument of this thesis that in this respect, medical autonomy had ceased to exist in NSW.

Conclusion

There is added evidence of the extinction of medical autonomy with respect to disciplinary issues since 1993. As was noted earlier, at that time joint assessment of complaints was being carried out through the nine-member Screening Committee of the MRB, the monthly deliberations of which were attended by the Director of the CU. However, that system changed drastically over the next few years and was described in the Annual Report of the MRB for 1999 as follows:

Complaints received by either body are now assessed jointly at a weekly assessment meeting held at the Commission with representatives from both the HCCC and the Board consulting on the proposed action (Medical Registration Board NSW, 1999 p18) .

That the meetings of this “Assessment Committee” take place in the HCCC offices, and that the two HCCC representatives include its Director while the MRB is represented solely by its Medical Director, could lend itself to the interpretation that the MRB has become the junior partner in the process. If this is indeed the case, it would be another indication that pure peer review with regard to medical discipline, had almost entirely ceased to exist in NSW and that of course, a situation which is conclusive evidence of “the recession of medical autonomy” referred to in the title of this thesis.

Given what has been said above about the jealous guarding by its members of the controlling functions of the MRB, it is significant that this body has expressed no objection to the "co-regulation of medical discipline"; in fact, it is held up as a

praiseworthy model. This was evident for instance in a paper delivered at the Third National Health Care Complaints Conference in March 2001, by the Medical Director of the MRB, Dr Alison Reid. She stated that while there was a legislative requirement for consultation between the two bodies, “the success of the approach is largely attributable to our shared commitment to public protection and quality in health care”. She noted further:

The New South Wales system provides a rigorous and consistent approach to the assessment and subsequent management of complaints and notifications received by the MRB or the Health Care Complaints Commission. Central to the success of the approach is the collaborative relationship between both bodies (Reid, 2001 p18).

Since to speak of autonomy and legally-required collaboration in the same sentence would be an oxymoron, Reid was in fact confirming that medical autonomy with respect to medical discipline had ceased to exist in NSW. That this statement was made by so senior a member of the MRB would hardly seem to make it necessary for the point to be further argued by the author and it is on that note that this study could be closed. However, some concluding comments are called for, because what has been demonstrated in this chapter has some major implications for the notions not only of medical autonomy, but also of medical professionalism. These are discussed in the final chapter.

CHAPTER NINE

CONCLUDING DISCUSSION

The conclusions drawn from the arguments presented in this thesis give rise to some reflections about the theoretical frameworks which have been used to analyse the subject matter as well as the notions of medical autonomy and professional status.

Bureaucratisation vs “community” power

The power that bureaucratisation confers on an occupational grouping (*rechtsgemeinschaft*) so brilliantly set out by Weber at the beginning of the 20th century, has often been demonstrated. The importance of the bureaucratisation process is reflected in the fact that earlier studies on the professionalisation of Medicine in NSW, especially those of Davis (1983), Lewis & MacLeod (1988) and Lloyd (1993), all made the attainment of genuine bureaucratic power by the MRB in 1900, one of their focal points. This study has attempted to go further by suggesting that not only bureaucratisation itself, but the form that the bureaucratisation of Medicine took in this State, was of crucial importance in determining how medical regulation and especially how medical discipline was exercised in terms of the "infamous conduct" clause.

It seems strange that the bureaucratic power of Medicine, based as it was on typically Weberian calculative considerations (for example its specification of the educational qualifications of doctors), should have had at its heart the wholly irrational notion of “infamous conduct”, which Dr John Creed in 1900, openly described as "indefinable" (Hansard 1:106 1/11/1900 p 4637). That the only challenge to that statement in the

parliament of NSW was made by a fellow medical practitioner, was due to the unquestioning attitude to the professions among the elite elements of society as represented in the Upper House at the time. No doubt feelings of class solidarity also played a role, but it also says much about the capacity of the most highly educated and powerful leaders in the land to be either awed or traduced by interest group claims when clothed in the language of “priestly mystery”. The representatives of lifeworld medicine in the Lower House also taken in by this mumbo-jumbo, but they can hardly be blamed for failing to see the significance of the “infamous conduct” terminology and the way it would entrench the non-accountability which would characterise medical practice in NSW over the next 80 years. When eventually the representatives of the community population structural interest questioned the “infamous conduct/misconduct in professional respect” terminology, they were also questioning the irrationality which lay at the heart of the system of medical discipline in this State. Their consequent demand that the framework within which medical discipline was applied be fully and completely rationalised, was more than satisfied by the Medical Practitioners (Amendment) Act of 1987. As noted in Chapter Seven, that Act replaced the old, single-phrase terms on which medical discipline was based with three pages of specifications as to exactly constituted professional negligence, incompetence and misdemeanour. To a lawyer like Smith (1994) this was rationalisation gone mad; however, the pendulums of history seldom swing in moderate arcs and practically never go back to their starting points.

From today’s perspective, it might seem that the acceptance by legislators and courts in the late 19th and early 20th centuries of the indefinable “infamous conduct” terminology was irrational, it should be remembered that this was a small element of an overall move

to rationalise the practice of allopathic Medicine in NSW. Certainly Weber would not have been surprised by this indication that the rational and irrational not only co-exist but flourish side by side. While Mommsen (1989) argues that the onset of the rationalisation and bureaucratisation of life in industrialised countries constituted for Weber an apocalyptic vision "of the eventual mechanised petrification of Western individualistic societies, directly inspired by Nietzsche's Zarathustra" which might well "end in the creation of a completely ossified social order in which there would no longer be any room for individual initiative, let alone a sophisticated personal culture like the one which developed in the West" (p109), Albrow (1996) points out: "Weber took it for granted that against rationality was counterposed by irrationality" (p129). For example, he saw human emotions as "a complex and differentiated field of forces interfering with rational thought and action" (p129) and "never ceased to reiterate, when it comes to the ultimate elements of a world-view, feeling is as important as reason" (p131).

However, it is true that Weber's main focus and his fame rest on his studies of the way rational calculation and bureaucratisation seemingly came to dominate life in both the public and the private spheres in the nineteenth and twentieth centuries. This means that his work provides little or no explanation of how lifeworld/alternative medicine continued in vigorous existence *sans* bureaucratisation over that same period. It was clear from the time of the passing of the 1838 Medical Witnesses Act that their diffuse nature and non-scientific "irrationality" would always preclude the practitioners and followers of lifeworld epistemologies from recognition by the modern state, in which supreme value was placed on what Weber called "legal rationality".

What that indicates is that while according to Pusey (1976) "bureaucracy is one of the most dramatic inventions of our time", and therefore an extremely important phenomenon, it is not all-important. On that score, writers such as Ouchi (1980), Taylor(1982), and Colebatch & Larmour (1993) provide a useful counterpoint with their postulation that bureaucracy is only one type of organisation, or as they term it "organising". They indicate two other powerful non-bureaucratic forms which characterise processes of organising in the modern world, those of market exchange and also "community" or "clan" organising, to use Ouchi's term (1980). In terms of this type of organising, action is not based on or bound by on impersonal rules or hierarchy as in a bureaucracy, but instead results from the commonly-held beliefs, values and relationships (hence the appellation of "clan") within groups. In many ways this type of "non-rational" action constitutes the most powerful form of organising, as is certainly indicated by the way in which the World Trade Centre in New York was destroyed on September 11, 2001.

If it is true that "community organising" supplies the most likely explanation for the survival and success of lifeworld/alternative medicine, it follows that by concentrating entirely on developments in the rational/bureaucratic sphere of scientific medicine, studies of health care (including the present one) only tell half the story. To date however, apart from Siapush (Siapush, 1999), few in Australia anyway, have attempted to investigate medical history from the perspective of lifeworld/alternative medicine. Obviously there are some very rich research potentials awaiting exploration in this field.

The structural interest perspective

This study has also set out to demonstrate that Weber's macro analyses of bureaucratisation can also usefully be supplemented by the more micro-analytical tools supplied by Alford (1975). These add convincing reasons for the total dominance of Medicine in NSW during the first half of the 20th century. Thus, while scientific medicine encountered significant resistance from the adherents of lifeworld medicine in NSW both before and after the granting of responsible government, from the 1890s onwards it enjoyed total support from those within both the corporate rationalist and government executive structural groupings. As was demonstrated in Chapter Four, the latter actually took the lead when the politically incompetent medical elite failed to get the necessary changes in the legislation on to the statute books. That development clearly points to the fact that those who comprise "the government", derived as much benefit from the bureaucratisation and professionalisation of Medicine as did the members of the profession themselves. The advantages of medical bureaucratisation for those in both the legislative and administrative arms of government were twofold. On the one hand, the willingness of government executives to allow Medicine to assume control of the MRB as a bureaucratic apparatus, demonstrated to voters in the higher socio-economic strata at least, that their calls for the establishment of "order and protection" in the health field (Weber, 1978 [1922] p972) was being heeded. As far as corporate rationalists were concerned, the establishment of the MRB satisfied the demands of the "bureaucratic imperative", while the use of legislatively legitimated medical professionals as "co-opted experts" provided an excellent means of administering this highly specialised section of the government apparatus.

The mutual benefits derived from medical bureaucratisation by these two structural interest groupings, created an alliance between them and the professional monopolisers which lasted for 60 years after 1900. As was noted in Chapter Five, in the face of that alliance, those who comprised the lower socio-economic strata of the community population structural interest stood little chance of having their voices or complaints about the delivery of health care, heard or heeded. Even the passion of the proto-typical "equal health advocates" such as Nurse Welsh and the Buledelah loggers failed to make any impression on the three-way alliance of the structural interest groups.

That alliance, as already noted, endured through the first six decades of the 20th century. However, when as a result of growing media interest in health care issues, the electorally dangerous stirrings within the emergent community population structural interest (in which socio-economic divisions were probably beginning to fade) became apparent, government executives found themselves locked in to their alliance with the professional monopolists. Thus the Labor-dominated government executive of the early 1960s was unable to prevent the professional monopolisers from blocking its attempts to pare back their power following the Windsor Hospital incident. Government executives were equally powerless to assuage the public outcry which resulted from Chelmsford scandal, since as their lack of action indicated, the corporate rationalisers seem to regard that situation with equanimity, or more probably, were still too closely aligned with the professional monopolist interest power to want to do anything about it. It is also probably true that government executives themselves were still wary of too directly challenging professional monopolist power at that stage.

Fighting bureaucratic fire with counter-bureaucratic fire

The popularity of the consumer movement and the emergence of new ideological forces antithetical to professional privilege in the 1960s, gave government executives the motivation to break their alliance with the professional monopolists in the 1970s. Their determination to do so was signalled, as detailed in Chapter 6, by the consumer-orientated legislation which was passed in the NSW legislature during that decade. In addition, the advent of administrative law had created the weaponry which could be used directly to assault the power of the professional monopolisers. Thus the most effective assault was launched by the newly created "counter-bureaucracies" which included the office of the Ombudsperson and of course also the CU/HCCC.

Weber cannot be blamed for never anticipating this development, although perhaps it might not have surprised him to learn that the best method of fighting the fire of bureaucracy was with the fire of counter-bureaucracy. However, on this score he may also be included in Albrow's critique of the Habermasian notion of "the colonisation of the lifeworld" as set out in Chapter One, viz that Habermas fails "... to take forward the possibility that the encroachments of the modern state on everyday life actually assisted in the empowerment of people, through education of course, but also in requiring participation in everyday bureaucracy" (1996, p177). This is exactly what happened as far as the CU/HCCC was concerned. The "colonial culture" of bureaucratisation was replicated and effectively used by the equal health advocates to attack the power of the MRB.

The emergence of these "counter-bureaucracies" also puts a different gloss on Weber's warning that once established, bureaucracies are "among those social structures which are hardest to destroy" (1922 p987). What is evident in the case of the MRB, is that the power of the professional monopolists which it embodied proved unable to resist the challenge it faced in the 1980s from a new alliance between government executives and consumer/equal health advocate interests. Of course the MRB has never been "destroyed"; if it were, the "bureaucratic imperative" would demand that it immediately be re-invented. But while it still operates as an autonomous statutory authority, none the less it has undergone profound change. Its autonomy, exercised within the parameters of responsible government, is certainly very different to the almost totally non-accountable autonomy it enjoyed right up to 1987. And of course, from the point of view of this thesis, one of the most important aspects of its existence after that date, has been the loss of its right to autonomous control over medical discipline. The implications of that development have some far-reaching consequences for the whole concept of professionalisation.

Dynamics without change

Before considering that issue, the oxymoronic postulation by Alford (1975) of "dynamics without change" (p254) calls for some comment. On the basis of the material presented in this thesis, it can be concluded this observation can be seen to be valid in some senses, but not in all. It is true from the point of view that although, as is particularly evident from Chapter 7, the professional monopolisers experienced little but defeat in their struggles with government executives and consumer interests during the last two decades of the 20th century, none the less this has had little or no effect on the overall shape of the

health care system in NSW. It remains a mix of private and public health care delivery and there is not the remotest suggestion that, even if NSW State governments could act on their own without reference to the rest of Australia, they would ever try to take advantage of the weakened state of the professional monopolists to, for instance, move the State towards a system of "nationalised medicine" under which all doctors became government employees. However, only a change of that magnitude would in Alford's terms, upset the "dynamic stasis" which has prevailed in this State ever since the start of the 20th century.

On the other hand, the purpose of this thesis has been to argue that the destruction of both the institutional and individual autonomy of the medical profession as set out in Chapter 7, does indeed constitute a major change in the power balance between the structural interest groups. The loss by the professional monopolisers of their autonomous control over medical discipline is extraordinary not only in historical terms in NSW, but also in terms of the present-day situation in other jurisdictions. While health care complaints bodies in other States and Territories in Australia, do have consultative relationships with MRBs, some of them closer than others, none have the legislatively-supported system of co-regulation which was established in NSW in 1993 (Thomas, 2002). In Britain and the United States, medical discipline remains the sole preserve respectively of the GMC (Stacey, 1992) and the State MRBs (Ameringer, 1999).

But while the dominance of the professional monopolisers in NSW has been broken, it is not true that they are powerless. They remain in place as one of the four major structural interests and neither governments, corporate rationalists, equal health advocates or

academic theoretical analysts could ever afford to ignore the way in which the power of the professional monopolisers continues to shape the health care system. As suggested elsewhere, despite the outcome of the surface struggles described in this thesis, the basic structures of the system, based on private, fee-for-service delivery of health care services by medical practitioners, remains in place. In fact it may actually have been strengthened by the growing corporatisation of medical practice, as pointed out by Dr Con Costa, president of the Doctors' Reform Society, in its magazine, *New Doctor*, in March, 2001. He reported that increasing numbers of GPs in private practice were being attracted to corporate service by the \$200,000 transfer packages offered by corporations "with unlimited investment capital" and also by "the prospect of regular holidays, ... being able to take time off if they need to" as well as the prospect of special deals such as childcare for women doctors. Costa reported a prediction by one corporate entrepreneur that within a year 50% of all medical consultations would be taking place in corporate medical centres. That figure was in all likelihood an inflated one, but it none the less reflected the rapidly growing situation of medical corporatisation not only in Sydney but in Australia as a whole.

One consequence of that development is that not only the medical profession, but also major capitalist enterprises now have a vested interest in the maintenance of the status quo as far as the delivery of curative services is concerned. From this point of view, the position of the professional monopolisers has actually strengthened and on this score, the material presented in this thesis relating to Medicine's loss of the total control of medical discipline, does little to disturb Alford's conclusions relating to "dynamics without change" or dynamic stasis.

Rethinking professionalism

However, the changed situation of the professional monopolisers at the beginning of the 21st century, raises broader questions with regard to theories relating to professionalisation. As was set out in Chapter 1, authorities such as Freidson (1970; 1975; 1985; 1990; 1994), Daniel (1994; 1995), Wolinsky (1993) and Southon and Braithwaite (1998) among others, agree that autonomous control of the discipline of practitioners is a distinguishing feature of professional status for any occupational group. Its loss of that control in NSW would be interpreted by some as another step towards process of "proletarianisation" of the medical profession, as argued by Oppenheimer (1973)), Haug ((1975; 1976; 1988), McKinlay & Stoeckle (1988). However, to describe an occupation which ranks as the highest paid in Australia and which consistently attracts the brightest and best of the student population into its ranks as being part of the "proletariat", is to stretch the meaning of that word impossibly far. While it may be true that as a result of their increasing corporatisation, members of the Medical profession are being forced to defend their interests in the same way as other "proletarian" occupational groupings, none the less their status and exclusive expertise gives them a head-start in any economic struggles in which they find themselves embroiled. It would be difficult for instance, to conceive of government guaranteeing any other occupation against indemnity suits in the way that it has the medical profession as a result of the crisis of 2002.

The same applies to technical definitions of autonomy. Strictly applied, these would mean that because Medicine has lost its autonomous control of professional discipline in NSW, it has gone a long way towards deprofessionalisation if it has not already been deprofessionalised. But given the continued public regard for Medicine as perhaps the

pre-eminent profession, the notion of deprofessionalisation is also difficult to sustain in the “real world”. Rather than measuring Medicine against a yardstick of strict sociological criteria for professionalisation, what seems to be needed is a re-examination and probably some adjustment of those criteria.

Thus, while the NSW MRB has lost its exclusive power over the medical discipline, it has been extending its controls over the medical profession in other directions. For instance, in the late 1990s it initiated moves that culminated in the passing of the Medical Practice (Amendment) Act of 2000 (No. 64) which had as its centrepiece the introduction of a "Performance Assessment Program". That program has enabled the MRB "to address the longstanding problem of practitioners who are not impaired or guilty of misconduct, but whose standards of practice appear to be unsatisfactory" (Medical Registration Board NSW, 2000 p3). Remedying that problem of course, means assessing the performance of individual practitioners in a fashion which would have been unthinkable for the MRB during the greater part of the 20th century. The incorporation of the "infamous conduct" clause in the Medical Practitioners Further Amendment Act of 1900 (No. 70) signaled that for Medicine at that stage and indeed until 1987, the protection of individual autonomy as far as practice was concerned, was one of the major functions of the MRB. Since the Performance Assessment Program represents a far-reaching diminution of that individual autonomy, it could be argued that it represents yet another step towards "de-professionalisation". On the other hand, it could be equally be argued that since in the words of Salter (2001), one of the basic functions of medical regulatory bodies is to "provide explicit standards" for the certification and registration of practitioners, the Performance Assessment Program is actually contributing to the professional standing of Medicine.

That statement however, begs the question of what exactly constitutes and determines "professional standing". On that score, the following statement by Daniel (1996), herself a leading sociologist, is useful. "Public perceptions of a profession will be governed by the way discipline is seen to be applied and enforced in a profession". That sentence contains a crucial preposition in the last line; Daniel uses the word "in" rather than "by". In those terms, *how* professional standards are applied becomes less important than the assurance that they are indeed being applied, no matter by what means. In that light, peer review is simply not an issue as far as "public perceptions" are concerned. In fact, on the basis of the evidence presented in this thesis, peer review can actually have counter-productive effects for a profession, in that its seemingly cabalistic nature arouses suspicions that disciplinary mechanisms are simply a façade behind which professionals protect each others' backs.

On the other hand if the community population structural interest, i.e. consumers of health care, as well as government executives, have confidence that discipline is being applied in a transparent and non self-interested fashion, that there are no attempts to defend the indefensible, then strict technical definitions of "profession" are not of any great significance. This is true not only for academic analysts; on the basis of the statements made by Reid (2001) quoted in the previous chapter, the professional monopolists are comfortable with and have confidence in, the way medical discipline is being applied in this State. This is despite the fact that in terms of the system of co-regulation, the MRB has been forced to share its disciplinary function with the HCCC. The lesson seems to be that peer review is not necessarily a *sine qua non* as far as

professionalism is concerned. Thus it might be argued that as long as confidence in the system of co-regulation in NSW is maintained by all structural interest groups involved, the professional status of Medicine is much safer than ever it was during the era of its complete autonomy and control over discipline.

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APPENDIX A

Failed Medical Practitioners Bills, Parliament of NSW 1876-1898

The following shows the fate of the Medical Practitioners' Bills between 1876 and 1898:
(References show NSWPD dates and pages):

1876	Bill passed by the Upper House. Committee stage not completed (<i>Sydney Morning Herald</i> 7/4/1876)
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1880	Bill debated in the Lower House. Debate adjourned due lack of a quorum. Bill lapsed. 14/5/1880, p2328
1886	Bill debated and passed by the Lower House 16/7/1886, pp3420. Upper House committee stage not completed. Lapsed. 19/10/1886, p5866.
1889	Bill presented to the Upper House. Withdrawn 21/9/1889, p3420.
1890	Bill passed by the Upper House, not considered in the Lower House. Lapsed, 4/10/1900, p3538.
1891	Bill passed by the Upper House, not considered in the Lower House. Lapsed 4/10/1900, p3538.
1892	Bill introduced into the Lower House. Lapsed after second reading. 21/9/1898, p732.
1893	Bill passed by the Upper House. Lapsed after first reading in the Lower House. 12/10/1893, p353
1894-5	Bill passed by both Houses. Upper House refused amendments proposed by the Lower House. Lapsed 6/6/1895 p6944.
1897	Bill passed by the Upper House. Lapsed after first reading in the Lower House. 4/10/1900, p3538
1898	Bill passed by the Upper House. Lapsed after the committee stage. 21/9/1898, p739

APPENDIX B

The Medical Practitioners Act 1912

APPENDIX C

THE COMPOSITION AND DISCIPLINARY MECHANISMS OF THE NSW Medical Registration Board, 1838-1992

1838-1938

Constituted by:

- Medical Witnesses Act, (2 Victoria 22) 1838
- Medical Practitioners' Act, (No.26) 1898
- Medical Practitioners' Amendment Act (No 33) 1900
- Medical Practitioners' Amendment Act (No. 29) 1912

Specified membership:

Minimum of three legally qualified medical practitioners nominated by government. [Note: the numbers mostly varied between six and 12.]

Disciplinary mechanisms:

1900-1912 None specified

1912-1938 The MRB constituted as a court to try disciplinary cases.

Official complaints pathway: None specified

1938-1963:

Constituted by the Medical Practitioners' Act (No 37) 1938

Specified membership

Minimum seven, maximum nine, to consist of:

- Seven medical practitioners nominated by government
- One nominated by the Senate of the University of Sydney
- One member, nominated by the BMA, representing doctors outside the County of Cumberland [i.e. outside the Sydney metropolitan area]

Official complaints pathway:

Complaints to be registered with and assessed by the Board of Health. Those found to have *prima facie* validity referred to the Disciplinary Tribunal

Disciplinary mechanism:

Disciplinary Tribunal:

- President: Judge of the Local Court
- Members: Members of the Board

1963-72

Constituted by: The Medical Practitioners (Amendment) (No 22) Act 1963.

Specified membership 13.

One nominee of each of the following:

- Royal Australasian College of Physicians
- NSW branch – Royal Australasian College of Physicians
- Royal Australasian College of Surgeons
- NSW branch – Royal Australasian College of Surgeons
- Royal College of General Practitioners, NSW branch
- University of Sydney
- University of New South Wales
- Minister for Health
- Department of Public Health

Three representatives of the AMA

One barrister nominated by the Minister

Disciplinary mechanism

Disciplinary Tribunal:

President: Judge of the Local Court

Members: Members of the Board

Complaints pathway

Complaints to be registered with the Investigating Committee which refers those adjudged to have *prima facie* validity to the Disciplinary Tribunal.

Membership: Chairperson – Stipendiary magistrate

One nominee of the AMA

Director-General (or his nominee of) Department of Health

1972-1987:

Constituted by the Medical Practitioners (Amendment) Act, (No 52) 1972

Specified membership 13. Consisting of:

One nominee of each of the following:

- NSW branch – Royal Australasian College of Physicians
- NSW branch – Royal Australasian College of Surgeons
- Royal College of General Practitioners, NSW branch
- Royal College of Obstetricians and Gynaecologies
- NSW Universities Board
- University of Sydney
- University of New South Wales
- Minister for Health
- Department of Public Health

Three representatives of the AMA

One barrister nominated by the Minister

Disciplinary mechanism

Disciplinary Tribunal:

President: Judge of the Local Court

Members: Members of the Board

Complaints pathway

Complaints to be registered with the Investigating Committee which refers those adjudged to have *prima facie* validity to the Disciplinary Tribunal.

Membership: Chairperson – Stipendiary magistrate

One nominee of the AMA

Director-General (or nominee of) Department of Health

1987-1992

Constituted by the Medical Practitioners' (Amendment) Act (No 127) 1987

Specified membership 18, nominated by the following:

The Department of Health – one medical practitioner

The Minister for Health:

One barrister or solicitor

Four general nominees, “two to be conversant with the interests of patients as consumers of Medical Services”;

Eight Royal Colleges – one medical practitioner from each;

The AMA – two representatives

The Ethnic Affairs Council (one medical practitioner)

The Universities of Sydney, New South Wales and Newcastle – one joint representative.

Complaints pathways

Complaints may be registered with either the MRB or the CU. They inform each other of complaints made. Complaints adjudged to have *prima facie* validity referred to the Medical Tribunal

1992+

Constituted by the Medical Practice Act (No 94) 1992

Specified membership: Unchanged

Complaints pathways

Complaints may be registered with either the MRB or the CU. They consult each other inform and collaboratively decide on action to be taken. each other of complaints made. Complaints adjudged to have *prima facie* validity referred to the Medical Tribunal