



# A History of Medical Administration in NSW 1788-1973

by CJ Cummins

Director-General of Public Health, NSW (1959-1975)

2nd edition

**NSW HEALTH**  
Working as a Team

## Photographic acknowledgments

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October 2003

# Preface

This new preface is the result of a request from the NSW Department of Health to republish the original *A history of medical administration in New South Wales, 1788-1973 Report*.

During my tenure as Director-General of Public Health from 1959 to 1975, there were incredible advances in medical sciences and technology following World War II. These changes rendered obsolete the concept of a Central Health Authority with its own legal capacity through the Public Health Act and the Board of Health. There was a shift towards greater involvement of community agencies and charities. This underlies the system now in operation, and the Report of 1979 provides the background and details of this change. It remains a valuable document which aids in the understanding of the historical development of health services in this state.



A handwritten signature in black ink, appearing to read 'C.J. Cummins'. The signature is fluid and cursive, written over a light grey background.

C.J. Cummins M.B., B.S., D.P.H., F.A.C.M.A.  
Sydney  
July 2003



**St. George Nursing Home**  
Nurses 1928

# Foreword

The administration of health services in NSW has a rich heritage. Conceived in the harsh realities of a struggling penal colony, growing through the challenges of epidemics and regular social upheaval, state health services developed into an organised system which catered to the ongoing medical needs of generations of residents. These days, with new research published daily and as models of health care adapt to incorporate new diseases, treatments, and community demographic changes, the public health system continues to evolve to meet the challenges of the 21st century.

In looking to the future, it is also important to learn from the past. As the Director General of Public Health for sixteen years, Dr CJ Cummins was in a unique position to lead health care providers through an era of emerging technology, a burgeoning and culturally diverse new population and changing social expectations.

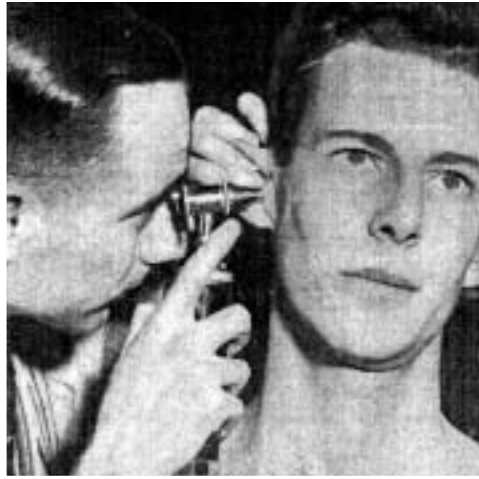
Sadly, Dr Cummins passed away earlier this year. A modest man, he was nonetheless flattered when NSW Health approached him to obtain permission to republish his significant work.

This republished volume, *A History of Medical Administration in New South Wales 1788-1973*, contains his valuable insights as a top administrator into almost two centuries of how the best available health care was provided to the people of NSW.

Updated with photographs and imagery from that period, this document is an important historical record of the times, from which future health administrators can draw insight and inspiration.



Robyn Kruk  
Director General  
NSW Department of Health  
October 2003



**Prospective Recruits for the  
RAAF receive a thorough  
medical examination**

A recruit having his  
ears examined  
1940's

# Foreword and Preface

## 1st edition 1979

### Preface

This study of the historical development of health administration in New South Wales was commissioned by the Health Commission of New South Wales in January 1977. The development of the topic is a logical extension of my earlier studies up to the period of self-government, and I am presenting the present study in two parts, before and after 1881, ie of the period when the conduct and rules of health administration were ill defined and pragmatic, as contrasted with the period subsequently when it was based on legislation and departmental organisation.

There will be areas of opinion and interpretation, especially in the second episode, when there may be personal and official differences to my expression of views. I emphasise that any views or opinions expressed are personal to myself, and in no way reflect the attitude of the Health Commission or its Officers, who may have assisted me in this study.

To the latter I wish to express my personal thank for their help and courtesy despite my demands, which, at times, were inconvenient and no doubt irritating. In particular I thank Mr. K. Brown, Secretary of the Health Commission; Mr. D. Hunt, Librarian, and Miss M. Petrich, Reference Librarian, of the Health Commission Library; and Miss Bruni Torreblanca who is responsible for the precise and accurate typing of the study.

C.J. Cummins m.b., b.s., d.p.h., f.a.c.m.a, Sydney, June 1979.

### Foreword

In November 1976, Dr C.J. Cummins, M.B.B.S., D.P.H., F.A.C.M.A. accepted an invitation by the Health Commission of NSW to write an historical account of the development of Government health services in NSW, from the foundation of the colony in 1788 to the establishment of the Health Commission in 1973.

Dr Cummins has had an eminent career in public health administration and has obvious ability as an historian. He is thus well qualified to compile this history.

The positions which he held gave him intimate knowledge of events in NSW related to health services administration in the quarter century prior to the formation of the commission.

These positions included the following:

Director, Division of Industrial Hygiene, Department of Public Health . . . . .	1950-52
Deputy Director-General of Public Health . . . . .	1952-59
Director-General of Public Health . . . . .	1959-75
President, Board of Health . . . . .	1959-75

The commission considers the history will be a valuable addition to other literature related to the health services of this state.

Roderick McEwin, Chairman, Health Commission of NSW, June 1979

*The*  
**CARDINAL  
POINTS**

EXERCISE



*of*  
**HEALTH**



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# A History of Medical Administration in NSW

## **Part I** **1788 – 1880**





**Royal Prince Alfred Hospital**  
4th Year Students 1889

# Introduction

## 1788-1880

The history of health administration in NSW from the foundation of the Colony in 1788 to the establishment of the Health Commission in 1973 spans an epoch pitted with turbulent, and often scandalous, episodes followed by surges of reform and development, which, in turn, receded into long periods of apathy. In reconstructing this panorama a broad chronological approach is inevitable, and such in detail, covering the period 1788 to 1855, has been completed by the author in several publications dealing with various components of health and welfare services(1). In this study an attempt will be made as far as possible to highlight persons and personalities, social and political movements, and other events which precipitated change and influenced development.

### The foundation of the Colony of NSW

The history of medical services in NSW commenced formally with the arrival of the First Fleet and the foundation of the Colony of NSW by Governor Arthur Phillip on 26 January 1788. For some years prior to this date, the possibility of a settlement in the Great South Land had been considered by the English government in a desultory fashion as a logical sequence of the voyages of George Anson in 1740 and Captain James Cook in 1770. The event which precipitated action was the campaign for American Independence which concluded in 1783.

The loss of its American colonies left England with a number of problems, the most pressing of which was the crowded state of England's goals and prison-hulks with convicts sentenced to transportation overseas. So critical and offensive to public and official conscience in London did the latter become that King George III, in 1786, gave instructions for a penal

settlement to be established at Botany Bay on the eastern coast of New Holland in the territory named by Captain Cook, NSW. A fleet of naval vessels, transports and supply ships was assembled to move 750 convicts, four companies of marines and a small cadre of administrative staff to Botany Bay.

Thus was commissioned the First Fleet which sailed under the direction of Captain Arthur Phillip, R.N., as Commodore during the voyage. Phillip was also appointed by George III as Governor of the Colony, to become effective from the date of disembarkation. His Royal Commission was all-embracing and granted him powers plenipotentiary, with civil authority as Governor and military authority as Commander-in-Chief of the armed services. The civil powers granted to him, and subsequent Governors, had substantial influence on the mode and organisation of the medical and ancillary services of the Colony, the aftermath of which was still apparent until the last quarter of the nineteenth century, particularly in the concept of lunacy.

Nine naval surgeons (including surgeon's mates) were allotted to the First Fleet, of whom four (John White, William Balmain, Thomas Arndell and Denis Conisden) were pre-chosen to establish a medical service for the Colony. It is only natural and logical that the Colonial Medical Service, and the private sector of medical practice, should follow closely the pattern of the Mother Country. There were significant differences in the organisation of medical benevolence in the Colony, and here the early settlers were influenced by the abuses of the workhouse system of Great Britain. The influence of Great Britain on medical practice, education and organisation was still dominant in Australia until after World War II. From the last quarter of the nineteenth century this influence was greatest in postgraduate education and public health practice and administration, in which Britain was pre-eminent.



## Medical practice and welfare in Great Britain in the eighteenth century

A brief description of medical practice and the administration of lunacy and welfare in England towards the close of the eighteenth century is a necessary background towards understanding the attitudes of the founders of the Colony, when establishing similar services in NSW. In general there were no laws which involved central government in Great Britain in the administration of medical practice or welfare. These services were regarded as attributes of daily living, and such controls as did exist were exercised by local government, as is largely the situation there today. Private practice was unimpeded, except for such restrictions as were imposed through the accrediting authorities of the Royal College of Physicians, the Company of Surgeons and the Society of Apothecaries. The organisation and attitudes of the medical profession were largely unaffected by the social changes of the century, and the pressures which influenced its later reform arose from within its structure, and reflected mainly the needs and ambitions of its members.

## Medical practice

The eighteenth century opened with two types of doctors with legal status to practise – the physician and the surgeon. The apothecary was a purveyor of drugs with some legal sanction to advise without fee on the type of drugs suitable for his client. The mass of the common folk were serviced by quacks, and village or itinerant herbalists. At the close of the century apothecaries had achieved the status of practising doctors with a close alliance to the needs of the masses. Systems of accreditation and training remained discrete and competitive for all three groups.

### Physicians

The physicians were the oldest, most respected and privileged of the three groups. They were professional men displaying skill of learning not of technology and they advised rather than did. They practised medicine only, and the ideal physician was a gentleman of culture and education, with, quite secondarily, an adequate knowledge of medicine(2). They owed their superior status to the Royal

College of Physicians which was established by Royal Charter in 1523. The organisation of the College was dissimilar to the guild structure of the Societies of Surgeons and Apothecaries, which were both educational and accreditation authorities. The College maintained itself as an accreditation and examining authority, relying on other educational systems, particularly the Universities of Oxford and Cambridge and Trinity College, Dublin.

Its examinations were conducted in Latin and were a test of classical knowledge as much as medical capacity. Its preoccupation with professionalism was criticised in 1768 by a petition from its trainees which stated of the Universities of Oxford and Cambridge that there are 'no patients, no clinical lectures which are the sine qua non of medical education(3)'. In practice it did require some medical training for its candidates seeking fellowship or the lesser level of licentiate. Until 1812 the requisite was six months' hospital practice although it was customary to walk the wards for 12 months.

There were two types of practitioners accredited by the Royal College of Physicians – the privileged group of Fellows, who were the physicians of professional class somewhat equivalent to the present consultant physicians, and the Licentiates, who were drawn from a different social group and with a different educational background. The latter obtained their medical education by apprenticeship to a practising physician, with practical tuition under his supervision in the voluntary hospitals.

### Surgeons

Physicians, by virtue of the powers endowed on the Royal College at its incorporation and its subsequent policy, could claim with validity professional status, and hence could govern their affairs removed from the restrictions and exemptions imposed upon trade guilds. Not so the surgeons who were bound by the Statute of Apprentices, requiring a term of apprenticeship before freedom was granted to practise their craft.

The Company of Surgeons was separated from the Barber Surgeons Company in 1745. Actually it was formed without any clear concept of its purpose, other than the desire of the surgeons to rid themselves of the barbers because of disparity of status between the two. The authority of the College

to conduct its own affairs was confirmed legally by the Guy case in 1759, and thereafter it was recognised as the major educational institution for the training of surgeons(4). It never achieved a monopoly of accreditation of surgeons. For example, army and navy surgeons were exempt under the general provisions of the Acts of 1749 and 1784, and a licentiate of the College of Physicians was an adequate qualification legally to practise surgery.

Towards the end of the century there was an increasing trend for doctors who wished to practise a general type of medicine to seek the diploma of this Company in addition to the licentiate of the Society of Apothecaries.

The objective of the education of a surgeon in this century was the skilled operator; the desiderata of which were speed and dexterity. The craft was learned by apprenticeship (usually for five years) to an established surgeon, superimposed upon which, in the latter half of the century, were systematic lectures in anatomy, physic, materia medica, and practical tuition in dressing and operating techniques obtained in private or hospital schools.

At the close of the eighteenth century there was general agreement among its members that the Company of Surgeons needed reorganisation. In 1800 it was reconstituted as the Royal College of Surgeons, thus upgrading surgery as a speciality in its own right.

### Army and Navy surgeons

Army and navy surgeons were the basis of the medical corps of the Colonial (civil) and Military Medical Services of the Colony until self-government. Doctors trained in the army or navy were able to enter civilian practice after their discharge or retirement without further accreditation from the Surgeons Company. By the *Act of 1749* ex-service officers were permitted to practise any trade without fulfilling civilian apprenticeship requirements(5). Army and navy surgeons ranked in terms of the Act as officers. The Company of Surgeons objected particularly to the latter, pointing out that many navy surgeons had not been apprenticed in the navy, and many others retired with the rank of mate (learner). A further *Act of 1784* extended the privileges of ex-servicemen,

permitting them to practise their calling without the permission of their appropriate corporate body(6). A period of service of three years was a preliminary requisite to this exemption. As the examination for entry into the Services was easier than that for applicants to the Surgeons Company, this was a legal backdoor method of entering surgical practice. The Company considered a challenge and took legal advice as to its right to impose continuing fines on such 'unqualified surgeons'. The opinion was quite definite – no person could be fined for carrying on a legal occupation – and the Company did not contest the matter further(7).

The system of training in the Services was not dissimilar to the civil counterpart, viz practical tuition under an established naval or army surgeon, the period of service being equivalent to a shortened apprenticeship. It was better organised in the army after the creation of the Army Medical Board in 1793 and the establishment of the general military hospitals at Chelsea, Deal, Plymouth, Gosport and Chatham.

There was very little organised medical education in England during this century... teaching hospitals did not exist.

### Apothecaries

The apothecaries received their charter of separation from the Grocers Company in 1617, which, similar to other municipal companies, granted them the sole right to practise pharmacy within the City of London and a seven miles radius. Originally they were tradesmen and compounders and purveyors of drugs and medicine. It was only natural that they should offer advice to their clients as to the suitability of the drugs they sold. They were not allowed to prescribe by law until 1703, when the Rose case established their legal capacity to prescribe and attend patients without fee, thus bringing them into conflict and competition with the physicians(8).

In towns the status of the apothecary was low, but not so in the country where, in the early part of the century, he was usually the only doctor in practice. The average apothecary did not come of a good or wealthy family, and indeed it was the one profession open to members of the lower classes with a grammar school education. By the mid-eighteenth century the apothecary was no longer the servant of the physician, but the practising doctor catering for the populace and the prototype of the general

practitioner. He referred his more difficult cases to the physician, and many physicians found themselves dependent for their practices on apothecaries' contacts and references.

The examination required for an apothecary's license was that of the Apothecaries Hall and was very sketchy. Apparently, even the requirement of apprenticeship was often conveniently ignored and it was possible to sit for the examination with no other qualification than certificates of instruction from a hospital. Because of the demand for general practitioners and its less formal and easier examination, the license of the Apothecaries Society was more popular than that of the Royal College of Physicians as a means of entering medical practice in the latter quarter of the century. The advantage thus gained by the Society of Apothecaries was further consolidated by the *Apothecaries Act of 1815*, but was again minimal in the second half of the nineteenth century, after the Royal Colleges of Physicians and Surgeons and established their co-joint Board. The examinations of this co-joint Board was acceptable for reciprocal registration in NSW until after World War II.

### Medical schools and voluntary hospitals

There was very little organised medical education in England during this century as compared with Scotland with its courses in its university medical schools. Teaching hospitals in the modern connotation did not exist. Students went to hospitals, particularly the London hospitals, to learn their techniques but the hospitals did not provide systematic teaching. The practice of 'walking' hospitals became customary as more opportunities arose due to the growth of the voluntary hospitals not only in London, but also throughout the provinces. The examining authorities either accepted, or required as a requisite to licensing, certificates of hospital practice, the customary periods of which varied from six to twelve months for the physicians and longer for the surgeons and apothecaries. The latter was determined by the period of apprenticeship usually to members of a hospital staff who divided their obligations to the apprentices between office and hospital practice. The London Hospital was the exception which did attempt to provide systematic

tuition and training. By 1785 it had defined its teaching component by the establishment of a School of Medicine and Surgery, so ensuring its dominance in the English scene for the century to follow.

### Accreditation

The eighteenth century closed with three types of medical practitioners recognised as legally eligible to practise medicine, with friction and discontent between the three licensing authorities as to their status and prerogative; with further friction and discontent between their own members, and all alarmed and discontented with absence of controls over 'unqualified' practitioners, who outnumbered the regular practitioners and were tolerated officially. Standards of teaching and accreditation were ill-defined. The Royal College of Physicians was shortly to publish its lists of Fellows, Licentiates and Extra-Licentiates, but these lists had no standing in law and were no deterrent to quackery. So far from proceeding against quacks, the authorities regarded these lists as attempting to establish a dangerous monopoly and interfering with the belief in freedom to trade. Public opinion was apathetic, if not hostile, and the reform of the nineteenth century, which was to lead to standards of medical education and competence, was a professional campaign and not a popular movement.

All this was in contrast to the Colony of NSW, where by 1808 an examination board had been established to list professional qualifications as a requisite to practise, and where the concept of a professional Medical Board, with powers of registration and accreditation, was established by law in 1838 – 28 years in advance of similar action in England.

### Welfare and benevolence

"Why is it that, in a thriving city the poor are so miserable, while such extreme distress is hardly ever experienced in those countries where there are no instances of extreme wealth(9)?"

Rousseau, in his inquiry, sums up the enigma of the eighteenth century, the consequences of which are still reflected in the welfare systems of Governments in the twentieth century. The upsurge of poverty amidst wealth and plenty may initially have been consequential to the agrarian reforms and the

Industrial Revolution which transformed the economic status, prestige and power of England during this century; but later, want and destitution were consolidated and accepted as the necessary corollary of industrial and commercial supremacy.

Poverty had commenced to intrude on society early in the eighteenth century as an aftermath of the Laws of Enclosure. Prior to these measures, individual destitution was contained within the family or approached at the parish level by a reasonably humane distribution of poor law relief. Rural stability rested on a pastoral economy, whereby the common man survived with dignity although at a lowly level, under the system of ownership or tenancy of small holdings supplemented by cottage industries.

There was massive disruption of the peasant farmer and agricultural labourer following aggregation of holdings to improve the economics of farming and animal husbandry. The result was a wholesale dispossession of the rural population especially in the south of England. Small farmers and rural tenants were reduced to the status of wage labourers.

The impoverishment of wage labourers was accelerated and extended throughout the country by the Industrial Revolution in the latter part of the century. The basic economy switched abruptly from agricultural and pastoral to industrial, and Britain became the 'workshop of the world'. Increasing demand stimulated increased production and this was achieved by improved technology, thus sounding the death knell to the cottage industries. The rural poor could no longer survive as community and family units, and necessity forced widespread migration to the cities and the industrial north, there to compete on unequal terms of skill with the resident labour force and Irish emigrants.

For those whose working capacity was diminished by age, infirmity, or insanity there was no other alternative to poor law relief, as was also the lot of the unemployed and unemployable. The poor law system was unable to cope with the demands made upon it, and the attitude of its administrators and supervisors yet further dehumanised and stigmatised those who were committed to their charge.

## The poor laws

The first poor laws in England were symptomatic of an anxious demand for public security against rogues and vagabonds rather than an expression of Christian charity. Early in the reign of Elizabeth I legislation began to take account of various classes of inoffensive poor people, destitute and infirm adults, and young children. By 1597 the first pattern of English poor law was complete and recognised four principles: that national uniformity in relief measures was essential; that the most suitable unit of administration was the parish; that funds should be provided by compulsory rating, locally assessed and collected; that wherever convenient the able-bodied should be made to work and the recalcitrant should be punished(10). The statute of that year for the first time required the appointment in every parish of Overseers of the Poor and specifically imposed on them, in conjunction with the church wardens, the duty of providing for all classes of destitute persons.

They were directed to raise whatever funds they required by a direct levy upon the parish. These principles persisted as 'the old poor law' until 1834 when they were terminated by the *Poor Law Amendment Act*.

Outdoor relief was by 'doles' or pensions and this was a facile solution to the lazy and disinterested Overseer. The administration of poor law relief was supervised by the Justices of the Peace whose scrutiny was often casual and superficial. It was difficult, in the absence of any other way of preventing

starvation, to refuse all assistance to any person without obvious means of subsistence. The applicant could always appeal to the humanity of a Justice of the Peace, who usually found the easy solution by ordering the Overseer to give relief. As a result the parish resources were strained and the individual pauper received between one and two shillings per week – insufficient for complete maintenance and so perpetuating destitution.

The principle of doles and allowances dispersed by Parish Overseers was developed by the Justices of the Peace into the Allowance System, whereby to subsist even at the minimal level recipients had to rely upon the proceeds of their labour. The alternative was relief in 'the House', either the poorhouse or the workhouse. As destitution increased so the more did indoor relief of this nature become a feature and scandal of poor law administration.

The London Hospital provided systematic tuition and training and by 1785 established a School of Medicine and Surgery.

## Poorhouses and workhouses

The parish poorhouse consisted of one or more cottages used as free lodgings for parish pensioners, the disabled and sick, and as a temporary shelter for tramps and vagrants. Admission went by favour of the Overseer and it was the simple answer to the parish's problem of pauperism and dependency.

The more characteristic form of indoor relief was the workhouse which, in the eighteenth century, almost entirely superseded the poorhouse. Sir *Edward Knatchbull's Act of 1723* (9 George I, c 7) gave to single parishes the legal powers (already conferred on unions of parishes) to build workhouses as means of employing the poor; as penal establishments for the idle; as deterrents to mendicity; as asylums to the impotent poor, and as institutions for specialised treatment. In practice the single institution fulfilled all these functions, and, in addition, was the main repository for pauper lunatics, idiots and often the criminally insane. Although the workhouse was differentiated from the poorhouse by a systematic regime, supervised by a governor or matron responsible to the Justices, effective discipline was often next to non-existent, and the oversight was often let out by contract to enterprising speculators on a fixed annual basis.

Perhaps even more telling and illustrative of the manner in which all its functions were combined and its inmates indiscriminately mixed without, any respect of their dignity or their individual needs, is the 'cool' description of an observer in the eighteenth century(11):

"Crowded workhouses are the sinks of vice, for in them the old and the young, the healthy and those afflicted with loathsome diseases, the necessitous and the abandoned, are all mixed in one house, and perhaps in one room. Here the young, the unfortunate, and persons of weak yet honest minds, repeatedly have their ears assailed with infamous oaths, and descriptions of every species of vices, deception and theft. The scene is in the highest degree horrid, and infinitely surpasses any powers of description."

The attitudes of the early settlers, emancipists and even the officials of the Colony of NSW, although often at variance each with the other, were alike in their determination to prevent any duplication of the 'old poor law system' of Britain in the new Colony. The depth of this antipathy was both a revulsion from, and a condemnation of the degrading consequences of the administration of poor law relief in England during the second half of the eighteenth century, and of the inhumanity and contempt of society towards its indigent and destitute members.

## Care of orphans

The care of pauper children and orphans under the methods of poor law relief in England in the eighteenth century is a continuing record of callous inhumanity, which, even in a complacent society, excited the spirited attack of novelists and reformers alike. The main approach was towards apprenticeship, preferably to a master in another parish, to relieve the parish and the workhouse of the expense of maintaining the child. The premium paid was often a temptation to needy persons to accept this assignment because of the bribe offered in the premium. The system of 'shifting the settlement' was an even greater temptation to the parish overseer, as duly indentured apprentices acquired a settlement in the parish in which they served. Thus, 'the parish was relieved, not only of the boy's keep, but also of any future liability for the maintenance of himself and of the woman he would presently marry, and of the family of young children whom he would soon bring into the world. Hence the worst possible matter in another parish was preferred to the best residing in the parish'(12). Few of the children served out their time, and most of them were either turned adrift or driven by neglect or cruelty of their masters into immorality and crime.

The care of orphans, abandoned and illegitimate children, was a problem which was early imposed upon the administration of the Colony of NSW, and had to be solved in a manner consistent with the social and economic capacity of the Colony. Its very isolation from the Mother Country was in this aspect fortunate, as it was able to approach the solution conscious of the disadvantages of the system of poor law control in England, and uninfluenced by pressures to translate this system in part, or whole, to the Colony.

## Lunacy

Poorhouses, workhouses and private madhouses were the main repositories for lunatics and idiots, depending on the social status of the person afflicted pauper or person with means. The principle in these institutions was absolute custody with personal restriction, often by ingenious and barbaric devices. The keepers were persons of lowly status with little or no interest in the welfare of the inmates, and the system of confinement, lacking statutory supervision until the latter half of the century, was itself conducive to abuse and brutality.

Until 1744 there was no obligation on the parish to cater for lunatics, and their custody in the poorhouse or workhouse was but an extension of poor law practice, more related to vagrancy than a recognition of the needs of lunacy. The Act of that year (12 George II c 5) imposed this responsibility upon the parish and provided for the cost of confinement as a charge against the Poor Rate.

In the poorhouses and workhouses throughout the whole of this century no special provision was made for caring for lunatics, nor was it thought possible. They were treated like other paupers. Webb describes graphically the lot of the lunatic in the poorhouse – not dissimilar in some respects to the situation in the early asylums of NSW(13).

“Nothing gives a worse impression of the eighteenth century poorhouse or workhouse than the presence in them, intermingled with the other inmates, of every variety of idiot and lunatic. Of all the horrors connected with this subject we need not dwell – the chaining and manacling of troublesome patients, the keeping of them in a state almost of nudity, sleeping on filthy straw, the mixture of melancholies, and persons merely subject to delusions, with gibbering and indecent idiots, the noisy with the quiet, the total lack of any proper sanitary arrangements.”

Admission to the parish poorhouse or workhouse was through the poor law procedure usually by order of the Parish Officer, and was based on the needs of the parish and not those of the lunatic or idiot. Hence no medical certification was required either by

custom or law until the nineteenth century, although one might assume that there was some medical scrutiny by those doctors who contracted to the parish for poorhouse medical services. The main criteria for admission were the degree of dislocation of the harmony of the parish by the lunatic if wandering at large; the capacity of the family to support his person, restrain his actions and social incapacity; or his involvement with the law. In the latter instance two magistrates could order his admission, otherwise the Parish Officer acted independently or at the request of the family or relatives.

Discharge procedures, likewise, were the responsibility of the poor law authorities, and any review to this end was conditioned not only by the medical remission of the inmate, but also by his degree of poverty which would not be enhanced by his term in the poorhouse or workhouse. The more recalcitrant and violent inmates in some parishes

were contracted out to private madhouses, and at least these had the possibility of periodic review after 1774, when the Act of that year (14 George III c 79) provided for yearly visits by Official Visitors. For those parishes which did not contract in this manner, the prospect of discharge for the idiot and chronic lunatic was remote indeed, and admission was a lifetime sentence.

...the prospect of discharge for the idiot and chronic lunatic was remote indeed, and admission was a lifetime sentence.

## Lunatic hospitals and asylums

The deficiencies of the poorhouses and madhouses stimulated the endowment of lunatic hospitals by enlightened corporations or citizens, who saw the alternative need for a more humane approach to, and medical supervision of lunacy. Initially these hospitals were not in competition with the private madhouses, and catered for the poor who were acutely insane, rather than for chronic madness. The first was the famous Bethlem (Bedlam) established in 1676, and followed by Bethel Hospital, Norwich, in 1724. Limits were often placed on the duration of treatment after which the patient was discharged whether cured or not. The lunatic hospitals in Great Britain were privately endowed and controlled by Boards of Governors, in contrast to those established in NSW which were, and still remain, a responsibility of central Government. This pattern, once set, was copied by all states of Australia.

## Lunacy laws

The lunacy laws related to certification, personal capacity and discharge. Certification had its roots as much in safeguarding the sane from wrongful confinement as in protecting the insane. Misuse of the power of detention for ulterior motives was common in the private madhouses of Great Britain which catered for persons of substance. This stimulated official action, and statutory certification was introduced in 1774 on the principle of single certification as the requisite for admission to a private madhouse (14 George III c 79). It was not until 1828 that certification for lunacy was extended generally to cover all types of institutions, hospitals, poorhouses and private asylums by the *Act to Regulate the Care and Treatment of Insane Persons in England* (9 George IV c 41).

## Personal capacity

Prior to 1774 English law was designed to determine the lunatic's capacity to manage his affairs, and to protect his property, possessions and rights of inheritance rather than his liberty. Thus no specific legal procedures were defined to test the mental capacity of paupers unless they committed an offence, this otherwise being left to the Parish Officers.

When the Colony of NSW was established the law of the mentally ill in England was to be found in the Royal Prerogative, in the statutes declaratory of it, in the Common Law writs and in the decisions of the Court of Chancery(14). Essentially it related to protection of the property of idiots and lunatics, and was a development of the historic Royal Prerogative of the King as the guardian of idiots and warden of their estates, with his consequent right to the income derived there from as a source of royal revenue. In return the King was bound in conscience to maintain idiots and lunatics from the royal purse.

The law recognised two grades of mental incapacity – idiocy (a navitate), and, as an alternative, madness of a defined period (non compos mentis). An idiot and his possessions could be handed over entirely to a trustee. A lunatic in his person could be committed to some friend or interested person with suitable provision from his estate for maintenance. In both instances the trustees of the idiot or the friend of the lunatic ('his committee') were responsible in law for the delegation committed to them.

Blackstone set out the procedure for the determination of idiocy or lunacy(15):

"By the old common law there is a writ de idiota inquirendo, to enquire whether a man be an idiot or not: which must be tried by a jury of twelve men; and if they find him purus idiota, the profits of his lands, and the custody of his person may be granted by the King to some subject who has interest enough to obtain them... it seldom happens that a jury finds a man an idiot a navitate, but only non compos mentis from some particular time... the method of proving a person non compos mentis is very similar to proving him an idiot. The Lord Chancellor, to whom, by special authority from the King, the custody of idiots and lunatics is entrusted, upon petition or information, grants a commission in the nature of the writ de idiota inquirendo, to enquiry into the party's state of mind; and if he be found non compos, he usually commits the care of his person, with a suitable allowance for his maintenance to some friend who is then called his committee."

The reluctance of juries to find a verdict of congenital idiocy no doubt related to the permanency of such a finding and the difficulty of revision. Non compos mentis could be revised to the benefit of the individual, by the same procedure, on recovery or remission.

## Discharge

As there was no particular law on lunacy, other than the Common Law, discharge mechanisms were not specifically defined, nor were there any procedural safeguards to protect the individual against continued detention after recovery. The remedy rested with the individual or his 'committee' to support his claim of cure or remission, in the jurisdiction of Chancery, by proof of recovery of mental capacity. If the jury decided that a state of non compos mentis did not exist, personal management of his affairs was restored to the individual, who then could no longer be retained in custody in a madhouse without the owner infringing the Common Law by illegal detention. This was also the only approach to secure release by anyone who considered himself unjustly admitted to a madhouse, on the pretext of insanity by collusion between an interested party and the proprietor of the madhouse.

The approach to the Lord Chancellor through the equity courts was of theoretical value only to the person without substance, and of no practical significance to the pauper in the poorhouse or workhouse.

The administration of lunacy in the early years of the Colony of NSW was but a logical extension of the systems of care; the medical and social attitudes; and the legal appurtenances of madness and idiocy in Great Britain during this century. It is interesting to note that discharge procedures was considered the least important of the components of administration of lunacy in the Colony, and was not clearly defined by statute until the last quarter of the nineteenth century.

## Prelude

The eighteenth century, which commenced with an ordered and balanced economy between rural and urban interests, ended with England at war and blockaded; the masses poor, suppressed, sullen and restless; the Establishment conscious of its status and bitterly resisting change which might impair its power, wealth or class superiority; and the law harsh and oppressive to those who queried or rebelled against the system. A working class was emerging seeking

leadership to right its grievances, and itself showing little interest in the needs of those who could not contribute to its cause. The nation was estranged preparing for social conflict, and medical administration was a non-sequential issue which was not seriously considered by the Mother Government until the middle of the nineteenth century.

Those chosen to found the new Colony were soon to be engrossed in its struggle for survival against a harsh unrelenting climate so foreign to the green fields and softer hues of England; caught in the

network of animosities and jealousies spewed from isolation and despair; enveloped in an environment in which social restraints were only enforced by brutal measures, and where sickness, and even death, were glad respites from unrelenting toil; so abandoned and discarded in a land of drought and famine that Principal Surgeon John White proclaimed in the depths of his depression that it was(16):

“a country and place so forbidding and so hateful as only to merit excretion and curses... there was not a single article in the whole country that in the nature of things could prove of the smallest use or advantage.”







**A party including John White (Principal Surgeon),  
George Woran (Surgeon of the 'Sirius'),  
and Governor Phillip, is shown here  
visiting a young Aboriginal woman,  
who is recovering from an illness**

*From 'An historical journal of the transactions at  
Port Jackson and Norfolk Island' by John Hunter,  
London: Stockdale 1793*

# The Colonial Medical Service

John White enjoyed a smile of contentment as he gazed across the placid waters of Sydney Cove with its thick woodlands shimmering in the haze of the hot January afternoon. He had just returned to his tent, on the west side of the Cove, from a meeting with Governor Phillip. His colleagues Balmain, Consider and Arndell had been present also, much to his satisfaction. Phillip, who was usually taciturn and sparing of praise, had been almost effusive in his commendation of the work of the surgeons during the voyage of the First Fleet, in maintaining the health of the convicts and marines over such a long voyage.

The land looked promising and was no hotter than Mauritius and other ports he had experienced during his brief naval career. There would be pleasant forays of exploration and opportunities for natural studies to relieve the tedium of camp life, and already he could envisage his journal as a bestseller; provided, of course, he could outsmart some of the marine officers who had similar ideas. He looked at the gold braid on his naval uniform – a somewhat paradoxical dress for a civilian surgeon. Yet he was a civilian. His commission committed him to establish a medical service after disembarkation, which would be responsible to Phillip as Governor and not in the military role of Commander-in-Chief. He was glad to be free of military discipline although he supposed he would still be liable under the *Military Act* and Articles of War for the time being. After all, he mused, there was no other law that Phillip could apply until the Colony was settled. There was no doubt about his personal authority as professional Head of the medical service. He remembered the words of his commission:

“We George III do, by these presents, constitute and appoint you to the Surgeon of the Settlement within our Territory called NSW(17).”

He made a mental note to discuss with Phillip the title he would assume. It should have no military or naval rank which might confuse his civilian authority. Surgeon to the Settlement was mentioned in the commission but was rather clumsy. Something shorter, perhaps Principal Surgeon or Chief Surgeon? No matter! Whatever of these alternatives suited Phillip would also suit him. The issue was not important.

But more important and annoying was the loss by damage and theft of much of the medical stores and necessaries during the voyage. One could not do as in London hospitals, just order afresh from the Apothecaries' Hall. Much worse, someone had forgotten to include the blankets, sheets and other comforts intended for the hospital, now being established in the tents around him. The first damage might be overcome by local initiative. Already he had sent Denis Consider into the bush to search for herbs and medical plants. There were stands of sarsaparilla and occasional wild myrtle trees quite near the settlement, which could be used for infusions against scurvy and the dysentery. As for comfort in the hospital! Well, the convicts would have to share what was available and the position would be rectified, hopefully, when the Second Fleet arrived.

As he turned to enter his tent he was undisturbed by his immediate problems. There would have been no air of complacency had he but an inkling of the tribulations which lay ahead of him – and in the near future. He was self-satisfied, the first among the Colonial Surgeons, with the immediate task to establish the Colonial Medical Service, after which he might anticipate his return to England and further service in the navy, before marrying (perhaps a heiress), and settling as a country squire among the green pastures of England, which were frequently in his thoughts.

## The Colonial Surgeons

The Colonial Surgeons serviced the Colony in an era wherein jealousies, frustrations and thwarted ambitions were resolved in vitriolic words and even with pistols. Nepotism was rife and conflict between individuals, and with authority, the rule and not the exception. Struggle for power was but vaguely disguised, and for property and riches open and unabashed. Social caste was paramount in the three decades following Foundation, but was less influential after this period, as free and freed settlers united in a single ambition to convert a prison settlement to a self-governing colony.

Throughout the period to self-government the Colonial Surgeons and their colleagues in private practice were prominent in commercial and political manoeuvres, sometimes to the disadvantage of their professional image and reputation. This was particularly so when military power was predominant and service in the Colony was a temporary phase to be endured, not perhaps without advantage, before return to the Motherland. Nor, at this point of time, can this attitude be wholly condemned. Who would willingly suffer privations of isolation and desolation; threats and actuality of famine; loss of domestic and cultural comforts; scenes of daily brutality and squalor; vagaries of discipline; environments charged with hostility and forboding; favouritism and conflict, and yet maintain equanimity and ideology of purpose? If there were villains, so were there heroes. Much can be forgiven the former as time mellows judgment, and the latter also had their peccadillos, which were trivial compared with their achievements.

After the arrival of the First Fleet, the four naval surgeons commissioned to establish the Colonial Medical Service were supplemented by Thomas Jamison, who had been surgeon's mate (apprentice) to Surgeon B. Morgan of H.M.S. Sirius, and by John Irving, a convict 'bred to surgery' about whom little is known, and who probably acted as a surgeon during the voyage. Both White and Balmain held commissions from George III each granted on the same day, the 24 October 1786. Although there are no records of similar Commissions for Surgeons Consider and Arndell, it can be assumed that their appointments were confirmed prior to their departure from England. This is implicit in the first estimates for the civil establishment in 1786, which provided salaries for a surgeon and three surgeon's mates.

These six surgeons servicing the convict hospitals were the first of a long line of Government doctors, until 1848. It is not possible, in the confines of this publication, to do justice to them all. Rather one can only dwell on those who achieved some degree of distinction or villainy, and whose efforts and behaviour added distinction or notoriety to the Service. It is convenient to consider their terms and conditions of service, their relationships to the Administration, and to their own professional Head in chronological compartments equating to the tenure of the Office of Principal Surgeon or its equivalent. A complete list of the Colonial Surgeons, and their appointments, during each of these periods of medical administration is listed in Appendix 1.

### 1788-1795 Principal Surgeon John White

John White was born in 1757 and entered the navy as surgeon's third mate in 1778. He was a man of means from a country family, probably with whig political convictions and philosophy. He obtained his professional qualifications from the Company of Surgeons in 1781, prior to which he achieved early promotion to the rank of surgeon in the navy in 1780 at the age of 23. He was occupying this post on H.M.S. Irresistible when he was proposed by its Commander, Captain Sir Andrew Snape Hammond, to Under Secretary Nepean as a candidate for Botany Bay. He was accepted and sailed on the transport Charlotte.

His was a most unenviable task under conditions which were more than usually trying. His career might have reached a sudden end in August 1788, when he fought Australia's first duel with his assistant William Balmain, and although Balmain's irascibility may well have contributed to this episode, there is evidence in the friction between White and his staff that he was too much the gentleman and 'naval officer' to command leadership despite his competence and diligence. White had no control over the appointment or distribution of his staff, surgeons or convicts. Such flowed from the Governor's authority over each individual in the Colony, and was exercised personally by Phillip and succeeding Governors, who filled vacancies in the establishment of Colonial Surgeons by recruitment locally or from England.

The efforts of White and his staff were directed to the specific needs of the Colony as a penal settlement. The Colonial Surgeons provided a comprehensive hospital and personal medical service to all the residents in the Colony, civil and military, prisoners, emancipists, and to invalided sailors from the ships which called at the port. In addition, they were expected to supervise floggings, of which there were many; attend executions; act as members of medical boards to advise on medical determinations for repatriation of civil and military staff; and to perform magisterial duties(18). Their remuneration for this latter obligation was indirect:

“...with the labour of four convicts each, victualled at public expense, which cannot be averaged at less than £20 a year for each convict(19).”

White and his colleagues were able to surmount the catastrophic epidemics which followed the arrival of the notorious Second and Third Fleets, inadequacy of medicine and medical supplies, famine and hospital food rationing, and the brutality and indifference of convict nurses. There were times when White was to disclaim in despair against the harsh, barren land and the settlement imposed upon it.

Balmain was confirmed as Principle Surgeon in August 1796.

Much can be forgiven White for the difficulties under which he laboured. If sometimes he buckled under the challenge it must be remembered that he bore the greater burden. It was inevitable that the stresses and brutality of the settlement would breed friction, animosity and jealousies between himself and his staff. His isolation was destructive to his equanimity and judgment. He was frequently frustrated in his objectives by lack of support and supplies, and his pleas, even when heeded, were, in the circumstances, often impossible to satisfy. Yet, in less troubled times, he too saw the vision of a great land, to which in the afterdays his contribution is gratefully remembered. He sought retraction of his hasty forecasts by his request that from the publication of his journal should be suppressed... ‘many remarks not very favourable to the Settlement, as I now trust from change of men (I mean Governors) measures will be pursued that will soon make it in a great degree independent of the Mother country’(20).

White was a person with high principles and a considerable sense of personal responsibility. This he demonstrated in the public acknowledgement of his natural son born in 1793 of his housekeeper Rachael Turner and the subsequent support and education of this child as a member of his own family. He returned to England in 1795 because of ill health where he married and reared a family. He severed all his remaining ties with the Colony when he disposed of his land grants in 1806. He died in February 1832, at the age of 75.

### 1796-1805

#### Principal Surgeon William Balmain

William Balmain was an able administrator; the recognition of which is often overlooked because of his personality clashes with his superiors and associates. He was a person of strong will and singular determination, easily stimulated to truculency and quick to take offence. He aroused hostility and antagonism in others which were not easily allayed or forgiven. The rift between him and White, arising from their duel, was never healed and the latter’s intense dislike of Balmain persisted, even to the extent of thwarting his justifiable request for a salary allowance while acting as Principal Surgeon during White’s absence on leave in England.

That Phillip transferred him to Norfolk Island in 1791 may have been no mere coincidence, but a tactful manoeuvre to separate the two. His temperamental indiscretions did not affect his seniority and he returned to Sydney as Acting Principal Surgeon in June 1795. He enjoyed the confidence of Governor Hunter who later praised his public spirit.

Balmain was confirmed as Principal Surgeon in August 1796. His aggressive attitude was still a source of constant irritation, often involving him in explosive, and even ludicrous situations, as when he accepted the collective challenges of the Officers of the NSW Corps to a duel on a one-after-another arrangement(21). His involvement with D’Arcy Wentworth in the rum scandal was probably but a profitable extension of his providing commercial activities.

There was no variation in the numerical strength of the establishment during this period. Governor Hunter described the minimum strength which he considered essential for staffing:

'It is to be understood that not less than three commissioned staff surgeons are to be resident in this Colony, and one at Norfolk Island, which will permit of two being absent on leave(22).'

Appearing also during King's regime as Governor is a concept of home leave for the staff of the medical establishment. White, Balmain and Jamison each at various times applied for such leave to the Home Authorities, usually on the pretext that such was necessary to supervise their personal affairs in England which had, or would, deteriorate with their prolonged absence in NSW. King appears to have accepted the principle that a system of home leave was necessary as a component of the term of service: 'Assistant-Surgeon Jamison having to obtain leave to return to England... his leave from the Colony is to continue only for one year from time of his arrival in England to enable other assistant surgeons to procure a similar leave(23)'. This principle was desirable as salaries (£182.10.0 per annum for the Principal Surgeon and £91.5.0 for Surgeons) were drawn in England by agents appointed by the Surgeons to act on their behalf. Mileham, for one, had his salary misappropriated by his agent.

James Mileham, who was later to figure in the Bligh Rebellion, was commissioned to the establishment in August 1796 and arrived in 1797. D'Arcy Wentworth, whose medical qualifications were dubious and who also was to become Principal Surgeon, was appointed surgeon in 1796. Other surgeons were appointed temporarily by Governor King as replacements for surgeons on leave. The exception was John Savage who was retained and subsequently included in the establishment.

Balmain was precise in his administration and early instituted returns on the 'State of the Sick and Hurt', at first on an annual basis for the years 1797-1799, and then on a less regular pattern, sometimes quarterly, sometimes half-yearly, until 1801. They were discontinued by Jamison in 1802 when acting in lieu of Balmain, then on leave.

Balmain frequently complained of the difficulty of obtaining adequate supply of drugs, medicines and provisions, and although his complaints were constant one gains the impression that never were situations as critical as in the period of his predecessor. He returned to England on leave for the second occasion in 1805, and died there in that year.

## 1805-1811

### Principal Surgeon Thomas Jamison

In 1894 Thomas Jamison had his seniority restored thus correcting a possible injustice because of a clerical omission in backdating his commission. With this action it was also confirmed officially 'that he was next in succession on the medical staff of this Colony to the present Surgeon-General, Mr Balmain(24)'. He was appointed to the office of Principal Surgeon in 1805 after a quiet and uneventful career in the medical service of the Colony, the greater portion of which was spent at Norfolk Island. He was well qualified having graduated from Trinity College Dublin in 1780, in which year also he joined the Royal Navy as surgeon's mate. He was still following his naval career when he was appointed to H.M.S. Sirius of the First Fleet as surgeon's first mate.

The latter half of his career as Principal Surgeon was as turbulent as the first half was placid, culminating in bitter differences and hostility between himself and Governor Bligh, over Bligh's intrusion into the medical administration. He was involved in the deposition of Bligh in 1808 with his colleagues D'Arcy Wentworth and Mileham, and Surgeon Harris of the NSW Corps. In 1809 he was recalled to England as a witness in the court-martial of Johnston for his part in the affair of Governor Bligh. After his return he resumed his office of Principal Surgeon and was restored to his magisterial position. He died in 1811. Ford attributes to him the first medical publication in the Colony on 'General Observations of the Smallpox' in the *Sydney Gazette* on October 14 1804(25).

Governor King confirmed the numerical strength positions and distribution of the medical establishment in a comprehensive document in August 1806, as one Principal Surgeon and one Assistant Surgeon to be located at Sydney, one Assistant Surgeon at Parramatta, one at Newcastle and one at Norfolk Island.

Jamison's regime was a period of rapid change for the Colonial Surgeons with deaths, suspensions for court-martials, resignations and recalls to England. The morale of the service was at its lowest during Bligh's governorship due to his forthright intrusion into its affairs – so much so that at one stage in 1807, after D'Arcy Wentworth had been further suspended on Bligh's charge of misuse of public labour in the hospitals, the active staff in Sydney and districts was two only, Jamison and Mileham, and Jamison had requested of the Home Authorities to be allowed to retire if Bligh's government continued. Even the surgeons of the transport ships refused to join the service. Bligh, by Government and General Order, transferred control of the medical stores from the Principal Surgeon to the public store under the Commissary, from which Jamison had to requisition for supplies. These requisitions in turn were scrutinised by Bligh – a cause of further irritation.

Surgeon J. Thompson (appointed in 1795), who had been superseded by Jamison, again became Senior Assistant Surgeon on Jamison's appointment as Principal Surgeon. He died on the 23 May 1807, from which date D'Arcy Wentworth was promoted to Senior Assistant Surgeon.

There was general discontent among the Colonial Surgeons at their duty to attend and treat settlers, not victualled by the Crown, without fee. The court-martials of Surgeons Mileham and Savage, both for refusing to attend women in labour – the latter in rather heartless circumstances – created a crisis. The sentence imposed on Savage, that he be cashiered, was not confirmed by His Majesty because it was not a military offence within the *Mutiny Act or Articles of War*(26). This intrusion of the authority of the Governor into the professional relationship between the civil servants and free settlers was resolved by permitting the surgeons a right of private practice.

Major General Lachlan Macquarie arrived in December 1809, to take charge of a medical service, disorganised in its branches, and with individuals in a state of unrest. He was to institute vigorous reforms, the benefits of which were to be enjoyed by D'Arcy Wentworth as successor to Thomas Jamison. The latter was a loyal and conscientious officer, who served the Colony faithfully and did not deserve the turmoil and intrigue into which he was precipitated.

## 1811-1819

### Principal Surgeon D'Arcy Wentworth

D'Arcy Wentworth arrived in the Colony in 1790 as a self-appointed exile to escape the consequences of his misdeeds and the possibility of criminal proceedings in England. Of all the Principal Surgeons he was the least qualified. A spasmodic study of medicine in the hospitals of London, plus his experience as assistant to the surgeon at Norfolk Island for some six years, was the total content of his professional qualifications when he was appointed to the medical staff in 1796. He succeeded to the position of Principal Surgeon by seniority in rotation, assisted also by the influence of Earl Fitzwilliam.

He was an opportunist quick to recognise and seize the chance and turn it to his own advantage. Despite criticism of the morality of some of his commercial ventures, his reputation stood high in the Colony as a shrewd man of affairs. That he was successful was justification enough. If further justification were needed, then his respectability was assured by his service in civil affairs as magistrate, treasurer of the Police and Orphan Fund, and superintendent of Police. His part in the rum traffic scandal was soon forgotten by the authorities and barely censured by his superiors. His participation in the contract for the General Hospital was condoned and justified by Macquarie as an unusual means to achieve a worthy objective. His career was certainly colourful and eventful, and more successful in civil affairs and commercial promotions than in medical administration.

He was fortunate in enjoying Macquarie's friendship. Although his professional deficiencies did not impede the latter's reform of the medical services, he, as Principal Surgeon, was of little assistance in the programme. Commissioner Bigge derided his capacity as a medical administrator with the scathing denunciation that it was 'little deserving of censure or praise'. Macquarie very tactfully concentrated on his extra-medical positions when he supported Wentworth's memorial for a pension on retirement bearing testimony to 'the indefatigable zeal, vigilance, activity, honor and integrity, uniformly manifested by him in due execution and faithful discharge of his various important public duties(27)'. If his energies were greater than his commercial morality then he redeemed himself by begetting a son whose name

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'was in the mouth of all as that of the ablest man on Australian soil' and founding one of the great Australian family dynasties.

Macquarie increased the establishment of Colonial Surgeons by the expeditious stratagem of paying their salaries from the Police and Orphan Fund, with the connivance of D'Arcy Wentworth as chairman of the controlling committee(28). He was scathing of the professional and intellectual capacities of several of the surgeons, Mileham, Luttrell and Henry St. John Young to name three. He used a system of partial banishment to dispose of Luttrell and St. John Young by posting them to Van Dieman's Land. This he could not do with Mileham, who was a permanent civil servant, and he left him at Nepean until his resignation in 1821.

Macquarie's actions did not go unnoticed by the Home Authorities. The determination of seniority in the medical service was again stated by Earl Bathurst whose decision also clarified the limits of the Governor's authority in appointing staff. The ruling left no doubt that entry into the permanent establishment and promotion in rotation could only occur after the surgeon 'has received a regular commission from home', and further that seniority should date from confirmation by commission and not from the time of provisional appointment by the Governor(29).

A procedure for granting pensions following cessation of service was instituted at the discretion of the Secretary of State and not as a right to the individual or within the authority of the Governor. The method of approach was a testimonial plea by the applicant to the Secretary of State for the Colonies supported by a covering testimonial from the Governor. When granted, the pension was at the rate of half pay following the military practice, although for lesser terms of service or less meritorious service a specific and lower annual sum might be granted. Allowance for pension payments was included in the Governor's estimates for the civil service.

There was no variation of salaries during this period from the increase which had been granted by Governor King in 1803, viz £365.0.0 per annum for the Principal Surgeon, £182.10.0 for the First Assistant Surgeon and £91.5.0 for Assistant Surgeons. Salaries were paid from civil revenue collected in the Colony and reimbursed from England.

As peripheral settlements were established so the population of the Colony increased rapidly, stimulated more by immigration than by transportation. In 1817 it had reached 15,175. The emancipist and settler proportion (the so-called non-victualled group) was 73 per cent of this total. The rise in population did not unduly strain the resources of the medical service, as much of the demand, particularly from the non-victualled group, was met by the emergence of private medical practice in the Colony. The colonial surgeon to population ratio of the segment to which personal medical service had to be provided varied from 1:519 in Windsor to 1:1,370 in Sydney. Hospital attention had to be provided for all inhabitants, other than the military staff in Sydney, and this duty reduced the opportunity of the surgeons to indulge in private practice. Redfern resolved this conflict between official and personal obligations by giving preference to private practice, correspondingly being dilatory and careless in his hospital practice at the General Hospital.

Wentworth's span as Principal Surgeon covered a period of transition during which civil procedures and civil government began to emerge as portents of the change in the function of the Colony from a penal settlement to a colonial state. Macquarie's emphasis in governing was more to the civil administration and in opposition to military dominance. The civil status of the Colonial Medical Service was assured but its reputation was not enhanced by Wentworth's administration. His successor, James Bowman, by comparison was a vigorous and dynamic leader who had at heart the interests of the Colonial Medical Service and the Colony.

### 1819-1836 Principal Surgeon (Inspector of Colonial Hospitals) James Bowman

James Bowman had previously visited NSW in 1816 as a Naval Surgeon on the transport Maryanne. His application for a position of Assistant Surgeon at Hobart was refused by Macquarie and he returned to England. He was appointed as Principal Surgeon by the Prince Regent in 1819, thus denying the policy laid down previously by the Secretary of State, that the senior position in the Colony should belong to the Assistant Surgeons by rotation in order of their seniority. This decision was undoubtedly directed against Redfern's recommendation by Macquarie

and as a mark of disapproval of Macquarie's emancipist policy. He assumed office on the 25 October 1819.

Not only was he an able clinician but he was equally dedicated and skilled as an administrator. He carried out his civic duties well but never to the degree of distraction from the affairs and destiny of the Colonial Medical Service. Equally he remained aloof from politics, and when he did intrude into local movements it was more in a passive than dynamic role. Because of his loyalty to the civil service and his identification with it he enjoyed the confidence of successive Governors, and was able to achieve reform by dogged persistence and without offence. Likewise he was respected by his colleagues who accepted his leadership in contrast to the relationships of previous Principal Surgeons to their staffs.

The basis of seniority by commission from England on which the establishment was structured was altered substantially during this period. In 1820 Bowman proposed a revision to provide for one additional Assistant Surgeon in Sydney, Parramatta and Windsor; and the creation of new positions at Castle Hill and Bathurst(30). The request was satisfied at the local level by Governor Macquarie and his successors using the resources of the Police and Orphans Fund. This then became the accepted procedure for appointment of Assistant Surgeons as vacancies occurred, and was confirmed after the formation of the Colonial civil service in 1827.

Of the Assistant Surgeons remaining after Wentworth's retirement, Redfern 'felt so hurt and mortified on the occasion' of Bowman's appointment that he resigned in February 1820, and Mileham submitted his resignation in July 1821, after 27 years of unobtrusive, but dedicated, service, most of which was spent in the Windsor District. He was but 57 years of age, financially desperate, almost blind and otherwise medically incapable of performing his duties.

The remuneration of the Colonial Surgeons underwent successive improvements. Commissioner Bigge instituted the first move to improve conditions in 1821 on the basis that the salaries were inadequate and the limited right of private practice was no longer a source of reasonable income.

Many of the surgeons, including Bowman, Hill and Anderson, drew military or naval pensions in addition to their colonial salaries, and Bigge proposed that this should be taken into account in the distribution of such fringe benefits as a servant, horse and forage at Government expense(31). The increases were not effected until 1828 following the reorganisation of the Medical Department and were substantial. Bowman as Inspector of Colonial Hospitals was granted £750 per annum plus quarters but no other allowances, and the junior staff was graded into two categories, Surgeons and Assistant Surgeons. The former received £273.15.0 per annum and the latter £182.10.0 respectively with quarters. In addition, as with other officials of the day, nearly all received grants of land to stand in lieu of pensions, Bowman receiving 2,560 acres, Mitchell, Brooks and Anderson 2,000 acres, and MacIntyre 1,000 acres. Similar land grants were made to the surgeons appointed after 1828(32). Bigge also proposed that a central fund for the civil service (created in 1827) should be established from which pensions would be paid after a minimum of twelve years service, which would include furloughs of up to two years. This principle was adopted with the alternative choice of land grants in lieu of pensions.

The Colonial Medical Service was then included in the civil service, the Principal Surgeon being classified in the second class and Assistant Surgeons in the fourth class. The further personal promotional post of Surgeon was created. The medical service was now a colonial career service, with the Principal Surgeon as its administrative superior responsible through the Colonial Secretary to the Governor for its efficiency, and no longer the chief technical medical adviser immediately responsible to the Governor.

Bowman had long anticipated this change. Shortly after his appointment he had made proposals for variation in the establishment, recommendations for the appointment of Assistant Surgeons and further suggestions for the control of stores and the appointment of civil staff for this purpose at the General Hospital. Additionally he made frequent inspections of the hospitals in the outlying settlements.

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In the earlier years of his administration he took an active part in the affairs of the General Hospital and reorganised its clinical and administrative structure. Subsequent to 1826 he was so preoccupied with the general oversight of the Colonial Medical Service that he left the clinical and routine work of the Hospital more and more to the Surgeons stationed in Sydney. Bowman's title was altered by recommendation of the Board of Enquiry in 1826 to Inspector of Colonial Hospitals, thus further emphasising his civil administrative responsibility.

Bowman supervised essentially a hospital medical service which was maintained primarily for the treatment of convicts, and outside Sydney for the military forces. His staff was expected to extend service to other government institutions on a visiting basis or at demand, including the Women's Factory at Parramatta, the Orphan School, and the penal establishments in Sydney. They performed forensic duties for coronial inquiries and participated in medical boards for the determination of mental or physical capacity particularly where administrative problems, such as repatriation to England, were involved. They were authorised to issue statements of opinion of insanity for admission to the Lunatic Asylum at Liverpool.

The control and supervision of medical stores rested with Bowman, who instituted a system of two years stock being maintained at the General Hospital to supply its needs and those of the other convict hospitals. Although Bowman demanded careful supervision and stock records and returns at the General Hospital, the stores procedures seemed to fail beyond this point and district hospitals and medical stations were often inadequately supplied. This was one of the reasons given for the reorganisation of the Colonial Medical Service in 1836.

Bowman apparently had intentions of resigning in 1827. Governor Darling disclosed this in a secret and confidential letter to the Colonial Under Secretary, wherein he also proposed an amalgamation of the civil and military medical services. Although in Sydney at that time the two were separate medical services there was no such distinction in the outstations, where the military detachments were too few in number individually to warrant the attachment of a military surgeon, and were attended by the nearest colonial surgeon. Nothing came at this

time of the proposal to amalgamate the two services and Bowman continued in office. It was implemented finally in 1836 by Lord Glenelg on the grounds of economy of staff and supplies to apply separately to Tasmania and Sydney. Bowman was supplanted by a superior officer, John Vaughan Thompson, in April of that year. He was never specifically discharged from the civil service but had no option but to cease active duty after Thompson's arrival. He was allowed to draw his salary for a further two years, and this irregularity was finally regarded as a retiring allowance(33). He became a very successful grazier supported by his marriage to Macarthur's daughter and her substantial dowry of cattle and sheep to stock his earlier land grant. His descendants are still prominent pastoralists in the Hunter Valley District. He was also restored to the naval half pay list.

### 1836-1848 Military Rule – Deputy Inspector General of Hospitals, John Vaughan Thompson and William Dawson

The official motivation behind the abrupt reorganisation of the Colonial Medical Service in 1835-36 is not clear. The immediate justification for this action was Bowman's failure to supply and distribute effectively medical stores and equipment to the peripheral hospitals and district settlements. The opportunity to effect the change arose from the decision to transfer the penal settlement from Van Diemen's Land to Norfolk Island, then re-established from 1824, and the need to reorganise the administration of the former, including its medical service. There was no associated audit of the convict administration of NSW, where the Colonial Medical Service had reached a stable phase.

Admittedly, there was the anomaly in having colonial and military surgeons providing for the same segment of the population but with different administrative loyalties. There is some reason also to believe that the personal standards and professional competence of the Colonial Medical Service, with some exceptions, compared unfavourably with the military surgeons. This viewpoint was implied by Thompson in one of his early dispatches to the Army Director-General of Hospitals, but his opinion may have been exaggerated as it was bound up with an attempt to replace civil surgeons with military surgeons in outlying posts(34).

Economy was probably the determining factor which precipitated the reorganisation of the Colonial Medical Service in NSW. Throughout the various instructions from the Director-General of Army Hospitals, Sir James McGrigor, to Deputy Inspectors General Thompson and Dawson is the constant reiteration for supervision of stores, distribution of medicines, revision of establishments and control of diets to prevent wastage. During this period the policy was to hold the status quo of the Colonial Medical Service despite an expanding population, with a continuing and strict financial scrutiny over its expenditure and activities.

The basis of the reorganisation was a report by Sir James McGrigor in which he proposed separate military medical establishments for Van Diemen's Land and NSW, each under the immediate control of 'a superior staff officer for the purposes of controlling the Medical Department connected with the military and convict branches of the services in those Colonies(35)'. Sir James was asked to select from the half pay list two Deputy Inspectors General of Hospitals, and he chose John Vaughan Thompson for NSW. He proposed also that an apothecary should be appointed to each service. There were no efficient apothecaries on the half pay list and a compromise was made with the appointment of Deputy Purveyors (stores officers). Thompson's salary was £1.10.0 per day (comprising 17/- per day half military pay and 13/- per day from the Colonial Fund).

Thompson arrived in the Colony in June 1836, with orders to take over from Bowman. From this date the Colonial Medical Service was no longer a component of the civil service. Its status was summarised by William Dawson on another occasion in 1844, when, in support of Busby's testimonial for a pension, he wrote that it 'was assimilated in rank and pay and in the nature of its duties to the medical staff of Her Majesty's Army(36)'. Thompson's authority and official duties are listed on page 27.

The responsibilities and lines of communication between the Deputy Inspector General of Hospitals and his army superiors were precisely defined in

these instructions. The Medical Service still had certain civilian responsibilities because of its monopoly of hospitals at least in the first half of Thompson's appointment. His responsibility in part to the civil administration was early a source of friction between himself and the Colonial Secretary. It was clarified by the Under Secretary of State for the Colonies through an unusual formula of informal and formal communications. He was to have direct and personal intercourse with the Governor without any interposition of the Colonial Secretary. If later official submissions became necessary because of these discussions they were to be made either through the Military or Colonial Secretary as appropriate(37). The relationship between him and his medical staff was quite definite. All communications from the medical staff to any superior authority must pass through him, and all appointments and exchanges were to be made by him.

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The immediate effect of the reorganisation on the Colonial Surgeons was that the stability of position and location previously enjoyed was lost, and they were liable to postings and exchanges on the same oasis as the military forces. They were not liable to discipline by military courts for refusal as they were not recruited into the army, but flagrant disobedience could result in dismissal, as with Mitchell from the General Hospital. Minor breaches, usually refusal to accept transfer; could interfere with promotion and loss of retirement privileges. Busby was thus penalised, despite long and meritorious service, for his refusal to accept promotion and transfer from Bathurst. After the closure of the Bathurst Hospital as a convict establishment in 1842, his position in the Colonial Medical Service was terminated and he was refused a half pension on these grounds.

The reaction of the Colonial Surgeons to the new system, and particularly to Thompson's autocratic attitude and disdain of their personal responsibilities was one of resistance and obstruction. Simultaneous resignations threatened to disrupt the service in 1839, but were not accepted by the Home Authorities because they were coupled with the condition of a retiring allowance to each(38).

Not all fault rested with Thompson. Many of the obstructions placed in his way by the Colonial Surgeons were retaliatory tactics of passive resistance as the additional duties imposed upon them interfered with their lucrative private practices or avocations as agriculturalists. To counter these attitudes, Thompson proposed that as vacancies occurred these should be filled by Assistant Surgeons from the army staff pay list at salaries of 10/- per day on the same formula as the make up of his own salary – the half pay still to continue from the English Treasury and the remainder from the Colonial Fund. This proposal was attractive to the Army Department as the salary suggested was lower than that enjoyed by the Assistant Colonial Surgeons, so it was approved and gradually resistance and obstruction subsided as the service was staffed with a greater proportion of surgeons, who had no experience of the old system and were accustomed to the new.

To ensure their dedication the Colonial Surgeons were no longer allowed to hold any other office in the Colony and were confined entirely to the execution of medical duties. They were not to enter into private practice except where there was no interference with their public duties, and then only under conditions established by the Governor, and enforced by the Deputy Inspector General of Hospitals. As a consequence the content of private practice was no longer significant, but additional fees were often drawn from local government for service to Government institutions in their districts. These fees were usually of the order of £20 per annum per institution serviced.

The Colonial Medical Service was now almost entirely a hospital service. As the convict hospitals in the districts closed or were transferred to civilian use, private medical practitioners were appointed by the civil administration as part-time District Surgeons to cater for any Government responsibility to persons or institutions still remaining. The salary of District Surgeons was £50 per annum, with additional emoluments for service to individual institutions. Thus commenced the present system of Government Medical Officers selected from the senior member of the practising profession in the town or district and still operative.

The principle of entitlement to superannuation by pension, or land grants in lieu, which was developed during Bowman's tenure of office, was not confirmed under the new system. The expectation was that retirement back to half pay would be the routine procedure for army or navy surgeons who had been recruited from the army list. There is doubt whether even this proposition was sound as it was never tested. The procedure for pension reverted to the formula in operation during the early days of the Service, by a memorial from the applicant with supporting documents from the Head of the Medical Service. Thus Busby's request for half-salary pension was refused by the Secretary of State for the Colonies, and the alternative of a gratuity of one year's salary was granted.

Thompson was an unpopular person, truculent and indiscreet and yet ruthless in obtaining his objectives. His cunning manoeuvres to displace Mitchell from the General Hospital were planned with a degree of assurance amounting to arrogance. He ruled, not by example or leadership, but by authority on strictly military lines meeting resistance with blunt truculency. He was constantly reprimanded by his military superiors for his approach and manner. Soon after his arrival Sir James McGrigor threatened 'I am of the opinion that henceforth no infirmity of temper will be displayed by the Deputy Inspector General of Hospitals for he has been informed if such should appear, that he will be superseded by an officer on whose discretion, prudence and zeal for the service I can fully rely(39)'. He was further cautioned and reported by both the Colonial Secretary and Governor Gipps for neglect of duty. Ultimately McGrigor did make good this threat in 1844 when he replaced Thompson as Deputy Inspector General of Hospitals with William Dawson, M.D.

Dawson was appointed Deputy Inspector General of Hospitals in September 1843, and arrived in the Colony in the first quarter of 1844. As with Thompson, he was selected by Sir James McGrigor from the army half pay list – on this occasion a more felicitous choice. He had the thankless task to preside over the disbandment of his own service. He appears to have been a reliable and efficient administrator who gave no cause for complaint in his personal attitudes or official actions. His plea on

behalf of Busby would suggest a depth of humanity and regard for his colleagues which was never displayed by his predecessor. He was respected by doctors outside the service and served as President of the Medical Board.

After transportation to NSW ceased in 1841 the demand on the convict institutions and the need for a separation of the convict and civilian components of the local administration, progressively diminished. In 1847 the British Government decided to break up the convict establishment in NSW, and Dawson was warned to arrange a corresponding reduction of the medical department. The male convicts were to be transferred to Van Dieman's Land.

All the medical officers, including Dawson, had volunteered for service in Van Dieman's Land when their duties in NSW terminated. While awaiting decision as to their future they were paid at a reduced rate on a half pay scale, which varied according to rank and length of service. The rate varied from 13/- per day for the most senior Surgeon, Patrick Hill, to 4/- per day to the least of the Assistant Surgeons, J. Silver. With their departure the Colonial Medical Service was reduced to Surgeon Patrick Hill, who had been appointed as Superintendent of the Parramatta Asylum (the Female Factory) in which were now lodged those female convicts who were aged, invalids or lunatics.

In 1848 Patrick Hill was appointed to succeed Dawson as President of the Medical Board and to the newly created position of Adviser to the Government on Medical Matters, Inspector and Consulting Physician to the Lunatic Asylum.

## 1848-1881, Medical Adviser to the Government

In 1848 Patrick Hill was appointed to succeed Dawson as President of the Medical Board and to the newly created position of Adviser to the Government on Medical Matters, Inspector and Consulting Physician to the Lunatic Asylum. This latter attribute was no doubt created to satisfy one of the recommendations of the Select Committee of the Legislative Council on the Lunatic Asylum of 1846. Hill thus became the Head of the Medical Civil Service (such as there was) and handled all correspondence. He was responsible to the Colonial Secretary, who also exercised administrative control

over the Tarban Creek Asylum and other medical matters including quarantine, the appointment of District Surgeons, medical services to the gaols and the Parramatta Asylum. Hill had no executive capacity in lunacy and idiocy but was expected to coordinate and oversee the other medical services. He provided the personal medical service to the Parramatta Asylum and assisted the Sydney Infirmary in screening patients for admission.

In 1850 the name of the Parramatta Asylum was altered to the Parramatta Lunatic Asylum although this did not in any substance indicate a change in its function other than it could now receive suitable females who were not ex-convicts. In 1852 it received male patients and Patrick Hill was appointed its first Surgeon Superintendent. He still retained his other titles and position in charge of the civil medical service.

The Medical Adviser's responsibility, to the Colonial Secretary, as Superintendent of the Parramatta Asylum, remained discrete from that of the Medical Superintendent of the Tarban Creek Asylum. Admission was probably informal between the two institutions by transfer, or otherwise direct from Summary Jurisdiction. The impression is gained that certification under the *Dangerous Lunatic Act of 1843* directed patients to Tarban Creek and not Parramatta.

Hill was succeeded on his death in 1852 as Adviser to the Government and Inspector to the Lunatic Asylum by Bartholomew O'Brien who was not appointed as Surgeon Superintendent at Parramatta. O'Brien was probably a part-time appointment. Richard Greenup was appointed to the post at Parramatta and he, in turn, succeeded O'Brien in 1856 as Adviser to the Government and head of the medical service.

Greenup's role at Tarban Creek was more formal than that of Hill and appears to be that of Chairman of the Official Board of Visitors recommended by the commission of Inquiry on the Lunatic asylums of NSW of 1855. He was Official Visitor also to the Private Asylum at Tempe.

After Greenup's death, selection as Medical Adviser was from leading members of the medical profession. It was an appointment of prestige and accepted successively by E.S.P. Bedford (1867-1875), H.G. Alleyne (1876-1881), C.K. Mackellar (1882-1885), Sir Norman MacLaurin (1885-1889), F. Norton Manning (1889-1892) and T.P. Anderson Stuart (1893-1896). With the exception of Alleyne, the appointment was part-time.

There was no organised Government Medical Service as such, any medical demands from Government being carried out by Government Medical Officers in the Districts and in Sydney. The government asylums were not under medical control but were serviced by visiting medical staff from private practitioners or Government Medical Officers. The lunatic asylums were organised under medical executive management in the Lunacy Department of the Colonial Secretary's Department, which had no relationship to the government asylums for the destitute or the general hospitals. The latter were independently controlled by their elected board, and any supervision as was exercised was through the Inspector of Public Charities, a non-medical post.

## The convict hospitals

"...to gather in the sick from the streets and to nurse the wretched sufferers, wasted with poverty and disease."

Saint Jerome's dictum for the first nosocomium in Western Europe could well have been written on the convict hospitals of NSW, so accurately does it depict their function and the social status of those who entered their portals. Admission was often a choice of desperation especially in the founding years following the first three fleets. Governor Phillip, a humane man, was forced to protest vigorously after the arrival of the Second Fleet in 1790. Words failed him:

"I will not dwell, sir, on the scene of misery, which the hospital and sick tents exhibited(40)."

Nor was the behaviour of the convict patients superior to their environment. The majority were covered in filth and vermin, and brutal and callous each to the other:

"when any convict was dying and had bread or lillipie (flour and water boiled together) given him; those nearest him would seize them, saying with an oath that they were useless to him as he was going to die; no sooner was the unfortunate dead than his body was stripped by those around him who were always in waiting to do so(41)."

Even in less troubled times when thoughts and ideals were turning from military dictatorship to instruments of self-government, it was the common practice of the staff of the General Hospital to sell the meat and other victuals provided for the patients, leaving them to fare as best they could on the charity and mercy of friends and relatives.

The convict hospitals never entirely lived down their reputation until the Colonial Medical Service passed to military control in 1836, after which conditions improved under military discipline and a systematic and accountable administration.

After the arrival of the First Fleet, Principal Surgeon John White's first task was to establish a hospital base from which he and his staff could operate a medical service. A series of tents was erected on the west side of Sydney Cove in the vicinity of the present Maritime Services Building. One tent was used as a consulting room and dispensary for minor treatments and dispensing of medicines, and the remainder as sick tents for patients' accommodation. This was soon replaced by a timber building with dirt floors, almost opposite the original site. So the General Hospital was established, to be replaced in 1790 by a wooden prefabricated hospital which was transported to the Colony in the transport Lady Juliana. Erected on wooden blocks, and attacked by white ants, it was soon in a state of disrepair, despite which it served the capital of the Colony until the arrival of Governor Lachlan Macquarie.

Lachlan Macquarie was a man of singular determination whose characteristic was independent action. He was appointed with specific instructions to bring the Colony to order; to restore authority; and, to act according to his discretion in emergencies which required prompt and immediate decision. One of his first tasks was to establish a town plan and building code. The General Hospital was high on his list of priorities as an essential institution, then in a state of total neglect, which

required reconstruction in permanent materials. This he interpreted as a situation of emergency to be acted upon without delay. On the 17 and 20 May 1810, he invited tenders in the Government Gazette for its construction, and this before his despatches of 8 May, describing the condition of the hospital could reach Lord Castlereagh.

The site chosen by Macquarie was on a high ridge of land south of Government House in Macquarie Street, a new street which Macquarie named after himself. Its architect has not been determined, although it is often surmised that it was Mrs Macquarie, who had an interest in architecture which lifted her to amateur status. Seven acres of land were reserved for the purpose, of which one acre was ceded by John Blaxland's widow under pressure from Macquarie and a vague promise of compensation. It was to be a grand building of noble proportions to accommodate 200 patients and to serve the needs of the colony for all time. There were two wings to house the Colonial Surgeons flanking the hospital proper. All buildings were of two storeys, surrounded by verandahs and enclosed by a high brick wall.

The first acceptable tender, including as one of the tenderers Principal Surgeon D'Arcy Wentworth, who later withdrew at Macquarie's request, was received on 6 November 1810, and after much controversy the building was completed in 1814. The controversy arose from the method of financing the building by the grant to the tenderers of a monopoly to import 45,000 gallons of rum over a period of three years, provided that construction was at no cost to the Government. Macquarie proposed initially that the rum imports would be free of excise tax, in direct contradiction to his obligations to impose a tax of 3/- per gallon to control the rum trade. The initial contract was modified subsequently to increase the amount of spirits imported to 60,000 gallons, on which excise would be paid with a time lapse of six months to meet payment. The hospital was known colloquially as the Rum Hospital and its origin is commemorated in the Coat of Arms of the Sydney Hospital today. It set the pattern for all other convict hospitals in its

The General Hospital was to be a grand building of noble proportions to accommodate 200 patients and to serve the needs of the Colony for all time.

function, criteria of administration, admission procedures and staffing. As mentioned in the Chapter on Medical Benevolence, it became the Sydney Dispensary and later the Sydney Dispensary and Infirmary in 1845 and 1848 respectively, and the Sydney Hospital in 1881. It was the only hospital serving Sydney (as a convict and then voluntary hospital) until St Vincent's Hospital was established by the Sisters of Charity in 1856.

The development and location of the convict hospitals followed the extension of the settlement beyond Sydney as population demanded. So hospitals were established at Norfolk Island, Parramatta, Liverpool, Windsor, Newcastle, Bathurst, Goulburn and Port Macquarie to provide a total medical service for the convict prisoners or indentured labourers and their military guards in the outposts of the Colony. In Sydney separate provision was made for the military garrison, by a military hospital staffed by military surgeons, until this was redundant after the General Hospital was placed under military control.

The convict hospitals were constructed of permanent materials, brick or stone, following a basic plan, which was contracted or expanded depending on the population of the town and district. They provided separate accommodation for the Colonial Surgeon, and were located close to the convict barracks or prison. So well were they constructed that it was a simple transition to civilian control, after transportation ceased, to form the nucleus of the general hospital system of the Colony.

Despite their vicissitudes the convict hospitals served the Colony capably. Their defects were those of their times magnified by problems of manpower and resources, when little was spared for the sick and institutions which housed them. They were essentially a base from which the surgeons provided an itinerant service to Government institutions and outposts, as well as an inpatient service to eligible persons. The General Hospital was always the senior in status and authority, in which the Principal Surgeons and their successors were located.

## The civil administration of the convict hospitals

Until 1836 the convict hospitals were institutions of the civil component of Government, during which there were varying degrees of administrative responsibility delegated to or assumed by the Heads of the Colonial Medical Service.

Two hospitals were established during White's regime – at Sydney and Norfolk Island. There was never any doubt about White's control over the hospital at Sydney. Some doubt does exist about the administration of the hospital at Norfolk Island. It was staffed by Colonial Surgeons but was treated in despatches by Governors Phillip and Hunter as though it was an independent institution subject to immediate military discipline. This is understandable as Norfolk Island was a secondary penal colony remote in communication from the major settlement.

Governor King left no doubt as to the authority of Principal Surgeon Thomas Jamison over the convict hospitals: '(the Principal Surgeon) has the charge and superintendence of the hospitals, makes his daily and occasional reports to the Governor; resides at Sydney and accounts to the Commissary for all stores and necessaries received quarterly(42)'. King's despatch also confirmed the immediate responsibility of the Principal Surgeon to the Governor and his right of direct access.

This edict was not generally accepted by the military, especially in the districts where the military commandants had delegated authority for civil and military administration. Here conflict arose as the Colonial Surgeons insisted on their civil rights to administer their hospitals. In 1810 a violent clash took place in Newcastle over this issue between Commandant Lieutenant Purcell and Assistant Surgeon Horner, who resigned as a consequence. Macquarie appointed William Evans to replace Horner and gave an emphatic ruling in favour of Evan's civil authority.

The conflict between civil and military areas of responsibility was symptomatic of the growing resentment in the Colony against the power of the Military, and the latter's reaction to any intrusion on their commissioned capacity. Bligh tended to favour the military, to the outrage of the civilian population, and permitted D'Arcy Wentworth to be twice

court-martialled for resisting military orders of admissions to his hospital. The second court martial on 1817 on charges laid by Colonel Molle finally determined the civil status of the Colonial Surgeons. Macquarie's decision that the court martial was invalid was upheld by the Home Authorities that Wentworth 'was not amenable to martial law from the tenor of his commission(43)'.

There was no doubt about the status of the Colonial Surgeons after the establishment of the Colonial Civil Service in 1827. The Principal Surgeons and Colonial Service were included in the Civil List, and reported to the Governor through the Colonial Secretary. The Principal Surgeon was able to concentrate on the reorganisation of the convict hospitals (including the General Hospital). The later title of Principal Surgeon Bowman, following the Board of Enquiry of 1826, Inspector of Colonial Hospitals, delineated his administrative responsibility as Head of the Colonial Medical Service and its convict hospitals.

It was during this period that the duties of the two surgeons on the General Hospital were defined: 'one was charged with the immediate duties of the Hospital, including the outdoor department, together with those of medical storekeeper and apothecary; to the other surgeon were allotted what were termed the exterior duties; the medical supervision of the convicts at Hyde Park Barracks, the Goal, Goat Island, the Hulk, the ironed gangs at Carter's Barracks and Woolloomooloo, and assistance at the Hospital when necessary(44)'. From 1825 James Mitchell was permanently associated with the inpatient duties of the General Hospital responsible to Bowman, the equivalence of Medical Superintendent.

## The military administration of the convict hospitals

There was a clearer chain of command after 1836 when the Colonial Medical Service was reorganised to become a segment of the military forces of the Colony, under John Vaughan Thompson in the newly created post of Deputy Inspector General of Hospitals. The effect of this was to provide a unified service under a single authority, charged with a continuing and strict financial scrutiny over the establishment, expenditure and activities of the convict hospitals. The Colonial Medical Service was

thus converted into a strictly hospital service, thrusting upon civil government the responsibility to provide visiting medical services for its civil establishment and institutions.

The duties of Thompson (and after 1844 William Dawson) were precisely laid down by Sir James McGrigor in his formal instructions to Thompson:

- “(i) To revise immediately all existing medical establishments connected with the Military and Convict Departments so as to be placed under hospital regulations of the army.
- (ii) To undertake personal inspections, initially and periodically, of each station and hospital and report to the Governor.
- (iii) Not to vary any of the medical establishments or construct new hospitals and buildings without previous sanction of the Government of England.
- (iv) To be guided generally in his administration of army ‘Instructions to the Principal Medical Officer of Foreign Stations’.
- (v) To organize and control the distribution of medical stores through the Deputy Purveyor. (Shades of Bowman’s lapse still lingered – Thompson was exhorted ‘that utmost vigilance was required in controlling this branch of public duty’.)
- (vi) To revise the scales of diets for use in hospitals. This obligation implied not only initial revision to set uniform standards through the convict hospitals, which Thompson did, but continuing supervision to see that these standards were applied appropriately. He was reprimanded in 1840 by Sir James McGrigor for neglect of this duty, which McGrigor emphasised was

The Colonial Medical Service was thus converted into a strictly hospital service, thrusting upon civil government the responsibility to provide visiting medical services for its civil establishment and institutions.

personal to him and not to be delegated to the prescriber’s sole judgement.

- (vii) To establish a quarterly Board of Survey on stores and medicines.
- (viii) To make reports on civilians and civil establishments to the Governor. Professional reports on army personnel were to be directed to the Director-General of Hospitals and expenditure returns to the Secretary of War.’

The relationship between the Deputy Inspector General of Hospitals and his medical staff was quite definite. All communications from the medical staff to any superior authority must pass through him, and all appointments and exchanges (to the limit of the establishments laid down) were to be made by him. The establishments were determined by the Director-General of Army Hospitals in Great Britain.

In many ways the assimilation of the convict hospitals into the army system was an advantage as ancillary support and services could be obtained from army facilities. The domestic establishments of the hospitals were placed on a rational basis with less dependence on convict staff and greater supervision by qualified army personnel.

These changes reduced the authority of the Colonial Surgeons over the administration of their hospitals, leading to further discontent and resentment. It was such a conflict of authority between the Deputy Purveyor (supported by Thompson) and Medical Superintendent Mitchell at the General Hospital, which started the chain of events culminating in Mitchell’s rebellion at this intrusion into his status, and which led to his dismissal for insubordination. Surprisingly, in view of Thompson’s policy of replacement of civil medical staff by Military Surgeons, Mitchell’s successor was a civilian recruit, Dr Kinnear Robertson. Thompson was replaced by William Dawson in 1844 who served in NSW until 1848 as Deputy Inspector General of the diminishing number of the convict hospitals.



## Medical staff establishments

Prior to 1836 the creation of the establishment for either the overall medical service or for individual hospitals was a component of the Governor's Authority, subject to ratification from the Under Secretary of State for Colonies. Likewise the Governor, alone had power to appoint, post or transfer medical staff and this power was never delegated to the Principal Surgeons. Movements of staff were effected by Government and General Orders. Temporary staff were appointed locally by the Governors subsequent to Macquarie, as a charge on local revenue. Permanent medical staff were a charge on the Civil Chest and reimbursed from England in the yearly budget. Until Bowman's appointment as Principal Surgeon, the Head of the Civil Medical Service was not consulted on the movements of medical staff. Bowman enjoyed the privilege of consultation and recommendation on staff movements by virtue of his position as a senior (Class II) civil servant. Bowman made recommendations on staffing and distribution of staff to the Governor through the Colonial Secretary. During the military regime the Deputy Inspector General of Hospitals was granted authority to effect appointments and exchanges, provided there was no variation in the establishment as a consequence.

There was a general seniority list for the whole of the civil service after 1827 in which the Principal Surgeon and Colonial Surgeons were included in different category levels. The Colonial Surgeons were in the lowest class (Class IV). Prior to this, individual seniority was on the basis of length of service dating from the granting of the monarch's commission. There was no grading of the hospitals to the seniority of the surgeons.

After the convict hospitals transferred to military control the Colonial Surgeons retained their seniority. Military Surgeons appointed from the retired list were restored to the active list and their seniority depended on rank and length of military service. A promotional post of Surgeon was created at a salary of 13/- per day. One position of Surgeon was included in the establishment of the General Hospital, otherwise promotion to Surgeon depended on seniority.

There was no mathematical formula to determine the active establishment of Colonial Surgeons in individual convict hospitals. The General Hospital always had an establishment of at least two surgeons, and other hospitals one. This latter could be increased on occasions, after much travail, if demand necessitated. However, never was the establishment of a regional hospital more than two Colonial Surgeons.

## Nursing staff establishments

No provision was made by the British Government for civilian staff to assist Principal Surgeon John White and his Assistant Surgeons in the performance of their medical tasks. The convicts in the First Fleet were the pool from which labour was supplied to maintain the Colony, including its hospital services. This principle pertained throughout in nursing, domestic and general staffing of the convict hospitals, with some modification, after control passed to the Military Service, by the appointment of Deputy Purveyors to supervise hospital equipment and stores. It was understandable that, with the tribulations of the Colony in its early days, the better skilled and more responsible convicts were allotted to duties essential for the physical survival of the Colony and the hospitals suffered both in numbers and quality. The disregard of the needs of the hospitals, and also a reflection on the status and standard of nursing, is illustrated by the actions of the magistrates who were prone to sentence female convicts for offences committed in the Colony to serve a term at the Hospital as a punishment in lieu of prison. The selection of convicts for nursing and other duties improved during Governor Macquarie's regime. Thereafter, they were carefully chosen by the Principal Superintendent of Convicts and were liable to instant dismissal for misconduct. A system of gratuities were introduced, and at the General Hospital (and presumably the other hospitals) one wardman and one nurse were made senior. The latter was officially called the Matron and was responsible for the supervision of domestic staff as well as the female nursing staff.

The first staffing establishment was laid down by Governor King for the hospitals (the General Hospital, Parramatta and Norfolk Island) as 'twenty persons acting as overseers, dressers, wardsmen, gardeners, boatmen etc. plus nurses (by assumption from the distinction drawn these were probably female) all of whom are selected from the convicts, and of course receive no other reward than their maintenance by the public(45)'. Bowman, in his reorganisation of the General Hospital, augmented the general staff and defined a ratio of nurses and wardsmen in proportion of one to each seven patients. After the medical service was reorganised in 1836 as a component of the Military Service the nurse-patient ratio was stabilized at one for ten for all hospitals.

### Stores and equipment

The First Fleet carried 'medicines, drugs, surgeons' instruments and necessaries' to the value of £1,429 as the basis of the Colony's medical stocks. Unfortunately, many of the drugs had perished on the voyage and of the remainder, many were of poor quality. There were no blankets, sheets or other comforts for the hospital, or an 'adequate supply of necessaries, (special foods) to aid the operation of medicine(46)'. White drew upon the commissary store for general stores, equipment and rations.

The convicts in the First Fleet were the pool from which labour was supplied to maintain the Colony, including its hospital services.

The hospital at Sydney Cove was the general repository for medical stores and surgical supplies from which the Principal Surgeon distributed to other medical units, including, in emergency, the NSW Corps. The Principal Surgeon ordered drugs direct through the Secretary of State for the Colonies and not through the Commissary of Stores and Provisions. The drugs were supplied from the Apothecaries Hall to ensure quality.

This arrangement, of a central medical store at the General Hospital to supply the hospitals of the Colony, and other stores and equipment being drawn from the Government Store, remained, with some variations, the system of supply to the convict hospitals throughout the period from 1788 to 1848.

The Assistant Surgeons at the hospitals until the military takeover, acted as apothecaries and dispensers and were responsible for custody of the medical stores, requisitioning, returns, etc. A convict acted as storekeeper and bookkeeper.

When the Colonial Surgeons were permitted the right of private practice it was their custom to provide medicines from the hospitals for their patients free; thus giving them an advantage over their colleagues in private practice. To minimise this advantage a payment of 2/- per individual dispensing of medicine was imposed upon the Surgeons who, no doubt, included this charge in their fees.

The custody and control of the medical stores were an important responsibility of the Principal Surgeons and we find Bowman shortly after his appointment offering suggestions to the Governor on the control of stores and the appointment of civil staff for this purpose at the General Hospital. Although the latter recommendation was not realized prior to 1836, the post of storekeeper was one of the trusted posts in the hospitals, for which a gratuity was paid.

Principal Surgeon Bowman instituted a system of a two years' stock being maintained at the General Hospital to supply its needs, and those of the country stations and the hospitals generally. It does appear that Mitchell from 1824 assumed some degree of control over the stores and equipment at the General Hospital, probably by a working arrangement with Bowman. Apparently there was no separation administratively between the working stock of drugs, stores and equipment for the Hospital and the reserves for the Colonial Medical Service.

After John Vaughan Thompson's appointment a Deputy Purveyor was appointed to the General Hospital to control the medical stores for all hospitals. The ultimate responsibility still rested with Thompson, who, in his instructions was exhorted to exercise the utmost vigilance in controlling this branch of the public duty.

## Patient's fees and maintenance

Essentially the convict hospitals rendered a free service to those persons in the Colony who were dependent upon the Government for supportive services or assistance. The majority of patients who were received into these hospitals were convicts and civilian paupers. Likewise members of the military forces were treated at the Colony's expense and were admitted where there was no alternative military hospital to accommodate them. Although members of the civil staff were eligible for free hospital treatment in practice they were treated in their homes by the Colonial Surgeons and medicines and other 'necessaries' were provided free from hospital stocks.

A distinction was drawn between convicts assigned to individuals and those assigned to the State. Until 1839 convicts assigned to individuals were victualled in the hospital free for the first fourteen days. Thereafter the master was responsible for victualling, or, as an alternative, he had to surrender his assigned convict to the State. The formula for payment for treatment of invalid sailors from the warships in port was curiously cumbersome. It was at 'a cost of 13/6 for each cure performed on His Majesty's seamen(47)'. This fee was a perquisite of the Principal Surgeon and has to be recovered by his agent in England from the Sick and Hurt Board. As an alternative Balmain proposed that his salary should be increased by five shillings a day, but there is no evidence that this request was granted, nor is it clear when this charge was discontinued.

In 1839, as a result of a Board of Inquiry presided over by the Deputy Inspector General of Hospitals, charges were imposed for patient care. Only those convicts at Government labour and military personnel were admitted free, otherwise there was a sliding scale from 3/- per day for free persons to 1/- a day for assigned servants. Free paupers were also admitted at a rate of 1/9 per day, the cost to be borne from the Colonial Government's funds. The actual cost per patient at this time was approximately 1/3 per day at the General Hospital.

The responsibility for admission of patients and their classification for the purpose of collection of fees was imposed on the Colonial Surgeon in charge of the hospital. He was required to admit civilians 'on payment being guaranteed to him of the accustomed

charge by two or more responsible parties'. He, personally, collected the money and paid it to the Commissary General. If the guarantors failed to make good their guarantee he could sue and occasionally such actions for recovery were brought.

Seamen were charged 3/- per day (under guarantee from the agent of the vessel) for as long as the vessel remained in harbour and for fourteen days thereafter, from which period they were classified as paupers and became a charge on the Colonial Government. Reimbursement for paupers (from civil funds) was 1/9 per day, and a certificate from a parish clergyman was sufficient declaration of indigency for this purpose.

The daily cost per patient was progressively reduced at hospital until it was about nine pence per day in 1844. Fees from civilian patients and reimbursements from colonial funds were now more than adequate to cover the cost of free treatment of the convicts and service personnel. Following a report by William Dawson the rate for private patients and those supported by the local administration was reduced to 1/3 per day(48). Although the financial dissections and calculations were made on the General Hospital, the fees determined applied generally to all the convict hospitals and the lunatic asylum.

The first convict hospitals were established in desperate circumstances to cope with the almost insurmountable burden of morbidity and mortality in the new Colony. If conditions in the early years were harsh and medical care and nursing primitive, this was but a sad reflection of the social environment of the Colony and its neglect by the Mother Country. As conditions changed so did a system of medical care evolve, tied to the state and adequate for its needs as a penal settlement. There was no pretence to extend its function beyond these boundaries. It was inevitable that the system would become redundant after transportation ceased. One would have hoped that the standards of the general hospitals, which supplanted the convict hospitals, would have been more in consonance with the medical and emotional needs of the free community they served. Unfortunately the traditions of the convict hospitals seemed to extend into the general hospitals, whose attitude to their patients were little, if any, improvement on the past.



**Lunatic Reception House Darlinghurst**  
Sydney 1800's

# Lunacy and idiocy\*

Lunacy was regarded as an extension of benevolence in the early years of the Colony, and it was not until some seventy years after Foundation that its medical significance was recognised by Government. This principle was in harmony with, and derived from, the 'old poor law' practice still in force in England, and accordingly lunacy was not included in the administration of the Colonial Medical Service. The exclusion of lunacy from the administration of the Colonial Medical Service was not a source of discontent in the early years of the Colony, when the Medical Service was preoccupied with providing hospital facilities and personal medical care with a depleted staff and inadequate rations, stores and equipment.

It was not until after the establishment of the first asylum at Castle Hill in 1812 that discontent within the Medical Service became apparent because of the minor role it played in the administration and supervision of the asylum. This disgruntlement was to erupt in the 1840s, and was responsible for the antagonism shown by the medical staff of the Colonial Medical Service to Joseph Digby, in his role of Superintendent of Tarban Creek Asylum. It was to lead to his deposal.

Even after the Royal Commission in England in 1834, when lunacy was divorced from the general system of poor law relief and came more and more under medical control, no similar movement took place in NSW until some two decades later. The continued separation from the medical administration was confirmed in the local circumstance by Governor Gipps in 1839 when the Colony's Medical Service was reorganised. Gipps ruled:

"...the lunatic asylum is not a hospital, it therefore is not under the charge of the Deputy Inspector General of Hospitals,

though in the management of it, it will often be necessary to have the benefit of his advice(49)."

So was lost the opportunity to integrate lunacy and medicine and develop a concept one hundred years in advance of its time. Instead the principle of separation was confirmed, which principle has pertained, with minor modifications, in the administration of health services, in the State until recent times.

Nor was lunacy administered in the Colony in the same manner as benevolence. The influence of the early settlers, emancipists and even officials, and their revulsion from any system apeing the 'old poor law' administration and instrumentalities of England, conditioned the unique system of private monopoly of benevolence with Government approval and support during the whole of this period. A stringent security was more essential for lunacy, especially in a penal settlement, and, as the liberty of the individual was involved, the extension of lunacy to the same mode of administration as benevolence was neither desirable nor constitutionally possible.

All in all the administration of lunacy in NSW prior to self-government, and beyond to the last quarter of the eighteenth century, satisfied the needs of the Colony and its social conscience. It was at least equal to, and often in advance of the Mother Country. The colonists were never loath to object strenuously and vocally to authority when misused or exercised to their disadvantage. In the absence of such protests one must assume adequacy in the administration of lunacy in coping with the immediate problems imposed on it. If frustration sometimes arose from bureaucracy this was not unique to lunacy nor to this period.

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\* The subject of lunacy and idiocy is developed in detail by J. Bostock in his publication *The Dawn of Australian Psychiatry 1951*; and by the author in his publication, *The Administration of Lunacy and Idiocy in NSW 1788-1855*.

## The lunatic asylums

The asylum system of containment of lunatics and idiots was early forced upon the administration of the Colony by the growth of population, which by 1810 had increased to 11,566. This expansion posed serious sociological problems arising from an increase in indigency, as prisoners who had completed their sentences, or who had been pardoned or emancipated, remained in the Colony and were unable or incapable of supporting themselves from the limited opportunities available. The convict segment was also much increased, and these two groups provided a reservoir which threatened the harmony and even the security of the Colony. The loose system of supervision with minimum restraint was no longer adequate for lunatics and more formal methods and institutions for security were established. There was no fine distinction drawn between social incompatibility and insanity, and the goal was the common repository for both groups.

### Castle Hill Asylum

Lunatics were confined in the town goal at Parramatta where conditions even in a rigorous age were harsh and unrelenting. Crowded with other prisoners, preyed upon, abused, subject to the vicissitudes of inmates and staff alike, they drew Macquarie's commiseration on 'the unhappy condition of persons labouring under the affliction of mental derangements'. Macquarie's sympathy, enhanced by the pressure on space at the Town Goal, conditioned him to allot the buildings on the farm lands at Castle Hill specifically for an asylum in 1811.

Despite his prediction that 'every provision that humanity could suggest has been made for their accommodation and comfort', the buildings were poorly constructed, in a state of decay and unsuitable for the purpose. Nonetheless, it was a distinct improvement on the accommodation at the goal, and there is evidence that convicts feigned insanity to secure transfer from the goal to the asylum. It was soon overcrowded, with patients sleeping in the kitchen, and, due to its distance from Sydney, inspection and maintenance of its facilities were neglected.

The control of the asylum was vested in a non-medical Superintendent responsible to the Governor and not to the Principal Surgeon. Apart from the Superintendent, it was staffed by convicts, chosen haphazardly and without consideration of personal capacity for these duties. It was to Castle Hill that William Bland was sent in 1814 as a professional prisoner and the first resident medical officer(50). It is no wonder, knowing of Bland's temperamental and personal difficulties that he was soon complaining that George Suttor, the Superintendent, was interfering with him in the performance of his medical duties. It was this interference, as much as his disgust with the standard of accommodation and regime, that conditioned Bland to request a transfer some fourteen months later.

The principle of a resident medical staff to the asylum was established in advance of its time when compared with the asylums in Great Britain. Equally enlightened were the rules and regulations drawn up by Governor Macquarie for the conduct of the asylum with insistence on cleanliness, comfort, humane treatment, recreation, medical attention and records.

George Suttor, landowner and free settler, was appointed second Superintendent (there is no information available to identify the first Superintendent). He was a humanist with a reputation of personal integrity and dedication to the cause of the under-privileged. His administration was marred by excess bureaucracy, difficulties with staff and discipline, and constant bickering between the medical and civil establishments. He was dismissed in 1819 and replaced by William Bennett, largely due to the contriving of Surgeon Parmeter to obtain medical control. Parmeter succeeded Bland and was assisted by an Assistant Surgeon, who was non-resident.

Suttor was replaced as Superintendent by William Bennett at a salary of £50 per annum. This circumstances of his dismissal were a callous injustice to one, who strove conscientiously to fulfill his duties under trying and difficult circumstances, lacking support from the Governor and frustrated by his medical antagonists.

The Castle Hill Asylum was an improvisation to meet the immediate needs of the Colony, and as such it was inevitable that it must be replaced as the demands upon it increased.

## Liverpool Asylum

In 1825 a Grand Jury reported adversely on the standard of care and adequacy of the buildings at Castle Hill, and recommended 'that these afflicted and unfortunate persons should be secured in a proper hospital more directly situated in the vicinity of the town'(51). When this report was made the Castle Hill Asylum was accommodating twenty-seven male and eight female patients.

The report was expedient to Governor Darling as the land at Castle Hill had been granted to the Church and some other arrangements was necessary to give effect to this grant. Ignoring the recommendation for 'a proper hospital', Darling allotted the Court House at Liverpool as the Government building which afforded the best and 'indeed the only means of accommodating them (the lunatics) at the moment'(52). The problem was urgent. The accommodation was so strained at Castle Hill that a number of lunatics were lodged in the Hyde Park Barracks— a matter of some concern to the Superintendent of Convicts.

The first Superintendent at the Liverpool Asylum was probably William Bennett. It is not certain when, or how, he ceased to occupy this position. His successor was a Mr Lloyd who was probably appointed in 1827, and promptly removed in 1828, to be replaced by Thomas Plunkett, then Superintendent of the Convict Barrack at Parramatta. His salary was £100 per annum plus £32.10.0 lodging allowance. Plunkett's tenure lasted until the establishment of the Tarban Creek Asylum in 1838, and the appointment of the first lunacy administrator with specific experience — Joseph Thomas Digby.

The basis of the administration and regime at the Liverpool Asylum did not differ significantly from that of Castle Hill. There were but three units of salaried staff authorised, including the medical service. The remainder were bonded convicts.

The cost of the asylum was a constant pinprick to the Government, and, as the staff and patients were almost exclusively convicts, expenditure was kept to a minimum. Such free settlers as were admitted were charged 7/- per day, which was met by

guarantors or from their estates unless they were paupers, when the Government met the cost from the Civil Purse. After 1836 the proportion of costs involving medical salaries and medical stores were paid from the Military Chest.

Central supervision over the asylum was by monthly reports from the Superintendent to the Governor through the Colonial Secretary. Medical records were maintained and diagnoses were made and annotated by the medical staff. With increasing emphasis on forms of civil administration after 1827, the monthly reports and supervision became the prerogative of the Colonial Secretary rather than of the Governor per se.

Just as Castle Hill ceased when it had served its immediate purpose, so also the passing of the Liverpool Asylum was inevitable when it could no longer meet the needs of a rapidly growing population. In 1838 it was replaced by the Tarban Creek Asylum (now the Gladesville Mental Hospital).

The principle of resident medical staff to the asylum was established in advance of its time when compared with the asylums in Great Britain.

## Tarban Creek Asylum

In 1837, following representations from Governor Sir Richard Bourke, Joseph Thomas Digby was selected in England as Stewart (Superintendent) of the proposed new asylum at Tarban Creek, and his wife was likewise appointed Matron. So

commenced an era of psychiatry which was to become the dominant arm of the Government Medical Service under the later regime of Frederick Norton Manning. There was now, with Tarban Creek, an institution built specifically for its purpose, under a Superintendent with previous experience and training in the care of the insane. Commencing also was a period of bitter friction and competition between medical and non-medical administrators, which had not subsided when the author was appointed Inspector General of Mental Hospitals in 1961.

The asylum opened on 29 November 1838, when the female convict attendants were transferred from the Liverpool Asylum together with female patients from the female factory at Parramatta. Male patients were transferred in 1839 from the Liverpool Asylum, which then ceased to function.

Tarban Creek received both free and convict patients, the proportion of the former increasing as transportation diminished. Correspondingly the establishment was varied towards a greater content of civil (free) staff to care for private and free patients, with the convict staff catering for its own group and pauper lunatics.

The admission of free patients brought complications in the financing of the asylum. Should there be some reimbursement from colonial funds for the care of pauper lunatics, as distinct from expenditure on the care of convicts now financed from the Military Chest? A Board of Enquiry was appointed under the chairmanship of the Colonial Secretary to report on this issue at the Tarban Creek Asylum and the General Hospital. The Board recommended a per diem payment of 1/9 per patient. Although this was implemented as the General Hospital it was never introduced at the asylum. Governor Gipps, realising that the transportation system was doomed, decided the asylum should be retained wholly as a colonial institution and its expenditure met from colonial sources.

Tarban Creek Asylum was the first Government medical institution to be granted full civil status, preceding the General Hospital by nine years. This action is interesting in reflecting the opinion of John Vaughan Thompson, one of the members of the Board of Enquiry, that the Tarban Creek Asylum should be classified as a hospital – an opinion that was vigorously and successfully pursued by his successor, William Dawson, in his opposition to Digby as Superintendent.

Digby was a conscientious administrator and firm believer in the existing philosophy of insanity, viz that it was due to moral causes associated with undue social and psychological stresses. Therapy emphasised 'close and friendly association with the patient, intimate discussion of his difficulties and daily pursuit of purposeful activity(53)'. This philosophy was the underlying factor in the struggle for control by medical staff, in the belief that only with medical control could a sympathetic therapeutic milieu be maintained in each institution.

Medical staff continued in full-time attachment to the Tarban Creek Asylum, from the staff of the Deputy Inspector of Hospitals, who demanded and received quarterly standardised return of admissions, discharges, deaths etc. The assistant surgeon had supervision of those patients actually ill, but no control over the others or the conduct of the asylum. All orders of admission etc. were addressed to Digby.

Digby's administration of Tarban Creek Asylum is an important milestone in the history of psychiatry in this State. His was an endless fight against frustration and opposition, and yet withal there is continuing evidence of his strong dedication to the welfare of his charges. He was pilloried for his failings and but grudgingly acknowledged for his successes.

His deposal commenced with a series of letters published in the *Sydney Morning Herald* in 1846, under the nom-de-plume 'latros', and obviously written by a medical man, which stated the case for medical executive control over the asylum. A Select Committee of Enquiry of the Legislative Council twice reported on this principle, the second report of which recommended that 'it was indispensable that the head of the institution should be a medical man'. The report recognised Digby's services and proposed that his services should be retained as Keeper or Steward. Other recommendations forecast a change in the official attitude to the function of the asylum, and dealt with staffing, inspection, registers, accommodation, recreation and finance(54).

So ended the administration of Digby, and Dr F. Campbell was appointed the first Medical Superintendent and commenced duty on 1 January 1848. Digby remained as Steward until 1850 when he was dismissed after two further Boards of Enquiry and returned to England. He was responsible for a change in attitude on staffing from convict members to salaried staff with internal training programmes. During his administration legal procedures were developed for the admission and transfer of patients; for the protection of the liberty of persons committed; for the admission of voluntary patients; for the establishment of visiting days, and for official inspections. Many of these improvements were incorporated in the *Dangerous Lunatics Act of 1843*.



Campbell remained as Superintendent of Tarban Creek Asylum until the appointment of Norton Manning in 1867. Campbell's fame rests upon his reputation as a clinician. He introduced concepts of non-restraint, adequate diet, planned recreation and clinical regimes. He failed as an administrator and was personally criticised to Henry Parkes by Surgeon George Walker as ineffectual.

Dr Frederick Norton Manning is an important name in Australian psychiatry who reorganised the asylums into a central system of administration, the pattern of which remained essentially unchanged until the *Mental Health Act of 1958*.

He was appointed by Henry Parkes following yet another commission of Enquiry into the Tarban Creek Asylum, which recommended, among other recommendations that:

“care should be taken to secure for the management of such an asylum, the highest medical talent, the largest amount of experience, and the greatest benevolence(55).”

Norton Manning certainly fulfilled these capacities. He was born in 1839 in Northampton, England and joined the Royal Navy as a Surgeon, serving in Australian waters in the brig *Esk* during the Maori War. He was 28 years of age when appointed as Medical Superintendent of Tarban Creek – already demonstrating a capacity for administration and professional skill. He was an ideal public servant, never attempting to usurp or minimise ministerial authority. It was this attribute that gained the support of Henry Parkes to his later proposals for an asylum service, a support not lightly given by a Premier who had an almost pathological distrust of senior public servants. He was an austere upright man, dedicated to his purpose and profession, who was respected by all for his contribution to medicine and to society of his day. He succeeded the Hon. H.K. MacLaurin as Medical Adviser to the Government and likewise President of the Board of Health in 1889. He retired on the grounds of ill health in 1898 and it is typical of the man that he would not accept a testimonial. It was said of him that ‘justice and impartiality have marked

Dr Frederick Norton Manning is an important name in Australian psychiatry who reorganised the asylums into a central system of administration...

your official actions, there has been shown to us all (the staff of the asylums) the kindest feelings of personal interest, help and encouragement’, and of the doctor and administrator ‘the treatment of the insane, has, under your guidance, been elevated and placed on a scientific basis, so that the hospitals for the insane in NSW now compare favourably with the most enlightened in other parts of the world’. He died after a painful illness in 1903 at his residence in Phillip Street, tended in his last days by his two great friends Norman MacLaurin and Christolm Ross. He was buried in the grounds of Tarban Creek Asylum, and the regard in which he was held was exemplified by eulogies from the Supreme and Equity Courts, both Houses of Parliament and obituaries in all newspapers.

Tarban Creek Asylum bore the main brunt of admissions to the lunatic asylums until Callan Park was established in 1873. It was a source of constant frustration to Norton Manning with its buildings becoming more dilapidated and for ever overcrowded. An editorial in the *Cumberland Mercury* in 1877 described Manning's efforts to stimulate Government action:

“Year after year, for a long time past, Dr Manning has found it his duty to warn the Colonial Secretary, and through him the legislature and the people, that the accommodation at Gladesville was

getting more straitened. That being so there is reproachful significance in his last report – that for 1876 – telling us on the 31 December, there were 642 people in the Institution, that great number in an old, badly constructed, inadequately fitted, and totally overcrowded building ... in which there is only proper cubic space for 450.”

Tarban Creek Asylum was for a short time the headquarters of Dr Norton Manning after he relinquished his post of Medical Superintendent in 1878 to become Inspector General of the Insane. It is illustrative of Norton Manning's vision that, shortly before, he succeeded in having the name of the institution changed to the Gladesville Hospital for the Insane, although officially it often appeared in documents as the Gladesville Asylum.

During the latter years of his superintendentship Norton Manning was involved more and more in the reorganisation of the asylums into a common system, centrally controlled, and the development of the *Lunacy Act of 1878*. It was inevitable that the immediate administrative supervision of Gladesville Asylum was exercised by the Manager, although Manning still found time to involve himself in clinical activities, and scientific meetings both within and external to Gladesville.

### Other asylums

The establishment of other asylums will be indicated briefly in chronological sequence, more to outline their functions as separate institutions later to be coordinated within the framework of the Lunacy Department of the Chief Secretary's Department.

### Parramatta Asylum

The Convict, Lunatic and Invalid Establishment at Parramatta was established in 1848 in the buildings of the Female Factory, which were adjacent to the land on which the present Parramatta Mental Hospital is located. The Female Factory was established by Governor Macquarie as a workshop and barracks to house the women convicts largely through the instigation of the Reverend Samuel Marsden. The structure was completed in 1821 to house 300 women, and was subsequently enlarged, mainly by the addition of cells for recalcitrant inmates. The institution was a source of discontent and a focus for riots by the women lodged therein, who were described by the Governor in 1846 as 'the dregs of the convict system'.

In 1847 the need for this factory ceased to exist, and it was closed down by granting the women convicts who were remaining either discharge or tickets of leave. It was thus cleared except for those women who were invalids and lunatics. When it was converted to an asylum, it was for the purpose of housing chronic or deteriorated patients, all of whom were paupers. Its first Matron and Superintendent were Mrs and Mr Stratham respectively, and it was regarded as a benevolent asylum remarkably similar in purpose and content to an English workhouse.

Its name was changed to the Parramatta Lunatic asylum in 1850, and Patrick Hill, the Adviser to the Government and Head of the Civil Medical Service, became its first Surgeon Superintendent in 1852. Hill was the first Adviser to the Government, which position also carried the responsibility of Inspector and Consulting Physician to the Tarban Creek Lunatic Asylum.

He was succeeded, on his death in 1852, as Adviser to the Government and Inspector to the Lunatic Asylum by Bartholomew O'Brien, who was not appointed as the Surgeon Superintendent at Parramatta. O'Brien was probably a part-time appointment. Richard Greenup was given the post of Surgeon Superintendent at Parramatta, in turn succeeding O'Brien as Adviser to the Government etc in 1855. Greenup's role at Tarban Creek included also the post of Chairman of the Official Board of Visitors recommended by the commission of Inquiry on the Lunatic Asylums of NSW of 1855. Later it is evident that he also acted as Official Visitor to the Private Asylum at Tempe. He achieved the sad distinction of being murdered by one of his patients at Parramatta.

The Parramatta Asylum was as much a benevolent institution as a place for the reception of lunatics. It received male patients in 1852, and in 1855 it accommodated 187 males and 92 females. It was used to assist Tarban Creek in its overcrowding especially of female patients, and it received also destitute persons suffering from forms of chronic disease with mental deterioration from Government institutions, the Sydney Infirmary and the benevolent asylums at Sydney and Liverpool. It is not to be confused with the Government asylum at Parramatta which was established in Macquarie Street towards the end of the next decade.

The Surgeon Superintendent was responsible to the Colonial Secretary and this responsibility was discrete from that of the Medical Superintendent of Tarban Creek. Admission was probably informal between the two institutions by transfer, or otherwise direct from summary jurisdiction. The impression is gained that certification under the *Dangerous Lunatics Act of 1843* directed patients to Tarban Creek and not Parramatta.

A small prison was erected in the Parramatta Asylum in 1866, authorised by a special Act of Parliament (24 Vic. No. 19), to serve as an asylum for criminal lunatics. The conditions of confinement were soundly condemned by Norton Manning in his report. Otherwise the Parramatta Asylum remained a repository for harmless chronic dements, receiving patients from the Government asylums as well as Tarban Creek Asylum.

One of the first tasks of Dr Manning in his capacity as Inspector General of the Insane was to report on the Parramatta Asylum in 1879, which was then recently included in the Department of Lunacy. Previously in his major Report of his overseas visit in 1868, Manning had been very critical of the facilities at Parramatta, which had not improved in the intervening ten years. He was particularly critical of the facilities for the criminally insane. He excused the deficiencies of the asylum and its management with the superficial comment 'the Parramatta Asylum has been placed at a great disadvantage in being isolated from other institutions for the insane for some years past'. He mentioned in passing, without the credit it deserved, Greenup's successful attempt to acquire the vineyards adjoining the asylum in 1865, with the hope, which was not realised, that the additional land would be used for the building of a new asylum. It was there that the new buildings were erected for the criminally insane in 1878.

The Parramatta Asylum was as much a benevolent institution as a place for the reception of lunatics.

Manning's report of 1879 was most forthright and proposed a programme of rehabilitation and restoration of buildings, until rebuilding was feasible. He was successful in having the Queen's Pleasure inmates removed from the criminally insane section to other asylums.

### The Lunatic Reception House Darlinghurst

The Reception House was opened at Darlinghurst on 24 July 1868 authorised under S.1, 31 Vic. No. 19. Procedures of admission were defined as follows:

- (i) Dangerous lunatics and idiots brought before the justices could be committed for observation and disposal to the Reception House. Previously it was the custom to remand the person to goal for observation.

- (ii) Patients on warrant from the Governor for detention in a lunatic asylum were detained at the Reception House until they could be transferred. This applied particularly to country patients.
- (iii) Other than (i) and (ii) no person could be received unless there were two independent certificates from medical practitioners, or unless two medical practitioners swore in open court that the person was of unsound mind and likely to commit an indictable offence.

### The Asylum for Imbeciles and an Institution for Idiots, Newcastle

This was the first asylum specifically for idiots and imbeciles and was established in the old military barracks in Watt Street, in 1872. Since 1867 the barracks had been a reformatory for delinquent girls and prostitutes taken from the streets of Sydney – much to the consternation and opposition of the citizens of Newcastle. The opposition increased as frequent riots occurred in the reformatory, usually encouraged by hoodlums outside the walls offering noisy and vociferous support. A special police detachment was permanently located at the reformatory to maintain order.

On the 16 March 1871 a public meeting of protest was held under the guidance of the Mayor, Aldermann James Hannell. A deputation was appointed to wait upon the Colonial Secretary (the Hon. John Robertson) who agreed that the locality was unsuitable for a girls' reformatory. The citizens of Newcastle were not appeased when they heard that a lunatic asylum was to substitute for the Reformatory, the Government being determined not to waste the site and buildings as an institution. A further public meeting was to no avail, and the first inmates were moved from Gladesville and Parramatta, under the care of Mr Michael Prin and Mrs Prin as Superintendent and Matron. Medical supervision was exercised by the appointment of visiting medical staff, the first of which was Dr Richard Harris. It was not until 1890 that a resident medical officer was appointed as Medical

Superintendent, and the position of Matron was separated as the senior nursing post. The first two such appointments were Dr Wilkinson as Medical Superintendent and Miss Newton as Matron. Thereafter the principle of medical executive direction prevailed as at other lunatic asylums.

Until 1887 it served a dual purpose as a hospital for the insane as well as an institution for imbeciles, with an increasing proportion of imbeciles and idiots being diverted there. The role of the Newcastle Asylum, was described in the Newcastle Chronicle, 15 April 1876:

“The asylum is set apart for the reception of chronic cases of idiocy, imbecility, and epilepsy, which are drafted off to it from the different lunatic asylums of the Colony. It is in fact a retreat for incurables, a sanctuary for the hopelessly demented, and under the system laid down by Dr Manning, and so ably carried out by Mr Cane (the Superintendent from 1873 to 1890), and his staff of assistants, it is indeed a haven of rest and peace, and even of cheerfulness, to the unfortunates for whom it has been instituted.”

This description as a sympathetic sanctuary for grossly mentally retarded persons was still apt when the author was Director-General of Mental Health from 1961 to 1963. It was then known as Watt Street Mental Hospital, retaining this name until 1967, when it became the Newcastle Psychiatric Centre, reverting to a dual purpose of a receiving and admission centre for Newcastle, and a long-stay institution for persons with congenital or acquired idiocy.

### Observation Ward for Criminally Insane, Darlinghurst Goal

The exact year when this unit was established is not clear: Until 1878 it was used by arrangement with the prison authorities for temporary detention of prisoners showing signs of insanity, or remanded from the Sydney Police Courts for alcoholism. After the *Lunacy Act of 1878* it was set apart for the detention of any prisoner who was supposed to be insane, or with a degree of mental imbecility unfit for penal discipline, to be there observed until certified by two medical practitioners, one of whom shall be either the Inspector General of the Insane or a Superintendent of an asylum for the Insane. Its function was taken over gradually by the Reception House.

### Callan Park Asylum

The Callan Park Asylum was established in 1873 in the residential estate of Mr Ryan Brennan, which was purchased for £13,000. The residence was a substantial building of stone and brick with extensive views over Iron Cove and the Parramatta River. It needed but minor modifications to accommodate patients, of whom 44 were in residence within a year of the purchase. At this stage it was a sub-unit of the Gladesville Asylum.

Callan Park was intended to be the modern asylum of Sydney ultimately to accommodate 666 patients. As a preliminary, Mr Charles Moore, Curator of the Botanic Gardens, was entrusted with the task of laying out the grounds. In 1876 Mr Barnett, the Colonial Architect, was commissioned to plan and build the asylum, using as his model the English prototype of a large secure building for acute and disturbed patients and a series of cottage pavilions scattered throughout the parklands for patients undergoing rehabilitation, work therapy, lodging of chronic patients and imbeciles. The groups were separated according to classification and progress of therapy. Norton Manning had described similar institutions in his report.

The subsequent development and role of the Callan Park Asylum will be described in Part II of this publication.

### The Private Asylum Tempe

The Private Asylum was known also as the Licensed House for Lunatics, and was established by George H. Tucker in 1865. Tucker was an American with a dubious doctorate in psychology, who previously conducted a private lunatic asylum in Melbourne. He was the author of a dull and commodious study on *Lunatic Asylums of the World*.

The Private Asylum was licensed under S II, 31 Vic. 19 in 1868. At first it contained private patients only. In 1870, due to the lack of demand, arrangements were made with the proprietor and Superintendent by which 25 female patients were received from Tarban Creek Asylum. This arrangement was increased to 100 in 1874 and 125 in 1876, when the number of private patients was 10 only. The Official Visitor to this asylum was the Adviser to the Government until 1880 when A. Roberts, H.G. Alleyne, M.D., and William Owen, Barrister-of-

Law were appointed Official Visitors under S 72 of the *Lunacy Act of 1878*. It survived as the Bay View Asylum after the expansion of the Government lunatic asylums until World War II.

## The Norton Manning Report

Henry Parkes was so impressed with Norton Manning's administration of the Tarban Creek Asylum, that he proposed to Manning that he should undertake a comparative study of asylum systems in the United Kingdom, the Continent and the United States. This was in consonance with Parkes' liberal concept as a Chartist, providing him with the opportunity to build, in NSW, a system for the care of the insane, which would replace the uncoordinated system of independent asylums. Norton Manning was overseas for a period of some fifteen months during which he assiduously carried out his task, and recorded his observations and recommendations in his voluminous report to the Colonial Secretary in 1868.

The magnitude of his task can be gauged by the instructions to him from the Chief Secretary as briefing for his study tour(56):

"You will visit the chief asylums in the United Kingdom, on the Continent, and in the United States. You will direct your inquiries in these visits to the principles on which the building have been erected... the different methods of treatment... the working of different systems of management and discipline... the efficient supervision and economy of expenditure ...you will obtain copies of all regulations dietary scales and reports... of all recent and important status, state papers and departmental reports relating to the treatment of lunatics."

In its sections the report follows closely the terms of his briefing although not always in the same order. It became the 'magna charta' of the care of the insane on which was based the system of organisation of lunatic asylums, standards of care, legal procedures and even architectural details of institutions.

Norton Manning's proposals for the legal safeguards and procedures of lunacy were incorporated into the *Lunacy Act of 1879* (42 Vic. No. 7) including his concept of an official Office of a professional inspector; the Inspector General of the Insane, who would have executive and legal capacity over the asylums of the State. Not all his recommendations were acceptable. He did propose a form of statutory authority to control lunacy and its institutions. I imagine this would have been anathema to Parkes, who detested any form of power at the public service level which would gloss the authority of Parliament and its Ministers. Paradoxically he did not object to Norton Manning occupying the authoritative position of Inspector General of the Insane. But then Manning was a public servant whom he could and did trust not to overstep the boundaries of his authority. Again the organisation was constructed as a sub-unit of the Chief Secretary's Department, in itself a secondary form of restraint over the individual.

Essentially Norton Manning proposed that all asylums should be incorporated into one organisation under the executive control of the Inspector General of the Insane. Within this system

asylums would be decentralised to rural and outer suburban areas close to the populations they served. The system would be served by staff from a career service with professional and sub-professional training programmes, and subject to a uniformity of policy extending to the areas of treatment and sustenance. It would be supported by defined legal procedures for admission and committal, care of the persons' assets, and the right of the patient after committal. Apart from the continuing supervision by the Inspector General of the Insane and his reports, a further audit in support of the patient and his rights was envisaged by a system of external visitors, who had substantial legal obligations and powers under the *Lunacy Act*.

Essentially Norton Manning proposed that all asylums should be incorporated into one organisation under the executive control of the Inspector General of the Insane.

Norton Manning became the First Inspector General of the Insane, and the organisation of which he was the professional executive head was variously referred to as the Lunacy Department or the Office of the Inspector General of the Insane. The latter was most frequently used by Manning and had a curious origin. When Norton Manning relinquished his super-intendentship of Tarban Creek Asylum in 1879, he continued to occupy office space at that institution. He believed firmly that the head of a lunacy system should not be identified with any particular hospital. To differentiate his mail from that of Tarban Creek his letterheads were printed Office of the Inspector General of the Insane. From this origin it became the accepted title for the government organisation of lunacy although the civil service title was the Department of Lunacy. Correspondingly when the position of Director-General of Public Health was created in 1913, within the Chief Secretary's Department, the organisation he directed became known as the Office of the Director-General of Public Health. These two curious descriptive titles continued to be used until 1941, when both sub-departments were removed from the authority of the Chief Secretary to become the nucleus of a separate Department of Public Health under a Minister of Health.

There is no doubt that within the structure of the civil service, Norton Manning was a permanent head in charge of the Department of Lunacy, which itself was a sub-department of the Chief Secretary's Department. He reported to the Colonial Secretary through the Principal Under Secretary of that Department, although it appears that he did have right of direct access in professional matters.

During his administration asylums were established at Callan Park, Orange, Goulburn and Newcastle; admission procedures were defined; and the Reception House at Darlinghurst established for observation after preliminary certification; and special provision was made, legally and physically, for the care of the criminally insane.

In the latter half of the nineteenth century the reputation of the asylums was high. Treatment was directed along physical lines of adequate diet, exercise and controlled vocational (mainly farming) therapy. Recruitment of staff was buoyant and quality was high, certainly with medical staff. The medical

profession itself recognised the therapeutic potential of the asylums, and opted out of private psychiatric care. There was but one private asylum, and it was in part contracted to the Government. The Office of the Inspector General of the Insane dominated the remnant of the Medical Department in its public and professional image, as well as its status within the Chief Secretary's Department and the civil service. Competition between the two services was again to emerge in the 1890s after the establishment of the Board of Health – competition and disputation which persisted, often bitterly, until the establishment of the Health Commission in 1973.

### Lunacy procedures and laws

The Governor's Authority was dominant as the legal basis of lunacy until the *Lunacy Act of 1878*. In the early years of the Colony it was applied directly and procedures were simple and devised extemporaneously as circumstances dictated. After the establishment of the Supreme Court in 1823, the Governor's Authority in lunacy was delegated to the Chancery Division of the Court, paralleling the delegation of the Royal Prerogative by the Monarch to the Lord Chancellor of Great Britain. After 1823 lunacy procedures were more consistent and were confirmed in local legislation in the provisions of the *Dangerous Lunatics Act of 1843* and the *Lunacy Act of 1878*.

### The Governor's Authority

The Governor's Authority was that of a military autocracy, the Governor having almost absolute powers until 1825. The rule 'quod gubernatori placet, legis habet vigorem' was applied vigorously. The law in Great Britain was translated to NSW and was unaffected by local statutes until the establishment of the first Legislative Council. This Council did provide a mechanism for the development of legislation pertinent and applicable to the Colony and its needs.

Governor Phillip was entrusted in his commission with the same delegation from King George III over the custody of lunatics and idiots as was held by the Lord Chancellor. The emphasis was on custodial confinement and restraint as much to conserve the harmony of society as to protect the individual lunatic. The details are set out in Phillip's second commission(57):

“And whereas it belongeth to us in right of our Royal Prerogative to have the custody of ideots and their estates and to take the profits thereof to our own use finding them necessaries and also to provide for the custody of lunaticks and their estates without taking the profits there of to our own use.

And whereas while such ideots and lunaticks and their estates remain under our immediate care great trouble and charges may arise to such as shall have occasion to resort unto us for directions respecting such ideots and lunaticks and their estates Wee have thought fit to entrust you with the care and commitment of the custody of the said ideots and lunaticks and their estates and Wee do by these presents give and grant unto you full power and authority without expecting any further special warrant from us from time to time to give order and warrant for the preparing of grants of the custodies of such ideots and lunaticks and their estates as are or shall be found by inquisitions thereof to be taken by the Judges of our Court of Civil Jurisdiction and thereupon to make and pass grants and commitments under our Great Seal of our said territory of the custodies of all and every such ideots and lunaticks and their estates to such person or persons suitors in that behalf as according to the rules of law and the use and practice in those and the like cases you shall judge meet for that trust the said grants and commitments to be made in such manner and form or as nearly as may be as hath been heretofore used and accustomed in making the same under the Great Seal of Great Britain and to contain such apt and convenient covenants provisions and agreements on the parts of the committees and grantees to be performed and such security to be by them given as shall be requisite and needful.”

The authority vested in the Governor by his commission added considerable weight to his prerogative powers, including those in lunacy, which devolved upon him as Vice-Roy. Until the 1820s

there was no doubt of the Governor’s personal control over all activities and all persons in the Colony.

The legal administration of lunacy being a direct responsibility of the Crown, was not appropriately vested in the early Civil Court under the Judge Advocate, but was a direct responsibility of the Governor. He could delegate the adjudication of lunacy cases to a civil judicial tribunal and could, as the Governors regularly did, consult the Judge-Advocate on legal procedures. In this manner the techniques of administration of lunacy were devised, which were improvised to meet particular circumstances.

The first mechanism of lunacy administration was devised from the need to secure and administer the estate of a free settler, Charles Bishop, who was deemed to be insane(58). To meet this contingency,

Governor King in 1805 issued a provisional order for committal consequent upon a jury ‘to make enquiry upon view of examination of Charles Bishop, to say on their oaths whether the said Charles Bishop is a Lunatic’. The inquest confirmed his incapacity, and he was committed to the custody of John McArthur and the Reverend Samuel Marsden (they being volunteers from motives of humanity). The same persons were authorised to

administer Bishop’s estate. Presumably, Bishop was maintained in custody in his own domestic establishment. Portion of the English procedure was here adopted, the Governor dispensing with the process of a writ ‘de lunatico inquirendo’ which would hardly have been applicable in the circumstances.

In 1810 a board of three surgeons substituted for a jury in the case of Alexander Bodie, and advised that he was labouring under such serious mental derangement as to justify the Governor to appoint committees of his estate(59). This was probably a spontaneous decision by the Governor, although it did not replace the jury system as Bostock suggests. A jury was used again in 1812 in the case of Jonathan Burke McHugh on the advice of Judge Advocate Bent, preceded prior to the assembly of the jury by the issue of a commission from the Governor in the nature of a writ ‘de lunatico inquirendo’(60). It was

The emphasis was on custodial confinement and restraint as much to conserve the harmony of society as to protect the individual lunatic.

the forerunner of a technique used frequently afterwards for admission of private patients to the asylum, and even for the discharge of some as in the case of Surgeon Daniel MacDonnell and John Duncan in 1825, then the only two private patients in the asylum. By this device Governor Thomas Brisbane was able to justify his action to repatriate both to England at Government expense.

The disposal of convict or pauper lunatics during this period is not defined in the official documents. For the former presumably it was merely a matter of the Governor's discretion and custody in the goal or hospital, depending on the danger to the community by the actions of the lunatic or the circumstances under which the deviation became obvious. For the latter a similar procedure may have applied, one hopes with preference to the hospital rather than the goal. Suffice to say that, until the establishment of Tarban Creek the inmates of the asylums were almost totally convicts, who, as such, were already in legal custody. Their admission was merely a process of transfer from a place of indenture, the convict barracks, the hospitals or gaols. It appears that a statement of opinion of insanity from a Colonial Surgeon was adequate or a magistrate's order. The right of admission rested with the Superintendent of the asylum. The medical staff had no discretion which would modify the Superintendent's authority. Mr Major West, one of the medical staff servicing the asylum, was quite emphatic on this point:

"I never knew an instance in which the Surgeons at Castle Hill have decided on the sanity or insanity of persons sent there(61)."

It does appear that the medical staff did have a discretion in routine discharges for convict and pauper patients. Bostock quotes Major West again relating the case of three men who were sent back to the asylum after he had discharged them as sane(62).

### Summary jurisdiction

Committal by Justices of the Peace or Magistrates was an accepted procedure in lunacy during the whole of the period until the *Lunacy Act of 1878*. Presumably such persons were brought before the Justices for disturbing the peace, wandering at large or for vagrancy. Probably also, and especially in

country areas, asylum tickets were issued by Justices or Magistrates without the formality of charge or committal. Commissioner Bigge commented critically on the Rev. Samuel Marsden and John McArthur for such a misuse of their magisterial office. Magistrates' committal orders to the asylum were often brief and terse with the offence indicated as 'insane'.

Even after the passage of the *Dangerous Lunatics Act in 1843* the powers of summary jurisdiction were often misused, especially in country areas, for local convenience to avoid admissions to the asylum. Norton Manning speaks of the abuse of this system(63):

"...under the old statute (*Dangerous Lunatics Act of 1843*) it was common practice especially in distant country places for Justices before whom an insane patient was brought to call on him to enter into recognizances to keep the peace or to be imprisoned in default for five or even six months as a wandering lunatic, a vagrant ... and to leave to the keeper of the prison to take action as regards the insanity either in the course of or at the expiry of this sentence."

By this device the gaols were used as reception houses for doubtful cases or patients with acute episodes.

### The Supreme Court

Reference has already been made to Section XVIII of the Supreme Court Charter of 1823 (4 George IV c 96) which translated to the Jurisdiction of that Court the King's Prerogative in Chancery, and authorised the Court to appoint guardians and keepers of the persons and estates of idiots and lunatics who are unable to govern themselves or their estates. Previously the delegation had been to the Governor of the Colony in his commission.

Section XVIII limited the jurisdiction of the Supreme Court to this component of lunacy and the appointment of guardians and keepers was not for the purpose of securing the person but rather his estate. It did not detract in substance from the authority of the Governor over the disposal of idiots and lunatics.



This Section is in two parts, the first of which likewise gives to the Supreme Court a similar authorisation to infants and their estates 'according to the order and course observed in that part of our United Kingdom called England'. The provision for idiots and lunatics is quite discrete and does not impose the same qualification to follow English order and procedure, but gave the Supreme Court discretion to 'inquire, hear and determine, by inspection of the person, or such other ways and means by which the truth may be best discovered or known'.

The Supreme Court was thus empowered to develop its own procedures, and was absolved from the obligation to observe existing English practice. However, there is no doubt that it did continue to exercise this function through English tradition and practice. The process of writ 'de lunatico inquirendo' with jury verdict was used in the first recorded, and probably the first actual case in 1828 under this jurisdiction of the Supreme Court. A record is contained in the *Sydney Gazette* in May of that year:

"A commission of lunacy, the first, we believe that has been held in the Colony, was summoned at the Court house, on Wednesday last, to inquire into the fact of mental imbecility alleged against Mr James Birnie of Sydney and to decide on the propriety of committing the management of his affairs for the benefit of his family, to other hands ... The verdict of the jury was, that Mr James Birnie was of unsound mind, and incapable of managing his own affairs."

The process of inquiry de lunatico inquirendo undoubtedly continued until the passage of the *Lunacy Act of 1878* (42 Vic. No. 7), which substituted a new mode of enquiry by petition to the Court, and created the Office of Master in Lunacy to manage the estates of insane persons, in lieu of personal trustees appointed by the Court.

The jurisdiction of the Supreme Court, although theoretically available to all, was in practice limited to those whose assets could ensure payment of the Court fees and other expenses. As the Judges of the Court personally collected and retained such fees the probability of a case from an impecunious litigant being listed was somewhat remote.

## The Dangerous Lunatics Act, 1843 (7 Vic. No. 14)

The process of admission to the asylum by single certification, often per se, or as a corollary to a process of summary jurisdiction or an order from the Governor or Colonial Secretary persisted until 1843. In that year a Captain Hyndman successfully sued Joseph Digby claiming that he was illegally confined in the Tarban Creek Asylum. The ground for the verdict 'was a belief (founded on the evidence) that due caution and care had not been exercised to ascertain the state of the plaintiff's mind'. This incident accelerated the passage of the first lunacy law of Australia through the Legislative Council.

The *Dangerous Lunatics Act of 1843* was 'an Act to make provision for the safe custody of and prevention of offences by persons dangerously insane and for the care and maintenance of persons of unsound mind'.

Committal by Justices of the Peace or Magistrates was an accepted procedure in lunacy during the whole of the period until the *Lunacy Act of 1878*.

The Act laid down the procedures for committal of the criminally insane or dangerous lunatics to gaols and hospitals and the protection of their interests while so detained. It further provided the mechanism whereby the Governor could direct convicted criminals who became insane, insane persons committed for trial, or persons acquitted on the grounds of insanity to a lunatic asylum. Other provisions of the Act provided for Official

Visitors to the asylum; indemnity of staff against action for acts already performed in the confinement of patients in Tarban Creek at the time of the passage of the Act; the method for the certification of persons not dangerously insane, and the authority for maintenance of persons in the asylum either from the funds of the Colony or from their estates.

The significance of this Act is that it provided for a system of double medical certification as part of the legal processes involved in the committal of both the dangerously insane and the not dangerously insane. In the latter, applications for confinement to the asylum could be made by relatives or guardians, and the applications were sanctioned in writing by a Judge of the Supreme Court on the basis of supporting certificates from two legally qualified medical practitioners. The principle of dual certification in lunacy remained in force in NSW until the *Mental Health Act of 1958*.

The *Dangerous Lunatics Act* was amended in 1845 (9 Vic. No. 4) 1846 (9 Vic. No. 34) and 1849 (13 Vic. No. 3). The amendment of 1845 was significant in the administration of lunacy as it gave power through a legal process for discharge from the asylum by a mechanism other than petition to the Governor. It provided for a Judge of the Supreme Court to examine the cause of any person where there is a petition or reason to believe that the person is of sound mind. The amendments of 1846 and 1849 were minor and specified the qualifications of medical practitioners who could provide certificates under the Act; established the mechanism of discharge to custody of friends; and invested the Superintendent of Port Phillip and the Resident Judge at Port Phillip with the same powers as exercised by the Governor and Judges of the Supreme Court of NSW.

### Insanity and criminality

The *Dangerous Lunatics Act of 1843* (7 Vic. No. 14) provided for the removal to an asylum of prisoners or persons committed for trial and certified to be insane or idiotic by two medical practitioners. It also defined the procedure for the exercise of the Governor's Pleasure for persons found not guilty of offences on the grounds of insanity (Section IV):

“And be it enacted, that in all cases where it shall be given in evidence, upon the trial of any person charged with any treason, murder, felony, or misdemeanor; that such person was insane at the time of the commission of such offence, and such person shall be acquitted, the jury shall be required to find specially whether such person was insane at the time of the commission of such offence, and to declare whether such person was acquitted by them on account of such insanity; and if they shall find that such person was insane at the time of committing such offence, the court, before whom such trial shall be had, shall order such person to be kept in strict custody, in such goal or place of confinement, and in such manner as to the court shall seem fit, until the Governor's pleasure shall be known; and it shall thereupon be lawful for the Governor to give such order for the safe custody of such person, during his pleasure, in such place and in such manner as to the Governor shall seem fit.”

The *Act for the Custody and Care of Criminal Lunatics 1861* (24 Vic. No. 19) provided for the proclamation of an asylum or other suitable place, as suitable for the care and custody of criminal lunatics.

### Reception houses

The *Act to Amend the Law for the Care and Treatment of the Insane 1868* (31 Vic. No. 19) gave capacity for the Governor, on the advice of the Executive Council, by proclamation to appoint houses and premises for the reception and temporary treatment of persons committed under the *Dangerous Lunatics Act*. It provided for admission procedures, records, medical visitation and Official Visitors for the reception house.

### The Lunacy Act 1878 (42 Vic. No. 7)

The *Lunacy Act of 1878* was a consolidation of the two existing Acts of the Colony, the *Dangerous Lunatics Act of 1868* (31 Vic. No. 19) and the *Act to Provide for Custody and Care of Criminal Lunatics of 1861* (24 Vic. No. 19), plus elaboration on the processes of committal, discharge and supervision of the affairs and estates of insane persons. Norton Manning was the influential person behind the drafting of the Act, and many of its provisions relate to his comparative study of lunacy laws during his study tour. One such was the concept of an Inspector General of the Insane with oversight over all the lunatic asylums of the State, including their standards of treatment and care.

The Act is exhaustive and divided into a number of parts dealing separately with procedures of restraint and certification; proclamation of hospitals for the insane, government and private, and the methods of regulation of these hospital by the central administration; reception houses for the protection of patients; proclamation of hospitals for the criminally insane; the appointment and duties of the Inspector General of the Insane; appointment and responsibility of Official Visitors; discharge procedures and safeguards for persons committed to mental hospitals and asylums, and supervision of estates by order of the Supreme Court or the jurisdiction of the Master in Lunacy.

The dual certification system was retained but the procedures of arrest and detention were more explicit than those in the *Dangerous Lunatics Act of 1868*. A limit of 28 days was placed upon the period of observation after committal by the Justices, after which the patient was discharged, or alternatively retained in an asylum by certification from the Medical Superintendent or an appropriate medical officer; that the person was still a lunatic who would be dangerous or incapable if released.

The whole tenor of the Act implies uniformity of procedures, and control from a central administration over all lunatic asylums or reception houses, or licensed houses, whether private or governmental. The Colonial Secretary replaces the Governor as the authoritative person in the Act on whom authority delved, other than the authority of the Supreme Court which was overriding when exercised. The agent of supervision was the Inspector General of Lunacy who was charged with periodic visits of inspection, notations in special Registers, and reporting annually to the Colonial Secretary. His administrative function was further broadened as the immediate advisor to the Colonial Secretary on standards and approval of all plans for new lunatic asylum buildings or renovations.

This Act put the imprimatur on an asylum system subject to central direction and authority. So was established the Lunacy Department of the Chief Secretary's Department, with Norton Manning as its head, using the powers invested in him as Inspector General of the Insane to administer the lunatic asylums of NSW.

The era closed with the administration of lunacy on a secure and stable footing within a central organisation, directed by a professional man of vigor, capacity and vision. The lunatic asylums were recognised by the medical professions as the centres for psychiatric treatment, and their doctors were the specialist psychiatrists of the times.

The first settlement in Australia was dependent entirely on Government for its support and control. It was an impoverished Colony, barely viable economically, beset with its own struggles for survival, and bereft of the usual community restraints and standards. Hardship, and with hardship,

abandonment and want were commonplace and of minor interest to Government, whose meagre resources were totally occupied with the immediate problem of consolidation of the Colony. The capacity of the medical service and the convict hospitals were fully extended, and barely capable of coping with the demands made upon them by convicts and others, whose welfare was the absolute responsibility of Government. A restrictive policy was adopted which denied the needs of those who were free or freed. This was of less social significance when the proportion of this group to the whole was small. Towards the end of the second decade the need for an alternative to cater for settlers, emancipists, freed-convicts and native-born population became acute as this proportion increased rapidly.

Poverty and destitution were rife. The lot of those whose only saleable asset was their personal labour was difficult enough. It was desperate when they were aged, infirm, widowed, or deserted, or in urgent need of medical and hospital treatment. The principle of self-help was the underlying basis of the philosophy of benevolence in Great Britain, and the official attitude was likewise in NSW. Systematic assistance to the sick, destitute and afflicted was left to voluntary private effort and not built-in to Government services. The possible exception was the care of orphans towards which, after 1810, assistance was provided from the Orphan Fund(64).

There was movement towards charitable assistance to the poor and destitute with the establishment of the Society for the Promotion of Christian Benevolence and Charity in 1813. This society was initiated by the journalist Edward Smith Hall, and the Memorial to Governor Macquarie was supported by a committee of citizens, comprising, in addition to Smith Hall, John Hosking, William Pascoe Cook, Jeremiah Campbell, Edward Edgar and John Ayre. Its objectives were to relieve the distressed of the Colony, to enforce the sacred duties of religion and virtue, and to support and supply missionaries to neighbouring islands. Public subscriptions were sought and the original list amounted to 25 only – an ominous portent of its future demise. Smith Hall was appointed secretary.

The era closed with the administration of lunacy on a secure and stable footing within a central organisation, directed by a professional man of vigor, capacity and vision.

Governor Macquarie gave reluctant approval to the principles of the Society, meanwhile cautioning that the grand point 'was to do good at home(65)'. The proposal, however, aroused the spleen of the Reverend Samuel Marsden, who refused to be associated with it in forthright terms:

"For as to the 1st object Relieving the Distressed and enforcing Piety – there are no beggars in the Colony – the sick are already provided in the Hospitals ...that as to enforcing Piety the chief good to be effected was among the rising generation in the schools ...and with regard to Missionaries they are already sufficiently provided for by the Missionary Society in London(66)."

Macquarie, influenced by, and one suspects somewhat relieved by Marsden's opposition which enabled him to retract from a hasty decision, immediately withdrew his imprimatur, but indicated, at the insistence of Smith Hall, that he would give 'only' his sufferance to the formation of the Society. And so was set in motion a movement which was to culminate in the formation of the Benevolent Society of NSW.

Public conscience, thus aroused, was extended during the next decade, to provide a non-Government medical service for the indigent sick with the formation of the Sydney Dispensary. And so, through the Benevolent Society and its asylums and the Sydney Dispensary (and later Infirmary), the needs of the Colony for charitable and medical benevolence were provided for until self-government.





**Benevolent Asylum**  
Sydney 1871

# Medical benevolence

## The Benevolent Society

In March 1817, the Colonial Auxiliary Bible Society was founded in opposition to the Society for Promoting Christian Benevolence and Charity, its chairman being Judge Advocate John Wylde. It had the approval and support of the British and Foreign Bible Society, and essentially its objective was to distribute unannotated bibles to the poor in their homes – an activity which was not enthusiastically accepted by the recipients, whose thoughts and needs were more engrossed in relieving their pangs of hunger than in digesting religious succour.

Smith Hall's Society for Promoting Christian Benevolence and Charity did not attract public support and was soon in debt. In contrast the Bible Society received promises of substantial financial support, no doubt stimulated by the patronage of the Governor and involvement of other prominent citizens, who accepted appointment to its committee. It was William Cowper, then Rector of St Phillips, and a member of both Societies, who had a foresight to perceive the solution to the problem, so that Smith Hall's Society could pass out of existence with good grace and without embarrassment to those who supported it.

The initiative had to come from the Bible Society. On 6 May 1818, at its annual meeting with Macquarie presiding, it was resolved 'that an association be formed for the relief of the poor, aged and infirm and for other benevolent purposes'. On 5 June, at a special meeting of the Bible Society, a new association was formed under the name of the Benevolent Society of NSW. The model on which it was established was the Society for Promoting Christian Knowledge and Benevolence, and in effect it was a transition of this Society into the Benevolent Society, the latter accepting responsibility for the debts of the former. The committee was composite of both organisations, with Governor Macquarie as patron and Judge Advocate Wylde as president.

Successively, Governors of the Colony remained its patron, and its presidency was occupied by some of the most influential citizens of the day, so ensuring a continuing monopoly of Government support.

The objectives of the Society were stated in its first regulation adopted at the Special Meeting on 5 June 1818:

"That, the object of this society be, to relieve the poor, the distressed, the aged, and the infirm, and thereby to discountenance as much as possible mendicity and vagrancy, and to encourage industrious habits among the indigent poor, as well as afford them religious instruction and consolation in their distresses(67)."

Initially, the Benevolent Society carried on its activities along the same lines as the benevolent function of the Society for Promoting Christian Knowledge and Benevolence, incorporating the same district boundaries, and restricting its function to outdoor relief by cash loans or grants and distribution of provisions and clothing. The author can remember vividly this function still operative prior to World War II, and the queues receiving their weekly doles of cash and provisions at the Quay Street Dispensary of the Benevolent Society.

Despite the hopes of its sponsors the finances of the Society were never adequate to meet the demands made upon it, and special public appeals had to be made to meet its yearly deficits in its foundation years. Particularly was it embarrassed by the continuing distribution of finance to secure lodgings for its pensioners. It was obvious that the simple solution to this dilemma was to extend into indoor relief, and provide shelter and care within its own organisation and control. And so the Sydney Asylum came into being, the progenitor of the system of State hospitals, still operating under the administration of the Health Commission of NSW.

## The Sydney Asylum\*

On 13 April 1820, a deputation comprising William Cowper, Richmond Hill and Walter Laury presented a petition to Governor Macquarie soliciting finance for an asylum. Macquarie was receptive and a suitable building with accommodation for 50 to 60 persons was designed by Mr Frank Lawless, foreman bricklayer of the Government Gangs, and erected at Government expense. The design was pseudo-classical, of brick construction with brick pilasters extending for the whole height, and with a meaningless gable which projected from the main roof with nothing to support it. It was located near the Turnpike House, at the corner of Pitt and Devonshire Streets, where Central Railway Station now stands. The asylum was opened to receive inmates on 12 October 1821, the Government having supplied furnishings for sixty persons. It was under the immediate supervision of a Master (Manager) and Mistress (Matron) in the persons of Mr and Mrs Dalton.

The Master was responsible for the general management of the asylum, internal accounting and records, and the distribution of outdoor relief to pensioners of the Society. Admission was by application to a special committee of Management of the Benevolent Society, which also appointed from its members Official Visitors to the asylum.

The management structure of the Benevolent Society was modelled on the subscriber system, a formula which was adopted by all non-government charities and hospitals which were later established in NSW throughout this century. The system was based on a number of annual subscribers, who alone could vote for the management committee. Each subscriber of one guinea became an annual member, and each subscriber of thirty guineas a life member. Subscribers were entitled to nominate pensioners for the asylum, and each application for admission had to be accompanied by a subscriber's endorsement.

The proportion of disabled and infirm inmates resident in the asylum rendered necessary the provision of a medical service. The indefatigable Dr Bland demonstrated again his principles of public service by 'gratuitously bestowing both attendance and medicine on all cases needing medical aid(69)'. It was Bland also who proposed that a hospital for forty patients be included in the extensions of the north wing in 1825.

The demand on the asylum continued to increase and it was consistently overcrowded despite the extensions of the north wing. By 1830 it was accommodating 112 men and 32 women, of whom 57 were 70 years of age and over. The pattern of demand, inadequate accommodation and overcrowding was recurrent throughout the whole of the period to 1851. Admissions were periodically restricted to the totally infirm, and temporary relief from overcrowding sought by wholesale discharges of the younger able-bodied men – a device (underage musters) which was still being implemented for the same purpose in the home section of the Lidcombe State Hospital in the 1960s.

Ultimately, the south wing of the asylum also was extended, but the relief was short lived. The depression of 1842 was reflected in increased demand for admission, and again restrictions were imposed – this time on moral criteria. Irrespective of needs, alcoholics or persons with 'blatant immoral habits' were excluded. The stimulus to immigration after the cessation of transportation did but increase the burden, and by 1849 the number of inmates were approaching the 500 mark, with an increasing demand on the hospital wards. More than half of the population were categorised as sick or infirm.

Nor was the establishment of the Sydney Infirmary in 1845 of assistance. The infirmary would accept only those inmates from the asylum who had met with accidents or were suffering from acute and curable diseases. In fact this policy, which is still essentially the policy of the general hospitals of NSW, left the asylum in greater isolation and jeopardy as the only repository for persons suffering from chronic and long term illnesses for the whole of NSW.

Overcrowding was for the first time effectively relieved in 1851 when the Governor gave the Society the temporary use of the Liverpool Hospital, which had been vacant for some years after it had ceased to function as a convict hospital. Male inmates were transferred to Liverpool Hospital together with the Resident Surgeon, Mr J.C. Russell, who was also appointed Manager – a precedent of a medically qualified chief executive officer which was to extend throughout the State hospitals in later years, and which is still operative.

\* Full details of the management of the Benevolent Society and the Sydney Asylum are contained in the author's publication *The Development of the Benevolent (Sydney) Asylum 1788-1855*(68).



The Society hoped to achieve some economy in medical staffing now that the Sydney Asylum was restricted to females only. In this they were frustrated by the insistence of the visiting medical staff, who demanded that an additional medical appointment should be made to the Sydney Asylum. Dr R.R. Norris was appointed, and the principle of separate institutions for male and female inmates consolidated. This principle persisted throughout the development of the State hospitals until 1969, when Lidcombe State Hospital again admitted females to its hospital section.

Two events of significance to the Benevolent Society and its future role occurred just before self-government. In 1852 it undertook the care of orphan children accommodating those under eight years of age at Ormond House Paddington, donated by the widow of Daniel Cooper, and above eight years at the female asylum. In 1854 it established the north wing of the Sydney Asylum (in which the hospital facilities were located) as an obstetric unit particularly for single women, although not excluding married women who were deserted or destitute.

The principle of Government in supporting and encouraging community involvement in benevolence was consistent with British practice, and valid enough when the settlement was essentially a convict colony. It was supported by the antipathy of the colonists towards any repetition of the parish poorhouse and workhouse system of the Mother Country.

But a new and exciting spirit was released as the Colony moved towards self-government. Many of the accepted practices were questioned, some in terms of function, some in terms of economy, and others in terms of responsibility and obligations of Government. The activities of the Benevolent Society were under frequent scrutiny as Government became more heavily involved in its support and yet had no effective voice in its management and policy. It was shortly to lead to dismemberment of the functions of the Society, leaving to it only the provision of outdoor relief, the care of orphans and the organisation of institutional obstetrics. Of particular significance to the health services of the State was removal of its asylums and the foundation of the system of State hospitals.

A new and exciting spirit was released as the Colony moved towards self-government.

## State hospitals

In 1855 the Government constituted a board consisting of Mr W.C. Mayne, Inspector General of Police, and Mr E.G. Mereweather, Acting Agent for Church and School Lands, to enquire into the operation and general management of the Benevolent Society, and to determine the position which the Government ought to adopt with respect to the Society in terms of continuing subsidy from public funds.

The *Mayne-Mereweather Report* was critical of the Society, particularly the laxity with which it distributed outdoor relief. The Commissioners argued that the practice of the Society was at variance with its aims, and, in effect, the Society encouraged mendicity and vagrancy and did not foster a spirit of independence among its applicants.

The report was presented when the Colony was on the verge of self-government and the Executive Council left any action to the incoming administration. The process of questioning and enquiry continued intermittently in an informal manner until 1862, when the Government moved to take over the care of the aged and infirm from the Benevolent Society, creating the Board of Government asylums for the Infirm and Destitute, with Frederick King, a public servant, as Secretary. The constitution of the Board remained constant until it was abolished in 1873, following a recommendation from the Royal Commission on Public Charities viz Chairman: Christopher Rolleston, Auditor-General; Members: Captain John McLerie, Inspector-General of Police; Mr Harold Maclean, Sheriff; and Dr J. Alleyne, Health Officer. Frederick King was to become the second Inspector of Public Charities under the *Institutions Inspection Act of 1866* replacing in 1869, the initial incumbent, Mr R.C. Walker. He retained his position as Secretary of the Board of Government asylums.

The Liverpool Hospital was placed under this Board, and the aged women were removed from the Sydney Asylum to the Immigration Barracks at Hyde Park. A third asylum was established at Parramatta in 1862, variously known as the Macquarie Street Home, Parramatta, or the Home for the Blind and Men of Defective Sight and Senility. It was located in the buildings of the Military Hospital (opposite the

Queen's Wharf), which had been erected as a military barracks by Governor Macquarie in 1822, and subsequently converted to the convict barracks and stables, before becoming the Military Hospital in 1843. In addition to siphoning off the overflow from the Liverpool Asylum it functioned as a receiving house for aged and infirm men. Its original Master and Matron were Mr and Mrs James Denis, who arrived from England in 1861. For a short time there was also an asylum at Port Macquarie occupying the convict hospital. It was very unpopular because of its location.

The attitude of the Board of Government asylums towards its responsibilities was a display of almost total lack of concern. It was inactive and, by default of its executive management, Frederick King discharged its functions personally. He described his duties:

"I am charged with the general supervision of the asylums, and held responsible for their good order and management. I have control of the expenditure under the board's direction, and am held responsible for all disbursements, and for the general accuracy of the accounts, books and records of this office. I give a £1,000 (bond) guarantee of faithfulness in the discharge of these duties(71)."

He did attempt some degree of supervision by personal inspections, but these were irregular and perfunctory, and of necessity so because of the burden of his duties in his combined posts. No such excuse could be offered to minimise the board's dereliction. The members rarely visited the asylums, explaining that their other duties did not permit of the time, and in any case 'it was of no use'.

The latter may have contained some element of truth. The Government appeared to be more concerned in containing expenditure at the expense of the welfare of the inmates under its charge. The total cost voted annually did not vary substantially from year to year and was in the region of £12,000 to £18,000 to cover all State asylums.

Conditions and care in the asylums varied. Apparently the women were reasonably catered for in the Hyde Park Barracks, and the discipline at Liverpool was such that men preferred to go to Parramatta despite its rigours and reputation. At least there they were allowed to wander freely between the town and the institution. It was the

shameful conditions at Parramatta which led to the abolition of the board of Government asylums.

Dennis' attitude to his inmates was callous and harsh, often bordering on brutality. He was insensitive to their needs and they had no redress. George Harris, an ex-inmate, in evidence before the Royal Commission on Public Charities (1873) describes one incident, which is still incredible allowing for exaggeration:

"Last Christmas Day (1872) there were 270 men left there without a bit of breakfast at all. Mr Dennis goes down the Bay in his yacht and never gives us a bit of bread and meat. He goes away with his two sons and two boatmen, and he leaves 270 men there without a bit of bread(72)."

Nor apparently were conditions substantially better in the hospital section established in the tweed millhouse adjoining the asylum. Dr Robert Champley Rutter, M.D., Visiting Surgeon to the asylum, complained bitterly to the Royal Commission on the attitude of the Sydney Infirmary to transfer of patients, and the primitive facilities for nursing and hospital care at the Parramatta Asylum.

The Chairman of the Board of Government asylums, in his evidence before the Royal Commission, absolved himself of responsibility for its shortcomings in terms which, paradoxically, were self-condemnatory:

"I have never been satisfied with Parramatta. It is a faulty institution and the Master is not up to his work either. The place is not healthy-looking, it is untidy-looking(73)."

The Royal Commission was not impressed by the management of the board or its Secretary. It criticised the former on the grounds that they were all busy men and could not afford the time to discharge their duties as members, and the latter as deficient in his active duties of inspection and supervision of the welfare of inmates. Its recommendation to abolish the board was accepted, but its further recommendation to absorb the positions of Inspector of Charities and Secretary of the board into a Department under a Comptroller of Charities was not implemented. King continued in his dual role to guide the destiny of the Government asylums.

A more responsible and enlightened approach to the administration of the government asylums was to be delayed until the 1890's when the Rookwood Asylum (later the Lidcombe State Hospital) was built. In the meantime the women from the Hyde Park Barracks had been transferred to the Blaxland property on the Parramatta River in 1882, and in 1884 an admission office was established as a central admission depot for State asylums. It was to expand in the twentieth century to a hospital admission depot for general hospitals, convalescent homes and state hospitals (asylums). These changes will be elaborated in Part II of this study. Suffice to say that in the last quarter of the nineteenth century, the State asylums were auxiliary hospitals – part poorhouses and part chronic diseases hospitals. Their facilities were limited, their policies restrictive, penny-pinching and open to frequent criticism. Yet, as Brian Dickey concludes, they were the hospitals for the chronic and incurable patients in the community other than those who could afford private treatment(74).

## The voluntary hospitals

The voluntary hospitals were as much a part of medical benevolence as were the benevolent asylums, and were founded by private enterprise on the same principle of mutual self-help divorced from Government interference. Unlike the benevolent asylums, which became Government institutions after self-government, the voluntary hospitals continued independent of Government control, each under its own individual board of management. Until the growth of friendly societies following the *Friendly and Other Mutual Benefit Societies Act* (37 Vic. No. 4), they provided a complete medical service to the poor and indigent through their outpatient and inpatient facilities, supplemented by the charitable attitudes of private medical practitioners, who would attend the poor in their homes for no fee or a nominal fee.

They were widely recognised by the community as benevolent institutions for the poor or charity hospitals. From their management there was a common attitude to their patients implying relative

or absolute pauperism. This was so evident that the Inspector of Public Charities suggested in 1877 that a payment of one shilling a day be asked of patients in order to inculcate 'feelings of self-reliance and self-respect by paying... in part for the benefits received'(75). This proposal was never effectively introduced as a compulsory requirement, and the voluntary hospitals (then known as the public hospitals and now the general hospitals) remained essentially free charities, although they sought voluntary contributions from patients able to provide.

The first such institution was the Sydney Dispensary, which, in 1845, became the Sydney Infirmary, when the board of the Dispensary accepted inpatient facilities in the south wing of the General Hospital. It was later to extend its facilities throughout the whole of the General Hospital and was incorporated in 1881 as the Sydney Hospital, as exists today.

The principles and mode of administration, on which the Sydney Dispensary and Infirmary, was based set the pattern adopted by all other voluntary hospitals which developed in this century. The implications of ownership and consequential independence from direct Government control was, and still is, jealously guarded by these hospitals, to the degree, that as late as 1972, they were able

collectively to exert pressure on Government not to proceed with Stage II of the *Health Commission Act* of that year. This Stage would have converted their boards of directors to the status of Government trustees.

### The Sydney Dispensary and Infirmary\*

Dr Redfern was an early protagonist of a separate medical service for the indigent poor. Mr R. Howe, editor of the Sydney Gazette, in defence of Redfern against certain accusations of his opposition to the Sydney Dispensary stated:

"Towards Dr Redfern, we think it our duty to state that he suggested a similar institution as long ago as 1816, but it was then found impracticable(76)."

A more responsible and enlightened approach to the administration of Government asylums was to be delayed until the 1890s...

\* For a detailed description of the foundation, development and management of the Sydney Dispensary and Infirmary the reader is referred to the author's private publication *The Sydney Dispensary and Infirmary 1788-1855*, and *A History of Sydney Hospital* by F.J. Watson, published by the Government Printer, 1911.

The concept of a non-government medical service remained dormant until 1826. In June of that year a group of influential citizens headed by Alexander McLeay, the first Colonial Secretary, appealed for public subscriptions to establish a dispensary. The objective of the appeal was stated in the preamble of the advertisement:

“As many of the Free Class of Poor Inhabitants of the City of Sydney, when suffering from Disease, are unable to pay for Medical Advice, and not having any claims on the Government Medical Establishments, are frequently doomed to hunger on the bed of sickness, and perhaps fall victims to its painful effects; it becomes necessary to appeal to the Benevolence of the richer Inhabitants, to endeavour, by their assistance, to avert the Evils to which their poorer neighbours are subject(77).”

Doctors Bowman, Ivory, Mitchell, Royal and McIntyre offered their professional services gratuitously, to which list of volunteers was later added Doctors Bland, Gibson and Redfern. The public meeting was successful and £286.5.0 was subscribed. A meeting of subscribers was called for 25 September, at the Sydney Hotel to elect a committee of management.

The committee, with Governor Darling as patron, and Alexander McLeay president, read like a ‘Whose Who’ of the notable citizens of the day. Drs. Bowman, Bland, Mitchell and Gibson were appointed honorary doctors. It became a prestige appointment to be appointed as an honorary doctor to the Dispensary (and later the Infirmary), and was a position sought by the most prestigious doctors of the Colony. So was born the ‘honorary system’ which still survives today, despite inroads of paid specialist staff in the larger general hospitals and the impact of the *National Health Act* and Medibank. I would suggest that the prestige of honorary appointment is still undiminished particularly in teaching hospitals.

The Sydney Dispensary was located in rented premises in Macquarie Street, then described as a part of the town inconvenient for the attendance of patients. Its address was changed on 1 October 1873 to Mr Terry’s New Buildings in Pitt Street. As a measure of economy the rent (£34.14.0 per annum) was shared conjointly with the Australian Library.

The rules and regulations adopted by the Dispensary are set out in Appendix 2. Of interest are the first and tenth:

- “1. A subscription of One Pound Sterling annually contributes a Member of the Institution, with a right of having one patient at all times on the books. An annual subscription of Two Pounds constitutes a Member, with the right of having two patients constantly on the books. A Donation of Ten Pounds constitutes a Life Member, with the right of having two patients constantly on the books. And larger Annual Subscriptions in the same proportion.
11. That One of the Medical Officers of the Institution be every day (Sunday excepted) in attendance of the Dispensary from eleven to twelve o’clock. Subscribers are requested to be particular that the persons they send as patients be such as really require the Aid of the Institution(78).”

The Dispensary was a private charity based upon the subscriber system. Only members (including life members) were eligible for appointment to the committee, which was elected annually by the subscribers and members. Under this system patients were sponsored for treatment by the subscribers, although in pressing emergency patients would be seen without this permit. While the Dispensary remained as an outpatient service this rule was rigidly enforced. Patients were required to visit the Dispensary, but medical staff would, if necessary, visit patients in their homes. Subscriber nomination fell into discard after the establishment of the Sydney Infirmary and patients were admitted on merit by the resident doctor, often on referral from the honorary staff.

The Sydney Dispensary was largely self-supporting by its annual subscriptions until it moved to the south wing of the General Hospital. In times of economic difficulty subscribers were canvassed to increase their subscriptions and solicit new subscribers. They were exhorted to do so on occasions for the benefit of their own social class, a concept somewhat unique in preventive medicine:

"...and as there is no limit to the savages of distemper among rich and poor, breathing in the same tainted atmosphere, it becomes a question of self-preservation, for persons in the more wealthy classes, to assist their poorer brethren in their struggles with poverty and ill-health(79)."

In 1838 Sir George Gipps replaced Governor Bourke. Gipps had foreknowledge of the British Government's intention to reduce the convict establishment and was convinced 'that something more than a mere dispensary will shortly be required and hope that the town of Sydney will not be backward in providing accommodation and medical treatment for its sick and indigent poor'(80). By this time the Dispensary was treating some 1,300 new patients annually, severely taxing its resources and the capacity of its honorary staff.

Gipps was sympathetic to an appeal from the management committee of the Dispensary for a Government grant of land or premises in which it could be relocated, thus saving rent. Several sites were considered but rejected as unsuitable. It was Gipp's determination despite implacable opposition from the Head of the Colonial Medical Service, Deputy Inspector John Vaughan Thompson, that the south wing of the General Hospital was granted to the Dispensary to be used as a hospital during the Governor's pleasure. In 1845 a private Member's Bill received assent in the Legislative Council, giving the Dispensary Committee power to sue and be sued in the name of their Treasurer, authorising them to hold or lease lands, and to receive voluntary grants from donations and estates. The board now had official recognition in law, presaging the first *Hospital's Act of 1847* (11 Vic. No. 59), which extended these rights to voluntary hospitals generally. These executive capacities are still confirmed in the present *Public Hospitals Act of NSW 1929* (as amended), Part V, Section 22. A deed of grant for the south wing was given in 1846.

The Dispensary continued as a separate outpatient service after the South Wing had been converted into the Sydney Infirmary to receive patients in 1845. By this time a resident surgeon had been appointed, the commencement of the intern system. Likewise

The Dispensary continued as a separate outpatient service after the south wing had been converted into the Sydney Infirmary to receive patients in 1845.

the Government recognised further its responsibility to support financially the institution, it now being incapable of maintaining its support from subscriptions. The formula was officially on £1 for £1 basis of income from subscriptions or other avenues, although from time to time this was conveniently forgotten, and the Government made up the difference between expenditure and income. The formula of £1 for £1 subsidy was subsequently extended after self-government to other voluntary hospitals, the Inspector of Charities being responsible for determining the amount of subsidy after inspection of the hospitals' accounts.

In 1848 the Infirmary took over the remainder of the General Hospital, and the Dispensary ceased to exist as a separate entity and became the outpatient's service of the Sydney Infirmary. The rights of subscribers to nominate patients had largely disappeared, although they were still responsible for election to the board of the Infirmary.

Throughout the mid and late 1800s the Infirmary had a turbulent existence, and was frequently criticised publicly for the quality of its services and its lack of regard for the care of its patients. The central wing remained much as it was in Macquarie's day. The Gibson case in 1866 presented a picture of a hospital 'in a very filthy state and swarming with vermin. All the destitute and incurable old men were brought in by the police and placed in one ward'. There was no efficient nursing:

"...all that was provided was the rough treatment of old women. There were charges of inefficiency, poor bookkeeping, unchecked drunkenness, improper practices and lack of a regular system(81)."

Henry Parkes proposed a Royal Commission but the power of the board was demonstrated by its refusal to allow 'such interference on the part of Governor and resolved to decline furnishing the commission... with the documents demanded, and ...to prohibit any of the servants of the Institution from appearing before the commission'(82). Parkes was thwarted only temporarily. He introduced the *Public Institutions Act* which provided for the position of Inspector of Public Charities to conduct inquiries into the management of institutions at the direction of the

Colonial Secretary, and to inspect hospitals and other institutions wholly or partly supported by the Government.

Reform of conditions at the Infirmary gradually occurred accelerated by the establishment of a nursing service under Lucy Osborne. Its reorganisation and revitalisation culminated into its incorporation as the Sydney Hospital by the *Sydney Hospital Act*, 43 Vic., in 1881.

### The growth of voluntary hospitals

After transportation to NSW ceased in 1841 the demand on the convict institutions and the need for a separation of the convict and civilian components of the local administration progressively diminished. The convict hospitals at Windsor, Bathurst and Goulburn were discontinued in 1842 and handed over to civilian control, then Port Macquarie, Newcastle and Parramatta in that order and finally in 1848 Liverpool and Sydney. The first religious hospital, St Vincent's Hospital, was established by the Sisters of Charity in 1856. It was a free hospital supported by charitable donations and the Catholic Church.

Elsewhere in country districts hospitals were established by local effort, usually on the basis of a grant of land from the Government, and a local board raising the capital sum in whole or part. A considerable number of these hospitals were founded between 1856 and 1870 wherever local opinion determined it expedient, and a doctor was available. Among those so established were the hospitals at Orange, Goulburn, Yass, Tamworth, Maitland and Deniliquin – all rural centres of expanding population. It is interesting that the Goulburn Hospital had no honorary system. At that hospital three doctors each received two guineas a week to service its twenty beds(83).

The boards of the voluntary hospitals were a variable mixture of local residents with local doctors providing honorary services. The basis of election and continuing finance rested on the subscriber system, with demand on the Government for £1 for £1 subsidy. There was no quality control and quality of care was generally poor. Dickey summarises their function:

“...as scarcely better than refuges for the poor. They provided nothing but the bare minimum... as centres of local patriotism they grew in

prestige. Yet their facilities remained restrictive and relatively primitive. They were all the community could afford(84).”

There was little or no Government supervision until the appointment of the Inspector of Public Charities, and even here it was superficial and beyond the physical capacity of one person to make the necessary inspections except at most infrequent intervals. Frederick King, when occupant of the post, did institute a system of inspections and reports made by the local magistrates, but these soon went into discard.

By the end of the 1870s a system of voluntary hospitals had arisen in NSW, with independent boards of management which were untrammelled in their administration. The function of these hospitals was restricted largely to the treatment of acute and episodic illness and trauma. The autonomy of the boards was guaranteed by the *Hospitals Act of 1847* (II Vic. No. 59), which enabled public hospitals to sue and be sued for their debts, and provided for the acquisition of real property by these hospitals. The voluntary hospitals were demanding of Government for financial support and likewise strongly reactive against any form of government supervision or control. Government itself was apprehensive and developing a statutory system of supervision, which at this stage was not effective.

There was no control over quality of care which in general was poor and of comparable standard with the government asylums. The boards of management were remote from the professional staff associated with the hospitals, who, in turn, were reacting aggressively to the apathy and lack of concern shown by management, in an attempt to condition public and official opinion towards a form and improvement of nursing care.

Reform was to come stimulated by the establishment of nursing services and a growing public awareness of their deficiencies, often and critically expressed in the press and Parliament. The culmination was the Second Royal Commission on Public Charities 1888-1889, after which Government mechanisms of inspection and financial control were to emerge, *pari passu* with the systematic organisation of administrative health services.



# A History of Medical Administration in NSW

## **Part II** **1881 – 1973**







**Royal Prince Alfred Hospital**

Hope Ward early 1900's

# Introduction

## 1881-1973

NSW from the foundation of the Colony in 1788 to the establishment of the Health Commission in 1973. The first part is concerned with the period up to 1881, embracing the turbulent era of direct colonial rule as a penal settlement until 1856, and the first twenty five years of self-government. During this latter period government health services, with the exception of lunacy, were disorganised and lacked central direction and policy.

The modus operandi of health services reflected the attitudes and priorities of Government. In the first forty years of the Colony the British Government was concerned with the security of the convict settlement, and correspondingly the health services were tightly organised, centrally controlled and directed specifically to those groups in the Colony for which the British Government assumed total responsibility, viz convicts, military forces, and, reluctantly, paupers. In the decade prior to self-government and after, the health services disintegrated as transportation ceased and the previously eligible groups were dissipated by pardon, age and death. With the exception of lunacy, health and welfare institutions were conducted by voluntary agencies independently of Government control, although supported by Government financial assistance. Lacking specific public health laws, other than quarantine, there was no need of a central health administration until the smallpox epidemic of 1881.

Lunacy was recognised as a medical service from the last quarter of the nineteenth century, and its independently structured lunatic asylums were drawn together in a Department of Lunacy, within the Colonial Secretary's Department, as a sequel to the *Lunacy Act of 1878* (42 Vic. No. 7). It was advantaged over such public health and benevolent asylum services as remained with Government, by the vigour, personality and leadership of Dr Frederic Norton Manning. He enjoyed the confidence of Sir Henry Parkes who supported him in restructuring the lunacy services.

There was no such person of stature in public health until Dr Ashburton Thompson was engaged as the Senior Medical Inspector by the Board of Health in 1885. As was Frederick Norton Manning to the lunacy service, so was Ashburton Thompson the protagonist of the Public Health Department within the Colonial Secretary's Department. Most of the historical discussions in this part involve the growth of, and competition between, the lunacy and public health divisions of the Government health services.

The story commences in the year 1881 when an event of great political and social significance occurred – a major smallpox epidemic and the first to seriously involve NSW. It stimulated public and political demand for health laws and preventive health services. It was responsible for the formation of the board of Health around which the organisation of public health services devolved until 1973. Medical men of consequence now had a vehicle within which they could advise and serve the State and involve the private practising sector of the medical profession. The Government, in turn, had expertise which it could harness in its Royal Commissions and Expert Committees, which were to influence its attitudes to the independent hospital and welfare institutions.

At the close of the nineteenth century organisations involving the administration of the three arms of the health services had evolved, and the pattern had been set to meet the challenges and scientific advances of the twentieth century. It is interesting and relevant to this part of this historical exercise to consider briefly the social and political climates of NSW as it entered the last quarter of the nineteenth century.

NSW was by then firmly established as a self-governing British Colony of more than 500,000 persons, seeking its own identity and destiny. Although it had cast off the bonds of colonial despotism, it was still sensitive of its origin as a penal

settlement and anxious to obliterate remnants which were a reminder of its past. It was a land of opportunity based largely on a pastoral economy, and differing markedly in its social values from the Mother Country. True there was poverty and slums, but one could aspire to the populous middle class which was electorally and commercially significant. A colonial nationality was emerging which was egalitarian and strident, as befitted its frontier image, in which pride of achievement and equality through personal endeavour were held in higher regard than inheritance of social caste. If there was an establishment class it was based on intellectual and material success, the latter being enhanced if associated with pastoral pursuits. The State could boast of its Council of Education and 800 public or common schools open to all, although not without payment, and accommodating about 75,000 pupils. Among the glories of Sydney was its new university to which access could be obtained by educational scholarship. Its first Registrar and Chancellor were both doctors in the persons of Richard Greenup and Sir Normand MacLaurin, and already there were plans for a medical faculty.

The pride of NSW was the capital of Sydney with its beautiful harbour extending east and west in sheltered coves and bays from the wharfs of Woolloomooloo and Darling Harbour. Its wooded foreshores were dotted with the comfortable villas of its wealthier citizens. Lower North Shore was coming into favour for accommodation now that the regular ferry service was in operation. The antiquity of the old town had its own persuasive charm with its narrow rutty streets meandering along the same paths as the bullocks had trod half a century previously. Here were the banks, the shipping companies and providers, the houses of commerce and the merchant stores. And if one tired of the city it was but a short stroll to Macquarie Street, now enjoying a genteel pre-eminence, with Government House, the Houses of Parliament and the Sydney Infirmary flanking the Botanic Gardens on its eastern aspect, and its opposite pavement lined with neo-georgian town residences, the public library, the Colonial Secretary's building and the Treasury. It was already assuming a medical significance as more and more houses were occupied by doctors servicing the Sydney Infirmary. Further south, past St Mary's Cathedral, doctor's practices had extended into

College Street, where general practice was more the mode than with the specialists of Macquarie Street. Phillip Street was also a favoured small residential area, but here there was a mixture of law and medicine, with the proximity of the Supreme Court favouring the former. The Australian, the Union and the Sydney Clubs were all close at hand to those with the social prerogatives to gain membership.

The poor and working class were housed largely in the inner suburbs of Woolloomooloo, Glebe, Darling Harbour, Pyrmont, Erskineville and further out Rozelle and Balmain. Housed is hardly the proper description. They were herded six to eight or more into labourer's cottages and terraces, built on minimum land areas for the profit of the landlord, with primitive sanitation and common water supply, stinking cesspits, leaking roofs, and damp walls with peeling paint charged with lead. The infant mortality rate was 100 or more per 1,000 births, and infectious diseases and malnutrition flourished. Relief could be sought in the taverns and pubs which were on every street corner; in visits to the Domain on Sundays, or on gala occasions to the picnic grounds of Botany, Neilson's Bay and Clifton Gardens. Swimming and surfing were not yet popular and restricted. The seaside suburbs of Bondi, Coogee, Manly and Randwick were sought as residential areas for the middle class. Waverley was developing a sporting flavour as trainers and bookmakers settled there in the vicinity of the Randwick Racecourse.

Away from Sydney, country towns were emerging to service the pastoral industry. They were small compared with the towns and cities of England, with populations varying from 500 to 7,000, of which only six had populations in excess of 2,000. With the exception of Newcastle, they had like resemblance of broad streets imperfectly filled with houses and conveying an atmosphere of straggling incompleteness and disappointment. And yet they had an air of permanence, each with its churches, banks, hotels and general stores, and the larger with their hospitals. It was already the fashion for the more affluent squatters to reside in a town house and participate with the bank manager, doctor, school master and clergy in the civic responsibilities of the town.

The first Parliament had been inaugurated on 23 May 1856, and the first responsible Ministry on 6 June. It was modelled on the English bicameral system, with a House of Assembly of 72 members each elected for four years by universal adult suffrage, and an Upper House or Legislative Council, being a nominated House, with nominations for life at the discretion of the Premier of the day. The latter was a conservative and responsible institution to which many of the prominent doctors of Sydney aspired.

The characteristic of the Parliament of NSW was the frequency with which its Ministries changed. Sir Henry Parkes, who was Premier at the time of the formation of the Board of Health in 1881 and whose liberal outlook had such an influence on the administration of lunacy, was six times Premier between 1872 and 1892. He alternated with his conservative opponents, Sir James Martin and Mr (later Sir John) Robertson. Martin was described as 'a protectionist' a foe to separation, strong in loyalty to the Crown, very English, very pugnacious and certainly a Tory (92). Robinson had a pronounced speech defect despite which he achieved a high parliamentary reputation as a friend of the free settlers and an enemy of the squatters.

Proceedings of the House of Assembly were in exact contrast to the dignified atmosphere of the Upper House. Strong and vigorous language and appeals to the Speaker were commonplace, and it was common for the Speaker to vacate the Chair and enter with considerable vehemence into the debate of the day. They were turbulent times and the burning issues of protection versus free trade, unemployment, and the rights of the masses were forever occupying the sittings. Health and health legislation had a low priority, occasionally surfacing in the scandals of the lunatic asylums and the Sydney Infirmary, and then largely determined by pressures from the press and Upper House.

Change was imminent in the administration of health services. Just as the cholera epidemic of 1847 precipitated health legislation in England so was the smallpox outbreak of 1881 the precipitating factor in NSW.

Health and health legislation had a low priority, occasionally surfacing in the scandals of the lunatic asylums and the Sydney Infirmary...

## Public health administration prior to 1881

Prior to the establishment of the Board of Health in 1881 there was no single administrative organisation endowed with statutory responsibility for public health services. Such services as did exist were rudimentary and largely concentrated in Sydney. They were fragmented between the Colonial Treasury with responsibility for quarantine; the Council of the City of Sydney and like local government municipal authorities for noxious trades, nuisances and sanitation generally; and a small number of statutory Commissions, often temporary and established by the Government as circumstances demanded.

There were two permanent Health Officers, both qualified medical practitioners, one associated with central government and the quarantine service, and the other with local government and the Council of the City of Sydney. Inspectors of nuisances were employed in Sydney and in some extra-metropolitan municipalities but were untrained and without dedication, direction and authority. The gap in public health inspectorial service was filled by members of the Police Force, especially in rural areas, who were invested with inspectorial powers over noxious trades and nuisances. Public health services were absent in rural areas unless associated with towns seeking municipal incorporation, which were then granted similar responsibilities as the Sydney model under the *Municipalities Act of 1867* (13 Vic. No. 12).

Public health was not a priority of Government despite isolated critical outbursts in the press demanding action and pointing to the example of Great Britain and its health laws following the cholera epidemic of 1847. Disease and death were commonplace especially in the lower socioeconomic groups, and were viewed with complacency, even by the medical profession, as inevitable to the times. Demand for reform and action arose not from outraged public morality, but from panic and fear engendered by the first major smallpox epidemic which threatened the personal security of all, rich and poor alike.

## Quarantine

Supervision of quarantine was the only major public health responsibility of the Government of NSW. Even so, as compared for example with lunacy which was well established in the Colonial Secretary's Department with specific legislation and developed organisation, quarantine was a truncated service administered by the Colonial Treasury and relying essentially on the *Quarantine Act of 1832* (3 Wm. IV No. 1). This Act was directed against cholera or any other infectious disease as proclaimed by the Governor. It imposed upon masters of ships the obligation to provide a bill of health manifest upon entering port. Subsequent amendments defined procedures of quarantine, medical inspections and medical authority of the Health Officer of the Port, and further obligations on owners and agents of ships to meet the cost of quarantine.

The quarantine service was controlled by the Superintendent of Quarantine assisted by the Health Officer of the Port. In times of need additional medical staff were employed on a temporary basis and daily rate. The Health Officer was responsible for inspection of ships under suspicion, and, in times of quarantine, for medical diagnosis, isolation and treatment, including medical supervision of contacts. He was not resident at the Quarantine Station at North Head as was the Superintendent of Quarantine, who was responsible for the bookkeeping, domestic and house keeping arrangements of the Station.

The Station was equipped to accommodate passengers and crew of ships under quarantine and provided first class and steerage quarters, including as part of the accommodation facilities, the hulk Faraday which was moored permanently in the bay at North Head and was used as an additional hospital for the Station. Isolation facilities were provided in the hospital sector proper. There was no permanent nursing staff attached to the Station. Such staff were transferred when necessary from the State asylums or the Sydney Infirmary.

The isolation of the Colony from sources of infection combined with the length of passage of sailing ships were effective barriers to the introduction of

quarantible diseases. The Station was in use only intermittently for the occasional case of cholera or suspected smallpox carried on ships which had shorter distance stops at Fiji or New Zealand.\* Staffing was minimum and untrained in personal prevention and hygiene, and without any experience of coping with major epidemics as occurred in 1881. The breakdown of discipline and pervading panic during this epidemic was inevitable and but an extension of the general fear and revulsion of the citizens of Sydney. Action had to be taken and urgently to review and restore the efficiency of the quarantine facilities and staff.

## The Royal Commission into the Quarantine Station

A Royal Commission to enquire into the management of the Quarantine Station was appointed on the 13 September 1881, under the presidency of John Rendell Street, Vice-President of the Sydney Infirmary (General Hospital), and including as members, Drs. Phillip Sydney Jones, Henry Normand MacLaurin, Frederick Norton Manning, and Mr Francis Hixson, President, Marine Board of NSW.

The Commission's report was scathing in its condemnation of the conditions at the Station, its management and medical supervision. It excluded from its condemnation the hospital enclosure and the care rendered by the nurses from the Sydney Infirmary. Conditions were deplorable especially on the hulk Faraday. Some of the patients were left without nursing; were allowed to wander and injure themselves at night; to go on deck in a naked condition in their delirium; to lie for days in their evacuations; and were denied medical comforts and indeed food, except for such as was prepared for them by convalescent patients.

Discipline throughout the Station was non-existent and staff morale at its lowest ebb. Fear, indeed terror, was predominant. The Superintendent was frequently drunk as were the undertaker's assistants who were provided with spirits to induce them to perform their disagreeable duties. Patients afflicted with smallpox were allowed to mix with persons free from the

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\* It appears that the Station was used only once for reception of smallpox cases since self-government, for the small outbreak of 1877 originating from the steamer Brisbane. The epidemic had a local spread in the vicinity of Millers Point. There were four deaths among twelve reported cases.

disease, and there was a general disregard of treatment and isolation. Nor did the medical staff set an example. Of Dr Michael Joseph Clune (who had been impressed on a temporary basis by the board of Health) the report was disparaging:

“...he failed to discharge his duties towards the patients in a manner which might have been expected of a gentleman in his position. He seldom or never went to the sick wards, was drunk on several occasions and generally depressed(94).”

The Royal Commission had two consequences:

- (i) A revision of standards at the Quarantine Station. The Superintendent was sacked and Dr Alexander Beattie was appointed as resident Superintendent with authority over the Station. Staff were upgraded in numbers and quality and routines for admission, care, isolation and discharge developed and published. Additional resident Medical Officers were provided, Dr Robert Beattie to the hulk Faraday, and Dr Henry Day to the Hospital enclosure. These reforms were permanent and the Station functioned adequately during the smaller epidemic of 1883.
- (ii) Greater emphasis and priority was given by the Government to the development of a second quarantine station at Little Bay, which was to become the Coast Hospital, and which is now the Prince Henry Hospital associated with the University of NSW.

The Coast Hospital was built in nine months by the Department of Works under the personal supervision of the Colonial Architect. It was completed towards the end of the 1881-1882 epidemic and duplicated the facilities at North Head, with separate hospital and isolation (sanitarium) facilities, each being independently and adequately staffed. It was used again as a quarantine station to house smallpox patients from the S.S. Gunga and Memmur in 1883, and when not required for

smallpox isolation it remained empty or received convalescent patients from the Sydney Infirmary and State asylums on a temporary basis. Dr Alexander Beattie was appointed Medical Superintendent in 1882 and resigned in 1883, after which the hospital remained empty. Up to this point it was a unit of the Quarantine Service and under the control of the Board of Health and Colonial Treasury. From 1884 it became a combined infectious diseases and convalescent hospital to cater for the outbreak of typhoid of that year. It was then transferred from the administration of the Treasury to the Colonial Secretary in consonance with the control of general hospitals by that Department. The North Head Quarantine Station was again the only quarantine facility for the State of NSW, still remaining within the administration of the Colonial Treasury and the Board of Health.

### Local government and public health

The *Municipalities Act of 1867* (31 Vic. Mo. 12) provided for control of noxious trades, nuisances, sanitation and infectious diseases by municipal councils incorporated on a voluntary basis in towns with a population of 1,000 or more, following a majority poll of local residents. It empowered municipal authorities to employ inspectors of nuisances, but this

provision was largely in discard, as were other public health provisions, as salaries and other expenses had to be found from rating income. Some were appointed, albeit grudgingly, from untrained labourers with meagre stipends who were often expected to combine their health duties with those of rate collection. Experience during the smallpox epidemic of 1881 indicated that both in the City of Sydney and elsewhere inspections were more efficiently performed by the police.

The powers of the Council of the City of Sydney were more extensive and direct than those involving other Councils relying upon by-laws under the *Municipalities Act*. It had inherited from its predecessor, the Sydney Corporation, control over abattoirs and butcher's slaughter houses in Sydney by the *Act of 1849* (13 Vic. No. 42); over the sale of adulterated meat and unwholesome food by the *Sydney Corporation Amendment Act of 1855* (19 Vic.

The Commission's Report was scathing in its condemnation of the conditions at the Station, its management and medical supervision...

No. 23); and over private and public cesspits and the sewage system of *Sydney by the Acts of 1850* (14 Vic. Mo. 33) and 1853 (17 Vic. No. 34). It had similar powers with regard to nuisances, infectious diseases and public health as other Municipalities under the *Municipalities Act of 1867*.

An early attempt to force the Sydney Corporation to respect its responsibilities in public health was successful in part. In 1857 Dr Henry G. Douglass proposed favourably in the Legislative Council, that the *Sydney Corporation Amendment Act* should be amended to make it mandatory that the Sydney Corporation appoint a qualified medical practitioner as Health Officer for the City of Sydney. Dr Isaac Aaron was appointed and became in effect the first Medical Officer of Health in NSW. He was able and conscientious and pursued his obligations with vigour, criticising the standard of housing and overcrowding in the Sydney slums, which, he stated, combined with the disgraceful disregard of the cesspits and lavatories, were responsible for the spread of disease and the increasing mortality of children up to five years of age. His campaign was taken up by the local press, and notably the Sydney Morning Herald, which further embarrassed the Commissioners (Aldermen) of the Corporation and strengthened their resolve to get rid of Aaron as the most facile solution to the problem. This they did by reducing his salary to a meagre £100 per annum, so forcing his resignation. His successor, Dr G.F. Dansey, was appointed in 1862 with great reluctance because of the statutory requirement. He was less contentious, but even so his services were terminated in 1888 on the excuse that his office was a sinecure.

A further attempt was made in 1867 to extend a similar provision of a mandatory Health Officer to all municipalities with a population of 3,000 or more during the debate on the *Municipalities Act*. This was defeated on the floor of the Legislative Assembly.

The reluctance of local authorities generally to pursue their public health responsibilities, and the attitude of the City of Sydney Council to the employment of Health Officers, were conditioning factors in the policy development by the Board of Health to centralise control of public health administration. And so, until its dissolution in 1973 it controlled the appointment of Medical Officers of Health, the

establishment of Health Regions and the official authorities under which public health personnel worked, irrespective whether they were employed by central government or local government or quasi-governmental Authorities. The capacity of the Board of Health over these activities was included in the *Public Health Act of 1896*, and from that date local authorities were agents of the Board of Health. This was an attitude and administrative device much criticised by local authorities after World War II, when they were anxious to extend their activities in health and welfare services, and equally as vigorously defended by the Board of Health as ensuring impartiality in application of public health legislation and equality of services irrespective of distance and economic resources.

## Commissions and Boards

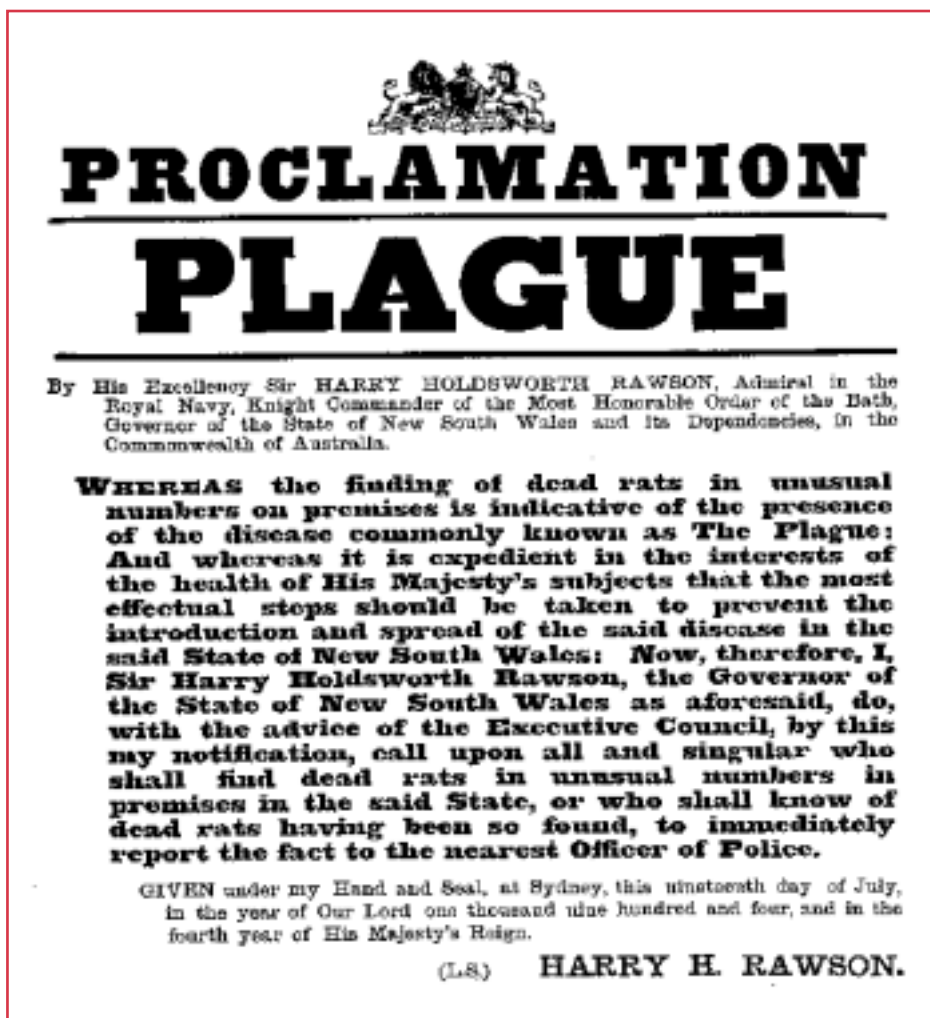
The creation of Commissions and Boards was a device used by the Government of NSW to manage problems of magnitude such as public works, roads, railways, education and some areas with public health significance. Food inspection and control, prior to the *Municipalities Act*, were exercised by the Sydney Corporation in Sydney, and in the larger towns elsewhere by elected Commissioners of Markets under the *Markets Act of 1839* (3 Vic. No. 19). The water supply through the Alexandria tunnel to Sydney was vested in Commissioners under the *Act of 1853* (17 Vic. No. 35), which defined their powers, including authority to extract rates, raise loans, prohibit independent supplies, and prevent pollution of the Sydney supply.

One of the most important of such Boards was the Sydney City and Suburban Sewerage and Health Board, which was appointed in 1875 to advise on the control of city sewers, and on pollution and silting of harbour waters from sewage disposal. It was composed of nine members who were engineers or scientists, including Dr H.G. Alleyne, Health Officer to the Port and Medical Adviser to the Government, and Charles Watt, Government Analyst. Over the next two years it completed a series of investigations and its reports were largely responsible for the *Water Pollution and Prevention Act of 1875* (39 Vic. No. 7) and the *Nuisances Prevention Act* (39 Vic. No. 14) of the same year. It pointed to inadequate and unpoliced building regulations, the disastrous condition of the City's sewerage disposal, to

contamination of its water supplies, and the correlation of these factors with diseases and epidemics. In its final report it proposed a Central Board of Health on the English model:

“The board should have a small membership, not directly subject to central control, because it was obvious that sanitary laws will not be stringently administered by any authority which possessed a dread of unpopularity. The board must be given power to compel(95).”

These principles were included in the *Public Health Act of 1896*. The Sydney City and Suburban Sewage and Health Board had served its purpose well in preparing the way for its successor the Metropolitan Board of Water Supply and Sewerage constituted under the Act of the same name of 1880 (43 Vic. No. 22). With these major public health facilities now controlled the stage was set for an extensive revision of public health laws.





# Public health administration: the genesis of the Board of Health

The morning of the 25 May 1881 was most unpleasant. A gusty southerly was blowing storm clouds across the harbour and the scudding showers were merging into heavy rain. It was a day of gloomy portent for On Chong in his humble abode at 223 Lower George Street. He was an inoffensive Chinaman, one of the many moon-faced coolies who had drifted into Sydney town. At this moment he was worried and bewildered, and oblivious of the chill wind whistling through the broken window pane into his drab and bare bedroom. Its only furnishings were two beds, the one in the corner still disturbed by the feverish tossings of his son throughout the night. He had tried to soothe him these last three nights as his delirium worsened, and pus sores erupted over his face and down his legs and arms. He had watched him grow weaker and his fretful cries sink into a pathetic whimper. And now he had gone, whisked away in haste to the North Head Quarantine Station with the dreaded smallpox. On Chong did not understand the implications nor the inoculation which had been forced upon him. He was more fearful of the reaction of his neighbours, many of whom were resentful of Chinese and the yellow peril which, the broadsheets had proclaimed, were threatening the morality and livelihood of 'white Australia'. He was unappreciative of the historical significance of the event – the commencement of the first major outbreak of smallpox in NSW since the inexplicable outbreak among the Aborigines in 1793.

Nor were the Government and the Medical Adviser unduly alarmed. None of the contacts or associates of On Chong displayed any evidence of the disease, and it appeared that it could be contained by isolating On Chong. But this complacency was to be shattered by the sequences which followed. The State was to be confronted with an outbreak in a population unprotected by vaccination and unprepared for its consequences. Within 20 days more cases appeared in the City suburbs followed by a further outcrop

after a similar interval. Now there was spreading fear and panic. The one doctor experienced with the disease, Health Officer Dr H.G. Alleyne, was absent on sick leave and refused to return to take control. In his absence a meeting of Heads of Departments was hurriedly summoned, and they decided that the Quarantine Station was to be used to isolate patients and those in direct contact with them. In the absence of any smallpox hospital there was no alternative. But even this was not absolute. Patients could be quarantined in their homes if they could afford the daily visit of a doctor and there was no effective law to prevent this. These arrangements were controlled by the Under Secretary of Treasury who used the police force to carry out his decisions.

The situation rapidly degenerated into a shambles. The staff of the Quarantine Station was small, fearful of the disease and loathe to support the patients. Supplies of stores and clothing were insufficient, and the general organisation lacked leadership and was unsuited to the occasion. Transport through the streets and to the Station was inefficient, and circumstances on the Station led to mixing of persons afflicted with smallpox with those who were free from the disease. Morale was non-existent and treatment negligible.

## The Board of Advice

Public panic was unallayed and criticism of the Government vociferous in the press and Parliament. Action had to be taken urgently and a special Cabinet meeting was called on 9 July, by the Premier, Sir Henry Parkes, at which the Colonial Treasurer, Mr J. Watson, and Under Secretary of Treasury, Mr Geoffrey Eager, were present to report on the quarantine law and the administration of quarantine services. The decision of Cabinet was unanimous. An organisation must be established to relieve Treasury of its quarantine administration, and it must

be composed of persons of authority and vested with special powers through these persons, to contain and control the epidemic threatening the security of the State and the future of the Government.

Sir Henry Parkes may have remembered the previous attempt by Dr H.G. Douglass to legislate for a Central Board of Health which would have been a very suitable instrument for the purpose. But the legislation had lapsed and there was no time for special legislation nor any existing which could give executive status to any Committee or Board on this

model. It had to be a Board of Advice only, but one which was strengthened by unqualified Government support and with sufficient funds for the purpose. Because of the latter and the present role of quarantine as a unit of Treasury, the board would likewise be responsible to Government through the Colonial Treasurer.

The Premier was pleased to announce the establishment of a Board of Advice on 11 July 1881, and of the same date the Colonial Treasurer issued a memo to its members setting out its composition and extraordinary powers(96):

**“Subject:**

**Appointment of a Board of Advice to Assist in Preventing the spread of smallpox**

I think it desirable that a number of gentlemen should be appointed as a Board of Advice or Board of Health to advise with and assist the Government in preventing the spread of smallpox; such board to have power to act in cases of emergency and incur expenditure without consulting the Government in cases of urgent necessity to an amount not exceeding £200 – the gentlemen are:

The Mayor of Sydney\*  
The Under Secretary for Finance and Trade,  
The Inspector General of Police,  
The Health Officer,  
The Colonial Architect,  
and Dr Alfred Roberts.

The latter gentleman to be paid reasonable professional fees for attending in such board.

J. Watson.”

Dr Charles MacKellar was appointed in September when he succeeded Dr H.G. Alleyne as Medical Adviser to the Government.

The first meeting was held on 18 July, with the Mayor in the Chair and all attended. Meetings were frequent at weekly or two-weekly intervals as determined by the board at its sittings. It had powers of co-option. The Mayor was Chairman when present, otherwise the board elected a Chairman for the meeting. It met at the Treasury Building at 127 Macquarie Street and existed as a Board of Advice until 31 December 1881, when it was translated into the Board of Health with statutory recognition as such under the provisions of the *Infectious Diseases Supervision Act 1881* (45 Vic. No. 25).

The Board of Advice was vigorous, efficient, and determined in its task of combating the smallpox epidemic for which it was created. In anticipation of its first meeting the Government had made regulations for the conduct of an ambulance and disinfecting staff. The first residence to be disinfected was that of Lum Kum Fry under the supervision of Dr Louis Foncart, Assistant Health Officer to the Port. The disinfectant used was carbolic acid which at that time was in short supply. The Under Secretary for Finance and Trade (Treasury) placed an order for 3,000 gallons on London.

\* The persons involved were: The Mayor of Sydney, the Hon. J. Harris; Under Secretary Finance and Trade, the Hon. G. Eager; Inspector General of Police, E. Fosberg, Esq.; Health Officer Dr H.G. Alleyne; and Colonial Architect, James Barnet Esq.

## The smallpox epidemic of 1881-1882\*

The epidemic lasted from 25 May 1881 to 19 February 1882. The total number of cases was 154 and the death rate 25.9 per cent. Of those treated at home (77 cases) the death rate was 29 per cent. Of the remainder, 52 cases were accommodated at the Sanitary Camp at Little Bay, together with 85 contacts. The Quarantine Station at North Head accommodated 31 early cases and an unknown number of contacts. It was rarely used after the establishment of the additional station at Little Bay (the Coast Hospital). Notification until December 1881, was optional. It appears that the medical profession were reluctant to accept responsibility for voluntary notification. Cumpston records that the reason for lack of cooperation was conditioned by the circumstance that the first two medical men who reported cases were quarantined against their will for some months. They were Dr M.J. Clune and S.M. Caffyn(97). The epidemic was almost entirely contained to the Sydney Metropolitan District, with the heaviest incidence in the poorer suburbs, in which the labouring classes were housed in unsanitary and crowded conditions.

The attack on the epidemic by the Board of Advice was systematic and assisted by powers which were granted to it in August 1881, by Regulation under the *Quarantine Act*, whereby 'the Health Officer and any two members of the Board could compel isolation or remove to isolation any person deemed likely to imperil the public health'(98). It employed its own doctors at a rate of 3.5 guineas per day plus buggy, horse and forage, and appointed Dr A. Beattie resident superintendent of the Quarantine Station at North Head with executive powers over the Station. It issued regulations defining the periodicity of visits by its doctors for the treatment of proven cases and supervision of contacts. It conducted a voluntary and successful vaccination campaign among the general population as well as immediate contacts. For this purpose it appointed public vaccinators from the practising profession who were paid correspondingly. An ambulance corps had been established on 12 July in anticipation of the first meeting of the Board of

Advice. The function of this corps was to convey patients and contacts from infected houses, to coffin and bury the dead and disinfect premises. They were under immediate police control as were also a small number of special constables.

Undoubtedly the major measures responsible for the containment of the outbreak were the vigilance of its medical staff; its statutory capacity to isolate patients and contacts, and its early development of the second quarantine station at Little Bay, where originally tents were used to house patients and contacts, pending the erection of temporary buildings. The wide spaces at Little Bay were effective barriers to the spread of infection, and of the contacts accommodated there only three subsequently developed smallpox.

By November 1881, the epidemic was diminishing and medical staff were being progressively dismissed. The success of the Board of Advice and the public confidence it inspired made its continuation inevitable after the immediate crisis had passed. It was to continue as the Board of Health, the most influential instrument in the administration of health services until the creation of the Department of Public Health in 1941. Thereafter, although still retaining wide executive powers it lacked resources to exercise these powers, which more and more were undertaken by local government and other agencies.

The Board of Advice was vigorous, efficient, and determined in its task of combating the smallpox epidemic for which it was created.

## The Board of Health

The Board of Health was established as a statutory corporation by the *Infectious Diseases Supervision Act* (43 Vic. No. 25). This is a significant although short Act which imposed compulsory notification of infectious diseases on medical practitioners and householders. The only disease mentioned in the Act is smallpox. The first section of the Act created the Board of Health with not less than six members (the same number as the Board of Advice) of whom three were a quorum. It does not define further the qualifications of president or Members. The final section (S4) is most important and was extended in

\* An excellent report of this epidemic is contained in *The Reports and Publications of the Board of Health*, Health Commission of NSW Library Vol. Q614.0981 who were sworn to guard quarantine premises.

the *Public Health Act of 1896*, viz the power of the Board of Health to make its own regulations to prevent the spread of infectious diseases, and to declare districts under the charge of a Government Medical Officer. Although this section was not implemented for almost twenty years it was the basis on which Health Districts and Medical Officers of Health were established, thus setting the pattern of public health administration until 1973.

The first meeting of the board was held at the Treasury Building 127 Macquarie Street, in the afternoon of 13 January 1882. Present were(99):

**George Eager**, Esq., Under Secretary for State and Finance (in the Chair)  
**E. Fosberg**, Esq., Inspector General of Police.  
**Dr George Fostescue** (who died in 1885 and was replaced by Dr S. Knages)  
**Dr C.K. MacKellar**, M.L.C., Medical Adviser to the Government  
**Dr H.N. MacLaurin**  
**Mr Alfred Roberts**, M.R.C.S., L.A.S (Roberts was knighted in May 1883)  
**Dr Arthur West** (who died in 1885 and was replaced by Dr George Marshall)  
 The Mayor of Sydney, the **Hon. John Harris**, was absent as also was the Health Officer of the Port, Dr H.G. Alleyne.

The main business at the first meeting was to receive reports of the waning smallpox epidemic and to authorise an advertisement for a permanent Secretary to the Board. The location of the Board was altered at this meeting when it accepted an offer of more commodious premises in the Department of Public Instruction Building. Mr Alexander Cumming was recommended as Secretary to the second meeting of the Board on the third of February, at which meeting the Lord Mayor occupied the chair, as was usual subsequently when he was present. When not present the Board elected a Chairman until 21 August 1883, when Dr C.K. MacKellar was gazetted as Permanent Chairman in his senior medical position of Medical Adviser.\* So were two precedents established, viz the

Chairmanship of the Board of Health was an appointment held by the Senior Government Medical Officer and the Lord Mayor of Sydney was always an appointment to the Board of Health. Both precedents held until the Board was abolished in 1973, although for two decades or more prior to this date the Lord Mayor rarely attended in person but was represented by his nominee.

The attendances at the board were consistently numerically more than the maximum of six appointed members as permitted under the Act. Some were co-opted by the board and others were officers of the board attending to advise the board. At one stage the latter were designated as informal members. Decisions were the unanimous collective opinion of the formal members and there was no attempt to record details of voting. This became also a precedent which remained in operation until approximately 1968, when the Crown Law Authority requested the board to record the details of individual member's voting for those resolutions which would be translated into *Regulations of the Public Health and Pure Food Acts*.

The principle of medical presidency continued after MacKellar who was succeeded in turn up to 1896 by H.N. MacLaurin in 1885, Frederick Norton Manning in 1889, and T.P. Anderson Stuart, Dean and Founder of the Faculty of Medicine, in 1893. Each of these gentlemen were appointed Medical Adviser to the Government, and for a short period lunacy and public health administrations were combined under Norton Manning. This was coincidental only and was reduplicated, for different reasons, when my predecessor Dr E.S. Morris was appointed Inspector General of the Insane in 1941 while holding the Office of Director-General of Public Health, and I likewise was appointed Director-General of State Psychiatric Services in 1961 while holding the same Office. Both Morris and I were also President of the Board of Health concurrently. When MacKellar resigned as Medical Adviser and President of the Board of Health on 21 August 1885 he was invited to continue as a Member of the Board.

\* Dr C.K. MacKellar succeeded Dr H.G. Alleyne as Health Officer to the Port one year previously in August 1882. He was appointed Medical Adviser in September 1881.

During the period up to 1896 the Board consolidated and improved its image as the statutory and official instrument of public health administration. Its reputation was enhanced by its impartiality and an excellent series of publications under its imprimatur including pamphlets on rules for disinfection, the lactometer, hydatid disease, influenza and cholera among others. After the smallpox epidemic of 1882 and the smaller outbreak of 1883 the Board of Health enjoyed a reputation for expertise which was acknowledged by Government, the medical profession and the public generally. In addition it was the administrative authority that controlled preventive measures against the spread of major infectious diseases, including and commencing with the typhoid epidemic of 1884. It required and received returns from the major hospitals of Sydney of typhoid and other infectious diseases, successfully advised the Government on the role of the Coast Hospital as an infectious diseases hospital, employed medical and other staff to supervise its activities and authority, and conducted several major investigations at the request of the Government. Many of these investigations were carried out by the Medical Adviser with other assistance; while medical and other personnel of the board were appointed to Select Committees, and with other senior Officers of the Board conducted investigations and reported to the Board. The scope of these reports included investigations into compulsory vaccination, the management of the Quarantine Station at North Head, the management of the Sydney Hospital, the smallpox epidemic of 1881-1882, the outbreak of typhoid fever due to polluted milk, the Coast Hospital, Little Bay, the influenza pandemic of 1890, and several others on sanitation.\*

As the Board of Health's official and public prestige increased so was it given more statutory responsibility for the supervision of dairies under the *Dairies Supervision Act of 1886* (50 Vic. No. 17), for the supervision of cattle slaughtering and the hygiene of butchers' abattoirs under the *Noxious Trades and Cattle Slaughtering Act of 1894* (57 Vic. No. 21), and for the control of leprosy under the *Leprosy Act of*

1890 (54 Vic. No. 20). It proclaimed a substantial list of notifiable infectious diseases in 1886, advised the Department of Public Instruction on regulations for exclusion of school children suffering from infectious diseases and carried out sanitary surveys in country towns. The activities of the Board in general sanitation were accelerated after the appointment of Dr Ashburton Thompson as its Medical Inspector in 1885. Ashburton Thompson was appointed also as Deputy Medical Adviser to the Government – a forerunner of things to come.

### *The MacLaurin Report*

Sir Normand MacLaurin was one of the most distinguished Scottish intellectuals whose influence on Australian society was as profound as his contribution to education and medicine. He was a member of the Legislative Council, first Chancellor of Sydney University, a gifted administrator, a distinguished parliamentarian to whom considerable credit is given in restoring financial stability during the bank crisis of 1893. He has been described by his grand daughter(100):

“Analytical, speculative, profoundly serious in mind ...proud, reserved, austere in character like his forefathers ... he was a true product of his country and his generation, a type so remote from the Australia of today as to seem

an almost legendary figure.”

MacLaurin was commissioned by the Colonial Secretary to inquire and report on the sanitary legislation in England during his visit in 1892. He provided a comprehensive report including an excellent historical summary on the development of public health laws in England from the Chadwick Reports on poverty of 1842 and 1843 to the passage and implications of the *Public Health Act of England of 1875* (38 and 35 Vic. c.55) and its implications on local government administration in that country. He illustrated dramatically the beneficial implications of this legislation by reference to comparative tables of death rates and survival rates prior to and following the introduction of the legislation(101).

During the period up to 1896 the Board consolidated and improved its image as the statutory and official instrument of public health administration.

\* A complete list of these Reports is held by the Health Commission of NSW in the publication, *Reports and Publications of the Board of Health*, Q614-0991.

In his conclusions MacLaurin was critical of the fragmented legislation in public health in NSW, and pointed to the attempt by Dr C.K. MacKellar to introduce a consolidating Bill in the Legislative Council in 1885. This had lapsed after the first reading due to a change of Government. He recommended that the Government introduce a measure to Parliament(102):

“...entrancing a full and complete sanitary code including notification and prevention of epidemic disease, prevention of building on unsanitary sites, regulation of common lodging houses, regulation of factories and workshops, prevention of adulteration of articles of food and drink and drugs, and compelling negligent local authorities to carry out the sanitary powers with which they may be entrusted.”

He was appreciative of the deficiencies of Local Government in NSW and was silent on the mechanism whereby these measures might be implemented. Undoubtedly he saw the Board of Health as the administrative vehicle, paralleling the local government Board of England.

The demography and social infrastructure of NSW was in marked contrast to Great Britain and the conditioning factor in limiting the responsibility of local government in the State. Government policy was to distribute essential services to rural areas with quality competitive to urban conurbations, irrespective of economics. So were the administrations of education, police and hospitals removed from local government administration and located in central government. The same policy of central administration with limited local government responsibility was confirmed in the central administration of public health services under the *Public Health Act of 1896* (60 Vic. No. 38).

### The Public Health Act 1896 (60 Vic. No. 38)

The *Public Health Act* was introduced into Parliament by the Premier, Sir George Dibbs. It reconstituted the Board of Health to provide for not less than seven nor more than ten members (inclusive of the President), four of whom shall be legally qualified practitioners. Four members shall constitute a quorum. This formula was not substantially altered in amendments up to 1973.

The Act provided also for right of entry of its authorised officers, the power to institute inquiries on its own initiative, and the power to report any government authority including local government councils and municipalities to the Secretary for Public Works if there was a danger to public health through any action or omission by those authorities. One of the most substantial powers granted to the board was the capacity to make its own regulations unfettered by Ministerial approval. This was a power jealously guarded by the board until its termination in 1973. Its inclusion in the *1896 Act* was a reflection on the confidence the board had achieved by its impartiality and competence in the fifteen short years of its existence.

The Act was specific as to the role of local authorities in the administration of public health – its provisions were to be administered by local authorities with overriding authority of the Board of Health, viz if a local authority was derelict in its duties and did not correct this deficit in three months after notification by the Board of Health, action could be taken irrespective of the attitude of the local authority. The Act provided also for the appointment of Medical Officers of Health who would report to the local authority, but whose salaries would be paid by Government funds and not from local rating. All sanitary reports by a Medical Officer of Health must be referred by a copy to the Board of Health.

Other sections of the Act followed closely the MacLaurin proposals and provided for notification and prevention of spread of infectious diseases; control of unhealthy building land and buildings, unwholesome or adulterated food or drink or drugs; regulatory capacity for registration and control of sanitation of dairies and cleanliness of dairy products supplementary to the *Dairies Supervision Act of 1886* (50 Vic. No. 17); and similar regulatory capacity for cattle slaughtering and abattoirs supplementary to the *Noxious Trades and Cattle Slaughtering Act of 1894* (57 Vic. No. 21).

### The Function of the Board of Health

The Board of Health was firmly established as the instrument of public health administration by the provisions of the consolidated *Public Health Act of 1896*. Two other decisions of importance were taken at this time:

- (i) The position of Medical Adviser to the Government was made the senior position in the administration of public health and was transferred to Dr John Ashburton Thompson as the senior of the Government medical staff. In conformity with the precedent already established he was appointed President of the Board of Health and held this position until his retirement in 1913.
- (ii) The appointment of Dr George Paton as Chief Inspector of Charities under the *Charitable Institutions Act*. The importance of this appointment was that Government asylums were now under medical direction, and the general hospital system and other charities under central medical supervision. Paton's office and staff were not included under Dr Ashburton Thompson and the Board of Health. This was to await another day and opportunity.

After 1896 the Board of Health's functions were both administrative and executive, employing its own staff and working under the provisions of various statutes. It was responsible to the Colonial Treasurer. It absorbed those aspects of health administration which had a public health impact, including the Quarantine Health Service which was under the immediate supervision of the Port Health Officer.

The Medical Adviser was a part-time position until and thereafter the succession of Dr Ashburton Thompson to this post. It was not created under any Act of Parliament nor was the occupant's Presidency of the Board of Health defined in those Acts which established the board's executive powers. Both were government appointments by the Governor in Council. Nevertheless the Medical Adviser controlled the small Medical Department within the Chief Secretary's Department. There was nothing unusual in this precedent even of recent times. It was considered by the Government that the functions of

the Medical Department were routine and undeserving of a full-time appointment, at least until the period when there was need to consolidate the various health acts into the *Public Health Act of 1896*. Even as recent as post World War II the corresponding positions in Western Australia and South Australia were part-time appointments. As President of the Board of Health the Medical Adviser was responsible to two masters, the Colonial Treasurer in his former capacity and the Colonial Secretary in his latter capacity.

Briefly, public health administration in 1896 may be summarised as set out in Table I.

The practical difficulties of such an administration was emphasised by Ashburton Thompson in his report to the Colonial Secretary of the Medical Department in 1899:

"It will be seen... that the occupations of the board and of the Medical Department differ widely in some respects. In other respects they are cognate, though rather in the practical detail of executive work than in a manner easy to describe briefly; in some others they actually overlap; while, lastly the divisions of subjects under the two Ministerial heads seem to be arbitrary rather than rational. It is clear, for example, that public vaccination should be a concern of the board; and, while the Analytical Branch is under the direction of the Chief Secretary, its head, the Government Analyst, is by the *Public Health Act*, an officer of the board."

From 1896 the functions of the Board of Health and the Medical Department were coordinated by the dual appointment of John Ashburton Thompson as Chief Medical Officer to the Government and Medical Adviser (and thereby President of the Board of Health). His position was anomalous being responsible as Head of the Medical Department to the Colonial Secretary through the Under Secretary, and as President of the Board of Health to the Colonial Treasurer direct.

## Table 1

### MINISTERS: The Colonial Treasurer THE BOARD OF HEALTH

#### Administers

*Dairies Supervision Act 1886*  
*Noxious Trades and Cattle Slaughtering Act 1894*  
*Public Health Act 1896*

#### Executes

*Quarantine Acts*  
*Abattoir Act 1850*  
*Infectious Diseases (Smallpox)*  
*Supervision Act 1881*  
*Leprosy Act 1890*  
*Diseased Animals and Meat Act 1892*

#### Miscellaneous

Advice to Minister on referral

#### Establishments

Quarantine Stations Sydney and Newcastle  
Glebe Island Abattoir  
Hospital Admission Depot  
The Lazaret (Coast Hospital)\*  
Microbiological and Pathological Laboratories

### The Colonial Treasurer MEDICAL DEPARTMENT

Examination of candidates for Public Service  
Vote for Relief of the Destitute Sick

#### Police Surgeoncy

The Goal Medical Service  
Government Medical Officers  
Medical Police Work  
Medical Care of Aborigines

#### Public Vaccination The Government Analyst Accountancy

Payment of medical witnesses fees  
for Coroners Courts,  
Police Courts and Lunacy  
Regulation and payment of fees for casual medical  
relief rendered through the police  
Payment of salaries to medical officers in part  
or full time  
Government employment  
Regulation and payment of fees to casual medical  
and nursing relief in epidemics in country areas

#### Miscellaneous

Advice to Minister on referral  
Payment of specialist or other medical fees for  
casual service  
Advice on management of subsidised  
country hospitals

#### Establishments

Chemical Laboratory  
Coast Hospital

\* The responsibility for admission, discharge and financial support of the Lazaret at the Coast Hospital remained with the Board of Health, and after 1941 the Department of Public Health until 1973. Subsidy of the remainder of the Coast (Prince Henry) Hospital was a function of the Hospitals Commission of NSW until it was absorbed into the Health Commission.



This dual ministerial control of medical services was not rectified until 1904, when a formal sub-department – the Department of Public Health was established within the Colonial Secretary's Department. The functions of the Board of Health were transferred in to this Department, and thereafter until its abolition in 1973, the Board of Health ceased to have administrative capacity over staff and services. It retained its executive authority

by virtue of the *Public Health Act of 1896* and other subsidiary Acts which were enacted over the following 65 years. If anything its executive capacity was enhanced after removal of its administrative function, and its image, official and public, remained as the central authoritative and irreproachable instrument in public health. Its enlarged executive authority will be discussed elsewhere.





### **Royal Newcastle Hospital**

Donor, Barry Kinmar gives blood at the  
Royal Newcastle Hospital Blood Bank in 1957

# Public health administration: Chief Medical Officer – Director-General of Public Health

The extent and complexity of the organisation involved in public health administration related to the status and authority of its leader, which in turn was reflected in the title endowed upon him in the public service system. The Medical Adviser was substantially a part-time role, the most important attribute of which was Presidency of the Board of Health. The succeeding positions of Chief Medical Officer and Director-General of Public Health were indicative of expanding authority and responsibility.

## Chief Medical Officer to the Government\*

The process of consolidation of the two medical administrations of the Board of Health under the Colonial Treasury and the Medical Department within the Colonial Secretary's Department was initiated by the creation in 1899 of the position of Chief Medical Officer to the Government, to which Dr John Ashburton Thompson was appointed still retaining his title of Medical Adviser. The public and professional prestige that Dr Ashburton Thompson had developed by his activities as servant and President of the Board of Health, undoubtedly influenced Government to promote him to a position of greater seniority within the public service, in which his administrative and organisational talents could be employed. He was outstanding, a giant among pygmies, and there were no alternative candidates who could seriously be considered as competitors. It was a wise decision, equally as sagacious as that by Henry Parkes to appoint Dr Frederick Norton Manning as Head of Lunacy in 1860.

## John Ashburton Thompson

John Ashburton Thompson was born in London in 1848, the eldest son of John Thompson, a successful solicitor. He graduated a Member of the Royal College of Surgeons and continued his studies in Belgium and Cambridge, obtaining his M.D. at Brussels University and the Diploma of Public Health at Cambridge.

He had practised in London as a general practitioner for some years before visiting Sydney on a health tour in 1884, and was at once appointed to the Government Health Service by Dr C.K. MacKellar, Medical Adviser and President of the Board of Health. He enjoyed a meteoric rise to Chief Medical Inspector and Deputy Medical Adviser in 1885, and President of the Board of Health and Medical Adviser in 1896.

Ashburton Thompson was a diligent student of medical literature, reflected later in his publications, and a practical sanitarian. This latter he demonstrated during his service with the Board of Health, by his excellent and painstaking reports on smallpox; typhoid fever from contaminated milk; the 1891 pandemic of influenza; leprosy in Australasia; and by his appointment to committees of enquiry including the Australian Sanitary Commission on Federal Quarantine (of which he was appointed Secretary); the Pavement Commission of 1884; and the Lead Poisoning Enquiry Board of 1893 among others. His sanitary surveys of this period, eg of Broken Hill, are classics of their type – lucid, thorough and precise, and still valid source documents for the social historian.

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\* The title was variously described as Chief Medical Officer to the Government or Chief Medical Officer of the Government. The latter variant was gazetted for Dr H.G. Wallace in 1952 and for myself in 1958.

He was a gifted administrator, endowed with natural leadership, who foresaw clearly the medical needs of the State and the methods whereby they would be met. His first task, after appointment as President of the Board of Health, was to organise the administration of public health based upon statutory responsibilities. He was co-author with Bernard Wide Q.C. of the first *Public Health Act* and he personally planned all the regulations and administration arrangements. He was sole draftsman of legislation to control leprosy; hygiene of dairies; noxious trades; and innovator of pure food laws on the basis of uniformity between the states, and uniquely later as Royal Commissioner for each state to advise on methods of enforcement.

He was wise in his choice of two trusted lieutenants, Drs. G. Armstrong and R. Dick, both of whom were loyal, dedicated and painstaking public servants who, in turn, were later to occupy his equivalent position of Director-General of Public Health. With the task of organisation settled he was able to devote himself to his professional studies, the first of which was stimulated by the plague epidemic of 1900.

Dr Ashburton Thompson's fame spread internationally through his original work in the transmission of plague. Just as with the smallpox epidemic of 1882, so did the plague epidemic of 1900 evoke widespread official and public excitement and apprehension. But, as distinct from 1882, there was no panic on this occasion and the system of management he introduced was eminently successful. He based his campaign upon his discovery, which was then unique, that epidemics of plague are caused by plague among rats and not by direct transmission from human to human. He declared war on rats and 'for the first time in the world's history, plague, here in Sydney, our ancient and most deadly enemy was beaten'(103). He was lauded throughout the world and addressed learned gatherings in Germany, England and the United States.

His work in leprosy was also widely acclaimed although more theoretical. In 1896 he was awarded the prize offered by the National Leprosy Fund for the best essay on the beginning of leprosy in Australasia. Later he visited Molokai and reported on the organisation of leprosy treatment in Hawaii. His experience there set the pattern for the Lazaret at the Coast Hospital.

Ashburton Thompson's reputation and ability stood in the same stead in public health as did Norton Manning's in lunacy. His career in the public service remarkably paralleled that of Morton Manning although at a later phase. The two were rivals and there is no evidence of any personal friendship between them, but rather each adopted a similar aloof and formal official attitude to the other. This competitive stance extended to their administrations and persisted unaltered for seventy or more years. I understand that remnants still exist in the Health Commission despite the diffusion of identity of the two professional administrations.

Although his latter years were disturbed with ill-health Dr Ashburton Thompson continued as Chief Medical Officer until the age of 65 years when he retired in 1913. He was the prototype of the Victorian era public servant, dour, dedicated, sardonic and humourless, whose sense of purpose and responsibility were absolute. He was comfortable with his senior colleagues and members of his profession, a disciplinarian to his staff and a leader who demanded and obtained obedience. His reputation and dedication made him a trusted servant of Governments, and his personal influence and direction gave a stamp of authority to the Board of Health which was never effaced, and which was a stimulus and inspiration to succeeding Presidents. Unfortunately he did not live long in retirement and died at Haddington Gardens, South Kensington, London in September 1915.

## The administration of the Chief Medical Officer

The status of the Chief Medical Officer within the public service organisation is difficult to define. As President of the Board of Health he was the immediate adviser to the Colonial Treasurer on health matters, reporting direct to the Treasurer and so bypassing his public service superior, the Under Secretary of the Colonial Secretary's Department. As a full-time public servant and Medical Adviser he was on the staff of the Colonial Secretary's Department, and responsible to the Under Secretary of that Department for the supervision and administration of the Medical Department which had expanded in range and variety of services under his administration. He had no responsibility in

lunacy, which was a separate Department; or for metropolitan hospitals; or for charities or State asylums, which institutions remained under a Chief Inspector of Charitable Institutions, and, from 1901, became a separate charitable institutional division under the Chief Inspector of Charities.

The dual Ministerial control of medical services was rectified in 1904, when a formal sub-department – the Department of Public Health was established in the Colonial Secretary's Department, within which were amalgamated the administrative functions of the Board of Health and the Medical Department.\* The location of the services of the new Department was concentrated in the Board of Health building which had been completed in 1899 at 93 Macquarie Street to house essentially the scientific Divisions of the Government Analyst and Microbiological Laboratories. The Chief Medical Officer did not transfer himself or personal staff, and the Board of Health, bereft of administrative function, now held at its meetings in the Colonial Secretary's Building.

Ashburton Thompson was granted the official status of Permanent Head. He was responsible for the whole of the administration of this enlarged Department and this is indicated by the dropping of the term Medical Adviser in correspondence and reports. He was never formally de-gazetted of the title which was awarded in succession to the Directors General of Health who succeeded Ashburton Thompson, including myself. It had no formal connotation although I found it useful to overcome public service procedure and precedent in tendering advice direct to Ministers. It was used formally by the Government on one occasion during my tenure as Director-General of Public Health when I was appointed in that capacity as Arbitrator, between the Department of Mines and the Metropolitan Water Sewerage and Drainage Board, in a dispute over a proposal to establish coal mining in the catchment of the Warragamba Dam.

From 1904 to 1913 the Chief Medical Officer controlled an expanding health service.

From 1904 to 1913 the Chief Medical Officer controlled an expanding health service. The official emphasis on quarantable diseases changed as quarantine facilities were better organised so permitting a concentration on other infectious diseases, including typhoid fever, diphtheria, venereal disease, poliomyelitis and influenza. Compulsory incorporation of local authorities provided for a greater span of sanitary supervision, which was reflected in increased demands on the Hunter River and Metropolitan Health Districts. Maternal and infant mortality rates were high and plans were formulated to assist the nutrition of young babies, which would be reflected later in the establishment of Baby Health Centres and Maternal and Child Health Divisions.

In 1908 the Dental Board and the Bureau of Microbiology were established within the Colonial Secretary's Department but external to the authority of the Chief Medical Officer. The former was in conformity with the policy relating to the Medical Board and the Pharmacy Board, but the latter was a departure from established practice as the microbiological service had previously passed from the Board of Health to the Chief Medical Officer. The reason for a further change was the altered function of the Bureau of Microbiology which was required to service all Government Departments. This arrangement persisted until 1913 when it was again included within the administration of the Department of Public Health. Activities previously conducted by the Bureau on the agricultural side were transferred then to the Department of Agriculture. The Port Health Officer, quarantine services and the Quarantine Station were transferred to the Commonwealth in 1910, and in 1913 control of abattoirs and supervision of the meat industry became a separate section of the Chief Secretary's Department. The year 1913 heralded further progressive changes in health administration, which unfortunately were retarded by the onset of World War I.

\* There is confusion in the use of the term Department of Health and Department of Public Health during the period when the health services were retained within the Colonial Secretary's Department. The confusion was less after 1913 when the alternative 'Office of the Director-General of Public Health' became standard nomenclature.

## The Director-General of Public Health

Two related events occurring in 1913 heralded yet another substantial change in the progress of health administration in NSW, viz the appointment of the first Minister for Health (although in some instances subsequently the portfolio was combined), and the appointment of Dr Robert Paton as the first Director-General of Public Health after Ashburton Thompson's retirement as Chief Medical Officer. Thereafter, until the title ceased to exist in 1973, it supplanted the title of Chief Medical Officer of the Government although the latter still continued as one of the subsidiary titles of Dr Paton and succeeding Directors General. It had a connotation in determining the official status and seniority of the Director-General of Public Health vis-a-vis his counterpart in lunacy, the Inspector General of the Insane. The Director-General of Public Health was also appointed President of the Board of Health, although surprisingly this duality was not confirmed by statute until the *Public Health (Amendment) Act of 1944*.

The Directors General were individuals who were given substantial responsibility and independence of action, although loosely constrained within the public service system. They reacted differently to the responsibilities of their Office in ways which reflected their personalities, professional interests and ambitions. Their loyalties were not solely to the administrative systems in which they served but shared by professional idealism in the unrelenting crusade to protect the health of the citizens of NSW, and to provide a safe and consistent ecology which could be accepted with confidence. As I know well, they were prone to more periods of despondency than elation, more conscious of failure than success, which was often disguised by remoteness and withdrawal. This was reflected, as I was wont to imagine, in the studied and formal portraits which graced the walls of the Board Room of the Board of Health – each starring uncomfortably into the distance with never a quirk of a smile to reflect their humanity. I resisted the temptation to join this 'rogues gallery', the whereabouts of which is now unknown. My tribute I can only express inadequately in short impressions as a background to a better understanding of the administration of this Office.

## Robert Thompson Paton

Robert Thompson Paton was a loyal and dedicated public servant who spent practically the whole of his professional career in the government health service of the State. He was born on 6 March 1856 at Bonnyrigg near Edinburgh. He was pursuing a brilliant undergraduate course at Edinburgh Medical School, when for reasons unknown, he interrupted his course in 1876 and came to Australia. He spent seven years in Australia, Samoa and Fiji, where in each country he spent most of his stay working as an assistant to a medical practitioner. He was stimulated by this experience to return to Edinburgh to complete his course in 1885, in which year he also married, securing later, in addition to his Licentiate qualification, the M.D. of Brussels University in 1885 and the Diploma of the Fellowship of the College of Surgeons in Edinburgh in 1887. After two years as House Surgeon at the Moorefields Ophthalmic Hospital he again set sail for Sydney, where he joined the medical service and was appointed resident surgeon at the Trial Bay (South West Rocks) Prison. His diligence and performance were exemplary and in 1890 he returned to Sydney to become Government Medical Officer and Police Surgeon. For eighteen years he was a conscientious police surgeon, in reward for which he was appointed Inspector General of Charities in 1908. He superseded both W.G. Armstrong and R. Dick when promoted to the position of Director-General of Public Health in 1913.

He was the only medical administrator to become Director-General who did not possess the Diploma of Public Health. He published little, but then he had little time to spare or opportunity for scientific investigation. He was a congenial person, who could be firm and determined when the occasion demanded, and yet was regarded with admiration and affection by his colleagues in the Service. His professional reputation outside the Service was not as substantial as that of his predecessor due in large measure to his retiring character and to his diffidence in associating with professional organisations and meetings. He was a firm believer in State rights and was critical and resentful of the intrusion of the Commonwealth Department of Health into health services of NSW.

Paton served in difficult circumstances when recruitment of professional staff was impeded by the priorities of the Armed Services during World War I. Much of the resources and support, which he could normally expect, was diverted for military purposes. Despite these handicaps he organised successfully against the last major smallpox epidemic from 1913 to 1916. His preparation for the variola epidemic of 1913 was also the basis of the State plan to meet the impact of the pandemic of influenza in 1919, the statistics of which are of a magnitude difficult to grasp by modern health administrators (approximately one-third of the population of Sydney was involved with a death rate of 1.3 per cent, and some 14,000 hospital admissions occurred during its course of 9 months). He became the first Commissioner under the *Veneral Diseases Act of 1918*, and practised privately in venereology for a short time after his retirement. He was very interested in the State asylums and in charitable organisations generally and was personally involved in the development of the Coast Hospital as an infectious diseases hospital and the Waterfall Sanatorium for Consumptives. He was held in affection and respect, and was described 'as always the most courteous and kindest of men' in one of the tributes paid to him on his retirement in 22 April 1921. He died on 17 February 1929, then holding the position of medical consultant to Anthony Hordern and Sons.

Paton served in difficult circumstances when recruitment of professional staff was impeded by the priorities of the Armed Services during World War I.

### William George Armstrong

William George Armstrong was Director-General for approximately three years (1921-1924), a fitting climax to a long career in public health, during which he held the positions of Medical Officer of Health for Sydney from 1898 to 1900, and in addition the post of Health Officer of the City of Sydney from 1900 to 1912 (the combination was the forerunner of the Metropolitan Sanitary District). In 1912 he was appointed Senior Medical Officer for the State of NSW, and was in effect Deputy and successor elect to Paton. He was also lecturer and examiner in jurisprudence at the University of Sydney until 1924. He retained a seat on the Board of Health after his retirement as President, so setting the precedent followed by subsequent Directors General, that the

retiring President was retained for a short period to assist the incoming President by his knowledge and experience – especially in policy and precedents.

Dr Armstrong had the unique honour of being the first graduate from the Medical School of Sydney University. The year was 1888 and there were three graduates. As they were called up alphabetically in that year, Armstrong went first. After a number of years in private practice at Tingha and Bowral he proceeded to England and obtained his Diploma of Public Health at Cambridge. He returned to Sydney in 1898 to enter the Health Department and was the senior appointment of the first two District Health Officers.

His career was not spectacular. He was industrious rather than innovative, sound and reliable, and remembered by medical historians for his contribution to the classical epidemiological study of the influenza pandemic of 1918-1919 with H.A. Smith and J.B. Cleland, and his continued dedicated and concerted action to reduce infant mortality. He introduced the first Health Visitor to the City of Sydney in 1904 to visit and advise the mothers of all newly born babies in infant care. His pamphlet *Advice to Mothers*, in which he advocated breast feeding to reduce infant mortality from gastroenteritis was distributed to all mothers throughout the State after birth registration.

He has been described as a magnanimous man, a gentleman under all circumstances, and a doctor whose long life was activated by the highest ideals of his profession. Although never a robust man, he lived beyond his allotted span and died in 1942 at the age of 82.

### Robert Dick

Robert Dick during his long period of occupancy of his office from 1924 to 1934 never enjoyed the same opportunities and support as did his predecessors. He was preoccupied with deployment of meagre resources constantly strained by recurrent epidemics and further dampened by the great depression. His training in public health was traditional and extensive, although limited geographically to the Newcastle-Hunter River

Combined Sanitary Districts, to which he was appointed as one of the first two full-time Medical Officers of Health in April 1898. Thereafter he served until his promotion to Senior Medical Officer of Health immediately prior to his appointment as Director-General of Public Health. He was one of the few Medical Officers who were permitted to undertake army service during World War I. Undoubtedly the reputation of the Department suffered during this period, especially in the eyes of the medical profession, and public health was no longer sought as a desirable vacation in medicine. He died on 31 October 1943.

### Emanuel Sydney Morris

I served under my two immediate predecessors – briefly and in the role of a Scientific Director under E.S. Morris during the years 1950 to 1952 and Deputy Director-General of Public Health to H.G. Wallace from 1952 to 1959. My comments are subjective impressions, and in some instances judgments of my short association with each. It is embarrassing to record the personality and ethos of one's colleagues whose descendants are still living, and I apologise should any such impression appear to diminish their image.

They were of a mould that I envied and could not emulate – examples of the 'grand' school of public health administrators, gentlemen of culture and professionals with deep knowledge and extensive experience. Both had experienced the dismay and pessimism which pervaded the apparently fruitless campaign against the ravages of infectious diseases, which, prior to World War II filled the whole horizon of preventive medicine. Each had the satisfaction of witnessing the dramatic success of this campaign in the immediate postwar years.

E.S. Morris was a Quaker, a kindly man who faced his world with understanding and deep spiritual conviction. He was never self-effacing and demanded from his equals and superiors the attention and degree of deference that he considered his due as Director-General. His mode of friendly greeting was 'Brother', into which he could inflect with unmistakable clarity the amount of familiarity which he would permit in return. Paradoxically, although he was of sober habits and clipped of speech, he was one of the best raconteurs and after-dinner speakers, with a risqué turn of phrase, than I have

heard.

I remember him with affection towards the end of his career – a small man with bowed sabre legs and a large head from Paget's disease. Although there were periods when he was quiet and tired, he rarely complained about his health except obliquely in his desire for tranquillity of retirement. Despite his disability he was never grotesque and emanated a personal aura of authority that commanded respect. 'Sid' he was behind his back, but never to his face except occasionally by the Minister or Chairman of the Public Service Board or his most senior colleagues when social circumstances were appropriate. But never officially.

He devoted the whole of his professional life to Government service. Born in 1887, he graduated M.B. in 1911 and Ch.M. in 1912 from Sydney University, after which he joined the Victorian Mental Health Service. His training in psychiatry was interrupted by service in the A.A.M.C. during World War I. He did not persist after demobilisation and turned towards public health and preventive medicine which was to remain his lifetime dedication, despite his appointment as Inspector General of Mental Hospitals in 1942 upon the establishment of the NSW Department of Public Health. In 1920 he obtained the Diploma of Public Health at Sydney University and was appointed Director of Public Health in Tasmania. There he developed an interest in maternal and infant health which enabled him to win the B.M.A. Prize of 1925 and the M.D. by thesis of Sydney in 1926. He was appointed Senior Medical Officer and Director of Maternal and Baby Welfare in the NSW Health Service in 1924 and succeeded Robert Dick as Director-General in 1934. His higher degree and official position made him an obvious choice to become one of the Foundation Fellows of the Royal Australasian College of Physicians in 1938, in which year he achieved the Fellowship and Presidency of the Royal Sanitary Institute in NSW.

He was not a team man but an individualist who was dominant as Chairman of committees but never comfortable in the subordinate role as member. He overawed the Board of Health whose meetings rarely lasted more than thirty minutes under his Presidency. His prestige as the senior of the public health administrators of the States and Commonwealth enabled him to adopt an influential



attitude at meetings of the National Health and Medical Research Council which pre-empted the Chairman's authority. I remember being present at one such session in 1951 as an observer. He sat throughout with his gnome-like head supported on his clasped hands above a small leather suitcase upturned on the table. If the discussion was prolonged he gave the impression that he was dozing fitfully, and was prone to interject with his usual summary:

"Yes, Brothers, another pious resolution!"

At that session to meet his convenience, and without any demur, a good half of the agenda was deferred until the next meeting so that he could make an early departure.

He was author of the report that led to the creation of the Department of Public Health as an independent Department in 1942 by transfer of all health services from the Chief Secretary's Department, yet he accepted loyally and without demur the decision to appoint his Secretary as Under Secretary and Permanent Head. Circumstances, in the advent of World War II, denied him the opportunity to display his administrative ability to the full. He was never happy in his additional appointment of Inspector General of Mental Hospitals, which diverted his time and enthusiasm from his public health administration. Although he was blamed for the declining reputation of his Department and its image in the eyes of his profession, he served in troubled times, when support was meagre and resources extended. After his retirement in 1952 he accepted appointment as Medical Officer to the Reception House for some years. He died on 31 August 1957.

### Hugh Gilmour Wallace

Hugh Wallace was a quiet diffident person, whose serious mien could change with a whimsical smile as he discoursed widely and variously on literature and the arts. The son of an erudite father, he spent his immediate post school years in Lyons with French relatives, so intensifying his capacity for literature and languages and appreciation of wine. He graduated M.B., B.S. in 1920 from Melbourne University and obtained his Diploma of Public Health from the same

University in 1923, after which he chose public health as a career, serving initially in New Guinea and then in NSW as Medical Officer of Health, Newcastle. He was posted to Sydney as Senior Medical Officer of Health and Director of Tuberculosis in 1934. The position of Deputy Director-General of Public Health was created for him in 1942 when Morris assumed his additional responsibility in mental health. Morris was so involved in the psychiatric services as Inspector General of Mental Health, that Wallace was in fact the senior administrator in public health. He succeeded Morris as Director-General in 1952.

He was not ambitious and I suspect he was happier in his previous roles of Senior Medical Officer of Health and Director of Tuberculosis where he could apply his professional expertise to the tasks in hand. He was indecisive and avoided problems especially where personal conflict was apparent. He could not delegate responsibility and his workload was so burdensome that he constantly continued far into the night and rarely took holidays. I remember that in my first years of Deputy Director-General I saw him only infrequently although we occupied adjacent offices, and even more rarely was I entrusted with even routine work in public health. It was a difficult period to which I contributed by my brashness and impatience which further estranged our personal relations. He was suspicious of my inexperience and I was frustrated in my attempts to overcome this obstacle due to his boycott. It was during this period that I had the opportunity and leisure to develop my interest in medical history.

His personal and gentlemanly qualities earned him the respect and loyalty of his colleagues, who regarded him not so much as their executive superior, but rather as a cultured and experienced exponent of public health practice. His last years were clouded by the tragic circumstances surrounding his wife's death to whom he was deeply attached. He died in January 1968.

### Cyril Joseph Cummins

The time has come which I have long avoided when I must speak of myself. I am no biographer of others and I have less inclination nor intention to write my own.

H. G. Wallace's personal and gentlemanly qualities earned him the respect and loyalty of his colleagues...

“I am! Yet what I am who cares or knows?”

It is with diffidence and embarrassment that I arrive at my term of Office. That which I record as not with overtones of self-aggrandisement, or to publicise my performance, or invite comparisons with my predecessors lest ‘my friends forsake me like a memory lost!’. But rather I will catalogue some of the events in which I have been involved, sometimes as innovator but more frequently as participant or observer. There is much with which I am proud to be associated. There is also the discord of disappointment.

I was born in 1914 the youngest child of humble parents who sacrificed much for my university education. I graduated M.B., B.S. from Sydney University in 1937 and had two years’ hospital experience before I joined the Royal Australian Air Force at the commencement of World War II. In this service I had my first experience of administration as Commanding Officer of No. 3 R.A.A.F. Hospital. This opportunity was fortuitous. There was but a handful of doctors in this Service when I enlisted, and rapid expansion saw us all promoted to command rank and thrust prematurely into areas of substantial responsibility. My taste for medical administration was stimulated at the expense of personal medical practice, and after the War I took the opportunity to undertake the most appropriate post graduate qualification, viz the Diploma of Public Health at Sydney University. Thereafter my career was decided and I concentrated first upon industrial medicine as a private consultant for some two years, an experience which qualified me for my entry into the Department of Public Health as Director of Industrial Hygiene in 1950. I was promoted to Deputy Director-General of Public Health in 1952, and succeeded H.G. Wallace as Director-General on the 8 November 1959. I was also appointed Chief Medical Officer of the Government, President of the Board of Health, Inspector General of Hospitals and Charities, Commissioner under the *Venereal Diseases Act* and Inspector under the *Anatomy Act*. I continued until the Office of Director-General was abolished in 1973 to make way for the Health Commission of NSW. For some eighteen months thereafter I remained in a supernumerary post as Medical Adviser to the Government with equivalent salary and personal staff until I reached the age of 60 and retired. The post was a sinecure to see out my time at my request and had no administrative

connotations nor any relationship to the historic title.

I served under three Chairmen of the Public Service Board and four Ministers of Health, through times of crisis, scandal and drastic reorganisation following the Royal Commission into Callan Park Mental Hospital; the prolonged period of consolidation and development thereafter; culminating in yet a further reorganisation following the *Eglington Report* and the consequential *Starr Committee Report of 1969*.

After the Royal Commission into Callan Park Mental Hospital I was appointed Director-General of State Psychiatric Services on 1 April 1961, and retained the position until I resigned from it in 1963. The circumstances leading to my resignation are elaborated in the chapter on Psychiatric Services.

During my term of Office I was fortunate to enjoy the confidence of Mr Wallace Wurth, the Chairman of the Public Service Board, and the Government of the day during the period when the Hon. W.A. Sheahan was Minister. I was given, temporarily, authority and privileges which were unique in the public service system. During 1961-1962 I was permitted to recruit key professional staff and propose salary levels, and determine terms and conditions of service, a situation quite foreign to other departments and government authorities. I am proud that I was associated with the recognition of the value of personal research within departmental service units; with the development of research units accredited by universities; with the location of psychiatric units in general hospitals, and the establishment of geriatric and psychogeriatric units, both within and external to the Department of Public Health; and with the Health Advisory Council, which was the agent of change.

For a further decade prior to my retirement I had the opportunity to participate in the reorganisation of the professional, administrative and service sectors of the Department. The planning was a combined and coordinated project under the guidance of the Under Secretary of the Department, Mr J.D. Rimes. During this decade, in the realm of my administration, a Bureau of Maternal and Child Health was constructed from the Divisions of Maternal and Baby Welfare and the School Medical Service; the Division of Venereal Diseases was upgraded to a Division of Epidemiology, and new Divisions of Maternal and Perinatal Studies and the

Cancer Registry were established, the only such of their type in Australia. Equally significant changes were made in the organisation of psychiatric services by a similar pattern of coordinated planning by the Under Secretary and senior psychiatric officers.

I could enumerate other changes but this would be repetitive of the text of other chapters. Perhaps if I was to nominate my personal rewarding appointments these would be President of the Board of Health, Chairman of the Health Advisory Council, my membership of the Expert Committee of Public Health Administration of the World Health Organisation and my position on the National Health and Medical Research Council and the Public Health Advisory Committee of that Council. My appointment to the Bright Committee to review medical services in South Australia was a most stimulating experience, and was also my subsequent survey of health laws in Tasmania during my supernumerary period.

Throughout my term of office as Director-General I moved among and identified myself with my profession without conflict of loyalty, although these were difficult times when the profession's attitude to Government Health Services was conditioned by its campaign to maintain a National Health Service in which free enterprise predominated. In retrospect I have no regrets about the career I chose and my decision to retire rather than participate in the Health Commission of NSW. My attitude and principles to public health and preventive medicine were too rigid and adjusted to an era of public health which was changing. The commission needed younger disciples with an enthusiasm for change, and a sense of urgency and impatience. I seem to recollect Hugh Wallace saying something similar at his farewell, and I hope that I was one such in the yesteryears to play a modest role in the progressive development of public health administration in NSW.

## The administration of the Director-General of Public Health

Although there may be argument whether Ashburton Thompson was proclaimed or accorded the status of a Permanent Head, there is no doubt that the first and subsequent Directors General, up to 1938 were formally granted this status. From 1913 to 1938 the Under Secretary (and also Permanent Head) of the Department of Public Health within the Chief Secretary's Department was the Under Secretary of the latter. It was not unusual in those days to have one Permanent Head as Under Secretary for several Departments. Within the Chief Secretary's Department the position was reversed. There were three Permanent Heads for the purpose of the *Public Service Act*, the other two being the Director-General of Public Health and the Inspector General of Mental Hospitals. This enabled the professional Heads to have direct access to the Minister on professional matters and to report to him. They controlled their own staff and had the capacity of 'hiring and firing' (subject to any limitations of the Public Service Act and policy).

Budgetary appropriation and control for the Chief Secretary's Department, including the professional sub-departments, was the responsibility of the Under Secretary of the Chief Secretary's Department.

The situation is clear after this date. In 1938 Mr E.B. Harkness retired as Under Secretary of the Chief Secretary's Department and Mr C.J. Watt, who had succeeded as Secretary to the Director-General and Secretary of the Board of Health in 1935, was appointed Under Secretary and Permanent Head of the Department of Public Health. This was forecast when C.J. Watt had been previously seconded to a special post of Senior Administrative Officer to the Minister. The Department of Public Health was now



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(L to R) Lordship Bishop Freeman  
Dr C. Cummins, Dr A.G. McManus

completely separated from the Chief Secretary's Department, and the designation of Permanent Head applying to the Director-General and Inspector General was withdrawn. It is quite definite that neither H.G. Wallace nor myself were formally gazetted as such. Many of the privileges of a Permanent Head still remained with us including the gold pass and salary levels, and there was always a tacit recognition of equality by other Departmental Permanent Heads with invitations to social gatherings limited to this group.

In the latter half of my regime the Public Service Board made it obvious that it was willing to permit the Director-General of Public Health to enjoy an equivalent although unofficial status similar to a Permanent Head, which was senior to other professionals in the Department but responsible to the Under Secretary as the official Permanent Head. This principle of status was a subject of conflict with the Under Secretary, and more and more I was dependent upon my role as President of the Board of Health in seeking Ministerial contact and independence of communication in professional matters to the Commonwealth, other States and external agencies. Much depended upon the Minister's attitude. I enjoyed a wide freedom of approach during the Ministry of W.A. Sheahan on a personal basis, which was denied by his successor, A.H. Jago, who insisted upon formal lines of communication through the Under Secretary of the Department, Mr J.D. Rimes. The latter was also demanding of this formality, and often remarked that never again after my tenure would a Director-General be other than the senior medical administrator. It was a cause of recurring friction, mainly covert, as we were each as stubborn in upholding our privileges, traditional in my case and formal and official in his. It remained an issue of consequence and was regarded as such by professional versus administrative staff. It was a principle of ideology that professional administrators were capable of controlling a professional Department. The principle was a live issue in other Departments as well as the Department of Public Health, and was jealously guarded in some.

There were two broad areas of administration for which the Director-General was responsible, although each varied in content and emphasis as the organisation of the Department developed in response to social and technical needs. These were the administration of the traditional public health service dependent directly or indirectly upon the executive powers of the Board of Health, and the administration of certain institutions, and scientific and service health divisions.

Until World War II infectious diseases and their aftermath and sanitation were the significant factors in determining the content and form of administration of the Director-General of Public Health. The principles on which this aspect of administration was based were laid down in the *Public Health Act* and associated Acts, including among others the *Pure Food Act and Local Government Act*, and the Board of Health was the instrument which gave statutory capacity to the streams of administration.

The Director-General remained by statute President of the Board of Health which was limited to ten members, four of whom had to be medical practitioners. Appointment was by Ministerial selection and, until 1963,\* was for life with an annual stipend of £200 per annum. Consistently the Lord Mayor of Sydney (or his nominee) was granted appointment, and likewise the Mayor of Newcastle and the Deputy Director-General of Public Health after the establishment of that position in 1942. Membership was a sinecure, attendances were irregular, business was conducted by appraisal of schedules which were a formality and the role of the Director-General as President was dominant. I remember one very famous doctor, who had been twice Vice-Chancellor of Sydney University and appointed to the board in 1914, who was still attending in 1952 in his extreme old age and blind, with an attendant to lead him to the door of the board room.

I was determined that the Board of Health should conduct its business responsibly and that its Members should participate in its deliberations as

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\*The Public Health Act was amended to provide for term appointments of three years and retirement at the age of 70. A fee was paid for each attendance.

well as its decisions. Until 1959 minutes of the board were not distributed on the pretext that they were confidential, and agendas and schedules were tabled for the meeting. I adopted the attitude as President that I should guide the board and not dominate it, that Members should be appointed for the personal contributions they could make, that minutes and agendas should be distributed at least seven days prior to the meeting, and that specialist officers should be available to advise the board on specific issues. Despite any criticism on the past of its performance, there was no doubt of the loyalty of individual members to the board, despite their political affiliations which were often the criteria for appointment. It was a responsible body, resistant on several occasions to Ministerial pressures, and dedicated to the preservation of the public health of the State. It became redundant and was ultimately dissolved about one year after the formation of the Health Commission. It was then an advisory board.

Of the other titles of the Director-General the most significant in terms of immediate administrative responsibility was that of Inspector General of Hospitals and Charities. This responsibility had been granted to Robert Paton in 1908 and remained with him when he became Director-General in 1913. It was the authority on which the Director-General administered the State hospitals until the creation of the Division of Establishments. In 1963 the Public Service Board directed that the administration of State hospitals was to be the responsibility of the Division of Establishments. The title was not withdrawn from the Director-General. Any role the Director-General played in supervising general hospitals became redundant after the formation of the Hospitals Commission in 1929. The development of State hospitals is discussed elsewhere.

The other major component of the Director-Generals' administration was the scientific and service Divisions. The importance of the Divisions and the magnitude of their administration increased

as the significance of infectious diseases decreased after World War II. Even after the appointment of a Director of State Health Services the Divisional Directors still referred to the Director-General for sympathetic understanding of their ambitions. The Divisions were the main group which reverted to my direct administration after I resigned as Director-General of State Psychiatric Services and resumed my active role as Director-General in 1963. Undoubtedly I was more secure and comfortable in my association with the Divisions which reflected my practical inexperience in traditional public health and my interest in scientific medicine. The competition for resources between the ambitions of the Divisions and the psychiatric services in later years was a focus of friction between my administration and the Under Secretary, who rightly or wrongly was considered to favour the latter because of his interest in institutional administration.

The commission needed younger disciples with an enthusiasm for change, and a sense of urgency and impatience.

Apart from these set patterns of administration, the Director-General was Chairman or member of other boards and committees within the Department such as the Nurses Registration Board, the Special Committee Investigating Maternal Mortality (now the Maternal and Perinatal Mortality and Morbidity Committee), the Pure Food Advisory Committee, the Poisons Advisory Committee, other committees on radiation, water and air pollution etc and enjoyed membership of Commonwealth committees and particularly the National Health and Medical Research Council and its major sub-committee, the Public Health Advisory Committee. During my period of Office I was also privileged to undertake assignments for the World Health Organisation, including membership of its Expert Committee in Public Health Administration.

The administration of the Director-General of Public Health is not complete without a brief consideration of the position of Deputy Director-General of Public Health and Director of State Health Services.

## The Deputy Director-General of Public Health and Director of State Health Services

The position of Deputy Director-General was created in 1942 to relieve Dr E.S. Morris of the administration of public health services, so that he could concentrate on the obligations of his dual appointment as Inspector General of Mental Hospitals. Dr Morris retained the Presidency of the Board of Health, his appointment to the National Health and Medical Research Council, and several other statutory appointments to Boards and committees. There was no statutory provision for formal delegation of authority to the Deputy Director-General.

In 1961 when the duality of appointment to Public Health and mental health was duplicated, the various public health Acts were amended to enable formal delegation of function and authority to be made to the Deputy Director-General, whose title was then changed to Director of State Health Services. He enjoyed a status equivalent to that of the Director of State Psychiatric Services. Dr E.S.A. Meyers had been appointed Deputy in 1959 and was the first and only Director of State Health Services. From 1961 he carried out the administration of public health with a delegated statutory authority normally reposed in the Director-General. After 1963 I assumed administration of the Divisions and the Private Hospitals. Following Dr Morris' example I had always retained the Presidency of the Board of Health and the appointment to the National Health and Medical Research Council.

## Public health administration: Health Districts, Divisions and Branches

The development of public health administration is reflected in the growth of Public Health Divisions and Branches, each catering for specific components of service. Historically their growth covers three epochs corresponding with major changes in organisation. The first was of short duration from 1882 to 1904 when the executive authority of the Board of Health was singular and unchallenged. The board was established shortly after Pasteur had demonstrated the microbial theory of

communicable diseases, and in an era when the biological sciences were the least developed of the physical sciences. Its needs for assistance were minimal and related to analytical chemistry for water supplies and sewerage, complemented after 1896 by microbiology in discharging its functions of supervision of nuisances and the control of quarantine and infectious diseases. More typical of the board's divisional activities was the establishment of two Health Districts in 1898 servicing the Hunter River and Metropolitan areas. In this epoch the responsibility and loyalty of its Divisions was to the Board of Health as an independent Statutory Authority and not to the public service generally.

The second epoch was also of brief duration from 1904 to 1913, and coincided with a more restrictive role of the Board of Health and a wider area of responsibility of the Chief Medical Officer of the Government. This was illustrated in the transfer of the functions of the Board from Treasury to the Colonial Secretary's Department and the upgrading of the status of the Chief Medical Officer. It was a transitional period wherein new Divisions were appearing, under the control of the Chief Medical Officer, although on some occasions, as with the Bureau of Microbiology and the Dental Board, they were within the organisation of the Colonial Secretary's Department but outside the administration of the Chief Medical Officer. The incorporation of Federation in 1901 was also influential in a further disturbance of function when port health services and quarantine were transferred to the Commonwealth in 1913. Likewise in 1913 control of abattoirs and supervision of the meat industry were transferred from the Board of Health to become a separate section of the Colonial Secretary's Department. The Chief Medical Officer controlled an expanding health service which was loosely organised.

The final epoch extended from 1913 to 1973 consequent upon the establishment of the Ministry of Health and the position of Director-General of Public Health. The mechanism now existed to aggregate the health components within the Colonial Secretary's Department into an organisation catering largely for public health and lunacy, but providing also for administrative control of other services, such as the Pharmacy, Medical and Dental Boards, which did

not fit functionally within either of the two main streams. The Board of Health was now restricted to the exercise of a limited executive function and had no immediate responsibility for services flowing from such function. Lines of communication and responsibility were well defined and the loyalty and control of Public Health Divisions was to the Director-General of Public Health by virtue of his position in the public service. The responsibility for Health Districts was never wholly clarified although the Board of Health in its executive capacity was still influential. There was no administrative conflict as the Director-General accepted this position proudly and with loyalty to the board. It was during this period, and especially after World War II, that there were explosive advances in medical technology and science. The capacity of the Director-General was inadequate to the task of directing and coordinating increasing demands for public health services of increasing complexity. The need for expertise and specialisation was met by an increase in scientific and service Divisions and Branches. The development of Divisions and Branches will be discussed under two headings: Health Districts and Public Health Divisions.

## Health Districts

The *Public Health Act of 1896* became operative on 1 January 1897. The Act was practically a local government measure, its administration being placed in the hands of municipal councils of municipalities, and, in unincorporated areas, such Officers of Police as were authorised by the Board of Health. The relationship of the Board of Health is 'that of a supervisory authority; though where a local authority fails to exercise any powers or perform any duties conferred or imposed on it, the Board of Health may exercise such power if of opinion that failure on the part of the local authority is likely to endanger the public health'. (Section 16)(104): Section 10 provided for the appointment by the Governor of Medical Officers of Health, and the first two so appointed in 1898 were

Dr Robert Dick, M.B., Ch.M.(Syd), D.P.H.(Camb), to the Hunter River Combined Districts, and Dr W.G. Armstrong, M.B.(Syd), D.P.H.(Camb) to the Metropolitan Combined Districts.\* At the date of establishment, in Newcastle there was a total population of approximately 66,000 throughout 19 local authority districts, and in the Metropolitan District 450,000 approximately extending to Parramatta in the west, Vaucluse in the east, Hurstville in the south and Willoughby and Hunter's Hill in the north. It is interesting that such suburbs as Ryde, Bankstown, Canterbury, Kogarah and Lane Cove were classified as Rural Districts.

The initial Health Districts were based on the English model and essentially were detached units of staff, under a Medical Officer of Health, to provide professional expertise and inspectorial assistance to local government. They were constrained within the boundaries of a number of local government areas, and both boundaries and Medical Officers of Health were approved by the Board of Health. The provisions of the first *Public Health Act*, and the principles on which health districts were established in 1898, remained unchanged in theory and application until the abolition of the Board of Health as an executive health authority by the *Health Commission of NSW Act of 1972*.

The criteria were explained to me by Dr H.G. Wallace. The district to be proclaimed should have a population density which would warrant the employment of a Medical Officer of Health, preferably 100,000 or more. The area involved should be compact and contained within local government boundaries so as not to hinder personal communication between the Medical Officer of Health and the local authorities. A rough guide was that no portion of the boundary should be more than one day's travel from the centre of the health district. Although this was satisfactory in the days of horse and rail, or early motor car and rail, it was still the guideline applied by the Board of Health when the Riverina Health District was under consideration in 1965.

The position of Deputy Director-General was created in 1942 to relieve Dr E.S. Morris of the administration of public health services, so that he could concentrate on the obligations of his dual appointment as Inspector General of Mental Hospitals.

\* They were known as Combined Health Districts because they were the combination of a number of local government Districts. Later they were known as Metropolitan Health District and Newcastle Health District.

Additional Health Districts were established whenever the Director-General of Public Health considered that the population and needs of a country region warranted a full time administration. From the 1960s there was some pressure from the Regional Planning Authority of NSW to proclaim Health Districts to coincide with regional boundaries. Whenever possible conformity was reached, bearing in mind that Health Districts had to relate to local government boundaries, which was not an obligation imposed upon regional planning.

From 1968 attempts were made to coordinate district public health administration with public hospitals by associating the District Officer of the Hospitals Commission with the Medical Officer of Health in the same office complex. Although it could not be claimed that this experiment was successful it laid the basis on which Health Regions were structured under the *Health Commission Act of 1972*.

The Health Districts in NSW, and the years of their incorporation by the board of Health were:

- The Hunter River Combined Health District 1898
- The Metropolitan Combined Health District 1898\*
- The Broken Hill Health District 1916
- The South Coast Health District 1947
- The Richmond-Tweed Health District 1947
- The Mitchell(Western) Health District 1947
- The North Western Health District 1962
- The Riverina Health District 1965
- The Western Metropolitan Health District 1969

The far western area of the State, largely inclusive of the Western Lands Division, was never proclaimed a Health District because of its sparse population and size. From 1963 I, unofficially, provided service to this area working in conjunction with bordering Medical Officers of Health and their staffs.

The local government Municipalities and Shires included in the Health Districts are given in Appendix 6, together with the Medical Officers of Health who were appointed to administer these Districts.

## Medical Officers of Health

The Medical Officer appointed had to be a doctor experienced in sanitation and preventive medicine and this was tested by the qualification of the Diploma of Public Health. This Diploma has always remained an essential qualification for appointment and accreditation by the Board of Health. In the twilight of the last quarter of the nineteenth century and the first quarter of the twentieth century the only opportunity to obtain this diploma was to attend a course in England. As a consequence the number of qualified persons in NSW was minimal and this undoubtedly had an influence on the delay in establishing more Health Districts until after World War II. When facilities at the School of Public Health and Tropical Medicine were available for the Diploma of Public Health at Sydney University, the Department of Public Health supported this institution with postgraduate scholarships. After representations by Dr E.S. Morris, Director-General of Public Health, to the then Chairman of the Public Service Board, Mr Wallace Wurth, a policy was established that at least one Medical Officer from the Department would be seconded for one year to undertake the Diploma at Government expense. Dr Morris' representations were very vigorous and forthright including a caustic description of the salaries and incentives to join the Department, as 'attracting only drug addicts or alcoholics and usually combinations of both'. Wallace Wurth, who was totally absorbed in the reputation of his public servants, agreed to a minor hierarchical system whereby doctors obtaining the Diploma of Public Health would be promoted to Assistant Medical Officers of Health, with a line of succession to Medical Officer of Health and theoretically to Deputy Director-General and Director-General of Public Health. The two Health Districts of Newcastle and Metropolitan remained senior in salary and status compared to others throughout the State, with the Metropolitan Medical Officer of Health most senior with immediate expectation of next appointment to Deputy Director-General of Public Health.

\* A plan was prepared in 1968 to divide the Metropolitan Health Districts into the Western, Southern, Northern and Central Metropolitan Districts Only one such, the Western, had been established by 1972.



The role of Medical Officer of Health and his relationship vis-a-vis to the Department of Public Health, the Board of Health and the Local Government Authority has been confused and at times contentious. There was no doubt that the first appointments were intended to occupy an independent position to the board of Health, although they were permanent public servants and their salaries paid through the Health Department of the Colonial Secretary's Department. Dr Armstrong describes their duties and responsibilities in 1899, and this description is a fair summary of the position as existed certainly until 1913 and probably later:

"The medical officers of health are not officers of the board of Health, but occupy a purely municipal position. Their duties are, in brief, to advise the local authorities of their districts in all matters affecting the public health, and on all sanitary points involved in the action of local authorities; to keep themselves informed respecting all influences affecting, or threatening to affect, injuriously the health of their districts; and to inquire into the cause, origin and distribution of disease. They are required to make an annual report for each year, and to make additional reports to local authorities on any sanitary matters when requested to do so by the local authorities, or without such request if the medical officer of health considers such report desirable. The local authorities are required by law to furnish copies of all reports received from the Medical Officer of Health to the Board of Health (105)."

The two Health Districts of Newcastle and Metropolitan remained senior in salary and status compared to others throughout the State...

The appointment of the first Minister of Health and Director-General of Public Health in 1913 was a period of reorganisation and audit of public health services. There was now a professional leader with personal responsibility for public health administration as distinct from his executive role as President of the Board of Health. Likewise, a career service of status and merit was now available within which Medical Officers, and particularly Medical Officers of Health, could aspire to senior positions. The Medical Officers of Health saw themselves as senior officers of this system and their loyalties were directed, and encouraged to extend, towards the

Director-General of Public Health and the Public Health Department rather than to local authorities. They were Officers of the Public Health Department and as such regarded as professional experts in public health and infectious diseases within the Department, the public service and the medical profession.

This demand for recognition and acquisition of professional expertise equated with a narrow stream of seniority was ultimately to lead to bitterness between professional groups when the organisational structure and emphasis changed after the formation of the Department of Public Health in 1941. The significance of the Diploma of Public Health was progressively diminished as Scientific Divisions were established and expanded, and other professional post-graduate qualifications were recognised as equal and even superior to that of the Diploma of Public Health in status and promotional prospects. The situation worsened and became embittered as more candidates were selected and recruited direct to undertake the Diploma of Public Health, as much to support the course at the School of Public Health as to satisfy the needs of the Department of Public Health. Consequently Assistant Medical Officers of Health were frustrated and denied promotional prospects by the changed emphasis within the system, and were used as professional officers for minor administrative posts rather than as training positions for the self-sufficing positions of Medical Officers of Health.

The degree of resentment can be gauged by my initial appointment to the position of Director of Occupational Health. I was appointed, with the Diploma of Public Health, with a differential salary over other Directors, as was the late Dr Marshall Andrew to the position of Director of Tuberculosis at the same time. It could be said that we were the first two medical practitioners appointed from outside to senior positions external to the stream of Medical Officers of Health. I was surprised, as was Marshall Andrew, as the personal boycott from other professional staff for some months as a mark of disapproval, a reaction which conditioned me to refuse initially the appointment to Deputy Director-General of Public Health in 1952. The reaction was

even more dramatic after this appointment. The Metropolitan Medical Officer of Health resigned, and I was for some years bemused and bewildered by the reaction of my superior, who, inadvertently or otherwise, contained all the administration within his own personal capacity.

Essentially the role and status of Medical Officers of Health was changed by events rather than discrimination, as the impact and consequences of infectious diseases diminished because of scientific advances in medicine, medical technology and therapeutics. This trend was worldwide in Western countries and ultimately was to lead to the disappearance of the prestigious Colonial Medical Service from the British scene.

### Sanitary Reports

The *Sanitary Reports* of the Medical Officers of Health provide an interesting panorama over the years of the pattern of disease and social responsibility throughout NSW. The format was set by the first reports from the Hunter River and combined Metropolitan Health Districts, and were confirmed by successive Directors General. Each commenced with a general description of the state of the health throughout the Health District, and were followed in succession by vital statistics; tables of notifiable infectious diseases (with descriptions of local outbreaks); details of sanitary inspections; personal activities of the Medical Officer of Health and his staff; and, miscellaneous involvements. Later, these latter included statistical activities in such public health involvements as pure food inspections, baby health centre workloads and the association of the Medical Officer of Health with other professional and community groups.

Originally the channel of communication was in accordance with the distribution of immediate responsibility, viz to the local authorities concerned and a copy to the Board of Health. After 1913 the order was reversed and the reports were made to the Director-General of Public Health with copies to appropriate local authorities. They formed the basis of the reports of the Director-General of Public Health, who collated the statistics for the State and published his collective comment, as well as the individual regional reports. Although the Medical Officers of Health were required to make an annual

report no such responsibility was imposed by law on the Director-General. His reports were published by the device of presentation to the Minister and tabling in Parliament, after which they were printed as documentary proceedings of Parliament. The tale they unfold, and a detailed analysis of the changing pattern of health administration described within their pages will be elaborated elsewhere.

The Health Districts were the first health regions of the State. They were modified on the English model of Local Government responsibility for health to suit the needs of a State with substantially different demographic, social and economic considerations. Despite their vicissitudes they were valid for the time and purpose.

### Health and Scientific Divisions and Branches

With the exceptions of the Division of Establishments formed in 1961 and the Division of Health Services Research and Planning in 1970, all health Divisions and Branches of the Department of Public Health were within the ambit of the administration of the Director-General of Public Health, and reported direct to him. They were separate administrative units dedicated to a defined function or purpose. Their annual reports were reproduced and published in the *Annual Report of the Director-General of Public Health*, which was also the vehicle in the first quarter of this century for their scientific publications.

Their formal designations as Branches and Divisions are confusing to the historian, and did not necessarily imply a difference in hierarchical status, or that the lesser was the appendage of the greater. After the 1960s it could be affirmed that Divisions were larger and more technical than Branches, but this distinction was by no means absolute prior to this period. The Government Analyst's Branch was the first technical service to be established by the Board of Health and its name was not altered until it moved its location in 1969 and became the Division of Analytical Laboratories. Similarly, the Government Medical Officer's Branch became the Division of Forensic Medicine when its function changed from a general purpose Branch to a specialist Division. There were no units nominated as Divisions before 1923, after which it became customary to ascribe

the title 'Division' to new units or to existing Branches which developed a specialist function. There was no formality associated with these changes. On occasions Ministerial approval was sought, otherwise there was informal usage of Division for Branch until it became the customary usage and letterheads were changed. Sometimes the consent of the Public Service Board was sought concurrently with a submission for reorganisation.

Two major Divisions were designated as Bureau and Institute, the Bureau of Maternal and Child Health in 1965 and the Institute of Clinical Pathology and Medical Research in 1959. Here there was significance in the variation of title. The Bureau signified the amalgamation of two existing major Divisions, the Division of School Medical Services and the Division of Maternal and Baby Welfare, and a change in function towards comprehensive public health programmes for mother and child. The Institute of Clinical Pathology and Medical Research was so named to emphasise new attributes of teaching and research, superimposed upon the responsibilities of its predecessor, the Microbiological Laboratories. Both variations provided the opportunity to pay differential salaries to attract Directors of note, without infringing industrial principles.



**Department of Health**  
1970

### The origin of Divisions and Branches\*

Most Divisions and Branches were created to provide a service component to the administration of the Board of Health and subsequently the Director-General of Public Health, or to meet a deficit in medical services which was not provided externally by the medical profession, the general hospitals or voluntary or other agencies. Thus the Board of Health required sanitary inspections to supervise the activities of local authorities and the Sanitation (Health Inspection) Branch was early established. The board needed chemical assays to

assist it in its function of protecting water supplies and supervising sewage disposal and other sanitation requirements. The Government Analyst's Branch provided this need and its services were expanded to cater for other Government Departments. For a time it was separated from the board, because of its wide clientele, to become the Bureau of Microbiology. After its return to the Department of Public Health in 1913 it continued to provide an expanded service, primarily to the Department of Public Health and secondarily to other Government Departments in selected areas, as for example Government contract specifications. The Microbiological Laboratories were established after the Board of Health was granted responsibility for the control of infectious diseases. Pathology services

were lacking in general hospitals at the turn of the last century, and it filled this void as a central pathology laboratory until the major general hospitals established their own pathology departments. Even to the present day vestiges of this function persist. Its successor, the Institute of Clinical Pathology and Medical Research, provides reference facilities and specialised services to the general hospital system and the medical profession, and a limited histopathology service to rural general hospitals. The

Government Medical Officers Branch arose from the responsibilities of the Metropolitan Government Medical Officer in the Colonial Secretary's Department to the City Coroner; to the public service for medical examinations; to the Prisons Department for medical service to gaols; and to the State asylums for admissions through the Hospitals Admissions Depot. After it shed these latter responsibilities, it retained and expanded its responsibilities in forensic medicine, primarily to the City Coroners of Sydney and Newcastle, and secondarily to the State generally at police or coronial request. It became the Division of Forensic Medicine. Likewise, to fulfill needs peculiar to the

\* A brief account of the historical development of each Division and Branch is given in Appendix 7.

Department of Public Health, the Division of Health Education, the Medical Examination Centre and the Police Medical Branch were established in 1964, 1963 and 1971 respectively.

Some Divisions and Branches were established essentially to service legislation. In this category are the Food Inspection Branch (the *Pure Food Act of 1908*); the Private Hospitals and Rest Homes Branch (the *Private Hospitals Act of 1908*); the Venereal Diseases Branch, later the Division of Epidemiology (the *Venereal Diseases Act of 1918*); the Central Cancer Registry (the *Public Health (Amendment) Act 1970*, Part IIIA Dangerous Diseases; and the Division of Occupational Health and Pollution Control (the *Factory and Shops Act of 1962*, the *Radioactive Substances Act of 1957* and various Pollution Acts).\*

The Bureau of Maternal and Child Health and the Division of Dental Services are traditional public health Divisions servicing children and mothers through the school system, child guidance and child health centres, and baby health centres (well baby clinics). The opportunity of these Divisions to provide treatment is limited by the policy that the Department of Public Health will not intrude into active treatment of individuals in competition with private practice. There has been no difficulty with child psychiatry where the Department has historically been the therapeutic agent, but elsewhere the policy is fairly rigidly enforced, and the two Divisions staffed on the basis of a restricted therapeutic role. One offset from the Bureau of Maternal and Child Health was the separation of programmes directed against maternal and perinatal mortality and morbidity in 1969 to a new Division, the Division of Maternal and Perinatal Studies, which services the prestigious Maternal and Perinatal Committee and its publications.

The Divisions and Branches of the Department of Public Health are classified in the report of the Director-General of Public Health for the year 1971 as follows:

### Public Health Services

- Health Inspection Branch
- Food Inspection Branch
- Private Hospitals and Rest Homes Branch
- Division of Health Education
- Medical Examination Centre
- Poisons Branch
- Police Medical Branch

### Preventive Medicine

- Bureau of Maternal and Child Health
- Division of Maternal and Perinatal Studies
- Dental Services
- Central Cancer Registry

### Scientific Services

- Division of Analytical Laboratories
- Division of Forensic Medicine
- Division of Occupational Health and Pollution Control
- The Institute of Clinical Pathology and Medical Research

The exceptions to this list were the Division of Establishments and the Division of Health Services Research and Planning. The former has been described fully in the Chapter on Mental Health Administration. The latter was responsible to the Under Secretary of the Department. It was established on 27 January 1970, under Dr S. Sax, who have previously been Director of Geriatrics within the Division of Establishments. It was planned as a data finding unit to service both the Department of Public Health and the Hospitals Commission of NSW. Although placed within the Department of Public Health, the Chairman of the Hospitals Commission was granted direct access to the Director. Its function was '...to collect, analyse and present objective data in a form which would help decision making'(106).

A standing committee was established to advise on priorities, to frame terms of reference for each project, consider budgets for each task and monitor progress. The membership of the committee was the Under Secretary, Department of Public Health, the Chairman of the Hospitals Commission of NSW, the Director-General of Public Health, the Director of State Psychiatric Services and a representative of the Public Service Board.

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\* Since 1973 the supervision of air and water pollution and domestic noise has been transferred to the Pollution Control Commission.

## The administration of Divisions and Branches

The Divisions and Branches are discrete administrative units, self-contained with technical, clerical and supportive staff, and with degrees of freedom to pursue their responsibilities within the overall restraint of the parameters of their function. The larger, and particularly the Scientific Divisions, are located independently of the Headquarters of the Department and for all practical purposes operate as independent units within their budgetary appropriations. This latitude is illustrated on the growing emphasis on research and affiliation with tertiary education authorities. The only restriction imposed is unwritten and understood, that any such involvement or activity will not interfere with either the quality or quantity of services, which have an overriding priority.

Each Division and Branch is controlled by a Director or Chief, who is graded into senior and junior depending largely upon the size of the Division or Branch. Their salaries are graded accordingly, and also whether the Division is directed by a medical or non-medical Director. In general terms Branches are less independent than Divisions and restricted to advisory or minor administrative functions.

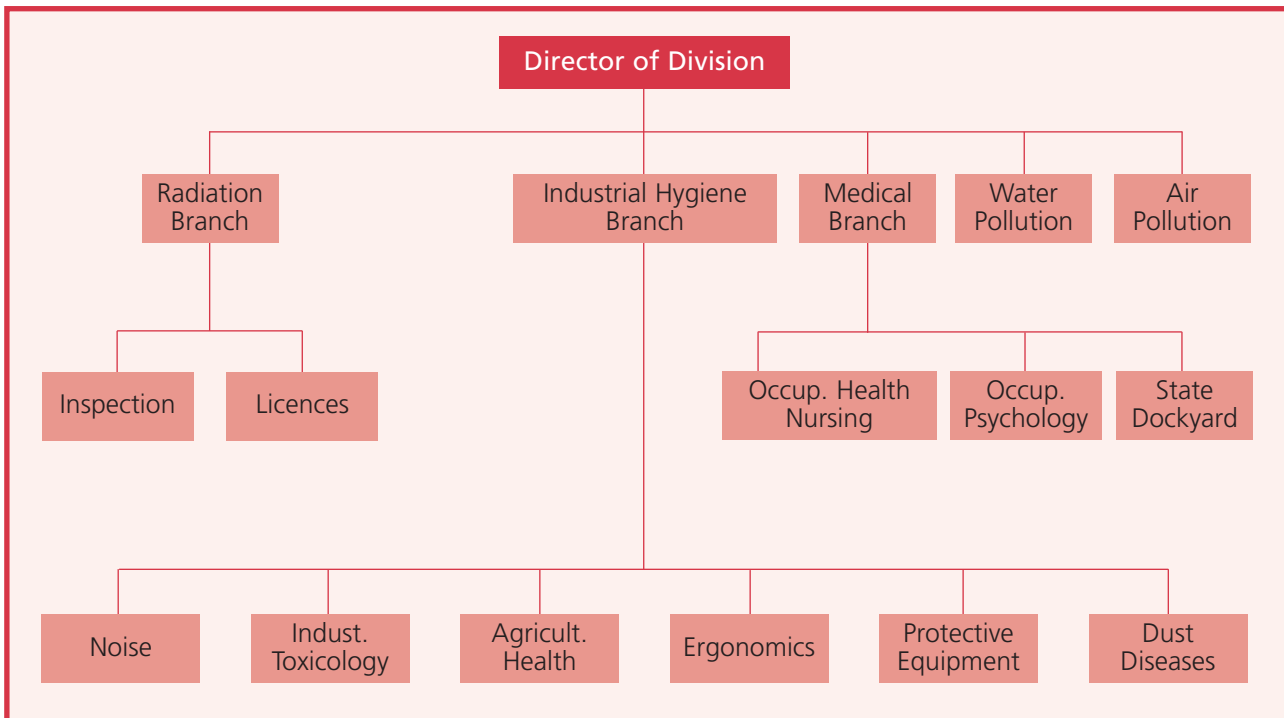
I have spoken elsewhere of the competition between Health Districts and Divisions for status and recognition and it might be assumed that sweet reason and tranquillity prevailed between Divisions and Branches. Here equally there was simmering resentment between non-medical and medically directed Divisions because of salary differentials and personal resentment of arbitrary status levels implicit in the latter and inbuilt into the system, and between medically directed Divisions because of the stratified system of senior and junior Divisions.

There was one area of mutual agreement, viz that they were central units of the public health organisation and should remain as such and not be dismembered by alteration of the structure and philosophy of Health Districts. This attitude was justified on number of grounds, many of which were valid:

- (a) The need to husband scientific resources and skills, the better to utilise expensive and sophisticated equipment and resources.

- (b) The approach to personnel recruitment in a competitive system, wherein career, research and other incentives could be offered within a larger organisation as contrasted with a number of barely viable smaller organisations.
- (c) The stimulus of cross fertilisation between Government and private organisations of like nature which is possible in major centres of population. In this manner Divisional staff could participate in scientific and teaching functions of universities and similar organisations, and there are avenues for mutual exchange with obvious benefits to the repositories of knowledge and experience of each. This aspect was vigorously pursued from 1960.
- (d) Central divisions were remote and unlikely to be influenced in translation of policy by local issues. Implicit in this concept is the principle that services and policy should be equally distributed with undiminished quality between urban and rural communities, irrespective of the capacity of the latter to financially support such services.

In their early and formative years, recruitment of staff was largely by a cadet system with emphasis on in-service training. In some areas this still persisted in the 1960s, although generally, as the Divisions increased in complexity emphasis was placed on recruitment of qualified staff trained by technical and tertiary educational authorities. Incentives were inbuilt into conditions of employment to retain staff by opportunities for post-graduate study, for ongoing education through seminars and overseas study tours, and to indulge in research. Above certain levels, promotion was assessed on the individual's administrative and professional progress through these opportunities. Promotional positions were increased within Divisions as they were organised into specialised sub-units. An illustration of this subdivision is the organisational pattern of the Division of Occupational Health and Pollution Control in 1971:



An issue of importance involving the scientific Divisions became apparent as they became more sophisticated in outlook and facilities, viz whether there should be some charter which would preserve their independence within the public service system, and enable them to contribute to the advancement of science and technology and professional education in NSW. After prolonged planning between the Director-General of Public Health and the scientific Divisional Directors, a proposal was advanced to the Public Service Board for an Institute of Health Science, whose charter would be defined by an Act of Parliament, which would remove these Divisions from the immediate authority of the Public Service Board, but still obligate them to the service needs and scientific support of the Department of Public Health. Although it was never specifically rejected the proposition was left in abeyance by the Public Service Board, and lapsed in the discussions over the next three years which were to lead to the formation of the Health Commission. The proposal is set out in Appendix 8.

The period 1960 to 1970 saw the rapid growth and expansion of the Divisions, but not the Branches whose functions were static and narrowly defined. It was obvious towards the end of this period that the impetus was slowing and that there would be increasing competition from universities and technical institutes in fields which were once the

prerogative of Government and the Department of Public Health. Their significance in health administration and even the identity and the existence of some would be further threatened by any major reorganisation of the administration of health services as was proposed in the *Starr Report*(107).

## The administration of Mental Health

The history of the administration of mental health in NSW is contained within the continuing saga of the lunatic asylums and mental hospitals of the State, at least until the last two decades when community psychiatry became prominent. Interwoven with it are the efforts of a small group of doctors, isolated from their profession, who were concerned with reform in a period when reform was unpopular and misunderstood. They saw visions of penal-type asylums being translated into therapeutic mental hospitals with strong affiliations with general hospitals. Their ideals were constantly frustrated by the apathy of Government and the indifference of the system in which they laboured. It is no mark of human frailty that some escaped from the system into private practice, while the majority succumbed to the unequal struggle and accepted the bondage of conformity to consolidate their careers.

And yet the light was never extinguished. Over the decades, from the last quarter of the nineteenth century to the middle of the twentieth century, there was a gradual shift of emphasis within certain mental hospitals in response to the leadership and direction of their medical superintendents. Others languished, still loyal to nineteenth century concepts in the twentieth century, until the ground was prepared for the audit and drastic overhaul of the system following the Royal Commission of Inquiry into the Callan Park Mental Hospital in 1961.

It is difficult to estimate the influence of the Inspectors General of Mental Health in stimulating change. One gains the impression, perhaps unjustly, that, with two exceptions, they were totally preoccupied with the statutory responsibilities of their position. There is little doubt that changes commenced in the 1950s were stimulated by extraneous factors including, among many, the discovery of certain drugs after World War II which transformed the treatment of mental illness, combined with a coincidental worldwide change in the philosophy of community responsibility to persons who were socially or medically bereft. Of the local circumstances in the twentieth century none were more important than the establishment of the Broughton Hall Hospital in 1918, the Chair of Psychiatry at Sydney University in 1922, and the Royal Commission of Inquiry into Callan Park in 1961.



**Broughton Hall**  
Hairdressing Salon 1957

## The administration of the Inspector General of Mental Hospitals\*

There were six Inspectors General of Mental Hospitals (not including Dr W.H. Coutie a temporary occupant in 1925) from Frederick Norton Manning to Donald Fraser, spanning a period of 85 years from 1876. It is not my intention to provide detailed biographies of their careers, ambitions, achievements and personal attributes. I hope that this will be the commission of some other author in a more profound study of the development of mental health services in NSW.

Dr Frederick Norton Manning was the first and the most publicised as the originator of the Service. Towards the end of his career he was plagued by ill-health, and this was reflected in his attitude towards the Service which became more burdensome to him as his health deteriorated. No doubt he appreciated the convenience of his headquarters in the Domain to the Union Club, where he was wont to find relaxation from cares of office. Many of his memos to his staff were written on Union Club stationery. In 1887 he obtained one year's sick leave to visit England, and such was the dedication of the man that he spent most of this period in visiting mental hospitals in Great Britain. He was a man of stature, who for a short period was Medical Adviser and President of the Board of Health from 1889 to 1892. It is interesting to conjecture that, had he enjoyed good health, he may have been able to combine the Public Health and Lunacy Departments of the Colonial Secretary's Department into one integrated service. It was not to be and he retired because of ill-health in 1897.

\* This title is inclusive of the statutory title Inspector General of the Insane which remained in the *Lunacy Act* until the amendments of 1958.

He was succeeded by Eric Sinclair who served until his sudden death in a train on an inspection tour in 1925. He was born in Greenock Scotland in 1860 and graduated from Glasgow University M.B., Ch.M. in 1881 and M.D. in 1886 (four years after he joined the Lunacy Department of NSW). Dr Sinclair built on Norton Manning's foundations and his achievements bear favourable comparison with those of the founder father. He saw the mental hospitals increase in size and number and was influential in the establishment of the Chair of Psychiatry of Sydney University in 1922. He had visions of the expansion of psychiatric units into general hospitals and, to set the example, established the first voluntary institutions within the service at the Reception House and the Broughton Hall Clinic. He supported outpatient services in the general hospitals and encouraged his staff to participate on an honorary basis. It was said in tribute to him(108):

“It was due to him that asylums changed from pseudo prisons in which the insane were incarcerated to mental hospitals where patients received skilled attention for definite disease and where active treatment replaced mere care and restraint. He introduced systematic training of nurses and attendants... introduced the voluntary system of care of patients and was the means of having the Chair established at Sydney University.”

It was no coincidence that his title was changed by administrative action from Inspector General of the Insane to Inspector General of Mental Hospitals in 1918.

The opportunities for spectacular advancement of the Mental Hospitals Service were denied the next two occupants, Dr C.A. Hogg (1926-1935) and John Andrew Leslie Wallace (1935-1942), both of whom served during periods of financial stringency, as an aftermath of the Depression of the late twenties and early thirties and the commencement of World War II. One gains the impression that they were willing to accept the status quo and there is little doubt that the reputation of the mental hospitals suffered during their regimes. A custodial attitude based on legal sanctions prevailed in all but the Broughton Hall Hospital, which was spared by the enthusiasm of its Medical Superintendents, Evan Jones and Herbert Prior, and its associations with the Professor of

Psychiatry. Hogg was a cricket enthusiast and the teams and grounds of the mental hospital were a match for players and amenities with those outside. It was often stated that a good basis for entry into the service during his administration was proficiency with the bat and ball. John Wallace was a quiet person, who like Hogg had seen long service in the system before his appointment as Inspector General by virtue of seniority. He acquiesced in *Dr Morris' Report of 1942*, even though it meant the loss of his position. Perhaps the imminence of his retirement was a conditioning factor:

In 1942 the Offices of the Inspector General of Mental Hospitals and Director-General of Public Health were merged with Dr E.S. Morris assuming both titles(109). The statutory provisions of the *Public Health and Mental Health Acts* were apportioned between Morris and his two deputies, one in public health and the other in mental health. The latter was Dr D. Fraser. The consequences of this merger are discussed elsewhere under the administration of public health. In brief Dr Morris concentrated on mental health and mental hospitals, sharing inspections with his deputy. He was never secure in his position, and from what I have heard was never totally acceptable as Inspector General to the professional staff within the mental hospitals. On his retirement in 1950 the two areas of professional administration were again separated, and Dr D. Fraser succeeded as Inspector General of Mental Hospitals.

Donald Fraser was a gregarious, ebullient extrovert, who had the misfortune to inherit a service whose reputation had reached a level where it was considered as a contemptuous necessity by his professional colleagues, during a period when private psychiatry was itself depressed and tolerated as a most unrewarding branch of the medical profession – to be enjoyed by those who were unambitious or failures from the general stream. He did not deserve the turmoil and the indignity of removal from his Office. With better support, the Royal Commission into the Callan Park Hospital would never have been necessary. It was not until I replaced him in 1961 that I realised fully the difficulties which beset him from within his own organisation as well as the apathy previously of governmental and public service policy.



## The Office of the Inspector General of Mental Hospitals

The organisation surrounding the Inspector General of Mental Hospitals, including the mental hospitals, was known, until 1942, as the Office of the Inspector General of Mental Hospitals. I have not been able to find any official derivation for this unusual title. I have assumed that it arose accidentally and was confirmed by usage rather than formal approval. When Dr Norton Manning relinquished his position of Medical Superintendent of Gladesville Asylum to become Inspector General, he remained at Gladesville occupying some of the office accommodation of the administrative building. To avoid confusion he addressed his corresponding from the Office of the Inspector General of the Insane, Gladesville Asylum. The term became synonymous with the headquarters administration of the Lunacy Hospitals Service, and was retained at each successive movement of this staff to Callan Park in 1885, back to Gladesville in 1887 and finally to Richmond Terrace, Sydney Domain, in 1901, where it remained until transferred to Winchcombe House, 52 Bridge Street in 1941. From 1941 to 1958 the administrative organisation supporting the Inspector General of Mental Hospitals was known within the Department of Public Health as the Division of Mental Hospitals. After 1958 it became the Division of State Psychiatric Services. It lost its identity within the Division of Establishments in 1961.

The Office of the Inspector General of Mental Hospitals was a sub-department of the Colonial Secretary's Department until the Department of Public Health was established in 1913 as a separate Ministry. It was then a sub-department within that Ministry equal to and comparable to the Office of the Director-General of Public Health. As with the Director-General of Public Health, so was the Inspector General a Permanent Head for the purposes of the *Public Services Act*, until the first Permanent Head of the Department of Public Health was appointed in 1938.\* This attribute was

It was due to him (Sinclair) that asylums changed from pseudo prisons in which the insane were incarcerated to mental hospitals, where patients received skilled attention for a definite disease and where active treatment replaced mere care and restraint.

removed from both senior professional administrators after this appointment. Previously it had enabled the Director-General and the Inspector General direct access to the Minister on professional matters involving their administration, and, although a clumsy device, it did not infringe upon the capacity of the Permanent Head of the Colonial Secretary's Department, under whose overall administration they were placed. Both organisations occupied premises separate from the Colonial (Chief) Secretary's Department, and to all practical purposes, other than budgetary appropriation, were separate Public Service Departments.

The professional component of the headquarters of the Office of the Inspector General consisted, again until 1942, of the Inspector General only, who would call upon the senior Medical Superintendent to relieve him in his absence. Since 1942 there has been an official Deputy, Dr D. Fraser being the first such. Medical staff for the mental hospitals were recruited on the basis of serving at least one year in a mental hospital as nominated by the Inspector General, after which, if they so requested they were posted to a metropolitan Mental Hospital to start the Diploma of Psychological Medicine at Sydney University. If successful they continued in the Service proceeding to Deputy Medical Superintendent, then Medical Superintendent of a smaller mental hospital and finally of a large mental hospital. Seniority was significant for promotion. Other professional staffs were recruited direct from university, and nursing staffs were trained by in-service programmes.

The clerical administration paralleled that supporting the Director-General of Public Health, the most senior position of which was secretary, then senior clerk, accountant and other promotional clerical positions. Entry into the clerical sector was through the Office of the Inspector General as a junior clerk, then progression through various grades in the mental hospitals to the senior position of manager, subject to passing public service promotional examinations.

\* Personal communication from Mr C.J. Watt, the first Permanent Head of the Department of Public Health.

## The Reports of the Inspector General of Mental Hospitals

Section 73 of the *Lunacy Act of 1878* (42 Vic. No. 7) required:

“The Inspector General shall early in each year make a report in writing to the Colonial Secretary of the state and conditions of the several hospitals, licensed houses, reception houses and other places visited by him during the preceding year and of the care of patients therein and of such other particulars as he shall think deserving of notice and a true copy of such report shall forthwith be laid before Parliament if then in session or if not then in session within twenty one days of the next Session of Parliament.”

These reports were duly delivered and published for each successive year from 1878 to 1960.\*The earlier reports of Norton Manning were dynamic critical documents which often excited supportive newspaper editorials and feature articles on the causes of insanity, the problems of overcrowding and the miserable conditions within the mental hospitals and particularly Parramatta. Norton Manning saw and used these reports as a vehicle for public exposure in his drive for reform. In his latter years of office, his belligerency was less apparent and his drive diminished by ill health. This is reflected in the reports which became repetitive statistical documents of lunacy statistics, finance, staff changes and the need for progressive revision of the original *Lunacy Act*. The pattern persisted throughout the years to the degree that the editorial context was repeated year after year with only the alteration of numerical statistics. One such report shows the method of restructuring in the bound volume containing the 1921 and 1922 reports. In the latter report the 1921 report substitutes with the relevant years and statistics cancelled and updated in red ink without alteration of any other word of context. The responsibility for these alterations was with the Secretary to the Inspector General. Although this format was a boon to the typesetters of the Government Printer, it is of little assistance to the historian, other than indicating trends and the lack of influence they exerted on Government.

A number of factors do emerge from the reports, some positively and some by inference. Of these the most important are persistent overcrowding due to the legal procedures of admission and certification of the insane; the economics of the institutions and the low cost of patient maintenance, reflecting understaffing and the use of patient labour; the need of legislative reform to accommodate voluntary admissions and to diminish the stigma of certification; the absence of proper classification and segregation of patients (impossible to achieve with increasing overcrowding); the need for better discharge procedures, rehabilitation and support after discharge to minimise readmission; the problem of low salaries, professional disrepute and discontent, and the extreme difficulty of recruitment of quality staff; and the absence of research or opportunities for research within the system. Repeated pleas in all these issues went unheeded until action was forced at a political level by political embarrassment and incipient scandal.

Most of these issues are taken up elsewhere. The reports reflect the disappointments of the Inspectors General and their format is sufficient evidence of this disappointment and frustration. Compiling the reports was a routine chore, enforced by law, to be suffered as a necessary yearly task by the Medical Superintendents of the mental hospitals and the staff of the Inspector General. One meritorious feature is prominent throughout the series, viz the diligence with which the Inspectors General carried out their inspections especially in the days when transport was slow and travelling laborious.

## The role of the Inspector General of Mental Hospitals

The role of the Inspector General of Mental Hospitals was largely defined in the original statute of 1878, and remained substantially unaltered until the *Mental Health Act of 1958*. He was in essence the Inspector General of the Insane as his original title implied, committed to oversee the lunacy institutions, both within and outside the Mental Hospital Service, by formal inspections and visits, and invested by law with substantial powers to safeguard patients and prevent abuses.

\* From this year they were replaced by Annual Reports of the Director of State Psychiatric Services.

## The statutory role

The statutory role of the Inspector General is set out in the main in Part VI of the original Act and the *Act of 1898* relating to inspection transfer and discharge of patients. This sets out the requirement of the Inspector General to visit every hospital and licensed house housing the insane at least twice a year; the thoroughness with which the inspections are to be carried out; the recording of same in the Inspector General's Book; the inquiries he must make as to treatment and care of patient, including the degree of use of restraint; and the scrutiny of medical certificates and admission procedures.

All plans for building or enlarging or improving any hospital for the insane, whether government or private, had to be submitted to him for his report to the Colonial Secretary, which report was in effect approval or denial. He had other powers relating to transfer and discharge of patients which could be exercised under particular circumstances in variation of normal procedures. He had minimal oversight over hospitals for the criminally insane, other than his statutory inspections, even though these hospitals were included in the lunatic asylums under his jurisdiction. The Colonial Secretary had power to make regulations for the government and management of hospitals for the criminally insane, and was also the authority authorising declaration of insanity and discharge from the obligations imposed thereon.

There are other minor additions to the Inspector General's basic statutory role imposed by other Lunacy Acts, such as the *Inebriates Act of 1900*, or amendments of the basic Act as eg the amendment of 1934 permitting voluntary admissions to licensed hospitals and houses, including the Reception House. These are extensions of the Inspector General's authorities relating to admissions, transfers and discharges granted in the *Act of 1879* and endorsed in the *Act of 1898*.

Repeated pleas went unheeded until action was forced at a political level by political embarrassment and incipient scandal.

## The administrative role

Apart from this statutory role the Inspector General of Mental Hospitals had to exercise an administrative role as Permanent Head of the Mental Hospital Service. This involved recruitment, transfers, and promotions of staff; exercising disciplinary action when necessary within the restraints of the *Public Service Act*, at least until 1938; advising the Minister and the Under Secretary of the Colonial Secretary's Department on budgetary appropriations and establishments, and in other matters as might arise in the exercise of his administration. Most of these actions and issues would involve the system of mental hospitals, which occupied the whole horizon of his administrative vista.

## The mental hospitals (lunatic asylums) and licensed houses

The title of the senior professional administrator in mental health was, until 1961, initially Inspector General of the Insane, and from 1918 Inspector General of Mental Hospitals. The total content of his administration during that period were the lunatic asylums, later designated mental hospitals. In some of the institutions the change of designation did not infer substantially a change of function, but rather the pious hope that a change of name would compensate for the inadequacies of the system. With a few exceptions, the mental hospitals as I knew them in 1961 still conformed to the functions of an asylum as described by James Currie, M.D. in 1789(110):

"In the institution of a lunatic asylum there is this singularity, that the interests of the rich and poor are equally and immediately united ... the objects of a lunatic asylum are twofold. It holds out an institution for both the curable and incurable. To the first it proposes the restoration of reason, and while it relieves society of the burden of the last, it covers the hopeless victims from the dangers of life, and from the selfish conflict of an inflicting world."

It is most gratifying to record that from 1961 to 1972 a tremendous change occurred in the mental hospitals involving changes in the philosophy, function and physical environment, associated with a vigorous and enlightened programme of professional, technical and public education. Therefore, historically, that which follows relates to the system in its development, as a prelude and necessary background to the *Mental Health Act of 1958* and the Royal Commission of Inquiry into the Callan Park Hospital of 1961, the better to appreciate the influence of these two events on the reformation of the 1960s.

### The system of mental hospitals

In the first section of this publication dealing with the historical development up to 1882 the influence of the *Lunacy Act of 1878* and the administration of Frederick Norton Manning in upgrading the lunatic asylums to lunatic hospitals has been discussed in some detail. Three factors are significant arising from this period:

- (i) The asylums were placed under medical control both in their overall administration as a system and in their particular administration as therapeutic institutions.
- (ii) They were receiving houses which operated on a legal process of committal, into which were incorporated the principles of continued constraint and confinement with legal sanction.
- (iii) They were part of a system, contained within the Government Health Service, enjoying a monopoly of psychiatric therapy (private asylums were never a significant feature although envisaged in the *Lunacy Act of 1878*), and with an emerging policy that each was a general purpose institution, to be located to meet demographic demands.

They were located in areas where population density justified the accommodation, the greater number and larger in the metropolis of Sydney, and others singly in Newcastle and two country areas

when the metropolitan hospitals were unable to cope. The only classifications of patients within the lunatic asylums prior to 1890 were the separation of free and convict patients at the Parramatta Asylum, and the separate enclosure for the criminally insane, also at Parramatta. The Observation Ward within the Darlinghurst Goal was an expediency which was a temporary holding situation for prisoners who were mentally disturbed awaiting sentence and disposal, and as a detoxification unit for alcoholics appearing before the magistrate.

The consequent development of mental hospitals catering for special groups of patients (such as idiots, quiet dements and psychogeriatrics) was largely coincidental, and reflected the needs of the major institutions in Sydney to overcome overcrowding. Newcastle Asylum was established in the premises of the Military Barracks at Watt Street in 1872 as a central institution for idiots and imbeciles, to which patients could be transferred from the unsatisfactory accommodation at Parramatta and Gladesville, which was then used for general accommodation. When Watt Street Asylum itself was inadequate so was Rabbit Island (Peat Island) established in 1911.

Callan Park was proposed and the site purchased in 1873 to relieve the demands upon the accommodation of Gladesville and Parramatta and in response to Norton Manning's policy of a third metropolitan asylum. He had hoped that this might enable Parramatta to be reconstructed. His hopes were short-lived. In March 1878, the Colonial Secretary, Mr Fitzpatrick, in reply to a question in the Legislative Assembly described the policy for the asylums:

- (i) **Gladesville**  
a new wing to accommodate 150 patients at a cost of £35,000.
- (ii) **Parramatta**  
Temporary accommodation for 350 patients at a cost of £38,000.
- (iii) **Callan Park**  
Temporary accommodation for 100 patients at a cost of £7,635 and a new asylum for 666 patients to cost £205,000. This latter objective was achieved in 1887.

The policy for Callan Park was to receive all new patients from Sydney as well as providing for transfers from Gladesville. Overcrowding was consistently the problem as the population and insane rate increased. The temporary hospital at Cooma, closed in 1884, provided only a minuscule of relief. The Private Asylum at Tempe was almost totally supported by the Government, and was in effect an annex of Gladesville accommodating 120 of its quieter patients. Parramatta was still the most distressed of the large Sydney institutions, and was granted relief in 1890 to use the orphan school in the municipality of Dundas as a branch of the hospital to receive quiet chronic cases of dementia. It was to extend to become the Rydalmere Mental Hospital, yet catering largely for the same type of patient.

After many years of protestations by Frederick Norton Manning and Eric Sinclair the Government agreed to the establishment of the mental hospitals at Kenmore and Orange to serve the southern area mid western areas of the State. Kenmore was opened in 1901, and at its opening Sinclair spoke of the need for mental hospitals at Orange and in the North Coast District(111). The latter was never realised. Although plans were prepared for Orange and the site cleared in 1903, it was not until 1923 that patients were received. In the meantime some relief was envisaged for Newcastle. The Quarantine Station at Stockton was acquired in 1911 and the permanent accommodation used for female patients from both Newcastle and Sydney. Again the type of patient was similar to that at Rydalmere with a large proportion of adult mental defectives. Temporary calico wards were erected to accommodate male patients. These were constructed of wooden frames with calico panels, wood doors and a canvas fly roof(112). Wards had already been erected in 1906 at Morisset to receive 150 to 200 patients from

other mental hospitals, and it too was to expand to become a mental hospital accommodating chronic patients. And so the grouping and numbers of mental hospitals remained constant until the establishment of the Cerebral Surgery and Research Unit in 1958, the Psychiatric Centre North Ryde in 1959, Allandale Hospital in 1963 (for psychogeriatric patients), Grosvenor Hospital in 1965, the purchase of the King's School in 1968 to supplement residential accommodation for mental defectives and so enable Milson Island to close, Marsden Hospital for lower grade mental defectives in 1969, and the transfer of the Collaroy Convalescent Home in 1969 to become an annex of Marsden Hospital.

The basis of co-ordination was determined by the function which individual hospitals had assumed. Each of the general purpose mental hospitals received patients from the central Reception House and daily transport was organised to the country hospitals from the Reception House.\* Local reception was also available in the country mental hospitals. The hospital for criminally insane males was transferred from Parramatta to Morisset in 1936 and a maximum security unit was built within its grounds. Otherwise it, Rydalmere and Stockton were large geriatric

units, receiving quiet patients who were either physiologically or chronologically aged, or mentally deficient without multiple physical handicap. Peat and Milson Islands remained as institutions for mentally deficient persons to which were later added Grosvenor and Marsden Hospitals and the King's School. Watt Street had a special unit catering for babies and young infants.

Many mental defectives still remained within the back wards of other mental hospitals, mostly forgotten, as the Royal Commission into Callan Park was to disclose.



**Gladesville Hospital  
for the Insane**  
1900-1927

\* This policy was later modified into regional admission areas after the Reception House Darlinghurst was transferred to St Vincent's Hospital as the Caritas Centre in 1962. Regional admission policies are discussed later in this context.

Surprisingly, no specific accommodation for alcoholics was provided. For many years the Salvation Army was licensed as a private institution to receive inebriates under the *Lunacy Act*, and was the main source to which Judges, the Master in Lunacy or the Magistrates directed persons under order of the *Inebriates Act 1900*. From the period 1930 onwards Bloomfield (Orange) Mental Hospital was the principal receiving hospital for alcoholics under legal order and referral to the Salvation Army went into discard.

Of minor interest to this history were the small number of private licensed houses, other than to emphasise the monopoly enjoyed by the State, and the lack of medical interest in psychiatry outside the psychiatric services of the State. The Private Asylum at Tempe was viable only because of State support utilising most of its accommodation. It survived World War II shortly as Bayview Private Mental Hospital and closed because of lack of demand.

The licensed houses at Picton were two cottages licensed privately in 1881 under Section 42 of the *Lunacy Act of 1878*, each to receive one patient. The Inspectors General were conscientious in including them in their rounds of yearly inspections. The licensed house at Ryde, first licensed in 1896, is now the Mount St Margaret's Hospital, and still operates as a licensed hospital.

### Voluntary patients

Until 1958 the emphasis in the mental hospitals was the need for institutions to meet demands for treatment and accommodation of committed patients. Although voluntary admissions to mental hospitals are now the rule, the concept was well known to the early Inspectors General and advocated by them. In 1886 Norton Manning reported on the need to separate socially paying and those of higher education and social status as a therapeutic measure to aid their recovery. He lamented that due to overcrowding the only classification of patients was psychological but perhaps in the future a ward could be set aside at Gladesville and cottages built at Callan Park(113).

In 1883 he drew unfavourable comparison with Victoria where five wards were in operation in country hospitals. He complained that Section 48 of

the *Lunacy Act of 1878* provided for like action in NSW but it was left to the initiative of the committees of the general hospitals.

Eric Sinclair carried on the crusade more successfully. He realised that if the Office of the Inspector General could set the example, it would indicate to the general hospitals that psychiatric patients would not disturb their therapeutic environments. Proudly he was able to report (114):

“The Mental Ward Darlinghurst (Reception House) opened in May 1908, for uncertified cases of insanity. It is but small and was established more or less to demonstrate to the general hospitals that such a ward was possible and eminently desirable. Accommodation for 20 patients, male only, is at present provided but alteration which are now in hand will provide accommodation for women. Seventy patients were admitted during the year and 72 discharged.”

Although he did not succeed in impressing the administrators of the general hospitals, he lived to see his dream fulfilled within his organisation. The 18th Military Auxiliary Hospital had been established in 1915 in the grounds of the Callan Park Hospital ‘for the treatment of soldiers returning from the front with nervous and mental disorders’(115). It is pleasing, so Sinclair continues ‘that it has been found practicable to treat all cases without recourse to formal certification of the Insane’. After the war the hospital reverted to civilian control, again under Sinclair’s administration, as a totally voluntary hospital – Broughton Hall, so named after Bishop Broughton’s house in its grounds. It prospered under Dr Evan Jones whose reputation as an horticulturist is tribute to the magnificent landscaping of its grounds, which he designed and completed as a therapeutic measure, to provide a beautiful and restful environment. Its progress was assured with the appointment of Sir John Macpherson K.B.E., M.D., F.R.C.P.E., previously Commissioner for Lunacy, Scotland as the first Professor of Psychiatry at Sydney University in 1922. Successive Professors of Psychiatry of Sydney University were appointed consultants and allotted a teaching unit within Broughton Hall. In return the Government subsidised the Chair of Psychiatry to approximately half its annual value.

Broughton Hall was always a proud and prestigious unit within the mental hospitals system. Its reputation was resented by other medical superintendents who complained that it exercised undue selection of patients to its advantage and results, and that it was unduly favoured in staff and appointments by the Department of Public Health because of its university affiliations. Be that as it may it did demonstrate an outward view in psychiatric thought and policy in NSW, and it fulfilled a very valid function as pacesetter and innovator. Its role was less significant in the 1970s with the development of facilities for voluntary admissions to all mental hospitals and many general hospitals. It is now a unit of Callan Park Mental Hospital.

### The administration of mental hospitals

The administration of mental and State hospitals ran along parallel lines and had similar hierarchical staff structures. The Executive Officer was a doctor, and with some minor exceptions, a qualified psychiatrist. The larger hospitals would carry the position of Deputy Medical Superintendent. Until a system of specialisation was introduced in 1962 in State and mental hospitals, the remaining medical staff would consist of a mixture of psychiatrists and medical officers under training for psychiatry, with few of the former and not infrequently very few of the latter.

From 1922, after the establishment of the Diploma of Psychological Medicine at Sydney University, the mental hospitals provided the only avenue for post-graduate psychiatric training in NSW. It was obligatory when accepting appointment that doctors would serve one year before commencing the Diploma of Psychological Medicine course. This was a measure used to augment the staff of the less popular institutions and the country mental hospitals.

After the formation of the Institute of Psychiatry in 1964, trainee psychiatrists were no longer under the control of the Director-General of State Psychiatric Services, and rotating postings for promotion or training became less significant as mental hospitals each worked within their own establishments of medical staff. A specialist promotion scheme, which ran parallel to promotion by administrative seniority,

provided more satisfying careers, professionally and financially, within the mental hospitals and was a major factor in retaining specialist staff. Job and financial satisfaction were enhanced by a limited right of private practice, and appointments to community psychiatric units in general hospitals. Rotation did occur, not infrequently as a disciplinary measure, but more frequently to achieve higher salary gradings as senior specialists, Deputy Medical Superintendent or Medical Superintendent. The mental hospitals were graded also for salary levels of senior medical and clerical executive staff by size of patient accommodation.

Clerical staff training followed the same pattern of personnel organisation as with the State hospitals, the top hierarchical positions of which in each institution were the Manager, Assistant Manager, and Chief Clerk in that order. Within the Office of the Inspector General of Mental Hospitals there was a small clerical organisation, independent of the Office of the Director-General of Public Health, and following like guidelines and like positions. The two areas were integrated with personal interchange after Dr E.S. Morris occupied the combined leadership of both administrations, although it was never totally effective until the later amalgamation of 1961 and the creation of the Division of Establishments.

This amalgamation resulted in additional senior clerical positions at Head Office, to which promotion through the hospitals systems was incidental rather than absolute. Tertiary qualifications and higher secondary school qualifications became important, and reduced the significance of clerical in-service training within the hospital system.

Prior to the last two decades, nursing staff was under the control of a Matron if female, or a Chief Attendant if male. They were responsible to the Medical Superintendent. The Matron was also in charge of domestic arrangements. There was an outdoor supervisor and a staff of outdoor attendants in charge of farming, trades and outdoor activities, responsible immediately to the Manager.

The mental hospitals provided the only training facilities for mental health nurses, male and female, and individual training and educational programmes were mounted in each hospital, with the Norton Manning prize for first aggregate the acme of

Surprisingly  
no specific  
accommodation  
for alcoholics  
was provided.

success. General trained nurses were rarely employed or sought employment in mental hospitals. Some general trained nurses undertook psychiatric training and less the reverse. Psychiatric nursing training suffered in its general and social image as compared with general training, and to attract recruits special financial conditions applied in favour of psychiatric training.

A more enlightened attitude now exists and general nursing training is freely accepted for positions in psychiatric hospitals and the psychiatric wards of general hospitals. There is one Director of Nursing within each hospital and if male, the Deputy Director is female and vice versa. There is interchange of male and female staff within the wards, which would have been unthinkable even as late as 1960. This bald description of nursing policies within mental hospitals does not pay due tribute to the dedicated groups of psychiatric nurses, who worked uncomplainingly under conditions which would not be tolerated today, and who exhibited a personal sense of responsibility to their patients which bears favourable comparison with present attitudes. They always enjoyed my admiration and support.

## Lunacy and mental health legislation

The *Dangerous Lunatics Act of 1843* (7 Vic. No. 14) and amendments and the *Lunacy Act of 1878* (42 Vic. No. 7) are discussed in the first section of this study, along with statutory procedures and other legislation reflecting on the administration of lunacy prior to 1878. In this section legislation subsequent to 1878 will be discussed briefly in generic and chronological sequence. For a detailed study of lunacy and mental health legislation in NSW, the reader is referred to a thesis for a doctorate of medicine by Dr Graham Edwards.\*

### Lunacy and mental health

#### *Lunacy Amendment Act 1881 (45 Vic. No. 16)*

This Act provided for capacity to remand prisoners of temporary or doubtful mental aberration to the Reception House instead of Darlinghurst Goal, and gave discretion for the Colonial Secretary to dispose

of such prisoners to a Hospital for the Insane or a Hospital for the Criminally Insane as he deemed expedient according to the nature of the Office or period of sentence. It also provided for special provisions for the examination of prisoners reported to be insane while under sentence of death.

#### *The Lunacy Act 1898 No. 45*

In 1898 the *Lunacy Act of 1879* (42 Vic. No. 7) was revised and consolidated in the *Lunacy Act* of that year. It did not differ substantially in format and substance from the *1879 Act*, and many of its sections and parts are repeated without alteration. It was not concerned with any variation of the philosophy of lunacy, and its provisions applied to those persons who had been legally committed and declared to be insane. It enlarged the definition of insane person; elaborated on the procedures for committal and provided for emergency procedures by the justices; it defined more precisely the powers and limitations of the magistrates; and endorsed the legality of transfers to adjacent States. It did not envisage voluntary admissions, nor did it provide specifically for other classifications of patients such as inebriates, idiots and other grades of mental deficiency, epileptics and the like.

#### *Lunacy Amendment Act 1924*

This is a minor amendment of Section 72 of the *Lunacy Act 1898* consequent upon the major amendments of the *Crimes Act No. 10 of 1924*.

#### *The Lunacy (Amendment) Act 1934*

This Act provided for the reception of voluntary patients into hospitals for the insane and licensed houses; extended the powers of Official Visitors to hold inquiries and order discharge; and, provided for admission to the Reception House on a single certificate (Schedule 2A), or on the request of the patient or his relatives.

#### *Lunacy Amendment Act 1937*

These are amendments to Sections 7, 69 142 and 170 consequential to the *Statute Law Revision Act No. 35 of 1937*.

\* The thesis is under preparation and Dr Edwards anticipates that it will be presented to Sydney University in June 1978. Its title is *Mental Illness and Civil Legislation in NSW*.



*Lunacy Amendment Act 1944 No. 38*

This was an Act to amend Section 76 of the *Lunacy Act 1896*, by inserting a Section 76a, providing for judges to order persons confined as criminally insane to be brought before them for examination.

*Lunacy (Amendment) Act 1945 No. 53*

Section 4 was amended to provide penalty for incorrect issue of Schedule 2A without the medical practitioner having seen or examined the patient. There were consequential amendments to Section 6, 10 and 13 arising there from.

*Lunacy (Amendment) Act 1946 No. 38*

This Act provided for amendments to Section 67 to provide procedures for trial of the issue whether a patient, detained in a hospital for the insane or a hospital for the criminally insane, is fit to plead if placed upon trial.

*Lunacy Amendment Act 1898-1947*

Is a consequential amendment of Section 107 relating to the *Jury (Amendment) Act of 1947*, No. 41.

*Lunacy (Amendment) Act 2952 No. 31*

This Amendment provided for important provisions setting out conditions under which leucotomy, electro convulsive therapy, electro narcosis therapy, insulin shock, and other treatments as may be proclaimed, could be carried out. The specific consent of the Inspector General is required in each instance, and a Consultative Committee is established to consider applications from Medical Superintendents for the performance of leucotomy. The committee is composed of medical practitioners appointed by the Minister, and is charged with making recommendations to the Inspector General. The Amendments relate to a new Section 179A.

*Lunacy Act 1898-1955*

The *Lunacy Act of 1898* was reprinted and consolidated in 1955 to become the *Lunacy Act 1898-1955*, which was to remain the basic Act until the *Mental Health Act of 1958* was passed. Previous amendments were consolidated into the Act, and a new Part VIIIA was added to the Act to provide for special provisions relating to the control of property, by the Master-in-Lunacy, of mental patients residing outside NSW.

*Mental Health Act 2958 No. 45*

This Act was the aftermath of a report by Professor W. Trethowan who was chairman of a committee appointed by the Minister, the Hon. W.A. Sheahan, to revise the *Lunacy Act* in light of modern trends in psychiatry. It was regarded as an enlightened piece of legislation which would set a standard for Australia, and was one of the Minister's achievements of which he spoke proudly on frequent occasions.

The Act discarded all the terms in previous Acts which implied the stigma of lunacy, lunatics, asylums and insanity. An insane patient is called a continued treatment patient or an incapable person, reception houses became admission centres, the Inspector General was replaced by the Director of State Psychiatric Services, the Master in Lunacy became the somewhat cumbersome Master in Protective Jurisdiction of the Supreme Court, and Licensed Hospitals became authorised hospitals. A schedule was set out in comparative form to cover all contingencies of these changes in nomenclature.

The powers and responsibilities of the Director of State Psychiatric Services were similar to those previously enjoyed by the Inspector

General provisions were made for a Deputy Director to enjoy all the powers of the Director in his absence. Dr Graham Edwards discusses the significance of the changes in some detail, and summarises the philosophy of the Act (116):

“The new *Mental Health Act* had a number of advantages as compared with the old *Lunacy Act*. In the main these were a more modern terminology, the elimination of the Lunacy Court and the adversary process in assessing the need for admission or otherwise of the mentally ill person, the encouragement of voluntary admission and the introduction of welfare officers.

These changes were seen to be important as they provided a more satisfactory legal framework in which a treatment orientated rather than custodial care approach could develop. There was retention of basic legal safeguards to protect individual civil rights yet at the same time some of the more strict and dehumanising legal sections were removed or modified.”

### *Mental Health (Amendment) Act 1964 No. 69*

This amendment relates largely to the control and management of the estates of persons who are mentally ill; of the control of patients' trust funds, and of the power of Medical Superintendents and the Director of State Psychiatric Services to authorise surgical operations on patients.

### **Mental hospitals**

#### *Ryde Mental Hospital Construction Act 1948 No. 2*

This is a short Act to amend the *Local Government Act* to provide for the construction of a mental hospital at Ryde, so that the provisions of Part XIIa of the *Local Government Act* shall not apply. It provided for resumption of the land. The Act proposes that the Hospital should consist of some thirty ward blocks to accommodate 1,400 patients, and that the Minister for Public Works should be the constructing authority.

#### *Gladesville Mental Hospital Cemetery Act 1960 No. 45*

This is a short Act which states the provisions for closure of the cemetery within Gladesville Hospital.

### **NSW Institute of Psychiatry**

#### *NSW Institute of Psychiatry Act 1964 No. 44*

This Act provides for the institute of Psychiatry as a corporate body, describes its educational and research functions, and defines its Board of Directors.

#### *NSW Institute of Psychiatry (Amendment) Act 1971 No. 46*

These are consequential amendments of the Act to delete the word 'Public' from Public Health (the Department having changed its title from Department of Public Health to Department of Health); to correct the title Director-General of State Psychiatric Services to Director; to permit appointment of a professor of psychiatry rather than 'the professor' where two or more chairs exist in a university; and other minor amendments relating to accounting procedures.

### **Mental retardation**

#### *Mental Defectives (Convicted Persons) Act 1939 No. 19*

This Act makes special provision for the care and treatment of mentally defective prisoners. It provides for legal procedures, supported by medical evidence, to have a prisoner declared a mental defective under the Act, whereupon a magistrate, after proper inquiry, can order the prisoner to be detained in an institution during the Governor's pleasure. It provides for appointments of institutions for this purpose, and gives the Inspector General right of access to such institutions.

### **Inebriates**

#### *Inebriates Act 1900 No. 32*

This Act provides for a Judge or Magistrate, on application by the person (while sober), the husband, wife or member of the family, or partner in business, or a member of the police force above the rank of Sub-Inspector, and after medical evidence in verification, to make an order committing the inebriate to the care of a person or persons or in a licensed house or hospital or a private hospital, for a period varying from 28 days for a non-licensed house or hospital or personal custody to a period up to 12 months for care in a licensed institution. It proposes legal safeguards to protect the inebriate during the process of committal and for the care of his estate if he was incapable. The Act provides the mechanism to license institutions for this purpose. No such institution was licensed within the mental hospitals system for some decades until Bloomfield Hospital was established and a section set aside within that institution. There were frequent pleas in the annual reports of the Inspectors General for facilities under this Act to replace the procedure then in vogue of referring inebriates to the control of the Salvation Army.

*Inebriates (Amendment) Act 1909 No. 2*

The *Inebriates (Amendment) Act 1909* states precisely the powers and duties of a guardian of an inebriate; provides for voluntary recognisance; provides for the establishment of inebriates institutions under the control of the Inspector General; establishes conditions for inebriates convicted of other offences and their disposal; makes provision for release on license from inebriates institutions or conditional release; and establishes an Inebriates Board to consist of the Chief Medical Officer to the Government, the Inspector General of the Insane and the Comptroller-General of Prisons. The functions of the board are to recommend removal of inebriates between State Institutions, and to conduct inquiries and report to the Minister.

*Inebriates Act 1912 No. 24*

The *Inebriates Act 1912* was a consolidation of the provisions of the 1900 and 1909 Acts.

*Inebriates Act 1912-1949*

The *Inebriates Act of 1912* was reprinted in 1949 with consolidation of previous amendments of the *Inebriates Act 1900*. There was also included in the Act provision for institutional pensions under the *Mental Institutions Benefits Agreement Act of 1949*.

**Commonwealth Acts***The Lunacy and Inebriates (Commonwealth Agreement Ratification) Act 1937*

This Act provides for an agreement whereby citizens of the Australian Capital Territory could legally be treated in mental hospitals in NSW (the Australian Capital Territory lacking any such facility), and determines a formula for cost-sharing between the Commonwealth and State of NSW. The Inspector General has to report yearly on the locations and numbers of ACT citizens under treatment in state mental hospitals.

*Lunacy (Norfolk Island) Agreement Ratification Act 1943*

This is a similar Act, and in almost identical terms, to the *Lunacy and Inebriates (Commonwealth Agreement Ratification) Act of 1937* to validate the treatment of citizens of Norfolk Island (a Commonwealth territory) in the mental hospitals of NSW, on a cost-sharing basis.

*Mental Institutions Benefits Agreement Act 1949 No. 43*

This Act provides for amendment to the *Lunacy Act 1898-1947* and the *Inebriate Act 1912* and ensures that no means test or charge can be made on qualified persons in mental institutions.

*Mental Institution Benefits Agreement Act 1949*

This Act validates an agreement between the Commonwealth and State whereby the Commonwealth can pay an institutional pension to persons within mental institutions under the *Lunacy Act of 1898* and the *Inebriates Act of 1912-1949*.

*State Grants Mental Institutions Act 1955*

This is a *Commonwealth Act*, following the *Stoller Report*, which provides assistance to the States on the basis of 10/- Commonwealth subsidy to every £1 spent by the States on building or renovation of wards and related accommodation in mental hospitals.

*Mental Health (Commonwealth Agreement Ratification) Amendment Act 1962 No. 14*

This is an Act to validate the powers previously exercised by the Inspector General and now exercised by the Director-General of State Psychiatric Services with respect to treatment and confinement of patients from the Australian Capital Territory who are committed as insane or inebriate, and to provide for admissions, continued treatment and discharges to institutions whose nomenclature was changed by the *Mental Health Act 1958*, and to provide for voluntary admissions. It modifies in these issues the financial Agreement first entered into between the State and Commonwealth in the *Act of 1937*.

**Miscellaneous Acts***Health Commission Act 1972 No. 63*

In the Schedule of this Act there are listed appropriate amendments to the *Inebriates Act 1912*, the *Mental Health Act 1958* and the *Institute of Psychiatry Act 1964*, to provide for the Health Commission to exercise powers under these Acts and supplant the Director of State Psychiatric Services, who is redundant under this Act.

## Commissions, reports and inquiries

The statutory provision for an annual report of the Inspector General of the Insane (Mental Hospitals) provided the vehicle for public disclosure of conditions within the mental hospitals. The repetition and periodicity of these reports were self-defeating and, if anything, had the effect of mollifying any public or official discomfiture. Insane persons, confined within mental hospitals did not influence the ballot box, in fact they were disfranchised, and if conditions were a little worse in the mental hospitals this year than last year it was only marginal and there was no collective protest from the patients. As source documents, the reports of the Inspectors General are important to the historian in delineating the responsibilities and structural details of the administration of the Lunacy Department. As public documents they were ineffectual although occasionally slightly irritating for the moment thereof. I can recollect a Chairman of the Public Service Board expressing his opinion that there was too much emphasis on overcrowding and the unpleasant aspects of staff quality and recruitment failures.

Occasionally there were circumstances which aroused unfavourable reactions, which could not readily be allayed other than by an external inquiry into the mental hospitals. In general, and because of the circumstances surrounding the commissioning of a public inquiry, these investigations were more significant in initiating change and reform. The more important of these are summarised herewith.

### The Royal Commission on Lunacy Law and Administration 1923

Throughout the latter portion of the nineteenth century and the first two decades of the twentieth century there were frequent complaints in Parliament and the press of overcrowding, unsatisfactory accommodation, criticisms of the *Lunacy Act* and its procedures, staff attitudes to patients and inadequate treatment regimes due to staff shortages. In 1923 the Government decided on a Royal Commission consisting of Members of the Legislative Assembly and Council to survey the situation in depth and propose guidelines for future policy and expenditure (117).

The commission consisted of four members each from the Legislative Assembly and Council, under the Chairmanship of Dr Richard Arthur M.L.A., Minister for Health. Other members were Messrs. David Moore Anderson M.L.A., Tom James Hoskins M.L.A., (resigned 15 January 1923), Dr Robert Stopford M.L.A., Sidney Reginald Innes-Noad M.L.C., Edward John Kavanagh M.L.C., Thomas Januarius Smith M.L.C. (resigned 26 February 1923), and John Henry Wise M.L.C. The terms of reference were broad, and the Commissioners were instructed to inquire and investigate (118):

1. The methods of admitting patients to public and private mental hospitals under the provisions of the *Lunacy Act*, No. 45 of 1898.
2. The methods of treating patients in such hospitals, and the methods of discharge from such.
3. What defects, if any, there are in the existing conditions at the abovementioned hospitals.
4. Any improvements that can be suggested in reference to existing conditions in public and private mental hospitals.

The Inquiry was extensive and occupied 48 sittings, at 47 of which evidence was taken. The report was in four parts, covering admission procedures, accommodation, treatment, and mental deficiency. The recommendations were disappointing and inconclusive and did not propose any major changes in lunacy legislation, other than provision for admission of voluntary patients and the possibility of some discharge alternative to Section 99 when conflicting opinions were expressed. Overcrowding was admitted (it could not be otherwise ignored). It was suggested by the commission that special accommodation be provided for idiots and persons of feeble mind; that the hospital for the criminally insane at Parramatta be condemned as unfit for human habitation; that the mental hospital at Orange be constructed to relieve overcrowding; and that the Industrial School for Girls at Parramatta be transferred to the Department of Mental Hospitals to accommodate the criminally insane. There was a further recommendation concerning the appointment of Official Visitors.

The opportunity provided through this Royal Commission to provide a systematic programme for upgrading mental institutions and reviewing the legal basis of insanity was not achieved, nor could it be expected from the composition of the Commission. Further opportunity did not arise until the Royal Commission of 1961. Dr Graham Edwards summarised the impact of the 1923 Royal Commission 'The report was a fairly defensive document in that it defended the problems that existed and did not propose any immediate significant changes'(119).

### Inquiry by the Public Service Board into conditions at Callan Park 1948 (120)

A Public Service Board Inquiry was conducted into the Callan Park Mental Hospital in July 1948, to investigate allegations made in the Sun newspaper, on the state of disrepair of the buildings; the inadequacy of food in quality and quantity; insufficiency of clothing for patients; misuse of patient labour; lack of or improper treatment of patients; and ill-treatment of patients and neglect of duty by staff. The Board of Inquiry consisted of Wallace C. Wurth, Chairman, and Messrs. A.W. Hicks and M.K. Weir, members of the Public Service Board. It reported to the Minister of Health on 4 August 1948.

The report admitted overcrowding, proposed new institutions as long-term measures, and suggested that £100,000 be spent on renovations to mental hospitals in the financial year. It admitted shortage of staff and difficulties of staff recruitment, especially nurses, but made no specific proposals to overcome these defects. It dismissed allegations of poor food, unsatisfactory clothing and staff cruelty to patients.

The report is superficial in its investigations and its recommendations. The impression is gained that it served its purpose to quieten public and political criticism. I am not aware that it conferred any long-term substantial benefit on Callan Park or the mental hospitals, which would not have occurred in its absence. The term 'whitewashing' may be too harsh to describe the exercise. Perhaps it could be described as negative in approach and conciliatory in

its recommendations. This was not unexpected as any substantial verification of the complaints would reflect also on the oversight exercised by the Public Service Board over the Department. No doubt also the newspaper criticism was exaggerated to create an effect. It is interesting that the Royal Commission of 1961 was less apologetic and more trenchant in its criticism.

### The Stoller Report 1954 (121)

The *Stoller Report* was a report to the Commonwealth Government and a preliminary to that Government's interest in formulating a national policy to upgrade State health facilities as a component of a national health scheme. The initial entry by the Commonwealth to provide financial assistance to the States on a predetermined formula was the Commonwealth-States Agreements on tuberculosis. As with the latter, the first proviso of a co-operative effort in mental health was to survey the scene throughout Australia, and Dr Alan Stoller (Senior Psychiatrist of the Repatriation Department) and Mr K. Arscott were appointed to conduct this survey by the Commonwealth Minister for Health, Sir Earle Page. Sir Earle Page was a doctor and the originator of national health legislation following the Constitutional Referendum of 1946, which granted this power to the Commonwealth Government.

Dr Graham Edwards discusses this report in detail in his thesis, and I do not intend to repeat his remarks(122). The significance of the report was the acceptance of the Commonwealth Government of the responsibility to provide financial assistance to the States to renovate and provide modern accommodation in mental hospitals, on a formula of 10/- Commonwealth for each £1 State monies expended. This was confirmed in the *States Grants (Mental Institutions) Act of 1955*.

### The Trethowan Report 1957 (123)

Professor W. Trethowan was Chairman of a Ministerial Committee, appointed by the Minister for Health, to review the *Lunacy Act of 1898*. There were two other members, Mr Stanley Cruise and

...there were frequent complaints in Parliament and the press of overcrowding, unsatisfactory accommodation, criticisms of the Lunacy Act and its procedures, staff attitudes to patients and inadequate treatment regimes due to staff shortages.

Dr E. Marsden. There was disharmony in the committee's deliberations as Dr Marsden submitted a minority report, and Mr Cruise threatened likewise, although the threat did not eventuate. Dr Marsden's proposals retained much of the format of the existing Act, while Professor Trethowan's proposals were concerned with updating and rewriting the Act in consonance with principles of community psychiatry. The Minister accepted Professor Trethowan's version, and his report was the basic document on which the *Mental Health Act of 1958* was modelled.

### The Trethowan Report 1960 (124)

This is a report of a committee established by the Minister for Health to advise on legislative control of mental defectives. Its membership consisted of Professor W.H. Trethowan (Chairman); Mr B. Le Gay Brereton, Education Officer Spastic Centre; Dr Allan Jennings, Senior Psychiatrist, Childrens Unit, North Ryde Psychiatric Centre, and Dr John McGeorge, Consultant Psychiatrist to the Department of Attorney General and of Justice. The report was presented in March 1960, and proposed an Act to be known as *'The Intellectually Handicapped Persons Act'*, which would replace the *Mental Defectives (Convicted Persons) Act of 1939*; extend the scope of control by establishment of an Intellectually Handicapped Persons Committee; and provide for notification and registration. The report was never adopted due to the investigation proposed by the Health Advisory Council. The influence of this report is apparent in the *Third Interim Report of the Health Advisory Council*.

### The Royal Commission of Inquiry into the Callan Park Hospital (125)

The circumstances leading to the Royal Commission into Callan Park Mental Hospital are more redolent of a cloak-and-dagger melodrama than a Public Service Department, which was proceeding, within the resources available to it, towards a more progressive programme of mental health following the passage of the *Mental Health Act of 1958*. It could point proudly to two unique institutions in the Australian context, the Psychiatric Clinic North Ryde with its specialised units and the Cerebral Surgery and Research Unit within the Callan Park Mental Hospital. The reputation of Broughton Hall as a voluntary hospital was high and the teaching unit

therein, under Professor W. Trethowan, was stimulating professional interest in psychiatry as a satisfying career in medicine. There was awakening interest in psychiatric units within the general hospitals and the first inpatient unit was functioning at the Royal Prince Alfred Hospital. A similar type of unit, the Admission Ward for Callan Park, had progressed from the planning to the construction stage. In the first half of 1960 there was no indication that political and departmental equilibrium was to be shattered by a public upheaval, which was to result in industrial turmoil, bitterness, resignations and depots, and a drastic reorganisation of the Mental Health Service.

There are three main characters in the plot which unfolds towards the end of 1960, Dr H.B. 'Harry' Bailey, the Minister for Health the Hon. W.F. 'Billy' Sheahan and Judge John Henry 'Jock' McClemens, a Justice of the Supreme Court, who had published articles on lunacy law in association with J.M. Bennett. In the wings, playing brief but important roles are the Chairman and members of the Public Service Board and the Under Secretary of the Department of Public Health, Mr G.A.G. Cameron. There are other members of the supporting cast, some of whom will be mentioned as they make their appearance.

As the action commences the stage is occupied by Dr H.B. Bailey, who had been Medical Superintendent of the Callan Park Mental Hospital for less than one year. He was recruited into the Division of Mental Hospitals in 1952 to establish the Cerebral Surgery and Research Unit, which was completed in 1958 although not fully functional in 1960. Dr Bailey had returned recently from a World Health Organisation scholarship, and had been appointed Medical Superintendent of Callan Park in 1959, still retaining his position of Director of the Cerebral Surgery and Research Unit.

Dr Bailey was one of a small group of innovative and progressive psychiatrists, who were stimulated to enter the Division of Mental Hospitals of the Department of Public Health by the enthusiasm and example of Professor Trethowan. They saw a challenge to their modernism in psychiatric concepts in deployment in the mental hospitals. Some, such as Drs. Neville Yeomans, Gerald Ogg and William Grant were able to practise these concepts at the modern institution at North Ryde.

Dr Harry Bailey was a person of unusual intellectual attributes with a straight and unconventional approach to problems inherent in the system. In appearance he was also distinctive, a young man with a beard, an unusual sight in those years, which somehow or other seemed to be contrary to the rigid ethics of the public service protocol of dress. He was unusual in his knowledge and skill in electronics which he put to good use in inventing an improved electro convulsive therapy machine and in purchasing and modifying sophisticated equipment within the Cerebral Surgery and Research Unit, and to dubious use when he secretly taped an interview with the Minister for Health, an incident which was later to strengthen the Minister's impression of disloyalty.

As the prelude to the drama, Dr Bailey had discussions with Mr Wallace Wurth, Chairman of the Public Service Board, on a personal matter arising from his World Health Organisation fellowship, during which he made startling allegations against the staff at Callan Park, alleging neglect of duty, dishonesty, cruelty to patients and scandalous behaviour. He was requested to put these allegations in a report, which he did on plain foolscap notepaper in his own handwriting. He claimed that

confidentiality and opportunity for confirmation would be lost by leakage, if the report was to be typewritten by a member of his staff. Alas for secrecy! Dr Donald Fraser, Director of State Psychiatric Services, records that on 5 March 1960, at a barbecue at Broughton Hall Psychiatric Clinic, he heard Dr Bailey discussing these affairs at his hospital with departmental officers. As a result, Dr Fraser subsequently took action to dismiss one staff member of Callan Park and discipline others (126). Rumours quickly circulated throughout the Hospital about the contents and the deployment of staff informers. This report was the infamous 'secret document' delivered personally by Dr Bailey to the Chairman of the Public Service Board in March 1960, and which was later to disappear in the original.



**Callan Park**  
Recreational Grounds 1943

There is no doubt that Dr Bailey was genuinely concerned at the conditions at Callan Park, and rightly so. The hospital had been trenchantly criticised in the past and conditions were ripe for scandal. The standard of accommodation had received adverse comment, but little action, in the Royal Commission of 1923; in 1937 the Minister for Health, the Hon. H. Fitzsimmons, had suggested an inquiry into the administration of the hospital; in July 1948, a Public Service Board Inquiry was held following allegations of staff attitudes and neglect in the *Sun* newspaper, obtained by a reporter who sought and obtained a staff position at the hospital; in September 1949, there was an unsuccessful attempt by the Opposition for appointment of a Parliamentary Select committee to investigate conditions at Callan Park; and, newspaper articles in

1950, the *Medical Journal of Australia* in 1953, and the *Stoller Report of 1955* were all critical of overcrowding, poor accommodation and other unsatisfactory circumstances associated with patient care at the hospital. Early in 1960 prior to Dr Bailey's report, there had been critical articles in the *Sydney Morning Herald* associated with patient escapes, which did not arouse ongoing discussion or stimulate official reaction.

That the scandal did erupt was due in no small measure to Dr Bailey's methods and staff revolt. He was impatient and vigorous in his efforts to achieve reform. Likewise his methods and proposals for solution were unconventional and aroused implacable staff reaction, which was expressed in open resistance to his administration.

It is alleged that this document was conveyed to the Under Secretary of the Department by courier in the person of a senior officer of the Public Service Board, with the instructions that it was not to be disclosed to the Minister. I am unable to determine whether these allegations were true or false as no written documentation exists in support or denial. The allegations are mentioned because they were the circumstance which determined ultimately the establishment of a judicial Royal Commission.

On 14 March 1960, Dr Donald Fraser was summoned by the Under Secretary of the Department of Public Health and given the report to read. He was annoyed that the report had bypassed him and regarded its contents as 'highly disturbing but so grossly exaggerated as to be useless for the purpose of conducting an enquiry' (127). A false prophecy!

That there was justification for Dr Bailey's allegations appeared to be confirmed by the discovery of a locked cupboard full of groceries by the Manager of the hospital, which was the subject of a Section 58 Inquiry by Mr L.C. Holmwood, a member of the Public Service Board. Many of the allegations in the report had implication in criminal law, and these were discussed with the Commissioner of Police, Mr C. Delaney, by Messrs. W. Wurth and G.R.G. Cameron, apparently at this stage without any disclosure to the Minister. Some police action, including search of staff leaving the hospital, aroused further antagonism and bitter resentment, although at this stage there was no threat of industrial action. And so the cauldron simmered until the opening scene.

One can envisage Dr Bailey leading into his role after negotiating with the *Sydney Morning Herald* for free publicity for a fete which was to be held on 29 October 1960, and from which he hoped to raise £50,000. He was reading a feature article in two parts in the *Herald* of 22 October, which was to conclude on the morning of the fete. But the article was not entirely to his liking. The headlines proclaimed:

### Callan Park: Its obsolete system breeds apathy

and then in smaller print somewhat in Bailey's defence:

"If the beginning and end of Callan Parks' troubles were that sections of its staff were incompetent, dishonest and even sadistic, the task of Dr H. Bailey, who was appointed Medical Superintendent late in 1959, would be heavy indeed.

But the staff situation is only one symptom of a more general condition at this mental hospital whose obsolete system of locked wards has bred apathy, dirt and decadence."

He may well have objected to the *Herald's* call for a Royal Commission, but not to its further comment when it stated 'he (Bailey) is resolved to give back Callan Park its self respect'.

The attack by the *Sydney Morning Herald* was not a solitary piece of journalism. The caldron was boiling over and staff industrial action was imminent and could no longer be contained. On the previous day the *Sun* and other newspapers had reported a resolution by 200 male nurses at Callan Park to walk out claiming 'a gestapo-like system is being used to spy upon them'(128). Letters to the Editor of the *Herald* were in profusion in the days that followed, both in support and rebuttal of newspaper and staff allegations, including a reply by Dr Bailey. Industrial action was imminent and both the NSW Nurses Association and the Hospitals Employees Union demanded a full inquiry by the Public Service Board. The plot thickens as two male nurses resigned due to irregularities prior to their employment, which were only discovered after the bubble burst. They were the 'alleged informers'.

The scene shifts to the Public Service Board where Mr J. Goodsell was Acting Chairman following the untimely death of Mr Wallace Wurth. Here action was swift. On 27 October the board decided that it would investigate the situation at Callan Park, and on 3 November, it announced that the investigation would be conducted under Section 9 of the *Public Service Act* by the two legally qualified members of the board, Messrs. L.C. Holmwood, Deputy Chairman, and E. Howitt, exercising the powers of a Royal Commission under Section 10. The terms of reference were(129):

"Whether any patients at the hospital had been subject to neglect or cruelty by any member of the staff at that hospital, and if so under what circumstances and by whom.

Whether money, food, comforts or other articles provided or intended for the use of patients of the hospital were misappropriated or diverted by members of staff.

Whether the procedures and methods directed to be observed at the hospital in relation to the supply and handling of food and other articles for the sustenance and comfort of patients were being adhered to...



The suitability of clothing... The condition of accommodation...

The quality and dietetic value of food...

Such other matters... as the board may consider relevant."

A meeting of the Board of Inquiry was held on 9 November, and adjourned until 22 November, to enable a special committee to make a preliminary investigation on its behalf. This committee comprised Dr C.J. McCaffery, Medical Superintendent of the Royal Newcastle Hospital, Mr V.H. Cohen, Deputy Auditor General and Mr J.B. Holliday of the staff of the Public Service Board.

At this point there was consternation. The secret document could not be located. It was not in the Public Service Board or in the safe at the Department of Public Health. What happened to the original is still a mystery. Whether it was destroyed or lost after its transit to the Police Department cannot be determined. The Under Secretary, Mr G. Cameron, maintained that it was never in his possession after the visit to the Police Department. Fortunately there was a photostat copy within the Police Department from which copies were made for the benefit of the Public Service Board Inquiry.

The hospital had been trenchantly criticised in the past and conditions were ripe for scandal.

Dramatically, there is a sudden shift of scene to Honolulu. The Minister for Health was overseas during this controversy and was returning to Australia when news reached him of the newspaper articles and the 'secret document'. The Hon. W.F. Sheahan was a volatile and dynamic Minister who had totally identified himself with his Ministry, who was familiar with its problems and difficulties, and who had consistently supported his officers, at times to his own disadvantage. He was persistent in his battle for government resources and finance and expected loyalty and support in return. This document was to him an unforgivable act of disloyalty, which was more sinister because of its disappearance and disclosure during his absence. After his return on 15 November, his first action was typical of his impetuosity. He made a visit of inspection to Callan Park on the following day to test personally the validity of the allegations.

Although he publicly refuted the allegations as exaggerated and mischievous, the die was cast. He obtained a copy of Bailey's report, and presented it to Cabinet towards the end of November as evidence of the necessity to have a judicial Inquiry in place of that already commenced by the Public Service Board. He was suspicious generally of the Public Service Board's implication in the drawing and reception of the report. After some misgivings Cabinet agreed to a Royal Commission and appointed the Honourable John Henry McClemens, a judge of the Supreme Court, as Commissioner on 13 December 1960. The terms of reference were similar to those already determined for the Public Service Board Inquiry, to which were added two additional terms(130):

(8) Whether there has been:

- (a) Any neglect of duty by any member or members of the staff of the said hospital:
  - (i) in improperly absenting themselves from their place of duty during hours on which they were rostered on duty
  - (ii) in relation to any deceased patient.
- (b) any improper conduct in attending to the body of any deceased patient.

(9) The truth or otherwise of the allegations contained in the report written by the Medical Superintendent of the said hospital (Dr H.R. Bailey) in March 1960.

The scene is occupied solely for the next nine months by Mr Justice McClemens conducting the Royal Commission. The proceedings attracted daily publicity in the press with emphasis on the more sensational and controversial evidence. The Royal Commission did not deserve this type of exposure. It was a detailed and thorough investigation, centred on Callan Park, but also involving the philosophy of mental health, community and institutional needs and requirements, the status of psychiatric nursing, psychiatric therapy, supportive and rehabilitation services, community attitudes and official responsibilities. As Dr Graham Edwards describes its achievement...

“It achieved not only a thorough investigation into the malaise at Callan Park but a total review of the role and problems of mental hospital care in a contemporary society(131).”

The findings verified factually many of the criticisms made against Callan Park, and found others unproven. Some of the complaints had been rectified before the Royal Commission commenced. Concerning Dr Bailey's report of March 1960, the Commissioner found some justification in part of the charges of staff delinquency and dereliction of duty. His criticism of the report was twofold. It was exaggerated and tended to ascribe generally to the staff the misdeeds of a minority. He dismissed the solutions proposed by Bailey for use of 'dummy staff and patients', unexpected raids and night rounds, and replacement of senior staff etc as 'impossible in the Australian sense(132)'.

The importance of the Royal Commission and its report lies not so much on its conclusions but rather its disclosure generally of deficiencies in the mental hospital system, which were accepted in the past but were out of phase with contemporary social attitudes. The comparison drawn by the Commissioner between NSW and Victoria, under the administration of Dr F. Cunningham Dax, was unfavourable to this State. Drastic change in the administration of mental health was now inevitable, and continued progressively over the next decade. The Commissioner's aspiration was to become fact:

“...and can only hope that, in the interests of the whole community and of the mentally ill, we may be able to justify the assertion that the time is at hand and (our) courage is such that (we) may make history in adopting a new policy for mental health(133).”

There were two scapegoats of the Royal Commission, Drs. Donald Fraser and Harry Bailey. Dr Fraser was deposed from the position of Director of State Psychiatric Services to Senior Relieving Superintendent and Medical Superintendent of the Mental Hospital, Stockton, in September 1961. Dr E.T. Hillard succeeded him as Director of State Psychiatric Services and Senior Medical Superintendent in the same month. Dr Bailey was induced to resign in February 1962, and entered private psychiatric practice.

Even before the report of the Royal Commission it was obvious in 1961 that reorganisation of the Division of State Psychiatric Services was inevitable, and should commence without further delay. Furthermore, it was agreed that any such reorganisation should bridge the gap which existed in the Department between the public health and mental health sectors, and that all professional activities should be under unified direction.

For these reasons I was invited to accept a new position of Director-General of State Psychiatric Services, still retaining my position of Director-General of Public Health to achieve the desired unity, with the proviso that I was to concentrate on planning the reorganisation of psychiatric services, and delegate largely my public health responsibilities to my deputy, Dr E.S.A. Meyers. In turn he would become the Director of State Health Services (in equality with the Director of State Psychiatric Services), and appropriate Acts would be amended to permit this delegation. I agreed to these conditions and was appointed on 1 April 1961. Shortly after, Donald Fraser went on extended sick leave, and Dr W. Grant, then Deputy Director of State Psychiatric Services, acted in his stead.

I accepted the position of Director-General with some reluctance because of the possible adverse effect that this additional blow might impose upon Fraser's waning health, and because of the sympathy that it might arouse for him, and corresponding backlash toward me, from the Medical Superintendents and other staff. Dr E.S. Morris experienced a similar attitude when he accepted the dual positions in 1942, and I was even more vulnerable because of my wide gap in knowledge and experience of psychiatry. My acceptance was conditional on assurances of continued support from the Public Service Board and the Minister; support which was never denied me during my short term of office.

I was by no means astray in my estimate of the reaction to my appointment, and the attitude of the Medical Superintendents was made patently clear to me by their hostility at a meeting I called to outline the plan for reorganisation. Dr E. Ogg, Medical Superintendent of the North Ryde Psychiatric Clinic, resigned immediately in protest, and I still suspect that the later resignation in August of Dr W. Grant was for similar reasons. The consequence of this

opposition was a worldwide recruitment programme for psychiatrists, to attract psychiatrists to the Division of State Psychiatric Services who had knowledge and experience of modern concepts of psychiatric practice and so improve the image of the State Psychiatric Service and the mental hospitals, and also who would owe no loyalties to the system that had existed, and so educate or weaken the enclave of medical superintendents, bound in loyalty to a system which was becoming obsolete. I was given wide powers of employment by the Public Service Board and I proceeded overseas for personal interviews. The campaign was partially successful, not so much by numbers recruited, as by the quality of successful applicants, and the publicity the campaign attracted here and overseas. From thence there was a steady entry into the Department of qualified psychiatrists and a greater response from doctors wishing to train in psychiatry.

1961 was quite a memorable year, not only for the events so described but also for the changeover in senior staff. The professional changes have already been indicated. The Under Secretary and Permanent Head of the Department, Mr G.R.G. Cameron, retired in September, and was preceded by the retirement of his deputy, Mr B.B.C. Hughes in July. Mr Cameron was succeeded by Mr J.D. Rimes, who was the first Under Secretary of the Department with tertiary qualifications. He had pursued a career from boyhood in the public service, and had obtained a reputation for superior administrative capacity as Inspector and Senior Inspector of the Public Service Board. As Departmental Inspector he had acquired an intimate and wide knowledge of departmental institutions, and thereafter until his retirement in 1973, he was a dominant figure in the Department, and particularly in the administration of mental health.

Mr Rimes' concept of the role of Under Secretary was conditioned by his training and experience in the public service. He disapproved of the practice, which had hitherto existed in the Department, of senior professional officers being invited to advise the Minister, and was the protagonist of a single line of communication, even in professional matters. He was assiduous, totally dedicated, and indefatigable in his visitations and staff contacts. He saw himself as the

Drastic change in the administration of mental health was now inevitable, and continued progressively over the next decade.

leader, and did not easily accept that this role might occasionally be more appropriate in other hands. For these reasons, and because he thought it glossed Ministerial authority, he was opposed to the autonomy of the Board of Health under the *Public Health Act*. As President of the Board of Health I was the custodian of this autonomy, a source of difference between us on many occasions. This ideological conflict was an important factor in my later decision to resign the Office of Director-General of State Psychiatric Services. It was one of the reasons I retained the Presidency of the Board of Health during my incursion into psychiatric administration.

Two circumstances were important as the mechanisms of reorganisation, the creation of the Health Advisory Council and the Division of Establishments, although the latter was established for a different objective. Each was essential to the reorganisation and deployment of the facilities of the State Psychiatric Service, the one for planning and the other for management and translation of policy into action.

### The Health Advisory Council

It was obvious before World War II that the competing administrations of the Offices of the Inspector General of Mental Hospitals and the Director-General of Public Health had become entrenched in philosophies, which, although valid in part, were rigidly deployed and resistant to change. The services originating in lunacy and public health were unattractive to responsible and capable members of the medical profession, leadership was anything but dynamic, and originality, change and inquisitiveness were discouraged and regarded as heretical and insubordinate trends. The gulf between the Government health services and the private sector of the medical profession was marked. Only one doctor who graduated in my year (1937) chose public health as a first choice profession, and he looked to England and the Colonial Medical Service and not NSW. Not one entered psychiatry. Generally, both public health and lunacy were regarded as necessary but inferior arms of medicine. These attitudes of the medical profession were in some degree counterproductive, and resulted in further isolation and withdrawal into a caste system within departmental organisations, and a determination to preserve the system.

Any thought of reorganisation of structure or function of the Department of Public Health was untenable during World War II. The rigid hierarchical structure in lunacy and public health was beneficial during this upheaval when shortage of manpower produced a situation demanding rigorous supervision of traditional services with depleted resources.

Experiences gained in World War II in field sanitary control and field medicine; dramatic advances in medical science, technology and therapeutics; demand for welfare services and support; development of hospital services of a highly specialised nature; intrusion of government financial resources to support personal medical services; changing concepts in psychiatry; and dramatic advances in prevention and control of infectious diseases demonstrated vividly the deficiencies in the traditional role and organisation of health departments. Drastic change was inevitable. That it was inevitable was accepted by the Public Service Board and the Minister for Health, the Hon. W.F. Sheahan. The problem was how to grasp the opportunity to effect this change and the creation of a mechanism to do so quickly with minimal disturbance to a career service.

The mechanism had to be one which would be competent and impartial in its assessments and advice; which would be acceptable to the Government, the medical profession and the

community; and which would carry sufficient prestige to minimise personal conflicts and antagonism when career incentives were disturbed by its recommendations. And so was created the Health Advisory Council. When I proposed this Council to the Minister for Health and the Public Service Board, I structured it on similar principles to the policy planning committee associated with the Pentagon in Washington, U.S.A. The Public Service Board and the Minister agreed with the basic concepts that a depth of personal and professional capacity and experience was essential for appointment as a member of the Council, and that membership should be restricted to avoid protracted deliberations and sectional obligations. The latter was achieved by appointments external to the Public Service of NSW.

The Council was constituted early in 1961 to include an expert in each of the three disciplines of health administration (hospitals, preventive medicine and psychiatry), together with an executive member; and the Director-General of Public Health as Chairman. It was granted a considerable degree of freedom in its activities and was provided with a special vote through the Department of Public Health. Its independence from the Department was confirmed by its channel of communication direct to the Minister; and this independence was jealously safeguarded by the Council.

#### The Council as appointed consisted of:

##### Chairman

Dr C.J. Cummins, Director-General of Public Health and State Psychiatric Services.

##### Members

Sir Edward Ford, Professor of Preventive Medicine, University of Sydney.

Professor W. Trethowan, Professor of Psychiatry, University of Sydney

(from January 1962, Professor David Maddison replaced Professor W. Trethowan).

Dr John Lindell, Chairman, Hospitals and Charities Commission of Victoria.

##### Executive Member

Mr R.H. Hicks, C.B.E., formerly Director of the Child Welfare Department.

##### Secretary

Miss Thelma Critchlow.

The function of the Health Advisory Council was expressed in broad terms by the Premier in his official announcement of its establishment. It was left to the Council to specify its areas of investigation and relevant priorities. Due to the urgency to implement a mental health programme in NSW because of the disclosures of the Royal Commission of Inquiry into Callan Park Mental Hospital, the first reference of the Health Advisory Council was to submit proposals for a coordinated programme in mental health in light of modern trends in social and administrative psychiatry and public health, including the problems of the aged.

The Council undertook a study of these components which lasted fifteen months. In formulating its reports the Council considered personal and written submissions received by advertisement or invitation, and either collectively or individually made comparative studies of existing facilities within and external to Australia. The Council visited various States and New Zealand, and two of its members (the Chairman and Dr J. Lindell) visited Canada and examined its health facilities in another model of Federation.

It published three interim reports within 15 months, viz.\*

*The First Interim Report on Preventive Psychiatry* – June 1961.

*The Second Interim Report on the Care of the Aged* – March 1962.

*The Third Interim Report on Intellectually Handicapped Persons* – October 1962.

I remember well Cardinal Norman Gilroy, in his address at the opening ceremony of Caritas Centre then being transferred to St Vincent's Hospital, stating that the unusual value of the reports of the Health Advisory Council was not so much in the contents thereof, although these were pertinent to the problems studied, but in the fact that Government implemented their provisions.

Government indeed! The Minister for Health, the Hon. W.F. Sheahan was the culprit. He would contrive to release each report to the press at a social gathering called for the occasion to gain

maximum publicity. This was assured when he would announce, simultaneously, Government acceptance without consulting his Cabinet colleagues. The resultant favourable public reaction was such that Government of any political persuasion, would find it difficult, if not nigh impossible, to deny or chastise the Minister for his presumption. The time also was opportune, and people and electorates were expecting vigorous action to remedy the revelations of the Royal Commission.

The recommendations of the three interim reports and their consequences on the administration of mental health, both within and external to the Department of Public Health, will be discussed briefly.

### The First Interim Report on Preventive Psychiatry (134)

This report had three important consequences on psychiatric administration. It introduced the concept of preventive psychiatry to NSW; it defined the philosophy and facilities which were necessary, and particularly the role of the general hospital; and, it upgraded the mental hospital system and removed its isolation from general medical practice.

The report emphasised the concept of primary prevention and early diagnosis through health and community educational programmes, combined with a revision of technical education of professionals of first contact, including medical practitioners, para-medical professionals, nurses, clergymen and counsellors.

Specifically it proposed the establishment of early diagnostic and treatment centres, with outpatient, day hospital and inpatient facilities. It recommended that these centres be located in association with general hospitals and with certain mental hospitals. Back-up facilities and public convenience and access were determining factors on a geographic basis in selecting the type of hospital. When associated with mental hospitals, the Council considered that community psychiatric units should be sited outside the hospital boundaries, so that would be separately identified as such.

Any thought of reorganisation of structure or function of the Department of Public Health was untenable during World War II.

\*The Council completed five reports, only three of which were published. The Term *Interim Report* was used by Council as it hoped, at a later stage, to consolidate all its interim reports into one document, spanning the whole of the administration of health services in NSW.

Other important recommendations of the report were, that there should be a process of integration between the Public Health Service facilities and those of the Division of State Psychiatric Services, and that this might be achieved by the latter extending its activities into the community; that the Division should associate itself with psychiatric units in general hospitals, to augment professional resources and to receive long-stay patients from general hospitals into mental hospitals for continuing therapy; and, that psychiatric staff of the Division should be included in the establishments of Health Districts, to act as consultants generally in the District, and develop community psychiatric clinics at the Health District base.

The projects which originated from this report were the establishment of a diagnostic, early treatment and rehabilitation unit in the City of Parramatta (The Eric Hillard Clinic), in association with an inpatient unit for short-term voluntary treatment opposite the Parramatta Mental Hospital, Cumberland House, both staffed from the mental hospital; the conversion of the Reception House, with additional separate inpatient facilities, into the Caritas Centre which was transferred to St Vincent's Hospital; The C.J. Cummins Psychiatric Unit at the Royal North Shore Hospital; a large and elaborate day hospital and outpatient complex at the Broughton Hall Clinic; enlargement and updating of the psychiatric unit already operating at the Royal Prince Alfred Hospital; and, a re-planning of the facilities at Callan Park Mental Hospital to make maximum use of the admission ward as a short term treatment centre. In addition to improvement of treatment facilities, an area of Callan Park was converted to a neuro-physiological research unit under Dr R. Davis. The Cerebral Surgery and Research Unit remained as a separate therapeutic unit, largely inactive apart from its x-ray and electroencephalographic facilities.

The outstanding feature of this period of enthusiasm for reform was that all these facilities were planned and completed within a period of some three years from the publication of the first interim report. That this progress was achieved was due to the continuing support of the Minister; and the co-operative team approach of the public service planning agencies, including the Public Works

Department, the Government Architect and the Hospitals Commission of NSW. A standard plan for a community psychiatric unit speeded the erection of community psychiatric centres at Parramatta, the Royal North Shore Hospital, and shortly after this period, at Watt Street Mental Hospital Newcastle.

There was one other important institution which was created from the recommendations of the first interim report: the NSW Institute of Psychiatry, which was established under its own Act of 1963 as a statutory authority. It was a unique concept, operating independently under its own board of management, to coordinate programmes and facilities for post-graduate training in psychiatry, with additional attributes to establish extension programmes for psychiatric workers, to organise seminars and conferences, and to stimulate and support research. It was funded from the general health appropriation.

The proposal for the Institute met with considerable resistance from the late Sir Victor Coppleson, who considered that its functions should be more appropriately invested in the Post graduate committee in Medicine of the University of Sydney, of which he was Director. Sir Victor had spent many years organising post graduate medical education in NSW and was a formidable foe. I am grateful to the late Sir Stephen Roberts, Vice-Chancellor of the University of Sydney, who persuaded the university to drop its long-established Diploma of Psychological Medicine in favour of the Institute, and who supported me in repelling the attack from his own Post graduate Committee in Medicine.

Under the leadership of its Chairman, Mr Desmond Mooney, and guidance of its first full-time Director, Dr Maurice Sainsbury, the Institute has matured and operated successfully in its educational and extension fields.\* It has enhanced the status of the mental hospitals as accredited institutions to the Institute, in which the practice of psychiatry is taught and demonstrated in the Institute's post-graduate educational programmes. The involvement of departmental psychiatric professional staff has been a stimulus to recruitment to the mental hospitals, and has helped bridge the gap between psychiatric workers in mental hospitals and general hospitals.

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\* Although the Institute commenced operations in 1964 it did not appoint a full-time Director until 5 February, 1968.

## The Second Interim Report on the Care of the Aged (135)

This report had more significance on the function of the State hospitals and their transition to geriatric hospitals than on the mental hospitals, although, as the report stated, the lodgement of psycho-geriatric patients in either was often a matter of circumstance or convenience. The report stressed the role which legitimately is borne by religious and voluntary organisations in this area of charitable care, and proposed support especially to the former. With this objective in view, and in the rather pious hope that it would relieve the burden on mental hospitals it suggested a coordinated approach by religions in combination, rather than in competition, for funds and facilities. So was planned and erected in 1964 a geriatric complex, of four villas at Parramatta, administered by a Board representative of four religions already active in this field. As an experiment it demonstrated that ecumenism was possible, but it did little to relieve the Parramatta Mental Hospital as was intended. The report did stimulate the appointment in 1964 of a Director of Geriatrics, Dr S. Sax, within the Division of Establishments, but his responsibility was largely towards the oversight of State hospitals. The report had only minor influence on the administration of mental hospitals.

There was one other important institution which was created from the recommendations of the first interim report: the NSW Institute of Psychiatry...

## The Third Interim Report on Intellectually Handicapped Persons (136)

This is the most comprehensive report of the three interim reports and traverses incidence by grade of mental deficiency; diagnosis and registration; case-finding and counselling; supportive services; facilities for care and training; formal and special education and training; activity centres; residential and hospital care; hostels; the special needs of babies and infants; parent education; the role of parent groups and voluntary agencies; the mechanism of accreditation and financial support; and legislation.

Where prompt action was possible it was undertaken. The Oliver Latham Laboratories at the North Ryde Psychiatric Clinic commenced a screening programme for inborn errors of

metabolism utilising the Baby Health Centres as the source of contact with newborn babies; formulae were introduced for support of voluntary agencies; educational programmes were coordinated and expanded in the schools system of the Education Department and departmental hospitals; diagnostic clinics were established at the Royal Alexandra Hospital for Children and the North Ryde Psychiatric Clinic; priorities were given to establish or expand sheltered workshops and activity centres; educational programmes were projected to school teachers, parent groups and voluntary workers; and a special residential unit (based on the principles operating at Levin in New Zealand) was approved for immediate planning and construction.

The value of this report was to set the guidelines for future programmes, which would be costly and which would require continuous planning over a prolonged period. The position of Director of the Intellectually Handicapped was created within the Division of Establishments to plan and coordinate programmes involving these concepts. Dr A.N. Jennings was appointed to the position in 1964. The choice was felicitous. Dr Jennings had dedicated his professional career to child psychiatry, as a senior psychiatrist in the School Medical Service and then as psychiatrist-in-charge of the intellectually handicapped unit at the North Ryde Psychiatric Centre. He was well known and appreciated by the medical profession and community and parent groups, and he was able to effect significant changes, both within and without the Department, in attitudes towards mental deficiency.

During the period of his administrative oversight Grosvenor Hospital was established in June 1965, as a diagnostic and training centre; Marsden Hospital was erected and opened in 1969 as a residential unit for children suffering from moderate and severe degrees of intellectual handicap; the Kings School was purchased and converted into an additional residential unit; a special training course for nurses was introduced; the departmental institutions at Peat and Milson Islands and Stockton, were upgraded with greater emphasis on classification and activity and rehabilitation programmes so that patients

undergoing rehabilitation programmes would qualify for invalid pensions;\* and two committees were formed in 1964 to assist in planning and staging the ongoing State programme.

The first of these committees was the Inter-Departmental Standing Committee consisting of representatives from the Department of Public Health, Education, Child and Social Welfare and State Treasury. This committee was charged with appraisal of requests for capital subsidy from voluntary organisations. The Government recognised the major role that voluntary organisations could play in educating and supporting intellectually handicapped persons to remain as members of the community, by offering a subsidy of £3 for every £1 raised towards capital expenditure.

Likewise, the importance of community effort was emphasised by the formation of the Consultative Council for the Intellectually Handicapped representative of the Department and Voluntary Agencies' to function as an advisory and coordinating body in the development of services and community education programmes for the mentally retarded'(138).

After Dr Jennings resigned his position in 1969 to become Medical Superintendent of the Marsden Hospital, this area of psychiatric administration was absorbed within the Division of Establishments. It was no longer a discrete entity.

## The Division of Establishments

The formation of the Division of Establishments in July 1961, was achieved by amalgamation of the Division of Mental Hospital and the Building and Equipment Branch of the Department of Public Health, which serviced both State and mental hospitals. The basis on which it was created is set out in the *Regulation 32(1) Report of the Department to the Public Service Board of 1962*(139):

“In April 1961, the Public Service Board advised the Health Minister that the problems of the hospitals of the Health Department were of such a particular and important character that the creation of an Establishment Division was necessary in the Central Administration. The board felt that only such a Division under a capable director would be able to effect all the improvements considered desirable in foreword planning, in policy formulation and in the day to day care of patients in State hospitals.”

Dr G. Procopis, Inspector of State Hospitals and Medical Superintendent of the Lidcombe State Hospital, was asked to report on the function and organisation of the proposed Division, and it was on the basis of his report that the Division was structured. I understand that a similar Division had operated efficiently in the Department of Child Welfare, although somewhat differently based.

The first five years of the Division's activities were almost entirely directed towards implementing the recommendations of the Health Advisory Council as they related to Mental and State hospitals. From 1966 independent policies started to emerge, and the Division assumed more responsibility for decision-making and policy. Its weakness was its structural organisation concentrating on departmental institutions, with no authority to coordinate departmental services with those established in the general hospitals under the administration of the Hospitals Commission of NSW.

The organisation of the Division reflected its institutional function. Initially there were two senior executive positions, both medical, the Director of Establishments and the Director of State Psychiatric Services. The status of the former was equivalent to a public health or scientific Divisional Director.\*\* Until 1964 the Director of Establishments performed, in addition, the duties of the Inspector of State hospitals, although he did not retain this title. The Director of State Psychiatric Services carried

\* In 1967 the *Commonwealth Social Services Act* was amended to grant the invalid pension to mentally retarded persons over 16 years of age, resident in mental hospitals, provided they were undergoing rehabilitation and were segregated in separate wards. There was similar activity in the general purpose mental hospitals to segregate intellectually handicapped patients into separate rehabilitation wards(137).

\*\* There were two Directors of the Division, Dr G. Procopis until his retirement in June 1972, from which date he was succeeded by Dr W.A. Barclay.



out the statutory duties of his position, including inspectorial responsibilities for the mental hospitals. Two additional medical senior executive posts were established in 1963 and 1964, the Director of the Intellectually Handicapped and the Director of Geriatrics respectively. They were responsible to the Director of Establishments for the oversight of the appropriate departmental institutions. Until 1963 both the Director of Establishments and the Director of State Psychiatric Services were immediately responsible to the Director-General of State Psychiatric Services. After my resignation in 1963 the Director of Establishments was responsible to the Under Secretary of the Department.

In summary the Division of Establishments was an administrative device operating within the Department of Public Health in much the same manner as the Hospitals Commission of NSW operated outside the Department, but lacking the executive authority of the latter. It was a necessary and valuable expediency to complement the Health Advisory Council in achieving the rehabilitation of State and mental hospitals within a defined period, at a time when Government and the Public Service Board were supportive of rapid change. Its image was more dynamic and positive after the Health Advisory Council ceased to function.

The first five years of the Division's activities were almost entirely directed towards implementing the recommendations of the Health Advisory Council as they related to mental and State hospitals.

### The resignation of the Director-General of State Psychiatric Services

The resignation of the Director-General of State Psychiatric Services in 1963 was the first event which presaged the release of the Division of Establishments from rigid administrative restraints and allowed it to pursue its own destiny. After his appointment as Under Secretary in 1961, Mr J.D. Rimes immersed himself energetically in the reconstruction of the psychiatric services. By his personal endorsement he ensured the Success of the Division of Establishments, which at that point had not been received with enthusiasm by many of the senior psychiatric staff who, as a result, saw themselves superseded by the two non-psychiatrists, myself and Dr G. Procopis. Mr Rimes devoted his activities to the mental hospitals leaving to myself, as the Director-General of State Psychiatric Services, the latitude to concentrate on the development of psychiatric units in general hospitals and the community.

Although at first beneficial to the programmes devised by the Health Advisory Council, this division of function resulted in a degree of conflict in which my position as Director-General of State Psychiatric Services became more and more untenable. The Under Secretary established himself within the Psychiatric Service as the dominant figure under which the mental hospitals would retain their influence at the expense of external psychiatric agencies. This became obvious to me early in 1963 when he announced his programme for 'project wards' in each mental hospital, utilising fully the offer of Commonwealth assistance under the *States Grants (Mental Institutions) Act*. This was received quite enthusiastically by the staffs of the mental hospitals, and it was now obvious to me that the mental hospitals had found a leader in substitution of my position as Director-General of State Psychiatric Services. Equally as important to all other considerations which conditioned me to resign was the lack of definition of freedom to pursue administrative policy as Director-General of State Psychiatric Services, vis-a-vis the statutory powers of the Under Secretary as Permanent Head.

I submitted my resignation on four grounds(140):

1. I had accepted my appointment on a temporary basis, and for 2½ years I had devoted myself exclusively to psychiatric administration. I considered that I had exhausted my personal and professional capacities to contribute further to the development of mental health services as Director-General of State Psychiatric Services.
2. That further extension of the programme could not be achieved unless there was continuing leadership within the Government psychiatric services, and stimulation of professional enthusiasm and morale. For this to be effective the executive position controlling the psychiatric services should be filled by a psychiatrist. I was supported in this concept by the Professor of Psychiatry, and also, I was informed, by the psychiatrists in the employ of the Department.

3. That there should be precise definition of the status, responsibilities and authority of the Director-General of State Psychiatric Services. My experience was that it had become a post of senior technical adviser to the Under Secretary, and inferior in concept and practice, within the public service, to my other rank of Director-General of Public Health.
4. That my status in public health had diminished because of my absence.

I agreed to continue temporarily until a successor was found and inducted into the position. Preliminary negotiations with Dr Eric Cunningham Dax were fruitless and Dr Alan Stoller withdrew his application at interview. There appeared to be good prospects of Dr Stanley Smith accepting the position, and he was brought from England to Sydney for interview. Somewhat surprisingly on his return he also withdrew. There were several reasons for the failure of these candidates, all with established reputations, to pursue further their claims. Salary levels were inadequate to persuade them to move to a new location. One other conditioning factor was the lack of definition of their independence from the statutory powers of the Permanent Head(141). There were several unsuccessful applicants from within the service.

My resignation was effective in October 1963, and the post of Director-General of State Psychiatric Services lapsed.

## The Director of State Psychiatric Services

The first Director of State Psychiatric Services was Dr D. Fraser who was replaced in 1961 by Dr E.T. Hilliard. After Dr Hilliard's retirement in July 1963, Dr W.A. Barclay was appointed to the position, at first in an acting capacity and confirmed in 1966. He continued until the position became redundant with the *Health Commission Act of 1972*.\*

A most important consequence of Dr Barclay's final appointment was the directive of the Public Service Board that the Director of State Psychiatric Services was responsible direct to the Under Secretary on matters of psychiatric policy(142).

Dr Barclay was a young psychiatrist, an able administrator with innovative ideas, whose loyalties were largely towards the mental hospital system, which he saw as the instrument which should be stimulated to provide a statewide service. In this concept he was supported by Dr E. Cunningham Dax, who could point to his results in Victoria. If there was one psychiatrist within the Department who could implement this policy it was Dr Barclay, and he proceeded to do so immediately and vigorously.

Before accepting the Harkness Fellowship in 1964, Dr Barclay had been associated with several movements to improve the quality of service in the mental hospitals, including regional admission centres; industrial rehabilitation units within the hospitals; revision of psychiatric nurse training and development of central nursing schools; integration of male and female nursing staff; planning of community units at St. George and Wollongong Hospitals as components of a regional service; and reduction in the population of mental hospitals by alternative placement of institutionalised patients to Allandale Hospital, private convalescent homes and selected hostels.

On his return in 1966 these policies were well established and the morale of staff and patients was high. Reduction in population permitted better classification of patients, specific therapeutic and rehabilitation programmes and rapid turnover to external supportive agencies. Illustrative of this change was the reduction of resident population by approximately 20 per cent over the five-year period ending 1967, accompanied by an increase in the admission rate from 1.93/1000 of the population in 1956 to 4.83/1000 in 1966. This increase was an optimistic trend reflecting, not a resurgence of mental illness, but the capacity of the system to deal with an increased demand from patients seeking early treatment, with consequent short stay and early return to social activity(143).

\* During Dr Barclay's absence on study leave, Dr B.J. Shea was Acting Director from August 1964 to December 1965, to be replaced by Dr A.N. Jennings from December 1965 to April 1966. Dr Barclay was confirmed in the position from April 1966.

The time was opportune to propose a total plan for a comprehensive mental health service. This was outlined in the report of the Director of State Psychiatric Services for 1967(144). It was in four phases:

1. Allocation of regional responsibility for approximately 500,000 to 800,000 people to the admission centres of the four major metropolitan mental hospitals at Callan Park, Gladesville, North Ryde and Parramatta. This concept had been in progress since 1959, the variation being that each hospital would now be totally responsible to provide a comprehensive mental health service for its region. Administrative zones in the country, apart from Newcastle, were not so rigidly defined in terms of population, but rather in broad geographic areas, as eg the south and south-western districts of NSW would relate to Kenmore Mental Hospital at Goulburn, the western district to Bloomfield Mental Hospital at Orange and so on.
2. Associated with regional responsibility would be a subdivision within mental hospitals into sub-regional units with responsibility for adjacent local government areas of 15,000 to 20,000 persons. This had relevance only to the large metropolitan mental hospitals and envisaged admission teams with their own wards.
3. Decentralisation of services into local communities working from existing facilities eg baby health or child health centres. There would be mobile units of nurses, psychiatrists, and social workers available for early assessment of mental illness at the request of hospitals, general practitioners and community agencies.

4. The fourth phase was foreshadowed only, viz decentralisation of inpatient services to link-up with the mobile community teams. These would be introduced at selected general hospitals on the ratio of 0.4 beds per 1,000 of the population over a population spread of 200,000 to 250,000. They would differ from the community units already established at certain teaching hospitals, in that they would be staffed from the sub-regional teams. This phase was never fully implemented, although the units at Wollongong and Wagga District Hospitals followed these concepts.

There were variations of this comprehensive service. One such was the development of outpatient services extending from the mental hospitals to areas within their ambit. Illustrative of this was the capacity of Parramatta Mental Hospital to conduct outpatient clinics at Katoomba, Penrith, Blacktown and Windsor.

The Director of State Psychiatric Services was the adviser in psychiatric matters to the Under Secretary and the Minister. Nowhere was this more important than his involvement in the decision-making mechanisms associated with the State Health Ministers' Conference. Much of this effort was spent in unsuccessful attempts by the States to have mental hospital patients equated with patients suffering from physical illness for the purposes of pension entitlements and hospital reimbursement under the *National Health Act*.

In 1972 Dr Barclay became both Director of Establishments and Director of State Psychiatric Services. He held these positions until the establishment of the Health Commission of NSW, when they were absorbed into the Bureau of Personal Health Services of which he became the Commissioner.

Dr Barclay was a young psychiatrist, an able administrator with innovative ideas, whose loyalties were largely towards the mental hospital system...

## The Alcoholism and Drug Dependence Programmes

In May 1970, Dr D. Bell submitted a plan to the Under Secretary for a Drug Dependence Service in NSW. As a consequence, the position of Assistant Director of State Psychiatric Services was established within the Division of Establishments to develop and take charge of the Drug Dependence Service and Alcohol Treatment Programmes(145). Dr Bell was not appointed to the position. He laid down certain conditions of staffing and freedom of action which were not acceptable to the Under Secretary and the Public Service Board, and he considered that he could not continue within the restraints which could be imposed from both the Director of State Psychiatric Services and the Under Secretary. He resigned from the Service and Dr M. Frame, Medical Superintendent of Gladesville Mental Hospital, was the successful candidate to the position as advertised.

A similar strategy was used as with other functional activities of the Division, viz to appoint advisory councils involving Governmental and voluntary representatives. So were appointed the Interdepartmental Liaison and Advisory Committee and the Drug Services Council. The former was a committee to coordinate activity and resources of Government agencies involved in the detection and treatment of drug dependent persons, and its terms of reference reflected its capacity..

“...to advise on necessary management facilities, examination of changing patterns of the drug scene, and to make recommendations regarding law reform and problems faced by the Department of Health (146).”

The latter committee, despite its prestigious title, was vaguely commissioned with representatives of the Departments of Health and Education, general hospitals, parole and probation services, the Commonwealth Department of Labour and National Service, and voluntary organisations. It had no specific terms of reference but attempted to resolve problems involving duplication of services, unfulfilled needs and difficulties of inter-agency communication. Neither were dynamic bodies and the organisation and direction of the Alcoholism and

Drug Dependence Programme rested with the Assistant Director of State Psychiatric Services, subject to overriding veto from either the Director or the Under Secretary.

The Drug Dependence Programme relied heavily upon a methadone maintenance programme which was controlled by rules established by the Director-General of Public Health, on the advice of the Medical Committee established under Section 30 of the *Poisons Act of 1966*. There were a small number of inpatient units for diagnosis, withdrawal and rehabilitation, which not coordinated, and controlled by individual mental hospitals.

The main inpatient rehabilitation centre for drug addiction was Wisteria House at Parramatta Mental Hospital established by Dr Stella Dalton. Associated with Wisteria House was a self-care hostel for eight persons at Coogee. A further inpatient unit for 24 patients was established at Morisset Mental Hospital. Apart from these designated centres, each mental hospital was available for treatment of addicts seeking voluntary admission. There was also a ‘drop-in’ centre in the City.

The community activity in the drug dependence campaign was from a cadre of drug and alcohol counsellors who functioned in close liaison with community mental health clinics. These counsellors were specially trained and acted in a consultant capacity to community organisations, general practitioners, police and clergy.

The Alcohol Dependence Programme was tackled with less vigour, despite the fact that up to 17 per cent of patients admitted to mental hospitals have primary diagnoses of alcoholism(147). In some mental hospitals, for example Cameron House at North Ryde Psychiatric Centre, there were special programmes, but largely rehabilitation activity remained with voluntary agencies and Alcoholics Anonymous. One external general hospital, the Langton Clinic was the only short-term inpatient and detoxification centre. Surprisingly the *Inebriates Act* remained un-amended, reflecting attitudes and lack of enthusiasm for this campaign. Bloomfield Mental Hospital at Orange continued as the main reception centre for alcoholics committed under the *Inebriates Act*.

The 1960s was a decade of challenge and achievement in mental health in NSW. Probably not since Norton Manning's time has there been so much responsibility thrust upon the Head of the Psychiatric Services. Certainly in no previous era has so much been accomplished in one decade. From a depressed service the system of mental hospitals was transformed to a service in which psychiatrists were proud to serve and the medical profession proud to acknowledge. Much of the credit rests

with the Division of Establishments and those who guided its destiny. Despite its success the demise of the Division of Establishments was inevitable with the concept of integration of the administration of general and departmental hospitals implicit in the formation of the Health Commission of NSW. Perhaps in the context of current events this was fortunate. History recalls periods of renaissance under Drs. Frederick Norton Manning and Eric Sinclair followed by equally despondent sloughs.





### **Royal Newcastle Hospital**

Poliomyelitis was a scourge right up to the 1960s. In this 1938 picture a polio patient, Max Lumley, is treated in an iron lung by Newcastle Hospital nursing staff members E. Pullen and N. Wynn

# The Ministry of Health

The Ministry of Health was established in 1913 by the Holman Government when the Hon. Frederick Flowers was appointed the first Minister for Health with the portfolio of Public Health. This appointment was consequential to the retirement of Dr Ashburton Thompson as Chief Medical Officer of the Government and his replacement by Dr Robert Thompson Paton. The Government took the opportunity provided by this changeover of executive authority to integrate the administration of the health Acts, health institutions and services into a unified departmental structure. George Paton was the obvious choice to achieve this objective. He already had a long career in the public service, in the latter years of which he displayed administrative capacity in his supervision of State asylums and Charities as Inspector General of Charities and Head of the Branch of the Government asylums for the Infirm. His supervisory powers were extended to metropolitan hospitals in 1912 and his title was altered correspondingly to Inspector General of Metropolitan Hospitals and Charities. Although he was not the senior of the medical officers in the Government Health Services, the imminence of his promotion was forecast when he was appointed Chairman of the Tuberculosis Advisory Board in June 1912. This board comprised the most senior and influential doctors of the time, the litany of which brings back nostalgic memories of the grand masters of medicine and surgery, in an era when individual reputations and skills were attributes for public discussion. It was inconceivable that the Government medical institutions would be divorced from Paton after his promotion, and he (and successive Directors General) continued as Inspector General of Hospitals and Charities as well as Chief Medical Officer of the Government. It was logical to return the Bureau of Microbiology to the Department of Public Health and transfer the Board of Health from the Treasury to the new Ministry. The amalgamation of health services ranging from public health

supervision and control of infectious diseases to scientific divisions and health institutions demanded a title indicative of the change and the enhanced status of Robert Paton in the Ministry. He was appointed Director-General of Public Health.

The other addition to the Ministry was the organisation of the Inspector General of the Insane, including the mental hospitals, the Deputy Master in Lunacy and other appurtenances of the *Lunacy Act of 1898*. The only health units which remained within the administration of the Colonial Secretary's Department were the Professional Boards, at that time the Medical Board, the Dental Board and the Pharmacy Board. There was no attempt at this stage to transfer medical services provided by other Departments, such as the Department of Public Instruction, into the new Ministry. That was to await a further development in 1941.

## The Office of the Director-General of Public Health and the Department of Public Health

The Department of Public Health, when transferred to the Ministry of Public Health in 1913, consisted of a central administration servicing the Chief Medical Officer of the Government, the public health sanitation and infectious diseases services; the Pure Food Branch; the Private Hospitals Branch; the Veterinary Branch; the public health laboratories; the Government Medical Officer and staff (including the gaol medical services), and the Hospitals Admission Depot. These were housed at 93 Macquarie Street from 1898, in a building built to accommodate the laboratory services. After the amalgamation of the State hospitals with the public health services, the central administration of the Director-General was known formally as the Office of the Director-

General of Public Health, in consonance with the similar title for the administrative unit of the Inspector General of the Insane. The clerical sector of the Office of the Director-General of Public Health serviced the Board of Health, and the Secretary to the Director-General was also Secretary of the Board of Health. The location of the clerical services of the Office of the Director-General of Public Health was moved to rented

premises at 52 Bridge Street in 1935: the scientific services, the Government Medical Officer's Branch, the Hospitals Admission Depot and the Venereal Diseases Branch remaining at 93 Macquarie Street. The Board of Health met in the boardroom of the Chief Secretary's Department until 1935, after which it enjoyed its own boardroom in Winchcombe House at 52 Bridge Street.

### The seniority levels of the headquarters staff of the Office of the Director-General of Public Health in 1913 were:

Robert Thomas PATON, Director-General of Public Health

George William ARMSTRONG, Senior Medical Officer of Health

Frank Martin SUCKLING, Assistant Medical Officer to the Government

Arthur Aubrey PALMER, First Government Medical Officer for Sydney

Arthur Charles CAHILL, Second Government Medical Officer for Sydney

George Hulton Smyth KING, Secretary

James Julius POTTER, First Clerk

Ernest John THRONWAITE, Accountant

Alfred LAKE, Inspector of State Hospitals

Nine clerical officers, three junior clerks, eight shorthand-typists, three attendants, one messenger and one night officer (for the Hospitals Admission Depot)

This pattern of staffing and relative seniority did not alter substantially until 1941 when the administrations of public health and mental hospitals were amalgamated in yet a further reconstruction of the Ministry.

The Office of the Director-General of Public Health contributed the greater variety of services, although not the greatest numbers of staff, to the Ministry. The latter was provided by the Office of the Inspector General of the Insane and the staffs of the mental hospitals. Although their administrations were separate, that of the Director-General assumed a superior status within the Ministry, due to his official endorsement as Chief Medical Officer of the Government. There was very little interaction between the two major professional sectors. Their seniority lists were separate and staff feeling was one of veiled hostility, or at the best indifference, each to the other. This had not altered substantially when I joined the Department of Public Health in 1950.

## Ministers of Health

Since 1913 the Ministry of Health has continued, often in a combined portfolio until 1925, since which, with one exception, it has been a single portfolio. There is no significance in the various designations of Minister of Public Health or Minister of Health. The term public health was commonly used prior to World War II as a generic description of health services indicating professional and public preoccupation with infectious diseases and their aftermath. The term Minister of Health conjures up a wider scope of administration and the economic significance of institutions and hospitals in government budgets. It was the Ministry nomenclature of the Commonwealth and other States, and probably for no other reason than uniformity was adopted in NSW.



**Ministers of Health since the Hon. Frederick Flowers to 1973 are:**

1915	George BLACK, Col. Secretary and Minister of Public Health
1916	John FITZGERALD, Minister of Public Health and local government
1919	David STOREY, Minister of Public Health
1920	Albert MOLL, Minister of Public Health
1920	John Joseph McGIRR, Minister for Public Health and Motherhood
1922	Charles OAKES, Colonial Secretary and Minister of Public Health
1925	George CANN, Minister of Public Health
1927	Robert STUART-ROBERTSON, Minister of Public Health
1927	Richard ARTHUR, Minister of Public Health
1930	James McGIRR, Minister of Public Health
1931	William ELY, Minister of Health
1932	Reginald WEAVER, Secretary Public Works and Minister of Health
1935	Herbert FITZSIMMONS, Minister of Health
1941	Christopher KELLY, Minister of Health
1950	Maurice O'SULLIVAN, Minister of Health
1956	William SHEAHAN, Minister of Health
1965	Arthur Harold JAGO, Minister of Health
1973	John WADDY, Minister of Health

There is no classification of Ministries in NSW at a political level, each Minister belonging to the one central cabinet. One gets the impression that unofficially it was not regarded as a prestige Ministry, although some occupants later achieved higher political posts, and others personally had strong political influence within their parties. It became a more difficult and significant Ministry of recent years because of Commonwealth involvement in health under the *National Health and allied Acts* and the major economic demands that the health profession and health institutions made on the public purse.

Generally it was a demanding portfolio for personal visits and appearances, and the interest and vigour of the occupant determined the public image of the Ministry and its services. The most interested and vigorous Minister of my experience was the Hon. William 'Billy' Sheahan, during whose period significant changes took place in health administration. But, 'Billy' Sheahan regarded no office as a sinecure and was equally as vigorous, and sometimes as controversial, in his other portfolios. His Department owes much to him for his support of reform and of his officers in difficult and trying circumstances.

The relationship of the Minister to his senior staff is important in a professionally orientated Department. My impression was that Ministers until 1965 did not differentiate significantly between the professional Heads and the Permanent Head, but sought advice as appeared appropriate. Certainly it was so with me and the Hon. W.A. Sheahan, and my observations of my predecessors confirmed this close relationship with their Ministers.

The Minister consequent from 1965, the Hon. A.H. Jago, was strongly influenced by the Under Secretary in maintaining very formal lines of communication through the Permanent Head. In fact written instructions were issued to this end involving both internal and external communication. The gulf became so wide that on one occasion it was proposed that it would be unnecessary for the Director-General to accompany the Minister to the Australian Health Ministers Council. I record with some amusement and appreciation that there were personal pressures exerted from other State Ministers, two of whom offered me senior positions if I wished to emigrate.

## The administration of hospitals and charities

Prior to the establishment of the Ministry of Health, the administration of hospitals and charities was a function of the Colonial Secretary's Department. The lunatic asylums were the responsibility of the Office of the Inspector General of the Insane after the *Lunacy Act of 1878*. This aspect of the administration has been explored in the chapter relating to the administration of mental health. As a preliminary to the exposition of the organisation of the Ministry, a brief account will be given of the administration of general hospitals, State hospitals, and private hospitals and rest homes.

### General hospitals

It cannot be stressed too frequently that general hospitals developed as voluntary charities for the indigent poor, and survived essentially on the subscriber system, with irregular Government assistance, during the nineteenth century. Each hospital possessed its own executive authority in its hospital board and Government intrusion was minimal. They operated under the *Public Hospitals Act of 1896 Act No. 16*) which was enacted subsequent to the Acts 11 Vic. No. 59, 45 Vic. No. 3 and 58 Vic. No. 6. This Act defined the procedures for election of the boards of hospitals by subscribers, and nominated the Treasurer as the person who could sue or be sued on behalf of a hospital. The Act included a schedule of hospitals to which its provisions were to apply. The statutory hospitals were not included in the listing.

There was no section within the Colonial Secretary's Department prior to the Royal Commission on Public Hospitals and Charities in 1897 dedicated to the oversight of general hospitals, and such supervision as was necessary from time to time was handled by the Division of Charitable Institutions. It was not until 1912 that a degree of supervision was formally structured by the appointment of Dr Robert Paton as Inspector General of Metropolitan Hospitals and Charities, and this responsibility was transferred with him when he was appointed Director-General of Public Health in 1913. In his report of that year he drew attention to the shortage of accommodation in metropolitan hospitals, and the urgent need for increase in infectious diseases accommodation in both Sydney and Newcastle.

The main avenue of admission to general hospitals, as well as State hospitals, was the Hospitals Admission Depot, and some idea of the demands upon this agency can be gleaned in the 1916 report (reflected also in subsequent reports). Over 12,000 persons were examined for admission, of whom 3,420 were diverted to the Coast Hospital, 436 to the Royal Prince Alfred Hospital, 267 to Sydney Hospital 172 to the Women's Hospital Crown Street, and 117 to the Hospice for the Dying. The remainder were admitted to the State Asylums for the Infirm.

Robert Paton complained on several occasions about the haphazard arrangements for administration of public hospitals. He had little authority other than 'examination and revision of all plans for erection of new hospital buildings or for alterations and additions' (148). If approved, and if finance was available, assistance for capital expenditure was provided by the Government, which also met the deficit between income and expenditure on a £1 for £1 basis.

Paton's pleas were heard and in June of 1918 the Hospital's Advisory Board was created with himself as Chairman, and Doctors W.G. Armstrong, Richard Arthur, G.H. Taylor and the Under Secretary, Mr E.B. Harkness as members. The board was advisory only to the Minister, but nonetheless a forecast of what was to come.

By 1923 the situation had not improved. The Director-General, William George Armstrong was forthright (149):

"The question is a very important one for the State, as the method of control of Public Hospitals throughout NSW is rather haphazard... The Government which contributes practically half the cost of all hospitals retains very little effective control over these institutions, and hospital committees throughout the State have the power to do very much as they please. It is understood that a Bill is to be presented to Parliament at the forthcoming session."

A conference of various persons, organisations, and bodies connected with hospital administration took place in March and June, presided over by the Minister to assist him in drafting a new Hospitals Bill. William Armstrong was sent to New Zealand, Victoria and South Australia to report on the

legislation and administration of public hospitals in those areas. Dr M. MacEachern, who had a wide experience of hospitals systems in Canada and America, was invited by the Minister to report on the system in NSW during his visit in 1924(150).

Despite these reports, and continuing protests from Dr Dick who succeeded William George Armstrong, no action was taken until 1929. In that year the Hospitals Advisory Committee was dissolved and the *Public Hospitals Act* passed. It constituted a Hospitals Commission as a separate statutory authority within the Ministry of Health and external to the Department of Public Health. The significance of this Act was to confine the Commission to the administration of general hospitals. The administration of Charities and Private Hospitals remained with the Director-General of Public Health. The historical development subsequently of the Hospitals Commission is not pertinent to this document other than its location as a statutory authority within the Ministry of Health. Surprisingly the title granted to Paton in 1912 was only inconsequentially modified, and Robert Dick and all succeeding Directors General were still appointed as Inspector General of Hospitals and Charities.

### Private hospitals

Since the passage of the first *Private Hospitals Act of 1908* the administration of private hospitals has been a responsibility of the Chief Medical Officer and the Director-General of Public Health. The *Consolidated Act of 1954* included rest homes in its licensing provisions, as the prelude to Commonwealth assistance under the National Health Scheme. The Private Hospitals Branch was responsible for periodic inspections of private hospitals and rest homes, for advice on licensing and renewals and for orders on licences in compliance with the Act. The licensing authority was the Board of Health and for this reason the administration was

originally placed with the Chief Medical Officer. From 1950 there was a dual inspectorial service from the staff of the Commonwealth Department of Health prior to approving individual private hospitals or rest homes for hospital or nursing home benefit under the *National Health Act*. The requirements of the State were published in the Regulations to the *Private Hospitals Act*; those of the Commonwealth were not published. This led to conflicts of opinion and confusion as to the standards which were never satisfactorily resolved.

The Branch was a small administrative unit with a Medical Officer of the Department in charge and a number of nurse inspectors. It was transferred to the Hospitals Commission of NSW in 1972 by amendment of the *Private Hospitals Act 1908-1954*.



**Newcastle Mater  
Misericordiae Hospital**  
Children's Ward, 1939

### State hospitals and homes\*

In many aspects the State asylums for the Infirm (the forerunners of the State hospitals and Homes) were complementary to the lunatic asylums in their function and development. Both systems were expressions of Government philosophy in the nineteenth century towards social and economic indigency, just as their development in the

twentieth century into therapeutic institutions reflected consequential changes in this attitude. They served, and still serve, segments of the community to which the State considers it has a social responsibility to discharge.

There was a critical point in each of these systems when change was inevitable. In the psychiatric services it was the *Lunacy Act of 1878*. In the State benevolent asylums it was the Royal Commission on Public Charities and Hospitals of the Colonies appointed in 1897 under the Chairmanship of Joseph Barling, who was also Chairman of the Public Service Board. Although it never took evidence on the State asylums for the Infirm (which were

\* A brief historical sketch of the development and function of each State hospital is provided in Appendix 9.

included in its terms of reference), undoubtedly it stimulated a coincidental inquiry by the Public Service Board. Unfortunately the proceedings of the Public Service Board Inquiry have been lost and it is not possible to estimate its influence in formulating changes in the administration of these institutions within the Colonial Secretary's Department.

Hitherto there was a small administrative unit within the Department, the Division of Charitable Institutions, under the Senior Inspector of Charitable Institutions. This provided a loose system of supervision of all charities including the government asylums for the Infirm. The reports of the Royal Commission consistently emphasised that this system be strengthened, especially towards public charities, as the basis for continuing subsidy. In 1901 this Division was split into two sections, the State Children's Relief Branch and the government asylums for the Infirm Branch. In 1906 the latter was extended to cover all subsidised charities and the Director was appointed Inspector General of Charities.

Dr Paton was transferred to this position in 1908, and when he was appointed Director-General of Public Health in 1913 the Department of Charities was amalgamated with the Department of Public Health. Thereafter until 1938 the position of Inspector of State hospitals was a senior post in the clerical administration of the Office of the Director-General of Public Health. After its abolition in that year responsibility for inspections and supervision generally was delegated by the Director-General to the Senior Medical Officer of Health and then the Deputy Director of Public Health, when the latter position was established in 1942. It remained a responsibility of the Director-General's administration until it was transferred to the Division of Establishments in 1963.

Admissions to State hospitals were via the Hospitals Admission Depot. In latter years hospital patients were accepted by the Depot on request from metropolitan general hospitals and private medical practitioners, each State hospital notifying the depot daily of its vacancies. The exceptions were the tuberculosis hospitals at Waterfall and Randwick. The tuberculosis waiting list was maintained and operated in strict chronological sequence by the Director of Tuberculosis. Prior to World War II, when the Coast

Hospital was the main repository for hospital admissions from the depot, most patients attended in person and were medically examined and classified at the depot. 'Home' inmates were required to present personally to the depot and make personal application for admission. There they were issued with a rail pass to Lidcombe, Liverpool or Parramatta stations when they were met by hospital attendants. On arrival at the State hospital they were compulsorily bathed and issued with institutional clothing. The routine on arrival was the same for female patients, who were delivered by relatives or friends at Newington having first receiving approval from the depot. After reception inmates were medically examined and classified as feeble (non-workers), or hospital cases, or fit to work.

The home sections of the State hospitals were modified poor houses and were units of all State hospitals including the tuberculosis hospitals, David Berry Hospital and Strickland Convalescent Home. The latter institutions were supplied direct with working inmates from the Hospitals Admission Depot. Those assigned to work were given set tasks under Outdoor Attendants on the farms or grounds, in the kitchens and laundries. They were paid one shilling per day and were known as 'bob a day' workers. Special overseer posts were paid three shillings a day. The hospitals provided a refuge for alcoholics, derelicts and unemployables who were the main cadre of the working inmates. The situation was ingrained and accepted, and despite continuous protests from medical superintendents, was justified on the grounds of economy and as a rehabilitation measure. I have never seen any statistics justifying the latter claim. Of recent years the situation was modified as the State hospitals became therapeutic geriatric units and as the farm lands were abandoned and used for other purposes, or disposed of as convenient land to other Departments or Divisions.

A feature of the State hospitals were the farming activities, copied from the mental hospitals where they were introduced as therapeutic facilities. In the State hospitals, as I knew them, the farming industry was largely restricted to pig farming, although in the past there had been dairy and other pastoral activities. Even the small obstetric and convalescent State hospitals of the 1920s reported proudly each year on the productivity of their vegetable gardens.

Even less desirable was the earlier practice to use inmate workers as maids, servants, cleaners, laundresses, ironers, cooks and nursing assistants. It was the use of this labour which permitted costs to be restrained in comparison with general hospitals, but it was also responsible for the ill-reputes in general of the State hospitals in public and professional opinion. It was almost a phobia within the Department that these hospitals had to demonstrate a financial self-sufficiency which was a carry over from the conditions so soundly condemned by the Royal Commission on Hospitals and Charities.

The Medical Superintendent and Matron of the State hospitals and Homes were the lord and lady of the manor, and ruled as such demanding obeisance from patients and staff alike. They were constantly bickering and at ends with each other, like a married couple after the first blush of the honeymoon had faded. But let any intruder dare to question their autocracy and they were united as one in defence. They were institutions within their institution and frequently as well renowned.

Next in the hierarchy was the Manager, which was the most senior clerical position to which the majority of clerical staff could aspire in the Department. Clerical progression was from junior clerk at entry, usually in the central office, to the ranks of hospital clerks of various grades, hospital accountant, assistant manager and manager. The bulk of their experience was obtained in State and mental hospitals, and they were responsible for the daily administration of the hospitals. The capacity of the medical superintendent as executive officer was a cause of conflict between managerial and professional staff, especially in the situation, which was not uncommon, of a strong manager and a weak superintendent.

One of the very positive contributions of the State hospitals was the nurse-training programmes, male and female. This was by a system of inservice training and lectures, and the dedication of this staff to their patients, often under most difficult circumstances, was deserving of utmost praise. Trained nurses were difficult to recruit because of the type of work and industrial conditions, and were used in key positions of a technical nature such as operating theatres. The burden was borne by State-trained nurses and adequately accomplished. The situation is now reversed as more wards qualify for Commonwealth assistance under the *National Health Act*, to the stage that Lidcombe Hospital is recognised as a training school for general trained nurses.

The State hospitals did provide a supplementary system to the general hospitals, catering for aged patients, or those with intractable chronic diseases. They can be classified under a number of headings: State hospitals, convalescent homes, general and maternity hospitals, and tuberculosis sanatorium.



**The Coast Hospital**  
Trainee nurses at 'The Coast'  
La Perouse, Sydney NSW  
Early 1900's

### State hospitals

These were the core of the State hospitals and the derivatives of the State asylums for the Infirm. They provided refuge for the indigent poor; sick and homeless. After 1950 much of their function was taken over by private rest homes operating within the National Health Scheme. Two major State hospitals were closed and the remainder developed as geriatric hospitals and rehabilitation centres. The list of State hospitals and Homes is: Liverpool State Hospital (1851-1958); Macquarie Street Home Parramatta\* and Aged Couples Cottages (1862-1936); Newington State Hospital (1882-1964); Lidcombe State Hospital (1893-); Garrawarra Hospital, previously Waterfall Sanatorium (1958-); and Allandale Hospital, Cessnock (1963-).

\* The Macquarie Street Home Parramatta was also known as the Home for the Blind and Men of Defective Sight and Senility.

## Convalescent homes

Convalescent homes were provided by the State to assist poor persons recovering from illness, or showing signs of malnourishment. With one exception, the State has opted out of this field of care. The three convalescent homes were: Denistone House Eastwood for males (1913-1933); Carrara (Strickland) Vaucluse for females (1915-); and Fernleigh Rest Home (Pre and Post-Maternity) Ashfield 1920-1930. Carrara has a dual purpose and provides permanent lodging for a group of women who are socially bereft and unable to cope with independent living,

## General and maternity hospitals

These are of historic interest and comprise: the Coast Hospital (1881-1935); the Lady Edeline Hospital for Babies Vaucluse (1913-1935); and the David Berry Hospital Berry (1909-). Both the latter were unique among State hospitals. The Lady Edeline Hospital had its own board and the David Berry Hospital was a foundation to the State confirmed by its own Act.

## Tuberculosis sanatoria

The Department of Public Health was always heavily involved in the treatment of tuberculosis and provided the major sanatorium in 1911 for this purpose at Waterfall, the State Sanatorium for Consumptives. Following the success of the anti-tuberculosis campaign, Waterfall was converted to a geriatric institution in 1958, and renamed Garrawarra Hospital. When the Coast Hospital ceased to be a State hospital in 1935 the Department accepted responsibility for its tuberculosis patients in the Randwick Auxiliary Annex. This was renamed the Randwick Chest Hospital and is still in operation for the diagnosis and treatment of tuberculosis. It was the centre for thoracic surgery for patients from departmental hospitals, including mental hospitals.

## The organisation of the Ministry of Health

The Ministry of Health was composed of a number of administrative or advisory units grouped around the Minister and comprising statutory authorities, advisory committees and the Department of Public Health.

### Statutory authorities

The Statutory Authorities were the Board of Health (1882-1972), the Hospitals Commission of NSW (1929-1972), the Milk Board (1931-1955), the Ambulance Transport Board (1920-1976), the NSW State Cancer Council (1955-), and the NSW Institute of Psychiatry (1964-). With the exception of the Board of Health, the Chairmen of these statutory authorities had direct access to the Minister, and their administrations were independent of the administration of the Department, and of the Under Secretary as Permanent Head of the Department.

### Advisory committees

The advisory committees were of two types, statutory and Ministerial. The Statutory Advisory Committees were involved in the administration of certain health Acts, and their composition was defined in the appropriate Act. In general there was a fair content of expert representation from external agencies, and the Chairman was the Director-General of Public Health or his nominee. They were largely concerned with advising on the formation of regulations, although some had specific authority pertinent to the Act itself and its administration. The list comprised the Pure Food Advisory Committee, the Poisons Advisory Committee, the Air Pollution Advisory Committee, the Radiological Advisory Committee, the Clean Waters Advisory Committee, the Fluoridation of Water Supplies Advisory Committee, and the Investigating Committee under the *Medical Practitioners Act*.

The Ministerial Advisory Committees were appointed by the Minister, usually on a personal rather than representative basis. They advised on particular problems and existed at the discretion of the Minister. Action flowing from these committees was taken by departmental administrative units. They were four in number although some were very influential because of their collective professional prestige. The more important were the Special Committee Investigating Maternal Mortality (now the Maternal and Perinatal Committee), the Special Committee Investigating Anaesthetic Deaths, the committee for the Physically Handicapped, and the State Nutrition Committee which functioned during World War II.

Somewhat allied to Ministerial Committees was the one Foundation associated with the Ministry. This was the King George V and Queen Mary Foundation for Infants and Babies established by its Act of 1937, under which a welfare fund was established to commemorate the twenty-fifth anniversary of the coronation of King George V. The income from the fund was to be utilised in the work of investigation and research into the causes and treatment of maternal and neonatal mortality and morbidity... and postgraduate teaching in relation to maternal and neonatal welfare. It was dissolved at its request by amendment of the Act in 1968, and its capital donated to establish an obstetric hormonal laboratory.

### The Department of Public Health

The Department was the largest and most diverse unit of the Ministry, and reflected changing patterns in health needs and administration. There were three epochs from 1913, the first to 1938 when the first Under Secretary of Health was appointed as Permanent Head, the later reorganisation in 1941 following a report by Dr E.S. Morris, and the reorganisation following the Royal Commission of Enquiry into the Callan Park Hospital in 1961.

### 1913 to 1938

The organisation of the Ministry was static between 1913 and 1938 during which period it was a major Department of the Colonial Secretary's Department. It is represented diagrammatically in Table I.

### The Morris Report

The next phase was the regrouping of health services in 1941 within the independent Department of Public Health, including the amalgamation of public health and mental health.

The circumstance leading to the restructuring of the Department were practical and mundane and are

contained in the appropriate Public Service Board file. The impact of World War II was being felt and there was pressure on Government Departments to conform to the constraints of a reduced budget, and yet maintain essential services with such manpower as was available. Reasonably the Armed Services had priority, and Government Departments were expected to perform their functions, and develop additional functions supportive of the war effort from straitened resources.

At this point of time there were two major health

organisations in the Ministry of Health, the Offices of the Director-General of Public Health (including the Board of Health) and the Inspector General of Mental Hospitals, each independent, and, in some aspects, competitive of the other. There were minor health units external to the Ministry of Health in the Chief Secretary's Department, the Department of Social Welfare, the Department of Labour and Industry, and a major health service within the Department of Education catering for the medical and dental needs of the schoolchildren of the State. Mr John Goodsell (later Sir John) then Senior Inspector of the Public Service Board, proposed to the board that all medical units should be aggregated within one Department of Public Health, to



**Dr E.S. Morris**  
Health Department, 1953  
*(The Morris Report)*

Table 1. Organisation Ministry of Health 1913-1938

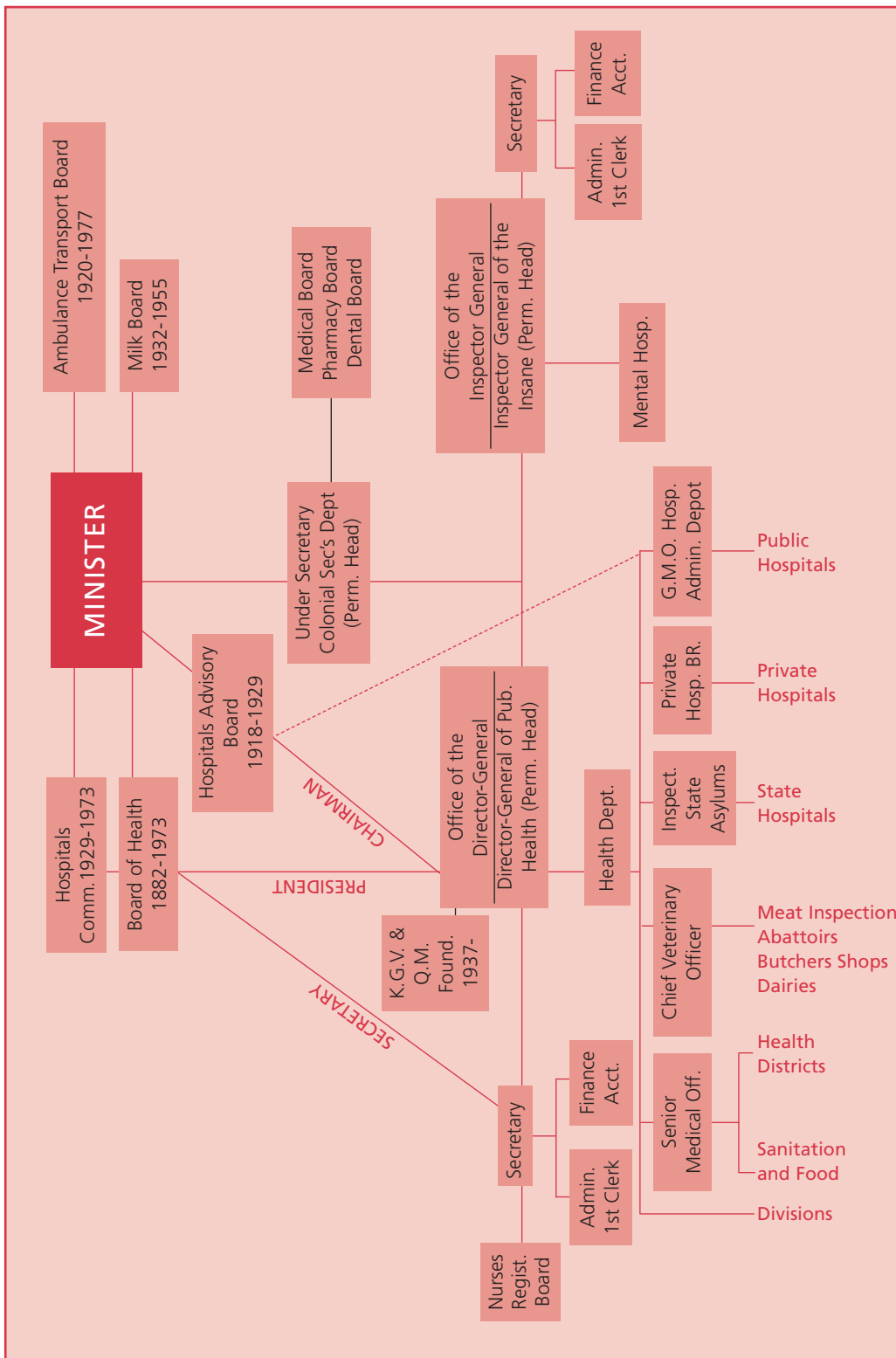




Table 2. Organisation Chart Morris Report (Adapted)

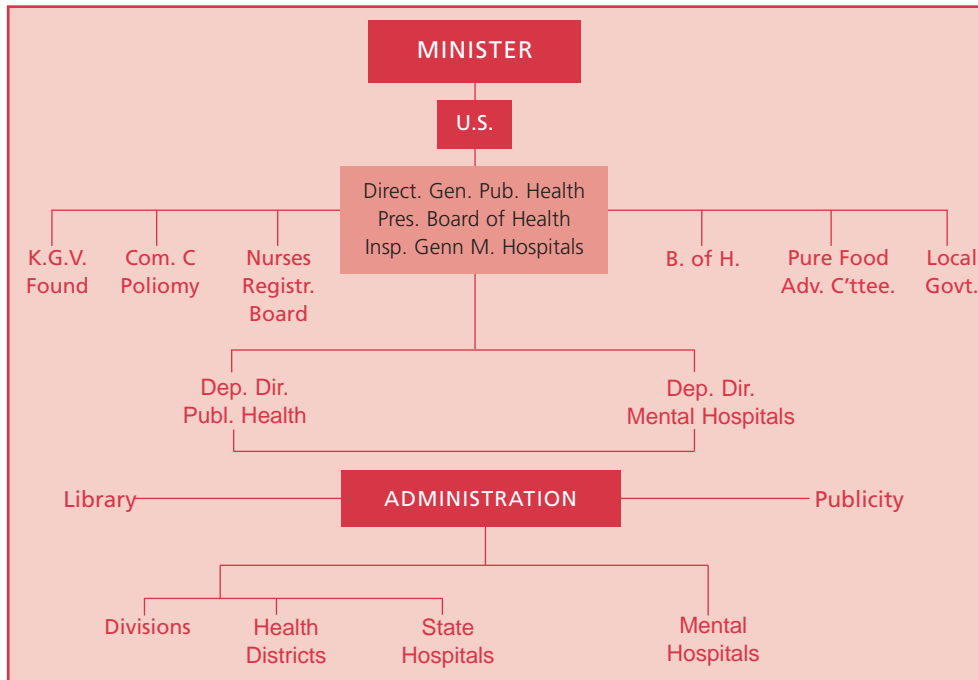
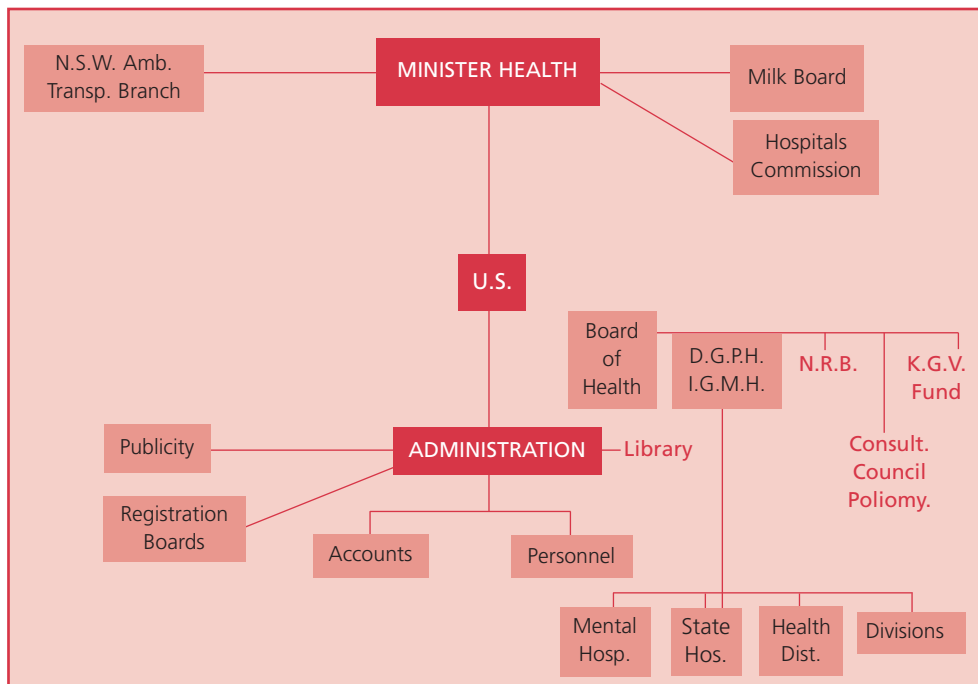


Table 3



eliminate competition, improve quality of service and provide career prospects within a large service, with interchangeability, to stimulate recruitment. The economic advantages of this proposal were stressed and were no doubt theoretically attractive in selling the proposition to the Government. The proposal was accepted in principle and Dr E.S. Morris was instructed by the board to prepare a detailed report in conjunction with Dr John Andrew Leslie Wallace, Inspector General of Mental Hospitals and Dr Arthur Edward Machin, Director of the School Medical and Dental Service within the Department of Education. This latter had grown to quite considerable size, employing 15 medical officers and 11 dental officers with a larger number of nurses and auxiliaries.

The report was presented in little over two months on 21 June 1940, and was based on the need to structure a health organisation to deliver services consistent with a national policy on preventive medicine. This was stated to involve nine significant areas, including, surprisingly research. The report quoted extensively in justification of its recommendations from the *Haldane Report of England* which was the basis of a similar exercise recently completed in England. The service areas were similar in both reports and were based upon maternal and infant health, the school child, industrial hygiene, environmental sanitation, prevention and control of infectious diseases, mental health, health education and research. With the exception of the latter they were predicable and Divisional or other organisational units were already in operation in these areas. One gets the impression that mental health was not given a high priority but regarded as an institutional service with little preventive or public health component, as also was the system of public hospitals.

The report was unanimous and proposed a Department, responsible to the Minister of Health through the Under Secretary with its professional components looking to a professional Head combining the elements of public health and psychiatry, who would be Director-General of Public Health, President of the Board of Health and Inspector General of Mental Hospitals. The relationship and independence of the Hospitals Commission was rather vague, and the organisation chart (reproduced hereunder) proposed in the

report showed an impractical line of communication through the Director-General – Inspector General (Table 2).

The report was implemented in 1941 and the organisation of the Ministry of Health is schematically represented in (Table 3).

Dr E.S. Morris devoted himself almost entirely to the administration of mental hospitals until his retirement in 1952. He was never entirely happy or comfortable in this role, nor did he enjoy the support of his psychiatric colleagues. During this period there is no doubt that the mental hospitals were conducted as closed institutions and novelty of approach and experimentation were discouraged. Dr Morris retained to himself Presidency of the Board of Health and the Nurses Registration Board, some other statutory committees and representation on the National Health and Medical Research Council. He maintained an interest in the Divisions and particularly Maternal and Baby Welfare and the School Medical Service.

Dr H.G. Wallace was appointed Deputy Director-General of Public Health in 1942, still retaining his position as Director of Tuberculosis. To him Morris delegated the administration of State hospitals, the public health component and loosely the Divisions. This was an informal delegation with the consent of the Public Service Board. As distinct from the reorganisation in 1961-1962 there was no amendment of appropriate Acts to provide for the legal instrument of delegation. Consequently Wallace was never sure of his position and authority, and likewise Morris' reputation in public health diminished as he appeared to discard his interest in favour of psychiatry.

After Dr Morris' retirement in 1952 the administration of psychiatric services and public health services were again separated, the Department reverted essentially to the organisation which existed prior to the *Morris Report*.

### 1961-1973

The final reorganisation of the Ministry reflected the second amalgamation of public health and psychiatric services in 1961 and the establishment of the Division of Establishments in that year. After 1963, when I relinquished the role of Director-

General of State Psychiatric Services, the Division of Establishments became the major unit of administration of State and mental hospitals, and the psychiatric services were no longer identifiable. These changes have been developed in detail elsewhere in this publication. (The format of the Ministry remained unchanged until the establishment of the Health Commission of NSW in 1973.)

## Department to Commission

From the mid-1960s there were frequent although informal discussions at Ministerial, Departmental and Public Service Board levels, of the possibility of reorganisation of the health services, with the immediate objective of integrating the public hospital system into the central health administration by a form of Health Commission. At one stage there was serious discussion that the composition of the Commission should comprise the Director-General of Public Health, the Chairman of the Hospitals Commission and the Under Secretary of the Department. In principle the proposition of a Commission was favourably regarded, but the obstacle was to create the opportunity and devise an appropriate mechanism whereby the proposal could be studied in depth and its implications assessed and evaluated.

Within the Department, the Public Health and Mental Health Services were operating independently of each other, each on the assumption, and with reasonable justification, that their objectives were valid and their administrations efficient and effective. External to the Department, the Hospitals Commission of NSW was pursuing its course to the apparent satisfaction of the general hospital system, and such voluntary agencies as were included in the schedules of the *Public Hospitals Act*. Individual general hospitals were very possessive of their executive authority, and sensitive to any action which might disturb the 'status quo'. Equally, the medical profession was involved in an acrimonious campaign to protect its independent status, which it saw as being threatened by the National Health Scheme. When faced with challenge, the profession

was not concerned with niceties between Federal and State responsibilities, and the cry of 'nationalisation' and 'socialisation' was easily aroused and a safe defence.

There was stress and an atmosphere of uncertainty within the administration of State health services. In my sector there was consistent denigration of the board of Health and Baby Health Centres (to mention but two examples) which produced emotional over-reaction and wary caution and suspicion. The newly elected Liberal Government had succeeded unexpectedly after a prolonged period in opposition. It was anxious to consolidate its image in government, and somewhat chary of its public service advisors, whose loyalties had for twenty-three years been directed to a Labor Government. There were demands from within the Department, and more vociferously from academics, proclaiming a new concept of community medicine and preaching a form of social medicine, with emphasis on total care of the individual and family in their social environment. Their models were based on Scandinavian and British experience, reinforced by theoretical propositions from the United States which were very experimental.

There was no doubt that health services were at the crossroads when old and tried values were being challenged, and new values novel and untested. Some method of review was inevitable. The question was in what form? I favoured a Royal

Commission to evaluate existing services and set guidelines for the future. I had spoken and written of this need at scientific and other meetings although realised that Royal Commissions were expensive and not in good repute as agents of change. The Under Secretary and the Minister were supportive of a review mechanism but one which was less spectacular and informal. The memory of the Royal Commission into the Callan Park Hospital still lingered. The initiative was taken by Mr H.H. Dickensen (now Sir Harold), a member of the Public Service Board, through the Administrative Research Committee of the Board (ISI).

After Dr Morris' retirement in 1952 the administration of psychiatric services and public health services were again separated; the Department reverted essentially to the organisation which existed prior to the Morris Report.

## The Eglington Report

The method and form of inquiry were unusual and, in my experience, unique. Mr G.C. Eglington, a young solicitor and Administrative Research Officer of the Consultant and Research Division of the Public Service Board, was permitted to undertake 'independent research and investigations of *Community Health Services and the Public Hospitals Act of NSW*' (152). Mr W.K. Pilz, Director of the Division, had laid down guidelines for such exercises including tentative recommendations only, which would not obligate the agency under study as would a more formal inquiry.

The action was unexpected and confusing to Officers of the Department because of the vagueness of any official imprimatur. We were restrained in offering frank criticism for fear that this might rebound to our disadvantage – a reservation which was justified in part when some candid comments were quoted verbatim in supporting documents to the report. Mr Eglington embarked upon his task with elan and enthusiasm, giving the impression that he was already converted to the philosophies inherent in the British system. The report lent credence to this supposition.

His report was published in three parts, the first of which, in accordance with the guidelines, was the *Interim Report of Conclusions and Recommendations*. The two supporting parts summarised his personal discussions and listed his resource documents. These latter parts were not generally distributed with the interim report, which itself was classified as a confidential document by the Public Service Board, not to be released without authority.

His conclusions were predictable although overstated. He was critical of the administration of health services, of 'voluntary' hospitals, of health districts, of public health and psychiatric services and of the independence of voluntary bodies. In fact there was hardly a word of praise for any component of the existing organisation. This is understandable although nonetheless regrettable. The report carried the stigmata of an incomplete study resembling an intellectual exercise in preparation for an academic qualification. Basically his conclusions should have relied on a studied audit and assessment of existing services. No such study was conducted by him. Rather, his approach was a

comparative study of systems and not results.

There were three main principles underlying his recommendations:

- “1. Central Government ('the Crown') should assume responsibility for organisation and distribution of all health services.
2. There should be a Central Ministry of Health patterned on the English system, which would be the employer of health services personnel, and the coordinating, central planning and policy agency. It would have additional inspectorial and arbitration functions, and remain 'the clearing house for technical specialist and general advisory services, and medical research' (153).
3. Regional distribution of services should be centered on the hospital as the primary medical community instrument. Here he was influenced by the New Zealand model.”

Although he protested naively that the private practice of medicine would be uninfluenced by his plan, it is inconceivable that a Government monopoly could function adequately without control of the medical profession; without disruption of voluntary and religious organisations and private charities; and without intrusion into the areas of responsibility of local government and official and voluntary health and welfare organisations. It was a contentious report which contained areas of merit; a courageous attempt to solve a serious problem, but too inaccurate and abrasive to be seriously considered. The preface admits this in apologetic terms:

“The contents of this interim report are tentative only. It is designed to form the basis for much closer work should any plan for reorganisation go forward. Little attempt has been made to justify the conclusions reached or recommendations made as the reasoning behind them will be embodied on the body of the *Final report on community health services* when completed.”

The final report was never completed. The interim report had achieved a purpose totally different from Mr Eglington's expectations. It did not receive serious considerations or study, but became the basic document on which a formal inquiry could be mounted. This was to result in the *Starr Report* on which action was taken to reorganise the health services and establish the Health Commission of NSW. Eglington was frustrated and disappointed. After a short term in the London office of the NSW Government, during which he suffered ill-health, he left the public service.

### The Starr Report of 1969\*

The report which was to sound the death knell of the Department of Public Health and the Hospitals Commission was the *Starr Report of 1969*. The committee was established in April 1968, and comprised:

**Chairman:** **K.W. Starr**, C.M.G., O.B.E., E.D., M.B., B.S. (Syd.), M.S. (Melb.), F.R.C.S. (Eng.), F.A.C.S., F.A.C.S. (Hon.), F.R.A.C.S.; President, NSW Medical Board; Medical Director, NSW State Cancer Council; Past President, Royal Australasian College of Surgeons; Elected Member (with gold medal) of James IV International Association of Surgeons.

**Members:** **Sir Edward Ford**, Kt, O.B.E., M.D. (Melb.), D.P.H. (Lond.), D.T.M. (Syd.), F.R.C.P., F.R.A.C.P., F.Z.C., F.R.S.H., F.R.A.Hist.S. (Hon.); Professor Emeritus of Preventive Medicine, Sydney University and former Director, School of Public Health; Member, Board of Health.

**R. L. Harris**, M.B., B.S. (Syd.), F.R.A.C.P.; Member, NSW Medical Board; Member, Board of Royal Prince Alfred Hospital; Hon. Physician, Royal Prince Alfred Hospital.

**N. Larkins**, M.B. B.S. (Syd.), M.R.A.C.G.P., F.A.C.M.A.; Medical Secretary, NSW Branch, Australian Medical Association; Member, Board of Health.

**John H.D. Marks**, C.B.E., F.C.A.; Chairman and Managing Director, Development and Finance Corporation Limited; Chairman, Boards of Directors of Prince Henry Hospital, Prince of Wales Hospital, and Eastern Suburbs Hospital.

**N. Oakes**, B.Ec. Assistant Under Secretary, NSW State Treasury.

**J.D. Rimes**, LL.B., Dip.Com.; Under Secretary and Permanent Head, NSW Department of Public Health.

**H. Selle**, B.A., B.M., B.S. (Syd.), F.H.A., F.A.C.M.A.; Chairman, Hospitals Commission of NSW.

**Dennis Smith**, Chairman, Riverina Region Hospitals Advisory Council; Member of Board of Deniliquin Hospital.

\*Sir Kenneth Starr was the chairman of a previous committee which reported on the structure of a second Medical School at the University of NSW. That report has no relevance to this publication..

I was invited to join the committee and I declined because of my loyalty to the Board of Health and the Public Health Services of the Department, which considered would be dismembered by the committee without valid reason, other than to replace them with an alternative administrative device which was untried and improved in Australia. I was disappointed, as also was my Deputy, Dr E.S.A. Meyers, that no inquiry was envisaged to disprove their efficiency. In fact we both believed that they were regarded throughout Australia as a model of achievement and success. We both appeared in person before the committee to defend this situation, myself concentrating on the general principles of public health administration, and Dr Meyers on the validity of the Board of Health.

The terms of reference of the committee were restrictive and left to the interpretation of the committee:

“The committee throughout its operation regarded its scope as being the recommendation to the Minister of the acceptance, modification, or rejection of any matter contained in the report (*Eglington Report*) and the submission of any alternative proposals(154).”

The Minister justified the establishment of the committee in his press statement.

“I have received a report suggesting very radical changes in the Hospital and Health Services of NSW ... It represents the opinions of the Research Division of the Public Service Board and since its implications are far-reaching, I have appointed an expert committee to consider them. It includes men prominent in those sections of the community which will be most affected – hospitals, the medical profession and the university medical schools – as well as senior officials from the Treasury and Department of Health(155).”

The inaugural meeting of the committee was held on 22 April, and was for the purpose of publishing its functions. Its method of procedure was established at its second meeting, and invitations were extended to interested persons generally by public advertisement, and to others and major organisations, which had a direct interest in the

administration of the State's health services, by invitation to make written submissions. Seven personal interviews were granted including myself and Dr E.S.A. Meyers, Director of State Health Services. We had made submissions to the committee by mutual agreement, myself defending public health administration and proposing an alternative form of commission by bureaux to Mr Eglington's monolithic central authority, and Dr Meyers in support of the continuance of the Board of Health (Appendix 10).

I still remember vividly my interview. Never have I been so disconcerted or embarrassed. I was ushered in, invited to sit facing the Chairman, who made a few perfunctory remarks of introduction, and then abruptly:

“Now you may begin.”

I had expected a more friendly and informal reception and I was flabbergasted – I had forgotten where to begin. Nor did I regain my composure as I was heard in stony silence and then thanked and invited to depart. I fear my performance was poor and unimpressive. I felt like a condemned person, attending his appeal, who could read in the faces of the judges that his cause was lost.

Dr Meyers' experience was not dissimilar, although he had hopes of success, with two members of the Board of Health on the committee. Both had endorsed the defending document before it was submitted to the committee. His hopes were dashed even more than mine.

The report of the committee was published in November 1969, and was unanimous. I was pleasantly surprised with its proposed form of Health Commission which preserved the identity of public health services, although without the support of the Board of Health. It recommended a Commission of five all of whom should be full time appointments(156):

Director-General of Health Services (Chairman)  
Director of Public Health  
Director of Hospitals  
Director of Administration  
Director of Finance

The Commission would be assisted by three advisory committees; the Health Advisory Council comprising persons and organisations associated with health services; the Medical Services Advisory Council, representing medical, nursing and allied professions; and a Public Health Services Advisory Council, which was to be a reconstituted Board of Health without executive function.

It proposed that health services should be administered on a regional and integrated basis, the distribution of the regions to be modelled on existing Health Districts, expanded or retracted as need demanded. There was to be a Regional Director for each Region, who should be a medical practitioner, and who would be assisted by regional advisory committees.

The third major and most revolutionary series of recommendations proposed that the general hospitals should lose their executive independence, and be managed by Boards of Trustees, over whom the Commission would have power of direction. Further to this issue, the committee recommended that the 'Health Commission, by legislative action, should be deemed to be the 'employer' of employees of public hospitals for the purposes of the *Industrial Arbitration Act*(157). This was one area where it was in consonance with the *Eglington Report*.

The report was received favourably by the Government. The Premier in his policy speech of 28 January 1971, stated the Government's intention(158):

"to establish a Health Commission and integrate the activities at present associated with the Department of Health, the Hospitals Commission and the Ambulance Transport Board."

After the publication of the report, and throughout 1971, a working party under Mr G. Slough was set up to study and report on the reorganisation implicit in the recommendations of the *Starr Report*. The working party was responsible to a steering committee with the Minister as Chairman, the Chairman of the Public Service Board, the Under Secretary of the Department of Health, the Chairman of the Hospital Commission of NSW and

myself, as Director-General of Public Health. A prototype Act had already been drawn up to constitute the Health Commission and it was proposed to publish this and other material in a consultative document. The steering committee was more nominal than actual, and verified decisions already taken. It met only once or twice, otherwise consensus was by telephone.

### The consultative document

The consultative document was published by the Minister for Health in April 1972, as a vehicle to stimulate public comment prior to the Government committing itself by legislative action. It proposed two stages of legislation:

- Stage 1: Involved the establishment of a Health Commission from 1973. In this respect the Government's intentions were firm and an enabling Bill was introduced almost simultaneously, and allowed to remain in Parliament for some months after the first reading.
- Stage 2: Set out the Commission's role should reaction be favourable to the Starr Committee's proposals over the general hospital system.

In the interim between the publication of the *Starr Committee Report* and the consultative document the format of the Health Commission had been altered to provide(159):

"A Chairman and Deputy Chairman, appointed by the Governor on the recommendation of the Public Service Board, one of whom must be a doctor. The Deputy Chairman would be one of the Members."

Four members were designated:

- Personal Health Services
- Environmental and Special Health Services
- Manpower and Management Services
- Finance and Physical Resources

I realised that the battle for Public Health was lost, and from that point I resolved not to apply for appointment to the Commission. I made a final gesture as Chief Medical Officer to the Government and provided a personal submission to the Minister to modify the proposed Act and retain the Board of Health. I was deeply disappointed with lack of response from the medical profession and its organisations to the variation of the consultative document from the *Starr Report*.

The reaction to Stage 2 was the reverse to the apathy to Stage 1. The Minister was inundated with protests against interfering with the autonomy of the public hospital system, with very few submissions in favour. So vigorous and organised were these protests that one organisation, representing Catholic hospitals, engaged senior counsel to present and support its submission. One wonders how much of the opposition from the medical profession was stimulated by consideration of the challenge to economics of private practice, and the autonomy of the profession to direct events to its advantage. The Government retreated in face of this opposition and Stage 2 was abandoned.

### The Health Commission Act No. 63 of 1972

The *Health Commission Act* received assent on 23 November 1972. It provided for a Commission as set out in the consultative document (Section 6) and dissolved the Health Department and the Hospitals Commission (Section 16). The function of the Health Commission was described in Section 18.1:

“For the purposes of promoting, protecting, developing, maintaining and improving the health and wellbeing of the people of NSW to the maximum extent possible...”

It was given wide powers to investigate, plan, conduct health services, and support research. Powers of delegation, essential to regionalisation, were granted in Section 22, and a schedule to the Act amended appropriate Acts to invest executive function in the Commission. The Board of Health

was converted into an Advisory Board of Health and continued as such for approximately one year when it was allowed to dissolve. Two advisory bodies were created under Section 23: The Professional Services Advisory Council and the Health Advisory Council (not to be confused with the Health Advisory Council of 1961).

### The Health Commission of NSW

The Health Commission was established on 1 April 1973. Dr R. McEwin was appointed Chairman, but as he could not take up office until July, Mr J. D. Rimes, Under Secretary of the Department, was appointed for the interim. Other appointments were Mr G. Slough, Commissioner for Manpower and Management Services (previously Assistant Under Secretary of the Department and later a Member of the Hospitals Commission of NSW); Dr D. Storey, Commissioner for Environmental and Special Health Services (previously Member of the Hospitals Commission of NSW); Dr W. Barclay, Commissioner for Personal Health Services (previously Director of Establishments and State Psychiatric Services); and Mr K. Boylan (previously Chief Executive Officer of the Balmain District Hospital). Neither I nor Dr H. Selle, Chairman of the Hospitals Commission, applied for appointment. The Ambulance Transport Board was not transferred to the Commission until 1976.

And so my tale is ended. I make no apology for my personal intrusion into its pages. I have attempted to record events in which I was personally involved and on which I can now reflect, without arousing emotions which have since subsided. I have tried to be impartial and yet stress the influence of persons and personalities in promoting change over the past two decades. I was privileged to participate in a Department with a long and proud record of service despite its vicissitudes and disappointments. I am proud to have been the last Director-General of Public Health in direct lineage with the first progenitor, Principal Surgeon John White. One possession I cherish is the original agenda of the last meeting of the Board of Health.





**Newcastle Mater  
Misericordiae Hospital**  
Ward E Christmas decorations, 1939



**Mr William Balmain**  
Principle Surgeon, 1796-1805

# Appendix 1

## Colonial Surgeons 1788-1855

### 1. Principal Surgeon John White 1788-1795

Name	Position	Appointment
J. White	Principal Surgeon	1788-1795
W. Balmain	First Assist. Surgeon	1788- ?
T. Arndell	Assist. Surgeon	1788-1794
D. Consider	Assist. Surgeon	1788-1794
J. Irving	Junior Surgeon	1788-1795
T. Jamison	Assist. Surgeon	1788- ?
S. Leeds	Assist. Surgeon	1793-1796
J. Thompson	Assist. Surgeon	1794- ?

### 2. Principal Surgeon William Balmain 1796-1805

Name	Position	Appointment
W. Balmain	Principal Surgeon	1788-1805
T. Jamison	First Assist. Surgeon	1788- ?
D'Arcy Wentworth	Assist. Surgeon	1796- ?
J. Thompson	First Assist. Surgeon	1794-1807 (superseded Jamison)
M. Mason	Assist. Surgeon	1800-1804
C. Throsby	Assist. Surgeon	1802- ?
J. Savage	Assist. Surgeon	1802-1805
J. Mileham	Assist. Surgeon	1797- ?

### 3. Principal Surgeon Thomas Jamison 1805-1811

Name	Position	Appointment
T. Jamison	Principal Surgeon	1788-1811
D'Arcy Wentworth	First Assist. Surgeon	1796- ?
J. Connellan	Assist. Surgeon	1807- ?
E. Luttrell	Junior Surgeon	1811- ?
J. Mileham	Assist. Surgeon	1797- ?
W. Redfern	Assist. Surgeon	1810- ?

### 4. Principal Surgeon D'Arcy Wentworth 1811-1819

Name	Position	Appointment
D'Arcy Wentworth	Principal Surgeon	1796-1819
J. Mileham	First Assist. Surgeon	1797- ?
J. Connellan	Assist. Surgeon	1807-1813
E. Luttrell	Assist. Surgeon	1811-1816
(transferred to Hobart)		
W. Redfern	Assist. Surgeon	1810- ?
*W. Evans	Junior Assist. Surgeon	1814- ?
H. St. John Young	Assist. Surgeon	1814-1815
(transferred to Hobart)		
Major West	Assist. Surgeon	1815- ?
R.W. Owen	Acting Assist. Surgeon	1817- ?

\* W. Evans had served previously from October to December 1809, then being dismissed for currency speculations.

## 5. Principal Surgeon (Inspector of Colonial Hospitals) James Bowman 1819-1836

Name	Position	Appointment
James Bowman	Principal Surgeon	1819-1836
J. Mileham	First Assist. Surgeon	1797-1821
W. Redfern	Assist. Surgeon	1810-1820
W. Evans	Assist. Surgeon	1814-1822
R.W. Owen	Assist. Surgeon	1817-1820
C. Tattersall	Assist. Surgeon	1820-1821
T. Allen	Assist. Surgeon	1821- ?
H.G. Douglass	Assist. Surgeon	1821-1825
G. Brooks	Assist. Surgeon	1819- ?
P. Hill	Assist. Surgeon	1821- ?
J. Mitchell	Assist. Surgeon	1823- ?
(later surgeon)		
W. Richardson	Assist. Surgeon	1826- ?
G. Busby	Assist. Surgeon	1826- ?
J. MacIntyre	Assist. Surgeon	1826- ?

## 6. Deputy Inspector General of Hospitals John Vaughan Thompson 1836-1844

Name	Position	Appointment
J.V.Thompson	Deputy Insp. General	1836-1844
J. Mitchell	Surgeon	1823-1837
G. Busby	Assist. Surgeon	1826-1842
G. Brooks	Surgeon	1819-1842
T. Allen	Assist. Surgeon	1821-1842
W. Richardson	Surgeon	1826-1848
P. Harnett	Surgeon	1837-1844
J. Lee	Assist. Surgeon	1840-1848
A. Garnock	Assist. Surgeon	1840-1848
J. Eckford	Assist. Surgeon	1842-1848
D. Sallow	Assist. Surgeon	1842-1848
D. Reid	Assist. Surgeon	1839-1844
P. Hill	Surgeon	1821- ?

## 7. Medical Adviser to the Government 1848-1855

Name	Position	Appointment
P. Hill	Medical Adviser (from 1848)	1821-1852
B. O'Brien	Medical Adviser	1852-1856

# Appendix 2

## The rules and regulations of the Sydney Dispensary

The rules and regulations adopted by the Sydney Dispensary at its foundation are set out in the first report as follows:

- I A Subscription of One Pound Sterling annually constitutes a Member of the Institution, with the right of having one patient at all times on the books. An Annual Subscription of Two Pounds, constitutes a Member, with the right of having two patients constantly on the books. A Donation of Ten Pounds constitutes a Life Member, with the right of having two patients constantly on the books. And larger Annual Subscriptions in the same proportion.
- II All Members of the Institution are eligible to be chosen Members of the committee; and the committee are to be elected by ballot.
- III The committee is to meet at seven o'clock in the evening of every second Tuesday in each month of the year. Three Members shall be a quorum.
- IV General Meetings are to be held on the second Tuesday in January in every year to receive the report of the committee, and to conduct the affairs of the Institution; they may make bye laws subject to the approbation of the next General Meeting (such new by-law being previously advertised in the public papers), and they are to inspect the accounts.
- V An Extraordinary General Meeting may be called by a Requisition, signed by any Five Members of the committee, or by any Ten of the Subscribers, specifying the occasion thereof, addressed to the Secretary, who will summon a Meeting accordingly by advertisement.
- VI The Medical Gentlemen attached to the Institution are at all times to be Members of the committee.
- VII That the intended division of the town into four parishes be the Division adopted by the Institution, and that such parishes be subdivided into districts as may hereafter be found necessary for the convenience of Visitors. (This was apparently not put into practice until the revised Rules of 1844).
- VIII That the committee choose from their own body as many persons may be deemed necessary who shall be called visitors. To each district a Visitor shall be appointed, whose duty will be to inquire into the circumstances of the patients.
- IX That the Dispensary be opened every day (Sundays excepted) at half-past 10 o'clock.
- X That One of the Medical Officers of the Institution be every day (Sunday excepted) in attendance at the Dispensary from eleven to twelve o'clock. Subscribers are requested to be particular that the persons they send as patients be such as really require the aid of the Institution."



**Bourke District Hospital**

Barrow ambulance outside  
Bourke NSW 1918

# Appendix 3

## Medical qualifications and accreditation

### Medical qualifications

Any scrutiny of professional competency to enter the Colonial Medical Service or indulge in private practice in the early years of the Colony was of necessity superficial. This can be excused because of the confused status of medical education in Great Britain towards the end of the eighteenth century, to which can be added the desperate need to attract recruits into an unattractive and poorly recompensed service.

### Administrative control 1788-1838

Administrative and statutory controls over medical practice were direct and germane to the circumstances of the Colony. Commissions were granted through the Secretary of State, but there as with local appointments scrutiny was casual, especially where there was strong personal representation. There was more complaint from the Governors on the quality of commissioned appointments than on the calibre of local recruits. Macquarie suggested to the Home Secretary after Henry St. Young's arrival in 1814, that applicants for commissions as colonial surgeons should be tested by an examining board in England similar to the Army Medical Board(85).

The responsibility for local recruitment rested with the Governors. As the opportunity was limited almost entirely to the ships' surgeons arriving on the transports there was no great need to query professional qualifications. Most of these surgeons had been trained in the navy, or, if not, their competence was assumed because of the positions which they held.

There was no administrative barrier to free entry into private practice. Mason in one of his testimonials stated that he had established himself in private

practice after he resigned from the Colonial Medical Service in 1804, but this was possibly an overstatement and his services were probably more available to the settlers in the Windsor District in an emergency rather than on an organised basis. Likewise William Bland, a professional prisoner originally attached to the asylum at Castle Hill in 1811, was not impeded in his action to commence private practice after he had been refused entry into the Medical Service in 1813.

The first administrative test of professional competence was carried out in 1801 when Redfern was examined by a board comprising Thomas Jamison, John Harris and William Behan as a prerequisite to entry into the medical service(86). Redfern was issued with a certificate of qualification. Watson states that this system was subsequently extended to an examination of all who commenced practice in the Colony, and anyone failing to pass the examination was gazetted and ordered to desist from practice. This statement is a little too definite and probably such boards were convened as necessity arose rather than as a standing measure. The same administrative device of a medical board was commonly used to overcome an immediate problem with a medical connotation and was limited to action which was pertinent to the Government of the Colony, as, for example, determination of mental capacity and invaliding from the civil or military services where repatriation to England was involved.

That there was need of a more effective mechanism became obvious in 1830 from a survey conducted by the Royal College of Physicians. Bowman, in his reply to the College, stated 'there are several individuals in the Colony, who have been educated at the Medical Schools in London, Edinburgh and Dublin, and many others who have not received any regular professional instruction'(87).

## Statutory control 1838-1855

The need for some measure of statutory control over medical practice became more pressing as the number of private practitioners was swelled by the discontent and resignations of the colonial surgeons from the Medical Service. The professional capacity and personal conduct of many practitioners in the Colony was the subject of criticism of Deputy Inspector General of Hospitals, John Vaughan Thompson, in one of his first reports to Sir James McGrigor...

“...the prevailing Vice or Drunkenness has got among the medical men, and although there are several qualified to take District Surgeoncies there are very few that can be trusted(88).”

The first Act of significance leading towards the regulation of medical practice was the *Medical Witnesses Act of 1838* (1 Vic. No. 3) which provided that the Coroner could summon to give evidence any qualified witness where the deceased was unattended at the time of death, or the medical attendant, when he was under treatment at the time. It did not elaborate on the term ‘qualified’ and presumably to this date qualifications when in doubt were still tested by the usual administrative technique of a convened medical board.

The second event was 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 Vic. No. 22 1838), which for the first time laid down a statutory mechanism to test the qualifications of medical practitioners and provide public records of qualified persons. The original Bill for this Act was entitled A Bill to Regulate The Practice Of Medicine. It proposed a Court of Examiners, penalties for practising medicine unless approved by the Court of Examiners, procedures for apprenticeship to practising physicians and surgeons, examination fees and the like(89).

Most of the provisions in the preliminary Bill were deleted in the Act itself which established a Medical Board of not less than three members of the profession appointed by the Governor to be known as the NSW Medical Board, and which was charged with keeping a register of qualified medical practitioners to be published annually for the information of Coroners, Magistrates and the public. It also laid down acceptable qualifications as ‘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 of Great Britain or Ireland, or a member of the Company of Apothecaries of London or is or has been a medical officer duly approved and confirmed of Her Majesty’s sea or land service’.

Although the board as constituted was limited somewhat to the provisions of the *Medical Witnesses Act of 1838*, and was a mechanism to define the term ‘qualified medical practitioner’ for the purposes of that Act, the fact that it did publish its list for the benefit of the public also, established its claim as the first Medical Board from which the present board is derived. Amendments in 1844 (8 Vic. No. 8) and 1845 (9 Vic. No. 12) were inconsequential.

The constitution of the first board was John Vaughan Thompson, President, and Doctors Dobie R.N., Robertson, Nicholson and Wallace as Members. The first gentleman registered was George Thomas Clark of Penrith, who had been admitted as a Licentiate of the Apothecary’s Company of London on 14 March 1828. Dr James Ellis R.N. was registered as No. 5 without demonstrating his qualifications ‘as in the terms of the Act all medical officers of the army and navy can claim the privilege without any other qualification’(90).

John Vaughan Thompson was succeeded by W. Dawson (1844-1848), Patrick Hill (1848-1853) and Bartholomew O’Brien (1853-1855). After O’Brien, the Head of the medical service was not necessarily the President of the Medical Board, although usually a member.

The role of the Medical Board was consolidated in the Medical Registration Act of 1855 (19 Vic. No. 17) which included also similar provisions for medical education (suitably amended to meet the later circumstances) as were proposed in the Bill of 1838. It laid down a minimum course of study of not less than three years in a School of Medicine and included the University of Sydney as an examining authority. As a consequence it then defined the acceptable qualifications for foreign medical practitioners. It provided also for the procedures of the Medical Board. The University of Sydney was established in 1851 and from its foundation it was determined that it would provide a Faculty of Medicine. Although this was not organised until 1882, the *Act of 1855* provided for this contingency, and introduced the concept of priority of local qualifications and local authority.



# Appendix 4

## The Military Medical Service

There were no alterations in the *Medical Registration Act* until the end of the nineteenth century.

The responsibility of the military forces to provide their own medical service did not arise until the arrival of the NSW Corps with the Second Fleet in 1790. Until that date there was no distinction of function in the Colonial Medical Service between service personnel and others, and likewise any need of a separate military service disappeared when the Medical Service was reorganised on military lines from 1836 to 1848. After 1848 the military medical service ceased with the withdrawal of the military forces.

Except for the period of the Deputy Inspector General of Colonial Hospitals there was never a specific medical service for the military forces under a unified control. Nor is it certain that individual hospitals were dedicated to military needs only. The first military surgeon was Assistant Surgeon John Harris of the NSW Corps, who was attached to the staff of the General Hospital and presumably cared for service patients as well as assisting with convict patients.

There is evidence that a military hospital operated in Sydney. Ford states that a military hospital was erected about 1797 and reproduced an illustration of this institution from the Mitchell Library prints(91). Its history is somewhat uncertain if indeed it did exist. In 1822 a Military Hospital was erected on the site of what was, until 1976, the Ford Street Girls School. In 1823 a wing of the General Hospital was used for the military, and in 1828 in the

Colonial Secretary's archives it is stated 'one of the wings of this building (ie the General Hospital) is a hospital for the 39th Regiment and has for some time past been appropriated to one of the Corps in the Garrison'.

In the peripheral settlements and stations the numbers of military personnel were generally too small to warrant the attachment of a military surgeon, and they were attended by the colonial surgeons as a segment of the 'victualled' group to which free treatment was extended.

The basis of the army arrangement was the regimental system, each regiment of a battalion having its own regimental surgeon and regimental nursing staff under the immediate supervision of a sergeant. The regiment could establish its own field hospital or if in a static location a permanent hospital was established at regimental headquarters. The regiments as they came to the Colony thus carried their own medical staff and facilities and operated on this basis using existing hospital facilities, and interchanging with the colonial surgeons when the concentration of military forces warranted the stationing of the regimental surgeon and his staff.

The administration of the Colonial Medical Service when it was reestablished as a unit of the Army Medical Board during the period 1836 to 1848 is described in detail elsewhere in this publication.



**The 'Aoraangi' in quarantine**  
Passengers in the powerboat 'Pasteur' 1935

# Appendix 5

## Quarantine

The medical security of the Colony particularly in its founding years was very vulnerable to the introduction of disease from the transports and supply ships arriving at Port Phillip. The need for a more rigid control was recognised by Governor Hunter in 1804 when he issued a Government and General Order to provide for medical inspection of incoming vessels. The liability for such inspections rested with the Naval Officer who was responsible for the supervision of shipping generally. This post was equivalent to that of Comptroller of Customs, and was occupied successively by Principal Surgeon Balmain, Surgeon Harris of the NSW Corps and Principal Surgeon D'Arcy Wentworth. These appointments were made not because of any medical significance arising from the Government and General Order but rather through lack of suitable civilian administrators. There is no evidence that medical inspections were carried out as a routine, and subsequent statutes would appear to verify the observation that quarantine was not an administrative function of the medical services, civil or military.

The first *Quarantine Act* was passed in 1832 (3 Wm. IV, No. 1) and was practically a verbatim copy of the *English Act of 1825* suitably modified to colonial conditions. It did not provide for medical inspection and the powers of quarantine were invested in a non-medical Superintendent of Quarantine and the Executive Council. In 1839 the medical deficiency was partly overcome by Governor Gipps who created the position of Health Officer of the Port and appointed John Dobbie, a Naval Surgeon, to the post. Dobbie was succeeded later in that year by Savage also a Naval Surgeon. The authority of the Health Officer was confirmed in the amendment of the *Quarantine Act* in 1841 (5 Vic. XII 1841), which granted him power to inspect ships and order, if necessary, into quarantine. There were further amendments of the Act in 1849 (13 Vic. No. 25) and 1853 (17 Vic. No. 29). The amendments were minor and inconsequential.

Throughout the period of the Deputy Inspector General of Hospitals, the quarantine service, including its medical component, was controlled by the Colonial Secretary as a civilian function and, therefore, not pertinent to the role of the medical services. When the medical services were restored to civilian status in 1848, the Adviser to the Government became also Health Officer of the Port and medical supervisor of the quarantine service.



### **Royal Newcastle Hospital**

Nursing staff stand ready to admit the first patients  
to the completed North Wing in 1916

# Appendix 6

## Health Districts

*(Statistics as of 1971)*

### Newcastle (Hunter River combined) Health District established 1898

#### Content

The Newcastle Health District includes the cities of Greater Cessnock, Newcastle, and Maitland, the Municipalities of Kempsey, Muswellbrook, Port Macquarie, Singleton, Macleay, Manning, Merriwa, Patrick Plains, Port Stephens, Scone, Stroud and Wyong. It extends from the Hawkesbury River in the south, to the northern boundary of the Macleay Shire, where it meets the North Coast Health District. The Western and North Western Health Districts form the inland boundary.

#### Population

Approximately 405,000

#### Medical Officers of Health

R. Dick, M.B., Ch.M. (Syd.), D.P.H. (Camb.) 1898-1921.

J. Booth-Clarkson, L.R.C.P. and S.(Edin.) D.P.H.(Camb.) D.T.M. & H.(Camb.)  
(Acting while R. Dick on Active Service during World War I 1914-1918)

K.F.Vickery, M.B., Mast.Surg. D.P.H.(Syd.) 1922-1924

H.G.Wallace, M.B. B.S. D.P.H.(Melb.) 1924-1934

T. Lewis Dunn, M.B., B.S., D.P.H. 1934-1936

J.R. Shannon, M.B., B.S., D.P.H. 1936-1954

T. Lewis Dunn, M.B., B.S., D.P.H. 1954-1961

H.R. Dugdale, M.B., B.S., D.P.H. 1961-1970

B.M. Nolan, LL.M., R.C.P. & S.I., D.P.H., F.A.C.M.A. 1970-

## Metropolitan Health District established 1898

### Content

39 local government Municipalities within the defined metropolis of Sydney.

### Population

Approximately 2,900,000

### Medical Officers of Health

W.G. Armstrong, M.B., B.S., D.PH.(Camb.) 1898-1913

J.S. Purdy, D.S.O., M.D., C.M.(Aberd.), D.PH.(Camb.), F.R.S. (Edin.) 1913-1936

F.M. Suckling, M.B., Ch.M., D.PH.(Syd.), D.T.M. & H.(Camb.) (1914-1918 while J.S. Purdy on Active Service)

J. Grahame Drew, M.A., M.B., B.Ch.(Camb.), M.R.C.S.(Eng.), L.R.C.P.(Lond.), D.PH., D.T.M., D.T.K.(Syd.),  
F.R.San.I. 1936-1952

J.J. Donnellan, M.B., Ch.M., D.PH. 1953-1961

A.A. Douglas, LL.B., M.B., Ch.B., D.PH., D.T.M. & H. 1961-1966

I.K. Hay, M.B., Ch.B., D.PH., D.T.M. & H. 1967-

## Broken Hill Health District established 1916

### Content

The Broken Hill Health District is confined to the County of Yancowinna. The County covers an area of 16,000 square miles, with the city of Broken Hill at the centre of the County. The South Australian border forms the western boundary. The Broken Hill Health District is a centre of metal mining and pastoral industries.

### Population

29,743

### Medical Officers of Health

J.F. Bartley, M.B., Ch.B. 1916-1924.

R.S. Trotter, M.B. 1925-?

W.G. George, M.B., Ch.M., M.R.A.C.P. 1928-1946 (From 1925 to 1928 the post was not filled).

Dr J.T. Cullen, M.B., B.S. 1946-

## South Coast Health District established 1947

### Content

The district extends from Helensburgh in the north to the Victorian border in the south, and to the Tablelands to adjoin the Australian Capital Territory. The district comprises the following local authority areas:

Municipalities: Bega, Bombala, Bowral, Cooma, Goulburn City, Kiama, Shellharbour; City of Wollongong, Queanbeyan.

Shires: Bibbenluke, Crookwell, Eurobodalla, Gunning, Imlay, Mittagong, Monaro, Mulwaree, Mumbulla, Shoalhaven, Snowy River, Tallaganda, Wingecarribee, Wollondilly, Yarrowlunla.

### Population

353,523

### Medical Officers of Health

Dr E.S.A. Meyers, M.B., B.S., D.P.H. 1947-1948

Dr A.J. Geoffrey, M.B., Ch.M., D.P.H., D.T.M., D.T.H. 1948-1960

Dr A. Douglas, LL.B., M.B., D.P.H., D.T.M.T.H. 1960-1962

Dr E.C. Wallace, M.B., B.S., D.P.H. 1962-

## North Coast Health District established 1947

### Content

Municipalities: Ballina, Casino, City of Grafton, city of Lismore, Mullumbimby.

Shires: Bellingen, Byron, Coffs Harbour, Copmanhurst, Gundurimba, Kyogle, Maclean, Nambucca, Nymboida, Terania, Tintenbar, Tomki, Tweed, Ulmarra, Woodburn.

### Population

160,970

### Medical Officers of Health

J.J. Donnellan, M.B., Ch.M., D.P.H. 1947-1952

T.K. Abbott, M.B., B.S., D.P.H. 1954-1956 (Office vacant until Dec. 1957)

H.R. Dugdale, M.B., B.S., D.P.H. 1958-1961

I.K. Hay, M.B., Ch.B., D.P.H., D.T.M. & H. 1961-1967

J.R. Whitfield, M.B., B.S., D.F.M., F.A.C.M.A. 1967-

## Western (Mitchell) Health District established 1947

### Content

The Western Health District adjoins the Western Metropolitan, Newcastle and Northwestern Health Districts to the east, the South Coast and Riverina Health Districts to the south, and Broken Hill District and the Queensland border to the west and north respectively.

The district comprises twelve municipalities and twenty-seven shire areas, the Blue Mountains City having been transferred to the Western Metropolitan Health District on 22 October 1971. The areas in the district are as follows:

Municipalities: City of Bathurst, City of Dubbo, City of Lithgow, City of Orange, Condobolin, Cowra, Forbes, Mudgee, Narromine, Nyngan, Parkes, and Peak Hill.

Shires: Abercrombie, Blaxland, Bogan, Boree, Brewarrina, Canobolas, Cobar, Coolah, Coonabarabran, Coonamble, Cudgegong, Darling, Gilgandra, Goobang, Jemalong, Lachlan, Lundhurst, Molong, Oberon, Rylstone, Talbragar, Timbregongie, Turon, Walgett, Warren, Waugoola, Wellington.

### Population

272,210

#### *Medical Officers of Health*

A.J. Geoffrey, M.B., Ch.M., D.P.H., D.T.M., D.T.H. 1947-1948

E.G. Wallace, M.B., B.S., D.P.H. 1948-1962

T.F. Rennie, M.B., Ch.B., D.P.H. 1962-1967

B.M. Nolan, L.R.C.P.I., L.R.C.S.I., D.P.H. 1967-1970

H.P. Swan, M.B., B.Ch., B.A.O., D.P.H. 1970-

## North Western Health District established 1962

### Content

This district lies between the North Coast and Western Health Districts and the Queensland border and includes the cities of Armidale and Tamworth, the municipalities of Glen Innes, Gunnedah, Inverell, Moree, Narrabri, Quirindi, and Tenterfield, and the shires of Ashford, Barraba, Bingara, Boolooroo, Boomi, Cockburn, Dumaresq, Guyra, Liverpool Plains, Macintyre, Manilla, Murrurundi, Namoi, Nundle, Peel, Severn, Tamarang, Tenterfield, Ural La, Walcha, and Yallaroi.

### Population

166,184

#### *Medical Officers of Health*

J. Henson, M.A., M.B., Ch.B., D.P.H., D.T.M. & H. 1962-1970

P.A.M. van de Linde, M.B., B.S., D.P.H., D.I.H. 1970-



## Riverina Health District established 1965

### Content

Comprises forty-five shires and municipalities and being almost 50,000 square miles in area the Riverina Health District is the second largest Health District. It is bounded in the south by the Victorian border and in the west by the South Australian border. The northern boundary extends from the South Australian border eastwards along the northern boundaries of the shires of Wentworth, Balranald, Carrathool, Bland, Weddin, Burrangong, and Boorowa to a point approximately 20 miles southwest of Cowra. Thence, the eastern boundary extends southwards along the eastern boundaries of the shires of Boorowa, Goodradigbee, Tumut, and Tumbarumba to the Victorian border.

### Population

254,227

### Medical Officers of Health

D.J. Law, M.B., B.S., D.P.H. 1965-

## Western Metropolitan Health District established 1969

### Content

The district comprises the areas of the cities of Parramatta, Campbelltown, Liverpool, Penrith and Blue Mountains, the municipalities of Auburn, Blacktown, Camden, Fairfield, Holroyd and Windsor and the shires of Baulkham Hills and Colo.

### Population

810,833

### Medical Officers of Health

T.F. Rennie, M.B., Ch.B., D.P.H., F.A.C.M.A. 1970-



**Balmain Hospital**  
Radiology Department 1940s

# Appendix 7

## Divisions and Branches

### Divisions

#### The Division of Analytical Laboratories

The Division of Analytical Laboratories (previously the Government Analysts' Branch) is the senior of the Scientific Divisions. The title Government Analyst dates from the early 1870s, and, like the title of Chief Medical Officer to the Government, was initially a part-time position. The Branch was formed under Charles Watt, whose chemical training was obscure but who, nevertheless, had established himself as an assayer and analytical chemist at 93 Pitt Street prior to his appointment. The laboratories were located in a tin shed on the corner of Macquarie and Albert Streets in 1883, moving to the first floor of the Board of Health building on the same site after it was erected in 1897. The selection of the site was made by William Michael Dougherty (later also to become Government Analyst) who as the youngest member of Watt's staff was more easily spared to make the 'voyage of discovery' along Macquarie Street and select a vacant site. When the author joined the Department of Public Health in 1950 the Government Analyst substantially occupied the same space as in 1897 with but a small extension to the ground floor, although the work and staff had increased tenfold.

The Government Analysts' Branch serviced most government departments and had specific responsibilities to the Board of Health for analysis of foods, drugs and water, and forensic toxicology. Essentially these are still the main functions of the present Division. Charles Watt retired in 1886 to again enter private analytical practice, reputedly a wealthy man with large commercial interests, including a half share of the North Shore Gas Works. He was succeeded by William Mogford Hamlet, affectionately known as 'Moggie', and described by A.D. Dibley 'as a most polite gentleman of the Victorian era', and in turn the position was held by Thomas Cooksey from 1915, William Michael Doherty from 1929, Sidney Gilbert Walton from

1930, Harold Burfield Taylor from 1946, Ernest Samuel Ogg from 1954 and Lister John Clark, the present occupant from 1968. The Branch moved to its present commodious laboratories in the grounds of the Lidcombe State Hospital in 1969.

Until recent years the Government Analyst's Branch was regarded as a service laboratory, the output of which could be mathematically calculated and its budget and staff assessed accordingly. Its training programmes were a mixture of in-service and technical training commencing with junior cadetships with promotional opportunities equated more with length of service than ability and additional qualifications. It was due mainly to the efforts of E.S. Ogg and Lister Clark that greater emphasis was placed upon professional recruitment, specialisation and research, with consideration to promotion of the individual rather than fulfilment of establishment vacancies.

Its status within the organisation of the Department was always depressed in comparison with Medical Divisions, due to the in-built emphasis given to the latter in a medical hierarchical dynasty and its connotation as a routine service technical branch, from which nothing more was expected than competence. It is now a sophisticated scientific institution, divided into a number of specialised sections (including research) and its reputation is acknowledged within and without the Department of Public Health and the public service by its standards of performance, its publications, its teaching capacity and formal association with universities and Colleges of Advanced Education, and the contribution to committees of national importance by its Director and senior staff. Two marks of recognition of its enhanced status are the change of title of the Government Analyst's Branch to the Division of Analytical Laboratories in 1969 and the recent recognition by the Public Service Board that promotion to higher graded positions can be achieved on a personal basis by outstanding ability irrespective of establishment.

## Division of Occupational Health and Pollution Control

The Division of Occupational Health and Pollution Control evolved from the Division of Industrial Hygiene which was established in 1923, under Dr Charles Badham, on the recommendation of the NSW Arbitration Court. Its purpose then was primarily to provide the Courts with an independent and unbiased medical opinion on contentious issues involving occupational health and hygiene. As distinct from the Government Analysts' Branch recruitment was of professional staff, working in tandem with the Director. Until 1939, the Division's activities involved the physical and personal effects of exposure to toxic substances, including sandstone dusts, the studies of which gave the Division and its Director an international reputation. The range of activities increased and the Division became the adviser and technical inspectorial unit for the Department of Labour and Industry to the degree that in 1950 an Inspector of that Department was permanently detached to the Division as a Liaison Officer, and the Scientific Officers of the Division enjoyed the same statutory privileges as Inspectors of the Department of Labour and Industry.

In 1939 the Ferguson Royal Commission into the Safety and Health of Workers in Coal Mines recommended the appointment of engineers for close surveillance of dust exposure in coal mines. So were the first two specialist Scientific Officers appointed, and the trend towards specialisation has continued and accelerated after World War II. As specialised instrumentation became commercially available so was it installed in the Division, which became independent of the Government Analyst for its chemical and physical assays. Its self-containment and specialisation is reflected in its internal organisation into a number of internal sectors dealing with specific objectives such as industrial hygiene, medical noise, radiation and later air and water pollution to mention the main parameters.

In 1951 the Division, then under the direction of the author, moved from 93 Macquarie Street, to more commodious premises in 86-88 George Street North, and in 1970 to large, modern, well-equipped laboratories in the grounds of the Lidcombe State Hospital. Its name was changed to the Division of

Occupational Health in 1958 by Ministerial approval, the change reflecting the breadth of the Division's activities more adequately than previously. Until 1959 the Division's activities were advisory. In that year it was given the *NSW Radioactive Substances Act* to administer, and in 1961 the *Clean Air Act* and the *Clean Waters Act* in 1971. In 1971 the title of the Division was extended to include pollution control. The Division now had five major branches: Industrial Hygiene, Medical, Air Pollution, Radiation and Water Pollution.

It is one of the Scientific Divisions which has long enjoyed academic association with universities (and particularly the University of NSW) and other scientific institutes. Much of its activities were developmental in determining the degree of hazard and human response and disability there from and proposing standards and reform. Its publications reflect this philosophy and have received wide recognition, which in turn has been reflected in invitations by international organisations to contribute in person to international seminars and conferences, and even, as with the World Health Organisation, to participate in its activities as temporary members of staff and visiting consultants to near Asian countries.

There have been but five Directors since its inception: Dr Charles Badham, Dr Gordon Smith, Dr Cyril Cummins, Dr C.G. Roberts (who unfortunately died within a few months of taking up his appointment) and Dr Alan Bell, the present incumbent.

## Division of Forensic Medicine

The Division of Forensic Medicine developed from the Government Medical Officers Branch, its name being altered when it moved into substantial premises opposite Sydney University in Parramatta Road in 1971. Its name indicated more its growth to cope numerically with an increased workload rather than a fundamental change in function, although the additional space enabled informal sections to be created in forensic histology and forensic haematology, which previously had been conducted largely by the Microbiological Laboratories.

The metropolitan Government Medical Officer always was a full-time appointment within the Colonial Secretary's Department responsible for coronial post-mortems, providing the Police Surgeon, providing expert advice to the City and other coroners and the public, performing examinations of women alleging rape or carnal knowledge and carrying out medical examinations for entry into or retirement from the public service. The small staff involved in these duties was accorded the informal status of a Division due to the pre-eminence of successive Metropolitan Government Medical Officers in forensic pathology and toxicology. As a Division it was not formally associated with the police. Quite the reverse. The police were treated as yet another client and there was pride in its standard of impartiality, untainted by any imputation of bias. So much was this principle observed that it is stated that Dr A.A. Palmer, when occupying the position of Government Medical Officer would insist on all police, irrespective of rank, remained standing during interviews with him. It is told also that the same gentleman once gave evidence in contradiction of that given by a very junior resident. The next day he discovered his error and insisted upon re-entering the witness box, retracting his opinion and supporting the hospital resident, much to the confusion of the Court.

After World War II medical examinations were conducted at Head Office of the Department of Public Health and the Government Medical Officer and staff concentrated upon forensic medicine. One unit of the staff was detached to Newcastle to service the Newcastle Coroner. This was regarded as a training situation for the doctor most likely to succeed in the senior position.

Until the period commencing in 1960 all training, medical and technical, was on an in-service basis after preliminary qualifications either in medicine or scientific certificates or diplomas. Eighteen months of practical training qualified a doctor for promotion to the equivalent of Senior Medical Officer, subject to a report on satisfactory progress. The Division was associated with the City Coroner although plans had been prepared to undertake similar responsibilities for other metropolitan coroners. Staff recruitment difficulties did not permit this extension of function during the period under consideration. In fact so difficult was recruitment of medical staff that the volume of post-mortem examinations could only be accomplished by part-time assistance from Registrars training in pathology in metropolitan hospitals. Although in-service training persisted intermittently after 1960, recruitment of medical staff was sought from qualified pathologists.

The Government Medical Officers in succession from 1913 were: Dr A.A. Palmer; Dr C.E. Percy, Dr J. Laing and Dr R.B. La Brooy.

### Division of Dental Services

As early as 20 September 1904, a deputation from the Dental Association of NSW drew the attention of

the then Minister for Public Instruction (Mr B.B. O'Connor) to the need for dental attention of schoolchildren. The Commonwealth Dental Review of 10 December 1906, recorded the results of a comprehensive dental examination undertaken by the Dental Association: 3,156 children were examined of whom 94 per cent had decayed teeth. Each child had an average of 4.28 defective teeth. Medical inspection of schoolchildren, including dental examination, was instituted by the Department of Public Instruction in 1907. Initially the scheme was restricted to the Metropolitan Area of Sydney and the Newcastle-Maitland district.



A booklet dated September 1914, describing school medical work in NSW drew attention to the difficulty or impossibility of children living in remote parts in obtaining medical and dental treatment. Already in 1913, a Principal Medical Officer (Dr C. Savill Willis) had been appointed and a self-contained Medical Branch established within the Department of Public Instruction. The *Annual Report of the Principal Medical Officer* in 1915, describes the addition of a dentist to the staff of the Travelling Hospital, the establishment of a Metropolitan School Dental Clinic associated with the United Dental Hospital at Railway Square, and the creation of a Travelling School Dental Clinic for the country. It is probable that school dental treatment had been carried out earlier in 1914, or even possibly 1913. The original School Dental Officers were Messrs. F. Hamilton, W.T. Hyder, L. Gowing, Hawkes and English. Miss Mildred Fyson, a trained general nurse, was the first Dental Assistant. By 1915, the School Dental Service had become a separate segment of the School Medical Service. The first Travelling Dental Clinic staffed by Mr Hamilton and Miss Fyson commenced at Tamworth.

Dr B.C. Barkeley was appointed dentist to the Travelling Hospital at Tenterfield. Much of the dental work in the early Travelling Hospital was prior to tonsillectomy. This operation was undertaken in the schoolroom using the teacher's table.

By 1916, in addition to a Travelling Hospital which included a dentist, six Travelling Dental Clinics were operating in both metropolitan and country areas. The dental staff now consisted of seven full-time dentists, six dentists employed half-time, and six dental assistants. Dr (later Professor) Harvey Sutton succeeded Dr Willis as Principal Medical Officer. Subsequent to negotiations between Dr Harvey Sutton and Dr S.W.G. Ratcliffe, the Medical Superintendent of Royal Alexandra Hospital for Children, an outpatients' dental department was opened in Quay Street, Sydney. Miss Hazel Crow and Miss Dulcie Skinner commenced duties on 5 May 1923 as the first dentists. Miss Leila Blackmore was the first dental assistant. This staff was provided by the School Dental Service of the Department of Education. The hospital assumed full responsibility for the dental clinic in 1951.

The Stewart House Preventorium at Curl Curl opened in 1930, and a dental service by School Dental Officers was maintained on a voluntary basis until approximately 1941. A full-time service staffed by Department of Health Dental Officers was commenced in 1958, a modern clinic being established at the home.

The lease of the building which housed the Metropolitan Dental Clinic was not renewed in 1931 due to the depressed financial conditions of the time. Also, during the Depression years all but one of the Travelling School Dental Clinics (Mr W.T. Hyder in the Far West) were withdrawn temporarily from country service.

A Senior Dental Officer, Dr Leslie Pudney, was appointed in 1938 to control the School Dental Service. Dr Pudney first joined the Service in 1916 and retired in 1956. He was succeeded by Mr W.B. Haymet.

In 1941, the staff establishment consisted of one Senior Dental Officer 17 School Dental Officers and 8 Dental Assistants. In 1946, the School Medical Service was transferred to the Department of Public Health, and in 1947, the Division of Dental Services was created with its own Director and administration. The Division expanded its activities into the State Psychiatric, Geriatric and Tuberculosis Hospitals, in which modern dental facilities were established. In 1950, the service was extended to the prisons and in 1955 to Child Welfare Department homes. Also in this year the location of the Service was changed from the Education Department to 86-88 George Street North.

In 1959, the first road mobile dental clinics were put into service in the country at Albury and Walcha. By 1969, nineteen air-conditioned vehicles were operating. An Aerial Dental Service based at Broken Hill was commenced in 1960, Mr R.J. Byrnes, School Dental Officer, being the first permanent flying dentist in NSW. This service covers the remote areas of western NSW and parts of south-west Queensland and north-east South Australia. Clinics have been established in the hospitals and the major centres. Portable equipment is carried in the aircraft, and the closer centres are visited by a road mobile dental clinic. The staff, which consists of a Dental

Officer, a Dental Nurse and a Dental Assistant, fly approximately 40,000 miles, and travel 10,000 miles by road each year. The service is not restricted to children.

In 1962, the first five modern dental clinics were erected as separate buildings in school grounds in Sydney, Newcastle and Wollongong. This policy has been continued to include some country centres. Facilities for general anaesthesia to schoolchildren were introduced soon after the completion of the clinics.

In 1964, after investigation by a Select Committee of the Legislative Council, the *Dentists Act* was amended to permit the use of New Zealand trained School Dental Nurses in dental therapeutic programmes. Four New Zealand School Dental Nurses who had been employed as Dental Assistants, commenced their new duties in June 1965.

Consistent with the general policy of the Department of Public Health, decentralisation of dental services was undertaken in 1967 when a Principal Dental Officer was appointed at Newcastle. A Principal Dental Officer was also appointed to the Western Metropolitan Health District in 1969, and the policy is being continued.

The Division of Dental Services in 1972 contacts at least 100,000 patients per annum, of whom 27,000 are treated in 102,000 visits. Some 40,000 extractions, 87,000 fillings and 1,200 dentures are completed annually in addition to other treatments including general anaesthetics and orthodontic services.

### The Division of Establishments

The formation of the Division of Establishments in April 1961, was achieved by amalgamation of the Division of Mental Hospitals and the Building and Equipment Branch of the Department of Public Health, which serviced both State and mental hospitals. The basis on which it was created is set out in the Regulation 32(1) report of the Department to the Public Service Board of 1962, and is quoted there from:

“In April 1961, the Public Service Board advised the Health Minister that the problems of the hospitals of the Health Department were of such a particular and important character that the creation of an Establishment Division was necessary in the Central Administration. The board felt that only such a Division under a capable director would be able to effect all the improvements considered desirable in foreword planning, in policy formulation and in the day to day care of patients in State hospitals.”

Dr G. Procopis, Inspector of State Hospitals and Medical Superintendent of the Lidcombe State Hospital, was asked to report on the function and organisation of the proposed Division, and it was on the basis of his report that the Division was structured. I understand that a similar Division had operated efficiently in the Department of Child Welfare, although somewhat differently based. Certainly Dr Procopis' proposals proved valid in the years ahead.

The first five years the Division's activities were almost entirely directed towards implementing the recommendations of the Health Advisory Council as they related to mental and state hospitals. From 1966 independent policies started to emerge, and the Division assumed more responsibility for decision making and policy. Its weakness was its structural organisation concentrating on departmental institutions and thus excluded from the general hospitals under the administration of the Hospitals Commission of NSW.

The organisation of the Division was utilitarian and reflected its institutional function. Initially there were two senior executive positions, both medical, the Director of Establishments and the Director of State Psychiatric Services. The status of the former was equivalent to a public health or scientific Divisional Director. Until 1964 the Director of Establishments performed, in addition, the duties of the Inspector of State Hospitals, although he did not retain this title. The latter carried out the statutory duties of his position, including inspectorial responsibilities for the mental hospitals. They were assisted by four senior

An Aerial Dental Service based at Broken Hill was commenced in 1960, Mr R.J. Byrnes, School Dental Officer, being the first permanent flying dentist in NSW.

inspectors, each of whom was allocated a group of State and mental hospitals. Two additional medical senior executive posts were established in 1963 and 1964, the Director of the Intellectually Handicapped and the Director of Geriatrics respectively. They were responsible to the Director for the oversight of the appropriate departmental institutions. Until 1963 both the Director of Establishments and the Director of State Psychiatric Services were immediately responsible to the Director-General of State Psychiatric Services. After my resignation in 1963, the Director of Establishments was responsible to the Under Secretary of the Department and remained so until it was disbanded in 1973.

### Division of Health Education

A Publicity Branch of the State Health Department was set up in NSW in 1926 to provide continuous health propaganda by means of press and radio, posters, exhibitions and leaflets for mass issue. At about the same time an annual National Health Week was inaugurated as a periodic reminder to the community that health matters of topical importance required attention and public concern.

In 1955, Health Department representatives attended an Australian national seminar on health education sponsored by the Commonwealth Department of Health and the World Health Organisation. Guidelines for the development of health education programmes in Australia were discussed with the assistance of W.H.O. consultants from Geneva and the Regional Officer for the Western Pacific.

After a latent period of six years the Department of Health established a Health Education Advisory Council in 1961 with the duty to advise the Minister for Health on the need for and mode of implementation of a health education programme in the State. The Council consisted of representatives of the State Health and Education Departments, of the health professions, university departments of social and behavioural science, the mass communications media and the fields of commerce and industry. The Chairman of the Council was the Under Secretary and Permanent Head of the Department of Health.

An early recommendation of the council selected two matters of priority in developing health education in the State, the first being the introduction of a modern health education curriculum into the schools system and the second, the establishment of a Branch within the Health Department which would become the professional directing agency for developing health education training, research and community programmes.

As a direct consequence of the latter recommendation, a health educationist was appointed in 1964. The first incumbent was a Medical Officer of the public health service, Dr S.J. Krister, who was seconded to the Department of Applied Psychology at the University of NSW for a one year training period in 1963.

A Health Education Branch was formed in 1964 by amalgamation of the existing Publicity Branch and Nutrition Section, together with several new training and research positions. An early task of the Branch was to set out guidelines for health education development in the ensuing decade, and a pilot scheme staffed by a full-time officer was set up in the Ryde Municipality to study the community aspects of departmental programmes.

The Branch was given the status of a Division in 1967 as its responsibilities had increased. Decentralisation of services was begun in 1969 with the secondment of Health Education Officers to two of the Health Districts, Wollongong and Western Metropolitan.

The Division's functions include:

- (i) studies of community health attitudes
- (ii) preparation of educational material
- (iii) liaison with community organisations
- (iv) community education programmes
- (v) training in health education
- (vi) school health education
- (vii) public relations and publicity
- (viii) health publications.



## Division of Health Services Research and Planning

The concept of a Central Planning and Survey Division was first taken up in June 1966, following a report to the Under Secretary drawing attention to trends overseas in regard to coordinated forward planning. Proposals were explored by senior officers in the Department of Public Health, and informal discussions with the Hospitals Commission of NSW followed.

In March 1967, the Public Service Board agreed in principle to a proposal to set up a joint committee to make specific recommendations. Members were: the Under Secretary, the Director-General of Public Health, the Director of the Division of Establishments, the Chairman of the Hospitals Commission and the Senior Inspector of the Public Service Board. These officers agreed that one central unit should be established to provide basic information for both the Hospitals Commission and for the Department. All were aware of deficiencies then existing in the State in regard to the collection and analysis of data required for rational forward planning.

A working party was formed to report on:

- “1. The functions of an operational research, survey and planning unit in NSW.
2. The organisation of such a unit and its relationship to Divisions and Branches within the Department of Public Health, the Hospitals Commission, and outside organisations.
3. Priorities in the development of the project.”

The working party completed this task in September 1967, and, following further consideration by the joint committee, a formal submission to the Public Service Board in December 1967, recommended that approval in principle be given for a Health Planning and Survey Division within the Department of Public Health. The Chairman of the Hospitals

Commission was to have direct access to the unit. Its prime function was to facilitate long-range planning, and in order to conserve this objective, it was to have status independent of that of a division or branch concerned with programme management.

The Department's proposals were approved, and it was decided then that the working party should visit New Zealand to study the operational research unit which had been established there. It was intended that detailed recommendations about staffing, office requirements and expenditures should be deferred until practice elsewhere had been examined. The visit to New Zealand took place in March 1968, firm proposals for the establishment of a Division of Health Services' Research and Planning were submitted to the Public Service Board in July 1968, and approval was received in September 1968.

A Publicity Branch of the State Health Department was set up in NSW in 1926 to provide continuous health propaganda by means of press and radio, posters, exhibitions and leaflets for mass issue.

The approval covered arrangements for the establishment of a standing committee 'which would advise on priorities for work to be undertaken by the Division, frame terms of reference for each project, consider budgets for each task, monitor achievement of programmes and recommend action to keep programmes 'on the rails'. Where competing claims for priority cannot be accommodated, the Director should act in accordance with the recommendations of this Standing Committee'. The committee's membership was approved as follows:

The Under Secretary, Department of Public Health  
 The Chairman, Hospitals Commission of NSW  
 The Director-General of Public Health  
 The Director, State Psychiatric Services  
 A Representative of the Public Service Board

In October 1969, approval for the establishment of the Division was received from the Premier and Treasurer. The Division began operations on 27 January 1970. It was responsible to the Under Secretary not the Director of the Division of Establishments. The first Director was Dr S. Sax.

The type of project undertaken by the Division is illustrated by a random selection:

- (a) A study of the health and hospital services required for the South-West sector of Sydney 1970-1985.
- (b) A study of nursing in general hospital wards.
- (c) A census of the mentally retarded in NSW.
- (d) Forecasts of births for each local government area of Sydney for 1975 and 1980.
- (d) A follow-up study of long term psychiatric patients.

### Division of Tuberculosis

One of the great successes peculiar to Australia was the combined Commonwealth State campaign against tuberculosis, following the Wunderly Report of 1946. Dr 'Harry' (later Sir Harry) was commissioned by Sir Earle Page to survey the facilities for diagnosis and treatment of tuberculosis throughout Australia, and to propose measures for a coordinated Commonwealth-States attack on this problem. The report suggested that the States should be the agents for detection, prevention and treatment, and that early detection should be programmed by miniature mass radiography, on a compulsory basis for adults. The Commonwealth role was financial support of these programmes and for extension of therapeutic facilities. One of the most revolutionary of the recommendations, which was adopted, was the guarantee of security to the individual and family, through a tuberculosis pension while there was evidence of infectivity. The programme Australia-wide was uniformly planned and monitored by the Australian Tuberculosis Advisory Council, representative of the Directors of Tuberculosis of each State and the Commonwealth, and other clinical representatives. On these principles was structured the *Commonwealth Tuberculosis Act of 1948* and the subsequent Commonwealth-State Tuberculosis Agreements.

The State had been heavily involved in the treatment of tuberculosis prior to this date with its two sanatoria at Waterfall and Randwick Auxiliary Hospital, its support of sanatoria conducted by voluntary organisations, and the establishment of outpatient clinics at a small number of general hospitals. There was also one voluntary organisation conducting a limited case-finding programme, the Anti-Tuberculosis Association. The first Director of Tuberculosis was Dr H.K. Denham who was succeeded by Dr H.G. Wallace. Dr Wallace was supported by Dr J. Hughes and a small staff of Tuberculosis Nurses, who acted as health educators to the family where the tuberculosis patient had to be supported. They were partially trained as health and hygiene inspectors, and so attempted to prevent the spread of the disease within the domestic household. They reported on the progress of the patient to the Director of Tuberculosis. The organisation at this stage did not enjoy the formal status of a Division and Dr Wallace accepted his responsibilities in addition to his other duties as Deputy Director.

The coordinated attack as envisaged by the Commonwealth and States, and the formal acceptance by the State of NSW of the Commonwealth-State Agreement in 1949, made it imperative that the organisation within the Department had to be restructured to a composite Division, with a Director dedicated to the anti-tuberculosis campaign. Dr Marshall Andrew was appointed as Director in 1950, and thereafter the history of the Division is a recapitulation of the successful campaign against tuberculosis in NSW, which the author hopes will be reported in detail on another occasion.

The NSW Agreement, as distinct from other States, provided for the continuance of the Anti-Tuberculosis Association as a case-finding organisation with mobile x-ray units. It shared this function with the Tuberculosis Division, which was responsible for allocating the territory in which both would participate. To provide for cases of tuberculosis discovered by this component of the campaign, tuberculosis units were established at three metropolitan hospitals, St Vincent's, Royal

Prince Alfred and Royal North Shore, in association with thoracic surgical units. These specialised hospitals were established with Commonwealth finance. Chest clinics with outpatient and inpatient facilities, were established at a number of country hospitals, in addition to the outpatient units already operating in some of the metropolitan hospitals. Following the *Public Health (Amendment) Act 1952*, providing for compulsory notification of persons suffering from tuberculosis and other consequential provisions, the Division was expanded to provide for Visiting Nurses, Radiography and Tuberculosis Allowances Sections. A B.C.G. vaccination of 'school leavers' campaign was commenced in 1951, and a case register and contacts register was organised as the basis of a section devoted to epidemiology. In 1958 mobile x-ray surveys were conducted in psychiatric hospitals, and further inpatient units established in general hospitals in 1958 and 1959. These units were serviced by consultants on a visiting basis.

In 1960 Dr Marshall Andrew retired and Dr Keith Harris was appointed Director and still retains that post. During his tenure compulsion to attend for x-ray was implemented; special training courses in tuberculosis nursing were organised, the first at the Randwick Chest

Hospital; existing services were coordinated and decentralised; criteria were drawn up to determine frequency of mass x-ray surveys; standardisation of bacteriological procedures and x-ray readings were determined; and the organisation of the Division was restructured to accommodate the decreasing demand due to falling incidence. The tuberculosis wards at the Lidcombe Hospital for 'recalcitrant' patients were closed as also was the Waterfall Sanatorium. It was to reopen as the Garrawarra Hospital. Likewise several of the sanatoria conducted by voluntary organisations either closed or were diverted for other purposes.

The campaign still continues although much abbreviated – a tribute to the efficiency of the campaign and the Commonwealth-State partnership.

## Division of Epidemiology

The Division of Epidemiology is the successor to the Division of Venereal Diseases, the origin of which was initiated by the *Venereal Diseases Act of 1918*. The Director-General, Dr R.T. Paton, was responsible for the preparation of this Act and the organisation through the Microbiological Laboratories of free laboratory examinations for venereal disease. Until 1929 this and collation of notifications and some educational material were the main activities of the Division, treatment being carried out at general hospitals or by private venereologists.

In 1929 a Director of Venereal Diseases, Dr J. Cooper Booth, was appointed, and the departmental clinic for male patients was established at Albert Street in 1933 staffed by two medical officers and supporting

personnel. Although the load was considerable, the staff was small in number and it did not warrant the status of a Division. This was granted in 1934 as a personal tribute to the Director. The name was changed to that of Social Hygiene in 1937 without any significant variation of function.

In 1954 the function of the Division was broadened to include the epidemiology of all communicable infectious diseases and a statistician was added to the staff. It was

renamed the Division of Epidemiology, and a link was established with the Bureau of Census and Statistics. For a short period between 1965 and 1967 the supervision of non-venereal communicable diseases was transferred to the Director of State Health Services. The Division produced a monthly bulletin on the incidence of communicable diseases primarily for the information of the Board of Health, and the medical profession and the *Medical Journal of Australia*.

After the retirement of Dr H. Johnston in 1970, Dr S. Fisher was appointed Director. Dr Fisher was a highly qualified bacteriologist who had published many articles on the epidemiology of infectious diseases. He was anxious to improve the Division's activities in epidemiology and separate that function from its involvement in the detection and treatment



**TB Hospital at Randwick**  
Surgery 1950's

of venereal disease. He immediately organised general epidemiological studies, as well as in-depth studies of outbreaks of communicable diseases, and 'spotting' stations in general practices to establish patterns and trends. He proposed that the Division should extend its activities to include studies on drug addiction, road accidents, cancer, suicide and chronic illness. This extension of its epidemiological function was not acceptable because other agencies, within and outside the Department were likewise involved. After his retirement in 1977, the Division reverted to a venereal diseases Branch. In 1970 a clinic for females was established in contiguity with the existing male clinic.

### The Medical Examination Centre

The Medical Examination Centre commenced operation at its present location, 86-88 George Street North, on 20 May 1963. It was established to bring together under one control all the medical examination activities previously conducted at Head Office for public servant entrants and retirements, by the School Medical Service for Trainee Teachers, and by the Government Medical Officer at 93 Macquarie Street for the Ministry of Transport.

The Centre was established with a Physician-in-Charge, Dr J. Voss, and a staff of fourteen including four doctors, one nurse and nine clerical staff. Two psychiatrists were employed on a sessional basis. Dr Voss resigned in 1964 and for six months it was supervised by the School Medical Service. Dr J. Orr commenced as Physician-in-Charge in August 1964.

The work of the Centre increased due to the demands of an expanding public service and teacher training, with a corresponding increase in staff. It was given the status of a Division in 1969 and Dr Orr was appointed Director. By 1971 it was providing service to 83 public service and allied Departments (including some 14,000 examinations annually for teachers and teachers college students) and was equipped with diagnostic aids for cardiology, chest diseases, and deafness testing. It relies upon the Institute of Clinical Pathology and Medical Research for pathology. For purpose of convenience it is responsible for staffing a first aid station in the State Office Block, and providing vaccinations and inoculations. It is, of course, the main instrument for superannuation assessments of public servants.

### Division of Maternal and Perinatal Studies

The Division of Maternal and Perinatal Studies was created in 1969 by removing the administration of the Maternal and Perinatal Committee from the Bureau of Maternal and Child Health to form a new Division under Dr Maureen Grattan-Smith, who was Deputy Director of the Bureau. It is the first such Division in Australia to concentrate upon the public health challenge of maternal and perinatal mortality and morbidity. The impact of the maternal component is minimal compared to infant and perinatal mortality (0.15 maternal deaths per 1,000 live births as compared with 24.51 perinatal deaths per 1,000 total births and 17.37 infant deaths per 1,000 live births). The committee's activities is largely concerned with prevention of perinatal morbidity and mortality, and the Division provides and analyses statistics obtained from compulsory registration of perinatal deaths under the provisions of the *Births Deaths and Marriages Act*. It also provides editorial staff for the committee's publication, *Obstetrics Practice in NSW*. The Division has completed and published its first major study on perinatal mortality, report of Perinatal Deaths in NSW 1963-71.

In addition to activities directly or indirectly associated with the committee, it maintains the Obstetric Consultant Register and processes applications for obstetric consultations from this register; visits obstetric units in general hospitals to study obstetric and paediatric facilities; compiles a list of general practitioner obstetricians; investigates 'cot deaths'; and engages in peripheral studies, as eg retrospective surveys on thromboembolism, the incidence of caesarean section, obstetric requirements and facilities for medical undergraduates and post-graduate students, relation of antenatal care to perinatal deaths etc.

The Division is essentially a small research and service unit which is represented on the committees of the National Health and Medical Research Council, and on State committees most of which it has been responsible for constituting to further the study of specific and important components of prevention of maternal and perinatal morbidity. Some such committees include working parties on Resuscitation of the Newborn, Hyperbilirubinaemia and Hypoglycaemia, and Perinatal Genetic Diagnosis.

## Bureau of Maternal and Child Health

The Divisions of Maternal and Baby Welfare and School Medical Services were amalgamated in 1965 into the Bureau of Maternal and Child Health. The objective was to provide a health programme catering for mother and child (up to 18 years of age) which could be distributed through the institutions of each Division, and which would be continuous for the individual. Both Divisions had given meritorious service and it was considered that any further improvement could only be achieved by amalgamation, providing a composite organisation allowing for interchange and optimum use of skills and facilities.

### *The Division of Maternal and Baby Welfare*

The Division of Maternal and Baby Welfare was established to coordinate and manage the Baby Health Centre movement. Prior to World War II a campaign was mounted to reduce maternal mortality by the establishment of a Special Committee to Investigate Maternal Deaths and advise on measures to reduce maternal mortality.

Up to 1885, most of the large cities in Australia had infant mortality rates greater than that of London, and as high as that of most other great cities in the World. Although summer diarrhoea, now known as gastroenteritis had long been recognised as the great scourge of infant life, it was not until 1899, that Dr (later Sir Arthur) Newsholme, Medical Officer of Health for Brighton, galvanised public health authorities to a realisation that gastroenteritis was a filth disease, due to contamination of infant foods, usually in the home.



**Newcastle Mater Misericordiae Hospital**  
A midwifery trainee caring for new infants in the Mater nursery 1947

In 1904, at the suggestion of the Medical Officer of Health, Dr W.G. Armstrong, the Municipal Council of the City of Sydney appointed a trained Health Visitor to emphasise to mothers the importance of breastfeeding and to educate them in general health measures in the care of the baby. The work of this trained Health Visitor met with immediate response. The staff was gradually increased to three Health Visitors and within the first ten years of operation, the infant mortality rate for the City of Sydney fell from 116 deaths per 1,000 live births in 1903 to 68 deaths per 1,000 live births in 1914. One important factor came into operation in 1912, was the establishment of a bonus of £5 for each live birth. This brought about a very early registration of births and enabled visits to be made when the baby was only a few weeks of age.

In 1908, the National Council for Women established the Alice Rawson School for Mothers. These schools were open each afternoon to give practical advice to mothers and they greatly assisted in the development of the work undertaken by Health Visitors employed by the Municipal Council of the City of Sydney.

However, despite the home visiting service provided by the Council of the City of Sydney, and the service provided by the Alice

Rawson Schools for Mothers, gastroenteritis still remained the outstanding cause of infant mortality, and to cope with the large number of sufferers, the Government established the Lady Edeline Hospital for Babies 'Greycliffe' Vaucluse in 1913.

In June 1914, the Minister for Public Health, The Honourable Frederick Flowers, M.L.C. called a conference to discuss the question of nursing and instruction in the homes of the people.

The Minister presided at the conference and the various institutions were represented as follows:

*Department of Public Health*

Mr G.H.S. King, Under Secretary. Dr R.T. Paton, Director-General

*Department of Public Instruction*

Dr C.S. Willis, Principal Medical Officer

*Metropolitan Combined Districts*

Dr J.S. Purdy, Medical Officer of Health

*District Nursing Association*

Dr C.B. Clubbe. Mrs Lilian M. Antil, (Hon. Secretary)

*Alice Rawson School for Mothers*

Dr Blackburn, (Hon. Secretary). Dr Guy Griffiths. Mr W.P. Faithfull. Miss A.M. Friend. Rev. Charlton

*Sydney District Mission*

\* Dr Ethel Goode, Medical Superintendent

As a result of this conference, a Baby Clinics, Pre-Maternity and Home Nursing Board was created in 1914 to carry out the Minister's policy relating to the preservation of health of women and children and it was charged with the duty of creating and maintaining baby clinics in various parts of the metropolis. These clinics were to advise mothers on infant care and nutrition and assist in antenatal care of pregnant women.

The members of the Baby Clinics, Pre-Maternity and Home Nursing Board were:

- Dr C.B. Clubbe, Chairman.
- Mr E.F. Harper, Government Press  
Commissioner Secretary
- Dr Paton, Director-General of Public Health
- Mr Neville Mayman, President of the  
Benevolent Society of NSW
- Miss Alice M. Friend, (Alice Rawson School  
for Mothers)
- Mrs Jessie Dickie

In 1914, the Government established the first Baby Health Centre at Alexandria. The clinic was conducted by Miss Williams and came under the control of the Baby Clinics, Pre-Maternity and Home Nursing Board. This brought about the amalgamation of Baby Clinics with the Alice Rawson School for

Mothers which were actually precursors of the present day Baby Health Centres. However, this board was dissolved in July 1915, after the members resigned because of differences with the Government concerning funds. In August 1915, the Baby Clinics, Pre-Maternity and Home Nursing Board was reconstituted and the undermentioned were appointed as members:

- The Honourable George Black,  
M.L.A. Chief Secretary and Minister of  
Public Health – President – ex officio
- The Honourable Frederick Flowers, M.L.C.  
President of the Legislative Council –  
Chairman
- George Hulton Smyth King, Esquire,  
Under Secretary, Chief Secretary's  
Department and Department of  
Public Health
- William George Armstrong Esquire, M.B.  
University of Sydney, D.P.H. Univ. Camb.  
Senior Medical Officer of Health, Office  
of the Director-General of Public Health.
- Edward Ludowici Esquire, M.B. Ch.M.  
University of Sydney
- Mrs Rosalind Black
- Mrs Jessie Dickie
- Miss Alice M. Friend

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\* Unable to attend.

In the same year, Miss Spencer was appointed Nurse Inspector to supervise the nine clinics which had been established in Sydney and Newcastle. The new board carried on for four years and at the end of 1919 the number of clinics increased to 28.

In 1918, the Royal Society for the Welfare of Mothers and Babies came into existence, and the Honourable S.R. Innes-Noad, M.L.C. became the first President of the Society. In September 1919, the Baby Clinics Board was dissolved and the power of control was transferred to the Royal Society, and the members of the Baby Clinic Board were appointed to the General Council of the Royal Society for the Welfare of Mothers and Babies.

A special meeting of the Baby Health Centres Board was held on 16 October 1925, and the following resolutions were passed:

- “(i) That the time has now arrived when the Baby Health Centres should be placed under direct Medical Supervision.
- (ii) That a Medical Officer be appointed under the direction of the Director-General of Public Health; and an advisory committee similar to the present one be appointed.”

The Honourable J.H. Cann, Minister for Health favourably endorsed these recommendations and Dr E. Sydney Morris, Senior Medical Officer of the Department of Health was appointed the first Director of Maternal and Baby Welfare in 1926. The appointment of Dr E. Sydney Morris as Director of Maternal and Baby Welfare raised the question of the functions of the Baby Health Centres Advisory Committee and as a result the committee was disbanded in December 1926.

Dr Morris continued to administer the Baby Health Centres from 1926 to 1934. However, as the Baby Health Centres increased in number and his departmental responsibilities increased as Senior Medical Officer, Department of Public Health, Dr Sandford-Morgan was appointed to assist with the administration of the Centres. Dr Sandford-Morgan became the first full-time Director of Maternal and Baby Welfare in 1934. After a few years however, Dr Sandford-Morgan resigned and Dr Grace Cuthbert (Dr Grace J. Browne) was appointed Director of Maternal and Baby Welfare in 1937, a position she held until her retirement in December 1964.



From 1926 until 1930, all Baby Health Centres were established by the Department, but in the latter year the establishment of new Baby Health Centres was made subject to the provision of suitable premises by local organisations who would bear the financial responsibilities for renting and/or constructing and maintaining the premises, the Department providing the nursing staff. Dr Morris was successful in enlisting the support of the Country Women’s Association which not only spread the idea widely, but by providing the premises and equipment, also lessened the drain on the Treasury. However, during

this period, local authorities would not assist in any way, arguing that it was national work and exclusively a Government responsibility.

During the period of Directorship of Dr Grace Cuthbert (Dr Grace J. Browne) the Division of Maternal and Baby Welfare rapidly expanded the Baby Health Centre Services and introduced new services for the promotion of the Health and Welfare of the Mothers and Babies throughout NSW.

It was due to her efforts that the attitude of the local government authorities became sympathetic towards the need for the establishment of Baby Health Centre Services and as a result local authorities began competing with each other in providing up to the minute buildings and equipment. In 1943, the first Baby Health Centre built by a local authority to the accepted standards of the Department of Health was opened at Concord in the metropolitan area of Sydney.

In 1944, the Honourable W.J. McKell M.L.A., the then Premier and Colonial Treasurer announced a new policy for the establishment of Baby Health Centres and those constructed from 1944 were subsidised to the extent of 50 per cent of the capital cost of the building and up to 75 per cent on the cost of equipment. Rented premises were subsidised to the amount of 25 per cent of the rent payable. In 1950, the subsidy was increased to 75 per cent of the capital cost of the building and equipment and rented premises were subsidised to 37.5 per cent of the rent payable.

In addition to Baby Health Centres the Division supervised Pre-Natal and Well-Baby Clinics. The first Pre-Natal Clinic commenced operation at Newtown in 1929, and by 1931 clinics had been opened at Manly, Campsie, Parramatta, Hurstville, Hornsby, Balmain, Mascot and Rockdale. Originally they were conducted by nursing staff with periodic supervision by medical officers but by 1942 all clinics had regular medical supervision with the exception of the clinic at Auburn. The medical supervision at three of these clinics was provided by private practitioners employed on a sessional basis.

During 1929, 25 Well-Baby Clinics were established to provide medical advice for feeding or nutritional problems and behaviour problems for mothers who could not afford private fees.

In 1939, as part of a campaign for the reduction of maternal mortality in the Metropolitan Area, the Director-General of Public Health with the approval of the Minister for Health, set up a committee to consider the deaths of women due directly or indirectly to pregnancy, childbirth or the puerperal state.

The original committee comprised:

The Director-General of  
Public Health Chairman  
Director of Maternal and Baby Welfare  
Medical Secretary  
Professor of Obstetrics, University of Sydney  
A representative of the British  
Medical Association.  
Medical representatives from the  
Women's Hospital, Crown Street and the  
Royal Hospital for Women, Paddington,  
respectively.

When the committee was first formed in 1939, only deaths occurring in the Metropolitan Area were considered. In 1952 this field was extended to cover deaths in the South Coast and Hunter River Health Districts and in 1954 the remainder of the State was included. The Obstetric Consultant Panel was formed by the Department of Public Health in 1939 as part of a scheme for the reduction of maternal mortality and provision was made for payment for a consultation by the Department of Public Health when the medical practitioner in charge of the case considered it necessary, and the patient was unable to meet the cost of the consultation. No means test was applied. Initially, the scheme only covered the Metropolitan Area for emergencies occurring during the confinement and the puerperium but in 1954 it was extended to advice during the pre-natal period. In 1958, the scheme was extended to include the radius of 50 miles from Sydney and in 1959 the service was extended to the remainder of the State.

The Special Committee Investigating Maternal Deaths was one of the most prestigious and influential committees within the Department of Public Health, and had great influence in reducing maternal mortality through its scrutiny of maternal deaths, its sponsorship of the Obstetric Consultant Panel and its publication to the medical profession *Obstetrics in NSW*. This latter enjoyed the reputation of a minor textbook.



Between 1944 and the end of 1964 the following services were introduced by the Division of Maternal and Baby Welfare:

1944-45 – Children attending pre-school centres conducted by the Sydney Day Nursery and Nursery Schools Association and the Kindergarten Union received medical supervision and lectures on health were included as part of the course for teacher trainees attending the Kindergarten Union and Sydney Day Nursery and Nursery Schools Association during the period 1950-1956.

1959 – Obstetric Consultant Services available throughout NSW, introductions of translations of pre-natal diets and health questions for New Australian mothers.

1961 – Service for Rh negative mothers and their babies and introduction of discussion groups for mothers.

1962 – Itinerant Baby Health Centre Service introduced at Balranald.

1963 – Consultant Obstetric Clinic at Parramatta; Hillston itinerant service commenced.

1964 – Screening tests for the Detection of Inborn Errors of Metabolism, Paediatric Consultant Service, Anaesthetic Consultant Service and Preparation for Parenthood Classes.

At the end of 1964, the Division of Maternal and Baby Welfare conducted the following services: 415 Baby Health Centres, 6 Baby Health Centre Services at Migrant Hostels or Aboriginal Stations, 12 Pre-Natal Clinics, six Consultant Pre-natal Clinics, twelve Well Baby Clinics and supervised 13 Day Nurseries and Pre-School Kindergartens.

In January 1965, following the retirement of Dr. G. Browne as Director, the Division of Maternal and Baby Welfare became amalgamated with The School Medical Service to form the Bureau of Maternal and Child Health and the Division was retitled the section of Maternal and Infant Care.

### *The Division of School Medical Services*

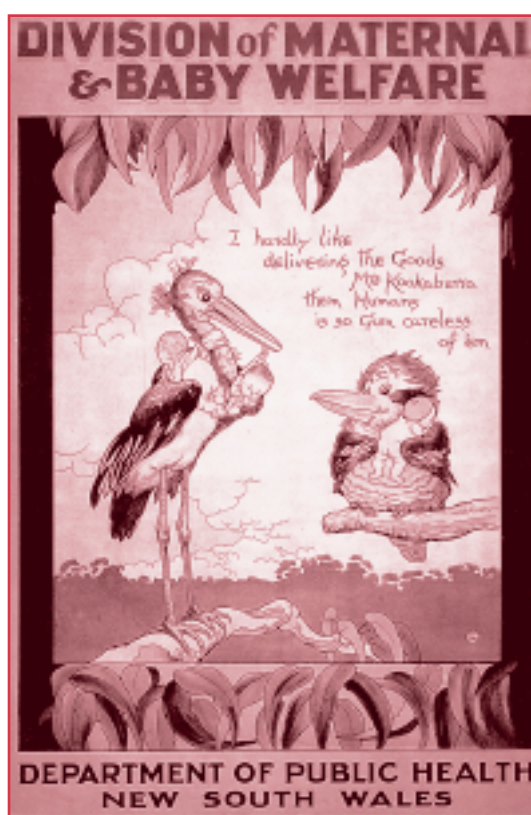
In NSW medical examination of school children was instituted in May 1907, when two part-time medical inspectors were appointed, Dr R.E. Roth for the Sydney Metropolitan area and Dr May Harris for Newcastle. The only children examined were those

referred by teachers. In 1910 the system had been extended and became the Medical Branch of the Department of Public Instruction. By then the medical staff were advising on hygiene in schools and lecturing teachers and pupils on home hygiene and medical care. The staff had been expanded to include trained nurses to assist the doctors.

In 1913 Dr C.S. Willis was appointed Chief Medical Officer and it was decided to carry out medical inspection of school children in all State schools and offer a similar service to private schools. This included vision and hearing testing a complete medical examination of each child at least twice during his

school career. In 1914 a travelling hospital and ophthalmic clinic was established with two doctors, one dentist, and a nurse to visit those areas of the State where there were no resident doctors or dentists. The first oculist was appointed in 1915, but plans for further expansion, including four additional travelling hospitals, were cancelled due to opposition of the British Medical Association and the advent of World War I.

Dr Willis died suddenly in 1919 and Dr Harvey Sutton (later Professor of Preventive Medicine) was appointed Chief Medical Officer in 1920. He



occupied the position until 1925 when he was succeeded by Dr C.F. Stewart. Dr Stewart died in 1930 and was succeeded by Dr A.E. Mackin who held the position until 1953. He became Director of School Medical Services when the Medical Branch was transferred to the Department of Public Health. He was succeeded by Dr E.S.A. Meyers until 1959, then N. Solomons until 1964 (from 1964 to 1967 Dr Solomons was Director of the Bureau of Maternal and Child Health).

In 1957 a Public Service Board committee, chaired by Mr P.G. Price, Deputy Director-General of Education examined the needs of the School Medical Service. The recommendations of this committee were accepted and led to a rapid growth of the Service into child guidance clinics and the development of a child health centre system in the Metropolitan Area. This was in addition to a further extension of medical inspections in schools, a service to pre-school children through five Baby Health Centres in Sydney, and involvement in student health and lecturing at teachers colleges.

The Service continued essentially along these lines until its amalgamation into the Bureau of Maternal and Child Health.

### *Bureau of Maternal and Child Health*

In 1964 a special Child Health Committee was set up by the Under Secretary to investigate and report on the formation of a Bureau of Maternal and Child Health. This committee recommended that the two Divisions be brought together under a single director of Maternal and Child Health to provide a comprehensive integrated health service for the mother and the child from birth to school-leaving age.

The first Director of the Bureau was Dr N.S. Solomons, who had been the Director of the School Medical Service until this time. Early in 1967 Dr Solomons retired and the present Director, Dr A. Douglas, formerly the Metropolitan Medical Officer of Health, was appointed as Director of the Bureau.

The Bureau consisted of three separate sections or divisions: Section of Special Services, Section of Maternal and Infant Care and Section of Child Health.

The Section of Special Services, under Assistant Director W. Hemphill, provided diagnostic clinics for atypical children from country areas and specialist

services for the other two sections of the Bureau. These services were essentially paediatric and psychiatric, and the senior members of staff eg social workers, clinical psychologists, speech therapists, were also supervisors of the same disciplines in the other sections.

The Section of Maternal and Infant Care, under Assistant Director Margaret M. Scott, was essentially the Division of Maternal and Baby Welfare conducting Baby Health Centres, Well Baby Clinics, Pre-natal Clinics, Preparation for Parenthood Classes and health services to nurseries and pre-school kindergartens. It was involved in screening programmes for inborn errors of metabolism and hearing defects in babies, and lectures to pre-school teacher training colleges.

The Section of Child Health, under Assistant Director J.R.F. Boger incorporated the School Medical Service with less emphasis on routine medical examinations, and more on utilisation of Child Health Centres on a district basis to identify abnormalities in school children through parent, teacher or medical referral. These clinics provided a child psychiatric service. The section supplied medical services to the Child Welfare Courts, including psychiatric evaluation, and service to the teacher training colleges.

The Bureau continued to exercise these functions until the establishment of the Health Commission in 1973, when it was dismembered in accordance with the reorganisation of this event and regional administration of services.

### **The Institute of Clinical Pathology and Medical Research**

One of the brightest chapters in the history of the Department of Public Health is its pathology services. Throughout the years there was a procession of persons who contributed to the scientific knowledge of Australia by their research, and who, equally, were proud of the quality of the service they offered to the Board of Health and the Department.

The *Public Health Act of 1896* imposed upon the Board of Health the obligation to supervise the impact of infectious diseases upon the populace of NSW. The Microbiological Laboratories were established when the Board of Health building was erected in 1897 to house the scientific laboratories.

In conformity with the knowledge and standard of pathology of the times, these laboratories were essentially concerned with bacteriology and serology, with a small content of histopathology mainly relating to the forensic component of the Government Medical Officers Branch. They offered a service to the general hospitals as well as the departmental resources, on the basis that patients were indigent – a concept that persisted until the mid 1960s. Hospital pathological services were rudimentary before World War I and the Microbiological Laboratories became central reference laboratories, especially for histopathology. Its reputation for quality and expertise was a major contributing factor.

The first Microbiologist (Director) was Dr F. Tidswell who was a pathologist of distinction who never sublimated his personality to his public service role. After one bitter clash with the Public Service Board, he picked up his equipment and decamped to establish a laboratory service in the attic of Sir Charles Clubbe's house in Macquarie Street. Wiser counsel prevailed on both sides and Tidswell was encouraged to return to 93 Macquarie Street. He was in charge of the Laboratories when they became the Bureau of Microbiology in 1908 and an independent unit of the Colonial Secretary's Department. The reason for this change was the separation of the Department of Agriculture from the Department of Mines, and the need of the former for laboratory services to deal with questions relating to microbic and parasitic diseases of plants and animals. The Bureau provided service for both the Departments of Health and Agriculture until the formation of the Ministry of Health in 1913, when some half of the staff were detached to establish a separate laboratory service for the Department of Agriculture. The Bureau again became the Microbiological Laboratories for the Ministry of Health. Dr Tidswell resigned to become Pathologist at the Royal Alexandra Hospital for Children, and was succeeded by John Burton Cleland.

During Tidswell's tenure the reports of the Bureau were collections of individual research projects mainly concerned with animal and veterinary topics. After Cleland's succession the Laboratories' major publications were published in the *Annual Report of*

*the Director-General of Public Health*, and were brilliant in concept and execution.

The reputation of the Laboratories and its research output were such that its staff were in demand for positions of importance in Government and academic circles. Dr C.H. Shearman resigned in 1913 to become Government Pathologist and Bacteriologist in Western Australia, and in the same year Dr C.H.B. Bradley was appointed to the Department of Physiology of the University of Sydney. These staff movements enabled Eustace W. Ferguson to transfer from the staff of the Inspector General of the Insane to senior Assistant Microbiologist to John Cleland, whom he succeeded as Director in 1920 when Cleland was appointed to the Chair in Pathology at Adelaide University.

Eustace Ferguson was the most famous of the early Directors and his study of the epidemiology of the 1919 pandemic of influenza is still a classic example of applied research. He died in 1927 after a prolonged and severe illness with a lifetime of achievement including among his appointments and recognition President of the Linnean Society of NSW, President of the Royal Zoological Society of NSW, Member of the Australian National Research Council and Member of the Royal Society of NSW. He published 97 scientific papers and was as much respected for his humane qualities as for his scientific achievements.

Following Eustace Ferguson were Dr E.L. Morgan until 1953 and Dr F.W. Fraser until 1959. Both had obtained their knowledge in pathology by in-service training and progression through the Departments of the Microbiological Laboratories. They directed the Laboratories during a period when finances were restricted due to the Depression and World War II, and their energies were concentrated in maintaining pathological services to meet an increasing demand, especially from rural hospitals which lacked any pathology services. The demands from forensic medicine, venereology, State hospitals and other departmental and public health agencies were forever increasing as the value and extent of pathology assistance was appreciated.

One of the brightest chapters in the history of the Department of Public Health is its pathology services.

By 1959 it was obvious, that space requirements, if for nothing else, would make reorganisation of the Microbiological Laboratories imperative. The tenor of pathology had changed with increasing emphasis on chemical pathology, and the deployment of sophisticated apparatus and machines for accurate analyses of minute quantities of blood and tissues. In-service training was no longer adequate, and any restructuring of departmental facilities must seek for qualified staff who had been trained in theory and techniques.

And so was the concept of an Institute of Clinical Pathology and Medical Research conceived – an Institute which would be equipped and staffed to cope with a full range of modern techniques, and yet would have reserve of space and expertise for teaching and research. The first step was to obtain a Director with similar ideals, well qualified and experienced, who would command respect from an equally qualified staff, and who could translate these principles into service and action. I personally negotiated to obtain Dr H. Kramer who fulfilled these specifications at a differential salary above other Directors. He had been engaged by the NSW State Cancer Council as a research pathologist, and had later joined the staff of the Australian National University. As events turned out the choice was felicitous.

A site was chosen for the Institute within the grounds of Lidcombe State Hospital so that it could utilise the clinical facilities of that hospital, and thus gain recognition as a training institution by the newly formed College of Pathologists of Australia. A firm of architects, Kevin Curtin and Partners was engaged to build the Institute using a modular pattern of pre-formed building units. The building was complete and equipped in a period of nine months.

The Institute was divided into four main sections – bacteriology, biochemistry, histopathology and virology – and an attempt was made to recruit a recognised expert in each of these sections. It was considered that the people so recruited should be capable of stimulating and supervising research, as well as establishing a quality department. This objective was achieved in all but bacteriology, in which department subsequently a doctor was placed who had trained within the Institute.

The Institute has fulfilled its functions of service,

education and research. It supplies service to the State hospitals, and to the State generally in venereology and its other reference laboratories including virology, and to a lessening extent in histopathology as pathologists are gradually moving to rural areas. Its educational capacity recognised by the Royal College of Pathologists of Australia as an approved training institution, and by the University of Sydney, one of whose professors, E.S. Finckh, is Deputy Director to Dr Kramer; still retaining his Chair at the University. Its research potential has been demonstrated by the number of publications issuing from its staff and invitations to participate in scientific conferences and seminars.

And yet again its physical facilities are inadequate to cope with the extent and volume of its services. As this era closes in 1973 a larger complex is being built within the grounds of the Westmead Hospital to which the Institute will move, to commence yet another phase.

## Branches

### Private Hospitals Branch

One of the recommendations of the Royal Commission on Public Charities in its Fourth Report of 1899 was 'that private hospitals be placed under supervision as in Victoria, and that they be licensed after inspection'. At this point of time, subsidised general hospitals, government asylums and charities were a responsibility of the Charitable Institutions Division of the Colonial Secretary's Department external to the administration of the Chief Medical Officer to the Government. In 1909 Dr R.T. Paton was transferred from the sub-Department of Public Health to assume control of the section catering for government asylums. Prior to this transfer the first *Private Hospitals Act* was passed in NSW in 1908, and the supervision and licensing of private hospitals later passed to Dr Paton (in 1912) when he was appointed Inspector General of Metropolitan Hospitals and Charities. It was transferred to the sub-Department of Public Health when Dr Paton succeeded Ashburton Thompson as Chief Medical Officer and the first Director-General of Public Health in 1913, and thereafter remained as a small branch of the medical administration.

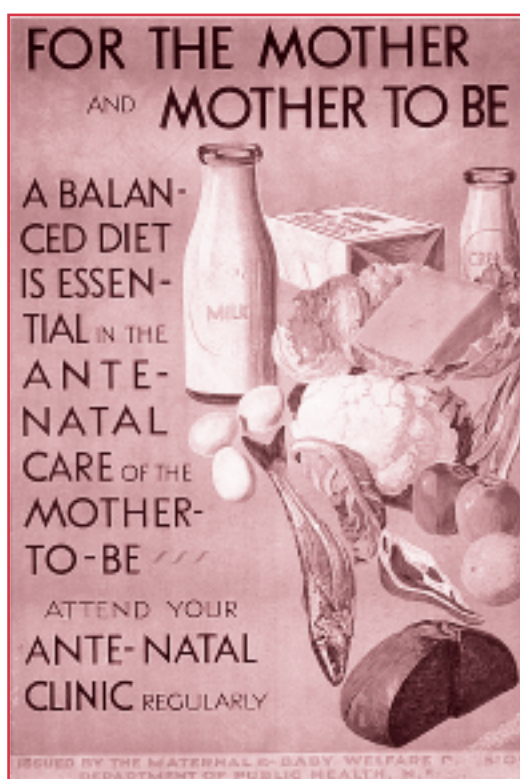
Until 1945 this Branch catered only for private

hospitals and inspections were carried out by supervisory nurses. In that year a Medical Officer of the central administration of the autonomous Department of Public Health was appointed in charge of the section. In 1947 inspection of rest homes commenced although there was no enabling legislation until February 1954, when an *Amended Private Hospitals Act* was proclaimed to bring rest homes within its influence. Regulations were proclaimed setting out standards as the basis for licensing.

The intrusion of the Commonwealth into the realm of private hospitals and rest homes in 1955 was an extension of its constitutional capacity in social welfare under the *National Health Act*. From this date there was a dual and potentially conflicting inspectorial and accreditation services between State and Commonwealth Health Inspectors, the former working under a disclosed list of standards and requirements of the *Private Hospitals Act*, and the latter from standards drawn up departmentally but not published. Close personal liaison between the two sectors and goodwill minimised areas of conflict, although undoubtedly the Commonwealth exercised the greatest influence on proprietors as financial subsidy flowed from their accreditation and orders.

The Private Hospitals Branch remained small numerically and in 1972 was transferred to the Hospitals Commission because of the competition of private hospitals and rest homes with the general hospital system. The growth of rest homes particularly was of the order that the total number of beds available was two-thirds that of the general hospital pool. It was argued that the change of administration would enable the Hospitals Commission to regulate this growth, to determine location and reduce competition with established

general hospitals. The growth was a reflection of the closed honorary system of the general hospitals and exclusion of general practitioners. With some exceptions private hospitals and rest homes were outlets for general practitioners. Certainly the bulk of rest homes absolved general hospitals and psychiatric hospitals (in part) from providing for chronic and long-term stay patients. The function of the Private Hospitals Branch remained as previously: licensing and inspections of private hospitals and rest homes covering general conduct and management and care of patients; physical attributes of premises; equipment; adequacy of records; patient-nurse ratios and standards of nursing.



### Health Inspection and Pure Food Branches

The Health Inspection and Food Inspection Branches evolved from the responsibilities imposed upon the Chief Medical Officer to the Government and the Board of Health to supervise the sanitary obligations of local authorities. The activities of these Branches expanded to accommodate an increased number of public health statutes, which at the time were administered by the Board of Health. The two main Acts, which still remain the bases on which these Branches function, are the *Public Health Act of 1896* (as

amended) and the *Pure Food Act 1908* (as amended) respectively.

Both Branches were inspectorial in content and advisory to the Director-General of Public Health, and neither enjoyed the independence granted to other Divisions. The main reservoir of inspectorial staff was centrally located within the physical confines of the administration of the Director-General of Public Health. Units of each were detached to Health Districts as established, and although District Health Inspectors were closely allied with the District Medical Officer of Health, District Pure Food

Inspectors regarded themselves as units of the central health administration. This anomaly, which caused resentment between the two groups, and with the Medical Officers of Health, was a deliberate policy of successive Director-Generals of Health. Whereas the *Public Health Act* was administered by local authorities, the *Pure Food Act* was never so proclaimed and was administered personally by the Director-General. This was on the basis that food (and drug) quality and standards must be uniform throughout the State, and measures to secure this must not be influenced by local conditions. Various attempts in latter years to combine the two Branches into a common Branch staffed by dual purpose Inspectors was resisted successfully by the Director-General, despite considerable pressure politically from the Public Service Board and from the departmental senior administration.

#### *Health Inspection Branch*

In 1896 P.A.E.L. Getting, a qualified English sanitary engineer was appointed Government Sanitary Inspector on the staff of the Board of Health. He was required to deal with complaints and inspections under a number of Acts, but mainly the Public Health and associated Acts as the latter were later proclaimed. In 1901 the staff of sanitary inspectors was increased by four, two of whom in 1902 were transferred, one each to the staff of the Medical Officers of Health for the Hunter River and Metropolitan Health Districts. In the same year (1901) Dr Ashburton Thompson's representation to the Royal Sanitary Institute were successful and it established examinations in Sydney for sanitary inspectors, training being in-service, and in the years to come through private schools and the Sydney Technical College. The imprimatur of the Royal Society for the Promotion of Health (previously the Royal Sanitary Institute) is still sought as an additional qualification to that obtaining through the State technical education system.

And so the pattern was set which has persisted unchanged: a central cadre of health inspectors under a Chief Health Inspector servicing and advising the Metropolitan Medical Officer of Health and the Director-General of Public Health or his deputy, and a smaller number of Inspectors in each Health District determined by the population density of the

District. Apart from its statutory inspectorial and advisory role, the Health Inspection Branch has published pamphlets on infection and sanitation for public and official distribution.

When local authorities were required to employ inspectors of nuisances after the consolidation of the *Public Health Act of 1902*, it became a matter of policy that more qualified inspectors were employed by the local authority on the principle that their individual capacities were approved by the Board of Health. Appointment consequently was supported by the Government on a half-pay subsidy basis from central Government to complement the other half from local rates. This support was abolished as an economy measure by Premier J. Lang in the mid 1920s. After World War II the Chief Health Inspector was assisted by a Deputy and the seniority thereafter was the Metropolitan and Hunter River Districts with other Districts being equal. The Metropolitan Senior Health Inspector had a salary differential over all rural district health inspectors. The Chief Health Inspectors in order were: P.A.E.L. Getting 1888-1913; E.A. Cresswick 1913-1933; T.A.W. Curry 1933-1935; G. Garrow 1935-1952; K.R. Home 1952-1963; D.H. Way 1963-1965; H.K. Evans 1965-1969; and K.W. Bagnall 1969-.

#### *Pure Food Branch*

The Pure Food Branch was established in 1908 to police the provisions of the Act of that year. Essentially the organisation remained unchanged throughout the years, with a number of inspectors working under the Chief Inspector. In each Health District there was one position of Senior Pure Food Inspector and at Head Office a Deputy. The Branch inspected premises and collected samples of food and drugs for analysis by the Government Analyst. Prosecutions were conducted by the Inspectors after approval by the Director-General of Public Health or his nominee. Chief Health Inspectors since 1908 were: Mr A. Kench until 1930, Mr C.V. Francis to 1940, Mr P.C. Williams to 1952, Mr W.J. Madgwick to 1972, and Mr A. Downer. Mr Downer was the first food technologist appointed to the position. Mr W. Madgwick was the best known of the 'Chiefs' appearing frequently on radio and television and always available for lectures and addresses. He made a particular study of food standards and food

legislation and was a member of several expert committees.

### Poisons Branch

The Poisons Branch is one of the most recently developed Branches in the Department, and relates to the administration of poisons legislation. Paradoxically poisons legislation is one of the earliest health Acts, the *Sale and Use of Poison Act 1876*, preceding the *Public Health Act* by 20 years. This Act established a Board of Pharmacy with responsibility for control of poisons. This responsibility passed to the Pharmacy Board of NSW under the *Pharmacy Act of 1897*. A consolidated *Poisons Act of 1902* confirmed this responsibility which remained substantially unaltered until 1966.

The *Police Offences Amendment Acts of 1908 and 1927* provided for the control of opium and other dangerous drugs, with similar properties of addiction. It provided also for licensing of manufacturers and wholesale distributors and authorisation of possession and sale by pharmacists, and others specially authorised. The issue of licences and other administrative functions were the responsibility of the Chief Secretary's Department on the advice of the Pharmacy Board, until 1966.

The *Poisons Act 1952* established a Poisons Advisory Committee to advise the Minister for Health on the composition of the Poisons Lists, but otherwise did not alter the relative roles of the Pharmacy Board and Chief Secretary's Department. The *Poisons Act 1966* was significant in consolidating the control of poisons under the Department of Public Health, including the dangerous drugs provision of the *Police Offences Amendment Act*. The Poisons Advisory Committee was retained, and a Poisons Branch established under the control of Mr R. Dash, a Pharmacist, on 28 March

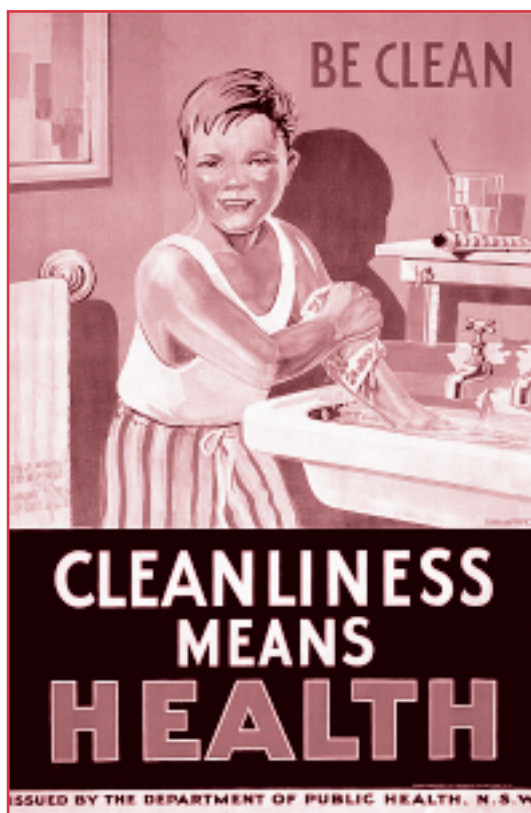
1966. He was the Senior Pharmacist-in-Charge until the end of this period.

The functions of this Branch were inspection of retail pharmacies; oversight of manufacture, distribution and sale of dangerous drugs and poisons; and later quality control and licensing of manufacturers of therapeutic goods and substances, under the *Therapeutic Goods Act of 1972*. In addition to the functions which involved an inspectorial staff of Pharmacists, the Director and his Branch were involved in the activities of the Poisons Advisory Committee, the Drug and Cosmetic Committee and the Poisons Schedules Standing Committee. The Director was also adviser to the Director-General of Public Health, and was involved in the detection and prevention of drug abuse with the Drug Squad of the NSW Police Force, including the methadone maintenance programme. The Branch was the main resource within the Department for speakers on drug education programmes and helped train health education officers and drug educators for the Division of Health Education.

The Commonwealth Health Department and the Custom Department were in close liaison with the Poisons Branch in policing drug abuse under the Pharmaceutical

Benefits Section of the *National Health Act*. The former computerised audit of prescriptions generally, and of drugs of addiction in particular, was available to the Poisons Branch, as were the Branch's records to the Commonwealth agencies.

The Branch, under the guidance of Mr R. Dash, pursued a course which was more educative than punitive, and this was particularly apparent in its attitude towards good manufacturing practice under the *Therapeutic Substances Act*. It was, and still is held in high regard by State and Commonwealth agencies and by commerce and manufacturing industries.



## Central Cancer Registry

On several occasions during the 1960s the Medical Statistics Committee of the National Health and Medical Research Council recommended that the States should establish cancer registries. A committee was established in 1967 to evaluate this proposition consisting of:

- Dr C.J. Cummins, Director-General of Public Health and Chairman
- Dr A. Lilley, Chairman, Hospitals Commission of NSW
- Dr D. Storey, Member, Hospitals Commission of NSW
- Dr G. Scott, Epidemiologist, School of Public Health and Tropical Medicine
- Dr K. Starr, Medical Director, NSW State Cancer Council

The committee decided that a central cancer registry was feasible and desirable in NSW and that it should be by compulsory notification from hospitals of cancer patients undergoing inpatient or outpatient treatment. This would be on a monthly basis of discharges or deaths.

The *Public Health Act 1902-1965* was amended in 1970 to provide for notification under Part IIIA – Dangerous Diseases. The Central Registry was established in that year under Dr Joyce Ford with the assistance of a Hospitals Programmes and Central Cancer Registry Committee. It was an advisory committee to the Registrar on cancer statistics, to assist in planning future functions, and propose area of research to which the Registry could contribute.

The initial members were:

- Dr C.J. Cummins, Chairman
- Dr R. Melville, representing Post Graduate Committee in Medicine of the University of Sydney
- Professor K.R. Cox, representing the University of NSW Post-Graduate Committee in Medical Education
- Dr F.W. Niesche, representing NSW State Cancer Council
- Dr D. Storey, representing the Hospitals Commission of NSW
- Professor L. Atkinson, Director of Radiotherapy, Prince of Wales Hospital
- Dr G. Scott, epidemiologist
- Dr H. Kramer, Director, Institute of Clinical Pathology and Medical Research
- Dr J.F.S. McKee, representing the Repatriation (Veterans) Department

The Registry continues to operate under the initial Registrar, Dr J. Ford and has published its first annual report.

## Police Medical Branch

Since the foundation of the Police Force in 1862 a medical officer has always been associated with the Department. This service was provided by the Metropolitan Government Medical Officers Branch and the person so detailed was known as the Police Surgeon. The Branch was separated from the Government Medical Officer when the latter Branch moved to new premises in 1971 and became the Division of Forensic Medicine. The title Police Surgeon was changed to Police Medical Officer and Dr E.B. Pedersen was appointed to the position.

The function of the Police Medical Service is to provide a comprehensive medical service within the Police Force, including medical examinations on entry and periodic examinations for promotion; vaccinations; special medical examinations for shallow water divers and members of special squads; supervision of a daily sick parade; and assessment of fitness to continue in the Force. A further function has been diverted to this Branch from the Division of Forensic Medicine: examinations for alleged carnal knowledge.

The Branch consists of two medical officers and a small supporting staff supplied by the Police Department.



# Appendix 8

## An Institute of Health Science\*

### Preface

In recent years I have been conscious of the need for a different form of administrative structure within the Department to meet the impact and increasing significance of technology within the Scientific Divisions. It is obvious that such a structure should aim at coordinating the functions and resources of these Divisions. Coordination in absolute terms is essential to contain their economic needs within reasonable and accessible limits; to better utilise technical equipment and conserve technical skills; to improve quality and provide for audit of service; to integrate training programmes for the common benefit of the Divisions as a group rather than individually as at present; to develop and stimulate training programmes where none exist; and to co-operate with other scientific organisations and universities to contribute to the general repository of scientific knowledge and experience.

This administrative mechanism can be achieved by the establishment of an Institute of Health Science. The physical structure of the Institute would comprise the four Scientific Divisions of the Department: the Institute of Clinical Pathology and Medical Research, the Division of Analytical Laboratories, the Division of Occupational Health and the Division of Forensic Medicine.

Such an Institute could develop a formal and close association with the Universities of Sydney, NSW and Macquarie, which would be of further advantage towards recruitment and retention of scientific staff. Without committal, I have explored this concept of university association and bilateral accreditation with the ex-Vice Chancellor of the University of NSW, and the Dean of the Faculty of Medicine and the Professor of Medicine of Sydney University. Although no discussions have taken place on a personal basis with Macquarie University, it has displayed an interest in the science component of the Department, and has reached an informal agreement with the

Department for the practical training of its senior science undergraduates within the Division of Analytical Laboratories. The discussions with the Universities of Sydney and NSW were productive, and the interest displayed by these universities is indicative of the benefit which would flow to the Department and the universities from this concept.

That such a mutual association is possible has been demonstrated by the appointment recently of Associate Professor E.S. Finckh of Sydney University as Deputy Director of the Institute of Clinical Pathology and Medical Research. The Vice-Chancellor of Sydney University has proposed that Dr Finckh retain his university appointment and title, and that one-third of his service time be spent at the university. The university will recoup the Department for this proportion of his service. Professor F.R. Magarey, Head of the Department of Pathology of the University of Sydney, is anxious to develop a similar type of liaison with the Division of Forensic Medicine for undergraduate and post-graduate teaching when the Division moves to its new premises in proximity to the university.

Originally I advanced the proposition of an Institute of Health Science to the Science Advisory Panel, then constituted by the Public Service Board to advise it on the future of Scientific Services within the public service, and, more recently, to the committee, under the Chairmanship of Dr Starr, currently considering the Eglington Report on the reorganisation of Government health services in NSW. The opportunity to advise the concept in further detail, and independently of the Starr Committee, has been stimulated by the change in location of the Divisions of Occupational Health and Analytical Laboratories to Lidcombe. This change has brought these two Divisions into physical aggregation with the Institute of Clinical Pathology and Medical Research in the one situational complex.

Two other events are pertinent to the consideration

\*The document was submitted to the Under Secretary and the Public Service Board in October 1969, by Dr C.J. Cummins, Director-General of Public Health.

of this proposition. Before the end of 1970 the Division of Forensic Medicine will move into modern facilities in Parramatta Road. The Director of the Institute of Clinical Pathology and Medical Research has submitted plans for additions to the Institute at a cost of approximately \$2,000,000. This proposal will be considered by a departmental committee as a preliminary to seeking a priority for its construction from the public building vote.

The combination of these circumstances emphasises the urgency for such an Institute at this point of time.

## Centralisation of scientific services

It could be alleged that the establishment of an Institute of Health Sciences would create a monolithic central organisation, and so, diminish, or deny, the opportunity for decentralisation of scientific activities in any reorganisation of the administration of Government health services. Superficially this criticism is valid, but only on the assumption that all health services must be decentralised.

The principle of decentralisation has been advanced in a limited scope and practised by this Department since the establishment of the first Health District at Newcastle towards the end of the nineteenth century. As a principle it is warmly supported by public health administrators, including myself. It is fundamental in the administration of public health services, and particularly where these services are structured towards personal contact with individuals or segments of the community in a preventive, advisory, or semi-therapeutic role.

Although some scientific services, especially pathology, relate more to therapeutic than preventive medicine, decentralisation is not as practicable a proposition as it is with traditional public health services. In large measure this is because of the peculiar demographic distribution of the population in NSW and the need to maintain an evenness in the technical quality of service (within a forecastable cost structure) throughout the whole of the State irrespective of local influences.

In providing scientific services, large sums of money, in terms both of capital and maintenance expenditure, have to be expended on buildings,

equipment and technical skills. To justify this expenditure these Divisions must have access to a catchment area which will provide technical volume and diversity. Provided there are adequate channels of communication, the demands from the whole of NSW can be brought to a central source where scientific skills are aggregated, and where mechanisation can handle the demand with consequent economic advantage. Furthermore, staffing, training and career prospects are more attractive in a large organisation with a full range of scientific interest and experience than in smaller peripheral units, where economically such a range could not be justified. I do not see any difficulty in providing prompt and adequate service from a central source. Centralisation would not preclude a limited service being developed within regions where population and economics permit.

Apart from practical considerations of quality and accessibility of service and finance there is a need for the Department to define its scientific role in an era in which medical science and technology are becoming increasingly significant. Some administrative mechanism must be devised to provide for continuing assessment of scientific functions and services, and re-adjustment in terms of organisation, skills and equipment to meet the challenges which technology is imposing on public health science. Some areas from which these challenges arise are: traffic accident analysis; sophisticated technology of food products; the development of international food standards in which quality is a paramount factor; quality control of drugs and therapeutic substances; control of pollution (chemical, radiation and noise) of the environmental infrastructure; support of personal therapeutic services in the hospital system of the State by a greater quantum and diversity of pathology services, many of which are complex and costly; and support of industry, the community generally and other Government agencies in the fields of epidemiology; occupational health and safety (including occupational psychology); medical analytical chemistry; forensic medicine, etc.

Scientific services should be centralised both for better economic control and adequate quality control to take maximum advantage of automation, common facilities, skills and experience. The principle of centralisation of these services has been accepted implicitly by the Department in the aggregation of the greater number of these facilities at Lidcombe. The establishment of an Institute of Health Science is a logical extension of this principle towards effective coordination of activities and controlled direction of functions.

## The functions of the Institute of Health Science

This proposition envisages the creation of an Institute of Health Science as a statutory, part advisory and part executive. A similar mechanism has proved very successful with the Institute of Psychiatry, and I am confident that the same concept would be equally successful if applied to the scientific activities of the Department.

As proposed, the Institute would not interfere with public service or departmental authority over the Scientific Divisions. The enabling statute would define the role and limitations of the Institute as a corporate body and the composition of its Governing Council, on which the Department would have majority representation. As a Statutory Authority it has the advantage that, in the composition of its Governing Council, it involves directly by representation the metropolitan universities. This involvement would assist the development of the teaching and research functions of the Scientific Divisions. On all these issues will elaborate later.

The Institute would have three functions: service, training (including teaching) and research.

### (i) Service

The Institute would have no executive authority whatever over the service functions, and extensions thereof, of the Scientific Divisions. Nor would it intrude into the lines of communication between the Directors of these Divisions and the Director-General of Public Health in matters involving service, including those aspects of administration which flow from Acts of Parliament such as the *Clean Air Act* and the *Radioactive Substances Act*.

Its role to the service components of the Scientific Divisions would be advisory in the development of policy, or interpretation of existing policy, where these Divisions are involved as a composite unit; in advising on priorities for new services and extensions of existing services which might have major significance on one or more units to the Institute; in assessing demands for service and investigating sources of supply; and in conducting technical and financial audits on the structure and validity of existing

services.

In its advisory role it would be a useful instrument to proffer advice to the Minister, whenever requested, on the scientific needs of the Department as a whole, and the impact which these needs might have on medical services generally in the State.

As the Governing Council of the Institute would include the Directors of the Scientific Divisions, much of its advisory role would develop from propositions advanced by the Directors, and considered in the overall context of the resources and functions of the Institute.



## (ii) Training and education

With the emphasis today on education and particularly the demand for tertiary education, there is competition between Government, industry, universities and scientific organisations (including hospitals) for technological and scientific staff. This competition is reflected in the difficulty in obtaining and retaining staff, especially at the scientific level, for some of the Scientific Divisions. It has been demonstrated by the Institute of Clinical Pathology and Medical Research that adequate training programmes within its own facilities can, in large measure, overcome this difficulty. An extension of this principle to cater for the total complex of Scientific Divisions would be an important function of the Institute.

Apart from assisting recruitment there is an additional advantage to the Divisions in participating in staff training as a composite unit. Staff under training could then move from Division to Division during the period of training to those areas where they would receive optimal tuition and experience.

Post-graduate training programmes both formal and informal, are also essential to stimulate staff morale and improve technical capacity. It is here that I see the benefit of a coordinated programme between the Department (through the Institute) and the universities, each having access to the facilities of the other. This would require a formal association so that the Institute could be accredited by the universities as an organisation in which post-graduate training could be structured.

With such recognition the facilities of the Institute could be used for the training of students for higher degree and particularly the Doctorate in Philosophy. Such an arrangement exists between the Walter and Eliza Hall Institute and the University of Melbourne. Reciprocally, the facilities of the Institute would be available to the universities for its under-graduate and post-graduate programmes. Accredited members of the staff of the Scientific Divisions could participate in university educational programmes. This form

of personal accreditation might well involve invitations to university positions on an acceptable formula. I am confident that a formula can be developed which would be satisfactory to the Department, the Public Service Board, and the universities to permit of such accreditation of individuals.

The function of the Institute in training and education would be more than advisory. It would be an approving authority for training and educational programmes embracing the Scientific Divisions and would supervise the performance of these programmes. As its Governing Council would contain representatives of the universities it would be the agency which would nominate individuals as worthy of accreditation by the universities in their educational programmes. It would negotiate with universities for bilateral agreements.

## (iii) Research

There is a very real potential for technical research within the facilities of the Scientific Divisions of the Department. This potential should be explored, defined and developed. Some technical research is undertaken at present on an individual basis. Such as is undertaken is applied or clinical, using material which is available from the services which these Divisions render.

There is no need to emphasise the stimulation to professional morale and quality of service which research engenders, as well as the increase in reputation and status which flows to the whole organisation, and to the units and individuals who participate. Until recent times research was not considered to be a function of Government departments, but a prerogative of universities and independent organisations endowed for that purpose. This attitude was understandable when research was largely structured around individuals, who had opportunity and access to finance and special equipment which was available only in university and research foundations. Today the emphasis is on team effort, organised programmes and continuing finance.

The Department has accumulated a large reservoir of sophisticated equipment in its Scientific Divisions. It has a small cadre of highly qualified scientists, who, given the opportunity could be integrated into research teams. Also, it has access to biological and clinical material which is not readily available in the same quantum to universities and research foundations. However, it lacks trained research workers and specific finance for this purpose.

I am interested particularly in the concept of quaternary research where in an individual of calibre is supported and allowed to develop his own line of research for a stated period of time. This concept is one which might well interest the Institute of Health at a later stage. It is pertinent to the concept of the Institute because of the wide variety of facilities and equipment which it could offer; thus permitting tangential investigations to be conducted simultaneously with the development of the main theme. This type of research has been responsible for many of the major advances in biological sciences such as the development of anti-poliomyelitis vaccines. It is the type of research which is carried out by many of the larger pharmaceutical firms in their search for new products.

The research function of the Institute of Health Science would be largely executive. As an identifiable Statutory Authority it could attract funds for project research from industry and other granting authorities, such as the National Health and Medical Research Council and the Australian Universities' Grants Commission (support from the latter would be through the universities with which the Institute is associated). Apart from attracting research grants it could engage technical staff for approved projects for a finite period of time from its own funds. This could occur either by granting research scholarships or alternatively by direct support of project research.

## Organisation of the Institute of Health Science

The proposition advanced is that the Institute of Health Science be established by an Act which would be similar to the Act which incorporated the Institute of Psychiatry. If acceptable the principles of its organisation would be included in the enabling Act:

- “1. The Act would provide for the establishment and incorporation of the Institute of Health Science, and would define its powers, authorities, duties and functions.
2. The foundation units included in the Institute would be the four Scientific Divisions of the Department. The Act would provide for subsequent inclusion of other scientific sections of the Department, when appropriate, and subject to Ministerial and/or Public Service Board approval.”

Likewise its functions would be stated in the Act:

- “1. To advise on measures and priorities to coordinate the scientific services of the four Scientific Divisions.
2. To conduct financial and technical audits on the scientific services of these Divisions.
3. To advise on priorities for new services from these Divisions.
4. To advise on priorities for major items of scientific equipment for these Divisions.
5. To advise generally on such matters as may be referred to it relating to the needs and functions of these Scientific Divisions, including their co-ordination and collaboration with other scientific organisations operating in similar areas of service.
6. To organise training and educational programmes within these Scientific Divisions and supervise their effective performance.

7. To enter into agreements, subject to the consent of the Minister, with universities for participation in the educational programmes of the universities at under-graduate and post-graduate level, including accreditation of members of the staff of the Division within the teaching establishment of the universities.
8. To approve and sponsor research within the facilities of the Institute.
9. To coordinate programmes of research in collaboration with industry, other Government agencies, universities and other scientific organisations.
10. To distribute research grants and scholarships for research within the Scientific Divisions or in collaboration with the universities and to engage suitable staff for this purpose.
11. Generally to offer advice on any matters referred to it relating to the quantum or quality of scientific services, scientific training or educational programmes, and scientific research within the Department of Public Health.
12. With the approval of the Minister for Health to include any other scientific sections of the Department within the organisation of the Institute.
13. Without limiting the generality of any of the objects of the Institute it shall have the power, subject to the approval of the Minister, to accept the invitation of or to co-operate with the Government or a Health Authority, or any other authority of the Commonwealth of Australia, or of any State or Territory of the Commonwealth of Australia, or of any country within the British Commonwealth, or with any international organisation recognised by the Commonwealth of Australia in implementing any of the objects for which the Institute was founded.

In this section I have not attempted to define precisely the person (Minister or Under Secretary) to whom the Institute will tender advice, or from whom it will receive references for advisings. Rather I have attempted to describe the Statutory functions and responsibilities of the Institute in broad terms). As a body corporate it will consist of members appointed under the Act for a specific term. These members will constitute the Governing Council as follows:

“(i) A prominent citizen nominated by the Minister as Chairman. (This is suggested because the same device has been so successful with the Institute of Psychiatry).

The Scientific Directors agree the Chairman should be a person who is not involved in any of the components of the Institute or the universities with which the Institute may enter into agreements (I consider further the Chairman should preferably have commercial experience).

(ii) The Director-General of Public Health.

(iii) The Directors of the Institute of Clinical Pathology and Medical Research, the Divisions of Occupational Health, Analytical Laboratories, Forensic Medicine, and any other units subsequently included in the Institute.

(iv) The Under Secretary of the Department of Public Health, or his nominee, who shall not be an officer of the Scientific Divisions in (iii) above.

(v) A representative of the Public Service Board.

(vi) A representative each of the Universities of Sydney, NSW and Macquarie.

(vii) A representative of the State Treasury.

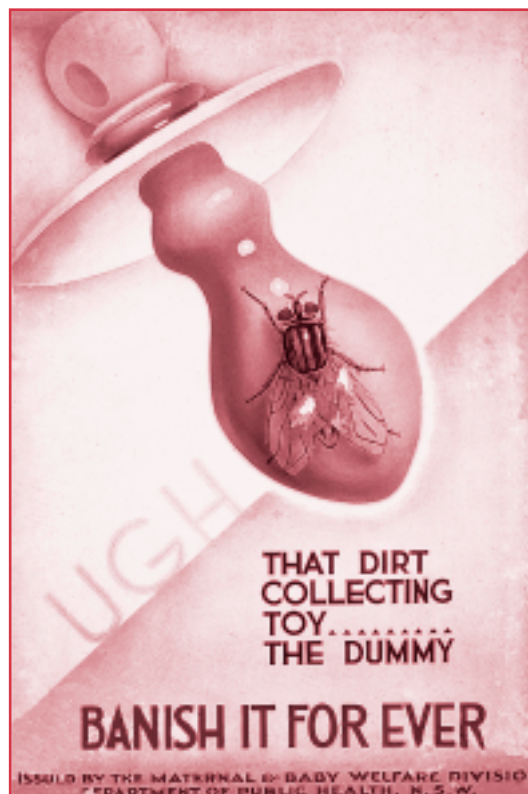
(viii) A representative of employees' organisations.

(ix) A representative of employers' organisations.”

The Institute should have authority to seek funds for research purposes and accept research grants from donor organisations. To consolidate this research function it should also be provided with Government funds for this purpose, and be given capacity to administer and distribute all research funds for specific research projects or research fellowships. It should be required to provide an Annual Report to the Minister, and it should have power to make by-laws relevant to its educational and research functions.

I would submit that the concept of an Institute of Health Science, as is outlined in this document, is a valid method of administration of the Scientific Divisions of the Department. I hope that it will receive your favourable consideration and support.

C.J. Cummins M.B., B.S., D.P.H., F.A.C.M.A  
Director-General of Public Health  
3 October 1969  
Under Secretary





**Royal Prince Alfred Hospital**  
Administration Driveway 1882



# Appendix 9

## State hospitals

A brief historical account of the function of each State hospital is given in this Appendix, under the same classification as in the text.

### State hospitals and homes

#### Liverpool State Hospital and Asylum

This was the oldest of the State hospitals, and its origin as a benevolent asylum to relieve the pressure on the Sydney Asylum has been dealt with in Part I. Until its closure it was comparable in size and facilities with Lidcombe State Hospital, admitting only males to the asylum component, but male and female to the hospital section which serviced the local community. Many of Sydney's foremost surgeons and physicians gave service to the hospital on an honorary basis, and it never had the same difficulty of other State hospitals in attracting qualified nurses to its staff. Three of its Medical Superintendents, Drs. Alexander Beatty, Donald Wallace and 'Cliffy' O'Brien were well known medical identities in the District. Unfortunately its main buildings were historic institutions, and quite unsuitable for extensive renovations. It closed in 1958 and its more modern facilities were retained as the nucleus of the District Hospital, to which Dr O'Brien was transferred as Medical Superintendent during his remaining years of service.

#### The Parramatta Homes

The Parramatta Homes were a triad of institutions comprising the George Street Asylum for men, the Macquarie Street Home for the Blind and Men Suffering from Defective Sight and Senility, and the Aged Couples Cottages.

The George Street Asylum for Aged and Infirm Men was established in the main building of the Military Hospital in 1862. Shortly after, the old tweed factory erected by J. and W. Byrnes on adjacent land was converted into a hospital section for frail and feeble

men. In 1880, on the Macquarie Street boundary, accommodation was provided for blind men and aged men suffering from defective vision and senility. There was a small number of cottages in the grounds which were utilised as domestic residences for indigent aged couples.

The Parramatta Homes were run as poorhouses and were never under direct medical control. The first Master and Matron were Mr and Mrs James Denis. The standard of accommodation and the impersonal administration by Denis were criticised severely by the Royal Commission into Public Charities of 1893. The Homes were neglected throughout the years until they were so dilapidated that the only solution was closure and demolition. This was effected in 1935 for the Macquarie Home and 1936 for the George Street Asylum. The old tweed mill had been demolished in 1920, since when hospital cases had been retained at Lidcombe. The inmates remaining in 1935 and 1936 were transferred to the Lidcombe State Hospital, and special wards were set aside for the blind which are still in service.

#### Newington State Hospital and Asylum

The Newington State Hospital and asylum was established in the Blaxland property on the banks of the Parramatta River in 1882 as a State asylum for women. It replaced the Hyde Park Barracks. Although it had hospital wards for very feeble or chronically ill aged women, it operated essentially as an asylum on the workhouse principle for destitute or aged women. A test of indigency was applied as a prerequisite for admission, and no charge was made other than deduction of a proportion of the social services pension. It was never a dynamic institution in terms of social rehabilitation. Demand for admission was diminishing during the 1950s, and it was closed as a State hospital in 1964. Its patients were dispersed among the other State hospitals.

## The Lidcombe Hospital

The Lidcombe Hospital, as it is known today, was initially the Rookwood Asylum for the Aged and Infirm, and then the Lidcombe State Hospital and Home. It was established in 1893 on 1340 acres bought by the Government in 1879 and originally intended as a boys reformatory. Cottage and dormitory accommodation and supporting services were completed in 1887 but remained unoccupied until 1893, when it was decided to use the premises as an asylum to relieve overcrowding at the Parramatta Asylum. In 1896 it was decided that the Rookwood Benevolent Asylum should be the main State asylum for men. It accommodated then a population of 581 persons. In 1899 it was further enlarged to permit indigent men of good health to be received into 'The Home Section', thus increasing its accommodation to 800. In the same year the original iron pre-fabricated St Stephen's Presbyterian Church was removed from the site now occupied by the Mitchell Library and re-erected at Lidcombe, where it was familiarly known to generations of staff and inmates as the iron church.

The Rookwood Asylum was placed under medical control in 1906 and its title changed to the Lidcombe State Hospital and Home. From this date the hospital component of the institution received increasing emphasis over the Home Section, which became largely an abode for derelicts and alcoholics, with a minority of aged persons seeking shelter. I remember well the 'under-age' musters when, periodically to relieve pressure on the accommodation, there would be a compulsory expulsion of all men under 45 years of age.

By 1913 clinical departments under visiting honorary doctors were established and the hospital wards divided into medical and surgical divisions, with other wards accommodating special medical categories, such as the blind and chronic neuro-muscular diseases. New hospital wards were erected after World War II, and also a major recreation hall and other facilities for rehabilitation, physiotherapy and occupational therapy.

Under Dr George Procopis as Medical Superintendent, its hospital and rehabilitation services were expanded, a nursing school was established, professional staff was increased, and the hospital was recognised as a prestigious geriatric hospital with emphasis on activity and rehabilitation therapy.

## Allandale Hospital

This is the only State hospital which was never under the control of the Director-General of Public Health. It was intended originally as a mental hospital and located at Cessnock to overcome a local problem of unemployment. Protests by the citizens were successful and its function changed to a geriatric institution to receive suitable patients from metropolitan mental hospitals. It opened in 1963 and operated under the Division of Establishments.

## State hospitals

### The Coast Hospital for General and Infectious Diseases

There is no need to elaborate on the history and development of the Coast (now the Prince Henry) Hospital. Its history has been fully researched and published by Dr C.R. Boughton,\* and the circumstances leading to its establishment have been detailed in Part I of this publication. It remained a State hospital until 1935 catering for general medical and surgical cases and as the major infectious diseases hospital. In that year it became a general hospital under its own Board of Management and was renamed the Prince Henry Hospital. Its support became a responsibility of the Hospitals Commission of NSW. It is now a major teaching unit of the University of NSW Medical School, and still the infectious diseases unit for NSW. Within its boundaries and staffed from it is the leper unit, which received special finance from Health Department funds until 1973. This was a continuing precedent from the days when the Lazaret was the responsibility of the Board of Health. The control of admissions and discharges remained with the Board of Health until the dissolution of the executive authority of the board upon the formation of the Health Commission.

\* BOUGHTON, C. R. A Coast Chronicle, N.S.W. H. Comm. Lib. 362.0991/B.

### David Berry (General) Hospital

The Berry family were the first white settlers in the South Coast in 1813. David Berry, one of the sons, had great faith personally in the future of this district and left most of his fortune for projects which he hoped would stimulate the growth and agricultural importance of the district. In his will, among other bequests he left £100,000 to provide a hospital at Berry for the Shoalhaven District. A small hospital was built on the river flats at Berry but was unable to attract sufficient income to remain usable. After negotiations with the Government, in 1906 the *David Berry Hospital Act* was passed. The trustees of the David Berry Hospital handed over 88 acres at Berry's Bay North Sydney, in return for which the Government of NSW agreed to provide and maintain in perpetuity a hospital at Berry. So came to be built the David Berry Hospital of 26 beds in 1909 on high land and replacing the smaller previous hospital.

It has been a hard bargain for the Government. The population is too small to support a general hospital in competition with the larger and well endowed hospital at Nowra some 20 kilometres away. The inhabitants of the town and surroundings of Berry regard the hospital as a free endowment irrespective of their means. The Chief Executive Officer is the Matron, and the doctor at Berry is subsidised as a part-time medical superintendent with exclusive rights to the hospital. Surprisingly it has usually attracted a responsible surgically orientated doctor whose reputation has been a source of embarrassment to the neighbouring doctors. I remember when one such doctor had difficulty in obtaining assistance for operations and especially anaesthesia. The Matron was taught to give ether anaesthesia as also was the gardener. The latter became particularly adept and surreptitiously his services were often sought by the doctors in Nowra. The hospital is unable to compete with the Shoalhaven District Hospital and is an anachronism from which the Government would like to be relieved. It was the most expensive of the State hospitals because of poor utilisation.



**Prince Henry Hospital  
(formerly The Coast Hospital)**  
Polio Ward 1950's

### Lady Edeline Home for Sick Babies, 'Greycliffe' Vaucluse

This home owed its existence to the initiative of the Hon. Frederick Flowers, M.L.A., the first Minister of Health. The Government had resumed the property Greycliffe at Vaucluse, originally the home of Mr Fitzwilliam Wentworth. The residence was easily converted to a hospital for sick young babies especially for the treatment of infantile gastroenteritis. It was opened by the Premier, the Hon. W.A. Holman, on 19 November 1913, and was conducted under a Board of Directors headed by the Minister's wife as President, and the Premier's wife as Vice-President. The Chairman of the Board of Directors was the Director-General Robert T. Paton with a staff of visiting honorary medical specialists.

The institution was maintained by the Department of Public Health. It had provision for 30 cots and was well needed, treating up to 300 babies annually with a mortality rate of approximately 16 per cent. Although the emphasis was on gastroenteritis, sick babies with other serious medical conditions were admitted. It was controlled by a Matron with a staff of nurses and included a training school for nurses in conjunction with the Coast Hospital. It was used to

receive influenza cases from the 1919 pandemic. Its function was taken over in 1935 by the Renwick Hospital for Babies in 1935 and the premises were leased to become the Karitane Mothercraft Home.

### Montrose Maternity Hospital Burwood

This maternity hospital was opened on 17 January 1920, to provide obstetric facilities for a special group of women, many unmarried, who were socially or economically bereft and unable or unwilling to afford obstetric care. It operated in conjunction with the Fernleigh Rest Home, although not exclusively so, and there was a free interchange of patients to and fro.

It had a resident staff of a matron, two double certificated nurses and five obstetric trainees. Accommodation was provided for sixteen maternity cases in three wards, and it was used to capacity with a yearly case load varying from 100 to 150 confinements. It was recognised as an obstetric training school for general trained nurses, and its confinements were conducted by the nursing staff with assistance when necessary from a visiting medical staff of five obstetricians. It became redundant as additional obstetric beds became available in the metropolitan hospitals, and it closed on 12 May 1930, the premises being transferred to the Child Welfare Department.

## Convalescent homes

### Denistone House Eastwood

Denistone House Eastwood was a convalescent home for males established as the complementary unit to Carrara Convalescent Home for Women. The property was purchased by the Government in 1913 and formally opened by the Premier, the Hon. W.A. Holman on 25 February 1915. It had commenced to receive patients from August 1914. It provided accommodation for 25 patients, and was staffed by a Matron, one female nurse and four male attendants. Its closure was effected in 1933 when the patients were transferred to the recently completed male unit at Carrara. The site was utilised for the construction of the Ryde District General Hospital.

### Carrara (Strickland) Convalescent Home

Carrara or Strickland Convalescent Home is still functioning and is located on some twenty-one acres adjoining Vacluse Road, Vacluse, in perhaps the most desirable residential area of Sydney. The land was an original grant to W.C. Wentworth in 1838, and passed through several hands before being purchased by the first Lord Mayor of Sydney. He erected the mansion 'Carrara', so named after the Italian town from where the marble was imported or its elaborate fireplaces and the two large carved dogs adjoining its entrance. In June 1913, it was purchased by the Government from the Gavan family and converted into the Carrara (Strickland) Convalescent Home for Women. It commenced operation in January 1915.

It operated under a Matron and two to four nurses, providing accommodation for 25 women with a small number of costs. It received patients largely from the Sydney general hospitals, but in addition would accept women and girls suffering from overwork and worry, who needed rest, good food and temporary oblivion from the cares and stresses of living. There was one ward for delicate mothers with babies in arms.

From 1933 for a short period it accommodated males after the closure of Denistone House. The male dormitory block was built at the furthest end of the grounds from Carrara House and conducted as though it was a separate institution, with its own domestic facilities and male attendant staff. It still operates for females only, the male dormitories now accommodating more active females, many of whom are mildly mentally defective and socially unable to adapt to the strain of daily living outside the institution. It is a long-term convalescent home providing an alternative to what was the 'Home' section of Newington State Hospital before its closure.

### Fernleigh Rest Home (Pre and Post-maternity) Ashfield

This institution was formerly the residence of Mr W. Ducker, from whom the Government purchased the property in 1919. The rest home was opened in January 1920, and was really an auxiliary unit to Montrose Maternity Hospital. Its name aptly describes its function and 'it catered for the poorer mothers from the crowded suburban areas'. It did provide the opportunity for pregnant mothers in distressed circumstances or with large families to have a period of rest and recuperation before returning to the stresses of their environment. It closed in January 1930, as a preliminary to the closing of Montrose Maternity Hospital, and the premises were sold to the Freemasons to establish the Masonic Hospital Ashfield, still one of the superior private hospitals.

## Tuberculosis sanatoria

### Waterfall Sanatorium for Consumptives (Garrawarra Hospital)

In 1907, 800 acres at Waterfall was set aside for reception of incurable consumptives. The site was chosen because it was the most elevated area in the country of Cumberland, an attitude then being considered important in the treatment of tuberculosis. The sanatorium was built to accommodate 500 patients, roughly in equal proportions male and female, and received its first patients from the Coast and metropolitan hospitals in 1911. It was a sanatorium for advanced and incurable tuberculosis until the 1950s, when therapeutic drugs were more effective and earlier and curable cases were admitted. There was a long waiting list and admission was in rotation by applicant, many patients dying before their turn was reached. By the mid 1950s facilities for tuberculosis were improved dramatically in the State by the anti-tuberculosis programme, and treatment became very effective as cases were discovered earlier in a responsive phase. Demand for accommodation fell dramatically and in 1958 it became a hospital for the aged who were chronically ill – similar but less dynamic in concept to Lidcombe State Hospital. Its name was changed to Garrawarra Hospital to obliterate its gruesome reputation of the past. It continues as a large nursing home for geriatric patients, and it has been overshadowed by Lidcombe Hospital. Because of the type of patient it never received the same support as Lidcombe in staff or facilities despite the protests of the late 'Nick' Wright, a Medical Superintendent of high ideals whose constant battle was for the welfare of his patients.



**Garrawarra Hospital**  
Waterfall – Wards 9 to 12 1950's

### Randwick Auxiliary Hospital (Randwick Chest Hospital)

The Randwick Chest Hospital stands in grounds adjacent to the Prince of Wales Hospital, which now occupies several of its wards. It commenced as the Randwick Auxiliary Hospital in 1919 when the Repatriation Department transferred its temporary V.D. Wards to the Coast Hospital. It became an auxiliary unit of the Coast Hospital in which the tuberculosis patients were lodged. In 1935, after the Coast Hospital ceased to be a State Hospital and became the Prince Henry Hospital, the Randwick Auxiliary Hospital remained as a State institution receiving chronic tuberculosis patients from the Department waiting list and also from the voluntary agencies. Its reputation and status changed dramatically after Dr Bruce Fry was appointed full-time medical superintendent.

During the period 1950 to 1960 it began to specialise in surgical treatment of tuberculosis due to the efforts of Dr M. Sussman, a pioneer thoracic surgeon, and later Dr Harry Windsor. It received patients for surgical therapy from Waterfall Sanatorium and other sanatoria such as the Queen Victoria Homes. One of its medical staff, Dr F. Ross,

who was to become medical superintendent in 1968, succeeding Dr A.L. Waddington, was trained through the Department at Brompton Hospital in thoracic surgery, and continued its specialised identity as resident surgeon until his retirement in 1972. It attracted well qualified visiting and resident staff and was the first unit to establish a specialised course in tuberculosis nursing. Due to the success of the tuberculosis campaign, and a change in emphasis from surgical intervention to expectant treatment, its importance in the programme diminished, and again it receives largely the more chronic type of patient.



**State Health Ministers  
begin Sydney Conference**  
Legislative Council Chambers 1950's

# Appendix 10

## Comments of the Board of Health of NSW on Community Health Services

### 1. The Eglinton Report

This report proposes a mechanism of administration for the health services of NSW which is cumbersome and confusing. It is often contradictory of its own proposals and this may reflect its interim status. Mr Eglinton is himself apologetic in paragraphs (iii) and (iv) of his preface, and again in his summary where he states 'while the outline of the Community Health Service appears in the foregoing pages it cannot be said that a complete set of *internally consistent* recommendations have been made'. It is surprising, in view of Eglinton's own reservations, that it should have received the endorsement of the Administrative Research Committee of the Public Service Board Consultant and Research Division.

In the document available to the Board of Health it does not appear that this report and its recommendations are based on a properly structured survey and audit of existing services. It avoids absolute values and rests upon the imagination and judgment of one individual. There is no evidence advanced as to the nature and extent of the deficiencies at present existing. In the absence of such evidence it is hard to reconcile an approach which is destructive of tradition and discriminatory against agencies other than a health ministry, which contribute substantially to health and welfare services to the economic advantage of Government. Such an approach may well impose upon Government liabilities which would strain its resources, and impede rather than accelerate progression towards a more adequate community health service.

As there is no evidence that such a reorganisation is necessary, if it is applied 'in toto' to the economic, social and medical climates of this State, it could create a situation of crisis, resentment and insecurity among the community and the agencies which it

seeks to involve. Even more fundamentally the document diminishes the responsibility of local government as a valid and continuing instrument in community health, arising from and servicing the community, and responsive to community demands and needs. It offers a monolithic alternative, which although regionalised, has loyalty to a central bureaucracy. This is the essence of the criticism which is so frequently levelled against the English system under its *National Health Act*, on which the pattern of this report is based. It is hard to define the role of the local authority in this report but it would seem to be limited to certain statutory and mechanical aspects of health administration and remote from personal health and welfare services.

The document is centred around a concept of a Ministry of Health and implies that the form proposed is the only and valid alternative to the system now operating. Although allegedly preaching decentralisation of function it is in fact a system of centralisation of authority. It introduces the concept of a powerful bureaucracy at the level of central government, thereby creating a mechanism, self-centred and remote from the community. This appears to be recognised by the author who advances the proposition of an ombudsman – certainly a situation which must be unique in health administration throughout the world. It is a dubious honour to thrust upon NSW that it should become the pioneer in this regard.

The propositions advanced for such a drastic reorganisation could well result in widespread antagonism and resistance, as is usually the case when empiricism replaces logic. There are no alternatives to which withdrawal could be made to avoid recurrent crises and allay suspicions and fears. Medical administration must proceed in an orderly and structured progression towards its goal and should at each step involve those to which its objectives are directed. Each stage should be

consolidated and assessed, with latitude for modification in light of appraisal. A recent American editorial in *Modern Medicine of America* criticising the National Commission on Community Health Services supports this dogma of slow and orderly progression:

“Too many of these broadly conceived national commissions do not produce a true plan, but rather a wish. It is the slow, carefully argued, specific change based on old and new philosophies that finally wins the day. It know this sounds tiresome to those who want to sweep the landscape clean. But I fear responsibility for human life and health is much too complicated for that. Rather, let us make haste slowly and try to foresee some of the results before we take irreversible steps.”

This comment is applicable to the *Eglington Report*.

The Board of Health does not intend to comment specifically on the structure of the organisation proposed and the recommendations included in the *Eglington Report*. It suggests to the committee that it should reject this report and substitute therefore the report advanced by the Board of Health, which is attached to this comment. The recommendations of the Board's report are included in the third section of this document.

One additional and cogent reason for adopting the Board of Health's proposals as the basis for the present and future principles of administration of health services is that the trends predicted are in consonance with attitudes in other States and the Commonwealth. The forces which will condition the pace whereby these trends are implemented will vary from State to State according to the needs and resources of each State. Not the least of these influences is the attitude and reaction of the medical profession. There is reason to believe that it would co-operate with an orderly progression towards a community health service. Its attitude to the *Eglington Report* is not predictable as its role and influence do not receive more than passing comment in that report.

## 2. The Board of Health

The Board of Health was established in May 1881, as a consequence of the panic arising from the smallpox epidemic of that year. Initially it was a Board of Advice and was later consolidated as a statutory authority in the *Infectious Diseases Supervision Act*, December 1881. The constitution of the board and its powers generally in public health we're defined in the *Public Health Act of 1896*.

At this stage the Board of Health's functions were both administrative and executive. So important was its role that it was responsible to the Colonial Treasurer for its administration. It absorbed those aspects of medical administration which had a statutory basis. The Medical Adviser (then the equivalent of the present title of Director-General of Public Health) was its President.

It supervised the administration of the *Dairies Supervision Act 1886*, the *Noxious Trades and Cattle Slaughtering Act 1894*, and the *Public Health Act 1896*. It was the executive authority employing its own staff, under the *Quarantine Act*, the *Abattoir Act 1850*, the *Infectious Disease (Smallpox) Supervision Act 1881*, the *Leprosy Act 1890* and the *Diseased Animals and Meat Act 1892*. It controlled the quarantine stations at Sydney and Newcastle, the Glebe Island Abattoir, the Lazaret (Coast Hospital) and the microbiological and pathological laboratories.

One of its most important functions was to advise the Treasurer and the Colonial Secretary on health matters generally. It continued in this role until 1913 when Paton was appointed to succeed Thompson as the first Director-General of Public Health. It was transferred to the new Ministry of Health created within the portfolio of the Chief Secretary, and its service functions were absorbed within the organisation of the Medical Department. Its function after this transition period is described in the report of the Director-General of Public Health for the year 1923:



“The functions of the board are administrative and executive under several statutes: *Public Health Acts, Dairies Supervision Act, Private Hospitals Act, Noxious Trades Act, Cattle Slaughtering and Diseased Animals and Meat Act*. It discharges important advisory duties towards the Minister for Public Health and the Government and it exercises supervision over the manner in which local authorities carry on their public health functions. Except indirectly through its President, the Board of Health has no control over officers of the Department.”

This description well fits the functions of the Board of Health in the administration of health in NSW today with the substitution of other Acts than those nominated in 1923. The Board of Health in 1968 has executive and administrative functions under the following Acts – a considerable extension of the scope and principles of its role:

*Public Health Act 1902, as amended*  
*Pure Food Act 1908, as amended*  
*Private Hospitals Act 1908, as amended*  
*Noxious Trades Act 1902, as amended*  
*Fluoridation of Public Water Supplies Act 1957*  
*Local Government Act and Ordinances 1919-1967*  
*Medical Practitioners Act 1938-1964.*

The board submits that it has fulfilled and still continues to fulfil a key role in the administration of public health in NSW. Never since its inception has it been alleged that it has failed in its duty and its public and official image is untarnished. A threat to call in or report to ‘the Board of Health’ is well appreciated by members of the general public and usually sufficient in itself to rectify a situation of disadvantage to the public health.

It has served loyally all Governments and never reflected political opinions or philosophies in its decisions and actions. Its members have always displayed a personal dedication and loyalty to it, which has enabled it on many occasions, in the interest of public welfare, to resist pressures to modify its opinion or action.

Because of its composition (a mixture of professional and non-professional appointments in which neither predominates) it is a community instrument receptive to community opinion and needs. As a result its decisions are acceptable to government and populace alike. Its present composition reflects the variety of interests which are implicated in or involved in health administration and its implementation:

The Director-General of Public Health – President (ex-officio).

A member of the City Council of Sydney, representing the Lord Mayor (at present one of the Commissioners representing the Chief Commissioner)

The Director of State Health Services of the Department of Public Health.

The Professor of Public Health and Preventive Medicine of the University of Sydney

A medical member of the Hospitals Commission of NSW. A medical practitioner nominated by the Australian Medical Association (NSW Branch)

The Lord Mayor of Newcastle.

An Alderman of the Newcastle City Council who is also a member of the executive of the Local Government Association

A prominent businessman representing commercial interests

A prominent woman representing the general community and especially the female sector of it.

A very large segment, and possibly the most important, of the present organisation of the Department of Public Health is built around the functions of the Board of Health. It is indeed mystifying, if not incredible, that this board, which has for so long proved the test of its capacity and value, should be arbitrarily excluded from the reorganisation advanced in the Eglington Report. This could not be an omission. If so the whole of the report is immediately negated by an error of this magnitude. It must be assumed to be a deliberate act, and one which cannot be justified in any proposal which purports to embrace community health and community health services.

The board submits that in any recommendations by the committee on Community Health Services to the Minister the board's position in health administration be not disturbed, and this proposal is implicit in its own scheme. It is a community instrument with a store of tradition and experience which is invaluable in community service and which could not easily be replaced by a substitute without grave disadvantage to the supervision of the health of NSW.

### 3. The plan of the Board of Health for reorganisation of health services

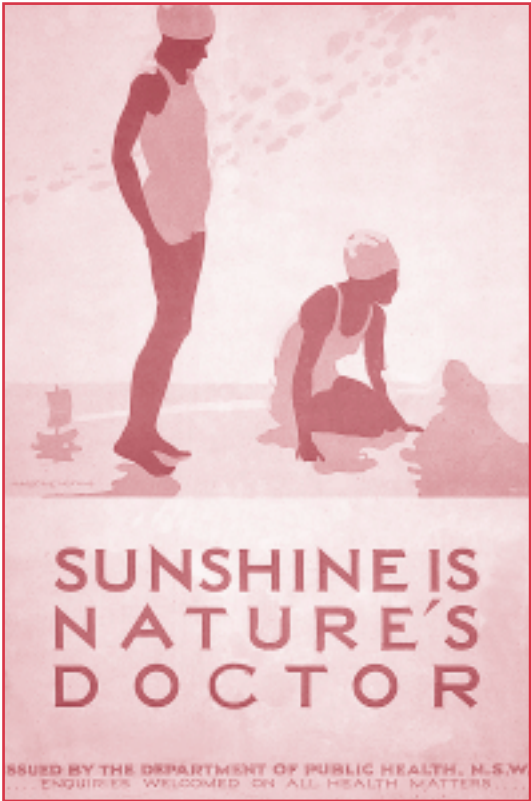
A plan for the reorganisation of health services and administration in NSW towards a greater emphasis and participation in community health is appended hereto. The board submits that it provides an orderly progression to this objective without disrupting those services and instruments of administration, which have proved of value and which would continue to function effectively in the future. By its plan crisis would be avoided; bureaucracy diminished; community participation enhanced; effective regionalisation ensured; co-ordination structured without strain and phasing accomplished within the economic resources of government without interference with other essential services.

A summary of the recommendations of the board's report is as follows:

Although great advances have been made in all branches of medicine resulting in an improvement in the health of the community, there are still many medical and health problems requiring attention. Many matters require action by government, the most important of them being:

- (1) The establishment of an integrated public health service in order to permit the highest degree of co-ordination between its various components of the service.
- (2) Closer association of general practitioners with public hospitals.

- (3) The acceptance of the concept of a general practice team, consisting of the general practitioner; public health nurse and domiciliary nurse, and its implementation.
- (4) An improved form of training for the general practitioner.
- (5) The Medical Board of NSW to be responsible for providing a common curriculum for the medical schools of this State.
- (6) The adoption of measures which will assist the country general practitioner.
- (7) Greater availability of specialists to country areas.
- (8) The training of para-medical personnel to become the responsibility of appropriate statutory authorities, where this is not already provided.
- (9) The expansion of hospitals or groups of hospitals into balanced hospital communities.
- (10) Public hospitals to accept the responsibility for the provision of certain community health services.
- (11) Ambulance transport to be provided for public hospitals
- (12) The division of the Metropolitan Health District into a number of smaller health districts.
- (13) Security of office to be provided by the Board of Health for Chief Health Inspectors of local authorities.





**Newcastle Mater Misericordiae Hospital**

Student midwife with a new arrival at the nursery 1940's

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23. *Ibid*: 247, Government and general order.
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25. Vide 20.
26. *H.R. NSW*, Vol. VI:330, Surgeon Jamison to Viscount Castlereagh.
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151. The Administrative Research Committee of the Public Service Board comprised:  
Professor J.F. Clark, Pro-Vice Chancellor of the University of NSW. Professor R.N. Spann, Professor of Government, University of Sydney. Mr S.C. Derwent, Director of the Institute of Administration in the University of NSW. Professor D. Thomson, Associate Professor of Industrial Law, in the Law School of the University of Sydney.  
The Committee approved research projects from the Consultant and Research Division.
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